

Final REPORT

July 16, 2010

Inter-Agency Health and Nutrition Initial Rapid Assessment

Southern Kyrgyzstan - Jalal Abad and Osh Oblasts

June 29 - July 3, 2010



Executive summary

i. Kyrgyzstan has experienced escalating violence since the previous government was overthrown on April 7 and an interim government took power. Subsequently, violent clashes took place in Osh and Jalal-Abad Oblasts (province) throughout April and May and fighting reached its highest intensity from June 10-14 during which shooting, killing, looting, and property destruction were widespread in cities as well as in rural areas leading to mass population displacements. After four days, a state of emergency was declared and an uncertain peace prevailed until the June 27 referendum.

ii. On June 24th, in Osh oblast, UNHCR registered a total of 25 settlements / centres that received IDPs from different rayons (districts). One assessment team met with one displaced Uzbek community in Mady village (Kara Suu rayon) that was not registered by UNHCR. The exact figures on IDPs (how many and where they were/are) and on settlements are not available.

iii. As of July 5th, the Ministry of Health in Bishkek reported the following data for both Jalal-Abad and Osh Oblasts: 2,319 persons were provided with medical care, including 1,075 hospitalised patients and 1,243 patients treated in outpatient departments. Currently 141 patients are still hospitalised. Disaggregated data are not available for the moment. The total number of reported deaths is 309 persons, including 249 registered by the Office of Forensic Expertise. Ninety-two percent (229/249) were men. The official figures provided at central level may not correspond with the figures reported at Oblast level.

iv. Overall, the crisis has not had a significant impact on the health of the population in the affected areas in the short term. Health providers have been able to cope with the flow of patients during the conflict. However, the crisis has clearly showed weaknesses and limitations in the health system highlighting old infrastructure and unavailability of appropriate equipment and supplies. This raises the need to focus on health system strengthening, to provide better care to populations in the area and to avoid a health crisis if another emergency occurs in the future.

v. **Medical supplies:** according to the health authorities and health professionals, with a few exceptions, secondary health care facilities were oversupplied with essential drugs and medical supplies through the humanitarian aid, while PHC facilities were undersupplied. As hospitals are officially not required to supply PHC facilities, medical supplies were not distributed to PHC facilities and health points. Meanwhile, health workers from PHC facilities didn't approach relevant authorities to request their needed supplies. The drug supply for chronic patients was interrupted during the crisis and remain a challenge. In Osh, only the central pharmacy is open for the time being, while the other pharmacies are either closed, or have no drug supplies. Usually drugs for 6 chronic diseases are provided by the State, which covers up to 70% of the cost, while patients pay the remaining 30%.

vi. **Access to health care:** it was reported that many patients in need of health care did not seek medical assistance at the health facilities due to insecurity, road blocks, and lack of public transport. In addition, Uzbek patients, feared going to the hospital where medical services are provided mostly by Kyrgyz staff. At the same time, Kyrgyz medical staff were afraid/reluctant to serve Uzbek communities. Most Uzbek medical staff didn't report to work during the crisis: some stayed either at IDP points or with host families. Consequently, certain areas were underserved or not sufficiently covered. According to local authorities, however, many of the staff who didn't work during the crisis have since resumed working.

vii. **Health care delivery:**

- A few health facilities were slightly damaged and a total of 5 ambulances were destroyed, 2 in Jalal-Abad and 3 Osh but overall, health facilities are functioning.
- The number of home deliveries have increased during the crisis as most women, particularly Uzbek women, didn't go to maternity houses at primary health care level because of lack of security. According to the director, there was a significant decrease in the number of births in the Osh Oblast Maternity Hospital. Usually the average number of births per 24 hours in the maternity hospital is about 12-14, however during the conflict the number went down to 4. The number is now recovering and is reaching 8-9 deliveries a day. The number of home

deliveries has also significantly increased. While in 2009 the total number of home deliveries was 36, there were 73 home deliveries in four days of the conflict only. Access to maternity hospital was substantially reduced due to insecurity as well as the outflow of women to neighbouring districts and Uzbekistan. Many women have also requested to be discharged immediately or on the next day after birth. Pregnancy related conditions such as eclampsia and haemorrhage were reported as increasing. There were also many spontaneous abortions occurring, however the exact number is not available.

- Ambulances play critical role in timely provision of services. The number of home deliveries increased during the conflict. Timely transportation to maternity houses, referral in timely manner as well as health providers' capability to ensure safe delivery if it happens at home is critical for the health of mothers and newborns. Some villages are up to 600 and 700 kilometers away from the closest maternity house. The tertiary level Maternity Department of Osh Oblast Hospital, has requested a new ambulance to serve 9 maternities.
- The number of reported cases of sexual violence is relatively low when compared to the many reported gender-based violence cases, where survivors were severely beaten. A total of 18 cases of sexual violence were registered by the Oblast joint hospital, 17 of them were killed. The healthcare facilities often did not have PEP nor were emergency contraceptives administered in a timely fashion. Staff are not trained on WHO methodology for clinical management of rape in a crisis situation. Immediate referral systems are not in place between crisis centres and healthcare providers and needs to be addressed. It is critical that referral mechanisms be available between health, psychosocial and legal assistance for victims of GBV (Gender Base Violence).
- The provision of immunization services stopped during the conflict and gradually resumed. In addition, IDPs didn't have their immunisation cards with them. Vaccinations have not yet been provided to remaining IDP points in Osh because they are not registered with the Family Group Practitioners Centres of the neighbourhood.
- The TB centre (a 240 bed hospital), was partially damaged by the conflict. The laundry facility of the Osh Oblast TB Centre was burned. However the facility was easily accessible during the conflict and services were provided free of charge for TB patients. 25 out of 50 Multiple Drug Resistant TB patients were displaced and had no access to their drugs.

viii. Particular attention should be given to mental health care. Many of the conflict-affected populations experience fear, anxiety and insomnia. Several international and national NGOs as well as ICRC are currently focusing their activities on psychosocial and mental health care. According to the Ministry of Health, there are about 145 available state clinical psychologists and psychiatrists in the Osh and Jalal-Abad cities and oblasts and in Bishkek, out of which 43 are employed in the South. A pressing problem is the limited number (eight only) of trained children psychiatrists, who are all working in Bishkek. Some are ready to be deployed to the South with mobile outreach teams to address children's, specific needs.

ix. Sanitary Epidemiological Stations (SES) took samples of the surface and drinking water and tested it in the SES laboratory. The results revealed *Shigella flexneri* in samples from some open water reservoirs. SES staff also provided assistance to IDP points with water disinfection. After the crisis, SES disinfected the bazaars in Osh and the streets in Mahalas and districts.

x. *Humanitarian assistance and aid* was provided right at the on-set of the conflict by the Ministry of Health, ICRC, MSF and UNICEF with additional support from several governments in the form of medical equipment, material and drug supplies. Humanitarian aid that was planned for the refugees in Andijan, Uzbekistan, was redirected to Osh. The amount of equipment, supplies and drugs received and delivered is being analysed. International assistance was quick, but consists mainly of essential medicine

and medical supplies, and less of medical equipment. It is recommended that humanitarian assistance should shift from the secondary to the primary health care level.

xi. The sudden onset of the crisis in April was exacerbated by floods in May, that have already destroyed 700 households and several thousands of hectares of cultivated fields in Southern Kyrgyzstan. This has resulted in the inability of people to properly start their planting season. There is great concern among the population regarding their crops and credits. Added to that is the increase in the price of fuel and fertilizer which will result in poorer crop yield. Farmers also reported that irrigation pipes were damaged as a result of the flood and consequently are not able to water their fields. Men who usually migrate abroad to support their families through remittances have stayed home to protect their homes and land. The looting and destruction of property has decreased market activity and emptied both homes and stores of assets. There is a risk of increase in gastro-intestinal diseases caused by potential food poisoning as a result of inadequate food storage due to inadequate living conditions. It should be noted here that the nutrition situation does not seem a major issue at this time however, no special attention is being given to the diet of children under five and especially children under two. Children are fed the same diet as the rest of the family which is carbohydrate loaded. Neither vegetables nor meat or milk products are available to children. Micronutrient deficiency is a great concern if no proper attention is given to the diet of children.

xii. The Ministry of Health has requested forensic assistance due to a number of unidentified bodies found. However, an ICRC expert worked already for 3 weeks to provide training and basic equipment to the MoH.

xiii. Health cluster coordination meetings are for the moment held both in Bishkek and Osh on a weekly basis. A Mental Health (MNH) working group has been established, and is holding weekly coordination meetings in Bishkek and Osh.

xiv. The sampling methodology was purposive, and not random. The assessment team agreed to use the IASC Initial Rapid Assessment (IRA) tool, and adapted the questionnaire to the local context. The team developed one additional questionnaire to be carried out at the community level. Both questionnaires included basic questions on food security, mental health, and WASH, in addition to the health-system-related questions. Both questionnaires were used more as a check list than as a questionnaire designed for quantitative purposes.

1. Main Findings and Recommendations

Summary of key findings:

1. All refugees and the majority of IDPs have returned home, except for IDPs in a few IDP points and host families.
2. The overall findings regarding the health facilities are summarized as follows:
 - a. In both Jalal-Abad and Osh during the recent crisis, the health facilities faced an influx of injured persons and responded within their current capacities. The crisis exacerbated chronic deficiencies in care, availability of essential equipment and some drugs. A number of health institutions have obsolete medical equipment which requires immediate replacement (i.e. X-ray machines, newborn resuscitation equipment, anaesthesia equipment, surgery kits, refrigerators, etc). Additional immediate support was provided by the Ministry of Health, Bishkek referral hospitals, international organizations and donors. The Ministry of Health in Bishkek reported in the period from June 10th to July 5th, 309 deaths, 2,319 persons were provided with medical care in both Osh and Jalal-Abad, including 1,075 hospitalised patients

- and 1,243 patients who had received outpatient treatment. Currently 141 patients are still hospitalised.
- b. Only limited physical damage was reported by health facilities. Five ambulances have been destroyed.
 - c. At the Primary Health Care level temporary health points were set up in close proximity to major IDP gathering (particularly near the border areas).
 - d. With a few exceptions, secondary health care facilities were oversupplied with essential drugs and medical supplies, while Primary Health Care facilities were mostly undersupplied.
 - e. Due to security concerns and limited access to appropriate level of care, there was an increase in home deliveries, deliveries in rural hospitals, pre-term deliveries and late admissions to hospitals.
 - f. Due to persisting security concerns late hospitalization and fear to seek medical assistance continues to be reported.
 - g. Inadequate follow up and rehabilitation of people with injuries.
 - h. Interrupted supply of drugs for chronic disease patients.
 - i. Surveillance and early warning activities in IDP settlements was conducted episodically. To date, the routine surveillance system works under the overall coordination of the Sanitary Epidemiological Stations (SEs). No major outbreaks have been reported by SEs.
 - j. Hygiene practices, which were poor prior to the conflict, remain poor and need to be addressed. Provision of water supply via water trucking is ongoing by ICRC in Osh and surrounding areas. Currently, all agencies involved in the WASH cluster are basically involved in the distribution of hygiene kits to affected families.
 - k. Being mainly pastoralists or agro-pastoralists, most families' livelihoods have been disrupted. Farmers were not able to tend their fields and there is great concern about the upcoming harvest. The current conflict has exacerbated the existing damage that occurred as a result of the May floods where irrigation pipes were destroyed. Moreover, there is concern regarding the quality of irrigation water.
 - l. The food ration consists mainly of wheat flour, sugar, rice, macaroni and vegetable oil with little or no protein and low in micronutrients. The food ration is not targeting children under the age of two which is the critical age for growth and development
3. Major concerns raised by conflict affected individuals and communities are:
- a. The overwhelming majority of people interviewed requested improved security and protection, as well as an independent investigation of the recent eruption of violence.
 - b. Psychological trauma is reported as the most important health issue. Both children and adults require professional counselling and psycho-social support.
 - c. There are reports of deteriorating food security situation in some communities, due to increased prices and still limited availability of some food commodities. Fair distribution of food and non-food items is requested by conflict-affected communities.
 - d. Most communities are not reached by Primary Health Care providers, due to remaining insecurity.
 - e. And at the same time some communities are scared to access health facilities.

Recommendations:

1. While the acute phase of the crisis is over, there should be a thorough review and inventory of medical supplies distributed to health facilities, with the main objective to identify gaps and plan together with the Ministry of Health and international donors, to address remaining gaps. Part of

the supplies not used for immediate needs, should be prepositioned for emergency preparedness purposes.

2. Immediate outreach programmes for all conflict affected communities are required for both promoting disease prevention and care-seeking behaviours.
3. Strengthen the capacity of health providers at primary level to address needs of survivors of GBV.
4. Strengthen coordination with other sectors, and in particular with the Protection Cluster, to improve response to GBV.
5. Mental Health and psychosocial support is required for all people in need and appropriate training should be provided to relevant medical staff at all levels of the health care system.
6. Establish adequate follow-up system for rehabilitation of conflict-affected patients
7. Ensure the uninterrupted supply of drug for people with chronic diseases
8. Strengthen the surveillance and early warning systems in case of other emergencies, including laboratory capacities
9. Enhance the preparedness capacity of local health authorities in planning and providing emergency response.
10. Together with the WASH cluster address identified critical gaps both at health facility level and in communities, including hygiene education and ensure safe and reliable water supply.
11. Consider procurement of water quality monitoring kits and continue the distribution of WASH hygiene kits.
12. Consider partnership with Health Promotion Centre and Village Health Committees to disseminate hygiene and other health promotion messages.
13. Work with Acted to explore the possibility of linking sanitation and hygiene promotion through schools and at the health centres as well as the child friendly spaces.
14. Stronger social mobilization will be required for the Polio Supplementary Immunization Activities in the conflict-affected area.
15. The Osh health cluster should provide support in coordinating the Jalal-Abad response.
16. The joint assessment findings should be presented in a special health cluster meeting involving Protection, WASH and Early Recovery clusters.
17. Based on the assessment findings a short and mid-term plan should be developed:

Immediate Response (1-3 months):

- a. Review of humanitarian assistance provided to health facilities, addressing gaps and pre-positioning supplies as part of the emergency preparedness process.
- b. Strengthen the emergency response capacity of local health authorities.
- c. Strengthen coordination mechanisms at local level both in Osh and Jalal-Abad.
- d. Strengthen the referral system between primary and secondary health care levels
- e. Build capacity of PHC providers to provide quality care and adequate referrals to GBV survivors.
- f. In close cooperation with the Protection Cluster, provide psychosocial support to affected populations.

- g. Build the capacity of health providers on provision of SRH services in emergency settings
- h. Protect and Promote exclusive breastfeeding, adequate complimentary feeding - including micro-nutrients, de-worming activities and promotion of hygiene practices.
- i. Ensure the rapid implementation of SIAs for Polio, and measles if needed.

Mid-term response (3-6 months):

- j. Review the needs and provide additional basic equipment and medical supplies required both at the Primary Health Care and secondary levels to address the chronic gaps hindering quality of care.
- k. Ensure reliable provision of safe water and electricity in case of emergency.
- l. Review the status of the cold-chain equipment and supply additional equipment as per the gaps identified.
- m. Supply all maternity wards with basic equipment required for newborn care including resuscitation.
- n. Strengthen the capacity of Primary Health Care facilities to implement IMCI and community-based treatment of priority childhood diseases, danger signs in pregnancy, and other priority health issues.

2 Pre-assessment background information

2.1 On June 10th 2010, a wave of deadly violence began in the city of Osh in Southern Kyrgyzstan, and over the course of several days spread to surrounding districts and the neighboring province of Jalal-Abad. On the night of June 10-11, a mob of unidentified masked men armed with firearms and metal bars started rioting, looting and setting commercial and private properties on fire, as well as marching on some of the Uzbek neighbourhoods, attacking people in their houses, looting, and setting them on fire, thus forcing thousands to flee. In the same time, in several areas, Kyrgyz bystanders were attacked, or kidnapped, and killed.

2.2 As of June 16, the Ministry of Health (MoH) has recorded 187 conflict-related deaths as a result of the conflict, and 1,966 people injured. In addition, the affected areas have seen widespread arson, looting of state, commercial and private property, and destruction of infrastructure.

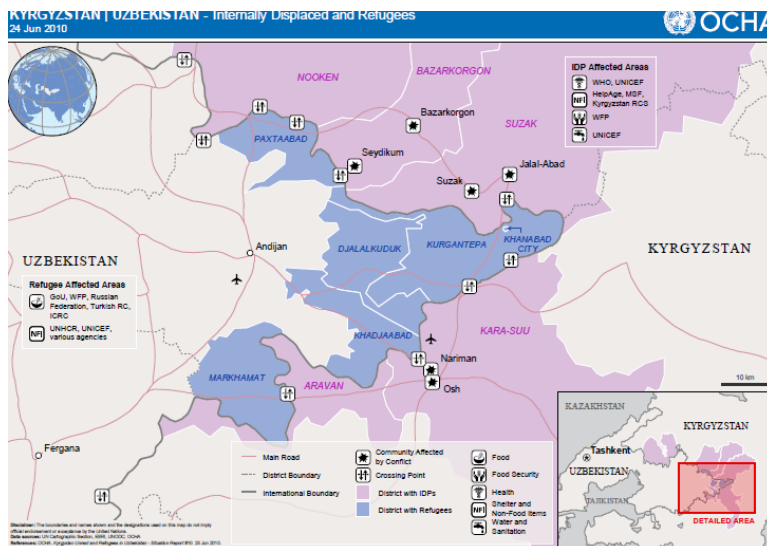
2.3 An estimated 375,000 people were reported to have fled the conflict in Osh (258,100) and Jalal-Abad (92,100) or the surrounding areas¹, including 75,000 of them crossing the border into neighboring Uzbekistan. Over 90% of the IDPs were women and children. An estimated 40,000 IDPs settled in public buildings, schools, or open air locations at the Kyrgyz-Uzbek border and were in urgent need of assistance for shelter, water, food, and protection,. A further estimated 260,000 IDPs hosted by families living in the area required support. In addition to IDPs, up to 765,300 people have been affected by the conflict, including communities hosting IDPs and communities devastated by the conflict (see map below, as of June 24th)..

2.4 Due in large part to the sudden nature of the crisis, the displaced populations lacked essential life-sustaining support, including shelter, water, food, and sanitation, essential domestic items and access to health care. Key protection concerns included reports of killings of civilians, gender-based violence (GBV), separation of families (particularly of children and elderly), and unequal access to humanitarian assistance. Conflict-affected populations were both impacted by physical ailments as well as mental stress.

2.5 The Interim Government requested international support to deal with the humanitarian consequences of the conflict and has established coordination centers for humanitarian assistance in the cities of Osh and Bishkek.

2.6 According to ICRC, thousands of people started to return home from 23 June on. However, people still feared for their safety as there were reports of renewed violence. The security forces attempt to restore law and order were viewed with apprehension, as the conflict triggered mistrust between the different communities.

¹ Source: Draft Flash Appeal



3. Objectives of the joint assessment mission

1.1 In the context of the Southern Kyrgyzstan ongoing emergency response, the joint mission objectives included the assessment of threats to human life and health, damage to health infrastructure for primary and secondary care, the state of health referral and support systems, such as the cold chain, laboratory, essential drugs and health information systems, and the vital needs for conflict-affected populations.

1.2 The joint mission evaluated the overall health situation by examining the main causes of illness and death, crude and under-five mortality rates, the occurrence of epidemics, the presence of endemic diseases, food security in the affected communities and assessed the state of relief operations, security and accessibility of the affected territories, displacement and migration of the population, state of communications and patterns of external assistance, and patterns of violence against the general population.

1.3 The overall goal is to identify priority gaps and recommend adequate health response interventions to be included in the flash appeal health sector plan.

4. Methodology

4.1 Overall methodology

4.1.1 As of June 24th, several UN health professionals (UNICEF, UNFPA and WHO) have been deployed at the request of their respective agencies from their HQ and/or regional offices to Kyrgyzstan to support the country office in organising and carrying out the Initial Rapid Assessment of the health and nutrition sector.

4.1.2 As UN security clearance to travel to Jalal-Abad and Osh Oblasts (regions) was not provided before June 29th, UN staff members who were to be deployed at field level to conduct the assessment, met regularly between June 25 and June 29. WHO, with the support of the State Ministry of Health, established a list of health facilities to be assessed in Osh and Jalal-Abad Oblasts and rayons (districts). The assessment teams agreed that each type of health facility defined in the health system would be assessed, as well as temporary health facilities that were established during the crisis, either in affected communities in the cities and villages or in settlements close to the Uzbek border. The teams also decided that all affected rayons of both oblasts should be assessed. Considering the limited time available for the assessment teams, it was decided to spend 2 full days in both Oblasts. The joint

assessment teams left Bishkek in a convoy on June 29th for Jalal-Abad Oblast and travelled to Osh Oblast on July 1st.

4.1.3 In Jalal-Abad Oblast, partners were divided in 3 teams, whereas in Osh Oblast one additional joint assessment team was established. Each assessment team chose one team leader and one member that would do the interview. Interpreters assisted 2 teams in order to allow international members, non-Russian speakers, to better understand the health situation.

4.1.4 On the first day of the joint assessment, all team members met with the Director of the Oblast Joint Hospital and the Coordinator of the Primary Health Care, who is also the chair of the management of the Health Emergency Committee. Following the recommendations of both health authorities, the assessment teams revised the list of health facilities and the list of rayons to be assessed. The teams split and started their respective health assessment. The same exercise was done in Osh Oblast.

4.1.5 At the end of the health assessment carried out in each Oblast, each team elaborated a joint preliminary report per Oblast. The respective reports were then compiled and joint findings and recommendations were developed.

4.1.6 In addition to the assessment, some of the teams and/or team members had individual meetings with health partners (Commissioner for the Humanitarian Coordination at Oblast level, International and National NGOs, UNHCR, ICRC, Swiss Red Cross, MSF, WFP and Health Village Committees) and attended health cluster meetings both in Bishkek and in Osh and the food security cluster meeting. A list of organisations interviewed, health facilities assessed and meetings attended can be found as well as in the annex or in paragraphs below.

4.2 Adapted Initial Rapid Assessment Tool

4.2.1 The assessment team agreed to use the IASC Initial Rapid Assessment (IRA) tool, and adapted the questionnaire to the local context. The team developed, one additional questionnaire to be carried out at the community level. Both questionnaires included basic questions on food security, mental health, and WASH, in addition to the health-system-related questions.

4.2.2 Both questionnaires were used more as a check list than as a questionnaire designed for scientific use. The sampling was purposive, and not random.

4.3 Assessment teams and Locations

Jalal-Abad Oblast

TEAM 1: Patricia Kormoss (WHO, Team Leader)
Octavian Bivol (UNICEF, Regional Office for CEE/CIS)
Cholpon Imanalieva (UNICEF, Kyrgyzstan country office)
Gulmira Kojobergenova (UNICEF, Consultant)

TEAM 2: Anne Golaz (UNICEF, HQ, Team leader)
Meder Omurzakov (UNFPA, Assistant Representative)
Rima Imarova (UNICEF)

TEAM 3: Emil Omuraliev (WHO Country Office, Team Leader)
Vilma Tyler (UNICEF, Nutrition, Regional Office for CEE/CIS)
Elvira Toyalieva (UNICEF, consultant)

| Health Facility/IDP settlement/ communities | RAYON | TEAM 1 | TEAM 2 | TEAM 3 | TEAM 4 |
|----------------------------------------------------------------------------|-----------------|--------|--------|--------|--------|
| Jalal-Abad Oblast joint Hospital | Jalal-Abad City | | X | | N/A |
| Suzak Territorial Hospital | Suzak | X | | | |
| Bazar-Korgon Territorial Hospital | Bazar-Korgon | | | X | |
| Nooken Territorial Hospital | Nooken | X | | | |
| Oktyabrskaya Territorial Hospital, Oktyabrskaya village | Suzak | | | X | |
| Bazar-Korgon Family Medicine Centre | Bazar-Korgon | | | X | |
| Oktyabrskaya Family Medicine Centre, Oktyabrskaya village | Suzak | | | X | |
| Jalal-Abad Oblast Family Medical Centre | Jalal-Abad City | | X | | |
| Jalal-Abad Family General Practitioner Centre #1 | Jalal-Abad City | | X | | |
| Bek Abad Family General Practitioner Centre | Suzak | X | | | |
| Nooken Family General Practitioner Centre | Nooken City | X | | | |
| Oktyabrskaya Family General Practitioner Centre #22 | Suzak | | | X | |
| Chek-Tukur Feldsher Accoucheur Point, Seidukum village | Bazar-Korgon | | | X | |
| Symkat Feldsher Accoucheur Point, Symkat village | Suzak | | | X | |
| Tosh Kutchu Feldsher Accoucheur Point | Jalal-Abad City | | | | |
| Temporal Medical Point, Balta-Kazy village | Suzak | X | | | |
| Family, Balta kazy village | Suzak | X | | | |
| Family, Sahmat village | Suzak | X | | | |
| Family, Tashbulak village | Jalal-Abad city | X | | | |
| Tashtak Community, household (Kyrgyz) | Jalal-Abad City | | X | | |
| Tash Bulak Community, head of local administration (Uzbek) | Jalal-Abad City | | X | | |
| Community, Symkat village, Oktyabrskaya, | Suzak | | | X | |
| Community, Sabarahimov and Jalalabatskaya streets, Bazar-Korgon village | Bazar-Korgon | | | X | |

Osh Oblast

TEAM 1: Patricia Kormoss (WHO, HQ, Team Leader)
Octavian Bivol (UNICEF, EURO Regional Office for CEE/CIS)
Gulmira Kojobergenova (UNICEF, Country Office Consultant)
Katia (WHO, interpreter)

TEAM 2: Anne Golaz (UNICEF, HQ, Team leader)
Meder Omurzakov (UNFPA, Country Assistant Representative)
Rima Imarova (UNICEF, Country office)

TEAM 3: Emil Omuraliev (WHO Country Office, Team Leader)
Vilma Tyler (UNICEF, Nutrition, Regional Office for CEE/CIS)
Elvira Toyalieva (UNICEF, consultant)

TEAM 4: Berit Olsen (UNICEF, Expert, Kyrgyzstan Country Office)
Maha Muna (UNFPA, HQ)
Cholpon Imanalieva (UNICEF, Country office)
Aijana (UNICEF, Osh sub-office)

| Health Facility/IDP settlement/ communities | RAYON | TEAM 1 | TEAM 2 | TEAM 3 | TEAM 4 |
|-------------------------------------------------------------------------------------------|-----------|--------|--------|--------|--------|
| Osh Oblast joint Hospital | Osh, city | x | | | |
| Osh City Territorial Hospital | Osh, city | X | | | |
| Osh Inter-Oblast Children Clinical Hospital | Osh, city | X | | | |
| Osh Inter-Oblast Maternity House | Osh, city | X | | | |
| Osh city SES | Osh, city | | | X | |
| Osh Oblast TB Center | Osh, city | | | X | |
| Osh City Family Medical Centre # 1, branch 2 | Osh | X | | | |
| Osh Oblast Family Medical Centre | Osh | | X | | |
| Osh Oblast Family Medicine Centre Branch 1 | Osh | | X | | |
| Branch # 2 Family Medicine Center # 1 | Osh city | | | | X |
| Aravan Family Medical Centre | Aravan | | | X | |
| Karasuyskiy Family Medicine Centre | Karasuu | | | X | |
| Ak Tash, Feldsher Accoucheur Point | | X | | | |
| Medical point, IDP settlement in Sevchenko School | Osh city | | X | | |
| Temporary medical point at the IDP camp in Jashtyk children's camp | Osh | | | | X |
| Camp on Jambul street | Osh | | | | X |
| Village Health Committee, Ak Tash village | | X | | | |
| Maternity house, Ak Tash village | | X | | | |
| Uzbek Community, Mady village | | X | | | |
| Aktash camp, Kashkar-Kyshtak village | Karasuu | | | X | |
| Community, Suratash Village | Karasuu | | | X | |
| Community: Uzbek IDPs in Sevchenko School | Osh city | | X | | |
| Uzbek Community leader from Shevchenko school neighbourhood | Osh city | | X | | |
| Representative from Kyrgyz Community of neighbourhood of Family Medicine Centre Branch #1 | Osh city | | X | | |
| Representative from Uzbek Community of neighbourhood of Family Medicine Centre Branch #1 | Osh city | | X | | |

5. Summary of the crisis in Jalal-Abad Oblast

5.1 The violence in Osh spread to Jalal-Abad, and on 11 June, a mob of unidentified men armed with firearms and metal bars started rioting, looting and setting commercial, state, and private properties on fire, as well as marching on some of the Uzbek neighbourhoods, attacking people in their houses, looting, and setting the houses on fire, forcing thousands to flee. In the same time, in several areas, Kyrgyz bystanders were attacked, or kidnapped, and killed. People from neighbouring rayons (districts) and Suzal rayon fled in the direction of Uzbekistan. At the very beginning of the crisis, the border was open only for pregnant women, children under 1 year of age and injured people. After some days the border opened for all women, children, and elderly.

5.2 The majority of IDPs at the border area of Suzak rayon were women and children and it was reported that approximately 50% were children below the age of 5 years. At the time of this assessment, as per reports from health care managers, health workers and local communities the majority of people, if not all, have returned to their homes, or living with relatives.

5.3 The total estimated population of Jalal-Abad rayon is 241,000 of which the following communities were directly affected by mass displacements of populations:

- Communities in Baltakasi village where about 30,000 IDPs were living in one camp in the rural area and with several host families at the border with Uzbekistan.

- Communities in Bek Abad village where around 1,000 IDPs were living with host families. There were no reports of burnt houses. Host families were not registered. Only wounded people were registered. Currently, all IDPs and refugees from Uzbekistan have returned to their homes.

5.4 According to the Director, Jalal-Abad Oblast joint hospital has registered 76 wounded patients/injuries, including two women, no children, 35 patients who were hospitalised for severe gunshot wounds and burns, and 44 patients treated for minor gunshot wounds. In addition, between 30-40 patients left the hospital after receiving basic treatment and fled to the Uzbek border. Among them were women whom had just delivered newborns. In total 10 death were reported by the Oblast hospital, including 3 who died after surgery and 7 were brought dead to the hospital morgue.

5.5 None of the health facilities run by the Ministry of Health were affected by the conflict. However hospital and primary health facilities were less accessible during the conflict because of insecurity, road barricades, lack of public transport, which resulted in patients in need of care remaining at home, and 4 reported deliveries in an IDP camp. People were scared to go to health facilities, in the same time, medical staff were scared to go to communities and patients' home, as there were reports of staff kidnappings and killings. Health services were free of charge during the crisis. Otherwise health services are provided within the approved state guaranteed benefit package of health services. Most facilities reported that for referral to the respective upper level of health services, transport was available, as well as minimum quantities of fuel. There were reports of electricity cut-offs, particular in rural areas, but for a short period time. A generator was available in some of the facilities.

5.6 There was a reported decrease in the number of institutional deliveries in the Oblast and territorial hospitals during the crisis. However at community level, there was a notable increase of home deliveries. For example, the maternity house in Bek Abad village reported they normally have between 10 to 12 deliveries per month, but during 2 weeks of the crisis they registered 37 deliveries.

5.7 No major disease outbreaks were reported during and immediately after the crisis, although a slight increase in diarrhoea was registered, consistent with seasonal fluctuations. In the temporary IDP camps, health workers of neighbouring family health centres performed family periodic health checks in order to prevent and identify communicable diseases. The Early Warning and Surveillance System is working as per the established national standards and the coverage of EPI coverage is reported to be of 90%, for the Oblast in general. Overall the cold chain is in relatively good condition. Few FAPS and FGP centres requested additional refrigerators. But during 2 weeks of crises vaccination was stopped in the affected areas.

5.8 During the conflict and immediately after, people with chronic diseases did not always have access to key medication because pharmacies were closed and they didn't have access to health facilities. At the time of the assessment, access was improving. There are no reports of sexual violence. There are repeated reports at all levels, including communities, of psychosocial stress in both children and adults with the following symptoms: fear, feeling of hopelessness, insomnia, and anxiety. The Oblast HIV centre is responsible for providing ARV treatment. However none of the visited facilities reported having registered people living with AIDS and thus have not requested drugs

5.9 All facilities reported sufficient supplies of antibiotics, ORS, anaesthesia, antipyretic, dressing and bandages, vaccines and insulin. However, insufficient supplies included surgery kits, functional X-Ray equipment, part of cold chain for vaccination services, sterilisation -, oxygen -, and inhaler equipment and respirators, contraceptives, as well as, in particular in rural hospitals, basic resuscitation equipment.

5.10 Essential basic health services are in general available at the time of the assessment, and were provided at all primary health care facilities. However, depending of the type of health facility, prevention and treatment of diarrhea, HIV/AIDS, management of moderate and severe acute malnutrition, clinical management of sexual violence and mental health care are often not provided, including community-based care at the community level. In general maternal and newborn health care is provided at the maternity houses, either attached to the oblast and territorial hospital or attached to the Family Medical Centre (FMC) and Family Group Practitioners Centre (FGP).

5.11 At the secondary care level the health facilities are providing all health services, with the exception of psychiatric services, in and outpatient services and psychological counselling as it is usually provided at the psychiatric hospital.

5.12 Hospitals and Family Medical Centres are provided with tap water, but FGP and FAP centres generally do not have a central water supply. Soap was available in most of the health facilities, with the exception of the territorial hospital of Suzak. All primary care health facilities have outside latrines shared by both patients and staff, are poorly maintained and located in poorly lit areas.

5.13 The impact of large number of people staying with host families was substantial as stocks of food and other household commodities were rapidly exhausted. For example, one the families that were visited, had 10 children of their own two of whom are disabled , hosted 150 people during one week and had only food stock for 2 days. Host communities and families ensured food supplies to IDPs. Many small businesses and individuals were distributing bread, flour, pasta, meat, water, and milk. Local administrations also distributed flour to most vulnerable families identified by local communities. All markets are now functional and prices, after a substantial increase, reverted back to normal. Overall there was no reported distribution of baby formula or other milk products. There is also the perception that exclusive breastfeeding has increased due to lack of other products. The food distributed is poor in micronutrients, and particularly not suited for children under two.

5.14 In terms of priorities, the affected communities expressed great concern regarding their security and safety. Equitable and transparent distribution of humanitarian assistance through the well functioning local coordination mechanisms as well as the provision of psycho-social support were rated as the highest priorities that needed immediate attention.

6. Summary of the crisis in Osh Oblast

6.1 Violence started during the night of 10-11 June. Large numbers of people were hospitalized in all health facilities in Osh despite difficulty of access. As violence spread in the city and to the neighbouring districts, many people fled either to the border area or crossed into Uzbekistan. Houses and entire districts were burnt down and looting was widespread (about 1,500 houses were burnt). Some communities, particularly in the suburbs and neighbouring districts, set up barricades and road blocks as violence between armed groups continued throughout the week.

6.2 Large numbers of people were displaced. Some of them, crossed into Uzbekistan while a significant number of both Kyrgyz and Uzbek communities fled to neighbouring districts in Kyrgyzstan. A number of temporary camps for IDPs (and returnees) were set up. At the time of the assessment, the majority of people were reported to have returned from Uzbekistan and neighbouring districts leading to emptying of significant number of IDP camps or settlements. There are only a few settlements left in Osh and UNHCR is currently up-dating its list. Tracking displaced populations is a major challenge as many of them are constantly moving from one family to another, while at the same time some family members are returning and establishing temporary shelters next to their burnt houses to make sure they are present for the on-going damage evaluation conducted by local authorities and humanitarian actors.

6.3 The total estimated population of Osh Oblast is 1,109,500 people (2009 census), the most vulnerable groups identified include:

- individuals affected directly by the conflict (people whose houses were burnt and are currently living with relatives, relatives of victims, neighbours of affected families)
- IDPs living in settlements or with host families, and
- host families

6.4 Access to health facilities, for patients as well as medical staff, was impeded by continuous shooting, violence against civilians, road blocks, and lack of public transport. Some health facilities were also targeted, in particular the centre for emergency medicine was blocked and 3 ambulances were destroyed. However, only some minor damage of medical facilities was reported (one burnt laundry facility

and several broken windows). Armed people entered hospitals and reportedly a few doctors targeted, kidnapped and killed.

6.5 According to the deputy director of Osh Oblast joint hospital 1,588 patients who sustained injuries were registered by the hospital, including 775 patients who had to be hospitalised in the Oblast hospital, of which 506 have been discharged to date. The majority of people had gunshot wounds and required surgical interventions; 20 were severely wounded, and had to be sent to Bishkek hospital and 793 were treated at primary health care centres (Family Medical Centres). The Oblast hospital reported 226 deaths, including 82 who died in the hospital.

6.6 Generally, access to health facilities became difficult during the conflict, and remains so due to persisting problems with security. Also, representatives of different communities avoid moving around because of fear of crossing check-points. There are no reports of doctors denying medical treatment to anyone seeking medical care in health facilities. There was only one episode mentioned by the Uzbek community where the local FMCs was reported reluctant to send doctors to the community. However, this information requires further confirmation from other sources.

6.7 Health services were provided free of charge during the crisis. Otherwise health services are provided within the guaranteed benefit package of health services. All facilities reported that for referral to the respective upper level of health services (primarily to Bishkek), transport was generally available, but the allocated budget for fuel is not sufficient. Additional and more modern ambulances are needed. Electricity cut-offs were reported, the longer ones occurring in the maternity hospital (3 days), but generators are available in most facilities.

6.8 There was a significant decrease in the number of deliveries in the Oblast Maternity Hospital. Usually, on average, the number of deliveries per 24 hours at the maternity hospital is about 12-14, while during the days of the conflict it went down to 4 per day. At the time of the assessment, the maternity reported 8-9 deliveries a day. In consequence, the number of home deliveries significantly increased. While in 2009 the total number of home deliveries was 36, there were 73 reported home deliveries during the four day conflict. Access to the maternity hospital was substantively reduced due to insecurity, as well as the outflow of women to neighbouring districts and into Uzbekistan. During and immediately after the conflict, many women also requested to be discharged immediately or the next day after birth. An increase number of pregnancy-related conditions such as eclampsia and haemorrhage were reported. There were also an increased number of spontaneous abortions however the exact number is not available.

6.9 No major disease outbreaks were reported, neither any cases of measles, AFP, pneumonia, or cholera. An increase in diarrhoeal cases were being reported in the camps and among returnees. During the visit to the Municipal Children's Hospital, mothers reported that due to insecurity, they were not able to seek medical assistance and therefore many children reached the hospital in serious condition, including sepsis and severe dehydration. The Early Warning and Surveillance system is working as per the established national standards. It has to be noted however that there were no surveillance or early warning systems put in place in IDP settlements. Vaccination services were interrupted for approximately one - two weeks, and have since resumed. Routine vaccination is not provided to IDP settlements such as the Sevchenko School, because they do not belong to the neighbourhood. Vaccination sessions will have to be organized. In 2009, coverage with EPI vaccines is reported to be over 90%. Overall the cold chain is in a good condition but its monitoring is not properly established. However outdated refrigerators need replacement in a number of health facilities.

6.10 At the time of the assessment, most people with chronic diseases have access to key medication. The Oblast HIV centre is responsible for providing ARV treatment and is providing drugs as required by the maternity hospital which is in charge for all HIV positive deliveries. Testing of pregnant women is interrupted at this point in time due to lack of tests. Additional needs assessment of services for patients with HIV is needed.

6.11 There are repeated reports at all levels, including in communities, of psychosocial stress in both children and adults with the following symptoms: fear, feeling of hopelessness, insomnia and anxiety.

6.12 The Oblast TB Centre reported that 140 patients with TB out of 240 remain at the hospital and others are out of hospital. The big concern is that 25 out of 50 MDR-TB patients were displaced during the conflict and have no access to their drugs. They try to contact their physicians by phone to send relatives to get their TB drugs.

6.13 The Osh Oblast Maternity hospital reported violence against women: in a students dormitory, 15 girls were reported raped and killed. In addition three girls were kidnapped and raped, two of them killed while one survived and was hospitalized. The other hospitals have not reported hospitalization of women victims of violence, including sexual violence.

6.14 All primary health care facilities reported sufficient supplies of antibiotics, ORS, antipyretic, contraceptive, dressing and bandages, vaccines and insulin. However, at secondary health care level, and in rural hospitals, insufficient supplies of surgery kits, functional X-Ray equipment, parts of cold chain, sterilisation, oxygen anaesthesia equipment and respirators, basic resuscitation equipment were reported. Disposal birth kits are found in limited amount. The Oblast General Hospital reported insufficient quantities of anaesthetics due to the delay of the tender. It is also noteworthy that, at the time of the assessment, the Children's Hospital received only some ORS and dressing from the oblast hospital. Taking into consideration that they are the only referral hospital for diarrhoea, diarrhoea kits should be made available to the hospital Diarrheal kits have been sent to the hospital as of report writing.

6.15 Osh Joint Hospital and Maternity Hospital are tertiary level facilities servicing the Southern part of Kyrgyzstan, and are therefore able to perform all necessary medical interventions. Additional equipment (as per above) is however necessary in order to enable them to provide services at a higher standard.

6.16 The primary health facilities are not providing sufficient community and family services (IMCI component 3, nutrition and treatment of diarrhea) nor are in a position to provide psycho-social support required by most visited families and communities.

6.17 Hospitals are provided with tap water. However water supply is discontinued in the entire city during and after the rain because of outdated purification filters. The Maternity hospital has its own bore-hole however it is not functional and requires repair. An additional tanker for water collection is required. Generally soap was available in hospitals, however there was a lack of detergents and disinfectants' mentioned by almost all health facilities.

6.18 Host communities and some families ensured food supplies to IDPs. Local administrations distribute flour and other food items to most vulnerable families as identified by local communities. Many small businesses and individuals are also distributing food. However, there are communities which report that food stocks are just sufficient for few days. Local markets have re-opened their activity, however they remain inaccessible to some communities because of the perceived lack of security. Most of the people living in the area are agro-pastoralist or run small businesses. Again due to security issues, many communities are not able to perform seasonal agricultural works or re-open their shops.

6.19 Humanitarian assistance and aid was provided at the onset of the crisis. The Oblast hospital received immediate support with additional surgeons and equipment which were deployed from Bishkek. Medicines and surgical equipment and dressing were provided by the MoH and humanitarian organizations. ICRC provided immediate support to five hospitals in Osh. Together with the Kyrgyz Red Crescent, the ICRC distributed medicines and surgical kits in 20 medical centres and distributed water and food rations in the city of Osh, and in Osh province along the Kyrgyz-Uzbek border. Additional medical supplies and equipment were provided by UNICEF, WHO, MSF and the Governments of Japan, Russia and MoH. The Oblast General Hospital mentioned the need to preposition the standard trauma and first aid kits, as well as other medical kits as part of emergency preparedness.

ANNEXES

- 1. Health and Nutrition Initial Rapid Assessment, Field assessment form**
- 2. Community Based Questionnaire**

ANNEX I

| |
|--------------------------------------------------------------------------------------|
| HEALTH AND NUTRITION INITIAL RAPID ASSESSMENT (IRA) FIELD ASSESSMENT FORM |
|--------------------------------------------------------------------------------------|

Name (Team Leader first) Institution Title/position Profession/qualifications:

Date(s) of field assessment: ___/___/___ - ___/___/___ Admin level I name: Oblast

Principal contact(s) at the site: _____ Admin level II name: Rayon

Position in community: _____ Admin level III name: Village

Telephone #: _____ Site name: _____

GPS coordinates in decimal degrees: _____ P-code: _____

Summary of the crisis

- overall judgment of humanitarian situation and the severity of needs identified
- threats to security (natural hazards, population movements, armed groups, etc)
- short-term outlook (whether the crisis is worsening or becoming less serious)
- risk-factors that could worsen humanitarian conditions or impede relief operations (bad weather, insecurity etc.) Underlying causes of problems and risks
- population groups that are inaccessible (and if so, why)

Problems and priorities identified by the affected population:

Source of information code (Key Informant interviews, Group Discussions or Observation)

1.7.1 If there is information suggesting that some groups are under- or over-represented (e.g. women or girl children, ethnic minorities), explain here:

1.7.2 Estimated number of **infants under 1**: # _____
 Out of it without parents (or other long-term primary carers): # _____

Estimated numbers of **children under 5**: # _____
 Out of it without parents (or other long-term primary carers): # _____

1.7.3 Estimated number of **older people** (over 60 years) in the community: # _____

Number of isolated older people without family: # _____
 Access to health services: YES: _____ NO (if No, explain): _____

Access to medication for chronic diseases (diabetes, CVD, hypertension, bronchitis-asthma, kidney dialysis, epilepsy) ? YES: _____ NO: _____

1.7.4 Estimated number of **persons with disabilities**: # _____

Numbers of people with physical disabilities: # _____
 Access to specific health services: YES _____ NO (if No, explain): _____

Access to rehabilitation health services (post-operative care, physiotherapy, orthopaedic devices etc) :
 YES: _____ NO: _____

SECTION 2 AVAILABILITY OF HEALTH SERVICES and HUMAN RESSOURCES

| | |
|--------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------|
| 2.1 Number of Centre of Family Medicine (CFM) in cities | Adequacy of health workers for the immunization |
| Specify the number for: Osh city: Jalal-Abad city: | Have they adequate health workers (epidemiologists, immunologists and vaccinators (nurses)) Routine : YES NO For polio campaign: YES NO |
| 2.2. Number of Family General Practitioners (FGP) in cities | |
| Specify the number for: Osh city: Jalal-Abad city: | How many health workers (doctors, vaccinators (nurses) are available? In general: For polio campaign: |
| 2.3 Number of Centre of Family Medicine (CFM) in regions (Oblast) | |
| Specify the number for: Osh region: Jalal-Abad region : | How many health workers (doctors, vaccinators (nurses) are available? In general: For polio campaign: |
| 2.4 Number of Family General Practitioners in the regions (Oblast) | |
| Specify the number: Osh region: Jalal-Abad region: | How many health workers (doctors, vaccinators (nurses) are available? In general: For polio campaign: |
| 2.5 Number of Feltcher Midwifery Point (lower level) at Rayon | |
| Specify the number: Osh Rayon: Jalal-Abad Rayon: | Have they adequate vaccinators (Fletcher, midwives and vaccination nurses)? YES: _____ NO: _____ |

SECTION 3 NUTRITION AND FOOD SECURITY

3.1 Resource persons and other information sources:

3.2 Existing capacities and activities: (NOW)

| | Activity specification (present/absent) | Organisation/person(s) | Geographic coverage | Comments |
|------------------------------------------------|-----------------------------------------|------------------------|---------------------|----------|
| 3.2.1 General food distribution | Yes: No: | | | |
| 3.2.2 Micronutrient supplementation programmes | Yes: No: | | | |

3.3 Does the community have physical access to functioning markets?

| | | |
|------|-----|------|
| YES: | NO: | DNK: |
|------|-----|------|

3.4 Changes in the total amount of food that people are eating since the crisis began, on Average:

| | |
|--------------------------------|------------------------------------|
| Amount consumed has increased: | Amount consumed is about the same: |
| Amount consumed has decreased: | DNK: |

3.5 How many people in the community currently have food stocks in their households?

| | | | | |
|-------|-------------|-------|-------|------|
| Most: | About half: | Some: | None: | DNK: |
|-------|-------------|-------|-------|------|

3.6 On average, how long will food stocks last in the households, according to the community?

| | | | |
|--------------------------|-----------|------------|------------|
| Cereals and roots/tuber: | < 1 week: | 1-2 weeks: | > 2 weeks: |
| Pulses and legumes: | < 1 week: | 1-2 weeks: | > 2 weeks: |
| Oils and fats: | < 1 week: | 1-2 weeks: | > 2 weeks: |

3.7 Have infant milk products (e.g., baby formula) and/or baby bottles/teats been distributed since the emergency?

YES: NO: If YES, by whom?: _____

3.8 What percentage of infants in the area are formula fed /formula dependent?

| | | | | |
|-------|--------|---------|---------|-------|
| None: | < 10%: | 10-25%: | > 25% : | DNK : |
|-------|--------|---------|---------|-------|

3.9 Has the community/health staff identified any problems in feeding children < 2 years since the crisis started?

YES: NO: If YES, what problems? : _____

3.10 Describe the current livelihood/food situation in this area:

| | |
|-----------------------------------------------------------|-------------------------------------------------------------------------------------|
| 3.10.1 What are the major livelihoods in the area? | 3.10.2 Has the crisis had an impact on livelihoods, markets and food stocks? |
| Agriculturalists: | Livelihoods disrupted: |

| | |
|-----------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------|
| Agro-pastoralists: | Food prices increased |
| Pastoralists: | Food stocks disrupted/depleted |
| Small businesses/trading: | Other (<i>specify</i>) |
| Other (<i>specify</i>): | |
| 3.10.3 What population groups are most affected? | 3.10.4 What are the priorities expressed by the population concerning livelihoods, food security or infant and young child feeding? |
| Children/youth: | |
| Women: | |
| Men: | |
| Elderly people | |
| Different religious/cultural/ socio-economic groups, (<i>specify</i>): | |
| Other: (<i>specify</i>): | |

SECTION 4 HEALTH STATUS AND HEALTH RISKS

4.1 Resource persons and other information sources :

4.2 Health profile :

4.2.1 How many **BIRTHS** have there been between June 1-10, 2010 and June 11-30, 2010? How many of these with skilled attendant present?

| | # Births (total) | # Births (w/ skilled attendant) | Home deliveries | Deliveries at IDP points | # Visibly pregnant women at the IDP site |
|------------------|------------------|---------------------------------|-----------------|--------------------------|------------------------------------------|
| June 1-10, 2010 | | | | | |
| June 11-30, 2010 | | | | | |

| | Infant mortality | Under 5 years mortality | Maternal mortality | # of fertile age women |
|------------------|------------------|-------------------------|--------------------|------------------------|
| June 1-10, 2010 | | | | |
| June 11-30, 2010 | | | | |

Morbidity (disease in population)

4.2.2 Main health concerns from clinic records or reported by health professionals (list) :

| | # cases in 1-10 June | # deaths in 11-30 June | | # cases in 1-10 June | # deaths in 11-30 June |
|------------------------------------|----------------------|------------------------|-------------------------------|----------------------|------------------------|
| Measles | | | Cholera | | |
| Fever | | | Injuries | | |
| Diarrhoeal diseases | | | Pregnancy-related conditions* | | |
| Upper Acute respiratory infections | | | Worm infestation | | |
| Pneumonia | | | Other (specify) | | |

*including severe anaemia, hypertension, pre-eclampsia, eclampsia, and diabetes

4.2.3 Have there been any reports of any unusual increases in illness or rumours of **OUTBREAKS**?
 NO YES (specify) _____

4.2.4 Are patients suffering from **CHRONIC DISEASES** for which sudden interruption of therapy could be fatal (e.g. hypertension, heart disease, insulin-dependent diabetes, kidney dialysis, epileptics, bronchial asthma) still able to receive treatment?

NO
 YES (specify) _____ # Patients _____

4.2.5 Have there been reports of any **specific violence targeting women** (Sexual Violence)?

NO
 YES (specify) _____ # Cases since the conflict: _____

4.2.6 Is there evidence of **PSYCHOSOCIAL TRAUMA** among the affected population? If so, describe

NO : YES (specify):

| | | |
|----------------|------|--------|
| Hopelessness | Few: | A lot |
| Insomnia | Few | A lot: |
| Anxiety | Few: | A lot: |
| Aggressiveness | Few | A lot: |

4.2.7 Have there been reports of **HAZARDOUS SUBSTANCE USE** (e.g. injecting drugs, heavy alcohol use, and opiates)?

NO: YES (specify) _____

Disease control and prevention

4.2.9 Is there a functioning **EARLY WARNING/ SURVEILLANCE SYSTEM** in place? How regularly is data reported? (12 diseases)

NO YES at least weekly:
at least monthly:
Other (specify): _____

4.2.10 Local measles vaccination coverage of under-five (at 12 months) ____ (EPI activities -2009)

Oblast: _____ % City : _____ %

4.2.11 Existence of special disease control /surveillance:

AFP: NO YES (specify) _____
MEASLES: NO YES (specify) _____

4.2.12 What is the quality of vaccine storage: Oblast: GOOD: NOT GOOD:
Rayons: GOOD: NOT GOOD:
Primary Health Facility:GOOD: NOT GOOD:

4.2.13 How is the capacity of cold chain? (freezer, refrigerators, cold box, ice-bags, electricity availability, generator, fuel):

GOOD NOT GOOD

4.2.14 Impact of crisis on disease control programmes? (check one box for each programme)

| Disease control programme | Completely interrupted | Somewhat disrupted | Unaffected |
|---------------------------|------------------------|--------------------|------------|
| | | | |
| | | | |
| | | | |

4.3 Humanitarian health intervention and Humanitarian Supplies

Current humanitarian health interventions No Yes

| Organization | Since when? | Main activity | Humanitarian Supplies |
|--------------|-------------|---------------|-----------------------|
| | | | |
| | | | |

| | | | |
|--|--|--|--|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

4.4 What are the priorities expressed by the population concerning health?

5.1 General information

5.1.1 Name of facility :
Contact :

5.1.2 GPS location in decimal degrees:

5.1.3 Facility type: Health post: Oblast Hospital:
 FMC: Territorial Hospital:
 Mobile Units: Other: _____

5.1.4 Management: Ministry of Health: NGOs: Other: _____

5.1.5 Is facility temporary or permanent? Temporary: Permanent:

5.1.6 Has facility been damaged? NO YES

If Yes identify degree of damage: partially: fully:

5.1.7 Physical access to facility (check one):

Easy :
 With obstacles (explain): _____
 Very difficult (explain) : _____
 Distance in km to the most remote catchment area? _____
 Number of hours by normal means of transport (specify): _____

5.1.8 Financial access to facility (check one)

Free of charge:
 Small payment (explain): _____
 Large payment (explain): _____

Cost per consultation in local currency: _____

5.1.9 Name and type of closest referral facility?

5.1.10 Are vehicles or other means of transport available for referrals?

YES: NO: DNK:

5.1.11 Is Fuel available for the referrals?

YES: NO: DNK:

5.1.12 Daily and continuous Electricity YES: NO:

If NO shortage in hours: _____
 Back-up generator (fuel): YES: NO:

5.1.13 Water and Sanitation:

a. Daily and continuous water supplies: YES: NO:

| | | | |
|-----------------------------------------------------------------------------|---------------------|-----------------------------|--------------------|
| b. From where do you get drinking water at this health institution? | | | |
| i. Canals / ponds / rivers / streams: | | ii. Protected hand pump: | |
| iii. Protected well / spring: | | iv. Unprotected hand pumps: | |
| v. Unprotected well / spring: | | vi. Piped water supply: | |
| vii. Bowser / tanker: | | Other (specify) | |
| c. How is water stored at the health institution? Select at most Two | | | |
| i. Decanted storage: | ii. Closed storage: | iii. Open storage: | iv. Dirty vessels: |

| | | | |
|-------------------------------------------------------------------------|-------------------------|----------------------|------------------------------|
| d. Are water and soap being used to wash hands (Select one only) | | | |
| | After defecation | Before eating | before breast feeding |
| Water and soap | | | |
| Only water | | | |
| No water nor soap | | | |

| | | | |
|------------------------------------------------------------------------------------------------------------------------------|------|--------|----------|
| e. If defecation takes place at latrines, how many are there? | | | |
| | Male | Female | Combined |
| i. Available | | | |
| ii. Functional | | | |
| e. Are these latrines sufficient to satisfy the needs of all the people in this health institution? (Select one only) | | | |
| Yes: | | No: | |

5.1.13 Continuity of ARV treatment to HIV infected children: YES: NO:

5.1.14 What are the priorities expressed by the medical workers:

SECTION 6 HEALTH CARE DELIVERY

6.1. Are community-based and IDP points health services delivered in catchment area of the health facility? If YES, who provides and how many?

_____ village midwife/midwives
 # _____ community health worker(s)
 # _____ traditional healer(s)
 # _____ others (specify) _____

6.2. Resources

6.2.1 Who provides health care in this facility? (Check all that apply)

| | # staff | # consultations/day | | # staff | # consultations/day |
|-----------------|---------|---------------------|----------------|---------|---------------------|
| GP | | | Midwife | | |
| Surgeon | | | Lab technician | | |
| OB/GYN | | | Feldsher | | |
| Paediatrician | | | Vaccinator | | |
| Epidemiologists | | | Nurse | | |
| Immunologists | | | | | |
| Other | | | | | |

6.2.2 Consultations:

Occupation rate: total Inpatient departments:
 # consultation: Outpatient department:

6.2.3 How many injured people were treated in your Health Facility? # injured: _____

Did you receive Humanitarian Aid and/or support from MoH? YES: NO:

6.2.4 Essential drugs, vaccines and supplies

| | Available | Unavailable | | Available | Unavailable |
|--------------------|-----------|-------------|-------------------------|-----------|-------------|
| Antibiotics | | | Tetanus toxoid | | |
| ORS | | | MMR | | |
| Anaesthetics | | | Pentavaccine | | |
| Antipyretic | | | Polio | | |
| Contraception | | | BCG | | |
| Dressing materials | | | Insulin | | |
| Surgical kits | | | Functioning cold chain? | | |
| X-ray | | | | | |
| Ultrasound | | | | | |

Health Facility providing each of the Health Services listed below:

| Level of Care | Sub Sector | | HEALTH SERVICE | | Total |
|----------------------|---------------------------------------------|--------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------|--------------|
| C. Community Care | C0 | Collection of Vital Statistics | C01 | Deaths and births | |
| | | | C02 | Others: e.g. population movements; registry of pregnant women, newborn children | |
| | C2 | Child Health | C21 | IMCI community component: IEC of child care taker + active case findings | |
| | | | C22 | Home-based treatment of: fever/malaria, ARI/pneumonia, dehydration due to acute diarrhoea | |
| | | | C23 | Community mobilization for and support to mass vaccination campaigns and/or mass drug administration/treatments | |
| | C3 | Nutrition | C31 | Screening of acute malnutrition (MUAC) | |
| | | | C32 | Follow up of children enrolled in supplementary/therapeutic feeding (trace defaulters) | |
| | | | C33 | Community therapeutic care of acute malnutrition | |
| | C4 | Communicable Diseases | C41 | Vector control (IEC + impregnated bed nets + in/out door insecticide spraying) | |
| | | | C42 | Community mobilization for and support to mass vaccinations and/or drug administration/treatments | |
| | | | C43 | IEC on locally priority diseases (e.g. TB self referral, malaria self referral, others) | |
| | C5 | STI & HIV/AIDS | C51 | Community leaders advocacy on STI/ HIV | |
| | | | C52 | IEC on prevention of STI/HIV infections and behavioural change communication | |
| | | | C53 | Ensure access to free condoms | |
| C6 | Maternal & Newborn Health | C61 | Clean home delivery, including distribution of clean delivery kits to visibly pregnant women, IEC and behavioural change communication, knowledge of danger signs and where/when to go for help, support breast feeding | | |
| C8 | Non-Communicable Diseases and Mental Health | C81 | Promote self-care, provide basic health care and psychosocial support, identify and refer severe cases for treatment, provide needed follow-up to people discharged by facility-based health and social services for people with chronic health conditions, disabilities and mental health problems | | |
| C9 | Environmental Health | C91 | IEC on hygiene promotion and water and sanitation, community mobilization for clean up campaigns and/or other sanitation activities | | |
| P. Primary Care | P1 | General Clinical Services | P11 | Outpatient services | |
| | | | P12 | Basic laboratory | |
| | | | P13 | Short hospitalization capacity (5-10 beds) | |
| | | | P14 | Referral capacity: referral procedures, means of communication, transportation | |
| | P2 | Child Health | P21 | EPI : routine immunization against all national target diseases and adequate cold chain in place | |
| | | | P22 | Under 5 clinic conducted by IMCI-trained health staff | |
| P23 | | | Screening of under nutrition/malnutrition (growth monitoring or MUAC or W/H, H/A) | | |

| | | | | | | | |
|-----------------------------------|----------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------|-----|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| SEXUAL & REPRODUCTIVE HEALTH AREA | P3 | Nutrition | P31 | Management of moderate acute malnutrition | | | |
| | | | P32 | Management of severe acute malnutrition | | | |
| | P4 | Communicable Diseases | P41 | Sentinel site of early warning system of epidemic prone diseases, outbreak response (EWARS) | | | |
| | | | P42 | Diagnosis & treatment of Malaria | | | |
| | | | P43 | Diagnosis & treatment of TB | | | |
| | | | P44 | Diagnosis & treatment of other relevant communicable diseases (if applicable) | | | |
| | P5 | STI & HIV/AIDS | P51 | Syndromic management of sexually transmitted infections | | | |
| | | | P52 | Standard precautions: disposable needles & syringes, safety sharp disposal containers, Personal Protective Equipment (PPE), sterilizer, P 91 | | | |
| | | | P53 | Availability of free condoms | | | |
| | | | P54 | Prophylaxis and treatment of opportunistic infections | | | |
| | | | P55 | HIV counselling and testing | | | |
| | | | P56 | Prevention of mother-to-child HIV transmission (PMTCT) | | | |
| | | | P57 | Antiretroviral treatment (ART) | | | |
| | | | P6 | Maternal & Newborn Health | P61 | Family planning | |
| | | | | | P62 | Antenatal care: assess pregnancy, birth and emergency plan, respond to problems (observed and/or reported), advise/counsel on nutrition & breastfeeding, self care and family planning, preventive treatment(s) as appropriate | |
| | | | | | P63 | Skilled care during childbirth for clean and safe normal delivery | |
| | P64 | Essential newborn care: basic newborn resuscitation + warmth (recommended method: Kangaroo Mother Care - KMC) + eye prophylaxis + clean cord care + early and exclusive breast feeding 24/24 & 7/7 | | | | | |
| | P65 | Basic essential obstetric care (BEOC): parenteral antibiotics + oxytocic/anticonvulsant drugs + manual removal of placenta + removal of retained products with manual vacuum aspiration (MVA) + assisted vaginal delivery 24/24 & 7/7 | | | | | |
| | P66 | Post partum care: examination of mother and newborn (up to 6 weeks), respond to observed signs, support breast feeding, promote family planning | | | | | |
| | P67 | Comprehensive abortion care: safe induced abortion for all legal indications, uterine evacuation using MVA or medical methods, antibiotic prophylaxis, treatment of abortion complications, counseling for abortion and post-abortion contraception | | | | | |
| | P7 | Sexual Violence | P71 | Clinical management of rape survivors (including psychological support) | | | |
| | | | P72 | Emergency contraception | | | |
| | | | P73 | Post-exposure prophylaxis (PEP) for STI & HIV infections | | | |
| | P8 | Non Communicable Diseases and Mental Health | P81 | Injury care and mass casualty management | | | |
| | | | P82 | Hypertension treatment | | | |
| | | | P83 | Diabetes treatment | | | |
| | | | P84 | Mental health care: support of acute distress and anxiety, front line management of severe and common mental disorders | | | |
| P9 | Environmental Health | P91 | Health facility safe waste disposal and management | | | | |

| | | | | | |
|--------------------------------------------|----|---------------------------------------------|-----|---------------------------------------------------------------------------------------------------------|--|
| S. Secondary and Tertiary Care | S1 | General Clinical Services | S11 | Inpatients services (medical, paediatrics and obstetrics and gynaecology wards) | |
| | | | S12 | Emergency and elective surgery | |
| | | | S13 | Laboratory services (including public health laboratory) | |
| | | | S14 | Blood bank service | |
| | | | S15 | X-Ray service | |
| | S2 | Child Health | S21 | Management of children classified with severe or very severe diseases (parenteral fluids and drugs, O2) | |
| | S6 | Maternal & Newborn Health | S61 | Comprehensive essential obstetric care: BEOC + caesarean section + safe blood transfusion | |
| | S8 | Non Communicable Diseases and Mental Health | S81 | Disabilities and injuries rehabilitation | |
| | | | S82 | Outpatient psychiatric care and psychological counseling | |
| | | | S83 | Acute psychiatric inpatient unit | |