Community-based health care in disasters

by Dr. Bruce Dick

Introduction: disasters and health for all

"Health for All by the Year 2000" has been a major goal, an important rallying cry for individuals and organizations around the world concerned about improving the physical, mental and social well-being of vulnerable people. Of course it has been a somewhat idealistic goal, as has the World Health Organization's definition of health. However, it has served a useful function, both in terms of what it says positively about our vision for the future and also by reminding us, implicitly if not explicitly, that for many hundreds of millions of people the reality is still very far from the dream.

Of course, at the same time that many of us are working towards the attainment of the Health for All goal, there are a number of forces which work in exactly the opposite direction. National debt repayments, structural adjustments, continuing expenditure on armaments, the pushing of infant formulas and inappropriate medicines, cigarettes, alcohol and other drugs, all negatively affect the progress that is being made.

There are also other factors which are often even less under our control, that continue to undermine our efforts, and the most notable among these are disasters. Many disasters are increasing, or at least their impact is, due to technological "progress", environmental degradation, population growth and the power of micro-organisms to outwit our schemes to control them.

Disasters and community-based health care

The main strategy to achieve the goal of Health for All by the Year 2000 has been primary health care (PHC), with its emphasis on prevention, equity and appropriateness, and with the priority that it

places on different sectors working together and on community participation. This latter aspect of PHC has, for a number of reasons, been the most difficult to transpose from the planning and policy documents into action in the real world.

Over the years, non-governmental organizations (NGOs) have identified the lack of real community participation as a major obstacle to the Health for All goal. They have therefore put a great deal of effort into exploring different ways of really working with communities, ways of identifying and prioritizing the problems with them ("their" problems, not "ours"), exploring solutions to these problems with the communities concerned, and strengthening the communities' resources in order to empower them to meet the priority problems that they have identified.

Again the ideal has often been difficult and time-consuming to achieve—none of us are particularly used to working in this way. However, through such an approach we have managed to avoid many of the problems that programmes planned from the outside have encountered in the past. The League of Red Cross and Red Crescent Societies has committed itself to PHC through resolutions adopted by the General Assembly in 1981 and 1986. In addition, it has focused on the development of community-based health programmes and has emphasised the need to strengthen such an approach in its Strategic Work Plan for the Nineties.

Disasters: who is affected and what are their health problems?

During the 1980s it became increasingly clear that despite all the social, economic, technological and infrastructural progress made, many individuals, families and communities remained untouched by the developments that have taken place. The most vulnerable people will differ from country to country, and even within countries from district to district. However, certain groups will be common to most situations, including people living in extreme poverty, women, children, the disabled, the people who suffer from discrimination, and single-parent families. People who are affected by disasters are also particularly vulnerable and, ironically, the groups who are most vulnerable on a daily basis are, in general, also most seriously affected by disasters.

Most of us have an intuitive understanding of what a disaster is. There are, however, a number of more formalized definitions. These vary depending on the sector and the perspective, but most of them include some concept of change, often sudden, and the idea that the affected people's capacity to cope becomes overwhelmed, at least temporarily. Of course we can broaden our concept of disasters to add many of the daily disasters to the list of media-intensive ones. The millions of deaths from diarrhoea and the vaccine-preventable diseases have been called the silent emergencies, or hidden disasters, and certainly AIDS, malaria and other endemic debilitating diseases are on-going disasters for many communities.

It is of course these very problems that are exacerbated by disasters, since disasters generally do not give rise to new diseases but merely increase the load of the common diseases that are related to proverty, lack of clean water and food, and the absence of basic medical care.

Disasters: how do they differ from "normal" times?

It is very questionable how useful the traditional ways of classifying disasters are, particularly when it comes to thinking about response. The "natural/man-made" divide is extremely difficult for most disasters since the two are so interrelated. If we take the example of a flood, is this natural (after all the rain is natural enough) or man-made (the people affected are living in high-risk areas only because they are poor and because of population growth, and the flood has occurred only because of deforestation)?

Another way to classify disasters is "sudden impact/slow onset". This is also not particularly useful since we may need a rapid response to slow-onset disasters if the warning signs have been ignored, and we may need to concern ourselves primarily with the rehabilitation phase of sudden impact disasters if the community response to the immediate effects has been adequate.

Since disasters are only disasters if there are people around to be affected by them, directly or indirectly, classifications focusing on the people, the communities affected, or the problems that were caused, both immediately and in the long term, would be more useful when it comes to thinking about what needs to be done, when and for/with whom.

In general the groups most seriously affected by high-visibility disasters are the same as those affected by life's daily disasters. The diseases that they suffer from are also much the same in disaster and non-disaster times, although some disasters, such as technological disasters, Bhopal and Chernobyl for example, and earthquakes may give rise to a new set of health problems.

In addition to the physical health problems, a recent Red Cross and Red Crescent Consultation on the psychological impact of disasters emphasized that the risk factors and psychological needs are much the same following disasters as they are following other stressful life events, such as the death of a loved one, or the loss of one's job.

Another important similarity between disasters and normal times is the community response. Following disasters, it is the local community members who give food to the newly arrived displaced populations, who pull people out of collapsed buildings, who give shelter and clothes to the people whose possessions have been washed away in the flood. They may not get as much media time as the outsiders with their sniffer dogs and infra-red cameras, or the expatriate medical teams with their aluminium trunks and their logos, but they do what needs to be done none the less.

A community-based response to disasters is not a new idea, it is what happens (contrary to popular belief, disaster-affected communities are not passive and apathetic). What might be new, however, is the idea that we should be putting our resources into reinforcing the community's capacity to respond, both before and after the event.

Finally, while there is a need for a rapid response to the so-called silent emergencies, in the case of disasters this need is often even more acute. For some disasters there must be a response within the first 24 hours (long before the medical teams fly in), for example search and rescue operations after earthquakes. For others, the major unmet needs will surface only during the rehabilitation phase (long after many of the teams have flown out). However, for almost all disasters, the most important time to act is *before* they occur, in the form of disaster preparedness.

What needs to be done — principles

It is becoming increasingly clear that our response to the health problems caused by disasters will need to be based on the PHC approaches and infrastructures that have been developed to respond to everyday health problems. This makes good theoretical sense since the

vulnerable groups, the health problems and the need for a community-based approach are common to both. It also makes good practical sense, since in the same way that it is the already vulnerable people who are most vulnerable to disasters, so it is with countries. It is inconceivable that poor countries which cannot even cope with the daily disasters that confront them will be able to develop a separate system for responding to the high-visibility disasters (which receive great media attention but which in general cause a very small percentage of the daily toll of disease, disability and death).

Of course there will have to be central planning and a national programme, just as such things exist for the daily emergencies of diarrhoea, vaccine-preventable diseases, malaria, acute respiratory infections or AIDS. But at district level our response will, as with all other health problems, rely on the local community.

Not only should disaster preparedness and response be integrated, but there also needs to be a focus on the national and local level response. Whilst some aspects of international response will often be necessary, focusing on the national and local levels will help to contribute to sustainable development, something that the disasters themselves will tend to undermine. There also needs to be a much greater emphasis on supporting national capacity to coordinate the response, both centrally and at local level, if the agency anarchy of the past is to be avoided in the future.

What needs to be done — practice

National Red Cross and Red Crescent Societies are obviously in a very good position to make an important contribution to coordination at national and local levels, as was seen recently in the response to the Kurdish refugee problem in Iran and Turkey. It is to be hoped that with the support of the League and their respective governments this role will be strengthened and that this in turn will help to focus on strengthening a community-based response.

National Societies are also in a very good position to give a lead on the issue of integration. Many have already demonstrated that their long-term programmes develop skills and activities that can contribute to disaster response. For example, the volunteers of the Indian Red Cross's Child Alive programme have responded to outbreaks of cholera, and it is to be hoped that a similar response will be possible from the Child Alive programmes in Central America to the cholera pandemic in this region. Similarly, the Philippine National Red Cross

community-based Barangay Health Workers were able to respond to the problems of the people affected by the earthquake in the Philippines in 1990.

Refugees often pose different problems, and for a number of reasons, from government policy to social disorganization within the "community", it may sometimes be difficult to base the response on the community. However, this should be the aim, and it is certainly the optimal option, at least in the longer term. Expatriate health teams will often continue to be needed, but their focus should be on training the refugees themselves to deal with basic health problems in terms of the prevention and home management of common diseases, something that has been taking place in the Pakistan Red Crescent's health programme for Afghan refugees.

Although refugees may present an extreme case, even under less difficult conditions community participation is likely to be difficult and time-consuming, for a number of reasons. These range from the fact that communities are often much less homogeneous or cohesive than the ideal community that features in the planning documents, through the myth that community participation is a quick or cheap option, to the fact that many governments would like people to do the work but are often less keen for them to have a major role in deciding about problems and priorities.

It is clear that even within the Federation there is a wide diversity of opinion about the meaning of "community-based health programmes". For many it describes those health activities that are carried out in the community rather than in a hospital or a clinic. However, such a definition clearly falls far short of effective community participation.

To emphasize the need for a community-based health approach to disasters should not, of course, be seen as implying that there is no need for external assistance, either from within the country or internationally. Many of the definitions of the word "disaster" include the concept of the community being unable to cope using its own resources. There will often be a need for food, for shelter materials, for medicines and for technical advice and support.

However, what the community-based approach does emphasize is the need to listen to and involve the people affected in the decisions that are taken about what needs to be done and for whom, and in their implementation. It means listening to the community when it comes to decisions about vulnerable groups, food distribution, water and sanitation. It also has important implications for disaster preparedness.

Disaster preparedness — a priority for community-based response

Disaster preparedness involves much more than physical structures. It means identifying relevant activities, developing the necessary skills to carry out these activities, and ensuring that there is an organizational capacity and an appropriate political environment in which what needs to be done can be done — these were the lessons of Henry Dunant, and they apply as much today as they did 130 years ago.

Whilst there will be a continuing need for the political environment and attitudes to develop and move with the times (a current example is the debate about the right to act, internationally, on humanitarian grounds), there is still a great need for politicians and policy makers to fully appreciate the need for disaster preparedness, and the need for it to be community-based.

National Societies have a number of ways to contribute to a community-based response to disasters, as was emphasized at the League's Consultation on the health aspects of the International Decade for Natural Disaster Reduction. First, they can develop and strengthen their existing community-based health programmes and ensure that these are able to respond in times of disaster as well as in normal times. Several examples of this have already been mentioned. It is perhaps interesting to note that community-based health programmes may also develop out of disaster response, as for example in Sudan and Ethiopia, and disaster preparedness programmes may themselves provide opportunities for community-based development, for example the Bangladesh Red Crescent's cyclone shelter programme.

The second possibility is community-based first aid. First aid has grown from a variety of influences, from Christian charity, by way of Florence Nightingale and the Countess of Gasparin, to Henry Dunant. Although for some people first aid has retained a very narrow meaning, namely the stabilization and transport of people on the battlefield under the protection of the emblem, for most National Societies first aid has evolved into something much broader and more relevant to a range of emergency situations.

In essence, over the years, National Societies have done two things with their first aid programmes. Some have used their battlefield skills to respond to other disasters where these skills would be appropriate, for example earthquakes, or to other emergencies, for example accidents on the roads in the mountains or in factories.

Others have expanded their first aid programmes to include skills which would help volunteers respond to the common emergencies in their communities, and the health problems resulting from the common community disasters, for example the home management of diarrhoea. Many have also been influenced by primary health care and have added elements of prevention to their programmes.

Patrick Couteau, in his review of first aid in francophone West Africa, discovered, amongst other things, that although many thousands of first aiders were trained by the National Societies in the region, the National Societies very quickly lost touch with the people they had trained. One of the main reasons for this was that the skills the first aiders learnt bore little relation to the types of problems that they encountered, either in their daily lives or following the common disasters that affected the communities with whom they lived and worked.

The League is currently building on the findings of this study and a number of regional workshops that have been held, in Africa, the Pacific and the Caribbean, to identify ways of strengthening and developing first aid programmes in the Federation. First aid is the major training programme of the majority of Red Cross and Red Crescent Societies and our most unifying health activity. There is a growing feeling that they could also contribute more appropriately and effectively to dissemination, to disaster preparedness, and to providing a community-based response that would meet the sudden and the daily emergencies that surround vulnerable individuals, families and communities.

In our attempts to simplify a complicated reality, there has been a tendency to separate disasters and emergencies from the everyday problems that confront vulnerable people. While this may make bureaucratic sense, it does not necessarily help our understanding of the problems. It also does not always contribute positively to our response, particularly those aspects of the response that must come before the relief effort, namely prevention, early warning, mitigation and preparedness, and the rehabilitation and recovery that must take place afterwards.

For most disasters, since the vulnerable groups and the health problems are much the same as in normal times, we need a more integrated approach. We also need to learn from the lessons of responding to the daily disasters that surround vulnerable people, which we call development. Of all the lessons that we have learnt, one of the most important is the need for a community-based approach. The more we can apply this to our disaster response activities, the more effective we

will be, and the more we will contribute not only to preventing and alleviating the suffering caused by high-visibility disasters but also to the sustainable development that will counteract the impact of daily disasters.

Dr. Bruce Dick

Bruce Dick, M.B., D.C.M., M.F.C.M., qualified from Guys Hospital, London, in 1971, and intended to become a paediatrician. However, his experience of clinical paediatrics in South Africa moved him into specializing in Community Medicine at the University of Cape Town. He worked as an academic and then as a district medical officer in a rural hospital in South Africa. He returned to England in 1980 where he worked as a community physician in the National Health Service, during which time he became a member of the Faculty of Community Medicine, and as a research fellow in the Evaluation and Planning Centre of the London School of Hygiene and Tropical Medicine. For the past five years he has been Head of the Health Department of the League of Red Cross and Red Crescent Societies.