2024

Mobile Health Team Badin Under Monsoon DREF Operation'24

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HEALTH DEPARTMENT PRCS SINDH

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A. Brief Description of Project

A. Project Title	Mobile Health Team under Monsoon Disaster Relief Emergency Fund'24
B. Period	11th October to 9th November'24
C. Donor/ Partner (if any):	International Federation of Red Cross & Norwegian Red Cross
D. Project manager/ Focal person:	Health Coordinator PHQ (Dr Hira Aftab)
E. Geographical coverage:	District Badin, Sindh
F. Reporting person(s):	Health Coordinator PHQ (Dr Hira Aftab)
G. Reviewed/ vetted by:	Provincial Secretary

B. Executive Summary

The monsoon season of 2024 has led to severe flooding across Sindh, especially impacting urban areas such as Dadu, Naushahro Feroz, Jacobabad, and Sukkur. As of September 2, 2024, the National Disaster Management Authority (NDMA) reported extensive destruction, including 40 bridges, 119 kilometers of roads, and 20,653 houses, which resulted in 306 fatalities, 584 injuries, and the displacement of approximately 9,500 people in Sindh. Floodwaters also submerged 58,789 acres of cultivated land, damaging vital crops like rice, tomatoes, and chickpeas, and causing the loss of 1,100 livestock, which significantly impacted the livelihoods of rural communities. The Sanghar district reported the displacement of 9,524 individuals, including 4,867 children. In addition to the damage caused by the flooding, tropical cyclones affected the coastal regions of Sindh, particularly Thatta, Sajawal, Mirpur Khas, and Badin, leading to severe rainfall and winds from August 29 to 31. This caused damage to villages, canals, and infrastructure, displacing many residents.

As an essential partner to the government, PRCS has been instrumental in addressing critical gaps and delivering urgent emergency relief to affected communities. Following detailed impact assessments and recognizing the urgent health needs, particularly in Badin, PRCS initiated a 26-day mobile health camp to provide vital primary healthcare to populations isolated from essential services. This report outlines the geographic scope of the mobile health response, the progress made toward established targets, and the key lessons learned throughout the process. It highlights the significant impact of PRCS's intervention and the continued efforts to reduce the health consequences of the ongoing disaster.

C. Geographic Coverage of Mobile Medical Services

During the 26-day deployment under the Monsoon DREF'24, the Pakistan Red Crescent Society (PRCS) Mobile Health Team provided critical healthcare services across 15 union councils and 26 villages or clusters of villages, obtained after consultation with District Branch Representatives, District Health Officer and based on recent Needs Assessment.

These areas, severely affected by the recent monsoon rains, faced significant challenges in accessing healthcare. Many of the locations were remote, with limited or non-existent primary healthcare services. Moreover, no other humanitarian actors were operating within these areas, and government primary health coverage was minimal, if not absent. The deployment strategy targeted these vulnerable, underserved communities to bridge the healthcare gap and ensure essential medical services reached those in critical need.

Table 1.1 depicts the list of Union Councils and Villages of mobile medical coverage in Badin:

S No	Union Councils
1.	Oleya Jarkus
2.	Abdullah Shah
3.	Chakar Panwhar
4.	Behdami
5.	Fatehbad
6.	Taraie
7.	Ghulam Shah
8.	Dodo Soomro
9.	Bughrha Memon
10.	Fazil Raho
11.	Peero Lashari
12.	Paharh Maree
13.	Gharho
14.	Seerani
15.	M Khan Burgrhi

S No	Villages
1.	Ishaque Bhounrio
2.	Ghulam Fareed Solangi
3.	Budhon Dasti
4.	Mohd Ali Solangi
5.	Chakk 22 Village Ali Hassan Norhio
6.	Chakk 3 Mir Mohd Norhio
7.	Ismail Odejho
8.	M Mithan rahokrho
9.	Haji Aalam jamali
10.	Gul Mohd Lund
11.	Ghaji Mallah
12.	Menh wasayio Mallah
13.	Haji Abdullah Jat
14.	Safar Maallah
15.	Umer Chandio
16.	Ab Wahid Buledi
17.	M Umer Soomro
18.	H Soomar mallah
19.	Miharan Mallah
20.	Ahmed Khaskheli
21.	Ali Bux Panwher
22.	Chak 36 Hussain Abad
23.	Ismail mallah
24.	Kando Faqeer
25.	Siddique Khoso
26.	Ghino Kolhi

D. Quantative Section (Activity Wise Beneficiary Detail)

Table 1.2: Below table provides a breakdown of beneficiaries who received outpatient consultations from both male and female doctors of the Mobile Health Team.

Out Patient Consultation				
Date	Male	Female	Child	Total
11-Oct-24	61	83	60	**204**
12-Oct-24	31	57	76	**164**
14-Oct-24	71	105	44	**220**
15-Oct-24	82	90	58	**230**
16-Oct-24	66	63	14	**143**
17-Oct-24	48	52	56	**156**
18-Oct-24	45	48	35	**128**
19-Oct-24	37	53	46	**136**
21-Oct-24	40	89	28	**157**
22-Oct-24	32	51	34	**117**
23-Oct-24	20	46	35	**101**
24-Oct-24	22	70	29	**121**
25-Oct-24	58	52	26	**136**
26-Oct-24	28	48	23	**99**
28-Oct-24	35	41	37	**113**
29-Oct-24	38	30	19	**87**
30-Oct-24	46	41	9	**96**
31-Oct-24	36	41	30	**107**
1-Nov-24	23	39	25	**87**
2-Nov-24	42	35	35	**112**
4-Nov-24	9	72	21	**102**
5-Nov-24	28	32	30	**90**
6-Nov-24	42	48	12	**102**
7-Nov-24	74	83	48	**205**
8-Nov-24	78	170	45	**293**
9-Nov-24	93	74	72	**239**
Total	1185	1613	947	3745

Table 1.3: The table below presents a breakdown of beneficiaries who received daily health awareness and key messages on critical topics related to the flood impact. Topics covered included prevention of vector-borne and waterborne diseases, along with essential hygiene practices aimed at reducing health risks associated with flooding.

	HEALTH PROMOTION AND AWARENES			
Date	Male	Female	Child	Total
11-Oct-24	0	22	17	**39**
12-Oct-24	15	16	12	**43**
14-Oct-24	50	22	33	**105**
15-Oct-24	23	60	29	**112**
16-Oct-24	25	38	30	**93**
17-Oct-24	30	32	35	**97**
18-Oct-24	40	28	48	**116**
19-Oct-24	**22**	**35**	**33**	**90**
21-Oct-24	**23**	**40**	**36**	**99**
22-Oct-24	**25**	**28**	**29**	**82**
23-Oct-24	**0**	**20**	**12**	**32**
24-Oct-24	**16**	**35**	**29**	**80**
25-Oct-24	**25**	**22**	**60**	**107**
26-Oct-24	**18**	**28**	**30**	**76**
28-Oct-24	**0**	**20**	**14**	**34**
29-Oct-24	**15**	**21**	**18**	**54**
30-Oct-24	**16**	**15**	**23**	**54**
31-Oct-24	**22**	**25**	**26**	**73**
1-Nov-24	**0**	**25**	**16**	**41**
2-Nov-24	**25**	**25**	**36**	**86**
4-Nov-24	**0**	**20**	**12**	**32**
5-Nov-24	**18**	**20**	**17**	**55**
6-Nov-24	**30**	**30**	**30**	**90**
7-Nov-24	**22**	**35**	**28**	**85**
8-Nov-24	**25**	**38**	**32**	**95**
9-Nov-24	**0**	**42**	**20**	**62**
Total	485	742	705	1932

Table 1.4: This section outlines the common disease conditions observed among patients presenting at the medical camps. In the absence of rapid diagnostic kits or specialized equipment, diagnoses were primarily determined based on the clinical acumen of the attending doctors, utilizing thorough patient history and physical examination to establish differential and final diagnoses.

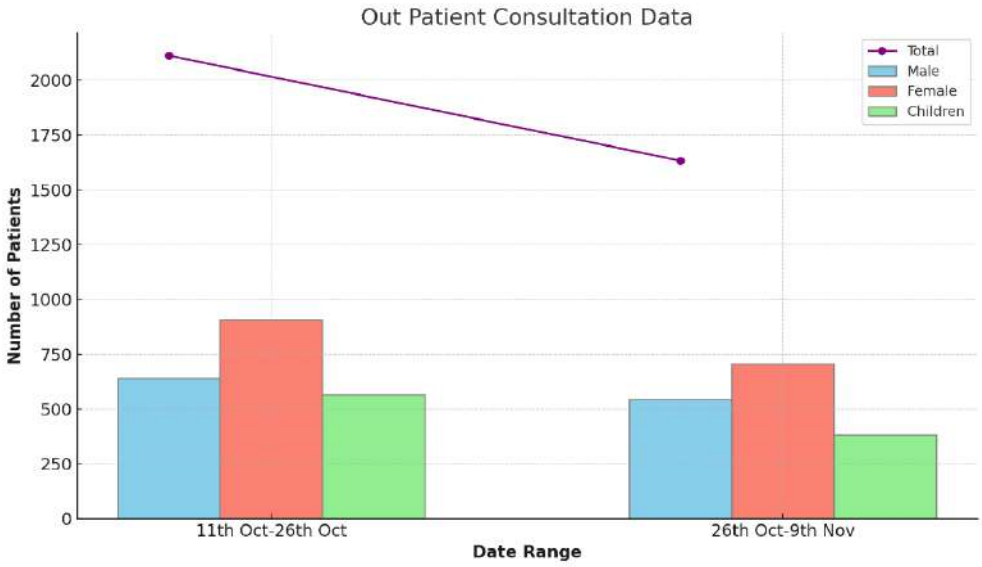
Disease/Condition	Cases
Acute Upper Respiratory Tract Infection (>5 years)	630
Acute Upper Respiratory Tract Infection (<5 years)	326
Diarrhea (>5 years)	198
Diarrhea (< 5 years)	156
Suspected Malaria	143
Scabies / Skin Conditions	462
Others (Chronic Diseases DM,HTN, Anemia, Arthritis etc)	943

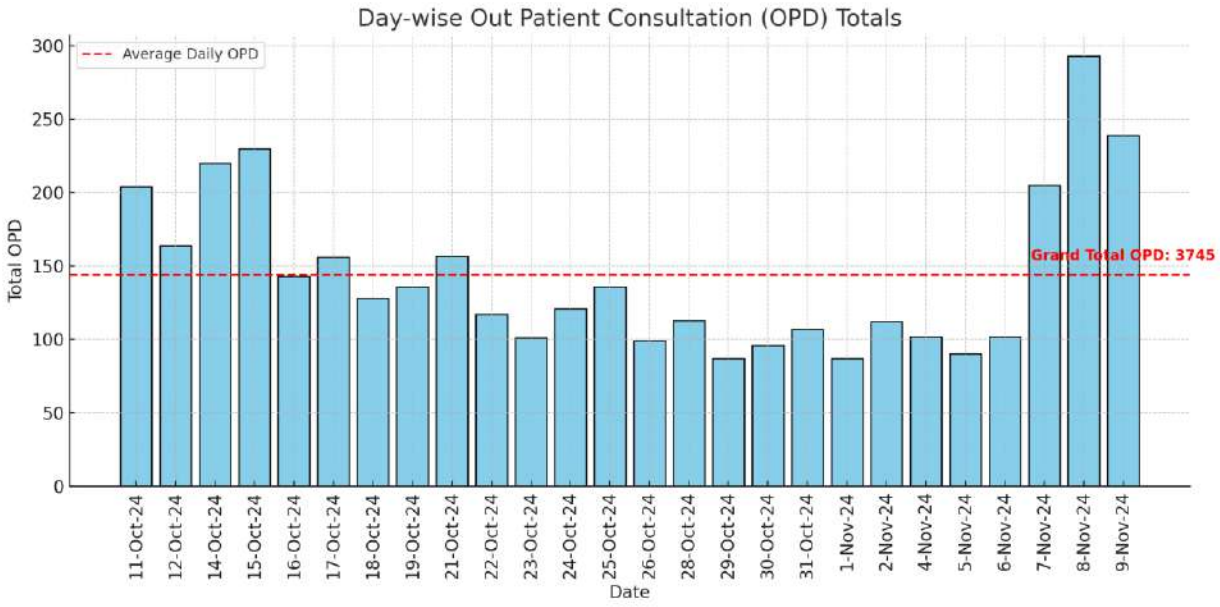
E. Narrative Section (Analysis against Projected Targets)

Planned Intervention	Target	Achieved
Number of mobile health service units functional to provide quality primary healthcare.	1	1
Number of people reached, assisted with emergency health care and medical treatment through RCRC primary healthcare services	4500	5677*

* Under RCRC primary health care via outreach services 3745 individuals were reached with outpatient consultation and 1932 reached with health promotion and education.

The PRCS Mobile Health Team's deployment under Monsoon DREF'24 effectively reached underserved, flood-affected areas in District Badin, surpassing the cumulative target of 4,500 beneficiaries. Through the RCRC movement's approach to providing emergency and mobile medical services, the team offered outpatient consultations and health promotion activities to address gaps in healthcare stemming from weak infrastructure, limited climate resilience, understaffing, and shortages of essential medicines. The team, consisting of male and female doctors, social mobilizers, a dispenser, two volunteers (one male and one female for crowd control), and a data entry operator, provided a culturally sensitive, gender-balanced model of service delivery in line with local norms in Sindh. Over the deployment period, the team exceeded targets by delivering primary healthcare services to a total of 5,677 individuals.





The graphs provide insights into patient demographics and daily OPD trends during the operation. The first graph shows patient data segmented into two periods: October 11–26 and October 26–November 9, while the second graph displays day-to-day patient footfall along with the average OPD over the 26-day period.

ANALYSIS:

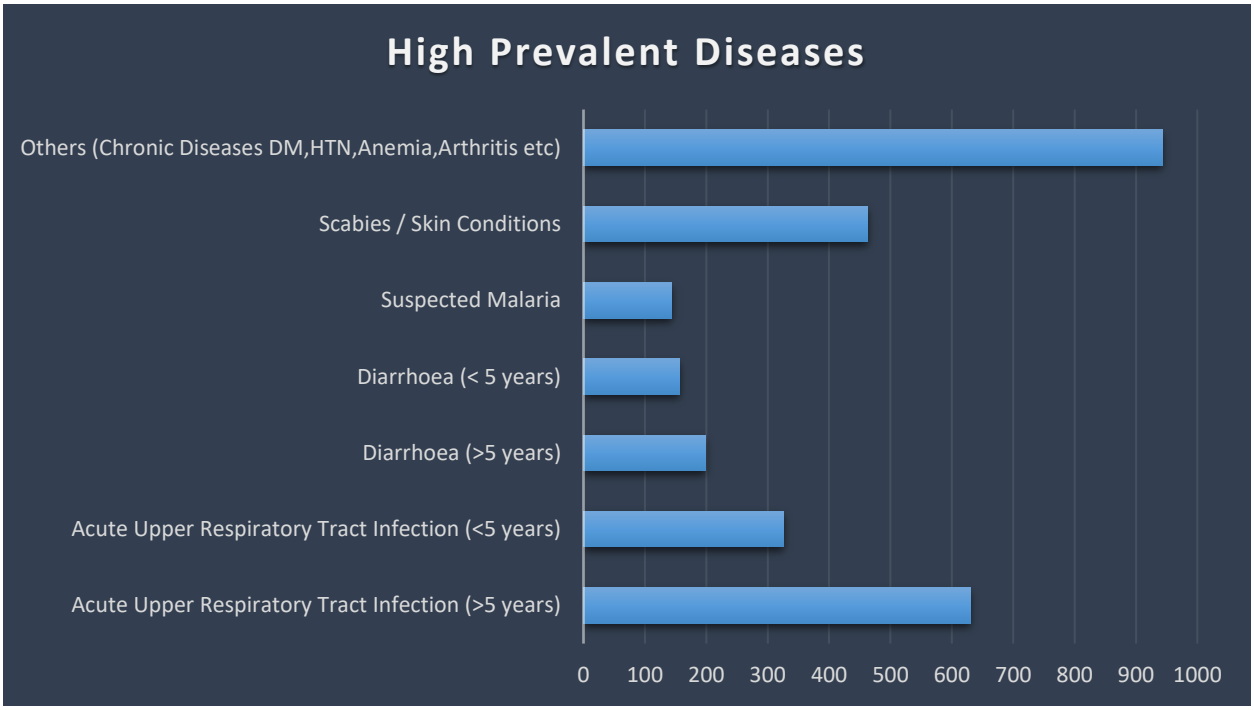
Initial Surge and Subsequent Decline: OPD numbers initially exceeded 250 patients per day, reflecting the significant demand for healthcare services in affected communities. However, as the stock of essential medicines, particularly pediatric medications, began to deplete, the team

had to manage OPD numbers more cautiously. This was done to ensure that resources could sustain the full 26-day deployment period without running out of critical supplies.

Average Daily OPD and Stock Constraints: The average daily OPD count, marked at around 150 consultations, reflects this careful adjustment. The decline in OPD numbers in the latter half of the deployment period is directly related to the need to conserve medicines. This decision highlights the challenge of balancing healthcare demand with limited resources, especially in emergency deployments.

Impact of Seasonal and Occupational Factors: The decrease in total OPD between the two periods may be partly attributed to seasonal factors, particularly the rice cultivation season. During this period, male community members were often engaged in fieldwork, especially during the peak morning hours. Since the mobile health team operated from 9:00 a.m. to 5:00 p.m., with peak service hours between 9:30 a.m. and 3:00 p.m., this timing likely affected male attendance, reducing their participation in consultations.

Demographic Breakdown: Throughout both periods, female patients consistently outnumbered male patients, and children had lower consultation numbers due to limited pediatric stock availability. This demographic distribution highlights the need for targeted stock planning, as pediatric medicine shortages impacted the team's ability to fully serve the younger population.



ANALYSIS:

This graph provides an overview of the most prevalent diseases encountered by the PRCS mobile health team during the Monsoon DREF Operation 2024 in District Badin. The disease distribution reflects the diverse healthcare needs that arose in the aftermath of heavy monsoon rains, impacting various age groups and revealing specific health vulnerabilities.

1. **Chronic Conditions (represented by 'Other Diseases' in reporting data base)**: Chronic diseases such as diabetes mellitus, hypertension, anemia, and arthritis/chronic pain represent the highest category, with nearly 1,000 cases. This high prevalence suggests limited access to routine healthcare for managing chronic conditions in the affected communities. The crisis focus led to a disruption in continuity of care for non-communicable diseases. Even nearby health facilities faced staff shortages and lacked essential medications for chronic ailments, resulting in unmet healthcare needs for these patients.
2. **Respiratory Infections**: Acute upper respiratory tract infections (URTI) in patients over 5 years were highly prevalent, with approximately 600 cases, while URTI in children under 5 also had a significant count. These infections are likely attributed to the changing weather patterns and increased humidity following the monsoon rains. Respiratory infections demand immediate attention, as they may worsen in unhygienic conditions and overcrowded areas.
3. **Skin Conditions (Scabies)**: Cases of scabies and other skin conditions were also notably high, likely due to prolonged exposure to floodwater and limited access to hygiene resources. This is common in post-flood situations, where water stagnation and reduced sanitation increase the risk of skin infections.
4. **Suspected Malaria**: Malaria cases were significant, reflecting the increased mosquito breeding due to standing floodwater, which provided ideal conditions for mosquito proliferation. The high number of suspected malaria cases underlines the need for vector control and preventive measures in such emergency settings.
5. **Diarrheal Diseases**: Diarrhea, especially in children under 5, was prevalent, which may be linked to contaminated water sources following the floods. The lack of safe drinking water and hygiene facilities, contributes to the spread of diarrheal diseases, posing a severe risk, particularly for young children.

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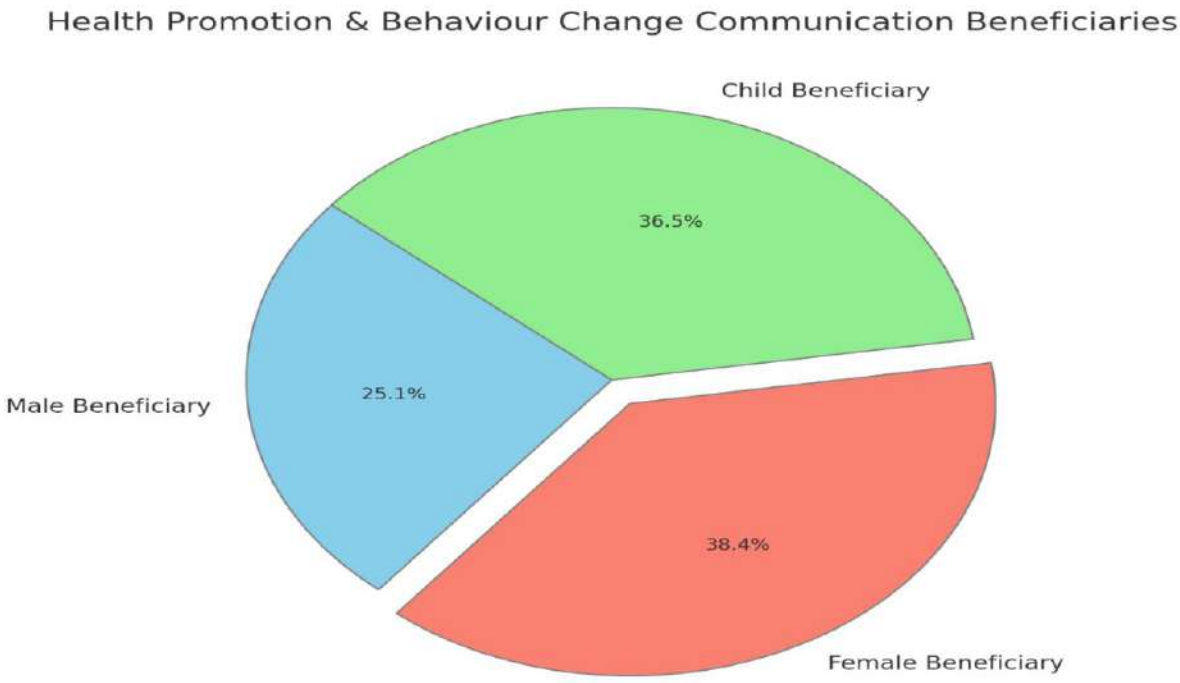


The mobile health team's focus on health education and behavior change in an area at high risk of climate impacts is crucial. Through daily awareness sessions on topics like water & vector-borne disease prevention, hygiene, first aid, mother and child nutrition and immunization, the team aimed to empower community members to adopt healthier practices and reduce preventable illnesses. Such efforts help alleviate the strain on an already overstretched health system and build community resilience against future health challenges.

ANALYSIS:

Female Beneficiaries (38.4%):

- The highest proportion of beneficiaries were female, reflecting the team's focus on engaging women, who often play a central role in household health and caregiving. Educating women on disease prevention, personal hygiene, and managing common illnesses like diarrhea can have a cascading effect, as they are likely to apply this knowledge within their families and communities.

Child Beneficiaries (36.5%):

- Children formed a significant portion of the beneficiaries, underscoring the importance of instilling healthy habits early. Topics like routine immunization, personal hygiene, and

disease prevention are critical for reducing disease risk in children, who are particularly vulnerable to vector-borne and waterborne illnesses. This outreach also supports building a foundation for long-term health resilience in these communities.

Male Beneficiaries (25.1%):

- Although men represented the smallest proportion of beneficiaries, their inclusion is vital, especially in rural areas where men may be decision-makers regarding household practices and health expenditures. The sessions aimed to raise awareness among men about the importance of preventive health measures and safe practices, which can reduce the overall burden on the local health system.

F. Monitoring & Coordination

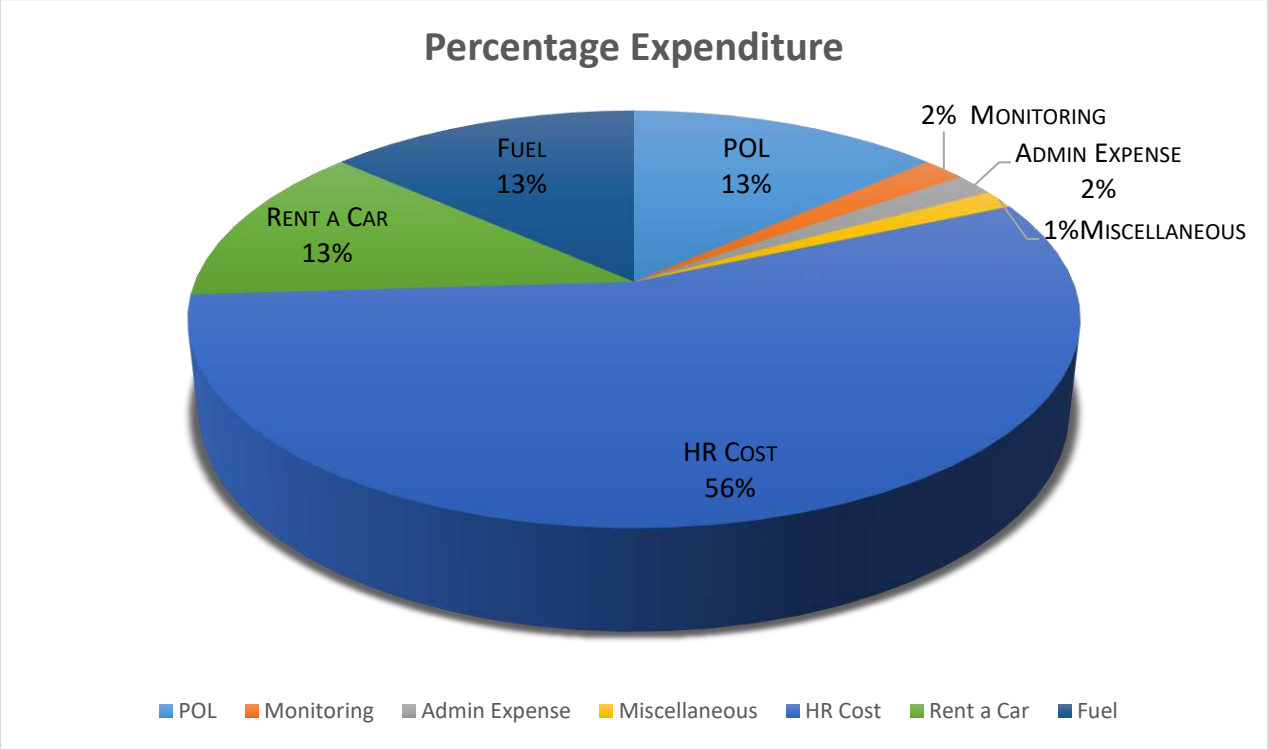
Although the deployment of the Mobile Health Team (MHT) was a short-term intervention aimed at mobilizing resources to deliver immediate assistance in flood impacted areas of Badin, robust monitoring and coordination efforts were integral to its success. Over the course of the 26-day operation, two essential monitoring visits were conducted to ensure alignment and enhance local coordination.

The first visit was led by the Assistant Director of Health from the NHQ, who provided an introductory briefing to the local team and facilitated coordination with the District Health Office (DHO) to support targeted area selection.

The second monitoring and coordination visit was conducted by the Provincial Headquarters (PHQ) team, including the Health Coordinator and Branch Development Officer. During this visit, the PHQ team reviewed MHT ground operations, assessed challenges, and noted the team's progress, offering constructive feedback. Meetings were also held with the Branch Secretary and DHO to reinforce support for MHT activities, promote data sharing, and ensure continued collaboration. For a comprehensive account of the monitoring activities, please refer to the "MHT Badin Monitoring Report".

In addition to these visits, the team held regular meetings with the Assistant District Health Officer (ADHO), District Health Officer (DHO), and District Branch Secretary. The District Branch Secretary also visited the camp site, offering support and reinforcing local ownership of the MHT activities.

G. Financial Reporting



From the first tranche of funds, amounting to PKR 900,000, 100% of the allocated funds were utilized, with an additional 23% overspent. This overspending will be reconciled upon receipt of the second tranche of funds from NHQ. For a comprehensive financial overview and detailed summary, please refer to the financial report of the Mobile Health Team in Badin.

H. Challenges/Recommendations/Lessons Learnt

Stock and Supplies for Mobile Medical Coverage:

It is essential that the stock and supplies for mobile medical coverage are tailored to the specific needs on the ground. This includes ensuring a standardized mix of essential equipment, particularly rapid diagnostic tools. In addition to medicines, the supply list should be guided by a thorough needs assessment, disease prevalence data, and demographic information, ensuring alignment with actual field requirements. Headquarters should ensure that branches are equipped with standardized stock, and decentralized preparedness stocks must be in place to address potential gaps in supply distribution.

Human Resource Limitations:

The district and provincial branches are currently operating with limited staff, which poses a significant challenge in managing emergency health responses. It is critical to not only build

the capacity of the existing staff in emergency health management but also to prevent staff burnout. Based on needs, strategic investments from donors and HQ are necessary to strengthen human resource capabilities, particularly in key areas such as data management, PMER (Planning, Monitoring, Evaluation, and Reporting), inventory management, and warehousing. Enhancing these functions will ensure efficient operations and more effective outputs during emergencies, improving overall response capacity.

Planning Thoroughness:

While emergency operations demand a swift response, it is crucial that planning is thorough and comprehensive. Provincial and national-level staff must be well-aligned and properly oriented on their tasks to ensure confidence in their ability to deliver an effective and high-quality response. The coordination of medicine supply, dispatch, and finalization should be carried out in close consultation with the branch, as local teams are best positioned to assess and communicate on-the-ground needs and potential challenges.

Challenges Associated with Hiring Short-Term Staff:

Hiring staff for emergency health responses presents several challenges, particularly in securing personnel who meet both the technical and behavioural competencies required for effective service delivery. In many cases, the urgency of the emergency makes it difficult to identify and on board the right candidates quickly. Additionally, training short-term staff during an emergency phase is also difficult. To mitigate these issues, the National Society should prioritize building a pool of trained human resources that can be deployed in such scenarios. Alternatively, establishing Memoranda of Understanding (MoUs) with the Ministry of Health (MoH) to source ad hoc staff, with PRCS covering human resources and operational costs for these short-term deployments, could provide a sustainable solution. This would ensure that qualified staff are readily available for emergency response operations.

Local Solutions:

Implementing locally-driven programs that integrate both soft and hard components of service delivery is essential for achieving a balanced and sustainable impact. Ensuring the continuity of such health programs, in collaboration with district branches and local stakeholders, can significantly reduce public health risks and improve community resilience. Examples include community-based disease surveillance, disease screening camps, and periodic camps for the management and early detection of non-communicable diseases (NCDs). These initiatives create an infrastructure for ongoing health monitoring and response at the local level, ultimately strengthening public health outcomes.

I. *Annexure:* Supporting documents include:

- Pictures/Videos
- Monitoring Report
- OPD data base

J. Pictures Gallery:

Outpatient Consultations:

Dispensing Free Medicines to Camp Patients:

Separate Waiting Areas & Queues:

Health Education & Dissemination of Key Messages:

Monitoring & Coordination: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