Highlights

- Health Cluster established in Gilgit Baltistan to respond effectively to the ongoing winter and snowfall emergency which has affected about 85,000 population in the remote and inaccessible areas and upstream of Attaabad Lake. The priority districts are Hunza Nagar, Diamer, Skardu, Ghanche, Ghizer for needing assistance from health cluster.
- WHO has planned to establish 98 ARI Centres out of which 67 are operational throughout the country.
- Health Cluster workshop will take place from 7 to 9th February 2011 in Islamabad to identify best practices as well challenges during the health sector humanitarian response to flood affected population in August 2010 - January 2011
- Damage & Need Assessment (DNA) report revealed that Out of 9,271 health facilities across the country, a total of 515 (5.3 percent of the total) have been partially damaged or completely destroyed. In the two worst affected provinces, KP and Sindh, about 11 percent of total health facilities in the affected districts were damaged or destroyed.
**Health Cluster Response in Gilgit Baltistan**

Health Cluster has been established in Gilgit Baltistan and first Health Cluster meeting took place on 27th Januray in Gilgit co chaired by DG Health Gilhit and DG Health Baltistan. Doh Gilgit reported that 25000 are in upstream of Attaabad Lake need continuous assistance from Shelter, Food, WASH, Nutrition and Health Clusters. 10 beds hospital is operational in the upstream of lake where no lady MO is available and DG Health requested UNFPA to provide Female Medical Officer/Gynecologist to the Civil Hospital. MO of PAK ARMY and Medical Staff of PPHI is providing support the affected population. OCHA mentioned that 3400 shelters needs identified. PRCS, Shining Light, APBS, Diamer Area Poverty Program are providing shelter support. Measles cases were identified in Diamer 287, Gilgit 18 and Ghizer 26. Mesales case Line listing should be maintained for which format will be provided by WHO to PPHI. DG Health mentioned that Vitamin A for Measles is also needed. WHO will provide Vitamin A to DoH GB. The priority districts are Hunza Nagar, Diamer, Skardu, Ghanche, Ghizer for assistance from health cluster. Organizations/Partners on Ground are DoH – WHO, NATPOW (Diamer), PAK ARMY, UNICEF, PPHI, AKHS, PRCS, UNFPA, MAF, Shifa Foundation, FPAP, MARFI, Foundation (Baltistan), Khubaib Foundation (Baltistan). Shifa Foundation mentioned that they are working in Ganche and Skardu. Nebulizer were needed which will be provided in next 2-3 days. Gap also exists in referral services in Gama and Skurdu areas. It was concluded by partners that priority Needs/Gaps in Healthcare Services Delivery are HF Need Assessment, Surveillance System needs to be strengthened, Referral System – Location/Mechanism need to be strengthened , Health Education & Hygiene – Awareness Issue (strengthening), Maternal Mortality Ratio & Infant Mortality Rate – High Health Cluster partners are continuing to meet each week in Islamabad, Sukkur, Hyderabad, Quetta, Multan and Peshawar Hubs to share epidemiological data and review health response operations.

**Health Cluster Lesson Learned Workshop:**

This three day workshop is planned to achieve specific objectives based on lessons learned to date in the humanitarian crisis experienced by Pakistan. The workshop participants need to be enabled to identify achievements and the problems faced in the response and then to work together on determining effective solutions. It will be essential to maximise effectiveness of relevant roles at country, regional and global levels to continue response to the identified health needs in Pakistan.

The need now is to align country needs and recommendations with the partners (at country, regional and global levels) potential and projected capacity for continued response to needs.

**Objectives**

1. Identify best practices as well challenges during the health sector humanitarian response to flood affected population in August 2010 - January 2011
2. To identify what actions, systems, mechanisms and resources are needed in the next phase for health cluster partners in Pakistan in order to achieve a common strategic framework for health sector recovery in 2011

The situation in Pakistan was one of extreme need, particularly regarding health. Identified areas of need included:

1. Preserve and restore access to basic health care, reducing financial barriers and ensure rehabilitation/ re-establishment of primary and secondary health services. Treatment of injuries, critical chronic treatments, mental health and psycho-social
support, HIV/AIDS, acute malnutrition and referral systems of life threatening conditions.

2. Provide sexual and reproductive health services including: services for GBV related health problems according to MISP standard as part of basic public health care; provision of MNCH in a safe environment and an adequate referral system to reduce related mortality rate.

3. Prevent, control and provide public health response to communicable disease outbreaks

4. Ensure water quality control, water-borne and vector disease control, sanitation and hygiene promotion, including messages for proper health seeking behaviour during consultations

5. Develop national and local health emergency management capacities: risk assessments, disaster risk reduction, emergency preparedness and safer hospitals integrated in the early recovery and reconstruction process.

Under the UN Humanitarian Approach, WHO is the lead agency for health and the established the Global Health Cluster (GHC) in 2005. The Global Health Cluster (GHC) brings together UN agencies, Red Cross-Red Crescent Movement, nongovernmental organizations (NGOs), donor organizations and academic centers and institutions committed to responding to health needs in emergencies. The GHC approach recognizes the value of local knowledge, expertise and advice; promotes lessons learned exercises and ongoing review, monitoring, adaptation and evaluation; and seek to secure effective response capacity in the field, focusing specifically on capacity building at country and local level.

Pakistan was the first country to implement the Cluster approach following the Kasmir earthquake in 2005. WHO was designated lead agency for the humanitarian response and ensured that there has been a dedicated Health cluster coordinator.

Following the onset of the Floods in late July 2010, the Pakistan Health cluster established the central coordinating mechanism in Islamabad with sub-national hubs in Multan, Sukkur, Hyderabad and Quetta. The sub cluster was already operational in Peshawar due to the IDP’s crisis in the region. There are 128 partners involved in the health cluster.

Each health cluster hub has a full time health cluster coordinator. The health cluster meetings are co chaired by WHO and Department of health. In the initial period of the current floods emergency, the health cluster meeting was held weekly. The health cluster meeting is now held on a fortnightly basis and is attended by Donors, UN agencies, INGOs and NGOs that are active in the hub.

**Rationale**

At the Health Cluster Coordinator (HCC) Lesson Learned Workshop in Geneva, June 2010 and the Geneva Global Health Cluster meeting in June 2010, coordinators and HGC partners expressed the need for the country in collaboration with the GHC to review the health cluster response. The aim is to improve in leadership and coordination efforts, capacity building and documenting information and good practices. This is now particularly relevant for Pakistan.

**Epidemiological updates (21 to 27 Jan 2011)**

- Between 21 to 27 Jan 2011 (epidemiological week no. 4, 2011), 58 districts in 4 provinces provided surveillance data to the DEWS system.
- 2,190 fixed health and 8 mobile medical outreach centres provided surveillance data for this week.
- A total of 729,416 consultations were reported through DEWS of which 31% were acute respiratory infections (ARI), 9% skin disease, 6% acute diarrhoea, and 5% were suspected Malaria.
- Total 19 alerts in past two weeks were received and responded: 6 were for Measles, 6 for suspected Influenza, while 1 each for
Tetanus, Meningitis, Leishmaniasis, Acute Watery Diarrhoea, Diphtheria, Acute Flaccid Paralysis, and Viral Hemorrhagic Fever

- There were two cases of confirmed poliomyelitis reported this week one was from flood-affected districts.

**Essential Medicines:**

The following are the updates of essential medicines provided in the affected districts.

- For the measles cases in Gilgit Baltistann 1000 doses of vitamin A have been provided.
- 15 EHK have been provided upon the request of FATA directorate in PESHAWAR for 15 Health facilities including 6 Agency Head Quarters Hospitals, 4 Civil Hospitals, 3 THQs and 2 RHGs.
- 11 EHK has been provided to DCO Kohistan for 11 BHUs based on the Monitoring & Evaluation report of WHO Surveillance Officer while KPK 48 ARI kits have been supplied.

**Establishment of ARI centers in the floods affected areas:**

As the weather changes especially in the northern areas, the numbers of Diarrheal cases decreased while Acute Respiratory Infection (ARI) cases increased very rapidly. Nearly 30% of all cases were of ARI during last few weeks, which are a threat to the community, especially the children.

To reduce the morbidity and mortality due to ARI, WHO is supporting the district health system to ensure 24-hour care to children hospitalized with pneumonia and similar illnesses in the flood-affected districts. The interventions to control ARI can be divided into four basic categories: immunization against specific pathogens, early diagnosis and treatment of disease, improvements in nutrition, and safer environments. The first two fall within the purview of the health system, whereas the last two require multisectoral involvement. The Federal EPI program is providing support for vaccination while WHO is providing technical and financial support in early diagnosis and treatment of disease. It is planned that 98 ARI units will be supported for 2 to 3 months in flood-affected districts.

The ARI units supported by WHO are in Public Health facilities designated in consultation with the district and provincial health departments and organized under the supervision of the hospital administration and pediatrician. The existing health staff and additional staff, where needed, are involved in two days’ training on case management of ARI imparted to them by expert trainers on WHO guidelines. In this manner, these ARI units are providing quality services for the hospitalized children 24 hours round the clock. Essential medicine for ARI and some equipment which includes Nebulizers, Ambu Bags, Oxygen concentrators and Oxygen cylinders will also be provided to the special ARI units where needed.

**Damage and Need Assessment (DNA)**

*Cost: PKR 4,222 million (US$ 49.67 million):*

The floods resulted in mild to moderate damage to the country’s public health infrastructure, including basic health units and dispensaries, which suffered the most damage. However, most of the secondary health care facilities were unaffected. Out of 9,271 health facilities across the country, a total of 515 (5.3 percent of the total) have been partially damaged or completely destroyed. In the two worst affected provinces, KP and Sindh, about 11 percent of total health facilities in the affected districts were damaged or destroyed, followed by 8 percent in FATA. Damage to health facilities in the rest of the country’s floods-affected areas total 2 percent or less.

The reported damage to primary public health infrastructure including basic health units (BHUs) and dispensaries has been mild to moderate. Most of the secondary health care facilities remained unaffected. No health staff were reported to have died or been
injured. The 2010 floods covered significant parts of the country and mostly rural areas were affected. Of the total of 9,721 health facilities country-wide, 515 facilities (5.3 percent) were damaged of which 186 facilities (1.9 percent) were completely damaged and 329 facilities (3.4 percent) partially damaged. Sindh sustained the largest damage followed by KP. Damaged BHUs and dispensaries constituted 86 percent of the total number of damaged facilities; the remainder were damaged RHCs (10.8 percent), THQs (3.2 percent) and two DHQs. Table 2 below shows the province/region-wise number of damaged health facilities as a percentage of damaged health facilities in the affected districts and as a percentage of the total health facilities in the province/region.

The total damage to the public health facilities has been estimated at PKR 1,561.6 million (US$ 18.37 million). This estimate takes into account a depreciation factor of 50 percent of the replacement cost based on the assumption that the affected health facilities were generally older than fifteen years. Using the revised costs worked out by WHO for early recovery i.e. US$ 104.6 million [including: repair of health facilities, equipment and supplies (32 percent) preventive and curative emergency health programs (53 percent), assessment and surveillance (11 percent) and coordination and health information management (4 percent)], a preliminary assessment for indirect losses has been calculated as US$ 31.3 million based on the assumption that 70 percent of US$ 104.6 million (WHO estimates needed for early recovery) would be required to cover organizational/salary related expenditures. The breakdown of the direct and indirect damage (combined) among the provinces and regions has been estimated as follows; Punjab US$ 4.78m, Sindh US$ 22.6m, KP US$ 16.65m, Balochistan US$ 2.18m, AJK US$ 2.35m, Gilgit-Baltistan US$ 0.03m, and FATA US$ 1.08m.

Health Cluster Early Recovery Plan:

The goal of the health recovery plan is to support the reactivation of the health care system in areas damaged by the floods, with special emphasis on maximizing the access of the returning and resident population to a basic package of quality essential health services.

The expected results of the health early recovery plan are:

Improved access to an essential package of public health services for the affected and returning population with a reasonable degree of contact (above 0.5 new cases/person/year) between the population in the catchment area and the public health delivery system in each of the priority districts.

The concept of “district health planning” is promoted and universally applied as the main cornerstone for health planning and management.

Quality technical assistance is available at provincial and district levels (in view of the 18td Constitutional Amendment).

A well functioning surveillance system (DEWS), guaranteeing early detection of health alerts and timely responses

Improved articulation of the DEWS system with a functioning broader District Health Information System

Services delivery and the role of outsourcing of services is clarified and better regulated.

Priority actions for the health reform process are taken into account in the early recovery process.

Capacity to pursue longer term health development goals within a context of good governance, to assure human security and extend social protection in health.

Early recovery refers to efforts in all sectors from the initial relief phase so that the necessary foundations for full-fledged recovery work are laid. Early recovery continues during the prolonged periods of protracted emergencies and the long transition that follows both the aftermath of natural disasters and post-conflict situations. There
is no clear-cut boundary between the relief and the recovery periods. It is important to emphasize that the disaster-management cycle is an unbroken chain of human actions whose phases overlap. The early recovery plan has been drafted in consultation with the MOH (federal and provincial) and a large number of health partners including a cross-section of medical NGOs and the ICRC. UN agencies with a specific health focus (such as UNICEF, UNFPA and UNAIDS) have been particularly involved. Special attention has also been given to the opinion of donor organizations with a particular interest in the health sector (USAID, DFID, ECHO, AusAid, CIDA, ADB, WB). Damage in the health sector infrastructure (DNA and preliminary results from the HeRAMS assessment)

- According to the Damage Needs Assessment (DNA) of November 2010, 515 (5.3%) of 9721 health facilities across the country have been partially damaged or completely destroyed, the largest number being basic health units (BHUs).
- Compared to other sectors, the floods resulted in mild to moderate damage to the country’s public health infrastructure. BHUs and dispensaries suffered the most damage. However, most of the secondary health care facilities were unaffected (with exceptions in each province) Many damaged or destroyed BHUs and rural health centres (RHCs), as well as some hospitals, lost the bulk of their equipment and furniture.
- The total damage to the public health facilities has been estimated at U$ 18.37 million (not including indirect losses). This estimate takes into account a depreciation factor of 50% of the replacement cost (see below) based on the assumption that the affected health facilities were generally older than fifteen years.
- The reconstruction cost of these health facilities has been estimated at U$ 36.7 million. This estimate should be viewed with caution, since many facilities have already been partially rehabilitated by governmental or nongovernmental entities or are already integrated in different action plans. Further detailed verification of individual health facilities is currently under way.
- In the two worst affected provinces, KP and Sindh, about 11% of total health facilities in the affected districts were damaged or destroyed, followed by 8% in FATA and AJ&K at 6% (both however with less than 40 facilities damaged). Damage to health facilities in the rest of the country’s floods-affected areas accounts for around 2% (or less) of the total available. Preliminary results of the recently carried out HERAMS (¹) survey (assessing individual primary health care (PHC) facilities for services delivered, functionality, damage, etc) show slightly different results but similar trends, with the highest level of damage in Sindh and KPK.