North West Frontier Province

Serving the health needs of Pakistan’s displaced and host communities

2009

World Health Organization
INSECURITY DISPLACED over 2 million people between August 2008 and May 2009 in the North-West Frontier Province’s districts of Peshawar, Mardan, Nowshera, Charsadda and Swabi.

Many of the hospitals, clinics and other health care services in the areas affected by the fighting were severely damaged. In areas receiving the displaced people, already weak health services were massively overburdened.

This extraordinary crisis generated an extraordinary response, primarily from ordinary citizens who accommodated 90% of the displaced. The rest took refuge in more than 20 temporary camps.

The World Health Organization and its Health Cluster partners are supporting Pakistan’s response. WHO coordinates the activities of dozens of local and international health care providers, has delivered hundreds of tons of supplies and advocates globally for greater support for the hundreds of thousands at risk.

Hospitals and other facilities are under extreme strain but are successfully struggling to counter multiple health threats, such as diarrhoea, acute respiratory infections, measles, traumas and mental distress. Most health care services, both public and private, stopped functioning in the affected areas due to damage and looting.

Many of the displaced began returning home in July 2009. But support continues to be required for those who remain in camps and other people’s homes, as well as people newly displaced by fresh fighting. Those returning home also need sustained humanitarian support.

This publication shows key areas where health interventions are needed and where health providers deliver life-saving support.
The cluster approach has enhanced the effectiveness of the response by improving coordination among health partners. Cluster meetings are a regular forum for sharing critical updates, deciding on action, voicing issues, needs and recommendations, as well as adjusting the response to changing needs and conditions during the crisis.

Hundreds of thousands of people are vulnerable and living in a high risk environment, underscoring the need for a well-funded, strategic and coordinated response by the health partners to mitigate these risks. Dr Khalif Bile, WHO Representative to Pakistan
Quality health interventions

THE HEALTH CLUSTER in Pakistan has developed standards to monitor the quality of service delivery for different levels of healthcare facilities.

"According to government officials, more health workers, particularly female doctors and Lady Health Workers, are needed to address the needs of IDPs."

The implementation of such standards depends on several factors, including having the necessary human and financial resources, as well as the existing infrastructure and public health operational norms that regulate healthcare delivery.

For example, the Health Cluster is working to mobilize more female doctors and Lady Health Workers within areas of return and areas affected by conflict.

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Essential health services

IN EMERGENCIES, access to an essential package of health services is what determines how many lives are saved or lost. During the current crisis, the Health Cluster response has included delivery of essential health services through health camp facilities set up and supporting the existing network of health centers and hospitals.

The Health Cluster provides the tents and infrastructure for the health camp facilities. Once established, health partners start operating the facility and providing the package of essential health services.

The package of services provides immediate life-saving as well as promotive, preventive and curative services. The minimum essential health package service includes:

- Immunization
- Maternal, neonatal child health, reproductive health and family planning
- Nutrition
- Curative and referral services (including essential drugs)
- Health promotion
- Mental health and psychosocial support
There are major challenges facing the displaced and those people still caught in the conflict area, for example in the Swat Valley, where health facilities have been damaged or destroyed. Dr Eric Laroche, WHO Assistant Director-General for Health Action in Crises.
Hospitals have been overwhelmed by the influx of hundreds of thousands of displaced people into hosting districts. These health facilities receive medical emergencies referred from peripheral health centers. They also perform medical and surgical interventions and provide pediatric care.

In the five IDP-hosting districts, the Health Cluster delivers support to referral services at four district headquarters hospitals, six tehsil headquarters hospitals and 22 rural health centers.

WHO and the Health Cluster have established diarrheaea treatment centers in selected district headquarters hospitals and IDP camps. Patients are referred to these centers from camps’ health facilities. In hospitals, they receive life-saving treatment that cannot be delivered in camps and the network of basic and rural health centers.
DURING THE current emergency, dozens of suspected and confined communicable disease outbreaks have been detected and contained through the Disease Early Warning System (DEWS) conducted by Health Cluster partners. About 180 health facilities in IDP hosting districts are reporting weekly to the DEWS system.

This system’s success relies on the rapid identification and sharing of disease notifications and intense surveillance to monitor disease incidence.

When a symptomatic patient presents to a health clinic, immediate medical intervention is provided and the key facts on the illness are recorded and reported through DEWS. This information is forwarded to WHO data monitoring teams followed by an investigation and outbreak validation process.

During an outbreak, a communicable disease rapid response team is sent to the specific area to undertake the relevant control interventions. Waterborne outbreaks are acted upon also by testing water at source, distribution and home points. Monitoring and response are coordinated with health authorities and health partners.
MALNUTRITION, combined with emergency-prone diseases such as diarrhoea, pneumonia, malaria and tuberculosis, is the biggest contributor to mortality among children caught up in the ongoing crisis.

Before this emergency, acute malnutrition was the underlying cause of 54% of child mortality. Nutrition partners introduced community-based management of acute malnutrition in early 2009.

As with the health status of the displaced, the nutrition situation of many people living outside of regulated camps is not clear. According to UNICEF’s May 2009 Nutrition Survey Report, acute malnutrition among IDPs is higher than for people living in host communities.

Prior to this emergency, Pakistan already had high rates of malnutrition with acute malnutrition at 13% and a very high rate of under-weight of 38%. Now, due to this mass displacement, the health team has established nutrition surveillance system to closely monitor the trend.” Dr Ahmed Shadoul, WHO Child Health Specialist
The mental and psychosocial effect of the conflict on the victims and their communities is another major health issue. Some 30% of displaced people have faced first-hand a life-threatening situation during this crisis, according to a May 2009 assessment conducted by the NGO International Medical Corps.

"It is estimated that 4% of the population is suffering from severe mental disorders and a bigger number from common mental health problems."

A much wider portion of the population suffers from transient mental health problems linked to the stress of living in conflict.

WHO and the Health Cluster help mobilize NGOs and institutions working with IDPs. Provincial health department teams and Health Cluster partners provide psychosocial support. WHO also works with the University of Rawalpindi’s Collaborative Centre to strengthen the response to IDPs in distress.
PERSONS WITH disabilities have a more complex burden in this emergency. They are disadvantaged in camp settings, especially during the distribution of humanitarian aid and are more susceptible to mental health and psychosocial suffering.

More than 2100 people with disabilities have been identified in Swabi, Jalozai and Kacha Gari camps. WHO is supporting NGOs to better assist persons with disabilities.

For example, the Health Cluster in partnership with the Pakistan Institute of Orthotics, provides outreach services for orthotics and prosthetic devices to IDPs with disabilities. It is estimated over 6000 such devices are needed to support people with disabilities.

“Persons with disabilities – especially in this emergency – urgently need combined assistance across five pillars; health, education, livelihood, empowerment and social integration.” Dr Maryam Mallick, WHO Advisor for Disabilities and Rehabilitation.
Acute diarrhoea accounts for 8% of all conditions reported by the disease surveillance system. Annual monsoon rains further exacerbate health risks, particularly in crowded camps, where excess water places increased strains on hygiene, sanitation and disease control systems.
ACCESS TO potable drinking water is a problem in IDP camps and host communities and is a major area of concern for WHO.

The quality of drinking water is closely related to outbreaks of waterborne diseases, primarily acute watery diarrhoea, which is endemic in Pakistan. Poor environmental conditions in areas hosting displaced people increases the vulnerability to these diseases.

The WHO environmental health team monitors IDP community drinking water quality in consultation and action with partners.

"Health partners are on a heightened state of alert to implement emergency steps needed to ensure that water, sanitation and hygiene at camp and community level are safe."
WHO is the main supplier of essential medicines and supplies in this emergency. Through opening warehouses, WHO can strategically position essential medicines closer to IDPs to improve access and distribution to health partners. Using the Logistics Supply System, WHO can track and monitor the supply chain and improve the way stocks are replenished.

Based on previous disaster work in Pakistan, the Health Cluster has developed a list of essential Primary Health Care medicines that are packed in mini-emergency kits to serve the basic medicine needs of thousands of people. Since the current crisis began, WHO has been procuring and supplying these kits to its health partners.

Generous international support has helped WHO provide life-saving medicines and supplies to partners in the field. Oral rehydration salts, soap, IV fluids, surgical equipment, antibiotics and other potentially life-saving materials have been dispatched, often making the difference between life and death.

"Delivering medicines to crisis-affected populations is critical. Drugs are needed for life-saving interventions like communicable disease control, reproductive health and childhood diseases."
HEALTH PARTNERS, including WHO, are operating in a sensitive cultural environment. While promoting awareness of hygiene and other health practices, there is an emphasis on mobilizing and training community members to better engage with their community.

The network of WHO medical officers and health engineers deployed to IDP communities and hosting districts in this emergency regularly hold training and refresher sessions for volunteers and health workers. Thus guidance is provided on a range of preventable health issues that can be addressed via improved hygiene, sanitation and nutrition.

It is vital to spread key health messages to ordinary people in their own language. This way people will know what to do before harm strikes.
THE CONFLICT underscores Pakistan’s volatile emergency profile, which includes earthquakes, annual floods, drought and food insecurity. Despite international aid, national authorities carry the main burden of responding to the crisis.

The response phase has exhausted stockpiles of drugs and other medical supplies, stretched logistics capacities and strained financial and human resources. Replenishments of materials and strengthening of health systems are required to sustain the continuing response as well as conduct the recovery phase.

“Basic needs in water and sanitation are being met in camps, but the situation is critical for the vast majority of IDPs living in host communities, as well as for the host communities themselves.”
Health sector early recovery

THE DESTRUCTION of vital social services requires a health sector recovery plan to restore essential health facilities. The Ministry of Health is preparing the plan, while provincial authorities requested a joint national-UN taskforce to facilitate the return home of the displaced.

Assessments conducted in areas where security has partially improved showed that infrastructure and social services, such as health, water and sanitation and schools, have been destroyed. Of the province’s 228 health facilities, 27 were destroyed and 60 others are not working due to damage or looting.

The assessments identified new population displacement and disrupted public health programmes like surveillance and communicable disease control, immunization, tuberculosis and malaria control, environmental health, maternal, neonatal child health and health education.
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