GOVERNMENT OF KHYBER PAKHTUNKHWA
HEALTH DEPARTMENT

World Health Organization

Health Cluster

Situation Report No. 04

Displacement from Khyber Agency-IDPs Crisis

A. Cluster Details

1. Lead Organization:	**WHO**
2. Cluster Website:	**www.whopak.org**
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B. Reporting Period

1. Report Number:	**HC-004**
2. Report Date:	**16.04.2012**
3. Time Period Covered:	**09.04.12 – 15.04.12**

C. Humanitarian Needs

WHO along with health cluster partners, UNICEF and provincial health authorities lead the emergency health response for the newly displaced IDPs in Jalozai camp and living in host communities in the district Nowshera.

Health services in the camp need to be further strengthened to meet the needs and gaps for health care for IDPs, including availability of treatment of most common diseases as diarrhea, acute respiratory infections, scabies, skin infections, eye and ear infections, hypertension, diabetes, fever, bronchial asthma and anemia. There are further requirements to improve implementation and practice of integrated MNCH, reproductive health and family planning components, including IMNCI, antenatal, delivery, newborn and, post partum care, detection and management of STIs, etc. There are serious efforts to be undertaken to

ensure regular functioning of expanded program on immunization to provide routine EPI services, cover pregnant women and eradicate measles and polio cases. Nutrition gaps are still existing and requiring comprehensive approach and partnership with provincial nutrition program. Malaria and TB cases should be regularly screened, referred and treated as per available guidelines and protocols. There are gaps in provision of mental health and psychosocial support to IDP families. Required counseling, identification and treatment of mental disorders remain as one of regularly unmet health priorities. Functioning health posts must properly be equipped to provide emergency health assistance linked to minor surgical assistance, including snake and poisoning cases. Laboratory and x-ray services are of limited accessibility for IDPs in the camp. Required social mobilization efforts must be in place to meet the needs of people with disabilities residing in the camp.

WHO identifies camp hygiene conditions as extremely poor which will continue to deteriorate in the future, thus the risk of an outbreak of waterborne disease is highly increasing. 80% of camp' population does not have access to soap and other hygiene supplies. Latrines have been built, however, their appropriate use is still a problem. It requires further sensitization of the camp population for the appropriate and correct use. Overcrowding combined with inadequate hygiene and nutrition is further exacerbating vulnerabilities of the affected population to WASH related diseases. Social mobilization needs to be strengthened in terms of coordination and articulating information on water safety to the community.

D. Humanitarian Response

Coordination:

UNHCR updates (April 14, 2012) a total of 145,947 families (677,643 individuals) as IDP population in KP and FATA, including 44,652 families (194,281 individuals) is registered in Jalozai camp. More IDP families opt to for off camp residence with 12,385 families are currently residing in the camp.

PDMA informed about the return of Mohmand Agency IDPs (500+ families) from Jalozai camp scheduled from 17 April 2012. Clusters were requested to arrange for return packages. Similar return for Bajaur IDPs residing in Jalozai camp is set up for April 20, 2012.

Health facilities remained closed for two days following the threat of security incidents in the camp area.

WHO as a health cluster lead chairs daily basis coordination activities in the camp together with other health partners, WASH, Nutrition, Food and CCM clusters working in the camp where issues are discussed and decisions are taken on the spot to address any loop holes in the health response for containment and control of disease outbreaks in the camp. Three health cluster meeting were held in Jalozai camp. Planned activities are focused on strengthening preparedness for prevention of diarrhea diseases and follow up on polio and measles campaigns. WHO shares all the updates and the minutes of camp health cluster meetings with EDO Health Nowshera as requested.

WHO plans to conduct the regular provincial health cluster meeting on April 19 (10:00-12:00) in DG Health in Peshawar.

Health cluster partners with support of WHO and UNICEF in the camp continue establishment of additional health posts in new phases of the camp to ensure provision of PHC; MCH; CMAM (SFP, SFP PLW, IYCF and OTP); pharmacy; immunization; community outreach & health awareness and referral services to IDP population. There are 4 static health posts run by Merlin, 1 by CAMP and 2 by CERD.

A mobile health team of FATA is working in the camp. A request was put forward to WHO for assistance with medicines and supplies.

WHO updated the draft of 4W matrix for Jalozai camp reflecting the presence of all functioning health cluster partners and shared with OCHA.

A coordination meeting was called by EDOH Nowshera for all health cluster partners present in Jalozai camp as response to Suo Moto Action of Chief Justice in regards to the provision of social services in the camp. EDO Health expressed entire satisfaction on the performance of Health Cluster in Jalozai camp with still remaining space for improvement but overall present health teams were in the position to control potential outbreaks and keep morbidity and mortality rates at lowest. A request was put towards Health Cluster to expand immunization and other activities for IDPs residing in other union councils which were not covered by the last immunization campaign.

WHO and UNICEF took part in the coordination meeting called and chaired by the DG PDMA attended by PDMA representatives, Agency Surgeon Khyber Agency, representatives of FATA Health Directorate. The meeting focused on update of health coverage and situation in and off Jalozai camp, including 1) immunization and polio vaccination; 2) current and potential increase of health care services inside the camp; 3) transfer and deployment of Khyber Agency health force inside of Jalozai camp; 4) availability of sufficient health human resources (especially female doctors, gynecologists, etc.) and required supplies and treatment for snake and dog bites. WHO Health Cluster provided the update on existing health care services in the camp. WHO Polio and UNICEF briefed in details about on going activities and efforts in partnership with DG Health on immunization and vaccination. Polio and measles campaigns' aspects were fully reported to DG PDMA (coverage, gaps and recommendations). UNICEF highlighted the need to formulate a better communication strategy to ensure sharing information with general public on services provided in and around the camp. DG PDMA expressed concerns, requirements for better registration and service provision to off camp IDP population. A clear cut mechanism is required to be put in place in coordinated manner with all stakeholders. UNICEF, WHO, DG Health shared consensus on sufficient number of EPI static and transit points in Jalozai camp. It was requested that no tolerance and compromise should be practiced while to ensure all children vaccination. A request was made to ensure a more stringent involvement of law enforcement structures at transit points off camp to detect and refer all observed children. DG PDMA was well satisfied with ongoing plans and activities of 6 BHUs and 3 MCH center to be deployed inside the camp. DG PDMA expressed a recognition of extensive use of social mobilizers in Health and WASH clusters. FATA Health Secretariat was requested to facilitate and streamline the coordination and modalities of presence of new health staff from Bara tehsil to assist own people in and around the camp. More details will be shared later on proposed mechanisms and types of health services to be provided by Bara tehsil health staff. WHO expressed its readiness to provide available assistance, including supplies and training of health staff, especially on DEWS. Khyber Agency health staff will be expected to report back to WHO on DEWS when present in Jalozai camp. DG PDMA expressed his understanding and confirmed the fact on the existing highest levels of comprehensive health care activities undertaken by health cluster. DG PDMA instructed his staff to ensure regular coordination meetings especially on coverage and inclusion of off camp IDP population into the existing and future health care activities

Assessments:

WHO rapid response team (two DEWS surveillance officers, two environmental health engineers and one essential medicines' expert), is permanently based and active in and around the camp.

WHO assessed (Health Resources Availability Mapping System) the provision of health care services in health facilities of 3 union councils hosting most of IDP population, including Dag Ismail Khel, Dag Behsood and Jalozai, of which 4 are permanent and 5 camp based. For community based services 78% of health facilities report and collect vital statistics such as "deaths and births" (HMIS) and register data on population movement, pregnant and newborn children. On c**hild health** 44% of health facilities are introduced and aware of IMCI community component; 100% report home based treatment of

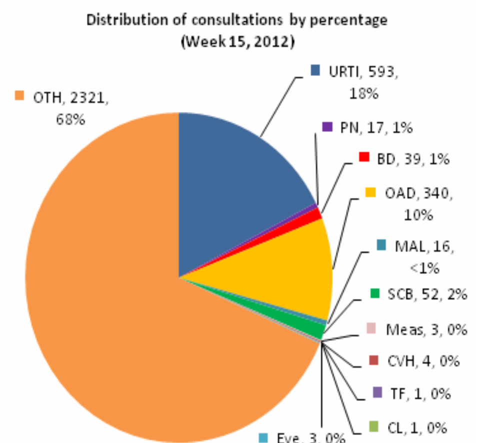
fever/malaria, ARI/Pneumonia, dehydration due to AD; 89% take part in community mobilization in support of mass vaccination. On nutrition 56% screen acute malnutrition (MUAC); 33% provide supplementary feeding of moderate acute malnutrition (SFP) and community therapy care of severe acute malnutrition. On **communicable diseases** 44% report vector control activities (IEC, bed nets, insecticide spraying); 78% take part in community mobilization in support of mass vaccination and 56% use of IEC materials on locally priority diseases. On **maternal and newborn health** 84% report clean home delivery and use of IEC and other means of communication. On non-c**ommunicable diseases 6**7% promote self-care, provide basic health care and psychosocial support, identify and refer severe cases for treatment. On **environmental health** 67% use IEC on hygiene promotion and water and sanitation.
67% have access to basic laboratory services. 44% have short hospitalization capacity (2-10 beds). 89% report referral capacity. On c**hild health** 100% report EPI as routine immunization on all national target diseases and adequate cold chain. 67% screen for under nutrition/malnutrition. On nutrition 67% screen for malnutrition for PLW and 44% have organized OTP. On co**mmunicable diseases** 78% have capacity to diagnose malaria and only 11% TB. On m**aternal and new born health** 78% report family planning. 100% provide antenatal care. 89% provide skilled care during childbirth. 56% provide for essential newborn care and basic emergency essential obstetric care. 89% are involved in post partum care (up to 6 weeks). 11% report comprehensive abortion care. On s**exual violence n**one of the health facilities are aware of clinical management of rape survivors, emergency contraception and post exposure prophylaxis for STI infections. On e**nvironmental health** 78% provide safe waste disposal and management.

WHO visits most of district health facilities in the area monitoring and evaluating the overall daily performance with provision of necessary guidance and technical advise on areas of improvement (eDEWS, job training, alert investigation and proper classification, sample' taking, outreach sessions, etc.).

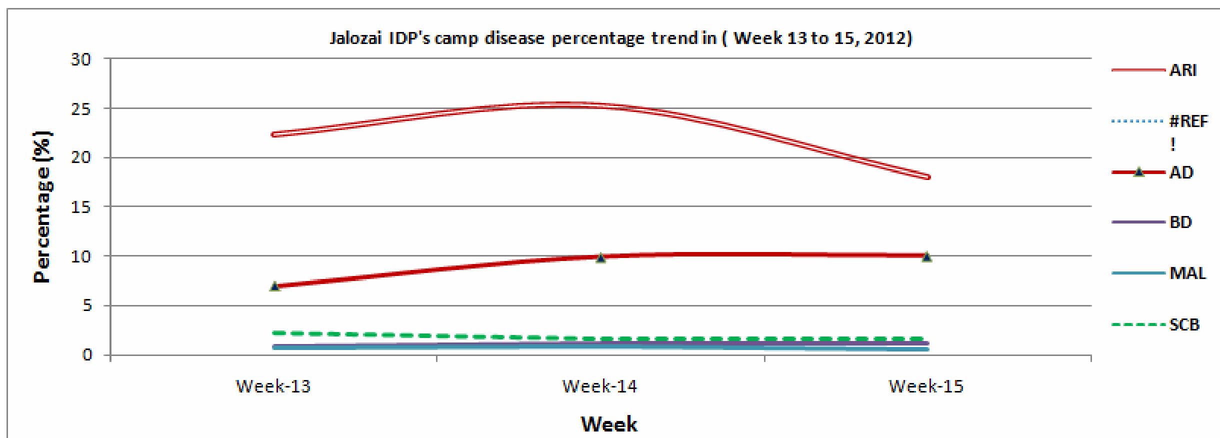
***Communicable disease control and prevention*:**

WHO with support of health cluster organizations monitors and updates partners on daily disease consultations provided to IDPs, disease trends, including upper respiratory infections, pneumonia, bloody diarrhea, other acute diarrhea, malaria, scabies and other diseases. WHO shares on a daily basis compiled updates linked to specific diseases and general health situation in the camp on district, provincial and national levels.

WHO reports the disease trend for Acute Respiratory tract Infections (ARI) accounted for 18% or 610 cases of the total patients (3,390 consultations) in all age groups. Other Acute Diarrhea (OAD) accounted for 10% or 340 cases. Bloody Diarrhea (BD) shared 1.2% or 39 cases of all visits. Skin Infections (SCB) reported as 1.5% or 52 cases. A total of 3 measles alerts were reported and followed up by WHO.



A total of 3,390 consultations were reported through WHO supported DEWS (April 8-14, 2012) from 7 health posts (4 – Merlin, 2 –CERD and 1 - CAMP) in the camp. The most leading disease consultations include other diseases (group of miscellaneous non communicable diseases) (2,312), upper respiratory tract infections (593), other acute diarrhea (340), scabies (52), etc. 2,160 consultations are registered via MERLIN run health posts, 1,014– by CAMP NGO and 216 – by CERD NGO.



There are 1,315 consultations (39%) provided to male IDP population and 2,075 (61%) to female IDPs.

Timely prevention and response to leishmaniasis disease remain a challenge for local district health system. Twenty cases of leishmaniasis reported from BHU Kahi were line listed and responded by WHO through PPHI Nowshera. WHO continues environmental health interventions in the area.

WHO builds up the capacity of district health care system through continuous support and implementation of eDEWS on district level by all health facilities managed by EDOH and PPHI.

Five days measles and vitamin A supplementation campaign in the camp and three union councils namely Jalozai, Dag Behsood and Dag Ismail Kheil was conducted by WHO, UNICEF and district health authorities. A total of 113 teams were involved in the campaign, including 51 in the camp (8 phases). A total of 43,206 children were planned to be covered by OPV, including 32,250 in the camp. OPV covered 26,986 children (62% coverage), including 13,746 (43%) in the camp. A total of 58,936 children, including 31,032 were planned to be measles vaccinated. 35,754 (61%) children received measles vaccination, including 12,915 (42%).

WHO collected and shared the information on routine vaccination provided to 31,159 children and women, including BCG, Polio, Penta, Measles and TT vaccination provided by camp based partners (Merlin and CERD). Laboratory services are available in the camp (with a total of 423 tests conducted on a weekly basis or 1,695 lab tests since onset of influx.

WHO continued preparations and arrangements to open three months Diarrhea Treatment Center in Pabbi Satellite Hospital in Nowshera district.

Essential medicines:

WHO continues daily monitoring of rational use of medicines by all partners present in the camp. All additional requirements for essential medicines and other supplies by health cluster partners in the camp are being addressed and responded immediately by WHO. WHO provided the following supplies to ***KTH Peshawar*** (Amlodpine 5 mg Tabs 896, Atenolol 50 mg oral 340, Dalteparin (fragmin) 5000 inj90, Defazocort 6 mg oral 440, Doxycycline 100 mg oral capsule 800, Face Masks 53, I/V Cannula 22 G 150, I/V Cannula 24 G 100, Povidone Iodine Solution 3, Tranexamic Acid 60); ***PPHI Nowshera*** (Meglumine Antimonite Inj 500).

Environmental health:

WHO provides a daily water quality and quantity status daily surveillance report. To ensure water safety residual chlorine is routinely monitored by WHO and 450 samples tested for residual chlorine in various sites of the camp, around 79 % of samples were found to have residual chlorine matching WHO standards. WASH partners informed to ensure 100% chlorination of all drinking water supplies. 42 samples were also tested for microbiological contamination and 16% samples were found to have microbial contamination. Water station operators were advised to adjusted chlorine dose where samples without residual chlorine were detected.

Six chlorinators were installed by WHO in 6 main water supply stations, with operators properly trained on the chlorine dosage and preparation. Hygiene promoters and health workers have been tasked to educate people on the inter-linkages of health and water safety. 28 hygiene promoters including 15 females and 13 males were trained to respond to the diarrhea alerts in the camp. WASH partners were sensitized on water quality testing, preparation of chlorine solution for chlorine dosage at the chlorinators and hygiene promotion. Two water quality monitors, ten tube well operators were also trained on water safety issues.

As of today, two Wagtech kits for routine water physiochemical and microbial testing were provided to SSD and WASH partners in the camp for regular water quality monitoring. Digital chlorine comparators have been provided to the partners for residual chlorine monitoring. 56 gallons of liquid chlorine was provided by WHO to the tube well operators for regular chlorination of water supplies. 50 Kg temephose organic granules provided to the health partners for larva control in the camp through malaria control program.

WHO provided the following supplies to ***Pabbi Satellite Hospital*** (Apron 10, fixed waste segregation bin 65, face masks 10, garbage removal trolleys 5, general waste bins with wheels 40, general waste bins with two wheels 10, general waste bins with cover 40, gloves heavy duty 10, hampers bag 20, lab coat 10, multi purpose trolleys 10, needle cutter 60, waste bags 1000) and ***HRDS*** in Jalozai camp (Sodium Hypchloride 30% 26 Gallons).

MCH, Reproductive Health and Nutrition:

WHO, UNICEF and UNFPA facilitate coordination efforts on ensuring provision of required and sufficient MCH, reproductive health and nutrition services to camp and off camp IDP population in the district of Nowshera.

Following the latest assessments in the camp the provision of MCH services is generally well organized, including conditions of available labor room. Emergency referral system is in place. Family planning component needs to be strengthened and further promoted among IDP population. There is an established need for camp based health workers to receive required training on ENC and EmOC. Nutrition services are present with available staff and materials displayed. There is as well functioning system of health promoters in the camp in sufficient quantity and providing quality services.

UNFPA assessed the reproductive health services in Pabbi Satellite hospital identifying the following findings. Caseload from Jalozai camp was not much as necessary services in the camp provided. Sufficient HR was available at the hospital (one WMO for the night shift if provided would be enough to cater 24/7 BEmONC; there was one gynaecologist and one WMO already available). Referral linkages with Pabbi Hospital, DHQ Nowshera and LRH were already established. UNFPA plans to provide RH kits (1, 2, 4, 5, 6, 7, 8) to accommodate the IDPs caseload for RH/ MNCH at Pabbi hospital. UNFPA is ready (upon identified requirement) to establish one 24/7 SDP to provide RH services with focus on BEmONC, STIs, FP.

WHO and UNICEF monitor the nutrition situation in the camp ensuring proper screening and required admissions of children between 6 to 59 months and pregnant women.

WHO and UNICEF put efforts to facilitate provision of necessary MCH services to all women in need on ante- and post-natal care via support of present health cluster organizations.

WHO and UNICEF supported partners, MERLIN and CERD report 166 new antenatal cases registered, 290 ante-natal consultations and 110 post-natal provided and 18 deliveries per reported period. Health partners (Merlin, CERD) in the camp provided 982 health education sessions at the registration point attended by 1,876 males and 8,814 females (per week – 172 sessions for 340 males and 843 females).

UNICEF continues supporting MCH and EPI services in the camp through CERD NGO and DoH respectively. CERD has established two MCH centers providing 24/7 Basic EmOC services. Routine EPI services are provided by EDO Health through UNICEF supported 7 fixed EPI centers and EPI posts at registration and enlisting points. CERD new health facility in phase 8 of Jalozai IDP camp is functional now and provides MCH services. CERD operates 2 MCH centers with 2 referral points and 2 registration points in Jalozai IDP camp.

E. Gaps & Constraints

Close inter cluster coordination is required between Health, WASH and Nutrition clusters to address issues related to water born diseases and malnutrition among the IDP population living in and outside the camp.

WHO as health cluster together and under the leadership of the provincial Department of Health should address the overall weakened capacity and increasing need of primary health care system in the districts of Nowshera and Peshawar where most of off camp IDP population reside.

There is a gap in reflection of levels of medical assistance provided to IDPs (as compared to indigenous population) by functioning health facilities managed by EDOH and PPHI. WHO, UNICEF and UNFPA assessments illustrate that significant changes and assistance efforts should be undertaken for both community and primary care levels of provision of health services. Limited services and technical capacity exist on every aspect of health system, including child health, nutrition, communicable diseases, STI and HIV/AIDS, maternal and newborn health, non communicable diseases, injuries and mental health, environmental health, general clinical services, etc.

In addition, the majority of health care facilities in return areas of FATA are not functioning and in situation of not having expected capacity to provide even most basic primary health care services. This factor is one of the leading social constraints for consideration for potential return to the place of origin in FATA. Health cluster is limited in ensuring strengthening and building up the capacity of FATA based health facilities.