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Complex Humanitarian Emergencies

Abstract

Komplexe humanitäre Notfälle (complex humanitarian emergency, kurz CHE) stellen in Bezug auf Public Health schwere Ausnahmesituationen dar. Die Sterblichkeitsrate kann aufgrund einer Kombination aus Krankheit, Unterernährung und gewaltbedingte Traumata bis auf das 60-fache des durchschnittlichen Wertes ansteigen. Gegenwärtig sind CHEs für mehr Todesopfer, Krankheiten und Körperbehinderungen verantwortlich als alle anderen Arten von Katastrophen zusammen. Derzeit protokollierte Statistiken zu Katastrophenfällen stellen mit großer Wahrscheinlichkeit eine Unterbewertung des wahren Ausmaßes von durch aktuelle humanitäre Notfälle hervorgerufenen Problemen dar. Eine in der Demokratischen Republik Kongo durchgeführte Studie des Internationalen Rettungskomitees (International Rescue Committee, IRC) zeigte, dass zwischen Januar 2003 und April 2004 über 600.000 zusätzliche Todesfälle allein auf den Krieg zurückzuführen waren. Diese Zahlen veranschaulichen, dass weltweit kein Konflikt seit dem 2. Weltkrieg und kein einziger Krieg in der Geschichte Afrikas so viele Todesopfer gefordert hat wie dieser.

Durch den Zusammenbruch der lokalen Gesundheitssysteme und medizinischen Einrichtungen wird die effiziente ärztliche Versorgung der Betroffenen beträchtlich

erschwert. Es ist deshalb unbedingt erforderlich, dass internationale humanitäre Hilfsorganisationen die Professionalisierung der Katastrophenhilfe weiter vorantreiben. Durch eine Verbesserung der Ernährungssicherheit und einen erleichterten Zugang zu grundlegender medizinischer Versorgung in komplexen humanitären Notfällen kann eine deutliche Reduktion der überhöhten Sterblichkeit erzielt werden.

In the jargon of disaster management, the term "complex humanitarian emergency" (CHE) is relatively new. It was first introduced during the early 1990's to describe humanitarian crises that are characterised by political instability, armed conflict, large population displacements, food shortages, social disruption, and collapse of public health infrastructure (1,2,3). Recent examples include the crises in Afghanistan, Darfur, Bosnia, Rwanda, Kosovo, the Democratic Republic of Congo (DRC), and East Timor.

According to the International Federation of the Red Cross and Red Crescent Societies, between 1994 and 1998 reported disasters averaged 428 per year, while from 1999 to 2003 this figure shot up by two-thirds to an average 707 disasters each year. The biggest rise was in non-developed countries, which suffered an increase of 142 per cent. Based on United Nations definitions, more than 310 million people live in countries that are currently experiencing CHEs. These crises are distributed widely over 4 continents, with only Australia and North America being free of the direct impact of these emergencies.

For the health professional, CHEs represent true public health catastrophes (1). Mortality rates may be up to 60 times higher than normal, due to a combination of disease, malnutrition, and violent trauma (1,4, 5). Importantly, CHEs currently result in more death, disease and disability than all other types of disasters combined (3, 6). Most health professionals will be familiar with the health consequences of natural disasters, technological disasters and major vehicular crashes. Few, however, have had the experience or training to address the medical and public health needs associated with CHEs.

Context and Characteristics of CHEs

It is indeed difficult to separate the enormous public health needs associated with CHEs from the political, social, economic, and historical settings in which they develop. Current CHEs are increasingly characterised by intrastate identity conflicts, more commonly recognised as civil wars occurring within the borders of sovereign states, though their effects often spill over into neighbouring states. This has frequently presented difficulties for the international community in providing humanitarian assistance to affected populations, especially if the national government has failed to address the insecurity or cooperate with the relief effort. During recent crises in places such as Darfur, Chechnya, Kosovo, DRC, and East and West Timor, for example, sovereign governments significantly restricted the access that humanitarian agencies had to

populations in need. Had straightforward and coordinated public health efforts been possible, the majority of the deaths in these CHEs could have been averted.

The present-day Democratic Republic of Congo serves as an example of such a highly insecure and restricted environment where crude mortality rates are much higher than the reported baseline for sub-Saharan Africa, and where the lack of humanitarian services leaves much of the population without essential health care services. A recent study by the International Rescue Committee (IRC) in the DRC demonstrated that between January 2003 and April 2004, over 600,000 excess deaths occurred due to the war. This is equivalent to almost 38,000 lives lost every month and more than 1,200 deaths every day as a result of the conflict (7). When combined with the results of the three previous IRC surveys, it is estimated that approximately 3.9 million people have died as a result of the conflict in the DRC between August 1998 and April 2004.

Another key finding of the IRC survey is that the overwhelming majority of deaths were due to preventable causes such as malnutrition and infectious diseases. Some epidemic diseases, like measles, even appear to be on the increase. Moreover, it is young children who are disproportionately affected by these illnesses.

Increased rates of infectious diseases during CHEs can be largely attributed to mass population displacements, bringing with them, the associated problems of poor water supplies, inadequate sanitation, overcrowding, malnutrition, disruption of public health programs, and limited access to basic health care. Improving food security and increasing access to essential health services, such as immunisations, clean water, insecticide-treated bed nets and case management of common diseases, have the potential to help significantly reduce excess mortality. Most of the deaths recorded in the DRC study could have been averted by such relatively straightforward public health interventions.

Despite the increased number of disasters, average annual death tolls have reportedly dropped from over 75,000 per year (1994 to 1998) to 59,000 per year (1999 to 2003). These published figures are, however, almost certainly an underestimate of the true scale of the problem and should be re-evaluated in light of the results from the most recent mortality surveys being conducted amidst CHEs. IRC's surveys in the DRC demonstrate that the Congolese conflict is by far the deadliest war in the world since World War II and the deadliest ever recorded in Africa. Though critical, it should be noted that collecting accurate health statistics in the setting of CHEs is often extremely difficult because of lack of security, lack of access to affected populations and the collapse of health systems. The true scale of death due to violence and disease in places such as Sierra Leone, Angola, Sudan, Chechnya and Afghanistan is almost impossible to determine accurately.

Conclusion

Complex humanitarian emergencies in Africa, Asia, and Eastern Europe have become increasingly commonplace over the past two decades. The health consequences of CHEs can be catastrophic, with high rates of infectious diseases, malnutrition, and trauma frequently documented. More deaths occur due to CHEs on an annual basis than due to all other types of disasters combined. The collapse of local public health and medical systems further exacerbate the problems of providing effective health care to affected populations. Priority health interventions during CHEs are based on the models of public health and primary health care, with particular emphasis given to disease prevention and health promotion. It is inevitable that international relief agencies will be forced to become increasingly professionalised in order to more effectively address these major global health challenges.

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