PART II SCOPE OF HEALTH SERVICES

CHAPTER 4 The Basic Health Unit – Focal Point for Services

In refugee villages (RVs) the health services are provided in Basic Health Units (BHUs) and occasionally in additional smaller sub-units. The BHUs are administered either by the Government of Pakistan and funded by UNHCR, or are operated by Private Voluntary Organizations which provide additional external funds.

The optimal target population served by each BHU is 15,000. The actual range is from a low of about 4,000 to a high of about 28,000. In 1984 the average population was 13,588. The number of refugees per physician was 12,117 and per female worker was 8,014.

In 1985 there were 191 BHUs serving the 310 RVs. A description of the BHUs by province and provider appears in Table 4. The information in Table 4 was correct as of 1 November 1985.

Most of the teams working in BHUs have their own multipurpose vehicle which provides general transport and also serves as an ambulance. The entire health team, or at least a part of the team, resides in the refugee village or near-by in order to provide 24-hour service.

During the first few years of the refugee health programme, and in a few cases even in 1985, EPI immunization activities, malaria control and tuberculosis control were operated as separate programmes. Sanitation, including construction of latrines, combined with health education was also organized through separate projects. Integration of these activities into the BHU structure began in 1983. Integration of services is the policy of GOP and UNHCR although its

implementation still varies somewhat, especially in Private Voluntary Organizations and between provinces.

Table 4

Providers of Basic Health Units by Provinces

Province	Govt./ UNHCR	PVO	Total
NWFP	85	45	130
Baluchistan	42	12	54
Punjab	6	1	7
Total	133	58	191

Scope of Services Offered

A full range of integrated basic health services is provided through the BHUs, including preventive, promotive and curative services. BHU activities should include the following programmes:

- Maternal and child care (MCH)
- Immunizations (EPI)
- Disease control (TB, malaria, diarrhoeal diseases)
- Supply of essential drugs
- Nutrition/supplementary feeding
- Health education
- Treatment of common ailments.

These activities are briefly described below and the

guidelines for each appear in Part III. While it is common to divide activities into promotive/preventive and curative ones, it is useful to think of health status as a continuum where intervention at one point (whether through health education or treatment) prevents a problem from requiring more sophisticated care or from resulting in disability or death. Early intervention is generally less cost in both monies and human welfare than is late intervention.

BHU staff refer refugees to Government hospitals or other health units for hospital treatment or examination or for specialized care.

Maternal and Child Care

Maternal care includes identification of pregnant women (case-finding), pre-natal care, labour and delivery, and post-natal care including child-spacing counselling to protect the woman and infant. It also includes diagnosis and treatment of gynaecological problems. Additional staff such as midwives or traditional birth attendants (dais) are provided to help with deliveries. There is a programme directed toward immunizing all women of child-bearing age against tetanus with tetanus toxoid.

Child care includes routine diagnosis and treatment of minor ailments, weighing and measuring, immunizations (see below) and referral for complications. "Road to Better Health Charts" are kept for children at special risk, but are not yet routinely established. Family records are kept to facilitate better care.

Immunizations (EPI)

The Expanded Programme for Immunizations for refugee children focuses on vaccines for six main vaccine-preventable diseases: measles, polio, diphtheria, pertussis, tetanus and tuberculosis. Any other vaccines are considered exceptional.

All children 0-5 years of age are eligible for immunization; in actual practice all children under 12 are immunized against the six diseases, because it is unlikely they were vaccinated in Afghanistan. Immunization against tetanus is offered to women aged 15-45. The standard national programme of Pakistan has been adopted to avoid confusion, since the BHU staff and vaccinators were trained to follow that programme. The Medical Officers should refer for vaccinations all eligible children and child-bearing aged women who visit the BHU.

Sanitation

The goal of the sanitation programme is to include at least the following: health education, provision of safe drinking water, construction of latrines, elimination or control of environmental hazards and training of sanitarians. Initially sanitation services were organized solely through separate projects. Plans for coordinating the sanitation activities in all provinces and for integrating sanitation services in the BHUs started in 1985. During 1985 a programme for training sanitarians will be developed. Implementation of the programme is planned for 1986 and it will be integrated into the BHU's. UNHCR has responsibility for ensuring provision of water, but this has not fallen under the health programme. Limited water testing was started by BHU sanitarians in Baluchistan in 1985 and may be extended to the other provinces in 1986.

Disease Control, including Tuberculosis, Malaria and Diarrhoeal Diseases

In 1983/84, 24 laboratories for TB and malaria testing were established under FSMOs in NWFP and 10 were established in Baluchistan. This has enabled transmission to BHUs of laboratory findings within three-four days, thus permitting BHU staff to make effective diagnoses. More laboratories are planned for NWFP and specialised referral laboratories are being developed in NWFP and Baluchistan.

Tuberculosis: Services include: case-finding through examination of patients attending BHUs; laboratory testing (Sputum test) of persons with TB chest symptoms; chest x-ray; and treatment according to either a standard regimen or a short-course regimen.

Malaria: Services include: presumptive treatment of those with malaria symptoms; laboratory examination of blood slides; and radical treatment of those with diagnosed malaria. Environmental measures concentrate on residual spraying of insecticide and pre-and post-survey studies are made of malaria transmission.

Diarrhoeal Diseases Control (DDC): Services related to control of diarrhoeal diseases include: health education, namely, encouragement of proper domestic hygiene, promotion of breast-feeding and appropriate weaning and proper dietary management during and after acute diarrhoea; provision of adequate clean drinking water; and widespread distribution and use of oral rehydration salts in sufficient quantities. Teaching women to prepare homemade salt and sugar solution correctly is appropriate (Appendix K). Antibiotics are not used except on rare occasions.

Supply of Essential Drugs

A list of essential drugs selected for distribution to BHUs has been prepared. It was originally based on those listed in the "WHO Emergency Kit", but in 1985 the list was revised. The revised drug list is based on another WHO publication, "The Use of Essential Drugs" (Technical Report Series 722, Fourth Revision). This revised list is more consistent with the nature of the health programme at the present time and not the emergency situation that existed when the health programme was initially developed (Appendix B). A drug order form has been designed. The BHU storekeeper is authorized to order a supply adequate for two to three months. A copy

of this form (AR 21 Revised 11/85) appears in Appendix C. Orders are sent to the PDH at the provincial level CAR.

Health Education

An active health education programme helps ensure that health conditions that would otherwise lead to overcrowding or over utilization of the BHU, are prevented or are treated simply and appropriately in the home. The purpose of health education is to enable people to take wise, appropriate steps to prevent illness or to prevent a current illness from worsening.

Health education should build on the healthful, appropriate practices people already have, and should help them adopt new practices that are beneficial to them. Dialogue and demonstration are better than lectures, as people are more willing to accept what they understand and what fits into their lives. This is particularly important in a refugee community that has been uprooted and yet is very traditional and conservative.

Health education is an essential responsibility of each health worker. No one person is designated as health educator at the BHUs. Instead, health education is an integral part of each encounter between a refugee and a health worker. Training courses organized by GOP/UNHCR for various levels of health workers have emphasized this point; some audiovisual aids including flip-charts, posters and models have been developed and distributed to health workers.

There are several types of opportunities for health education. It is the responsibility of the M.O to stress the need for continuing health education and to organize the time needed for it. It is also the M.O.'s responsibility to guide the staff in educating the people. Some appropriate settings and methods for health education are:

At the BHU, one-to-one teaching can be done when a patient, sometimes accompanied by the family, visits for a health problem.

At the BHU, small-group discussion, where a health worker talks with several people who have similar health problems (for example in TB clinic or at pre-natal consultation where several women are gathered).

In the home, where a health worker like the Lady Health Visitor, or the dai or Community Health Worker, visits homes to observe and discuss health problems or to follow-up particular patients. Home visiting is important as it is one of the few ways that women can be reached by the health team.

In the community or school, where the health worker discusses community health and sanitation problems and solutions with shopkeepers, mullahs, or pupils.

At mass gatherings where more formal presentations on prevention and care can be given.

When a person comes to the BHU for treatment, instructions in how to prevent a recurrence of the same problem and encouragement to teach this to family members should be given. He/she also should be taught the best methods of caring for this complaint after leaving the BHU.

The priority topics should be those directly related to the immediate public health problem, for example, the disposal of human excreta and refuse, and the need for immunization of children. Health education should be directed also to the immediate health needs of the individual or family concerned.

Treatment of Common Ailments

In addition to care for diarrhoeal diseases, the main treatments provided in the BHUs are for the ear, eye and skin diseases and upper respiratory infections. These constitute 59 percent of all patient visits. Leprosy identification and treatment is available.

Staffing

Minimum standard staffing has been introduced for the BHU level. The health personnel in BHUs are either Pakistani or Afghan. Expatriates only serve at this level in an administrative or advisory capacity. However, Private Voluntary Organizations may have expatriate administrators and medical directors. Guidelines have been set forth by GOP/UNHCR for salary scales for personnel. These appear in Appendix D.

Because of general unavailability of trained female staff, only 15 percent of the total health staff are female. Less than one percent of Medical Officers in GOP/UNHCR BHUs are female. Lack of female staff has serious consequences in this culture as male staff may not be allowed to attend female patients even in emergencies. A few expatriate female staff work in the field in some areas of Baluchistan where the lack of female staff is greatest. A training programme for traditional birth attendants, dais, is underway to provide additional, adequately trained female personnel to each BHU.

Minimum Staff for the BHU includes the following:

Medical Officer (in charge)
Staff (at least one of each)
- Lady Health Visitor, (LHV) or Nurse
- Compounder/Dispenser
- Midwife/Dai
- Malaria Supervisor/Sanitary Inspector
- Vaccinator/Motivator

Driver – if a vehicle is provided
Watchman
Labourer
* Community Health Worker Supervisor (2)
* Community Health Workers

* In areas which have a Community Health Worker Programme, these two staff positions have been added.

Optimal staff: population ratios have not been developed. However, greater numbers of each category of personnel are obviously needed in the larger BHUs.

Illustrative job descriptions for the staff appear in Appendix E. A set of authorized salary scales has been adopted. These appear in Appendix D.

A separate Sub-Unit staffing standard has been developed. The following staff are required for the Sub-Unit level:

- Compounder/Dispenser
- Vaccinator
- Lady Health Visitor (LHV) or Nurse
- Watchman
- Labourer.

Data Collection and Record-Keeping

The BHU has an important role in data collection and record-keeping that contributes to the overall management and success of the refugee health programme. Registers and reports of the Afghan Refugee Health Programme were revised in 1983 to correspond with the information requirements of its operation. A second revision of some of these forms is being carried out in 1985. Data from these are used for planning and evaluation of the qualitative development of the programme, and to improve the follow-up of individual

and family health status. The records basically follow the Pakistan Government's health services registration and reporting system, but have been adapted to meet specification requirements of the AR Health Programme.

An effort has been made to keep registers and reports as simple and limited in number as possible.

In all, 22 records, registers and forms are in use. They include:

Form AR-1	Family Record
Form AR-2	Family Card
Form AR-3	Ante-natal Record
Form AR-4	Growth Chart
Form AR-5	TB Record
Form AR-6	TB Card
Form AR-7	EPI Card
Form AR-8	Referral Form
Form AR-9	Monthly Report
Form AR-10	EPI Register
Form AR-11	EPI Monthly Report
Form AR-12	TB Monthly Report
Form AR-13	TB Summary Report
Form AR-14	Malaria/TB Worksheet
Form AR-15	Malaria Summary Report
Form AR-16	OPD Register
Form AR-17	EPI Permanent Register
Form AR-18	Note pad
Form AR-19	Supply Control Register
Form AR-20	Supply Control Card
Form AR-21	Drugs and Materials Order/ Supply Form
Form AR-22	Cold Chain Performances Worksheet

The forms and a brief explanatory note on the purpose of each appear in Appendix C.

Surveillance

New emphasis on and procedures for surveillance are being undertaken by the BHUs. It is important that the staff of the BHU consistently provide information on their case-load to the FSMO. Surveillance activities are intended to focus on the most important diseases (other than diarrhoeal disease) which are preventable or treatable. This important activity has two main elements:

- Laboratory tests will be carried out only for TB and malaria. Greater emphasis will be placed on testing for these major public health problems, as accurate diagnosis can be established only through laboratory testing.
- Surveillance will be increased for vaccine preventable diseases, particularly for measles. The Monthly Surveillance Report (AR9) has been revised to improve the accuracy of data collection. A copy of this Report is in Appendix C.

CHAPTER 5 Primary Health Care

Since 1983 efforts have been made to reorient the Afghan Refugee Health Programme (ARHP) toward Primary Health Care. The term as established at the Alma- Ata WHO/ UNICEF Conference in 1978, refers to "Essential health care made accessible at a cost the country and community can afford, with methods that are practical, scientifically sound, and socially acceptable. Everyone in the community should have access to it, and everyone should be involved in it. Related sectors should be involved in addition to the health sector. At the very least it should include education of the community on the health problems prevalent and on methods of preventing health problems from arising or of controlling them; the promotion of adequate supplies of food and of proper nutrition; sufficient safe water and basic sanitation; maternal and child health care including family planning; the prevention and control of locally endemic diseases; immunization against the main infectious diseases; appropriate treatment of common diseases and injuries; and the provision of essential drugs." (WHO/UNICEF Glossary of Terms, 1984).

The AR Health Programme Primary Health Care approach emphasizes health promotion and disease prevention within an integrated service structure; it is also expected to lead toward greater self-reliance of the refugees. It is expected that curative services will continue as the major activity of the programme. However, greater emphasis is being placed on general guidance and coordination, strengthening of field supervision and support, and on training of refugee personnel including community health workers (CHWs) and dais. Under this approach the CHW is definitely part of the BHU staff. It is the responsibility of the M/O and existing staff to utilize the CHWs to the maximum as a link among the community and other health team members.

Primary Health Care (PHC) is still new to many health workers, thus its implementation is in many ways still experi-

mental and evolving. A structure for implementing PHC has been put into place, necessary personnel posts have been allocated to the BHUs and various agencies are involved in expanding outreach and the involvement of the refugee community in health care. Community involvement through health committees and other health-related activities is occurring in some camps.

For the PHC approach to be successful, it is necessary to obtain information about the people of the camp – the numbers of men, women and children, prevalence of diseases and disabilities, seasonal differences in diseases and disabilities, principal health practices and beliefs, languages spoken, groupings of people by tribe or origin, and the like.

This information is best obtained at the level of the camp through formal survey, with good sampling methods. Such an approach is being used presently in pilot projects in several camps. However, much information is also available from the routine reporting system and surveys that cover the entire refugee population, such as the CDC infant mortality, maternal mortality and child nutrition survey, and anthropological and sociological studies conducted by the ILO and by the UN Research Institute for Social Development.

Encouraging Self-Reliance Among Refugees

The status of being a refugee in many cases brings about a dependency on those who help provide food, clothing, shelter and other necessary assistance. In refugee camps boredom caused by relative inactivity, fear of the fate of loved ones, anxiety about one's former home and longing for the home country contribute to mental illness among refugees.

The Primary Health Care approach can help in several ways:

- The programme can provide some refugees with health skills they can utilize if they are repatriated or resettled.
- Training and employment, as well as the health activities that follow, can help alleviate the low level of activity and resulting boredom encountered in the camps.
- Health education and services directed specifically at women can provide them with new activities and opportunities to learn new things, as well as improving their health status and that of their children.
- Trained refugees can help the health care programme be less dependent on national and international health staff, and thereby promote the refugees' capacity for self-care.

Role of the Community Health Worker and the Community Health Worker Supervisor

The role of the CHW is still evolving. The main functions of this role include:

- Health education with regard to basic hygiene;
- Instruction in prevention and control of diarrhoeal disease, TB, malaria, including teaching the preparation and appropriate use of ORS;
- Health education concerning environmental hazards (still water, garbage dumps, unhealthful food storage and handling in bazaars) and environmental hygiene;
- Promotion of latrine construction and use;
- Promotion of immunizations;
- Case-finding and referral to the BHU;
- Follow-up (of TB patients, immunizations, injuries);
- Provision of simple treatments, including injections (after prescription at the BHU) and first aid.

There is one CHW Supervisor for each camp and each CHW is responsible for 30 families. The CHW Supervisor supplies the CHWs with materials, provides training, monitors activities for them and ensures CHW coverage of the camp.

Selecting, Training and Supervising Community Health Workers

The AR Health Programme through several pilot efforts has begun to train previously untrained refugee community health workers and previously untrained but experienced dais. This effort has several advantages that can directly improve the health of refugees:

- CHWs are refugees who are invaluable members of the health team, acting as intermediaries between the target population and the health services.
- Being selected by the community itself, these trained refugees are far more likely to understand the cultural and behavioral circumstances contributing to ill health in the camps. They are more likely to speak the language commonly spoken by refugees.
- They can significantly ease the workload of the professional health workers.
  By being responsible for a defined number of households, or sections in the camp, they are invaluable for community-based health activities.
- They can have access to families otherwise likely not to be reached by the busy professional health team and can play a strong role in case-finding, health education, and follow-up.

Several Private Voluntary Organizations - Save the Children Fund, Austrian Relief Committee and UNICEF-have already been involved in selecting and training Community Health Worker (CHW) Supervisors. A model four-month training course for CHW Supervisors has been prepared. A

key feature of this training is to prepare CHW Supervisors to train CHWs.

Selection of CHW Supervisors and CHWs

Community selection and acceptability of CHWs are important. The ultimate goal is to include women as CHWs. This is difficult due to the tradition of Purdah, but vital if refugee women are to be adequately served.

The PHC approach requires that persons selected as Community Health Workers and CHW Supervisors be acceptable to the Community they serve. The pilot programmes using CHWs have used different approaches in making this selection. These approaches have included consultation with Maliks and other tribal elders; informal discussions and surveys in the camps; identification of people who seem trusted and able natural leaders; and formal meetings with community groups. The extent to which the community has been involved in final selection has varied. In one pilot programme considerable care has been taken to ensure acceptability of the CHWs to the community.

Training of CHW Supervisors and CHWs

CHW Supervisor training programmes have been developed by the agency, Save the Children Fund – United Kingdom.

Problem Areas

There are several impediments to rapid integration of PHC into the health programme:

- The use of CHWs is a much different approach to health care from that which physicians learn in medical schools. Thus many doctors have difficulty in accepting the new approach.

- Cultural barriers make it difficult to recruit women as CHWs. Separate training of dais is being organized as a parallel activity.
- Personnel with experience in selecting, training and supervising CHWs are lacking.
- The BHU structure continues to have an overall curative orientation.
- There is rapid turnover of senior medical and nursing staff, requiring constant orientation of new staff in the PHC approach.

CHAPTER 6 Referral Services

For hospital treatment or examinations the refugees are referred to Government hospitals or other health units. Financial compensation for these services is included in the AR health budget in the form of grants, paid by the relevant Project Directorate Health. A Referral Form (Form AR-8) is in use. It can be found in Appendix C.

Referral hospitals include the Government hospitals in provincial capitals (Peshawar, Quetta, Mianwali) and in each district. Financial support from UNHCR has been extended to Government hospitals to cover the drugs, equipment and materials used for treatment of refugees in these hsopitals. Private Voluntary Organizations' and bilateral assistance from other Governments have been channeled to these facilities and to numerous "Afghan Hospitals" in Peshawar and Quetta. There are twelve "Afghan Hospitals" of varying sizes in NWFP and eight in Baluchistan. Some of these offer specialized services such as eye care, obstetrics, surgery, or orthopaedics. They are listed in Appendix F.

The International Committee for the Red Cross (ICRC) maintains two surgical hospitals for war wounded, one in Quetta and one in Peshawar. In Peshawar, ICRC also supports a paraplegic centre and an artificial limb workshop.

A project to identify the disabled among refugees in RVs was started in 1985. The number of disabled refugees identified is projected to be between two and a half and three percent of the people. Cataracts and physical impairments are the disabilities most frequently seen.

The GOP/UNHCR plan to develop referral services for eye care, orthopaedics, war injuries and sequelae to neurologic disorders, using local volunteer services and government facilities. Patients with heart diseases are sent to specialized cardiac facilities. Hopefully dental services will be established.

Criteria have been established for refunding of individual medical claims. These criteria do not apply to the special agreements with hospitals. A copy of the criteria is in Appendix G.

Referral of Refugees for Treatment Abroad or Resettlement on Medical Grounds

Referral of refugees for treatment or for resettlement abroad on medical grounds may in some rare cases be necessary when the treatment or appropriate follow-up cannot be arranged in Pakistan. It is important that the cases for referral are prepared carefully and that all information necessary for making decisions is provided when presenting the case.

A case of referral or resettlement must be based on a certificate of a physician registered by the Pakistan Medical Association. The certificate must be typed or otherwise legible and carry the stamp or other identification of the physician. This physician may be one selected by the UNHCR Office/ Sub-Office or the patient's own physician.

The certificate must clearly state the diagnoses, symptoms or deficiencies, medical history, result of medical, laboratory, X-ray and other examinations with dates.

The physician must give his recommendations of additional examinations and treatments which he considers necessary, indicating also which examinations and treatments cannot be provided in Pakistan. The physician must state the reasons for his recommendations in respect to referral or resettlement abroad.

UNHCR Office/Sub-Office should make sure that the certificate and any other documents supporting the case are translated in English if the originals are in another language.

The Office must refer the case for consultation to

another physician for a second opinion before submitting the case for referral or resettlement. This physician must be a UN Examining Physician or a specialist selected by him or by the Director Medical Services for Afghan Refugees (in Islamabad) or by the Project Director Health for Afghan Refugees (Peshawar, Quetta and Lahore).

The documentation on each case must be checked for adequacy by the UNHCR/WHO Senior Health Coordinator or by the UNHCR/WHO Programme Officers Health (Peshawar and Quetta).

In emergency cases the procedure may be shortened in consultation with the Health Coordinator or with the Programme Officers Health. Essential information for decision making at the receiving country must be provided in these cases as well.

CHAPTER 7 Organization of Emergency/ Disaster Assistance

It is important to plan for emergency assistance within an ongoing relief programme. Disasters can be either environmental (earthquakes, floods, landslides) or ma -made (the physical consequences of war and other strife). Medical staff must be alert to further needs for emergency or disaster assistance and cooperate with other officials. Trained, aware staff are best able to cope with emergencies. There have been frequent overflights and random bombings by planes crossing the Afghan/Pakistan frontier. Most of the refugee camps are located in an active earthquake zone and some are subject to floods or landslides. Some property damage, injury, and loss of life of refugees and of nearby local inhabitants have occurred because of strife, earthquake, or accident. Refugee Village Administrators optimally have plans for evacuation or emergency care of refugees that may be affected by these occurrences. Every BHU needs to be a part of RVA planning for emergencies. Prompt medical response is particularly essential in traumatic disasters where surgical care, blood, or plasma may save lives in the early stages.

Procedures

The Pakistan Red Crescent has been designated in charge of disaster assistance. In event of an emergency, ICRC has full access to UNHCR vehicles, helicopters, and other material assistance. The UNHCR stockpiles drugs for 10,000 refugees for 3 months, plus emergency tents. Additional emergency personnel would be procured as needed from the GOP and local agencies.

At the onset of an emergency, BHUs should cope according to their possibilities, and should immediately make an appropriate request to UNHCR. UNHCR in turn will notify the following authorities:

1. CAR
2. PDH, to secure vehicles, personnel, etc.
3. ICRC, to inform them what vehicles and materials are available.

In the event that UNHCR cannot be reached, the others may be contacted directly by the BHU staff.

Triage

Triage is the selection and classification of the sick and wounded patients for attention in the face of overwhelming needs and insufficient resources. The aim is to provide priority assistance to those most likely to benefit. While it is a likely requirement after a severe natural disaster or in times of conflict, triage is rarely necessary in refugee emergencies. If there is a need for triage, classification is usually by three categories: those who cannot benefit from the treatment available under the emergency conditions and are therefore not treated; the seriously ill or injured who should be attended to first; and those who, after initial first aid, can wait for medical attention until after the second category of persons has been treated.

Assessment of an Emergency

Only infrequently can an emergency be predicted with accuracy. Thus it is important to have plans that can be set into action without advance warning. The following information must be obtained and evaluated to assess the extent of an emergency and to plan initial responses. Each Medical Officer should review this periodically with his staff to ensure preparedness. The MO should cooperate with RVA authorities in general emergency planning. In the event of an emergency, all staff should meet at the BHU, if possible, to make initial plans and obtain emergency supplies.

Planning Questions

- What is the nature of the emergency? Is assistance needed or can the refugees cope by themselves with the problem?
- How serious is the situation? What are the main problems? (List in order of priority.)
- How many people are affected? Men, women, children, elderly or ill?
- What are the strict medical needs? Surgery, plasma, or other?
- What medical rescue measures are indicated? What trained personnel are available?
- What are public health needs? For example, prevention of spread of typhoid, mass innoculation.
- What inputs are needed? Cash, supplies, personnel?
- What should be planned for short, mid and long term? What should be the objectives?
- What shelter is available?
- Is evacuation indicated?
- What factors are likely to lead to a further deterioration in health? For example, lack of safe water, lack of shelter.
- Are identified leaders of the refugees available to assist with an evacuation or other emergency needs?
- Where can the refugees go? Nearby town or village; by what road?
- Are vehicles available to assist with evacuation? How many? What kind?
- What communication links are available? With UNHCR? With PDH? With ICRC?
- Does the situation lend itself to orderly removal of population if necessary? Or is the best direction for removal unclear?

CHAPTER 8 Management, Coordination, Monitoring and Training

Management

The GOP/UNHCR framework for management of the AR Health Programme is described in Chapter 3. In practice there is a close liaison between GOP and UNHCR in overall management of the funding and implementation of the programme. Private Voluntary Organizations are subject to the general management practices and reporting requirements of GOP/UNHCR. However, they follow their own policies for purposes of internal management. Each participating organization working in the AR Health Programme manages its staff and fiscal practices according to its own policies.

Coordination and Collaboration

Coordination of activities and collaboration among GOP, UNHCR and PVOs is essential. In addition to the provincial level structure, FSMOs have been established at the district level to enable closer coordination of field activities. The staff of FSMOs include supervisors in maternal and child health, EPI, sanitation and malaria control, as well as laboratory staff for TB and malaria diagnostics.

Methods for coordination include:

(1) **Establishment of standards, guidelines and practices**

The purpose of establishing standards, guidelines and practices is to ensure that overly large differences do not exist among agencies and that the elements in one agency programme affecting the work of others are essentially the same. These include salaries of local staff (Appendix D), management of priority preventive programmes and monthly reporting. Pertinent standards and guidelines are described in this booklet.

(2) **Regular contacts between the agencies**

Periodic workshops and regular meetings among agencies have been established. Such meetings may provide an opportunity for the agencies to share information on their experiences in a specific work area, for example, Primary Health Care NWFP has routine meetings. National, annual refugee health workshops have been held since 1982. Less formal individual meetings at the national or provincial level take place frequently to provide continuous communication between government and the agencies. These meetings have added to the flow of information and the coordination of activities.

(3) **Provision of standard supplies of items like vaccines, insecticides etc.**

An importation service and cold chain have been established for the Afghan Refugee Expanded Programme for Immunizations (EPI Programme) which is administered separately from the GOP EPI programme. Principles have been developed for supplying drugs to BHUs. The following time table should be followed:

- ORS should be ordered in advance and new stock is received every April.
- Insecticides will arrive by March for twice yearly spraying.
- Vaccines will arrive as needed.
- Vaccines are supplied as needed from the central Warehouse (cold room).

The flow of ordering at GOP/UNHCR BHUs is as follows: Dispenser to PDH to Warehouse directly to BHU. Sometimes the Warehouse sends drugs to the BHU via the FSMO.

The PVOs should obtain and maintain their own supply system in accordance with the timetable noted above for obtaining ORS and insecticides; they should refer to the

guidelines for EPI for the timetable for vaccines (Chapter 12). Otherwise, they should have ample stock on hand as described in the drug list in Appendix B.

Monitoring

The registers and reporting system of the AR Health Programme are discussed in Chapter 4 and in Appendix C. Statistical information obtained from the system is routinely collated and presented in the AR Health Programme Annual Report. The information is used to indicate progress and weaknesses of the programme so that programme strategies may be improved. It should be noted that cholera and typhoid are diseases reportable to GOP.

Routine reporting from BHUs cannot be expected to provide information which would be sufficient to monitor the health status of the population. Therefore, a system of annual surveys of a representative sample of refugees has been established to provide information on several health status indicators. These are:

- Infant mortality,
- Childhood mortality,
- Maternal mortality,
- Immunization coverage, and
- Nutritional status of children.

The surveys seek information on the causes of death as well as on main diseases. The methodology has been standardized in collaboration with the Centers for Disease Control (U.S.A.). The first survey took place in 1984.

Other surveys have been undertaken to study particular problems, for example, tuberculin testing to establish estimates on prevalence of tuberculosis, a small-scale survey of malaria incidence and studies on malnutrition. Such specific studies will be conducted whenever necessary.

Training

The professional staff members of the AR Health Programme are largely young, recent graduates from medical colleges and from Public Health Schools. Staff turnover is high. The experience of the entire staff in health promotion and disease prevention is minimal and extensive training and reorientation have been necessary. Private Voluntary Organizations are encouraged to send their staff for training offered by GOP/UNHCR and to open any courses they offer to Government staff.

Types of Training Offered

The following types of training have been organized for staff. They will be repeated as required by staff turnover or, if additional refresher training is indicated, as resources become available.

- Primary Health Care and Health Education Medical Officers and Lady Health Visitors.
- Health Programme Management – FSMOs.
- Preventive health, including Primary Health Care, management of integrated health programme, TB control, malaria control, EPI, diarrhoeal disease control, health education, sanitation – Medical Officers and LHVs.
- TB and Malaria laboratory diagnostics – Microscopists.
- On-the-job training – Sanitarians.
- Nutrition education training – selected Supervisory level staff.
- Diarrhoel disease control and EPI – selected Supervisory level staff.
- Primary Health Care – for Community Health Worker Supervisors, Community Health Workers, and Dais (TBAs).

Standardization of Training

Materials for training sessions have been compiled and distributed, including health education materials and posters designed in collaboration with Private Voluntary Organizations.

Materials used in training include WHO's *Primary Health Care Worker* and *On Being in Charge,* distributed to all supervisors and all BHUs. Other specific WHO publications and *Refugee Community Health Care* have been distributed to all supervisors. A small library of publications is available in the UNHCR offices for the use of all agencies.

The training programmes are conducted under the sponsorship of GOP/UNHCR, Private Voluntary Organizations and certain academic institutions in Pakistan and abroad.

CHAPTER 9 Transport, Supplies and Equipment

Transport

There are five main aspects of the transport system used in the AR Health Programme:

(1) Considerations that should be taken into account when selecting and purchasing new vehicles;

(2) Considerations that should be taken into account when using presently-available vehicles;

(3) When it is appropriate to lease instead of buy a vehicle;

(4) Appropriate use of government vehicles not directly under the control of FSMOs and BHUs;

(5) Responsibility for maintenance of vehicles.

Selection and Purchase of Appropriate Vehicles

Various means of transport should be considered when planning for a new BHU programme or for replacement of existing used vehicles. Different types of transportation may include:

- multi-purpose van or pick-up,
- ambulance,
- front-wheel drive vehicle,
- rear-wheel drive vehicle.

Due to financial constraints not every GOP/UNHCR BHU will find it feasible to have an ambulance. A multi-

purpose vehicle such as a Toyota Hilux pick-up will prove useful for most purposes. For community aspects of the BHU programme, including transport within camps or some in dispersed settlement areas, alternatives to four-wheel vehicles should be considered. These alternatives may include: motorcycle, motorized bicycle and animal transport.

The cost of maintenance and operation as well as initial purchase price should be taken into consideration. The purchase price and fuel/oil price have been shown to escalate increasingly over the years of operation of the health programme. Local terrain, nearness to paved roads and similar considerations also should be evaluated.

Use of Presently Available Vehicles

Use of transport by all agencies should follow certain rules of common sense:

Light delivery vehicles and other less expensive vehicles should be used for routine daily staff transport rather than expensive, special-purpose designed vehicles. Two or three two-wheel "pick-up" trucks cost the same as one four-wheel drive vehicle.

Four-wheel drive vehicles should be used only in a limited number of situations in which it is essential for the vehicle to be able to cover exceptionally difficult terrain (where no roads exist). These vehicles are expensive to buy and to operate. They should not be used in towns and where roads are generally good. The running (operating) cost of a four-wheel drive is double the cost of a small van.

"Purpose-built" vehicles, such as ambulances, x-ray units, dental units and others should be used only for the purpose for which they were designed. It has been the experience in other relief activities that in practice such vehicles are used for other purposes such as general transport. Prac-

tical considerations are that the vehicles are too large for any but the best roads; their life expectancy is generally quite short. Care should be taken before a decision is reached to buy additional special-purpose built or adapted vehicles.

"Mobile" units are far less cost-effective than the provision of care from fixed clinics. This finding has been made in many relief and non-relief situations. Fixed clinics are more routinely available to people, have the psychological advantage of being perceived as available and have lower equivalent annual capital costs than do mobile units.

Leasing Instead of Buying Vehicles

For programme needs for hauling of materials, leasing or hire of vehicles rather than purchase should be considered. It may be less expensive to budget for intermittent hire than for purchase. Anticipated needs for hauling should be estimated (e.g. number of trips per week, times, number of km.). These figures should be compared with the purchase, operating, driver costs of a vehicle, taking into account its anticipated life expectancy.

Appropriate Use of Vehicles Owned by Other Branches of Government

The transportation and bulk distribution of relief supplies to the provinces is controlled by the CCAR at Islamabad. Two transport battalions have been raised under National Logistic Cell for Baluchistan and NWFP while a small number of cargo trucks have been supplied to the Punjab. Relief goods are dispatched to the Provincial Headquarters by rail or by road. From the Provincial Headquarters they are distributed to the individual RVs by road, using NLC or hired transport; NLC is the main means and avoids double handling enroute by private carriers.

Maintenance and Repair

The maintenance and appropriate use of motor vehicles by health programmes are historically poor. Health programmes are seldom equipped to run adequate maintenance and repair facilities for vehicles.

Maintenance and repair of GOP/UNHCR vehicles is the responsibility of the PDH. There is no central maintenance center for vehicles. Maintenance needs to comply with owners' manual recommendations for each vehicle. Maintenance and repair of vehicles owned and managed by PVOs is their responsibility.

When vehicles are ordered, most commonly needed spare parts as recommended by the manufacturer for servicing and routine replacement, equalling 10% value of the vehicle, should be ordered to ensure their availability when needed. UNHCR keeps a small stockpile of spare parts for its vehicles.

Supplies and Equipment

Distribution and Storage of Supplies

Programme supplies including EPI, administrative forms, drugs and other routine supplies rely on a Government-operated distribution system. Storage facilities are available at Provincial and District/Agency Headquarters for short term storage before actual distribution of goods to the RVs. Temporary storage facilities exist in the RVs to prevent stores from deteriorating in poor weather and to prevent pilferage until they are distributed to refugee families.

Antipilferage Measures

To guard against mis-appropriation, pilferage and losses in transit, the following measures are enforced:

a) On receipt of shipments, contents are checked carefully for short receipts, breakage and losses through other means.

b) Railway wagons are properly loaded and sealed with appropriate lead seals before dispatching in the presence of a board of officers (comprising Director, C&F/Director, Food/MINFA/Provincial Representatives).

c) Consignees are required to open the wagons in the presence of a board of officers and record all losses, shortages/breakages immediately on receipt (Representatives of CARs/CCAR).

d) The disbursement Registers are required to be filled in at the time of disbursement and signatures of tribal elders/councillors are required in the appropriate column of the register as evidence.

e) All issues are made during the appointed working hours and from the authorized distribution points only.

Acquisition of Equipment

It is extremely important that equipment which is purchased or donated for the AR Health Programme be appropriate for use in Pakistan. Electrical equipment is difficult to utilize effectively as most refugee villages do not have electrical power. In the facilities that do have electric power there is another consideration: During the spring and summer months there are many hours each day when there is no electricity available (load shedding) making electric equipment totally useless. In addition the voltage is 220 and not all equipment is designed for this voltage. A voltage regulator is required to protect motors from power surges which occur frequently.

It is difficult to service and obtain repair parts for equipment procured abroad. Frequently neither the technology for repair nor the parts are available locally. In order to purchase parts from abroad, the purchaser must have foreign currency as rupees are not always accepted. The process of obtaining foreign currency is a lengthy one. Achieving access to foreign suppliers is also a difficult task. The best approach to the acquisition of appropriate equipment is to procure it locally; only then can its repair, replacement and servicing be assured.