EVALUATION OF INFANT MORTALITY AND CHILDHOOD NUTRITIONAL STATUS AMONG AFGHAN REFUGEES IN PAKISTAN, 1986

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In collaboration with staff of the U.N. High Commissioner for Refugees
Pakistan
INTRODUCTION

In March, 1986, the United Nations High Commissioner for Refugees (UNHCR) in Pakistan requested assistance from the Centers for Disease Control (CDC) of the United States Public Health Service, to conduct a survey to assess the infant mortality and childhood nutritional status among Afghan refugee children under five years of age. Similar surveys of this population were completed in 1984 and 1985 in collaboration with CDC. The results of the 1986 survey are compared to the previous surveys, and this report evaluates significant changes in infant mortality and certain disease conditions among refugee children over the past year. In collaboration with the Pakistan Government Project Directorate for Health, Commissionerate for Afghan Refugees, the data collection was completed in May of 1986.

METHODS

Sampling

Approximately 2.4 million Afghan refugees residing in Pakistan were included in the sampling frame. The basic sample consisted of 30 clusters or sample sites selected from the sampling frame using a two-stage, random start, skip interval cluster sampling method as used in the past surveys. An additional six clusters were randomly selected in Baluchistan Province to increase the sample size and, therefore, increase the accuracy of the data. The Baluchistan data can then be compared with the findings of the other Provinces. The first stage of the sampling procedure identified the districts and specific refugee camps in which clusters would be located. The second stage identified households within the clusters to be visited.
In each cluster, the households to be visited were selected by the team supervisor. Fifty-four households were selected by consistently moving to the household to the left of the one previously visited. If there was no household located to the left, the next closest household was visited.

**Data collection**

Data collection methods were the same as those used in 1984 and 1985. Data were collected by three teams of three-to-four Lady Health Visitors (LHVs), and a team supervisor. The team supervisor was responsible for providing guidance, selecting households to be visited, performing anthropometric measurements, and reviewing completed questionnaires. Each team was provided with a vehicle and a driver.

As in the 1984 and 1985 surveys, emphasis was placed on obtaining accurate information on dates of birth and death. For this purpose, an updated calendar of events familiar to the Afghan women was again used (Appendix A). Forms used for the recording of data are in Appendices B and C.

Both arms of each live child were examined for the presence of a BCG vaccination scar. Every fourth child one through four years of age was weighed using a Salter scale, and the child’s height or length was determined using a portable measuring board. Infants less than one-year-old were neither weighed nor measured. Weight-for-height measurements were then compared to the WHO/NCHS/CDC reference standard to determine the percent of survey children greater than the reference median, less than 80%, and less than 70% of the median.
Information was collected on the occurrence of diarrhea during the seven days prior to interview for all children less than five-years-old. Diarrhea was defined as more than four watery stools per day for two consecutive days of the prior seven days. Mothers were also asked if the child had had measles in the past year. For children under five years of age who had died in the preceding 12 months, information collected included age at death and a history of measles occurring in the month prior to death, of diarrhea in the seven days prior to death, and of malaria in the 14 days prior to death. Measles and malaria are diseases known to the mothers, and their occurrence was as defined by the mother. Finally, a series of questions concerning signs and symptoms compatible with neonatal tetanus was asked of mothers of infants who died in the first month following birth. Neonatal tetanus was considered a possible cause of death in any child who died within the first month of life and who (1) sucked normally following birth, (2) stopped sucking, and (3) had trouble opening his/her mouth and/or had seizures.

Infant mortality rates were calculated by dividing the number of children who had died in the previous 12 months and were less than 12-months-old at the time of death by the number of children born live in the previous 12 months (the child having cried following delivery). Calculation of neonatal mortality was accomplished by dividing the number of children who had died during the previous 12 months and were less than one-month-old at the time of death, again using as the denominator all live births.
RESULTS

For the standard random sample of 30 sample sites, interviews were conducted within 1612 households. Information was obtained on 2439 children who were less than five years of age at the time of the interviews, including 2368 living children and 71 children who had died in the previous 12 months. Of the live children, 584 (25%) were less than one-year-old, and 1784 (75%) were one- through four-years-old. Fifty percent of the children were male, and 50% were female. The age at death of the 71 children who had died showed 25 (35%) were less than one-month-old, 26 (37%) were at least one month but less than one-year-old, 10 (14%) were one-year-old, 5 (7%) were two-years-old, 2 (3%) were three-years-old, and 3 (4%) were four-years-old.

The **infant mortality rate (IMR)** for the Afghan population within the refugee camps was **81 per 1000 live births** (51/627 X 1000) with 95% confidence intervals of 58 and 104 (Table 1). Twenty-five of the infant deaths occurring in the sample population occurred during the neonatal period resulting in a **neonatal mortality rate of 40 per 1000 live births** (25/627 X 1000) with 95% confidence limits of 25 and 55. If the mortality rate of children in each age group is applied consecutively to an assumed cohort of 1000 live births, 121 (12.1%) of the children would have died before reaching their fifth birthday.

Infant mortality rates for Northwest Frontier Province (NWFP) and Punjab were 64/1000 live births and for Baluchistan, 109/1000; neonatal mortality rates for these areas were 40/1000 and 43/1000, respectively (Table 2).
Of the children who died, all died in Pakistan. However, 7 (10%) of the children who died had been born in Afghanistan. This compares to 28% of the live children who had been born in Afghanistan. It is not known how long the children had been in Pakistan prior to death. Weight and height measurements were available on systematically selected children one- through-four years of age (Table 2). Of these children, 42% were above the median of the reference population. Only 1.9% of the children were less than 80% of the median, and one child (0.2%) was less than 70% of the median. In NWFP/Punjab, 42% of the children were equal to or above the median of the reference population, and in Baluchistan 33% were in this group. In NWFP/Punjab, 1.1% of the children were less than 80% of the median index, and, in Baluchistan, the corresponding figure was 4.2%. The one child who was less than 70% of the reference median was from NWFP.

A history of diarrhea within seven days prior to interview was given for 655 (28%) of all live children (22% in Baluchistan and 29% in NWFP/Punjab). Measles infection within the past year was reported for 369 (16%) of the live children with a similar percentage distribution in each of the two geographic areas. Overall, 55% of the children had evidence of previous BCG vaccination, 51% in Baluchistan and 55% in NWFP/Punjab.
Among the 71 children who had died, diarrhea was reported to have occurred in the week prior to death in 24 (34%) of the children (Table 3). In Baluchistan, 36%, and in NWFP/Punjab, 31% of the deaths were associated with diarrhea. In Baluchistan, the majority (79%) of the diarrhea-related deaths occurred in children aged one month-to-one year, while in NWFP/Punjab, only 50% of these deaths occurred in that age group. Measles was reported in 4% of the children who died, and malaria was reported for one child. Signs of neonatal tetanus were reported in 9 (36%) of the 25 children who died in the first month of life. The mortality rate from tetanus was 13 per 1000 live births for the total sample population; rates did not differ by province.

DISCUSSION

Thirty-three of the pre-selected sample sites or clusters were visited. Three clusters originally selected were located in urban areas of Peshawar with the population widely scattered throughout the city. These sites were not included, and, instead, the next camp listed on the sampling frame was selected for study. Thirty sites composing the basic random sample and an additional six sites randomly selected in Baluchistan were visited. With the exception of one cluster where only 46 households were available, 54 households were visited in each cluster. Of all clusters visited, 22 were in NWFP, 12 were in Baluchistan, and two were located in the Punjab. Calculations for the refugee population as a whole are based on data collected from the 30 randomly selected clusters only. Data from the additional six clusters
are used only in the calculation of rates for Baluchistan. The additional clusters were necessary because of the small number of camps from Baluchistan that fell into the random sample of the entire population and the likelihood of higher mortality rates and poorer health status in that region as described in the 1985 report.

Table 1 demonstrates the continued marked decrease in neonatal and infant mortality and improvement in indicators of nutritional status of the Afghan refugee children. Some confidence intervals continue to overlap, but the continued improvement in all indicators suggests that the changes are real. These rates are independent of seasonal variation in occurrence of disease and death because they consider all deaths occurring over an entire year. Regardless of the time of year the survey was performed, the mortality rates would be the same. What would be different if the time of the surveys changed would be the number of live children experiencing disease conditions in the recent past.

Suggestions in the 1985 survey report that the mortality and malnutrition rates in Baluchistan could be considerably worse than those observed in NWFP/Punjab required verification using a larger sample from Baluchistan in the 1986 survey. In 1986, the study design was modified in a manner which doubled the sample size from Baluchistan to provide more accurate data for that geographic area but maintained the original sampling scheme for the study as a whole allowing for comparison of 1986 data with the results of previous studies.
The 1986 data support the 1985 findings and suggest that infant mortality is 70% higher in Baluchistan than in the rest of the Afghan refugee population. The data from both the 1985 and 1986 surveys indicate that neonatal mortality is not different by province and that the difference is the death of children one month-to-one year old in Baluchistan. In that province, 57% of the children one month to one year of age who die experience diarrhea prior to death. The extent to which diarrhea-related deaths in this population are due to dehydration needs to be determined as such deaths can be reduced by application of intervention strategies.

In 1985, 41%, and in 1986, 55% of all children surveyed had evidence of a BCG vaccination, an encouraging improvement over time. No data exists for 1984. In most situations in the developing world, however, BCG vaccination coverage is the highest of that associated with vaccines included in the WHO Expanded Program on Immunization (EPI). If this is also applicable to refugee populations, then vaccination levels for DPT, polio, and measles are grossly inadequate. Although few deaths from measles were reported in the 1986 survey, it is possible that a buildup of susceptibles is occurring which might result in large-scale epidemics with accompanying high mortality in the future. It is strongly advised that a determination of vaccination coverage be made for this highly vulnerable population using either the standard WHO survey methodology or, if this is not feasible, a calculation of doses administered divided by the target population.
Even though the mortality rate may be declining, tetanus continues to be an important cause of neonatal mortality in the refugee population. The global EPI which is coordinated by WHO has set a goal of less than 1 death/1000 live births from neonatal tetanus by the year 1990 and no deaths from that cause by the year 2000. Given the current neonatal tetanus mortality rate in this refugee population of 13/1000 live births, it is recommended that, while all immunizations continue to be stressed, tetanus immunization become a focus of the refugee EPI program.

The percent of children above the median of the WHO/NCHS/CDC reference has increased from 26% in 1984 to 42% in 1986. This rather remarkable increase is supported by personal observation of the interviewers over each of the three survey periods. Interviewers entered the compound area of each household thereby having an opportunity to observe all the children. Interviewers also observed an increase in the number of camps visited with enclosed water supplies and an increase in the percent of compounds with domesticated animals, all of which support the indicators of improved health status found in the survey. Nevertheless, malnutrition does exist, and it has not been made a reportable condition as was recommended in the 1985 report. As a result, it is not possible to define the malnutrition in a manner amenable to intervention. Although the nutritional status of the children as a whole is good, it should be noted that decreases in food resources could potentially lead to increases in malnutrition.
One must look at the results of these surveys with both encouragement and cautious optimism. The rapid improvements in the indicators of health status are a tribute to the efforts of those working with the refugees and to the refugees themselves. The vast majority of the interviewers have participated in all three of the surveys and now work with greater speed and efficiency than in the first survey. To assure that familiarity with the procedures has not produced a carelessness in the interview process, it is recommended that, should future surveys be undertaken, a quality control component be added. A certain percentage of the interviews should be repeated by a quality control staff person who would verify the responses recorded by the interviewer. Such control would add little in the way of time or cost to the survey but would allow heightened confidence in the results.

It is also suggested that the need for an annual survey of this nature be evaluated. It is clear that the results from past surveys have been useful for focusing program planning activities within UNHCR. With the considerable decrease in infant mortality over the years of the surveys, it becomes more difficult to measure significant changes in health indicators. It is suggested that a survey of this scope is not needed on an annual basis, though it might be helpful on a less frequent basis when there is reason to believe that significant changes in indicators have occurred. Other alternatives include more detailed evaluation of particular aspects of the program, for example, the immunization coverage levels of the children.
RECOMMENDATIONS

1. Reevaluate the need for repeating this type of survey on an annual basis. Survey activities can be focused on particular areas such as immunization coverage and diarrheal diseases.

2. Continue to emphasize immunizations for children less than five years of age and women of child-bearing age.

3. Determine the level of vaccination coverage in young children and women of child-bearing age.

4. Continue to stress health education efforts concerning the availability and correct use of oral rehydration salts, particularly (though not exclusively) in Baluchistan.

5. Since diarrhea is a major associated cause of morbidity and mortality, isolate the risk factors for diarrheal illness in the population and plan interventions.

6. Consider the addition of a quality control component to future surveys of any type.

7. Consider the possibility of a registry to record cause of death in the refugee population. Such a registry would eliminate the need for surveys such as this and provide information on cause of death not covered in this survey.

8. Consider the implementation of the nutrition surveillance as recommended in the 1985 report.
<table>
<thead>
<tr>
<th>ITEM</th>
<th>1984</th>
<th>1985</th>
<th>1986&lt;sup&gt;1&lt;/sup&gt;</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of live births in past year</td>
<td>595</td>
<td>632</td>
<td>627</td>
</tr>
<tr>
<td>Children &lt;1 year, died past 12 months</td>
<td>92</td>
<td>75</td>
<td>51</td>
</tr>
<tr>
<td>Infant mortality rate</td>
<td>156/1000</td>
<td>119/1000</td>
<td>81/1000</td>
</tr>
<tr>
<td>Confidence limits</td>
<td>125-186</td>
<td>93-144</td>
<td>58-104</td>
</tr>
<tr>
<td>Neonatal mortality rate</td>
<td>61/1000</td>
<td>46/1000</td>
<td>40/1000</td>
</tr>
<tr>
<td>Confidence limits</td>
<td>42-80</td>
<td>30-62</td>
<td>24-56</td>
</tr>
<tr>
<td>Percent dying before fifth birthday</td>
<td>22.5</td>
<td>18.8</td>
<td>12.1</td>
</tr>
<tr>
<td>Percent of children weighed:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>≥ median</td>
<td>26</td>
<td>35</td>
<td>42</td>
</tr>
<tr>
<td>&lt;80% of median</td>
<td>3.5</td>
<td>2.3</td>
<td>1.9</td>
</tr>
<tr>
<td>&lt;70% of median</td>
<td>0</td>
<td>0</td>
<td>0.2</td>
</tr>
<tr>
<td>Percent with diarrhea in last seven days</td>
<td>38</td>
<td>35</td>
<td>28</td>
</tr>
<tr>
<td>Percent with BCG scar</td>
<td>NA</td>
<td>41</td>
<td>55</td>
</tr>
</tbody>
</table>

<sup>1</sup>Based on the random 30 cluster sample comparable to the 1984 and 1985 samples

NA—Not available
### Table 2

**SURVEY RESULTS BY GEOGRAPHIC AREA**  
**AFGHAN REFUGEES IN PAKISTAN, 1986**

<table>
<thead>
<tr>
<th>Item</th>
<th>All areas(^1)</th>
<th>NWFP/Punjab(^2)</th>
<th>Baluchistan(^3)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total families interviewed</td>
<td>1612</td>
<td>1228</td>
<td>648</td>
</tr>
<tr>
<td>Number of children &lt;5 years old</td>
<td>2439</td>
<td>1943</td>
<td>970</td>
</tr>
<tr>
<td>Alive at the time of interview</td>
<td>2368</td>
<td>1892</td>
<td>934</td>
</tr>
<tr>
<td>Died past 12 months</td>
<td>71</td>
<td>51</td>
<td>36</td>
</tr>
<tr>
<td>Number of live births in past year</td>
<td>627</td>
<td>502</td>
<td>230</td>
</tr>
<tr>
<td>Children &lt;1 year, died in past year</td>
<td>51</td>
<td>32</td>
<td>25</td>
</tr>
<tr>
<td>Infant mortality rate</td>
<td>81/1000</td>
<td>64/1000</td>
<td>109/1000</td>
</tr>
<tr>
<td>Neonatal mortality rate</td>
<td>40/1000</td>
<td>40/1000</td>
<td>43/1000</td>
</tr>
<tr>
<td>Percent dying before fifth birthday</td>
<td>12.1</td>
<td>11.1</td>
<td>15.5</td>
</tr>
<tr>
<td>Percent of children with BCG scar</td>
<td>55</td>
<td>55</td>
<td>51</td>
</tr>
<tr>
<td>Percent of children weighed:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>&gt; median</td>
<td>42</td>
<td>43</td>
<td>33</td>
</tr>
<tr>
<td>&lt; 80% of median</td>
<td>1.9</td>
<td>1.1</td>
<td>4.2</td>
</tr>
<tr>
<td>&lt; 70% of median</td>
<td>0.2</td>
<td>0.2</td>
<td>—</td>
</tr>
</tbody>
</table>

\(^1\)Represents 30 clusters  
\(^2\)Represents 24 clusters  
\(^3\)Represents 12 clusters
Table 3

DISEASE PROBLEMS POSSIBLY CONTRIBUTING TO THE DEATH OF AFGHAN REFUGEES LESS THAN FIVE-YEARS-OLD
PAKISTAN, 1986

<table>
<thead>
<tr>
<th>Disease problem</th>
<th>0–30 Days No. (%)</th>
<th>1–11 Months No. (%)</th>
<th>1–4 Years No. (%)</th>
<th>All ages No. (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tetanus</td>
<td>9 (36)</td>
<td>0 –</td>
<td>0 –</td>
<td>9 (13)</td>
</tr>
<tr>
<td>Measles</td>
<td>0 –</td>
<td>3 (12)</td>
<td>0 –</td>
<td>3 (4)</td>
</tr>
<tr>
<td>Diarrhea</td>
<td>1 (4)</td>
<td>12 (46)</td>
<td>11 (55)</td>
<td>24 (34)</td>
</tr>
<tr>
<td>Malaria</td>
<td>0 –</td>
<td>1 (4)</td>
<td>0 (0)</td>
<td>1 (1)</td>
</tr>
<tr>
<td>Unknown</td>
<td>15 (60)</td>
<td>10 (38)</td>
<td>9 (45)</td>
<td>34 (48)</td>
</tr>
<tr>
<td>Total</td>
<td>25 (100)</td>
<td>26 (100)</td>
<td>20 (100)</td>
<td>71 (100)</td>
</tr>
</tbody>
</table>
# List of Children Who Died in Past Year and Were Less Than Five Years Old at the Time of Death

## Death Within 40 Days After Birth

<table>
<thead>
<tr>
<th>CLUST NUMBER</th>
<th>HH NUMBER</th>
<th>ID NUMBER</th>
<th>NAME OF CHILD</th>
<th>DATE OF DEATH</th>
<th>AGE AT DEATH</th>
<th>DIARRHEA IN 7 DAYS PRIOR</th>
<th>MEASLES IN 30 DAYS PRIOR</th>
<th>MALARIA IN 2 WEEKS PRIOR</th>
<th>SUCKED OK INITIALLY</th>
<th>SUCKING STOPPED</th>
<th>SEIZURE/STIFFNESS</th>
<th>TROUBLE WITH OPENING MOUTH</th>
<th>PLACE OF DEATH</th>
<th>HOW LONG IN COUNTRY</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

## How Long in Country

<table>
<thead>
<tr>
<th>Prior to Death</th>
<th>Whole Life</th>
</tr>
</thead>
<tbody>
<tr>
<td>(6 MOS)</td>
<td>(1 YR)</td>
</tr>
<tr>
<td>(2 YRS)</td>
<td>(3 YRS)</td>
</tr>
<tr>
<td>(4 YRS)</td>
<td>(5 YRS)</td>
</tr>
</tbody>
</table>
Calculate the percent dying before the fifth birthday

a. Record the age of each child, and tally the number of children (alive and dead) at each age.

b. Calculate the age-specific mortality rates by dividing the number of deaths in each year of age by the number of children in that year of age.

c. Multiply the mortality rate for children <1 year by 1000.

d. Subtract (c) from 1000.

e. Multiply (d) by the mortality rate for 1-year-olds.

f. Subtract (e) from (d)

g. Multiply (f) by the mortality rate for 2-year-olds.

h. Subtract (g) from (f).

i. Multiply (h) by the mortality rate for 3-year-olds.

j. Subtract (i) from (h).

k. Multiply (j) by the mortality rate for 4-year-olds.

l. Subtract (k) from (j). This represents the number of children out of 1000 who are alive for their fifth birthday. Subtract this number from 1000 for the number of children who had died by their fifth birthday. Divide the final number by 10 to calculate the corresponding percent.
Quantifying the increase in variance resulting from the cluster method of sampling:

1. Calculate variance of the cluster sample (V_{pc1})

\[
V_{pc1} = \frac{(1-f) \xi a_i^2 - 2\bar{p}(\xi a_i m_i) + \bar{p}^2(\xi m_i^2)}{n(n-1)(\bar{m}^2)}
\]

\( n \) = number of clusters

\( m_i \) = number of units per cluster

\( \bar{m} \) = average number of units per cluster \( m_i/n \)

\( a_i \) = number of units in cluster 'i' with characteristic of interest (e.g. children who died)

\( p \) = proportion in population with the characteristic

\( f \) = proportion of population in the sample

\( N \) = number of clusters in the sample

\( n \) = possible number of clusters

(if \( f < 0.1 \) then it can be ignored)

2. Calculate variance of the simple random sample (V_{psrs})

\[
V_{psrs} = \frac{(p)(q)}{n}
\]

3. Calculate the design effect

\[
\text{Design effect} = \frac{\text{variance of the cluster sample}}{\text{variance of the comparable simple random sample}} = \frac{V_{pc1}}{V_{psrs}}
\]

4. Calculate new sample size

\[ n = \frac{1}{\text{de}} \]

5. Calculate confidence intervals using new sample size

\[ \pm 1.96 \frac{(p)(q)}{n} \]
### Events in Afghanistan from 1979 - 1986

<table>
<thead>
<tr>
<th>Date</th>
<th>Event Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>16 September 1979</td>
<td>Taraki is replaced by Amin.</td>
</tr>
<tr>
<td>27 December 1979</td>
<td>Amin is killed and Babruk Karmal became President.</td>
</tr>
</tbody>
</table>

### Appendix A

#### Section A Determining the Year of Birth

<table>
<thead>
<tr>
<th>Season Crops</th>
<th>Calendar</th>
<th>Western</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rice, Cotton Harvest Winter</td>
<td>Safar-Rabi-Ul-Awwal</td>
<td>December</td>
</tr>
<tr>
<td></td>
<td>Rabi ul-Sani</td>
<td>January</td>
</tr>
<tr>
<td></td>
<td></td>
<td>February</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Akhri Char-Shamba (Last Wednesday of Safar)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Eid Milad-ul-Nabi (12th day of R. Awwal)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Holy Prophet recovered from illness.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Birth &amp; Death of Holy Prophet.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>24 Jan</td>
<td>16 Jan</td>
</tr>
<tr>
<td>Wheat Harvest Spring</td>
<td>R.Sani,J-Awwel</td>
<td>March</td>
</tr>
<tr>
<td></td>
<td>J.Awwel,J-Sani</td>
<td>April</td>
</tr>
<tr>
<td>Rice Cotton Summer</td>
<td>J-Sani-Rajab</td>
<td>May</td>
</tr>
<tr>
<td></td>
<td>Rajab-Shaban'</td>
<td>June</td>
</tr>
<tr>
<td>Summer</td>
<td>Shaban-Ramzan</td>
<td>July</td>
</tr>
<tr>
<td></td>
<td>Shab-e-Barat (14th night of Shaban)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Juma-tul-Wida</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Holy Prophet travelled (spiritually) from Mecca to Jerusalem to the seven Heavens and beyond (paradise). He returned on the same night. God gives food to the people. People’s destinies decided.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Last Friday of Ramazan before Eid.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>22 June</td>
<td>10 June</td>
</tr>
<tr>
<td>Moharram-Safar</td>
<td>November</td>
<td>1-2 Nov</td>
</tr>
<tr>
<td>Ashura (10th day of Moharram)</td>
<td>December</td>
<td>1 Dec</td>
</tr>
</tbody>
</table>
The International Committee of the Red Cross (ICRC) has tried to develop its traditional activities, i.e. assistance and protection, in favour of all victims since the outbreak of the Afghan conflict. After two short missions in January - April 1980 and August - October 1982, ICRC delegates were present again in Kabul during September 1986 to develop and negotiate medical assistance and protection activities with the Afghan Red Crescent Society and the Afghan Authorities. Since then, negotiations are ongoing between ICRC and the concerned authorities.

In Pakistan, ICRC has been present since the beginning of 1980, developing its activities initially in NWFP and, since 1983, extending them to Baluchistan.

ICRC has opened two surgical hospitals for Afghan war-wounded: one in Peshawar (June 1981) with a capacity of 100 beds, extendable to 150 in case of emergency, and the second in Quetta (July 1983) with a capacity of 60 beds.

In the border area with Afghanistan, First Aid Mobile Teams (FAM Teams) are run by the Pakistan Red Crescent Society (PRCS) in collaboration with ICRC. They provide first aid on the spot to the wounded and send major cases by ambulance to ICRC hospitals. Presently, there are 6 FAM Teams: 4 in NWFP (Parachinar, Miramshah, Wana and Khar/Bajaur) and 2 in Baluchistan (Chaman and Badini). According to needs, a third FAM-post can be opened in Baluchistan, in Girdi-Jangal (near Dalbandin), as well as a sub-post of Parachinar in Alizai and another one at Khar in Shahi (Dir District).

As many patients admitted in ICRC hospitals suffer injuries to the lower limbs, an orthopaedic center was opened in December 1981 in Peshawar. Prosthesis and orthopaedic appliances are manufactured in the workshop of the center.

Among the patients, a significant number of spinal cord injuries is recorded. A paraplegic center has been set up to provide these patients with rehabilitation treatment. Present facilities in Hayatabad, Peshawar, were opened in February 1984. The center has a capacity of 100 beds to receive Afghan as well as Pakistani patients. Since July 1986 the center is under the responsibility of the PRCS. The ICRC continues to finance it, with the presence of an ICRC advisor.

ICRC gives first aid courses to Afghans coming to the delegation in Peshawar and the sub-delegation in Quetta.

The ICRC delegation in Pakistan keeps regular contact with Afghan opposition movements for extending dissemination of the basic rules of international humanitarian law and trying to develop protection activities for prisoners in hands of the movements.
### 1. FIRST AID MOBILE TEAMS (FAM-TEAM)

<table>
<thead>
<tr>
<th>Location</th>
<th>Number of patients</th>
<th>Octobre 1986</th>
<th>transferred to ICRC</th>
<th>total</th>
<th>since Jan.1986</th>
</tr>
</thead>
<tbody>
<tr>
<td>Khar/Bajaur</td>
<td></td>
<td>3</td>
<td>8</td>
<td>11</td>
<td>105</td>
</tr>
<tr>
<td>Parachinar</td>
<td></td>
<td>6</td>
<td>43</td>
<td>49</td>
<td>403</td>
</tr>
<tr>
<td>Sub-Post Alizai (reopened March 86)</td>
<td></td>
<td>1</td>
<td>16</td>
<td>17</td>
<td>191</td>
</tr>
<tr>
<td>Miramshah</td>
<td></td>
<td>8</td>
<td>9</td>
<td>17</td>
<td>343</td>
</tr>
<tr>
<td>Wana</td>
<td></td>
<td>7</td>
<td>25</td>
<td>82</td>
<td>178</td>
</tr>
<tr>
<td>Badini (reopened March 1986)</td>
<td></td>
<td>58</td>
<td>14</td>
<td>72</td>
<td>366</td>
</tr>
<tr>
<td>Chaman</td>
<td></td>
<td>358</td>
<td>26</td>
<td>384</td>
<td>3'589</td>
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### 2. ICRC SURGICAL HOSPITAL FOR AFGHAN WAR WOUNDED

<table>
<thead>
<tr>
<th>Location</th>
<th>Peshawar</th>
<th>since opening in June 1981</th>
<th>Quetta</th>
<th>since opening in July 1983</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Oct. 1986</td>
<td>Admissions</td>
<td>198</td>
<td>9'172</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Surgical operations</td>
<td>416</td>
<td>17'483</td>
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<td></td>
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<td>Out-patients</td>
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<td>46'048</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
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<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Location</th>
<th>Peshawar</th>
<th>since opening in Dec. 1981</th>
<th>Quetta</th>
<th>since opening in July 1983</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Oct. 1985</td>
<td>Orthopaedic appliances provided</td>
<td>52</td>
<td>2'503</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Production of Rubber feet</td>
<td>47</td>
<td>919</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Number of patients on 31 October</td>
<td>34</td>
<td></td>
</tr>
</tbody>
</table>

### 3. ORTHOPAEDIC CENTER (PESHAWAR)

<table>
<thead>
<tr>
<th>Operation</th>
<th>Peshawar</th>
<th>since opening in Dec. 1981</th>
<th>Quetta</th>
<th>since opening in July 1983</th>
</tr>
</thead>
<tbody>
<tr>
<td>Students attending:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Oct. 1986</td>
<td>16</td>
<td></td>
<td>225</td>
<td>30</td>
</tr>
<tr>
<td>- since beginning</td>
<td>717</td>
<td></td>
<td>8'944</td>
<td>30</td>
</tr>
</tbody>
</table>

| Students attending: |          |                              |        |                            |
| - Oct. 1986 | 1        |                             | 11      | 2                         |
| - since beginning | 44     |                             | 464     | 2                         |

### 4. FIRST AID COURSES

<table>
<thead>
<tr>
<th>Location</th>
<th>Four week courses</th>
<th>Red Cross courses (of 1 day)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>(Begin of courses)</td>
<td>Peshawar</td>
</tr>
<tr>
<td></td>
<td>March 82</td>
<td>March 84</td>
</tr>
<tr>
<td>Students attending:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Oct. 1986</td>
<td>16</td>
<td></td>
</tr>
<tr>
<td>- since beginning</td>
<td>717</td>
<td></td>
</tr>
</tbody>
</table>

| Students attending: |          |                              |        |                            |
| - Oct. 1986 | 1        |                             | 11      | 2                         |
| - since beginning | 44     |                             | 464     | 2                         |

### 5. REHABILITATION CENTER FOR PARAPLEGICS (HAYATABAD, PESHAWAR)

<table>
<thead>
<tr>
<th>Operation</th>
<th>Peshawar</th>
<th>since opening in Sept. 1981</th>
</tr>
</thead>
<tbody>
<tr>
<td>Admissions</td>
<td></td>
<td>15</td>
</tr>
<tr>
<td>Discharges</td>
<td></td>
<td>16</td>
</tr>
<tr>
<td>Number of patients on 31 October</td>
<td></td>
<td>84</td>
</tr>
</tbody>
</table>

Peshawar, 6 November 1986
Minutes of the Meeting held on Sunday 2 February 1986 at the Commissionerate Office

Dr. Aurangzeb welcomed participants to the meeting. He then asked each organization to give a 5 minute presentation of their work during 1985 and their plans for 1986.

Save the Children plan to move on slowly during 1986 and to consolidate their work in Dir, Haripur, Bajaur and Peshawar. At present they have trained 567 CHWs and another 340 are under training. 39 CHSs have also been trained. During 1986 they plan to train more CHSs and CHWs.

Pakistan Red Crescent have a BHU in Adezai, 4 first aid mobile teams on the border which are run in collaboration with ICHR, an eye hospital in Mardan and the Project for the Identification and Rehabilitation of Disabled Afghan Refugees, funded by UNHCR. During 1986 they plan to carry on with the work being done during 1985.

International Rescue Committee are working in Kohat at Hangu and Thal where they have 9 BHUs and a sanitation programme. During 1986 they plan to consolidate their programme further and expand the number of BHUs to 11. They will also expand the sanitation programme with shallow wells, vector control and water testing. They plan to have a referral system for patients coming into Peshawar, a primary health care worker system and a resource centre.

Austrian Relief Committee have a primary health programme in Baghicha and Gandaf refugee camps. 70+ CHWs and 30 TBAs have been trained. The CHWs work under 6 CHSs and are involved in community activities - sanitation, water, regular home visits, first aid treatment, treatment and diagnosis of minor illnesses, active case finding and follow-up of TB. There is a small laboratory in each camp. Infant mortality has been considerably reduced.

Austrian Relief Committee Sanitation project runs up to June 1986. They plan to complete the last of the major projects and to move into a modification and maintenance phase to maintain and continue to improve both the sanitation in the RVs as well as to upgrade the skills of the people working in the BHUs. They would like to know if there is a need for formal training sessions for sanitarians. They also have a pilot project for construction of latrines in areas where high water table or stony soil make pit latrines impossible.

Union Aid for Afghan Refugees reported that, as the situation in Afghanistan is getting worse, they are increasing the number of their BHUs and dispensaries. This is to improve the quality of service because the refugees are becoming semi-permanent. They plan to have additional equipment and to increase the number of their doctors and LHVs. Vaccinators and malaria inspectors have now been taken onto the staff of UAAR. There is a hospital with a laboratory. In 1986 they plan to construct dispensaries in Peshawar and Mardan.

Christian Hospitals Refugee Extension Project (CHREP) reported that they have now taken over activity previously carried out by InterAid in Manshehra. They have 7 BHUs in 9 refugee camps. Their emphasis is on strengthening the maternal and child health programme. There are about 25 TBAs and they also have a crash programme for immunisation. They have started a community health day when the whole team concentrates on a group of 20 or 30 houses. Now they will expand the clinics for malnourished children in the under 5 clinics. They are at present drawing up a series of lesson plans. Several thousand pit latrines have been installed by ARC. They hope to give some staff additional training in environmental sanitation. ICD have helped and advised on the TB programme including visits by the mobile X-ray unit. With the assistance and guidance of SCF they plan to train CHWs.
The Salvation Army are working in Ghazi and Haripur, where they have 2 BHUs and 3 BHUs respectively plus a VTC at Haripur. Their main aim is to encourage preventive health practices. In addition they have income generating projects - quilt making, leatherwork, tailoring; carpet weaving and embroidery. 2 additional BHUs and a vocational training centre were started during 1985. As there are no hospital facilities near to Ghazi, a 24-hour emergency and ambulance service is provided. In 1986 they plan to continue the present services. They also propose (a) to set up another BHU at Haripur, (b) to install pit latrines wherever permission has been given by the landowners, (c) to carry out a survey at Ghazi where the LHV s and CHWs will weigh each child under 5 and find out the vaccination status of each child, and (d) training of TBAs started in January 1986 at Haripur and will soon start at Ghazi.

Kuwait Red Crescent have 3 hospitals, 2 in Peshawar and one in Miranshah. In Peshawar one is a 150 bed hospital of which 40 beds are now in operation, the others will be in use once a lift is installed. The second is for women and children. The hospital at Miranshah is a 40 bed hospital. These hospitals are fully equipped. They also have 8 clinics, as well as a first aid training centre at Peshawar which takes 40 students for 2 weeks. There are 2 first aid centres which have ambulances at Nawagai and Terimangle. They help poor Afghans by providing medicines or giving financial help to patients in need of blood.

Islamic Relief Agency have 6 clinics in the NWFP, 2 of which are specialised (one being a dermatology clinic and the other a psychiatric clinic) as well as 4 small clinics attached to orphanages. They are sharing in the TB programme and have a trained nurse in each clinic. For the vaccination programme they have 2 mobile teams for Jamrod and Darra camps and a team attached to each clinic. They have a vocational training programme for orphans - tailoring and mechanics. In 1986 they will have a new mobile team in Chitral which should start operations within the next few weeks. A seasonal First Aid course was started last winter and a mid-level health worker training for Afghan medical students is planned to start soon.

ICRC have 2 surgical hospitals for Afghan war wounded - 100 beds extendable to 150 in an emergency in Peshawar and the second in Quetta with a capacity of 60 beds. There are first aid mobile teams run by FRC in collaboration with ICRC, 4 in the NWFP and 2 in Baluchistan. There is an orthopaedic centre with a workshop as well as a paraplegic centre for rehabilitation. First aid courses are given to Afghans in both Peshawar and Quetta.

SERVE are involved in 5 projects. (1) Public Health - charts in Pushtu and Dari and this year a teachers guide. 9 books for schools. Additional books are being prepared. (2) Eye care - a clinic as part of the Ebeneeza-E-Balki hospital. Monthly clinics are held at Haripur (The Salvation Army) and Hangu (ICRC). This month they hope to open an independent eye hospital. (3) Solar/agricultural project - more than 500 solar ovens have been distributed in the camps. These are working well. They are also encouraging the refugees to grow fast growing trees. (4) Carpet weaving training - 19 boys graduated from the carpet weaving centre. These have trained additional family members (5) Relief supplies have been distributed to more than 30,000 refugees primarily in Swabi, Haripur and Peshawar.

ICD - December 1985 marked the completion of two years of the TB control programme. Two more years are planned. They hope to improve the service of the X-ray mobile units and a radiologist is coming from Italy to train and work together with Pakistani doctors. They are now setting up a culture laboratory in the Jamrud Road referral laboratory. The 13 microscopists who were previously on the ICD
payroll are now to be transferred to PDH but will continue to be funded by ICD - this will save complications with such things as annual leave requests.

GTZ have an orthopaedic workshop at the Khyber hospital. The project to assist Afghan refugees ended in June 1984 and from July 1984 it has been a technical assistance programme between the Government of West Germany and the Government of Pakistan. Afghan refugees are about half of the workload. Previously they would help all refugees, now they just help those who have a ration card. One of the difficulties is those refugees who already have one prosthesis which they don't like and they then try to get a second one. Another problem is that now the programme has been converted to one of technical assistance between two Governments and rehabilitation is not an emergency programme. The local people pay the full cost whereas the service is free for refugees. Therefore the future of the workshop is in doubt and funding is needed if it is to continue in 1986.

Afghan Obstetrics and Gynaecology Hospital provides medical aid to AR women. It started as a clinic with initially only an OPD service and minor surgery. OPD hours were from 8am to 1pm and from 1pm to 4pm medical staff were given study talks by expatriate doctors. Then in September 1985 a 5-bed inpatient service was started with normal deliveries at the hospital and difficult cases referred to Dr. Johar Khattoon, with the clinic bearing the expenses. A vaccination programme was started for babies and expectant mothers. Patients needing surgery are referred and the clinic pays all expenses. Now they plan to have an operating room and hope by March this year to be able to provide all services. Expatriate doctors will come for a month at a time to train their doctors until the local doctors are fully trained. They plan to set up a pediatric unit at the hospital and to start a specialized training programme in Ob/Gyn/Ped for female Afghan nurses. They also plan to set up a mobile medical unit to visit the camps around Peshawar. They will provide medical aid there or ambulance service as needed. Permission from the Commissioner and PDH is needed. At present they only have 5 bed facilities. However, KRC have donated money for the construction of a 10 room building. This will start to be used in a few days and then they will have facilities for 20 patients. IRC is supporting the hospital financially but they also need the help of other organisations.

The Afghan Health and Social Assistance Organization (AHSAO) have an AR child health centre in Peshawar. Patients are treated or referred as necessary. Other services provided at this centre are a visiting psychiatrist and a TB section. They also have a health education programme and 20 students whose study was interrupted in Afghanistan were selected for training in the Khyber and Lady Reading Hospitals. A first aid training course was started with the help of FRC. They also run an English language course for refugees. Future programme - they hope to open a vaccination section within the OPD of the AR child health centre as well as to open a 20 bed hospital for better treatment of children.

The Afghan Refugees Humanitarian Islamic Unity distribute tents, blankets, foodstuffs and also have a polyclinic. In 1986 they plan to consolidate work in the polyclinic. Now they have bought radiology equipment and are looking for someone to install it.

Following the presentations, Dr. Nakamura from the Leprosy Centre, Mission Hospital Peshawar, was given five minutes to talk about his findings at the Leprosy Centre and his proposals. They have been treating Afghan patients for many years. At present there is no activity in the camps but they would like
<table>
<thead>
<tr>
<th>Condition</th>
<th>MEN</th>
<th>WOMEN</th>
<th>CHILDREN</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eye infection</td>
<td>212</td>
<td>259</td>
<td>309</td>
<td>242</td>
</tr>
<tr>
<td>ENT infection</td>
<td>231</td>
<td>345</td>
<td>611</td>
<td>332</td>
</tr>
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<td>Upper respiratory infection</td>
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<td>480</td>
<td>1249</td>
<td>454</td>
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<td>Bronchitis</td>
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<td>676</td>
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<tr>
<td>TB suspected</td>
<td>174</td>
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<td>205</td>
<td>132</td>
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<td>TB confirmed</td>
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<td>420</td>
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<tr>
<td>Diarrhoea</td>
<td>178</td>
<td>180</td>
<td>721</td>
<td>236</td>
</tr>
<tr>
<td>Dysentery</td>
<td>250</td>
<td>254</td>
<td>783</td>
<td>247</td>
</tr>
<tr>
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<td>134</td>
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<td>Other gastric problems</td>
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<td>264</td>
<td>180</td>
<td>112</td>
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<tr>
<td>Urinary tract</td>
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<td>70</td>
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<td>Nervous system/epilepsy</td>
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<td>64</td>
<td>18</td>
<td>32</td>
</tr>
<tr>
<td>Joints/Bones</td>
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<td>180</td>
<td>17</td>
<td>68</td>
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<td>701</td>
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<td>71</td>
<td>273</td>
<td>120</td>
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<td>172</td>
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<td>Cancer</td>
<td>8</td>
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<td>4</td>
</tr>
<tr>
<td>Dogbite</td>
<td>16</td>
<td>12</td>
<td>0</td>
<td>21</td>
</tr>
<tr>
<td>Whooping cough</td>
<td>1</td>
<td>0</td>
<td>5</td>
<td>12</td>
</tr>
<tr>
<td>Other (Specified on attached list if necessary)</td>
<td>99</td>
<td>77</td>
<td>62</td>
<td>81</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>6091</td>
<td>8378</td>
<td>7986</td>
<td>5561</td>
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**STATS FROM MCH: No. of cases**

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<tr>
<th>Category</th>
<th>No. of cases</th>
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<td>2nd degree</td>
<td>200</td>
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<tr>
<td>3rd degree</td>
<td>46</td>
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<tr>
<td><strong>Total Malnutrition</strong></td>
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<table>
<thead>
<tr>
<th>Category</th>
<th>No. of cases</th>
</tr>
</thead>
<tbody>
<tr>
<td>No. of births</td>
<td>113</td>
</tr>
<tr>
<td>No. patients referred to government hospital</td>
<td>96</td>
</tr>
<tr>
<td>No. of deaths</td>
<td>13</td>
</tr>
<tr>
<td>Condition</td>
<td>MEN</td>
</tr>
<tr>
<td>-----------------------------------</td>
<td>------</td>
</tr>
<tr>
<td></td>
<td>0-4</td>
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<tr>
<td><strong>Eye infection</strong></td>
<td>1922</td>
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<tr>
<td><strong>ENT infection</strong></td>
<td>1443</td>
</tr>
<tr>
<td><strong>Upper respiratory infection</strong></td>
<td>4608</td>
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<tr>
<td><strong>Bronchitis</strong></td>
<td>3701</td>
</tr>
<tr>
<td><strong>TB suspected</strong></td>
<td>1522</td>
</tr>
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**STATS FROM MCH: No. of cases**

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**No. of births** 1031

**No. patients referred to** 717

**government hospital**

**No. of deaths** 72
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**STATS FROM MCH: No. of cases**

- Malnutrition: 1st degree: 4041
- Malnutrition: 2nd degree: 1314
- Malnutrition: 3rd degree: 260

**Total Malnutrition:** 6415

- No. of births: 1031
- No. patients referred to government hospital: 713
- No. of deaths: 72
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<p>| Measles       | 288            | 270    | 348      | 348       | 2       | 0        | 1006      |         |         |          |       |         |          |         |</p>
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<th>Katora II</th>
<th>Thal</th>
<th>Thal</th>
<th>Lakhli</th>
<th>Banda</th>
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| PREGNANT WOMEN |       |         |         |          |          |      |      |        |       |       |      |      |       |       |
| New attendance  | 22     | 15      | 10      | 14       | 16       | 38   | 53   | 15     | 45    | 44    | 38   | 310  |       |       |
| **Old attendance** | 46     | 30      | 17      | 33       | 36       | 33   | 61   | 31     | 66    | 33    | 70   | 506  |       |       |
| Registered but not attending | 49     | 11      | 42      | 33       | 19       | 26   | 93   | 40     | 55    | 43    | 56   | 467  |       |       |
| Total registered | 117    | 56      | 69      | 80       | 71       | 147  | 207  | 86     | 156   | 120   | 164  | 1283 |       |       |
| Attending within 30 days of delivery | 16     | 10      | 4       | 14       | 27       | 30   | 21   | 15     | 30    | 21    | 30   | 226  |       |       |
| Of this group, attnd during preg | 6      | 5       | 2       | 9        | 22       | 17   | 13   | 6      | 21    | 12    | 15   | 128  |       |       |

| WOMEN DELIVERED BY: |       |         |         |          |          |      |      |        |       |       |      |      |       |       |
| MCH/Dai | 3      | 5       | 1       | 2        | 4        | 2    | 12   | 0      | 4     | 1     | 1    | 35   |       |       |
| TBA     | 0      | 3       | 2       | 2        | 0        | 1    | 0    | 3      | 0     | 1     | 1    | 13   |       |       |
| LHV     | 0      | 0       | 0       | 0        | 0        | 0    | 1    | 0      | 0     | 0     | 0    | 1    |       |       |
| MCH Dai/LHV | 0     | 0       | 0       | 0        | 0        | 1    | 0    | 1      | 0     | 0     | 1    | 3    |       |       |
| Total women delivered | 3      | 8       | 3       | 4        | 4        | 4    | 12   | 3      | 6     | 2     | 3    | 52   |       |       |

<p>| TBAs: |       |         |         |          |          |      |      |        |       |       |      |      |       |       |
| Number trained | 4      | 7       | 5       | 6        | 0        | 3    | 22   | 7      | 4     | 5     | 11   | 74   |       |       |
| Number in training | 0     | 0       | 0       | 0        | 11       | 17   | 0    | 0      | 0     | 0     | 0    | 28   |       |       |
| Refresher training | 0     | 0       | 0       | 0        | 0        | 0    | 0    | 4      | 0     | 0     | 0    | 4    |       |       |</p>
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<th>Thal I</th>
<th>Thal II</th>
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<tbody>
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CONTENTS

- Addresses UNHCR Offices, CCAR Office and Voluntary Agencies

- Abbreviations

- Geographical Areas

- Health Activities

- Future Planning

- Questionnaire
INTRODUCTION

Attached are the results of a survey which was conducted by the Office of the Senior Health Coordinator, UNHCR. The purpose of the survey was to gather information about activities of voluntary agencies involved in health programmes, and how to contact the voluntary agencies if more information is desired. Information of this type, up to this point has not existed in an easily obtainable fashion. A review of this information will show that a very wide range of health projects are being done by many different agencies on behalf of the Afghan refugees.

Since this represents an initial effort on the part of the Senior Health Coordinator’s Office, ways to improve on this are welcome. If voluntary agencies are not included, they can be if information is sent to UNHCR immediately. Inaccurate information should be called to our attention so that it can be corrected.

Plans are for this information to be issued every six months. In this way personnel and address changes can be updated. All individuals who participate in keeping the information current will automatically receive a copy. Additional copies may be obtained by writing to the Senior Health Coordinator.

In regards to this initial effort, special thanks is to go to Mrs. Paula Berends who organized, collected and compiled this information. Without her untiring work, this project would not have been completed.

J. Ahtone, M.D.
WHO/UNHCR Senior Health Coordinator
c/o UNHCR
P.O. Box 1263
Islamabad, Pakistan
The addresses of the UNHCR offices and the voluntary agencies involved with the health programme are listed alphabetically. The abbreviations used here are also officially used by these voluntary agencies.

**UNHCR Office Islamabad**

Houses Number 18 and 25  
Street No. 8  
Shalimar 7/3

P.O. Box 1263  
Telephone: 826004  
820383  
825471

Chief of Mission  
Mr. J. Amunategui  
Telephone: 826001

Deputy Chief of Mission  
Mr. A. H. Utkan  
Telephone: 826005

**UNHCR/WHO Senior Health Coordinator**  
Dr. J. L. Ahtone  
Telephone: 826002

**UNHCR Sub-Office Peshawar**  
House Number 1  
Gulmohar Lane  
University Town  
P.O. Box 767  
University Post Office  
Telephone: 41037  
41038  
41039

Head of Sub-Office  
Mr. B. D. Rigby  
Telephone: 41036

Deputy Head of Sub-Office  
Mr. D. Carminati  
Telephone: 41866

Health Programme Officer  
Telephone: 41165
4. **Afghan Obstetrics and Gynaecology Clinic**  
   2 Circular Road  
   University Town  
   Peshawar  
   P.O. Box 448  
   G.P.O.  
   Peshawar  
   Telephone: 40721

   Director: Mr. M. Hussain Momand

5. **Afghan Refugees Humanitarian Islamic Unity**  
   53 B/2 Park Avenue Road  
   University Town  
   Peshawar  
   P.O. Box 455  
   University Post Office  
   Telephone: 41023

   Director: Mr. Amanullah Rassoul

6. **Austrian Relief Committee (ARC)**  
   80-d, Park Road  
   University Town  
   Peshawar  
   P.O. Box 489  
   G.P.O.  
   Telephones: 42592  
               42584  
   Telex: 5210

   Director: Mr. Nassim Jawad  
   Deputy Director: Dr. W. Blumhagen, M.D.

   **Headquarters Address**  
   Dr. Alfred Janata  
   Salztorgasse 7/6  
   A-1010 Wien  
   Austria

   Telephone: 6340885.
7. **Caritas Pakistan - Afghan Refugee Programme**
   c/o Catholic Church
   36 the Mall
   Peshawar

   Telephone: 75144

   **Director:** Most. Rev. Bishop Bonaventure Patrick Paul
   O.F.M. Bishop of Hyderabad
   **Programme Supervisor:** Mr. George Murad

   **Headquarters Address**
   Caritas Pakistan
   c/o Bishop's House
   A-37, G.O.R. Colony
   Hyderabad

   Telephone: 25349

8. **Catholic Relief Services - U.S.C.C. (CNS)-Pakistan Programme**
   House 31-D
   Street 31
   Shalimar 7/1, Islamabad

   P.O. Box 1657
   Telephone: 824342

   **Director:** Dr. Muriel Latham Pfeifer.
   Telephone: 855505

   **Headquarters Address**
   Catholic Relief Services
   1011 First Avenue
   New York, New York 10022
   U.S.A.

   Telephone: 212-830-4700
   Telex: 224 241
9(a) **Church World Service (CWS)**
(part of CHREP)
House 11
Street 51
Shalimar 7/4
Islamabad

Telephone: 824680

Director/Head: Mr. Bruce A. Rogers

9(b) **Christian Hospital Refugee Extension Project (CHREP)**
(formerly Inter Aid Committee)
c/o Guy E. Alling
Lohar Bunda
Banda Lal Khan
Mansehra

Telephone: 718

Director/Head: Mr. Guy E. Alling

**Headquarters Address**
Church World Service
House 11
Street 51
Shalimar 7/4
Islamabad

Telephone: 824680

9(c) **Christian Hospital Refugee Extension Project (CHREP)**
(formerly Inter Aid Committee)
3D Mission Hospital Compound
Mission Road
Quetta

Telephone: 72461

Director/Head: Mr. F. S. Innis (Committee Member)

**Headquarters Address**
Church World Service
House 11
Street 51
Shalimar 7/4
Islamabad

Telephone: 824680
10. **Freedom Medicine**
4A Railway Road
University Town
Peshawar

Director: Ms. G. Brenner Leclerc
Deputy Director: Mr. Robert Brenner

**Headquarters Address**
941 River St. Suite No. 201
Honolulu
Hawaii 94813

Telephone: (808) 521-2251

11. **German Afghan Committee**
Nasir Bagh Road
(Behind Secondary Education Board)
Peshawar

P.O. Box 540 G.P.O.
Telephone: 74484

Director: Mr. M. Ebrahim Rashid
Deputy Director: Mr. Mohammad Khalid

**Headquarters Address**
Meckheimer Allee 91
5300 Bonn 1
West Germany

Telephone: 0228/693240
Telex: 886834 FSBBOD.

12. **German Agency for Technical Cooperation (GTZ)**
c/o Orthopaedic Unit
Khyber Teaching Hospital
Peshawar

University Post Office
Box 751
Telephone: 41181 Ext. 307

Director: Mr. Rainer Gimple
Headquarters Address
Dag Hammarskjoldweg 1
6236 Eschborn/Ts
West Germany

Telephone: 06196/79-0
Telex: 415230 GTZ-D

13(a). Hayat Services
P.O. Box 1778
Islamabad

Temporary: P.O. Box 214
Gujranwala
Telephone: 84685 (Gujranwala)

Director: Mr. Wilbur G. Ericson

13(b). Hayat Services
P.O. Box 711
University Town
Peshawar

Deputy Director: Ms. Judy M. Blumhagen

Telephone: c/o 42584/42592
Telex: c/o 5736 HICR PK

Headquarters Address

See Above

14. Help the Afghans Foundation

No local representative

Headquarters Address
Ms. Y.L. Luijckx-Westerop
Alexanderstraat 2
2514 JL Den Haag
The Netherlands
15(a). **International Committee of the Red Cross (ICRC)**
15-B Old Jamrud Road
University Town
Peshawar

Telephones: 41673
41371

Director: Mr. Francois Zen Ruffinen
Deputy Director: Mr. Michel Mordasini

**Headquarters Address**
17 Avenue de la Paix
1202 Geneva
Switzerland

Telephone: 022 - 346001
Telex: 22269

15(b). **ICRC**

16. **International Rescue Committee, Inc. (IRC)**
39-C Shahibzada Abdul Qayum Road
University Town
Peshawar

G.P.O. 504
Telephone: 41274

Director: Mr. Thomas L. Yates
Telephone: 73674
Deputy Director: Mr. Sher Haider
Telephone: 42320

**Headquarters Address**
386 Park Avenue South New York, N.Y. 10016 USA

Telephone: (212) 679-0010
Telex: (23) 237611
Islamic Relief Agency
(formerly Islamic African Relief Agency)
17-Chinar Road
University Town
Peshawar

Telephone: 42245

Director: Dr. Abdel Rehman Ahmed
Deputy Directors: Dr. Mohammed Ahmed Mohammed
Dr. Mohammed Ibrahim Suliman
Dr. Samir Mohammed Hassan Shaheen

Headquarters Address
33 Helena Road
London NW10
England

Telephone: 70305-78766
Telex: 22383 I.A.R.A.

Supportive Head-Office
P.O. Box 3372
Khartoum
Sudan

Italian Corporation for Development (ICD)
3/C Gulmohar Lane
University Town
Peshawar

P.O. Box 813 U.P.O.
Telephone: 41496

Director: Dr. Giovanni de Virgilio
Deputy Director: Dr. Sergio Spinaci

Headquarters Address
Dipartimento Cooperazione allo Sviluppo
Ministero Affari Esteri (MAE)
Via Cottarini 25
00194 Roma
Italia
Telephone: 06/399809
19. **Kuwait Red Crescent Society**
   49-A Shami Road
   Peshawar Cantt.

   P.O. Box 782
   Telephone: 76201

   Director: Dr. Ali Abdul Aziz Alhudaib
   Telephone: 73312
   Deputy Director: Mr. Abdul Wahid Farhan

   **Headquarters Address**
   P.O. Box 1359
   Safat, Kuwait

20. **League of Red Cross and Red Crescent Societies in Collaboration with**
    **Pakistan Red Crescent Society**
    c/o Pakistan Red Crescent Society National Headquarters
    Sector H-8
    Islamabad

   Telephone: 854885
   Telex 54103 PRCS PK

   Chief Delegate: Mr. Eberhard Halbach

   **Headquarters Address**
   P.O. Box 276
   1211 Geneva 19
   Switzerland
   Asia/Pacific Department

   Telephone: 345580
   Telex: 22555 LR CS CH
21. **Norwegian Refugee Council**  
17-A Park Avenue Road  
University Town  
Peshawar  

Telephone: 76093  
Director: Ian Erl. Haugland  

**Headquarters Address**  
Norwegian Refugee Council  
Professor Dahlsgt. 1  
0335 Oslo 2 - Norway  

Telephone: 47-2/603942  
Telex: 72343 NORFU N  

**Norwegian Church Aid**  
P.O. Box 5868 Hegdehaugen  
0308 Oslo 3 - Norway  

Telephone: 47 2/463970  
Telex: 19493 CHHELP N  

22. **Operation Handicap Internationale (OHI)**  
c/o UNHCR  
P.O. Box 30  
Quetta  

Telephone: 79237  
Director: Mr. Bart Verclyte  

**Headquarters Address**  
18 Rue de Gerland  
69007 Lyon  
France  

Telephone: 7861 1737  
Telex: BIOFOR 37 5217 F
23(a). **Pakistan Red Crescent Society**  
National Headquarters  
Sector H-8  
Islamabad  

Telephone: 854885  

Director: Air Commodore (Retd): M. R. Mahmood  
Telephone: 65632  
Deputy Director: Lt. Col. (Retd): Qamar Ahmad Khan  

Telex: 54103 PRCS Pk

23(b). **Pakistan Red Crescent Society Baluchistan Provincial Branch**  
Silachi House  
Silachi Street  
Sariab Road  
Quetta  

Telephone: 78406  

Director: S. Tajammul Hussain

**Headquarters Address**  
(Same as 23a)

23(c).  
**Pakistan Red Crescent Society NWFP Provincial Branch**  
Dabgari Gardens  
Peshawar  

Telephone: 66036  

Director: Lt. Col. (Retd) M.A. Shah  
Telephone: 74052

**Headquarters Address**  
(Same as (23a))

23(d). **Pakistan Red Crescent Society**  
Punjab Provincial Branch  
Fatima Jinnah Road  
Lahore  

Telephone:  

Director: Mr. Sunbul
24. **The Salvation Army (SA)**  
9-B Rafique Lane  
Peshawar  

Telephone: 74545  
Deputy Director: Mr. J.W. Kanis  

**Headquarters Address (Territorial)**  
35 Shara-e-Fatima-Jinnah  
Lahore 3  
P.O. Box 242  

Director: Colonel Gordon Bevan  

**Headquarters address (international)**  
101 Queen Victoria Street  
London EC4P 4EP  
England  

25. **Saudi Red Crescent in Pakistan**  
76-Defence Officer's Colony  
Peshawar  
P.O. Box 347  
Telephone: 74264/75715  

Director: Mr. Hamad Ibrahim Al-Bubtain  
Deputy Director: Dr. Abdullah M. Al-Shahri  

25(b) **Saudi Red Crescent**  

26. **Save the Children Fund, United Kingdom (SCF/UK)**  
10-Gulmohar Lane  
University Town  
Peshawar  

Telephone: 76657  

Director: Mr. Jonathan Mardall  
Telephone: 75987  
Deputy Director: Ms. Margaret Usher  
Telephone: 42271
Headquarters Address
17 Grove Lane
Camberwell
London SE5 8RD-UK

Telephone: 7035400
Telex: 892809 SCFLON G

27. Serving Emergency Relief and Vocational Enterprises (SERVE)
5 Mulberry Road
University Town
Peshawar

P.O. Box 477
Telephone: 41706
Telex: 52698 POPO PK ATTN SERVE

Director: Mr. Gordon Magney
Deputy Director: Mr. Ron Lung

28. Swedish Committee for Afghanistan
41-a Circular Road
University Town
Peshawar

G.P.O. Box 689
Telephone: (41247) 40415
Telex: 5265 SCA PK

Director: Mr. Anders Fange
Deputy Director: Mr. Lars Nelson

29. Union Aid for Afghan Refugees
Said Jamalludin Afghani Road
University Town
Peshawar

P.O. Box 428
Telephone: 41579

Director: Dr. T. Nassery
Deputy Director: Dr. Fazel Ruhim

Headquarters Address
Keigerplatz 3
Bonn 1
West Germany
United Nations Children's Fund (UNICEF)
NWFP Programme Office
4844 Warsak Road
Arbab Coloney, Peshawar

P.O. Box 476 (or through UNICEF Islamabad pouch)

Telephone: 78524.
Telex: 5258

Director/Head: Mr. Peter Hammister (till 16 Dec. 1985)
Deputy Director: Ms. Zubeida Khatoo Sher Khan

Headquarters Address
UNICEF, 58862 Khayaban-e-Iqbal
Shalimar 7/2, Islamabad
Telephone: 825142-6
Telex: 5535

31. Young Men's Christian Association (YMCA)
In order to have a schematic outline of geographical areas covered and activities implemented abbreviations of the names of VOLAGS are made. Some of these abbreviations are officially used by the agencies, others are not.

AICF  Action Internationale Contre La Faim
AHSAO  Afghan Health and Social Assistance Organization
AMA  Afghan Medical Aid
AOGCC  Afghan Obstetrics and Gynaecology Clinic
ARHIU  Afghan Refugees Humanitarian Islamic Unit
ARX  Austrian Relief Committee
CP  Caritas Pakistan
CRS  Catholic Relief Services
CHREP  Christian Hospital Republic Extension Project
   (formerly known as Inter Aid Committee-IAC/Church World Service)
FM  Freedom Medicine
GAC  German Afghan Committee
GTZ  German Agency for Technical Cooperation
HS  Hayat Services
HAF  Help the Afghans Foundation
IRC  International Rescue Committee
IRA  Islamic Relief Agency (formerly known as Islamic African Relief Agency)
ICD  Italian Cooperation for Development
KRCSC  Kuwait Red Crescent Society
LRC  League of Red Cross and Red Crescent Societies
NRC  Norwegian Refugee Council/Norwegian Church Aid
OII  Operational Handicap Internationale
PRC  Pakistan Red Crescent Society
SA  The Salvation Army
SRC  Saudi Red Crescent
SCF  Save the Children Fund (UK)
SCRE  Serving Emergency Relief and Vocational Enterprises
SCA  Swedish Committee for Afghanistan
UA  Union Aid for Afghan Refugees
UNICEF  United Nations Children's Fund
WHO  World Health Organization
YMCA  Young Men's Christian Association

MTA  Med. Training for Afghans
IMC  International Medical Corps
SAO  B-38 Chinar Road
GEOGRAPHICAL AREAS

The geographical coverage is based on the responses which the voluntary agencies have supplied. Some agencies have mentioned which camps they are actually working in. These camps are put between brackets.

Pakistan

PRC

NWFP
(throughout)

ARC, CHREP, ICD, KRC, PRC, SERVE, SCF, UNICEF, ICRC, CRS

District/Agency
Abbottabad

SA (Haripur and Ghazi), SCF (Haripur)

Bajaur

SCF, GAC

Bannu

IRA (Bizon Khel, Naurang)

Dir

SCF

Di.I. Khan

CHREP (Tank)

Kohat

IRC (Hangu and Thal Areas), FM

Kurrum

GAC

Mansehra

CHREP

Mardan

ARC (Baghicha and Gandaf), RC (+LRC), UA, KRC (Jalala)

Peshawar

AHSAO, AMA, ARHIU, AOUG, Caritas, FM, GTZ, IRA (Jalozai, Warsak, Kacha Ghari, Nasir Bagh, Zanday and Zangalay), IRC, KRC (Abora Khattak), SA PRC (Adezai), SCF (Badda Ber), SERVE, CHREP, HS, UA, SRC (Jalozai, Nasir Bakh, Kuchaghari, Daag Baisood).

Waziristan North

GAC

Waziristan South

GAC
<table>
<thead>
<tr>
<th>Baluchistan (throughout)</th>
<th>AICF, PRC, ICRC, SRC, CRS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Agency/District</td>
<td></td>
</tr>
<tr>
<td>Chaman</td>
<td>PRC (also Badini)</td>
</tr>
<tr>
<td>Quetta</td>
<td>CHREP (Mohammad Khel No. 5), OHI, SRC</td>
</tr>
<tr>
<td>Zhob</td>
<td>CRS</td>
</tr>
<tr>
<td>Punjab</td>
<td></td>
</tr>
<tr>
<td>District/Agency</td>
<td></td>
</tr>
<tr>
<td>Mianwali</td>
<td>PRC (Mianwali), HS, (Kot Chandnu)</td>
</tr>
<tr>
<td>Islamabad</td>
<td>HS</td>
</tr>
</tbody>
</table>
HEALTH PROJECTS

A general subdivision is made in the health projects. Some agencies specified their activities. They are summarized below.

Norwegian Refugee Council and Norwegian Church Aid are channeling their aid through ARC, IRC and CHREP (previously IAC).

League of Red Cross Societies is channeling their aid through Pakistan Red Crescent.

1. BHU's Supervision: SCF, PRC, CHREP, ARC, AICF, UA, SRC, CRS

2. Mobile Teams:
   PRC+ICRC: First aid, NWFP
   KRC: Ambulances
   IRA,
   SRC

3. Static Provisions:
   PRC+ICRC: First aid Baluchistan
   PRC: Hospital Mianwali+LRC
   ICRC: Surgical hospitals
   OHI: Orthopedic and physiotherapy centre Quetta
   KRC: hospitals
   CHREP
   ARHU: Polyclinic
   AOGC: Hospital
   AMA: Hospital and polyclinic
   UA: Hospital
   SRC: Hospital and physiotherapy center

4. Primary Health Care: SCF+UNICEF, SA, PRC, Baluchistan
   IRA, IRC, AHSAO, CRS

5. Sanitation: SA, PRC, IRA, IRC, ARC+CHREP, AICF, UNICEF+Safe water supply, CRS + ARC

6. Training:
   SERVE: Teaching progr. for women, children and teachers
   SA: AR Comm. Health Workers
   OHI: Orthopaedic & physiotherapy topics
   KRC: First aid
   ARC: Dais
   AHSAO: Male & female students: Health, education
   GAC: Medical training for youth
   FM: Health workers for Afghanistan and in camp
   SCA: Financing medical training courses for Afghans
   UA: First aid
   ICRC: First aid
   SRC: Health education
7. Public Health:
   SERVE: public health books - charts and guides,
   Pashtu, and Dari
   SA
   CHREP,
   UNICEF

8. Disabled:
   PRC + UNHCR, OHI, KRC, GTZ
   ICRC: Paraplegics, orthopaedic center

9. TB Control:
   ICD, IRA (Mobile clinic)
   AMA, WHO

10. Malaria Control:
    IRA, WHO

11. EPI:
    IRA, AICF, WHO

12. Dental Care:
    KRC, Caritas

13. Eye-Work
    SERVE: Eye clinic
    PRC + LRC: Mardan

14. Financial aid/Support:
    KRC, CHREP, HS

15. Others:
    SCA: Supply of medicines to hospitals
    SCA: Supply of medicines and equipment to
    Afghans with medical education
    UA: Nutrition
    HS: Technical Assistance
    FM: Medical and Surgical facilities
This paragraph concerns question in the questionnaire. The agencies were asked to list future projects which they would like to share with UNHCR. Follow-up of these data is required.

Information obtained on projects regarding other activities than health will be sent to UNHCR staff concerned.

Start of Hospital/Clinic:
- Primary Health Care
- Mianwali 25-30 beds
- Hospital on border
- Dermatology
- Surgical Service on border
- 2 hospitals on border
- 1 hospital
- 1+ b hospital

Expansion of Existing Hospitals/Clinics:
- Addition pediatric unit
- Child health centre

Physiotherapy centre Peshawar:

Artificial limbs workshop Peshawar:

Instruments for psychiatric clinic:

Operation room equipment

Mobile medical unit

Training:
- Nurses
- Nurses
- Afghan Students on health
- Afghan Students on health
- Primary health care workers
- Health workers
- Technician
- Staff psychiatric clinic
- Medical Personnel Refresher course
- Training facilities in Dir and Chitral area
Addition of BHUs Quetta
Increase on emphasis primary health care
Replacement of tented dispensaries
Nutrition education/demonstration
Extension Nutrition Programme
By means of the attached questionnaire we would like to compile general information of all the voluntary agencies involved with the Afghan Refugee Health Programme.

The purpose is two-fold:

- to update information on the concerned voluntary agencies;
- to make information of agencies accessible to the others so that it may facilitate mutual contacts. (Sharing experience, coordination of projects, etc.).
ANNEX 5 page 2

VOLUNTARY AGENCIES IN NWFP 31 DECEMBER 1984

ADDRESS

TEL. NO.

1. AUSTRIAN RELIEF COMMITTEE (ARC)

Nasim Jawad
ARC for Afghan Refugees
80-D Park Road
University Town
Peshawar
42592

2. AUSTRIAN RELIEF COMMITTEE SANITATION PROJECT

ARC Sanitation Project
80-D Park Road
University Town
Peshawar
42584

3. CARITAS PAKISTAN

John D'Cruz, Director
George Murad, Programme Supervisor
c/o Sr. Michael's Church
Mall Road
Peshawar Cant.
75144

4. GERMAN AGENCY FOR TECHNICAL COOPERATION (GTZ)

Rainer Gimple
GTZ
Orthopaedic Unit
Khyber Teaching Hospital
Peshawar
P.O. Box 741
University Post Office
Peshawar
41181/2 EXT. 307
5. INTER AID COMMITTEE (IAC)

Harrison Massey
Inter Aid Committee
18 Chinar Road
P.O. Box 488
University Town
Peshawar 41918

6. INTERNATIONAL COMMITTEE OF RED CROSS (ICRC)

Mr. Francois Zenuffinen
Head of Delegation
International Committee of Red Cross
15B Old Jamrud Road
P.O. Box 418
University Town
Peshawar 40815
Dr. Bjorn Ranhime
Medical Coordinator

7. INTERNATIONAL RESCUE COMMITTEE (IRC)

Mr. Mark Ice
IRC
39C Sahibzada Abdul Qayyum Road
GPO Box 504
University Town
Peshawar 41274

8. ISLAMIC AFRICAN RELIEF AGENCY

Dr. Abdur Rehman Ahmed
Islamic African Relief Agency
47-C/11 Sahibzada Abdul Qayyum Road
University Town
Peshawar 40968

9. ITALIAN COOPERATION FOR DEVELOPMENT

Dr. Giovanni di Virgilio
TB Control Programme among AR's in NWFP
3C, Gul Mohar Lane
University Town
Peshawar 41496
10. KUWAIT RED CRESCENT (KRC)

Dr. Mohammad Al-Sharhan
Kuwait Red Crescent Society
49A Shami Road
Peshawar 76201

11. NORWEGIAN REFUGEE COUNCIL

Mr. Johan Sigmunn Heboes
Refugee Relief Coordinator
17A Park Avenue Road
University Town
Peshawar 76093

12. PAKISTAN RED CRESCENT SOCIETY (PRC)

Lt.Coll.(Retd.) M.A. Shan, Secretary
Pakistan Red Crescent Society
NWFP Branch
Dabgari Gardens
Peshawar 76036

13. THE SALVATION ARMY

Captain David J. Burrows
The Salvation Army
9B Radziqhi Lane
Peshawar Cant. 74545

14. SAUDI RED CRESCENT (SRC)

Mr. Abdul Qadr Mohammad Ramadhany
President
Saudi Red Crescent
76 Defence Officers Colony
Peshawar Cant. 75715

15. SAVE THE CHILDREN FUND (SCF)

Mr. Jonathan Wardall
Save the Children Fund
9A Shami Road
Peshawar Cant. 76657
16. SWEDISH COMMITTEE FOR AFGHANISTAN

Mr. Ingemar Andersson
15A G-1 Minar Lane
University Town
Peshawar
41247

17. SERVE

Mr. Gordon Magney
SERVE
5 Mulberry Road
P.O. Box 477
University Town
Peshawar
41706

18. UNION AID FOR AFGHAN REFUGEES

Dr. T. Nassery / Dr. Fazli Rahim
Union Aid for Afghan Refugees
P.O. Box 428
27-A Jamaluddin Afghani Road
University Town
Peshawar
41579
Main Clinics

All seven teams were busy this month receiving a total of 28,016 patient visits in the eleven Basic Health Units (BHU's). This represents an increase of over 3,500 visits over last month's total and is the highest number of patient visits recorded to date. The weather is still hot, but despite this, patients are still coming to the clinics where they sometimes must wait for quite a while before being seen, often outside in the sun.

The most commonly seen illnesses this month were skin infections, upper respiratory tract infections and malaria; the usual pattern at this time of the year.

The first round of malaria spraying is almost complete -- the malaria supervisors and sanitariums are still working in Dallan. The second round will start in October. We are hoping that the spraying will reduce the high incidence of malaria in our camps -- 2254 suspected cases were seen this month.

Construction of the new clinic in Kotki II is now near completion. This new clinic (replacing the tented clinic) should be in operation by the end of October.

The SERVE eye clinic team came to Hangu this month and attended 54 cases. We are grateful to SERVE for this assistance.

We were very proud this month to receive a visit from Princess Christina Magnusson of Sweden. She was accompanied by an official of the Swedish Embassy in Islamabad and a representative of Redd Barna (Sweden). These visitors were impressed with the work our staff is doing and most definitely helped to boost their morale during a very busy time.

We are not happy to report that on September 22 there was a car bomb blast in the Hangu bazaar in which 2 persons were reported killed and 10 others injured. This type of incident occurs rarely, but for some time our staff will be most cautious when entering the local bazaar.

Malaria

We are presently in the peak of the malaria season. This is evidenced by the statistics provided above -- 2254 suspected cases. Of these, 367 were confirmed as having malaria (34 falciparum and 333 vivax). Again, we are hopeful that the
efforts of the malaria supervisors and sanitarians, both in routine spraying and health education, will pay off.

Tuberculosis

A total of 86 new cases were registered for treatment this month -- 50 pulmonary and 36 extra-pulmonary. This is an increase of 22 over last month's new registrations which totalled 64. Of the pulmonary cases, 8 are AFB positive and 42 AFB negative. We managed to discharge 117 cases this month, leaving us with a balance of 633 cases presently under treatment. Of this total, 414 cases are pulmonary and the remaining 219 extra-pulmonary.

Expanded Program on Immunization

A total of 8950 immunizations were given in the clinics this month. Of these 112 were for polio at birth; 982 BCG; an additional 2926 polio; 1986 DPT; 836 DT; 1102 tetanus toxoid for women of child bearing age and 1006 measles inoculations. In the tetanus toxoid category, 632 women were started on the series. At outreach sessions an additional 469 tetanus toxoid injections were given, as well as 1810 inoculations in the various categories to children.

Laboratory

We welcomed Robert Menzies, an Australian volunteer of the Overseas Services Bureau, to the laboratory staff this month. Rob will assist the three persons now working in the laboratory. September was a fairly busy month with almost 3000 samples examined. Rob has helped considerably to even out the work load placed on the laboratory technicians. He is also looking at ways in which the work done there can be improved. It already seems clear that some better quality microscopes are greatly needed as well as additional equipment and we are trying to locate sources for these items and also funds to pay for them.

Maternal and Child Health Centers

Visits from children under five totalled over 13,000 this month, so our teams were again busy. The usual diarrhoea, dysentery and skin infections were seen.

Special Care and Supplementary Feeding

Over 2200 children presently fall into the Special Care category and of these, over 1600 came to the centers.
regularly for Special Feeding. We were again able to record that a substantial number (over 900) children in the Special Feeding Program were gaining weight. The numbers of children in these categories makes for a lot of work, but the staff in all camps have coped very well. One of the problems facing the MCH’s is lack of space. In some camps where attendance in the Feeding Program is especially high (perhaps 100 or more a day) the tents become very crowded and this makes it difficult for our staff to properly supervise the mothers and children. For example, in Darsamand a special building was constructed for feeding, but this has proved now to be too small and the feeding section has been moved to the MCH tent. This is alright for now, but when the weather becomes colder other arrangements will have to be made. Plans are presently being discussed for ways in which to handle this problem.

Ante-Natal

There are now nearly 1300 women registered for ante-natal care in the MCH’s. In addition to these women, 320 have thus far been registered through the Outreach Program. Unfortunately, about a third of the women registered at the MCH do not attend the clinic as regularly as they should, but we do our best through community health efforts to encourage them to come. It is not always easy for these women as they face both cultural and time constraints -- some of them live a long way from the clinics and have a lot of work to do at home. Depending on what is going on in the home on a given day, attending the clinic can become a low priority.

Training

This month we are very pleased to report that we have 28 women undergoing Traditional Birth Attendant (TBA) training. Four women are also in refresher training. Refresher courses are necessary as almost all our trained TBA’s are illiterate and so cannot review materials left by us on their own. When the current 28 women have completed their training, we will have a cadre of 102 trained TBA’s.

Our TBA’s delivered 13 babies this month (unassisted by a Lady Health Visitor) and our trained MCH assistants delivered 35. One of the MCH assistants in Lakhti Banda camp delivered 12 babies, again, unassisted by our Lady Health Visitors.

We find this kind of progress very encouraging.

Five new Lady Health Visitors were hired this month to replace those who have left. These women are now undergoing in-service training. We welcome them to our Hangu staff.
Sanitation

During this month 140 slabs were issued and 102 pit latrines completed. This means that for the year we have now completed 2002 latrines and made 3140 concrete slabs. Latrine use has been particularly consistent in the more crowded camps where refugees can see for themselves that this helps to keep their environment cleaner.

Work on the water situation continues. This month 10 shallow wells were improved and one maintained. The sanitarians also managed to disinfect 21 of the shallow wells. Of course, community, rather than family compound wells, are our priority for improvement and maintenance as they are used by more people. Due to the constant problem of water contamination in the wells, we plan next month to install hand-operated water pumps in some of them. We will see how the refugees are using these, and if the response is good, we will expand this project. The hand pumps are cost effective and much cleaner, so we hope this new system will work. We are systematically installing covers on the wells now and this will also help cut down on contamination. So far this year, 14 shallow wells have been improved, 7 maintained and 159 disinfected.

Also during the month 142 public health education sessions were held. We have had very good response to these in the camp schools -- and this is encouraging. Children are given a presentation, later tested and those children having high scores on the test are given a small prize such as a cake of soap, a towel or a comb -- items all having some relation to personal hygiene. We are planning to also begin such work at Hazrat Ali Lycee, the school IRC has taken over in Hangu. We can reach a fairly wide community through these students who come from many camps in our catchment area and also from Kohat.

In the Kohat camps this month we distributed 196 slabs, 64 latrine covers and 64 PVC pipes. So far this year 1499 slabs have been made for these camps and 146 latrines completed.

Outside of their regular work the sanitarians are always on the lookout for sick people who should be seen by a doctor. This month they managed to find four Special Care Program defaulters, three suspected TB cases and two suspected cases of malnourished children. All of these people were referred to their camp BHU.

Community Health Worker Program

Work of the Motivation Team continued at a steady pace during September. Community participation in the selection process of Supervisors has been very enthusiastic. Within our camps,
this has been the first serious effort to involve representatives from most every family in a recruitment procedure. The Health Committee is given a large degree of respect by the refugees for its role in the nomination of Supervisor candidates. This respect is founded not only on the fact that 1-3 Supervisors per camp will receive a stipend, but also on the basis, that a nomination for Supervisor means that person is endorsed by a representative from every tribe as acceptable to the entire camp. This is particularly worthy of note as many cultural and political differences exist between tribes (Kai alone has 18 different tribal subgroupings). Thus, an endorsement by the Health Committee becomes a very prestigious acknowledgement.

A very tangible step in our program's development took place during the last two days of September, when the candidates were interviewed and 3 men were selected for Darasamand, and 2 for Kai. All 5 of these men will begin their three month training course on October 12 at the Save the Children Fund training center in Badaber. Building to this point of "training of trainers" has been a lengthy and methodical process. A process, which because of its nature of maximum community involvement, has created a substantial interest in Primary Health Care. We look forward to when these men will complete their training in December. At that point, they will return to their respective camps to select and train 1 Volunteer Community Health Worker for every 30 families. Simultaneously, we will continue with the work of our Motivation Team in Mohammed Khoja, Dallan and one other camp during October, November and December. As our first group of Supervisors return from training to begin their work in Darsamand and Kai, the second group of six Supervisors will have been selected and the cycle will continue.

The Medical Referral Program

This month 124 refugees were referred to Peshawar for consultation (last month's total was 86). Specialists' opinions were sought for all these patients regarding their management in Khyber an other local hospitals. Among these patients 38 were advised admission to Khyber and other hospitals and an additional 20 were given dates for admission. We managed to arrange surgery for one patient on the day of his arrival in Peshawar.

Most of the patients referred were suffering from chest and cardiac problems (59 patients). Another 56 patients needed orthopaedic consultations or needed attention to general surgical disorders. One patient suffering from a neurological illness was referred to Lahore for therapy. Two of the cardiac patients were examined completely and are now ready for surgery.
Monthly Report
September, 1986

Once again, we are happy to report good cooperation from
Khyber, Afghan Surgical and the Kuwait Red Crescent Hospital.

Conclusion

There has never been a month when we have reported a low
level of activity in the Hangu Medical Program -- and
September was no exception to this. The basic out-patient
services in both the main clinics and the MCH's continue to
be more readily utilized by the refugees, and as winter
approaches bringing with it the usual high incidence of upper
respiratory infections, we expect to be even busier.
In addition, with the augmentation of these basic services by
the Sanitation Program and the Community Health Worker
Program, we feel certain that the present level of activity
will increase as more and more refugees become aware of what
they and IRC have to offer their communities.

Dr Ishaq
Acting/Assistant Medical Director
THE EDUCATION PROGRAM

Inter-Party Schools

The party schools were visited this month by our monitors, members of the teacher training staff, the Deputy Director of the Education Program and myself. The following is a report of our findings:

Omar Farooq (Peshawar)
Political party: Harakat-e-Inquilab-Islami

Education President Yousufzai accompanied us to this school which is located on the outskirts of the city of Peshawar. The condition of the building was excellent. The school was moved to this new location after it was learned that IRC would be taking over. The rent is quite higher than we had expected but we have come to an agreement with the party that IRC will pay for half while they will pick up the balance. Everyone seems pleased with this arrangement. Their previous school looked like a prison and now they have a building that looks like a school.

While at the school our staff split up and went to different classrooms to determine the exact attendance on that day. It is necessary to do this so as to get an accurate attendance rate. The actual attendance was 353 in grades one through twelve, although it had been reported as 501. We explained that we are not concerned with high enrollment, but that they report accurate attendance figures so as not to jeopardize future funding. We notified the school that our monitors would be coming at least three times a month. We also told them that their salaries would be raised and that they would be receiving supplies soon.

Very few students had books or notebooks and many of the rooms had no blackboards. Yet the morale among the teachers, administrators and students was very good. The teachers want teacher training and the principal said he would like us to come out as often as possible. We felt that they appreciated the attention we were giving them and think that the possibility of improving the quality of teaching in this school is very good.

Hazrat Ali Lycee (Hangu)
Political Party: Mahaz-e-Milli-e-Afghanistan

We found this school to be in a deplorable state. Many of the classes are being taught in rooms with no light or in tattered tents in the courtyard. The teachers were not prepared for their classes and we estimated that many of them could not have more than a tenth grade education. The
principal seemed a very depressed man who has a poor relationship with his staff. The students also had very few books, pencils or notebooks.

On the day we visited 544 students were in attendance. Transportation of students seems to be a problem and accounts for a considerable portion of the budget. We found, for example, that 80 students are being bussed from Darsamand camp at a cost of US$562 per month. We believe that there already is a school in Darsamand and that some competitive political finagling might be going on. In any event, we told them that if there was a school in Darsamand, we would not be able to provide the cost of transportation from that area.

The most depressing aspect of this school was the low morale among teachers, which, of course, is affecting the students. There are several reasons for this. The school is impoverished and what little money they have is being spent on transportation and teachers' salaries. They did not even have enough money to offer us tea. They felt ashamed and apologized. We gave them some money and told them that they should have tea every day and asked them to have staff meetings during their tea breaks; they agreed.

The low morale is a result of the history of this school. In the days of the old three party alliance they had teachers from all three parties. When the alliance broke up, the teachers that were working there, and who were not members of Mahaz, could only keep their jobs by becoming members of that party. While they have become constituents of Mahaz, some of them have loyalties to their old parties, or are apolitical. We think that a principal who has some initiative and charisma could help to create some harmony among this diverse staff and we will work with the Board to try to effect this change.

Bajur Lycee (Bajaur)
Political Party: Juba-e-Nijat-e-Milli

We had been told that the attendance of this school as of February 1986 was 607 students. On the day of our visit we counted 133. We also found out that since February two secondary schools (one Hizebe-e-Islami and one Jamiat-e-Islami Afghanistan) have started within a 300 meter radius of this school. We had no prior knowledge of the existence of these two schools. As there is such a discrepancy in the numbers of students in attendance compared with what we had expected, we can only assume that most of Bajur Lycee's other students have been absorbed by these other two schools or that there never were 607 students in the school. Another possibility for the low attendance is that since this school has its vacation from November to February, their funding was cut in the middle of the school year, whereas funding for the
other party schools was cut during their summer vacation. Since the teachers stayed on for three months without pay, this must have affected teacher morale, which would have adversely affected attendance. Whatever the reason, or reasons, for the low attendance, we have decided to recommend to the Board that the number of teachers be decreased. There were nine classrooms that had fewer than eight students in each class. We will also conduct a survey in the camps to see if children are going to the other party schools or if they aren’t attending at all. If we find that the children are attending the other two party schools, we will recommend that Juba-e-Nijat-e-Milli close this school and open up another one in a camp area where no schools exist. However, if we find out that many school aged children are not attending school, we will try to recruit these children and improve the school. During the months of November, December and January (school vacation for this area) we will conduct a survey to determine what course of action we think should be taken, and then present our findings to the Board for a final decision.

Summary

All three of these schools have to be considered as distinct institutions with different dynamics and problems. However, there are some characteristics that they all share:

1. Instruction is carried out in a rote manner. Teachers lecture and students write notes. Very few questions are asked of the students. Students are rewarded for memorizing formulas, verses from the Koran or whatever information is given. Problem solving or creative thinking is not encouraged and students appear to be bored. However, the memory of these students is remarkable.

2. All of these schools lack books, teaching aids and notebooks. These will be supplied through the services of our printing press.

3. All of the teachers are not qualified, but we believe with teacher training the quality of their instruction can be somewhat improved.

Within the next few days we will have our first Board meeting. A thorough report including the above information with our recommendations will be presented to them. The Board will then begin setting policy.

**Teacher Training and Textbooks (TTT)**

The Director and staff of TTT has decided to evaluate the effects of the Teacher Training Program on classroom instruction. This summer our incoming and outgoing
examinations of student/teachers demonstrated that our participants were learning a significant portion of the materials that were taught to them in the seminars. Now we want to see if they are using the material in their classroom, if their methodology of instruction is effective, if they are incorporating the experiments we have given them in their classes, and if their students are motivated and learning. Accordingly, a teacher evaluation form has been designed and a questionnaire has been created that will be given to the students.

The staff, in addition to observing the teachers and giving them suggestions, will also demonstrate some of their teaching methods within the classroom. As of now, we have trained 251 teachers in our teacher training program. We hope to be able to observe about 100 of them in the camps and Peshawar. We will spend about two months on this in conjunction with other activities.

More charts have been created in biology, math and chemistry. Distribution of lecture notes continues and 1365 seventh grade science text books which we printed have been distributed to several schools.

The staff has also continued to be of assistance to the Experimental School. They prepared a list of laboratory equipment that will be purchased for the school and have prepared a list of experiments that should be performed for each class level for the duration of the school year.

The Experimental School of the Sciences

The teachers for the Experimental School have all been selected. We interviewed the upper fifteen percent of applicants who took our examination. The examination was prepared by the teacher training staff.

Some of the teachers who were hired worked for their political parties or at party schools. All of them received written permission from their Educational President to come to work for us. Once they were all hired, they began work on designing an entrance examination and placement test for students. The test emphasized science, math and English. Teachers also began registering and interviewing students.

The Board of the Experimental School had its first meeting this month which started with a recitation from the Holy Quran. The principal reported on the activities of the school regarding hiring of teachers, curriculum development, and the design of an entrance examination.

The Board decided that the textbooks other than the science books that have been developed by our teacher training
department should be revised in order to adapt them to the present refugee situation. They also set maximum age limits for each grade so that, for example, we would not allow a seventeen year old student who placed at the seventh grade level into the seventh grade. Other recommendations regarding the highly complicated process of grading and placing students into the appropriate grade level were also made. Tom Yates has also suggested that at least two applicants for each grade be selected at random with no regard for the test results. Everyone liked this idea.

On September 24 and 25 tests were given to 800 Afghan students who were competing for 180 seats in the school. We had expected a large number of students to apply, but were surprised that the number was this high.

The atmosphere at the center where the tests were administered was one of tension and excitement. One young man who was about to take the test told me in perfect English, "I am only in the seventh grade but my grasp of science is that of at least a ninth grade student. If I score high on the exam, can I get admitted into the school at the ninth grade level?" I agreed.

Construction for the building of the school is almost completed. Classes will begin on October 6, 1986.

Secondary Female Education

Tajwar, the Director of the female education program, has now hired two other women and they have finished designing the survey, which is now being given to women in our English Language Program, camps, and neighborhoods in Peshawar. The survey will provide us with the data that will help us determine what direction to take in secondary female education. By the end of next month the survey should be completed and we can begin analyzing the results.

In meetings with Peter Schoof of UNHCR and Perveen Khan of the Department of Women's Education in Allama Iqbal University, secondary female education was discussed. The Department of Women's Education is now piloting a well-planned, non-formal course for secondary female education for Pakistani women. It consists of homestudy materials with a tutorial one day a week. Since it is targeted toward dropouts -- girls have to be 15 years old to apply -- it doesn't compete with regular schooling. This is an appropriate means of study for young rural women whose distance from regular schools is great and whose child care responsibilities and home chores make it difficult for them to attend a school five days a week. The curriculum is functional and versatile. It is now available only in the Urdu language, but will be translated into Pushto, at which
time it could then be used with Afghan girls.

If our survey results show that there is a demand for a homestudy course for female secondary education, we would have an excellent prototype to adapt. However, in our visit with Peter Schoof we looked at statistics on girl’s middle school education, which were not encouraging. We found that 29 girls were enrolled in Commissionerate schools in the fifth grade in Peshawar, and only 22 in all other districts. In the sixth grade the statistics are worse: only 7 girls were enrolled in Peshawar and none in other districts. In Peshawar there are two non-Commissionerate girls’ schools as well, so secondary female education is feasible in Peshawar, but most likely not in any other areas. If the survey shows that a regular secondary female school would be appropriate, UNHCR is very interested in assisting with additional funding if needed.

Calligraphy and Art Department

The following activities were carried out by this department.

One hundred and eight pages of the book "Where There is no Doctor" were written by hand.
Ninety pages of physics lecture notes were proofread.
Pictures for the above books and others were drawn by our artists.
The artist completed two paintings, which are for sale.
Two chemistry charts were completed.
Photographs of schools were taken by the staff photographer.

Printing Press Project

UNHCR notified us that the Government of Pakistan will not allow the press to be used as a commercial enterprise, and that it cannot become independent of IRC, which was our objective. This means that we cannot compete in the Pakistani marketplace, although we are not restricted from charging voluntary agencies, the Commissionerate, and IRC programs for books and stationery products. We still think that this project can become self-sufficient within two to three years, printing for only these markets. The voluntary agencies print a lot of materials and we can offer them quality work at a reduced rate. There are at present more than 40 voluntary agencies in Peshawar.

Our goals now are the following:

1. To make the program self-sufficient but not independent of IRC
2. To provide "permanent" employment for the Afghans working in the project while they remain as refugees in Pakistan.
3. To provide educational materials and stationery to school children.
4. To provide voluntary agencies printed materials at a reduced cost, which will enable them to use their savings on other Afghan refugee related activities.

We have proceeded to look for a new location for this project. It is now located in an area that is far from the voluntary agencies. We would like to have it in an area that is easily accessible to those that will use its services. Secondly, we need a larger building to accommodate the new equipment that we will be purchasing. Stichting Vluchteling has allocated funds for the purchase of an automatic press and other equipment which will increase our output. At present we cannot keep up with the demand from the voluntary agencies and the need for textbooks for schools with our semi-automatic machine.

The following materials were printed this month:

Eleven thousand copies of notebooks for school children at the Experimental School and Hangu and Bajaur lycees.
Six hundred attendance sheets for the Experimental School.
Two hundred copies of Persian/English dictionaries for USIS and the Education Program.
Five hundred pedagogy lecture notes for the Teacher Training Department.
Eighty voucher pads for the American Club.

**English Language Program (ELP)**

The first month of this term finished with an enrollment of almost 500 students. Classes were overfilled with the expectation that a typical dropout rate of about 25 percent will bring classes down to a manageable size by the middle of the term. However, we still have to turn down many of the requests of various refugee agencies and political parties who ask for special consideration for their employees or members. Because over 100 female students are now attending, the Austrian Relief Committee has generously funded the rental of another minibus. (All females have to be transported by bus.)

We were fortunate to have been able to hire two new teachers who are native English speakers this month. They will add to the quality of teaching, especially in our upper level courses.

The English Program Director and IRC Special Assistant visited English classes in the Hangu-Thal refugee camps and spoke with students in the clinics. Progress is impressive. Students were able to carry on simple conversations, and two
students who are illiterate in Pushto are learning to read English.

The ELP has been inundated with requests for help with materials and teacher training for English classes that other agencies sponsor. In the last two months, we have provided aid to two political parties, the International Medical Corps, Pak-German Technical Training Center, as well as continuing aid to several Pakistani institutions. We feel that helping other agencies improve their English programs is a vital service, so that they can serve their own students better as well as many of the students that we have to turn away. One instructor said that since he has started using our materials and attending our training sessions, attendance in his classes has improved greatly.

Through contacts with Dr. Frye, the Perry School in New Hampshire has offered some exciting opportunities for our students. They have requested that Afghan students correspond with their students, and the initial correspondence went out this month. This gives our students a chance to communicate in written English, and helps students in the West to better understand the plight of the Afghan refugees. Secondly the school has offered to sponsor an Afghan refugee secondary student for one year. Although all the arrangements haven't been finalized, we are beginning the selection process. A reading, writing, and listening skills test using content typical of secondary instruction in the States was developed and given to students. The final candidate will be determined through a series of interviews.

The ELP is also assisting the Inter-Party schools in English instruction. The schools in Hangu and Peshawar were visited by the Director of the ELP, and appropriate texts have been chosen. Almost no real English instruction has been taking place, but since one teacher in each school has attended our summer training session, we believe we can improve the quality of the English classes.

A representative from the Norwegian Student Committee visited the female classes. He interviewed the students, took photographs, and taped a song and poetry composed by one student. Translations were provided, and this material will be used in a radio program advertising the campaign Norwegian students have organized to raise funds for Afghan refugee education. One of our female students has been chosen to go to Norway for this campaign.

The Director met with Anais Khan, the head of the English Department of Allama Iqbal Open University. They provide excellent non-formal English language instruction from the secondary level to postgraduate teacher training. She would be happy to allow a number of Afghans to take part in their courses. We would have to make arrangements for quotas and
admission requirements, but this could be the beginning of a program of accreditation for Afghan university education. It is definitely something we will follow up on.

We would also like to thank USIS for their generous donation of a 16 mm movie projector, speaker system, and screen to the program, as well as a collection of materials on journalism and media instruction. I think we have borrowed their equipment so often they figured it would be more efficient to give us our own.

The first edition of the ELP newsletter was also completed this month and put on our bulletin boards. It was beautifully designed and contains news, editorials, and student writing. We have begun work on the second edition, which the printing press will print. Additionally, work has begun on a literary magazine which will be written by the students and staff of the English language program and printed by our printing press. It will be titled Bouquet Among the Ashes.

Steven Segal
Education Program Coordinator
The materials have been completed and delivered.

Catholic Relief Services from Quetta would like Resource Center assistance with the provision of health education materials for their 54 "rehydration centers". These centers are homes of Afghan families of which the women have been allowed to be trained by C.R.S. Lady Health Visitors in the preparation of Oral Rehydration Solution. These women then will teach visiting mothers who bring their dehydrated children in. As this seems a worthwhile project to support, further correspondence and activity together are planned.

The importance of health education may be emphasized by a first overview of survey data as they were collected in July in the camps between Hangu and Thal. This survey has been mentioned in previous monthly reports.

Main data were compiled manually and must therefore be looked at in terms of trends. (More precise calculations will be made by computer).

For interest, and because no other area specific data are available yet, the information presented here is put next to the results that were found with the UNHCR-CDC surveys conducted over the last three years to represent the population in all refugee camps in all provinces.

IRC's preliminary results contrast in an interesting way with apparent trends suggested by UNHCR-CDC data of 1984 and 1985. Even more contrasts and similarities will become clear when the final results for the UNHCR study of 1986 will be published.

<table>
<thead>
<tr>
<th>Item</th>
<th>UNHCR 1984</th>
<th>1985</th>
<th>IRC 1986</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total families interviewed</td>
<td>1512</td>
<td>1566</td>
<td>588</td>
</tr>
<tr>
<td>No. of children &lt; 5 years of age</td>
<td>2136</td>
<td>2425</td>
<td>838</td>
</tr>
<tr>
<td>Alive at time of interview</td>
<td>2011</td>
<td>2313</td>
<td>860</td>
</tr>
<tr>
<td>Died during past 12 months</td>
<td>125</td>
<td>112</td>
<td>28</td>
</tr>
<tr>
<td>No. of live births in past year</td>
<td>595</td>
<td>632</td>
<td>246</td>
</tr>
<tr>
<td>Children &lt; 1 year, died in past 12 months</td>
<td>92</td>
<td>75</td>
<td>28</td>
</tr>
<tr>
<td>Infant Mortality Rate</td>
<td>156/1000</td>
<td>119/1000</td>
<td>73/1000</td>
</tr>
</tbody>
</table>
Neonatal Mortality Rate  61/1000  46/1000  16/1000

Percentage children with diarrhoea in last 7 days  38  35  39.7

Additional data collected for IRC camps:

Percentage of children measured
> median  87%
< 60%  9.7%
< 70%  4.2%

Children with measles in last year  14.3%

Children with BCG inoculation scar  68.7%

General Fertility Rate  413 births per 1000 women in 1985-86

Child-Women ratio  1510 children < 5 for every 1000 women

Percentage
Drinking Water Source
Stream  21%
Spring  11%
Improved Well  19%
Katcha Well  42%
Faucet Water  2%
Unknown  5%

Percentage
Presence Improved Latrines  43%

Percentage
Presence Kitchen gardens  35%

Percentage
Presence Animals in Compound  52%

Several observations can be made from the above data:

- The Infant Mortality Rate in the IRC camps seems to be somewhat lower in comparison with data for all camps. (The final report will outline more precisely the statistical significance of such comparisons.)
The Neonatal Mortality Rate seems lower as well, but as with all Neonatal and Maternal Mortality surveys, there can be a wide margin of error unless a very large percentage of the population is surveyed.

With regard to children who had their Mid Arm Circumference measured, there unfortunately still is a considerable percentage of children suffering from various degrees of mal- or undernourishment. It should be noted that, on a purely observational level, the mothers of a large amount of those children had Special Care Feeding Cards from the IRC clinics. Further data compilation will show the actual percentage of children in Special Care.

The percentage of children with diarrhoea in the past 7 days in the IRC camps seems to be higher than the average for all camps. This is more likely due to the systematic sampling of 5 separate areas in each of our camps whereas the UNHCR-CDC sampling technique selected just one centrally located area in each camp. Therefore, the environmental conditions in the IRC camps may in fact not be much different than in others.

Both the General Fertility Rate and the Child-Woman Ratio are extremely high in comparison with other areas/countries.

Other data from the survey cannot be compared with overall Refugee Health Status, but can be revealing for comparisons between IRC camps. Some examples are:

Thal I camp has the highest percentage of deaths of children related to diarrhoea and vomiting while 77% of its population is using stream water as a drinking source.

The percentage of diarrhoea related deaths seems to be above average in Mohammed Khoja and Lakhti Banda as well, while these camps show very high percentages of presence of animals in the compounds (respectively 74% and 94%).

For children with diarrhoea in the past week there are higher percentages for Thal II and Kotki, Kai and Thal I than for the other camps (Resp. 49%, 49%, 47% and 44%).

The percentages of mal- or undernourished children is higher than average in Kai (17% < 80), Lakhti Banda (12% < 80), Thal II (9% < 80 and 1% < 70), Thal I (8% < 80 and 5% < 70), Darsamand (11% < 80 and 8% < 70) and Mohammed Khoja (3% < 80 and 13% < 70).

More optimistically, Thal II stands out for its very high percentage of children with BCG scars (92%) while simultaneously registering the lowest percentage of children
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with measles (4%).

- Lakhti Banda, Kotki and Thal II have above average percentages for the presence of improved latrines (Resp. 78%, 64% and 64%), while the lowest percentage is to be found in Mohammed Khoja (7%). Kata Kanra is perhaps the highest, but data from that camp regarding the presence of latrines were incomplete.

- The percentage of improved wells is highest in Darsamand and Doaba (Resp. 28% and 24%), while the lowest is in Kai camp.

A final report with all respective details of camp data will become available as time allows.

Ellen Krijgh
Health Education Resource Center Coordinator
INTEGRATED AFGHAN REFUGEE SELF RELIANCE PROJECTS

Kitchen Gardening

Three major demonstration plots (Kai, Lakhti Banda and Thal) have been prepared for the next seedling production. Also, 3000 new families have been given seeds of turnip, radish, dahina, spinach, lettuce and carrots. We now have 12,290 families involved in kitchen gardening with half this number also under training.

The poultry raising project continued to expand this month as 17 small poultry cooperative farms have now been set up. The farms are located as follows: one in Thal II with 150 chickens; nine in Thal I with 950 chickens and seven in Dallan with 700 chickens. Basically, 10 chickens are given to each family and about 10 families join together to make a small farm.

Other activities have included the delivery of chicks from Rawalpindi and Multan and the conducting of a survey to select areas for sapling yards.

Handicrafts

Rs. 17,678 was paid to the Afghan women in the camps for a total of 403 items. Approximately 153 women are employed in Kai, Kata Kanra, Darsamand, Lakhti Banda, Dallan and Kotki. Each woman received an average of Rs. 116 per month.

Sales from the new office/showroom totalled Rs. 6,845 for items sold such as pillow covers, embroidered shalwar kameez, tablecloths, placemats and baskets.

The following is a list of the items collected from the women this month:

65 uniforms for IRC’s Education Program
144 embroidered pieces for quilts
105 embroidered pillow covers
14 embroidered fronts for shalwar kameez
9 floral design tablecloths
27 baskets
5 sets of embroidered placemats
6 embroidered material for nightgowns
8 sets of napkins with embroidered hems

An order is being prepared for export to the United States. IRC handicraft items will be sold at an Afghan Cultural Fair in California at the end of November. Some Rs. 20,000 worth of items will be flown over including baby quilts, nightgowns, khamgeri embroidered cosmetic purses, children’s
pillow cases with a colorful lion motif, pillow cushions, etc. Some of these items will be featured in a major crafts tradeshow in Los Angeles in January which will be attracting 50,000 buyers from around the United States.

The two new handicraft centers in Lakhti Banda and Kai will be finished this month. Mrs. Sediqua, the new handicrafts assistant, will be teaching tailoring to the women so that besides uniforms, the women will soon be sewing embroidered nightgowns, skirts, blouses, and pants. As well, the women will be taught to do the finishing work on purses, jewelry cases, etc.

AFGHAN REFUGEE CONSTRUCTION TEAM

This month activities completed included: the maintenance of the IRC houses in Hangu; moving the Hangu workshop to a larger space; carpentry and some construction work on the poultry brooding house in Doaba and the manufacture of five chairs.

On-going activities included: construction of two handicraft centers in Kai and Lakhti Banda; manufacture of two wooden shelves; construction of the Kotki II clinic.

Other activities connected with the special UNHCR Maintenance contract involved work on six geodesic domes in Darsanand (i.e., installing doors and windows and repairing the roofs); construction of a storage facility in Kata Kanra camp and construction of a warehouse in Orakzai.

Mir Aqa Kabiri  
Self Reliance and Construction Projects Coordinator
THE AFGHAN OBSTETRICS AND GYNAECOLOGY HOSPITAL

Statistics

The total number of patient visits/revisits to the hospital out-patient service was 890 this month, with 354 of these being new patients. We believe the slight drop in patient visits this month is due to the holidays which occurred this month.

A total of 72 patients were admitted to the in-patient department with various OB/GYN problems. Of these 50 were admitted for delivery.

Three patients were referred to other hospitals/clinics for treatment.

Surgery

During September, while Drs. Levinson and Durant were here, nine surgeries were performed. All of these were laparoscopies. Dr. Latifa was selected to be trained by Dr. Levinson in laparoscopy technique. With further supervised teaching, she will be able to perform laparoscopy herself and train the other Afghan doctors.

Drs. Levinson and Durant arrived with the expectation that the surgical facilities at the hospital were functional and that the staff was equipped to handle elective and emergency surgeries. Instead, their impression was that there existed a general lack of organization which resulted in conditions unsuitable for safe surgery. These included inadequate sterile technique; unavailability, when needed, of essential supplies such as oxygen, sterile water, etc. They were also concerned about the level of skill of some of the operating room staff. As a result, much less surgery was performed during their stay then had been scheduled. The nearly 100 patients had to be turned away, and this was most unfortunate.

More About the Visit of Drs. Durant and Levinson

As well as performing surgery, Drs. Levenson and Durran also worked with our doctors in the out-patient service. In this area also they raised a number of concerns about the care being provided to the out-patients and the overall organization of the out-patient department.

The visit of these doctors brought into focus a number of problems created by the rapid and unanticipated expansion of the patient population and by the addition of in-service facilities. They gave us many suggestions about ways to
raise the standard of care provided to patients. However, we feel that their most important contribution was to make us start thinking about the various problems we face and to start looking for workable solutions. We are grateful to Drs. Levinson and Durant for their active interest in the OB/GYN Hospital and for their helpful advice. We hope they will keep in contact with us in the future.

Organizational Meeting

A meeting was held in the first week of September with Tom Yates, the expatriates working at the hospital and the hospital staff. At that time a number of organizational changes were announced. The most important among these were the appointment of Dr. Latifa and Dr. Zakia as the senior doctors in charge of the in-service and the out-patient clinic, respectively. The goals and priorities of the hospital were also discussed. One of the issues brought up was whether we should continue treating infertility patients given the limited results and resources.

Pediatrics

In our last report we mentioned that, with Dr. Cathy Anson here, we would go ahead with plans to add a pediatric unit to the hospital. After much deliberation, it has now been decided to postpone this project.

Other Priorities

At the moment our priority is to find solutions for problems arising from the expansion in patient numbers and the corresponding increase in staff. Dr. Anson has been appointed as an advisor to our doctors. We feel she can contribute most by helping us improve the standard of care provided in the hospital. At present she is focusing on upgrading the quality of care provided to babies born here. These include instituting charts and records and teaching the doctors and nurses appropriate newborn care.

Vaccination Program

Lena Sym, our expatriate nurse advisor, has been busy working on the vaccination program, teaching vaccine technique to our nurses as well as student nurses from the Afghan Medical Aid.
Nursing Care and Scheduling

Lena is also working out ways to improve the quality of nursing care. Toward this end she is working together with our nurses on charts and records to be used by the nurses in the in-service. Lena is also working on a new duty schedule for the nursing staff. This has been demanded for a long time by the nurses who feel that their efficiency is negatively affected by the long working hours. We hope we will be able to work out an acceptable schedule.

Dr. Hussain Monard
Hospital Director