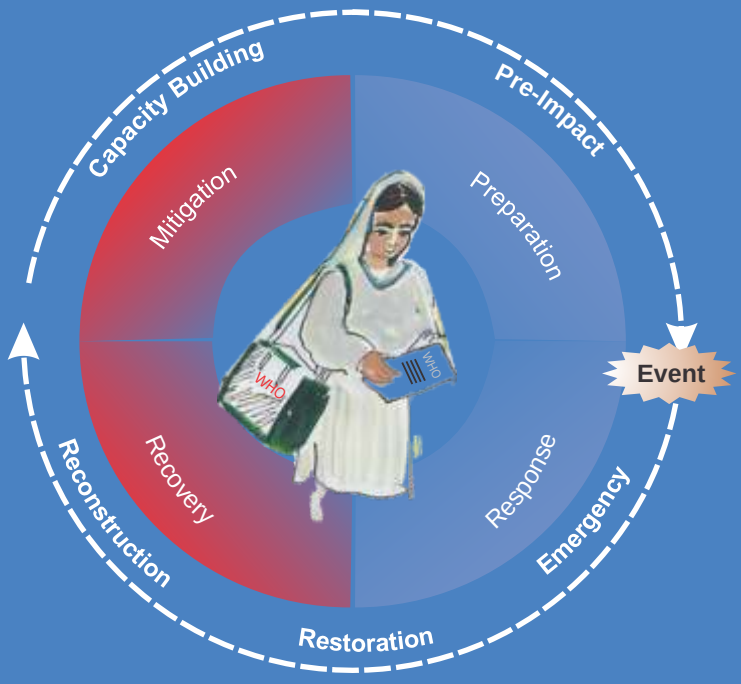
Module 4

Community Based Health Workers: Action After a Disaster The Humanitarian Response



Community Based Health Workers: Action After a Disaster The Humanitarian Response

Introduction

This module contains five sessions, each covering the concept of increased exposure of the community to certain health risks and the response required from community-based health workers, elements of camp management and SPHERE standards, basic psychosocial support, referrals and reducing treatment gaps and the basic concepts, aims and elements of the recovery, rehabilitation and reconstruction respectively.

Module's Objectives

1. Understand the increased exposure of the community to certain health risks and the response required from community-based health workers, with a focus on the most vulnerable
2. Understand the elements of camp management and SPHERE standards
3. Be able to provide basic psychosocial support
4. Be able to coordinate with other health service providers for making referrals and reducing treatment gaps
5. Know the basic concepts, aims and elements of the recovery, rehabilitation and reconstruction

Sessions to be covered in this module:

Session 4.1:

Health Risk Exposure and Community-Based Health Worker Response

Session Objectives

At the end of the session, participants are expected to:

- ✓ Understand the increased exposure of the community to certain health risks;
- ✓ Recognize the response required from community-based health workers, with a focus on the most vulnerable.

4.1.1. Importance of CHW in Post-Emergency Phase

In a disaster's recovery and post-emergency phases, Community Health Workers (CHWs) are community members who are trained to act as direct intermediaries between the beneficiary population and the health care system.

- The reasons for setting up a network of CHWs is to extend emergency health care coverage through mobilizing the community for public health initiatives and through preventive health activities such as disease control and surveillance

- Community Health Workers reduce health facilities' patient burden by increasing the population's awareness of how to improve their own health and take preventive health measures such as proper water and sanitation practices. This allows staff at health facilities to concentrate on more serious conditions

Role of CHW During Post-Emergency Phase

4.1.2. Consequences of Disaster on Health Services

For CHWs, it is very important to understand the impact of disaster on health so they can understand the increased exposure of the community to certain health risks and take appropriate measure against them.

- Disasters can cause serious damage to health facilities, water supplies and sewage systems. The damage can severely limit health systems' provision of medical care to the population in the time of the greatest need
- The supply chain (medical equipment and pharmaceutical supplies) for the health facilities is often temporarily disrupted
- Limited road access makes it at least difficult for disaster victims to reach health care centre
- Climatic exposure because of rain or cold weather puts a particular strain on the health system
- Inadequacy of food and nutrition exposes the population to malnutrition, particularly in the vulnerable groups such as children and the elderly
- Mass migration can introduce new diseases into the host community
- While natural disasters do not always lead to massive infectious disease outbreaks, they do increase the risk of disease transmission. The disruption of sanitation services and the failure to restore public health programmes combined with the population density and displacement, all culminate in an increased risk for communicable disease outbreaks
- The incidence of endemic vector-borne diseases may increase due to poor sanitation and the disruption of vector control activities

4.1.3. Health Risks for Vulnerable Population and Role of CHW

Women, children, older persons, people with disability and minorities, and indigenous groups are widely recognized as particularly vulnerable and in need of specific protection in disaster situation.

Children are particularly vulnerable to disasters. They are more likely than adults to be injured or separated from their families and unable to access care. Children under five have been shown to have the highest rates of morbidity and mortality in an emergency.

Children are Vulnerable to Disaster

The main causes of child mortality

- Diarrhoea,
- Acute respiratory infections,
- Malaria and
- Malnutrition

For this reason, it is essential that CHW focused on children under five for their preventive services that are geared to lowering excess mortality, such as measles immunization and Vitamin A dosing, improvement of sanitation, oral rehydration therapy, and malaria treatment as per protocols.

Medical Treatment to Woman

When disasters strike, women are often the most affected. Moreover, after the disaster, they bear the responsibility of caring for their children, the elderly, the injured, and the sick. Besides the effects of the disaster, women become more vulnerable to reproductive and sexual health problems and are at increased risk for physical and sexual violence.

CHW should disseminated preventive public health messages amongst the pregnant women and mothers in the population through home visits about breast feeding and the early treatment for symptoms of potentially dangerous diseases such as diarrhoea and fever as well as antenatal care referral for pregnant women to improve women's health outcome.

Disseminating Preventive Public Health Information to Pregnant Woman

Older people are among the most vulnerable populations to the direct impact of natural disasters. Following a disaster, chronic illness can easily worsen due to lack of food and water, extreme heat or cold, stress and exposure to infection.

Medical First Aid to Elderly People

CHW should pay special attention to older people and communicate their special needs to the relevant authorities.

Individuals with disabilities are disproportionately affected in disaster, emergency, and conflict situations due to inaccessible evacuation, response (including shelters, camps, and food distribution), and recovery efforts.

Individuals with Disabilities

CHW can provide assistance to such people on priority basis and link them with organizations who deal with disabled people.

Exercise:

Question: *What special measure should be taken by CHW for:*

- *Children*
- *Women*
- *Older people*
- *Disables people*

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Session 4.2:

Camp Management and SPHERE Standards

Session Objectives

At the end of the session, participants are expected to:

- ✓ Understand the elements of camp management;
- ✓ Know the SPHERE standards.

4.2.1. Camp Management

- In large scale disasters in which existing structures are not safe to use as shelters like in floods, earthquake or conflict leads to massive population movement
- Emergency settlements for refugees and displaced people need to be established rapidly
- One possibility is to use tents or shelters made of plastic sheets or local materials in a secure location where these people can live safely on temporary basis and water, sanitation and food can be provided

Emergency Shelters

4.2.2. Managing Camps During Emergencies

- Based from careful assessment of the need to establish camps and the existing environmental condition
- Available resources for shelter management
- Coordination with local authorities
- Services needed in camps or shelters

4.2.3. Important Element of Camp Management

The measures listed below are designed to provide healthy living conditions for disaster-affected people in both the short term and the long term;

a. *Communicable Disease Control*

- The site should be free of major water and vector borne disease
- If endemic diseases are present, care should be taken to avoid or control vector habitats and provide personal protection against mosquitoes, black flies, tsetse flies, etc.
- To facilitate the management and control of communicable diseases, camps should hold no more than 10,000 - 12,000 people, or should be subdivided into independent units of no more than 1,000 people

Control of Communicable Diseases

- The minimum standards for communicable disease prevention and control in camps are given in *Annex:* 4.1

b. *Location and Topography*

- Should permit easy drainage and the site should be located above flood level
- Rocky, impermeable soil should be avoided
- Land covered with grass will prevent dust, but bushes and excessive vegetation can harbor insects, rodents, reptiles, etc., and should be avoided or cleared
- Steep slopes, narrow valleys, and ravines should be avoided. Ideally, the site should have a slope of 24% for good drainage, and not more than 10% to avoid erosion and the need for expensive earthmoving for roads and building construction

Careful Selection of Shelter Place

- Area should be naturally protected from adverse weather conditions

  Areas adjacent to commercial and industrial zones, exposed to noise, odors, air pollution and other nuisances should be avoided

c. *Water Sanitation and Hygiene:*

- Drainage ditches should be dug around the tents or other shelters and along the sides of roads, especially if there is a danger of flooding
- Care should be taken to lead water away from shelters, latrines, health centers, and stores
- Persistent areas of stagnant water that are difficult to drain can be backfilled, or covered with a thin layer of oil to control insects

Water Sanitation and Hygiene

- Water points should also have adequate drainage to avoid mud
- The surface of roads can be sprinkled with water to keep dust down. Sullage wastewater can sometimes be used to keep down dust on dirt or gravel roads. Restricting traffic and imposing speed limits can also help to reduce dust
- Educational campaign should be promoting key messages about safe drinking water, sanitation and hygiene as given in below table

Table 4.1: Examples of Key Educational Messages

Drinking Water:
• Boil your drinking water
• Cover water container with lid
Hygiene:
• Wash hands with soap after defecation
• Wash hands with soap after cleaning babies
• Wash hands with soap before preparing food
• Wash hands with soap before eating
Sanitation:
• Go to the defecation zone and help children to go to the defecation zone
• Use the shovel to dig a little hole in the ground
• Cover the excreta with soil after defecation

d. *Layout and Design:*

- Tents should face the upwind to avoid odors from latrines
- Ample space for the people to be sheltered and for all the necessary public facilities such as roads, firebreaks and service areas
- Areas for public spaces (e.g. market) should be defined

Arrangement of Shelters

- Food distribution areas
- At least two access roads for security and safety
- Shelters should be arranged in rows or in clusters of 10-12 on both sides of a road at least 10 meters wide
- Built-up areas should be divided by 30 meters wide fire breaks approximately every 300 meters
- Shelters should be spaced 8 meters apart so that people can pass freely between them without being obstructed by pegs and ropes
- Minimum space of 3.5m^2 per person in warm climates
- Minimum space of 4.5-5.5 m^2 per person cold climates
- Plastic sheeting used as shelter, one piece, 4 meters by 67 meters, per household

4.2.4. Health Risks in Camps

- The risk of disease outbreaks in camps after floods and tsunamis is greater than for earthquakes, volcanoes, hurricanes and other high-wind natural disasters
- Risk of disease spread increases when populations live in crowded camps, lack access to safe water, latrines and health services, have poor nutritional status or low immunity to vaccine-preventable diseases. The following table lists some diseases and factors that might have contributed to the outbreaks

Table: 4.2: Risk Factors and Diseases likely to occur in Camps

Disease	Transmission	Risk factors
Cholera Typhoid Hepatitis A and E Dysentery	Water-related	Contaminated water Population displacement Overcrowding Malnutrition Water scarcity
Measles ARI Leptospirosis Malaria Dengue	Airborne Vector borne	Overcrowding Low baseline immunization coverage Disruption of electricity Proliferation of rodents Seasonality Changed habitat Disrupted environmental control Changed human behavior
Tetanus Scabies Worms	Other	Injuries Low baseline immunization coverage Poor Hygiene

4.2.4. Sphere Minimum Standards

- 1997 A group of humanitarian non-governmental organisations and the Red Cross and Red Crescent Movement aims to improve the quality of their actions during disaster response
- The Sphere Handbook sets clear benchmarks for what actions can be considered as humanitarian
- *Define humanitarian response as one which is concerned with the basic rights of populations affected by disasters and conflicts*

4.2.5. Minimum Standards for Camp Management

a. *Water Supply*

- Average water use for drinking, cooking and personal hygiene in any household is at least 15 liters per person per day
- Maximum distance from any household to the nearest water point is 500 meters
- stand in line time at a water source is no more than 30 minutes

b. *Water Source*

Table: 4.3: Maximum Numbers of Person Per Water Source

250 People Per Tap	Based on a flow of 7.5 liters/minute
500 People Per Hand Pump	Based on a flow of 17 liters/minute
400 People Per Single User Open Well	Based on a flow of 12.5 liters/minute

c. *Water Quality*

- There are no fecal coliforms per 100ml of water at the point of delivery
- Any household-level water treatment options used are effective in improving microbiological water quality provided its accompanied by appropriate training, promotion and monitoring
- Taste is not in itself a direct health problem but if the safe water supply does not taste good, users may drink from unsafe sources and put their health at risk

d. *Water Supply Facilities*

- Each household has at least two clean water collecting containers of 1020 liters, one for storage and one for transportation
- Water collection and storage containers have narrow necks and/or covers for buckets or other safe means of storage, for safe drawing and handling, and are demonstrably used
- There is at least one washing basin per 100 people and private laundering and bathing areas available for women

Table 4.4: Hygiene Promotion

BASIC HYGIENE SUPPLIES	
10-20 Liters capacity water container for transportation	One per household
10-20 liters capacity water container for storage	One per household
250g bathing soap	One per person per month
200g laundry soap	One per person per month
Acceptable material for menstrual hygiene (e.g. washable cotton cloth)	One per person

e. *Additional Items*

Existing social and cultural practices may require access to to additional personal hygiene items per person per month

- 75 ml / 100g toothpaste
- 1 toothbrush
- 250ml shampoo
- 250ml lotion for infants & children up to 2 yrs of age
- 1 disposable razor
- Underwear for women & girls of menstrual age
- 1 hairbrush and/or comb
- Nail clippers
- Diapers & potties (dependent on household needs)

f. Sanitation

- Toilets are appropriately designed
- Location minimize security threats to users
- allow for the disposal of women's menstrual hygiene materials and provide women with the necessary privacy
- in high water table or flood situations, the pits or containers for excreta are made watertight in order to minimize contamination of groundwater and the environment

g. *Excreta Disposal*

- Toilets are appropriately designed
- Location minimize security threats to users
- allow for the disposal of women's menstrual hygiene materials and provide women with the necessary privacy
- in high water table or flood situations, the pits or containers for excreta are made watertight in order to minimize contamination of groundwater and the environment

h. Latrines

- maximum of 20 people use each toilet
- Separate, internally lockable toilets for women and men are available in public places, such as markets, distribution centers, health centers, schools, etc.
- Toilets are no more than 50 meters from dwellings
- Use of toilets is arranged by household(s) and/or segregated by sex
- People wash their hands after using toilets and before eating and food preparation

Table: 4.5: Types of Safe Excreta Disposal

SAFE EXCRETA DISPOSAL TYPE	APPLICATION
Demarcated defecation area (e.g. sheeted off segments	1st Phase: the first 2 -3 days when a huge no. of people need immediate facilities
Trench Latrines	1st Phase: up tp 2 months
Simple Pit Latrines	Plan form the start through the long term use
Ventilated Improved Pit (VIP) Latrines	Context based for middle to long term response
Ecological Sanitation (Ecosan) with urine Diversion	Context based: in response to high water table and flood situations, right from the start or middle to long term
Septic Tanks	Middle to long term phase

i. *Emergency Shelter*

- Minimum covered floor area of 3.5m^2 per person
- Ensure sufficient surface area and adequate fire separation in temporary planned and self-settled camps
- Minimize vector risks

i. *Non Food Items*

- All women, girls, men and boys have at least two full sets of clothing in the correct size that are appropriate to the culture, season and climate
- Each household or group 4-5 individuals has access to two family-sized cooking pots with handles and lids, a basin for food preparation or serving, a kitchen knife and two serving spoons
- All disaster-affected people have access to a dish, plate, a spoon or other eating utensils and a mug or drinking vessel
- All affected people have a combination of blankets, bedding, sleeping mats or mattresses and insecticide-treated bed nets where required to ensure sufficient thermal comfort and enable appropriate sleeping arrangements

Exercise:

Q: What advise do you want to give camp management authority to control communicable diseases in camps?

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Q: What advise do you want to give camp management authority for site selection for camps?

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Q: What steps do you advise to camp management authority for proper water, sanitation and hygiene facilities for camps?

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Q: What is SPHERE?

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Session 4.3:

The Basics of Providing Psycho-Social Support

Session Objectives

At the end of the session, participants are expected to:

- ✓ Understand the concept of psycho-social support;
- ✓ Be able to provide basic psycho-social support.

4.3.1. Basic Concept of Psycho-Social Support

- Disasters result in loss of property and lives; they may cause loss of loved ones or property
- The emotional effects may manifest immediately or may appear later
- The more severe the disaster i.e. greater the perceived threat to life, greater the exposure to destruction, hearing distressing things- the more negative the outcome
- Survivors and personnel working in such scenarios experience stress
- It is important to know the signs of burnout and how we can reduce the effects of stress through psycho-social support
- Psycho-social support refers to the actions that address both the psychological and social needs of individuals

4.3.2. Psychological Responses to a Disaster

The psychological responses to a disaster can be divided into three different categories, which are: thoughts, feelings, and behavior.

Psychological Stress after the Disaster

a. *Thoughts*

The major thoughts responses are;

- Recurring dreams / nightmares
- Reconstructing the events in mind
- Difficulty in concentration
- Repeated thoughts or memories of the disaster

b. *Feelings*

For feelings, the major response can include the following:

- Fear and anxiety when reminded of disaster
- Lack of involvement and enjoyment
- Depression
- Feeling irritable
- Sense of hopelessness/emptiness/deep loss

c. *Behavior*

In regards to behavior, this includes:

- Overprotective about safety and self and family
- Startling easily
- Experiencing problems falling sleep
- Tearful for no apparent reason

As a CHW, you must be aware of the emergence of these thoughts, feelings and behaviors. This will help you to look at survivors' reactions as a natural reaction/response.

Spirituality is a major coping mechanism in our society. Many people look to their faith in times of crisis. It is important to understand the role of religion as a coping mechanism.

4.3.3. Steps to Acceptance of Situation

People use various methods to come to acceptance of their situation. Usually starts with denial, anger, bargaining, depression and finally acceptance stage. The time taken by different individuals for these stages varies according to individuals. Many people cope and move on with their lives after accepting their situation.

- Denial Stage "Not me!"
- Anger Stage "Why me?"
- Bargaining Stage "Okay, but first let me..."
- Depression Stage "Okay, but I haven't.."
- Acceptance Stage "Okay, I'm not afraid anymore"

4.3.4. Vulnerable Groups

Although every individual is susceptible, there are groups which are more vulnerable to the psychological consequences of disasters. They are:

- Elderly persons
- Children and adolescents
- Women (especially pregnant or lactating)
- Single-parent families
- Extremely poor people
- People with disabilities or health conditions
- The bereaved
- Rescue and relief workers

Q: Do you want to add any other group?

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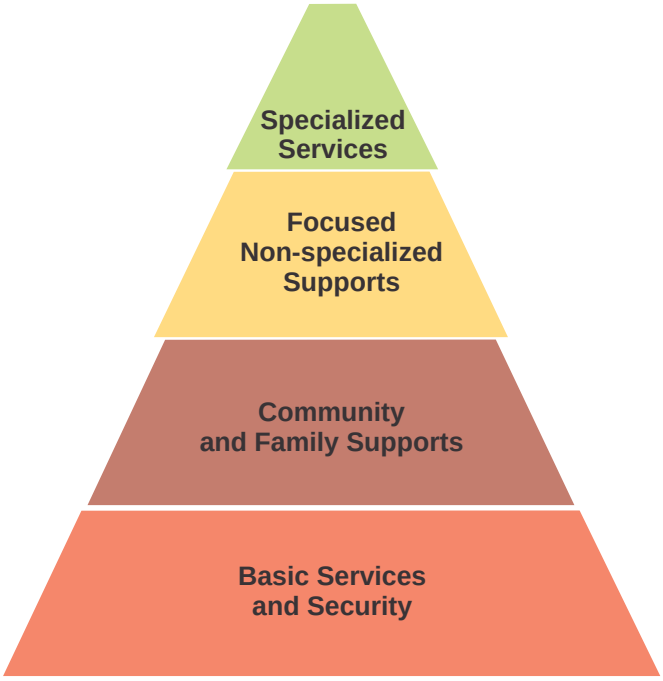
4.3.5. Psycho-Social Support Needs and Role of CHW

- In emergencies, people are affected in different ways and require different kinds of supports
- A key to organizing mental health and psycho-social support is to develop a layered system of complementary supports that meets the needs of different groups
- This can be illustrated by a pyramid. All layers of the pyramid are important and should ideally be implemented at the same time

CHW supports offered at these levels are as follows:

Figure 4.1: CHW Support at Different Levels of Pyramid



a. *Basic Services and Security*

People's well-being is protected through meeting their basic needs and rights for security, governance, and essential services such as food, clean water, health care and shelter.

A psychosocial response by CHW here might be advocating that these basic services and protections are put in place and are done in a respectful and socially appropriate way.

b. *Community and Family Supports*

A smaller number of people may need to be helped in accessing key community and family supports. Due to the disruption usually experienced in emergencies, family and community networks may be broken.

A psychosocial response by CHW here might be to involve in family tracing and reunification or it could involve the encouragement of social support networks.

c. Focused Supports

A still smaller number of people will in addition require supports that are more directly focused on psycho-social well being. This might be individual, family or group interventions, typically carried out by trained and supervised workers.

A psycho-social response here may include activities to help deal with the effects of gender-based violence e.g. support groups for victims of rape.

d. Specialized Services

At the top of the pyramid is additional support for the small percentage of the population whose condition, despite the supports mentioned already, is intolerable and who may have great difficulties in basic daily functioning.

Assistance here could include psychological or psychiatric supports for people with mental disorders that cannot be adequately managed within primary health services.

4.3.6. Qualities Required for CHW to be Able to Provide Basic Psycho-social Support

- Active listening
- Good communication skills
- Trustworthiness
- Approachability
- Patience
- Kindness
- Commitment
- Caring attitude
- Non-judgmental approach
- A good knowledge of psycho-social issues

Active listening and good communication skills are the basic prerequisite for CHW for providing psycho-social support to affected people.

a. Active Listening

Hearing and listening is not the same thing. Hearing is the act of perceiving sound; it is involuntary. Listening is a selective activity which involves the reception and the interpretation of sound. Listening is divided into two main categories: passive and active.

Passive listening is little more that hearing. It occurs when the receiver or the message has little motivation to listen carefully, such as music, story telling, television, or being polite.

Box 4.1: Qualities of active listeners

- Spends more time listening than talking.
- Does not finish the sentence of others.
- Does not answer questions with questions.
- Are aware of biases. We all have them...we need to control them.
- Never daydreams or become preoccupied with their own thoughts when others talk.
- Lets the other person talk.
- Does not dominate the conversation.
- Plans responses after the other person has finished speaking...NOT while they are speaking.
- Provides feedback, but does not interrupt incessantly.
- Keeps the conversation on what the speaker says...NOT on what interests them.
- Takes brief notes. This forces them to concentrate on what is being said.

b. *Communication Skill*

CHW as a psychosocial support worker should consider the following key points for good communication;

- Ability to establish open, interactive relationship with the client
- When speaking or trying to explain something, ask the client if they are following you
- Ensure the client has a chance to comment or ask questions

- Consider the feelings of the client
- Be clear about what you say. Look at the client
- Make sure your words match your tone and body language (nonverbal behaviors).
- Vary your tone and pace
- Do not be vague, but on the other hand, do not complicate what you are saying with too much detail
- Do not ignore signs of confusion

4.3.7. Activities Through which Psycho-Social Support can be Provided

Psycho-social support, whether provided as a specially designed activity or integrated within a broader programme, should involve people in participating actively in social networks. Sometimes this may mean re-establishing or strengthening the social support in the community to enable people to actively respond to crisis events.

Activities that provide psycho-social support are many and varied. Some examples are:

- Psychological first aid after a crisis (comforting and listening to the affected person)
- Discussion groups
- Visiting home
- Creating social networks
- Establish peer support groups
- School-based activities where children can play and regain trust and confidence
- Vocational training

Exercise:

Q: Name two most important qualities required for CHW to be able to provide basic psychosocial support?

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Session 4.4:

Coordination, Referral and Reducing Treatment Gaps

Session Objectives

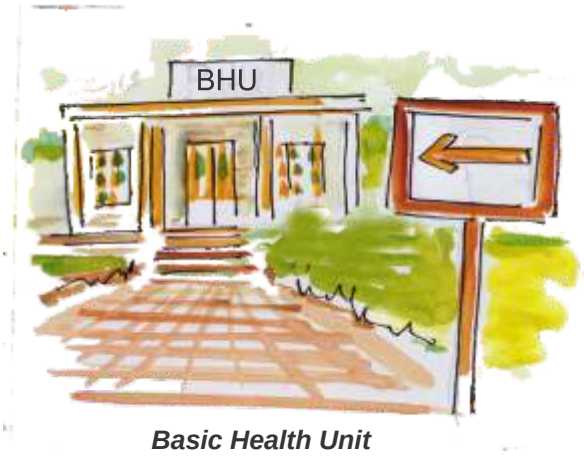
At the end of the session, participants are expected to:

- ✓ Be able to coordinate with other health service providers for making referrals and reducing treatment gaps

4.4.1. What is the Meaning of Referral?

Referral is the process in which CHW send people who needs health care beyond her treatment skills to a place where they can get additional care and treatment from a trained health provider.

Referral is an important part of the work that a CHW does. A CHW gives people in his or her village valuable information about where to get treatment.



Basic Health Unit

4.4.2. When Should You Refer a Person to a Trained Health Worker at the Health Unit?

- Refer any pregnant woman, young Child, or newborn if she or he has one or more danger Signs.
- Refer patients who do not respond to treatment at the community.

Referring Women

4.4.3. Why is it Important to Make Referrals?

- To save lives
- To make sure that people get appropriate treatment

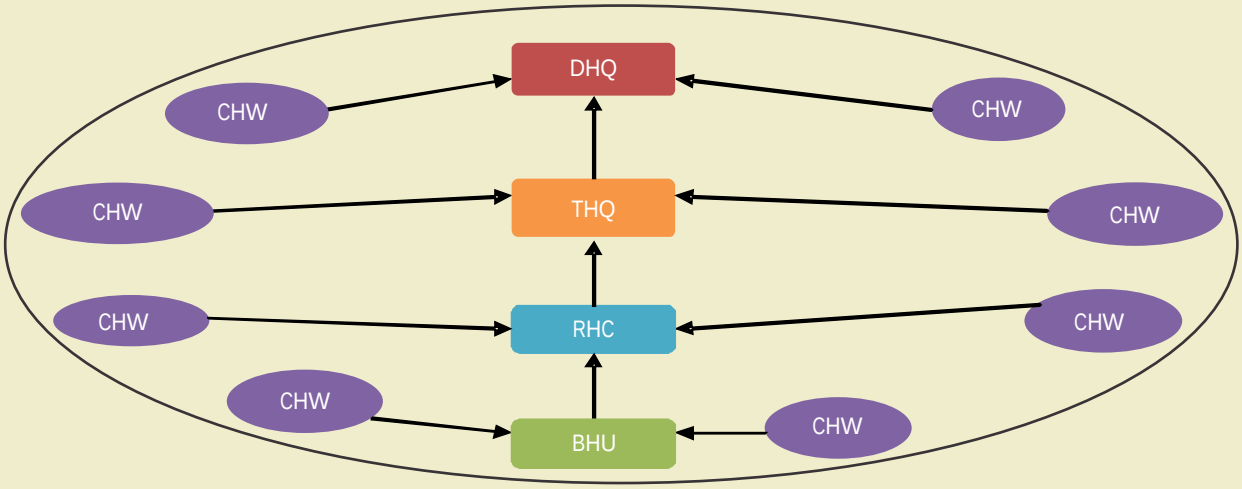
4.4.4. What Information Must You Know About Your Nearest Health Unit?

As a CHW, it is important that you make yourself aware of the health care services available in your community for effective referral and reporting of major health problems and emergencies.

- Name of the health unit
- Where the health unit is located
- Phone number of the trained health worker
- Services offered at the health unit
- Hours of operation

Mostly CHW refer the patient to first level of referral i.e. Basic Health Unit (BHU) but referral can be made to Rural Health Center (RHC) or Tehsil Head Quarter (THQ) hospital or District Head Quarter (DHQ) hospital depending upon the level of required services.

Figure 4.2: Basic Package of Health Services For Pakistan
Simplified Referral Structure



You should regularly update your information about the addition of new health facilities, changes in working hours, new specialized health staff at your referral hospital.

4.4.5. How should you Refer someone to a Trained Health Worker at the Health Facility?

- To help health workers better understand why the person is coming who you have referred, you should fill out a basic Referral Form

- This will help the health to understand the health issue that patient is having and also know that a CHW has referred this person

- Remember to give the patient the referral form so that they can bring it with them to the health worker

4.4.6. How Do You Fill Out a Referral Form?

The Referral Form should be filled out right away and left with the patient or the parent of the patient, so that they can take it with them as they travel to the health unit as quickly as possible.

Note: If you do not have a Referral Form, write a note for the person to take to the health unit. Include the following information in that note:

Name of person being referred
Sex
Date of birth
Village/town/city Name & Address
Reason for referral
Name of CHW making the referral

4.4.7. Following-up with Patients you Referred to the Health Center

You should always follow-up with patients you referred to the health center for the following reasons:

- To check whether they have gone to the health center
- To check they have received the appropriate medication or treatment
- To check they are taking the complete dose of medication they have received (you can also take this opportunity to explain Drug Resistance, discussed later in this Training, and why it is important to take the full dose not just enough to make the person feel better
- To answer any health related questions they might have
- To provide health education about their illness, including ways to prevent it in the future

Exercise:

Q: How do you refer someone to near health facility?

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Session 4.5:

Recovery, Rehabilitation and Reconstruction

Session Objectives

At the end of the session, participants are expected to:

- ✓ Know the basic concepts, aims and elements of the recovery, rehabilitation and reconstruction;
- ✓ know the health priorities at each stage.

4.5.1. Basic Concepts

Actions taken during the period following the emergency phase is often defined as the recovery phase.

It includes both rehabilitation and reconstruction. The precise time when one phase ends and another starts will vary in each situation.

a. *Rehabilitation:* refers to the actions taken in the aftermath of a disaster to enable;

- Basic services to resume functioning,
- Assist victims' self-help efforts to repair physical damage and community facilities,
- Revive economic activities and
- Provide support for the psychological and social well being of the survivors.

It focuses on enabling the affected population to resume more-or-less normal (pre-disaster) patterns of life. It may be considered as a transitional phase between immediate relief and more major, long-term development.

Enabling the Affectees

b. Reconstruction: refers to the full restoration of all services, and local infrastructure, replacement of damaged physical structures, the revitalization of economy and the restoration of social and cultural life.

Process of Reconstruction

Reconstruction must be fully integrated into long-term development plans, taking into account future disaster risks and possibilities to reduce such risks by incorporating appropriate measures.

To clarify the two definitions, following a damaging flood the rehabilitation of the power lines would aim to restore the system as rapidly as possible so that the essential services would continue to function. Whereas, reconstruction of the power lines should aim to rebuild the system to a higher or safer standard than before so that the future risks to the power lines from a similar damaging event would be reduced.

The processes of rehabilitation and reconstruction are complex and depend largely on the analysis of the disaster itself:

- The nature of the disaster (hazard type)
- The scale of the damage
- The location of the events
- The particular sectors affected

Planning for rehabilitation and reconstruction will depend on the losses sustained by the community. These are typically:

- Buildings
- Infrastructure
- Economic assets

- Administrative and political systems
- Psychological
- Cultural
- Social
- Environmental

Although rehabilitation and reconstruction are distinctive activities, they should not be seen in isolation from other pre- and post-disaster actions.

Reconstruction after a disaster provides many mitigation and development opportunities that may not be possible in 'normal' conditions. If properly utilized, these opportunities can, in return, improve the effectiveness of recovery from possible future disasters.

Similarly, integration of rehabilitation planning into local and national preparedness plans contributes to better recovery.

4.5.2. Health Needs in Rehabilitation and Reconstruction Stages

During recovery stage, usually mortality is controlled and basic health needs are met but the biggest challenge is the maximum integration into the pre-disaster primary health care system is critical.

In addition to emergency health services, CHW can support to

- Introduce psychosocial services
- Monitoring nutritional status of mothers & children
- Reintroduce programmes such as the Expanded Programme on Immunization (EPI)
- Re-establish the care and treatment of chronic illnesses and infectious diseases such as TB and HIV/AIDS

In addition to rebuilding health facilities seriously damaged or destroyed in a disaster, planning for reconstruction in the health sector should look to the future and prioritize other areas where strengthening contributes to improved preparedness and response, including:

- Strengthening the primary care level

- Procurement of basic equipment
- Water and sewerage networks
- Strengthening the sector's Emergency Operations Centers (health EOCs)
- Strengthening technical units and programs
- Updating guides, standards, and regulations

During this transition CHW must be coordinated with the health department and other organisations involved in the continued health care support in order to provide community-level health input on:

- Quality of health services required
- Access for community
- Special needs of vulnerable groups of the population
- Any additional health service
- Updating guides, standards, and regulations
- Disposal or treatment of hospital waste, in light of the potential risk of contamination to the environment.

Exercise:

Q: What does the term "reconstruction" mean?

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Q: What does the term "rehabilitation" mean?

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Q: Why is the distinction between these terms important?

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