IMPLICATIONS OF A BROADENED VISION

Moving towards a broader vision of refugee health that fully encompasses a primary health care approach will affect numerous aspects not only of health services but also of the overall refugee assistance system. What follows is a discussion of the major issues that need to be addressed if the primary health care approach is to gain greater adherence in the refugee field. This discussion takes experience, debate and study to date regarding refugee health -- including deliberations of the international Symposium -- as an underpinning. It then goes on to explore some of the implications for how assistance to uprooted people might need to be changed if this broader vision is to be implemented in practice.

Expanding the Concept of the Health Sector

Typically the health sector in refugee assistance programs is viewed as the activities of agencies that provide health services. Such a limited concept is both inaccurate and dangerous. It is inaccurate in that it fails to reflect the full range of important activities that are relevant to the health needs of uprooted people. It is dangerous in that failure to view the health sector more broadly delays adequate attention to many of the problems that most often cause unnecessary illness and death -- including deficient general food distribution, poor sanitation, inadequate water supply, lack of vector control and improper shelter. For example:

- Poor decision-making regarding the food rations can result in diets lacking in essential nutrients and consequently, in life-threatening diseases.

- The lack of water wells located near communal cooking facilities can make cooking for large groups difficult.

- Improper construction or placement of latrines can result in indiscriminate defecation in the camp or settlement and consequent spread of disease.

- Inadequate planning and education for home-gardening projects can result in the production of vegetables that do not contribute to a balanced diet.

- The failure of pottery workshops to direct production towards fulfilling priority community needs for household containers can result in inability to properly cook food and to boil and store water.

- Insufficient understanding of the refugees' mental health needs by social service, education and other workers can result in lost opportunities to address those needs or even in unintentional acts that may aggravate emotional problems.

- Insufficient attention to health issues in leadership training courses can lead to distorted priorities and inappropriate planning for health-related activities.

- The failure to include school work on health subjects overlooks a valuable source of educational information.

A more accurate and constructive concept of the health sector includes all of those activities which affect the health status of refugees. With this concept, in addition to the provision of health services, a number of activities that are not generally seen as health care activities should be recognized as being integral parts of the health sector.

For example, the World Food Program and major bilateral food donors perform a crucial role in the provision of food rations, one of the most important elements of a good health plan for refugees. In many instances, the most important personnel for ensuring adequate rations are the logisticians and non-health officials back in headquarters offices who allocate food shipments. Non-health care NGOs often organize projects, such as vegetable gardening or supplemental feeding programs, that add elements to the food rations. Decisions regarding purchases of wood or the use of other fuels for cooking are handled by general program managers.

Similarly, sanitation and provision of water are activities that involve numerous non-health care agencies. The provision of safe drinking water often involves water specialists (such as engineers and drilling rig operators) under direct contract themselves or working through a commercial firm, a non-governmental organization or the special host country government branch that deals with potable water. Latrines are also often designed and built by specialized organizations. NGOs involved in income generation projects may play a role as well, for example with soap-making projects.

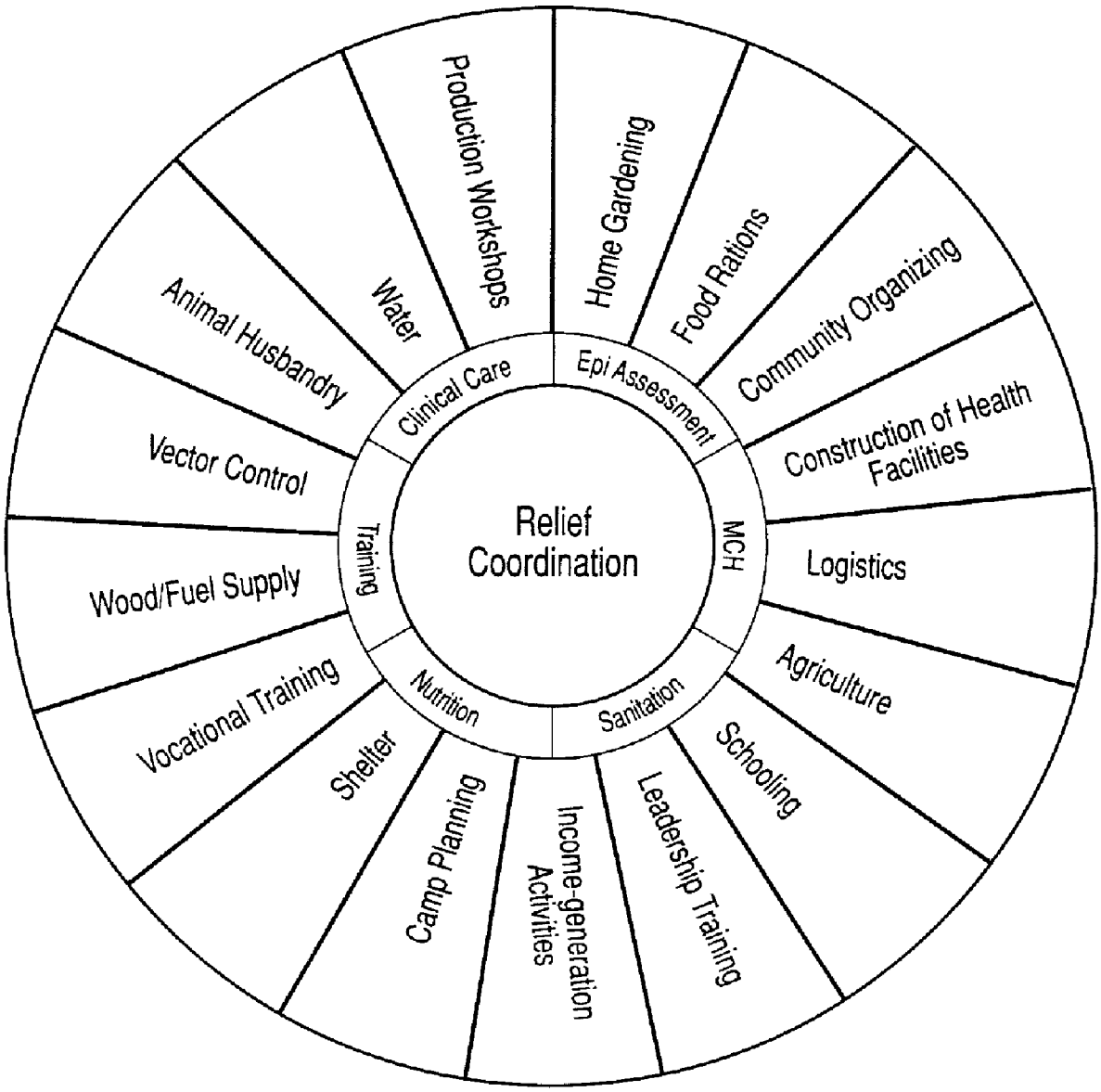
A third example of health-related activities relates to the provision of shelter, clothing, blankets and other protection from exposure and spread of respiratory diseases. The provision of shelter rarely involves health care professionals or agencies. For shelter, the key decisions typically involve what kind of building materials will be available and in what quantity, the design of the shelters and the overall layout of the camp or settlement.

Non-health agencies are often involved in activities that fall under the area of social services. These endeavors include community organizing, leadership training, pastoral work and recreational activities. They also encompass individual and group counselling on issues ranging from marital disputes to rape and other forms of violence. Mental health concerns, arising from the traumas experienced prior to becoming refugees or from the refugee experience itself, are an integral part of such social service work.

All of these activities, and many more, are central to the health of refugees. They all involve institutions that have not traditionally been defined as part of the health sector, yet that play an essential role regarding the health of refugees. The expansion of the concept of the health sector in refugee assistance activities is meant to embrace all those activities that contribute to good health, while not becoming so all inclusive as to lose entirely the concept of a distinctive health sector or to downplay the role of the more traditional health agencies -- quite the contrary. The primary agencies responsible for health care should, in fact, be playing an expanded role. In addition to providing their own health services, they should be: paying considerable attention to how

effectively the other health-related programs are carried out; identifying the obstacles that the other programs face; and developing approaches to overcome these problems.

In effect, the activities associated with traditional health care agencies could be seen as the hub of a wheel whose spokes are the health-related activities. The diagram below depicts these relationships. At the hub are a set of activities that are vital aspects of the primary health care



approach: epidemiologic assessment, maternal and child health (MCH) programs, personal hygiene and community sanitation, nutrition, health worker training and clinical services. Radiating from this hub are general food distribution, water provision, vector control, agriculture and home gardening, construction of shelter and health facilities, income-generation activities, production workshops and all of the other activities that have an impact on the health of refugees. (It is emphasized that this is a depiction of the relationships among the various health-related activities, and is not meant to suggest relative priorities, degrees of importance or supervisory roles.)

Part of the task of the traditional health care agencies is to identify and acknowledge the linkages between health services and other assistance sectors. This will also entail redefining the relationship between health professionals and the larger array of institutions and individuals in sectors not directly related to health care as traditionally viewed but that nevertheless play an important health role.

The task also involves heightening awareness and understanding regarding the health role of the health-related agencies. Those responsible for overall coordination of assistance programs (such as the relevant government and UN officials) and officials of the health-related agencies themselves are most in need of this heightened awareness. They should receive information and training regarding ways to analyze health needs within this broader perspective and regarding the key health-related interventions which fall under their responsibility. The importance of effective leadership and coordination in this regard is discussed below.

Key Health Services

As described above, certain traditional health services are vital aspects of primary health care. These health services ideally encompass the following activities: health information system employing epidemiologic methods, maternal and child health programs, personal hygiene and community sanitation, nutrition, health worker training and clinical services.

- **Health information system employing epidemiologic methods.** Fundamental to health planning and evaluation is monitoring of the health and nutritional status of the population, particularly that segment composed of children under the age of five years. The epidemiologic approach identifies the priority health problems and assists in the determination of appropriate health interventions. Once baseline data have been gathered, periodic follow-up evaluations and ongoing surveillance make it possible to monitor changes in the status of the population and to assess the effectiveness of the health intervention program. The program can be changed, expanded or otherwise improved based on the results of surveillance and periodic evaluations.

- **Maternal and child health programs.** MCH programs encompass health education and other outreach activities; prenatal, delivery and postnatal care; provision of nutritional supplements as required; support for breastfeeding; family planning; and well-child clinics, immunization and weight monitoring for children under the age five. All of these activities are affected by the other health and health-related services. For example, the ability of refugee women to breastfeed is influenced to a large degree by the quality and quantity of the general food rations plus any supplementary feeding programs for high-risk women. While the actual relationship in practice between MCH programs and other health activities and services can vary, MCH services work best when closely intertwined with all other services. For example, health education can be performed in a clinical, supplementary feeding, school, home and/or other setting. Home visiting -- an important part of MCH -- is most effective when tied by a referral system to clinical care or to supplementary feeding services. Immunization campaigns can be linked to schools, supplementary feeding services, or health centers.

- **Personal hygiene and community sanitation.** Some of the major causes of mortality in refugee situations -- diarrhea, malaria, respiratory infections, communicable diseases -- are the result of severe overcrowding and lack of opportunities

to maintain good personal hygiene and adequate community sanitation. These diseases are addressed in part through the construction and maintenance of latrines, the provision of an adequate supply of clean water located in close proximity to homes and health facilities, availability of bathing and clothes washing facilities, control of vectors, solid waste disposal and the availability of soap. While many of these activities are actually carried out by non-health personnel, the health agencies can oversee all of these efforts. The most direct role of health agencies in the area of sanitation is through health education and organizing the refugees to maintain a clean environment.

- **Nutrition.** Malnutrition is an underlying cause of almost all refugee mortality. Nutritional rehabilitation and maintenance can, therefore, have a greater impact on the health of refugees than any other single health intervention. Supplemental feeding is an important consideration for pregnant and breastfeeding women; young children; and aged, handicapped and ill refugees, especially if the general ration is inadequate. Epidemiologic assessments are important to determining when to implement supplemental feeding and to evaluating the effectiveness of the program. Since general distribution of food is the most fundamental aspect of nutrition, camp-wide rations also must be closely monitored and evaluated for quality and quantity. In addition to evaluation of dietary adequacy, decisions regarding nutrition take into consideration cultural acceptability, adapting relief rations to weaning foods for young children, the dangers of the use of infant milk formulas, access to fuel, availability of cooking utensils and many other non-technical considerations.

- **Health worker training.** The training of refugees to attend to their own health needs is the one activity that has the greatest long-term impact on the health of the refugees. Training provides them with skills which they can apply not only in the refugee camp, but also on their return to their home communities. Refugee health training, just as health activities in general, emphasizes prevention over cure and

community health over the care of the individual. Training activities also respond to the cultural, social and educational needs of the refugees. This issue is addressed in greater detail later in this paper.

- **Clinical services.** The provision of clinical care is a necessary aspect of refugee health services. However, it should not be over-emphasized, since preventive efforts have been shown to have a far greater positive impact on health than efforts to cure individuals after they have become ill. The priority accorded to curative services in refugee situations should reflect this reality. In addition to direct patient care, clinical services include disease control programs (including for malaria or other location-specific diseases), the provision of essential drugs, laboratory facilities for diagnosing major diseases, rehabilitation of injured and disabled refugees, attention to psychological needs and problems, and a system to refer the most severely ill or injured patients to the host country hospital facilities. One aspect of clinical services that must receive careful consideration is the level of services that are appropriate for refugee situations. It is important not to introduce highly technical diagnostic and curative measures into such circumstances, especially where they are lacking in the local health services. In general, those curative services that are integrated with and rely upon the resources available to the host population are the most appropriate.

Monitoring, Advocacy and Protection

As described above, often the most critical decisions that determine the health of refugees are made by assistance officials such as the camp planners, UNHCR staff, host government officials, and major donor government representatives who are not health professionals themselves. Further, the actual provision of food, shelter, drinking water, and sanitation facilities is often administered under the general assistance program.

Health care personnel need to cease defining their work so narrowly that they end up treating the casualties of poor decision-making or performance in other areas (such as camp planning and ration distribution) rather than seeking ways to be more influential in shaping these decisions. This will require more involvement of health personnel in planning, administration, logistics and evaluation. Many health workers feel very frustrated when they discover that much of their time involves being an administrator and supervisor. However difficult this may seem, it is an important contribution, given that an important objective of health care in refugee settings is to create and operate effective systems.

For example, some health care agencies deal with one aspect of nutrition through the operation of special feeding programs for vulnerable groups. However, very few are involved in decision-making or program implementation in the most essential facet of nutrition -- that of the general ration. While field personnel are busy with issues of supplemental feeding for severely malnourished and high-risk groups, inadequacies in the general camp ration (both quality and quantity) can result in widespread suffering from nutritional deficiency diseases.

Bringing about the changes that are needed will require more than merely attending meetings or writing program plans. It will require applying pressure on those individuals and organizations with final decision-making authority. One way of generating such pressure is for health agencies and personnel to more extensively document the costs of failure, for example to provide adequate food rations, as well as the gains of successful program implementation. The role of public health specialists and epidemiologists (or of other health workers who have some training in these areas) is especially important regarding such advocacy efforts. Such persons are trained to monitor the health of the population and to seek out the causes of the problems they note, and can thus provide much of the information base needed for well-informed and persuasive advocacy by health care professionals.

Those concerned with the health of uprooted persons must then be aggressive in seeing that this information reaches and is used by institutions such as advocacy groups and the media to push for change. In addition, health personnel should themselves advocate more strongly for the changes that are needed, both at the field level and, just as importantly, through their headquarters offices.

Another important non-traditional role to be played by health personnel is in the area of refugee protection. Health personnel are often the first and sometimes the only persons to be in contact with refugees and to learn about human rights violations committed in the camps. Through health-related contacts, they are well positioned to determine if the refugees are subject to abuse by host country nationals, other refugees and outside forces. Further, these health personnel are often able to reduce human rights abuses against refugees through their mere presence.

In some refugee situations, protection concerns can be a paramount problem. In spite of heavy demands on time, protection must be recognized as a significant facet of refugee health work. Feelings of security and freedom from violence are essential to the refugees' physical and emotional well-being.

This protection role is by no means a trouble-free endeavor for most health staff. Having learned of problems, it is not always clear what they should do with the information. Senior health staff, therefore, must make difficult decisions regarding whether and how to make public information that could compromise the safety of the staff or of refugees or lead to the agency's expulsion from a country. For this to occur, however, each agency must have clear policies and guidelines. Further, ideally the entire field staff in any given refugee situation should have a coordinated, agreed upon strategy for dealing with human rights violations. This problem is too serious and all too common to be left to the individual spontaneous judgments of unprepared field personnel.

Personnel Requirements

At the outbreak of refugee emergencies, recruitment of expatriate physicians and nurses is often a high priority for health care agencies. The demands of the primary health care approach do not necessarily require large infusions of these skilled health professionals, however. Most expatriate physicians and nurses have been trained in Western medical practices and may have little understanding or experience in third world community health care.

This leads to a key issue concerning the role of expatriates in refugee programs -- the relative proportion of positions that should be held by expatriates versus host country nationals versus refugees. This is a controversial subject, with a wide spectrum of views depending upon the particular refugee situation, program objectives and funding considerations.

For example, for the sake of long-term program sustainability, refugee programs are best managed by nationals and refugees. Yet, at the same time, expatriates play an important role in attracting and maintaining international donor interest and confidence. In certain situations, advocacy and protection responsibilities can be carried out more effectively by expatriates, rather than host country nationals or the refugees themselves who are more subject to pressure and intimidation by governments, agency personnel and others.

During the initial emergency relief period, there is a need for public health professionals knowledgeable about refugee health to guide policies and programs in the right direction. If preparedness training in potential host countries were adequate, host governments could provide these experts. However, given current realities, these individuals might need to be expatriates. Thus, while each refugee situation is unique, it is useful to evaluate the extent to which nationals and refugees can carry out the actual health services, while expatriates focus more on those areas where they can make the greatest contribution.

The type of health worker needed in refugee situations is another key -- and controversial -- issue. The primary health care approach does not require large numbers of highly skilled medical personnel. Instead, a variety of professionals are likely to play a greater role in refugee assistance activities. These include camp planners, sanitarians, water engineers, logisticians, nutritionists, public health specialists, vocational trainers, management specialists, civil engineers, epidemiologists, agriculturalists, community organizers and many other types of personnel. In the multisectoral approach necessitated by the primary health care strategy, health personnel must be able to work closely with all of these other relevant workers.

The qualifications, attitudes and experience of health workers is another concern in refugee health care. During the emergency phase, expertise in rapid implementation of priority interventions is required. Over the long-term, the primary health care approach requires that health workers possess many of the same attributes that make for a successful international health and development worker. Health workers must be able to work with the community. They must have the skills and experience needed to be able to mobilize and motivate the refugees to develop their own health programs and activities. Personnel must be able to work easily with the processes through which health activities are developed in and by the community, and not just focus on creating programs that deliver health services.

In fact, health personnel working with refugees should see themselves as development workers, rather than medical providers. They should be willing to learn about the culture, language, political organization and leadership structures of the refugees. It is particularly vital that they understand the refugees' traditional health practices and beliefs, as some of these practices may be incompatible with the approaches being introduced by the health personnel. Health personnel will have to work closely with representatives of the refugee community and with development planners of the host country government. They must be capable of incorporating refugee assistance efforts into the development programs of the host countries.

Refugee health assistance personnel need to receive training and in-country orientation to the specific refugee situation prior to beginning their work. Appropriate training and orientation are rarely provided, yet are essential to effective use of health staff.

A major difference at present between the refugee and development fields regarding health personnel involves length of service for expatriate workers. Development agencies generally ask their personnel to commit a substantial period of time -- a minimum of two years -- to work in a single community. Many refugee agencies rely on expatriate personnel who fulfill short-term assignments.

Since primary health care is a sustained process that builds steadily over time, high staff turnover is incompatible with this approach. The extreme hardships and excessive stress of refugee work, often cited as

reasons for the shorter time period, are very real problems in many refugee situations. However, some effort must be made to balance concerns about staff exhaustion and burn-out with the demands of the developmental approach. Again, part of the problem may be the idea that refugee displacements are short-term crises demanding only emergency responses. This view obscures the need to ensure that personnel have adequate living accommodations, ready access to health services for themselves, and ample rest and recreation breaks so that they do not become over-stressed and ill.

Insisting upon a minimum time commitment of two years may substantially reduce the pool of willing and available expatriate health workers. However, if this time requirement is compensated with salary levels, vacations and other benefits, and career opportunities commensurate with the higher level of commitment, the change may hold the added advantage of attracting more professional and career-oriented staff. This would upgrade the refugee health field and offer refugees a similar level of professionalism that characterizes the wider field of international health and development.

These more stringent demands upon expatriate health workers may present other advantages for the refugee health field in that host country nationals may find positions more open to them and that greater recognition would be given to the need to direct resources into developing local expertise. The replacement of expatriates by nationals would facilitate integration of refugee health activities into the national health system, enhance the sustainability of refugee health programs and strengthen the local human resource base.

Refugee Training

The primary health care approach assumes the involvement of trained community health workers who are at the heart of efforts to promote better health practices and to identify those who are at risk of illness. In refugee situations, trained community workers are often not available to play this important role. High priority must therefore be given to efforts to train refugee workers to assume these duties.

However, there continues to be a serious lack of health professionals with the ability and willingness to train others. A top priority for any health-related activity must be to transfer knowledge and skills and to build up the capacity of the refugees themselves, or in some cases of the host country government, to meet their own needs. Too often, such training either does not take place at all, or is done through ad hoc approaches under the guise of "counterpart training", which too often results in minimal and often contradictory information being transferred. This is particularly a problem of health programs built on emergency, relief activities where there is a high rate of staff turnover.

Just as with the health program as a whole, the primary health care approach should guide refugee training efforts. While teaching refugees to perform vital curative activities, training should emphasize those activities concerned with the prevention of ill health rather than the treatment of disease. This strategy may face challenges in overcoming the refugees' already acquired preferences for the more glamorous activities of clinical care. However, this approach will gain easier acceptance if the training activities are well integrated into an overall health promotion strategy.

Effective refugee training is characterized by clearly defined and agreed upon objectives, priorities, curricula and methodologies. The trainers must have a good understanding of and rapport with the refugee community. The program should build on the existing skills and knowledge of the refugees, and there should be active refugee participation in all aspects of the planning, implementation and evaluation of the training program. The training program should have a long-term perspective and be capable of being sustained and developed over long periods of time. It should be designed so that refugees can eventually not only take over the practical health work, but also become trainers themselves or move into management positions.

Women comprise a very large segment of most refugee populations and are often faced with greater responsibilities due to the breakdown in traditional family and community structures. Providing women with training opportunities in health care is an important way of ensuring that health programs are more responsive to the special concerns and needs of refugee women and their families and that women have the opportunity

to learn new skills. Use of trained female community health workers and traditional birth attendants also secures greater access to health services for refugee women, especially those from restrictive cultures.

Even with appropriate training personnel, barriers to effective training programs and the use of refugees as community health workers must be overcome. While most of these barriers also constrain training efforts in the wider field of international health, they tend to be more pronounced in refugee work and therefore require even greater sensitivity to the socio-economic, political and cultural nuances of the refugee community as well as the host country.

One example is the situation of a refugee health care program that is integrated into the host country health system. Not only do refugees have to be chosen and trained according to the demands of the refugee community, they must be selected with due consideration of their ability to fit into and adapt to the already established national health system. Decisions must be made regarding which language, curriculum and teaching methodology to use, if they differ between host and refugee populations. There are additional challenges concerning level of authority to be accorded the trained refugees, certification, and the amount of remuneration to be given, and the corresponding levels in the host country.

As another example, the selection of refugee health workers can be influenced by political considerations of refugee leaders, or perhaps by the requirements of military forces that need trained health cadre. The very fact of having received training can, in turn, make those refugees prime candidates for resettlement to third countries or, in the case of military considerations, for recruitment into the ranks of military forces.

Refugee training efforts are further complicated by the need to determine early in the training program the most likely ultimate resolution of the refugees' plight; that is, whether they are likely to remain indefinitely in the host country, return to their homes or resettle in third countries. Training and health program planning will need to be correlated with one of these eventual solutions if the training is to have more than very limited, short-term objectives.

Refugee Participation

Fundamental to effective implementation of a primary health care strategy is the institutionalization of refugee participation into all phases of the refugee assistance activities. This call for refugee participation, while being nearly universal in refugee program planning, is at the same time nearly universally ignored in practice. Participation is nevertheless the essence of the primary health care strategy, without which the entire system is rendered ineffective. This is not, therefore, just an idealistic, academic debate. It is a fundamental part of this whole approach for improving the health status of refugees.

The active involvement of the refugee population in program design, implementation and evaluation is more easily and naturally accomplished by agencies that have already adopted and are currently practicing the principles of primary health care. However, those agencies that truly incorporate the target population into the decision-making process are rare. This is especially so in refugee situations. In fact, the very nature of the refugee situation leads to a relationship between donor community/assistance providers on the one hand and dependent beneficiaries on the other characterized by paternalistic, authoritarian decision-making practices. Changing this orientation poses a strong challenge to donors, UN agencies, NGOs, host governments and virtually all players in refugee health activities. However, a way to bridge the huge gap between assistance providers and refugees must be found.

Authentic refugee participation requires radical transformation of the way assistance agencies, donors and host governments see themselves in relation to the refugees. It means that health agencies will not define, but support, the choices of the refugees. It requires an institutional political commitment to relinquishing some control to the refugees. The emphasis on longer-term developmental approaches means that host governments will need to overcome the fear that refugee participation and self-reliance may signal the long-term integration of refugees into the host country. Governments need to recognize the importance of developing a capacity within the refugee community to address health problems.

Undoubtedly it will be hard to involve the refugee community in decision-making during the incipient stages of emergency relief efforts, when immediate responses may be required to assist perhaps tens of thousands of people already weakened by the traumas that led them to flee and by the journey itself. Further, the need for immediate and visible results in refugee situations is important to donors and the UN/NGO community involved, where reputations and thus continued funding are at stake. However, the urgency of the situation should not preclude the earliest possible implementation of participatory approaches. While posing the greatest challenge to refugee assistance agencies, the inclusion of the refugee community in decisions regarding their own health and well-being will reap the greatest long-term gains.

Allocation of Resources

Given that the current refugee assistance programs worldwide are in financial difficulty, prioritizing the use of funds available for health services is a necessity. This paper has argued for a reorientation of the health services towards a primary care approach. To accomplish this, a reallocation of funding from curative to preventive services will be necessary. It will also be important to direct funding toward the strengthening of local capabilities to respond to refugee influxes and to manage refugee health programs over the long-term.

Shifting funds from curative to preventive activities may not be easy. One difficulty would be the question of whether donors who now contribute to direct medical care would prove willing to fund other health-related activities instead. Many assistance agencies have actively promoted the idea through their fundraising campaigns that the primary need in a relief operation is for direct medical care. This has, therefore, become the vision of a relief operation held by most donors, including the main donor governments and the general donor public in many Western countries (especially the United States).

It is certainly arguable that people are more likely to support programs when confronted with a picture of a sick child receiving medical treatment than one depicting a burly bulldozer driver digging a sanitation ditch. However, fundraising efforts could combine an effort to re-educate

donors to the broader needs of refugees with some creativity in showing the human side of this broader vision (for example, what happens to these people when their health needs are not met). This approach can probably encourage support of a program such as sanitation just as effectively as the handing out of pills -- if the will to do so exists.

In addition, there are longer-term economic benefits to be derived from a reallocation of funds. Such a reallocation would result in not only more effective health programs but also more sustainable programs. Activities that emphasize preventing ill health in the first place and that rely on refugee skills and capabilities are more cost-effective. The same can be said of efforts to develop local expertise and to encourage host country government management of refugee health activities.

An emphatic caveat to this argument is that the economic benefits of developmental, primary health care approaches do not suggest a diminished role for the international refugee system. Since the vast majority of refugees are located in some the world's poorest countries, there will always be a need for international resources to develop and maintain local expertise and to ensure that basic standards of health are met. If the international community does not make a strong commitment to sustaining an adequate level of health, disastrous consequences could result.

Coordination of Activities

The acceptance of a multi-sectoral approach to refugee health care will result in the involvement of a large number of diverse agencies, both international and local, as well as the refugees themselves, in the health program. At the international level, UNHCR is responsible for coordinating the provision of general assistance, including health care, to refugees. Other UN agencies, such as WHO, WFP, UNICEF and United Nations Development Programme (UNDP), work in collaboration with UNHCR. Several host country ministries of health and other specialized agencies play an active role in coordinating health and related services for refugees and local communities in refugee-affected areas. NGOs generally perform the actual field work as the operational partners of UNHCR.

This large number of agencies requires effective coordination of activities in order to avoid duplication of efforts or gaps in program coverage. Such coordination has not proven easy in most countries in the wider international health field, even though the importance of coordinating health and health-related sectors and programs has been recognized for years. This is often because the various administrative structures and divisions concerned typically resist actions which they feel will decrease their power and autonomy.

In this regard, the admittedly artificial nature of many refugee sites may for once work in a positive direction. In such situations the power of the main coordinating institutions, such the government ministry with responsibility for refugees and UNHCR, is such that they can play an important role in coordinating the work of the different institutions concerned. This presents an opportunity for those in the field of health for uprooted persons to take the lead in demonstrating the value of such coordination and in clarifying the areas and approaches where it can be most effective.

For this to occur most effectively, a number of actions need to be taken by different entities. For example, the institutional roles and relationships of the major organizations involved in refugee health care must be clarified, with identification of the specific areas where the policies and programs of the different health-related sectors overlap. International agencies, host country institutions and refugee representatives need to establish mechanisms for better communication and decision-making processes. Host country ministries of health need assistance in strengthening their ability to respond to refugee emergencies and to coordinate and manage long-term refugee health assistance efforts at the national and field levels.

This latter point is essential to ensuring refugee health program sustainability over the long-term. All too often the consequence of an uninvolved or weak ministry of health is the development of parallel health services for refugees. Health services designed just for refugees tend to be staffed largely by expatriate workers and to be of a higher quality than services available to the local population. This creates resentment in the local population and serves to isolate the refugees.

In strengthening the host government's capacity to deal with refugee emergencies, it is important to avoid the creation of new, autonomous agencies disconnected to existing institutional structures. Rather, an individual or unit located within the ministry of health could receive emergency preparedness training in order to be able to respond rapidly to refugee influxes. That individual or unit could then draw upon the relevant departments within the ministry of health and throughout the government for expertise and assistance.

Once past the emergency period, effective leadership by the ministry of health, supported by UNHCR, WHO and the other UN agencies, would facilitate integration of the refugee health care system with the national health system and development of a primary health care program serving refugees as well as locals.

Coordination of activities could be facilitated using the concept of the health team, encompassing all agencies that contribute to health promotion. Health agency personnel can play a role in supporting the coordination efforts of the program managers. They can help to define the roles and responsibilities of all team members, support the integration of all members of the team into the health work, and build the necessary sense of a common purpose among the often disparate agencies and people.