SWAT EARTHQUAKE RELIEF PROJECT

Phase II: Health Clinic Second Morbidity Report

Reporting period: April 16, 2015 – August 31, 2016
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I: BACKGROUND

1.1 Situational Background

On October 26, 2015, a magnitude 7.7 earthquake hit the Hindu Kush regions of Afghanistan and Pakistan. Due to the depth of the earthquake, the damage caused by its otherwise powerful tremors was controlled. However, the main quake was followed by 87 aftershocks, which along with the winter rains and snowfall, triggered a series of landslides in these mountainous regions, causing weakly structured houses built on hill slopes to collapse. 300 people died, 2,000 were injured, and nearly 59,000 houses were destroyed, rendering more than 600,000 people homeless.

The initial face of response was relief services. Augmenting the relief work by Pakistan government and military agencies, RMF Pakistan, with collaboration and funding from LDS, launched the Swat Earthquake Relief Project on December 1st, 2015 in District Swat. The two project sites were Mohalla Bhakharawan of Union Council Kabal, Tehsil Matta and Mohalla Akhonbaba of Union Council Shagai, Tehsil Saidu Shariff, District Swat. The project was divided into two phases:

Phase I entailed immediate relief services through three key objectives:

1) Provide winterized tents and blankets to 100 households
2) Provide uncooked food rations to 100 households for three months
3) Provide quality primary healthcare services to the local population of the project sites

All three objectives of Phase I of the project were successfully achieved by mid-March 2016.

Phase II of the project was to assist in the repair and rebuilding of houses damaged and destroyed by the earthquake. Phase II of the project, referred to as the Swat Housing Project was launched in June 2016.

Phase II does not include a health service component. However, during our first four months of implementation, RMF has observed that the local population in and around the field sites where we have worked is very poor and vulnerable, with limited or no access to health care. They need a continuation of this service.

What makes RMF unique is the characteristic of continuing to help communities long after the world’s spotlight has faded; we leave only when the community is self-sufficient or the government is ready to take over. Based on this approach, RMF Pakistan continues to provide this health service from our core funds until we can find suitable grants.

1.2 Health Clinic Set-Up

For selection of a clinic site, RMF’s policy is to choose a site outside of a minimum 20 km radius from the nearest health facility. Therefore, during Phase I of the project, our clinic was located in the remote village of Laloo Bandee, UC Bandai, Tehsil Kabal, where the nearest health facility is beyond a radius of nearly 20 km. The clinic was housed in the center of the village, with a team composed of a male doctor, a female doctor, a medical technician (who also worked as the pharmacist), a cleaner, and a security guard. As per RMF’s hiring policy, all the staff was from the surrounding local areas.

Procurement of clinic furnishings and medical equipment was limited, as we took several unused items from our existing inventory at the Nowshera Health Clinic. Medical supplies, transported via road to Swat, were procured from our Peshawar based vendor who has been supplying us with medicine for the Nowshera Health Clinic for the past two years.

1.3 Clinic Location

In Phase I, the clinic remained static in the selected location of Mohalla Laloo Bandee. After the end of Phase I, we decided to move to an area that was more in need of heath care. The snowball technique of gathering information was employed. The doctor in charge was given this responsibility, and being a local resident of the area, gathering this information was not a difficult task. Often, people of the community approach the doctor and inform him of families or persons who are in need of health care, but are unable to travel long distance.

In early April 2016, the clinic was moved to a makeshift camp in the village of Takhta Banda, Union Council Odigram, Tehsil Saidu Shariff. The clinic remained operational in this makeshift camp from mid-April to the end of May 2016. After serving this village for 6 weeks, the clinic location was once more changed. Following the same mechanism mentioned above, it was moved into a more solid structure in the nearby village of Odigram, Union Council Odigram, Tehsil Saidu Shariff. The clinic is still in this location as of August 31st, 2016. In August 2016, the husband and wife doctor team running the clinic resigned to join the local government hospitals. In replacement, we have a female doctor and a lady health visitor (LHV) to serve the patients.

II: MORBIDITY REPORT APRIL–AUGUST 2016

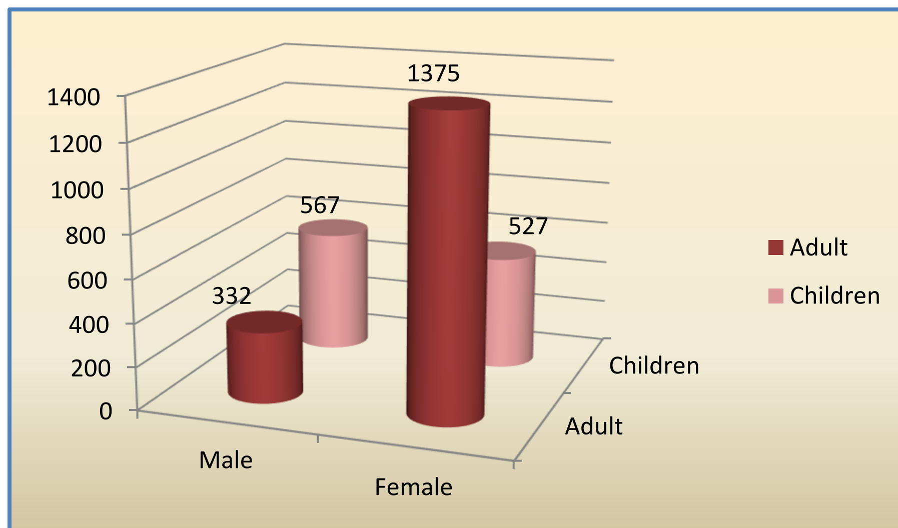
This second morbidity report covers four-and-a-half months: from April 16th to August 31st, 2016. The daily clinic operating hours were observed: 8:00 AM to 5:00 PM, Monday to Saturday. Sunday is a day off and Friday is a half-day, in line with religious demand for Friday afternoon prayers, which are considered sacred.

2.1 Demographic Distribution

Over the period of four-and-a-half months, with an average daily OPD of 25–30 patients, a total of **2,801 men, women, and children** from UC Odigram, Tehsil Saidu Shariff and its surrounding areas were provided with primary health care (PHC) and maternal and child health care (MCH) services.

The clinic treated 1,701 adults (60.7%) and 1,094 children (39.3%). Women constituted the majority of adult patients, at 1,375 (80.8%), as compared to men at 332 (19.2%). Among the children, the number of female and male patients was somewhat equal, at 567 and 527 boys and girls, respectively.

AGE AND GENDER DISTRIBUTION OF PATIENTS



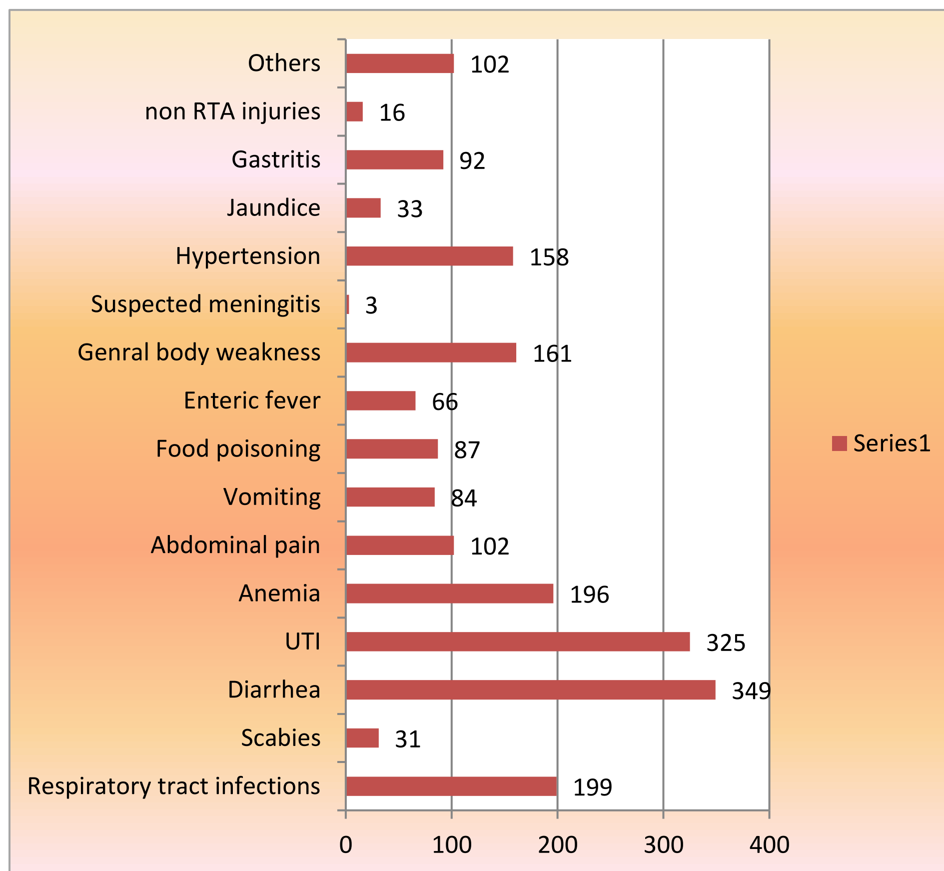
2.2 Primary Health Care Statistics

A total of 1,989 men, women, and children sought primary healthcare services. The most commonly presented illness overall during this four-and-a-half-month period was diarrhea at 17.5%, which is in keeping with the summer months and greater intake of water based drinks from all kinds of sources. A large number of these cases were children.

The second most commonly presented illness was UTIs at 16.3%, and nearly all the complainants were women. This can be attributed to a lack of hygiene, consistent with their dire living conditions. The third most common illnesses were anemia at 9.8% and respiratory infections at 10%. Anemia was deduced clinically, as lab investigations at this level are not possible, unlike our Nowshera Health Clinic, which has a pathology lab.

General body weakness was the fourth most common illness presented, at 8% of patients. As discussed in our first morbidity report, this is not an actual category of illness, but with our experience of health services in Pakistan over the past 10 years, this is a commonly presented symptom. Such cases often have no accompanying symptoms. Our conclusion is that psychological stress is manifested in many ways, and the words “general body aches and weakness” best describe the feeling of malaise and lethargy associated with depression. Our response to this, over the years, has graduated from initial rejection of complaint to using the placebo effect, whereby we prescribe multivitamins which will improve patients’ health. This has proven to be quite successful in the past.

Additional common illnesses presented at the clinic are also represented in the graph below. Rare or occasional illnesses presented are categorized as “other.”

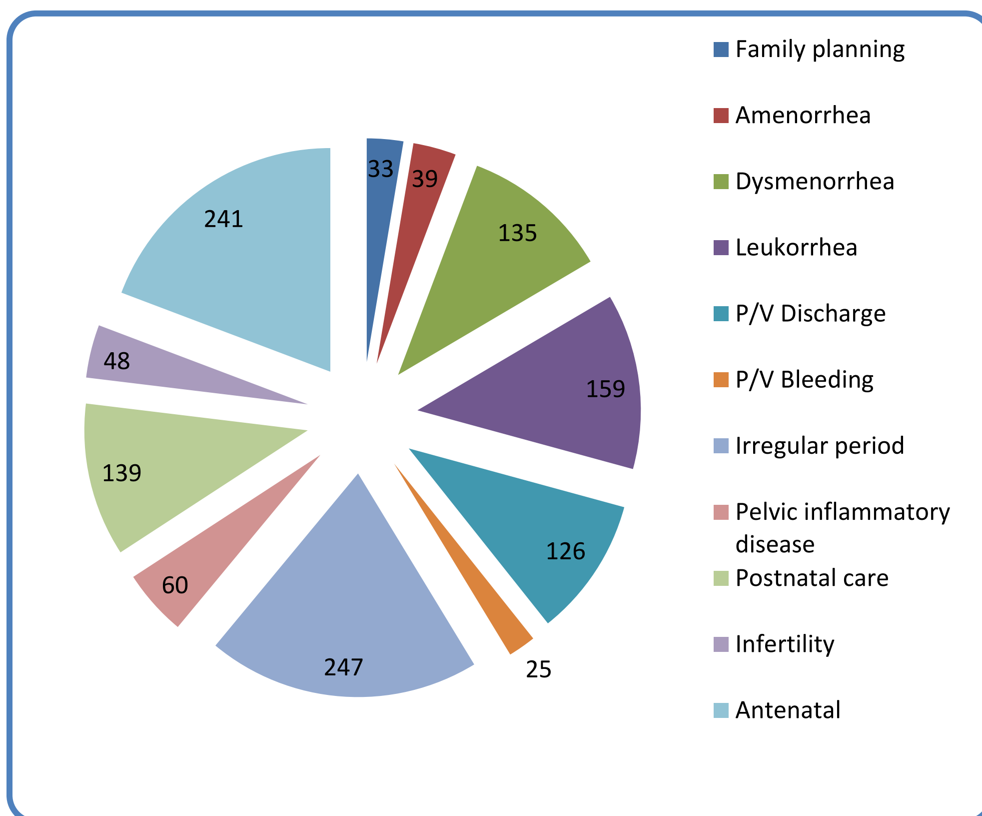


2.3 Maternal and Child Health Care Statistics

A total of 1,231 women and children sought MCH services. Antenatal care was provided to 220 pregnant women (22.7%) and postnatal visits by were sought by 139 lactating mothers (14.3%). Family planning services were offered to 33 women (3.4%).

Of the gynecology and obstetrics pathologies presented, the most common complaint was irregular periods: 247 women (25.5%), followed by complaints of abnormal leukorrhea by 159 women (16.4%). Dysmenorrheal complaints were the third most commonly presented cases: 135 women (13.9%).

The trends of these complaints vary in different months and in different locations. Other pathologies and their numbers reported at the clinic are represented in the graph below:



For additional details, please refer to the Annex.

III: ANNEX

Swat District Real Medicine Clinic: April 16 – August 31, 2016							
	Patients	**Mid-April**	**May**	**June**	**July**	**August**	**TOTAL**
1	Female	191	346	302	244	292	1,375
	Male	31	149	56	58	38	332
	Total Adults	**222**	**495**	**358**	**302**	**330**	**1,707**

2	Children (Male)	75	123	102	91	176	567
	Children (Female)	66	139	98	103	121	527
	Total Children	**141**	**262**	**200**	**194**	**297**	**1,094**
	Total Patients	**363**	**757**	**558**	**496**	**627**	**2,801**
	PHC Descriptions	**Mid-April**	**May**	**June**	**July**	**August**	**TOTAL**
1	Respiratory Tract Infections	36	67	27	34	35	199
2	Scabies	8	11	3	3	6	31
3	Diarrhea	21	51	108	71	98	349
4	UTI	33	61	77	65	89	325
5	Anemia	23	44	48	36	45	196
6	Abdominal Pain	16	25	21	33	7	102
7	Vomiting	7	21	11	21	24	84
8	Food Poisoning	3	17	34	12	21	87
9	Enteric Fever	8	14	8	19	17	66
10	General Body Weakness	19	35	66	24	17	161
11	Suspected Meningitis	0	2	0	1	0	3
12	Hypertension	21	32	46	26	33	158
13	Jaundice	3	4	12	6	8	33
14	Gastritis	13	24	31	22	2	92
13	Non-RTA Injuries	0	8	1	5	2	16
14	Other	15	20	19	26	22	102
	Total PHC	**211**	**436**	**512**	**404**	**426**	**1,989**
	MCH Descriptions	**Mid-April**	**May**	**June**	**July**	**August**	**TOTAL**
15	Family Planning	7	8	3	10	5	33
16	Amenorrhea	0	13	12	0	14	39
17	Dysmenorrhea	24	24	31	33	23	135
18	Leukorrhea	47	38	19	37	18	159
19	P/V Discharge	21	46	14	34	11	126
20	P/V Bleeding	1	8	3	3	10	25
21	Irregular Period	36	67	87	42	15	247
22	Pelvic Inflammatory Disease	3	34	3	0	20	60
23	Postnatal Care	21	28	39	19	32	139
24	Infertility	15	18	9	6	0	48
25	Antenatal	40	42	45	30	63	220
	Total MCH	**215**	**326**	**265**	**214**	**211**	**1,231**