What kind of evidence do we need to justify humanitarian medical aid?

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VIEWPOINT

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What evidence justifies humanitarian medical interventions? What role do human rights have in evidence-based approaches to such interventions? Recently, there has been a call for a more evidence-based approach in humanitarian medical work. Attempts to outline standards for promoting evidence-based humanitarian medicine are underway; the most notable example is the Sphere Project, a collaboration of a large number of humanitarian agencies, which has produced outcome guidelines for humanitarian medical interventions. We argue that it is crucial that decisions that affect humanitarian endeavours take account of human rights, human suffering, and social context. We propose a framework for evidence in humanitarian medical intervention that both complements evidence-based approaches and emphasises the centrality of human rights, suffering, and social context to all humanitarian work.

There exists already an evidence base for humanitarian medical intervention. Many approaches from evidence-based public health, such as the provision of food, potable water, and shelter are regularly applied during interventions. Infection control and vaccination programmes are also well established and based on a strong foundation of evidence. In most aid settings, short-term outcome data are available, and interventions can be assessed by tracking changes in crude mortality rates, case-fatality rates, attack rates, and nutritional anthropometry.

This evidence base has been criticised for the ad hoc nature of its application and the inconsistent performance of aid agencies in providing care. However, humanitarian medical intervention, like clinical medicine, clearly requires improvement and expansion of its scientific foundation.

By contrast, the effectiveness and efficiency of other aspects of humanitarian medical aid are difficult to assess. Conventional health-care evaluation is a technique that evolved in developed countries and presumes relatively stable populations and environments. Such evaluation requires assessment of the physical and organisational structures of health services, the process of care itself, and long-term morbidity and mortality.

The structure, process, and outcomes of health care are challenging to assess in a single hospital in a peaceful city; they are more challenging in humanitarian medical interventions, where instability is the rule, especially during emergencies. These difficulties have been illustrated by Griekspoor and Collins in their work during the 1998 Sudanese famine. Their investigations show that the minimum standards for humanitarian projects proposed by Sphere are unpragmatic and rigid. Sphere’s utilitarian criteria for effectiveness aim to promote accountability. In fact, such criteria can thwart the planning and evaluation of humanitarian interventions that should be appropriate to settings that are highly individual and often much more complex than the relief camps upon whose relatively simple conditions the Sphere standards seem to be premised.

Many determinants of effectiveness that are part of the physical and organisational setting of humanitarian medical aid (for instance, political decisions, military action, and natural disasters) are extremely variable and unpredictable. Not only are they therefore hard to measure and to document thoroughly, but they also render problematic extrapolations from one context to another, since settings of interventions vary greatly. The sheer number of determinants of effectiveness (which often change rapidly) also makes causal inferences tenuous. As a result, accurate quantitative estimates of effectiveness and efficiency are often either not possible in humanitarian medical work, or limited in important ways. Where these challenges exist, it is important not to mistake the absence of evidence as evidence for the absence of effectiveness or efficiency. Furthermore, other types of evidence can have an important role in justifying humanitarian medical interventions.

What do we mean by evidence?

In the current parlance of evidence-based medicine, evidence is typically taken to mean the results of epidemiological data in the form of a statistical statement. More generally, however, evidence means the basis for inferences and thus for the resulting beliefs. The consequentialist (purely outcomes-oriented) statistical formulation of evidence typically assumed in the context of evidence-based medicine is problematic as the sole basis of the justification and evaluation of humanitarian medical intervention. These endeavours should not be assessed simply according to morbidity and mortality prevented per dollar spent (even where such data are valid and reliable). Non-consequentialist outcomes, such as human rights, must be taken into account. In certain humanitarian situations, the consequences of actions, such as attempting to provide medical aid to displaced individuals in the midst of military conflict, are highly uncertain. We may also feel that our interventions are in vain; that the care may never reach the intended recipients because, for example, they are on the brink of being killed or imprisoned. Nonetheless, undertaking such humanitarian endeavours may be justified if we believe we have a duty to attempt to aid people even in
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*Examples of standard indicators; †examples of expanded indicators.

hopless circumstances, or if we believe we would be diminished in our own humanity if we did not attempt to help. Consequentialist, cost-effectiveness evaluations often omit or give short shrift to goals such as documenting and testifying to inequities and violations of human rights, as well as testifying to the resulting suffering. Such acts of bearing witness cannot, in themselves, be reduced to a measurable outcome, but they do constitute a form of evidence.

The act of bearing witness is an act with intrinsic moral value even beyond the good consequences that may flow from it. Bearing witness in humanitarian medical work conveys at least two meanings. First it entails being with people who are victims of injustice or violence and thereby showing that they have not been abandoned. Second, it entails testifying to the outside world about the injustice or violence observed, and advocating that the world community bring about change. Bearing witness can thus facilitate and fuel human solidarity in the face of tragedy, and contribute to focusing international attention. One hopes, of course, that such attention will lead to preventing suffering and saving lives; but even without such consequences, testimony to injustice has inherent worth. Testimony provides evidence of respect for the human rights and freedoms of oppressed people, even when witnessing does not result in succour or the saving of lives. This aspect of witnessing is indispensable if we believe the international community is truly accountable for its response to injustice. Respect for human beings means that witnessing and documenting their suffering and the violation of their human rights is a virtue or even a duty, a principled action we feel obligated to take, even if we believe such actions will be in vain. A personal reflection from a village in Kosovo in 1999 captures some of these dimensions of bearing witness:
Many intended beneficiaries of aid, as well as participants in humanitarian medical intervention, place a high value on responding to suffering people simply by being with them, even in apparently hopeless situations. The value of compassionate action motivated by concerns about justice and human solidarity, rather than measurable outcomes alone, corresponds to Albert Schweitzer’s statement that “the first step in the evolution of ethics is an enlargement of the sense of solidarity with other human beings.”

Human solidarity in the face of misfortune and injustice is a foundational requirement of justice. When seeking evidence to gauge the benefits of humanitarian interventions, should one not heed a full range of knowledge and experience, ranging from tables of epidemiological data to narrative accounts of suffering, abandonment, compassion, relief, hope, and advocacy? Such narrative accounts, from the perspective of orthodox evidence-based medicine, are inherently subjective. Yet it is empathy for subjective experiences of natural and man-made disasters that most strongly galvanises humanitarian intervention, and it is empathy and a sense of justice that fundamentally motivate humanitarianism.

Attempting to understand success in humanitarian interventions in exclusively quantitative terms, without attention to this full range of evidence, is problematic. Arthur Kleinman writes the following about clinical and behavioural science, and the same is likewise true of cost-benefit analysis: it possesses “no category to describe suffering . . . ethnography, biography, history, psychotherapy—these are the appropriate research methods to create knowledge about the personal world of suffering.” As well as standard quantitative outcomes, qualitative research methods should be applied to humanitarian medical intervention, since experiences of suffering, compassion, and advocacy may be qualitatively different one from another and thus incommensurable. There may be no metric that can adequately compare them. They must, nonetheless, be considered.

Non-consequentialist moral ends, such as bearing witness and solidarity, can be sufficient to justify intervention. Measuring effectiveness and efficiency where possible is commendable, but this endeavour should be built upon, rather than with disregard and possible detriment to, the core humanitarian values of bearing witness, solidarity, and justice.

An expanded evidence base

The call for an evidence base in humanitarian medical intervention is important because it spurs us to examine the aims of humanitarian medical work, to assess whether these aims could be achieved, and therefore to determine whether a particular intervention is justifiable. The multiplicity of aims and types of evidence reflects the fact that health care
comprises not simply the application of diagnostic and therapeutic science by using societal resources, but also the consideration of ethical ideals. These aims should include justice and respect for fellow human beings.

In humanitarian medicine, accountability for compassion and human solidarity is integral to accountability for effectiveness. The ombudsman-like positions proposed by the Humanitarian Accountability Project aim to provide a mechanism for ensuring that humanitarian work undertaken within the Sphere guidelines does not lose track of the needs and social and political realities of the specific communities the work intends to benefit. An ombudsman might well additionally comment on a humanitarian project’s manifestations of compassion, solidarity, and witness. Nevertheless, accountability for compassion, solidarity, and witness extends to the whole human community, even across history. As Jonathan Glover says with regard to modern atrocities and humanity’s response to them, ‘‘the past is alive in the present’. ’’ Past violations create precedents for future ones, and past humanitarian responses (or the lack of them) create precedents for future responses. Compassion and human solidarity are key aspects of responding effectively at a human level to demonstrable needs—as seen in the account above from Kosovo, and as seen in the international community’s continued willingness to give money to support humanitarian interventions, or take part in them. We are proposing that humanitarian medical activity should be assessed with an expanded but well defined notion of evidence, and a core of ethical goals that extend beyond cost-effectiveness to include solidarity, justice, bearing witness, and responding to suffering. As the examples in the panel show, all these ethical ideas can and have been put into effective action in humanitarian medical work.

For instance, Médecins Sans Frontières last year issued a report about the neglect of Angolan’s health-care needs by both warring parties in that country. The report is based primarily on narrative evidence, which was reported as useful in identifying practical challenges for humanitarian organisations and international justice. The uncertainty implicit in humanitarian medical crises means we must temper our reliance on quantitative calculations of consequences. Yet we need to recognise that this uncertainty does not mean we are lost, either morally or operationally, in deciding how to respond to crises. In such situations, the non-consequentialist ends that we highlight should and can have a central role in justifying and guiding humanitarian medical intervention.

Contributors
David Robertson wrote the original draft. All authors revised and contributed to subsequent revisions.

Conflict of interest statement
R Bedell is employed by MSF Canada and MSF Holland.
R Upshur worked as a paid consultant for MSF Holland in 1998.
J V Lavery worked for MSF Canada as a general volunteer from 1991 to 1996.

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