

## Chapter 2

# DISASTER MANAGEMENT

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### Rapid Response Mechanism

Currently, the RRT function as a rapid response mechanism primarily concerned with the management of disease outbreaks. By including emergency preparedness activities concerned with ensuring public health after disasters as part of the responsibility of the RRT, the capacity at local level to deal with and respond to public health threats from disasters can be greatly enhanced.

In 2000, the Ministry of Health (MOH), DHS and EDCD established a mechanism for managing epidemics. This mechanism consists of Rapid Response Teams (RRT) at three levels, i.e. one central team, five regional teams and 75 district teams.

The objective of the Rapid Response Teams at all levels is to establish an early warning and reporting mechanism for potential epidemics. This includes information gathering, investigation, verification and appropriate response. Managing disease outbreaks is one important aspect of disaster response and by heightening the preparedness level of the RRT they will be in a position to deal with all potential public health threats following disasters.

If emergency preparedness plans and procedures for disaster response are developed and institutionalised at district level, the RRTs can function as efficient first responders and the public health effects of any disaster can be significantly reduced. In order for the rapid response mechanism to function properly, it is important that the system of three levels of

RRTs is properly institutionalised as this will ensure timely and appropriate help whenever needed.

**Line of Communication and Coordination for Disaster Response**

1. Focal Point for district RRT: District Health Officer / District Public Health Officer
2. Focal Point for regional RRT: Regional Health Director
3. Focal Point for central RRT: Director, EDCD

**District Rapid Response Team**

Whenever there is a need for health related disaster response, the district level RRT could be the first responder. The responsibilities include carrying out an initial assessment (see appendix 1) as well as a more elaborate health assessment (see appendix 2), collecting and distributing information and coordinating the disaster response. The composition of a district RRT is outlined below. The line of communication and coordination in case of a disaster is from focal point to focal point.

	<b>Member</b>	<b>Designation</b>
1	Focal Point	District Health Officer / District Public Health Officer
2	Member Secretary	District Public Health Officer
3	Member	Medical Officer (Hospital)
4	Member	Health Assistant / Senior Auxiliary Health Worker
5	Member	Public Health Nurse / Staff Nurse / Assistant Nurse Midwife
6	Member	Vector Control Assistant / Malaria Inspector
7	Member	EPI Supervisor
8	Member	Auxiliary Health Worker
9	Member	Lab Technician / Lab Assistant
10	Member	Health Education Technician
11	Member	Statistical Assistant

## **Regional Rapid Response Teams**

The regional RRT will be mobilised if the impact of a disaster is beyond the response capacities of the district level. The responsibility of the regional RRT should primarily be to establish effective coordination between the central and district levels, NGOs, WHO and relevant donors. Furthermore, the regional RRT's responsibility is to enhance the emergency preparedness and disaster response capacities through the training of district level RRTs.

## **The Central Rapid Response Team**

The central RRT should be mobilised if the impact of a disaster is beyond the response capacities of the district and regional level RRTs. The central level RRT should be responsible for providing policy guidelines on emergency preparedness and disaster response to the regional and district levels. In addition, the central RRT will be in charge of coordinating and mobilising necessary resources and additional assistance with EDCD / MOH / DHS, WHO, donors and other institutions at central level.

For further clarification and questions on the role and responsibilities of the central, regional and district RRTs contact EDCD,

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All RRTs must undergo the necessary training in carrying out rapid health assessments, multiple hazard and vulnerability mapping, disaster related health consequences and best public health practices in emergency preparedness and disaster response.

The following section outlines specific tasks of the three different phases related to disaster management.

## **Emergency Preparedness**

### **➔ Emergency Preparedness Plan**

The district RRT should develop a district level emergency preparedness and disaster response plan in coordination with the District Disaster Relief Committees, Nepal Red Cross Society (NRCS), Armed Police, Nepal Police, Royal Nepal Army (RNA) and other relevant institutions. The preparedness plan should include a disaster management plan for hospitals and procedures for field based medical services, lines of communication and coordination among the key actors in the district. The emergency preparedness plan should furthermore include a detailed assessment format and a prioritisation of the existing health facilities, local resources and capacities. The existing health services should be assessed not only in terms of how they manage a short-term disaster response but also in terms of how a continuation of the health services is secured.

### **➔ EWARS and Information**

The mechanism for early warning and reporting of potential disasters should be strengthened in coordination with government line agencies, NRCS, Nepal Scouts, Nepal Police, RNA and other institutions in the district. An information centre receiving information from the field and distributing it to the relevant RRTs should be established. An ideal centre remains open 24 hours / 7 days a week (e.g. the Emergency Room in a district hospital).

### **➔ Training**

The regional Rapid Response Teams should facilitate the training of district RRT members and other health workers. The training should aim at enhancing the level of emergency preparedness and the capacity for disaster response including correct and prompt reporting systems from the field to the relevant health authorities.

### ➔ **Buffer Stock**

A minimum stock of medical supplies and equipment to be used after the declaration of an emergency must be prepared. District hospitals' medical and equipment supply should function as a buffer stock of essential supplies for the district RRT.

### ➔ **Water and Sanitation**

Environmental health aspects such as safe water supply and sanitation facilities should be considered in the preparedness plan. Safe water sources must be located before an emergency in order to ensure the health and the survival of the disaster-affected population. At the same time, a sanitation programme that outlines the district's needs during emergencies should be prepared.

## **Disaster Response**

### ➔ **Initial Rapid Health Assessment**

The RRTs must be activated as soon as possible after the occurrence of a disaster. An assessment team from the district RRT should be sent to the disaster site to conduct an **initial rapid health assessment** within the first 24-48 hours of the disaster using the Health Assessment Format provided in appendix 1. A more **elaborate disaster assessment** (see Appendix 2) should be completed and reported to the health authorities within the first 5 days following the disaster.

Both the initial rapid health assessment and the elaborate disaster assessment must be submitted to the national health authorities, i.e. the focal point of the central RRT, Director of EDCD through telephone and fax (Tel: 01-4255796 / 01-4262268, Fax: 01-4262268)

### ➔ **Health Services**

The RRT must coordinate the emergency relief health services in collaboration with the local health facilities, NRCS, police, army, private medical institutions, local NGOs and the local community. The main relief health services during an emergency response are concerned with mass casualty management services and management of public health issues.

Field-based mass casualty management includes prioritisation of casualties (medical triage), first aid, stabilisation and evacuation of victims for further health care services and hospital based health services to the disaster-affected population.

### ➔ **Water and Sanitation**

The state of water and sanitation facilities must be assessed as soon as possible. If necessary, safe palatable water and a sufficient number of hygienically safe toilets must be made available to the disaster-affected population in order to reduce the risk of communicable disease outbreaks. Potential outbreaks in the disaster area are to be identified and notified with the help of the existing disease surveillance and Early Warning Reporting System (EWARS).

### ➔ **Disease Surveillance**

Disease surveillance includes collecting, compiling and interpreting data and investigating all reported diseases with the assistance of an epidemiologist. All vaccination programmes should be carried out in consultation with the national health authorities and EDCD, but generally vaccination against measles should be given a high priority. However, no vaccination should be carried out until a reliable cold chain has been established.

## **Rehabilitation Activities**

In general, the inter-agency coordination should be strengthened to reconstruct, rehabilitate and restore the local health services as soon as possible after the initial phase of the disaster. Effective rehabilitation of health systems is dependent on an efficient coordination between national and local services as well as multi-sectoral coordination and collaboration.

### **➔ Health Services**

Public health services should be strengthened including implementation of measures to control communicable and vector-borne diseases (i.e. education on hygiene, water, sanitation campaigns) to prevent or lessen the influence of future disasters on public health. Emergency health service interventions (e.g. measures for communicable disease control, disease surveillance and health service monitoring processes) should be integrated with the existing health service systems to ensure stability during times of disaster.

### **➔ Mental Health**

Not only the physical well-being of the disaster affected population should be considered but mental well being as well. Counselling and active listening to reduce post-disaster mental health consequences including psychological traumas should be offered to the disaster affected population as a whole (see Chapter 3, control of non-communicable diseases Standard 3). Utilisation of local resources and involving the disaster affected population in rehabilitation activities should be encouraged, as this can help the mental well being of the local community.