Disaster Preparedness and Response: An all hazards approach

Requirements for teams that prepare and respond to global disasters

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Center of Global Health
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THE FUTURE OF DISASTERS: TODAY – 2020s*

• Unconventional **wars**

• Rapid unsustainable **urbanization** dominates excess mortality

• Increased frequency of major weather related disasters and climate change **migration**

• Increased threat of **nuclear events**

*Burkle FM, Future Humanitarian Crises, PDM, 2010*
Natural disaster summary 1900 – 2010 (linear–interpolated smoothed lines)

Year

Number of people reported killed

Number of disasters reported

Estimates are from the Office of the United Nations High Commissioner for Refugees (UNHCR), the U.S. Committee for Refugees and Immigrants (USCRI), and the Internal Displacement Monitoring Centre (IDMC).
THE PROBLEM*

- “Unacceptable practices” & questions about clinical competencies of some Foreign Medical Teams (FMTs)

- Current FMT guidelines “limited in scope”

- Need for “greater accountability, stringent oversight, better coordination”

THE PROBLEM*

- Procedures being performed by incompetent providers: total lack of coordination

- 40% of amputations NOT indicated

- No data documentation: essentially did not know who received care, who did not, of what quality, outcome and follow-up

Disaster Response: Gateway Drug

Figure 1: The CHE Mortality Cycle

Crude Mortality Rate

Emergency Phase: CARE Team response. Clients will include Governmental agencies, NGO’s, IGO’s, and Military,

Transitional Phase

Post-emergency/Development Phase

Baseline

Time in Months

12

Figure 1: The CHE Mortality Cycle
International Standards and Best Practices
Actors in Humanitarian Assistance

- Militaries and belligerents
- Beneficiaries
- NGOs and CBOs
- UN bodies
- Governments
- ICRC
- Funding agencies - “Donors”
- Academic institutions
# Humanitarian Principles

<table>
<thead>
<tr>
<th><strong>Humanity</strong></th>
<th>Assistance is provided without discrimination to prevent and alleviate suffering, to protect life and health and ensure respect for the human being</th>
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</thead>
<tbody>
<tr>
<td><strong>Universality</strong></td>
<td>All victims of conflict, disaster or calamity are worthy of assistance and protection, irregardless of borders or sovereignty</td>
</tr>
<tr>
<td><strong>Impartiality</strong>*</td>
<td>Assistance and protection are due to all victims and is given strictly and proportionately according to the need and priority is given to the most urgent cases</td>
</tr>
</tbody>
</table>
### Humanitarian Principles

<table>
<thead>
<tr>
<th><strong>Neutrality</strong>*</th>
<th>Humanitarian actors do not take sides and must stand apart from the political issues at stake unless the treatment of humans is egregious</th>
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<tr>
<td><strong>Independence</strong>*</td>
<td>Humanitarian actors remain independent of political or other affiliations whose interests, past actions and policies may impinge on universality and impartiality</td>
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<tr>
<td><strong>Voluntary Service</strong></td>
<td>Relief is provided on a voluntary basis and not prompted in any manner by desire for personal, political or financial gain</td>
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Ethical Dilemmas in the Field
Valdine
The Numbers since January 12

- 350 beds
- > 5000 patients and their families
- 2 amputations
- 1 Birth, 2 deaths
- 700 volunteers from 15 countries
- 270,000 meals
- 125 Haitian staff
- $30,000/month for operations
Do No Harm

Context of Conflict

Options | Dividers/Tensions | Assistance | Connectors/LCPs | Options
--- | --- | --- | --- | ---
Systems & Institutions | Attitudes & Actions | Values & Interests | Experiences | Symbols & Occasions
Mandate | Fundraising/Donors | HQ Organization | Systems & Institutions | Attitudes & Actions
Whom? | How? | Experiences | Symbols & Occasions
Redesign

Resources Transfers / Implicit Ethical Messages

Revised 2004. Substantially similar to the 1999 version in Do No Harm

http://www.cdainc.com

LCP: Local Capacities for Peace
Accountability & Legitimacy

Legitimacy

as the people
With the people
about the people
Professional standards
Business standards

Victims, Victims representatives, Donor states, popular supporters, internal staff

Accountability
Humanitarian Ethics

- “Something is better than nothing”?
- Codes of Conduct
- Ethical Dilemmas in the Field
- Research Ethics
## Which Principles?

<table>
<thead>
<tr>
<th>Humanitarian</th>
<th>Medical Ethics</th>
<th>Public Health</th>
</tr>
</thead>
<tbody>
<tr>
<td>Accountability</td>
<td>Autonomy</td>
<td>Effectiveness</td>
</tr>
<tr>
<td>Competence</td>
<td>Fidelity</td>
<td>Proportionality</td>
</tr>
<tr>
<td>Appropriateness</td>
<td>Beneficence</td>
<td>Necessity</td>
</tr>
<tr>
<td>Respect for culture</td>
<td>Non-maleficence</td>
<td>Least infringement</td>
</tr>
<tr>
<td>Participation</td>
<td>Justice</td>
<td>Public justification</td>
</tr>
<tr>
<td>Solidarity</td>
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Childress 2002
THE SOLUTION: 2 STEP PROCESS

1. Internal quality improvement of services & standards of performance of Foreign Medical Teams (FMTs)

2. Professionalize the education, training & certification of humanitarian providers & accreditation of their academic training centers & trainers

Frederick M. Burkle, Davos January 2012
This lack of sufficient and qualified Health Care Workers (HCWs)

1. Limited HCW staff prior to the outbreak

2. Disproportionate illness and death among HCWs caused by EVD directly

3. Valid concerns about personal safety among international HCWs who are considering responding to the affected areas.
### Numbers of HCWs/1000 in EVD
Affected West Africa

<table>
<thead>
<tr>
<th>Country</th>
<th>MD/1000 (latest available year)</th>
<th>Nursing and Midwifery Personnel/1000 (latest available year)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nigeria</td>
<td>0.408 (2009)</td>
<td>1.605 (2008)</td>
</tr>
<tr>
<td>Senegal</td>
<td>0.059 (2008)</td>
<td>0.42 (2008)</td>
</tr>
<tr>
<td>Guinea</td>
<td>0.1 (2005)</td>
<td>0.511 (2004)</td>
</tr>
<tr>
<td>Liberia</td>
<td>0.04 (2008)</td>
<td>0.274 (2008)</td>
</tr>
<tr>
<td>Sierra Leone</td>
<td>0.022 (2010)</td>
<td>0.166 (2010)</td>
</tr>
<tr>
<td>Mali</td>
<td>0.083 (2010)</td>
<td>0.43 (2010)</td>
</tr>
</tbody>
</table>

MD = Medical Doctor

The critical threshold for resource poor settings is 2.3 doctors, nurses and midwives per 1000 population [http://www.who.int/hrh/workforce_mdgs/en/](http://www.who.int/hrh/workforce_mdgs/en/)
HCW and Crude Fatality Rates (CFR)

- CFR of HCWs = 59% (488 deaths/ 830 cases of recorded Ebola illnesses)

- CFR of population= 40% (9380 deaths/23253 cases overall).
HCW and Crude Fatality Rates (CFR)

CFR is calculated by dividing the number of deaths that have occurred due to a certain condition by the total number of cases - but the outbreak in West Africa is still ongoing, so the proportion of fatal cases, PFC, is what is calculated, and often reported, and that is the number of deaths thus far divided by the number of cases to date.
WHY?

- excessively long hours
- inadequate working conditions especially in poorer clinics that may have increased the chances for greater exposure to and inoculation with the virus,
- lack of access to simple personal protective equipment like gloves and masks, minimal medical supplies, lack of appropriate medications or isolation facilities
- insufficient education and training in standard infection, protection and control measures.
Individual and Institutional Risk

- to personal health and safety while deployed,
- potential risks to the patients cared for at home after deployment
- costs that will and may be incurred, continuity of staffing at home while an individual is deployed overseas
- the credibility and capabilities of the organizations with whom they will deploy overseas
- unique social and political considerations that may become relevant for the individual and/or the organization
Individual and Institutional Risk

- informed decisions on their readiness for deployment
- restrictions on institutional trainees
- negotiating leave provisions and staffing coverage
- supporting gaps in medical and benefit coverage
- mitigating impacts on and concerns of other staff
- Limitations in assisting the individual while on deployment
- post-deployment health screening and monitoring.
Personal Readiness

- Professional Health Care Worker in current practice
- Knowledge, skills and experiences
- Clinical competencies required for their expected role in context of disaster and crisis
- Personal capacities for coping with the stressors, unfamiliar environments, and basic living conditions likely to be faced on deployment
Trainees and Exceptions

- lack of necessary supervision in such contexts
- lack of full medical licensing to practice independently
- limits on liability protection from their insurance carriers
- Professionalism and protection of trainees and beneficiaries
CLASSIFICATION AND MINIMUM STANDARDS FOR FOREIGN MEDICAL TEAMS IN SUDDEN ONSET DISASTERS
TO ALL INTERNATIONAL HEALTH VOLUNTEERS:

- COMMAND CENTER FOR HEALTH OPERATIONS IS AT THE CENTER FOR HEALTH DEVELOPMENT CENTRAL VISAYAS, LOCATED AT OSMEÑA BOULEVARD, CEBU CITY (NEAR FUENTE OSMEÑA CIRCLE)

  TEL. NO. (032) 418-7636

- PLEASE COORDINATE WITH DOH-COMMAND CENTER WHILE IN CEBU

- OPEN FOR 24 HRS.

THANK YOU.
Be flexible

- Offer to help even when it’s not ‘your job’
- Expect minute-by-minute changes
- Accept your lack of control
- Keep an open mind
Future of disaster response at academic institutions

- General Roster of trained, credentialed, accredited professionals
- Trainings and preparedness
- Partnerships

Roxas City, Philippines
THANK YOU!!

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