CHAPTER 14.
REESTABLISHING NORMAL HEALTH PROGRAMS

In the first weeks after a disaster, the pattern of health needs will change rapidly, moving from casualty treatment to more routine primary health care. Services must be reorganized and restructured, often because permanent facilities were severely damaged in terms of their infrastructure and vital systems, and severe financial constraints impede rapid reconstruction. Priorities also will shift from health care toward environmental health measures during the rehabilitation phase.

The Health Disaster Coordinator will be faced with decisions in three main areas that must not be overlooked during emergency operations: identifying and addressing long-term problems caused by the disaster; reestablishing normal health services; and assessing, repairing, and reconstructing damaged systems and buildings.

LONG-TERM HEALTH EFFECTS CAUSED BY DISASTERS

Extended Need for Medical Care

If large numbers of casualties have resulted from the disaster, a small proportion (probably less than 1%) will require long-term nursing at home, institutional care, or specialized rehabilitation for months or years. Examples are paraplegics, patients with severe brain damage, amputees, and patients with chronic sepsis. In countries where specialized services for long-term care and rehabilitation are limited, this will put a strain on the health services.

Funding long-term rehabilitation programs with international resources may prove difficult, since many organizations do not have funds for such expenditures. Preliminary statistics on the numbers of patients involved, and estimates of cost should be obtained as soon as possible and made available to both national decision makers and interested international agencies.

Surveillance of Communicable Diseases

As the weeks pass after a disaster, the public is likely to become progressively less concerned about the risk of epidemic diseases in the affected region, or the reemergence of diseases such as tuberculosis or malaria. Disease surveillance remains important and should be continued until normal disease reporting systems can be restored.

Care of Displaced Populations

A major disaster with high mortality leaves a substantial displaced population, among whom are those requiring extensive medical treatment and orphaned children. When it is not possible to locate relatives who can provide care, orphans may become the responsibility of health and social agencies. Assistance should be sought from national Red Cross societies who have considerable experience in identifying orphaned children.

Efforts should be made to reintegrate disaster survivors into society as quickly as possible through institutional programs coordinated by ministries of health and social welfare, education, and work, and family welfare institutions. Special needs of the disaster survivors should be addressed when making proposals for rehabilitation and reconstruction projects presented to international financial institutions, international agencies, and nongovernmental organizations.

REESTABLISHING NORMAL HEALTH SERVICES

Two problems may occur in restoring health services to the level existing before the disaster. In some cases, resources budgeted for six months or a year are depleted in a few days of emergency relief operations, and in disasters attracting massive voluntary or international assistance, the emergency level of services or care may temporarily exceed what the country can normally afford.

The Health Disaster Coordinator should keep in mind anticipated rehabilitation needs when formulating requests for assistance, considering requirements for the affected region before the occurrence of the disaster and the short-term needs of the affected population. In most cases, outside assistance will not exceed 10% of the total requirements, and most needs will have to be satisfied locally. Accepting certain types of assistance, such as equipment, medicines, and voluntary personnel, should also be decided in terms of long-term needs.

The rehabilitation period provides an excellent opportunity for making major changes in health care delivery, since during this phase decision-makers are receptive to new ideas. For instance, clinical laboratory services, epidemiologic surveillance, oral rehydration for diarrhea patients, expanded immunization, and maternal and child health programs have been strengthened as an indirect result of floods in the Region of the Americas.

ASSESSMENT, REPAIR, AND RECONSTRUCTION OF DAMAGED FACILITIES AND LIFELINES

When water supply and sewerage systems, hospitals, and other health facilities have been damaged, the engineering sector must arrange for an immediate survey to determine damage and functionality of the facilities, including cost estimates for repair or reconstruction of the damaged facilities and systems. Existing hazards and risks should be considered when carrying out damage assessments, so that appropriate mitigation measures can be applied when repairs and reconstruction are carried out, thus avoiding damage in future disasters.

If international assistance is required for reconstruction, project plans should be as accurate and detailed as possible, including vulnerability analysis studies, and be submitted as soon as possible, since this will increase the likelihood of obtaining funds.