Health cluster strategy for the crisis in southern Kyrgyzstan

By: the Inter-Agency Standing Committee
ABSTRACT

This joint report by health agencies working in Kyrgyzstan indicates that the health care delivery network coped relatively well during the civil unrest that began in June 2010.

The report also identifies focus areas for long-term health interventions – mother and child health services, immunization, child nutrition, health information management, outbreak detection and mental health and psychosocial support – and explains strategies for addressing these issues.

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Humanitarian consequences of the conflict in the south

Following the large-scale displacement of civilians triggered by the widespread violence and destruction that started on 10 June 2010 in the southern regions of Osh and Jalal-Abad, which left hundreds of people dead and thousands wounded, a massive return of refugees took place. By 28 June, almost all refugees had returned to Kyrgyzstan, except for a few hundred who remained hospitalized in Uzbekistan. It is estimated that 400 000 were directly affected by the violence (300 000 internally displaced, 75 000 returning refugees, 25 000 other people affected without being displaced). Of these 75 000 people remain displaced – 37 500 in poor shelter conditions, 37 500 fearful for their security. Osh city is the second largest city in Kyrgyzstan with a population of 1.3 million. Jalal-Abad is also a large city, with around 1.1 million inhabitants. Thus, in total, around 1.2 million persons, i.e., approximately half of the population of these two provinces, have been affected by the consequences of this conflict.

Health consequences of the conflict: an update

Although hospitals and clinics were overwhelmed by the large number of injuries, it seems that the extensive health care delivery network has managed the health aspects of the crisis relatively well so far. According to the Ministry of Health, as of 9 August 2010, in Osh and Jalal-Abad a total of 2326 persons received medical treatment, and 1084 were hospitalized. Outpatient services treated 1243 persons. The majority of all these patients were trauma cases. The death toll rose to 371. Hospital officials estimate that the majority of persons who required treatment during and after the conflict, especially those who were hospitalized, will return to hospital outpatient services for follow up treatment. Hospitals and health facilities should be supported in coping with this second wave. The mental health and psychosocial support needs of these victims remain largely unmet.

The large number of casualties during the crisis highlighted the need for rehabilitation services, which are lacking in the conflict affected area. Access to quality emergency health services can reduce disabilities. The disabled are usually at a disadvantage during the distribution of humanitarian assistance. Amputees and other handicapped people need orthopaedic devices to better adapt to disabilities and lastly, there is a need for rehabilitation programmes to help people living with disabilities to reintegrate into society.

While access to health services was severely limited during the acute stage of the conflict, partial restrictions due to real or perceived constraints continue to be reported: access to hospitals in Osh in particular was an extremely critical and emotional issue in the last few weeks. Although the military checkpoints in and around the hospitals were removed following a decision by the Ministry of Health the situation is still monitored closely by all partners in the health cluster (including non/cluster partners) and by other clusters, especially the protection partners.

Apart from a limited outbreak of anthrax in Jalal-Abad in June 2010 and typhoid cases in Osh early 2010, no major outbreaks were reported in the crisis affected provinces. Diarrhoeal diseases were near their usual annual average and there were no outbreaks of vaccine preventable diseases. The surveillance system, which needs to be supported, continues to function, although, at a slow pace. The outbreak of poliomyelitis (polio) in Tajikistan triggered national immunization days (NIDs) against polio on 23–29 July and August. The July NID showed very high coverage (above 97%) although the final figures have not yet been released. Conventional immunization programmes continued to function at primary health care (PHC) levels despite the need for support of the old cold chain. Kyrgyzstan managed to maintain high coverage for all EPI (Expanded Programme of Immunization) vaccines.

There are no relevant acute malnutrition cases reported from the conflict affected areas. Micronutrient deficiencies remain the main nutritional and health problems for children and pregnant women, contributing
to the high child and maternal mortality in the country.

A systematic health assessment, i.e. the rapid interagency (WHO/United Nations Children's Fund (UNICEF)/United Nations Population Fund (UNFPA)) assessment, was conducted 30 June – 3 July 2010. This was complemented by information from surveys and assessments by partners on some selected health aspects. However, it is clear that the situation is evolving and that a follow-up health assessment is needed to evaluate the health situation and to get a more in-depth understanding of the evolving post-conflict priority health needs.

Although many initiatives and activities were undertaken by partners, the mental health and psychosocial support (MHPSS) needs of the conflict affected population remain largely unmet, including those of health workers who were directly and indirectly involved in the conflict.

Assumptions

Contingency planning, which takes into consideration several scenarios, was initiated during the formulation of the Flash Appeal and should be further pursued and updated. The health cluster strategy is based on the most probable scenario, which envisages that the current situation will continue, improving only very slowly. It is assumed that a major flare up of renewed ethnic conflict is rather unlikely at present, but tension, mistrust, animosity and fear are predicted to continue, with local cyclic outbreaks of low level violence. The majority of the returned IDPs (internally displaced persons) will return to live in their houses, or in some cases, will be hosted by communities near their destroyed houses.

General objectives

- To reduce avoidable morbidity and mortality among conflict affected population IDPs, returnees and host population).
- To facilitate peace and reconciliation in the health sector and support health sector recovery.

Overarching principles and strategies

- The health cluster partners should implement their emergency interventions based on the principles of neutrality, impartiality and the humanitarian imperative, with the right to health as a fundamental human right.
- As the conflict subsides, the Ministry of Health needs to increasingly foster its stewardship role and coordinate the international action for recovery and transition.
- Information management should ensure advocacy for the needs of the conflict affected population and promote peace and reconciliation at the community level.
- Besides the risk of a flare up of local conflicts and the remaining ethnic tensions, Kyrgyzstan is a country, which is at high risk for several types of natural disasters (e.g. earthquakes, floods, mudslides, and drought). While authorities need to invest both in preparedness and recovery, health partners should integrate risk reduction efforts into the humanitarian health response interventions and be ready to support the Ministry of Health both in recovery and in building sustainable capacity through preparedness.
- The national and international health response should take into consideration the implications of the conflict for the health system reform process which has been ongoing for two decades and supported by a sector-wide approach (Manas Taalimi).
Severe shortage of funding remains a challenge, leaving priority needs for essential health services unmet.

**Operational strategies (as stated in the revised Flash Appeal)**

1. To ensure access to essential primary and secondary health services including emergency reproductive health services (ERH)

Access to essential health services is a critical key factor determining morbidity and mortality in this crisis. This includes emergency reproductive health (ERH) services, including services for gender based violence, emergency services including intensive care units emergency and trauma surgery, and curative and referral services (including availability of essential drugs). People living with HIV/AIDS, the disabled, and those suffering from noncommunicable diseases, (NCDs), especially cardiovascular diseases (CVD) and other chronic conditions need to have sustainable access to needed health services. The leading cause of mortality in Kyrgyzstan is cardiovascular diseases (48.3% in 2007).

Crucial in terms of access to services at the primary care level are mother and child health services.

Maternal mortality in Kyrgyzstan is high: according to statistical data from 2009, a ratio of 69.1 per 100 000 live births, ended with death in connection with childbirth. Up to half of these deaths are considered preventable. Infant and child mortality is high as well, with infant mortality in 2009 reported 24.2 per 1000 live births. Infant and neonatal deaths, and under-5 mortality appear to be underreported. The national under-5 mortality rate was reported as 29.3 per 1000 in 2009, for Jalal-Abad province this was 24.5 per 1000 and for Osh province 26.1 per 1000. For Osh city, however, it was 64.4 per 1000 live births. Despite some progress to reduce under-5 mortality rates Kyrgyzstan is currently not on track to attain the Millennium Development Goal target.

Due to the limited access to appropriate obstetric services, the number of home deliveries, deliveries in rural hospitals, pre-term deliveries and late admissions to hospital has significantly increased during the conflict, due to limited access of pregnant women to maternal health services. At the same time health providers were not able to reach those who needed emergency obstetric care. Access limitations are further aggravated through a weak health infrastructure, outdated equipment, and lack of adequate supplies and the often low professional capacity of health providers. These factors contribute to the high maternal and newborn mortality. There is no awareness of the availability of health services among victims of gender-based violence (GBV) and no referral system in place. It is critical that referral mechanisms be made available to provide health, psychosocial and legal assistance to victims of GBV which can also occur unrelated to the recent conflict.

At the onset of the conflict, the health care facilities often did not have any post-exposure prophylaxis (PEP) available, nor were emergency contraceptives administered in a timely manner. Staffs are not trained in clinical management of rape in a crisis situation. These weaknesses still persist. The health providers are not responsive to the needs of GBV survivors are often not supported to enter recovery processes, and there are persistent gaps in compassionate and qualified medical care.

Hospital services are responsible for the management of severely ill children and complicated deliveries, in addition to other surgical and medical emergencies referred from peripheral health centres. Hospital services are provided at secondary and tertiary care hospitals, formally free of charge. However, laboratory and X-ray tests and medicines frequently have to be paid out of pocket by the patient. The crisis clearly showed weaknesses and limitations in the health care system such as the antiquated infrastructure, and the lack of appropriate equipment and supplies. Five out of a total of eleven ambulances have been destroyed in Osh and Jalal-Abad.
The number of HIV cases more than doubled between 2001 and 2007. The south of Kyrgyzstan accounts for the vast majority of HIV/AIDS cases in the country, and also among women and children. Currently, there are 190 children registered in the Osh region as a result of an extensive HIV investigation, mainly in the districts of Karasu and Nookat. HIV in children has been mainly acquired through unsafe medical procedures and re-use of single use injecting equipment. Frequent shortages of injecting needles, along with overuse of certain invasive treatment procedures and outdated, dangerous practices in the use of blood and blood products, were identified as risk factors for HIV transmission in hospital settings.

**Tuberculosis** is a major public health problem in Kyrgyzstan and more attention is needed for TB patients who interrupted their TB treatment during displacement or who had no access to TB treatment. TB in prisons is a major problem, with multi drug resistant TB being of increasing concern. The conflict related detention of people in the south could further aggravate these problems.

**Operational strategies** for mother and child health (MCH) and respiratory health are:

- (a) to support of Ministry facilities in Osh and Jalal-Abad provinces for primary and secondary care of women and children with life-saving medical equipment, and the training of medical staff on newborn resuscitation and care, and management of acute respiratory infections;
- (b) to promote and provide information about hygiene, and infant and young child care, developmental feeding, home management of common childhood diseases, safe motherhood and care-seeking habits to the communities;
- (c) to provide respiratory health commodities, supplies and equipment to existing health services;
- (d) to raise the awareness of health providers about GBV victims, and to train health providers on how to manage GBV cases, including methods of addressing their needs;
- (e) to ensure blood safety and proper sanitation in the primary health care institutes and in hospitals, including hospital waste disposal;
- (f) to ensure sustainable supplies of free essential drugs for communicable diseases and NCDs for all populations in conflict affected areas.

### 2. To ensure proper immunization for all children in affected communities

Kyrgyzstan reported high national coverage rates (> 95%) for the first and second doses of measles–mumps–rubella vaccine during the past five years, but there are likely to be coverage gaps at the subnational levels. The recent conflict has displaced parts of the population to areas where they are not registered for health services. Until the population movement is stabilized, displaced children are likely to miss some routine immunizations. This might contribute to an increased susceptibility to measles. Providing multiresistant vaccinations to children affected by the conflict will reduce the risk of future measles outbreaks.

The cold chain infrastructure in Kyrgyzstan is generally weak, as highlighted in recent field assessments by WHO and UNICEF. Domestic refrigerators used in health facilities do not comply with international standards to preserve the safety and effectiveness of the vaccines. Frequent power outages occur all over the country. The planned interventions also aimed to restore and develop an adequate cold chain system in the conflict affected areas.

Measles vaccination coverage is one of the key health service indicators and aims to reduce the risk of an outbreak. Multiresistant vaccinations were selected as the vaccines of choice, due to their low rate of adverse effects in mass vaccination settings.

**Operational strategies** for immunization are:
(a) to target over 95% of children in camps or urban areas, and to ensure that over 90% of children in rural areas are reached and vaccinated against measles and rubella through supporting active outreach and health education, also using polio NIDs;

(b) to restore the cold chain in the affected areas through provision and maintenance of equipment;

(c) to train PHC workers in order to upgrade their knowledge and skills;

(d) to prevent mortality among displaced children through one dose of MR (measles and rubella) vaccine to be administered to displaced children less than 15 years of age, who are living in camps for IDPs, collective settings and in households with no immunization records status;

(e) to go through the Ministry of Health and MCH network to implement the strategy;

(f) to use polio NIDs for raising awareness and outreach.

3. To protect the nutritional status of children and women in affected local communities

Protecting the nutritional status of the affected communities by addressing major causes of micro-nutrient deficiencies is a priority. According to the multi-indicator cluster survey (MICS) conducted in 2006, the level of severe acute malnutrition was 3%. Chronic malnutrition (stunting) is, however, widespread and affects 18% of children under 5 years of age. Stunting is an important predictor of child development and is associated with school outcomes, which in turn leads to reduced productivity and income-earning capacity in adult life. It is also a contributing factor to the high mortality rates among children under 5 years in Kyrgyzstan (38 per 1000), and hampers progress in reaching the Millennium Development Goals 4 & 5 (maternal and child mortality). Malnutrition of women and iron-deficiency anaemia in pregnancy increases the risk of death during childbirth and may account for as many as 20% of the deaths. The highest rate of deliveries complicated by anaemia (71.2%) was recorded in the Osh region in 2009. Malnutrition during the early years of life has a negative impact on cognitive and motor skills and on physical, social and emotional development.

Under the current circumstances children need adequate and nutritious food to help fight stress and withstand different infectious diseases. In the next 6 months, the nutrition subcluster is planning to strengthen the government’s response capacity to improve the health and nutrition status of the most vulnerable population groups, women and children, in the affected areas.

UNICEF and nutrition partners aim to support, promote and protect breastfeeding, to enhance exclusive breastfeeding for children under the age of 6 months and to support adequate supplementary feeding for infants and young children, mothers and pregnant women, as well as home food fortification (multiple micronutrient powders) targeting especially children under the age of 2.

Operational strategies to protect the nutritional status of children and women are:

(a) to establish an evidence based base-line for planning and assistance through an in-depth nutrition assessment to determine the number of children and women at risk, their nutrition status, and risk factors for deterioration.

(b) to ensure adequate food distribution, complementary and supplementary, through coordination and provision of respective food items and supplies.

(c) to provide fortified food and micronutrients targeting 660 000 women and 280 000 children in the affected areas through the Ministry of Health/MCH network.

(d) to support monitoring malnutrition and raising awareness through procurement of anthropometric measurement tools and printing and distribution of communication materials.
(e) to reduce mortality of acute severe malnutrition through training of medical doctors from children’s hospitals on the detection and management of severe acute malnutrition.

(f) to support mobile teams with supplies, operational costs and technical expertise to provide health services, follow up visits, and monitoring of activities in affected communities.

4. Health information management and health cluster coordination

There are around 40 national and international nongovernmental organizations (NGOs) and three United Nations agencies working in the health sector collaborating as members of the health cluster to address the health consequences of this crisis. Médecins sans Frontières (MSF) and the International Committee of the Red Cross (ICRC), two major actors in health, attend as observers of the health cluster. The cluster meets on a regular weekly basis (Friday in Osh and Monday in Bishkek). Meetings are chaired by WHO and sometimes attended and co-chaired by the Ministry of Health. The main information products of the health cluster are the weekly Health Cluster Bulletins and the analysis and prioritization of the health projects in the Kyrgyzstan Flash Appeal (June) and the revised Flash Appeal (July). National and international guidelines are used and several guidance documents were translated into Russian.

A great deal of coordination and information management efforts go into monitoring, advocating and ensuring access to essential health services for all victims of the conflict. Access to essential health services is linked to real or perceived constraints triggered by ethnic clashes (violence, harassment, and human rights violations). This access limitation can affect any aspect of the basic health services including immunization, health education, trauma, obstetric care, disease surveillance and response and NCDs, although only limited data is available. The most important problem was the limited access to hospital services. The presence of armed personnel around and inside hospitals was reported by health and protection partners to be the main obstacle to reaching these facilities and services. These checkpoints were eventually lifted by the Ministry of Health as of 31 July 2010. A recent Survey carried out in July among the most affected communities showed that the majority of injured still were afraid to go back to health institutions for follow up treatment. 16% of parents stated that they will not send their children to school, as they are still concerned about security.

Operational strategies for information management and health cluster coordination are:

(a) coordinated assessment missions to relevant districts by cluster (and non cluster) members;

(b) subject to improvement in security, a more comprehensive assessment by the health cluster members, probably as part of a United-Nations-wide post conflict needs assessment (PCNA);

(c) support to the Ministry of Health to collect, manage, and analyse information on access restriction, and to initiate action through the Ministry of Health and partner mobile teams in the area, as well as to coordinate with hotlines established by the protection cluster (under the Office of the United Nations High Commissioner for Refugees (UNHCR) and other partners); using the health cluster mechanism to link NGOs (also those not officially members of the cluster) working with the most affected communities;

(d) to use national and international standards, protocols and monitoring indicators to guide interventions and to unite partners around common tools;

(e) to ensure regular cluster updates covering activities of all health partners (also non-cluster partners);

(f) to identify and address gaps in the health sector;

(g) intercluster coordination especially with the protection, nutrition and water and sanitation (WASH) clusters; as many actions and projects in these sectors are impacting the health status and can help prevent disease outbreaks;

(h) the Health cluster should be inclusive of all relevant health actors;
(i) the Health Cluster Coordinator should keep a balanced position and, in close collaboration with the Ministry of Health, support evidence based health interventions and advocate health as a basic human right.

5. Ensure early warning and outbreak detection of communicable diseases

During this crisis, the international community relied on the Ministry of Health disease surveillance system. The established surveillance system is geared for regular disease monitoring under normal circumstances rather than including early warning functions as relevant in crisis situations (a long list of diseases and conditions is reported, with a monthly collection of data from health services and monthly, quarterly and annual reporting). In disasters and crises, an early warning system tailored to the particular crisis with a focus on diseases which could trigger outbreaks, trauma and injuries and other health priorities should be initiated by the Ministry of Health and health partners. Reporting, analysis and response should be done on a daily basis using Ministry of Health and partner-supported sites. Partners can provide logistics to ensure completeness and timeliness of reporting and can help the Ministry of Health in rumor verification and in initiating appropriate response measures. The population movement, outbreak of Anthrax in Jalal-Abad in June, the weaknesses in water and environmental sanitation and the ongoing outbreak of polio in Tajikistan are additional justifications to consider establishing and supporting such a system.

Operational strategies for early warning and outbreak detection are:

(a) to expand and improve reporting completeness and timeliness and strengthen the disease early warning system (DEWS) through inclusion of centres presently not reporting through training, logistic support and outreach;

(b) to ensure standardized guidelines and case definitions are applied system wide;

(c) to ensure rapid verification of outbreak rumours through analysis of data and rapid investigation and verification teams;

(d) to prepare contingency plans for major communicable disease outbreaks;

(e) to strengthen the response capacity – logistics, workforce, drug and vaccine supplies (the latest include provision of generators and fuel).

6. Mental health and psychosocial support

Psychological trauma was reported as the most important health issue in the southern Kyrgyzstan crisis. The inter-agency (WHO/UNICEF/UNFPA) health assessment carried out 30 June – 3 July 2010 recommended the prioritization of mental health and psychosocial support services. Children and adults require professional counselling and psychosocial support. Many of the affected population groups experience fear, anxiety and insomnia. Timely and effective provision of mental health support will reduce the risk of developing post-traumatic stress disorder (PTSD) and other severe mental health conditions. Access to mental health services is further aggravated by the shortage of trained child psychiatrists (only 8 professionals), all of whom are based in the capital. According to the Ministry of Health, there are about 145 state clinical psychologists and psychiatrists available in Osh and Jalal-Abad cities and oblasts, and in Bishkek, out of which 43 are employed in the south. Some are ready to be deployed to the south with mobile outreach teams.

According to an assessment in July 2010, 72% of all children have been subjected to psychological trauma, and many IDPs suffer from various forms of mental distress, trauma and depression. The mental health and psychosocial effects of the conflict, especially for women and children, represents yet another challenge for the health system. In general, it is estimated that 4% of the population is suffering from severe mental
(psychiatric) disorders, and a larger number from common mental health problems. A much larger portion of the population suffers from mental health problems linked to the stress triggered by conflict and violence.

**Operational strategies** for mental health and psychosocial support are:

(a) close collaboration between all actors supporting mental health and psychosocial support to avoid uncoordinated assessments, training and assistance;

(b) alignment by all partners with the national training protocols and international guidelines, including the Inter-Agency Standing Committee (IASC) guidelines on MHPSS;

(c) to create a core roster of MHPSS trained staff, which all actors can tap into for their training needs;

(d) to ensure **management of urgent psychiatric conditions at PHC level** including referral to psychiatric hospitals and **continuation of treatment of chronic** psychiatric patients;

(e) to support and organize referral of psychologically traumatized children to adequate psychological/psychiatric care;

(f) to ensure that **social measures** including access to reliable information, especially by vulnerable groups (widows, orphans, victims of violence etc.), access to schools by children as part of the management.

**Total funds requested:** US$ 7 778 148, of which only US$ 1 591 637 has been received so far. **Shortfall is US$ 6 186 511.**

Further information is available from the WHO Regional Office for Europe web site ([http://www.euro.who.int/emergencies](http://www.euro.who.int/emergencies)).
The WHO Regional Office for Europe

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