Viewpoint

Stop propagating disaster myths

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The international response to the tragic earthquake in Turkey, the recent cyclone in India, and other natural disasters such as the floods in Venezuela highlights the need to reassess the myths and realities surrounding disasters, and to find ways to stop these destructive tales.

The myth that dead bodies cause a major risk of disease, which is reiterated in all large natural disasters from the earthquake in Managua, Nicaragua (1972) to hurricane Mitch, the Turkish earthquake, or the floods in Mozambique is just that, a myth. The bodies of victims from earthquakes or other natural disasters do not present a public-health risk of cholera, typhoid fever, or other plagues. On rare occasions when victims of a disaster are carriers of communicable diseases, they are, in fact, a far lesser threat to the public than they were while alive. The result of this mistaken belief is the overlooked and unintended social effect of the precipitous and unceremonious disposal of corpses. This action is just one more severe blow to the affected population, because it deprives them of their human right to honour the dead with a proper identification and burial. The legal and financial consequences of the lack of a death certificate will add to the suffering of the survivors for years to come. Moreover, the summary disposal of bodies, superficial "disinfection" with lime, mass burial, or cremation of corpses require important human and material resources that should instead be allocated to the people who have survived and remain in critical condition.

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Devastation in Venezuela, 1999

The experience of our Pan American Health Organization (PAHO)/WHO programme in the aftermath of the earthquake in Mexico City showed that health authorities and the media can work together to inform the public, make possible the identification of the deceased, and the return of the bodies to the families in a climate free of unfounded fears of epidemics. The routine epidemic prevention and control measures in use locally before the disaster are effective and familiar to health workers, although after a disaster they may be poorly implemented and supervised. In times of disasters, the prompt resumption of these programmes and action to improve quality control of the programmes is usually the best approach. There is no need for fancy aerial insecticide spraying or improvised mass immunisations which are so often recommended. The real needs are for access to essential drugs, water, and sanitary facilities, and for improved waste disposal. Natural disasters such as earthquakes, cyclones, and hurricanes do not result in imported diseases that are not already present in the affected area, and they do not always provoke secondary disasters through outbreaks of communicable diseases. Proper resumption of public-health services, such as immunisation and sanitation measures, control and disposal of waste, and special attention to water quality and food safety, will ensure the safety of both the population and the relief workers.

Another common myth about disasters is that the affected local population is helplessly waiting for the western world to save it. This concept is a fallacy, especially in countries with a large, although unevenly distributed, medical population. In fact, only a handful of survivors owe their lives to foreign teams. Most survivors are saved by their neighbours or by the local authorities. When foreign medical teams arrive, most of the physically injured people who are accessible have already received some medical attention. In many situations, western medical teams are not necessarily the best equipped to deal with local conditions.

As a professional disaster manager, the press coverage of the recent disasters leaves me with a sense of déjà vu—international rescue teams are made to look as though they are saving victims who have been neglected by incompetent or corrupt local authorities. We saw the same cliché after major earthquakes, hurricanes, or the recent floods in Southern Africa.

What does make those myths so endurable? Is it merely innocent misinformation or the pursuit of self-satisfying social or professional objectives? When consulted by elected authorities in an affected country, agencies such as PAHO/WHO share its assessment of the health situation and the actual needs of the population with the local authorities. We promote reliance on the national medical community, available and even eager to assist and advise against any rushed recourse to unsolicited personnel or supplies. Too often, our field experts report the arrival of teams of so-called disaster experts, who tend to be

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misguided individuals. Many such experts are sponsored by donor countries that are responding to the pressure and expectations of public opinion and not to the real needs of the affected country. One has to ask the difficult question: who is this assistance really meant to benefit? Those who work in the disaster-medicine business in developed countries seem sometimes to regard not having been in the latest international catastrophe as unbearable. Less-developed countries slowly come to realise that the funding for those highly visible teams is coming from the same budget as other more valuable and productive forms of assistance.

Disaster-stricken countries appreciate external assistance when it is directed to real problems. Unfortunately, too much of the assistance from donor countries is misdirected to issues that are not important or in ways that perpetuate myths about disasters. For example, a common myth is that any kind of international assistance is needed, and that it is needed immediately. However, PAHO/WHO's experience shows that a hasty response that is not based on familiarity with local conditions and meant to complement the national efforts only contributes to the chaos. It is better to wait until genuine needs have been assessed and to accept that international intervention can raise artificial expectations at an extraordinary cost to the local provision of disaster medicine. Indeed, in the long term, mortality from domestic violence and traffic accidents far exceeds the occasional toll of large disasters and receives no external attention.

Another myth is that disasters bring out the worst in human behaviour, but this assumption belies the truth that while isolated cases of antisocial behaviour inevitably occur, most people respond spontaneously and generously. National military assets are certainly more useful in natural disasters for search/rescue and logistical support than for law and order! Fears that donations may end up benefiting those who deserve them least are unfounded. Assistance needs to promote good governance and transparency in the affected country—for example, in the Americas, PAHO/WHO routinely implements an internationally supervised inventory control of all humanitarian donations through its SUpply MAnagement programme (SUMA®).

The myth that the affected population is too shocked and helpless to take responsibility for their own survival is undermined by the reality that many people find new strength during an emergency, as shown by the thousands of local volunteers who spontaneously united to sift through the rubble in search of victims after the earthquakes in Mexico City in 1985 and in Turkey last year. I will never forget the tranquil courage of so many affected people in the Americas in the face of such adversity. Perhaps it is this crosscultural dedication to the common good of so many local volunteers and institutions, without red tape or petty institutional turf fights, that keeps alive our faith in humankind and society.

The myth that things go back to normal within a few weeks is especially pernicious. The truth is that the effects of a disaster last a long time. Disaster-affected countries use up a substantial part of their financial and material resources in the immediate post-impact phase. Pharmaceutical and surgical stocks in non-affected areas are diverted to meet the immediate demand for supplies. A hospital's budget for 1 year can be spent in a day. The greater need for financial and material assistance is in the months after a disaster. External assistance is required for the restoration or rehabilitation of normal primary health-care services, water systems, housing, and income-producing work. Social and mental health issues emerge when the acute crisis has subsided and the victims feel (and often are) abandoned to their own means. 15 months after hurricane Mitch, temporary shelters in Honduras and Nicaragua are fully occupied and in some instances expanding. Successful relief programmes have to gear their operations to the fact that once international interest wanes, unmet needs become more pressing. In our experience of mobilising resources for the health needs of affected countries, we find that financial donations are rapid and generous in the first days of a disaster, but dry up quickly weeks or months later when these needs are greater. Vast sums were spent on humanitarian assistance after hurricane Mitch, almost exceeding the capacity of absorption of agencies, but once the attention of the mass media shifted away from Central America, the modest development funding PAHO/WHO requested to increase health preparedness has not yet materialised.

It is essential that the press and the donor community are aware of what is good practice and malpractice in public-health emergency management. Past sudden-impact natural disasters in the Americas and elsewhere have shown the need for long-term international contributions in cash and not in kind. This approach ensures that allocation of resources is field-driven by evidence of what is needed on-site. The population of Turkey, Venezuela, Central America, or Mozambique does not need used clothing, household or prescription medicines, blood and blood derivatives, medical or paramedical personnel or teams, field hospitals, and modular medical units. They want, as do any victims of disasters, to rebuild safer houses, have their "normal" health problems attended to at the health centre, put their children in school, and get back to their lives.

Unilateral contributions of unrequested goods are inappropriate, burdensome, and divert resources from what is needed most. Giving an uninjured victim of a flood, hurricane, or earthquake a choice between receiving airlifted bottles of water, canned food, used clothing, and once-in-a-lifetime western medical attention, or an equivalent cash subsidy for rehabilitation, their choice may differ from that of the humanitarian agencies. Indeed, most of the assistance provided by official relief agencies in developed countries is in the form of cash subsidies or loans to affected individuals or small businesses. Could a similar approach work internationally

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Effects of Hurricane Gilbert, Jamaica, 1998

in countries at a mid-point in the development process?

Provided that a local or regional economy exists and can adjust itself to meet the demand for "humanitarian" supplies or expertise, including health care, individuals or families may themselves make far more effective use of humanitarian funds than external humanitarian organisations. Both the short-term and long-term benefits for the affected countries would exceed those derived from a massive influx of costly expatriate personnel and unsolicited goods.

I believe there are lessons to be learned by the international community. The human-rights lobby should join efforts with humanitarian organisations to reform the humanitarian response in accordance with the needs of the affected populations. Medical assistance should respond to primary health-care needs in the affected countries rather than to the perceptions of a far away well-intentioned but misinformed public. The survivors of disasters have the right to proper identification and burial of their relatives and to sustained support for a prompt return to "normality".

Although local authorities are usually unprepared, who is ever ready for a disaster of this magnitude? WHO could have done more to strengthen the local capacity, but with what resources? The USA, European Union, and other countries spent millions of dollars to dispatch search and rescue teams—who usually arrive after the most critical first hours or days—to a country where thousands of local medical doctors have already volunteered their services. Donor agencies and private contributors should allow and encourage humanitarian organisations to use part of their relief funds to support medium-term rehabilitation. At governmental level, the policy to set aside a predetermined proportion of the bilateral human budget for preparedness and prevention activities should be more broadly adopted.

The World Bank's decision, announced Feb 4, 2000, to assign 15% of its emergency relief grants to the reduction of the vulnerability to future disasters should be emulated by other donors. We need to educate the donor public in more developed countries just as we need to educate potential victims of disasters. A little preparedness of how to interpret wisely the dramatic disaster images on prime time television and respond constructively as a concerned individual can go a long way toward alleviating the "secondary" disasters, which are so often visited on countries long after the disaster. Inappropriate donations are only occasionally the result of greed and selfishness; they usually reflect a lack of understanding and knowledge from generous individuals. Donor governments, humanitarian organisations, and particularly the International Red Cross and the UN must work together to educate the public through the mass media about how to respond more effectively to the needs of victims of disasters. Hopefully, the news industry would take part on a voluntary, rather than commercial basis, in a campaign of this sort. If we commit to strengthen the local capacity to respond to future disasters in Turkey, in the disaster-prone countries of the Americas, and other places, and learn what is important and what is futile in helping countries, the world would be better off.