- Part B -

Priorities for Programme Organization and Management

Given the limited resources available for refugee assistance, it is essential that health and nutrition programmes are managed efficiently to obtain the widest possible coverage.

This section addresses the four basic principles which underly the management of refugee health services, which, when integrated, allow the most effective use of health resources in refugee settings.

TOPIC B.1

EFFECTIVE ORGANIZATION OF HEALTH SERVICES

The effective organization of refugee health services rests on three fundamental principles:

- # co-ordinated action
- # standardized policies
- # decentralized health programmes

At all levels, when these principles are given the highest priority, health services can be organized in the best interests of the refugee population.

Specifically:

co-ordinated efforts	- ensure priorities are shared - rationalize services - prevent programme duplication - minimize gaps in services
standardized policies	- simplify monitoring - provide consistency between programmes and services - secure reliability of information and analysis of data
decentralized health programmes	- ensure widest coverage of target population

1.1 Co-ordinated Action

1.1.1 Importance of Co-ordination in Refugee Settings

Along with other more visible forms of assistance, effective co-ordination remains one of the most critical components of an organized system of refugee health. Of the many advantages associated with well-co-ordinated health services, the following are most relevant in a refugee setting:

		which:
#	rational allocation of activities to priority needs and agency capabilities	eliminates/minimizes programme duplication
#	assignment of programme responsibilities according to camp-wide health needs	ensures access to care for groups who might otherwise "fall through the gaps" in services
#	mechanism for co-ordination	introduces standardized guidelines
#	introduction of means to define camp-wide health priorities	continuity of care in response to changing levels of support; adaptation to changing needs

1.1.2 The Essence of Health Co-ordination in Refugee Settings

In the context of refugee assistance, the essence of health co-ordination is expressed in two ways.

It requires:

> a broad overall perspective of refugee health
> combined with
> an organizational ability to mobilize and integrate services effectively in the interests of the refugee community as a whole

(a) At all levels, the capacity to maintain this broad view of refugee health is an essential precondition for effective co-ordination. It involves:

> - o understanding how relief activities are integrated with host country priorities and policies
> - o maintaining a total perspective of each refugee settlement and its services as a whole
> - o being aware of how all services (health and nutrition programmes, administrative, logistical/support services) link together in the best interests of refugee health

(b) However, effective co-ordination is not merely a matter of perspective. It also requires an ongoing commitment to action - that is:

> action to organize and integrate health, nutrition and general assistance activities in order to achieve the greatest health impact possible

Specifically, this involves two complementary activities:

		for example:
o	horizontal co-ordination	controlling camp-wide malaria
	which is: the effectiveness with which activities are co-ordinated together at each level	which will involve: o community health services o camp sanitation/construction staff o out-patient/laboratory personnel
o	vertical integration	international drug procurement
	which is: the extent to which activities at different levels are streamlined	which involves communication and standardized procedures between camp ---- regional office ----- branch office ---- headquarters

1.1.3 Structuring Co-ordination Activities

Although the specific arrangements for health co-ordination vary between refugee situations, the general structure for co-ordinating refugee health programmes involves activities at camp, regional and national levels.

These relationship are represented below.

Co-ordination Structure, Showing Relationships Between Camp, Regional and National Levels

(a) Camp level:

> One lead agency should be designated

The lead agency is responsible to the host government and to UNHCR for co-ordinating health services within the camp and for reporting and representing the camp on health/nutrition matters at a regional level.

> A camp steering committee should be established

This should include representatives from:

o the host government	- camp commander
o the refugees	- refugee leaders
o UNHCR	- UNHCR field officer
o technical staff	- health, sanitation personnel
	- food distribution

Technical staff should be limited to one representative from each sector, and all policy decisions should be approved and monitored by the committee to ensure assistance activities are integrated.

(b) Regional level

A regional health co-ordinator must be appointed from either the host government, UNHCR or non-governmental organizations

The regional co-ordinator is responsible for preparing clear guidelines for health and nutrition programmes. These guidelines should result from policy meetings with the host government, UNHCR and non-governmental organization representatives and after clearance by the proper regional and national authorities should be regarded as binding directives by all concerned.

(c) National level

o

In large programmes, a senior health co-ordinator must be appointed* to: - supervise refugee health activities at a national level, and - discuss possibilities regarding integration of services

o

Tripartite agreements between the host government, UNHCR and the non-governmental organizations are essential for well co-ordinated health programmes

Tripartite agreements must be established by all agencies participating in the assistance programme, regardless of funding source. (However, where appropriate, budget allocations can be used as an additional mechanism for co-ordination at all levels).

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* In large refugee programmes, the refugee health co-ordinator should be appointed by UNHCR, and should collaborate closely with a designated counterpart appointed by the host country.

1.1.4 Preconditions for effective co-ordination

(a) As with other essential aspects of refugee health, certain preconditions must exist if co-ordination activities are to be effective.

These include:	for example:
o Recognized **mechanisms** for **co-ordination** at all levels	regional co-ordinator; lead health agency at camp level
o Explicit **designation** of **responsibilities**	job descriptions for health workers, specification of agency responsibilities
o Closely observed **channels** of **communication**	drug requests; procedures for reporting disease outbreaks;
o Clearly understood **lines of accountability and authority**	**Levels of medical supervision** from camp to national health co-ordinator
o Adequate **resources** - personnel - budget - equipment/facilities	regional co-ordinator, secretarial support; salaries, supplies, basic equipment; office space, typewriter, stationery

(b) For health co-ordination to be effective at a field level, it is essential that:

- o clear provision is made within the designated lead agency for carrying-out co-ordination activities (ie. allocation of co-ordinating responsibilities to one position, specific job description, sufficient resources and administrative support).
- o clearly understood channels exist for reporting, decision-making and communication between the camp co-ordinator and regional/national levels - as well as within the camp.

- o the health co-ordinator actively co-ordinates camp-level health services so that camp-wide priorities can be promptly identified, and programmes directed accordingly.

This involves:

- o chairing regular meetings with health personnel to discuss general routine matters
- o initiating and co-ordinating meetings to address specific health problems (for instance, an outbreak of pertussis in camp)
- o co-ordinating and evaluating disease surveillance reports from different activities to determine programme effectiveness and changing health
- o representing health concerns at a camp level with other sectors and camp administration - and co-ordinating as required with regional and national health co-ordinators

1.1.5 Co-ordination with Essential Services

While health teams are often preoccupied with providing curative and basic preventive services, the health impact of essential support services cannot be ignored.

These activities, which include:

- o overall camp administration
- o food supply and distribution
- o water supply and distribution
- o sanitation
- o infrastructure and maintenance

are truly preventive services in the broadest context.

Therefore, it is important that the camp steering committee is used as a forum for co-ordinating activities of health and nutrition services with those of other assistance programmes. This ensures that each programme manager is aware of the concerns facing other sectors and that limited resources are used as effectively as possible.

For instance:	It is important to know:	This information can be provided by:
In managing widespread malnutrition	o how regularly food supplies are being delivered o how effectively food is distributed o the composition of basic rations	o camp administrative personnel o food distribution staff

In controlling malaria	o what the local mosquito vectors are o if local conditions promote disease spread	o camp sanitarian o local resource people
In controlling diarrhoeal diseases	o what are the customary defaecation practices o what arrangement for latrines has been made o water supply sources o adequacy of distribution o daily ration allocation	o refugee resource people o camp sanitarian o camp administrative personnel o construction teams

1.1.6 In the context of refugee relief, co-ordination plays a central role in shaping both the efficiency and effectiveness of health services. Even in the early stages of assistance, it must remain a foremost priority for managers at all levels.

1.2 Standardized Policies

1.2.1 The Importance of Standardization in Refugee Health

Among the first priorities in the organization of refugee health services is the introduction of standardized guidelines and policies.

This is essential in refugee settings, as standardization of activities encourages programmes and procedures to be implemented consistently and efficiently.

Of those areas where standardization is essential, the following are most important:

i) Policies for action

- o essential drugs policy
- o policies for employment of refugee health workers
- o policies stating priorities for use of local hospitals
- o policies defining involvement of foreign/national health workers

ii) Organizational procedures

- o organizational levels and responsibilities
- o lines of authority/accountability
- o channels of communication (vertical and horizontal)
- o mechanisms for decision-making/co-ordination

iii) Administrative procedures

- o surveillance reporting requirements
- o ordering/storage procedures for drugs and supplies
- o minimum acceptable qualifications for health personnel
- o procedures for identifying refugees with health needs
- o patient referral procedures

iv) Technical protocols

- o areas of prescribing responsibility for differing levels of health worker
- o standardized treatment protocols
- o intersectoral approach for the control of specific diseases of public health importance

1.2.2 Introducing Standardized Policies and Procedures

The specific way in which standardized procedures are introduced, implemented and enforced varies between settings. It reflects differences in the complexity of relief programmes - particularly in the number of agencies involved, the number/size of refugee settlements affected and the organizational levels required for decision-making.

In many instances, general health policies are stipulated at a national level in discussions between UNHCR, the host government and other implementing agencies. **These policies should be endorsed by the host government before circulation to regional and camp personnel, and should be adhered to by all agencies involved.**

1.2.3 Requirements for Effective Standardization

Clearly, standardized policies can only be effective if they are observed and adhered to at all levels.

This requires:

that standardized procedures and protocols are written in simple understandable terms and are organized for easy reference (ie. they should be readable, understandable, usable).

This means:

- using unambiguous terms, diagrams and flow-charts to clarify procedures;
- critical review of draft policies by experienced personnel prior to circulation;
- attachment of instructions, where needed, for correct completion of forms.

that policies, protocols and guidelines are clearly communicated through correct channels to all concerned.

- in all situations, policies must be formulated clearly and simply in writing;
- disseminated promptly through correct channels to the health workers involved;
- clearly explained to the personnel concerned;
  and
- made readily accessible to them for ease of reference.

  [e.g. in camp settings, cover policy guidelines with plastic and put in a visible/accessible place: make copies]

that new staff members are carefully oriented to standardized procedures and regulations.*

This means:

- setting aside time for explaining health policies and protocols to all health workers;
- identifying programme co-ordinators as key resource personnel;

and

- insisting that their advice must be sought whenever procedures need clarification.

that all co-ordinators actively supervise the programmes for which they are responsible.

This means:

- on-site supervising of health and nutrition services to determine whether protocols are being observed;
- establishment of regular meetings with health workers to reinforce basic policies (ie. drug prescribing protocols);

and

- to identify possible problem areas;
- introduction of programme monitoring procedures which rapidly allow misinterpretation of policies to be identified and corrected.

difficulties in the implementation of policies and protocols can be promptly recognized to enable underlying problems to be corrected or policy modifications to be made.

This means:

- providing mechanisms vertically and horizontally for discussion of policy issues;
- understanding that lack of adherence to policies and protocols may be due to practical considerations (ie. lack of weighing/measuring equipment for supplementary feeding programme);
- maintaining a flexible perspective which recognizes different camps and health programmes must face varying operational restraints and difficulties in implementing health policies and directives.

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* See CHC.Doc.(1) for an example of regional guidelines.

1.3 Decentralized Health Programmes

1.3.1 Importance of Decentralized Services to Refugee Health

By quickly decentralizing health and nutrition activities, camp-wide coverage of high-risk groups can be promptly established in the early phases of assistance. This is important for making health services readily accessible to all refugee groups, irrespective of their location in camp and quickly establishes linkages between these programmes and the community.

1.3.2 Steps for Effective Planning of Services

In order to ensure services are relatively equally distributed geographically, the following steps should be taken:

1 **Assess general population distribution/location patterns** + **Geographic layout of camp**

to

2 **site decentralized clinics and other services close together**

to

- o encourage cross-referral
- o improve co-ordination
- o minimize confusion

and

3 **establish linkages between health services and target groups**

through

an active cadre of community health workers

(a) Assess general population patterns in camp layout

In order that the siting of health clinics, feeding centres and mother-child health services reflect actual camp needs, it is useful to review general population patterns and the camp's geographic profile in advance.

Relevant sources of information for planning include:

o rough maps	to show the camp's size and general layout
o general census information	population distribution
o administrative information	- size and location of camp sections - siting of food/water distribution points - estimated population size by section

(b) Siting for decentralized clinics and other services

This review of camp and population characteristics provides a useful basis for locating services so that maximum accessibility and coverage are attained.

(i) Whenever possible, different decentralized activities should be located close together, as this encourages cross-referral and co-ordination between programmes. It also simplifies the process of seeking health care for the refugee population by reducing the distance between the different services (whose various functions are often confusing).

(ii) Ideally, the catchment areas for the different services should correspond, as this allows home-visiting activities and follow-up for each programme to be better co-ordinated through community health workers.

(c) Establishing linkages between services and target groups

For decentralized clinics and health services to attain adequate coverage of their target populations, they must be linked with the refugee community by an active cadre of community health workers (CHWs). Again, to minimize confusion and improve co-ordination between programmes, it is important that CHWs are responsible for home-visiting in areas which fall within the catchment boundaries of clinics and MCH programmes.

It is this combination of appropriately sited services, plus co-ordinated home-visiting and outreach that is the basis for effective decentralized care. If these measures are given early consideration in the planning of refugee health programmes, camp-wide health needs can be promptly addressed.

Guide to Annexes and Documents

CHC.Doc.(1) Guidelines for Health Care in Refugee Camps
Refugee Health Unit Somali Ministry of Health (1983)

01 Priority Activities in Early Stages of Assistance
02 Suggested Organization of Services at Camp, Regional and National Levels.

TOPIC B.2

2.0 APPROPRIATE USE OF INFORMATION

2.1 Importance of Health Information in Refugee Settings

The collection, interpretation and appropriate use of qualified information is essential for the management of refugee health programmes.

However, if health information is to be effectively used to:

- define health needs
- set programme priorities
- evaluate changes in health status
- monitor programme effectiveness

it is important that programme managers understand:

- the range of information sources available
- the limitations of different kinds of information
- that difficulties exist in interpreting information
- that relevant data must be organized systematically

2.2 Sources of Information

2.2.1 Information that is relevant to refugee health and nutrition should be collected and compiled from multiple sources. These findings should be organized in such a way to present an overall view of camp health priorities - as well as programme capabilities/limitations - so that services can be promptly directed to areas of need.

The categories of information which are most useful in the management of refugee health and nutrition programmes include:

- demographic patterns
- mortality information
- patterns in health and nutrition
- health service utilization patterns
- information from related programmes

Possible sources for these information categories and the relevance of collected information to refugee health are summarized below.

Information category	Relevance to Refugee Health
o Demographic patterns	indicate: # population age and sex distribution
	Sources: o enumeration of camp residents (registration data); o enumeration of houses (multiplied by occupancy estimates); o indirect estimates from tally of ration cards
o Mortality information	indicates: # patterns in infant deaths and other high-risk groups; # changes in mortality (seasonal impact)
	Sources: o direct counts of burials; o community health workers; o hospitals/clinics

o Health/nutrition information	indicates:	# health/nutritional status of at-risk groups # changes in morbidity patterns due to seasonal or other factors

Sources
o surveys of specific health problems
o regular reports from health and nutrition programmes

o Health service utilization patterns	indicate:	# relative importance of problems # programme coverage # programme effectiveness # programme acceptability (when collated with information from other sources)

Sources	
o OPDs and clinics	o maternal-child health programmes
o nutrition services	o community health workers

o Information from related services	indicates:	# insect vectors; daily water allocation, bacterial content of water # basic ration/fuel allocation # population officially eligible for basic assistance (food cards, etc)* # population estimates of those eligible for, but yet with unmet assistance needs

Sources	
o water and sanitation services	o food distribution programme
o camp administration	o logistics officers

* This information is essential for determining high-risk groups. For instance, if only 80% of the camp population has been issued ration cards, food sharing between families can be assured - with unfavourable effects on the nutritional status of young children and pregnant/lactating women.

2.2.2 When this information is compiled centrally, it provides the basis for defining priorities and initiating action across different services. In this way, it is essential for effective co-ordination and cannot be separated from the overall organization of refugee health.

2.3 Limitations of Different Types of Information and Difficulties in Interpretation

Although the interpretation of most technical information is carried out by qualified health/nutrition personnel, it is important that programme managers understand some of the general principles involved.

2.3.1 General Principles

(a)

Quantified information is not a substitute for common sense

It is chiefly of value when combined with descriptive information and findings obtained from simple observation.

(b)

Cause and effect should not be assumed

For example, although a survey reports:

"30% of children under 100 cm height are malnourished"
this does not necessarily mean rations are inadequate in quantity.

High rates of malnutrition may also be related to:

- o high rates of communicable disease
- o unavailability of utensils/fuel
- o poor food quality/ acceptability
- o prolonged exposure

This example illustrates the need to carefully review all relevant factors before planning an appropriate response.

(c)

Health status and programme effectiveness are not always related

Declining population morbidity and mortality are often attributed to the effectiveness of environmental measures or health programmes. However, apparent improvements in health status may also be due to:

- o ineffective health programmes

  for example:

  A severe measles epidemic with high mortality will result in improved mortality rates once the epidemic is over. While this may indicate an apparent improvement in mortality, in actuality it does in fact reflect the inadequacy of immunization programmes to protect at-risk children against measles.

- o social and economic re-organization of refugees

  for example:

  By trading rations with the local population, refugees may improve the otherwise poor quality of food supplied by general rations.

(d)

The observation of a disease in a population does not always necessitate action

Key questions to ask when evaluating reports of a disease in a refugee population include:

- o can clear diagnostic criteria be defined for the disease (ie. diarrhoea)?
- o is the disease common and severe (eg. pneumonia)?
- o does the disease have epidemic potential (measles, meningitis)?

2.4 Consideration in Interpreting and Using Information

Information from multiple sources can be skilfully used in the management of health programmes. However, information must be carefully interpreted if it is to be applied appropriately. These considerations are summarized below:

Information source

Maps are useful for:
- # siting services appropriately
- # allocating addresses to households

key considerations

- o allocations of addresses is indispensable for control and follow-up of specific health problems (ie. tuberculosis)
- o early maps - may be rough; may need refining with time
- o ideally - all individual dwellings should be mapped

Population estimates are useful for:
- # calculating essential needs (food, water, fuel)
- # determining useful disease rates/ (mortality)
- # planning health needs (drug procurement, manpower needs)

key considerations

- o accurate enumeration of population is often difficult due to problems in registration
- o estimates based on ration cards also subject to error

Nutrition surveys + Census information are useful for:
- # estimating numbers of children eligible for supplementary feeding
- # evaluating effectiveness of health/nutrition programmes
- # planning/modifying services

key considerations

- o care needed in estimating total target population
- o selection of representative sample essential

Surveys of special diseases are useful for:
- # determining the extent of a suspected health problem
- # providing baseline information for planning control measures
- # planning an organized response to a chronic health problem

key considerations

- o careful standardized case definitions (eg. anaemia)
- o selection of representative sample essential

Reports from feeding programmes + Census data are useful for:
- # estimating coverage by nutrition programmes

key considerations

- o census data should correspond with feeding centre catchment areas
- o registration/attendance data must be collected and compiled systematically

Mortality data are useful for:
- # indicating general health status of at-risk groups

key considerations

- o declining mortality + morbidity may indicate improving health status or the impact of increased mortality in high-risk groups
- o increasing mortality should be investigated
- o increasing mortality reports may indicate improved surveillance

Morbitidy data are useful for:
- # showing gross trends in the level of a disease
- # indicating presence of a new disease
- # indicating gross differences in disease occurence (ie. between camps, or at different times)

key considerations

- o minor fluctuations in disease do no mean changes in actual disease levels
- o morbidity data do not provide a direct measure of disease in a population because data from clinics and out-patient centres may reflect health patterns of self-selected individuals - and do not always represent disease patterns in the refugee population

Drug consumption is useful for:
- # planning future ordering/procurement needs
- # detecting inappropriate patterns in drug use

key considerations

- o when linked with surveillance data, it provides a basis for evaluating prescribing/dispensing practices

2.5 Organizing Information for Effective Use

For health information to be useful in programme management, it is critical that data are organized in a systematic way.

Surveillance information as well as programme monitoring statistics should be compiled according to standardized reporting requirements specified by health co-ordinators at regional and national levels. As soon as feasible, this information should be summarized monthly to indicate general health patterns, the impact of seasonal factors, and to compare annual trends in refugee health.

However, for such information to be usefully applied to the overall management of health programmes, it should be accomapnied by brief yet pertinent comments. This is essential so that apparent changes in morbidity/ mortality patterns can be interpreted meaningfully by management personnel at all levels.

2.6 The Rapid Epidemiologic Assessment - Information for Decision-making

2.6.1 Purpose of Rapid Epidemiologic Assessment

The aims of the rapid epidemiological assessment are to:

- o assess the health problems of immediate priority
- o identify the resources to be mobilized
- o predict potential health problems which may develop due to:
  - the characteristics of the refugee population (ie. place of origin, demographic composition)
  - the effects of the local environment

In addition, the information gained from a rapid epidemiologic assessment provides important baseline data for identifying secondary priorities.

2.6.2 Methods

The rapid assessment is a combination of:

- o an assessment of refugee needs
- o an assessment of the local environment
- o collection of background information

(a) Assessment of refugee needs

(i) This is accomplished by:

- o visual assessments, which focus on the general condition of the refugees, the belongings they have brought (eg. cooking utensils, water containers, clothing, blankets) and how the refugees regroup - by family, clan, village of origin.
- o objective measurements, which require random sampling or, better, systematic screening. The method will depend on the number of refugees, the rate of influx, the time limitations and the geographical feasibility.

(ii) The initial assessment aims to

- o identify the population breakdwon by age and sex
- o estimate the nutritional status
- o estimate current levels of mortality
- o identify the main health problems of the population
- o identify the presence and intensity of vectors likely to influence disease transmission, e.g. lice, ticks
- o estimate the number and prevalence of severely ill and wounded persons for planning curative care

(b) Assessment of the local environment

An assessment of the local environment should focus on the areas listed below:

	in particular:
climatic conditions	o seasonal variations o specific health problems associated with seasonal changes o differences between present climate and that of refugees' place of origin
geographic features	o nature of the soil and slope of terrain o presence or absence of bush for fuel and shelter

local epidemiology	o prevalent diseases which are new to the refugees
local health services	o ways in which the existing system can serve as a baseline reference for developing refugee health services o integration - to the extent possible - of refugee and local health services o measures for strengthening local services
local vectors	o vectors which influence disease transmission (eg. mosquitos, sandflies)

(c) Collection of Background Information

Gathering background information on the refugees should focus on the conditions in their area of origin. Specific background information which provides an essential basis for health programme planning includes:

	for example:
o prevalence of main diseases	o infectious conditions, childhood diseases
o previous sources of health care	o traditional healers, drug vendors, midwives
o health beliefs and practices	o diet for prenatal women, treatment of diarrhoea
o social organization	o based on clan, extended family, role of women

Such information can be obtained through:

(i) interviews with refugee leaders, heads of families, and women. The interviews should aim to clarify the reasons for and conditions of the flight - which may assist in anticipating the health status of future arrivals. They should also focus on key health issues such as:

- traditional beliefs and customs regarding food, housing, preferences, hygiene practices and burial techniques (useful for collecting mortality data).

(ii) documents from host government, intergovernmental and voluntary agencies.

(iii) discussions with resource people with previous involvement/experience with the displaced population (ie. physicians who have worked in the refugees' place of origin, historians, anthropologists).

2.6.3 Organization of a Rapid Assessment

The initial assessment should be carried out jointly by the national authorities responsible for refugee assistance and UNHCR with assistance from voluntary agencies already at the site.

Two possibilities for the location of the rapid assessment include the centre of arrival and the camps. Camp assessments may require the use of survey methods and may extend over 2-3 days. Assessments at the centre of arrival are discussed in "Health Screening of New Arrivals", on page 44.

2.6.4 The Results of a Rapid Assessment

A report of the results must be presented immediately to the national authorities, UNHCR and voluntary agencies. The importance of the initial rapid assessment cannot be overstated. Not only does it provide the foundation for an ongoing disease surveillance system; more significantly, it provides the basis upon which immediate priorities are defined, tasks allocated and effective action taken.

TOPIC B.3

ACTIVE REFUGEE INVOLVEMENT

3.1 The Importance of Involvement

Among the main priorities in the organization of refugee health services is the active involvement of refugees, not only in the delivery of care, but also in the overall planning and co-ordination of services.

When one considers the organization of health and nutrition services, this involvement takes two forms:

specifically:	for example
o involvement in actual health programmes to	community health workers
- provide care	feeding centre personnel
- perform essential tasks	laboratory staff camp sanitarians
o involvement at a community level to:	formation of camp steering committee
- define health priorities	contact with community leaders
- co-ordinate action with administrative and health services	discussions with women dialogue with minority groups

3.2 Refugee Involvement in Health Activities

Clearly the involvement of refugees in the performance of essential tasks is necessary for the successful implementation of health programmes.

An issue of central concern, however, is that of payment for refugee health workers.

3.2.1 In the planning of health services, careful consideration should be given to:

- o host country policies regarding refugee payment
- o method of payment (in-kind or in cash)
- o basis used for determining salary scales
- o cultural preferences of refugees regarding payment

- o When possible, the host government should establish payment policies for refugees

- o It is also imperative that policies are introduced to standardize methods of payment.

Particularly, if salary scales are used, care must be taken when determining the basis for payment levels.

3.3.2 It may be advisable to initiate payment at low levels as they can and will be raised; it is very difficult, if not impossible, to reduce salaries once they have been established.

3.3 Community Participation

While definitions of "refugee involvement" are frequently limited to the activities refugees carry out in clinics and health centres, real refugee participation in health involves much more. It means an active and ongoing dialogue between the refugees, camp administrators and health/nutrition personnel and specifically includes:

- o joint efforts to define camp-wide priorities
- o agreement to adopt measures which best address these needs
- o willingness to co-ordinate appropriate action.

It is especially important that efforts are made to bridge cultural differences between the refugee population and foreign/national health workers in areas which include:

o health beliefs	o health practices
o acceptable treatments	o acceptable sources of care

Therefore, health services must be organized to respond to their special needs. Clearly, this requires a co-ordinated approach, so that the health and nutrition priorities of women and children are effectively addressed through an integrated effort, involving each of the health and nutrition programmes described in those guidelines.

3.4 Refugee Involvement in the Emergency Period

In the early stages of assistance, expectations of such community involvement are largely unrealistic. This is due not only to the disorganized nature of the emergency period, but also to the multiple concerns which face newly arriving refugees whose personal resources are often seriously depleted both physically and emotionally.

While it is often impossible to initiate a constructive dialogue between refugees and other services in this phase, it is essential that such involvement occurs as soon as possible during the emergency period.

Without this active refugee participation in the definition of health priorities and plans for action, "involvement" in health care is restricted to the performance of tasks allocated by outsiders. Not only does this severely limit the overall effectiveness of health and nutrition services, it also impedes the development of those linkages between the refugee community and other services which are essential for adequate coverage and care.

TOPIC B.4

SYSTEMATIC PROGRAMME PLANNING AND MANAGEMENT

4.1 Importance in Refugee Health

Given the limited resources available in refugee settings and the multiple problems which face displaced populations; it is clear that health and nutrition programmes must be implemented effectively. In these activities, the role of the manager is to ensure that programmes are responsive to the needs of the refugee population.

For effective programme management this involves:

- questioning the reliability of the information provided by technical staff;
- initiating appropriate actions on the basis of information received;
- establishing that there is sufficient justification, and that the organizational pre-conditions exist for new interventions that are proposed;
- obtaining specialized assistance for the investigation of specific health problems where this exceeds locally-available skills;
- suggesting changes in approach to the delivery of services where technical staff are inexperienced;
- ensuring that responsibilities are allocated appropriately between implementing agencies.

This means adopting a systematic approach to the management of refugee health activities. As in other aspects of refugee assistance, this strategy includes:

- clear formulation of objectives and progress indicators
- definition of target group
- definition of assistance needs
- effective programme implementation
- regular monitoring of activities

4.2 Integrating Management Principles with Other Assistance Activities

While these elements provide a framework for action, it is critical that they are linked with other organizational activities (ie. co-ordination, information use, refugee participation) in order to achieve a measurable health impact.

4.2.1 These linkages are illustrated below:

Define Programme Objectives

by:	to:
collecting relevant health information from multiple sources;	o define health priorities o identify at-risk groups o select appropriate progress indicators

Determine Target Population

by:	to:
evaluating census information; reviewing health statistics; consulting with CHWs;	o define coverage objectives o determine general assistance parameters (education, food, improved case-finding)

Determine Assistance Needs

by:	to:
co-ordinating with refugees and implementing agencies; assessing local resources and priorities;	o reach clear understanding of needs o identify potential sources of assistance o mobilize local, regional, national resources

Implement Programme Effectively

by:	to:
co-ordinating action between refugees and implementing agencies; standardizing procedures; using appropriate assistance;	o avoid duplication of programmes o ensure coverage of target group o prevent wastage of resources o avoid dependence on inappropriate aid

Monitor Programmes Closely

by:	to:
reviewing surveillance data;	o determine programme impact
evaluating monthly/quarterly reports;	o determine programme coverage
monitoring progress indicators;	o establish programme effectiveness
consulting with refugee target population;	o determine programme acceptability
	o introduce programme changes as indicated

4.2.2 The effective management of refugee health activities is a challenge for programme supervisors at all levels. Yet, when approached in a systematic way, programme management activities have an important role in shaping the responsiveness of health services.