Health Cluster

Situation Report No. 05

Displacement from Khyber Agency-IDPs Crisis

A. Cluster Details

1. Lead Organization:	**WHO**
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B. Reporting Period

1. Report Number:	**HC-005**
2. Report Date:	**23.04.2012**
3. Time Period Covered:	**16.04.12 – 22.04.12**

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 districts of Nowshera and Peshawar.

Upcoming summer season highlights the importance of all involved stakeholders to ensure the necessary levels of preparedness with all control measures to prevent and respond to the expected number of communicable diseases.

The analysis of spring-summer 2011 communicable diseases trends indicate and illustrate the overwhelming AWD alerts and outbreaks throughout the province (both flood affected and non flood

affected districts) which resulted in establishment of DTCs in various districts. Necessary risk mitigation measures should be envisaged at present with possible development and set up of the provincial task force on control of AWD (formulated in 2011) under the overall supervision of PDMA for making a more coherent and coordinated approach to address the issue involving other relevant line departments, such as TMAs, local government, education, irrigation, UN agencies, international and national organizations and civil society.

Table: Alerts/outbreaks/alert cases in Khyber Pakhtunkhwa (from April to September, 2011)

Disease	**Alerts**	**Outbreaks**	**Cases**
AWD	349	192	4,755
Measles	320	4	589
DHF	169	35	202
Pertussis	33	5	102
Leishmaniasis	25	11	292
BD	15	9	123
AD	12	3	732
NNT	12		13
Diphtheria	10	7	13
AJS	7	6	167
Typhoid	6	3	113
Chicken pox	5		8
Mumps	3		12
CCHF	2		2
Meningitis	2		3
UXF	2		62
H1N1	1		1
Scabies	1		36
Grand Total	**974**	**275**	**7,225**

D. Humanitarian Response

Coordination:

UNHCR updates (April 21, 2012) a total of 148,105 families (686,700 individuals) as IDP population in KP and FATA, including 47,472 families (206,664 individuals) is registered in Jalozai camp. More IDP families opt to for off camp residence with 12,129 families are currently residing in the camp.

WHO as a health cluster lead carries out regular (twice a week) 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. The last meeting was conducted on April 19 in J-3 Health Post of Merlin with participation of WHO, UNICEF, Merlin, CAMP, CERD, CDO, SSD, HRDS, SAMPAK, Islamic Relief and DoH EPI technicians.

Present health organizations coordinate registration and provision of PCH services through various established health posts. All alerts and records of patients with diarrhea get streamlined and shared with WASH partners for better and timely response.

FATA health team assigned from Bara tehsil to Jalozai camp (phase 6 of the camp as identified by PDMA) is expected still to participate in camp based coordination activities.

Islamic Relief expressed interests to open their health facility in the camp with available services of 1 medical officer, two women medical officers, 2 LHW, 1 MT, 1 psychologist and 2 hygiene promoters. IR was requested to coordinate their activities with provincial cluster and DoH (later recommendation was made to concentrate potential health project on off camp site).

WHO conducted the regular provincial health cluster meeting on April 20 in DG Health in Peshawar with participation of health organizations, including UNFPA, Save the Children, Merlin, Flowers, Johanniter International, DoH (EPI Cell), KKT, MDM-F, CAMP, EHSAR, Poverty Eradication Initiative, ICRC, MIHO, GIZ, IRC, UNICEF, SWWS, Custom Care, FOM, Malteser International. Detailed update of Jalozai camp situation was shared and discussed with participants.

There is a request and expectations to see the representatives of PPHI, LHW program and DoH Health FATA at coordination meetings.

CAMP established a new additional health post in phase 7 of the camp. WHO completed DEWS training for CAMP' health staff.

The Secretary of Social Services, FATA conducted a meeting with the representatives of PDMA, FDMA, DG Health KP, DG Health FATA, Political Agency Khyber, WHO and UNICEF. The agenda of the meeting was to get updates of status of IDPs from Khyber Agency in KP to assess the levels of assistance for off camp IDP population, analyze the levels of preparedness for immunization and upcoming NID campaign on April 23-25. The Secretary of SS, FATA expressed concerns about current displacement of IDPs from Bara tehsil in various areas of districts of Nowshera and Peshawar. The Secretary of SS, FATA inquired about existing strategies and modalities in place to deal with off camp IDPs. DG Health FATA responded that the overall responsibility for IDPs lied with PDMA/FDMA and district authorities and relevant line ministries. DG Health provided an update on consolidated response to IDPs based on joint activities by WHO, UNICEF and selected health organizations. The Secretary of SS, FATA inquired about the role and concrete inputs/interventions of DG Health, FATA to respond to the current influx of IDPs from Khyber Agency. DG Health updated on the latest decisions to deploy health staff from Bara tehsil to Jalozai camp. The concrete number of health staff and types of services to be provided are still under consideration and based on identified needs. PDMA reflected on the preliminary results of WFP/IVAP/IOM survey identifying the areas of residence of most of off camp IDPs. Some 9,000 families were discovered as the result of this survey. The Secretary of SS FATA highlighted that the problem of access and service provision to off camp population was still remaining and required further clarity and mechanisms. WHO updated about concrete vaccination activities in Khyber Agency and undertaken effort to carry out latest 3 polio passages in the camp, 3 UCs in Nowshera and 48 UCs in Peshawar. The Technical Focal Point for Polio from Chief Minister's Secretariat raised questions on remaining number of children in Bara tehsil and who required immunization coverage and on lack of mechanisms in place to track down the off camp families due to unavailability of addresses/or intended place of settlement in registration forms. FDMA gave a comprehensive update on division of duties of PDMA and FDMA and list ministries based on their jurisdictions, including inter-cluster activities for IDPs in Jalozai camp. UNICEF proposed a more careful and thoughtful mechanism of updating existing microplans clearly indicating the updates for targeted off camp IDP figures. DG Health FATA supported the direction of precise and concrete elaboration of micro plans on district levels. WHO recognized the responsibility and accountability of district health authorities of Nowshera and Peshawar for provision of required health services to off camp population in both

districts. WHO welcomed an improvement of identifying and registering the new families in those areas supervised and included into the catchment area by PHC staff, including LHW. WHO proposed to consider the existing DHIS (if possible) to ensure production of regular evidence based health documentation recognizing and reflecting the levels of health assistance provided to IDP population via government supported health facilities in districts where most of off camp IDPs reside.

WHO, UNICEF in cooperation with DoH Health KP initiated a provincial coordination meeting to discuss levels of health care provision to off camp IDP population with Health Emergency Preparedness and Response Cell, DoH KP. The meeting was attended by other DoH officials, WHO, UNICEF, Save the Children, EDO-H Peshawar, EDO-H Kohat, PPHI and Chief Coordinator for IDPs of PDMA. WHO raised the importance of provision of health services to off camp IDPs and urged for the immediate remedial steps to overcome the challenges and provide a comprehensive health care services package. The forum agreed to adopt a holistic approach to address the issue and device a comprehensive health service package, in consultation with other clusters such as WASH and Nutrition to offer to these off camp IDPs. The package should include: comprehensive primary health care services with enhanced routine Immunization; access to safe drinking water; establishment of ORT corners (UNICEF has already provided 250,000 sachets of ORS to the DoH); MCH services; screening of malnourished children and PLWs and services provided; enhanced WASH facilities; institutional strengthening of the health facilities in terms of HR and supplies and logistics. WHO suggested conducting SIADs (Short Interval Additional Doses) as a very successful strategy for IDPs in host communities. The UCs are already identified during the last month SNID. Similar activity can be planned in all 14 UCs of Peshawar identified by the latest assessment by Save the Children. UNICEF confirmed its support for measles campaign and urged the EDO-H of Peshawar and Kohat to start preparing micro plans for the mass measles campaign in risk UCs hosting IDPs from Khyber Agency. DGHS asked that the health service package should be in consultation with the DG office and should be transparent and clear. The DD and AD Public Health from the DG office asked for support in carrying out monitoring activities in shape of POL or vehicle support. UNICEF agreed to provide them rented vehicles or any other mode transportation support for monitoring purposes.

Separate coordination meeting was conducted at DoH KP to discuss immediate steps and actions to mobilize available resources to assist health facilities in UCs with most of off camp IDP population. WHO, UNICEF, UNFPA, Save the Children, Islamic Relief, Johanniter International, MDM-F representatives discussed the modalities of collecting updated information and mapping the most affected UCs and list of present health facilities with human health resources with marked recommendations by DoH KP on the requirements to assist.

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.

Save the Children conducted the assessment on the situation of 45 off camp IDP communities from Khyber Agency at the District of Peshawar. 2,157 families (approx. 16,500 people) were assessed in total. The following findings were shared in regards to the access to health care services: *o*nly 4.4% of respondents shared that people are receiving sufficient medical care; 30% of respondents travel more than 16 kilometers to access the nearest health facility; 96% of respondents accessing health facilities are not receiving subsidized or free medicines; 48.8 percent communities reported diarrhea as a common disease in children. Comprehensive beneficiary identification and tracking strategies should be adopted to reach the most vulnerable. There is a need to initiate mobile clinics and strengthening available health facilities.

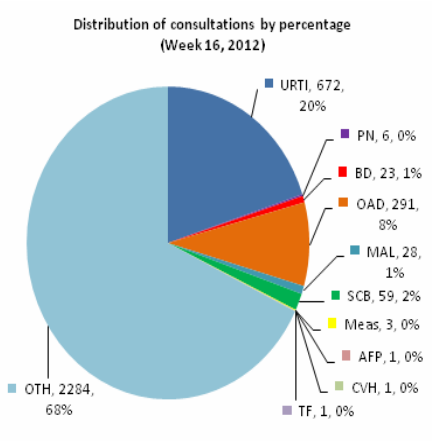
Health cluster partners are interested to receive the results of the survey (conducted lately by WFP, IVAP and IOM) on registration, identification and services available for off camp population in the districts of Nowshera and Peshawar.

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.).

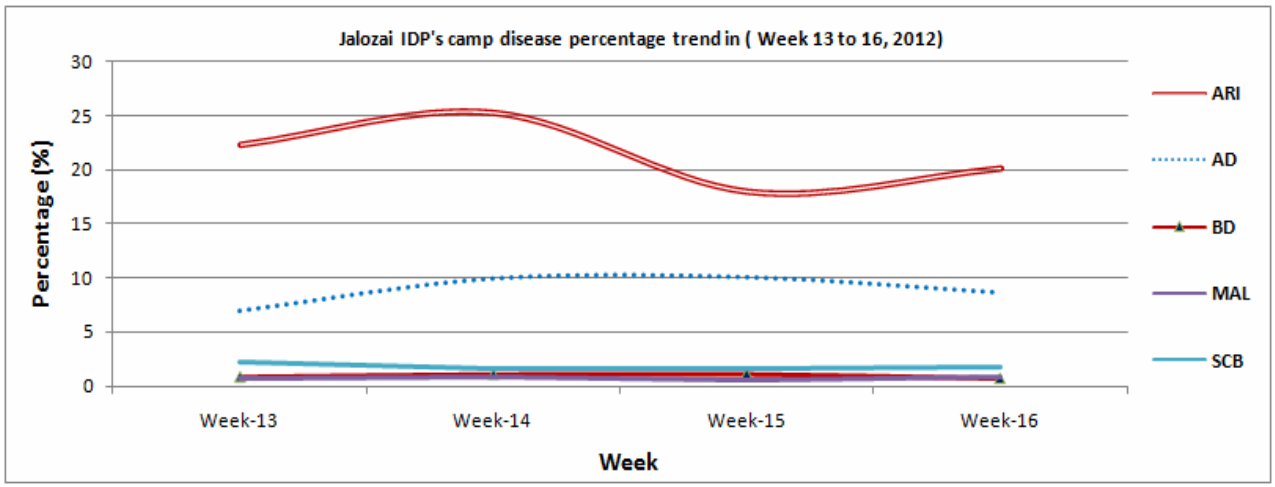
***Communicable disease control and prevention*:**

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 20% or 678 cases of the total patients (3,368 consultations) in all age groups. Other Acute Diarrhea (OAD) accounted for 9% or 291 cases. Bloody Diarrhea (BD) shared 1% or 23 cases of all visits. Skin Infections (SCB) reported as 2% or 59 cases. A total of 5 alerts, including 4 measles and 1 AFP were reported and followed up by WHO.



A total of 3,368 consultations were reported through WHO supported DEWS (April 15-21, 2012) from 6 health posts (4 – Merlin and 2 - CAMP) in the camp. The most leading disease consultations include other diseases (group of miscellaneous non communicable diseases) (2,282), upper respiratory tract infections (672), other acute diarrhea (291), scabies (59), etc. 2,199 consultations are registered via 4 MERLIN run health posts and 1,169 – by 2 posts of CAMP NGO.



There are 1,283 consultations (38%) provided to male IDP population and 2,085 (62%) to female IDPs.

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.

WHO collected and shared the information on routine vaccination provided to 40,823 children and women, including BCG, Polio, Penta, Measles and TT vaccination provided by camp based partners.

Laboratory services are available in the camp (with a total of 396 tests conducted on a weekly basis or 2,206 lab tests since onset of influx.

Preparation for NID on April 23-25 is in place. All partners will support present EPI force. Merlin and CERD will provide backup for EPI centers in their facilities.

Most of new IDP tents are not marked properly to reflect the signed address creating a problem of following up with reported diarrhea cases.

Merlin health facilities established 4 ORT corners. One additional health facility will be assigned 24/7 duties and functions. One more lab is planned to be opened in J-4 health post. A number of ambulances is increase from 3 to 5.

Mass measles, vitamin A and polio campaigns were successfully conducted in high risk UCs and Jalozai IDP camp. Regarding off camp population there are efforts in place with responsible district officials to ensure all population in the upcoming NID. UNICEF provided and supported services of 10 EPI vaccinators, 2 female vaccinators and 4 social mobilizers.

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

In Khyber Agency WHO registered and responded to an outbreak of suspected measles in the affected area of Kambila Tehsil Mulagori. During the outbreak response outreach vaccination was done, in which **175** children were vaccinated. An alert of Leishmaniasis from BHU Mian Morcha was responded where one case was found on active surveillance. WHO conducted coordination meetings with Agency Surgeon Khyber, FSMO, and PPHI. WHO completed monitoring visits CH Jamrud, BHU Mian Morcha, BHU Kambila, CD Pindi Lalma and CH Lowara Mina.

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 CAMP managed health post (400 Albendazole, 2000 Aluminium Hydro. + Magnesium Hydr. 3000 Amoxicillin, 2 Benzyle Benzoate 25 % application, 4000 Ferrous sulphate + Folic Acid 200 mg +4mg, 8 Gention Vilolet Powder, 25mg, 4000 Ibuprofen, 2000 Paracetamol,100 Tetracyline 1% eye ointment, 40 Elastic bandage 8 cm * 4mtr, 400 Gauze bandage,1000 Gauze swab, 200 Examination gloves, 60 adhesive tape, 20 soap Toilet, 60 Adhesive Plaster, 8 Exercise Plaster, 4000 Plastic envelope 10*15 cm, 1000 Bag for health card, 400 Oral Rehydration salts,1000 zinc sulphate dispersible tablets, 4 absorbant cotton wool, 2000 sulfamethoxazole + trimethoprim, 600 Dimenhdrinate, 1000 Erythromycin, 1000 Chorolquine phosphate, 600 Chlopheniramine, 500 Oral rehydration salts, 4000 zinc sulphate dispersible tablets, 25 volumetric chamber, 20 I V catheter, 245 I V set, 16 Absorbent cotton wool, 120 syringe,140 Syringe, 20 Surgical knife blade, 28 suture synthetic, 300 hypodermic needle, 50 scalp vein set,10 sharp collector, 60 I v set, 40 Ringer Lactate, 20 Dextrose, 50 Nebulizer kit, 100 Betamethasone cream, 60 mupirocin cream, 200 permethrin lotion, 300 benzyl benzoate, 4 chlorhexidine+ cetrimide soloution, 30 lidocaine, 4 povidone iodine, 10 hydrocortisone, 200 Folic Acid, 8 Magnesium sulphate Inj, 200 Pridnisole tab, 5 Ketamin, 240 Aqua tabs, 50 Benzaylpencilline vials, 400 metronidazole, 200 Salbutamol, 600 Retinol Vitamin A,800 Ascorbic acid, Vitamin C, 600 Doxycyline,100 ceftriaxone Inj, 500 claxacillin, 210 Sulfamethaoxazole + Trimethoprim, 140 Paracetamol, 20 Clean Delivery kit, 2000 Aluminum Hydro + Magnesium Hydr. 3000 Amoxicillin, 4000 Ferrous sulphate + folic Acid 200 mg +4mg ,4000 Ibuprofen,2000 Paracetamol, 4000 Plastic envelope,1000 Zinc sulphate dispersible Table, 2000 sulfamethoxazole + Trimethoprim,600 dimenhdrinate,1000 Erthromycin,1000 Cholroquine phosphate).

Environmental health:

WHO provides a daily water quality and quantity status daily surveillance reports. To ensure water safety residual chlorine is routinely monitored by WHO team and 522 samples tested for residual chlorine in various sites of the camp, around 81% of samples were found to have residual chlorine matching WHO guide value. WASH partners were informed to ensure 100% chlorination of all drinking water supplies. 51 samples were also tested for microbiological contamination and 12% 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 six 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.

WHO, UNICEF along with other WASH partners monitored and health facility staff responded to bloody diarrhea alerts received from the camp. The team visited the patients' tents, provided IEC materials and health education sessions. 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,

For the effective communication among the WASH and Health partners in the camp and reduce the issues related to diarrhea, it was decided in the camp cluster meeting that WASH partners would participate also in camp based health cluster meetings. WHO Environmental Health team links health and WASH activities through regular sharing of WASH updates with health partners and disease situation updates with WASH partners for active response and timely mitigation.

Two Wagtech kits for routine water physio-chemical 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 larvicides control.

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.

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 report 76 new antenatal cases registered, 258 ante-natal consultations and 73 post-natal provided and 26 deliveries per reported period. Health partners in the camp provided 1,356 health education sessions at the registration point attended by 2,480 males and 12,736 females (per week – 201 sessions for 360 males and 2,014 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.

UNFPA plans to establish STI and woman friendly health centers in the camp.

IRC supports reproductive health project in the district of Nowshera.

Johannitter International launches a two-years project on MCH for off camp population in the district of Nowshera..

UNICEF is in preparation of upcoming Mother and Child week will be held from 30th April to 5th May, 2012. During the week deworming of children from age 2 to 5, immunization of 0-2 years, TT, immunization of pregnant ladies will be done. 4 sachets of ORS will be given to every family and health and hygiene sessions will be conducted with communities. UNICEF supports DoH in development and production of IEC materials on dengue control and prevention.

UNICEF plans to purchase and supply ultrasound machine for MCH centre run by CERD with the support of required HR.

WHO continues technical support to the nutrition stabilization centre of the district of Nowshera. Sufficient staffing is available. 10 staff were trained on SAM+C. Nutrition supplies are available. WHO provided emergency health kit. Assessment of environmental health requirements is completed.

E. Gaps & Constraints

Funding of health cluster activities becomes one of the main constraints considering availability of limited funds for in camp population while increasing needs and identified gaps for organizations of adequate and accessible health service for off camp IDP population in the districts of Peshawar and Nowshera. At present, activities and assistance provided to strengthen and respond to the needs of health care facilities beyond the camp are from previously generated funds and available contingency stocks. There is an increasing reality of required continuation of present health services upon completion of currently implemented projects in Jalozai camp.

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. Additional efforts need to be undertaken to identify all union councils in IDP hosting districts; map out all available health resources and ensure accessibility of IDPs to government provided health services. There remains a gap in reflection of levels of medical assistance provided to IDPs.

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.

Some of the identified gaps in environmental health include substandard food items being sold in the camp resulting in rise in diarrhea cases in the camp. Ownership of the WASH structures by the community needs further strengthening through proper guidance to reduce maintenance and water losses problems. Maximum utilization of WASH structures, especially latrines, in order to reduce open defecation in the camp through repeated hygiene messages and education. WASH structures maintenance mechanism need

improvement along with security improvement in order to reduce damage to WASH structures and theft related issues. 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.