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Recovery of Health Systems in Aceh: Meeting an unanticipated need for health facilities in temporary location centers

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Repair and recovery of health systems:
What happens after emergency response?

• Two phases to IOM programs
  – Temporary health services for displaced populations
  – Reconstruction of health care infrastructure in affected communities

• Additional considerations
  – Poor quality of pre tsunami health care
  – Community environmental health practices
  – Training/Retraining for health care staff
  – Special long term needs of surviving population
Temporary Location Centers (TLC) in Aceh

- January: Over 150,000 persons living in unplanned tent camps
- Government emergency response agencies identified need for transitional housing for up to 2 years
  - Initiative to build TLC started in early January
  - Occupancy planned to start mid February
  - Over 125 TLC planned or built throughout affected areas
    - 500-5000 persons per TLC
Gaps in community health resources for TLC communities

- Minimal planning for health and WATSAN needs in TLC by emergency planning boards
  - Single 40m² room without water, electricity, equipment or furniture available for community healthcare
  - Ministry of Health and Provincial Health Office had limited roles during planning or building phase but then inherited responsibility for community health
- International community did not participate actively in TLC planning process
  - Unresolved concerns over possibility of forced resettlement
Planning and building satellite health centers

- In mid February MOH/PHO requested assistance from IOM to develop and build 51 temporary “satellite” health centers in newly opened and future TLCs
  - Staffing program developed separately by MOH
- Limited time for assessment
  - TLC already being populated
  - Initial facility planning based with informal PHO input and IOM experience from emergency phase public health activities
  - Clinic design derived from IOM shelter program
  - Site selection and prioritization coordinated with PHO and WHO
Initial IOM plan for satellite health clinics

• Use locally designed and manufactured modular shelter components to build health clinics
  – Reusable structure can be disassembled and used for other purposes when camp population relocates to permanent community

• Pilot 108 m² clinic model designed and built
  – Built either by professional contractors or “cash for work” labor teams in 2-4 weeks
  – Larger or smaller versions can be built from same components
  – Interior space flexible; partitions are not structural
  – Includes plumbing, toilet, electricity

• Cost of assembled clinic structure less than $10,000
• Housing for clinic staff integrated into clinic structure
Basic Shelter “Kople Ampat”

- Designed in Bandung at Research Institute for Human Settlements of the Ministry of Public Works
- Meets or exceeds SPHERE standards
- Earthquake resistant tested
- Designed to provide temporary shelter for up to two years
- Can be assembled / disassembled (repeatedly) with local labor for eventual use in permanent shelter construction.
108 m² clinic with living quarters for six staff
54 m² clinic with living quarters
Satellite Health Clinic Equipment

MOH/PHO specified medical equipment provided (with NGO partner Americares)

– Clinic furniture and utilities (desks, chairs, storage, exam tables, sinks, beds for staff)
– Water source and electrical generator
– Communications
  • Mobile phones or radios to permit contact with other health facilities
– Staff transport
  • motorbikes for transport of specimens, vaccines or staff to other district health facilities
Clinic Operations

• Clinic staff and operating budget are provided by MOH
• Administration of satellite health centers is through district health office
Ongoing Assessments and Issues

- Review of staffing needs for satellite health centers
- Refine clinic design and equipment
- Optimize speed of construction utilizing cash for work teams
- Define desired population to clinic ratio
- WATSAN still marginal in most TLC
- Training and supervisory support for clinic staff
What was done well?

• Flexible and rapid response
  – Ad hoc clinic development and building process worked effectively and efficiently
  – Rapid cycle change: The plan, do, study, act cycle worked well to allow incremental changes in design while construction was underway and avoided delays inherent in a more formal design and building process
  – WATSAN engineers were able to design appropriate water and septic systems despite challenging conditions
What was done well?

• Cooperation
  – PHO, IOM, WHO and NGO partners effectively divided responsibilities for building, equipping, supplying and staffing to minimize delays in commissioning of clinics

• “Rolling” needs assessment
  – starting pilot clinics before full needs assessment was done avoided delays.
  – Ongoing data collection and assessments planned to optimize clinic size, staffing, equipment etc.
What was done well?

• Appropriate local solutions
  – Clinic building components locally manufactured
  – Construction by “cash for work” labor contributed to livelihood of displaced population
  – National specifications and sourcing of medical equipment
  – National staffing
  – Clinics connected administratively to local district health office
  – Building recyclable for other community uses when no longer needed as satellite health center
What needs improvement?

• Coordination of health and water/sanitation needs assessment with shelter planning

• Better communication between emergency planning agencies (BAKORNAS, SATKORLAK) with other government (MOH) and UN agencies during planning

• International community should insure political considerations do not compromise need to participate in community health planning