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West Aceh, Indonesia

Inter-agency rapid health assessment

End of mission report, from the offshore platform - USS Abraham Lincoln

Introduction

1. Following the December 26 disaster, damaged roads, a devastated physical and human infrastructure and limited air assets posed huge challenges to early aid efforts. A systematic, detailed overview of the impact of the disaster on people's well-being had not been possible. Recently, under the overall guidance of the UN Co-ordinator for Sumatra, an inter-agency rapid health assessment team was formed. The team's objective was to acquire a first-hand picture of events on the ground and advance the collective understanding of the situation. The GoI and its partners can use this assessment to better define targets for relief and implement further lifesaving and life sustaining assistance while laying the foundations for recovery. To overcome logistical constraints and security concerns, the team based itself on a mobile offshore platform, the aircraft carrier USS Abraham Lincoln. The team did not carry out assessments in the Banda Aceh area, given the number of agencies in that region. Instead, the focus was on the hard-hit area south of Banda Aceh along the coast to Alue Bilie. The inter-agency team comprised 34 people with diverse but complimentary skills and experience. The team was drawn from the following agencies: Government of Indonesia (TNI), Ministry of Health, US Military, USAID, OFDA/DART, AusAID, CDC Atlanta, WHO, OCHA, UNICEF, UNHCR, WFP, SCF UK and IRC.

2. This summary report and its associated recommendations should be viewed as a work in progress. The team has based its findings on 25 field missions and ongoing detailed discussions with the Government of Indonesia, MOH, UN, NGOs, combined military forces and local people. As best we can, we have tried to shape our recommendations in a manner that is relevant to the response plans of the GOI, the international community (civilian and military) and local actors. The recommendations aim to improve service provision by steering the international response towards appropriate programming without undermining recovery activities.

Key findings and situation update

3. Nearly four weeks after one of the largest earthquakes in recent history, which destroyed virtually every village and town on a coastal zone lying below 10m elevation, extending 3-5km inland, the West Coast of Aceh continues to receive aid and assistance in a chaotic manner. The exact number of dead is still unknown. TNI estimates (which are broadly in line with our crude estimations) indicate that 34,000 people, or 3.5% of an original population of 961,000, have perished. Towns lying near the coastal zone have been decimated and the internally displaced population within the district is estimated at 125,000. The IDP population continues to be mobile, moving out of family homes to community shelters or away to other areas in Aceh, depending on their level of trauma or access to resources. This makes it difficult for the authorities or agencies to accurately count and target the population.

4. Despite the continued absence of a systematic response to the multiple needs of this population, there is some good news. Instances of malaria, measles, and watery diarrhea are significantly lower then expected. Food stocks, though limited in protein and calorie density, are reaching most large population groups via civil authorities and the Indonesian military. Schools are ready to re-open in a few areas and local foods have begun to re-appear in local markets.

5. To protect these fragile gains, many issues must be addressed. Despite their best intentions, local and international NGOs, largely operating on an ad hoc basis, need to better coordinate so that their efforts bolster the primary health care system and other essential sectors.

6. The timely rehabilitation of community health centers is crucial, as is a demand-based logistics system to place drugs and medical equipment within those centers. Equally important is the mobilization or training of new staff to replace the many health workers who died. Temporary health clinics, which are being staffed by international and local volunteers at intermittent hours, need to cede this role to others: either large NGOs that can provide services on a longer-term basis - consistent with the expressed needs of the population; or a gradual transfer of these responsibilities back to local health authorities. In particular, while most general health needs are being addressed, there remains a significant dearth of providers who can give maternal and child health care. Throughout the assessment area, women who had delivered babies within two weeks after the tsunami had to depend on either untrained family members or traditional birth attendants. This is an unacceptable increased risk to the reproductive health of women.

7. Sanitation is also a significant concern, particularly because the rainy season will continue for two months and virtually no viable waste disposal systems exist throughout the region. This has become one of the most pressing health concerns. Clean water is available, but not at the quantities needed by the population. However, since there are multiple water systems being used, such as wells, rivers, bottle water and tanks, there exists the possibility of increasing water supplies to within acceptable limits in a short period of time. More troubling (and less suitable to a ‘quick fix’) is the devastated road network. In particular, the reconstruction of bridges, which will require both considerable time and

manpower, remains urgent. These roads are necessary alternatives to the current aid airlifts and crucial to an unobstructed flow of goods to the devastated areas.

8. No master list currently exists that details the overall medical supplies and drugs being provided to interim health posts. This has resulted in shortages of materials like wound dressing kits, stethoscopes, delivery kits for safe birth and other common supplies. Oralit, amoxicillan and paracetamol are available in large quantities. One common complaint we received was that NGO groups brought in only enough supplies to treat clients but did not leave behind any supplies or medical tools when they left, rendering the community health care centers unable to treat patients. Other than medical equipment, non-food items such as hygiene products for women, laundry detergent and body soap have similarly not been delivered in sufficient quantity.

9. A key intervention that helped these devastated populations escape a secondary disaster was the timely deployment of military assets. These assets were made available to the Indonesian government and international aid agencies early on in the crisis. They airlifted water, rice and other food stocks to isolated populations, provided medical care and casualty evacuation, initiated aerial reconnaissance of roads and facilitated operational agencies in getting to remote sites. These assets were vital in conveying to the international aid community information on prevailing conditions, and in bringing supplies to those who needed them most desperately. More sustainable civilian logistics and transport systems need to be established as soon as possible.

10. The team did not come across any isolated settlements that had not received any kind of assistance as had been previously indicated. In addition, IDP populations were noted to be drifting towards larger population centers such as Meulaboh and Calang. Nonetheless, in the highly unlikely scenario that isolated small pockets of IDPs are identified; we must have the capability to respond immediately with the appropriate level of assistance.

11. The crisis has exacerbated the risks of transmission of communicable disease that are endemic in the region. Overall, cases of measles, malaria, and diarrhea remain within acceptable thresholds. A standardized health reporting system for communicable disease outbreaks has been established, but this is not yet being used across all agencies.

12. In response to the acute nature of the disaster, many nations deployed teams with tertiary health skills to address the severe wounds of the injured. This has resulted in an oversupply of temporary tertiary care facilities and medical staff (including, at one point in time, twenty surgeons in Meulaboh). These temporary field hospitals have noted a significant decrease in patient load between Week 1 post-tsunami, from 120 patients a day to a current daily caseload of 30-45 patients. Acute-care hospital bed capacity in western Aceh Province appears to be adequate for the immediate referrals.

13. The temporary field hospitals have met many of the acute needs of the population but will not suffice in the medium- or long-term. Most medical needs of the affected population relate to the

restoration of primary health care and preventive services. The community health center (puskesmas) - the backbone of the public health system - was severely impacted by the tsunami; the Government estimates that 41 of the province's health centers were destroyed. At least half of these were on the West Coast. In addition, many sub-health centres (pustu) were destroyed. Exact numbers are not known at this time.

14. The roles and responsibilities of the health agencies on the ground need to be clearly defined by the sector coordination groups. In some areas, as many as 22 NGOs are working in the health sector along with military and MoH health activities. Coordination is also needed between agencies that work on issues that closely impact on population health in order to optimize the health impact. These issues include the need to ensure better food distribution, proper resettlement of IDPs, access to suitable shelter, the restoration of livelihoods, and ensuring access to non-food items.

Food and Nutrition

15. Due to the timely, significant response by the militaries of a number of countries (both on and off shore), basic food staples, particularly rice and noodles, have been delivered by helicopter to most locations along Aceh's West Coast. In most locations, however, food supplies did not include protein, oil, sugar or vegetables. Micronutrient supplements are also lacking. For obvious reasons, no nutritional assessment of the affected population has been conducted. No serious targeting of food relief has occurred, nor any special effort to get food to the most vulnerable populations (primarily children under 5, elderly, and pregnant or lactating women). No acute cases of malnutrition were observed. Nevertheless, the nutritional status of IDPs cannot be sustained on the rations that are currently being distributed. Distribution of food is largely coordinated by the TNI, or in collaboration with civil administrators where they survived. Quantities received by IDPs varied according to available stocks, and the agency responsible for distribution. Survival of the fittest

Livelihood

16. The tsunami caused massive and widespread destruction of fishing villages and rice farmland. Farmers and fishermen who survived the tsunami now lack resources to maintain their livelihood and to contribute to the food security of the region. Some local markets have opened but people often do not have cash to purchase goods. Prices of basic food commodities have doubled in some areas. Survivors from the towns do not have jobs and have lost all assets by which to make their livelihood.

Shelter

17. Displaced persons are being housed in various types of shelters. Significant portions of the IDPs are living with host families in communities that were not affected by the tsunami. Others are living in community shelters such as schools, mosques and other public buildings. Another significant portion are living in makeshift shelter fashioned out of scavenged materials. A much smaller number are living in tents. Conditions are crowded in many of the shelters, with some school compounds hosting over 2000 persons.

18. Several representatives from the government of Indonesia (GoI) have indicated a national plan to consolidate IDPs into large centralized settlements within low-lying tsunami hazard zones. Local populations have expressed an unwillingness to move to these settlements citing a fear of tsunami as well as disease due to what is expected to be poor living conditions comparable with the conditions of their current surroundings. Many people want to return to their villages, or slightly inland, to re-establish themselves. Any planning for reconstruction or return to affected areas should factor in the potential risks for future disasters involving flooding, cyclones, earthquakes and tsunamis.

Sanitation/hygiene

19. Sanitary conditions are extremely poor in many of the IDP sites especially those with high population numbers. Some of the public buildings have sanitary facilities but the large numbers of persons living there overwhelms these. Most of the sites have no latrines at all. As a result, most IDPs are defecating in fields, open areas or canals near to their shelters. Some of these are close to rivers or ponds that are used for bathing and washing. Few organizations appear to be active in this sector.

20. Nearly all of the persons interviewed complained of a lack of soap for both hand washing and washing of clothes. In order to improve hygienic conditions and reduce the spread of hygiene related diseases distribution of soap or hygiene kits is urgently needed. Water

21. Sources of drinking water include hand-dug wells, spring-fed gravity flow systems, bottled water, trucked water and water collected from canals and rivers. Quantities of drinking water available to IDPs varied by location but were generally considered adequate at the current time. However much of the drinking water being collected from wells and other sources is contaminated and does not meet generally accepted standards for drinking water quality. Very little of this water is disinfected although most people reportedly boil their drinking water prior to consumption, which may help explain the lack of diarrheal disease outbreaks. In order to guarantee a safe supply of drinking water to IDPs and affected populations a greater emphasis must be placed on disinfecting drinking water supplies as well as the safe storage of drinking water in the home. This must be tied to a health promotion program as many people are not used to drinking chlorinated water. Finally as most families lack adequate water storage containers these should be distributed as soon as possible.

General recommendations - health response

22. While the following recommendations summarize the assessment's main findings, detailed, sector-specific recommendations are included in the six daily situation reports issued from the offshore platform, during the assessment.

Improve coordination and leadership within the health sector

23. Immediate improvements are necessary in regional health coordination within the affected regions of Aceh to ensure the most productive use of resources and to ensure that the health needs of the population are being adequately addressed. Many non-governmental organizations (NGOs), military units, and other local organizations provide health services throughout the area covered Coordination has not been strong, and information has not been flowing from NGOs to the UN or Ministry of Health (MOH) officials. UN agencies need to play a stronger role and ensure a more robust "on the ground" presence at major concentrations of affected people.

24. Multiple assessments of varying quality are taking place in all sectors. To this end, a detailed review of sector wide needs (field and desk studies pulling together the numerous assessments reports) should be completed within one month, analyzing gaps and looking at longer term recovery plans.

Address logistical needs

25. The response thus far has faced significant obstacle related to the effects of the tsunami. This is due to the great distances that need to be covered in the disaster area; the extended lines of supply; broken lines of communication and the severe destruction of roads, bridges, and telecommunications. UNJLC are well advance with the addressing this issue. Agencies should look to support there efforts.

Transition

26. We need to increase the role of local civilian authorities and Aceh Provincial Ministry of Health officials in planning and implementing the health aspects of this relief and recovery effort. Long-term strategies to rebuild public health, clinical, and preventive services should be initiated.

27. There should be an effort to re-establish efficient provincial, district and sub-district organization structures to administer and support primary health care. Acehnese staff should man this process along with additional staff others seconded from other provinces/districts. Upgrading and development of capacity (skills and management) at all levels in the health sector should be implemented using a dual mode method. Firstly, on-the-job training should be provided by 'accredited' international NGOs in the workplace. The NGOs may be involved in service delivery and management, but should also provide

on-the-job training for Indonesian counterparts in each position. Secondly, short-term training for multi-skilled village midwives, health center staff and district public health staff is needed.

Key challenges to proper recovery

Health information systems

- A regular epidemiological report and operational report including interpretation of the data and general situation should be published and shared with all relevant agencies, decision-makers on a regular basis.
- Health agencies should bring appropriate information technology, personnel, and training to the field to support these activities.

Proper targeting of health delivery programs

- Expanded clinical services, including trauma care, initially given higher priority during the first month after the tsunami, should now given way to an emphasis on primary care, maternal-child health and preventive services, (i.e. immunization, health promotion). It will be more effective to provide resources to community health centers, (i.e. puskesmas), so they can start working again or cope with the extra load rather than deploy advanced temporary field hospitals.
- Services should be made available to IDP settlements, people who remained at home in damaged communities, as well as to host communities. It will also be necessary to initially operate mobile clinics to meet the needs of isolated communities that have limited access to care.
- A strategy and policy for the health sector development needs to be accomplished. It is critical that health agencies responding to the disaster rebuild and strengthen local health systems in a coordinated and complementary way. There are opportunities now to revitalize and improve organization structures and management system to deliver services to standards better than before the tsunami.
- There is good capacity within Indonesia, and neighboring countries to support such capacity building within the health sector through technical inputs and for scholarship-funded training.

Sector specific assessments and WHO Action Plan for Health

- All health related sectors should have a focused assessment to further characterize the needs of their service populations. This information and all data from previous assessments by agencies should be evaluated and incorporated into a health “Action Plan for Health” within the next 7 days.

Acknowledgments

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Appendix

Table one: population of IDPs and names of NGOs / PVOs by location

舶獴物捻～畢ロ楳瑲楃	鰲瑩湯	倀慰瑯灬污瑩湯	乇佐楳
稈敨ｧ慹慦ロ吶晦潬	呵睬ｧ慷	8.041	獅桎瑯ｧ敆‐牯瑳ロ慲剣ロ湫瑮⁉佐ｧ义ロ潤瀷
	吶晦潬ｧ潳	713	欐瑥琞慧楲潳氥卣桂琴倶牱搢牣
稈敨ｧ慹慦ロ卣瑩慢慬	禮橡獏卵慬ｧ潮	397	
	賦湧湧敒潳猴	291	
	倶楋湧	175	呎漢捻湥
稈敨ｧ慷慦～慦楳	卡瑡瑩条	1052	艷㸇膝ぃ╜畨ロ湫瑮⁉慲剣ロ慰瑥敂浴⁉扵ｧ湩慦ロ瑡攃‐牯瑳ロ敐潉牣瑡潬
稈敨ｧ慷慦ｧ慷潣慣瑳	畚慢湯	180	龜渥
稈敨ｧ慷慦ｧ灬楲敭	麗污湯	4237	捫楯敆‐牯瑳ロ敆‐牯瑳ロ瑣潭⁉潬

舢獴物捻～畢□楳瑲楯	鵞□瑩潮	□倠侲灵污瑩潮	乇佳︶噏
稹敨⁂慛慴⁄牡杯渠□洹慬敷	觪椺浄剢浰慫	4000	□湡摩慮⁄敬椺映呐□□轣物穑湇⁈潬污湤
稹敨⁂敳慛◖桯潮	踦敵湧⁋慬	747	敳潢慬～桥楛猬]物□摳⁷椺桯畴湍摥牳
	□瑛□洆	456	□潢慬～桥楛猬]物□摳⁷椺桯畴湍摥牳
	偡牯	185	□潢慬～桥楛猬]物□摳⁷椺桯畴湍摥牳
	卡牡	327	
	鰰浪畚慮	530	佢湍]潵湤慴楛測⁄敤-牥敲□瑛景畮捺瑩潮□□牥□卷楳□□□]潯捌景燿瑶擁□湧特
	饑畴慰慮	232	穆扯瘷
	偡獦燿□潯湧	1411	□扯瘷
	黰渠□瑚	227	□扯瘷
	□湇番□	387	□扯瘷
稹敨¬慹愠□□浮	□浮	11.087	斜□⁎湍瑶睥獴◗敤楛慬□□浡潼瑹]楗獴□□剃□偡步獴慮◗楧楌特⁈湄灩瑚瓿⁄紵
稹敨¬慹愠□卡洆湨潼整	□洋呐畮杯	700	

Table two: List of acronyms

稲十鏰 糕獴牡汨愠稖□摓□湍⁉湴敧湡瑩潮慬⁄敶敬潰浥湴

稆十鐕 毯獴牡汩愠稭?摔口澵!?湴敲湡瑩潮慬⁄敬潧慴敳

鮎 䴀湴敲?景爠?獵慳瑡楮?湴牴氍慢捩?瑩潮

?剔 ?獦獴敲ⱁ獴楯滑瑡湤獭潮獵‿䵥

貜 䍨癥牳䍯湴䍯湴?摥灥獬

? ?瑥牳愠湯楴楳‿慤漠畲桥牳

鑋 ?瑥牳桥牳湡瑩潮慬⁄敶敬潰浥湴

鬖 ⁜灡潮散潮潭楣?浩湩獴特?楮

乇 ?湴?癥牳湴牣?慲浩湴敲

乍剕 ⁜敳?懃慮摡牤愠?浡湡来浥湴

佃鑨 ?湶楳口澵-潦⁴桥牴桥牳?灥牳畮摡牤湣桥牳?獣獴牡湶

但劄 ?湶楳湴?獥湴牳?獦獴敲ⱁ獴楯滑

偖 佰敲瑩潮慬⁃潮瑲潬敤潵湴特

千袚 卦癥獴-??獥牳

吙 啎湴湣?獣潮敲!?瑥牳愠湯?摥灥獬湣?汩慮特

铻 ?桥牳敲汦

铻?穚 ?桥牳敲汦!?湴敲湡瑩潮慬-??獥畲??慮杲潵?瑥

铻軔 ?桥牳敲汦?!湦潳?摩桥獴敲獵捣敳瑩潮

啓秬 啓⁄杲潵瑲?獴敲牳湡瑩?灡摣??

坆 坯獧湴?潮⁳瑡牴?

坈 坯獧湴?敲??浩湩獴特