

Disaster Relief—“What Can I Do to Help?”

By Lee Jacobs, MD

The recent tsunami disaster has led people throughout the world to ask: How can I help? As health care professionals, we wonder how our skills might help those in need.

After a disaster, the first responding agencies have limited roles for volunteers. When recovery efforts are complete and basic infrastructure is in place, there is usually a need for long-term health care support. Well-organized, short-term health care teams can be of tremendous value to a recovering community.

Most international agencies responding to disasters do not have the capability to mobilize large numbers of short-term volunteer teams. This is the role of the volunteer organizations.

The value of health professional teams is directly related to how well volunteers are recruited, oriented, and equipped. Over the past 12 years, I have mobilized teams of health professionals to remote regions of Central Asia and, as a flight surgeon in the US Air Force, I participated in disaster responses. While disaster re-

sponse and routine humanitarian support may be different in many ways, many of the logistical issues confronting volunteers on short-term teams are the same.

It is for this reason that I am presenting these practical lessons. I hope Permanente Medical Groups, as well as other medical groups, will take steps to develop the capability of sending numerous volunteer teams to countries in need, today and for years to come.

Practical Suggestions for Health Professional Volunteers

The idea is to help and not be a burden! This requires an effective three-way partnership with an on-field coordinator, a humanitarian agency, and a well-trained, well-equipped team of professionals under an experienced team leader. Success is directly related to how experienced these three partners are, how well they collaborate together, and how effectively they fulfill their roles (Sidebar 1). The lack of an experienced field coordinator and team leader will almost certainly compromise the team's effectiveness.

The Mission— What the Team Will be Asked to Do

The field coordinator will determine the specific activity of the team, possibly in collaboration with the agency. The team leader shares the capabilities of the team, including health disciplines, special skills, and time commitment of the team. The realization that the mission is field-driven helps team members understand that what they will do might be very dif-

Sidebar 1. The Three-Way Partnership Defined

A. Partnering Agency:

- Identify the most appropriate site and mission for the health care team
- Provide the field coordinator or identify a capable person in the field
- Provide the necessary clearance from local authorities

Few agencies, if any, have the capability for fulfilling what is stated below under Team Leader. Partnering Agencies do not mobilize teams of professionals, especially on a large scale for a short term.

B. Field Coordinator:

- Primary contact for the team leader
- Works with local authorities to tentatively plan clinic operations
- Provides appropriate cross-cultural orientation
- Organizes the pool of translators
- Determines housing and food sources

C. Team Leader:

- Responsible for selection, orientation, and equipping the team
- Collaborates with the Field Coordinator in pretravel planning
- Is the on-site supervisor
- If possible, makes a pre-trip to the field
- Overall responsibility for accomplishing team mission and creating a positive experience for first-time volunteers

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ferent from what they anticipate. This spirit of flexibility is of paramount importance to the success of the team.

Applicant Screening— Who Gets to Go

Many are willing, but few are chosen. Health care practitioners are, in general, compassionate individuals. Many would like to serve; however, there are many parameters for designing the team.

Health Status: This is probably the most common reason for not joining the team. Important considerations are: a) any physical condition that potentially may require medical attention within two days, b) any condition that may be aggravated by prolonged travel or rugged living conditions, and c) anyone markedly out of shape and unable to participate in a physically stressful trip.

Team members who are ill the day of departure should *not* be allowed to depart with the team. This includes members with unexplained fevers or with severe respiratory or gastrointestinal infections—Tough call but a precautionary necessity.

Application: Unless a person is well known, request a reference to substantiate that the person is emotionally, physically, and attitudinally able to function on a team. These aspects are greatly magnified by the stresses of remote village health care work and, if in deficit, can jeopardize the mission of the team.

Team Size: Although there may not be an optimum size, it is very

difficult to mobilize teams of more than 20 people. The logistics of transportation and housing are factors for consideration. My preference is to organize several teams of 15 or fewer.

Team Structure: The overall field and agency-driven humanitarian mission will suggest the make-up of the team. Registered nurses are especially helpful, and pharmacists provide essential familiarity with medications. It is helpful to blend experienced team members with newcomers. Finally, nonmedical personnel can also be valuable members of the team; many important activities do not require medical skills.

Team Orientation— Preparing for the Experience

Vaccinations: The requirements are available on the CDC's Web page (www.cdc.gov) and from any travel clinic. Generally, hepatitis A and B vaccinations, typhoid, and an updated diphtheria tetanus are needed. Geographic location determines the indications for inactivated polio, yellow fever, and malaria prophylaxis.

Cultural Awareness: This is probably the most important orientation activity and includes appropriate attire. For footwear, comfort is essential. Hiking shoes are fine unless you will be in a culture where you remove your shoes when you enter a house; then slip-on shoes work better. Scrubs are always appropriate; white coats are good but difficult to carry. People of many cultures expect their health caregivers to dress as health care professionals. In many Muslim settings, skirts and scarves for married women are appropriate. Display as little jewelry as possible.

Postcards of home and pictures of you and your family make great

gifts. *KoolAid*[®] is always welcomed. People love *Polaroid*[®] pictures. Be careful about passing out candy in public unless there's enough for all the children! Never give money or heavy objects.

There are many rules of etiquette but most important is to obtain a person's permission to take their picture. The use of alcohol is problematic in many cultures.

Only basic language skills are necessary. "Cheat sheets" for medical terms may be helpful.

If you have any questions as to what is appropriate, contact your team leader or field coordinator (see Sidebar 2).

Travel Logistics— Complex but Exciting

Planning Period: Although teams can mobilize in a few weeks, it usually requires 30-60 days planning. Passports are required.

Duration: I generally take health care teams for ten days or fewer, organizing the itinerary so we have at least five days in the field.

Transportation: Plane tickets can be purchased at group rates. In-country transportation is always a challenge but is the responsibility of the field coordinator. Vans (usually without seatbelts) or minibuses are superior to cars. Small planes in developing countries are very risky but may be the only mode of transportation available.

Safety: There are no guarantees. The field coordinator certainly will know if a location is safe. The greatest risk is from the transportation. The poor condition of the roads and vehicles and lack of seatbelts contribute to the risk. The team leader should obtain the best transportation possible and make certain drivers slow down.

Luggage: Most of the luggage allowance should be allocated to the

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Sidebar 2—The Don'ts

- Don't make promises or commitments.
- Don't consider bringing people back to the United States
- Don't give money, not even to the translators

medical supplies. The second checked-in piece is allocated to a team footlocker containing supplies. The exact weight (for all legs of the trip!) should be predetermined to avoid overage charges. All should be encouraged to carry on personal supplies so both checked items can be allocated for medical supplies.

Housing and Food: These are dependent on the capability of the infrastructure.

Water: The most important, least adhered to advice! Each team member should carry his or her own water bottle with a built-in filter. For example, the *Extream* water bottle filters bacteria and parasites but, most importantly, kills viruses (see picture).

Antibiotic Prophylaxis: As an infectious disease physician, I am sensitive to the appropriate use of antibiotics and am aware that this is a controversial topic. I am unaware of any evidence supporting or refuting the use of prophylactic antibiotics. This is a personal decision, but for very remote settings, I do recommend prophylaxis to our team members.

For the Team: A team First Aid kit to include medicines for team members and not for use in the clinic (examples: IM phenergan, lomotil, Epipen). A satellite phone is invaluable for emergencies and for volunteers to reassure their families.

Field Clinic Organization— Now We Make it Happen

Facility: An appropriate field worksite is essential. The facility needs to be a quiet place that has good natural lighting and good ventilation with, at least, curtains to provide some privacy. There should be a few large rooms with hallway waiting areas and a good door to control the flow into the clinic. In outdoor clinics, it is still important to keep the crowds away from the



Extream water filter bottle.

care site as much as possible.

Security: Most fields necessitate 24-hour security guards. Crowd control is critical and must be provided by the local authorities. This is a key point of discussion with the local authorities before the clinic opens. It is also important to make certain that the medicines and supplies are secure.

Patient Flow:

- **Focus Triage:** This is a critical area in both disaster relief and follow-up humanitarian relief. Planning with local authorities is critical.
- **Pace:** Team members should realize that they can't cure the world but can impact those in need, one person at a time. The team must take time to listen and provide emotional as well as physical support. Touching with the gloveless hand is important, so wear gloves only for the usual specific infection control problems.
- **Multiple complaints:** There are limits to the amount of time you can spend with each per-

son; so to avoid being presented with a long list of complaints, ask the local officials and triage workers to make it clear that only one or two problems can be evaluated.

- **Thankful patients?:** The vast majority of people you serve will be very grateful that you have traveled so far to care for them. However, team members should be prepared for the ungrateful or abusive person. This is rare but provides a reminder that we serve for personal reasons that go beyond the expectations that we will be appreciated.

Medicines: The mission will drive the inventory. Generally, a team can be equipped for approximately \$500/day—more if surgery or vaccinations are involved. Don't forget weight implications: for example, exclude cough medicines and adult vitamins; however, prenatal vitamins are considered essential.

Roles of Team Members: The mission dictates the make-up of the team. Nonmedical assistants can serve as patient flow coordinators, pharmacy assistants, assistants to the door guards, etc.

Working with Translators: This is a key area that is rarely mentioned in preparing teams. Team members must know how to relate to their translator. They are not only the voice of the team, they are also the resource to understand the culture. Be patient! Most nationals have learned their English in school and usually are unfamiliar with medical terms. The field coordinator should have a list of common medical words to brief the translators before the team arrives. The most functional translator support is one translator for each person on the team. The most proficient translators should be

assigned to the practitioners. The translator will want to please you; be appreciative and patient. Do not give any money or make any commitments to the translator without checking first with your team leader.

Lab Support: Minimal availability. Depending on the mission, glucometers and urine dipsticks may be available. Usually there is limited need or availability beyond these types of tests.

Specific Diseases: It is helpful to learn from the field coordinator and translator as much as possible about what you can expect to see in your clinic and local cultural terminology and myths. Understanding cultural bereavement is important in postdisaster situations.

Expect the Common: Most problems will be what you are used to seeing (eg, carbuncles needing drainage) and ailments simply needing a basic first aid approach.

Public Health Teaching: Training is a key area. Nurses can hold group training sessions on food preparation, water, sanitation, etc. Translators and the supporting agency can provide input to make the curriculum relevant.

Diarrhea: People are used to living in a different state of well-being than you may be used to. A specific example is widespread, mild diarrhea. Interventions should be reserved for marked diarrhea or significant increase in loose stools.

Involving the Local Health Care Professionals: This is an excellent opportunity to build relationships and teach. However, don't discuss approaches unavailable to the local professionals, and don't put them in a difficult situation by leaving stockpiles of medications in their custody. Most appreciated are BP cuffs and stethoscopes, a consideration for the team as they pack their supplies before leaving home.

Closing

I hope the readers of *The Permanente Journal* find these suggestions helpful as they consider their role in volunteering for health care teams providing relief in remote areas.

You will find this experience to be so rewarding that you will want to return again (our objective!) and to recruit others. Most important, you might want to be a future team leader, probably one of the most important factors in mobilizing effective teams.

Can you imagine if Kaiser Permanente and other large medical groups develop this capability so that they can annually mobilize effectively a large number of these health care teams? It would impact the lives of people serving and being served for years to come.

This is only the beginning of a dialog, so please send me your lessons learned so that together we can create an effective volunteer force. ❖

Joy

I slept and dreamt that life was joy;
I awoke and saw that life was service;
I acted and behold,
service was joy.

— Rabindranath Tagore, 1861-1941, 1913 Nobel Laureate
for Literature, Indian poet and composer