



## Paradigm Shift of Disaster Responses

Ali Mohajervatan<sup>1\*</sup>, Fatemeh Rezaei<sup>2</sup>

<sup>1</sup>Department of Health in Emergencies and Disasters, School of Emergency Medicine, Golestan University of Medical Sciences, Isfahan, Iran

<sup>2</sup>Department of Health in Emergencies and Disasters, Isfahan University of Medical Sciences, Isfahan, Iran

### INTRODUCTION

Long term health impacts of disasters are mostly ignored in the early response phase, which could cause more severe health issues, especially for those who have background illness. These susceptible people suffer from the interruption of the healthcare supply chain and are at more risk of psychological consequences. Therefore, the need to change the response paradigm from need oriented disaster management to systematic prevention based to cover the care of special groups should be considered with the spread of disasters, more people suffer from its long term consequences, such as mental health disorders and lack of social welfare. As a result, they are always worried because their livelihood and health are in danger. Among these, vulnerable groups are more exposed to mental health consequences and interruption of routine treatments. In the meantime, experiences in past disasters have shown that breaking the drug chain in methadone treated people leads to symptoms of withdrawal and discontinuation syndrome. Therefore, psychotherapeutic primary care should be given in the same acute phase of the incident. In this regard, it is suggested to change the response paradigm from need oriented to prevention-oriented and integrated to cover the care of special groups [1-3].

### ABOUT THE STUDY

Disasters are complex global problems accepted as inevitable facts. Currently, increasing disaster tolls of all types have become part of human life. Disasters are a fundamental challenge to achieving Sustainable Development Goals (SDGs).

In recent decades, a significant increase in death tolls and economic losses caused by natural and manmade disasters can be seen across countries. The influential factor in devastating consequences is urbanization growth, particularly, in settlements exposed to social disorder, political turmoil, and natural/manmade disasters. People and communities affected by disasters mainly have their mental health and well-being disturbed.

The widespread feeling of insecurity occurs when people lose their properties including homes and valuable assets. The death of loved ones also puts casualties in a state of insecurity due to being deprived of the feeling of loveliness, attachment and belonging. Various factors would lead to mental and psychological vulnerabilities among disaster victims, including family displacement, death of a beloved one, socio-economic damage, environmental degradation, lack of mental preparation, disruption of family ties, and loss of community support systems. Besides, studies show that some disasters could cause long term mental and psychological consequences such as loss of cultural and social values in floods. Moreover, vulnerable communities would experience worse consequences, which lead to severe stress and poor psychosocial state in susceptible and disaster stricken communities. Communities residing in disaster-prone areas such as coastlines are often victims of confidence. To be exact, they are exposed to alternative coping strategies, threatened livelihoods, and threatened life quality for several months. Children, infants, the elderly, and people with physical and mental disabilities will be adversely affected when instantaneous events strike the community. They are at risk of being neglected when displaced communities are forced to stay in temporary relief camps.

<b>Received:</b>	08-February-2023	<b>Manuscript No:</b>	IPJHCC-23-15677
<b>Editor assigned:</b>	10-February-2023	<b>PreQC No:</b>	IPJHCC-23-15677 (PQ)
<b>Reviewed:</b>	24-February-2023	<b>QC No:</b>	IPJHCC-23-15677
<b>Revised:</b>	24-August-2023	<b>Manuscript No:</b>	IPJHCC-23-15677 (R);
<b>Published:</b>	30-August-2023	<b>DOI:</b>	10.36846/2472-1654.8.4.8033

**Corresponding author:** Ali Mohajervatan, Department of Health in Emergencies and Disasters, School of Emergency Medicine, Golestan University of Medical Sciences, Isfahan, Iran; E-mail: mohajervatanali@yahoo.com

**Citation:** Mohajervatan A, Rezaei F (2023) Paradigm Shift of Disaster Responses. J HealthC Commun. 8:8033.

**Copyright:** © 2023 Mohajervatan A, et al. This is an open-access article distributed under the terms of the Creative Commons Attribution License, which permits unrestricted use, distribution, and reproduction in any medium, provided the original author and source are credited.

The first priority of health systems immediately after a disaster is providing access to basic health services for the affected people. In reality, response actions are based on need assessment and available capacities. On top of that, capacity constraints in the acute phase of disasters direct the relief efforts toward providing emergency services for seriously damaged victims. Notably, chronic disorders of in need individuals would be ignored or at least their treatments will be delayed. Therefore, many studies indicated that as major psychological consequences will appear for a longer period of time after a disaster, psychological needs are considered a part of public health services, and not in emergency mental health services.

The 2019 flood, in the North of Iran, resulted in deaths, injuries, and displacement of the population in several provinces. Response agencies encountered populations whose homes, families, and living environments were adversely affected. At the time, the elderly population who were receiving methadone therapy faced interruption of the drug supply chain, stress, and anxiety. Meanwhile, the interruption caused to a faster appearance of withdrawal symptoms and discontinuation syndrome. Having a lesson learned, we understand that although mental health services are considered in public health function, response teams were expected to provide emergency psychological first aid along with addressing the needs of the dead and wounded and the settlement of the affected population.

Studies have defined consecutive phases for the appearance of psychological disorders after disasters including the heroic phase, the honeymoon phase, the disillusionment phase, and the restoration phase. The psychological symptoms of each phase manifest themselves during a certain period of time after the disaster (for example, the heroic phase is one week, the honeymoon phase is two to eight weeks, disillusionment phase is two to 36 months). Adapting priority measures of disaster response in concern to the phases of psychological disorders is an undeniable necessity. It seems that the assumptions, beliefs attitudes, laws, and theories that we have about responding to disasters need a paradigm shift, a change from a need based response to a comprehensive, integrated and preventive approach based on the principles of prevention, preparation and reducing the long term consequences in the response phase. Changing the general paradigm of response function can be a valuable field for future research [4-7].

## CONCLUSION

As mental health caused by disasters is based on the principles of "preventive medicine", a paradigm shift is

recommended from response centered management post disaster to a systematic, multidimensional approach to health promotion, prevention, and preparedness. It is clear that the health response to a disaster must be based on the identified and anticipated needs of the affected population, but we must also prepare for the needs that will be created by the direct and indirect effects of the disaster during the response. Response plans should use the best available data to consider acute, short term, and long term health consequences after an event. The inadequate and on-demand resources in the early phase of disasters, as well as the dynamic and changing conditions, highlight the importance of timely and integrated measures. Therefore, disaster responders need to plan and implement integrated and coherent management, and it does not occur except with the use of lessons learned.

## REFERENCES

1. Martin ML (2010) Child participation in disaster risk reduction: The case of flood affected children in Bangladesh. *Third World Q.* 31(8):1357-1375.
2. Kraas F (2003) Megacities as global risk areas. *Urban Ecol.* 15:583-596.
3. Du W, FitzGerald GJ, Clark M, Hou XY (2010) Health impacts of floods. *Prehosp Disaster Med.* 25(3):265-272.
4. Bich TH, Quang LN, Thanh Ha LT, Duc Hanh TT, Guha SD (2011) Impacts of flood on health: Epidemiologic evidence from Hanoi, Vietnam. *Global health action.* 4(1):6356.
5. Menne B, Brown L, Muray V (2014) Floods and health, fact sheets for health professionals. World Health Organization pub, Regional office for Europe, Denmark. 1-91.
6. Mohajervatan A, Tavakoli N, Khankeh H, Raeisi AR, Atighechian G (2021) Health sector's flood response plan: A comprehensive review. *J Environ Health Sci Eng.* 8(3):169-178.
7. Math SB, Nirmala MC, Moirangthem S, Kumar NC (2015) Disaster management: Mental health perspective. *Indian J Psychol Med.* 37(3):261-271.