Lessons on humanitarian assistance

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Conflict almost completely destroyed Rwanda's infrastructure in 1994. Natural disasters, as well as disasters caused by humans, have severely challenged humanitarian aid available within the country. In this study, we have analysed the experiences of nongovernmental organizations since the summer of 1994 to evaluate how these difficulties may be overcome. One of the problems identified has been restrictions on the ability to introduce effective health planning due to the poor quality of available local information. The implementation of effective plans that show due consideration to the environment and society is clearly necessary. Effective monitoring and detailed observation are identified as being essential to the continuity of existing humanitarian assistance.

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Introduction

A nongovernmental organization's project for taking health care to victims of strife in Rwanda is described. Conflict almost completely destroyed Rwanda's infrastructure in 1994 and led to an urgent requirement for assistance in the health field. Many nongovernmental organizations undertook projects aimed at alleviating the situation, and experiences gained during one of them are reported.

Planning and implementation

The nongovernmental organization concerned (the Adventist Development and Relief Agency) was already running a number of health centres in Rwanda, and consequently had some knowledge of the country's population, resources and health infrastructure at the start of the conflict. One of these health centres was used as the base of operations. The initial requirement was to provide health care for some 700 000 people in a rural area of 400 km^2 at about 1800 metres above sea level over a six-week period during the rainy season. However, it was intended not only to bring immediate relief but also to train persons who would be able to maintain progress once the project had ended.

Special attention was given to the selection of personnel motivated to work in extremely difficult circumstances, taking into account the unpredictability of human behaviour, even among volunteers. Thorough medical checks were performed on the selected individuals and vaccination was provided against yellow fever, diphtheria, tetanus, poliomyelitis, hepatitis B and typhoid fever; vaccination against Japanese encephalitis, meningococcosis A and C, hepatitis A and rabies was optional. Prophylactic measures were taken against malaria and diarrhoea.

In order to meet the particular circumstances of the emergency, preparations were made for giving caesarean sections and other forms of surgical care. Treatment protocols and schedules were drawn up so that rapid and effective responses could be achieved, with the help of specialists and a range of publications (*1–6*). Common expressions in the local dialect were learned in the interest of communication at the grassroots level.

The team members were each responsible for preparing and maintaining the health equipment they needed and for providing a small medicine chest containing epinephrine, antihistamines, corticoids, analgesics, nasal decongestants, preparations for topical skin treatment, antacids, antidiarrhoeals, laxatives, antibiotics, anxiolytics, wound dressings and other items. Their personal effects included bednets, sunglasses, lamps, batteries, water bottles, lighters, writing pads, ballpoint pens, passports, vaccination booklets and currency.

Adjustments to plans had to be made because of unpredicted factors. For example, the population of the area was increasing by some 5000 daily as refugees poured in from Zaire (now the Democratic Republic of Congo). Allowances had to be made for short-term and long-term effects and for actual and potential risks. A study was made of the geographical position of the team's headquarters in relation to routes of communication, supply points, health missions, hospitals, national police and army units, United Nations forces, and other bodies, with a view to planning for evacuation and the rapid location of sources of support.

The emergency medical kit consisted essentially of injectables mentioned in the protocols. There was an adequate supply of syringes, needles, catheters and drip equipment. For cardiopulmonary resuscitation there were oropharyngeal and nasopharyngeal

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Table 1. **The most common health problems in the Rwankeri area**

Conditions	Proportion of population affected (%)
Upper respiratory tract infections	22
Intestinal parasites	15
Pneumonia[a]	7
Rheumatism	6
Amoebic diarrhoea	5
Bacterial diarrhoea	4
Scabies	4
Oesophageal and gastroduodenal pathologies	3
Malaria	2
Ophthalmological disorders	2
Severe malnutrition	2
Umbilical and inguinal hernias	2
Tinea	2
Cutaneous ulcers and abscesses	2

tubes, nozzles and facial masks, together with manual aspiration equipment, a laryngoscope with various blades, and endotracheal cannulae. Foley's catheters, plastic bags, clip forceps, sterile gloves and reagent strips for urine and blood were also provided.

The health care equipment provided by the nongovernmental organization's personnel included elastic and adhesive bandages, wire and plastic splints, cervical collars, sterile gauze, triangular and other bandages, sticking plaster, dressings treated with Vaseline, scissors, forceps, scalpels with spare blades, suturing materials, silk, catgut, syringes, needles, disinfectant and saline. Other items of equipment in this category were provided on the spot.

The logistic requirements included a radio transmitter providing a link with headquarters in Kingali, other health care groups in the area, and Nairobi and Burundi; and a cross-country vehicle for transporting drugs, health care materials, food, patients and so on, driven by a local bilingual person capable of providing explanations required at checkpoints.

A primary health care operation was conducted at the Rwankeri Health Centre. The treatment protocols proved to be of great value, since any health worker with basic diagnostic judgement was able to apply them, using the available medicaments.

Patients' health problems were tackled and attention was drawn to the need for correct hygiene, patient care and food preparation, and to essential procedures for dealing with wounds, diarrhoea and other matters. The population received basic education in hygiene and health, and training was given to three health workers from the community.

Various contacts were vital for implementation, monitoring and follow-up. Spain, the home country of the nongovernmental organization, was not represented diplomatically, so relations were established through Switzerland. Contact was made with local authorities, nongovernmental organizations, teachers, clergymen and other persons who could help to ensure widespread awareness of and participation in the project. Local people were recruited for manual work, cleaning, cooking, translation, health care and other tasks. Their involvement not only materially benefited the population but also increased the effectiveness of the project.

Monitoring and follow-up

An average of 200 patients were seen daily during the six-week period, and a record was kept of age, sex, diagnosis, treatment and, where possible, course, permitting identification of the commonest health problems (see Table 1). Malaria occurred mainly among the refugees from Zaire (because of the altitude there were no vector mosquitos in the area). In order to take account of the massive immigration that was taking place, the percentages in the table are based on an estimate of the average population during the intervention period. These statistics were communicated to the national authorities engaged in organizing health services. Also noteworthy, though less frequent than the conditions indicated in the table, were cases of abortion, complicated delivery, traumatism, tetanus and otitis. The disease pattern encountered was as had been expected, given the prevailing environmental and climactic conditions.

The training of three local people enabled the work to continue after completion of the project, as was confirmed by another group from the same nongovernmental organization which visited the health centre four months later: it was estimated that 80% of its activities were being maintained even though there was no physician in charge. ■

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Résumé

Enseignements tirés de l'aide humanitaire

Le conflit de 1994 a presque entièrement détruit l'infrastructure du Rwanda. Des catastrophes naturelles ont encore aggravé la situation et sérieusement compliqué les opérations d'aide humanitaire dans le pays. Dans cette étude, nous avons analysé le travail accompli par plusieurs organisations non gouvernementales depuis l'été de 1994 afin de déterminer comment pourraient être surmontées ces difficultés. Nous avons notamment constaté qu'il était difficile de bien planifier les actions de santé à cause de la mauvaise qualité des informations locales disponibles. Or l'élaboration de plans efficaces qui tiennent dûment compte de l'environnement et du contexte social est à l'évidence une nécessité. Il apparaît qu'une surveillance efficace et des observations détaillées sont essentielles au maintien de l'aide humanitaire en place.

Resumen

Lecciones sobre la asistencia humanitaria

Los conflictos acaecidos en Rwanda en 1994 destruyeron casi por completo la infraestructura de ese país, y los desastres naturales, unidos a los causados por el hombre, han dificultado enormemente la ayuda humanitaria allí disponible. En el presente estudio hemos analizado la experiencia de las organizaciones no gubernamentales desde el verano de 1994, a fin de evaluar cómo podrían superarse esas dificultades. Uno de los problemas identificados son las limitaciones impuestas por la deficiente calidad de la información local disponible a la hora de intentar llevar a cabo una planificación sanitaria eficaz. Hay una manifiesta necesidad de aplicar planes eficaces que presten la debida atención al medio ambiente y a la sociedad. Se señala que una vigilancia eficaz y una minuciosa observación son factores esenciales para garantizar la continuidad de la actual asistencia humanitaria.

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