INTERNATIONAL YEAR OF THE DISABLED

report by

The United Nations High Commissioner for Refugees in Thailand

related to

Programmes of Assistance concerned with Rehabilitation and Intervention for Handicapped/Disabled Refugees and Their Accompanying Family Members in Thailand

Bangkok, 1981

U.N.H.C.R. Regional Office for Western South Asia
Medical Unit

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INTERNATIONAL YEAR OF THE DISABLED

United Nations High Commissioner for Refugees

Programmes of Assistance concerned with Rehabilitation and Intervention for Handicapped/Disabled Refugees and Their Accompanying Family Members in Thailand

I. Introduction

The activities of U.N.H.C.R. in relation to handicapped refugees has traditionally taken two main forms:

1. Special resettlement schemes or temporary movement (duration of treatment) to countries where the complex rehabilitation needs of handicapped refugees can be adequately addressed and attended to, and

2. Development of specific on site programmes of assistance, treatment and rehabilitation services which are implemented through voluntary agencies on the behalf of handicapped individuals and their accompanying family members. The purpose of which is to accommodate, facilitate and support the integration of handicapped/disabled refugees into becoming maximum functioning, productive and independent members of their respective social and cultural communities, while waiting for a durable solution to their present situation as refugees.

In regards to the refugees in Thailand, it has been said (and is certainly self-evident) that they are among the best-cared-for of the world's displaced persons, especially concerning health care. However, as the work with refugees is relief oriented the form and type of assistance (in this case rehabilitation) that is implemented and actualized is not as comprehensive as one would find in another setting.

It is the purpose of this report to give the reader a brief overview of the present aspects of services and programmes currently being carried out and made available for handicapped individuals residing in the refugee camps and holding centres in Thailand.

Due to the complexity and vastness of the work being performed by numerous individuals, voluntary agencies and international organizations, it is not possible to include everyone's contribution into a report of this nature. However, a note of commendable praise and thanks is extended to The Supreme Command, The Ministry of Interior and the members of the Committee for Coordination of Services to Displaced Persons in Thailand

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(CCSDPT) without whose cooperation, support and most of all activities, the type of programmes outlined within this report would not have been possible.

II. Definition of Terms

An understanding of the concepts of impairment, disability and handicap and of the relentless escalation from one to the other is necessary in planning efforts directed towards both prevention and rehabilitation. For this purpose, WHO in its revised policy on disability, prevention and rehabilitation has defined these concepts as follows:

Impairment	"A permanent or transitory psychological, physiological or anatomical loss or abnormality of structure or function."
Disability	"Any restriction or prevention of the performance of an activity, resulting from an impairment, in the manner or within the range considered normal for a human being."
Handicap	"A disability that constitutes a disadvantage for a given individual in that it limits or prevents the fulfilment of a role that is expected at a particular time in ones life."
Rehabilitation	"The combined and coordinated use of medical, social,educational and vocational measures for treatment and training (retraining) the individual to the highest possible level of functional ability."

In reference to these definitions the following clarifications can be made:

1. An impairment may be a missing or defective body part, an amputated limb, paralysis, restricted pulmonary capacity, partial or total loss of hearing or eyesight, mental retardation, mongolism or psychiatric illness (organic or functional).

2. Disabilities as a result of an impairment involve difficulties in walking, seeing, speaking, hearing, lifting or taking an interest in and/or making appropriate contact with ones surroundings. Just as impairments may be permanent or transitory, a disability may last for a short or long duration of time, may be permanent, transitory or reversible, may be progressive or regressive and may vary in its impact from the demands of one situation to another.

3. A disability becomes a handicap when it interferes with ones ability to take care of oneself (activities of daily living).

Based on the above definitions, it can be concluded, that any person who suffers from a physical or mental defect that interferes to a great degree with the normal capacity of the individual to perform daily functional activities can be classified as handicapped.

A general categorization (representative) of those individuals who should be regarded as severely handicapped and in need of special consideration and follow-up can be outlined as suffering from the following:

- Amputation
- Blindness
- Cardio Vascular Accident (stroke)
- Leprosy
- Mental retardation
- Mongolism (Downs syndrome)
- Orthopedic complications
- Paraplegia
- Poliomyelitis (Post)
- Psychiatric illness

4. Rehabilitation A planned programme in which the convalescent, disabled or handicapped person progresses towards, or maintains the maximum degree of physical and psychological functional independence of which he or she is capable.

Within the context of relief work a programme for Physical Rehabilitation entails a combination of services which include physical therapy, provision of artificial limbs and/other ambulatory devices, vocational/skills training and a unifying social service component.

III. Survey

During the latter part of 1980 and first months of 1981 UNHCR Social Services in conjunction with the on site medical/public health personnel completed an initial general needs survey of handicapped individuals and their accompanying family members within the refugee camps/holding centres in Thailand.

This survey was conducted for the purpose of planning and implementing a comprehensive programme for provision of restorative/ rehabilitation services and preparing dossiers 1/ on specific handicapped cases for resettlement submission purposes.

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1/ documented cases/caseload statistics Appendix I.

The implementation and operation of this specialized programme was conceived and developed by utilizing existing medical/educational infrastructures in conjunction with the setting up of physical therapy units and prosthetic workshops in camps where a need had been indicated (certain sites are visited by a mobile physical therapy/prosthetic unit).

In close association with the above was the establishment of community based social welfare services which include handicap follow-up as part of their overall programming efforts. Further to this,a team of visiting field rehabilitation counselors ensure that the handicapped individuals needs related to activities of daily living are appropriately addressed, thus, preventing further debilitation and providing assistance in securing a resettlement offer or other appropriate alternative.

IV. Purpose

Access to field coordinated rehabilitation efforts and services enables handicapped individuals and their accompanying family members to adapt as well as possible to adverse physical and/or mental impairments, disabilities, or severe handicaps.

Outreach rehabilitation programmes are designed to assist severely handicapped individuals who require therapeutic intervention and follow-up, whether it be medical, vocational/educational or resettlement orientated. The coordination of rehabilitation services as has been mentioned, is achieved by using existing camp infrastructures (i.e. out patient clinics, hospitals, physiotherapy/prosthetic units, primary and secondary education programmes, adult literacy courses, language or vocational skill training centres) in conjunction with referral to district and provincial health facilities (Thai).

The following sample gives an overview of the types of services that are included in this comprehensive programme for handicapped refugees: physical therapy, provision of calipers, braces, special shoes and prosthesis, hospitalization with extensive nursing care, evaluation and treatment for mental illness (with psychiatric consultation), vocational training, and other specialized education or training.

To be more specific the type of intervention listed below assists in producing the following changes:

1. Physical Therapy

- Arrests muscle atrophy in post polio and paralysis, if applied as soon as possible after onset;
- Increases range of motion for all limbs;
- Gait training for amputees.

2. Ambulatory service

   - Gives mobility and agility to those formerly trapped by their disability. The psychological benefits and social outlets increase. The person regains mobile independency.

3. Mental health

   - Consultation and treatment can prevent the labeling of those who are experiencing transient stress reaction and/or depression. For those who are chronically and/or congenitally ill, treatment can be pursued thus stabilizing the condition.

4. Medical investigation/hospitalization

   - Can prevent further deterioration in cases of acute and chronic illnesses (e.g. heart disease).

5. Education and skill training [2/]

   - Provides for or rejuvenates lost working capacities while giving an individual back a vocation and the ability to be self sufficent and independant while increasing ones self esteem.

V. Systems Approach (3 types)

Various factors have contributed to the determination of the type of rehabilitation systems approach, which would be considered the most appropriate for the delivery and establishment of rehabilitation programming for the Laotian, Kampuchean and Vietnamese refugees in Thailand.

Three systems were developed in relationship to the existing infrastructures (medical, educational, skills training, etc.) as well as to the specific criteria that has been set for certain groups of refugees by various decision making bodies, concerning resettlement or repatriation.

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2/ An overview of the types of existing education/skills training programmes can be found in Appendix II.

These approaches are outlined as follows:

1. CLUSTERING and movement of handicapped refugees and their accompanying family members to a facility which offers a more comprehensive level of care. 3/

Aranyaprathet Laemsing Lumpuk Sikhiu Songkhla	Vietnamese & Old Khmer Refugee Camps Population as of 31 August 1981 3,496

2. AUGMENTING existing camp infrastructures with on-site physical therapy/prosthetic units and community based social service programmes. 4/

Ban Kaeng Kab Cherng Kamput Khao I Dang Mairut Panat Nikom Holding & Transit	Kampuchean Holding Centres Population as of 31 August 1981 113,369

3. PROVIDING mobile prosthetic and physical therapy services as well as rehabilitation counselors to provide adequate coverage. 4/

Ban Nam Yao Ban Tong Ban Vinai Chiang Kham Nongkhai Sob Tuang Ubon	Laotian & Hill Tribe Refugee Camps Population as of 31 August 1981 81,863

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3/ These camps are included in a specialized programme of clustering handicapped individuals and their family members in Panat Nikom Holding Centre. A copy of the operational guidelines for this programme can be found in Appendix III.

4/ A breakdown of the services offered and the voluntary agencies taking responsibility is outlined camp/centre by camp/centre in Appendix IV.

VI. STAFFING (UNHCR)

Presently, there are seven (7) locally recruited professional officers (two (2) Mental Health Consultants, five (5) Rehabilitation Counselors) secunded to UNHCR's Rehabilitation Unit and funded by a French based voluntary agency The Sovereign Order of Malta (SOM) for the duration of the INTERNATIONAL YEAR OF THE DISABLED.

These individuals work together with UNHCR's Assistant Welfare Officer/Coordinator of Programmes for Rehabilitation of Handicapped Refugees under the direction of UNHCR's Senior Health Coordinator.

These individuals provide personnel for two types of coordinating programmes:

1. Provision of Rehabilitation Counselors on a periodic basic to all Refugee Camps and Holding Centres in Thailand 5/

   Their duties are directed towards the effective integration and development of individual service oriented programmes for and on the behalf of the handicapped refugees:

   a) Their specific tasks are carried out in conjunction with camp physicians with a view to determining the level of care required, the immediacy of implementation and best plan of action.

   b) In addition they are concerned with preparation of dossiers 6/ for the resettlement section of UNHCR for submission purposes. After the completion of the dossiers the Rehabilitation Counselor follows-up the handicapped individual and his family to encourage optimum utilization of the existing medical, educational and social care programmes.

   c) This involvement in outlining a treatment plan and initiating a programme for recovery, adaption (stabilization) or rehabilitation and continuing health is performed by the Rehabilitation Counselor to ensure that the handicapped refugee's needs related to rehabilitation and activities of daily living are appropriately met.

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5/ The job description for Rehabilitation Counselors is attached in Appendix V.

6/ An explanation of the format for documentation and follow-up concerning the severely disabled can be found in Appendix III pages 17, 18, 19, 24 and 25.

2. A Consultant Mental Health Component [7/]

This programme seeks to examine and evaluate the mental health needs of refugees while identifying and mobilizing available resources. A contribution is being worked out in collaboration with the many existing agencies.

This specialized effort offers active support and where required training for voluntary agency staff who are called upon to provide services to the mentally disturbed. In addition to this, an attempt is being made to reduce the general level of anxiety within specific camps by constituting methods for improving the flow and reliability of information available to refugees.

VII. Conclusion

It has been the purpose of the work outlined within this brief report to identify, coordinate and initiate special on-site/outreach programmes to adequately provide for and address the needs of the severely handicapped residing in the numerous refugee camps/holding centres in Thailand.

Although all programmes of assistance for refugees,the world over, can be considered rehabilitative in character and design, we should bear in mind, the seriously damaging effects and exposure to undue hardship, prolonged confinement in camps, can have particularly on handicapped individuals. In relationship to this, it is important from a humanitarian point of view, that a continuous effort and vigilance be observed to ensure that the special needs and requirements of handicapped refugees are not overlooked. As 1981 has been designated The INTERNATIONAL YEAR OF THE DISABLED and inconjunction with this, special efforts and programmes of assistance have been developed, it is hoped that 1982 will not bring any less concern for the handicapped/disabled refugees residing in Thailand.

7/ The job description for a Mental Health Consultant can be found in Appendix VI.

RWS/pp
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DOCUMENTED CASES/CASELOAD STATISTICS [A/]

Breakdown by CAMPS

CAMPS	CASES	PERSONS
Aranyaprathet	5	16
Ban Nam Yao	36	203
Ban Tong	15	76
Ban Vinai [B/]	113	452
Chiang Kham	4	9
Laemsing	6	10
Lumpuk	7	24
Nongkhai	44	208
Sikhiu	4	23
Sob Tuang	29	185
Songkhla	39	99
Ubon	34	143
TOTAL	336	1448

Breakdown by DIAGNOSIS

DIAGNOSIS			CASES	PERSONS
Amputation			65	201
Break down by type: upper extremity	12	41		
Break down by type: lower extremity	48	140		
Break down by type: double lower	5	20		
Blindness			40	197
Cerebral Palsy			8	42
Cardio Vascular Accident (CVA)			13	78
Deafness			13	69
Leprosy			54	159
Mental Retardation			11	64
Mongolism (Downs Syndrome)			5	38
Mute			7	41
Orthopedic Complications (inclusive of Osteomyelitis)			12	49
Paraplegia			7	33
Poliomyelitis (inclusive of Muscular Dystrophy, Talipes, etc.)			49	261
Psychiatric Illness (inclusive of Epilepsy)			19	63
Others (i.e. Dwarf, Albino, Burns, multiple Sclerosis, etc.)			16	69
Multiple (any possible combination of above i.e. a deaf retarded leper who has a cleft palate)			17	84
			336	1448

A/ Severely handicapped/disabled individuals within the Kampuchean Holding Centres although receiving treatment and rehabilitation related services have largely been left undocumented (refer to page 5 section V paragraph 2 and page 6 paragraph 2 of this report for a clarification of this issue). However, the following statistics/facts are worth mentioning:

- 92 individuals with a diagnosis of leprosy (i.e. lepromatous, indeterminate or tuberculoid) from Khao I Dang and Ban Kaeng are being treated and followed up by a lepromologist from Malteser-Hilfsdienst Auslandsdienst E.V. (M.H.D.)

- The Catholic Relief Services (CRS) Rehabilitation Unit in Khao I Dang among other therapeutic activities records 140 - 160 visits per week by patients requiring physical therapy, gait training and other various ambulatory services.

- S.O.S. Enfants Sans Frontiers (SOS/ESF) Prosthetic Services reports that since their inception on 15 August 1980 they have provided and fitted 319 prosthetic devices to needy handicapped individuals in the Holding Centres, Aranyaprathet Hospital as well as on the Thai - Kampuchean border.

B/ Ban Vinai case statistics are based on a preliminary screening by a public health nurse in conjunction with the rehabilitation programme being operated by the Sisters of Charity. This figure includes 54 individuals suffering from Leprosy and residing communaly with their families. Compilation of initial documentation/treatment plans are presently being conducted.

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OVERVIEW - TYPES of EXISTING EDUCATION/SKILLS TRAINING PROGRAMMES.

A. Education and Culture

1. Pre-school Programmes - currently operating in all Kampuchean, Lao and Hill tribe refugee camps.

2. Primary Education Programmes - currently operating in all camps with the exception of Vietnamese camps. 1/

3. Adult Literacy - in all camps with the exception of Vietnamese camps.

4. Secondary Education - Kampuchean camps only.

5. Teacher training programmes - in all Kampuchean and Laotian camps.

6. Technician training - physicaltherapy assistants, prosthetic technicians/assistant nurses, paramedics, parasocial workers, etc.

7. Foreign language training (English/French) and cultural orientation - participants are those who are deemed likely to resettle in third countries.

8. Library and reading rooms - all Kampuchean, Lao and Hill tribe camps.

B. Skills training

The following skills training activities are performed in most camps with the exception of the Vietnamese camps.

1. Agriculture
2. Architectural drawing
3. Bamboo (furniture & Basketry)
4. Barbering
5. Bakery
6. Blacksmithing
7. Carpentry
8. Cement water jar making
9. Chicken farming
10. Clay pot making
11. Embroidery
12. Basic electricity

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1/ High rates of Resettlement from the Vietnamese camps has prevented

13. Fish farming
14. Fish net weaving
15. Gas welding
16. Gardening
17. Home economics
18. Knitting and crochet
19. Mat weaving
20. Mechanics (automotive and small engine repair)
21. Metal work
22. Musical instruments (traditional)
23. Noodle making
24. Pig farming
25. Pottery
26. Silk and cotton processing
27. Shoe repair
28. Soap making
29. Tailoring (hand and machine)
30. Seamstress (hand and machine)
31. typing
32. Weaving
33. Wood carving.

Note :

Special efforts are made by community based social workers and rehabilitation counselors to enroll handicapped individuals and their accompanying family members into appropriate existing programmes.

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Clustering of handicapped/disabled refugees and their families from Aranyaprathet, Lumpuk, Laemsing, Sikhiu and Songkhla Refugee Camps within the Panat Nikom Holding Center to facilitate their eventual resettlement and provide medical and rehabilitation services to prevent further debilitation.

- Operational Guidelines -

I. Introduction

In addition to the typical psychological stresses and physical demands which the flight to freedom and safety imply, handicapped individuals bear atrophied limbs or missing appendiges, suffer from blindness or paralyses or carry defective hearts.

Ironically, once these people reach first asylum countries they soon discover that, due to stringent immigration and health regulations of the countries of resettlement, they face long and arduous periods of waiting, prior to receiving a resettlement offer. In relationship to this, experience has shown that atypical attention and intervention is required if proper medical/rehabilitation care and resettlement goals are to be realized.

Since February 1981 a Rehabilitation/Field Officer attached to UNHCR's Social Services has periodically visited the above mentioned camps. His task has been carried out in conjunction with camp physicians with a view to determining the level of care required, and desirability for placement of a specific cases in the Handicap Processing Centre (HPC) located at Panat Nikom Holding Centre. The HPC was created to provide comprehensive medical/rehabilitation follow-up to prevent further debilitation while facilitating the resettlement of severely handicapped refugees. (see Appendix I).

For the latter portion of 1981, the following guidelines will serve to maintain effective referral and transfer of handicapped individuals and their family members to the Handicaps Processing Centre in Panat Nikom.

These guidelines are formulated into a step by step process while although pedantic, will lessen the chances of confusion and misapplication. A flow chart (appendix II) which describes the process in graphic form is presented for the convenience of the reader.

A note of thanks is extended to the Ministry of Interior and the Supreme Command of Thailand without whose support this programme would not have been possible.

II. Case Identification and Referral

This initial process is indepensible and without a comprehensive screening procedure, some appropriate referrals will remain untreated or their treatment and follow-up will be significally delayed. Handicapped individuals (both physical and mental handicaps) are initially identified by medical personnel, refugee camp leaders, section leaders, field resettlement interviewers, teachers, and other voluntary agency personnel.

Once a severe case has been initially identified, they should be presented to the camp physician in-charge for assessment, treatment and follow-up.

The medical personnel often can and should act as catalysts in an ongoing identification process. Assessment of new arrivals is the most comprehensive form of screening. Even if immediate attention is not possible, the individuals in question can be given appointments for their clinical examination at a more convenient time.

The selection criteria for placement of a specific case in the Handicap Processing Centre is based on a need for one of the following:

1. Specialized medical consultation, investigation, treatment and/or isolation (leprosy, malignant cancer, diabetes mellitus, osteomyelitis, psychiatric illness, heart disease, etc.)

2. Advanced diagnostic techniques requiring detailed documentation and/or treatment in connection with obtaining medical waivers pertaining to immigration/ health regulations (mental retardation, mental illness, mongolism, epilepsy, non-infectious leprosy, ect.)

3. Medical and health related services not available in camp clinics (physiotherapy) or additional ambulatory aides which require individual fitting (artificial limbs, breeches or calipers).

4. Handicapped cases which, although not in need of medical treatment or services, face undue hardship as a result of their inability to perform basic daily activities (blindness, elderly persons who are alone and susceptible to diseases, unaccompanied minors with mild handicaps i.e. blind in one eye, loss of fingers, etc.)

Once a case is selected, the medical officer in the camp must conduct a clinical examination (appendix III). At that time, related data must be gathered according to the above mentioned form. This information should be sent to the Assistant Welfare Officer, Social Services, UNHCR Bangkok.

Upon receipt of the clinical narrative, an officer of UNHCR Social Services will notify the relevant medical personnel and make arrangements for the movement of the selected handicapped individuals and their family to Panat Nikom. Further to this, the embassies of resettlement countries that have files opened on individual cases will be informed of the handicapped person's condition and forthcoming movement to a new location.

Prior to departure from the camp, sufficient time and effort should be spent counselling the handicapped individual and his family to encourage optimum understanding and utilization of the medical/health/ social care programme which has been established in conjunction with the

general resettlement programme. It is imperative that those scheduled for movement understand the nature and purpose of their transfer. Also, to ensure uninterrupted medical follow-up, it is suggested that these individuals approach the medical section for consultation at their earliest convenience, after arrival in Phanat Nikom.

The hospital personnel should also be reminded that handicapped individuals who are on medication should come to Panat Nikom with a 10 to 12 days' supply. In addition, individuals should bring their out-patient treatment cards (camp clinic) and x-rays (if available) so that the receiving physician will be able to follow-up accordingly.

III. Movement

Movement of handicapped individuals and their families from the camps to Panat Nikom is monitored by the UNHCR office. Generally speaking, movement is arranged and carried out through normally selected channels with emergency cases being an exception. A nurse, if required, will be assigned from the voluntary agency in the camp who is taking responsibility of medical coverage.

IV. Panat Nikom

Panat Nikom Holding Centre is located 19 kilometers from the town of Panat Nikom. It can be reached from Bangkok in appropriately two hours time. The camp provides the following facilities/services which are available to handicapped persons and their families: outpatient and hospitalization services, dispensary, examination, treatment rooms, dental office, rehabilitation center (with physical therapy and prosthetics), children's playgrounds, language and skills training facilities, schools, primary education, adult literacy training, etc.

V. Arrival

New arrivals are registered and assigned housing in close proximity to the rehabilitation unit and other medical/health facilities. The handicapped individuals and their family members are assisted in registering for educational, skills, and/or languages classes. In addition, they are registered with the OPD and consequently with rehabilitation personnel soon after arrival.

VI. Medical

Catholic Relief Service coordinates the OPD and rehabilitation efforts at Panat Nikom while COERR is responsible for inpatient treatment. Rehabilitation personnel receive a copy of the detailed clinical assessment which was compiled prior to movement of the handicapped individual to Panat Nikom.

Handicapped cases which have no need for further investigation but require maintenance therapy are followed up by the camp medical team. This would include cases of poliomyelitis, which are treated with physiotherapy.

Handicapped persons who require ambulatory aides are referred by the physician-in-charge to CRS rehabilitation which prepares and supplies on a case by case basis, artificial limbs, braces, orthopedic shoes, lifts, etc.

Handicaps who require advanced in-patient services such as those offered in a general hospital setting are referred for specialist consultation and treatment in Chon Buri or Bangkok. Psychiatric consultation is available in the camp itself, but some cases are referred to Bangkok if the condition indicates just such a need.

Exceptionally severe medical/handicapped cases are submitted to various countries of resettlement for intervention and expedition. Countries that have already guaranteed acceptance are requested to expedite departure on medical gounds if long-term comprehensive therapy for a particular disease/illness is indicated.

Medical Waivers

Individuals with specific illnesses (psychiatric, leprosy, tuberculosis) are required by immigration/health regulations of some sponsoring countries (i.e. USA, Canada, Australia) to obtain a medical waiver prior to departure. The physician-in-charge of pre-embarkation medical screening and processing generally treats these conditions which require obtaining a medical waiver and, if necessary, facilitates any supplementary action.

Psychiatric illness, on the other hand, proves to be more difficult and requires documented treatment which must indicate stability and improvement over a period of one year in some cases before a medical waiver will be issued.

In order to obtain a medical waiver for psychiatric illness, the rehabilitation officer or the resettlement officer will have to coordinate communication between the referring physician, the consultant psychiatrist, the physician-in-charge of pre-embarkation medical screening and the immigration health authorities of the accepting country.

Psychiatric cases are periodically reviewed for assessment and continuation of maintenance therapy by the consulting psychiatrist in the camp.

The information obtained from the above-mentioned medical consultant should be submitted on a tri-monthly basis to the relevant resettlement/health authorities. This information, accompanied by any other available descriptive documents will be of great assistance to the concerned parties when determining status of waivers for psychiatric cases.

Dossiers

Detailed dossiers for submission/resettlement purposes are prepared on every handicapped individual and his family. These dossiers are based on a medical model and are divided into four sections which contain the following information:

Subjective (from the handicapped person and accompanying family members)

- handicapped individual accompanied by whom, relationship, age.
- resettlement status
- other relatives in refugee camps in South East Asia
- overseas addresses of relatives
- education, employment, special skills, languages, etc., of accompanying family members
- additional information

Objective (examination by the referring physician)

- history and development of the illness
- laboratory findings
- clinical impression/assessment
- diagnosis/prognosis
- proposal for treatment and rehabilitation

Assessment (by the rehabilitation officer in consultation with the camp physician)

This portion is an evaluation of the above two sections to determine the level of care required and type of medical/health/social services that should be implemented, (isolation for leprosy, ambulatory services, medical expedite, psychiatric consultation, foster family placement in the camp for handicapped unaccompanied minor, referral for further investigation and treatment, surgery, etc.)

Plan (by the rehabilitation officer)

This portion lists in detail the necessary action required in order to fully implement the services outlined in the assessment section.

After the completion of the dossier the rehabilitation officer will forward copies to the following agencies and individuals:

- physician-in-charge at CRS clinic/sick bay
- CRS Rehabilitation Unit, Panat Nikom

- resettlement Section of UNHCR

- patient and his/her family.

Further to this the rehabilitation officer will monitor, follow-up and initiate, when necessary, the services outlined in the planning section of the dossier.

Master List/Follow-up Sheet

On a tri-monthly basis the rehabilitation officer will compile a master list of all handicapped cases, inclusive of all accompanying family members within the Centre. The master list is used for updating the handicap roster, as an information sheet for the resettlement delegations and presents an opportunity for the refugees to meet individually with the rehabilitation officer to express their concerns about resettlement, medical/health services and other problems.

The master list contains the following information in brief for all persons listed:-

Head of family
Name of handicapped
Accompanying family members
Relationship to head of family
Size of family
Language abilities
Age
Sex
Location
Date of arrival
Boat number
Registration number
Diagnosis and resettlement status related remarks.

During the compilation of the master list and the concurrent interview with each family, the rehabilitation officer will discuss and look into matters concerning proper medical follow-up, referrrals (surgery/psychiatric), provision of services (psysiotherapy/ambulatory aides) and admission into education/language classes, etc.

Resettlement Procedure

The resettlement procedure for handicapped cases is similar to that of other groups with the exception that the UNHCR resettlement section approaches various embassies for special consideration of these cases. Handicapped cases which are not under active consideration require presentation to resettlement countries on a case by case basis. Countries that have files opened on individual cases are notified of the handicapped person's condition and location.

Conclusion

The ongoing referral of cases and their movement to Panat Nikom will ensure that the handicapped refugee and his/her family receive proper medical treatment and appropriate rehabilitation. A religious adherence to this format will also guarantee follow-up for issues that present themselves.

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PROGRAMME PROPOSAL : FOR HANDICAP PROCESSING CENTRE (HPC)

I. PURPOSE

Clustering of handicapped/disabled refugees and their families from Aranyaprathet, Lumpuk, Laemsing, Sikhiu and Songkhla Refugee Camps within the Panat Nikhom Holding Center to facilitate their eventual resettlement and provide medical and rehabilitation services to prevent further debilitation.

II. PROGRAM PARTICIPANTS

Refugees from the above mentioned camps who, because of physical or mental disabilities are defined as handicapped and encounter undue delays in being accepted by/or departing for resettlement in a third country.

Two main categories of handicaps will be included :

Physically handicapped

The physically handicapped may be divided into those with acute physical illness requiring immediate medical attention, chronic diseases requiring continuous medical attention and physically disabled (requiring specialized medical and health related services).

Mentally handicapped

The mentally handicapped are categorized as mentally disturbed (organic or functional) and mentally retarded (genetic, as a sequel of childhood illness or head trauma).

A recent survey by the medical personnel of the camps in question indicated the following caseload of severly handicapped refugees who required intervention.

Aranyaprathet	3 cases	- 13 individuals
Lumpuk	1 cases	- 4 "
Laemsing	4 cases	- 14 "
Sikhiu	4 cases	- 19 "
Songkhla	11 cases	- 46 "
Total	23 cases	(inclusive of accompanying family members - 96 persons)

It is estimated that at any one time the total caseload within this programme would not exceed 35 cases 150 persons.

III. ADVANTAGES

A. Use of established medical facilities within the camp.

B. Use of advanced medical facilities and supportive systems in the general vicinity.

C. Ease of proper follow-up during treatment especially for cases requiring long-term therapy (e.g. psychiatric illness).

D. Enhancement of clinical assessment capabilities in relationship to obtaining medical waivers for resettlement purposes.

E. Ease of access of embassy delegations. (This is especially important for embassies of smaller countries which do not maintain regular resettlement staff.)

IV. SELECTION PROCESS AND CRITERIA

Handicapped individuals requiring special consideration will be periodically reviewed and monitored in the field by a medical/psychiatric social worker attached to the UNHCR Social Services Section. These tasks will be carried out in conjunction with camp physicians with a view to determining the level of care required and desirability for placement of a specific case within the Handicap Processing Centre located at Panat Nikhom.

Placement of individuals in the Handicap Processing Centre will be considered based on a need for one of the following :

A. Specialized medical consultation, investigation, and/or treatment(poliomyelitis, malignant cancer, diabetes mellitus, osteomyelitis, psychiatric illness, heart disease, etc.)

B. Advanced diagnostic techniques requiring detailed documentation and/or treatment in connection with obtaining medical waivers pertaining to immigration/health regulations (mental retardation, mental illness, mongolism, epilepsy, etc.)

C. Rehabilitation services not available in camp clinics (physiotherapy) or additional ambulatory aides which require individual fitting (artificial limbs, breeches or calipers).

D. Assistance in performing basic daily activities (i.e. blindness, elderly persons who are alone and susceptible to diseases, unaccompanied minors with mild handicaps).

Only people who cannot be treated by local medical facilities will be transferred to the Handicap Processing Centre in Panat Nikhom. Whenever practical, local medical facilities will continue to be utilised for the care and treatment of handicapped individuals.

V. MOVEMENT

Once it has been determined by the UNHCR medical/psychiatric social worker and the referring physician that transfer to Panat Nikhom Handicap Processing Centre is deemed necessary, the social worker (in liaison with UNHCR Resettlement Section) will make the appropriate arrangements through normal resettlement channels for movement.

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VI. ARRIVAL AND FOLLOW-UP

Upon arrival in the Handicapped Processing Centre located at Panat Nikhom, the handicapped individual and his or her accompanying family members will be integrated into the community at large, not segregated off into their own section or dormitories. However, as a group, residence with easy accessibility to the medical facilities (rehabilitation etc.) will be considered a priority.

Using the original movement calling list for identification purposes, the Centre's section chief in conjunction with the on-site social worker will explain the various programmes offered and assist the newcomers in enrolling in appropriate vocational/educational classes. In addition the UNHCR medical/psychiatric social worker will follow-up the handicapped individual and his or her family members to encourage optimum utilization of the existing medical/ rehabilitation/social care programmes.

VII. RESETTLEMENT

The resettlement procedure for handicapped cases will be similar to that of other groups with the exception that the resettlement section of UNHCR will approach various resettlement countries for special consideration of these cases. Handicapped cases which are not under active consideration will be presented to resettlement countries on a case by case basis. Countries that have files opened on individual cases will be notified of the handicapped person's condition and location.

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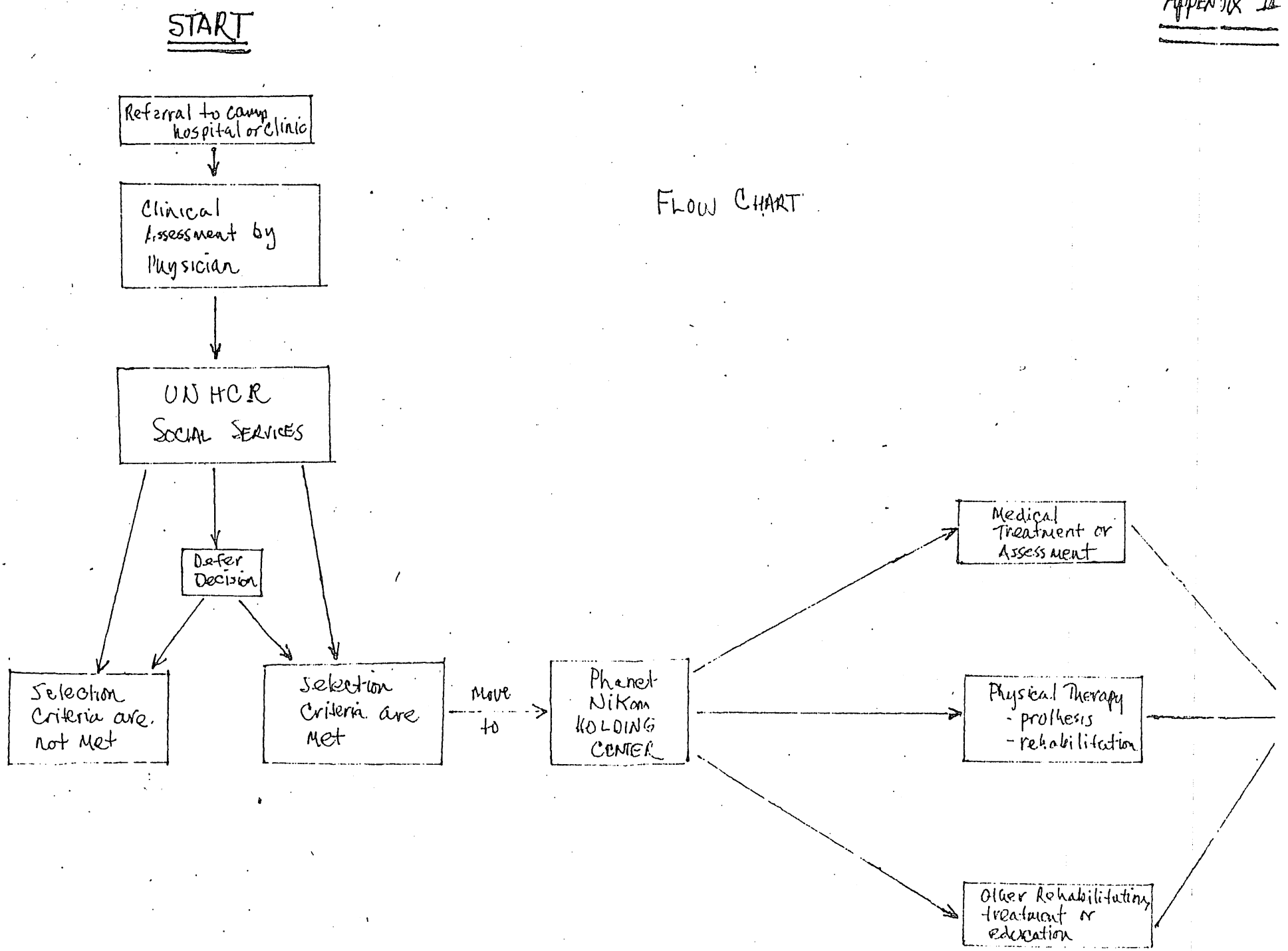
FLOW CHART


START
Referral to camp hospital or clinic
Clinical Assessment by Physician
UNHCR SOCIAL SERVICES
Defer Decision
Selection Criteria are not Met
Selection Criteria are Met
Move to
Phanet Nikom HOLDING CENTER
Medical Treatment or Assessment
Physical Therapy - prothesis - rehabilitation
Other Rehabilitation, treatment or education

Guidelines for Clinical
Assessments and Other Data

I. Personal Data (can be completed prior to meeting with the physician)

1. Name of Handicapped person
2. Head of Family (PRA)
3. UNHCR camp number
4. Date of arrival
5. Accompanying family members (give names, sex, age, occupations, languages spoken and relationship to PRA)
6. Family members abroad (give names, addresses, occupations, age, sex and relationship)
7. Resettlement status (indicate past interviews, with whom, and current status)
8. Willingness to move to Panat Nikom.

II. Medical History (to be completed by physician)

1. Give all relevant history (i.e. onset, course, duration, past medical treatment, medications and dosages, etc.)
2. Other antecedent data that is significant.

III. Physical Examination

1. Blood Pressure
2. Pulse Rate
3. Heart, Lungs, Abdomen
4. Other tests, x-rays, etc.
5. Other physical/extremities

A) Indepth neurological (especially in cases of polio)

a) indicate degree of atrophy and the muscles affected

b) note muscle force (using ratio)

c) note tone of the muscles affected

d) note reflexes (Babinsky and Achilleus)

e) note skin sensitivity

f) measure the length of each leg

g) indicate the degree of mobility (i.e. can walk unassisted, assisted, or with prothesis, etc.)

h) indicate the degree of dependence on others for the fulfilment of basic needs

i) incontinence

j) other details.

B) Other indepth examination (that is possible)(e.g. pulmonary, ophthamological, mental, etc.)

IV. Treatment in the camp (describe) (include medications, their dosages and frequency; any treatment in a Thai facility that has not been indicated).

V. Treatment Recommendations

1. Diagnosis
2. Prognosis
3. Recommendations.

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VOLUNTARY AGENCIES CONCERNED WITH HANDICAPPED/DISABLED REFUGEES

I. Kampuchean Holding Centres :

Ban Kaeng

- Lead Medical Agency - World Vision Foundation of Thailand (W.V.F.T.)
- Traditional Medicine - SOM.
- Surgery - The Japanese Medical Team
- Physical Therapy Unit - SOS Enfant Sans Frontiers (SOS/ESF).
- Prosthetic Workshop - SOS/ESF.
- Community based Social Services - W.V.F.T.

Kab Cherng

- Medical/Public Health - Mahidol University/CUSO
- Community based Social Services - Community based Emergency Relief Services (CBERS).
- Rehabilitation Counselling - The Sovereign Order of Malta (SOM).

Kamput

- Lead Medical Agency - Thailand Baptist Mission (T.B.M.).
- Traditional Medicine - SOM.
- Physical Therapy Consultation - SOS/ESF
- Prosthetics - SOS/ESF.
- Community based Social Services - Redd Barna of Thailand (RBT).

Khao I Dang

- Lead Medical Agency - International Rescue Committee (IRC).
- Intensive Rehabilitation Ward, Orthatics, Physical Therapy - Catholic Relief Services (CRS).
- Traditional Medicine - SOM.
- Prosthetic Workshop - SOS/ESF
- Leprosy Ward and Control Programme - Malteser - Hilfsdienst Auslandsdienst EV (MHD).
- Community based Social Services - RBT/CRS.

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Mairut

- Lead Medical Agency - Medecins Sans Frontieres (MSF).
- Community based Social Services - CONCERN, Save the Children, UNHCR/PRA
- Rehabilitation Counselling - SOM.

Panat Nikom Holding and Transit Centres

- Lead Medical Agency - CRS
- Inpatient Services - Catholic Office for Emergency Relief and Refugees (COERR).
- Medical (Transit side) - American Refugee Committee (ARC).
- Rehabilitation Unit, Physical Therapy, Occupational Therapy - CRS.
- Prosthetics - SOS/ESF, CRS.
- Community based Social Services - CRS, UNHCR/PRA.

II. Lao and Hill Tribe Camps

Ban Nam Yao

- Lead Medical Agency - Tom Dooley Heritage Foundation (TDH).
- Public Health - MSF.
- Mobile Prosthetics/Physical Therapy Unit - SOS/ESF.
- Rehabilitation Counselling - SOM.

Ban Tong

- Lead Medical Volag - COERR.
- Mobile Prosthetics/Physical Therapy Unit - SOS/ESF.
- Rehabilitation Counselling - SOM.

Ban Vinai

- Lead Medical Agency - W.V.F.T.
- Public Health - W.V.F.T.
- Rehabilitation Unit,Occupational Therapy, Leprosy Control Programme - The Sisters of Charity/COERR.

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- Prosthetics - SOS/ESF.
- Rehabilitation Counselling - SOM.

Chiang Kham

- Lead Medical Agency - COERR.
- Mobile Prosthetics/Physical Therapy Unit - SOS/ESF.
- Rehabilitation Counselling - SOM.

Nongkhai

- Lead Medical Agency - CRS.
- Public Health - CRS.
- Physical Therapy/Prosthetics Unit - SOS/ESF.
- Community Development/Youth Project - American Friends Service Committee.
- Rehabilitation Counselling - SOM.

Sob Tuang

- Lead Medical Agency - The Evangelical Alliance Relief Fund (TEAR).
- Mobile Prosthetics/Physical Therapy Unit - SOS/ESF
- Rehabilitation Counselling - SOM.

Ubon

- Medical/Public Health - SCF and MSF.
- Mobile Prosthetics and Physical Therapy Unit - SOS/ESF.
- Rehabilitation Counselling - SOM.

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Appendix V.

Job Description : REHABILITATION FIELD OFFICER

The Rehabilitation Field Officer is a professionally trained, at the graduate-level, social woker with relevant educational background and experience in working with the physically and mentally handicapped. Reporting directly to the Rehabilitation Coordinator in the UNHCR Social Services Section, the officer performs the following job duties:

1. Survey each Camp site to collect information on vocational skills training programs, educational/language classes, local medical resources, and other special programmes which can be utilized in referrals for handicapped refugees and their immediate family members.

2. Assures that each Camp is screened for potential handicapped referrals by coordinating referral guidelines with appropriate camp personnel, for example: medical coordinator, UN Field Officer, public health personnel, education personnel, and refugee section leaders.

3. Arranges for all cases to be screened by the camp physician, for the purpose of making appropriate medical referrals, and preparing detailed clinical assessments for each severely handicapped patient.

4. Interviews each severely handicapped refugee with the accompanying family members, gathers relevant documentation regarding the social/ vocational history, and makes appropriate vocational and educational referrals for all family members.

5. In conjunction with the camp physician, prepares a detailed dossier on each severely handicapped case, which serves as a treatment plan for future counseling and follow-up with the patient and family.

6. Ensures follow-up on all casework: monitors progress towards treatment goals.

7. Submits completed dossiers to the rehabilitation coordinator who passes them :

   A. to the Resettlement Section of UNHCR, for presentation to various Embassies for those handicapped individuals who have requested resettlement in a third country.

   B. to various specialists who visit the camps from time to time for consultation and treatment (i.e. mobile prosthetic/physical therapy unit or mobile ophthalmologist unit.)

8. Maintains statistics of camp casework to be utilized by the Rehabilitation Coordinator for on-going rehabilitation program planning.

9. Provides in-field consultation to community based social workers who are involved with monitoring the general welfare of handicapped individuals.

10. Acts as part of resource team interfacing with special-interest groups/workshops to provide case-specific information regarding the special needs and problems of handicapped refugees.

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Job Description : MENTAL HEALTH CONSULTANT

Undertakes :

1. The overview and monitoring of programmes of assistance for handicapped refugees (physical/mental) in ongoing consultation with UNHCR and CCSDPT.

2. Professional support of all rehabilitation staff.

3. Provides guidance and consultation to organizations and their staff who are involved in providing mental health care for refugees.

4. Examination and Evaluation of ongoing mental health and related programmes (i.e. community based Social Services) to provide coordinated efforts directed at providing adequate mental health coverage. This includes a special emphasis on mental health problems which are manifesting themselves in transit centres.

5. Development of specific proposals, to meet identified needs.

6. Implementation of proposals:

   A. Development of mental health skills for refugees, volag workers, and target groups such as teachers, medical workers, para-social workers, etc.

   B. Professional support of existing services in camps.

   C. Devise ways of bringing together available traditional, community and family based treatment processes.

   D. Clarify and institutionalise agreed procedures for obtaining reception, diagnosis, care, support and follow-up of patients and families.

7. Initiate a process of recording presentations, providing an associated bibliography of related subject matter, and the compilation of guidelines, to be utilised in training programmes.

8. Involvement in, and co-ordination of, activities related to the proposed Women's Regional Conference scheduled for the later part of 1981.

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RWS/pp

SSS/Rehabilitation Handicapped
SSS/Chron
Reading file
Chron

Dr. A.G. Rangaraj, Senior Health Coordinator

Richard Schmitt, Assistant Welfare Officer

HCR/BKK/SSS/0459

5 October 1981

Handicapped Refugees/Rehabilitation-completion of present programme and proposal for 1982.

Further to our recent discussions, concerning future prospects, programmes and efforts, directed towards the follow-up of the severely disabled/handicapped individuals, who will be remaining in the refugee camps/holding centres of Thailand after 1981, I have outlined in brief several possibilities addressing this situation, within this memo. In conjunction with this, I have also outlined activities, that will need to be completed prior to the end of my contract, on 31 December 1981.

In addition, please find attached for your usage a 30 page document/report concerning this years activities.

Activities that need to be completed

1. Documentation and initial follow-up of handicapped individuals within Mairut Holding Centre.

Note: It has come to my attention through the social workers from Concern, SCF and UNHCR/PRA, (who are providing community based social services in Mairut) that a number of individuals and their families (30-40 cases) have been rejected/deferred from resettlement possibilities in relationship to a physical/mental impairment or disability.

2. An additional follow-up and assessment of the handicapped individuals who are residing within the Handicapped Processing Centre (Panat Nikom) will be required.

Recently, I have been informed by the medical director of the American Refugee Committee that a similar situation

exists concerning rejection and deferment of handicapped individuals (related to strict immigration/health regulations of countries of resettlement) in Panat Nikom Transit Centre, as has been presented in Nairut.

3. Kamput and Sakaeo public health workers have sent to me, a list of the severely disabled residing within these two camps. I will need to send one of the rehabilitation counselors to each, for a period of not less than one month. The purpose of their visit will be to provide consultation to the community based social workers, whose job description indicates that they are responsible for seeing that the needs of the handicapped within their areas are appropriately met. (i.e. activities of daily living).

In addition, the medical coordinators of these camps, have recently presented me with several handicapped cases of whom they think third country resettlement is appropriate and required. These cases will require comprehensive assessment as well as documentation prior to presentation to the resettlement section.

Note: Of course this depends on whether or not resettlement opportunities for this group exists.

4. The rehabilitation counselor working in Ban Vinai has just recently completed the initial documentation for 54 individuals suffering from leprosy. She has an additional 50-60 handicapped cases (various) that will require documentation and social work follow-up within the next several months.

5. Further to the 54 leprosy cases mentioned above, there are 80-85 cases in Khao I Dang and another 10-15 cases in Ban Kaeng.

In reference, to our memo to Geneva on 14 May and their subsequent reply on 18 August, the above 85-100 cases of leprosy combined with the 54 cases in Ban Vinai will have to be assessed as a group, documented and presented to the resettlement section for their action.

In view of this, I have already spoken to John Schuster, the lepromologist from MMD and he is quite willing to assist us in doing the clinical assessments.

6. Taking into account the 400 or so cases we have already documented and followed up within the last 10 months, there are a number of chronic cases, as well as cases of special concern, which will require further follow-up. In order to adequately provide social work services for this group, I will

need to have my staff visit at least once more, before the end of the year, the following camps:

Chiang Kham
Ban Tong
Sub Tuang
Ban Nam Yao
Ubon
Nongkhai

Proposal for Augmenting camp medical/social infrastructures to ensure that services for the handicapped are adequately provided in the up coming year - 1982.

As a programme for rehabilitation is defined as "The combined and coordinated use of medical, social, educational and vocational measures for treatment and training (retraining) the individual to the highest possible level of functional ability."

And within the context of relief work we have defined a programme of rehabilitation as a programme which entails a combination of services which includes phycical therapy, provision of artificial limbs and/other ambulatory devices, vocational/ skills training and a unifying social service component.

I strongly think and feel that based on these definitions in relationship to the types of programmes and services which have been made available for the handicapped, during the last year, the best approach would be one in which the medical/social service oriented voluntary agencies who are taking responsibility for the health/social care of refugees at the camp level provide adequate personal within their own programmes to address the needs of the handicapped.

I have not chosen to outline a programme for 1982 similar to the Sovereign Order of Malta's (SOM) programme of 1981 as the SOM programme originally was conceived, to provide rehabilitation services to camps where their was an absence of such services, provide consultation to agencies involved in direct services, and document cases that required or requested resettlement.

I have made this decision in relationship to the problems that have manifested themselves, the type of logistics involved and agency verse agency complications. Reinstating once again, it appears to me that any efforts concerning programmes of rehabilitation for all the remaining holding centres/camps in 1982 should be the responsibility of the medical/social care implementing agencies.

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As far as coordination of social services or social work based rehabilitation programmes are concerned, it seems most needed that a senior social service consultant/coordinator should be placed directly under your supervision or paid for by UNHCR and seconded to CCSDPT.

Further to this and the overall need to properly coordinate social service orientated programmes, I feel a CCSDPT social service sub-committee meeting similar to the medical sub-committee meeting should be held in conjunction with the ongoing CCSDPT monthly meetings.

I feel that if someone is employed as a senior social service consultant/coordinator the background and experience of the individual should be relevant and appropriate to the situation, while at the same time, the individual should be given enough of a power/authority base to be judgemental with voluntary agencies to the point where he can determine the outcome of their programme, by making sure that they, hold up to the standards which were outlined within their original social service/welfare programme proposals.

Mr. David Drucker presently working for UNHCR/SOM as a project administrator/consultant and previously a P.4 (12) level social service consultant for WHO would be, in my opinion, the ideal candidate for just such a position. Besides, a professional history of international social services related activities, in 13 countries in the region, Mr. Drucker has been a university lecturer in social work and during the period 1971-1972 was sponsored by the Social Development Division of ESCAP and the United Nations Children's Fund (UNICEF) to conduct An Exploration of the Curricula of Social Work in Some Countries of Asia with Special Reference to the Relevance of Social Work Education to Social Development Goals. The results of this work can be found in the ESCAP library catalogue No. 372936 (5-012).

At the camp level for remaining camps (?)

Kampuchean Holding Centres

1. Khao I Dang

The existing programmes should remain and continue throughout the next year.

- Intensive rehabilitation ward, orthotics, physical therapy - Catholic Relief Services (CRS).

- Leprosy ward and Control Programme - Malteser-Hilfsdienst-Auslandsdient E.V. (MHD).

- Community based social services - Redd Barna of Thailand (RBT)/CRS.

2. Ban Kaeng

The existing programmes should remain and continue through next year, with additional personnel (i.e. psychiatric nurses) recruited by the lead medical agency - World Vision Foundation of Thailand (WVFT).

- Community based social services - WVFT.

- Physical Therapy Unit/Prosthetic Workshops - SOS Enfants Frontiers (SOS/ESF).

Note: A psychiatric nurse recruited by WVFT could play a dual role, that is, he or she could work as a general nurse practioner while at the same time, be ready and available with the necessary background, to deal with psychiatric problems which are not adequately treated within the traditional medicine centre ran by the Krue Khmer.

3. Kamput

Existing programmes should continue with the addition of a psychiatric nurse.

- Physical Therapy Consultation - SOS/ESF.

- Prosthetics - SOS/ESF.

- Community based social services - RBT.

4. Panat Nikom Holding and Transit Centres

Existing programmes should remain with the addition of psychiatric nurses on both the Holding and Transit side as well as a qualified medical/psychiatric social worker attached to the OPD (in the transit centre) and impatient hospital (in the holding centre). Further to this, a rehabilitation counselor should be employed by the Rehabilitation Unit ran by CRS.

- Rehabilitation Unit, Physical Therapy, Occupational Therapy - CRS.

- Prosthetics - SOS/ESF, CRS.

- Community based social services - CRS, UNHCR/PRA.

Lao and Hill Tribe Camps

1. Ban Nam Yao

As the present programme providing Ban Nam Yao with a mobile Prosthetics/Physical Therapy Unit and a rehabilitation counselor are likely to discontinue by the end of the year and the camp population will increase (due to a merger of camps) I would suggest that the lead medical agency (Tom Dooley Heritage Foundation - TDH) recruit a psychiatic nurse, a physical therapist and a medical/psychiatic social worker/rehabilitation counselor.

SOS/ESF could be requested to establish a fixed workshop, staffed with refugee trained prosthetic technicians to work together with TDH's physical therapist.

2. Ban Vinai

The lead medical agency WVFT should recruit a psychiatic nurse as part of their staff.

The community based social services programme initiated by WVFT should remain and continue.

The prosthetic workshop established by SOS/ESF should continue.

The Rehabilitation Unit Leprosy Control Programme ran by the Sisters of Charity/COERR should increase their personnel with the addition of a physical therapist, an occupational therapist, a rehabilitation counselor and a qualified registered nurse(with specific training in lepromology) plus a very strong minded, firm, assertive administrator.

Note: I don't think I need to elaborate on this.

3. Ubon

The lead medical agency should recruit a psychiatic nurse and a physical therapist. The physical therapist should set up a department together with a fixed prosthetic unit under consultation from SOS/ESF.

In conjunction with the above one of the established agencies in Ubon camps should develop a community based social service programme with the firm understanding that the coordinator in the field of this programme should be a qualified experienced social worker (i.e. at least a bachelors degree in social work with 5 years experience or a masters degree in social work with 2 years experience.)

4. Ban Tong

As the camp population would be small in comparison to other established camps possibly physical therapy, prosthetics, psychiatics nursing services, ect. would be drawn on a consultant basis from the TDH hospital in Ban Nam Yao.

Present medical agency - Catholic Office for Emergency Relief and Refugees (COERR).

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I hope this memo has provided the information you require.

As for the requests to the various agencies concerning the additional recruitment of personal or establishment of specific programmes as outlined above, with your permission, I will begin taking the necessary actions.

Regards,

cc: AS/RVL/CH , LR/FM/AH , GD/LD/RF , JW/100

RWS/pp