

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)
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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

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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)

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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