TOPIC C.6

IMMUNIZATIONS

Objectives:	o	conduct an emergency mealses campaign
	o	establish an ongoing expanded programme of immunization
	o	establish procedures for management of the vaccine cold chain
Target Population	o	children under five years old
	o	women of child-bearing age
	o	pregnant women
Co-ordinate Action	o	between field and central/regional vaccine stores at field level among MCH and CHW programmes
Collect Information	o	determine size of target groups from registration data
	o	determine vaccination priorities from surveillance reports
Monitor Progress	o	evaluate surveillance reports for trends in EPI target diseases
	o	investigate outbreaks to determine non-immunized groups
	o	determine coverage by conducting follow-up survey.

IMMUNIZATIONS

- o A considerable number of child deaths in refugee camps are due to preventable diseases.

- o Because immunization has a real impact on the prevention and control of such diseases this should be considered an early priority in all refugee settings.

In carrying out immunization programmes targeted for refugees, there are three important objectives:

- o conducting an emergency measles campaign

- o establishment of an ongoing expanded programme of immunization

- o safe management of the vaccine cold chain.

6.1 An Emergency Measles Immunization Campaign

6.1.1 Key Considerations

The major issues in conducting a measles vaccination campaign include:

- o effective organization at vaccination sites

- o preparation of the vaccine and equipment (establishment of the cold chain)

- o safe administration of the vaccine

- o thorough sterilization of syringes and needles

- o follow-up activities:

  - organizing records
  - vaccination coverage survey
  - second and third campaigns as needed to achieve a minimum of 30 percent coverage.

> Measles vaccination coverage rates must be at least 80 percent of the targeted group in order for the programme to effectively prevent an outbreak

6.1.2 Determining Target Population and Vaccine Needs

a) In nearly all refugee situations, measles epidemics are a major cause of death in children. Furthermore, because it is difficult to predict when a measles outbreak will occur, the only effective prevention is mass vaccination of young children. In emergency measles immunization programmes:

o the first priority	---->	children aged 9mths-3yrs.
o if resources permit	---->	children aged 9mths-5yrs.
o where prevalence of severe malnutrition is high	---->	consider children 9mths-12yrs.

b) Mass vaccination against measles is simplified because:

- o only one vaccine dose is necessary
- o an emergency cold chain kit has been designed by OXFAM-WHO-UNHCR (see I.Doc.(3))

When determining the quantity of vaccine required for a measles campaign, the steps to be taken are listed below:

1. Estimating the total population	
2. Estimating the number of children to be vaccinated.	with adequate resources: children 5-59mths = 12-20% pop with limited resources children 9-36mths = 5-8% pop.
3. Calculate number of doses required	a single dose per child
4. Allow a wastage factor (i.e. 10%)	

6.2 Expanded Programme of Immunizations (EPI) for Refugee Settings

6.2.1 Objective

The aim of an EPI programme is to reduce childhood morbidity and mortality from important communicable diseases which are vaccine preventable. (These include measles, poliomelites, diphtheria, tetanus and pertussis)*

The need for preventive measures such as immunisation is greater for refugee children because of the crowded and poor sanitary conditions common to refugee camps. Additionally, the organization of immunization activities may be easier among densely populated refugee camps than for local, scattered populations.

6.2.2 Early Priorities

The establishment of an effective expanded programme of immunization depends on several key factors. These include:

- o the establishment of basic services (e.g. water supply, sanitation, public health and curative services)
- o the feasibility of establishing an ongoing cold chain

* In some countries, other vaccination priorities may include immunization for yellow fever and meningococcal meningitis. These address a wider age-range of population.

- o the adequacy of coverage possible through available services such as CHW and MCH programmes
- o possibility of close collaboration with local authorities and adherence to national immunization policies.

6.2.3 Key Considerations in Programme Management

The main considerations in an effective expanded programme of immunization include:

- o definition of target groups
- o effective programme organization
- o health education
- o disease surveillance
- o programme evaluation
- o safe vaccine use
- o accurate recording
- o appropriate training
- o outbreak investigation

a) Target Group

- o Priority should be given to the immunization of children under five years, unless local epidemiological evidence warrants otherwise.
- o Admission of tetanus toxoid to women of child-bearing age is also important in preventing neonatal tetanus.

b) Safe Vaccine Use

i) Recommended vaccination schedule for young children:

Table: Vaccination Schedule for Young Children

Target Diseases	Birth or 1st contact Age	6 wks	10wks	14wks	9mths
T.B.	BCG				
Polio	OPV	OPV	OPV	OPV	
Diptheria		DPT	DPT	DPT	
Pertussis		DPT	DPT	DPT	
Tetanus		DPT	DPT	DPT	
Measles					Measles

ii) Comments on Individual Vaccines

- o OPV (Oral Polio Vaccine:)
  - There is strong evidence that OPV given to neonates provides early protection.
  - TOPV can be given at birth or at first contact.
  - Routine immunization with OPV can be initiated at six weeks of age.

- o D.P.T. (Diptheria, Pertussis, Tetanus)
  - Routine immunization with DPT can be initiated at six weeks of age
- o Tetanus Toxoid:
  - All women of child-bearing age should receive two doses of tetanus toxoid 4 weeks apart to protect infants against tetanus in the neonatal period.
  - The second dose should be administered at least 4 weeks before birth.
  - These injections should be given during the first pregnancy, if not before.
  - An additional "booster" dose is required for subsequent pregnancies.

> Tetanus toxoid (T.T.) may be administered to pregnant women any time during pregnancy

iii) Sterilisation of Equipment

> A sterile needle and a sterile syringe must be used for each injection to prevent transmission of hepatitis & AIDS

Needles and syringes are sterilized at a temperature of 121°C for 20 minutes. Pressure sterilizers have recently been developed for sterilizing instruments for immunization. In the absence of pressure sterilizers, needles and syringes should be cleaned and boiled in water for 20 minutes.

c) Effective Programme organization

Immunization schedules which require more than 1 vaccine dose need more organization. It is always more difficult to attain a high coverage for the second and third doses. There are 2 main ways to organize immunizations:

i) mass campaigns
ii) MCH services

The appropriateness of these two methods varies with the specific refugee setting, and is determined by:

- o the degree to which health services are organized
- o the extent of population stability
- o the size of the target population
- o the levels of current morbidity and mortality specific to vaccine-preventable diseases.

d) Accurate recording and reporting of immunization data

The number of immunizations should be recorded and reported regularly. The minimum information required concerns the type of antigen, the dose, and the children's ages. For the purposes of easy recording, age is divided into three major groups:

o less than one year o one to two years o over two years

This age breakdown is generally used worldwide, but it is advisable to check with the national immunization authorities so that reporting practices conform with the national requirements of the host country. Particularly in situations where refugee health services will be integrated with those of the host country, it may be appropriate to adopt the "national immunization card" used for local population.

e) Health education

The following points on immunization programmes should be emphasized within the context of general health education for the public:

o The purpose of immunization;
o The possibility of side-effects;
o The need for subsequent visits;
o The safe keeping of immunization cards.

f) Appropriate Training

i) Contra-indications

Two major reasons for the under-utilization of immunizations are the reluctance of health workers to administer vaccines when a child is not in perfect health, and the long list of contraindications for immunization. Generally mild and minor illnesses should not be considered as contraindications to immunization.

General guidelines to be stressed in the training of health workers are listed below:

o Health workers should use every opportunity to immunize eligible children;

o The risk of serious complications due to vaccines used in EPI is much less than the risk from natural diseases;

o It is important to immunize children suffering from malnutrition, low-grade fever, and mild respiratory infections;

o Diarrhoea should not be considered a contraindication to oral polio vaccine. Additional doses, however, should be administered when the diarrhoea has ceased;

- o Wherever possible, hospitalized children should receive appropriate immunization before discharge. In some cases, immunization may also be appropriate on admission, if there is an increased risk of hospital-acquired measles.

ii) Resources available for training

Six training courses have been prepared by WHO for use in EPI programmes. These include:

- Planning and management course (11 modules)
- Mid-level management course (9 modules)
- Primary Health Care logistics course (24 modules)
- Immunization in practice (7 modules)
- Training course on refrigerator maintenance (8 modules)
- Training course for repair technicians of compression refrigerators (7 modules).

Of these materials which are considered applicable to most immunization programmes, the two most relevant to refugee settings are:

	Which gives:
o Immunization in practice (Refer I.Doc(1).)	basic information for vaccinators and describes what vaccinators must be able to do
o Mid-level Management Course (Refer I.Doc.(2).)	information relevant to the management of immunization programmes

g) Disease Surveillance

Surveillance data on EPI target disease incidence trends. However, in many refugee camps it is difficult to accurately record disease-specific morbidity and mortality. Data on the incidence of the EPI target diseases reflects the impact of immunization and should be provided regularly by each camp or locality. The immunization history of cases of EPI target diseases should also be recorded. A simple format has been suggested which corresponds with many national reporting policies. If all the information cannot be made available, then at least the information on measles cases and deaths should be reported accurately as possible. (refer I(1).)

h) Outbreak Investigations

Outbreak investigation of the EPI target diseases is an important component of an effective immunization programme. Because it is expected that disease outbreaks will occur in non-immunized populations, it is essential that standardized procedures are followed in the investigation and control of these vaccine preventable diseases.

In refugee camps, the investigation and control of measles outbreaks is of extreme importance at all times.

i) Programme Evaluation

The accurate measurement of vaccination coverage is an essential step in determining expected reductions in morbidity and mortality from vaccine-preventable diseases, and is thus important for evaluating the effectiveness of the programme. The vaccine must also be given at the right time to the correct target population. This may be evaluated through a process called "coverage evaluation survey" based on the cluster sampling method described in Nut (3).

6.3 The Cold Chain

6.3.1 The cold chain is a system for distributing vaccine in a potent state from the manufacturer to the actual vaccination site. The cold chain system is necessary because vaccines are sensitive to heat. If vaccines are exposed to heat, they will have a shorter life. Some vaccines are more sensitive to heat than others. The following vaccines are listed in order of heat sensitivity: polio vaccine (most sensitive to heat), measles, DPT, BCG, tetanus.

6.3.2 The essential elements of the cold chain system are:

people to organize and manage the vaccine distribution;

equipment to store and transport vaccine.

The importance of people in the cold chain cannot be stressed enough. Often the cold chain is thought to refer only to the refrigeration of vaccine. Even if the finest and most modern equipment and transport are vailable, the cold chain will not be effective if people do not handle the vaccine properly.

6.3.3 In general, if vaccines are kept at the recommended temperatures, they will remain potent for a long time. The table below shows the recommended storage temperatures and storage times at various levels in the cold chain.

Table of Recommended Temperatures and Storage Times

VACCINE LEVEL: Maximum Storage Time:	CENTRAL STORE up to 8 months	REGIONAL up to 3 months	HEALTH CENTRE up to 1 month	TRANSPORT up to 1 week
Measles Oral Polio	-15°C to -25°C			
DPT Tetanus Toxoid BCC			0°C to +8°C	

Note: NEVER FREEZE DPT OR TETANUS (which both freeze at temperatures below about -5°C) - as these vaccines will lose their potency -

Storage times are recommended maximum figures - remember to check the expiry dates on the vaccines.

There is no way of telling if a vaccine is potent by looking at it. There are, however, 'time/temperature indicators' that can monitor temperature as the vaccine travels down the cold chain. These indicators should be used in all vaccine stores.

> If vaccines are exposed to higher temperatures, they can lose their potency rapidly. Once this is lost, it cannot be restored.

For example:	But:
Measles vaccine stored at + 5°C	measles vaccine exposed to 40+C
Maintains its potency for 2 days	loses its potency in 1 day

After dilution, measles and BCG vaccine are very heat sensitive and should be used as quickly as possible. After dilution, these vaccines should never be kept overnight for another vaccination session.

GUIDE TO REFERENCES

I(1) Immunization Monitoring and Surveillance Forms

I.Doc.(1) Immunization in Practice: A Guide to Health Workers Who Give Vaccines: Nos.1-7: EPI/WHO

I.Doc.(2) Training for Mid-level Managers EPI/WHO

I.Doc.(3) Handbook for the Emergency Immunization kit (OXFAM/WHO/UNHCR)

Nut(3) Guide to Conducting Nutrition Surveys: COR/UNHCR Health Unit, E. Sudan (1985)

TOPIC C.7

MOTHER AND CHILD HEALTH SERVICES

Objectives

- to provide health care to women and children throughout the periods of pregnancy, birth, lactation, early infancy and childhood

Target Groups

- children under five
- pregnant women
- lactating women

Co-ordinate Action Between

- traditional birth attendants and MCH programme
- MCH clinic activities and CHWs
- MCH services with decentralized clinics, feeding programmes and health care

Collect Information

- assess census data for size of target groups
- assess surveillance data to determine programme priorities
- determine traditional beliefs and practices concerning child care and women's health

Monitor Progress

- assess monthly coverage rates of target groups
- calculate and compare immunization coverage quarterly
- evaluate mortality patterns in under-fives (ie. compare death rates due to diarrhoeal diseases/dehydration)
- evaluate trends in nutritional status of under-fives - particularly children of weaning age

MOTHER AND CHILD HEALTH SERVICES

7.1 The Importance of Mother-Child Health Services and Programme Objectives

7.1.1 In refugee settings, women and children often comprise a large proportion of the camp population. It is important to realize that health workers can provide a valuable bridge between the assistance programme in general, and the needs of the refugee community as a whole. Because health programmes must respond to the refugees' most individual needs, health workers are in a special position to advocate on behalf of the refugee population. Furthermore, this relationship also enables health workers to bridge apparent differences in perspective, and to explain assistance priorities and constraints to the refugees. It is this special relationship between health workers and the refugee community that can allow differences to be better understood.

Furthermore, women and children are particularly vulnerable for several reasons:

- the process of displacement often disrupts family ties, and eliminates the sources of support previously available. For young women, this means the loss of older women relatives such as mothers, aunts, and older sisters from whom they would usually seek advice.

- in many instances, women must adopt the often unfamiliar role at household head, particularly if the refugee community has been depleted of men due to war fatalities or ongoing fighting.

- in developing countries, even in the absence of crisis, the major health problems are those which concern children and women in the child-bearing ages.

Because these disorders are often made worse by the overcrowded conditions in many refugee camps, the prompt estabishment of mother and child health services should be an important priority in all refugee communities.

The objective of MCH activities is:

> to provide health care to women and children throughout the periods of pregnancy, birth, lactation, early infancy (up to 12 months of age) and early childhood (under five years)

7.2 Organization of MCH Services

7.2.1 Because MCH programmes must address the needs of such a large and dispersed target group, they should be organized effectively.

This involves:

(a) **Assessing census information and maps showing camp layout**

- o to define the size and location of target groups
- o to determine appropriate MCH catchment areas

(b) **Reviewing survey findings and surveillance reports**

- o to determine programme priorities for mother and child health

(c) **Co-ordinating with other health and nutrition services**

- o to site MCH clinics near to other decentralized programmes
- o to link community health worker activities with clinic services so that:
  - eligible women and children are promptly referred for medical treatment
  - high-risk individuals and non-attenders are quickly followed-up at home

(d) **Establishing links with the refugee community**

- o to determine the presence of traditional birth attendants, and extent of their role
- o to develop an understanding of traditional beliefs regarding:
  - child care, health care in pregnancy and child birth
  - cause and treatment of common conditions (diarrhoea, fever)
- o to explain the <u>need</u> for MCH care to the refugee community
- o to explain <u>how</u> to use the services and <u>where</u> to seek these

(e) **Initiating training activities for refugee health workers**

- o to involve refugees in the overall management of MCH services

(f)

Standardizing procedures for:

- o registration
- o monitoring attendance and coverage
- o referral to other programmes
- o record-keeping

- o to ensure smooth programme management and co-ordination with other services

(g)

monitoring MCH activities

- o to determine programme: coverage
  acceptability
  effectiveness

7.2.2 When these actions are taken in the early phases of an MCH programme, ie. when:

- o the target group is known
- o active outreach to women and children occurs
- o decentralized activities are sited close together
- o MCH services are linked with other programmes and the community
- o procedures are standardized within the programme, and between other services
- o surveillance information is reviewed regularly to determine priorities and redirect activities

... then these services can make a real impact on the overall health of women and children.

7.2.3 Refugee manpower: the role of the traditional birth attendant (T.B.A.).

In many refugee populations, the T.B.A. plays a critical role in the health of women in the child-bearing ages. Therefore, for MCH services to be truly effective, it is important that a co-operative and mutually respectful relationship evolves between organized MCH activities and practising T.B.A.s.

7.3 MCH Activities

7.3.1 MCH programmes emphasize the curative as well as the preventive aspects of care for women and children. This includes:

preventing illness and nutritional deficiencies

through:

- active outreach by CHWs
- health education in clinics, households and community
- referral to feeding programmes for pregnant and lactating women
- immunization
- iron and folic acid supplements in pregnancy

early diagnosis of health and nutritional problems

through:

- growth monitoring of young children
- screening measures for common health/nutritional problems

prompt treatment, referral and follow-up

through:

- use of O.R.T.* for dehydrated children
- referral of malnourished children to supplementary feeding
- referral of children and women with health problems to decentralized clinics or camp health centre for treatment
- home follow-up of women and children considered at high risk

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* Oral Rehydration Therapy

7.3.2 Care for Women

MCH care for women should be directed to their needs:

- during pregnancy
- delivery
- in the post-natal period
- during lactation

(a) During the ante-natal period (pregnancy), these activities are aimed at:

	by:
o preventing illness and nutritional deficiencies	- health education - referral to feeding programmes - immunization against tetanus - administration of antimalarial tablets in high-risk areas - administration of oral iron and folic acid supplements to prevent anaemia
o early diagnosis of health and nutritional problems	- measuring blood pressure to detect hypertension - diagnosis and treatment of common problems - screening for anaemia and intestinal parasites
o prompt treatment, referral and follow-up	- identifying and referring women with non-serious health problems to decentralized clinics - identifying and referring women who are "high-risk" to the health centre for care*

(b) Care during Delivery

In most refugee settings, deliveries generally occur at home. Therefore, in those camps where traditional birth attendants supervise home births, it is important for health workers to develop co-operative relationships with these respected community members.

To promote safe home deliveries, plus the prompt recognition and referral of high-risk patients, the following MCH activities are essential:

	for example
o establishing co-operative relationships with traditional birth attendants	- training, supervision - supply of delivery packs (razor blade, string, gauze, soap, antiseptic tetracycline eye ointment 1%)

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* these conditions include: abnormal presentation
fifth or more pregnancy
severe anaemia
toxaemia
height below 151 cm
diabetes, tuberculosis

so that

TBAs will:

- recognize potentially complicated deliveries — prolonged labour, retained placenta, excessive bleeding during delivery
- have confidence to refer these to the health centre
- carry out safe hygienic home delivery

and

- seek additional assistance from other skilled health workers when necessary — seek advice from national/foreign midwives
- ensuring qualified staff and facilities are available to manage complicated deliveries — midwives, doctors; sufficient supplies; sterile instruments

o establishing a system for immediate transfer to local hospitals for extremely complicated deliveries — agreed upon referral protocols; transportation

(c) Care after Delivery and during Lactation

Beginning with the immediate post-natal period, MCH activities should focus on the needs of both mother and child, through:

(i) preventive efforts

which include:

- o training TBAs to closely monitor mother and child for complications after delivery
- o home-visiting by CHWs to provide advice, and to encourage attendance at MCH clinics for both mother and child
- o promotion of breast-feeding

and

- o referral of women to supplementary feeding to meet increased caloric needs created by breast-feeding

- o health teaching regarding:
  - children's health and nutrition needs
  - child spacing
  - preparation of weaning foods
  - importance of immunization
  - preparation of O.R.T.

(ii) **early diagnosis and referral**

which include:

- o identification of high-risk mothers
  - who are depleted <u>physically</u> due to many pregnancies
  - who are <u>socially</u> vulnerable (ie. widows with several children)
  - with health problems in need of care (TB, chronic anaemia)
- o identification of high-risk infants
  - those with low birth weight (less than 2.5 kg)
  - those with poor weight gain
  - those with repeated infections (A.R.I.s*, diarrohea)

7.3.3 <u>Care of Children under Five</u>

MCH activities play an important role in preventing and treating commone health problems which face the under-fives in a refugee camp. The main emphasis for activities targeted at under-fives is:

- o the prevention and prompt recognition of illnesses and nutritional problems
- o prompt treatment and referral

Preventive activities include:

- o immunization (through camp-based EPI activities)
- o nutrition education for mothers
- o promotion of breast-feeding
- o advice to mothers on child spacing
- o training mothers in the prompt detection of problems and preparation of O.R.T.

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* Acute Respiratory Infections

Health monitoring activities & referral

- o monthly growth monitoring
- o referral to supplementary feeding for moderately malnourished children
- o referral to therapeutic feeding for severely malnourished children, plus:
  - medical evaluation
  - home visits by CHW
- o home-visiting of non-attenders
- o prompt referral to decentralized clinics/ health centre of sick children

7.4 Record-keeping in MCH Programme

Effective record-keeping is an essential pre-condition for the management of MCH activities.

This takes two forms:

- o record-keeping within the clinic
- o individual records retained in the family

7.4.1 Clinic records

Well-organized systems should be set up for:

(a) overall programme management

Information which should be systematically recorded includes	which, when calculated monthly indicates:
o registration and actual attendance data	o effectiveness of outreach o adequacy of coverage o acceptability of programme

(b) Health and Nutrition Surveillance

Information which should be systematically recorded includes	this is useful for: indicates:
o numbers of children: - in each ht/wt category - who increase, decrease, or maintain a stable weight	o calculating percentages of malnourished children for nutrition surveillance

o numbers of children who have received immunization	o determining immunization coverage
o numbers of women found to have health problems in pregnancy - categorized by major problem	o determining health patterns associated with pregnancy
o numbers of births, categorized by delivery site (ie. home or clinic)	o determining birth rates and trends in delivery preference
o birth weights (if feasible in first 24 hours)*	o levels of ante-natal care o health status of new born

(c) Effective follow-up of high-risk individuals

Information which should be systematically recorded includes:	this is essential for
o names and addresses of malnourished children	o prompt follow-up if they fail to attend clinic weighing sessions
o names and addresses of women and children with more serious health problems (ie. children with diarrhoea, or women with TB)	o adequate follow-up and health teaching in the home o prompt recognition of problems by CHWs - with referral to MCH centre or decentralized clinic

7.4.2 Individual Records

Because of the mobility of refugee populations, it is important that pregnant women and children under five are issued with their own health records - in the form of simple, durable health monitoring cards.

for pregnant women	for under-fives
o ante-natal card (see MCH(1))	o road-to-health card

* One possible measure to encourage early weighing after birth might be to insist that an additional general ration will only be allocated to the household if the newborn has an MCH card with a weight recorded.

Because these are often the only record of complications in pregnancy, or of a child's immunization history, they must be:

- o valued and understood by the refugees
- o brought to each clinic attendance
- o accurately completed by clinic staff
- o safely protected - with a durable plastic bag

In some refugee settings, it may be appropriate to use ante-natal or under-fives' cards approved for use in the host population. This is clearly a practical measure when refugee health services are to be integrated with those of the host country.

7.5 Mother and Child Health Care as a Family/Community Concern

In many refugee camps, women and young chilren together comprise a significant proportion of the population. However, it should always be remembered that the health concerns of these groups are influenced by the refugee community itself and by factors within the family. For instance, in many cultures, decisions regarding preferred family size and food distribution within the family unit are made by the male head of household. Therefore, if MCH activities are to have an effective impact on the health of women and children, they must reach out and include other refugee groups. This involves the use of creative yet culturally appropriate methods to stress key points at all levels in the community:

	for instance:
At the family level	involving the husband in discussions initiated when a CHW visits the home
At a group level	organizing informal health classes amongst small groups of workers (include many topics. ie. simple first aid, along with MCH subjects)
At a community level	- colourful posters promoting immunization located at food distribution sites - mobile puppet shows/theatre plays/songs, etc.

Guide to References

MCH(1) Examples of Ante-natal Cards

MCH Doc.(1) Primary Health Care Technologies at the Family and Community Level, The Aga Khan Foundation, WHO, UNICEF (1986)

TOPIC C.8

CURATIVE CARE AND IN-PATIENT SERVICES

Objectives	o to provide basic diagnostic and curative services to a population within defined geographic limits o to provide prompt referral to other services so that appropriate care and follow-up can be given
Target Groups	o residents of geographically-defined catchment areas = decentralized clinics o the camp population = health centre
Co-ordinate Action between:	o decentralized clinics and health centre o decentralized clinics - MCH, CHW and nutrition programme o health centre and local hospital facilities
Collect Information from:	o attendance records o diagnoses made/laboratory findings
Monitor Progress by	o assessing average daily/weekly attendance levels o determining referrals to and from OPD to determine adequacy of cross-referral between services o assessing clinic compliance of chronic patients

CURATIVE CARE AND IN-PATIENT SERVICES

8.1 The Need for Curative Care

The major health emphasis in refugee settings is to prevent sickness through co-ordinated public health action and sanitation measures. However, provision must also be made for adequate curative care, as refugee populations - particularly in the early stages - are confronted by multiple health problems which require prompt diagnosis and treatment.

8.1.1 The aims of curative services are to diagnose and treat diseases in order to:

- o prevent further morbidity and mortality
- o interrupt disease transmission - limiting further spread to the community.

While such care is usually provided in health centres and decentralized clinics, it must be co-ordinated with the actions of other health programmes such as:

o nutrition services	o sanitation activities
o community health worker activities	o mother and child health services

to:

- o ensure adequate coverage
- o prevent duplication of services
- o provide adequate follow-up of high-risk patients
- o ensure cross-referral to other services

8.2 Levels of Curative Care

While curative care should respond to the differing needs of each refugee setting, it should always be organized to ensure the widest coverage possible with the most effective use of manpower.

This is best accomplished by a system of:

	to provide:
o community health workers	o basic first-aid o daily treatments (ie. TB patients) o follow-up for defaulters o referral of patients o patient education (eg. drug use)

o decentralized clinics run by health assistants/nurses	o general out-patient care o dressing and injection services o drug prescription and dispensing
o health centres run by doctors, senior nurses health assistants	o out-patient services for referred cases o dressing and injection services o central pharmacy o referral services for decentralized clinics, CHW programmes o limited in-patient care o special clinics for chronic patients

8.3 Providing Out-patient Services

8.3.1. At the decentralized clinics and the camp's health centre, the majority of patients require ambulatory or out-patient care, rather than in-patient attention.

The out-patient clinic addresses these needs by providing a service for the diagnosis and management of common health problems, which include:

- o diarrhoeal diseases
- o respiratory infections
- o malnutrition and other nutritional disorders
- o skin diseases
- o specific tropical illnesses (ie. malaria)

Although these diseases are prevalent in most refugee settings, actual O.P.D. attendance rates may be influenced by many factors, such as:

- o the degree of seriousness in the refugee situation
- o illness prevalence rates
- o clinic acceptability to the refugees
- o clinic accessibility
- o refugees' socio-economic background and expectations of health services

During the emergency phase, clinic attendance is often high due to the seriousness and widespread nature of the refugees' health problems. However, as conditions improve, consultations for minor ailments (insomnia, slight pains) become more frequent, and may indicate increasing levels of psycho-social stress and anxiety.

At all stages in the provision of out-patient care, it is an absolute necessity that clearly-defined protocols are formulated for the use of drugs by community health workers, in decentralized clinics as well as the health centre. This requires that a list of essential drugs is specified for use and that standardized treatment protocols are adhered to by all health workers (see D.Doc (2)).

8.3.3 Q.P.D. Organization

(a) Within the camp

Among the major organizational considerations in the management of out-patient services are:

- o effective utilization of health manpower
- o co-ordination with other services

(i) At a central level, the following staffing patterns are suggested for the camp's health centre:

o National, Expatriate or Refugee Professional Staff

Doctors or Senior Nurses	: 1 - 2 per 20,00 refugees
Nurses	: 5 - 8 per 20,000 refugees
Pharmacist	: 1
Laboratory technician	: 1 - 2

o Refugee Health Workers

Health assistants	nursing aids
Laboratory personnel	pharmacy personnel

plus co-ordination with

o MCH Services
(centres and camp-wide supervision)

- Midwives: 2-4 per 20,000 refugees
- Refugee Health Workers

o Community Health Workers

- Community Health Co-ordinator (1-2)
- Community Health Workers (1/500-1,000)

(ii) At a decentralized level, adequate staffing levels can be achieved, utilizing the following personnel

o Professional supervisory staff:

Out-patient department (1-2 nurses)

o Refugee Staff

Health assistants Pharmacy personnel

plus co-ordination with

o MCH Services

- Midwives: 1-2
- Traditional birth attendants

o Community Health Workers

- Community Health Supervisor
- Community Health Workers

(b) Within the clinic

The organization of the O.P.D. should ensure a logical flow of patients, including:

(i) a waiting area, adjacent to the building which protects against the elements.*

(ii) a selective screening area, essential during the early stages of an emergency. The purposes of selective screening are:

- to filter out the people with minor complaints who do not need treatment
- to refer emergency cases directly to senior health staff
- to direct patients for specialized consultations, eg. ante-natal clinic, nutrition assessment and monitoring

(c) A consultation area for health assistants and nurses

With training, health assistants can care for the majority of patients by:

	using:
o diagnosing common diseases	guidelines
o prescribing simple medications	a drug list
o referring complicated cases to senior staff	referral protocols

(d) A consultation area for senior health staff

Senior health staff are responsible for complicated cases, in-patients and for training and supervising nurses, health assistants and other workers.

The O.P.D. should be open six days a week with special arrangements for covering nights and days off.

8.4 Decentralized Clinics

Decentralized clinics are needed in camps with more than 15,000 refugees. One clinic should cater for 10,000 - 15,000 refugees.

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* In all refugee settings, health workers should be trained to quickly assess patients waiting for attention - to promptly identify those in need of immediate care.

Because such clinics increase accessibility to curative care, they should be established as soon as trained staff are available, co-ordinated closely with the activities of MCH and CHW services.

8.5 The Health Centre

One health centre is required in each camp. The activities of the health centre include:

- o providing a clinic with an out-patient department, dressing and injection services, and drug distribution activities for the nearest 10,000 refugees (which should be co-ordinated closely with MCH and CHW programmes targeted at the same population).

- o acting as the referral centre for decentralized clinics and community health programmes. The health centre should provide consultations by doctors and senior nurses, in-patients facilities, laboratory services, pharmacy services (see D.Doc. (1)) and, if necessary, dental services and rehabilitation activities.

8.6 In-patient Facilities

8.6.1 In-patient facilities provide care for refugees who must remain under close supervision due to the seriousness of their illness.

In most refugee settings, it is not appropriate to construct elaborate hospital facilities in-camp unless:

- o there are large numbers of casualties requiring surgical procedures
- o there is no possibility of referral to local hospitals

In-patient care is better accomplished by combining

patient referral to local hospitals - with - limited in-patient beds at the health centre

8.6.2 The Transfer of Refugee Patients to Local Hospitals

The use of local facilities requires careful discussions between national health authorities and refugee health co-ordinators at all levels. Once clear protocols for the transfer of refugee patients have been formulated and agreed upon, it is essential that these are clearly communicated to field workers. It is the role of the camp health co-ordinator to provide feedback to health personnel on ways to better streamline referral activities/ procedures.

Such policies must be closely observed by all personnel to avoid misunderstandings and confusion in transfer procedures.

8.6.3 Limited In-patient Care at the Camp Health Centre

After the emergency phase, in-patient care should not divert large numbers of health personnel and resources from other essential activities (ie. training, MCH, basic curative services). However, in most camps, it is important to provide limited in-patient facilities in the health centre.

In most refugee settings, the following guidelines should be applied to the management of in-patients in the camp health centre:

- Limit the number of beds, eg. 1 bed per 1,000 refugees during the emergency phase to 1 bed per 5,000 refugees during the care and maintenance phase. During an outbreak, tents may be required to provide extra beds, eg. meningitis, cholera.
- Limit admission to short stays, eg. only to allow for close observation.
- Limit laboratory investigations to those available to the O.P.D.
- Limit admission to those who are:
  - unconscious/difficult to wake up (cerebral malaria, ...)
  - severely dehydrated/not able to drink
  - severe pneumonia, complicated measles, or other illness in need of close supervision

Note: After the emergency phase has passed, it is important to establish services for patients with chronic illnesses or social/mental health disorders, so that in-patient facilities are not over-loaded by refugees in need of social support and chronic care.

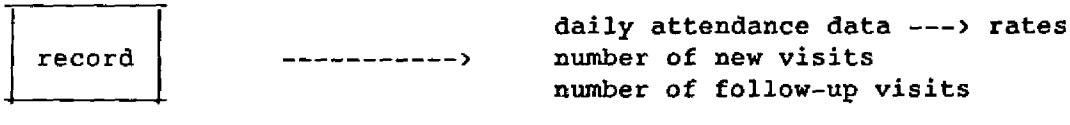
8.7 Record-keeping in Curative Services

As in MCH services, accurately maintained centralized and individual records are an essential requirement for the management of an effective curative programme-

8.7.1 Clinic records

Well-organized systems should be set up for:

- programme management purposes



- health surveillance

categorized by	---------->	disease category, eg. malaria
	---------->	symptom definition, eg. cough + fever
		major age classification

o effective follow-up of high-risk individuals

maintain	---------->	register of patients with chronic illnesses (TB, hypertension, diabetes)

8.7.2 Individual Records

The introduction of a standardized O.P.D. card is strongly urged in refugee settings - due to the mobility of refugee populations. See CC (1).

As with individualized MCH records, the purpose of the O.P.D. card must be understood and valued by the refugee. In addition, it must be adequately protected if it is to remain a durable record of a refugee's health history and medical care (ie. in a plastic bag).

In most large refugee camps, a centralized record-keeping system for individual patients is impractical and time-consuming. However, when such a register is limited to only high-risk and chronic conditions, it does provide an effective mechanism for follow-up and home supervision.

Guide to References

D.D. Doc (1) How to look after a Health Centre Store AHRTAG, London (1983)

D.D. Doc (2) UNHCR Essential Drugs Policy: Guidelines for the Use of Drugs in Refugee Settings: UNHCR (1986)

CC (1) Health Card