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OPERATION SALAM

COMMITTEE ON ASSISTANCE TO DISABLED AFGHANS

GUIDELINES AND PRIORITIES

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Office of the Co-ordinator for United Nations Humanitarian and Economic Assistance Programmes relating to Afghanistan

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FORWARD

It gives me great pleasure to introduce the "Guidelines and Priorities for Assistance to Disabled Afghans." The Committee on Assistance to Disabled Afghans (CADA) has done a highly commendable job in producing these guidelines. It is now our collective responsibility to ensure that programmes are conceived, based on the guidelines, that will contribute to the resumption of productive lives by disabled Afghans. The Office of the Co-ordinator for United Nations Humanitarian and Economic Assistance Programmes relating to Afghanistan (UNOCA - Operation Salam) is the focal point for implementation on an accelerated basis of these programmes. Responsible UN agencies are WHO, UNICEF, UNHCR, ILO, UNESCO, and UNIFEM among others. These agencies work in close relationship with all the NGOs and PVOs, who have traditionally contributed the sweat and toil that translate research and plans into real achievements.

The Guidelines describe a tragic situation caused by the effects of both war-related disabilities and of crippling diseases such as Polio, TB and Malaria. The guidelines also outline a three pronged approach to deal with the problem. These are 1) Prevention; 2) Medical Treatment and Referral; and 3) Rehabilitation. Currently, all three components are seriously deficient. Afghanistan needs new facilities, skilled medical and para-medical workers, training, and the integration of the few services that do exist. These guidelines provide a blue-print that will set the pattern for our joint efforts on behalf of disabled Afghans. Thousands of children, women and men who need our help to become once again a proud and productive part of a long and free tradition.

With every good wish,

Sadruddin Aga Khan

GUIDELINES AND PRIORITIES

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I. INTRODUCTION

1. Tens of thousands of people have been disabled through heavy injuries suffered during the war. The problem of Afghans with disabilities has been further compounded by the increasing incidence of poliomyelitis, leprosy, tuberculosis, etc., due to the lack of proper environmental sanitation and poor economic and social conditions in the rural and several urban areas. Due to the presence of mines and unexploded ordnance the threat of physical injuries exists for both the internally displaced persons and for the refugees when returning to their village of origin and resuming their normal activities. The types of disabilities most observed are those of amputees and polio. Less noticeable but still present in large numbers are the mentally ill and the visually and hearing impaired as well as the mentally retarded. The problem of mental illness related to the war may be much greater than previously recognized and cannot be dealt with by existing services.

2. The problem of the disabled Afghans has reached a proportion which requires a significant level of assistance from the international community. Given the magnitude of the problem, priority should be given to service development over data collection in an initial stage.

3. The prevailing situation, both in Afghanistan and in the neighbouring countries of asylum, asks for support to the invaluable family care provided to Afghans with disabilities by their own social structures. This support is to aim at a comprehensive approach taking into account all possible measures of social integration. This approach should among other measures promote the understanding that a high number of disabled people can become productive and self-sufficient when they are taught the correct skills. This understanding is not yet common knowledge given the actual lack of facilities to provide people with skills.

4. With forethought and appropriate action many disabilities can be prevented. Afghans with disabilities can be medically rehabilitated and taught skills which they can use both in Afghanistan and in countries of asylum pending their repatriation. Whilst

a great deal of effort has been made in providing medical services, very few organizations have considered the needs of disabled Afghans for skills to enable them to become independent or contributing members of their families and their society. Priority needs to be given to expansion of existing programmes and establishing of new programmes, particularly those covering a wider range of disabilities than dealt with at the moment. In so doing, one should aim at integrating and making accessible to disabled Afghans services for the general population. When this appears impossible or unfeasible, only then should special services be organized. A linkage between existing medical, social, educational and vocational services needs to be developed so that rehabilitation can become a continuous process. In addition, in order to overcome ignorance and prejudice, an awareness campaign needs to be started to encourage Afghans to give their disabled men, women and youths a chance to achieve social integration.

5. In order to achieve these overall objectives, the Co-ordinator has convened a Committee on Assistance to Disabled Afghans (CADA), in which relevant UN agencies, ICRC and NGOs are represented. One of the tasks of this Committee is to establish guidelines and priorities for programmes to assist the disabled Afghans. The present paper deals primarily with the situation in Pakistan and outline the actions to be taken until refugees return home. In Afghanistan, the needs are enormous but it would be premature under the present circumstances to establish priorities covering the whole country. The paper limits itself to mention services for disabled persons which are known to be in operation. The situation is very different in Iran where Afghans have access to public services. A separate document will be issued when services for disabled persons in general and the size of the problem of disabled Afghans will have been assessed through missions and surveys.

6. At present, an imbalance of services exists not only between Afghanistan and the two countries of asylum but also within Pakistan between the registered and the non-registered refugees, between services available in NWFP and Baluchistan, and between women and children on the one hand and men on the other hand. One of the aims of the guidelines and priorities is to assist in the elimination of these discrepancies.

7. The recommended guidelines and priorities will of course require revisions as the situation in Afghanistan and the neighbouring countries changes and more information on the situation and needs of Afghans with disabilities becomes available. Organizations dealing with disabled Afghans should bring to the attention of the Co-ordinator's Office any lacuna or errors noticed in the published guidelines and priorities as well as new services planned or already available for disabled Afghans.

8. The theme of "full participation and equality" for people with all types of disabilities was proclaimed by the UN General Assembly during 1981, the International Year of Disabled Persons. This theme, which also guides the UN Decade of Disabled Persons 1983-92, should guide all programmes which assist disabled Afghans.

9. The purpose of this paper is to provide guidelines to those organizations wishing to involve themselves in providing prevention, treatment and/or rehabilitation services to disabled Afghans, and to indicate to these organizations the priority areas. The paper also indicates the agency(ies) within the UN system whose field of competence covers a particular area.

10. The Committee for Assistance to Disabled Afghans reviews project proposals referred to it by one of its members or received directly from NGOs or other organizations supporting disabled Afghans. The Committee examines whether the planned project or action follows the guidelines and fits into the priorities. This being the case, the proposal is referred to the responsible UN agency which then contacts the organization having submitted the planned project or action in order to finalize the submission and define the technical and/or financial support to be provided within Operation Salam for the implementation of the project. According to its terms of reference, CADA assesses the impact on the situation of disabled Afghans of projects designed to support them.

11. This paper is divided into three parts: prevention, treatment and referral, and rehabilitation. Within each part the recommended guidelines differ, depending on the services already available and the category of disability: locomotor, mental, visual, or

hearing. Recommendations for immediate action refer to the period ending in December 1990. Recommendations for medium-term action refer to the two year period following, i.e., 1991-92.

II. PREVENTION OF DISABILITIES

A. HEALTH EDUCATION

1. Present Programme

The major education programme related to the prevention of disability is the Mine Awareness Programme (MAP) whose aim is to inform all Afghans of the danger posed by mines and ordnance. Special attention is being given to reaching women and children through schools, community centres, clinics, etc. This programme, which is carried out in the refugee villages in Pakistan, is accompanied by the training of personnel under the Mine Clearance Training Programme (MCT) and Medical Aid Training (MAT).

Some public education programmes are in progress within the refugee villages to create awareness about the importance of immunization for children and women of child-bearing age. The impact of these efforts seems to vary a great deal within the villages.

A small number of lady health visitors (female community health workers) within the Basic Health Units (BHU) in the refugee villages have been trained to provide health education to small groups of women. The information provided by the Community Health Workers (CHW) focuses on nutrition and diarrhoeal disease control for children.

Health education programmes in Kabul City use various media to disseminate information for prevention of diseases, including the ones which can cause disabilities. An evaluation of mothers' knowledge about prevention has shown positive results.

Health education has been incorporated into some health care programmes in Pashtu and Dari. The health messages include information on some preventive

measures related to disabilities. However, it is likely that such education programmes have had little priority within many parts of rural Afghanistan during the past few years.

2. Recommendations

Health education programmes which focus on prevention of disabilities should be strengthened along with general health education programmes. The following are priorities for disability prevention:

- awareness of the importance of complete immunization;
- knowledge of proper nutrition, including vitamin A to prevent blindness, and iodine for mothers to prevent mental retardation in children;
- awareness of eye and ear care which can be done in the home to prevent or treat infections.

Immediate Action

- Review existing health education materials used in Afghanistan, and Pakistan to determine what information relates to disabilities.

- Develop materials which are needed to provide education for prevention of disabilities.

- Expand all health education components which already exist in health care programmes. This should be done to include information on prevention of all disabilities.

- Incorporate health education into all existing health care programmes which do not have education components and into all new health care programmes.

- Train women for work in health education because they have greater access to women and children and will have a greater impact than male health educators.

In Pakistan female health visitors should train Afghan women on an out-reach basis. Women would then be able to be trainers in their own communities.

-Increase the involvement of community leaders, community groups, and health and social workers.

Medium-Term Action

- Continue to train women for health education.

-Coordinate health education programmes within all health care programmes for Afghans.

UN Agencies: UNICEF, UNHCR

B. IMMUNIZATION

1. Present Programme

The Expanded Programme of Immunizations (EPI) is extremely important in the prevention of disabilities, especially those due to poliomyelitis but also possible sequelae of measles and tuberculosis. Immunization coverage among Afghans has always been low, owing in large part to the cultural barriers upon access of women (and hence children) to health clinics. The minimum coverage needed in order to prevent epidemics is 80%.

In Pakistan, overall EPI coverage was less than 40% up until 1988. Since then, however, significant progress has been made. A survey in Baluchistan in April 1989 showed that 61% of children aged 12-23 months were fully immunized. Coverage for two doses of tetanus toxoid among women was 70%.

In Iran, a survey in May 1988 showed EPI coverage among Afghan refugee children that varied from 35% in Birjand District to 94% in Qaen District.

In Kabul city, it is estimated that 75% of children aged 1-12 months and 35% of women are fully immunized. The estimated average in other urban areas in Afghanistan is 20% and 10% respectively.

Immunization programmes are also being carried out in the rural areas of Afghanistan by 22 mobile units operating in 13 or 14 provinces mainly in the northern, north-eastern and western parts of the country. Because the programmes are carried out by local organizations and health care programmes without central planning or organization, it is not easy to assess the coverage. Some evaluations have indicated less than 30% coverage.

2. Recommendations

The programmes for immunization inside and outside Afghanistan should be strengthened and expanded. The programmes should be supported by the education programmes referred to above.

Immediate Action

-Increase the training and support of the workers in the BHUs Pakistan to make them more effective in the immunization programme.

-Train and deploy female vaccinators who can work on a mobile basis to provide out-reach immunizations at the village level. This should be done in the refugee setting and inside Afghanistan.

-Increase and organize the participation of religious and political leaders in the immunization campaign.

-Insure that all health care programmes in rural Afghanistan include an immunization programme. This should include the training of female vaccinators and the provision of the necessary medical equipment for immunization in established and future health posts.

-Coordinate all immunization services within Afghanistan to insure maximum coverage throughout the country.

Medium-Term Action

-Continue to strengthen immunization services within all health care services.

-Continue to expand immunization services and to link new services to those already existing.

-Strengthen the system of monitoring and evaluating programmes.

UN Agencies: UNICEF, WHO, UNHCR

C. EARLY INTERVENTION

1. Present Programme

Health care programmes in the refugee villages do not focus on early detection and intervention for conditions which can lead to disabilities. These conditions include eye and ear infections, muscle paralysis and mental disturbance. It is assumed that health services within Afghanistan do not focus on such conditions because of other pressing needs for medical care.

2. Recommendations

Health education programmes should include information which teaches families that something can be done to improve the conditions which cause disabilities.

Immediate Action

-Develop simple written and visual guidelines on early detection and intervention. These should be understandable to families as well as to health workers so that families can learn to detect the early signs of conditions which lead to disabilities and can take appropriate measures to deal with the conditions.

-Community workers in the health and social services, as well as village school teachers, should be taught how to detect early signs of disabling conditions and to support families in their efforts to detect and deal with these conditions.

-In the refugee villages in Pakistan the health care workers at the BHUs and in the community should encourage families to carry out the simple procedures needed to care for eye and ear infections. The BHUs should provide the needed support for medical care of these conditions.

-The health and social workers should also refer children who do not move their legs, or do not walk at the appropriate age, to the orthopaedic workshops which provide braces. Workers should also refer amputees who do not have prostheses to the workshops.

-Health and social workers should refer those with signs of mental illness to the centres which provide psychiatric care.

Medium-Term Action

-Procedures for early intervention in disabling conditions should also be developed within the health services inside Afghanistan. As services for health care and

rehabilitation are strengthened or developed, a system for referrals should also be established.

UN Agencies: WHO, UNICEF, UNHCR

III. MEDICAL TREATMENT AND REFERRAL FOR REHABILITATION

1. Present Programme

In Pakistan there are a variety of hospitals which provide medical services to Afghans with conditions related to disabilities. Many Pakistani hospitals accept Afghan patients. Some of these hospitals provide rehabilitation services for Afghans after they have received medical treatment. There are also Afghan hospitals in Peshawar and Quetta, as well as the ICRC hospital in Quetta. It seems that most people with lower limb amputations are referred from hospitals to centres where they can obtain artificial limbs. Some paraplegics are referred to the centre for people with spinal cord injuries in Peshawar. Two organizations in Pakistan (1 in NWFP and 1 in Baluchistan) operate with a mobile team in order to assess and to screen refugees with disabilities already identified by the BHUs. The organizations refer people to their centres or to other centres where appropriate services can be provided. Three centres in the refugee villages in Peshawar provide medical treatment and follow-up services for people with mental illness. Medical services for eye diseases are extremely limited. The few individuals who receive medical care for eye problems are rarely referred for rehabilitation services because those services are also very limited.

In Kabul there are a variety of medical services which are available to people with disabilities. The Training Hospital Ali Abad with the Faculty of Medicine and the hospitals of the Public Health Ministry (especially the Wazir Akbar Khan Hospital, Jamhuriat Hospital, the Noor Institute and the Institute of TB for Women) provide medical care for conditions related to movement, seeing, hearing and mental disabilities. Similar care is available in the Army and Police Hospitals. The Child Health Institute provides services for children with various types of disabilities. Since 1988, there is also a surgical hospital and an orthopaedic workshop run by ICRC.

In the provinces the hospitals of the Public Health Ministry provide medical services for people with conditions related to disability. These include the hospitals in Mazar-i-Sharif, Kunduz, Jawzjan, Herat, Parwan, Kandahar and Helmand.

2. Recommendations

Immediate Action

-Improve present procedures for the assessment and screening of people with disabilities at present living in Pakistan by reinforcing the existing mobile teams as well as by strengthening the links and cooperative efforts between the BHUs, the mobile units, and other professionals working in the refugee villages.

-Medical services for people with eye diseases or visual impairments should be developed. Services are needed at all levels, from care of infections to surgical treatments for trachoma and cataracts. These services are needed in the refugee villages, but must also be incorporated into the development and strengthening of services inside Afghanistan.

-Expand and strengthen medical services for people with mental illness. This should include an emphasis on psychological and social support, not just on medication.

-Prepare and maintain a list of rehabilitation services. The list can be given to medical personnel so that they know what rehabilitation services are available and they can make appropriate referrals.

Medium-Term Action

-The development and strengthening of all health services for Afghans should include a system for care of those with conditions related to disabilities, including musculoskeletal problems, eye and ear conditions, and mental illness.

UN Agencies: WHO, UNICEF, UNHCR

IV. REHABILITATION

A. ACTIVITIES OF DAILY LIVING

1. Present Programme

In the refugee villages in Pakistan there are some rehabilitation services available for people with locomotor or visual disabilities. The major types of locomotor disabilities for which services are available are amputations, polio, and spinal cord injury. Six organizations provide artificial limbs primarily for people with lower limb amputations, and braces for children with polio. Some of these organizations have physical therapy assistants who provide training in the use of the appliances. In Peshawar a rehabilitation centre for people with spinal cord injuries accepts approximately 50 Afghans. Wheelchairs and braces are provided for those who need them. Two organizations produce wheelchairs from materials available locally, one in Peshawar and one in Quetta. Two organizations try to provide services for people with other types of locomotor disabilities, such as cerebral palsy. These services consist of advice from physical therapy assistants for exercises or functional activities. However, the staff of these two organizations spend most of their time either with children who have polio or with amputees. Also, there is almost no follow-up or support to the family to continue a rehabilitation programme. One organization provides training for blind people in activities of daily living and mobility.

In Kabul the rehabilitation services also focus on locomotor and visual disabilities. There are two centres which provide artificial limbs and braces, as well as physical therapy services. People with other types of locomotor disabilities, especially children with cerebral palsy, can receive physical therapy services in two additional hospitals.

Any rehabilitation services which were available some years ago outside Kabul have most likely been disrupted. At present one organization has established an orthopaedic workshop in Herat Province to provide artificial limbs and braces along with physical therapy services.

2. Recommendations

The development of manpower is needed for strengthening the present rehabilitation services and developing additional services. Afghan personnel should be trained for services wherever they are located, and for carrying on the services under a national plan after political stability is established.

Immediate Action

-Keep health, education, vocational and social workers informed about available rehabilitation services so that appropriate referrals are made. The list of services recommended above for medical personnel should be distributed to all organizations or agencies with personnel who may come in contact with people with disabilities.

-Train additional prosthetists and orthotists for work both in rural and urban areas inside Afghanistan and link those services with other health care services being established inside the country.

-Provide additional training for the present and new physical therapy assistants so that they can assist more people with different types of locomotor disabilities.

-Train additional community workers who train blind people in activities of daily living and mobility.

-Initiate training of personnel to develop rehabilitation programmes for people with mental illness.

Medium-Term Action

-Develop a training programme for a mid-level rehabilitation worker who will be a link between national and local rehabilitation services for people with locomotor, mental, seeing and hearing disabilities.

UN Agencies: WHO, UNHCR

B. EDUCATION

1. Present Programme

Within the refugee villages of Pakistan there are no special provisions for education of children with disabilities. Social workers within the refugee villages have encouraged families to send their disabled children to the regular schools. However, the limited number of social workers means that few families have been contacted and among those very few have actually sent their disabled children to school.

In Kabul there is one school for about 110 blind children who are educated according to the regular school curriculum.

It is customary throughout Afghanistan to train boys who are blind to memorize the Koran. They then serve as resources to their communities for prayers and religious services.

2. Recommendations

Immediate Action

-All community-services workers who come in contact with disabled children and their families should encourage the families to send their children to school. Emphasis should be placed on the children with locomotor disabilities, such as polio or amputation, and children with seeing disabilities because they can easily benefit from the instruction provided in the regular school.

-Organizations currently providing assistance for primary education in the refugee villages and in rural Afghanistan should provide information on disabilities for all teachers so that they understand the limitations and abilities of children who have disabilities.

Medium-Term Action

-Develop content and methods of education which are meaningful to all Afghans in order to motivate families to send all children to school. Within this context, stress access to education for disabled children and aim at adaptation of educational facilities to the needs of these children.

-Incorporate basic concepts of special education in the teacher training programmes so that all teachers are prepared to accept children with disabilities into their classrooms.

UN Agencies: UNESCO, UNHCR

C. VOCATIONAL REHABILITATION, SKILLS TRAINING AND EMPLOYMENT

1. Present Programme

Several skills training programmes for Afghans in the refugee villages in Pakistan have included disabled men among their trainees. One of the skills training projects, Quetta, has as its aim to integrate up to 10% of disabled persons among its student population. These would be disabled males who do not require special adaptations.

Three NGOs in Quetta have included one or two disabled men within income-generating programmes. One of these organizations trains wives of disabled husbands if the latter are too severely disabled to be gainfully employed.

Three other NGOs in Peshawar provide skills training for a very small number of disabled persons. One of these organizations runs a training and production programme for able-bodied Afghans, but also include a few disabled men. One offers a small training programme for the visually handicapped in mobility and orientation, activities of daily living and in vocational skills training. A third organization runs a training course in office skills for men with low limb amputations.

In Kabul the Ministry of Technical and Vocational Education operates vocational training centres for able-bodied men. There have been discussions on integrating disabled men into these programmes, but current information on this is not yet available.

2. Recommendations

Immediate Action

-Encourage and facilitate the integration of disabled persons within existing skills training programmes for able-bodied Afghans. (This strategy would make immediately accessible to more disabled Afghans, a broader availability of regular training resources.)

-Develop a vocational training and employment resource unit or team whose function will be to provide technical advice on integrating the disabled within regular skills training programmes. (This strategy will also result in ensuring assistance to other disability groups, e.g. deaf, blind.)

-Develop a variety of skills training programmes for disabled Afghans within Afghanistan, including skills aimed at self-employment and small enterprise development.

Medium-Term Action

-Develop skills training programmes for disabled youth, disabled women as well as for widows and wives of severely disabled men.

-Assist in the planning for the creation of income-generating activities within Afghanistan for disabled persons (self-employment, cottage industries, small enterprises, etc.)

-For the severely disabled, provide training and employment adapted to their capacities, under sheltered conditions (e.g. for mentally ill, mentally retarded, etc.)

UN Agencies: ILO, UNHCR

D. SOCIAL INTEGRATION

1. Present Programme

The presence of disability among Afghans in refugee villages as well as within the country demands not only immediate action to address basic needs for survival, mobility, and daily living, but also a medium-term strategy to facilitate long-term integration into community life.

Social integration is based on the concept that despite the limitations caused by certain disabilities, individuals affected can use other strengths and capabilities in order to participate in the activities of their families and communities. Social integration is the most crucial part of the process of rehabilitation because it means that disabled people are encouraged to fulfil useful roles in society. However, the process of social integration can take a long time for some disabled people, and it requires the co-operation and understanding of all concerned.

Traditionally, the family unit bore the main responsibility for the disabled people in Afghanistan. The community accepted disabled members in the context of their families. Since the onset of the war the magnitude of the problem, combined with a breakdown in health infrastructure, has outstripped the capacity of the family and the community to meet the needs of dependent people with disabilities. What is needed at this stage, in addition to building up of treatment and rehabilitation services, is the mobilization of other elements in the community, such as schools and places of work, to encourage communities to accept and accommodate the disabled in their on-going activities. Similarly, families sheltering the disabled need to be reassured of the merits of social integration.

Encouraging social integration through various channels motivates the disabled person; reduces the emotional, financial and moral burden on the family; and also contributes to the productivity of the community and the society as a whole.

2. Recommendations

Immediate Action

-Develop a public awareness campaign to inform and sensitize all Afghans about the capabilities of disabled people, and to change existing attitudes so that families and all community members promote the following:

i) The maximum participation of disabled adults in productive, gainful economic activities.

ii) The attendance of disabled children in the normal schools and vocational services where possible.

-Promote these two concrete pre-requisites for successful change in current patterns and practices related to the disabled:

i) Ensure that vocational programmes are available to the disabled.

ii) Adapt school structures to facilitate access for disabled children.

Medium-Term Action

-Incorporate the concept of social integration into the curricula for training of various kinds of community workers, whether they be health care workers, traditional birth attendants, village-level school teachers, or rural development workers. A limited effort at this stage could have a long and far reaching impact.

-Continue to develop strategies and programmes needed to help traumatized families and communities to develop positive attitudes toward the disabled and to promote the social integration of their disabled family and community members.

UN Agencies: All UN Agencies assisting disabled Afghans

V. GENERAL RECOMMENDATIONS

1. All projects for disabled should aim at one goal: the full integration of disabled Afghans into their communities, giving them opportunities equal to those enjoyed by able-bodied Afghans.

2. The basic priority is to enable disabled Afghans to receive assistance as needed within the ordinary structures of training, education, health, social and income-generating activities. When this is not feasible, rehabilitation and supportive programmes should enable Afghans with disabilities to have access to such ordinary services. Only when this appears impossible should special services be organized for disabled Afghans.

3. Due to socio-cultural constraints, Afghan women in refugee villages have limited access to health and social services. In terms of both prevention and rehabilitation of disabilities, access to women is evidently a vital key. All project proposals concerning disabled Afghans in Pakistan must address this issue specifically and explicitly.

4. All preventive and rehabilitation services should include an outreach component. An appropriate proportion of the operational and managerial staff in such services should be women.

5. Afghan women must continue to be trained as community services and health workers, traditional birth attendants, educators and vaccinators. Such training must in large part be effected by women and on an outreach basis.

6. All proposed projects should take into account the present needs of Afghanistan. They should be planned to be implemented in Afghanistan even if they have to be initiated in a neighbouring country.

7. Any project implemented in Afghanistan should be linked with existing structures or institutions. Where required, these institutions should be reinforced, with the view that they will eventually assume alone the responsibility to run the services.

8. Many of the recommendations in this paper are for education aimed at prevention and for early detection and treatment of conditions which cause disabilities. Emphasis is placed on these measures not only because they are important but because there are structures in place both in Pakistan and inside Afghanistan which can immediately be strengthened in order to prevent disabilities. Prevention of disabilities will decrease the social and economic strain which disabilities can cause for families and communities.

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List of acronyms

BHU	Basic Health Unit
CADA	Committee on Assistance to Disabled Afghans
CHW	Community Health Worker
EPI	Expanded Programme for Immunization
ICRC	International Committee of the Red Cross
ILO	International Labour Organisation
MAP	Mine Awareness Programme
MAT	Medical Aid Training
MCT	Mine Clearance Training
NGO	Non-Governmental Organization
NWFP	North West Frontier Province
TB	Tuberculosis
UN	United Nations
UNESCO	UN Educational, Scientific and cultural Organization
UNHCR	Office of the UN High Commissioner for Refugees
UNICEF	UN Children's Fund
WHO	World Health Organization

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