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Satisfaction with the humanitarian response to the 2010 Pakistan floods: a call for increased accountability to beneficiaries

Thomas Kirsch, Muhammad Ahmed Siddiqui, Paul Clayton Perrin, et al.

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affected population in the province, resulting in 33 clusters in Sindh, 27 in Punjab, 17 in Khyber Pakhtunkhwa and three in Balochistan. Clusters were assigned at the district level using the same process. Randomly generated GPS coordinates were used to identify cluster locations; three starting points were inaccessible due to security or snow-blocked roads which resulted in the use of alternate starting points within the same affected district. Ten camp-based clusters were added to the sample to account for the low probability of randomly choosing a starting point within the limited geographic area of a camp, and to ensure an adequate sample from the camp population. Camp clusters were also selected proportionate to their population size using official lists of current camps and their registered populations.

A household was defined as a group of people residing in the same living quarters and sharing meals, regardless of biological relationship. The first household in each cluster was identified as the one nearest to the GPS starting point. In rural areas with large distances between houses, the next nearest house was chosen until all 20 cluster households were surveyed. In urban and camp settings with dense populations, each fifth house was sampled. Households were eligible for the survey if they had been affected by the flood through economic, health or physical damage, and if an adult member (>18 years) was present. If a household was not eligible, the selected residence was unoccupied, or household members did not agree to participate, the next closest household was approached. The survey was conducted by Pakistani interviewers selected by the WHO, in Urdu or local languages, as needed. Data entry was done in Microsoft Access, and analyses were conducted using Stata V.11 (STATA Corp LP, College Station). Descriptive statistics and summary measures were calculated, and comparisons were drawn using standard statistical significance tests including χ^2 and t tests. Logistic regression was used to test the univariate and multivariate associations between covariates and overall satisfaction (as a dichotomous variable where neutral responses were included as satisfied). To more accurately determine overall

satisfaction with receipt of humanitarian aid and access to and quality of services, models were adjusted for pre-flood financial status, household head's education level and age, and current location. Independent predictors of overall satisfaction were determined by including all the covariates, including receipt of humanitarian aid, access and quality of services, and socioeconomic and displacement factors, into one model for each time interval.

The survey was conducted in coordination with the WHO as part of the ongoing monitoring of the response. The Johns Hopkins School of Public Health Institutional Review Board, and the Pakistan Ministry of Health approved the survey.

RESULTS

Household demographics

A total of 1769 households were included in the final sample with an average household size of 8.1 and a total population of 14 506 at the time the floods occurred. Prior to the flood, 87.1% (n=1539) of sampled households lived in rural areas with the remaining 12.8% (n=230) in urban locations. Half the population (50.5%) was under 18 years of age, while 5.0% was above 60 years age. Household head respondents were male 96.3% of the time, with an average age of 46 years (range 18–96); the majority had no formal education (65.3%, n=1105), while 19.0% (n=321) and 10.2% (n=173), respectively, had completed primary and secondary education. Educational attainment among other household members was slightly higher: 45.7% (n=776) had no formal education, whereas 25.0% (n=425) and 19.1% (n=326) had completed primary and secondary school, respectively; 9.1% (n=155) had studied at institutions of higher education.

Flood impacts

Nearly all (94.4%; n=1661) the surveyed households reported damage to their homes: 54.7% (n=964) of residences completely destroyed, 28.7% (n=506) with significant but repairable damage, and 10.8% (n=191) with minor damage. Likewise,

Figure 1 Selected districts and tehsils.

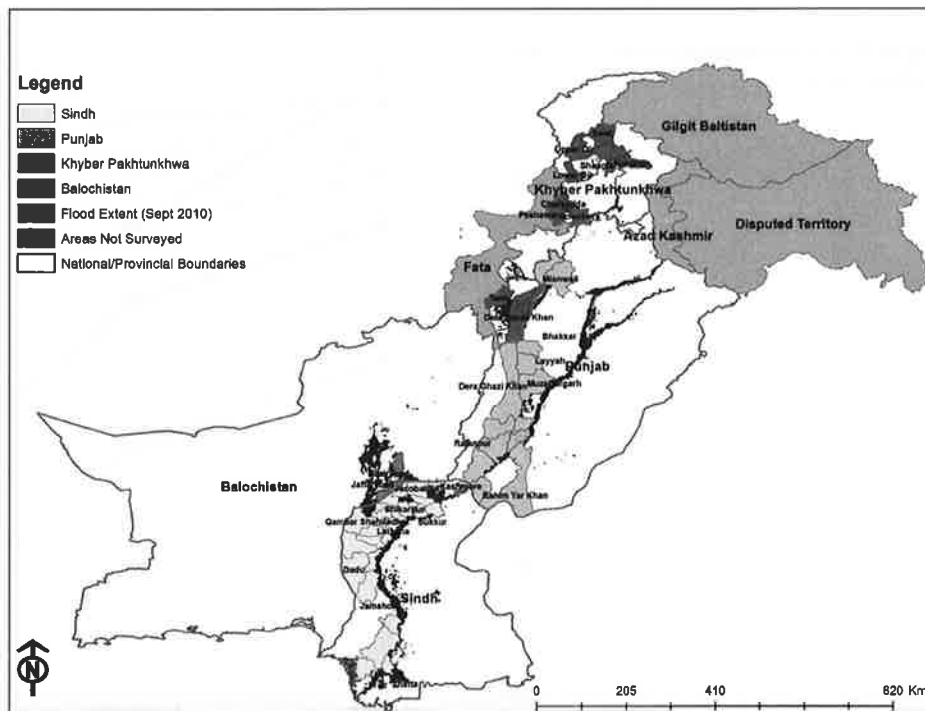
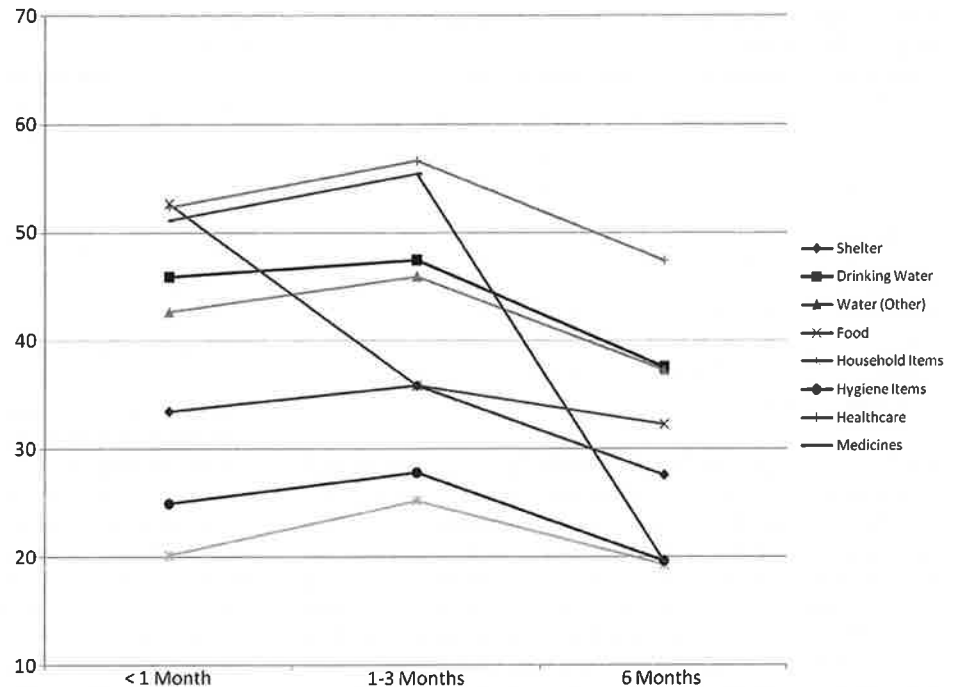


Figure 3 Per cent of those reporting needs having received assistance, by sector.



predictors in the model at 1 month. At 1–3 months, significant predictors included receipt of healthcare and household items, as well as having an indoor or attached toilet. At 6 months, the most significant predictor of satisfaction was access to food, followed by receipt of food, healthcare and hygiene items. Having a Head(s) of Household (HoH) in the age bracket of 26–35 years was also predictive of being unsatisfied at 6 months.

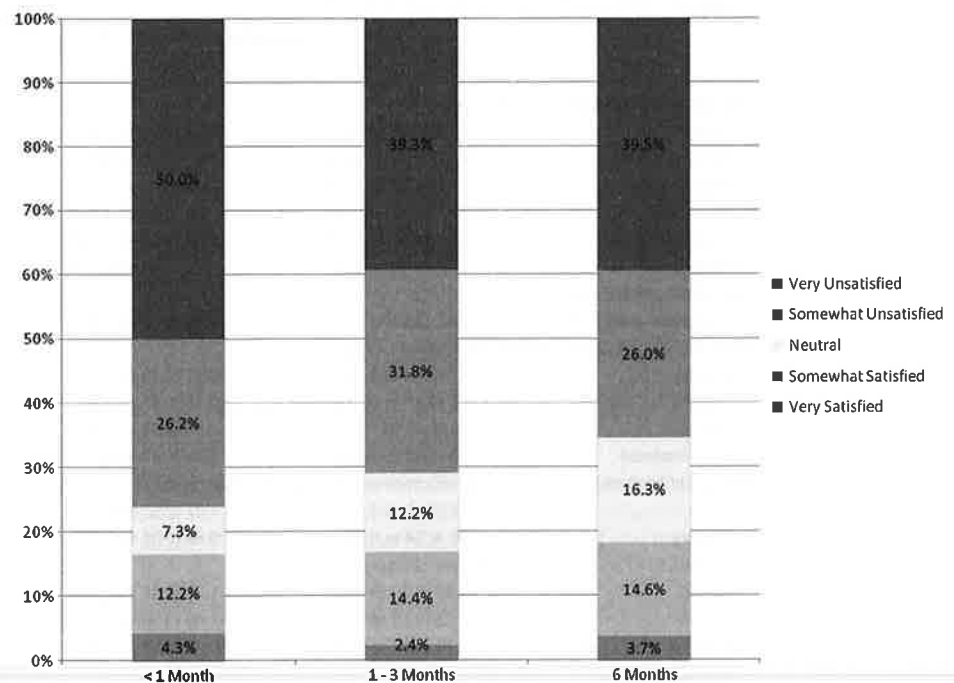
A multivariate regression was also used to further examine predictors of overall satisfaction (table 3), including household economic situation, displacement status, and age, education and sex of the head of the household. When the additional variables were introduced into the model, the receipt of both hygiene

items and drinking water still emerged as significant predictors of satisfaction at each time point, with healthcare, food and household items also predicting satisfaction at some, but not all, time periods. In the case of economic situation, a clear, consistent pattern emerged at all three time points of less satisfaction at lower economic levels, although these differences were largely not statistically significant at the $p < 0.05$ level.

DISCUSSION

Satisfaction surveys are common in service industries in both developed and developing world contexts.^{7 8} For example, healthcare in the USA aims to be ‘patient-centred’, and patient

Figure 4 Overall satisfaction with the humanitarian response.



humanitarian assistance efforts to support non-camp populations should be expanded, both as means of lessening dependency, and because remaining in communities is associated with better recovery.

Disaster relief and humanitarian response is a substantial industry: annual spending on global disaster response rose continuously from 2000 to 2005, to an estimated US\$18 billion.¹¹ Governmental humanitarian assistance contributions totalled US\$12.8 billion in 2008 while private contributions to humanitarian response agencies were around \$4.1 billion.¹² The UN's appeal for the Pakistan response alone was US\$1.9 billion.¹ The trend over the past few decades is towards more disasters—both in number and in terms of impact to societies.¹³ In Pakistan, negative perceptions of aid workers have led to Pakistan being classed among the countries with the highest number of violent incidents against aid workers. For example, there was a suicide bomb attack against the office of the World Food Programme in 2009, and in 2010, attacks against several non-governmental organisations forced them to curtail assistance efforts.^{14 15} An increase in disaster frequency compounded by a global economic crisis affecting humanitarian funding streams and negative perceptions of aid workers in certain contexts should prompt a renewed interest in making best use of limited humanitarian response resources. While there has been some criticism that the initial international humanitarian response to Pakistan was, for political reasons, far less than was offered to Haiti or Japan, it should also be recognised that the impacts of annual events, such as flooding in Pakistan, are better addressed over the long term through disaster mitigation and risk reduction efforts. The more appropriate metric for evaluating the sufficiency and effectiveness of the Pakistan flood response, therefore, would not focus exclusively on the acute phase of the emergency but on commitments over the long term by national and international actors alike to mitigate risk in the inevitable next event.

Humanitarian responders should use a 'rights-based approach' to guide response decisions, which is founded on the principles of participation and empowering individuals and communities to promote change.¹⁶ There have been many calls for 'accountability' and engaging the 'end-user' or 'community' in humanitarian response, but efforts have been limited and few specific tools have been developed to meet these goals. This is even truer in the acute phase of an emergency response than in later reconstruction and recovery periods. Much work has been accomplished to set general response standards and frameworks for overall accountability—most visibly through the Sphere project, which represents an important step forward in improving the quality of assistance and accountability of humanitarian agencies by providing an agreed-upon set of standards for various sectors of humanitarian intervention. However, some common criticisms of the Sphere standards are that they lack flexibility, do not guarantee quality, and may not always reflect the on-the-ground realities and priorities.^{17 18} Improvements in setting standards and creating frameworks notwithstanding, there have been fewer successes in engaging the recipients of aid^{19 20} in quality assurance efforts. While agencies have made progress in accountability, the emphasis remains on reporting to donors rather than evaluating impacts on beneficiaries.²¹

Although the findings of such an approach can help provide valuable insight, they must be contextualised in order to avoid drawing unwarranted conclusions. For instance, high levels of unmet need for various forms of assistance at later time points might not be an indication of inadequate response, but rather,

the natural result of the winding down of a disaster response effort that cannot and should not provide indefinite assistance. Because this is a population-based approach rather than an agency-based approach, satisfaction levels are likely to vary depending on the organisation that provided them, a fact that is not captured in the results. Likewise, although some of the relationships were not statistically significant, this may be a matter of insufficient power to detect differences due to the size of the sample in each group. The ultimate value of such surveys lies in the comparative data they generate, and should not be treated as the only element of quality assessment of disaster response efforts. Agencies should seek to use them to complement their own monitoring and evaluation efforts. This study should be replicated in other humanitarian settings to determine acceptable levels of satisfaction worldwide, and confirm the relationships that were discovered through this study. Qualitative studies could help provide further context to the results by helping to determine the reasons behind the findings.

CONCLUSION

The floods in Pakistan led to widespread public health needs that were only partially met during the initial 6 months of the humanitarian response. There was a close correlation between the receipt of aid and satisfaction with the response efforts. The affected population was generally unsatisfied with the assistance received, although satisfaction levels improved slightly over time. Independent, scientifically rigorous, population-based quality assessments can act as a valuable supplement to routine monitoring and evaluation activities and provide insight in humanitarian contexts where such activities are not undertaken. This approach gives disaster-affected populations a voice in identifying needed resources and judging the acceptability of the aid received. These types of direct surveys of the affected population can be used operationally to assess ongoing needs, serve to more appropriately redirect humanitarian resources, and ultimately, to judge the overall quality of a humanitarian response.

Contributors All authors were involved in some form in the conception and design of the study, as well as the interpretation of data and review of the manuscript. In addition, TK served as the lead investigator for the study, and MAS was the primary individual responsible for performing the data analysis.

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Competing interests None.

Patient consent Because no personal medical record information was collected, the patient consent form was not necessary. The study did, however, obtain full verbal consent prior to all surveys, in accordance with IRB ethical regulations.

Ethics approval This study was approved for human subjects research by the IRB (case #3311) of Johns Hopkins Bloomberg School of Public Health. Participants gave informed consent before taking part.

Provenance and peer review Not commissioned; externally peer reviewed.

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SPECIAL CONTRIBUTION

Global Emergency Medicine: A Review of the Literature From 2012

Gabrielle A. Jacquet, MD, MPH, Mark Foran, MD, MPH, Susan Bartels, MD, MPH, Torben Kim Becker, MD, DrMed, Erika D. Schroeder, MD, MPH, Herbert C. Duber, MD, MPH, Elizabeth Goldberg, MD, Hannah Cockrell, and Adam C. Levine, MD, MPH, for the Global Emergency Medicine Literature Review (GEMLR) Group

Abstract

Objectives: The Global Emergency Medicine Literature Review (GEMLR) conducts an annual search of peer-reviewed and grey literature relevant to global emergency medicine (EM) to identify, review, and disseminate the most important new research in this field to a worldwide audience of academics and clinical practitioners.

Methods: This year, our search identified 4,818 articles written in six languages. These articles were distributed among 20 reviewers for initial screening based on their relevance to the field of global EM. Two additional reviewers searched and screened the grey literature. A total of 224 articles were deemed appropriate by at least one reviewer and were approved by their editor for formal scoring of overall quality and importance.

Results: Of the 224 articles that met our predetermined inclusion criteria, 56% were categorized as Emergency Care in Resource-limited Settings, 18% as EM development, and 26% as Disaster and Humanitarian Response. A total of 28 articles received scores of 16 or higher and were selected for formal summary and critique. Inter-rater reliability for two reviewers using our scoring system was good, with an intraclass correlation coefficient of 0.625 (95% confidence interval = 0.512 to 0.711).

Conclusions: In 2012 there were more disaster and humanitarian response articles than in previous years. As in prior years, the majority of articles addressed the acute management of infectious diseases or the care of vulnerable populations such as children and pregnant women.

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In 2012, deadly earthquakes affected Iran, Afghanistan, and the Philippines, while Sri Lanka and southern India saw their deadliest tropical cyclone in years: Nilam. The most destructive storm of 2012, Hur-

ricane Sandy, left a wake of destruction stretching from Jamaica to Quebec. Meanwhile, the ongoing conflict in Syria left thousands dead and contributed more than three million additional internally displaced people to the

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Global Emergency Medicine Literature Review (GEMLR) Group members are listed in Appendix A.

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cally search the websites of these organizations for needs assessments, program monitoring, evaluation reports, topic reviews, white papers, conference proceedings, and other types of articles that met the predefined screening criteria for relevance to the field of global EM. Through our grey literature search process, we found 15 additional global EM research articles that met the inclusion criteria. These were combined with those identified by the Medline search to create a database of 224 research articles for formal scoring.

Once selected for scoring, the full-text article was obtained and classified as either an original research or review article. Each article was also categorized as emergency care in resource-limited settings, EM development, or disaster and humanitarian response. Emergency care in resource limited settings includes trauma care, acute medical care, triage, and prehospital care in low- and middle-income countries or resource-limited settings of high-income countries. EM development includes research on the development of EM as a specialty, EM educational programs, or emergency medical care systems outside of North America, regardless of the national income level. Disaster and humanitarian response includes research on the care of civilian populations in conflict; disaster mitigation, assessment, and response; and health care of refugees and internally displaced persons.

Each article was then scored by two separate reviewers using a predefined grading scale that assessed for clarity, design, ethics, importance, and impact. Final scoring ranged from 0 to 20 (Table 3), with the mean of the two scores used as the final score for the article. Any article with a score difference between reviewers of greater than two standard deviations above the med-

ian score difference was rescored by an editor. The new score was then used as the final score for the article. Twenty-eight articles had final scores of 16 or greater and were selected for formal review. These articles were then distributed to reviewers who produced summaries and critiques of each article.

RESULTS

Of the 224 articles that met our predetermined inclusion criteria, 56% were categorized as emergency care in resource-limited settings, 18% as EM development, and 26% as disaster and humanitarian response. Approximately 64% of the articles were original research, while the remaining 36% were review articles.

The median final score for all articles was 12.5, ranging from 4.5 to 19. The difference in mean scores between Medline (12.6) and grey literature (11.5) articles was not significant ($p = 0.069$), nor was the difference in mean scores between original research (12.5) and review (12.4) articles ($p = 0.700$) or the differences in mean scores between emergency care in resource-limited settings (12.4), EM development (13.2), and disaster and humanitarian response (12.1) articles ($p = 0.199$). Inter-rater reliability for reviewer scoring, measured using the intraclass correlation coefficient, was 0.625 (95% confidence interval = 0.512 to 0.711), considered "good" reliability in the literature.

The top 28 global EM articles for 2012 are listed in Table 4.⁶⁻³⁴ The complete database of all 224 global EM articles for 2012, as well as full summaries and critical analyses of the top 28 global EM of articles of 2012, can be found in Data Supplements S1 and S2 (available as supporting information in the online version of this article).

DISCUSSION

The most notable difference in the 2012 review, in comparison to previous reviews, was the inclusion of an article from the grey literature. This represented the first time a grey literature article scored above the predefined cutoff for full review. In addition, there were many more disaster and humanitarian response articles than had been selected for final review in previous years. While historically there have been more review articles, this year the majority of the chosen articles were original research articles. Below we summarize some of the 2012 trends in global EM research.

Emergency Care in Resource-limited Settings

As in years past, this category of articles remains the most represented among articles chosen for full review (66%). Highlighting the continued global focus placed on child and maternal mortality, most of the articles were centered on pediatric infectious disease or obstetric care.

Diarrheal illnesses continue to be a major cause of morbidity and mortality worldwide; several of the 2012 articles focused on the diagnosis and management of diarrhea. Lazzarini and Ronfani⁶ performed a systematic review on zinc supplementation in children with acute diarrhea. The authors found that in children less than 6 months of age, there is evidence that zinc

Table 2
Grey Literature Sources

| |
|--|
| Academic centers/think tanks |
| 1. Global Health Council |
| 2. Center for Global Development |
| 3. The United Nations University |
| 4. RAND Corporation |
| 5. The Woodrow Wilson Center |
| 6. The Bill and Melinda Gates Foundation |
| 7. Center for Global Health Research/University of Toronto |
| 8. Emergency Trauma Care Project |
| NGOs, UN, and government agency websites |
| 1. MEASURE Evaluation |
| 2. MSF |
| 3. Epicentre |
| 4. International Rescue Committee |
| 5. International Medical Corps |
| 6. Oxfam International |
| 7. Oxfam Great Britain |
| 8. GIZGTZ |
| 9. International Committee of the Red Cross |
| 10. Centers for Disease Control and Prevention |
| 11. World Health Organization |
| 12. Humanitarian Practice Network |
| 13. UN High Commission for Refugees |
| 14. UN Development Program |
| 15. Inter-Agency Standing Committee |
| 16. UNICEF |
| 17. JHPIEGO |
| UN = United Nations. |

Table 4
GEMLR 2012 Articles

| Category | First Author | Title | Journal | |
|---|----------------|--|--|---------------------------------|
| Emergency care in resource-limited settings | Tougher | Effect of the Affordable Medicines Facility–malaria (AMFm) on the availability, price, and market share of quality-assured artemisinin-based combination therapies in seven countries: a before-and-after analysis of outlet survey data | <i>Lancet</i> | |
| | Kausar | Nurses in low resource settings save mothers' lives with non-pneumatic anti-shock garment | <i>Am J Mater Child Nurs</i> | |
| | Das | Short-term therapeutic role of zinc in children < 5 years of age hospitalized for severe acute lower respiratory tract infection | <i>Paediatr Respir Rev</i> | |
| | Lazzerini | Oral zinc for treating diarrhoea in children | <i>Cochrane Database Syst Rev</i> | |
| | House | Estimating the weight of children in Kenya: do the Broselow tape and age-based formulas measure up? | <i>Ann Emerg Med</i> | |
| | Riaz | Efficacy and safety of <i>Saccharomyces boulardii</i> in acute childhood diarrhea: a double blind randomized controlled trial | <i>Indian J Pediatr</i> | |
| | Deen | Community-acquired bacterial bloodstream infections in developing countries in south and southeast Asia: a systematic review | <i>Lancet Infect Dis</i> | |
| | Cilliers | Anti-inflammatory treatment for carditis in acute rheumatic fever | <i>Cochrane Database Syst Rev</i> | |
| | Eizadi-Mood | Admission creatine phosphokinase in acute poisoning: is it a predictive factor for the treatment outcome? | <i>J Pakistan Med Assoc</i> | |
| | Singhi | Potential risk of hypoxaemia in patients with severe pneumonia but no hypoxia on initial assessment: a prospective pilot trial | <i>Paediatr Int Child Health</i> | |
| | Vinnemeier | Predictive value of fever and palmar pallor for <i>P. falciparum</i> Parasitaemia in children from an endemic area | <i>PLoS One</i> | |
| | Coulborn | Feasibility of using teleradiology to improve tuberculosis screening and case management in a district hospital in Malawi | <i>Bull World Health Org</i> | |
| | Ogwang | Community involvement in obstetric emergency management in rural areas: a case of Rukungiri district, western Uganda | <i>BMC Preg Childbirth</i> | |
| | Seward | Association between clean delivery kit use, clean delivery practices, and neonatal survival: pooled analysis of data from three sites in south Asia | <i>PLoS Med</i> | |
| | Liu | The gap in injury mortality rates between urban and rural residents of Hubei province, China | <i>BMC Public Health</i> | |
| | Groen Ameh | Untreated surgical conditions in Sierra Leone | <i>Lancet</i> | |
| | Page | The impact of emergency obstetric care training in Somaliland, Somalia | <i>Int J Gynaecol Obstet</i> | |
| | EM development | Page | Evaluation of rapid test for the diagnosis of cholera in the absence of a gold standard | <i>PLoS One</i> |
| | | Henry | Prehospital trauma systems reduce mortality in developing countries: a systematic review and meta-analysis | <i>J Trauma Acute Care Surg</i> |
| Sun | | The emergency first aid responder system model: using community members | <i>Emerg Med J</i> | |
| Wachira | | An analysis of clinical practice in a public emergency departments in Kenya | <i>Emerg Med J</i> | |
| Johnson | | Clinical skills and knowledge requirements of health care providers caring for children in disaster, humanitarian and civic assistance operations: an integrative review of the literature | <i>Prehosp Disaster Med</i> | |
| Mahabir | | Attitudes of ED staff to the presences of family during cardiopulmonary resuscitation: a Trinidad and Tobago perspective | <i>Emerg Med J</i> | |
| Mosley | | What is the impact of structured resuscitation training on healthcare practitioners, their clients, and the wider service? | <i>Med Teach</i> | |
| Disaster and humanitarian response | Mahamud | Epidemic cholera in Kakuma Refugee Camp, Kenya, 2009: the importance of sanitation and soap | <i>J Infect Dev Ctries</i> | |
| | Kirsch | Satisfaction with the humanitarian response to the 2010 Pakistan floods: a call for increased accountability to beneficiaries | <i>Emerg Med J</i> | |
| | Devnani | Factors associated with the willingness of health care personnel to work during an influenza public health emergency: an integrative review | <i>Prehosp Disaster Med</i> | |
| | Zhang | Hyponatraemia in patients with crush syndrome during the Wenchuan earthquake | <i>Emerg Med J</i> | |

GEMLR = Global Emergency Medicine Literature Review.

review of factors influencing the willingness of health care providers to work during public health emergencies such as these with important implications for disaster and pandemic planning at the hospital, regional, and national level.

Cholera still remains a significant public health concern among displaced populations such as in refugee camps. Mahamud et al.³⁴ conducted a case-control study at Kakuma Refugee Camp in Kenya and found that the provision of soap, education on hand hygiene, and cleaning water storage containers may be cost-effective interventions to prevent cholera. This article is a validation of prior work, confirming that hand washing and use of soap are effective means of combating cholera epidemics.

CONCLUSIONS

Global emergency medicine is a field that is rapidly growing in both depth and breadth. As the specialty expands, the body of literature it produces continues to increase and diversify. The articles chosen represent examples of both high-quality and high-impact EM research currently being conducted across the globe. While not an exhaustive list of all global EM articles, this review highlights a sampling of the most current and relevant literature in the field. We hope these articles will promote evidence-based practice, encourage global discourse, and further research in global EM.

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DR JEREMY BROWN TO DIRECT NIH OFFICE OF EMERGENCY CARE RESEARCH

The National Institutes of Health has announced in a press release that Jeremy Brown, MD, has been chosen to be the first permanent director of its Office of Emergency Care Research (OECR). Established in 2012 under NIH's National Institute of General Medical Sciences, OECR is a focal point for basic, clinical and translational emergency care research and training across NIH. It coordinates, catalyzes, and communicates about NIH funding opportunities in emergency care research and fosters the training of future researchers in this field. Dr. Brown is currently an associate professor of emergency medicine and chief of the clinical research section in the Department of Emergency Medicine at The George Washington University (GWU). He works clinically as an attending physician at the Washington D.C. VA Medical Center. His NIH appointment will begin in July. Dr. Brown will also represent NIH in government wide efforts to improve the nation's emergency care system. Alan E. Jones, MD, president of the Society for Academic Emergency Medicine, expressed the satisfaction of the emergency medicine community at the establishment of OECR and at Dr. Brown's selection as its first permanent director. "SAEM, along with other emergency medicine organizations, has been very involved in efforts to create a dedicated centralized national office for emergency care research. We are delighted at the progress that has been made since the announcement of OECR's creation last year, and congratulate Dr. Jeremy Brown on his well-deserved appointment as its first director." Dr. Brown is ready for the challenge of heading OECR. "I am excited to join this world-class institution and lead its efforts to improve emergency care in the U.S.," he says. "To pursue this goal, I look forward to partnering with all of the NIH institutes and centers, other government agencies, and a wide range of researchers and clinicians." Dr. Brown replaces Walter J. Koroshetz, M.D., deputy director of the National Institute of Neurological Disorders and Stroke, who had served as OECR's acting director since its inception.