21 November 2006 opened a new chapter in Nepal’s history with the signing of the comprehensive peace agreement between the Seven-Party Alliance and the Communist Party of Nepal (Maoist), bringing the long drawn conflict to an end. For our readers, working on humanitarian and developmental oriented health issues, this brings forth a time to re-think, re-plan and re-launch their programmes.

Nepal’s health sector comprises a complex mix of humanitarian and development issues. While the root cause of malnutrition lies in under-development and poverty, natural hazards like floods and droughts as well as conflicts exacerbate the condition leaving many, especially children severely malnourished. Similarly, water and sanitation, primary health care, maternal mortality and outdated denominators are main concerns of both government and international actors within the humanitarian and developmental sphere.

Most of these issues need short-term humanitarian interventions, as well as long-term development plans. EHA situated within WHO is uniquely poised to intervene in both crisis and post-conflict settings. We hope to use this dual responsibility to address some of the urgent health issues during the post-conflict period and build on their outcome to strengthen health service delivery. Rapid health assessments, monitoring of humanitarian needs, coordination, operational planning and targeted stop-gap procurement are the main tasks for EHA during this transitional post-conflict phase.

The usual celebrations of Tihar or festival of lights turned out to be a time of mourning for the villagers in Gangapur, Phatehpur and Hollya Village Development Councils (VDCs), in Banke district, in the Mid-Western region of Nepal. The District Public Health Officer (DPHO), Mr J B Karki claimed that 12 deaths in 4 wards of the 3 VDCs had occurred in the third week of October. The ‘mysterious’ illness, as reported in the media was diagnosed as *plasmodium (P) falciparum* malaria, the most dangerous form of the vector borne disease. The Communicable Disease Surveillance (CDS) programme of WHO, together with the Epidemiology and Disease Control Division (EDCD) – the government focal body to address outbreaks and emergencies - responded immediately to bring the crisis under control.

‘When the DPHO reported the situation to us, EDCD dispatched a team of experts from the central level to assist in the investigation’ explained Dr M K Banerjee, Director of EDCD. On 1 November, Dr G D Thakur, the malaria expert at EDCD, visited the VDCs together with 5 others from the outbreak response unit and a two member team from WHO. Local medical teams from the Nepal Medical College and International Nepal Fellowship (INF) based in Banke District joined them. According to the team, rapid diagnostic tests and blood slide microscopy were used to detect active cases. Besides providing medical services in health posts and sub-health posts, health camps were established in outbreak areas to carry out active case detection and clinical management of mild and severe forms of malaria. The team made arrangements to provide all patients with anti-malarial drugs distributed through a local NGO. Action was taken to transfer all severe cases to the Bheri Zonal Hospital and Nepal Medical College, in Banke district itself, which resulted in no deaths recorded since 5 November 2006.

Investigations revealed several causes for the mishap. Firstly, the region experienced unprecedented high rainfall during the monsoon, leaving the VDCs flooded from late August to early September. ‘We were
Nepal was put to test for emergency response this year; first during the People’s Democratic Movement in April, where several hundreds were wounded, and later during the floods and landslides that particularly affected the western regions during the monsoon season. The main problem the country faces in order to respond effectively to such crises is lack of access to reach the affected population quickly. The topography of the country and limited logistical networks have proved to be major barriers to assist people during disasters. Hence, the need to strengthen the peripheral health facilities, which could shoulder the response until external assistance reaches them.

Having completed a baseline assessment on the capacity of health facilities to respond to crises, EHA launched a bottom-up and modular training programme to enhance peripheral health services and respond to emergencies, whatever their nature may be. The EHA team chose Banke as pilot district to implement the new WHO CAP field programme.

Unlike the neighbouring Bardiya district, which was also affected by flooding, Banke has not been categorised as a malaria endemic area. ‘This was one of the main reasons why the district was not subject to mass vector spraying and bed net distribution after the floods,’ Dr Thakur pointed out. Sudden mortality among adults in the post monsoon period, with clinical symptoms of fever, chills, rigors, body-aches and state of unconsciousness, suggests a lack of herd immunity and prior exposure to malaria infection.

Since the outbreak, both local and central level authorities have been educating the public about best preventive and control measures against malaria. Use of Long Lasting Insecticide Nets (LLIN) and Indoor Residual Spaying (IRS) are two easy methods of preventing and controlling such vector outbreaks. WHO encourages use of bed nets that will prevent mosquito bites particularly for children and pregnant women. EDCD, with the support of Population Services International (PSI) will distribute 2000 LLIN to the affected population, i.e one net per household. IRS will cut off the malaria transmission and it has been rigorously implemented in all the affected and neighbouring districts, covering a population of about 8,000 people according to Dr Thakur, who also added that the Vector Borne Disease Research & Training Centre (VBDRTC) teams from Hetauda doing the microscopic test are still in the outbreak areas and will report regularly to central authorities. Health education messages about completing the full doses of anti-malarials need to be promoted among villagers as irrational use of these drugs may create emergence of drug resistance malaria parasites.

EHA Strengthens Health Response at District Level

Nepal was put to test for emergency response this year; first during the People’s Democratic Movement in April, where several hundreds were wounded, and later during the floods and landslides that particularly affected the western regions during the monsoon season. The main problem the country faces in order to respond effectively to such crises is lack of access to reach the affected population quickly. The topography of the country and limited logistical networks have proved to be major barriers to assist people during disasters. Hence, the need to strengthen the peripheral health facilities, which could shoulder the response until external assistance reaches them.

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Due to Nepalgunj’s strategic importance for the Western Regions of the country, it was essential to strengthen emergency health facilities. In addition, the district’s frequent flooding during monsoons, damaged health facilities and the presence of IDPs due to conflict were other reasons for choosing Banke as a pilot district.

One of the goals of the SIDA-funded CAP programme is to enhance the capacity of peripheral health facilities to respond to crisis. ‘After our discussions with the EHA team, we decided on a three level approach to build emergency response capacity of the health staff’ explained Mr J B Karki, the District
Public Health Officer (DPHO). Thus, health post workers, primary health care staff, members of the Rapid Response Teams (RRT) and the District Disaster Relief Committee (DDRC) were the target groups for this programme.

The aim of training the health post and primary health care centre staff was to build up their capacity as first responders. Given the poor transport facilities in Banke, these health staff would need to provide essential life saving treatment in an emergency until outside assistance reaches them. Past experience has shown that certain VDCs in Banke were cut off from communication and access for a few days. During desk-top simulation exercises, they discussed mass casualty management and public health priorities such as water quality, hygiene and sanitation.

RRT members received a one-day orientation. These teams usually consist of 13 members who have various health skills. They are mobilized to respond to any type of public health emergency. However, the teams have so far only been trained to respond to outbreaks, and are not qualified to deal with complex emergencies or natural disasters. Therefore, sharing with them key components of the Sphere guidelines, increasing their ability to carry out rapid health assessments, brainstorming on methods of effective coordination and communication during crisis were the highlights of the programme. Participants came up with a disaster plan at the end of the session.

While disaster plans are important to deal with crises, it is also essential to have a district level mechanism to cope with such situations. Thus, the final part of the programme involved bringing together all the stakeholders who would play key roles in a disaster response, to discuss issues that need to be included in an operational plan. DDRC, which includes the Chief District Officer, armed forces and members of political parties, participated at this session and decided unanimously to develop a common disaster plan that would be implemented during emergencies.

Three FHVs working at the health post

From a Health Post in Puraina, Banke District

About 6 kilometres away from Nepalgunj, passing some mustard fields and thatched houses, one arrives at the Puraina health post. Mr Saroj Kumar Shah, the Public Health Inspector who runs the facility with 6 other staff, said the catchment population of the health post is about 3,500 villagers. They are also assisted by Female Health Volunteers (FHVs), who have been with them for many years. Three of the FHVs we met, said they have dedicated their lives to provide better health to their fellow villagers during the past 10-15 years.

After attending the EHA workshop, Mr Shah is interested in developing a disaster plan with his staff. ’Although we have not faced a major disaster yet in our VDC, we think it is important to have a plan as some of the areas in our district usually experience disasters’, he added.

Improving Nutritional Status of Vulnerable People

Food insecurity and malnutrition have for some time been emerging as an important public health concern in Nepal. Ad hoc nutritional studies have been carried out. The implications of these studies have been discussed among various stakeholders and have resulted in different interpretations and operational approaches.

The development community tends to believe the current rates of high malnutrition in some areas of the country are mostly due to chronic underdevelopment, and uses a developmental approach to address them. The humanitarian community, on the other hand, takes a rapid, direct intervention approach, identifying communities affected and directly addressing their needs through food aid or other humanitarian mechanisms, often with little linkages to the existing health system.

In a recent mission to Nepal, the London School of Hygiene and Tropical Medicine reviewed the ad hoc assessments carried out by various humanitarian and development agencies. According to their report, ‘…in general, there appears to be a severe deficiency in implementation, reporting and coordination of nutritional surveys in Nepal, especially in areas where food insecurity is suspected.

A similar exercise was carried out in Ilam district with the DDRC, RRT and peripheral level health staff during the last week of November and early December. EHA plans to implement this programme in two further districts, which have been affected by the conflict.
The problem in Nepal appears to be two dimensional. Chronic under-development, poor child feeding habits and lack of access to remote mountainous areas have resulted in a large proportion of children under 5 being stunted (Low height-for-age) and underweight (Low weight-for-age). The civil conflict together with seasonal floods and drought have brought about a humanitarian crisis where children are wasted (Low weight-for-height), i.e. suffer from severe malnutrition (please refer table above). Data from this year’s preliminary District Health Survey (DHS) indicates 56.1% of children under 5 in the mountain areas as being stunted (24.2% severely stunted) and 15.6% of children under 5 in the Terai areas as being wasted. Such a scenario requires immediate as well as long term planning to improve the nutritional status of children in Nepal.

Kathmandu Valley is located in an active seismic zone. According to a study carried out by the National Society for Earthquake Technology Nepal (NSET) an earthquake similar to the ‘Bihar-Nepal Earthquake’ in 1934, would result approximately in 40,000 deaths and 95,000 injuries in the Valley. Under the supervision of Mr Amod Dixit, General Secretary of NSET, Mr Sujan Rai conducted a series of hospital assessments in June-July 2006 to analyse the health system’s capacity to respond to seismic risks.

A sample of 41 hospitals were selected from Kathmandu (29 hospitals), Lalitpur (7 hospitals) and Bhaktapur (5 hospitals). The assessment criteria included both structural and non-structural stability of the hospitals, the emergency facilities needed during a crisis and non-medical requirements to respond to a large influx of patients. Below are some of the main findings of the assessments.

Existing bed capacity among the surveyed hospitals in the Valley was found to be about 5,400, almost 20 times lesser than the expected number of injured people during a major earthquake. Moreover, most of these hospitals don’t have outside space, which makes it difficult for them to treat large numbers of casualties with minor injuries – a common scenario in any earthquake. Although it is difficult to estimate the exact number of doctors and nurses, because of the lack of systematic association with the hospitals, a rough estimate is around 2,050 doctors and 2,500 nurses.
The table below summarises the quantity of selected medical facilities and equipment assessed in Kathmandu Valley:

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<th>Selected facilities and equipment in the Valley hospitals</th>
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<td>Operation Theatres</td>
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<td>X-Ray Machines</td>
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<td>Blood Bank Units</td>
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<td>CT Scanners</td>
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<td>Magnetic Resonance Imaging (MRI)</td>
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<td>Ambulances</td>
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The assessment included lifelines like water and power. About 40% of the hospitals were found to have bore-wells (considered safer during an earthquake) and not all have water treatment plants. The remaining hospitals, supplied either from city networks, dug wells, or by tankers are most likely to suffer from shortage of water during an earthquake, due to damaged pipes or inaccessible roads. Although the assessed hospitals have backup generator, not all had sufficient capacity to run essential equipment during power disruption.

The assessments concluded that hospitals in Kathmandu Valley are highly vulnerable to structural and non-structural damage caused by earthquakes. The following recommendations are proposed:

- Expand the coverage of this assessment to include all hospitals (government, private, non-government)
- Systematically address the gaps identified by the assessment to reduce vulnerabilities in the health system
- Introduce awareness and preparedness programs in all health facilities
- Encourage all health facilities to develop disaster management plans as most (78% of the hospitals in the Valley itself) don’t have one
- Extend the reach of disaster preparedness and emergency response planning to peripheral levels – primary health care centres, health posts and sub-health posts
- Develop and enact policies and legislations to consolidate disaster safety in the health system

Seismic Risk Reduction and Mitigation of Health Facilities

Hospitals require special attention due to the vital functions they perform in non-emergencies, their high level of occupancy, and the role they play during disasters.

In Nepal, seismic vulnerability is a permanent threat to the health infrastructure, which might become non-functional or collapse during an earthquake and transform hospitals and health centres from places of relief to disaster sites.

In order to measure the risk of damage or collapse, it is essential to assess buildings from a structural (bearing elements) and non-structural (non-bearing elements) perspective. Based on such assessments, it is possible to suggest appropriate counter-measures in terms of structural retrofitting and non-structural mitigation options.

Years of close collaboration with NSET-Nepal and comprehensive seismic assessments of health facilities in Nepal have given EHA Nepal a strong position from which to initiate seismic risk reduction of the health infrastructure.

Based on the methodology of a PAHO-affiliated engineer, EHA and EDCD contracted NSET-Nepal to conduct a structural assessment of 14 hospitals in the Kathmandu Valley in 2002. The following year, this assessment was supplemented by non-structural assessment, of 9 hospitals in Nepal. Currently, NSET has been contracted to do seismic assessments of the National Public Health Laboratory, Epidemiology and Disease Control Division (EDCD) and 6 Nepal Red Cross Society blood banks across the country. The seismic vulnerability assessments of hospitals provide critical knowledge about urgent intervention options in terms of risk mitigation and retrofitting of buildings.
Disaster Health Working Group

On 1 September this year, the members of the Disaster Health Working Group was reconvened. The meeting was organised by the Department of Health Services and was chaired by Dr M B Bista, the Director General of DHS. The half day session was the first step taken by WHO towards revitalising the inter-agency group. A functional working group to address the disaster preparedness and emergency response in Nepal is vital given the frequent natural calamities the country experiences. In addition, the past conflict has contributed to the deterioration of the health system throughout the country.

To further strengthen the DHWG, a two day workshop for the members is planned for January next year. The members of the group will come together this time to discuss the process of implementing the Health Sector Emergency Preparedness & Disaster Response Plan for Nepal, which the group drafted three years ago. The discussions during the workshop will be prompted by the findings of the EHA field work.

The DHWG was created during the national flood disaster in 1993 and consists of approximately 50 representatives from various agencies/institutions related to the health sector emergency planning process.

WHO Collaborates with Nepal Red Cross Society

During the recent EHA field work assessment teams visited local district chapters of Nepal Red Cross Society (NRCS) to assess their capacity to respond to crises.

Since the assessments, EHA has been in touch with NRCS about strengthening their capacity at the local level. As part of the WHO CAP programme, EHA is in the process of offering essential first aid equipment to NRCS district chapters in conflict-affected areas based on agreed minimum standards. The equipment includes stretchers, rigid spinal boards, neck collars, splints and first aid kits. These kits will be offered to priority districts. First aid training in the districts will be carried out by NRCS.

NRCS is the largest local humanitarian agency having field presence in all 75 districts.

Transitional Support for Humanitarian Work in Nepal

An Inter-agency Standing Committee strategy for humanitarian support to Nepal is being launched early next year. This joint funding appeal for transitional support has been advocated to coincide with the recent positive political developments. The appeal will include proposals from the UN and international NGOs on humanitarian issues for a 12 month cycle starting from early next year.

The 11 areas of humanitarian work proposed are human rights protection, child protection, mine action, health, malnutrition, refugees, education, emergency food security, natural disaster preparedness and coordination. WHO led the health sector while UNICEF was responsible for the nutrition component.

WHO EHA recently organized an Emergency Health & Nutrition Working Group meeting to discuss technical issues related to next year’s public health activities. The meeting identified public health crisis monitoring, primary health care, essential drugs, reproductive health, mental health and HIV/AIDS as areas needing immediate health interventions. WHO, UNICEF, UNFPA, GTZ, IRC, Merlin and MDM have indicated their willingness to participate in the appeal for the health sector.

WHO has proposed to work in the following areas:
1. Conduct mortality and morbidity surveys among conflict affected populations
2. Strengthen access to and delivery of primary health care in conflict affected districts
3. Systematically monitor the public health crisis through coordination networks
4. Address immediate mental health requirements for victims of the conflict
5. Enhance first aid services in conflict impacted districts
6. Natural disaster risk mitigation and capacity building for mass casualty incidents
7. Provide HIV treatment and care to vulnerable groups
8. Improve environmental health in selected Terai districts
9. Rebuild safe shelter for internally displaced people
The folklore in Nepal has it that natural disasters occur when Gods express their displeasure with mortals. The literal meaning of disaster in Nepalese, ‘devi-prakop’ means God given punishment. Thanks to education and science, such beliefs have become myths, and more accurate information about the real causes of earthquakes and many other natural disasters are known to us today. However, when responding to a disaster, new myths have replaced old ones. For effective relief and rescue operations, it is important to counteract popular disaster myths, and provide guidance on what to do and what not to do.

EHA has developed 2 posters to dispel myths and inform people about correct response measures. One poster is about responding to a natural disaster and the other is about managing dead bodies after a natural disaster. The nepalised and translated messages have been extracted from the Pan American Health Organization (PAHO) templates and field tested in far-western districts of Nepal.

The poster will be distributed to health facilities around the country.

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### Emergency Health Action

**November 2006, Issue IX**

The Emergency Health Action Newsletter is published by the EHA team in WHO Nepal to serve as a channel of communication and source of information for humanitarian public health partners, donors and other disaster related practitioners.

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