PART I MEETING THE NEEDS OF AFGHAN REFUGEES

CHAPTER 1 Afghan Refugees in Pakistan

Location of Refugees

The Government of Pakistan (GOP) has granted refugee status to the massive inflow of refugees from Afghanistan resulting from the conflicts which have been developing in that country from 1978 onwards. During the years 1979-1981 Pakistan experienced a large influx of refugees from Afghanistan and the number rapidly exceeded 2 million registered refugees. Since 1982 the number of refugees in Pakistan has continued to grow steadily and is now established at some 3 million, of which 2.7 million are residing in organized Refugee Villages. Approximately 74 percent of the refugees live in the North West Frontier Province, 20 percent in Baluchistan, and 4 percent in the Punjab.

The refugees are physically located in special Refugee Villages (RVs) which, in some areas, are directly adjacent to the Pakistan-Afghan frontier, known as the Durand Line. The refugees have no right to purchase land or other immovable property. They may provide for any livestock they bring with them and are allowed to engage in limited economic activity. The Government does not restrict the movement of refugees in the country; however, only registered refugees living in organized Refugee Villages are entitled to relief assistance from the Government.

Most refugees are registered in the Refugee Villages (RVs) and are eligible for services provided by the Afghan Refugee Programme Administration. However, there are two groups of refugees who are not registered but add to the total number of Afghans in Pakistan: Refugees "recorded" in RVs who are waiting to be registered and those living in urban areas where refugees are not registered.

Afghan Refugee Programme Administration

Although the size of a Refugee Village for planning purposes is 10,000 refugees, in actual fact the RVs vary in population size, from as low as 3039 to as high as 105,000. The RVs are directly administered under an RV Area Administrator. Within the camps, Afghan elders, frequently Maliks who in Afghanistan were political leaders, are encouraged to take a liaison role between refugees and camp authorities.

The Government of Pakistan has assumed the responsibility for accommodating and caring for the Afghan refugees. Approximately 310 RVs have been established and additional RVs will be opened as more refugees are registered. The RVs are administered by the Government to provide shelter, the distribution of food and other assistance to refugees.

Within the Government of Pakistan, the States and Frontier Regions Division (SAFRON) has overall responsibility for Afghan refugees. The Office of the Chief Commissioner for Afghan refugees (CCAR) is in charge of logistical coordination of relief assistance. A Director for Medical Services (DMS) has been assigned to CCAR to coordinate health services. Copies of the organizational charts for refugee management in Pakistan and the organization of health services for refugees are contained in Appendix A. A Commissioner for Afghan Refugees (CAR) in each of the three provinces is responsible for day-to-day refugee programme operation. He is assisted by the provincial departments in charge of specialized sectors of the programme. A Project Director Health (PDH) has been assigned in each of the three provinces as head of the refugee health services.

Socio-Economic Characteristics of the Refugees in Afghanistan

Afghanistan is a tribal society, traditional and religious; nearly 100% of the population are Muslims, mostly Sunnis. It

has low living standards and low educational levels. The per capita GNP in Afghanistan was estimated around 1980 to have reached US $ 160. In the mid-1970s the urban population was considered to comprise 15 percent, the rural stationary population 70 percent and the rural nomadic population the remaining 15 percent. Agriculture based on irrigation and animal rearing occupies about 85 percent of the population. Fruit, especially grapes, wheat and cotton are the major crops. Health services and educational facilities are not generally available to the majority of the people, particularly to those in rural areas.

The Population Refugee Bureau (U.S.) in 1977 reported health characteristics of Afghanistan and these are presented in Table 1.

Table 1

Health Characteristics of Afghanistan, 1977

Characteristic	Rate
Crude birth rate (per 1000)	43
Crude death rate (per 1000)	21
Infant Mortality rate (per 1000)	182
	Percentage
Annual growth rate	2.2
Percentage under 15 years of age	44
	Years
Life expectancy	40

Socio-Economic Characteristics of the Refugees in Pakistan

The Afghan refugees represent a highly heterogeneous population of diverse tribes, and within tribes, sub-tribes and clan divisions. Yet, there is a strong tradition of leadership by achievement so that internal as well as external tribal alliances are somewhat fluid rather than hereditary or determined strictly by descent. Many of the ethnic groups represented among the Afghan refugees have long been represented among the local Pakistani population, the Baluchis and Pathans in particular. The majority of the refugees are Pathans and a sizeable number of those registered in Baluchistan are Baluchis. In the past, some nomadic and semi-nomadic tribal groups had a tradition of seasonal migration to parts of Pakistan, their numbers reaching some 60,000 before the present influx of refugees started. Other ethnic groups of refugees include Nuristanis, Tajiks, Uzbeks, Turkmen and Mongols. The major languages are Pushto and Darri (Persian).

The refugees represent a variety of occupational backgrounds: from wealthy landlords to subsistence farmers or landless tenants, big businessmen to petty traders and nomads with small or large herds. In general the better educated and wealthier refugees are residing in Pakistani cities, not in the RVs. The description that follows applies mainly to the majority of those people who come from rural villages.

A few generalizations can be made with regard to family structure which appear to apply fairly universally to the various tribes included in the Afghan refugee population. First is the emphasis on patrilineal descent from named ancestors, patrilocal residence with a fairly high incidence of extended or joint family living arrangements, and patriarchal ordering of power, authority and decision-making within the family. Achievement is more important than ascription in the distribution of power and authority among the Pathans, and most likely among non-Pathan tribal groups as well. Also

cutting across ethnic boundaries is the practice of female seclusion, belief in the defence of the honour of women, and a well-developed division of labour within the family. The emphasis on manhood and its association with strength is pervasive.

The social custom of purdah (seclusion of women) is practiced by the refugees. Women, on the whole, remain in their household compounds, although minor girls and elderly women may go out to collect water. The purdah custom is particularly strict for older unmarried girls and young married women before they have borne at least two children. Women are generally permitted to attend health services at BHUs, usually accompanied by a male relative. Women's movements are reportedly more restricted in the refugee camps than they were in Afghanistan, in part because of the new need to live in close proximity to people from different villages and tribes. However, people from the same area do tend to cluster together in the camps. Nomad women and a few tribal subgroups do not follow the purdah rules so strictly.

There is a well-developed division of labour within the family on the basis of age and sex. Women generally are responsible for child care, cooking, fetching water, cleaning, collecting fuel for domestic energy needs and building and maintaining traditional stoves/ovens and family level grain storage bins. Men assume responsibility for relationships and tasks outside the family compound including the purchase and sale of subsistence items from the market, agricultural production, house construction, wage labour and maintenance of social and political relationships beyond the immediate family (such as attendance at educational and religious institutions).

Within the general framework of purdah and division of labour, there is a wide range of behaviour deriving from special circumstances of camp life or from family background. For example, in certain non-Pathan groups women may be

responsible for carpet-weaving and men for fetching water, and in some nomadic groups women may engage in petty trade as well as animal-rearing.

In 1982-1983 Government/UNHCR/Austcare conducted surveys on the socio-economic status and nutritional status of refugees in Baluchistan and in NWFP. Selected findings from these surveys appear in Table 2.

Table 2

Socio-economic Characteristics of Refugees in Baluchistan and NWFP

Characteristic	Finding
Family Size	6.2 – 6.5
Children 0–5 as percent of total pop. (NWFP)	22.5 percent
Children 0–5 and women as percent of total population (Baluchistan)	40 percent
Male : Female ratio (Over 45 years of age)	260 : 100
Birth rate per 1,000	54 to 65
Literacy	Low (about 3 percent of women, 30 percent of men are literate)
Employment	At least 1 family member employed for irregular periods

CHAPTER 2 Major Health Needs

Health Status in Afghanistan

The information available on the nature of rural health problems summarizes the health status and services in Afghanistan in 1977 (O'Connor, 1980, p.177–184) as follows:

- Infant mortality rate calculated at 157 per 1000 live births.

- More than half of all deaths occur to children under five years of age.

- Symptoms suggesting tetanus (29.6 percent), respiratory diseases (17 percent) and diarrhoeal diseases (11.2 percent) account for 60 percent of deaths of children under 5.

- Respiratory illnesses (20.4 percent), diarrhoeal diseases (17.3 percent) and symptoms suggesting tetanus (14.3 percent) account for over 50 percent of all deaths.

- Women aged 30 to 45 have a rate of reported illness almost twice that of men of the same age.

- Fewer than 60 percent of children in any age group are classifiable as well-nourished according to arm circumference measurement. More strikingly, less than 10 percent of children 1–3 years of age are classifiable as well-nourished.

- High protein foods are not introduced into children's diet until almost two years of age which is the normal breast feeding period.

- Rural people in Afghanistan took a variety of approaches to obtaining health care. Home treatments included bed rest, prayer and vows, dietary prescriptions following the Greek humoral beliefs of hots and colds, herbal and medicines and special treatments for particular ailments. They attended Basic Health Units where these were available, but BHU's were not within the reach of most of the people. Village-level health services were obtained from dais, barbers, injectionists, pharmacists, traditional medical practitioners, herbalists and bone-setters. City-and towns-people additionally visited modern practitioners, clinics and hospitals. O'Connor (1980) found that purchase of pharmaceuticals constituted about 37 percent of payment for health care. Health care costs made up 7.4 percent of the annual household income of the average Afghan family.

Health Status in Pakistan Refugee Villages

Because of the paucity of modern health services in Afghanistan, many refugees have had little experience with modern and preventive health care Their previous heavy reliance on drugs obtained from pharmacies, as well as the new accessibility to modern care in the RV BHUs, initially led them to over-utilize the available health services. The refugees have been mainly interested in curative services and simple treatments, many for illnesses that could be prevented or that could be treated in the home. The AR Health Programme is therefore engaged in educating the refugees concerning proper utilization of health services and of drugs, and is stressing preventive measures.

Infant and Child Mortality and Nutritional Status

In April and May 1984, a systematic survey was under-

taken by Government/UNHCR/Centers for Disease Control to assess the current health situation among the refugees. This survey was repeated in April and May 1985. The survey focused on infant and child mortality, probable causes of death and nutritional status of children. A comparison of survey results for the two dates is contained in Table 3.

Comparison of the 1985 data with that of 1984, shows improvements in the infant mortality rate, neonatal mortality rate, percent of children dying before the 5th birthday, and percent undernourished. The differences were not statistically significant. The infant mortality rate (infants dying in the first year of life) of 119 per 1,000 live births in the 1985 survey compares favourably with that for other developing nations, and is an improvement over the 1977 rate estimated for Afghanistan. The 1985 survey found that among children who died, diarrhoea was reported to have occurred the week prior to death in 39% of the children; measles in the month prior to death was reported for 24%; and malaria or malaria and diarrhoea two weeks prior to death was reported for 5%. The signs of tetanus were reported for 38% of children dying within the first month of life. In the 1984 survey the estimated maternal mortality ratio (number of maternal deaths by number of live births) was found to be relatively high when compared with other developing countries; the 1985 survey did not address this issue.

Immunization Status

The immunization status of the refugees remains poor, but is doubtless an improvement over rates in Afghanistan. A scar indicating previous BCG vaccination was observed for 953 children (41 percent), 44 percent in NWFP/Punjab but only 26 percent in Baluchistan. There is still a high dropout rate between the first and second dose of polio vaccine and of those who received the second dose, less than one-third returned for the third dose. Completion of the second/third dose of DPT/DT considerably improved in 1984 in compari-

Table 3

Comparison of Survey Results, Afghan Refugees 1984–1985

Survey Item	Year 1984	1985
Total families interviewed	1512	1566
Number of children (5 years or under)	2136	2425
• Alive at time of interview	2011	2313
• Died past 12 months	125	112
Number of live births in past year	595	632
Children (1 year or under died past 12 months)	92	75
Infant mortality rate	156/1000	119/1000
(Confidence limits	125–186	93–144)
Neonatal mortality rate	61/1000	46/1000
(Confidence limits	42–80	30–62)
Percent of children dying before fifth birthday	22.5	18.8
Results of children weighed by percent*		
≥ median	26	35
< 80 percent of median	3.5	2.3
< 70 percent of median	0	0
Percent with diarrhoea in last 7 days	38	35

*Based on weight-for-height measurement of the WHO/NCHS/CDC reference median.

son with previous years and is expected to improve even more in 1985 In Baluchistan 25 percent of all children who died did so from a vaccine preventable disease.

Tuberculosis

The information on tuberculosis among refugees comes from three surveys. An x-ray survey in Baluchistan in 1981 showed x-ray positive TB in 6.89 percent of the refugees and 2 percent of the local Pakistanis. These results suggest a three to four fold higher prevalence of TB among refugees compared with the local Pakistani population. A tuberculin survey in NWFP also indicated a positivity rate in refugee children twice as high as in Pakistani children of the same age (5-9 years). Positivity rates for refugee children were 25.8 percent versus 13.2 percent for Pakistani children. A recent survey in January 1984 in NWFP and Baluchistan showed a positivity rate of 32.1 percent in the same age group of refugee children.

Malaria

Malaria is an important cause of morbidity and mortality among refugees. The prevalence of malaria was studied in August 1984 in Baluchistan and NWFP. The Baluchistan sample showed a slide positivity rate of 1.75 percent. The NWFP samples varied by camp, from a low of 2.1 percent to a high of 10.69 percent; the average rate was 5.5 percent.

Sanitation Practices

The most frequent diseases among refugees include diarrhoeal and parasitic diseases both of which are directly associated with poor sanitation (12.5 percent and 5.4 percent respectively of the total BHU caseload in NWFP in 1984). The surveys indicate a high prevalence of diarrhoeal diseases, between 30 to 50 percent among children. There is a direct relationship between diarrhoea and mortality among children

Sanitary facilities of a traditional type exist in most RVs, although they have not been constructed by all families. Traditional latrines afford privacy but allow excreta to spill out from an open exit. Many refugees use fields, open spaces, or areas of their courtyards instead of latrines of any kind. Men and boys tend to leave the compounds to defecate. Many women also use the fields, going at dawn or after dusk to ensure privacy. A pit latrine built with a "purdah" wall is perceived as a real convenience and as an aid to maintaining purdah. In most RVs personal hygiene and food hygiene need to be improved in order for diarrhoeal diseases to diminish.

Provincial Differences

Surveys indicate that refugee health status is higher in the NWFP than in Baluchistan. The 1985 Government/UNHCR/CDC survey indicates that Baluchistan had higher mortality rates for children of all ages except in the neonatal period. Children from Baluchistan are also more likely to experience acute undernutrition.

CHAPTER 3 The Afghan Refugee Health Programme

The overall health programme for the Afghan refugees is a collaborative effort of the Government of Pakistan (GOP), United Nations High Commissioner for Refugees (UNHCR) and Private Voluntary Organizations (PVOs) and is implemented within the framework established by the Government. Presidential Directive No. 57/1/CMLA, 17 December 1980 established the health service organization for Afghan refugees.

Role of Government

The Director of Medical Services (DMS) at the Chief Commissionerate for Afghan Refugees (CCAR) under States and Frontier Regions Division coordinates the largely independent implementation of the Afghan Refugee Health Programme by the Project Directors Health (PDH/AR) in Provincial Governments. The Government is responsible for coordination of efforts and for disbursing funds provided by the UNHCR in accordance with a planned budget.

The Provincial Project Directors Health (PDH) are responsible for the refugee health programmes in the provinces. At the district level, Field Supervisory Medical Officers (FSMOs) and their staff support and supervise the health services provided by the Basic Health Units (BHUs) in the RVs. The PDH manage directly the basic health service organization created for the UNHCR-financed part of refugee health services. The PDH and their FSMOs also supervise the health services provided by voluntary agencies.

Basic health services including both curative and preventive services are provided by the refugee health programme. For hospital treatment or specialty examination the refugees are referred to Government hospitals or other health units. Financial reimbursement for these services is included in the Afghan Refugee health budget and is paid directly to the Pro-

vincial Government by UNHCR. Payment is made only for those refugees referred to the hospitals by the GOP BHUs.

Role of United Nations High Commissioner for Refugees

The major share of the financial assistance for the Government to provide health care comes from UNHCR. These funds are used by the Government for the establishment of Basic Health Units and sub-units, salaries of health personnel, provision of drugs and equipment, purchase and maintenance costs of ambulances, disease control and health promotion programmes. The UNHCR budget also includes support to the Government health facilities which provide referral services for the refugees.

The UNHCR assists the Government in its programmes for refugees by making available advisory services. A Senior Health Coordinator seconded from WHO assists the UNHCR/ Government in coordinating the Afghan Refugee Health Programme.

Role of Private Voluntary Organizations

By mid-1985, voluntary agencies provided one-third of the refugees with basic health services and supported Government or private referral facilities. At the end of 1984 some five PVOs were operating in Baluchistan and 18 in NWFP. In 1985, there were six PVOs operating in Baluchistan, 24 in the NWFP and four in Punjab. The International Committee of the Red Cross (ICRC) operates two surgical hospitals. Several small hospitals have also been established by other private Voluntary Agencies and by Afghans in Peshawar and Quetta.

The Government and UNHCR wish to increase the number of BHUs administered by voluntary agencies for three main reasons:

(1) PVOs can bring newly available funds to support refugee services, and can help relieve UNHCR of budgetary constraints. This is important as UNHCR funds are increasingly being directed to assist with the refugee crises in other areas of the world.

(2) PVOs can bring specific expertise in administering refugee services.

(3) PVOs have the flexibility to try innovative approaches to health care problems. The UNHCR has identified certain programmes--malaria control, immunization, sanitation, tuberculosis control, basic health services including primary health care-which are important for improving the health status of refugees. The PVOs are able to take responsibility for these programmes and use new strategies to enhance their effectiveness.