Pakistan Floods 2010: Integrated Survival Strategy

This document is a joint product of the Health, WASH, Nutrition and Food Clusters

1. Introduction

The recent floods in Pakistan have affected over 20 million people, creating conditions that greatly exacerbate the risk of disease outbreaks and increased malnutrition. To minimize deaths resulting from these conditions, humanitarian agencies must address the multiple health risks associated with unsafe water and sanitation, food shortages, inadequate nutrition, and lack of access to health services. This will require close coordination and collaboration among the Health, Nutrition, WASH and Food clusters.

Drawing on their respective projects in the revised Pakistan Floods Emergency Response Plan, members of the above four clusters have developed a strategy that aims to ensure their ability to deliver critical activities jointly, and others in a coordinated, effective and timely manner. The strategy outlines the essential life-saving activities to be implemented, identifies principles for coordination, and describes the steps to be taken to strengthen planning across all four clusters. It addresses the needs of the most vulnerable flood-affected populations during both their displacement and the early phase of their return in difficult and/or under-served areas. In all provinces, particularly in the north, large numbers of people have already begun returning home.

2. Focus: Main Contributors to Mortality Risks

In Pakistan, the primary causes of mortality for children under five include acute diarrhoea, acute lower respiratory infections, malaria and measles, and malnutrition is associated with more than one-third of all child deaths. Neonatal mortality is extremely high, accounting for 54/1000 live births per year, while the overall infant mortality rate is 72/1000 live births per year. The very high neonatal mortality rate and maternal mortality ratio (320 per 100 000 live births) highlight an important pre-crisis gap in the public health system in responding to the needs of women and neonates.

There are around 850 000 pregnant women among the affected population. This means that many deliveries each month will be in an unsafe environment, without an adequate referral system, placing the lives of many women and their newborn children at risk. The present crisis has served to exacerbate the already poor reproductive health (RH) services. Efforts to strengthen RH services at district level must be considered a top priority.

Since the onset of the floods, the admittedly imperfect Ministry of Health and Health Cluster surveillance data have indicated an upward trend in the most common infectious diseases, those mentioned above as well as skin diseases and conjunctivitis. Of course, communicable diseases are not the only threats to health and other conditions, including psychosocial illnesses and temporary and permanent physical disabilities will require attention, in attention to the reproductive health issues already mentioned. The needs of other vulnerable populations, such as the elderly, should also be addressed, each according its priority.

3. Goal and approach

The overall goal of the survival strategy is to save lives and to reduce morbidity among the most affected populations through the provision of food, life-saving maternal and neonatal services, preventive and curative health and nutrition services, safe drinking water, and improved sanitation and hygiene. These services are aimed at the displaced population as well as those in the early phase of the return, when the vulnerabilities will remain extremely high and for as long there will be limited availability of social services and clean water supplies.

To address the factors that contribute to the major risks of mortality in the short- and medium-–term, an integrated approach is essential, with an emphasis on community-based interventions.

The integrated approach at the heart of the strategy has to be driven by 1) identifying and targeting 'hot spots' in each affected district, i.e. those with un-served populations and/or facing urgent emerging threats, and 2) rapidly scaling up coverage of selected life-saving interventions, using any available service delivery mechanism established by the relevant cluster/sector.

4. Key Deliverables

Implementation of the strategy will be at the sub-national level, to ensure integrated delivery. The key expected deliverables by the end of October 2010 include:

Health deliverables:

- The scaling up of the early warning system for epidemic-prone diseases in **all** affected districts;
- 8 million people covered by essential health services (delivered through community-based services, mobile teams, static health units and referral health facilities), including the provision of essential medicines and supplies;
- 68 Diarrhoea Treatment Centres (DTCs) functioning in 41 districts at higher risk of an acute watery diarrhoea epidemic, providing 1500 beds/night, with expansion capacity in the event of a major epidemic;
- Emergency mass vaccination campaigns (measles, polio), including the distribution of Vitamin A, conducted in two phases.
- The implementation of preventive and curative malaria activities in all endemic areas in the affected districts;

Nutrition and food deliverables:

- A quality, adequate food basket distributed to 6 million affected people with a target of ensuring a daily caloric intake consistent with Sphere Project standards and a full complement of micronutrients;
- 30 inpatient and 72 outpatient treatment centres functioning in disease outbreak districts in Punjab and Sindh provinces and in food-insecure districts as informed – reaching 15 000 severely malnourished children under five;
- 50 supplementary feeding programmes functioning (linked to outpatient centres) reaching 50 000 moderately malnourished children under five;
- Breastfeeding corners established to protect breastfeeding in IDP camps; breast milk substitute use discouraged and optimal infant and young child feeding practices designed and implemented.

WASH deliverables:

- 13 million people provided with safe drinking water, sanitation campaigns and hygiene promotion activities implemented.

5. Key Principles for Operationalizing the Strategy

The four clusters have agreed on the following key principles governing the design and implementation of the joint survival strategy:

- ✓ Focus on evidence-based, high-impact interventions to ensure survival: these include water disinfection, mass measles immunization campaigns (associated with polio vaccination, vitamin A distribution and de-worming), communication and support for life-saving behaviour changes (such as hand-washing with soap, exclusive breastfeeding for the first six months), and appropriate treatment interventions;
- ✓ Target the most vulnerable: in addition to prioritizing the most affected districts for those activities which will have general coverage (such as the provision of safe water supplies and sanitation facilities, and access to basic health services), specific life-saving interventions should target particularly vulnerable populations such as women, especially pregnant women, neonates , children under five, and to the extent possible, the elderly and disabled;
- ✓ Ensure an integrated outbreak response to strengthen the complementarity of interventions and ensure a continuum of care: from having a more sensitive Disease Early Warning System (DEWS) for communicable diseases of epidemic potential, to ensuring that case management at the health care facility level is combined with large-scale preventive measures at community level, including proper early detection and referral of severe cases, provision of treated water, sanitation and shelter, as well as food and nutrition;
- ✓ Identify and maximize opportunities for synergies between all players, through enhanced coordination and joint planning at Provincial/hub and particularly district levels. Strong commitment from all partners is essential to operationalize the strategy; opportunities to engage non-traditional partners from civil society, youth association and women's groups, as well as traditional and religious leaders should be sought;
- ✓ Work in coordination with and support of Government authorities at all levels, using existing systems to implement the response wherever possible, through the reinforcement or the establishment of effective local coordination mechanisms as the District Coordination Cells;
- ✓ Ensure real-time monitoring and evaluation of the strategy's implementation, to support district-level planning and adjustments as needed to ensure high coverage of the selected priority interventions in the target areas and to allow progress to be documented.

6. Next Steps to Operationalize the Strategy

6.1 Identification of Priority Districts and Hot Spots

A preliminary analysis of the available data has been undertaken, using:

- NDMA/OCHA figures on total affected population by district, and percentage of flood-affected over total district population;
- VAM data,
- pre-flood data on malnutrition rates (severe wasting - MICS; incomplete),
- mean of daily acute diarrhoea (AD) proportional morbidity over the period 7 August - 3 September (threshold: over 30%), trend of weekly mean of AD proportional morbidity for weeks 32 to 35 (consistent increase of the AD proportional morbidity over the last 3 weeks), districts with at least one location where more than one case of AWD has been confirmed for Vibrio cholera in the same period.

The list of priority districts will need to be reviewed and updated regularly at the provincial/hub level, based on the analysis of the most up-to-date available information, contextual factors and the evolution of the crisis.

A more disaggregated data analysis using additional available information will have to take place in the identified priority districts, in order to identify the hot spots at Tehsil and/or Union Councils or IDP camps/village levels that need urgent joint and sector/cluster-specific life-saving interventions.

The identification of hot spots in affected districts has to be carried out by each District Coordination Cell, with the support and guidance of the Survival Strategy Steering Group (see next paragraph).

Provided they are established in all affected districts with good coverage, DEWS, together with community outreach for screening for acute malnutrition, will contribute most to identifying hot spots.

6.2 Strengthening Coordination, Joint Planning and Management (see attached flowchart Draft of the Survival Strategy Structure by level)

OCHA has established four hubs (in Peshawar (KP), Multan (Punjab), Sukker and Hyderabad (Sindh)). It also plans to establish a base in Quetta (Baluchistan). As a recent and important development, OCHA has agreed with the National Disaster Management Authorities (NDMA) to set up **District Coordination Cells (DCCs)** in the worst affected districts in order to enhance the response capacity and the multi-sectoral response through a decentralized coordination mechanism under the leadership of the Provincial Disaster Management Authority (PDMA)**.**

In addition to regular inter-cluster coordination mechanisms, OCHA will support/facilitate coordination and information management around the survival strategy at the provincial/hub level through a '**Survival Strategy Steering Group**' (SSSG). OCHA will assign one staff member to each hub to facilitate and provide support to this process, and will co-chair this group with a representative of the Provincial/Local Disaster Management Authorities.

Responsibilities of the SSSG:

- Identify pockets of vulnerability for cross-sector intervention (to be reviewed frequently in light of evolving situation);
- Operational planning: identify opportunities for joint planning/delivery – and delegate responsibilities to agencies to follow up on detailed planning around specific activities at district level within the DCC;
- Identify/flag gaps in capacity, financial resources, supplies, and address them in close collaboration with the individual clusters in Islamabad.

The Health, Nutrition, WASH and Food Clusters will:

- ✓ be fully operational in Islamabad, Sukkur, Hyderabad, Punjab and Baluchistan (this includes ensuring dedicated capacity for information management). Each cluster will appoint a full-time dedicated staff member to work in the four hub Survival Strategy Steering Groups, in order to have a detailed survival strategy plan in each hub, as well as the capacity to jointly implement and monitor related activities;
- ✓ identify focal points for the survival strategy in each of the priority districts that will be planning and coordinating implementation of the activities within the above mentioned District Coordination Cells ;
- ✓ appoint a focal point to regularly be part of a small working group in Islamabad to monitor implementation of the overall survival strategy.

Coordination with other clusters will be maintained through regular inter-cluster coordination mechanisms.

The bulk of joint planning can only be done at district levels with Government actors and partners on the ground, developed around the specific needs of the hot spots identified within each district, and then completed at provincial/Hub level through a bottom up planning process.

Essentially, each province/hub "Survival Strategy Steering Group" will be responsible for establishing a timetable for the launch, implementation and expansion of key activities to cover identified gaps, and for determining the point at which full coverage will have been achieved.

6.3 Joint Implementation

The Matrix attached at the end of this document presents a wide range of activities that the Clusters are already implementing and where it is possible to add to on-going main activities, other ones relevant to the urgent needs in the priority Districts and hot spots areas.

Clusters and organizations will be given responsibility for individual activities, and held accountable for their implementation. An Islamabad-based monitoring scheme will be established to track the implementation of Survival Strategy activities at all levels from the hub down.

National Level

Actions identified (incomplete, currently under development)	**Responsible**	**Date**
Endorsement of survival strategy by Health, Nutrition, WASH and Food Cluster members	CCs, CLAs	Done
Integration of survival strategy into project sheets of the revised Pakistan Floods Emergency Response Plan	Cluster members, CCs	Done
Identification of priority districts to be targeted first – both overall and for specific interventions (e.g. measles immunization)	CCs, Survival Strategy team	Completed for Sukkur, planned for Hyderabad
Dispatch of 'planning and technical support' teams to 4 priority hubs (Sukkur, Hyderabad, Punjab, Baluchistan)	CLAs	Planned for of 13th Sept-30 Sept
Planning for 'Mother and Child Days' (from 20 September), using the LHW/CHW networks – agreement to include, as per local needs: a) Health, hygiene and sanitation, and nutrition messages; b) De worming of all children 2-5 years; c) Delivery of supplies to households: CDKs, newborn care supplies, LLINs, hygiene materials, nutritional commodities (other HH commodity such as hygiene kits, aqua tabs can be added, as per local priorities in hot spots areas).	MoH, WHO, UNICEF, UNFPA	Underway
Measles Mass Immunization Campaigns, in two phases for affected districts as per their readiness (ongoing and to be linked to MCH days)	MoH, WHO, UNICEF	Underway

Provincial and District Level

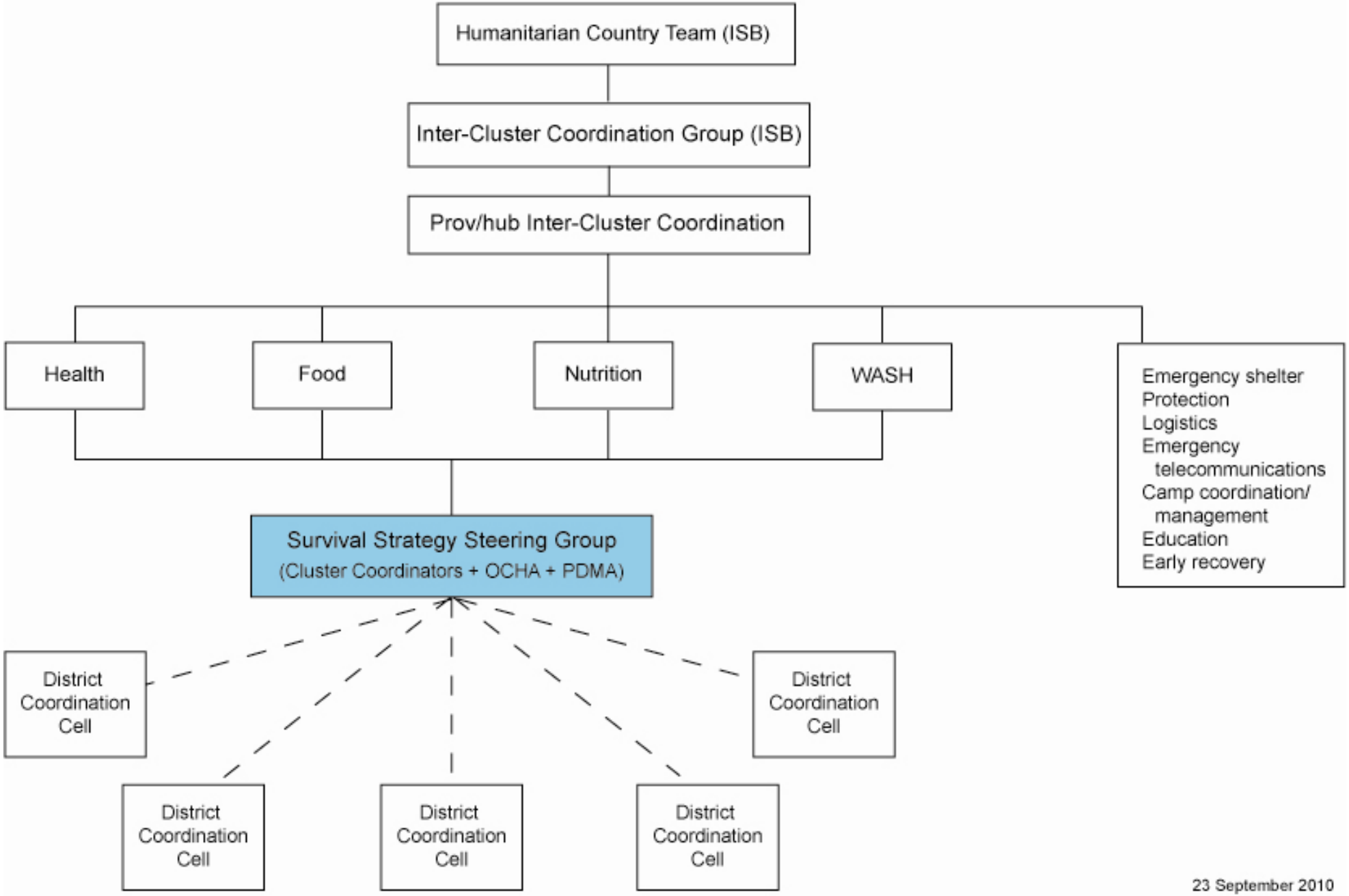
Action	**Responsible**	**Date**
Establishment and orientation of 'survival strategy steering groups' at provincial/hub level	CLAs, OCHA, CCs	Planned for week of 13th Sept
Identification of priority districts and hot spots – overall and for specific interventions (including reconciling districts stated in the PFERP project sheets)	OCHA, with CCs	

Action	Responsible	Date
PDMA and DCC accountabilities outlined: - identification of focal point agencies for each affected district, - identification of threats and gaps to be addressed, - planning of activities by hot spot areas and allocation of resources	Steering Group DCC	Week of 13th Sept
<u>Key activities outlined and implementation plan developed:</u> Food Distribution- WFP- distribute through local partners o Breastfeeding promotion and key messages o Hygiene materials • Immunization campaign o Malnutrition screening- only in areas where severe acutely malnourished children can be referred • Lady health workers to deliver same package that we do here plus ORS treatment • Mobile medical teams or camps o 4 staff: Doctor or nurse, lady health visitors, social mobilization and support staff • Compensation committees (NADERA?) are setting up a fixed presence in each district for compensation; people will receive an ATM card	MoH, Health Cluster, WASH Cluster	
Dispatch/pre-position supplies for planned synergistic activities	CLAs, Focal point partners	
Establish monitoring system for activities to be delivered, involving ALL partners involved in the service delivery, and ensure interaction with NDMA/PDMA for continuous exchange of data	Steering Group, DCC, CLAs	

7. Conclusions

The Survival Strategy described in this document recognizes that there is significant overlap in the mandates of the existing clusters. While each cluster, Health, Water/Sanitation, Food, and Nutrition implements discrete activities, the objectives towards which these activities are aimed are common: to reduce morbidity and mortality to the maximum extent possible. Towards this end, this Strategy proposes that many activities can be implemented more effectively if plans are made and acted upon in a coordinated manner. Doing so may mean putting less emphasis on the work of each individual cluster, but the result will be to put greater emphasis on the overall needs of the target population. This Strategy has the potential to be an improvement on the current system. If implemented properly, with a maximum of coordination and a minimum of duplication, it will save money, it will save time, and, most importantly, it will save lives.

Draft of the Survival Strategy Structure by level



23 September 2010

Activity/Service	Modality of implementation	Geographical Areas	Locations	By who	Cluster			
					Health	Nutrition	WASH	Food
Surveillance and Case Detection/ Referral	DEWS: - covering Acute Diarrhoea (AD), ARI, malaria, measles, polio	All affected provinces	HCF, Mobile/static health facilities, community (LHW)	Health auth. Central, provincial, EDO, WHO, PPHI, Military, NGOs/ICRC	- Scale-up and ensure DEWS coverage in all affected areas; - Share data with other clusters. Use epidemiological data to guide WASH prioritisation			
	Nutrition Information - establishment of community sentinel sites - weekly MUAC screening - active case detection through LHWs and community outreach workers - Nutrition surveys	All affected provinces	Camps, spontaneous settlements, returnee areas, host communities	LHWs/ Community outreach workers (NGOs) MoH, NGOs		- Establish consolidated weekly screening database - Provide training and support for LHWs/NGOs to expand outreach - Coordinated nutrition surveys (interagency)		
	Water quality testing	All affected provinces	All.	Provincial laboratories, Health and WASH cluster partners	- scale-up testing capabilities in health facilities	In nutritional facilities	Overall responsible: - scale-up testing capabilities community	
	Establishment of multi-sector Rapid Response Teams - to be deployed to coordinate and support the response to reported outbreaks	Prioritised 'hot spot' districts	District level	DOH/WHO/ UNICEF - mobile health teams, NGOs	- Lead establishment of rapid response teams at district level - Share information alerts with DEWS and NDMA	- identify focal points in hotspot districts	- Identify focal points in hotspot districts - Provide relevant equipment and supplies	
Health, hygiene and infant feeding communication campaign	Mass communication campaign (radio spots)	All affected provinces		Health, Nutrition, WASH, Food partners	Responsible for: - agree and communicate health education messages to other clusters; - communications in health facilities	Responsible for: - communications at nutrition rehabilitation centres, SF programs, and through CHWs/ CVs involved in screening and management of malnutrition. - promotion of breastfeeding and prevention of BMS donation	Overall responsible: - coordinate common messages between clusters; - agree terms and conditions for outreach workers; - massive scale-up of campaign (urgent identification of partners, esp Punjab/Sindh)	Responsible for: - supporting distribution of IEC materials on food hygiene and other key hygiene messages
	Face-face communication of messages *Opportunities*: Messages can be disseminated at GFDs; simple pamphlets (integrated IEC materials) can also be distributed (are already giving out material on use of supplementary food, food hygiene)	Prioritised 'hot spot' districts	Camps, spontaneous settlements, returnee areas, host communities	LHWs, Community volunteers (NGOs, CSOs, Red Crescent, religious leaders, teachers, etc)				
	Dissemination of health, hygiene and nutrition messages through the 'Mother and Child Days'	Prioritised districts	All	LHWs,				
Provision of essential HH supplies	Distribution of hygiene materials (hygiene kits, soap) to enable people to practice safe hygiene behaviours *Opportunities*: link to other distributions (e.g. GFD)	Prioritised 'hot spot' districts	Camps, spontaneous settlements, returnee areas, host communities	NGOs	Responsible for providing hygiene materials for health facilities . Hygiene kits, aqua tabs and sachets to be delivered by health facilities in hotspot areas for distribution in	Responsible for providing hygiene materials for nutrition rehabilitation centres, SF programs	Overall responsible	Coordinate GF distributions with other clusters

Activity/Service	Modality of implementation	Geographical Areas	Locations	By who	Cluster			
					Health	Nutrition	WASH	Food
					outbreaks.			
	Distribution of ITNs	Prioritised 'hot spot' districts	Camps, returnee areas, host communities	NGOs	Overall responsible			
Delivery of safe water (for drinking and hygiene)	Accelerating provision of safe water through: - increasing at source treatment; - water tankering for spontaneous settlements; - cleaning/repair of water points/systems;	Prioritised 'hot spot' districts	Camps, spontaneous settlements, returnee areas, host communities.	Gov't, NGOs, private sector contractors	Responsible for providing water supply for health facilities.	Responsible for providing water supply for nutrition rehabilitation centres, SF programs	Overall responsible	Coordinate with WASH on distribution sites to ensure provision of safe water along with SF
	HH WT – priority should be given to massively scale up distribution of products *Opportunities:* link to other health and hygiene education activities; other distributions	Prioritised 'hot spot' districts	Camps, spontaneous settlements, returnee areas, host communities	NGOs				
	HH Water storage – distribution of jerry cans *Opportunities:* link to other health and hygiene education activities; other distributions	Prioritised 'hot spot' districts	Camps, spontaneous settlements, returnee areas, host communities	NGOs				
Sanitation	Clearing campaigns for defecation fields – as an immediate and short-term option	Prioritised 'hot spot' districts	Spontaneous settlements	NGOs			Overall responsible: - urgent identification of partners to scale-up sanitation coverage - TWGs at sub-national level to share expertise	
	Latrines – trench latrines as an immediate and short-term option (to be replaced with improved facilities as possible)	Prioritised 'hot spot' districts	Camps, spontaneous settlements, returnee areas, host communities	NGOs	Responsible for providing sanitation for health facilities.	Responsible for providing sanitation for nutrition rehabilitation centres		
Vector control for prevention of malaria	Indoor residual spraying	Prioritised 'hot spot' districts		Health authorities, NGOs	Overall responsilble			
	Social mobilization to support community-level vector control activities	Prioritised 'hot spot' districts		Health authorities, NGOs	Overall responsible			
General Food Distribution	Full ration for each family (7p) identified (vulnerability criteria). Distribution through either: - directly in communities - at xx Hubs (each covering 20,000p)	6 million people in affected districts	GFD hubs, camps, communities	WFP, NGOs	*Link to health and hygiene campaign*	*Link to health and hygiene campaign*	*Link to health and hygiene campaign*	Overall responsible: - working with NGOs to open hubs and scale-up coverage
Blanket supplementary feeding	Each family given 2 rations of HEBs (total 4.5kg) and 1 of plumpy dose/RUSF (1.5kg) per month. Distributed alongside GFD.	857,000 children under 2 years; 1.7 million children aged 2-12 years	GFD hubs, camps, communities	WFP, NGOs		- Support for introduction of targeted SF program (phased) as possible		Responsible for procurement and distribution

Activity/Service	Modality of implementation	Geographical Areas	Locations	By who	Cluster			
					Health	Nutrition	WASH	Food
Services for prevention and treatment of malnutrition	Establishment of Mother/baby spaces- potentially set-up with ORT centres Protection & promotion of breastfeeding and prevention of BMS donations	Prioritised 'hot spot' districts	Camps, spontaneous settlements, returnee areas, host communities	Camps		Overall responsible: - working with Health authorities and NGOs to scale-up coverage		
	OTP and SCs for treatment of SAM	Prioritised 'hot spot' districts	Camps, spontaneous settlements, returnee areas, host communities	HCFs, camps, spontaneous settlements, returnee areas, host communities		Overall responsible: - working with Health authorities and NGOs to scale-up coverage		
Vaccination services	Measles, Polio and Vit A campaign (ongoing in camps and settlements and will reach all children under five years in 2 phases in September and October)	All affected districts		LHWs, NGO Community volunteers	Overall responsible			
	Tetanus for pregnant women	All affected districts	HCFs	HCFs	Overall responsible			
Restoration of basic health services/ support for health care providers *Focus should be on restoration of facility-based and mobile services for prevention and treatment of identified risks*	Ensure stocks of essential supplies: basic health kits, ORS, zinc, deworming tablets, safe delivery kits (clean delivery kits, neonatal kits, facility kits, family planning)	All affected districts	HCF, mobile clinics	Health authorities, NGOs	Overall responsible			
	Reactivation of Lady Health Worker network *- to support community based management of AD, malnutrition, malaria, ARI and maternal and neonatal care* *- to support 'Mother and Child Days' in second half of September*	All affected districts		Health authorities, NGOs	Overall responsible: -	Inputs for agreement on 'basic intervention package' for LHWs, and support for relevant training/materials	Inputs for agreement on 'basic intervention package' for LHWs, and support for relevant training/materials (e.g. hygiene promotion)	
	Support for NGO health worker networks *- to support community based management of AD, malnutrition, malaria, ARI and maternal and neonatal care*	All affected districts		Health authorities, NGOs	Overall responsible:	Inputs for agreement on 'basic intervention package' for CHW, and support for relevant training/materials	Inputs for agreement on 'basic intervention package' for CHW, and support for relevant training/materials (e.g. hygiene promotion)	
Treatment of Infectious Diarrhoea (including cholera outbreaks)	'ORT centres' for people on the road *Opportunities*: ensure information on referral services available (and transport for severe cases?); IEC materials on key health and hygiene messages; distribution of soap	Prioritised 'hot spot' districts			Provide inputs and supplies		Ensure provision of safe water and sanitation facilities	
	Community-based management of diarrhea:	Prioritised 'hot spot'	Camps, spontaneous	LHWs, NGO Community				

Activity/Service	Modality of implementation	Geographical Areas	Locations	By who	Cluster			
					Health	Nutrition	WASH	Food
	- provision of supplies (ORS, Zinc) and IEC materials to LHWs/CVs *Linked to health and hygiene communication campaign (signs and treatment of AWD)*	districts	settlements, returnee areas, host communities	volunteers, Mobile health teams				
	Establishment of DTCs - in response to alerts through DEWS			Health authorities, NGOs	Overall responsible: - pre-stocking of CTC equipment and kits, - training for health workers			