Mission report
Joint evaluation on WHO Emergency Response Operations in Pakistan in the context of the Health Action in Crises Three Years Program (TYP)

Evaluation by joint team
DG ECHO –DFID-WHO
26/03/06 to 02/04/06

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1. Introduction

A joint evaluation team composed of DG ECHO, DFID and WHO participants conducted an evaluation of the performance of the WHO/HAC Three Years Program in the context of the WHO Emergency Response Programme for the Earthquake in Pakistan from 26 March to 2 April 2006. The itinerary is attached in Annex A and the Terms of Reference in Annex B. Apart from Islamabad, the team visited sub-offices in the field, in Bagh district and in Battagram district.

This was the sixth joint evaluation mission of the Health Action in Crisis Three Years Program and the second one during the second year of implementation of the TYP Program (2006-2007) ([1]). As for the Tsunami affected area, this evaluation looked at the performance of HAC in the context of a major natural disaster.

Similarly as for the previous evaluation, the team looked at the four core functions of WHO/HAC and their related key tasks as defined in the terms of reference.

During the evaluation, the team consulted representatives of the Ministry of Health, Representatives of the Federal Relief Commission of Pakistan, UN sister agencies, non-governmental organisation (NGOs), other International organisations, internally displaced persons (IDPs) in temporary location sites, and had the opportunity to discuss also with some donors in Islamabad (DFID, CIDA and DG ECHO).

2. General Situation and WHO global operational response

On 8 October 2005, an earthquake with a magnitude of 7.6 on the Richter scale hit Pakistan, resulting in substantial mortality and widespread damage. Officially 73,000 deaths and over 70,000 severely injured have been reported while the total injuries assisted by public sector health facilities alone have crossed 150,000. Several more injuries and deaths have probably not been reported. Five districts from the North West Frontier Province (NWFP) and three from Azad Jammu and Kashmir (AJK) were affected, some very severely.

[1] First visit was to Liberia.

Given this emergency situation an extensive rescue and medical relief operation was immediately mobilized by the government, particularly its armed forces.
This was supported by a wide range of national and international organizations, governments and an overwhelming number of civil society organizations and voluntary groups. The collective effort has prevented the anticipated post-earthquake second wave of deaths related to delayed access to health care ([2]).

The toll on the health system was significant: 65% of health facilities were devastated, 5 districts headquarter hospitals and numerous smaller health units serving remote areas were completely destroyed. Large parts of the health workforce were left unable to work, having lost their homes or stricken by grief at the loss of family members ([3]).

The strategic response to the disaster launched by WHO in collaboration with the MoH, started with the immediate establishment of a health coordination cell at the Pakistan Institute of Medical Sciences, form which over 50 health cluster partners assembled to exchange information, discuss strategy, analyse the situation and provide services such as mapping, guidelines, action plans, etc. This was quickly followed by the establishment of six WHO field coordination cells in Bagh, Muzaffarabad, Balakot, Battagram, Mansehra and Rawalakot, staffed by over 40 expatriates including epidemiologists, public health officers, environmental health officers, field coordinators and logisticians. All this was accomplished within the first thirty days after the onset of the crisis.

A systematic assessment of needs was conducted in all affected areas. Actions were then prioritized to address these needs. To face the challenge of the approaching winter period, WHO led the development of the Health Cluster 90 Days Winter Plan which contained the following elements:

- Revitalising the system of primary health care (PHC),
- Revitalising the system of secondary health care,
- Establishing a system of disease surveillance and outbreak control,
- Coordinating the health relief response and managing information,
- Reducing risk of environmental health related diseases by promoting hygiene, safe water and sanitation,
- Improving access to health care for affected communities,
- Providing mental health and psychosocial interventions.

WHO has facilitated the deployment of 77 MOH mobile medical teams to provide medical services to earthquake affected populations, by providing basic health and surgical kits, transport and accommodation.

In collaboration with the MOH and health partners, WHO conducted mass vaccination campaigns against measles, diphtheria, whooping cough, tetanus, meningitis, influenza and polio. New emergency health kits have been distributed and support offered to health workers to reoccupy their posts. 37 mental health teams provided mental health

[2] Post-Earthquake Relief Operation in Pakistan "Health Cluster" Jointly Coordinated by Ministry of Health and WHO
[3] WHO Interim Report to Donor Governments- 24 January 2006

care and training throughout the affected region and around 35 prefabricated basic health units (BHU) have been built by WHO during the relief phase.

Through the UN Flash Appeal of 26 October 2005, the Health Cluster made a request for U$ 55,380,000 (of which U$ 27,750,000 requested by WHO) to meet health needs of populations affected by the earthquake. The grand total of the appeal amounted to U$ 549,585,941, thus the health component represented approximately 10 % of the total requirement.

As of March 2006, WHO had received around U$ 16.4 million from a broad variety of donors (EC/DG ECHO, DFID, Australia, USA, Denmark, Sweden, Norway, Italy, Ireland, Korea, Monaco, Slovak Republic, Switzerland, Japan, Canada, Kuwait, Turkey, etc…) covering 60% of its requirements.

The table below shows in details WHO-HAC requirements in the Flash Appeal:

WHO Proposed Projects	**Funds Requested**
Revitalize system for delivery of PHC	**9,000,000**
Revitalize Hospital Care Services	**4,000,000**
Disease Surveillance and Early Warning System	**3,200,000**
Emergency Operations Coordination and Information Management	**3,500,000**
Environmental Health Response	**3,200,000**
Increase Access to Health Care for Affected Communities	**4,000,000**
Mental Health and Psychosocial Interventions	**850,000**
Total	**27,750,000**

3. Global impression of WHO HAC performance and Summary

Against the background of a very challenging environment and taking into account the magnitude of the disaster, the joint evaluation team is impressed by the solid position WHO has taken up in this crisis. Partners are almost unanimously in agreement over the fact that WHO has indeed assumed its responsibility as leader in the health cluster.
Despite the fact that the cluster approach was still in a conceptual stage, WHO has taken on the role of health cluster leader with an excellent result.

The challenge was multi faceted:

- A large group of affected population with urgent needs (evacuation of the wounded, need for immediate installation of a skeleton health delivery system which was destroyed physically and in terms of manpower, coordination with a large number of health partners and the MOH, need for a surveillance and rapid investigation capacity,

need to manage the overwhelming number of external and national additional resources which had to be directed in an optimal way, etc)

- The wide geographic scope of the damage and the spread of the affected population in a mountainous area which caused major logistical constraints
- The crucial cooperation with the Pakistani Armed Forces and in particular with the medical corps (which have proven to be essential to overcome logistical problems and to back up the non-military medical resources)
- The imminent winter (starting few weeks after the earthquake) meaning a very short deadline to meet and a wide variety of needs to cover (shelter, medical care, NFIs, etc)

The main highlights of this operation are the following (for each topic suggestions for improvement are mentioned in the core of the document):

1. An efficient coordination system with wide cooperation from the major health partners in the capital as well as in the field hubs was installed in the early stages of the response.
2. An early warning system for epidemic prone diseases was installed in the beginning of the crisis (with the participation of a sufficient proportion of the health facilities).
3. Rapid investigation of alerts was made possible and was done in good cooperation with MOH and health partners. Almost no alert lead to an outbreak.
4. A Health Information management system was established within the cluster and was at least in the beginning providing a good one stop shop for health partners and authorities to gather the information on the health situation.
5. WHO has been recognised indeed as the main reference point for health and public health matters by the health cluster partners. Twenty five guidelines on pertinent issues were distributed and this was widely appreciated by the partners.
6. While no major gaps were left in the wider health response, the following suggestions are made for future operations:
    - Need for a code of conduct to be agreed upon in the cluster on how to remunerate health personnel hired by the external partners without destabilising the public health system
    - Management of pharmacological donations and external extra medical teams to be tackled from the first week (this was done in this crisis but not every where in the early stage)
    - Information sharing and dissemination from an early stage on the plans for physical rehabilitation of disabled (programmes exist but are not widely known)
    - A global framework on how to organise the mental health response to be provided in the early stages of the crisis (was also done in this crisis but it is stressed again that “the earlier the better” should be the guiding rule).

7. Priority setting in the different phases of the crisis was correctly determined in the health cluster.
8. Priorities for the health cluster during the transitional phase and the comparative advantage for WHO in view of the different support activities will have to be urgently but carefully defined. Capacity building of the district health authorities and technical assistance on the federal (and provincial) level in key aspects should constitute the cornerstone for the coming year.

Although the aspect of the operational platform (administration, logistics, delegation of authority to commit funds, recruitment and turn-over of staff) has been discussed only on the level of the peripheral hubs, it should again be stressed that this remains a major bottleneck for the WHO/HAC, also in Pakistan. Even though, improvements are noticed from other evaluations (in particular Darfur and Tsunami), further adaptation of the admin/logistic system and the personnel management system is indicated. Problems were mentioned about the speed of procurement and dispatching of goods, the rapid turn-over of staff (e.g. logistic officers) and the degree of flexibility of the admin/procurement system in this emergency.

4. Facilitation of coordination of the health sector in cooperation with the MOH structures

The complex nature of the health response and the challenge to keep a wide variety of different medical groups (external and internal, civilian and military) working together in a streamlined and complementary way have emphasized the requirement for a solid, rapid and efficient coordination structure. The key task of the WHO/HAC to facilitate coordination in the health sector coincides with one of the main tasks of the cluster approach ([4]).

Through the interviews held in Pakistan with a wide variety of partners but also via the different evaluation processes which were implemented before (e.g. IASC Real Time Evaluation of cluster approach - February 2006), the health cluster and in particular the coordination task seems to have been carried out in a outstanding way. The term "Coordination" was defined in the large sense including:

- Early establishment of a health cluster meeting co-chaired with the MOH and therefore embedded in the national system (twice daily at the start of the crisis and progressively less frequent after some weeks. Contact numbers and e-mails for this coordination cell including the responsible for each thematic and technical issue were given early in the response via the bulletin (see further) and the website. WHO made it easy for the international health community to find out quickly what was, and what was not needed.
- Information collection, analysis and dissemination,

[4] The HAC programme is in fact the cluster approach for health "avant la lettre".

- Action oriented meetings with clear identification of resulting activities to be carried out, though recently this aspect was getting insufficient emphasis (i.e. meetings more limited to information sharing) in some areas such as Muzzafarabad,
- Participation from most of the important health partners at "decision making level", including the medical corps of the Pakistani Armed Forces and the Federal Relief Commission who both played a crucial role,
- Identification of priorities at the different stages and unmet gaps (which were then promptly filled),
- Clear assignments of responsibilities within the cluster, guaranteeing complementarity,
- Management of the different human and material resources (foreign field hospitals, drug donations and purchases).

The central cluster meeting was reinforced with meetings held in the humanitarian hubs, where the emphasis was more on daily operational coordination.

Some issues and suggestions/recommendations:

- It is widely acknowledged that it is probably better to separate the responsibilities of WHO as lead agency for the health cluster from the WHO as implementing agency of part of the health cluster activities. It is clear that in particular in the beginning the workload and responsibilities of the health cluster coordinator is overwhelming and cannot easily be combined with the task to coordinate the health activities of WHO. This is especially the case on the central level, while in the field hubs, tasks (for the cluster and for WHO as a cluster member) are more parallel and could be more easily combined ([5]).
- Most interviewees estimated that the exchange of information between the central cluster and the field hub clusters was not satisfactory and should be improved. Some major decisions were not communicated to the field and sometimes information from the field did not trickle down to the central level. This is a problem faced by most clusters.
- The inter cluster coordination was also evaluated as wanting. The cluster head meeting should be the cornerstone for the overall "joined up" coordination and strategy setting. Even though there was a platform created in Pakistan where all heads of clusters meet regularly, the results were too much restricted to information exchange and not enough including joint policy establishment. The fact that other clusters were performing rather poor, jeopardises of course the overall inter cluster coordination.
- Pakistan is the first application of the cluster approach and the approach was launched without the back up of a number of clear guidelines and TORs. These TORs will be partially generic for all the clusters but the health cluster may have its own specific

[5] In Pakistan, during the early phases of the crisis, two separate persons were indeed assigned for the two tasks, but in January, these tasks were combined in the same person. It remains questionable if even now, in the transition phase, the combination of the two tasks will not lead to situations where the person in charge of the two tasks has to choose at a certain point in time between the interests of WHO and the interests of the health cluster (e.g. funds).

requirements. Based on the good experience from Pakistan and later from the three pilots in Liberia, Uganda, DRC, ([6]) WHO should not hesitate to write their own "handbook" on the health cluster including:

- Terms of reference of cluster head and reporting lines, standard operating procedures, degree of authority of the cluster coordinator,
- Role as central facilitator for joint need assessments
- Information management, role of HIC
- Expected outputs, model cluster bulletins and situation reports,
- How to link up with the other clusters, and how to exchange information between field and central level
- Role as a fund raiser and a fund manager for the cluster
- Role of cluster lead as provider of last resort,
- Support in terms of equipment and human resources needed to lead the cluster,
- Toolkit of guidelines which may be useful,
- Benchmarks to be obtained,
- Role of the donors in the health cluster
- Relation with the press,
- Usual traps to avoid and description of good practices.

This would greatly help the cluster coordinator in the next crisis ([7]).

- Clarification must also be sought to define better the respective roles of the UNCT, the IASC or Field Humanitarian Teams, and of the UNDMT. There seems now to be quite some overlap and duplication leading to too many meetings and potential inconsistencies.
- No health cluster will work well if WHO does not find the appropriate person with a wide range of skills combined in one person. The cluster coordinator should be a diplomat, a planner, a communicator, a decider and should have the charisma of a natural leader. Beyond these qualifications, this person should also have the technical knowledge of rapid health action in crises, should be dynamic and have the necessary facilitation skills to manage the operations of a group. People combining all these skills are rare.
- To empower WHO to fully take on the responsibilities as cluster coordinators in (almost) all humanitarian crises, the HEARNET (Health Emergency Action Response Network) or an adapted form of this, could become quite useful. WHO/HAC should develop an intensive high level training course open for UN, RC family and NGO senior health staff. The course should serve also as a selection process, based on observation of the candidates during the course. This could lead to a broadly based international rooster of potential cluster leaders from the wider humanitarian community who could be recruited on a WHO contract at the start of a new crisis.

[6] And now recently in the Horn of Africa

[7] Difference should also be made between natural disasters and manmade disasters and maybe between rapid onset crisis and protracted complex emergencies. The role of the cluster will vary significantly from crisis to crisis but general guidelines should be provided.

5. Management, analysis and dissemination of Health Information

In an ideal world, information management of the overall cluster system should have a common denominator in the form of the HIC (Humanitarian information Centre). The HIC in Pakistan has been evaluated in depth in February 2006 (see relevant report). It is clear from that report and from this mission's observation that the concept of the HIC is still unclear amongst the different stakeholders and that the potential role the HIC could play in the cluster approach has yet to be defined. This role could come to its full fruition via the cluster approach e.g. when information management would be recognised as a separate cluster or at least as a standard key task for all clusters with the HIC as the tool to be used to form a broad information management platform. We are currently far away from this ideal world and in fact WHO and the health cluster did not really use the HIC to organise their health information system.

As major outputs the health cluster produced a situation report and a Health cluster bulletin. While the two outputs in some way overlapped in content, there was a further duplication between Geneva and Islamabad. Moreover, there was a evolution noticeable from the initial weeks after the onset of the crisis compared to more recent weeks, where the report evolved from a real situation report looking at the "health situation" towards a mere inventory of activities implemented by the health cluster partners. While the need for promotion and visibility is to be fully acknowledged, the two should not be mixed up and the situation analysis of the health sector deserves to remain a high priority. An option could be that two documents remain the standard output from the cluster but that the situation report covers the situation analysis per se and is more for internal use inside the cluster and to share with other clusters and that the cluster bulletin (1 bulletin only) regularly updates the external world and the press.

It is also worth mentioning that there was the UN Pakistan earthquake response website (www.un.org.pk) and the WHO Pakistan website which had the health cluster bulletins, the minutes of the cluster meetings and the WHO situation reports posted on it.

An integrated 3W matrix defining "who is doing what and where", a key task of the HIC was tried out in Pakistan without getting sufficient support from the partners. WHO undertook by themselves to launch a health cluster operational matrix which seems much appreciated by the partners. If all clusters would have done this and brought this together on the level of the HIC, an interesting monitoring and planning tool would have been created. The challenge remains to keep this matrix updated.
Another integrated monitoring matrix containing a set of standardised performance indicators (to track progress towards meeting targets) was also tried out but again mainly the health cluster was cooperating and on an inter cluster level, the initiative got somewhat aborted. Even for the health cluster, improvement on the definition of the indicators is required.

The way the health information system is to be established in the cluster approach deserves a lot of attention and the potential role of the HIC should be evaluated and discussed.

Overall, most partners found that WHO played a crucial role to collect, analyse and disseminate the necessary information on the health sector but again the field was somewhat disconnected from the central level with lack of information sharing in both directions.

6. Emergency disease surveillance and early warning for epidemic prone diseases:

Generally considered by all partners as one of the most effective activities of WHO, the set up of the Disease Early Warning System (DEWS) was exemplary in this crisis even if it was a bit hectic at the beginning of the response and some improvements are needed. It is widely accepted that the system helped to avoid a "second wave" of mortality after the earthquake.

- ***Determination of sentinel sites for early detection of priority communicable diseases and guaranteeing sufficient feedback of data***

The weekly surveillance activities report concerns 12 main conditions/diseases of primary importance in emergencies: Acute Respiratory Infections, Acute Watery Diarrhoea, Injuries, Fever of Unknown Origin, Bloody Diarrhoea, Malaria, Jaundice, Measles, Meningitis, Acute Hemorrhagic Fever, Acute Flaccid Paralysis, and Tetanus.
This system was set up in week 42.

Data are received from around 196 reporting sites which provide a very good coverage, supported directly or indirectly by health partners, including from field hospitals. The timeliness of sending in the data to the central level should be improved.
While the system provides the necessary information regarding the most threatening diseases during the phase of emergency relief, there is potentially a lot more that could be obtained from this collection and analysis of data, particularly at the present time of early recovery for which health planning should be based on a rationalized basic health information system.

- First of all, the data should be further disaggregated (by gender, by age groups, etc…) and provide the information on the cause of death, particularly for the under 5 years old population. Now only a minor fraction of the mortality is communicated to the district and central level – this is not sufficient.
- Secondly, the analysis should be done using population based indicators. Some demographic data are available or can be estimated which would allow for analysis of coverage and use of health care services compared to the population denominator (e.g. attendance rates = number of new cases/per person and year in a health facility in relation to the estimated catchment area/population).

- ***Availability of rapid investigation teams***

There were approximately 166 alerts for which investigation teams composed of MoH staff and WHO were sent immediately on the spot for rapid investigations. No alert led to the outbreak of any emergency.
Diseases of particular importance in situation of displacement and crowding such as measles and acute watery diarrhoea were properly managed, e.g. the rapid identification and control of over 700 cases of acute watery diarrhoea outbreak in Muzzafarabad and the 55 alerts concerning measles. Thanks to this quick reaction and proper feedback to the partners (with the exception of one suspected case of hemorrhagic fever) no outbreaks could emerge.

- ***Availability of reliable laboratory and diagnostic facilities reachable in the field in a timely way with a guarantee of immediate feedback***

There was no laboratory capacity at district level and all samples were sent to Islamabad or even outside the country. That was the case for a suspicion of hemorrhagic fever whose sample was sent to South Africa and for which feedback information only came 4 months later to the partners.
Except for that case of suspected hemorrhagic fever, all other samples were quickly analysed and the related information rapidly fed back to partners.

- ***Possibility where necessary to provide a rapid response to contain the emergence of epidemic prone diseases with the appropriate means***

Contingency planning and appropriate measures were taken in a timely fashion for all situations of potential outbreaks. In particular, vaccination campaigns including for measles were effectively conducted in all areas.

Recommendations:

- To disaggregate further the analysis of the current system by gender, by age groups and provide insight on the causes of mortality in the category of "others" particularly concerning the under - 5 years age group.
- Support the evolution of the current system to a basic health information system including analysis of coverage and access to health care by using population-based data through real figures or estimations. Furthermore, a deeper analysis of the burden of diseases is needed in order to prioritize health interventions during the recovery phase. (e.g. the importance of mental health problems versus maternal health and child health)
- Strongly support the capacity building of district health managers and planners by using this expanded epidemiological surveillance and reporting system as a basic tool for health planning and rationalization of health services delivery.
- Support the establishment of basic laboratory services at district level.
- Develop a much faster feedback system for suspected cases of highly dangerous threats such as hemorrhagic fever.

7. Role of WHO as reference for public health matters and promoter/advisor for priority setting

WHO's role as a reference for public health matters was generally acknowledged. In particular, the availability of WHO staff to provide technical backup and information was appreciated as partners spoke about the "open door policy" of WHO. WHO played its role as promoter of reflection on priorities in the health sector and orientation of the larger health community in the appropriate direction.
Twenty five key guidelines (e.g. on Acute Respiratory Infection management, IMCI, etc…) were largely distributed to the partners. Of particular importance, the issue of field hospitals was discussed in the health cluster and WHO issued guidelines on the use of Foreign Field Hospitals. More than forty international field hospitals were operating in the affected areas at the peak of the emergency response and a specific working group to deal with this issue was set up within the health cluster. A close collaboration was established with the medical services of the Pakistani Armed Forces and the MOH to dispatch the field hospitals while avoiding overlap and gaps left as well as in order to design an efficient exit strategy for the proper handover of these resources to the national health system.

A strategic plan was quickly designed in a coordinated manner through the health cluster aiming at reducing excessive mortality and morbidity in the affected areas. The strategy agreed amongst health partners aimed at ensuring access to primary health care, referral to adequate hospital care, the implementation of a communicable disease surveillance system and early warning, and key aspects of environmental health such as potable water supply.

With the early recovery phase starting already, WHO's role as technical supporter to the national health authorities will be paramount in the coming weeks. WHO will need to be involved in strengthening district health management in the affected areas as well as at central and provincial level, to be in a consolidated position to offer full support to national capacity building. This will require a different mode than during the relief phase and a solid team of public health experts, well coordinated under the leadership of the WR and the Chief of Operations.

Recommendations:

- Make an inventory of all guidelines supplied to health partners and select a list of guidelines that should be systematically available during a similar response operation (drugs donations, disposal of dead bodies, foreign field hospital management, etc…)

- Fully engage in technical assistance to national health authorities at District, Provincial and Central level. Key issues include district health management, basic health information system, health planning and the development of a health emergency preparedness unit within the MOH.

8. Any gaps in the health sector left unidentified or unfilled?

- ***National health staff recruitment:***

While gaps identification and subsequent filling is a shared responsibility of all health partners (not solely of WHO), the lack of a concerted policy on health staff recruitment/employment/remuneration at the early stage of the relief operation has been identified by the evaluation team as a significant gap.
Indeed, at peripheral level, there was a shortage of human resources, especially of health staff and a lot of discrepancies existed in terms of incentives, salary offered by different international organizations, which had an destabilising effect on the national public system.

- ***Drugs donations:***

Support and technical expertise to the management of the donations of drugs and medical supplies from different sources and of different quality, though slow at the onset of the crisis, was much better tackled than in the Tsunami response. The set up of a warehouse in Bagh with the use of the Logistic Supply System (LSS) is a very good example of a key function of WHO in the context of natural disaster relief.
It can be concluded that the management of drug donation was not left as a major gap in this operation, though it would require a much faster implementation yet in the future.

- ***Physical rehabilitation of disabled persons:***

The earthquake caused 741 spinal cord injuries and 730 amputations.
This important issue was not left as a gap as WHO quickly provided information at the central level on the existing services and on the existing needs following an assessment. It is now to be addressed in the recovery phase, in the medium term through the development of a Community-Based Rehabiliation program endorsed at national level. The sharing of information on needs and available programmes was however not shared in a sufficient way to the peripheral humanitarian hubs.

- ***Mental Health:***

There was a quick reaction to the psychological consequences of the affected population by the earthquake, led by WHO through technical expertise and appropriate coordination in the health cluster (the working group on mental health). Again, compared to the response in the Tsunami affected region, this was set up and coordinated in a much better way and did not leave a gap in the response. However, the needs are so big that it seems to go beyond the national and international capacity. The challenge in the future will be to rightly balance the need for psychological support to persons affected by PTSD, the possibility to integrate mental health services within PHC, while prioritizing health interventions according to the burden of diseases in which mental health problems would not be necessarily a dominant feature.

- ***Coordination:***

It was sometimes felt that information exchange gaps existed between central coordination (the health cluster in Islamabad) and the health clusters at district level.

Recommendations:

- Provide guidance at the early stage of the relief operation on policy and code of conduct for recruitment and support to national health staff in terms of incentives and salary.
- Continue to provide support to the management of drug supplies through capacity building of local health district managers
- Advocate for the use of LSS as a central tool for emergency preparedness
- Avoid over-emphasis on mental health care in contrast to other priority needs such as maternal health, obstetric care and reproductive health in general. First of all, proceed to a comprehensive needs assessment in the field of mental health care and compare with national data if available
- Continue to provide information and support coordination in the field of community-based rehabilitation (CBR) of disabled persons
- Strengthen proper coordination of health clusters between the central and peripheral levels through regular and rapid transfer of information in both ways

9. Capacity building of MOH authorities and non governmental groups – Role of WHO/HAC in the Transition Phase

As said earlier, the greatest challenge may still be ahead when entering the transition phase.

The characteristics of the transition phase are as follows:

- History of massive external ad hoc support during the critical phase (last 6 months) with massive coverage of the health needs, an operational surveillance system, gigantic logistic support and the disaster area in full focus of the world's attention.
- Now, the bulk of the external health providers and logistic support has left or is on its way out. NGO's are expected to prepare their exit after the summer.
- The next winter (06/07) may not be as mild as the previous winter (05/06).
- The majority of the displaced population is now returning to their villages of origin. However, the infrastructural rehabilitation is still in its initial phase and many social services still lack.
- The district health administration system has suffered from depletion of human resources (some health workers died and some left), and in many cases lack even more than before the basic facilities and equipment to manage their district ([8]).

[8] The district health system suffered before the earthquake already from a lack of resources which did not allow the District Health Officer or a member of his team to frequently visit the peripheral Basic Health

While the name of the game during the immediate post crisis period (first 6 months) was substitution, the transition period will have to rely on an intensive and realistically planned capacity building on the central, provincial and district level.

WHO has started already in the emergency phase to work closely with the health authorities on federal, provincial and district level. Health authorities on federal and district level have been fully involved in the health cluster activities and therefore the capacity building and transition has already its foundation.

While the full handover to the MOH will have to be progressive, the Federal Relief Commission has already been replaced by the ERRA (Earthquake Reconstruction and Rehabilitation Authority). Moreover the health cluster will not continue to exist in its current form and whatever coordinating platform is replacing the cluster, it may not have the same supportive and coordinating role. The MOH will be the central point around which the new health system will be built. To facilitate this, the MOH has created a Disaster Management Cell. This cell is however in a conceptual stage and will need a lot of support.

During the transition phase, WHO should carefully weigh where its comparative advantages lay compared to the remaining health partners and the MOH. The traditional capacity of WHO in technical assistance and planning of health services, should now be fully exploited. Direct health service provision should now be left as much as possible to the remaining NGOs and the MOH.
It would also be counter-productive to try to aim too high. The health delivery system in the disaster area suffered from major structural and systemic deficiencies and it will not be easier to solve these now, compared to the pre-earthquake period.
A realistic planning of how best the health system can be re-launched in a sustainable way, taking into account realistic estimations of available financial and human resources will be the cornerstone of success. The health authorities should decide to which extent they are ready to build a better system than what they had before and should get support to achieve this.

In practical terms, the framework for the continued WHO involvement in the health sector could contain the following elements:

- Technical assistance to the disaster management cell in the MOH and to ERRA
- Technical assistance on the level of the provincial health authorities
- Support to the health district authorities to re-plan the health district and establish a capacity on the level of the district to supervise the peripheral health facilities (training of supervisors)
- Technical assistance to establish on the district level a solid drugs and medical supplies management system (explore rolling out of the LSS = Logistic Support System, when estimated ready)

Units. It was up to the BHU's to come down to the district capital to meet their supervisors. Many BHU's did not really operate well and had a very low coverage of their catchment area.

- Technical assistance to expand the DEWS (disease early warning system) into a broader epidemiological reporting system (with the aspect of surveillance and early warning maintained) – including population based data.
- Empower the district health authorities and cover the investment costs for a district health office, warehousing, transport, office equipment and initial incentives

This will require a progressive down scaling of the hands on approach on a permanent basis in the hubs on the district level and would shift the WHO involvement in the direction of short term but intensive capacity building and technical assistance on different levels. Regular consultations and workshops bringing together short and long term consultants with the health authorities (including districts) should streamline the effort and monitor progress made.

10. Conclusions and summary of recommendations

It is very encouraging to notice that the lessons learned from the Tsunami have been taken on board in this crisis to a large extent. This gives credibility to the learning curve that WHO/HAC is going through. Major mistakes or gaps left in the Tsunami setting were avoided and a self critical attitude was taken on by WHO which allowed correction of certain aspects in an early stage.

Despite the positive evaluation of the global performance, a major challenge is still ahead. Since early April the transitional phase has started and WHO will have to adapt its programme and that of the health cluster in view of the new situation. Less external support will be available (NGOs are planning their exit for September/October) and the capacity building of the local health systems will have to be tackled in detail. The next winter is only 7 months away and much is left to do.

A summary of the recommendations is listed below:

1 **Facilitation of Coordination of the Health Sector in cooperation with MOH Structure**:

- ⇒ It is probably better to separate the responsibilities of WHO as lead agency for the health cluster from the WHO as implementing agency of part of the health cluster activities.
- ⇒ Improve exchange of information between the central cluster and the field hub clusters and in between different sector clusters
- ⇒ Based on the good experience from Pakistan and later from the three pilots in Liberia, Uganda and DRC, WHO should start drafting a "handbook" on the health cluster
- ⇒ Adapt the HEARNET to empower WHO to fully take on the

	responsibilities as cluster coordinators in (almost) all humanitarian crises by creating a wide network of senior health workers who could serve as health cluster coordinators.
2	**Management, Analysis and Dissemination of Health Information**: ⇒ Avoid mixing promotion & visibility tasks with situation analysis of the health sector in situation reports and cluster bulletins. In addition, avoid duplication between the Country office and Geneva (WHO HQ). ⇒ Clarify the role of the HIC in the establishment of the health information system.
3	**Emergency disease surveillance and early warning for epidemic prone diseases**: ⇒ To disaggregate further the analysis of the current system by gender, by age groups and provide insight on the causes of mortality in the category of "others" particularly concerning the under - 5 years age group. ⇒ Support the evolution of the current system to a basic health information system including analysis of coverage and access to health care by using population-based data through real figures or estimations. Furthermore, a deeper analysis of the burden of diseases is needed in order to prioritize health interventions during the recovery phase. (e.g. the importance of mental health problems versus maternal health and child health) ⇒ Strongly support the capacity building of district health managers and planners by using this expanded epidemiological surveillance and reporting system as a basic tool for health planning and rationalization of health services delivery. ⇒ Support the establishment of basic laboratory services at district level. ⇒ Develop a much faster feedback system for suspected cases of highly dangerous threats such as hemorrhagic fever.
4	**Role of WHO as reference for public health matters and promoter/advisor for priority setting – role of WHO during the transition phase**: ⇒ Make an inventory of all guidelines supplied to health partners and select a list of guidelines that should be systematically available during a similar response operation (drugs donations, disposal of dead bodies, foreign field hospital management, etc…) ⇒ Fully engage in technical assistance to national health authorities at District, Provincial and Central level. Key issues include district health management, basic health information system, health planning and the development of a health emergency preparedness unit within the MOH.
5	**Any gaps in the health sector left unidentified or unidentified and unfilled**: ⇒ Provide guidance at the early stage of the relief operation on policy and code of conduct for recruitment and support to national health staff in

terms of incentives and salary.

- ⇒ Continue to provide support to the management of drug supplies through capacity building of local health district managers
- ⇒ Advocate for the use of LSS as a central tool for emergency preparedness
- ⇒ Avoid over-emphasis on mental health care in contrast to other priority needs such as maternal health, obstetric care and reproductive health in general. First of all, proceed to a comprehensive needs assessment in the field of mental health care and compare with national data if available
- ⇒ Continue to provide information and support coordination in the field of community-based rehabilitation (CBR) of disabled persons
- ⇒ Strengthen proper coordination of health clusters between the central and peripheral levels through regular and rapid transfer of information in both ways

6 **Capacity building of MOH authorities and non governmental groups**:

- ⇒ During the transition phase, WHO should carefully weigh where its comparative advantages lay compared to the remaining health partners and the MOH. The traditional capacity of WHO in technical assistance and planning of health services, should now be fully exploited. Direct health service provision should now be left as much as possible to the remaining NGOs and the MOH.
- ⇒ This will require a progressive down scaling of the hands on approach on a permanent basis in the hubs on the district level and would shift the WHO involvement in the direction of short term but intensive capacity building and technical assistance on different levels. Regular consultations and workshops bringing together short and long term consultants with the health authorities (including districts) should streamline the effort and monitor progress made.

7 **The importance to establish a flexible operational platform (admin, personnel, procurement, logistics) is again recognised as crucial to give WHO the best means to tackle humanitarian emergencies efficiently and rapidly.**

Annex A

ITINERARY FOR JOINT DFID / ECHO / WHO EVALUATION MISSION OF WHO HAC FOLLOWING PAKISTAN EARTHQUAKE, OCTOBER 2005

March 26 – April 2

Sunday 26 March

06:00 Arrive early morning and transfer to Marriott Hotel, Islamabad
(Debbie already in country and at Marriott or Serena)

14:00 Meeting with Dr Rayana Buhakah, WHO Chief of Operations for Emergency and Rachel Lavy, Donor Relations Manager,
WHO Emergency Office F7

16:00 Visit to PIMS Hospital site of joint MoH/WHO Emergency Operations Cell with Rachel Lavy.

18:00 Return to Marriott

Monday 27 March

09:00 WHO Staff Team meeting with presentations from sector co-ordinators.
WHO office F7/2

10:30 Meeting with Dr Rana Kokar, Communicable Diseases Co-ordinator; Dr Hammam El Sakka, Senior Epidemiologist; Dr Mateeen, WHO Representative to ERRA; Dr Maryam Malik, Disabilities Co-ordinator; Dr Khalid Saeed, Mental Health Co-ordinator; Dr Laura Gillini, TB Co-ordinator; Dr Jamal, Environmental Health Co-ordinator; Dr Khalid Bukhari, Medicines Supplies Co-ordinator.

12:00 Meeting with Dr Tamur Moeenuddin, UNICEF; Dr Hulki Uz, UNFPA;
WHO Office F7/2

13:30 Meeting with Dr Hassan Orooj, Deputy Director General Health and Focal Person for Earthquake, Ministry of Health.
Office of Dr Orooj, 2nd floor block C, Pak Secretariat.

15:00 UN Security briefing in UNDSS office 13th floor Saudi Pak Tower.

16:00 Meeting with Mr Andrew Macleod, former Cluster Co-ordinator, OCHA.
UNDP office, 8th floor Saudi Pak Tower.

17:00 Meeting with Michael Graves, Logistics Support System (LSS) Trainer

Tuesday 28 March

08:00 Helicopter flight to Bagh (via Mansehra, Battagram, Muzaffarabad) arriving Bagh 11.40

Meeting with Patricia Kormoss, WHO Team Leader Bagh, and team members.

Meetings arranged with health cluster partners and key medical and military personnel

Overnight in Bagh

Wednesday 29 March

08:50 Helicopter flight to Battagram (via Muzaffarabad) arriving Battagram10:00

Meeting with Osama Ali Maher, WHO Team Leader Battagram and team members.

Meetings arranged with health cluster partners and visits to Maidan and Meira Camps

Overnight in Battagram

Thursday 30 March

10:40 Helicopter flight to Islamabad (via Muzaffarabad and Bagh) arriving Islamabad 12:30

15:00 Meeting with Islamabad Health Cluster members
WHO office F7

Friday 31 March

09:00 Meeting with Jan Vandemoortele, Humanitarian Co-ordinator and UN Resident Representative, Pakistan
UNDP 9th floor, Saudi Pak Tower

11:00 Round table meeting with donors, Dr Ismat Aziz, CIDA, Mr Yassine Gaba ECHO and Ms Jane Edmondson, DFID.

14:00 Meeting with Melanie Mason, HIC Co-ordinator and Mr Jamie McGoldrick, OCHA Co-ordinator.
OCHA office, Street 11, E7

Saturday 1 April

09:00 Meeting with General (Dr) Usmani of the Federal Relief Commission
Army Medical College, Rawalpindi

11:00 Wrap up session with WR and WHO Pakistan team

13:00 Afternoon free for discussion or follow up meetings

Sunday 2 April

Departure

Annex B

Joint evaluation mission WHO-ECHO-DFID in Pakistan
March/April 2006

Objective:

A real time evaluation of the performance of WHO/HAC in Pakistan

Background: there are four key contributions that represent the standardised framework of WHO/HAC intervention before, during and after crises:

1. undertaking of reliable assessment and surveillance work focusing on health needs of populations affected by crises, identifying priority causes of ill-health and death, outcomes of which can be used by all stakeholders to set priorities and monitor progress;
2. convening and co-ordinating stakeholders for health to encourage open communication and joint action;
3. identifying gaps in preparedness and response, and making sure that these are filled (by WHO as a last resort)
4. Strengthening in-country and local capacity so that preparedness, response and recovery can be sustained and institutions for health are re-invigorated.

Among the key tasks supporting these contributions what has WHO set up in terms of:

i. Preparedness and early warning systems (including surveillance systems)

ii. Rapid investigation of outbreaks

iii. Information collection, analysis and dissemination (setting up of HIS: What kind of health information system is operational: accuracy, usefulness?)

iv. Technical expertise (Credibility: Is WHO perceived as the reference for technical, expertise?)

v. Have gaps been identified and how are they filled (WHO, MOH, NGO's?)

vi. Priority setting and definition of minimum health package appropriate for Pakistan; has there been reflection on priority setting, does a minimum package exist?

vii. Coordination structures in Islamabad, at the periphery

viii. Local capacity building and training

Furthermore, the following aspects will be examined:

How is WHO perceived by the international health partners in its role as health focal point and as leader of the Health Sector Cluster?

1. Collaboration/synergy between WHO and MoH
2. To which extent is WHO field oriented (presence of staff international and national)?
3. Relationship with ECHO, DFID, SIDA offices
4. Respect for reporting requirements?
5. How much funds were raised globally via the emergency appeals and what were the funds used for? What were the main constraints?
6. How quickly was WHO/HAC able to establish its operational presence in the right areas, and start pursuing their priority activities meaningfully?
7. How soon did the various elements of logistical support, communications, supplies etc come together to give WHO operational viability and credibility?

Methods:

⇒ +/- One week (1 day in Islamabad, 4 days in the field), 1 day wrap up in Islamabad

⇒ Intensive working meetings with WHO and ECHO

⇒ Meeting with other donors UK, SIDA, USA

⇒ Partner meetings (individual and plenary) in Islamabad and in the field

⇒ In principle to be organized by WHO

Period:

25th March to 2nd of April 2006

Results expected:

⇒ As much as possible consensus between ECHO/DFID/SIDA and WHO to be pursued

⇒ Overview of the positive accomplishments and the points where improvement is needed

⇒ Concrete suggestions for improvement and plan of action

⇒ Identification of major constraints and how possibly to solve these