- PART C -

# ESSENTIAL PROGRAMMES IN REFUGEE HEALTH

Despite the diversity in refugee settings, it is clear that certain activities can make a real impact on refugee health and nutrition.

This section addresses ten essential programmes, which when co-ordinated with other assistance efforts, are priorities for action in all refugee communities.

## TOPIC C.1

## 1.0 HEALTH SCREENING OF NEW ARRIVALS



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| | | |
|---|---|---|
| **Objectives** | o | identify individuals who need urgent care |
| | o | refer critically ill refugees for treatment |
| | o | prevent risk of measles outbreak by immunization |
| **Target Groups** | o | all new arrivals in camp |
| **Co-ordinate Action between** | o | health programmes and camp administration |
| | o | screening site and treatment/referral centre |
| | o | screening site and nutrition/MCH services |
| **Collect Information** | o | general demographic patterns (age/sex) |
| | o | population distribution by camp section |
| | o | numbers and location of high-risk groups |
| | o | major health/nutrition problems |
| **Monitor Progress** | o | tally daily results: |

- numbers of new arrivals
- immunizations given
- total vitamin A recipients
- numbers given ORT
- numbers referred to MCH/nutrition programmes

# 1.0 HEALTH SCREENING OF NEW ARRIVALS

## 1.1 Importance of Health Screening

It is important that health screening is integrated with the registration of arriving refugees wherever possible, as it is one of the first activities to be initiated during a refugee emergency. Each new arrival should be screened quickly so that large numbers of new arrivals can be registered and evaluated without delay. Food and water must be provided as necessary during the screening process.

## 1.2 The first priorities for medical personnel are to:

| | | Reference |
|---|---|---|
| 1. | Identify critically ill persons to be transferred directly to the health centre | |
| 2. | Identify dehydrated children and provide provide oral rehydration therapy | Annex D.D.(3) |
| 3. | Administer Vitamin A capsules to children under 12 years of age (200.000 I.U.) | Nut.Doc(5) |
| 4. | Administer measles immunization to all children between 9 mths - 3 yrs of age* | I.Doc(3) Page 92 |
| 5. | Screen children under 5 years for malnutrition and refer for further nutritional assessment when indicated | Page 81 |
| 6. | Refer pregnant & lactating women to mother and child health services and special feeding programmes | Page 83/104 |

**Dosage: 200,000 IU vit.A for children of 12 mths. or older, and 100,000 IU vit A for children less than 1 year old.**

* If vaccine availability permits, include all children under 5 years and where the prevalence and severity of malnutrition is high, consideration should be given to the inclusion of children less than 12 years of age.

## 1.3 Identifying and Tracing other Vulnerable Groups

By linking health screening activities with registration procedures, it is possible to identify - and then trace vulnerable individuals and groups who will need supervision by community health workers. These groups include:

- o the unaccompanied
- o elderly
- o widows
- o disabled
- o pregnant women
- o young children

A simple form as shown in figure 2. provides a method for organizing this information by section of residence, and can serve as a useful basis for determining health priorities by geographic location.

Figure 2
Simple Form for Tracing Vulnerable Individuals

| Vuln.Groups | Camp Section 1 | | 2 | | 3 | | Total |
|---|---|---|---|---|---|---|---|
| Child < 5 yrs. | 6 | 6 | 2 | 2 | 11 | 7 | 15 |
| Pregnant women | 3 | 3 | | 0 | 12 | 12 | 15 |
| Elderly | 1 | 1 | | 0 | 2 | 2 | 3 |
| Widows | 8 | 8 | 1 | 1 | 13 | 13 | 22 |
| Disabled | 2 | 2 | 1 | 1 | 3 | 1 | 6 |
| Unacc. | 10 | 10 | 8 | 8 | 1 | 1 | 19 |
| Others | 2 | 2 | 1 | 1 | 3 | 3 | 6 |

### Guide to Annexes and Documents

| | |
|---|---|
| Annex D.D.(3) | Examples of Calculations of O.R.S. Requirements |
| NUT.Doc(5) | Field Guide to the Detection and Control of Xerophtalmia A.Sommer WHO (1982) |
| I.Doc(3) | Handbook for the Emergency Immunization Kit WHO/OXFAM/UNHCR (1986) |

TOPIC C.2

## 2.0 HEALTH SURVEILLANCE AND SURVEYS IN REFUGEE SETTINGS



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| | | |
|---|---|---|
| Objectives | o | to monitor the health status of the population as a whole |
| | o | to identify high-risk groups |
| | o | to monitor the effectiveness of health programmes |
| Targets Groups | o | camp population |
| | o | high-risk populations (young children, pregnant women) |
| Co-ordination Between | o | personnel responsible for surveillance/surveys and:<br>- camp administration<br>- other health/nutrition programmes |
| Collect Information | o | data from all health/nutrition programmes |
| | o | camp census information |
| | o | information on births and deaths |
| | o | surveys for baseline data |
| Monitor Progress | o | collate information monthly in stable situations |
| | o | evaluate patterns in mortality/morbidity/nutritional status |
| | o | carry out surveys regularly to accurately determine health/nutrition patterns |

## 2.1 Surveillance

### 2.1.1 Definition

Surveillance is the systematic collection of information for action. It involves an ongoing watch over the health status of the refugee community as a whole - as well as specific high-risk groups, so that priorities for action can be promptly identified and services directed appropriately.

To be effective, refugee health surveillance activities must:

- o balance limited resources and time available to health staff with the need for collecting information for decision making
- o gather only that information which will actually be used in the selection and management of health programmes.
- o be linked with other aspects of refugee health through a cycle of:

Reporting

Response Analysis

Feedback Interpretation

2.1.2 Planning Surveillance Activities

a) Considerable care is needed when designing a surveillance system.

One of the first questions which should be addressed is:

**To what degree should the refugee surveillance system correspond with local reporting requirements in the host country?**

Early collaboration with national counterparts, and a detailed review of local and national reporting systems may prevent later difficulties, particularly if local reporting requirements are complex. Where this is the case, it may be more effective to limit reporting requirements to an essential but useful minimum; thus it is likely that the participation and compliance of field health personnel will be greatly improved.

b) The Choice of Indicators

1) When selecting indicators to be included in a surveillance system, it is essential to consider the intended use for this information. In general, the key indicators used in an ongoing system are based on findings from the rapid epidemiologic assessment (p.33) plus other sources of relevant health information. These include:

- o direct observation
- o reviews of available health records
- o interviews with health personnel
- o discussions with informed refugees

2) Suggested items for surveillance include:

- o diseases common to all refugee situations
- o diarrhoea, measles, respiratory diseases
- o childhood diseases
- o whooping cough, polio, tetanus
- o diseases presenting a risk in specific environments
- o meningitis in the Sahel
- o dengue fever in S.E. Asia
- o relevant demographic statistics
- o births, deaths, population movements

- plus -

- o coverage information from refugee health services
- o proportion of children under five years who have received measles vaccination

### 2.1.3 Key Considerations for Designing Reporting Forms

**Successful surveillance means simple surveillance!**

| When: | | this results in: |
|---|---|---|
| Information is limited to essential items in early phases. | ------> | increased participation; improved compliance; less complex analysis needs. |

(See Annex E.S.(1) & (2) for forms)

While the specific items included may differ between refugee situations, standard categories of information should include:

| | |
|---|---|
| o identification of the reporting unit | Camp Name |
| o identification of individual responsible for reporting | Camp Medical Co-ordination |
| o duration of reporting period | From Date: _____<br>To Date: _____ |
| o dispatch date for the report | Day Month Year |
| o demographic data | total population:<br>beg./month; end/month<br>age/sex distribution<br>total under fives |
| o mortality data | total deaths<br>infant/child mortality<br>causes |

| | |
|---|---|
| o morbidity data | - diarrhoeal diseases,<br>- communicable diseases |
| o information on unusual events | - festivals, camp emergencies, official visits |
| o comments | - delayed food deliveries<br>- changes in health/ nutrition programmes<br>- significant changes in camp policy, seasonal variations |

2.1.4 Implementation and Maintenance of a Surveillance System

a) Practical Considerations

Elaborate and complex surveillance activities are usually impractical in refugee settings. When designing a surveillance system, careful consideration must be given to the demands of each situation, and the limitations/capabilities of camp health/administration personnel, (i.e. staff time, competing work priorities).

Other practical concerns include:

- sufficient stationery, supplies, calculators.
- clearly understood standardized forms.
- training needs for refugee, administration, health workers.
- co-ordination of deadlines for data from individual programmes and reporting units.

b) Standardized definitions and procedures

It is essential to establish standard definitions and procedures for a surveillance system to work effectively.

This includes:

- o **standard disease definitions**
- o standardized reporting forms
- o **standard symptom definitions**
- o standardized procedures for form completion & submission

c) Methods for Introducing Surveillance Activities

Actual methods used to introduce a surveillance system may differ between refugee settings. The approach taken is influenced by several factors which include local reporting requirements as well as the skills/capabilities of camp health personnel to implement surveillance.

| Activities for Instance | It is necessary to: |
|---|---|
| o In all situations | hold camp-level meetings to co-ordinate reporting procedures and activities. |
| o In camps where health personnel have past experience/training in surveillance | organize a visit by regional/ national co-ordinators/ epidemiologists to provide general surveillance advice |
| o In camps where health personnel have little surveillance experience | organize assistance by trained personnel to introduce the system |
| o In situations involving multiple reporting units with different agencies | arrange regional/national meetings to standardize reporting forms and surveillance procedures |

The design and distribution of surveillance forms, diagnostic criteria and reporting guidelines do not ensure an effective surveillance system. It is also essential to:

- o involve the participating agencies at an early stage
- o carefully consider the demands that surveillance reporting makes on camp personnel
- o set up a mechanism for prompt feedback to:
  - camp health/administrative personnel
  - national health authorities
- o if an effective surveillance system is to be maintained

Technical assistance by trained surveillance personnel is particularly helpful at national, regional and camp levels in the planning and introduction of a surveillance system. Their involvement is useful for clarifying guidelines, motivating health staff, for practical problems solving assistance, and - at later stages - providing timely feedback.

d) Accuracy in reporting

Clearly one of the pre-conditions for effective surveillance is accurate reporting. This is affected by many of the factors already described (adequate resources, trained personnel, standardized forms). It is also important that health personnel submit "negative reports" when no cases of death or notifiable diseases are seen, as the objective of surveillance is the ongoing collection of health information.

e) Frequency of Reporting

Frequency of reporting varies according to the urgency of the situation:

1) For instance: May be appropriate for:

- o daily reporting ---> epidemics,
- o weekly reporting ---> early stages of assistance
- o monthly reporting ---> stable ongoing situation.

2) While monthly reporting may be adequate for ongoing surveillance needs in a stable situation, it is essential that communicable disease outbreaks are reported immediately to co-ordinators at all levels. In all situations, the first confirmed or highly probable case with the following communicable diseases must be reported by radio or telephone to regional/national co-ordinating personnel.

| | |
|---|---|
| o measles | o meningococcal meningitis |
| o diptheria | |
| o suspected typhus | o cholera |

(This list may be expanded in response to national communicable disease reporting requirements.)

This is necessary - not only for initiating prompt control measures, but also for notifying regional/national health authorities so that necessary protective measures can also be implemented for the local population.

f) Assessing the surveillance system

Two months after surveillance activities have been initiated, procedures should be reviewed to identify and solve difficulties in reporting. At regular intervals in an assistance programme, opportunities should be made at regional and national levels to refine/improve surveillance requirements so that the system can evolve and adapt to changing needs.

2.1.5 Uses of Data

a) The way in which data is presented greatly influences its interpretation. If information is to provide the basis for decision-making by administrators at all levels, it must be organized in a meaningful way.

b) Wherever possible, population denominators should be used so that percentages and rates can be calculated. This allows useful comparisons between different time periods and between different populations - rather than trying to interpret absolute numbers.

For example:

In two monthly surveillance reports from one camp, the following facts are provided:

| Month | Camp Population | Total Deaths | Population < 5 years | Deaths < 5 years |
|---|---|---|---|---|
| January | 20,540 | 40 | 3,780 | 28 |
| February | 23,260 | 35 | 4,830 | 30 |

However, to more clearly compare this information, some basic rates and percentages should have been included.

For instance:

| Month | Camp Population | Deaths No. | Mortality Rate* | Pop.< 5 yrs. | | Deaths < 5 yrs | |
|---|---|---|---|---|---|---|---|
| | | | | No. | % of Total Pop. | No. | Rate |
| January | 20,540 | 40 | 19.47 | 3,780 | 18% | 28 | 74 |
| February | 23,260 | 35 | 15.04 | 4,830 | 21% | 30 | 62.10 |
| * Deaths per 10,000 per day . | | | A | | B | | C |

These figures quickly show that:
A - total death rate has declined from 19.47/10,000 to 15.04
B - camp population of under fives has increased from 18% to 21%
C - death rates for under fives have decreased from 74/10,000 to 62.10

c) By calculating simple percentages and rates in this way, it is possible to detect trends in refugee health over time. As data is collected over the course of months - or years in long-term settlements - health patterns can be compared to determine the impact of seasonal or other factors - and related to health activities so that overall programme effectiveness can be measured (i.e. comparing the incidence of vaccine preventable diseases with imunization coverage estimates.)

By compiling information in this manner it is also possible to conduct further analysis (i.e. by calculating confidence intervals) to determine whether changes in mortality/morbidity patterns are statistically significant - or due to chance alone.

d) Percentages of specific diseases seen by a clinic or hospital may be useful for the planning and administration of the health service in question. However, they cannot be used in determining the rate of new cases of a disease in the population.

i.e.

| |
|---|
| the incidence of a particular disease (the number of new cases of disease) at a clinic |

| |
|---|
| is not the same |

| |
|---|
| as the incidence in total population |

Changes in health centre incidence should therefore, be used as an indicator for more extensive investigations.

2.1.6 Feedback

- o During the emergency phase, effective surveillance plays an important role in promptly identifying diseases and the major health problems facing a refugee population. In this way, it provides a sound basis for adapting health services to prevent further spread of diseases during this particularly vulnerable period. Even after the acute period has passed surveillance reports data may still show rising patterns of morbidity. This may be the result of improved reporting and case definition - rather than actual increases in sickness.

- o The distribution of surveillance information to a broad audience by the proper authorities is important for keeping camp staff, agency representatives, selected administrators, media personnel, and key decision-makers regularly informed. The creative presentation of data in simple tables, maps or graphics with comments and interpretation is strongly urged. Reports and articles should identify the names of contributing individuals and agencies.

  Maintaining surveillance after the acute phase of interventions has passed may become difficult. When necessary, adjustments in the original surveillance system and imaginative efforts to motivate participation may be required.

- Because surveillance data are particularly useful in comparing long-term trends, it is absolutely essential that reports are systematically filed. This is particularly important for reference purposes (i.e. in comparing infant mortality rates during the same season - but in different years).

- So that surveillance information can be applied to programme planning and evaluation, an annual surveillance report should be compiled at camp, regional and national levels.

- Based on statistics collected during the preceding twelve months, this report should provide information on:

| |
|---|
| o demographic patterns - population under five, in and out migration.<br>o mortality trends - particularly infant mortality.<br>o morbidity - as compiled from health centres and decentralized clinics.<br>o patterns in the health of young children:<br>- nutritional status<br>- immunization coverage<br>o patterns in communicable diseases<br>o coverage and attendance statistics for: mother-child health services, nutrition and T.B. programmes.<br>o average attendance for health centres/decentralized clinics.<br>o other relevant facts. |

Not only does this summarize seasonal illness patterns, it also provides a basis for comparison with regards from preceding years, and provides a timely opportunity to review health and nutrition programmes at all levels.

### 2.1.7 Action

Perhaps the most important aspects of surveillance activities are to use the information to:

| |
|---|
| o identify high-risk populations<br>o identify appropriate and relevant responses<br>o evaluate programme effectiveness |

When a surveillance system successfully achieves these objectives and is closely co-ordinated with the activities of other programmes, it becomes one of the most important tools for the management of health/nutrition programmes in refugee settings.

## 2.2 Surveys in Refugee Settings

### 2.2.1 Importance of Surveys in Refugee Communities

a) When surveys are carried out in refugee populations, they aim to describe the distribution of a disease or condition in some randomly selected group in relation to age, sex and other characteristics.

Although surveillance findings provide an ongoing view of refugee health patterns, these are usually based on reports from outpatient services and other programmes - which do not necessarily represent the actual distribution of disease in the community. Therefore, surveys are particularly useful for gathering more precise information about the prevalence of health problems in the population itself.

b) Specifically, survey activities can provide valuable information regarding:

| | |
|---|---|
| o the extent of a health/nutrition problem | to determine early priorities in programme planning |
| o the identification of high-risk groups | to target services more effectively |
| o disease trends over time and<br>o programme coverage | to enable programme monitoring, and provide a rational basis for modifying activities. |

c) In refugee camps, survey techniques have been effectively used to determine:

- o nutritional status of young children
- o prevalence rates of certain conditions
  i.e. - malaria
  - anaemia
  - tuberculosis
  - intestinal parasites
- o coverage estimates of key programmes
  i.e. - MCH
  - immunization

### 2.2.2 Potential Sources of Error

Although well executed surveys can give useful information for programme planning and management, they are subject to several sources of error:

- Non-randomness of the sample.

  For example anthropometric data may be obtained by a team walking from area-to-area of a camp. This may cause systematic biases. It is likely that older, healthy children will be included and young, ill children will be excluded from the sample.

- The failure to calculate confidence limits:

  All random sample surveys provide estimates not exact measurements. However, the accuracy of the estimate depends on several factors, including sample size.

  A random sample nutrition survey, for example, do not lead to the conclusion that, say 20% of a population is malnourished. Rather, the conclusion is that the sample drawn allows the prevalence of malnutrition in the general population to be estimated within defined limits.

  For example: If a sample of 100 children was taken randomly to determine a malnutrition rate, confidence limits could be calculated by reference to appropriate statistical tables which relate prevalence rates to sample size.

  In this example, the confidence interval - which reflects the degree of uncertainty created by the sampling - would be 12.6 - 29.2 ninety-five per cent of the time.

  If however, the samples were increased to 300 children then the degree of confidence calculated for a prevalence rate of 20% malnutrition would be increased, as the confidence interval would be smaller, i.e. 15.6 - 25.0 ninety-five per cent of the time.

  Therefore for the sample of 100 children with 20% prevalence of malnutrition

  - there is a 95% probability that the estimate of malnutrition will fall between 12.6 and 29.2

  while for the sample of 300 children with 20% prevalence,

  - there is a 95% probability that the estimate of malnutrition will fall between 15.6 and 25.0.

  In this sense, the smaller the confidence interval, the more useful the estimaed prevalence of a condition or disease.

  The calculation of confidence limits is particularly valuable when comparing apparently similar survey findings obtained at different times:

  > For instance, in comparing estimates of nutritional status established on two occasions for the same population. By calculating confidence limits, it is possible to detect whether a real change has occurred in this particular population.

o The failure to precisely define terms.

For example, a survey result showed xx% of diarrhoea. Diarrhoea has very different meanings to different people and within different societies. Therefore, when conducting surveys, it is an absolute necessity to precisely define the variables/factors being studied. In this example, a precise definition of diarrhoea might be "liquid or fluid stools at least 3 times a day for more than 48 hours".

### 2.2.3 Key Considerations in Carrying-Out Surveys

Although entire textbooks have been devoted to the in-depth description of survey techniques, only those considerations which are the most relevant to refugee situations will be outlined.

a) Methods for Selecting Random Samples

There are two random sampling techniques which are appropriate for use in refugee settings:

| | | which is appropriate for: |
|---|---|---|
| o | direct or stratified random (whereby the sample is drawn from a sampling frame: list of names, number of households etc...) | - small camp populations in<br>- stable communities with<br>- household addresses |
| o | cluster sampling<br>Refer to Nut.(3) | - large camp populations in<br>- disorganized settings where<br>- household addresses are non-existent or haphazard. |

b) Organization of a Survey

A well executed survey must be well organized and carefully planned and should be supervised by a qualified individual who has expertise in survey methods. Other essential components include:

- o clearly defining the survey's objectives
- o organizing and standardizing equipment
- o training survey personnel so that all procedures are standardized
- o co-ordinating with refugee representatives, camp administration and health programmes to obtain co-operation, support and advice
- o deciding in advance how the data will be analysed
- o considering important details
  - i.e. - sufficient tubes for collecting blood-samples
  - labelling and transportation of specimens to laboratories
- o COST

As surveys are often time-consuming and relatively expensive (i.e. manpower, equipment etc), the question which must always be addressed in the planning phase is:

Will the survey findings provide at a justifiable cost, information which is useful for:

- (re)defining programme priorities?
- targeting services more effictively?

c) Analysis and Interpretation of Data

i) The sophistication of data analysis and the way in which information is interpreted is determined by several factors.

These include:

- o the statistical expertise of survey personnel
- o the range and complexity of information collected
- o the survey's purpose
- o the likely audience for the survey's findings
- o access to computer facilities

ii) In general, it is most useful to organize survey data in simple 2 x 2 tables, relating the condition under study with important variables (i.e. sex, age, location in camp, duration of stay)

For example:

(C)

| | Nutritional Status | Duration of Stay in Camp <1mth. | % | 1-3mths | % | >3mths | % | Total | % |
|---|---|---|---|---|---|---|---|---|---|
| (A) | < 70% wt/ht | 6 | 28 | 5 | 23 | 2 | 8.3 | 13 | 19 |
| | 70-79% wt/ht | 10 | 47 | 7 | 33 | 8 | 33.3 | 25 | 37 |
| (B) | 80% + wt/ht | 5 | 23 | 9 | 43 | 14 | 58.3 | 28 | 42 |
| | Total | 21 | 100% | 21 | 100% | 24 | 100% | 66 | 100% |

By calculating simple percentages in this example, it is possible to identify a pattern in nutritional status which is related to duration of stay in camp. In the example given above, the table shows that for all children surveyed:

- o (A) 28% of those in camp less than one month were below 70% wt/ht, compared with 8.3% of the children who had been in the camp longer than 3 months.
- o (B) Only 23% of children who had just arrived were at least 80% wt/ht, compared with 58.3% of those who had stayed more than 3 months.
- o (C) Of all children surveyed, 19% fell below 70% wt/ht, while 37% found to be between 70-79% wt/ht, 42% were at least 80% wt/ht.

iii) Even without access to computer facilities, it is usually most feasible to calculate rates, percentages and confidence intervals from the data provided - as these are more easily understood than more complex forms of analysis, and can be readily compared with findings from preceding surveys.

iv) An important consideration in data interpretation is the impact of confounding variables which may distort the survey results. For instance, in the malnutrition example given above, it seems clear that nutritional status improves with duration of stay in camp. However, this trend may be due to the confounding effects of high mortality in new arrivals.

d) Reporting Survey Findings

i) This is a critical component of a well executed study. When survey results are presented in a clear understandable way, they become extremely useful for programme planning and management at all levels.

ii) **For survey findings** to be meaningful, they should always include:

- o a brief statement addressing the need for the survey
- o a clear statement of objectives
- o a detailed description of the methods used
  - i.e. - sample selection
  - definition of terms
  - data collection methods
  - data analysis
- o clearly presented statistics in labelled tables and graphs
- o a discussion of results
- o recommendations for action.

iii) Wherever possible, a brief one page description of methods and findings should be attached to the report, as this provides a useful summary for later discussion. The survey findings should be circulated promptly through appropriate channels, and discussed with relevant health and administrative personnel, so that programme changes can be implemented as indicated by the survey results.

Guide to Annexes and Documents

E.S.(1) Weekely Surveillance Reporting Form
E.S.(2) Monthly Surveillance Reporting Form

TOPIC C.3

## 3.0 COMMUNITY HEALTH WORKERS



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| | | |
|---|---|---|
| Objectives: | o | to provide a link between health services and the refugee community |
| Target Population | o | those households specified within designated catchment zones |
| Co-ordinated Action Between | o | CHW programme & decentralized clinics & health centres |
| | o | CHW programme & preventive services (i.e. MCH, Selective Feeding, Immunization, Vector Control) |
| Collect Information | o | determine population location from camp administration |
| | o | define catchment areas also from camp administration |
| | o | estimate size of target groups per section from CHW reports |
| Monitor Progress | o | record number of CHW referrals/month to and from clinics |
| | o | calculate total number of home visits made |
| | o | compare referral patterns with clinic utilization data between sections |
| | o | evaluate the nature of referrals to and from CHWs to identify gaps in care and breakdown in co-ordination (i.e. many feeding centre referrals - but few from MCH or outpatient clinic) |

### 3.1 The Need for Community Health Workers

3.1.1 The early establishment of a community health workers (CHW) programme is an essential step if health and nutrition services are to actively reach out to all residents of a refugee camp. As stated earlier, an effective CHW programme provides an important link between health services and the community, and:

- o enables health problems in the camp to be identified
- o enables prompt diagnosis and treatment
- o promotes understanding of communitie's perception of problems and is a vehicle for community education
- o allows health statistics to be collected

3.1.2 These important needs are addressed through home-visiting activities which include:

| | For example: |
|---|---|
| o case-finding | o malnourished children |
| o giving basic medical treatment | o first-aid, ORT etc. |
| o referring individuals | o to clinics, MCH |
| o following-up | o patients receiving T.B. treatment |
| o carrying out basic surveillance | o reporting births & deaths |
| o providing health education | o personal hygiene, Oral Rehydration Therapy (ORT), food and nutrition |

## 3.2 Initial Activities

During the emergency phase, the first tasks of community health workers include:

- o to screen house-by-house for malnutiriton and other illnesses, and to motivate those in need to attend the appropriate services;
- o to assist in the distribution of vitamin A and oral rehydration therapy (ORT);
- o to gather basic demographic data (e.g. total numbers of women/men, adults/children, etc.);
- o to assist in vaccinating against measles.

Due to initial time constraints, refugees who assist in these activities are likely to be young, multi-lingual men. Although they are necessary in the emergency phase, they may not be appropriate as long-term health care providers. It may be advisable to hire health workers initially for short periods or on a task basis rather than as 'permanent' staff.

## 3.3 Establishing a Community Health Worker Programme

The establishment of a CHW programme is clearly a priortiy after the needs of the emergency period have been addressed. However, for such activities to be successful, the following issues should be considered:

| | | |
|---|---|---|
| o selection | o organization | o payment |
| o supervision | o co-ordination | o responsibilities |

### 3.3.1 Selection

The selection of individuals who are acceptable to the community and who are willing to work with the health services is often the most difficult component of a CHW programme. Traditional health care providers and 'lay' persons can both be included in a CHW programme. In addition to the workers' individual characteristics, careful consideration should be given to their acceptability as health providers to the community. For instance, CHWs should have credibility with long-established health workers such as traditional birth attendants and traditional healers. For this reason, it is often preferable to select older individuals whoe advice will be respected, partiularly women who have had children.

### 3.3.2 Organization

Appropriate ratios of CHWs per population will vary according to each siutation. Some factors to consider include the geographical layout of the camp, the tasks of CHWs, the health status of the population and resources which are available. As a guide, one refugee CHW should be assigned to 80-100 families (400-500 people).

### 3.3.3 Payment

Payment is a concern which must be given careful thought especially as programmes based on voluntary service have been relatively unsucessful, particularly in long-term settlements. When considering payment for CHWs, it is essential to keep in mind:

- o the host government's policies and preferences
- o the type of payment (ie. in-kind, or cash)
- o the relativity between salaries of the CHWs and those of other refugee health workers.

### 3.3.4 Supervision

As with other health services, adequate supervision and support are essential if CHW activities are to be effective. In the programme's early stages, the demands for supervision and training may be considerable. Therefore, wherever possible it is essential that an organised system is set up for health workers to:

- o seek advice and assistance when needed
- o have on-going training
- o have opportunities for discussing problems encountered
- o replenish supplies and equipment
- o resolve organizational difficultires such as referral procedures and co-ordination with other problems

Specific arrangements for supervising CHWs may differ between settings. However, it is essential that specific responsibility for the overall supervision of outreach activities is assigned to a senior member of the health team (i.e. senior nurse).

### 3.3.5 Co-ordination

Because CHWs provide a critical link in care between curative services (i.e. decentralized clinics), preventive activities (MCH, health education) and the refugee community, their activities must be closely co-ordinated with these other services.

It is particularly important that catchment areas are carefully defined, geographically, to ensure all households are visited. This also avoids "double-visiting" by more than one CHW, which is not only confusing to the refugee families concerned - but a wasteful use of manpower.

### 3.3.6 Responsibilities

Because of the varied range of tasks CHWs perform (see para. 3.1.2), it is clear that they should not be assigned other duties in clinics, feeding programmes or related services. It is also important that health workers in other programmes clearly understand the CHWs function, so that they can be an effective link between these services and the refugee population. A clear understanding of their role for instance, ensures that clinic patients in need of follow-up are promptly referred to the appropriate CHW - and, in turn, when refugees are referred to the clinic by a CHW, they are assured of receiving prompt and appropriate care.

## 3.4 Assuring Programme Continuity

Because the effectiveness of CHW activities partly rests on their continuity over time, it is essential that long-term funding assurances are secured during the programme planning stages.