Health

<table>
<tr><td>Cluster lead agency</td><td>World Health Organization</td></tr>
<tr><td>Implementing agencies</td><td>WHO, UNICEF, UNFPA, UNOPS, DG Health KP, DG Health FATA, and NGO partners including IRC, MIHO, MDM F, MERLIN, HHRD, Johanniter, etc.</td></tr>
<tr><td>Cluster objectives</td><td>The overall objective of the Health Cluster response plan is to improve the health conditions of IDPs and hosting population in hosting districts of Kohat, DI Khan, Tank, Hangu, Peshawar and Nowshera of KPK and IDPs in Jalozai, New Durrani and ToghSaray camps, supporting the returning population of agencies in FATA through strengthening, provision of/and maintaining essential life saving health services interventions reducing morbidity and mortality.

Specific objectives:
• To ensure the provision of essential life saving Primary Health Care (PHC) services (including Maternal New-born and Child Health /Reproductive health, mental health and psycho-social support) at community level and in facilities for all crisis affected population especially for women and children, elderly, and people with disabilities;
• To address the emerging public health threats in a timely and appropriate manner by implementing and expanding the Communicable Disease Control and Surveillance System for all the affected areas of displacements and camps;
• To ensure the delivery of the health response in a coordinated manner and according to SPHERE, Global Health Cluster and National Health Standards.</td></tr>
<tr><td>Beneficiaries/
Population caseload</td><td>
<table>
<tr><td>Expected IDP population caseload:</td><td>Families</td><td>Size</td><td>Individuals</td></tr>
<tr><td>A. Population on 02/4/2012</td><td>125,832</td><td>7</td><td>880,824</td></tr>
<tr><td>B. Population on 01/7/2012</td><td>176,887</td><td>7</td><td>1,238,209</td></tr>
<tr><td>C. Population on 31/12/2012</td><td>146,994</td><td>7</td><td>1,028,958</td></tr>
<tr><td></td><td>Average</td><td></td><td>1,049,330</td></tr>
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<tr><td></td><td>Demographic Estimation of Health in Emergencies
<table>
<tr><td></td><td>Context Population</td><td colspan="2">Programming Groups</td><td>%</td></tr>
<tr><td>Total Population</td><td>1,049,330</td><td></td><td></td><td></td></tr>
<tr><td>1. Male (52%)</td><td>545,652</td><td></td><td></td><td>52%</td></tr>
<tr><td>2. Female (48%), including:</td><td>503,678</td><td>257,883</td><td></td><td>48%</td></tr>
<tr><td>A) Child bearing age (48.8% of female)</td><td></td><td>245,795</td><td>48.8%</td><td></td></tr>
<tr><td>Sub-total:</td><td>1,049,330</td><td></td><td></td><td>100%</td></tr>
<tr><td>3. Population below 15 years, including:</td><td>455,409</td><td>221,933</td><td></td><td>43.4%</td></tr>
<tr><td>A) Newborns 7% of total Pop under 15 years</td><td></td><td>78,175</td><td>7.45%</td><td></td></tr>
<tr><td>B) Children (Below 5 years excluding newborns)</td><td></td><td>155,301</td><td>14.8%</td><td></td></tr>
<tr><td>4. Population 15 - 64 years, including:</td><td>557,194</td><td>518,369</td><td></td><td>53.1%</td></tr>
<tr><td>A) Pregnant Women 3.7 % of 15 - 64 population</td><td></td><td>38,825</td><td>3.7%</td><td></td></tr>
<tr><td>5. Elderly (Above 65 years)</td><td>36,727</td><td></td><td></td><td>3.5%</td></tr>
<tr><td>Total:</td><td>1,049,330</td><td></td><td></td><td>100%</td></tr>
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<tr><td>Funds requested</td><td>US$ 17,659,802</td></tr>
<tr><td>Contact information</td><td>Dr. Jorge Martinez, Chief of EHA Operations/Health Cluster Coordinator
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Needs analysis:
In the aftermath of the influx of IDPs in Khyber Pakhtunkhwa and FATA, Health Cluster placed a great emphasis in ensuring that risks related to lack of safe water, proper sanitation and hygiene get recognized early and properly managed, so as to ensure the control of communicable diseases, with special focus on the vulnerable IDPs camps, hosting districts and the devastated returnee areas.

The latest influx of IDPs from Khyber Agency and settlement in and around “Jalozai” IDP camp in the district of Nowshera raised significant concerns and issues for health cluster to be put in place to ensure the preparedness and response of local health care system to the increased burden of already weakened health services.

A rapid assessment was conducted by WHO field teams in the IDP hosting health facilities (UC's were identified by IVAP) in DI Khan, Tank, Hangu and Kohat from 31-01-12 till 01-02-12. The objectives of the assessment weretoassess the overburdened health facilities in selected union councils as identified by OCHA/ IVAP in the four IDP hosting districts (DI Khan, Tank, Hangu and Kohat); to assess the health service delivery network in the districts, to collect, compile and analyze as much information as possible to identify gaps in terms of provision of services, disease trends, human resource, equipment, essential drugs and referral services; and to analyze the coverage and needs in respect to the provision of adequate and appropriate health care services in the IDP hosting areas.

A total of 65 public health facilities were assessed in four districts of KP, including district headquarter hospitals, tehsil HQ hospitals, rural health centers, basic health units and civil dispensaries.

In addition, in April 2012 WHO completed the HeRAMS (Health Resources Availability Mapping System) for all 25 districts of KP. A special focus was made on health care system gaps and weakness in the district of Nowshera, including 3 union councils (Dag Ismail Khel, Dag Behsood and Jalozai) hosting most of off camp IDP population from latest influx from Khyber Agency.

Influxes of population due to displacement have further increased the burden on the already under-resourced health care system of the districts of KP including Kohat, Hangu, Tank, DI Khan, Nowshera and Peshawar as well as in Kurram Agency. If a timely assistance is not provided, the mortality rates are likely to increase, mainly due to the lack of the access to the health care, especially for trauma and infectious diseases. There are evident gaps in the capacity of the health care providers in handling emergency situations. The provision of comprehensive primary health care services is urgently required for the returnees and displaced populations of the affected areas of KP and FATA. There is also a need to support the supply chain mechanism of the essential medicines. This includes both provision of medicines in adequate quantity and emergency infrastructural support to ensure necessary storage practices. Special attention and assistance needs to be given to the vulnerable groups including elderly, pregnant women, disabled etc. Large numbers of IDPs are still staying in three camps i.e. Jalozai (Nowshera), ToghSarai (Hangu) and New Durrani Camp (Kurram) while the predominant number is in host communities of DI Khan, Tank, Kohat, Hangu, Nowshera and Peshawar districts.

The already resource constrained health facilities report increased number of IDPs applying for regular health care, and, especially, specialized paediatric services. There is a definite need to strengthen these hospitals through filling of human resource, supply, equipment and technical capacity gaps.

Preventive programs especially Lady Health Workers Program, MNCH Program and EPI are the most affected. Due to many factors, including security situation and restriction on movement of females, community health workers (LHWs) are not able to perform their duties optimally. There is a need to revitalize LHW Program to provide PHC services at the doorstep of the affected communities. Similarly Community Midwives of MNCH program need strengthening through provision of midwifery kits, other relevant supplies and refresher trainings.

Under the immunization coverage during the displacement, most vaccination services and activities were interrupted in the government-run health facilities due to weak or non-functional facilities; unavailability of electricity or fuel for generators; movement restrictions in insecure areas (specially Tank, DI Khan and Hangu) affecting the distribution and delivery of vaccines; and shortage or absenteeism of health facility or field staff.

Water quality monitoring and control is also of paramount importance in controlling the spread of water borne diseases. Water quality monitoring and treatment should be conducted to avert waterborne diseases and health education and hygiene campaigns will be conducted to educate the communities on hygiene and safe drinking

water and effective health seeking behaviour. In addition, viable technical strategies for waste disposal will be promoted to ensure patient safety and local environmental health.

Health Cluster partners under the leadership of WHO work in partnership with government are focusing on primary health care (PHC) service delivery, early detection and response to outbreaks, rehabilitation of health facilities with appropriate water supply and latrines, warehousing of contingency medical supplies and equipment, referral system strengthening, and provision of life-saving drugs. A standardized package of PHC service delivery has been developed and cluster partners are helping existing public healthcare facilities to cater for the health needs of most vulnerable population including women, children and elderly. The health cluster partners are contracted for provision of PHC services where government resources are inadequate.

Overall primary health care (PHC) services in the targeted districts require immediate and continuous provision of assistance and service support. This is coupled by the fact that first referral health facilities as well lack the very essential services required to improve and promote the health of groups at risk such as mothers and children. The service delivery deteriorates in all IDP districts as compared with similar study in 2009/2010 and remains stagnant considering increased number and influx of IDPs in the area. Health facilities in IDP hosting districts illustrate a lack of resources including unavailability of qualified HR, services, equipment and supplies as major factors which lead to their continuous overburdening. Unless intensive interventions and commitment of partners little progress will be witnessed to address the needs of IDPs and reduce maternal and child mortality.

Assessing communicable diseases and outbreaks in IDP hosting districts there is a clear indication of similarities of trends of seasonal diseases. The proportional morbidity for Acute Diarrhea shows two peaks – one in spring and one in late summer. The seasonal trend for Acute Respiratory Infections (ARI) shows a consistent peak in late January each year. The analysis showed that 2010 summer was worst for AWD/ cholera while measles and pertussis were prominent threats in spring and winter of 2011. Both AWD and Measles spread rapidly where population is congested and poverty-stricken, conditions existing in camps and areas where IDPs have joined hosting populations for temporary stays. Control of cholera depends on awareness and capacity of communities to find safe drinking water. Measles epidemics threaten where children have not been immunized, and measles mortality is worst in under-nourished children. There is an increasing risk for cholera and measles in the camps and hosting districts.

Communicable disease always put significant percentages on overall disease burden as well as mortality rates and availability of essential medicines always vital to response not only epidemics but also can serve basic health needs of the majority of the population. It is quite alarming that supplies of key essential medicines at first level health care facility averaged less than 50% of all the health facilities assessed.

Water and sanitation infrastructure need urgent attention. More than 50% of hospitals dump away their waste without any safety control measures as proper healthcare waste management is not implemented posting a threat to the surrounding population, with the risk of contaminating the ground water and other environmental health risks. Water supply is available in 74% of health facilities and electricity for 81%. 40% of health facilities do not have any functioning toilets. 80% of HF have damaged/blocked sewerage system and water supply pipes. 90% of water samples collected from assessed hospitals have shown microbiological contamination. District Tank has acute shortage of drinking water problems as the water table is very low. Sanitary staff is available only in 10% of the hospitals. General hygiene and safe drinking water are of major concerns requiring immediate health education awareness campaigns in all districts.

Response strategy:

i. Health Cluster Coordination, Emergency Preparedness and Humanitarian Response and Disaster Risk Management

In support to the provincial and FATA Directorates of Health, the World Health Organization as the Health Cluster lead, along with cluster partners, is ensuring that:

- A coordinated response is put in place to ensure delivery of health services to the most vulnerable;
- The communicable disease surveillance and outbreak response system is expanded and is robust for timely detection of disease, and prevention of outbreaks;
- Stocks of necessary medicines and supplies are delivered to warehouses, as requested by the health authorities;
- Water and sanitation condition is improved in the targeted agency/areas.

The Health Cluster has set up an effective and efficient mechanism of coordination at provincial and national level whereby the health partners share/map the information, produce situation reports and 'who is doing what and where' matrix. The information is used to identify the gaps and plan the response activities. Information management activities will also be strengthened at all levels to guide decision making, identify needs and critical gaps, and monitor impact of interventions. Communication and information Management (C&IM) will provide continuous updates on health cluster interventions by developing Who, What and Where (3W), and health maps using GPS coordinates. Newsletters, Health Bulletins, situational reports and web sites will be produced to inform partners as well as the general public on health interventions and needs. Communications will be responding to, and lobbying for effective collaboration and sensitization of media as well as utilizing their resources to address the wider audience. Brochures, information, education and communication messages (IEC material), pictorial coverage of health cluster initiatives, outbreaks, disaster reports, video interviews, documentaries as well as developing need / human interest, success stories and messages via channels of mass media communication will be used.

Under the health response in emergencies health cluster has to ensure provision of support to national and provincial health authorities in strengthening their capacity in risk reduction, emergency preparedness and timely and efficient response to disasters. The DRM support will help in reducing, mitigating, preparing for and respond to public health risks to vulnerable populations and hence prevent avoidable mortality and morbidity through improving access to health care for affected populations and putting effective disease control measures in place.

HeRAMS (Health Resources & Services Availability Mapping System) is a standardized approach supported by a software-based IT Platform that aims at strengthening the collection, collation and analysis of information on the availability of health resources and services in humanitarian emergencies. It supports WHO, Department of Health, and health partners better achieve the provision of equitable, relevant and efficient health services and better allocate resources towards fulfilling humanitarian needs and ensuring their sustainability beyond humanitarian interventions.

ii. Provision and strengthening of essential package of Primary Health Care services (including live saving medicines and supplies)

Ensuring that government health facilities in the affected areas are made operational through provision of essential medical equipment and provision of necessary medical male and female staff through health cluster partners and support to health department.

Uninterrupted and sustained provision of essential medicines, medical supplies, and equipment has been critical to health delivery at all levels of health service delivery. The Essential Medicine package provided during the relief phase covers the treatment for communicable diseases, non-communicable diseases, MNCH related medicines, paediatric preparation and item for the minor surgery, as well as maintained the contingency stock of key medicines for preparedness and response to alerts. These lifesaving interventions played a vital role in reducing the incidence of morbidity and mortality. In addition the provision of essential medicines increased the utilization of underutilized public health facilities evident from the consultation data (increased from 0.12 visits per capita per annum to 0.8 visits per capita per annum).

Essential medicines and supplies will be provided on regular basis to avoid any lapse in the delivery of essential healthcare. Geographic stockpiling will be planned for in a way that allows immediate response to outbreak alerts as well as for the district. Medicines will be bought and imported in accordance with the National and WHO essential medicines list. In order to reach population faster, medicines and equipment will be purchased and dispatched in ready-to-deploy kits. Some kits will require international air shipment to ensure timely availability and delivery.

Capacity of the health partners and Department of Health staff will be enhanced on medicine management. The essential medicines team set up within the coordination mechanism will monitor the rational use, storage and dispensing activities. The Logistic Support System (LSS) installed at district for transparency and traceability of supplies will be expanded. Essential Medicine Team (Pharmacists) is working to check the rational utilization of medicines and capacity building of the health care providers (implementing partners and government health department) on evidence based quantification and adherence to the standard treatment protocols.

Continuation of provision of essential primary health care (PHC) services including activities within the Minimum Initial Service Package (MISP) for reproductive health will be ensured. Mass

vaccinations/immunization campaigns and awareness campaigns of healthy practices for the masses would be launched for the community.

Rehabilitation/ reconstruction of assessment identified partially damaged and full destroyed health facilities including water supply and storage and/or setting up of ad-hoc temporary health facilities to revitalize the primary health care services will be ensured with the support of the Department of Health.

The foremost requirement that has been identified is the dearth of human resource which immediately needs to be addressed. Therefore, relevant health personnel would be duly appointed at the targeted health facilities and special incentives would be given to female staff working in the security compromised areas. This could also be carried out by outsourcing to partners with due consultation of Department of Health.

iii. Communicable Diseases Control, including Diseases Surveillance and Response, Environmental Health, control of Malaria, Leishmaniasis and Dengue.

In view of the threats of water-borne diseases such as Cholera and Dysentery and the vaccine-preventable diseases such as Measles, Pertussis and Dysentery, support to the Disease Early Warning System (DEWS) for early detection and response to epidemics is crucial for reducing morbidity and mortality from communicable disease in the camps and among the IDPs in the hosting districts.

While in some areas of the country, the provincial governments are taking on the challenge of running DEWS, in the targeted IDP hosting districts of Khyber Pakhtunkhwa and in FATA, the government does not have the resources or capacity to implement DEWS. WHO requires funding to continue support to DEWS for 2012 to respond to the epidemic threats in the areas of greatest risk due to: crowding, poverty, under-nutrition, poor coverage of immunization and health services, unsafe water supply, and inadequate sanitary facilities – the vulnerable IDP populations in camps and hosting districts.

DEWS teams will continue efforts to mitigate morbidity and mortality caused by epidemic-prone diseases through alert and outbreak detection and timely and effective response. DEWS team includes an Environmental Health Engineer to address water-borne disease outbreaks, and implementation will be linked to efforts by the Nutrition and WASH Clusters, and other Health Cluster stakeholders to provide an integrated response to prevent and control spread of communicable diseases. Support to DEWS operations requires logistical support for investigation of alerts and response to outbreaks and for active surveillance and data collection from peripheral facilities.

In addition to control of communicable disease, DEWS provides public health professionals on the ground in the targeted districts and agencies for immediate reporting of any public health event to the health partners as well as weekly reporting of disease trends seen in the health facilities. DEWS team analyzes data on a weekly basis and disseminates a report to all government and non-government partners. The new "eDEWS" or electronic online DEWS will be introduced in the targeted districts to further streamline the information collection system and timely alert detection and response.

By sharing weekly analysis of disease trends and disease alerts and outbreaks at provincial and FATA Directorate levels, DEWS will also play a role in health education for care of newborns and young children; advocacy for immunization; prevention and control of waterborne diseases; infection control in hospitals; vector control; water quality testing; sanitation and hygiene promotion. DEWS focal persons in each health facility and district/Agency team will be nominated by the local authorities and will be trained on standard case definition, data collection, alert generation, and reporting and will jointly investigate and respond to outbreaks.

Routine vaccination would be accelerated by increasing the number of vaccination sites with specific emphasis to Polio, Measles vaccination, Maternal TT and vitamin A supplementation. Moreover, mass communication and social mobilization activities would also be undertaken for awareness of the masses on healthy practices and protection from diseases.

Sanitation facilities and hygiene conditions amongst the affected population and in the assessed health facilities is very poor. Hygiene and safe drinking water is a major concern. Health education awareness campaigns should be increased in all the districts.

The following activities will be implemented:

- Improve water quantity and quality of the healthcare facilities serving affected communities;

- Improve water quality and quantity and sanitation facilities addressing specially needs of women (keeping privacy);
- Health facility sanitation services of critical units of the health facility will be improved, with repair of existing latrines where necessary, with female health workers and patients access to appropriate and separate (male/female) sanitation facilities ensured;
- Provision/repair of hand-washing facilities in critical units of the health facility, where needed as per accepted standards;
- Provision of soaps, detergents and other health facility disinfectant chemicals, to improve overall hygienic conditions and infection control mechanisms of the critical units of the health facility;
- Equipment, hand tools and other supplies (waste bins of different sizes, brooms etc) needed for the collection, transport and safe disposal of healthcare waste will be provided;
- Personal protective gears (clothes, gloves, boots, aprons, etc) will be supplied to sanitary workers;
- Conduct healthcare hygiene promotion and awareness raising trainings in each health facility, for senior medical staff, nurses and sanitary worker, with focus on infection control;
- Provision of hygiene and healthcare infection control education materials (messages, pamphlets, brochures etc)
- Adequate detailed information regarding the hazardous nature of waste material to persons responsible for its handling, transport, treatment, storage or disposal will be provided;
- Hazardous wastes handling staff will be provided with appropriate safety devices such as safety masks, goggles, hand gloves, and boots;
- Adequate Occupational Health and Safety (OHS) standards will be introduced at facilities handling hazardous wastes
- Conduct regular water quality surveillance affected areas, and routinely disseminate microbial water quality results and trends with all WASH partners;
- Monitor the environmental health conditions (safe water surveillance, sanitary and hygiene conditions) of affected communities, with special focus on inside camps IDPs;
- Support water borne diseases alert response, through water quality testing, disinfection and hygiene promotion.

iv. Health Promotion and Protection, including Maternal, Newborn, Child Adolescent Health, Non Communicable Diseases and Mental Health, Health Promotion and Nutrition.

Under the Health Promotion and Protection the dissemination of key health messages including risk awareness, mental health counselling, disaster management and first aid support among the affected communities will be ensured to prevent major health risks among the affected population. The response will address major health risks including Hygiene Promotion; Malnutrition; Malaria and Dengue Fever; Mother and Child Health; vaccine preventable diseases and snake bites among the affected displaced population. Development of a Manual on Community-based Disaster Risk Management (CBDRM) for the health sector is one of the core activities for health promotion during emergency response.

Provision of emergency health services, for basic care of under-five children, would be ensured by WHO by establishing under 5 clinics in all health facilities where Integrated Management of Newborn and Childhood Illness (IMNCI) strategy will be implemented. Maternal and Newborn care would be provided through Basic Emergency Obstetric Care (BEmOC) and Essential Newborn Care (ENC) packages respectively. The health care providers would be trained on IMNCI, ENCC and Basic EmOC for enhancement of their skill and knowledge through the outsource partners.

The following activities would be undertaken in IDP camps and hosting communities under the leadership of UNICEF and in partnership with Government, UN organizations and NGOs:

a) Assisting Department of Health through provision of technical inputs and actualization of the decisions made in and by the health cluster;

b) Strengthening of Routine EPI through provision of cold chain equipment (ILRs, Solar refrigerators, Deep freezers, cold boxes and vaccine carriers) and capacity building of staff and filling of HR gaps;

c) Children 6-59 months receive measles immunization & Vitamin A supplementation (268,161 children;

d) Under-five children & their mothers living in IDP camps and hosting communities will be provided a standard package of maternal, child health and newborn care services (ANC, vaccination, multi micro

nutrient supplementation and deworming), NFIs (newborn kits, clean delivery kits and LLINs), and information through Mother and Child Days/Weeks;

e) Emergency affected families receive messages on diseases preventions, home care and care-seeking in illnesses;

f) Community based health programs (LHW and MNCH programs) will be revitalized through provision of supplies and incentives along capacity building so that emergency affected communities have access to basic Maternal, Newborn and Child Care services at their doorstep;

g) Emergency affected communities in IDP camps and hosting communities in Khyber Pakhtunkhwa have access to 24/7 basic & comprehensive emergency obstetric care & newborn care services;

h) Strengthening of MCH services including Basic and Comprehensive EmONC in selected public sector health facilities through filling of HR, supplies and equipments gaps and capacity building of the relevant staff;

i) Strengthening of specialized pediatric services in DHQ Hospitals of DI Khan and Tank.

The following activities will be implemented by UNFPA and partners:

UNFPA along with partners and DoH will be at the forefront to fulfill the life saving Reproductive Health needs of IDPs to prevent excess maternal and newborn morbidity by implementing Minimum Initial Services Package (MISP) for which the following activities are being proposed:

1. Equipping and strengthening of selected service delivery points, including RHCs, THQs and DHQ hospital to facilitate the provision of 24/7 Basic and Comprehensive EmOC services

2. Establishing Referral Pathway to strengthen the community- based referral system by ssupporting the LHS, LHWs.

3. Provision of essential RH medicines, kits (RH/ hygiene and newborn)and equipment that have been identified as deficient by partners through assessments conducted

4. Conduct awareness-raising sessions on RH with focus on addressing first two delays to improve health seeking behavior of the affected population to ensure that men, women and girls are aware of safe motherhood interventions

5. Enhance capacity of the relevant staff in MISP and other life-saving competency based trainings to ensure provision quality RH services

6. Conducting RH/GBV information sessions for women, men and youth.

Response objectives:

Objective 1: Continuation and strengthening of essential PHC services, including essential life saving medicines and other medical supplies in all affected areas and camps for filling gaps and unmet needs in the health response.		
Outcomes	**Indicator**	**Activities**
Continuation and immediate restoration of the essential life saving primary health care services, availability of essential life-saving medicines, supplies and equipment and strengthening of referral mechanisms along with mobile health units coverage.	# of static health units re activated for provision of essential PHC services # of active mobile units in the affected districts # of LHWs reached # of EHKs, DTKs, ARI kits LLINs, procured and distributed.	- Reactivation/strengthen static health units with provision of necessary essential medicines, essential medical supplies. - Filling gaps in the establishing referral system from primary to secondary and tertiary health facilities - Conducting campaigns (measles, polio, vitamin A supplementation & deworming tablets etc). - Revitalization of services by addressing LHWs needs
Accessibility to essential PHC services including	# of health units operationalized # of consultations related to	- Provision of health services 24/7 a week in communities with referral

MNCH/RH and immunization coverage to the affected population.	MNCH/RH and other key diseases undertaken #of complicated cases referred # of coordinated health promotion activities delivered # No of CBDRM training courses held/ no of volunteers trained # of LHWs and Community Health Workers(CHWs) trained on CBDRM #No of HOPE training courses held/ no of health and hospital staff trained	system to static health units for complicated cases - Provision of essential medical equipment - Establishing mobile teams in line with essential minimum mobile team standards - Endorsement of health promotion guidelines for emergencies by health department. - Facilitate dissemination of guidelines and IEC materials through Government and non-government partners - Facilitate coordination of health promotion activities, through Government, at district level - Facilitate endorsement, dissemination and implementation of Community-Based Disaster Risk Management Manual for the health cluster - Training of LHWs and Community health workers on Community-Based Disaster Risk Management Manual developed for health cluster - Training of Health Cluster and hospital officials & staff for hospital operational preparedness for emergencies (HOPE)
Objective 2: Continuous communicable disease surveillance and response to mitigate morbidity and mortality among affected and displaced population		
Outcomes	**Indicator**	**Activities**
Prevention against emerging health threats and outbreaks through early detection and response and strengthening of speedy, timely, effective and coordinated joint health interventions. Waterborne diseases surveillance and identification of affected communities facing greatest health risks from water borne diseases identified and appropriate response mechanisms put in place.	# of alerts and outbreaks identified and responded within 48 hours. #No of training courses held for communities and health workers on DEWs # of workers trained in each course # of Rapid Response Teams deployed # of water samples collected, tested and reported	- Active surveillance in all affected areas through surveillance officers - Remedial actions to mitigate the outbreak - Carrying out laboratory tests for confirmation of an outbreak - Weekly analysis of consultation reports data from implementing partners - Deployment of rapid response teams (male and female members) to investigate alerts and outbreaks - Training of Communities & health workers for strengthening of DEWs - Speedy dissemination of IEC materials for mass awareness - Conduct regular water quality surveillance affected areas, and routinely disseminate microbial water quality results and trends with all WASH partners;
Objective 3: Coordinate and streamline health response within the cluster mechanism and in partnership with local authorities and other actors		
Outcomes	**Indicator**	**Activities**
Coordination meetings and federal, provincial, agency and district level	# of health cluster meetings held per month at federal/provincial/district/agency level	- Continuation of the health cluster at federal, provincial and district/agency level - Coordination with the government counter-part for chairing the coordination meeting

		- Active information sharing and participation from all implementing partners in the meeting for effective coordination
HeRAMS activation and regular updates information sharing in the form of bulletins and situation reports	# of health facilities reporting to HeRAMS. # of Health Cluster bulletins published/month	- Active updates from health Cluster partners Collection and compilation of 4W matrix and HeRAMs Collation of information and development of the monthly Health Cluster bulletin

Cluster Monitoring Strategy

Health Cluster partners will monitor health interventions according to the indicators outlined above disaggregated by sex and age, and conduct evaluations and assessments to measure the impact of the interventions and to facilitate improvement / changes where required. Specific areas of focus such as the DEWS will deploy surveillance officers in the districts affected for close monitoring and supervision of the disease trends and investigate any alerts and outbreaks to provide the timely and appropriate response. The essential drugs team will monitor the rational use, storage and dispensing activities and capacities of the department of health and all the proposing organisations through the deployment of a pharmacist in each district.

Joint monitoring visits along with the EDO Health are one of the successful mechanisms for the monitoring of cluster activities. Health Cluster uses IASC standard indicators for communicable and non-communicable diseases, including average population coverage, emergency obstetric care, maternal and neonatal care, etc. Health Cluster uses different data collection tools and methods for the assessment of health facilities like HeRAMS (Health Resources Availability and Mapping) and IRA (Initial Rapid Assessment).

ORGANIZATIONS	SITE / AREA
WHO, UNICEF, UNFPA, UNOPS, DG Health KP, DG Health FATA, and NGO partners including IRC, MIHO, MDM F, MERLIN, HHRD, Johanniter etc.	DI Khan, Tank, Kohat, Hangu, Nowshera and Peshawar. IDP camps: Jalozai, Togh Saray in Hangu, New Durrani in Kurram Agency, and population in return areas in FATA.