

REPATRIATION AND MEDICAL SERVICES IN BAN NAPHO CAMP

Susanna Maybin and Kevin Ireland

"In recognising that for the majority of refugees their likely destination is repatriation to Laos (especially in the face of ever decreasing numbers resettled), it is our duty now to switch the camp basis from pill pushing to health education. We must provide the refugees with the knowledge to improve their standard of living when back in their villages in Laos, to understand nutrition, to seek help sooner than later, especially for a child who is sick, to train a number to be village health workers being able to treat fevers, diarrhoea and the like. If we do not achieve this, all the pill pushing will have been in vain."

Comment by Dr. Julian Maitland.
SCF(UK) Medical Officer (1)
August 1983.

Background-General

Ban Napho Camp, 23 kilometers from the provincial capital of Nakhon Phanom in Northeast Thailand, accommodated 500 refugees from Laos when it first opened in 1977. In the period to 1980 more refugees arrived, although most of these were transferred to an alternative camp in Ubon. In 1981, following a decision of the Royal Thai Government to bring together Indochinese refugees in four main camps, the capacity of Ban Napho was expanded to 15,000, although the actual population rose to 20,000 with the closure of

Dr. Susanna Maybin is the former Medical Coordinator of Save the Children Fund, UK (SCF(UK)) at Ban Napho camp. Mr Kevin Ireland is the Director of SCF(UK) Thailand.

the Ubon and Nong Khai camps in 1982 and later to a peak of 42,000 in 1985. Since that time the population has declined as a result of official and unofficial movements to stand, in June 1989, at 14,720 (UNHCR figures).

The majority of past departures from Ban Napho have been for resettlement to third countries, principally the United States. This was reflected in the psychology of the camp's residents, for many of whom the goal of resettlement in the US was much sought after. During this time there was little official repatriation to Laos, although there always has been an unknown amount of unofficial movement. In spite of this, reports of agency personnel at the time suggest that the idea of repatriation was always very present for the authorities of the camp (SCF(UK) Medical Officer, 1981).

Since the end of 1988 a change of atmosphere in the camp has been noted with more refugees talking about and considering repatriation. In the first six months of 1989 446 refugees were officially repatriated (compared to 160 for all of 1988) and as of June 1989 there was a list of 694 refugees awaiting repatriation (UNHCR figures). This is a low figure relative to the population of the camp and the numbers of those resettled, (*) but in addition there are said to have been many unofficial repatriations, with a figure of 5 unofficial to every one official repatriation having been given as an estimate (UNHCR, Vientiane).

In May 1989, a tripartite agreement was made between the Lao and Thai governments and UNHCR when Laos agreed to take 150 voluntary returnees per month. By August 1989 this number was increased to 300 per month. This, along with spontaneous repatriations and the decreasing number of refugees eligible for resettlement in third countries, indicates that repatriation for many of the refugees is a strong possibility for the future.

(*) As of 31 July 1989 a total of 172,757 Lowland Lao have been resettled in third countries (114,599 in the USA). (UNHCR statistics).

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Background - Medical Services

Initially, medical services were provided to camp residents by a mobile team from the Ministry of Public Health (MOPH) in Nakhon Phanom Province, funded by SCF(UK). Direct agency involvement in medical services in Ban Napho dates from 1983, when SCF(UK) took over, however still working with assistance from MOPH medical staff in outpatients, the dental clinic, overnight cover and for referrals. SCF(UK)'s medical team moved, in fact, from the Ubon camp, where it had been providing a comprehensive system of preventative and curative health services since 1976.

The medical services in Ban Napho were expanded, operating essentially in a similar fashion to those which had been set up in Ubon camp, with SCF(UK) staff supervising Lao workers in the clinics, a public health programme and supplementary feeding programme. More Thai nursing staff were employed as the population of refugees grew. Problems were experienced related to overcrowding and poor sanitation, increasing numbers of arrivals in the camp, poor nutrition status and low immunisation coverage. In addition, efforts had to be put into maintaining training for SCF Lao refugee health workers as there was a rapid turnover of workers resettled in third countries. Over the next six years nutrition and immunisation status improved, maternal and infant mortality reduced, the sanitation improved and, with decreasing population, the camp became much less crowded. At this date the health status of the camp population is comparable to, if not better than, the official figures reported for the province of Nakhon Phanom from the Ministry of Public Health. SCF(UK) has thus, on the surface, achieved its objective of provision of health care and supplementary feeding for the refugees.

An Appropriate Model for Health Care?

It has been stated that the primary objective of refugee medical services is to provide:

- a) equal access to services for the entire population;
- b) an effective system of diagnosis and treatment.(2)

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Ideally, such services are established also to incorporate the principles of primary health care (PHC) and this objective has been important in the development of SCF(UK)'s services in Ban Napho. One of the most important aspects of PHC is prevention of disease, in which case we need to be looking to the future to assess the success or otherwise of our service provision, not only the past data on morbidity and mortality. For many of the Laotian refugees repatriation means return to an area with little access to medical care. If their stay (perhaps for years) in a refugee camp has not provided them with the knowledge and skills to maintain their health status on return to their country of origin, it must surely be judged that the health services in the camp were deficient. In fact, we may actually be doing the refugees a disservice. Those living in the camp will have lost a certain amount of initiative. Everything is provided for them - food, shelter, sanitation and health care. We have provided them with high expectations of easily accessible medical care and a reliance on western medicines.

Factors which contribute to the orientation of medical services to the present (curative) rather than the future (preventative) include:

- * the urgency of present health problems;
- * the natural tendency of western medical staff to focus more on curative than preventative care;
- * medical systems and standards inherited from other camps;
- * the pressure to conform to certain systems, reporting procedures and standards laid down by UNHCR;
- * the rapid turnover of refugee staff;
- * the pressure from refugees (and refugee staff) for "western medicine";

- * the nature of camp life, which reinforces the view of refugees as recipients rather than actors;
- * the difference between the refugee's environment and circumstances in the camp and those to which she/he came from;
- * uncertainty of what the future holds for the refugees.

In short, the health care system operating in refugee camps often tends to be aimed at the present, with little provision for the future, other than the vague hope that the knowledge gained by refugee health workers may somehow be useful for them in their future lives. Further, once a health care system has been set up and appears to be running well and providing a good standard of medical care there is a reluctance to change it. One would rather save one's energies to deal with immediate problems, particularly when the future is uncertain.

Although the Laotian refugee situation is still far from certain, it is evident that there is the possibility of significant numbers of refugees repatriating to their home country in the near future. At the beginning of 1989, therefore, it was decided that it was important for SCF(UK) to review the nature of its medical programme in Ban Napho. As part of this review it was necessary to obtain more information about the health care system and resources in Laos and the refugees who will return.

Health Care in Laos

SCF(UK) has worked in Laos since 1973, in co-operation with the Ministry of Public Health and Social Welfare. It has therefore been possible to obtain useful information from the SCF(UK) Field Director in Laos. This was supplemented by information from a consultant paediatrician, who visited Laos in February 1989 to advise on SCF(UK)'s medical programmes, and from visits by the Field Director for Thailand and the Medical Co-ordinator, Ban Napho.

The population of Laos is small, around 3.5-4 million, of which some 45% are under 15 years of age. It is widely dispersed and communications are poor, especially in the wet season. Over 85% of the population are rural and more than 60% of the agricultural workforce are women. After many years of war, refugee exodus and insurgency there are more women in the population than men and the flight of refugees has led to a dramatic reduction in trained manpower.

The country is poor: one estimate of the GNP per capita quotes US\$ 135 (compared to US\$ 881 for Thailand).(3)

A government health delivery system exists but it operates ineffectively due to the lack of trained manpower, lack of resources, poor communications, poor organisation and inaccessibility. The system is vertical and primarily curative, with little practical connection between the different elements.

Compared to the refugees in Ban Napho the health situation in Laos is very poor, as the following comparisons indicate:

Health Indices, Laos and Ban Napho

| | <u>Laos</u> | <u>Ban Napho</u> |
|--|---------------|------------------|
| Population | 3.5-4 million | 15,500 |
| - under 5 years | 17% | 12% |
| - under 15 years | 45% | 36% |
| Birth Rate | 46.1/1,000 | 28.6/1,000 |
| Crude Death Rate | 17.1/1,000 | 3.0/1,000 |
| Neonatal Mortality | N/A | 13.5/1,000 |
| Infant Mortality | 151/1,000 | 15.8/1,000 |
| Under 5 Mortality | 180/1,000 | 5.9/1,000 |
| Maternal Mortality | 5.5/1,000 | 0.0/1,000 |
| Low Birth Weight (<2.5 kg. - % births) | 18% | 5% |
| Immunisation Status - % Under 5 population fully immunised | 30% | 90% |

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Health Indices, Laos and Ban Napho (continued)

| | <u>Laos</u> | <u>Ban Napho</u> |
|--|-------------|------------------|
| Percentage of population with safe water in the home or within 15 minutes walking distance | 42% | 100% |
| Percentage of population with adequate sanitary facilities in home or immediate vicinity | 11% | approx. 100% |

Notes

1. Laos statistics from Ministry of Public Health and Social Welfare, WHO and UNDP sources - generally for 1985 or 1987. (Infant mortality 1989).
2. Ban Napho statistics average for July 1988 - June 1989.

The reality for most Laotians, certainly those living outside the major towns, is that there is currently little effective access to health services and minimal understanding of the principles of preventative health care. A patient visiting a rural health centre would be unlikely to find trained personnel who could diagnose and prescribe appropriate medications. Also the possibility of the necessary drugs being available at the health centre would be remote. Drugs are reported, however, to be more available in the market for those who are able to pay. Whilst the Lao Government is attempting to improve health care delivery at district level it is unlikely that changes will be effected which will alter significantly the circumstances to which most refugees will return.

Repatriation Candidates

All candidates for repatriation are given a medical examination prior to departure. Most of those examined over the last six months have come from rural areas in Laos and will return there. They tend to have been living in the poorer sections of the camp and have lower than average education levels. Many will have

had little contact with the camp authorities or the agencies providing services - including medical services. Surprisingly, however, it has been found that immunisations have tended to be up to date, possibly as a result of the aggressive follow up policy.

UNHCR has made certain health care provisions for those refugees returning voluntarily to Laos:

- All those returning receive a medical examination to identify anyone who is unfit to travel. SCF(UK) has extended this to include a check on immunisations, to advise those with a chronic illness, to treat minor complaints and to provide Vitamin A and deworming as necessary.
- A first aid kit is provided to each family by UNHCR. This contains a limited range of medications.
- SCF(UK) has also provided some of its trained medics who are repatriating with a copy of "Where There Is No Doctor" in Thai language.

Further Steps to Assist Returning Refugees

Following the review of its medical programme and the impact it can have for refugees returning to Laos, SCF(UK) has adopted further courses of action as set out below:

1. Improvement of health in the home by provision of an appropriate training to women in cleanliness, nutrition, sanitation, breast feeding, management of simple health problems and how to avoid illness. A three week course has been piloted, which does not include any written material and is thus accessible to those women who are not literate. Coupled with an improved notification system of those families registering for repatriation it is hoped that most women will have the opportunity to learn some basic primary health messages before returning to Laos.

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2. Extended training of traditional birth attendants. Drawing largely upon the training content for TBA's within Laos, SCF(UK)'s midwifery training programme has been adapted to provide the opportunity for women returning to Laos to obtain skills in this area and thus to help have an impact on maternal and infant mortality, even if only within the immediate family.
3. Extended training of camp medics. SCF(UK)'s training course for refugee medics spans nine months and provides the medics with sufficient skills to work in a controlled and supervised environment, according to established systems and protocols. It has been suggested that it is unlikely that any such medics will have the opportunity to work in the government health system in Laos, but experience has already shown that some medics who have repatriated have begun to practice on a private basis. To try and minimise the potential pitfalls of such unsupervised activity a simple pharmacy course has been established, based on those drugs that are likely to be available in Laos. The course deals with how to store and prescribe such drugs and importantly, when not to prescribe them and how to recognise side effects.
4. Improved medical screening and advice. In conjunction with advance information from UNHCR on those refugees volunteering for repatriation, a more organised system of medical screening has been established. This attempts to check all candidates shortly after they register for repatriation, thus giving more time for any necessary treatment and investigations, as well as providing returnees with health education and training and ensuring that all their immunisations are up to date.

The above elements have been incorporated into SCF(UK)'s medical programme with the aim of improving the circumstances and understanding of refugees who are likely to return to Laos, their country of origin. The objective is to try and help the refugees re-orientate to the circumstances they will find on their

return. In the final analysis, however, the most appropriate way of assisting this orientation process would be to avoid - as much as possible - the disorientation from the outset. This requires a conscious and determined effort to organise services as closely as possible to the model relevant to the home country situation, to incorporate traditional leaders and healers wherever possible and to avoid the tendency to aim for western structures, systems and levels of care. The goal should be to try and develop a programme which provides for the health needs of the refugees in the camp, but also relates as much as possible to their home environment, thus avoiding unduly raising expectations.

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