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Panel 2.9  
Repair and Recovery of Health Systems

Displaced persons (DPs) surviving the tsunami that devastated Aceh have relocated either to host communities or in tent-based temporary camps. The Government of Indonesia determined that transitional living centers (TLC) would be necessary to provide transient living arrangements for DPs as an interim stage before permanent resettlement. Government planning for the TLCs did not include the MOH and was limited to site selection for building of barracks. Minimal planning was given to water, sanitation or other health needs of the intended residents. Reestablishing health services requires planning for short term needs (1-2 years) while displaced persons are living in transitional camps or in host communities.

During early phases of emergency response, the international community did not participate in the planning process for the TLC largely due to unresolved political concerns regarding the potential for forced resettlement of the DPs. Many TLC were sited in regions remote from existing functional community health centers. TLC sites were built and only as an afterthought was the need for health care considered. This oversight was not appreciated until shortly prior to the opening of the first TLC. The International Organization for Migration (IOM) was approached at that time by the MOH to assist in developing and implementing a strategy to build satellite health centers (SHC) in or adjacent to TLCs.

A brief planning phase organized by the Ministry of Health and IOM included WHO representatives as well as the international NGO, Americares, and the provincial health department. The objective was to design and build a small clinic either as an independent clinic or as a satellite of a nearby neighborhood clinic in order to alleviate strain on existing resources. Camps of different sizes and varying distances from functioning hospital inpatient services require differently sized and configured temporary clinics. There are currently over one hundred TLC sites planned or built throughout Aceh with approximately 50 requiring new or supplemental medical clinic facilities.

A rapid needs assessment was done based on existing knowledge of tent based camps and government lists of planned or operational TLCs. As transitional camps are expected to be operational for up to two years, tents are not sufficient. Permanent structures would take too long to build and would be a wasted investment. An alternative is to use flexible modular temporary housing components to build clinics. Such locally designed and manufactured modular shelters are currently being supplied as transitional housing units by IOM and are easily adapted for use as a clinic simply by reconfiguring interior non structural partitions. The modular design allows clinic size to be varied as needed and include living quarter for the healthcare staff. A small attached inpatient unit is added if necessary.

Coordination of planning, though delayed, was relatively efficient once initiated by the MOH. The provincial health office (PHO), IOM and other partners participated in the planning process. A prototype shelter unit was rapidly erected so local officials and health providers could assess the basic structure and give advice on desired changes in clinic design. Site selection, driven by known or planned TLC sites was coordinated with public works officials in order to obtain necessary permission to build on private or public land. Suboptimal building sites required further planning and site preparation, especially for sanitation and water supply. Prototype clinic designs were reviewed with local health officials and providers. Two standard designs, a small and medium sized clinic, were approved. Space and facilities adequate for one physician and several nurses along with two or three exam rooms, a reception and waiting area, clean and dirty utility spaces, staff and patient bathrooms and office space for a nutritionist and sanitarian were included. Electrical and plumbing service including hand washing sinks in exam rooms is included. Housing for clinic staff is incorporated into the clinic design. Equipment needs were determined by the MOH and a list assigned to a cooperating NGO for procurement.

A standard 108m<sup>2</sup> SHC can be assembled, furnished, equipped and operational within three weeks using local “cash for work” labor teams once they have been trained and gained experience. Use of professional contractors shortens construction time approximately by half. Extraordinary site preparation or water and sanitation requirements may extend construction time. The structural elements of the clinic unit are recyclable by non-destructive dismantling and reassembly in a new location. Similarly, investment in equipment and supplies for the temporary camp health clinics will be recycled by transferring these items to permanent health centers as TLC camps are decommissioned.

To date, two pilot SHC have been finished, staffed and turned over to the district health office for operation. Six more are currently under construction and we anticipate building ten per month using a combination of “cash for work” teams and professional contractors.

In keeping with recent health care reform changes in Indonesia, the district health office maintains administrative responsibility for the clinics and provides full staffing and operational costs. Communication with district level hospitals or sub-district puskesmas clinics for backup will be established through provision of mobile phones as land line telephones are not expected to be available in transitional camp sites. Motorbikes are provided by NGOs for official health business to allow clinic staff to transport specimens and vaccines to and from affiliated district health centers.

Staffing and operation of SHC is the responsibility of the MOH. Initial MOH decisions on staffing numbers and patterns at the national level were made with little input from district health officers or international organizations. These staffing decisions appear to be modeled on normal clinic requirements rather than adapted specifically for SHC facilities. Basic but minimal training was organized by MOH for newly hired staff. Given the unique nature of this new program and increased burden on district health

offices, IOM will work with partner NGOs, national universities and coordinate with the MOH and WHO to better assess SHC staffing needs and to deliver training programs for healthcare staff.

Continuing district health planning is needed to determine the optimal distribution and size of clinics for each camp, based on the desired clinic-to-population ratio. Other considerations such as need for inpatient (“short stay”) beds are individually considered depending on factors such as distance, or access if roads are yet to be repaired, to nearest district hospitals.

IOM will evaluate the clinic operations on an ongoing basis and to incorporate lessons learned into future clinics. Lessons learned to date include 1) need for integration of planning for health, water and sanitation with, not after, emergency shelter planning, 2) site preparation needs for water and sanitation should be considered during initial clinic site selection, 3) Use of cash for work labor has benefits to the displaced persons community but significantly slows construction times, 4) better coordination early with MOH needed to clarify staffing needs and clinic size requirements, 5) training and supervisory support needs for clinic staff require consideration in the planning process.