

## REFUGEE HEALTH STRATEGY

2014 – 2018

PAKISTAN



# Contents

<i>Abbreviations</i> .....	3
<b>Executive Summary</b> .....	5
<b>PART ONE: THE STRATEGY</b> .....	8
<b>Section 1: Introduction</b> .....	8
1.1 Background .....	8
1.2 Rationale for the strategic planning .....	8
1.3 Key considerations .....	9
1.4 Sector context for the refugee population .....	11
1.5 Sector context for the host population .....	12
1.6 Existing initiatives, key stakeholders supporting health programmes in Pakistan ...	16
<b>Section 2: Goal, overall objectives, guiding principles and outcomes</b> .....	17
2.1 Goal .....	17
2.2 Overall objectives .....	17
2.3 Key Guiding Principles .....	17
2.4 Planning Assumptions .....	17
2.5 Outcomes .....	18
<b>PART TWO: IMPLEMENTING THE STRATEGY</b> .....	19
<b>Section 3: Strategic models, objectives and strategies for each outcome</b> ...	
3.1 Strategic models .....	19
3.2 Objectives and strategies for each outcome.....	20
<b>Section 4: Implementation arrangements, financial plan and management structures</b> 33	
4.1 Institutional Framework .....	33
4.2 Implementation Arrangements .....	33
4.3 Financial Plan .....	34
4.4 Roles and Responsibility and Core Functions .....	34
4.5 Linkage between the refugee community and the public health sector .....	36
4.6. UNHCR Human Resource Requirements .....	37
<b>Section 5: Monitoring and Evaluation</b> .....	38
5.1 Performance monitoring, evaluation and reporting .....	38
5.2 Data Collection .....	40
<b>Section 6: Risk and Risk Mitigation</b> .....	42
<b>Section 7: Timeline</b> .....	43
<b>Annexes</b>	

## Abbreviations

ARC	American Refugee Committee
BHU	Basic Health Unit
CAR	Commissioner for Afghan Refugees
CCAR	Chief Commissioner for Afghan Refugees
CWS	Church World Council Services
DHIS	District Health Information System
DHQ	District Headquarter hospitals
DoH	Health Department
DDoH	District Department of Health
TB DOTS	Tuberculosis Directly Observed Treatment Short Course
EPI	Expanded Programme on Immunisation
FLCFs	First Level Care Facilities
FPHC	Frontier Primary Health Care
HIS	Health Information Systems
KP	Khyber Pakhtunkhwa
IMC	International Mercy Corp
MCH	Mother and Child Health
MDGs	Millennium Development Goals
MNCH	Maternal Neo-natal and Child Health
NOC	National Programme Coordinator
NGO	Non Government Organisation
PDH	Project Directorate of Health
PDoH	Provincial Health Department
PPHI	People's Primary Healthcare Initiative
RAHA	Refugee Affected and Hosting Areas
RHC	Rural Health Centre
SAFRON	Ministry of State and Frontier Regions
SC	Save the Children
TB	Tuberculosis
THQ	Tehsil Headquarter hospital
TR	Teraqee Foundation
U5MR	Under five mortality rate
UAAR	Union Aid for Afghan Refugees
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
WHO	World Health Organization





# Registered Afghan Population & Presence of Refugee Villages in Pakistan

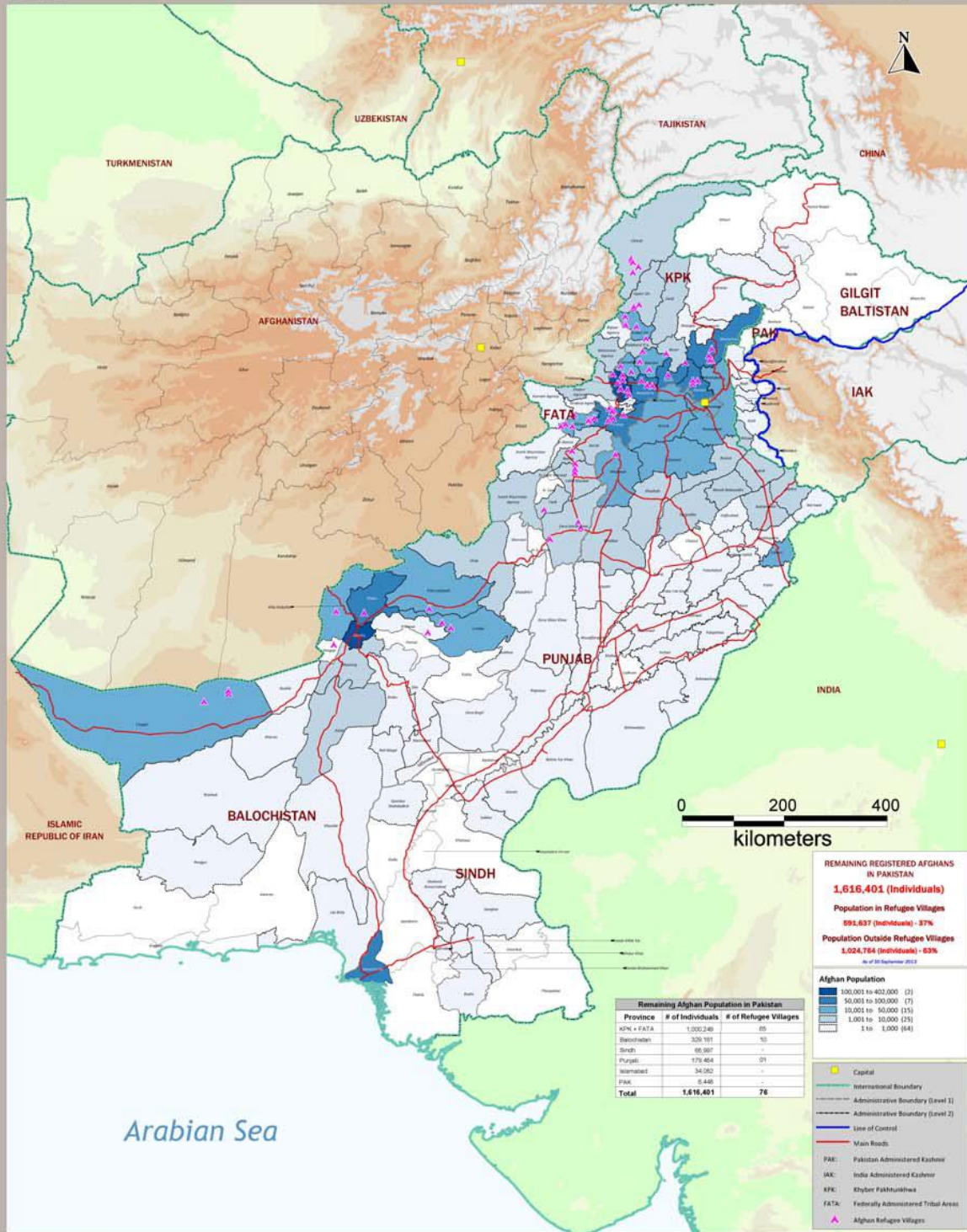
October 2013

Information Management  
GIS Unit

UNHCR Country Office Islamabad

Sources:  
Afghan National Registration  
Database

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Provisional 30/09/2013 (06/01/13)

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## Executive Summary

Afghan refugees constitute the largest and longest-standing refugee situation in UNHCR's history. Despite the return of more than 5.7 million Afghans since 2002, there are still approximately 1.6 million registered Afghan refugees in Pakistan. Of the total registered refugees, 40% live in refugee villages and 60% live in urban areas in Balochistan, Khyber Pakhtunkhwa (KP), and Punjab provinces. The refugees who live in the refugee villages have direct access to essential health services supported by UNHCR. Provision of essential health services for those 60% who live in urban areas is covered by the national health care systems of Pakistan. In addition, all secondary and tertiary healthcare services for both rural and urban refugees are also covered by the national health care systems.

The refugee health programme supported by UNHCR for this 40% of the registered refugee population living in refugee villages has remained largely unchanged for the last 34 years. It is still managed as a long standing care and maintenance project and runs parallel to the Government programme for the host communities. This parallel health system is not sustainable in the long run as it is entirely dependent on external funding from humanitarian donors which is currently at 4.4 million US dollars in 2013. This funding has substantially declined over the last few years and further funding cuts are envisaged over the next coming years. Furthermore, the parallel health care system does not adequately promote equality of services and linkages between the refugee and hosting communities. A key challenge in addressing this is to design and implement a health strategy that enhances sustainable, equitable and cost effective access to essential health services for the refugees while phasing out the parallel health care systems.

In order to guide the country's programme planning and operations, and to promote long term sustainability at the time of funding reduction, UNHCR has developed a five-year Health Sector Strategic Plan for Afghan Refugees Residing in Pakistan (HSSP: 2014-2018).

The HSSP sets out four objectives and five priorities for the next five years. The HSSP defines the way UNHCR will facilitate access to essential health care services for the 40% of registered Afghan refugees who live in refugee villages in Balochistan, KP, and Punjab in Pakistan. The focus will be on vulnerable and marginalized refugee populations, in particular women and children, who are currently the main users of the UNHCR supported health services in 62 basic health units in the refugee villages.

The overall Goal of the strategy is to promote, protect and maintain the health of Afghan Refugees in line with the targets set under the Millennium Development Goals (MDGs) for Pakistan, through sustainable and cost effective public health interventions.

The HSSP introduces the following key approaches:

- i) A shift from Facility Based services to Community Based services  
Through building the refugee community's capacity to take more responsibility in managing their own health needs.
- ii) Harmonization of essential refugee health services supported by UNHCR with the provincial health programmes  
Building on existing collaboration; special attention will be given to provide support to the Departments of Health in strengthening the local health capacity of the Departments of Health to enable them to effectively provide health care services for both local and refugee populations.

- iii) Engaging new development partners to take responsibility for a wider range of activities, including refugee health monitoring, and to support linkages between the refugee and government health programmes.

Special focus will be on the development partners who are already working with the Departments of Health as part of the Public Private Partnership (PPP) Initiative. Implementing partners involved in providing humanitarian health assistance will be gradually phased out.

In order to achieve this goal, UNHCR has set the following four objectives:

1. Facilitate equitable access to primary health care services for refugees with a focus on vulnerable and marginalized groups in particular women and children.
2. Enhance collaboration with the Provincial Departments of Health to ensure that the refugee health programmes are harmonized with those of the government; strengthen the local health capacity where it is necessary.
3. Build the refugees' community capacity to be able to take more responsibilities in managing their own health needs
4. Foster partnerships with a view to optimizing primary healthcare service delivery and resource utilization

The HSSP has five broad outcomes and each outcome has its specific objectives:

**Key Outcome 1:** Ownership and commitment to the new Health Strategy by refugee communities, Government and partners promoted

**Key Outcome 2:** Enhanced sustainable access to primary health care services through cost effective public health interventions

**Key Outcome 3:** Disease prevention and control programmes harmonized in line with those of the national health systems

**Key Outcome 4:** Increased community capacity and social health protection

**Key Outcome 5:** Increased partnerships and coordination

The strategic plan will provide the basis for UNHCR's programme and budget planning for the next five years. It is expected that by the end of this period, there will be:

- Increased community capacity to manage their own health needs in all refugee villages
- Increased access to and utilization of essential health services for the refugees (both within the refugee villages and nearby local health facilities)
- Harmonized health care services between refugee and government health systems
- Adequately equipped and functional health infrastructure at nearby local health facilities to enable service delivery for both refugees and surrounding local populations
- Increased partnerships and new financial mechanisms to support refugee health services
- Increased efficiency and cost effectiveness for resource utilization, reduced long term budget dependency

The HSSP will be managed by the Health Section of UNHCR. UNHCR will work closely with the Government of Pakistan at the Federal, Provincial and District levels, partners and

donors through consultative mechanisms. The action plans outlining the activities, targets, timeframe and responsible parties will be jointly developed with both government and partners.

The HSSP does not seek to hand over UNHCR's responsibilities in meeting refugee health needs or add additional burden to other actors, including the Government of Pakistan, but intends to enhance synergies and promote long term sustainability. Linking long term refugee assistance with the government development programmes such as those supported by the Multi Donor Trust Fund (MDTF) will benefit both refugees and host populations through improved accessibility to health and social services.

Furthermore, the harmonization of refugee and host services will not only promote equitable access, but also enhance cost effective delivery of health services for both refugees and local populations through the pooling of resources and increased investments made to improve the capacity of the national host health systems. Strengthening refugee communities and local health capacity, institutionalizing collaboration with the Department of Health (DoH) and other partners, enhancing the use of the Public Private Partnership (PPP) Initiative currently implemented by the DoH, and introducing safety net programmes such as the introduction of health insurance schemes to support vulnerable refugee groups, will be the cornerstones of this HSSP.

While the document articulates a five-year plan, it will be necessary to balance the importance of meeting the stated goal and objectives with the need to re-evaluate annually and adjust priorities accordingly. Based on the yearly re-evaluation, yearly work plans will be developed. This will require that UNHCR continues to be flexible in anticipating and responding to the health needs of refugees. Robust monitoring and evaluation systems will be put in place and will play an important role within the HSSP by overseeing implementation. The monitoring and evaluation exercise has been built into the HSSP to facilitate follow up by UNHCR. The agreed targets for each of the key outcomes form the basis for measuring the progress and achievements of the plan over the next 5 year period. Monthly and quarterly monitoring (subject to security) is planned during the first year and a mid- term review plan after 24 months of the implementation to adjust the HSSP as needed. In areas where security does not permit, implementing partners and third party partners will be used for progress monitoring.

Public health is complex and success requires a comprehensive approach that brings together partners from across all sectors. UNHCR will enhance engagement of its many partners including government health departments at all levels, stakeholders, donors and development and implementing partners. By working collaboratively to develop the priorities outlined in the HSSP, UNHCR will be able to make an effective contribution towards achieving its goal and objectives.

The HSSP consists of the following:

#### **PART ONE: THE STRATEGY**

- Section 1: Introduction: background, rationale, key considerations, health sector context for refugee and local populations, existing initiatives, key stakeholders
- Section 2: Goal, overall objectives, guiding principles, assumptions and outcomes

#### **PART TWO: IMPLEMENTING THE STRATEGY**

- Section 3: Strategic models, objectives and strategies for each outcome
- Section 4: Implementing arrangements, financial plan and management structure
- Section 5: Monitoring and evaluation
- Section 6: Risk and risk mitigation
- Section 7: Timeline

# PART ONE: THE STRATEGY

## SECTION 1: INTRODUCTION

### 1.1 Background

Despite the return of more than 5.7 million Afghans to their homeland since 2002, there are still approximately 1.6 million registered Afghans in Pakistan, of which 40% live in refugee villages and 60% live in urban areas. The 40% of the total registered refugees who live in the refugee villages have direct access to essential health services supported by UNHCR. Provision of essential health services for those 60% who live in urban areas is covered by the national health care system of Pakistan. All secondary and tertiary healthcare services for both rural and urban refugees are covered by the national healthcare systems.

In order to guide the country health programme planning and operations, UNHCR has developed a five-year Health Sector Strategic Plan for Afghan Refugees Residing in Pakistan (HSSP: 2014-2018). Wide consultation among stakeholders in the sector took place from May to October 2013. During its preparation, clear guiding principles were used to identify the critical challenges and strategic results frameworks including the prioritized areas of work and strategic directions. The HSSP's development process examined refugee health situations in various settings as well as those of hosting communities. A holistic approach was used to encompass the broader health sector, socioeconomic factors, determinants of health, and national policies and strategies that have a major bearing on refugee health.

The HSSP reflects UNHCR's medium-term vision for the refugee health programmes in Pakistan and defines a strategic framework for Programme implementation within the country and with the government. The HSSP will be implemented in the refugee villages in Balochistan, KP and Punjab. The HSSP seeks to promote synergies with the Government Health Programmes and will strengthen collaboration with the Provincial Health Departments. It also aims to bring together the strength of UNHCR refugee programme support at country, Regional Office and headquarters levels in a coherent manner to address the refugee's health priorities and challenges. The HSSP takes into consideration the work of all other partners and stakeholders in health programmes.

The HSSP recognizes the critical importance of bringing everyone on board, ranging from policy makers and implementers at all levels to the refugee communities themselves. It is envisaged that UNHCR will have to face and resolve many technical, managerial and other challenges along the way. During the implementation process, a robust monitoring system will be put in place. UNHCR will learn many lessons from the implementation and these will enrich the HSSP further.

### 1.2 Rationale for the strategic planning

Ensuring access to health care is a key component of UNHCR's protection activities as well as a programme priority. UNHCR's public health programmes are delivered within a public health and community development framework, with an emphasis on primary health care and support for limited specialist care. The principal objective of UNHCR's health programme is to minimize mortality, morbidity and improve quality of life of refugees.

The refugee health programme supported by UNHCR for the 40% of the registered refugee population who live in the refugee villages has remained largely unchanged for the last 34 years. It is still managed as a long standing care and maintenance project that runs parallel



to the national health programme. This parallel health system is not sustainable in the long run as it is entirely dependent on external funding from humanitarian donors, which is 4 million US\$ in 2013. This funding for the refugee health programmes has substantially declined over the last few years and further funding cuts are envisaged over the next coming years. Furthermore the parallel health care system does not adequately promote equality of services and linkages between the refugee and host communities. As a consequence, there is a critical need to develop and implement a health strategy that can enhance sustainable, equitable and cost effective access to essential health services for the refugees and the national surrounding populations while phasing out the parallel health care systems.

The HSSP defines a new approach to the way UNHCR will provide assistance to 40% of the registered Afghan refugees in accessing primary health care services in Pakistan. These include building the refugee community's capacity in managing their own health needs; harmonization of essential health services into those of the government; strengthening local health capacity of the Departments of Health to enable them to effectively provide health care services for both local and refugee populations; and fostering partnership to optimize health service delivery.

The interventions in the HSSP will focus on maternal and child health, including pre-natal and post-natal care and safe deliveries; immunization in line with the national expanded immunization programme; and the prevention and control of key communicable diseases such as tuberculosis, malaria and HIV, as well as putting in place effective referral systems. Special attention will be given to vulnerable groups, women and children which are the main users of the current health services supported by UNHCR.

The implementation of the HSSP will help generate economic, social and health benefits to both the refugees and local populations in term of optimizing resource utilization for service delivery through harmonization of health services and partnerships; promoting synergies, improving access and equality of health services available to both refugees and surrounding local populations. The direct health benefits are the reduction of mortality, and excessive morbidity, to enable both refugees and the surrounding local populations to live normal lives, therefore improving quality of life. Improving health status means that they can work more efficiently and contribute to economic growth and social development.

### 1.3 Key considerations

**Geographic and security considerations:** The HSSP recognizes the importance of specificity of each refugee village in terms of geographic location and access, security, ethnic sensitivity, economic status and readiness of the refugee communities to take charge of their own health. It also takes into consideration of the local capacity of the government public health sector. Based on a comprehensive mapping exercise, the refugee villages are categorized and the models tailored to the refugee villages have been designed accordingly.

**Refugee community's capacity:** The HSSP aims to build the capacity of refugee households and communities to know and progressively realize that they have vital roles to play in managing their own health needs, rather than relying only on service provision from UNHCR. There is a need to engage with the refugee communities as equal partners in their own health care provision, and give them a chance to influence the way care is delivered. The HSSP recognizes that there is some degree of existing capacity within the refugee communities, including community based health structures, which can be developed to enhance self-reliance in managing their own health. To facilitate this process, a community strategy will be developed to improve community based health programming. The existing Community Health Committee will be empowered and put into function. Special attention will

be given to maintain existing refugee workforces currently working for the implementing partners supported by UNHCR.

**Local capacity:** The HSSP takes into consideration the local capacity of the government public health sector and the potential for improved service provision. Strengthening the capacity of the local public health sector in close collaboration with other development partners will be a high priority of the HSSP (e.g. through initiatives such as RAHA, One UN, or the Multi Donor Trust Fund (MDTF) led by the World Bank). UNHCR does not intend to increase the workload and burden of the Provincial Health Departments and will ensure that provincial health systems in refugee affected areas are sufficiently supported. The utilization of the government's initiative on public-private partnership through its contracting partners will be one of the key features for this HSSP.

Linking long term refugee assistance with the host country development programmes such as those supported by the MDTF, will benefit both refugees and surrounding populations through improved accessibility to health and social services. The harmonization of refugee and national health services will not only promote equitable access, but also enhance cost effective delivery of health services for both host and refugee populations through the pooling of resources and increased investments made to improve the capacity of the host health systems.

**Availability of alternative health care providers:** The availability of alternative health care service providers in and outside the refugee villages, and refugees' care seeking behaviors have been taken into account and strategies to formally strengthen their linkages and synergy have been considered in designing the new approach, since they are significantly valued by the refugees. Where appropriate, providing formal training and capacity-building to the various informal health service providers and turning them into collaborating partners will add value to all and benefit the refugees more by building on available resources and promoting long term sustainability. It will also promote better efficiency and cost effectiveness for UNHCR in a context of donor fatigue and shifting donor priorities.

**Linkages between refugee and host health systems:** Despite 34 years of parallel health programming, refugee and hosting communities already share supportive health resources to some extent. Many refugees tend to use nearby local health facilities where possible. At the same time, some UNHCR Implementing Partners report that 5 to 10% of their patients are from the local populations. Similarly, collaboration already exists on an ad-hoc basis in the areas of communicable disease prevention and control programmes, such as for HIV/AIDS, malaria and tuberculosis. As with harmonization of refugee and local health provision, institutionalization of this collaboration would further strengthen effectiveness and sustainability of these programmes.

**Flexibility:** While the HSSP articulates a five-year plan, it will be necessary to balance the importance of respecting the goal with the need to re-evaluate annually and adjust priorities according to the refugee situation. This will ensure that UNHCR continues to be flexible in anticipating and responding to the health needs of the refugees.

**Security constraints for effective monitoring and evaluation:** The current security situation of the country posts major challenges for UNHCR staff to monitor the implementation of the HSSP. Keeping in mind the variable and often limited access that staff have to health facilities and refugee communities because of the changing security environment, a comprehensive monitoring framework has been developed consisting of multiple tiers including remote monitoring. Innovative means of monitoring performance will be reinforced, including regular field visits where security permits, reports, midterm, and end

term review, and external evaluations. In areas where security does not permit, implementing partners and third party partners will be used for progress monitoring.

## 1.4 Sector context for the refugee population

**Provision of refugee health services:** UNHCR has provided support for essential health care services to Afghan refugees residing in refugee villages (which represent 40% of registered Afghan refugees in Pakistan) in 62 Basic Health Units (48 in KP, 13 in Balochistan and 1 in Punjab). These services which are provided by nine implementing partners, include basic care and treatments, laboratory services, reproductive health (ante-, post-natal care and safe delivery), immunization, prevention and treatment of tuberculosis, malaria and leishmaniasis, HIV/AIDS), referral services and hygiene education. Essential health care services for the remaining 60% of the registered Afghan refugees who live in urban areas are provided by the national health care system of Pakistan. Secondary and tertiary healthcare services available to nationals under the national health system are also accessed by both rural and urban refugees.

**Health Impact:** UNHCR Pakistan country office's efforts in providing health services to the Afghan refugee population during the last 3 decades have contributed to better health status with steady improvement of infant and under-five mortality rates and lower maternal mortality ratios, improved diagnosis of tuberculosis, higher immunization coverage rates and increased prevention of malaria and other communicable diseases. The burden of communicable diseases, childhood illnesses, reproductive health problems and malnutrition is low amongst the refugee population. Malaria is no longer the leading cause of mortality among refugees living in refugee villages. Non communicable diseases (NCDs) such as cardiovascular diseases have become the leading cause of death for the refugees, followed by injuries and respiratory infections. Leading causes of morbidity include respiratory infections, diarrheal diseases, skin diseases and non-communicable diseases including cardio vascular disease.

**Utilization of health services at UNHCR supported health facilities:** There have been significant successes from refugee maternal and child health and other preventive programmes. These services are well attended by refugee women and children resulting in high coverage in ante- and post-natal care as well as immunization. However, there has been a steady decline in the utilization of Out-Patient Departments (OPDs) for consultation and treatment at the basic health units (BHUs) supported by UNHCR. Most OPDs are serving fewer refugees and are underutilized (0.6 OPD visits/ person/ year vs. the standard benchmark of 1-2). This implies that at 40-70% of refugee patients living in the refugee villages are using other providers for basic care and treatments besides the BHUs supported by UNHCR. Lack of medical doctors (in particular female doctors in many BHUs due to lower salaries than those of the government and unwillingness to work in remote areas), poor performance due to lack of motivation resulting in high staff absences contributes further to low utilization of the health facilities for basic care and treatment.

**Utilization of health services from non-formal health providers within the refugee communities:** Besides formal health facility based services, there are currently 300 Afghan doctors registered with Office of the Commissioner for Afghan Refugees in KP. These doctors are allowed to practice only in the refugee villages. exact figures are not available for Afghan doctors in Balochistan and Punjab . Some of these doctors work for UNHCR's implementing partners. In addition to these community resources, there are other non-formal and traditional sources of care readily available in the refugee communities, such as traditional birth attendants and healers. Similar informal and traditional health providers exist in local hosting communities as well.

**Utilization of health services at the Government health facilities:** In addition to the 60% of the registered urban refugees who already use the local government health facilities, many refugees from the refugee villages also use the nearby government basic health units and rural health centers. PPHI has reported that at least 10% of the patients at their basic health units nearby the refugee villages are refugees. Similarly, major hospitals in Peshawar and Quetta reported they received many refugee patients.

**Utilization of UNHCR funding for refugee health services:** The current operating budget in 2013 for the UNHCR health programmes in Pakistan is 4.4 million US dollars. 80% of the allocated budget was utilized by implementing partners for salaries and operating costs, only 18% was used for supplies, medicines and vaccine, and 2% for capacity building. There is a discrepancy in resource allocations for Balochistan, KP and Punjab. Per capita cost of refugee health care services is two times higher in Balochistan and 1.5 times higher in Punjab than in KP (US\$ 7.6 vs. US\$ 5.4 vs. US\$ 3.6 respectively). A similar trend is observed for an average cost per each BHU which range from US\$ 110,000 in Balochistan, US\$ 101,000 in Punjab vs. US\$ 56,000 in KP. Underutilization of the health facilities in some BHUs results in higher unit costs for each consultation.

Discrepancy in resource allocation does not appear to affect the performance (using utilization as an indicator) and health outcomes of the refugees. Double spending per BHUs and per capita by IPs in Balochistan does not yield better utilization or better health outcomes and coverage for the refugees than those of the KP. High costs by the implementing partners (IPs) in Balochistan due to scattered geographic locations of the refugee villages and higher IP's operating and overhead charges results in the differences in the unit costs between KP and Balochistan. Various cost cutting measures such as the introduction of mobile health teams by some Implementing Partners in KP contributes further to lower the average unit costs per each basic health unit. Similar cost cutting measures have not been taken place in Balochistan and have to be considered for the future programme and budget planning.

**Safety net for vulnerable refugee population:** Funds collected from the user fees are kept separately by the IPs as part of the **Community Funds**. The community may submit a proposal to utilize the funds for community related projects but the proposals need prior approval from UNHCR and IPs. Vulnerable groups identified by the refugee community are exempt from user fees and delivery charges. In addition, the Community funds are used to support UNHCR in the procurement of additional medicines and supplies, running costs for community labour rooms, and to support the poor for referral and other treatment outside the refugee villages.

A good example on the utilization of funds from user fees is seen in Balochistan and KP where some IPs use the community funds to finance the running costs for labour rooms utilized by both refugees and the local communities. UNHCR assists for the shortfalls of the running costs. In Mardan District in KP, in addition to funds collected from user fees, the implementing partner FPHC collected additional funds from the communities for the running costs of the hospital used by both refugee and local populations.

## 1.5 Sector context for the host population

**Management structure:** The Pakistan health system comprises federal, provincial and district levels. As a result of the implementation of the 18<sup>th</sup> amendment to the constitution of Pakistan, the health sector has been devolved to the provinces and the Federal Ministry of Health has been abolished. All the vertical health programmes have also been devolved to the provinces. Provincial health department's roles and responsibilities have been expanded



to cover policy development and formulation, standard setting and technical support in the areas of M&E, management and training of staff. The district level is responsible for the management and provision of health care facilities through District Head Quarter Hospitals (DHQ), Tehsil Head Quarter Hospitals (THQ), Rural Health Centres (RHC), Basic Health Units (BHU); Mother and child Health Centres (MCH) and Dispensaries. The BHUs, MCH Centres and Dispensaries are classified as the First Level Care Facilities (FLCF). The districts are also responsible for prevention and control of infectious and contagious diseases, data collection, monitoring, supervision and planning.

**Health Impact:** Pakistan has made efforts in the past few decades to improve its Primary Health Care (PHC) system in terms of access, coverage, and availability of services. There is a slow measured progress in improving health outcomes including a reduction in child, infant and maternal mortality, and in enhancing the provision of reproductive health services. Selected health indicators -such as full immunization rates and prevalence of diarrhoea- have improved in the past few years. However, under-five mortality remains one of the highest amongst the large South Asian countries. Significant gender and rural/urban disparities persist. Coverage by public health programmes to address communicable diseases remains low. Pneumonia is the number one leading cause of child mortality accounting for a quarter of all post neonatal deaths. Most deaths are caused by a failure to take the child to a health facility for treatment. Diarrhoea accounts for over 10% of all deaths among children in Pakistan. Polio is endemic; a third of the confirmed cases were from KP. Tuberculosis accounts for 5.1% of the total national burden of disease with approximately 1.5 million people in Pakistan living with the disease. HIV in Pakistan is considered a low-level epidemic in general population with a prevalence rate of less than 0.1%. Malaria affects more than half a million people each year with the Annual Parasitic Incidence (API) of 1.88 in 2011. Sixty-seven percent of reported cases were due to *P. vivax* infection and 33 % due to *P. falciparum* infection. It is estimated that about 70-80% of the population goes to private sector for treatment therefore, according to a conservative estimate, the actual malaria burden could be four to five times higher.

Pakistan is facing an increasing burden of Non communicable diseases (NCDs). NCDs were estimated to account to 46% of all deaths in Pakistan in 2011 (source: WHO). It is estimated that one in four adults over the age of 40 (27%) suffers from coronary heart disease. Diabetes prevalence in Pakistan is among the top ten in the world, with around 5.2 million people living with the disease. There are no reliable cancer statistics available for Pakistan but based on WHO estimates (180 cases per 100,000), there would be over 200,000 cases expected annually. Based on this estimate, only 25-30% of these cancer cases are seen by oncologists. There is a lack of public awareness, health seeking behaviour and availability of diagnostic and treatment facilities, particular at the district level for NCDs.

**Health care reform and Public Private Partnership Initiatives:** The pressure to meet the Millennium Development Goals (MDGs) has pushed Pakistan to search for ways to address the existing inefficiencies and poor responsiveness of health care systems, especially of PHC service delivery and management, through the development and testing of innovative models.

With technical and financial support by the World Bank and other development donors through the Multi Donor Trust Fund (MDTF), a number of primary health care (PHC) reforms have been introduced in the country. These reforms have adopted approaches such as outsourcing the management of PHC services or alternate management arrangements; adopting public private partnerships (PPP) modalities and introducing basic minimum health service packages. The Pakistan Primary Health Care Initiative (PPHI) Model and the Batagram Model managed by Save the Children have been launched to manage the First Level Care Facilities in Pakistan for the delivery of primary health care services.

**People Primary Health Care Initiative (PPHI):** PPHI now manages the government basic health units in 13 districts in KP (658 BHUs, 70% of the total) and all districts in Balochistan (650 BHUs, 100%). PPHI has full autonomy on financial matters and authority to recruit staff against vacant spots. According to a third party evaluation team, in the districts where PPHI has been operating, PPHI has achieved significant improvements in staffing, availability of drugs and equipment and physical condition of facilities, including rehabilitation and repossession of hitherto dysfunctional BHUs. However, community outreach and prevention programmes remain its weakness.

**Batagram Model by Save the Children:** The Provincial Department of Health in KP with support from the World Bank/Japan Social Development Fund through the MDTF, has a tripartite agreement with Save the Children (SC) for revitalizing and managing all health care facilities as well as providing healthcare services across the district for a period of 3 years. A Memorandum of Understanding (MoU) was signed between the Department of Health, the District Government of Batagram and SC to revitalize, improve and manage the healthcare services in the district. Through the MoU, salary and non-salary health budget of the district was transferred to SC as one line item. The additional costs required for rehabilitating the health facilities, provision of equipment, hiring of additional staff, building technical and management capacity of the health care providers and managers and provision of performance based incentives were covered by JSDF grant from the World Bank.

Besides operationalizing and managing all PHC facilities in the districts, the project focused on improving immunization, ante-natal, safe delivery and post-natal services, prompting institutional deliveries, and improving access to quality basic obstetric newborn and nutritional care in the district. Two innovative approaches -‘the hub approach’ and the ‘performance based incentive approach’- were adopted. The hub approach aims to make available a higher level of service than usually are provided at a Rural Health Center (RHC). The performance based incentive approach aims to reward staff who are providing a high standard of services, thus improving the quality of health care services available in Batagram.

The project was successful in renovating, staffing, equipping and operationalizing health facilities. In addition to strengthening healthcare at the facility level, the project is ensuring provision of health care to the communities in remote mountain areas. In coordination with the DoH, Health Days were organized with free mobile medical camps which provide communities with diagnostic facilities, treatment of minor illness, referral of complicated cases and vaccination of women and children. In the three years of partnership utilization of health services increased across the board to almost five-fold in many facilities.

**World Bank Supported Project under the Multi Donor Trust Fund (MDTF): Revitalizing health services in KP (2012 – 2015):** Based on the successful experience of revitalizing and improving healthcare services under a public-private partnership model in Batagram, the project will provide support in 6 districts in KP, namely Batagram, Kochistan, Tor Ghar, Buner, Lower Dir and Dara Ismail Khan. The project address key priorities of the government related to provision of services, infrastructure and monitoring and evaluation capacity. This includes i) out-sourcing of management of health services to a third party; ii) rehabilitation of health facilities, and iii) strengthening of the health systems with an emphasis on monitoring and evaluation. The total project cost will be 61 million US\$ out of which 16 million US\$ will be financed by the MDTF and 45 million US\$ will be supplied by the government of KP. A competitive bidding process is underway to identify third parties for contract out-sourcing.

Six UNHCR’s supported BHUs are located in three of the six districts supported by the MDTF (Buner, Lower Dir, and Dara Ismail Khan).

**Social Protection Programme:** To strengthen the safety net systems and increase coverage for Pakistanis, the government launched the Benazir Income Support Program (BISP) in September 2008, with the objective of providing cash grants to the poorest families in the country identified on the basis of a robust targeting methodology. The program intends to cover the 7 million poorest families, prospectively covering close to 25 % of the population. As such, BISP is by far the largest social safety net program in Pakistan. Currently, this BISP programme does not cover the refugees as it is intended only for Pakistani citizens. However, the model could be explored and replicated for the refugees.

**Health Insurance schemes:** With support from the World Bank and KfW, the Provincial Department of KP is in a process of introducing health insurance schemes for the poor. Health insurance companies are being identified and undergone a competitive bidding process. The review of the bidding is under way. The scheme intends to cover in-patient care, transportation, and maternity related costs at the pre-identified private health facilities. Average premium charge will be around 1,800 Pakistani rupees per a family of up to 7 members for the coverage of up to 25,000 Pakistani rupees. This scheme does not cover out-patient care.

UNHCR is in a process of exploring the use of health insurance schemes (used by the government) for the refugees. This will benefit not only the refugees living in the refugee villages but also to those who live in the urban areas. There could be numerous direct and indirect benefits in providing health insurance to the refugees. Improved access to health services and financial protection are clearly the two largest benefits while the costs to UNHCR could significantly be reduced due to a decrease in a number of transactions, administrative, and overhead charges by existing implementing partners. Furthermore it will decrease the burden on the health services directly provided by the national health systems due to the use of private healthcare providers by the insurance companies.

Cost effectiveness compared with benefits of the health insurance schemes will need to be examined. A careful analysis of socio economic status, healthcare spending by the refugees including out-of-pocket payments (transport, consultations, medicines, laboratory tests, and hospital care) will be conducted to help determine the actual cost of health care versus the buying-power of refugees as well as what niche services the schemes would be most suitable for the refugees. Information from the Health, Shelter, and WASH survey conducted by UNHCR in late 2013/early 2014 will be carefully reviewed. In addition an examination of premiums, co-payments, ceiling for payments, exclusion criteria, and methods of reimbursement will be conducted in the next coming months.

In addition to the contribution in the premiums, UNHCR can contribute financially to insurance schemes in several ways that include complete or partial payment of premiums and funding to pay the co-payment for the costs of the service. In order to reduce premiums, UNHCR could consider providing funds and equipment to those health centres and hospitals used by the health insurance scheme that would allow for a more favourable deal for the refugees.

## 1.6. Existing initiatives, key stakeholders supporting health programmes in Pakistan

### RAHA and linkage between Pillar 1 and Pillar 3

The RAHA initiative supports infrastructure, environment, education and health systems in the hosting areas inhabited by refugees to mitigate the impact of an additional population living alongside the local community. The initiative aims to create and support basic services through development interventions for both Afghan refugees and Pakistani communities. Health projects supported by RAHA concentrate mostly on infrastructure upgrading and provision of equipment for BHUs, labour rooms, rural health centres, hospitals, and minor funding for capacity building.

### One UN Initiative

Pakistan is one of the eight pilot countries for the UN Reform for Delivering as One. The aim of this reform is to align UN programmes and funding more closely to policy priorities at the national level in order to capitalize on the strengths and comparative advantages of the organizations working within the UN. Increased coordination and coherence achieved through this reform is expected to strengthen government leadership and ownership and assist member countries achieve their Millennium Development Goals (MDGs).

### Development Partners and Donors

USAID and DFID are the major contributors to the health and nutrition programs in Pakistan; they contribute to the National Health Fund. ADB, UNICEF, UNFPA, GTZ, EU, Save the Children US and the Agha Khan Foundation mainly contributes to the MNCH/reproductive health programs, while GTZ is working in three main areas which include supporting tuberculosis control, human resources development and health structure reform, JICA's major areas of support are communicable diseases control including tuberculosis, Health Management Information System (HMIS), and maternal and child health. A large amount of vaccine has been provided as grant aid. The World Bank on the other hand, supports maternal and child health, HIV/AIDS program and public health surveillance. GFATM and GAVI have major contributions in communicable diseases. CIDA, JICA and AusAID are bilateral organizations working in the health sector.

### Multi-donor Trust Fund (MDTF)

The Multi-Donor Trust Fund (MDTF) for the 41 border regions in Khyber Pakhtunkhwa, Federally Administered Tribal Areas and Balochistan was established in August 2010 as one of the key instruments to support the reconstruction, rehabilitation, reforms and other interventions needed to build peace and create the conditions for sustainable development in the aftermath of the 2009 crisis. The MDTF aims to facilitate harmonization of donor programs with government's priorities as well as a mechanism for enhanced donor coordination across sectors in line with strategic priorities agreed between donors and government. The MDTF is administered by the World Bank and supported by eleven donors - Australia, Denmark, European Union, Finland, Germany, Italy, Netherlands, Sweden, Turkey, UK, and the USA. The MDTF management committee has representation from ADB, IDB and UN.

### Technical Resource Facility (TRF)

The Technical Resource Facility (TRF) is a five years project, funded by the UK's Department for International Development (DFID) and the Australian Aid Agency (AusAID). The TRF is managed by a member of Mott MacDonald Group, in partnership with John Snow Inc. (JSI) and Semiotics. The TRF is mandated to support improvements in policy, strategies and systems and help to build the capacity of government functionaries at federal, regional and district levels by providing strategic technical assistance. The purpose of the technical assistance is to help the government achieve its goal of improving people's access to quality health care services thereby improving their health, with focus on poor people and marginalised groups. In KP, the TRF has supported the provincial government in the development of Health Sector Strategic Plan for 2010-2017.



## SECTION 2: GOAL, OVERALL OBJECTIVES, GUIDING PRINCIPLES, PLANNING ASSUMPTIONS AND OUTCOMES

### 2.1 Goal

The overall goal is to promote; protect and maintain the health of Afghan Refugees in line with those of the targets set under the Millennium Development Goal (MDG) targets for Pakistan, through sustainable and cost effective public health interventions.

### 2.2 Overall Objectives

1. Facilitate equitable access to primary health care services for refugees with a focus on vulnerable and marginalized groups in particular women and children.
2. Enhance collaboration with the Provincial Departments of Health to ensure that the refugee health programmes are harmonized with those of the government; strengthen the local health capacity where it is necessary.
3. Build the refugees' community capacity to be able to take more responsibilities in managing their own health needs
4. Foster partnerships with a view to optimizing primary healthcare service delivery and resource mobilization

### 2.3 Key Guiding Principles

Special emphasis guiding the health strategy will be put on the following principles:

1. *Equity and right of the refugees*: The HSSP seeks to ensure that all refugees can access to primary health care programmes.
2. *Prioritization and Effectiveness*: Prioritizing and adjusting service delivery structures to meet the basic health needs of the refugee population will be the heart of the HSSP.
3. *Efficiency*: The HSSP aims to get the best outputs from available resource inputs
4. *Designed model tailored to refugee village based specificity* (geographic location, access, availability of alternative health providers, security)
5. *Evidence-based decision making with realistic targets and robust monitoring and evaluation mechanisms in place*. The implementation of this HSSP shall be evidence based, forward looking and take into account emerging trends and lessons learned.
6. *Partnership and collaboration*: Close working relationship with all partners to promote synergies

### 2.4 Planning Assumptions

For the successful implementation of the HSSP, the following assumptions have been identified:

- Political support and agreement at Federal, provincial and district levels by SAFRON and the Provincial Departments of Health.
- Successful social mobilization and empowerment of refugee community and advocacy with the local community
- No further deterioration of security situation
- No major catastrophe or disaster happens during the implementation
- Availability of resources to implement the strategy

These assumptions will be part of the implementation process and will be monitored and evaluated to see the rate of progress towards achieving the targets set in the HSSP.

## 2.5 Outcomes

Recognizing the challenges and uncertainties facing the Afghan refugees living in Pakistan in the coming years, the strategy emphasizes a more focused prioritization on key outcomes with flexibility to enable UNHCR to meet emerging challenges and opportunities.

The HSSP has five key outcomes and each outcome has its specific objectives and strategic actions and targets. These outcomes are:

**Key Outcome 1:** Ownership and commitment to the new Health Strategy by refugee communities, Government and partners promoted

**Key Outcome 2:** Enhance sustainable access to primary health care services through cost effective public health interventions

**Key Outcome 3:** Disease prevention and control programmes harmonized in line with those of the national health systems

**Key Outcome 4:** Increased community capacity and social health protection

**Key Outcome 5:** Fostering partnerships and coordination

## PART TWO: IMPLEMENTING THE STRATEGY

### SECTION 3: STRATEGIC MODELS, OBJECTIVES AND STRATEGIES FOR EACH OUTCOME

#### 3.1 Proposed strategic models

##### Refugee village's specificity and categorization

During the development of the HSSP, a preliminary mapping exercise of each refugee village (Annex 1) was conducted to identify the RV's population, utilization of supported basic health unit, access to alternative health care services, its distance and availability of public transport as well as security situation surrounding the RVs. Through this exercise, the HSSP proposes to categorize refugee villages into 3 categories:

**Category 1:** RVs with access to nearby alternative health care services (proposed criteria: on foot or by public transport less than 1 hour, distance less than 10 km)

- **Balochistan:** Chaghai, Leji Karaz, Saranan (old), Saranan (new), Mohammad Khail
- **KP:** Koka, Naguman, Utmanzai, Kalkatak, Basumera 18,20, Dheenda 13,16, Padiana 3,4,5, Panian 6,8,14, Panian 7,12, Panian 9,10,15, Ghulam Banda, Baghicha camp, Jalala camp, Kagan camp, Gambella, Chakdara, Barari, Khaki, Icharian, Akora1, Akora3, Kharirabad Haripur, Turkaman, Khazana, Khursasan, Barakai1, Barakai2

**Category 2:** RVs without nearby access to alternative health care services (proposed criteria: distance >10 km, public transport > 1 hour)

- **Baluchistan:** Posti, Malgagai, Chazgi Minara, Katwai, Zar Karez, Surkhab IV, SurkhabV, Surkhab Model
- **KP :** Adezai, Gamkol1, Gamkol2, Oblan, Zangai camp, Taimer, Toor, Akora2, Kababian, Gandaf
- **Punjab:** Miawali

**Category 3:** RVs located in volatile security areas or have ethnic sensitivity – difficult to implement new initiative and to monitor

- **KP:** Mundapul, Pushapul, Dalan, Doaba, Kata Karain, Thal 1, Badabair, Baghbanan, Matani, Mira Kachawari, and Zindai

##### Proposed Models specific to refugee's village categorization

Recognizing that changes will have to be done gradually and must be based on RV's specificity as categorized above, the HSSP proposes 5 different models to be implemented (Annex 1):

**Model 1 (Mobile Health Teams):** Essential basic care and treatment services provided by mobile health teams, preventive and community based programmes for maternal and child health to be gradually managed by the community

- Where it is geographically feasible, establish one mobile health team per 2 refugee villages, operating 2-3 days per week in each refugee village.

- Closure of non necessary BHUs.
- Gradually strengthen and empower the refugee community to take charge in managing their own health programme and gradually move into Model 4.
- Institutionalize collaboration with DoH for EPI, tuberculosis, malaria, HIV, Leishmaniasis for immunization, diagnostics, treatments, referral and reporting.

**Model 2 (Use of existing local health facilities):** Essential basic care treatment services provided by nearby existing local health facility, preventive and maternal and child health to be gradually managed by the community

- Use of nearby local health facility (within a defined distance and time required for public transport or walking) and closure of RV's BHU,
- Strengthen local health facility's capacity (human resource and infrastructure) to absorb more population catchment,
- Gradually strengthen and empower the refugee community to take charge in managing their own health programme. Institutionalize collaboration with DoH for EPI, tuberculosis, malaria, HIV, Leishmaniasis for immunization, diagnostics, treatment, referral and reporting.

**Model 3: Newly constructed Health Facility** to be used by Refugees and local community: Essential care and treatment services provided by newly constructed health facility which could benefit both refugees and local surrounding population

- Basic services for treatment and preventive programmes including maternal and child health and referral to be gradually managed by the refugee community
- Institutionalize collaboration with DoH for EPI, tuberculosis, malaria, HIV, Leishmaniasis for immunization, diagnostics, treatment, referral and reporting.

**Model 4 (Community strategy):** basic services ran by the refugee communities

- Basic services for treatment and preventive programmes including maternal and child health and referral to be managed by the refugee community.
- Institutionalize collaboration with DoH for EPI, tuberculosis, malaria, HIV, Leishmaniasis for immunization, diagnostics, treatment, referral and reporting.
- A pilot project will start in 2014 in selected RVs based on geographic location, readiness of the community and likelihood of success. This will form a solid foundation and good experience for scaling up.

**Model 5:** Basic Health Unit remains but subject to further assessment and review

- This will include the refugee village in Category 2 and 3 of which there is no nearby local health facility and/or the refugee villages are located in highly volatile or insecure areas or have ethnic sensitivity.
- Further analysis and assessment will be conducted over the course of the implementation of the strategy. Eventually, the strategy intends to promote and strengthen the community to take charge of their own health activities.



## 3.2 Strategies for each outcome

### Key Outcome 1: Ownership and Commitments for the new Strategy by Refugee Communities, Government and Partners Promoted

**Objective:** To promote ownership and commitments for the implementation of the Strategy

Strategy	Strategic Actions
1) Advocate and obtain consensus for the implementation of the strategy	1.1) Advocacy meeting(s) at the Federal level to obtain an consensus for the implementation of the strategy 1.2) Advocacy meeting(s) at the provincial level (DoH) to obtain an consensus for the implementation of the strategy 1.3) Advocacy meetings with CAR at the Provincial level to discuss the implementation of the strategy 1.4) Advocacy meetings at the District Health Departments to discuss the implementation of the strategy 1.5) Establish a joint Committee to oversee the planning and implementation of the strategy  <b>Target outcomes:</b> ➤ Health Strategy agreed by January 2014
2) Advocate and develop a joint workplan with existing implementing partners for the transition period	2.1) Advocate the Strategy and develop an operation workplan with IPs  <b>Target outcomes:</b> ➤ Joint workplan developed and reflect in the proposal for UNHCR funding by February 2014
3) Create a common will and vision for change, promote ownership and commitments for the implementation of the Strategy at the refugee communities	3.1) Develop communication strategy and social mobilization strategy 3.2) Engage IPs to implement communication and social mobilization strategies to promote the change 3.3) Advocacy meetings for UNHCR and the refugee communities  <b>Target outcomes</b> ➤ Communication strategy and social mobilization strategy developed and implemented from March 2014

## Key Outcome 2: Enhanced sustainable access to primary health care services through cost effective public health interventions

**Objective:** Facilitate equitable and sustainable access to primary health care programmes with special attention to vulnerable refugees

### Strategic areas of focus

- Essential basic care and treatments
- Maternal and child health
- Effective referral systems
- Community health outreach and disease prevention, and hygiene promotion.

Strategy	Strategic Actions
1) Develop, identify and implement suitable models for the implementation of the health strategy, taking into consideration of camp based specific situations and priority	<p>1.1) Conduct mapping and assessment of health facilities in RVs and nearby to assist in the development of a policy and strategy</p> <p>Review and update existing mapping, conduct joint assessments of health facilities in refugee villages and nearby local health facilities</p> <p>1.2) Categorize refugee villages based on specific criterion such as access, availability of alternative health services, security.</p> <p>1.3) Identify a suitable model for each RV, implement the model, and gradually decrease a number of basic health units</p> <p>1.4) Closely monitor the implementation of the models and gradually scale up the roll out of a sustainable model (Model 4) - subject to feasibility and further assessment</p> <p><b>Target outcomes</b></p> <p>➤ Model tailored to refugee village's specific situation agreed by April 2014 and implementing process initiated by June 2014</p>

<p>2) Enhance/ establish community based primary health care services with focused health activities to be managed by the community</p>	<p>2.1) Design and implement innovative approach for community based health strategy in order to provide community level services, taking into account their needs and priorities - promoting best practice</p> <p>2.2) Build the capacity of the community in managing their community primary health care services through existing IP - building into their programme planning and budget during the transition period</p> <p>2.3) Strengthen preventive and basic curative health services through expanding the vital roles of community health workers and lady health visitors; building on the current successful preventive programmes</p> <p>2.4) Build the capacity of the community health workers (CHWs), lady health visitors (LHVs) and other community - owned resource persons such as registered refugee doctors, paramedics and other health workers practicing in the refugee villages to provide services at the community level.</p> <p>2.5) Design and establish a community based information system (CBIS)</p> <p>2.6) Strengthen existing Community Health Committee or establish new committees/structures to manage the changes and oversee the community health service programme</p> <p>2.7) Gradually bring in new development IPs or expand the roles of existing Protection IPs to assist in supporting and monitoring the work of community based health service programme.</p>
	<p><b>Target Outcomes:</b></p> <ul style="list-style-type: none"> <li>➤ Community based services implemented and fully managed by the refugee community by 2017</li> <li>➤ CBIS designed, established and in function by 2016</li> <li>➤ Community Health Committee strengthened and able to oversee the community based health services by 2015</li> <li>➤ IPs identified to oversee community based health services by 2014</li> </ul>

<p>3.) Use of alternative health care options to provide basic care and treatments, especially for vulnerable groups, women and children within the refugee villages</p>	<p>3.1) Mapping of registered Afghan doctors, paramedics and other form of health workers practicing in the refugee villages</p> <p>3.2) With the community, identify doctors/paramedics/HCWs who could be service providers for refugees for basic care , treatments and managing referral – Doctors/Health workers currently work for IPs at BHUs will be the top priority -</p> <p>3.3) Build capacity of local Afghan doctors/paramedics practicing in the RVs through basic and advance training and accreditation</p> <p>3.4) Advocate and negotiate with the Provincial Department of Health for these Afghan health workers to continue to be employed within the refugee communities.</p> <p>3.5) With the community, identify appropriate mechanism to cover the treatment costs for vulnerable groups, i.e. through vouchers, or reimbursement to the community funds or other rewarding systems directly provided to selected doctors such as stipend.</p> <p><b>Target outcomes:</b></p> <ul style="list-style-type: none"> <li>➤ refugees (vulnerable groups in particular) have access to basic care in refugee villages,</li> <li>➤ mechanism for reimbursement in place for vulnerable groups</li> </ul>
<p>4. Facilitate access to basic care and treatments at the nearby local health facilities through strengthening DoH's capacity</p>	<p>4.1) Review mapping and conduct joint assessments of the conditions of nearby local health facilities with Department of Health</p> <p>4.2) Institutionalize collaboration with the Department of Health for refugees to use the local health facilities, develop modality for the implementation arrangements and joint monitoring systems</p> <p>4.3) Upgrade or construct new local health facilities as needed through RAHA or other funding mechanism.</p> <p>4.4) In close collaboration with other development partners, support or facilitate assistance to the Department of Health to build the capacity of the District Health Department of Health or PPHI or other Government's partners who manage the local facilities.</p> <p>4.5) Where it is possible, encourage existing IPs to participate in DoH's bidding to run the local health facilities (item 4.3), negotiate with DoH to retain existing IPs' health workers.</p> <p>4.6) Implement communication strategy with the local health workers and local population to reduce potential conflicts</p> <p><b>Target outcomes:</b></p> <ul style="list-style-type: none"> <li>➤ refugees have equitable access to basic care at local health facilities</li> <li>➤ DoH's Local health facilities strengthened/upgraded</li> </ul>

<p>5. Enhance referral services and facilitate access to specialist care at national health system</p>	<p>5.1) Establish an effective referral system including reimbursement mechanism and for it to be eventually managed by the community</p> <p>5.2) Establish and formalize collaboration framework with the DoH for referral and the use of existing ambulances. The ambulances could be donated to respective district hospitals through MOUs ensuring the availability of these services to refugee community as well surrounding local population on the agreed terms and conditions.</p> <p>5.3) Through the community, protection or UNHCR field staff, proper utilization of reimbursement mechanism once it is introduced will be closely monitored.</p> <p>UNHCR's role will be limited to monitoring and reimbursement of actual cost of the transport on submission of original receipts</p> <p><b>Target outcome:</b></p> <p>refugees have equitable access to specialized care at the government health facilities</p>
<p>6). Develop and implement a Strategy for maternal and child health (MCH)</p>	<p>6.1). Review and define preventive MCH activities to be provided and managed by the refugee community</p> <p>6.2) Identify new workforces and scale up a number qualify service providers within the refugee communities</p> <ul style="list-style-type: none"> <li>• With the community, identify candidates from all refugee villages for community midwives (CMWs) training</li> <li>• Negotiate with the DoH for the refugee CMW candidates to participate in the existing 2-year CHW training programme, identify training Institution</li> </ul> <p>6.3). Management of MCH activities (ante and post natal care, delivery by trained personnel, family planning, integrated child management (IMCI)</p> <ul style="list-style-type: none"> <li>• Use IPs to build the capacity of the refugee communities in managing their MCH activities during the transition period</li> <li>• Strengthen the refugee community (committee) to be able to gradually manage the MCH activities and resources.</li> </ul> <p>6.4). Identify and implement mechanism for sustainability and safety net</p> <ul style="list-style-type: none"> <li>• Delivery fees could be increased in consultation with communities so that facility can continue services in a sustainable manner.</li> <li>• Voucher scheme can be introduced for the vulnerable families.</li> <li>• UNHCR may continue support for referral of difficult cases through re imbursement procedure.</li> </ul> <p><b>Target outcome:</b></p> <ul style="list-style-type: none"> <li>➤ MCH programme is managed by the community by 2016</li> </ul>

<p>7) Implement SGBV strategy (Health aspect)</p>	<p>7.1) Develop integrated approach involving health, protection, and community based protection for sexual and gender-based violence (SGBV)</p> <p>7.2). Implement SOPs for clinical management of rape survivors, train health care providers in clinical management of rape survivors</p> <p>7.3). Improve access to SGBV related services for refugees in urban areas</p> <p>7.4). Raise awareness of the population on early reporting, and available services through effective communication</p> <p>7.5) Strengthen referral systems including training for service providers, influential community members</p> <p><b>Target outcomes</b></p> <ul style="list-style-type: none"> <li>➤ Integrated approach involving health, protection, and community based protection for sexual and gender-based violence (SGBV) developed and implemented</li> <li>➤ All SGBV survivors have access to SGBV services</li> </ul>
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## Key Outcome 3: Disease prevention and control programmes harmonized in line with those of the national health systems

**Objective:** To harmonize communicable and non communicable disease prevention and control programmes in the refugee villages with the government programmes

### Strategic areas of focus:

- Expanded programme for immunization (EPI),
- Communicable diseases such as tuberculosis, malaria, HIV and leishmaniasis; non communicable diseases such as heart disease, and diabetes
- Emergency and epidemic planning, prevention and control.

### Specific objectives

- 1) The refugee's expanded programme (EPI) integrated into the provincial EPI programme by 2016 and at least 90% of refugee children under 5 years old are fully immunized.
- 2) Communicable and non communicable disease prevention and control programmes such as tuberculosis, malaria/Dengue, HIV, heart disease, and diabetes fully integrated into programmes by 2015. All refugee patients suffer from , tuberculosis, malaria and dengue, HIV, as well as non communicable diseases received diagnostic and treatment at the government health facilities
- 3) Refugee health programme is included in the Provincial health planning by 2018

Strategy	Strategic Actions
1.) Integrate the Expanded Programme for Immunization (EPI) for the refugees with the Provincial EPI Programme	<p>1.1) Institutionalize collaboration with the DoH through signing a Memorandum of Understanding (MoU) to include refugee children population in their routine immunization programme (EPI).</p> <p>1.2) Facilitate and build capacity for the Provincial EPI Programme in the following areas:</p> <p><b>Vaccine and supplies related to vaccination</b></p> <ul style="list-style-type: none"> <li>• DoH to include vaccine for refugee children in their vaccine procurement programme.</li> </ul> <p><b>Logistics (Cold chain and storage, transport)</b></p> <ul style="list-style-type: none"> <li>• In collaboration with partners or other donors, assist the Provincial EPI programme in strengthening their storage and cold chain capacity so that they can be eventually handle vaccines for both local and refugee population. RAHA funds may be needed for this purpose.</li> </ul> <p><b>Human resources</b></p> <ul style="list-style-type: none"> <li>• Use of existing field staff and supervisor of the refugee programme until DoH is able to recruit additional staff on</li> </ul>

	<p>permanent / contractual basis either by itself or through its partners such as PPHI.</p> <p>1.3) Field monitoring and reporting to be conducted jointly with DoH, or by IP with DoH at an initial phase, and gradually to be completely integrated with DoH system.</p>
	<p><b>Target Outcomes:</b></p> <ul style="list-style-type: none"> <li>➤ vaccines procurement covered DoH by end of 2014</li> <li>➤ EPI report sharing with DoH EPI by 2014</li> <li>➤ Cold chain integrated by 2015.</li> <li>➤ DoH EPI Staff recruited and delivering services by 2016</li> <li>➤ Refugee EPI programme is fully integrated into the national EPI by 2016</li> </ul>
<p>2). Harmonize and facilitate access to early diagnosis, treatment for refugee patients with priority communicable and non communicable diseases</p>	<p>2.1) Institutionalize collaboration with the DoH through a MoU to include refugee population in their TB, Malaria/dengue, HIV and Leishmaniasis as well as for non-communicable disease prevention and control programme</p> <p>2.2) Develop mechanism to ensure an effective mechanism for cases findings, diagnosis, treatments, reporting and case referral for communicable and non communicable diseases.</p> <p>2.3) Ensure the availability of relevant supplies and medicines for diagnostics and treatment of TB, malaria, dengue, HIV and Leishmaniasis.</p> <p>2.4) Support the DoH in establishing the Leishmaniasis Treatment Centres to be utilized for both refugees and local populations (services currently only available in refugee villages and used for both local refugees) – explore the use of RAHA funding.</p> <p>2.8) In close collaboration with other partners such as WHO, support DoH to strengthen technical and operational capacities of the Provincial disease control programmes of AIDS, Tuberculosis, Malaria and Leishmaniasis for diagnosis, and case management as necessary.</p> <p>2.9) Improve knowledge for health care providers in the refugee villages and refugee community on prevention measures, risk behaviour, and case management through trainings of health workers in close collaboration with DoH and WHO and effective awareness programme.</p>

	<p><b>Target Outcomes:</b></p> <ul style="list-style-type: none"> <li>➤ MoUs signed with Provincial Disease Control Programmes</li> <li>➤ Tuberculosis,, Malaria/Dengue and other disease control programmes (communicable and non communicable diseases) fully integrated into programmes by 2015</li> </ul>
<p>4.) Strengthen institutional mechanism to ensure close collaboration and effective information sharing with DoH in disease control and response</p>	<p>4.1) Form a joint Coordination Committee on refugee health. The Committee members shall include DoH, CAR, UNHCR and relevant partners providing health assistance to the refugees.</p> <p>4.2) Organize monthly or quarterly meetings to discuss progress</p> <p>4.3) Ensure that the community based information system (CBIS) is established and fully function. Share the CBIS with the District Health Information Department</p> <p><b>Target outcomes</b></p> <ul style="list-style-type: none"> <li>➤ Joint Committee established</li> <li>➤ Monthly/quarterly meeting organized</li> <li>➤ CBIS shared with DoH</li> </ul>
<p>5.) Advocate, negotiate with the DoH to include refugee health activities in the Provincial Health Strategic Plans</p>	<p>5.1) Advocate with DoH to include refugee health programmes in the next Provincial Health Strategic Plan (timeframe will be varied between provinces)</p> <p><b>Target outcome</b></p> <ul style="list-style-type: none"> <li>➤ Refugee health programmes are included in Provincial Health Sector Plan by 2018</li> </ul>
<p>6.) Develop Emergency and epidemic response plan for refugee communities and ensure that the refugees are included in the provincial emergency and epidemic plans</p>	<p>6.1) Encourage and support the development of emergency management capacity in government - DoH to include refugee population; emphasize emergency mitigation and preparedness, including better hazard vulnerability assessments.</p> <p><b>Target outcome</b></p> <ul style="list-style-type: none"> <li>➤ Refugees are included in the government emergency and response plan by 2018.</li> </ul>

## Key Outcome 4: Increased Community Capacity and social health protection

### Objectives:

- 1) To build the capacity of the refugee to be able to take more responsibilities in health related needs
- 2) To implement social health protection/safety net programmes to support vulnerable groups
- 3) To identify and implement alternative models for health care financing and service delivery for Afghan refugee health programmes

### Strategic Areas of Focus

- Social health protection - safety net including health insurance
- Livelihood

Strategy	Strategic Actions
1) Develop a holistic integrated organization wide approach for refugee assistance (instead of separated vertical programmes)	<p>1.1) Develop a comprehensive organization wide approach for refugee assistance with holistic approaches – integrated health, education, livelihood, protection programme into one programme at the refugee village level</p> <p>1.2) Engage new development partners to take responsibility for a wider range of activities, including refugee health monitoring, and to support linkages between the refugee and government health programmes</p> <p><b>Target Outcomes:</b></p> <ul style="list-style-type: none"> <li>➤ Organization wide approach developed</li> <li>➤ Development partners/IPs engaged</li> </ul>
2) Empower/build the community capacity to take charge of their health and other activities	<p>2.1) Development comprehensive community strategy aims at empowering the refugee communities to take charge of their own health and other activities</p> <p>2.2) Establish/ support community organization in the refugee villages, mapping of existing community organizations</p> <p>2.3) Identify mechanism(s) for community organization to become self reliant, establishment of revolving funds, top-up funds as necessary.</p> <p><b>Target outcomes</b></p> <ul style="list-style-type: none"> <li>➤ Community strategy developed and implemented</li> <li>➤ Community organization established and functioned</li> </ul>

3) Explore, design and implement Social Health Protection programme including health insurance to protect vulnerable groups

- 3.1) Explore, design and implement Social Health Protection Programmes to protect vulnerable groups by reducing Out of Pocket Expenditure, identify suitable health care financing and alternative models of service delivery
- Explore the use of existing safety net programs implemented by provincial governments to better address the health and social health protection needs of the vulnerable refugee population.
  - Explore health insurance schemes established (or to be) by the provincial governments, conduct a study on cost and benefits, premiums, types of coverage etc.
  - Explore the use of vouchers for reimbursement
  - Pilot alternative models for service delivery
- 3.2) Reduce the vulnerability through strengthen:
- The livelihood opportunities - agriculture based and rural small enterprises - of poor households focusing on vulnerable groups such as women, disabled and youth.
  - Community-based programs focussing on the enhancement of productive assets of the poor, including their skills and financial assets, and
- 3.3) Explore with the World Bank and development partners for their income generation programmes.

**Target Outcomes:**

- Social mechanism developed and implemented
- Livelihood programme developed and implemented
- Alternative health care financing mechanisms and models identified, piloted and implemented

## Key Outcome 5: Fostering Partnerships and Coordination

**Objective:** Enhance partnership with development stakeholders and other sister UN agencies to support the implementation of the Strategy

Strategy	Strategic Actions
1) Strengthen partnership arrangements at all levels with key stakeholders	1.1) Strengthen joint planning 1.2) Strengthen joint performance monitoring 1.3) Institutionalize participatory planning, monitoring, and evaluation  <b>Target outcomes:</b> <ul style="list-style-type: none"> <li>• joint workplan and joint M&amp;E plans developed</li> <li>• MoUs signed</li> </ul>
2) Enhance partnerships with existing humanitarian and new development stakeholders and other sister UN agencies to support the implementation of the Strategy	2.1) Explore possibilities for expanding partnerships with development and other new partners -make inventory of development partners and donors supporting health related programmes in refugee districts.  2.2) Advocate for UNHCR new strategy, policies, roles and functions to government, the international community, donors, and the United Nations system in Pakistan;  2.3) Advocate for support investment in refugee health in Pakistan, from national and international sources;  2.4) Strengthen partnerships among health actors as appropriate, for example NGOs, UN and bilateral agencies, universities and development partners and banks;  2.5) Facilitate exchange of information about local-level health initiatives to influence refugee health policies and programmes; and improve knowledge management in UNHCR, including the dissemination of relevant public health information  2.6) Through developed joint programmes and existing MoU with stakeholders, enhance coordination/alignment of activities to support the specific outcomes of the HSSP.  <b>Target outcomes:</b> new partners identified, partnerships fostered
3) Identify new refugee health care financing mechanism and sources	3.1) Diversify the donor base by engaging non-traditional donors and financial institutions  3.2) Explore the use of new financial mechanisms such as the Multi Donor Trust Funds (MDRF), Technical Resource Facility (TRF), establishing revolving funds to support refugee communities in managing their health programmes  <b>Target outcomes:</b> Alternative health care financing mechanisms and sources identified/implemented



## SECTION 4: IMPLEMENTATION ARRANGEMENTS, FINANCIAL PLAN AND MANAGEMENT STRUCTURES

### 4.1 Institutional Framework

The Health Sector Strategy for Afghan refugees will be implemented as part of the One UN Initiative and the five outcomes outlined in the Afghan Solutions strategy under; 1) 'enhancing access to shelter and essential services'; 2) 'enhancing social and environmental protection by supporting peaceful co-existence between refugees/host communities and returnees/communities of return'; 3) 'strengthening the capacity development of national authorities, organizations and communities.

### 4.2 Implementation Arrangements

#### Management of the HSSP

The implementation period of the HSSP will be 5 years, operating from 2014-2018. The Health Coordinator of UNHCR will be responsible for the overall coordination, monitoring and implementation of the HSSP at the national level. The supervision and implementation at the provincial and district level will be managed by the UNHCR Sub Offices in close coordination and collaboration with the Provincial Health Sector Reform Unit (HSRU) in KP and designated Health Unit in Balochistan and Punjab, District Health Management Teams (DHMT) in relevant districts, implementing partners and refugee community health committees. At the refugee community level, the existing Refugee Health Committees will be strengthened. The action plans outline the activities, targets, timeframe and responsible parties will be jointly developed with the government and partners.

#### Overall oversight arrangements

The Joint Committee for the Refugee/Host Health Strategy will be established to provide the overall leadership and guidance with respect to the implementation of the HSSP with UNHCR Health Coordinator as a chair person and the designated person(s) from the Provincial Departments of Health as a co-chair. The members will consist of UNHCR health officers, representatives from CAR, and implementing partners. The Committee shall meet six monthly and provide guidance to the implementation of the HSSP.

### 4.3 Financial Plan

The implementation of the HSSP, if successful, will help reduce the financial requirements for the refugee health programme (currently at 4million US\$). This budget reduction can be achieved through harmonization and pooling of resources; partnerships; utilizing different financial mechanisms for refugee health care programmes such as the Multi Donor Trust Funds (MDTF); building refugee capacity to take more responsibilities in managing their own health needs; and increased efficiency and introducing cost cutting measures. The implementation of the HSSP if successful, will potentially help reduced the UNHCR health budget by 20% in 2015 (compared with 2013 budget), and 30-40% in 2016-2017 and 50-60% by 2018. At the same time, it is expected that additional RAHA funding and funding from other development partners will be required to support in upgrading and capacity building of the local health facilities surrounding the refugee villages. It is not possible at this stage to quantify the financial requirements from RAHA or other partners for local capacity building at this stage. More information can be provided in the next coming months.

## 4.4 Roles and Responsibility and Core Functions

Under the HSSP, the stakeholders include the GOP (Office of SAFRON), , the Department of Planning and Development, the Provincial and District Departments of Health in Baluchistan, KPK and Punjab, refugee community leaders implementing and development partners, donors and UNHCR offices at all levels. Their core functions are listed in Table 1.

Table 1: Specific Roles of key partners at different levels in managing the HSSP

Level	Core functions	
Refugee Villages	<p>Refugee community: Management of the community health services</p> <ul style="list-style-type: none"> <li>• Participatory planning and action</li> <li>• Targeted health promotion</li> <li>• MCH through trained CMWs</li> <li>• Water and sanitation activities</li> <li>• Home-based care</li> <li>• Delivery of defined health programme interventions</li> <li>• Monitoring and reporting on community actions (one person to be assigned with stipend)</li> </ul>	<p>Existing Implementing Partners (Health)</p> <ul style="list-style-type: none"> <li>• Social mobilization and advocacy for the implementation of the HSSP with refugee communities</li> <li>• Strengthen, build capacity of the refugee community capacity to take more responsibilities in managing health during the transition period</li> <li>• Train and employ and register Afghan doctors and other health workers living in the RVs during the transition period</li> </ul> <p><b>Development IPs (existing or new)</b></p> <ul style="list-style-type: none"> <li>• As part of integrated organization wide approach (under protection?), support, monitor the work of the community organization/doctors, ensure that vulnerable groups receive essential health services</li> <li>• Catalyze and provide bridging with the government health sectors</li> </ul>
.Provincial/ District	<p><b>CAR:</b> Overall oversight, coordination and management of refugee programmes in the province</p> <p><b>Department of Health</b></p> <ul style="list-style-type: none"> <li>• Overall planning and management of public sector health services in the province</li> <li>• Strategic and operational planning for public sector health services</li> <li>• Disease prevention and control, surveillance, reporting and HIS</li> <li>• Capacity building and logistics support for public sector health services</li> <li>• Monitoring and evaluation (jointly)</li> </ul> <p><b>UNHCR Sub Office</b></p> <ul style="list-style-type: none"> <li>• Planning, implementing, monitoring of the strategy implementation</li> <li>• Providing leadership on refugee health matters critical to health and engaging in partnerships where joint action is needed;</li> <li>• Monitoring the implementation of the HSSP</li> <li>• Articulating evidence-based policy options;</li> <li>• Providing technical and operational support, catalyzing change, and building sustainable Institutional capacity; and</li> <li>• Monitoring the health situation and assessing health trends</li> </ul>	

Country	<p><b>SAFRON:</b> Overall oversight, coordination and management of refugee programmes</p> <p><b>UNHCR Branch Office</b></p> <ul style="list-style-type: none"> <li>• Oversight, overall coordination, planning and supervision, monitoring and evaluation of the strategy</li> <li>• Capacity building in terms of staff development</li> <li>• Resource mobilization,</li> <li>• Necessary administration, human resources and financial support through budget allocations and</li> <li>• Coordination of support with the Sub Offices, Regional Office and HQ, identify external technical and resource persons as needed.</li> </ul>
Region	<p><b>UNHCR Regional Office</b></p> <ul style="list-style-type: none"> <li>• Participation and substantive involvement in planning, provision of prompt technical support for mobilization and implementation of strategic directions</li> <li>• Participate in the joint Monitoring and evaluation</li> <li>• Sharing of regional experiences, and best practices</li> <li>• Capacity building in terms of staff development</li> </ul>
Headquarters	<p><b>UNHCR HQs</b></p> <ul style="list-style-type: none"> <li>• Prompt and effective provision of technical support</li> <li>• Support in Monitoring and evaluation including participating in the midterm and end term review of the HSSP</li> <li>• Sharing of global experiences</li> <li>• Standard setting and clearinghouse for information and publication</li> <li>• Necessary financial support through additional budget allocations and extra budgetary resources</li> <li>• Coordination of support with the Regional Office and Branch office, identify external technical and resource persons as needed.</li> </ul>

## 4.5 Linkages between the refugee community and the Public Health Sector

To ensure sustainability, there must be linkages between the refugee health programmes and those of the public health sectors. A development partners could be used as to catalyze and provide bridging between the two systems until they convert into one system. The linkages envisaged in the HSSP are shown in the below table 2.

Table 2: Health functions by the refugee community and the public health sector

Refugee community level	Public Health Sector (level 1, 2 and 3)
<ul style="list-style-type: none"> <li>• Maternal and child health (by CMWs)               <ul style="list-style-type: none"> <li>- Community midwifery</li> <li>- Family planning</li> <li>- Antenatal care</li> <li>- Delivery</li> <li>- Postnatal care</li> <li>- SGBV</li> <li>- Family planning</li> <li>- Integrated Management of Childhood Illness (IMCI)</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>• Maternal health care and child health care               <ul style="list-style-type: none"> <li>- Delivery for complicated cases (by local BHUs, RHCs, hospitals)</li> <li>- Immunization (by EPI team)</li> </ul> </li> </ul>
<ul style="list-style-type: none"> <li>• Basic health care/Treatment of minor and complicated ailments (by Refugee doctors, LHVs,, Paramedics)               <ul style="list-style-type: none"> <li>- Treatment of common ailments</li> <li>- Referral</li> <li>- Home based care</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>• Basic health care/Treatment of minor and complicated ailments</li> <li>• 1<sup>st</sup>, 2<sup>nd</sup> and 3<sup>rd</sup> referral and specialized care</li> <li>• Outreach</li> </ul>
<ul style="list-style-type: none"> <li>• TB/HIV/malaria (by CHWs)               <ul style="list-style-type: none"> <li>- Follow-up/defaulters</li> <li>- Support for treatment and care</li> <li>- Home based care</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>• HIV/AIDS (by PACP)               <ul style="list-style-type: none"> <li>- Voluntary counseling and testing</li> <li>- Anti-retroviral therapy</li> </ul> </li> <li>• Malaria and dengue (by PMDP)               <ul style="list-style-type: none"> <li>- Diagnostics and treatments</li> </ul> </li> <li>• Tuberculosis (by PTBP)               <ul style="list-style-type: none"> <li>- Support in case findings and reporting</li> <li>- Diagnostics and treatments</li> </ul> </li> </ul>
<ul style="list-style-type: none"> <li>• Health promotion Behavior change communication (by CHWs)</li> </ul>	<ul style="list-style-type: none"> <li>• Health promotion (behavior change communication/Health education) – DdoH</li> </ul>
<ul style="list-style-type: none"> <li>• Environmental health (by CHWs)</li> </ul>	<ul style="list-style-type: none"> <li>Environmental health (DDoH)</li> </ul>
<ul style="list-style-type: none"> <li>• Community surveillance (by CHWs)</li> </ul>	<ul style="list-style-type: none"> <li>• Surveillance (DDoH)</li> </ul>

CMWs – Community midwives  
 BHUs – Basic health Unit,  
 PACP – Provincial AIDs control programme  
 PTB - Provincial TB Programme

CHWs – Community health workers  
 RHCs – Rural Health Center  
 DDoH – District Department of Health  
 PMCP - Provincial Malaria Control Programme

## 4.6 UNHCR Human Resource Requirements

UNHCR will work closely with the Governments of Pakistan at the Federal, Provincial and District levels, partners and donors through consultative mechanism. The Joint Steering Committee for the Refugee/Host Health Strategy will be established to provide the overall leadership and guidance with respect to the development and implementation of the joint strategic plan. The action plans outline the activities, targets, timeframe and responsible parties will be jointly developed with Partners.

The following staff will be needed for the implementation of the strategy:

### **One Health Coordinator (Islamabad) to:**

- Coordinate and oversee the overall implementation of the HSSP in the country; planning, and monitor and evaluate the Strategy implementation
- Provide leadership on refugee health matters critical to health and engaging in partnerships where joint action is needed; as needed, ensure linkages and facilitate regular dialogue between the government, donors, UN, and implementing partners based on available information.
- Closely monitor the implementation of the HSSP and the work of Health Officers in Peshawar and Quetta; undertake regular visits when security situation permits
- Monitor the health situation and assess health trends; compile, monitoring data from the community, and produce periodic HIS reports at the country level, discuss the data for action – addressing facility-based and community-based issues causing gaps indicated in the data
- Convene experience sharing forums with stakeholders at the national level, and organizing meetings.
- Provide technical and operational support to two Health Officers in Quetta and Peshawar

### **Two National Health Officers (Peshawar, Quetta) to:**

- Coordinate with government and partners at the provincial level, make inventory of stakeholders - Advocate and facilitate collaboration with stakeholders
- Plan, implement and closely monitor the implementation of the HSSP within the Province; undertake regular visits when security situation permits
- Monitor the health situation and assess health trends; compile, monitoring data from the community, and produce periodic HIS reports, Oversee the processing of community based and facility based HIS, discuss the data for action – addressing facility-based and community-based issues causing gaps indicated in the data
- As needed, facilitate regular dialogue between the community and the health service providers based on available information.
- Convene experience sharing forums with stakeholders in the province
- In close collaboration with DoH and other technical agencies such as WHO, organizing and conducting capacity building sessions, including in-service training.

**International and national consultants** as needed for specific purposes/activities

## SECTION 5: MONITORING AND EVALUATION

### 5.1 Performance monitoring, evaluation and reporting

#### 5.1.1 Framework for monitoring and reporting

Robust monitoring and evaluation systems to oversee implementation of the HSSP will be required. The HSSP recognizes the limitations in accessing some of the refugee villages for regular programme monitoring by UNHCR personnel, particularly the refugee villages under Category 3 (Section 3.1). UNHCR will seek to mitigate these risks through proactive measures to reduce exposure of staff to security risks and through alternative means of supervision and desk review, along with continued attention to capacity building and robust fiduciary arrangements such as those involving third-party monitoring

The results frameworks matrix will be used to provide the overall basis for monitoring outcomes under the HSSP.

A comprehensive monitoring framework has been developed consisting of multiple tiers:

1). **Monitoring missions:**

- Monthly field visits to refugees villages if the security situation permits by UNHCR international/national health coordinator, UNHCR Health Officer(s), UNHCR Field Officer(s).
- Quarterly to six monthly joint visits - participants shall include the UNHCR international/national health coordinator, UNHCR Regional Public Health Officer and National Health Officer(s), UNHCR Field Officer(s), CAR, and DoH (where it is applicable).
- Independent Monitoring: Quarterly during the first year and six monthly from year 2 by UNHCR Regional Office/ HQ or an international consultant

Where security does not permit, use of local consultants or implementing partners for field monitoring will be considered if security situation does not improve over the a long period.

- 2). **Third Party Monitoring:** For quality assurance and cross verification, a third party monitoring mechanism has been inbuilt in the project with the third party will be hired to conduct a baseline survey, verifying the current data, conducting a midterm review and an end line assessment.
- 3). **Community based health system reporting (CBIS) and UNHCR Health Information System** (during the transition period) and District Health Information System: The progress in achieving the HSSP's objectives against the performance indicators will also be measured through the CBIS, HIS and household surveys. The UNHCR Health Officers shall verify the data produced by the CBIS/HIS) during routine supervisory visits in the districts where security permits.
- 4). **Field monitoring reports:** The field monitoring reports by the UNHCR Health Staff and consultants can also be utilized for monitoring of the HSSP implementation.



### 5.1.2 Indicators for monitoring progress

The selection of indicators was guided by the need to be able to detect change and progress in key outcomes the sector is targeting. These indicators relate to both the level and distribution of inputs and outputs. Output indicators in the results frameworks will be monitored and consolidated for monitoring progress.

#### Health Indicators

The HSSP recognizes that once the refugee health programmes are fully harmonized with those of the government, it may not be possible to obtain facility based health information specific to refugee populations. It is also recognized that the health information data collected by the refugee communities (CBIS) may not be reliable. In order to address this issue, based line and periodic household surveys will be conducted in the refugee villages by the third party. Baseline data will be established accordingly.

Table 3 illustrates baseline and end of term measurable health indicators to monitor and evaluate the HSSP

Table 3: Key Health Indicators

Measure Health Indicators	Baseline	End term target
Utilization of health facilities (number of visits per person per year)	0.6	0.6
Proportion of pregnant women receiving ante natal care Proportion of women receiving post natal care	>90%	>90%
Proportion of deliveries by skilled attendants	60%	60%
Proportion of fully immunized children	90%	90%

### 5.1.3 Health Strategic Plan Review

**Periodic review and midterm evaluation:** The selection of indicators was guided by the need to be able to detect change and progress in key outcomes the HSSP is targeting .The results frameworks will be used to conduct reviews.

Missions by regional office or external consultant(s) will periodically take place to review progress made toward the outcomes reflected in the strategic frameworks. These reviews will be consolidated as part of the annual country health review mission for discussion with the implementing partners and provincial governments to assess overall progress toward the HSSP outcomes and to identify areas where improvements are required. A subsequent country programming mission will report back to the UNHCR Sub Offices and Branch Office, RO and HQ on the final assessment of progress on an annual basis, and point to any necessary changes or fine tuning required in the HSSP indicators or targets.

**End term review and evaluation:** A third party HSSP evaluation will be conducted at the end of five year to review the progress towards the implementation of the HSSP. Results Framework matrix, inputs and outcome and goal indicators will be used as a basis for the evaluation.

**Third party review:** For quality assurance and cross verification, a third party monitoring mechanism has been inbuilt in the project with the third party will be hired to conduct a baseline survey, verifying the current data, conducting a midterm review and an end line assessment.

#### 5.1.4 Reporting process

The monitoring and evaluation of progress shall be done within the monitoring and evaluation mechanisms. These are the monthly, quarterly, and annual, midterm and end term review processes. Progress against outcomes, and the activities delivered to implement them will be monitored at the operational level quarterly, and annually, mid-term and end-term of the plan. This is elaborated in the table 4 below.

Table 4: Reporting requirements for monitoring and evaluation of the HSSP implementation

Frequency	Target	Focus	Level of monitoring and review
Monthly	Monthly activity reports, field visits	Identify activities whose implementation is delaying delivery of outputs, and plan to address challenges	Activity level
Quarterly	Quarterly progress reports	Identify outputs that whose achievement during the year is threatened, and plan to address challenges affecting them	Output level
Annually	Annual progress report, annual review	Identify progress, issues and challenges affecting implementation of outputs, and so make recommendations of priorities for coming year	Output levels
Mid- term	Mid- term review	Identify progress, issues and challenges affecting implementation of outcomes towards supporting achievement of the overall goal, and so make recommendations for remaining half of the strategic plan	Output levels
End –term	End- term review	Identify progress, issues and challenges that affected achievement of the overall goal, and so make recommendations for the next strategic plan focus to enable it support achievement of overall sector policy	Goal level

## 5.2 Data Collection

### **Community-Based Information System (CBIS)**

It is critical that the management of health action be evidence-based, beginning at the community level. In an absence of Basic Health Units in the RVs, it is essential that data be collected at the community level for effective monitoring, evaluation and planning. Members

of the health facility committees, community leaders, CHWs, LHVs, and CMWs should be trained on the importance of data collection, analysis, storage and utilization. A dedicated person in the community should be identified to be responsible for the overall management of the community-based information system (CBIS). Table 5 summarizes the categories and types of information to be collected at community level, and identifies possible sources of the information.

Table 5: Types of health information to be collected in community by category and source

Category	Types of data	Collection and source
Demographic	<ul style="list-style-type: none"> <li>Population by age and sex</li> <li>Births and deaths (with cause)</li> <li>Migration in and out</li> </ul>	<ul style="list-style-type: none"> <li>Village register</li> <li>Birth and death register</li> <li>Community health worker</li> </ul>
Utilization	<ul style="list-style-type: none"> <li>Patient records</li> <li>User records</li> </ul>	<ul style="list-style-type: none"> <li>Register from OPD, private doctors, other health workers practicing in the village</li> <li>Survey</li> </ul>
Immunization	<ul style="list-style-type: none"> <li>Under one year registered, vaccinated against BCG, Polio (3 doses), measles, pentavalent vaccine, fully immunized children</li> <li>Pregnant women protected against tetanus with at least 3 doses of tetanus toxoid</li> </ul>	<ul style="list-style-type: none"> <li>Under five registered,</li> <li>Growth monitoring cards</li> <li>Household survey</li> <li>Visit form, registers</li> <li>Provincial EPI reporting</li> </ul>
Maternal and child health	<ul style="list-style-type: none"> <li>ANC visits, ANC referrals, causes of referrals</li> <li>Deliveries, referrals during delivery, complications</li> <li>Mother and child outcome, deaths and causes</li> <li>New and current family planning users by method</li> <li>IEC/BCC session conducted</li> </ul>	<ul style="list-style-type: none"> <li>Delivery register</li> <li>Family planning register</li> <li>Household/catchment area survey form</li> <li>LHV records (ante and post natal)</li> </ul>
Nutrition	<ul style="list-style-type: none"> <li>Number of identified severe and acute malnutrition</li> <li>Number of admissions for severe and acute malnutrition</li> <li>Moderate and acute malnutrition</li> </ul>	<ul style="list-style-type: none"> <li>Treatment register</li> <li>Nutrition survey</li> </ul>
Health status	<ul style="list-style-type: none"> <li>Under-fives with fever, diarrhoea, measles, chest tightness,, NCDs</li> </ul>	<ul style="list-style-type: none"> <li>Household survey/visit/referral sheet</li> <li>Register</li> </ul>
Socio-economic	<ul style="list-style-type: none"> <li>Number of vulnerable refugees</li> </ul>	<ul style="list-style-type: none"> <li>Community</li> </ul>

**UNHCR Health Information System (HIS)**

Existing health data collected for the HIS will be modified to reflect the indicators as identified in the HSSP during the transition period. It is expected that the refugee health information system will be eventually merged into the government District Health Information System (DDHIS). The health indicators specific for the refugee population may therefore not be available from the system. Periodic household surveys will be conducted by a third party to obtain the information and use for monitoring purposes.

## SECTION 6: RISKS AND RISK MITIGATION

The overall risks that may hinder the ability for UNHCR to implement the HSSP are as follow:

- The Government does not agree with the HSSP

**Mitigation:** high level advocacy and dialog. At the same time, it will be important for UNHCR to seek to further mitigate this risk by building more ownership and buy-in by working to build understanding of, and support for needed harmonization across the political spectrum.

- Capacity from the national counterpart is weak

**Mitigation:** In partnership with other development partners, sister UN agencies under One UN, and RAHA initiative, technical assistance and financial assistance, as well as capacity building activities will be provided to improve the capacity of the counterparts.

- New influx of refugees due to unforeseen reasons

**Mitigation:** Develop a contingency plan with partners. The plan should specify how the health activities could be scaled up quickly in case of emergency

- Macroeconomic Risks: the persistence of conflict in KP and FATA as well as natural disaster poses a threat to some of the most vulnerable and marginalized refugee populations in Pakistan, while also challenging economic stability.

**Mitigation:** Support under the UNHCR could be enhanced to include support for agricultural/livestock-linked employment and livelihoods, expansion of general and technical/vocational education, investment in referral, and social protection.

- Limitations to implement and monitor health services due to security and impaired access. Security issues, terrorism and violence have an enormous negative impact on efficiency, and effectiveness of the implementation of the HSSP including monitoring

**Mitigation:** UNHCR will continue to monitor the overall security situation and take action to mitigate security risks to staff

- Insufficient funding as traditional donors reducing funding and development donors do not come forward to provide funding

**Mitigation:** Enhance resource mobilization, advocacy, identify new potential donors/partner, development donors/partners in particular.

## SECTION 7: TIMELINE

Key activities and tentative timeline for the HSSP's implementation are summarized:

Activity	Timeline	Responsibility
Agreement on the draft HSSP by: <ul style="list-style-type: none"> <li>- SAFRON at the Federal level</li> <li>- Provincial Department of Health</li> </ul>	by 30 June 2014	Assist Rep, Senior Public Health Officer (SPHO), National Health Coordinator (NOC)
Meetings with Provincial Departments of health and CAR, to agree on modalities, priorities, management structure and timeline	by 30 August 2014	SPHO, NOC/NOA
Inventory of health programmes, development partners/donors working in the refugee effected areas	by 30 June 2014	NOC/NOA
Discuss with potential development partners and donors for areas of collaboration and potential funding support	June – December 2014	Assist Rep, Programme Officer, SPHO, NOC/NOA
Workshop with government and partners to develop an action plan for 2014-2015	By 10 September 2014	SPHO, NOC/NOA, RPHO
Disseminate the HSSP, advocacy meeting with donors	By 30 June 2014	Ext. Relation Section, NOC
Advocacy and social mobilization with refugee communities in all refugee villages	Mar – Dec2014	NOC/NOA, field Officers, Protection Officers, IPs,
Review mapping of the health facilities within the RVs and nearby local health facilities, agree on model to be implemented in each RV	by 31August 2014	NOC/NOA with DoH and CAR
Health insurance study	May- September 2014	SPHO; NOC, consultant
Baseline survey to establish baseline health indicators for monitoring	Sept 2014	SPHO; NOC/NOA
Model 1 (mobile team) implemented in all identified RVs Model 4 (community model) piloted in KP Model 2 (used of local health facilities) implemented in all identified BHUs Model 3 (constructed new BHUs) in nearby local villages Model 2,3, 4 implemented in all refugee villages	By end 2014 in KP, 2015 in Baloc. By end 2015 By 2015 y 2017 by 2018	NOC/NOA, IPs, DoH, Contractors working for DoH as part of public private partnership
Vaccination and disease prevention and control programe harmonized and include in the provincial health programmes	by 2016	DoH, Contractors working for DoH as part of public private partnership, NOC/NOA
Health insurance scheme piloted	by 2016	NOC/NOA, Health insurance companies
New financial mechanisms identified and implemented	By 2017	Assist Rep, Programme Officer, SPHO, NOC/NOA
Mid -term, and end-term review	2015, 2018	Consultant, RPHO, NOC/NOA





# Annex 3: Refugee BHUs and nearby local health facilities in KP

## Health Facilities in Afghan Refugee Villages of Khyber Pakhtunkhwa

July 2013

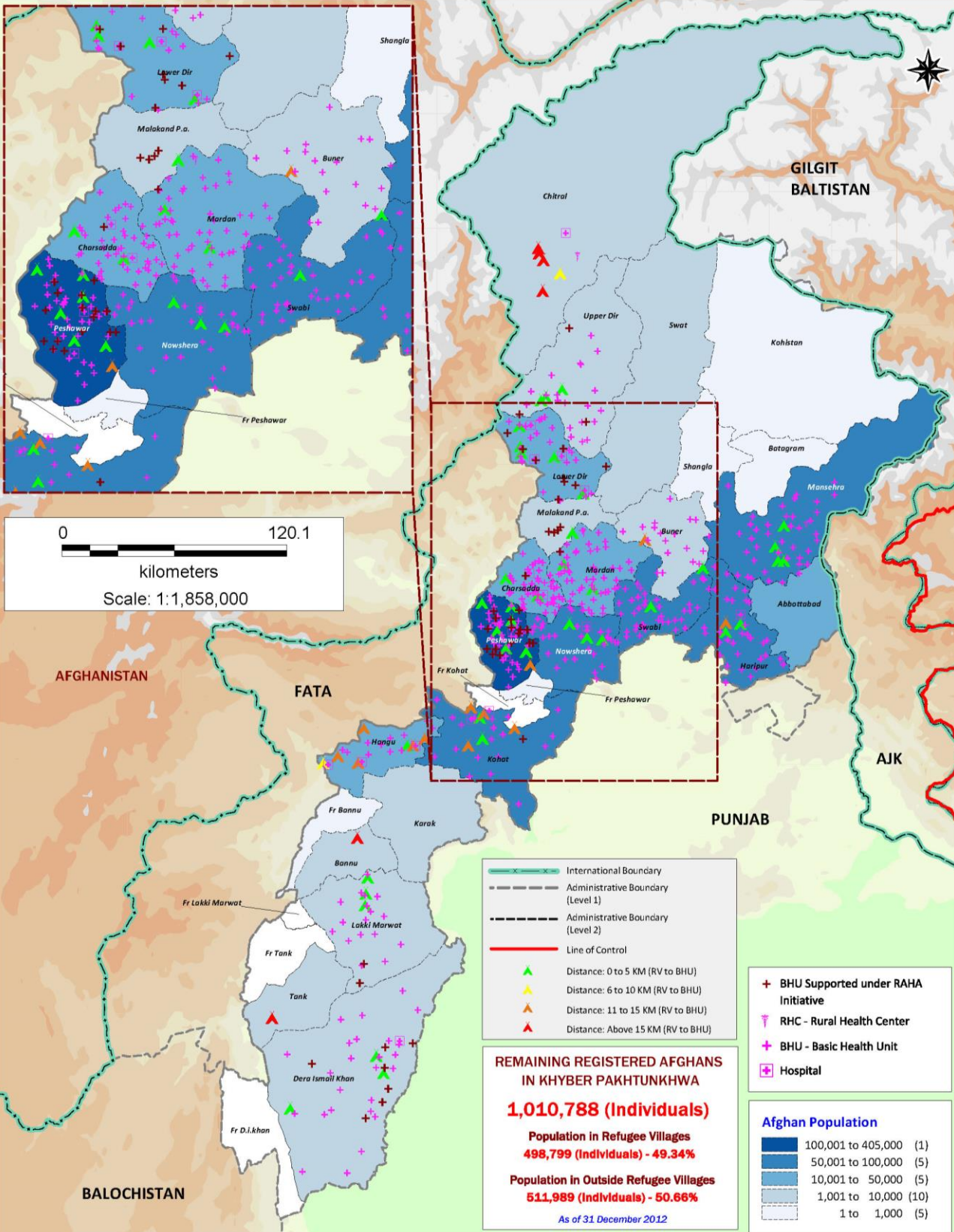


Data Management/GIS

Unit  
UNHCR Country Office Islamabad

Sources:  
ANR SCAC Database/  
WHO

The boundaries and names shown and the designations used on this map do not imply official endorsement or acceptance by the United Nations.



- International Boundary
- Administrative Boundary (Level 1)
- Administrative Boundary (Level 2)
- Line of Control
- Distance: 0 to 5 KM (RV to BHU)
- Distance: 6 to 10 KM (RV to BHU)
- Distance: 11 to 15 KM (RV to BHU)
- Distance: Above 15 KM (RV to BHU)

- BHU Supported under RAHA Initiative
- RHC - Rural Health Center
- BHU - Basic Health Unit
- Hospital

**REMAINING REGISTERED AFGHANS IN KHYBER PAKHTUNKHWA**  
**1,010,788 (Individuals)**  
**Population in Refugee Villages 498,799 (Individuals) - 49.34%**  
**Population in Outside Refugee Villages 511,989 (Individuals) - 50.66%**  
*As of 31 December 2012*

**Afghan Population**

- 100,001 to 405,000 (1)
- 50,001 to 100,000 (5)
- 10,001 to 50,000 (5)
- 1,001 to 10,000 (10)
- 1 to 1,000 (5)