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## **Refugee Health Care Professor Gilbert Burnham**

### **Reading List**

#### **Module 1**

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# Welcome to Refugee Health Care

**Gilbert M. Burnham, MD, PhD**  
**Johns Hopkins University**





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# **An Increasingly Important Topic**

Today the lives of refugees are in increasing danger.

We are moving beyond traditional definitions.

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## **An Increasingly Important Topic**

People still flee across borders to become refugees.

We must help people displaced in their own country.

People with no place to flee are often unseen by the media or international observers.



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## Changing Circumstances

In the past, people fled individual persecution.

Today, they more commonly flee violence abuse of human rights and state collapse.

Organizations which once just cared for refugees are now having to rebuild health systems and social services.



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## Purposes of the Course

Assess the challenges of providing care to displaced populations.

Identify the resources available.

Examine the difficult environment in which refugees exist.





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## Course Goal

Give you a thorough understanding of who refugees are, what they need, and how to get them home again or someplace like home.



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## Course Objectives

Equip you with basic skills needed to provide care to refugees including the following:

Planning skills.

How to do an epidemiological assessment.

Skills to control communicable disease.

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## Course Objectives

Equip you with basic skills needed to provide care to refugees including the following:

Collecting information and doing surveillance.

Setting up environmental health provisions.

Meeting food and nutritional needs.



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## Speakers for the Course

Speakers for the course come from a variety of background.

Each is an expert in his or her field.

Each brings a different perspective.





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## Textbooks

### *War and Public Health*

Pierre Perrin, Chief Medical Officer  
International Committee of the Red  
Cross

### *The Public Health Guide to Emergencies* (CD-ROM)

By JHU faculty and the Red Cross

### *Course*

*Course*  
*Reader*

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## Course Assignments

Three case studies to work on as groups.

Questions on the bulletin board to discuss from time to time.

LiveTalks

A final paper



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## Final Paper

2000 words on a refugee health topic of your choice.

This must be a serious paper, well referenced, and with original thinking.

The paper must be submitted a week before the end of the term.

We can provide assistance with selecting a topic if you are stuck.



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## Final Thoughts

We very much look forward to having you in the course, and we hope that you will enjoy it.

We look forward to your questions and papers, which are interesting and every year follow different themes.



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# Refugee and Disaster Definitions

**Gilbert Burnham, MD, PhD**  
**Bloomberg School of Public Health**

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## Plight of Refugees

Flight from violence underlies most refugee population movements

Refugees need for assistance is greater than needs of victims of natural disasters

People fleeing conflict need assistance longer than if fleeing natural disasters

Return to normality is more difficult after conflict than after natural disasters



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# Humanitarian Response

Increasing difficulty in gaining access to people displaced by conflict.

No guarantee of neutrality for humanitarian actors.

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# Humanitarian Response

Humanitarian imperative to assist emergency affected population

Humanitarian aid used as an alternative to difficult political decisions





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## Causes of Conflict

Usually man-made or man-inspired, as a result of political actions

Conflicts may have underlying natural roots, such as famines or floods



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# Defining Complex Humanitarian Emergencies

Multiple contributing factors

Conflict often present with collapse of civil order

Excess mortality and threats to life

Population lacks access to basic needs food, water, health care, protection



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## Definition of Asylum

*Asylum* protection, refuge, security

Concept at least 3,500 years old

Found in many cultures

Enshrined in Universal Declaration of Human Rights

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# Definition of Asylum

Strict interpretation of persecution

Bureaucratic hurdles to granting asylum





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# History of Refugee Policy

## League of Nations (1921)

Helped persons in danger return to homeland

## United Nations (1951)

UNHCR established with protection mandate

Convention on refugees ratified

Defined

# Demica refugees

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## UN Definition of a Refugee

A person who has left country of origin because of well-founded fear of persecution due to

Race, religion, nationality, political opinion, membership of a social group

A person who is unwilling to return to country of origin due to fear

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# UN Definition of a Refugee

A person of no nationality

No forcible return to country where persecution may occur: *Nonrefoulement*



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## **OAU Convention (1969)**

Expanded UN definition of refugees to include those fleeing conflict from

External aggression

Collapse of civil order

Assured asylum and repatriation without prejudice





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# Cartagena Declaration (1984)

Basis for asylum includes those fleeing  
widespread human rights abuses



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## Persons of Concern

Persons not covered by existing definitions

Given UN protection by Security Council  
or Secretary General

Kurds in Iraq

Civilians in Bosnia

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## **Internally Displaced Persons**

Flee for same reasons as refugees

Do not cross an international border  
outside UN mandate

Limited access for assistance because of  
sovereignty issues

At increased risk of continued abuse



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# Economic Migrants

Late 20th century phenomenon

120 million persons live outside country of  
birth or citizenship



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## Economic Migrants

100 countries classified as having major inward or outward population movement

U.S. and Europe spend \$9 billion on asylum management annually

May have between 10 and 30 million illegal immigrants

*Source: ICRC*

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# Distinguishing Refugees from Economic Migrants

Increasingly difficult as reasons for flight are multifactorial

Many push pull factors

Evidence of persecution may be unavailable

Industrialized states may not recognize

Generalized violence

Breakdown of civil order

Internal

# internal conflicts

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# Persons Not Covered by UN Refugee Mandate

Criminal elements

Subversive elements

Hostages

Victims of natural disasters

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# Persons Not Covered by UN Refugee Mandate

Economic migrants fleeing economic  
privation

Eco-refugees



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## Who Looks after Refugees

Stateresponsible for its own citizens

Host countrypoor, resources limited

UNnot an implementing agency

Non-governmental organizations are  
implementing partners of UN

For example, CRS, CARE, IRC, ADRA, MSF

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# Who Looks after Refugees

## Members of the Red Cross Movement

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# Who Looks after Refugees

Members of the Red Cross Movement

National Red Cross/Red Crescent Societies

International Federation of Red Cross/Red Crescent Society coordinates all national societies

International Committee of Red Cross assists wounded in conflict situations



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# What Happens to Refugees

*Repatriation* return to home of origin

Must be preceded by political change

*Integration* less common unless similar culture or language

*Resettlement* in a third country no longer an option after Cold War





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# Consequences of International Migration

Asylum has become more difficult

Persons with legitimate claims rejected

Or returned to transit country

Search for new approaches in migration  
management

Visa requirements, interdiction at sea,  
fast track procedures



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## Refugee Numbers

Counting of refugees is difficult because

- Refugees dont want to be counted

- Host governments dont want international attention to internal problems

- Humanitarian community may not want to intervene

Difficult to assist without denominator since cannot make

# estimations

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## Final Underlying Principle

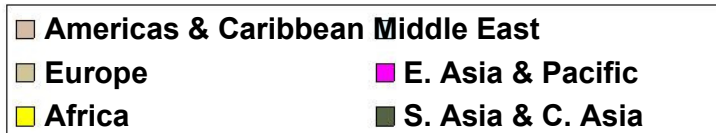
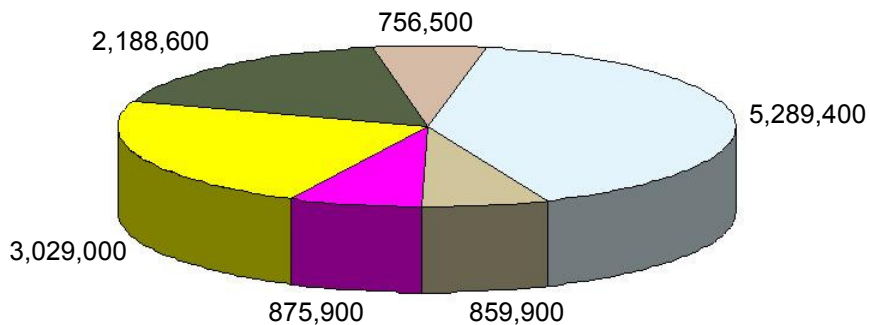
Everything about refugee situations is political

Politics determine origin, maintenance, and resolution



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## Where Refugees Are in 2002



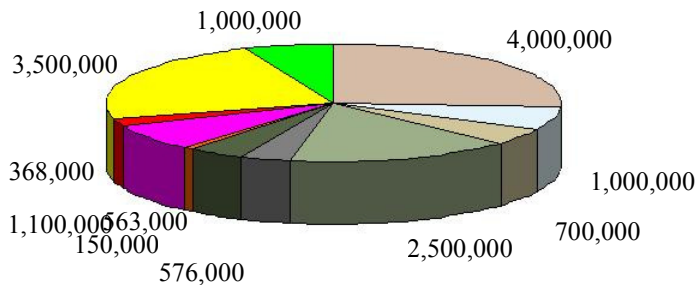


*Data from: World Refugee Survey 2003, U.S. Committee for Refugees*

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# Internally Displaced Persons *in 2002*



*Data from: World Refugee Survey 2003, U.S. Committee for Refugees*

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## Voluntary Repatriations

To	From	Number
Afghanistan	Iran & Pakistan	1,800,000
Angola	Congo-Kinshasa, Zambia & Others	80,000
Burma	Bangladesh & Thailand	1,760
Burundi	Tanzania	50,000
Central African. Republic	Congo-Kinshasa	15,000
Croatia	Yugoslavia & Bosnia	11,000
East Timor	Indonesia	32,000
Eritrea	Sudan	20,000
Total	Total	1,115

iraq	iran	1,145
Kazakhstan	Uzbekistan & Others	16,000

*Data from: World Refugee Survey 2003, U.S. Committee for Refugees*

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# Ratio of Refugee to Host Country Population

Host Country	Ratio of Refugee Pop. to Total Pop.	Number of Refugees
Gaza Strip	1:2	879,000
Iran	1:30	2,209,900
West Bank	1:3	607,800
Lebanon	1:11	409,000
Guinea	1:46	182,000
Yugoslavia	1:30	353,000
Liberia	1:51	65,000
Djibouti	1:27	23,000
Nepal	1:181	132,000
Zambia	1:40	247,000
Sudan	1:114	287,000
Tanzania	1:72	516,000
Pakistan	1:95	1,518,000
Uganda	1:112	221,000
Japan	1:19,538	6,500
Mexico	1:25,500	4,000

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*Data from: World Refugee Survey 2003, U.S. Committee for Refugees*

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## Voluntary Repatriations

To	From	Number
Afghanistan	Iran & Pakistan	1,800,000
Angola	Congo-Kinshasa, Zambia & Others	80,000
Burma	Bangladesh & Thailand	1,760
Burundi	Tanzania	50,000
Central African. Republic	Congo-Kinshasa	15,000
Croatia	Yugoslavia & Bosnia	11,000
East Timor	Indonesia	32,000
Eritrea	Sudan	20,000
Total	Total	1,115



iraq	iran	1,145
Kazakhstan	Uzbekistan & Others	16,000
<i>Data from: World Refugee Survey 2003, U.S. Committee for Refugees</i>		<i>Continued</i> 32

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## Voluntary Repatriations

To	From	Number
Liberia	Cote D'Ivoire & Sierra Leone	20,000
Namibia	Botswana	1,000
Nigeria	Cameroon	8,000
Rwanda	C-Kin, Tanzania, Burundi	30,000
Sierra	Guinea, Liberia & Others	90,000
Somalia	Djibouti, Ethiopia, Kenya	20,000
Sudan	Uganda	2,000
Tajikistan	Kyrgyzstan, Kazakhstan, others	1,100
Yugoslavia	Germany, Switzerland	3,100

*Data from: World Refugee Survey 2003, U.S. Committee for Refugees*

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# Causes of Conflicts and Population Displacement

**Gilbert Burnham, MD, MPH**  
**Johns Hopkins University**



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# Origins of Refugees

## 1980s

Vietnam  
Cambodia  
Afghanistan  
Mozambique  
Ethiopia  
Angola  
Sudan

## 1990s

Iraq  
Yugoslavia  
Armenia  
Georgia  
Tajikistan  
Somalia  
Rwanda/Burundi



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# Past Causes of Displacement

Principal reasons for people fleeing

Ideology

Individual acts of persecution

Proxy wars





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# Present and Future Causes of Displacement

Most displacements follow wide-spread violence spiraling from the following:

Weak states with weak institutions

Poverty and economic collapse

Environmental disasters

Ethnic tensions exploited through political opportunism

Wide-scale human

# wide scale human rights abuses

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## Current War Trends

Previously saw wars between states

Now minor contributor to population displacement

Most wars resulting from states targeting a single ethnic group

War *within* states

Attempts to seize control of weakened or collapsed

'  
states

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## Who Is Displaced.

Subsistence, peasant farmers

Educated people

Urban dwellers

Certain social groups

Religious groups

Professionals



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# Political Roots

Who is persecuted often depends on who controls the state



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## Political Roots

Who has power, privilege, patronage, and perks.

Which groups are stigmatized.

Education or status

Geographic location

Religion

Language, culture, social group



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## **Circumstances that Create Conflict**

Weak states prone to internal violence

May lack historical identity and  
cohesiveness

Have poor resolution mechanisms

Political institutions not representative

Judiciary not independent

Lack of impartial law enforcement

*Continued* 9

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## Circumstances that Create Conflict

Violence falls as per capita GDP rises

Armed insurrection may be seen as the only way to change

Especially with ready access to cheap arms

Opposition weak and often divided

Political controversy disintegrates into anarchy

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## External Political Factors

External forces may complicate unstable internal events as follows:

Raise the level of violence



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## External Political Factors

External forces may complicate unstable internal events as follows:

- Disrupt traditional mediation processes

- Prop leaders that lack legitimacy

- Military aid increases destructiveness of conflict

- Economic aid may raise the stakes



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## Economic Roots

Economic tensions increase potential for population displacement

Even though poverty alone may not cause displacement in static situations:

- Extreme poverty breeds resignation

- Poverty may increase ethnic and communal tensions

- Poverty may interact with other

forced displacement

*Continued* 13

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## Economic Roots

As economy declines . . .

- Tensions may rise

- Distribution of resources becomes politically explosive

- Search for scapegoats to blame

- Often minority groups



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# Conflicts Accelerate Economic Decline

Food production and distribution often early casualty

- Precarious in subsistence economies

- Resulting malnutrition accelerates disease and death

- Salaried workers particularly at risk

Rapid economic growth can also contribute to development of



conflict ' .

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## Environmental Roots

Migration occurs as traditional lands become uninhabitable

- Natural disasters

- Man-made

- Eco-refugees do not qualify for UNHCR protection

Ecological factors may combine with other factors to promote

displacement

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## **Ecological Effects with Other Factors**

As population increases, competition over arable land increases

Increasing land pressure leads to soil exhaustion/erosion, overgrazing

Drought increases the impact of other factors

*Continued* 17

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## **Ecological Effects with Other Factors**

Existing tensions may be turned into armed conflict

Government or other forces may target environment of ethnic groups for development projects



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## Ethnic Tensions

Some nations still cling to the idea of homogeneity of population

Race in Germany, Rwanda/Burundi, Yugoslavia, Somalia

Orthodox beliefs in Serbia

Sheriat law in Sudan

Language in Quebec



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## Ethnic Tensions

Irredentism Based on race, religion, culture

The worlds 190 nations have 5,000 ethnic groups

Continuing efforts to create/impose homogeneous states is a major source of conflict



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## Consequences of Ethnic Tensions

Ethnicity highly susceptible to political exploitation

Groups seek community support by fanning ethnic antagonism, reactivating ancient hatreds

Political movements may use religion in same way

Ethnic conflict likely when one ethnic

group takes  
control of state

*Continued* 21

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# Consequences of Ethnic Tensions

Nationality defined by characteristics of one ethnic group

Even though nation may have multiple groups

Those not belonging may be seen as obstacles to nation-building



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# Conflict Resolution Depends on Power

Powers of central government are important  
in controlling group conflicts

Mediating capacity lost in single-group  
government

Cold war patronage often supported one  
client group





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# Mediation to Alleviate Ethnic Tensions

Mediation to alleviate ethnic tensions is a challenge

Prevent them escalating into violent conflicts

Promote acceptance of ethnic diversity

Promote tolerance within and without national borders



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## Human Rights Abuses

Forced departure violates the right to remain peaceably in ones home

Intentional targeting of civilians via military actions

Military sweeps  
thought to be  
sympathetic to  
the enemy

# Use of land mines

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# Human Rights Abuses

Human rights violations often at core of humanitarian emergencies



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# States Responsibility

States responsibility encoded in the following:

The Universal Declaration on Human Rights

International Covenant on Civil and Political Rights (Binding Form of the UDHR)

International Convention on Economic,



# Social, and Cultural Rights

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# Defenders of Human Rights

Sovereign state primary defender of citizens rights as follows:

- Freedom from torture and arbitrary detention

- Freedom of expression, thought, or belief

International community responsible once states fail in their duties



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# Human Rights Abuses Do Not Occur in a Vacuum

Usually coexist with . . .

Economic strains

Disruption in food supplies

Political weakness and instability

Ethnic conflict

Tradition of violence

Ecologic deterioration



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# Resolving Conflict Situations

## *Process Involves Three Main Components*

### **1. Immediate protection**

Cease-fire agreements to stop human rights violations and persecution

Provision of humanitarian assistance

Corridors of peace

*Continued* 30

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# **Resolving Conflict Situations**

## ***Process Involves Three Main Components***

### **2. Build structures**

For mediation

For resolution of conflict

For the return of refugees

### **3. Develop an economic base**

To reduce resource inequality





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# Causes of Conflicts

## *An Alternate View*

Conflict is inevitable

Violent conflict is often inevitable

In some conflicts, violence is appropriate

Conflicts have two principal origins

Conflict over resourcesthe majority

Conflict over identitythe minority



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## Defining Conflict Resolution

Mainly has to do with power and compromise

Resolved when parties begin to realize pain  
and see that they may not win total control

Conflicts are then ripe for resolution

The mediators role may be that of helping to  
ripen the perceptions of pain

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# **Information and Surveillance Systems for Refugee Populations**

**Gilbert Burnham, MD, PhD  
Johns Hopkins University**



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## Section A

# *The Need for Information and Data Collection*





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## Definition of Surveillance

*Surveillance* is the ongoing, systematic collection, analysis, and interpretation of health data, essential to the planning, implementation, and evaluation of public health practice

It includes timely dissemination of data to those who need to know



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# Information in Humanitarian Emergencies

Information is the backbone of all public health activities

- Monitoring health services

- Control of disease outbreaks

- Program evaluation

Although importance is recognized at one level, data collection is often done poorly in the field, although

improving ' ~

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## Information May Be Simple

Very basic information needed

*Numerators* E.g., whos affected or vulnerable, whos experienced illness, etc.

*Denominators* E.g., population size, population risk, vulnerable population, target group

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# Information May Be Simple

Goal is not to understand full picture

But to have enough data to plan and  
implement emergency response

Initial information can be updated  
regularly from many sources





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## Phases in Information Needs

Information needs differ for each phase of the emergency in terms of . . .

- Type of data needed for decisions

- Amount of information required

- Frequency of collecting data

- Methods of data collection



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# Methods of Data Collection

Rapid assessments

Initially to establish baseline data

Surveillance Ongoing data collection

Health facility

Sentinel

Community health workers

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# Methods of Data Collection

Intermittent population-based surveys

E.g., nutritional status, KPC



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## Phases in Data Collection

<b><i>Pre-Emergency Phase</i></b>	Pre-flight information on health status Rapid assessment surveys Establish a surveillance system
<b><i>Emergency Phase</i></b>	Rapid assessment surveys Baseline data



*Continued* 10

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## Phases in Data Collection

<b><i>Post-Emergency Phase</i></b>	Targeted population surveys or sampling Consolidate surveillance
<b><i>Maintenance Phase</i></b>	Regular population-based surveys Continue surveillance Modify disease list

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## Phases in Data Collection

	<i>Emergency Phase</i>	<i>Post-Emergency Phase</i>
<b><i>Duration</i></b>	14 months	1 month indefinite
<b><i>Collection of Data</i></b>	Mostly active Largely qualitative	Passive and active More quantitative
<b><i>Method</i></b>	Qualitative	Mostly quantitative
<b><i>Case Definitions</i></b>	Few Simple	More +/- case definitions



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# Rapid Assessment

The initial rapid assessment

Begins when displaced persons arrive

Forms the basis of the surveillance system



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## The Assessment Team

Team members have health care and epidemiological skills

Collect background information

Maps, demographic/health data

Require support personnel

Translators, data collectors, transport





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# Emergency Phase: Initial Information Needed

Depends on decisions to be made

Demographic

Mortality

Morbidity

Nutritional status

Program monitoring



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# Emergency Phase: Additional Information

## *Background information*

Circumstances surrounding the flight

Host/home country disease patterns

Host country treatment protocols and  
antibiotic resistance

Usual level of health care received

Social structure

*Continued* 16

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# **Emergency Phase: Additional Information**

Environmental conditions

Climate and geography

Shelter and sanitation

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# Emergency Phase: Additional Information

Resources available to host country

Among the refugees themselves

Within host country (emergency food and drug supplies, health personnel, health care capacity)

Host country information system





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# Approach to Initial Assessment

Quick survey for serious problems

- May need convenience sampling

- Gather as accurate data as possible

Detailed survey if less urgent

- Can use various sampling techniques



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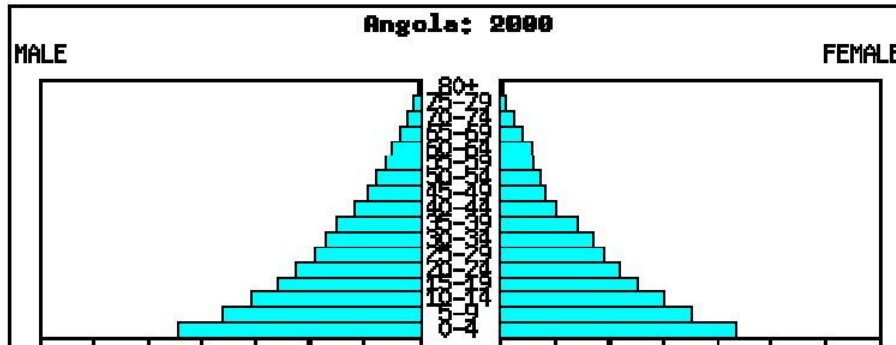
# Demographic Information

Critical denominator total population

Population structure

Age distribution

Number of males and females



1.4 1.2 1.0 0.8 0.6 0.4 0.2 0.0 0.0 0.2 0.4 0.6 0.8 1.0 1.2 1.4

Population (in millions)

Source: U.S. Census Bureau, International Data Base.

*Continued* 20

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# Demographic Information

Vulnerable groups

Unaccompanied minors

Female-headed households

Rate of new arrivals and departures



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## **Section B**

### ***Population Size and Sampling***





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# Problems in Estimating Population Size

Estimating population size difficult

Increasing situations where counting is  
not allowed

General lack of information

Lack of confidence in results

*Continued* 23

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# Problems in Estimating Population Size

Many reasons not to have numbers

Results may be manipulated

By refugees

Agency

Or host country



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## Direct Estimation of Population Size

1. Count number of arrivals
2. Aerial photographs
3. Calculate with GPS
4. Count total number of dwellings
5. Random sampling of households
6. Indirect methods
7. Full registration



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## Count New Arrivals

Count the number of people entering an area  
(bridge, road, or buses)





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# Aerial Photographs

On-the-ground sampling at same time as over-flight

Check for empty huts, moving population

Refugee population must be distinct from local population



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## Calculate with GPS

Calculate the circumference of a settled area  
with GPS

Estimate household densities within area

Carry out a household census on selected  
samples

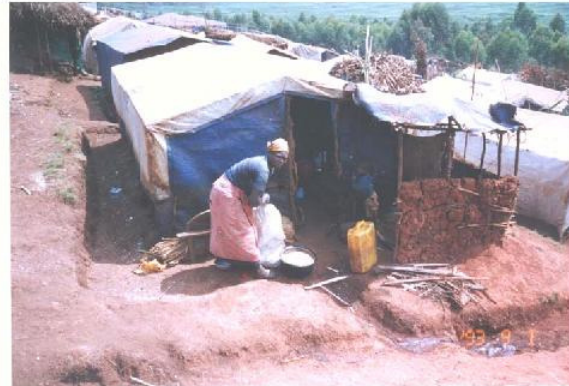


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## Count Total Dwellings

For a small settlement, estimate the mean household occupancy and composition

In a sub-sample, calculate the household size





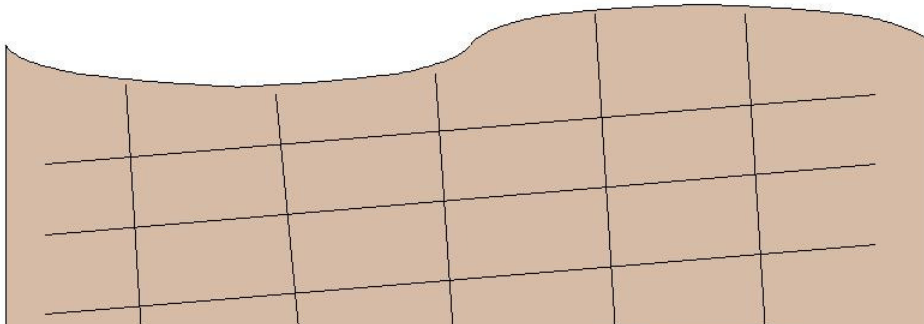
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# Random Sampling of Households

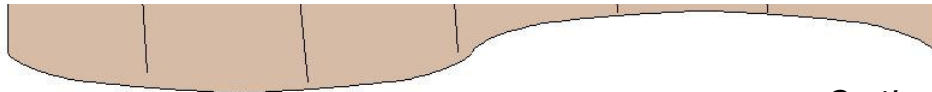
To estimate the number of households

Draw a map, estimate size

Draw grids to create sections





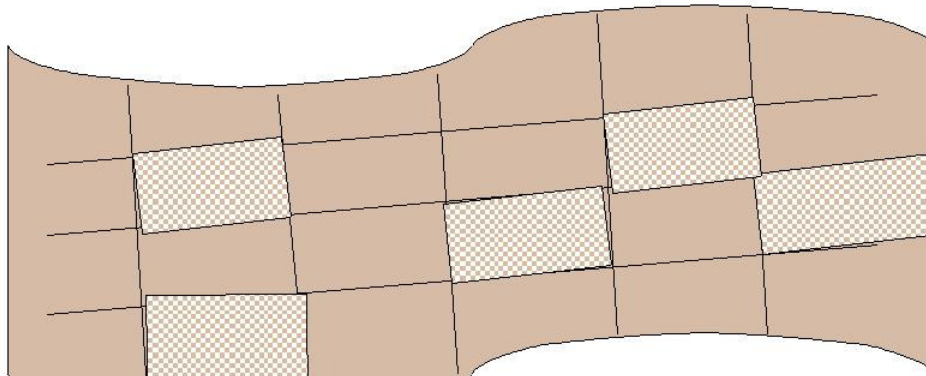


*Continued* 30

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# Random Sampling of Households

Count the number of households in a proportion of the sections





*Continued* 31

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# Random Sampling of Households

Calculate mean household census and composition for a sample

Can use a more formal cluster sampling approach

Where population is self-settled and lack registration



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# Full Registration

Registration process for refugees

Collect demographic data

Issue registration cards

*Continued* 33

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## Full Registration

Takes months to organize/conduct

Subject to multiple registrations

Follow up sample of registrations to  
determine percent invalid





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# Indirect Estimation of Population Size

Count the number of children under five  
years (or less than 110 cm)

They average 1520% of total population

*Continued* 35

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# Indirect Estimation of Population Size

Use number of immunizations given

Calculate coverage rates

Estimate total-under-five population



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# Section C

## *Indicators*



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# Emergency Phase: Mortality Indicators

Mortality can be reported as . . .

- Crude mortality rate (CMR)

- Age and sex-specific mortality rate  
(particularly for children)

- Cause-specific mortality rate

- Case fatality rate (CFR)





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## Crude Mortality Rate

CMR of 1/10,000 persons/day delineates the phases of emergency

Calculated as

Deaths/10,000 persons/day during acute phase

Deaths/1,000 persons/month during post-emergency phase

Consider age-specific and gender-

specialty rates

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# Emergency Phase: Morbidity Indicators

Incidence rates (attack rates)

Age and sex-specific incidence rates for  
primary causes of disease

Especially among children

Cause-specific morbidity rates

Case definition critical

*Continued* 40

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# Emergency Phase: Morbidity Indicators

Reporting initially very simple

Morbidity register in Goma, 1994, started  
with three diseases



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# Post-Emergency: Health Information System

Morbidity and mortality indicators

Disease-specific surveillance

Nutritional surveillance

Environmental health indicators

Program monitoring indicators

Reproductive health indicators

Violence/human rights abuse indicators





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# Morbidity Indicators

Primary diagnosis

Age-specific incidence rates

Sex-specific incidence rates

Relation to season

Changes in CFR (cholera CFR)

Reportable diseases

Hospital referrals



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# Disease-Specific Surveillance

## Priority diseases

Measles, malaria, ARI, diarrhoea,  
meningitis

Monitor for antibiotic resistance

## Other diseases

STI, TB

## Location-specific disease outbreaks

Clostridia

# sleeping sickness

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## Nutritional Surveillance

Periodic assessment of under-fives

Commonly use WFH or MUAC

Acute malnutrition reported as:

Moderate if

> -2Z (<80% WFH)

Severe if

>-3Z (<70% WFH)

*Continued* 45

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# Nutritional Surveillance

Stunting Indicates long-term problem

Weight gain patterns at under-five clinic

Screening for micronutrient deficiency





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# Food Security Indicators

Per capita food distribution

Number receiving supplementary feeding

Food basket content

*Continued* 47

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# Food Security Indicators

Household food reserves

Market prices



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# Environmental Health Indicators

Water supply

Quality

Quantity available

Individual consumption

Distance it is carried

Sanitation

Latrinesratio to population, usage

~ ~ ~

Solid  
waste  
disposal

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# Program Monitoring Indicators

Health facility access indicator

U-5 children seen

Antenatal clinic attendance, TT doses given, FP services



*Continued* 50

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# Program Monitoring Indicators

EPI coverage and drop-out rates

(DPT1 DPT3)

Health worker performance quality  
indicators



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## **Section D**

### ***Establishing a Surveillance System***



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# Objectives of Surveillance System

1. Determine what resources are needed
2. Determine what health status is
3. Set program priorities
4. Detect and monitor outbreaks
5. Assess effectiveness of programs
6. Determine quality of services
7. Allow donors to anticipate particular needs



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# Establishing a Surveillance System

1. Build initial assessment data
2. Train from people to collect/analyze/use data  
One person responsible for directing
3. Define the information to be collected  
Only that which will be acted upon
4. Design quality checks for information
5. Identify program objectivescoverage, KAP, access to services



*Continued* 54

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## Establishing a Surveillance System

6. Establish case definitions for common diseases
7. Develop and test surveillance forms
8. List data sources for each indicator
9. Establish data analysis and reporting procedures
10. Review function of the surveillance system periodically

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# Establish Standard Case Definitions

Develop case definitions for . . .

Diarrhea

ARI

Measles

Dysentery

Malaria

Meningitis

Cholera

Hepatitis

STIs

Micronutrient deficiencies



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## Examples of Case Definitions

<b><i>Malaria</i></b>	Fever and periodic shaking, chills
<b><i>Measles</i></b>	Fever, cough, rash, conjunctivitis
<b><i>Watery diarrhea</i></b>	More than three watery stools per day, but no blood or rice-water in stools
<b><i>LRTI</i></b>	Fever, cough, rapid breathing (more than 50 breaths per minute)



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## Surveillance Forms

Develop simple, standardized forms . . .

Total adult, under-fives, male, female

Weekly mortality forms

Weekly morbidity forms





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## Example of Simple Morbidity Form

<b>Cause</b>	<b>04 yrs Male</b>	<b>04 yrs Female</b>	<b>5+ yrs Male</b>	<b>5+ yrs Female</b>	<b>TOTAL</b>
<b>ARI</b>					
<b>Diarrhea</b>					
<b>Malaria</b>					
<b>Malnutrition</b>					
<b>Measles</b>					
<b>Other</b>					
<b>Repeat Cases</b>					
<b>TOTAL</b>					



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# Sources of Information

Health facilities

- OPD

- Under-five clinics

Community

Population surveys

- Periodice.g., during an outbreak

Grave sites



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## Data Analysis

Dont collect data for the sake of it

Examine and interpret it to make  
appropriate and timely changes

Establish data analysis procedures

Train staff to do simple analysis

Calculate rates, draw tables, compare to  
previous season



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## Data Reporting

Determine frequency of reporting

- Daily during epidemic

- Less frequently in post-emergency

Determine information flow and feedback process

- Epidemiologic bulletin or meetings

- Encourage informal feedback





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## Dissemination of Data

Who gets.

- Health coordinators

- Host country health system

- Refugee leadership

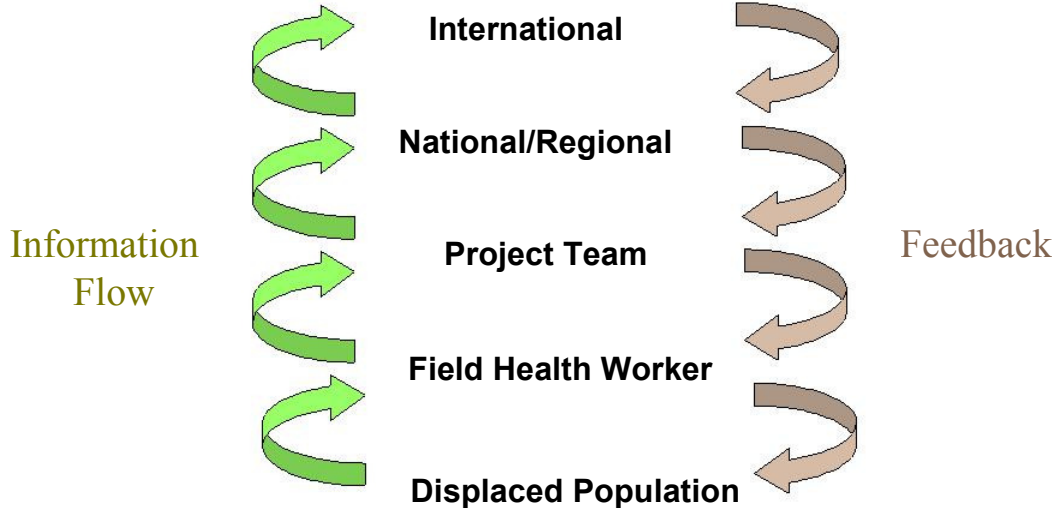
Who follows up.

Who documents.



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# Flow of Information





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# Evaluation of Surveillance System

Periodically review the information system  
function

- % deaths reported as unknown

- % morbidity reported as other

- Assess use of case definitions

- Compare diagnosis to treatment

- Use of information for decision making

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# Hemorrhagic Fever Outbreak Investigation

**Saade Abdallah, MD, MPH**  
**Johns Hopkins University**





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## **Section A**

### ***From Surveillance to Outbreak Investigation***



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# From Surveillance to Outbreak Investigation

Major objective of surveillance is to detect and respond to epidemics

For surveillance system to pick diseases that can cause epidemics

- Need a list of reportable diseases

- Establish procedures for immediate reporting



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# Commonly Reportable Diseases

Diseases that can cause epidemics

Measles

Cholera

Meningitis

Hepatitis

Yellow fever

Tuberculosis

–

Dengue  
hemorrhagic  
fever

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## Background Information: Kenya

El Nio rains nationwide

Poor access to health care

- Inadequate health facilities

- Nurses and lab technicians on strike

No government

- Election fever

Many districts/towns hit by cholera

- Local/international NGOs took



Local/international NGOs work  
affected communities

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## **Background Information: North-Eastern Kenya**

Heavy toll of El Nio rains on animal and human health

Poor access to most villages due to  
Flooding

Insecurity from bandits

All water/sanitation systems disrupted

*Continued* 6

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# Background Information: North-Eastern Kenya

IFRC assisting Garissa flood victims

MSF assisting refugees in Wajir





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# Kenya





Source: The CIA World Factbook

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# IFRC Cholera Preparedness

Installed water purification systems

Health education community and leaders







*Continued* 9

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# IFRC Cholera Preparedness

Set up treatment/lab facilities

Basic health care for acute illness

Trained personnel

Seven health workers, 100 CHWs/TBA

Stockpiled cholera kits

Latrine construction materials available

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# IFRC Cholera Preparedness





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# Diarrheal Disease Surveillance

Establish surveillance system for watery and bloody diarrhea

- No./age/location of new cases

- No./age/location of deaths

- Data analyzed and reported weekly

Health data collected from community and health facilities (private, NGO)

Only declare outbreak on lab

Only declare outbreak on lab  
evidence

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# Cholera Outbreak Response Plan

Response plan for outbreak

Immediate investigation to confirm outbreak, active case-finding, etc.

Strengthen water/sanitation system

Aggressive health education

Treatment protocols in place

Disinfection, disposal of bodies





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# Initial Reports of Hemorrhagic Fever Outbreak

Kenya December 21, 1997

143 deaths in two districts

Characterized as bleeding disease

Somalia December 19, 1997

335 deaths in seven villages in Torotoro

Characterized by bleeding and fever



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# Clinical Features of Hemorrhagic Fever

Characterized by acute onset of . . .

Fever

Headache

Bloody stools

Vomiting blood

Bleeding from other orifices



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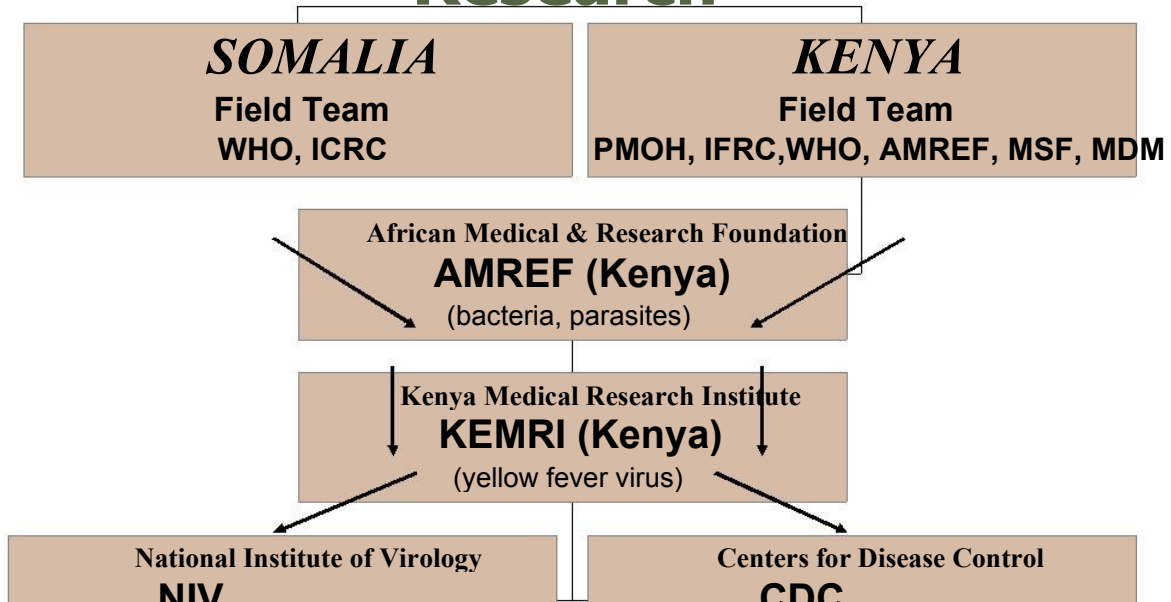
## Differential Diagnosis for HF

<b><i>Viral</i></b>	Yellow fever, rift valley fever, Crimean Congo HF
<b><i>Bacterial</i></b>	Meningococemia, typhoid, leptospirosis, rickettsiosis
<b><i>Protozoal</i></b>	Plasmodium malaria
<b><i>Other</i></b>	Bleeding disorder, (vasculitis, TTP, HUS)



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# Coordination of Initial Research





**NTV**  
(EB, MB, L, **(S)**, DF, YF, TE, S, HV, WN, HE)

**Africa)**

**SDC**  
(like N (USA) known viruses)

*Continued* 17

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# Coordination of Initial Research





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# Section B

## *Stage I*



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## **Stage I: Confirm Outbreak and Determine Possible Cause**

Interviewed people reporting bleeding symptoms and collected blood samples

Torotoro (Somalia)no active case

*Continued* 20

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## Stage I: Confirm Outbreak and Determine Possible Cause

Found human cases and contacts and ill livestock in nine villages in Garissa and Wajir districts (Kenya)







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## Stage I: Findings

Possible risk factors for HF

Occupation herdsman/spouse

Association with livestock goat, sheep

Age mainly adults between 25-40 years old

Gender males more than females

*Continued* 22

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## Stage I: Findings

### Laboratory results

15/36 specimens had evidence of recent RVF infection



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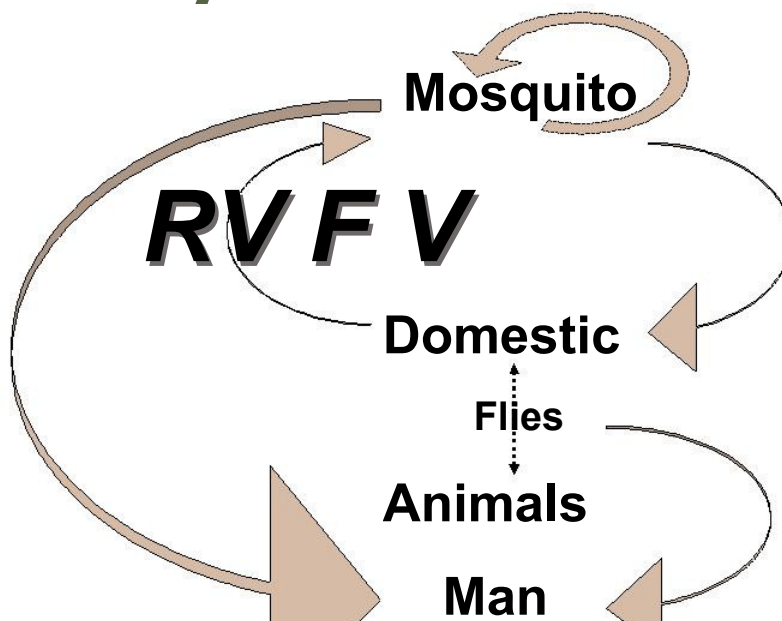
# History of Rift Valley Fever Outbreaks

<b><i>Africa</i></b>	Low-level endemic transmission in most regions with poor surveillance. Periodic epidemics/epizootics every 5-10 years.
<b><i>Kenya</i></b>	<i>1930</i> First identified as fatal lamb disease at farm near Lake Naivasha <i>1962</i> Last outbreak in NE Kenya <i>1989</i> Most recent epidemic
<b><i>Somalia</i></b>	No prior outbreak reported



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## Rift Valley Fever Transmission







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# **RVF Control Measures**

**BBC Somalia**

**Warn against slaughter**

**No aspirin treatment for febrile patients**

*Continued* 26

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## RVF Control Measures

CHWs/local  
leaders

IEC  
on  
risks of  
slaughter  
or  
consumption of sick livestock



*Continued* 27

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# RVF Control Measures

Improve handling of dead humans and animals





*Continued* 28

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# RVF Control Measures

## Health staff

Improve patient care, specimen collection,  
self-protection







*Continued* 29

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## **RVF Control Measures**

*Surveillance/counseling* of community

*Press releases* via local/intl media

*Press conferences* update general public on  
RVF status

*Neighboring countries* health officials urged  
to increase surveillance



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## **Section C**

### ***Stages II and III***



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## Stage II: Establish Magnitude

Revise case definition/reporting forms

Case of recent RVF = positive IgM

Establish national surveillance for RVF reporting and follow-up of cases

Alert all health authorities and NGOs

Active case-finding in affected districts

Train rapid outbreak response teams

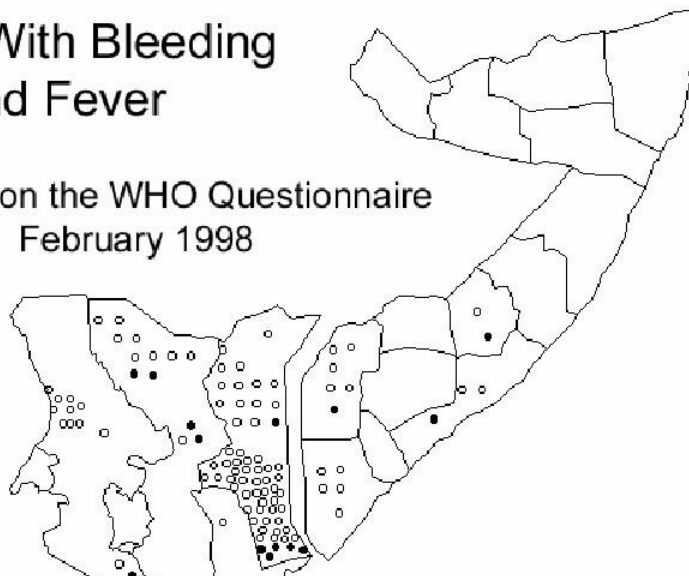


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## Stage II

Cases With Bleeding  
And Fever

Reported on the WHO Questionnaire  
February 1998







- Case with IgM or PCR positive
- Case without IgM or PCR positive

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## Stage II: Laboratory Results

<b>RVF</b>	<b>Case</b>	<b>Non-Case</b>	<b>Total</b>
<b>IgM +ve</b>	21 (32%)	17 (44%)	<b>38</b>
<b>IgM -ve</b>	45	32	<b>77</b>
<b>Total</b>	<b>66</b>	<b>49</b>	<b>115</b>



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## Conclusion of Stage II

RVF most likely accounted for 1/3 of the cases with hemorrhagic fever

Other diseases may account for the other hemorrhagic fever cases (2/3)



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## **Stage III: Confirm RVF Disease and Risk Factors**

To determine the following:

RVF seroprevalence among human and  
animal populations

Different modes of transmission

Personal and lifestyle factors and  
exposures in sample population

Other possible causative agents



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## Stage III Field Study Team

Many teams joined local investigators:

Min. of Health/Agriculture/Livestock

WHO

EPICENTRE, EPIET

CDC

NIV

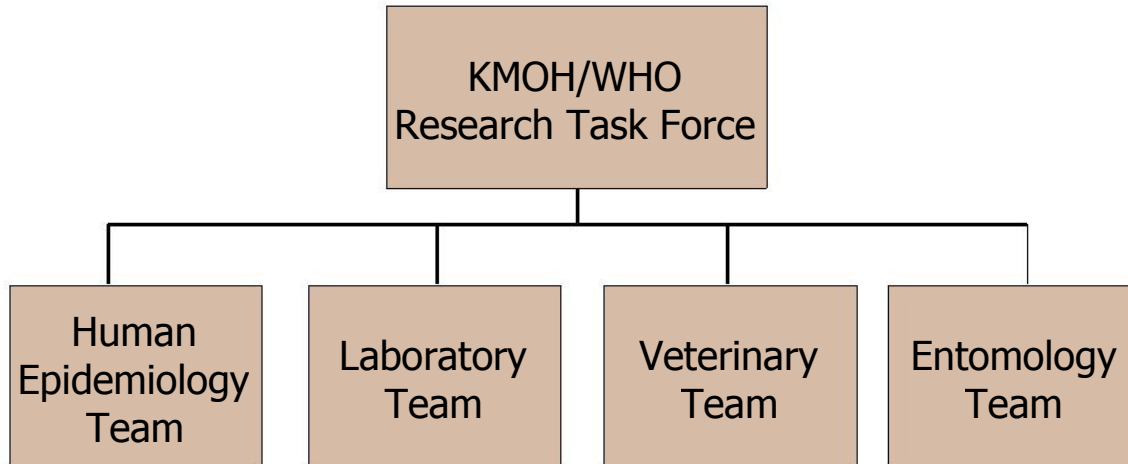
SDR (Swiss Disaster Relief)

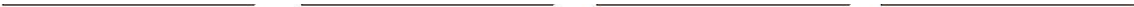




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# Coordination of Field Studies





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## Description of Field Studies

<b><i>Human Cross-Sectional Study</i></b>	New case-finding Repeat case-finding Clinical services
<b><i>Laboratory Processing</i></b>	Serum separation Blood cultures Malaria, rbc's, wbc's
<b><i>Animal Data Collection</i></b>	Herd loss/abortions Vaccination status Biological specimens
<b><i>Mosquito Traps</i></b>	Wild ponds (sylvatic) Peri-domestic Urban domestic



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# Sampling

Garissa 84 sub-locations 12 divisions

Population 231,022 (non-refugee)

Randomly selected

30 clusters (sub-locations)

Seven households per cluster

Recruited one person/household for study

Cluster 1 (29ys) + 5 (1049ys) +

1

↓  
(>50ys)

40

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## Field Study Population

29 Clusters by GPS coordinates

Cluster #7 (Harehare) not found  
geographically => Liboi volunteers

Urban = 6, rural =13, nomadic = 10

Cluster #19 only six sampled

Four clusters replaced children with adults

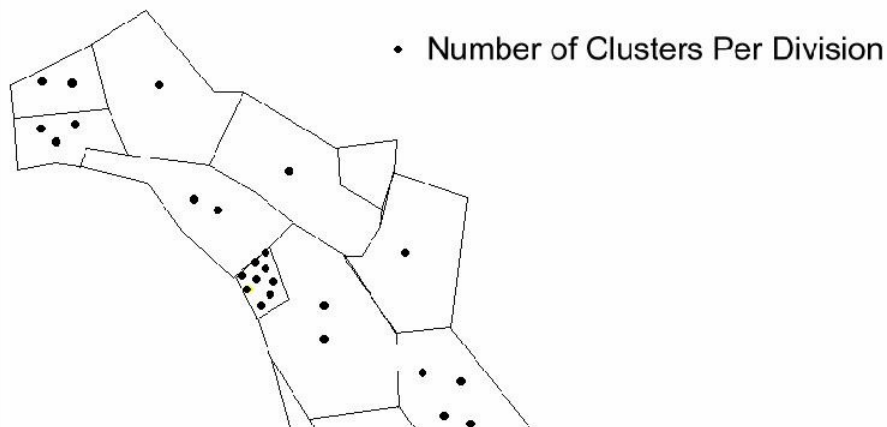


*Continued* 41

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# Field Study Population

Cross-Sectional Survey, Garissa, Kenya  
February, 1998





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## Data Collection: Humans

Interviews from 2/82/14, 1998

(20 minutes)

First obtained verbal consent

Trained health-workers fluent English,  
Swahili, and Somali issued questionnaire  
(under supervision)

Enquired on exposure/illness since floods  
started

## Blood specimens collected

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# Data Entry and Analysis

Survey data analyzed with Epi-Info 6.04

Demographic characteristics

Lifestyle factors (butcher, animal)

Diet factors (intake of raw milk/meat)

*Continued* 44

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# Data Entry and Analysis

Survey data analyzed with Epi-Info 6.04

Environmental factors (shelter,  
displacement)

Economic factors (loss of livestock)

Different groups and exposure categories  
further analyzed





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## Field Study Results: Human and Laboratory

<b><i>Human Cross-Sectional Study</i></b>	172/202 had illness 78% had fever 56% had headache 7% had bleeding
<b><i>Laboratory Processing</i></b>	Survey 8.9% positive (+ve) Bleeding (survey) 1/12 +ve All tests 22% +ve All bleeding cases 22% +ve



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## **Discussion/Recommendations (Human and Laboratory)**

Survey confirmed major RVF outbreak

Suggests RVF as a major contributor to  
hemorrhagic fever cases/deaths

Low RVF positivity among true cases

Implies other causes of HF

Or false negative results

New HF cases to be properly investigated



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## Field Study Results: Veterinary and Entomology

<b><i>Animal Mortality</i></b>	Sheep 84% Goats 78% Cattle 30% Camels 23%
<b><i>Mosquito Traps</i></b>	3,180 mosquitoes <i>Anopheles coustani</i> <i>Mansonia africana</i> <i>Mansonia uniformis</i>



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## Discussion/Recommendations (Veterinary)

2080% livestock died since floods

>75% among sheep/goats

RVF not a major contributor of loss

Excess abortions from many factors (foot rot, pleuropneumonia)

Livestock loss economically costly



*Continued* 49

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# Discussion/Recommendations (Veterinary)

Establish appropriate disease control  
measures

Vaccination

Drug supply



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## Discussion/Recommendations (Entomology)

*Anopheles coustani* potential RVF  
transmitter during epizootics

*Mansonia africana/uniformis* low density,  
confined to water ponds

Conclude outstanding studies

Flight range, host preference, infectivity  
rate of *A Coustani*

Vector

*Mansonia*

competence  
of

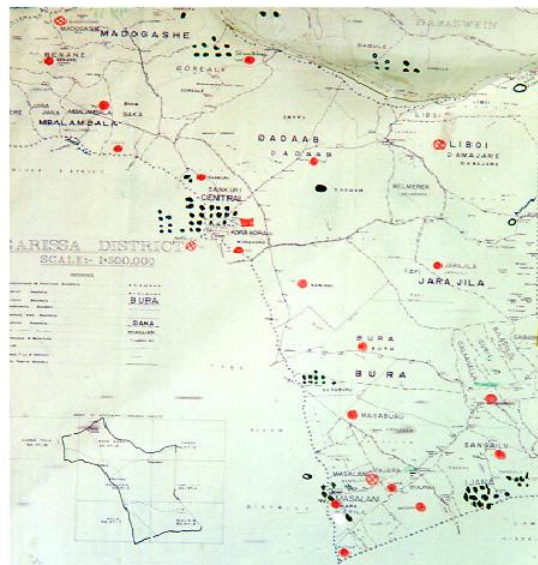
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## Field Study Conclusion

11 clusters with IgM  
positive

Implied RVF  
widespread





*Continued* 52

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## Field Study Conclusion

Survey found 8.9% RVF seroprevalence

Total RVF infections ~ 89,000

(Garissa/Wajir/S. Somalia ~ 1 million)

445 HF cases, assuming all susceptible  
and 0.5%

Close association between RVF positivity with  
animal contact





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## **Section D**

### ***Conclusion***



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# Outstanding Research Questions

Validity of +ve IgM results,

Validity of reported HF cases,

Sensitivity/specificity of Elisa test

Reporting bias

Repeated negative specimens to be tested  
for other causes



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## Lessons Learned: National

Heavy toll of El Nio rains on human and animal health

Worsened by poor health care access

Surveillance affected by inadequate systems, health workers strike, no government

*Continued* 56

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## Lessons Learned: National

Initial epidemic response rapid

Slowed by logistics, infrastructure,  
resources

Need to strengthen national laboratories  
serology, virus isolation





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## Lessons Learned: International

WHO mobilized resources, partners

Much achieved through collaboration with all centers and NGOs

Local/international media drew attention of authorities and world

Powerful health education medium

Given/reported accurate information



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## **Lessons Learned: Role of NGOs**

Local and international NGOs vital link  
between donors and affected people

Locally based NGOs can develop effective  
partnerships in surveillance



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## Final Recommendations

Conclude outstanding studies/reports

MOH and partners to improve surveillance

MOH and WHO to build local capacity

Multi-sectoral collaboration

*Continued* 60

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# Final Recommendations

Improve media collaboration

EWS via satellite remote sensing

WHO/FAO to address Somalias livestock export embargo





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## Summary

Initial reports of HF morbidity/mortality in humans and livestock in NEP, Somalia  
Initial case finding showed RVF present  
Further studies on risk factors revealed existence of known vectors of RVF  
RVF antibody rates in Garissa reflected in Wajir and Somalia

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# Health Needs of Refugees

**Gilbert Burnham, MD, PhD**  
**Johns Hopkins University**



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# **Section A**

## ***Emergencies***



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# Phases of Emergencies

Emergencies divided into phases by death rates

Mostly among children

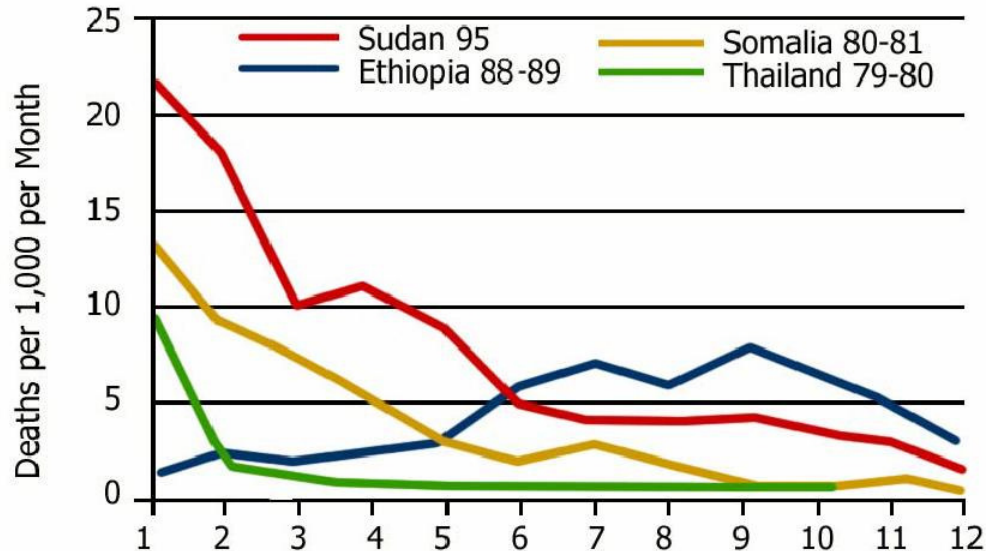
Needs and services differ for each phase



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## Phases of Emergencies



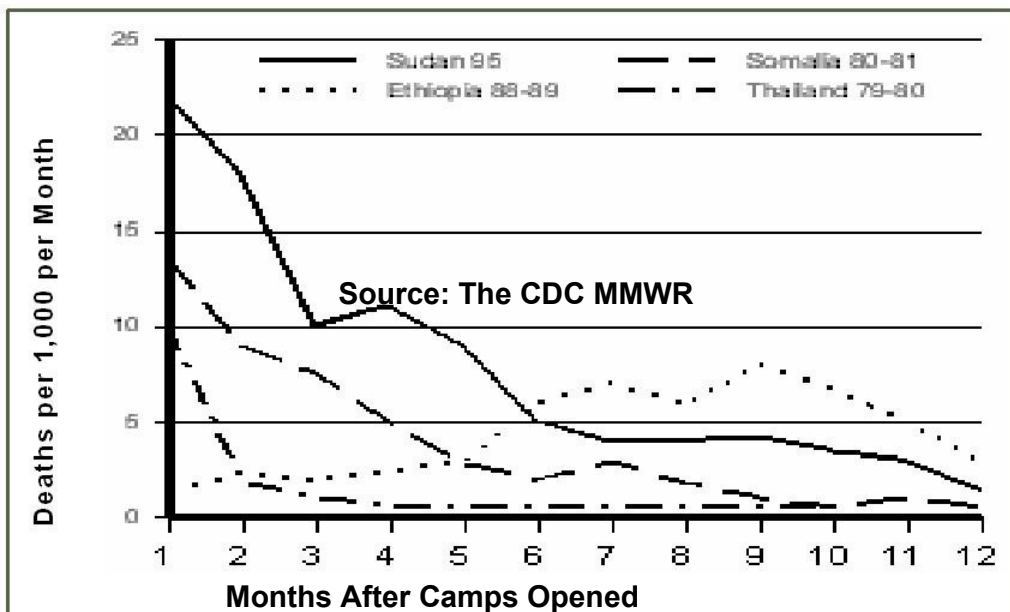
Months After Camps Opened

**Source: The CDC MMWR**

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## Phases of Emergencies





**Source: The CDC MMWR**

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## Phases of Emergencies: Crude Death Rate

Death rates  $> 1/10,000/\text{day}$

May approach  $1/1,000/\text{day}$

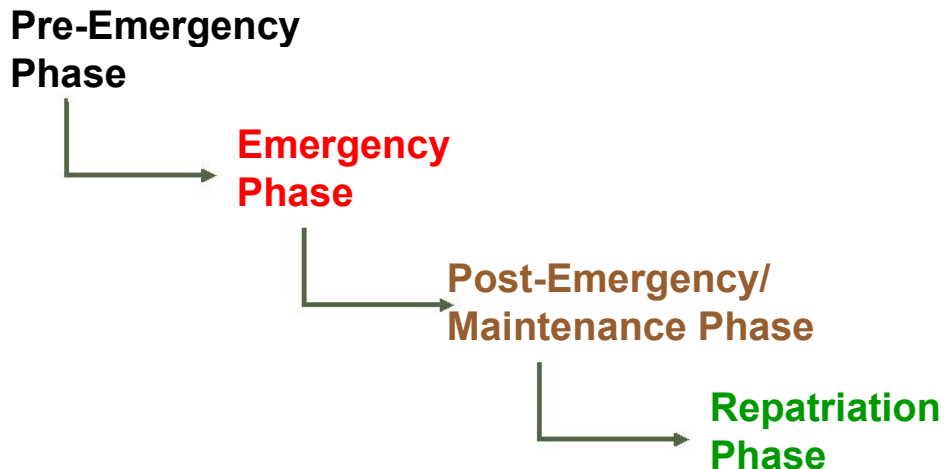
Death rates may be 560 times higher than the normal rates

Normal CMR for sub-Saharan Africa 0.5  
0.9 deaths per 10,000 persons per day



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# Phases of Emergencies







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## Pre-Emergency Phase

Events developing

Access prevents full understanding

Political interventions still possible

Preparation for mass migration



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## Emergency Phase

Length of emergency phase determined by excess mortality

Concentration is in getting mortality rates down as fast as possible

Strong emphasis on food, water, sanitation, prevention of epidemics

Requires a simple information system



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## Post-Emergency Phase

Death rates < 1/10,000 persons/day

Basic services in place

Food supply

Water

Sanitation

Health care

Shelter



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## Repatriation Phase

Return home is usually spontaneous

Refugees make their own decisions

Most refugees return unassisted







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# Repatriation Phase

## Role of NGOs

Can provide information to inform decisions

Assist refugees returning

Rehabilitate essential services in country of origin



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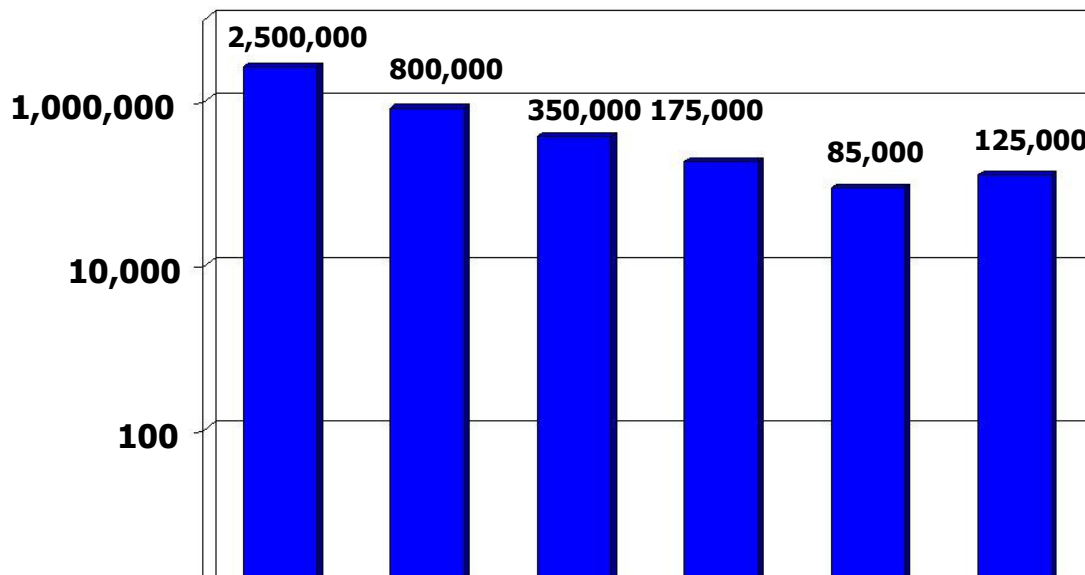
## Key Indicators

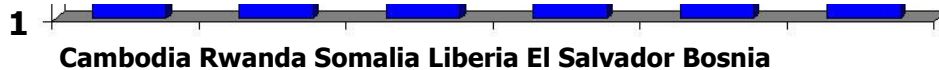
Crude mortality rate or death rate is one of the key indicators of health status in all phases



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## Estimated Excess Mortality





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# What are Health Needs in Emergencies.

Priorities vary with phases of the emergency

Protection/security

Food

Water

Sanitation

Shelter





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# Health Care Objectives: Emergency Phase

Treatment of common diseases

Prevention of epidemic diseases

Particularly malaria

Excess loss of life

Tying up resources

*Continued* 16

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# Health Care Objectives: Emergency Phase

Prevent endemic diseases

Tick-borne typhus, scabies, lice

Prevent injuries

From hostilities or household

*Continued* 17

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# Health Care Objectives: Emergency Phase

Care of the vulnerable

Mental health services

Reproductive health services

Surveillance health information system

*Continued* 18

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# Health Care Objectives: Emergency Phase

Services based on PHC principles

Community-based services

Social and educational services

Needs of adolescents

Need for information



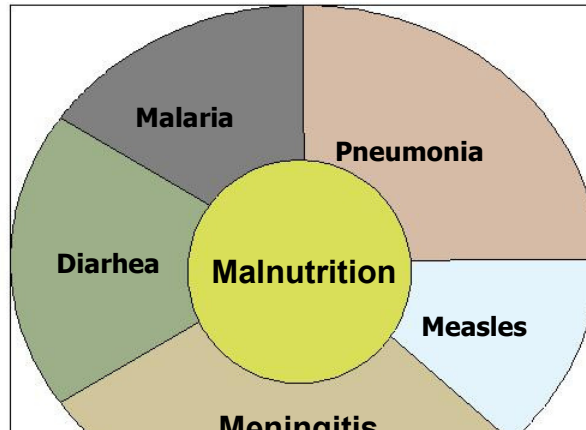


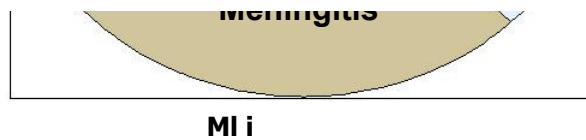
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# Health Concerns in Emergency Phase

Most deaths from five conditions

CFR ↑





*Continued* 20

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# Health Concerns in Emergency Phase

Risk of meningitis

Frightening but not often large-scale



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# Health Concerns of Middle Development Countries

New problems in former Soviet bloc

Some epidemic diseases, e.g., head lice, typhoid

More concern with chronic diseases e.g., diabetes, hyper-tension, heart disease

*Continued* 22

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# Health Concerns of Middle Development Countries

Lack of medication and specialized care

Difficulty with existing health care protocols

Hypothermia among the aged who cannot move





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# Priorities in Emergency Phase

## General health priorities

Water (quantity more important than quality)

Short-term sanitation provisions, including soap

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# Priorities in Emergency Phase

General health priorities

Food distribution

Shelter



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## Priority Health Activities

Disease prevention and control

Epidemic diseases e.g., measles,  
shigella, cholera

Less common diseases e.g., typhus,  
relapsing fever, conjunctivitis

May require special feeding programs

*Continued* 26

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## Priority Health Activities

Immunization against measles

Basic PHC with outreach to increase coverage

Basic health information system as early as possible





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## Late Emergency Phase

Death rates generally decline

Both the Crude Mortality Rate and Case Fatality Rate drop

Threats from epidemic disease may cause increases in death rates



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## Programs Reaching for Basic Standards

<b><i>Food</i></b>	2,100 kcal/person/day (Be alert for micronutrient deficiencies)
<b><i>Water Availability</i></b>	1520 Liters/person/day
<b><i>Sanitation</i></b>	1 latrine/20 persons <i>or</i> 1 latrine/family (better)
<b><i>Health Care</i></b>	Death rates <2/10,000/day

*Continued* 29

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## Programs Reaching for Basic Standards

<b><i>Solid Waste</i></b>	Appropriate disposal, includes safe disposal of medical waste
<b><i>Space</i></b>	30m <sup>2</sup> /person in settlement 3m <sup>2</sup> /person in shelters
<b><i>Fuel</i></b>	Adequate fuel at hand, i.e., 1kg fuel wood/person/day



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# Late Emergency Phase Concerns

Concern over security increases  
Infrastructure-building activities



*Continued* 31

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# Late Emergency Phase Concerns

Community-based activities

Community health workers

Community mobilizers

*Continued* 32

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## Late Emergency Phase Concerns

Standard case definitions established

Standard treatment protocols

Information system should expand

Good idea of denominators

Increased concern for vulnerable population

*Continued* 33

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# Late Emergency Phase Concerns

Promotion of community structure

Entails risks, how to control.

Schools linked with health care

*Continued* 34

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# Late Emergency Phase Concerns

Introduce income-generating activities

Especially for women

Promote gardens





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# Maintenance or Post-Emergency Phase

Defined by death rates

Approaching pre-flight or host community  
levels

**Below 1 /10,000 persons/day**



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## **Maintenance Phase: Approach to Health Services**

Health services integrated with host country health services (if possible)

- Using local referral system

- Using host country essential drug program and treatment protocols

May be oriented toward country of origin

*Continued* 37

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# Maintenance Phase: Approach to Health Services

Health promotion and preventive services  
functioning well

Services pitched at level of host or country of  
origin

*Continued* 38

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# Maintenance Phase: Approach to Health Services

More refugee health personnel involved

Increasing concern for health of host country  
community





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## **Maintenance Phase: More Specialized Programs**

Implementation of more specialized health care programs

Control of tuberculosis and leprosy

Reproductive health care, including control of STI, and HIV/AIDS

Mental health programs for persistent mental disorders



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# Maintenance Phase: Other Concerns

Emphasis on improving efficiency and effectiveness of program

Increasing concern about damage to the environment



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# Moving out of Program (Closure)

Handing over of services from relief organizations

National NGOs

Development-oriented NGOs

Community-based organizations

Reliance on refugees for sustainability

Training to promote repatriation



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## **Section B**

### ***Public Health Issues to Consider***

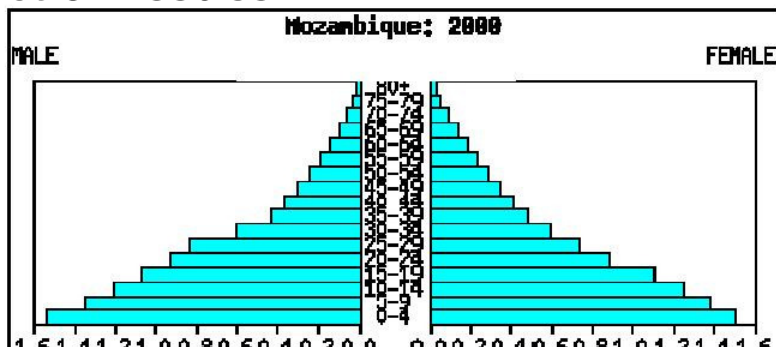




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# Population Distribution of IDPs and Refugees

Population distribution usually skewed  
 Increase in vulnerable populations  
 Protection issues



1.0	1.4	1.2	1.0	0.0	0.0	0.4	0.2	0.0	0.0	0.2	0.4	0.0	0.1	0.1	1.2	1.4	1.0
Population (in millions)																	
Source: U.S. Census Bureau, International Data Base.																	

*Continued* 44

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# Women and Children

Health services to address needs

Gender roles change

Unaccompanied minors or separated children



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# Food and Nutrition

## Feeding refugees

- Food sources and preferences

- Logistics and distribution

- Targeting populations

- Composition of general rations

- Special feeding programs.

- Monitoring for micronutrient deficiencies



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# Environmental Concerns

Water

Latrines

Solid waste

Vector control

Environmental damage

Fuel wood

Shelter

Planting





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# Psychosocial Issues

Emotional stress

Dealing with stress

Pre-existing mental illness exacerbated

*Continued* 48

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# Psychosocial Issues

Resettlement/repatriation stress

Adolescent issues





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## Mental Health Services

Low priority in acute settings

Single episodes of emotional disorders  
common

Community efforts major resource

Violence and delayed social development

Role of traditions and cultural activities

Use of refugee resources



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# Security and Protection Issues

Raids from country of origin

Recruitment by insurgents

Exploitation by host country

Protection of vulnerable

Protection of relief workers

Prevention of forced repatriation



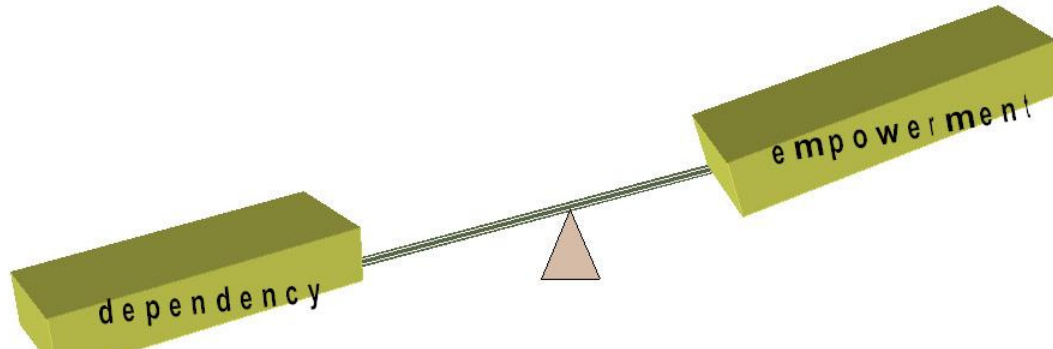


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# Programming Issues

Create dependency by contracting provision  
of essential services

Food, health care, environmental health





*Continued* 52

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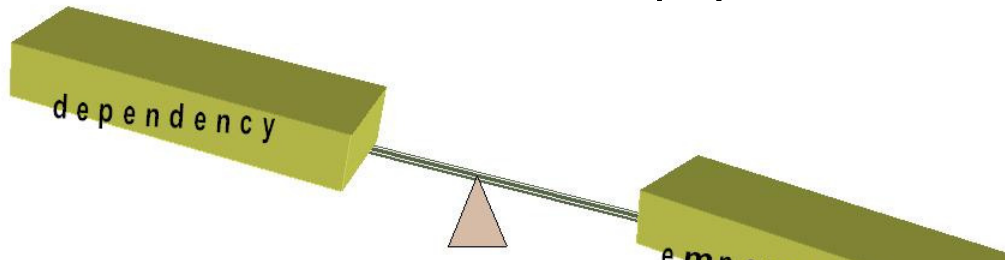
# Programming Issues

Or enabling community to meet needs

Community organization

Community power structure

Volunteer vs. incentive vs. pay





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# Principles of Health Care to Consider

Displaced camp

Camp

Dependent on rations

Treatment at home

Own house

Self-settled

Growing some food

Treatment in health  
facilities



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# How a Health System Should Be

Nature of health care system

Integration

PHC-based

Nature of illness

Health care workers

Curative vs. preventive care



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# Assessing Health Needs

**Gilbert Burnham, MD, PhD**  
**Johns Hopkins University**



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## Section A

### *What Are Assessments.*



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## Purpose of Assessments

- To identify what peoples needs are
- To define baseline status for future comparison
- To determine what changes have occurred as a result of the program
- To identify program weaknesses or gaps



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## Rapid Assessments

Similar to planning other health activities

Pace is accelerated in the emergency

Needs are often more urgent

May differ from those before flight



*Continued* 4

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## Rapid Assessments

Selecting priorities may be difficult

Consider consequences of inaction

Identify critical needs, then repeat  
assessment week later for less urgent needs



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## Assessment Checklists

Many checklists exist

For example, OFDAs *Field Officers Guide*  
(FOG) download at [www.info.usaid.gov](http://www.info.usaid.gov)

Need to understand how they are used

Are not a substitute for understanding the  
environment



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# Possible Assessment Questions

## Why have things happened.

How did things get the way they are now.

## What is likely to happen next.

Are people ready to go home.

Are more people coming.

Is cholera likely to break out.

Are there any possible outbreaks of  
hostility.

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*Continued* 7

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# Possible Assessment Questions

## **What is the situation in the host country.**

What are the common local diseases.

What kind of support is available.

Is the host population compatible.

How will things develop.





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## Basic Planning Cycle

Not unique to refugee situations

Provides a basic approach to address needs that have been identified



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# Basic Planning Cycle: Step 1

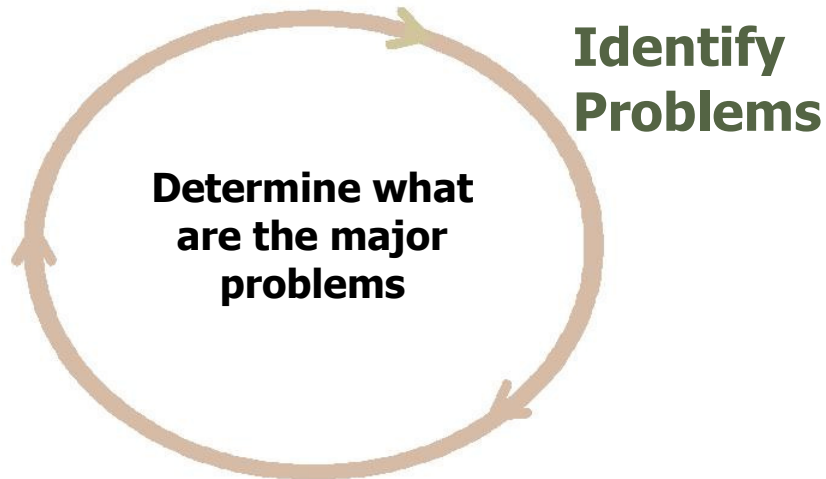
## Assessment





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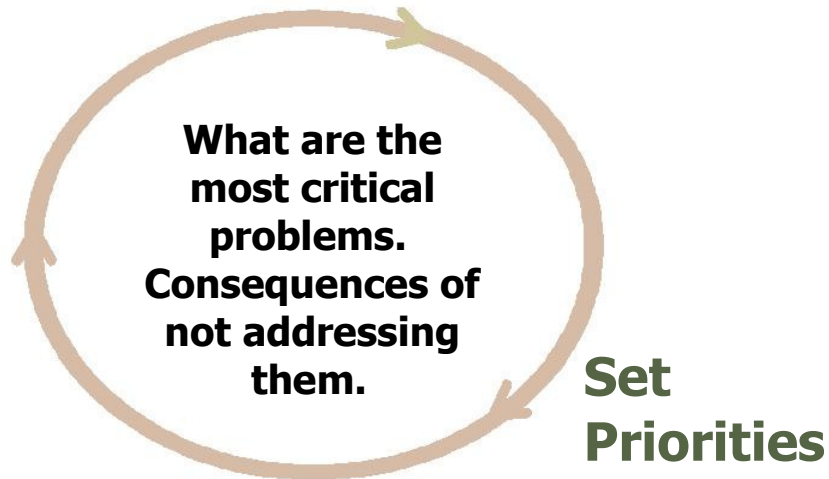
## Basic Planning Cycle: Step 2





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## Basic Planning Cycle: Step 3

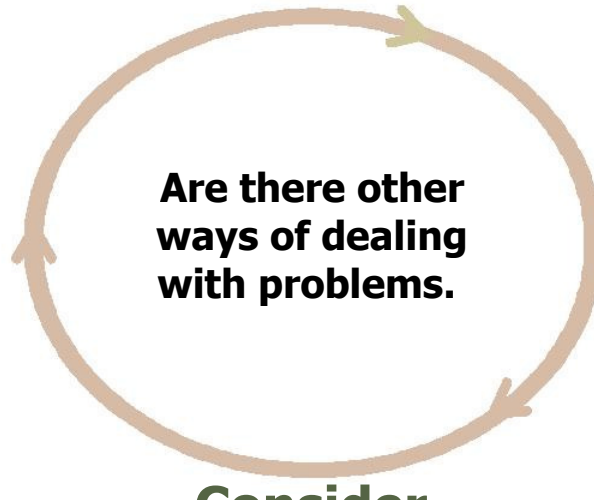






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## Basic Planning Cycle: Step 4

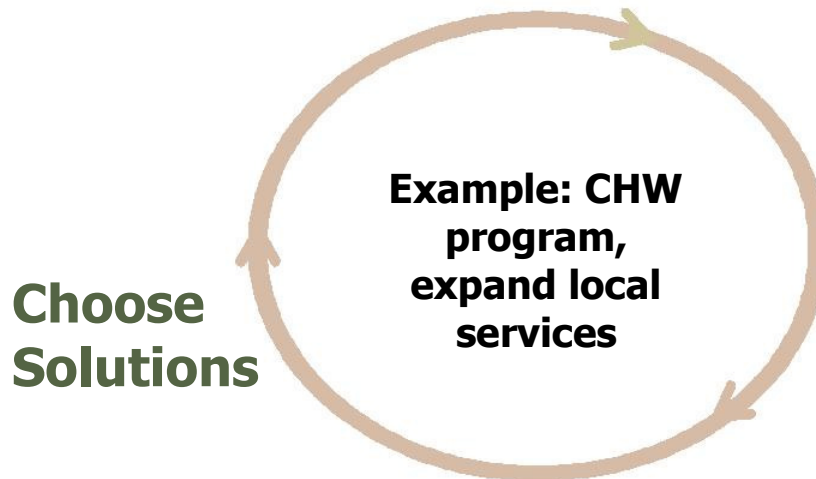


# Consider Alternatives

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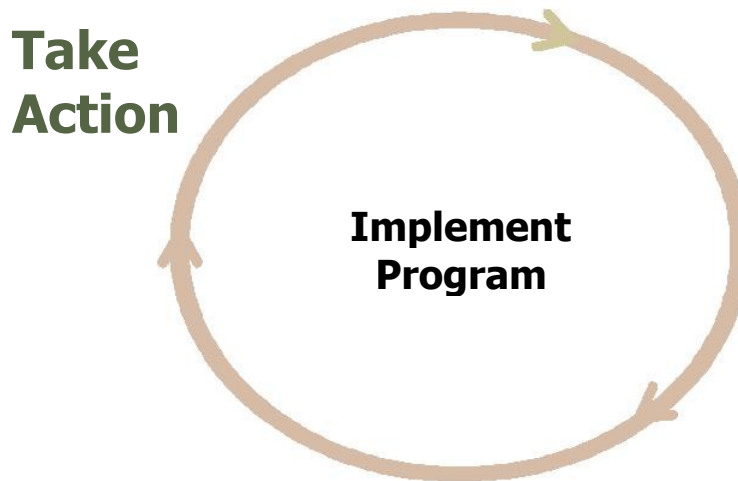
## Basic Planning Cycle: Step 5





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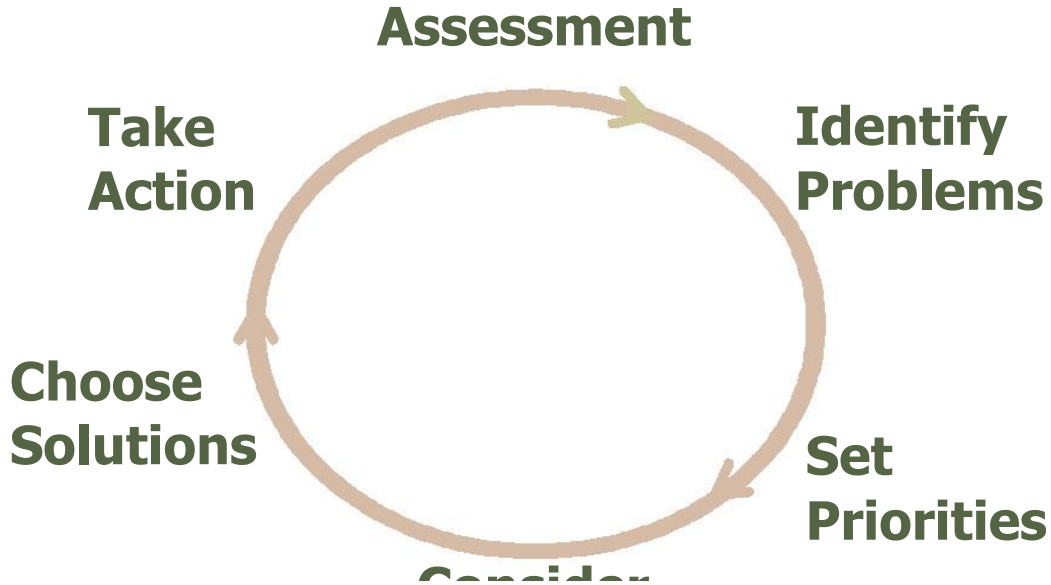
## Basic Planning Cycle: Step 6





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# Basic Planning Cycle





# Consider Alternatives

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## Section B

### *Conducting Assessments*



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# Conducting the Assessment

**Assessment is the basis for program development**

Poor assessments lead to weak programs

*Continued* 18

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# Conducting the Assessment

**Basic principle is to determine the following:**

What are the needs now.

What are the likely future needs.

What resources are available now.

What resources will be needed.



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# Thinking in a Systematic Way

## What has happened.

What is the impact on the community.

What is the impact on the household.

What is the impact on the vulnerable individuals/groups.

How is the situation likely to change.

What is the political environment.



*Continued* 20

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## Assess Specific Problems

Are there problems with shelter and clothing.

Are there problems with water for cooking, washing, bathing.

Are there problems with food and fuel.

Are there problems with disease threats.

How is the community coping with illness.

*Continued* 21

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# Assess Ways of Assisting Target Groups

Are vulnerable populations in danger.

How can protection be organized.

What must be done immediately to ensure survival.

*Continued* 22

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# Assess Ways of Assisting Target Groups

What must be done immediately to ensure survival.

How can this assistance be delivered.

What are the target groups.



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## Assess Local Resources

How can displaced people help themselves.

What are people doing now.

How can displaced people help themselves.

What unmet needs are there.



*Continued* 24

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## Assess Local Resources

How much assistance can the host government provide.

What are the government policies that will affect assistance.



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## Assess the Host Population

How have the refugees affected the local population.

How will assistance programs affect the host populations.

Is there poaching of health workers by high salaries.



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## **Assess the Host Population** *Set Priorities and Objectives*

Are local services and drug supplies overwhelmed.

What are the needs of the host population.



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## Assess the Host Population

Does the host have common unmet needs that can be addressed.





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# Developing an Assistance Program

Setting of mission

Why are we here.

Identification of needs

Should be specific and quantified  
wherever possible

Needs will serve as basis for monitoring  
program impact



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# Set Priorities and Objectives

Selecting priorities

What can we do.

What do we want to do.

Clear objective as basis of strong programs

Objectives must be measurable

Indicators for each must be easily assessed

Have alternatives to program

have alternatives to program  
design

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# Define Strategies and Alternatives

Strategies to implement objectives

How are we going to do it.

Clear series of tasks set out

Identify required resources

Consider alternatives in program design



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# Program Monitoring and Evaluation

Monitoring system needed to assess progress towards objectives

Evaluation based on objectives

Are the objectives the correct ones.

Have they been reached.

Is there clear evidence of impact.



*Continued* 32

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# Program Monitoring and Evaluation

How will the program be altered based on this information.

Establish evaluation criteria right from the beginning of the program

Determine the feedback mechanisms for informing the health workers and community who participated in evaluation process

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# Establishing Health Services

**Gilbert Burnham, MD, MPH**  
**Johns Hopkins University**



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## Lecture Outline

Section A: Health Needs

Section B: Disease Focus vs. Health Focus

Section C: What Should a Health System Be Able to Do in Emergencies.

Section D: Manner of Providing Health Services

Section E: Making Specific Decisions

Section F: How Much of What Is

# SECTION 1: HOW MUCH OF WHAT IS Needed.

2

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# Section A

## *Health Needs*





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## **What are the Health-Related Needs of the Displaced.**

When people are displaced to an area, what would cause them to become ill.

Diseases they brought with them

Diseases they acquired locally

Diseases related to changes in their circumstances



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# What Health Services Do Displaced Persons Need.

Treatment of diseases and injuries

Prevention of illness via medical means

<b><i>Primary Prevention</i></b>	Immunization against measles, meningitis, etc.
<b><i>Secondary Prevention</i></b>	Treatment of tuberculosis, leprosy, cholera, etc.
<b><i>Tertiary Prevention</i></b>	Rehabilitation of land mine injuries

*Continued* 5

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# What Health Services Do Displaced Persons Need.

Provision of health-related services

Water, food, shelter

Identifying the vulnerable for improved access to those at risk of disease

A major risk factor is forced dependency



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## **Section B**

### ***Disease Focus vs. Health Focus***





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## **Disease Focus vs. Health Focus**

Disease focus unable to address issues

Disease is not just the absence of correct diagnosis and treatment

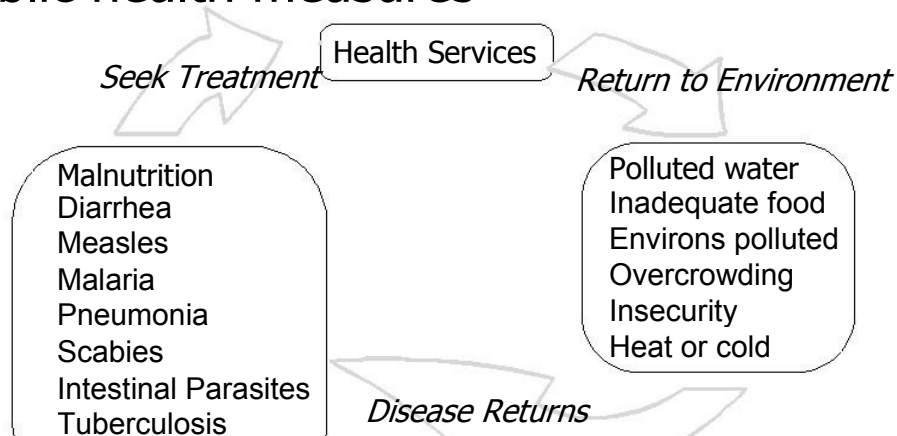
Disease is the absence of a correct public health approach looking at all factors which address health of a community



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# Vicious Cycle of Health Care

Curative services futile if not coupled with public health measures



STIs



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## Section C

### *What Should a Health System Be Able to Do in Emergencies.*



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# **What Should a Health System Be Able to Do in Emergencies.**

Overall goals for the health system

Reduce crude death rates to regional levels

Improve health status to regional norms



*Continued* 11

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## **What Should a Health System Be Able to Do in Emergencies.**

1. Diagnose and treat common conditions, especially if life-threatening
2. Active case-finding
3. Maintain adequate resources to sustain health services
4. Prevention of diseases
5. Measure/analyze activities and results
6. Communicate with and

## 6. Communicate with and train staff

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# Specific Health Services: Child Health Care

Immunization (EPI) programs

Nutrition

- Promoting breastfeeding

- Growth monitoring

- Selective feedings if necessary

- Micronutrients vitamin A, iron

*Continued* 13

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# Specific Health Services: Child Health Care

Treat childhood illness (IMCI approach)  
Standard treatment protocols



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# Specific Health Services: General Curative Care

## Common diseases

Priorities, e.g.,  
measles, ARI

Trauma and  
fractures

Chronic diseases,  
e.g. TB, asthma

In mid-level  
development countries

Diabetes,  
hypertension, heart  
disease, arthritis



*Continued* 15

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# Specific Health Services: General Curative Care

Provision for outpatient and inpatient care  
Prescription of drugs in an acceptable  
manner



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# Specific Health Services: Reproductive Health Care

Care during pregnancy

- Provide for safe delivery

Family planning

Care during delivery

Post delivery/post abortion care

STI treatment

HIV prevention

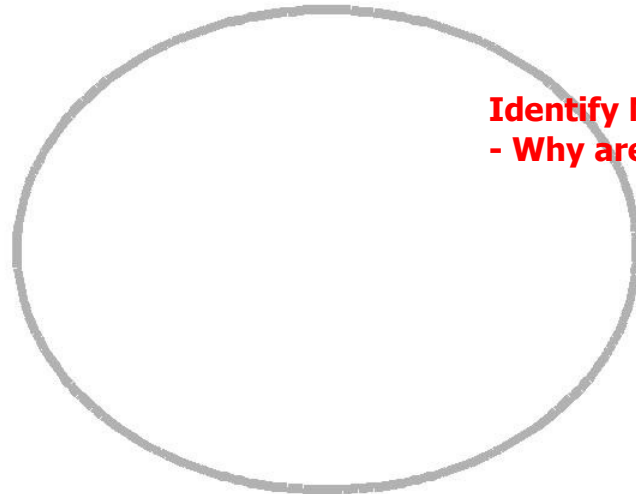
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# Testing and counseling

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# Developing the Program



**Identify Needs**  
**- Why are we here.**



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# Setting of Mission

## Identification of needs

Should be specific and quantified  
wherever possible

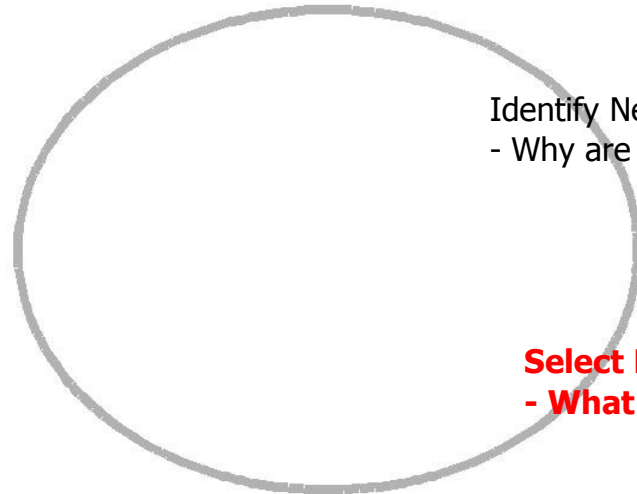
Needs will serve as basis for monitoring  
program impact





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# Developing the Program



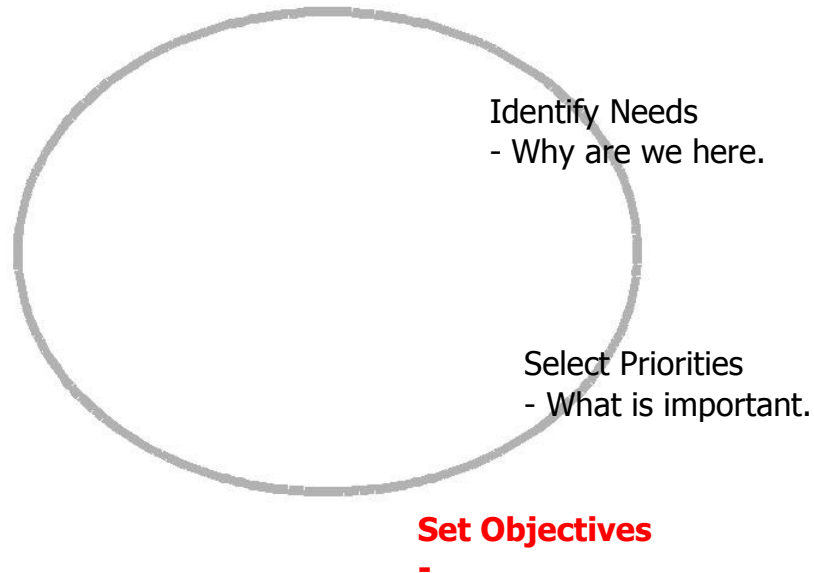
Identify Needs  
- Why are we here.

**Select Priorities**  
**- What is important.**

*Continued* 20

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# Developing the Program



**What do we want to do.  
What  
can  
we  
do.**

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# Clear Objectives are Basis of Strong Programs

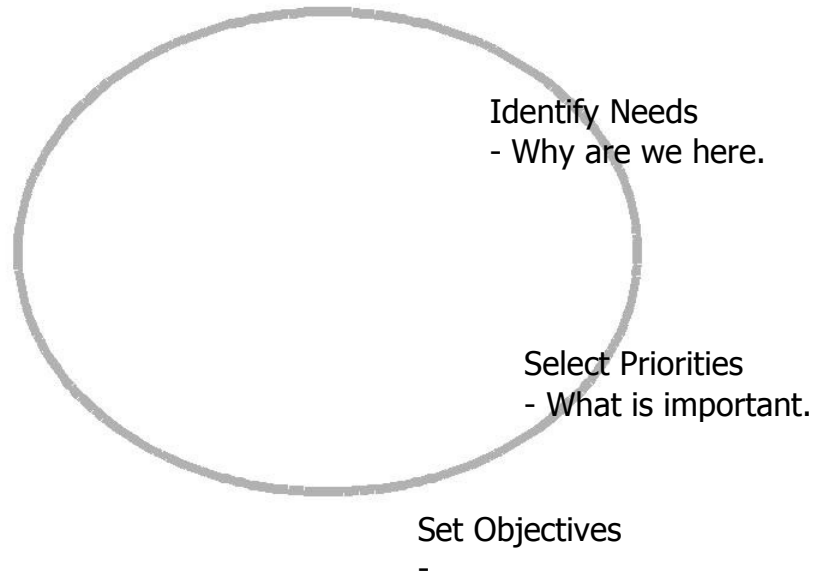
Objectives must be measurable

Indicators for each must be easily assessed



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# Developing the Program





What do we want to do.

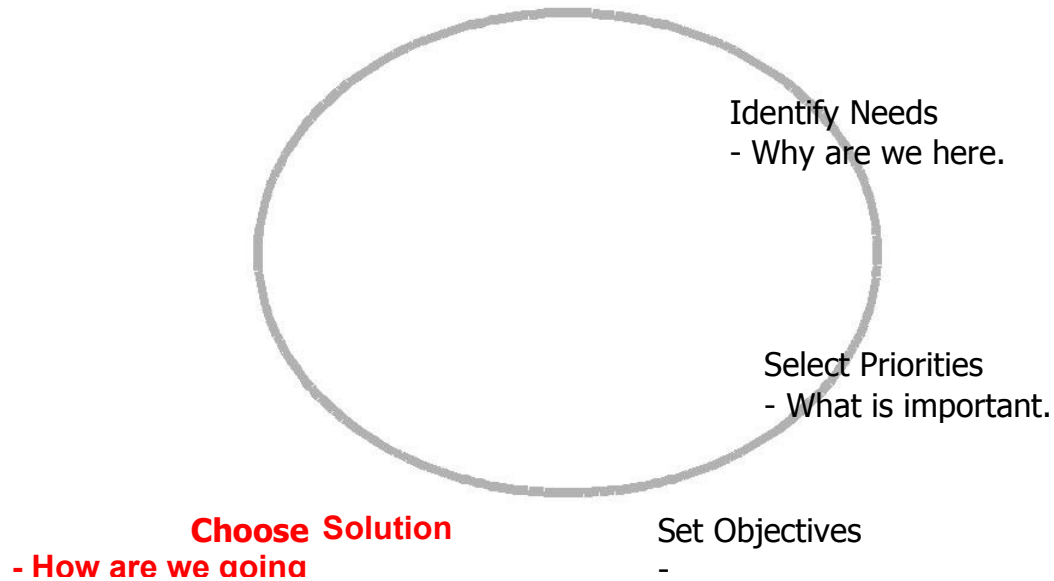
**Consider Alternatives**

What  
can  
we  
do.

*Continued* 23

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# Developing the Program



-----  
to do it.

What do we want to do.  
What  
can  
we  
do.  
Consider Alternatives

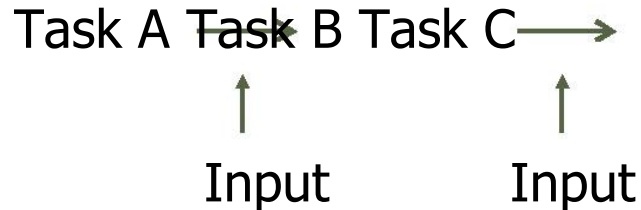
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## Strategies Formulated to Implement Objectives

Clear series of tasks set out

Required resources identified





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# Developing the Program

**Monitor Progress**  
**- How are we doing.**

*Implement Program*

Identify Needs  
- Why are we here.

Select Priorities  
- What is important.

Choose Solution  
- How are we

Set Objectives  
-

going to do it.

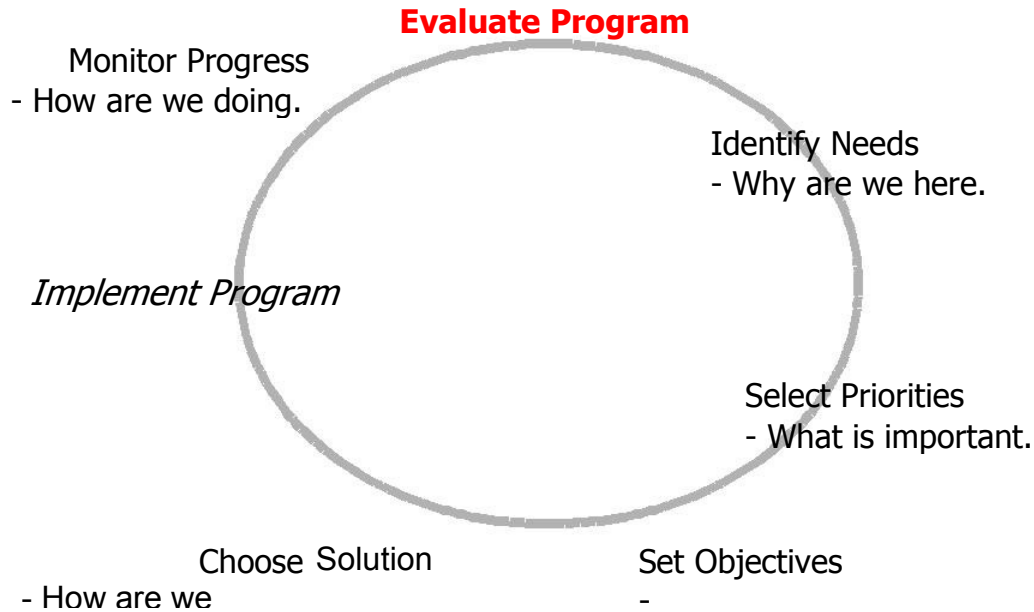
What do we want to do.

Consider Alternatives  
Can we  
do.

*Continued* 26

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# Developing the Program





going to do it.

What do we want to do.

Consider Alternatives  
Can we  
do.

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## Evaluation Based on Objectives

Are the objectives the correct ones.

Have they been reached.

Is there clear evidence of impact.

How will the program be altered based on the information.



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# How to Establish Services for a Displaced Population

Think through the development of health system from the first

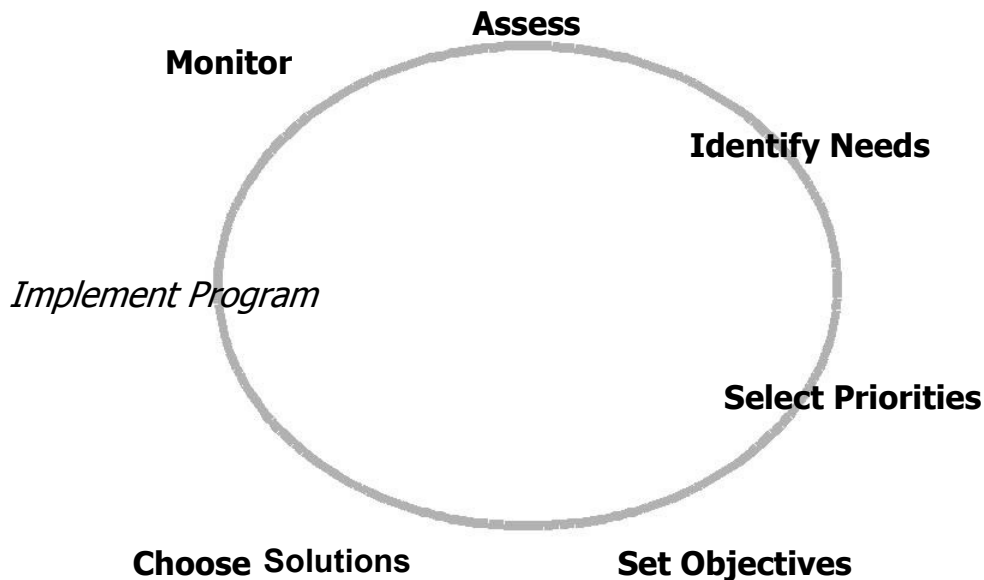
Since **x** is present, we will do **y**

If **f** occurs then **g** will be needed



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# Apply the Planning Cycle



## **Consider Alternatives**

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# Carry out a Systematic Assessment

Identify all obvious health problems

Some for immediate attention

Others for subsequent attention





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# Decide on Immediate Priorities for Treatment

*The 2 X 2 table:*

Frequency of disease  
diagnosis

High

Low

Risk of serious  
illness or death

High

Low

	High	Low
High		
Low		



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## **Consider Consequences of Not Addressing the Problem**

Consider the consequence of . . .

Low immunization coverage for measles

Low immunization coverage for BCG

Large population in known cholera area

Widespread scabies or lice

Large adolescent population



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# Involve Affected Community

Seek refugee community participation

In priority selection

In program design

This will promote program ownership



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# Consider Alternatives and Select Appropriate Solution

Use decision matrix to select the potentially most feasible and effective solution

<i>SOLUTION</i>	<i>A</i>	<i>B</i>	<i>C</i>	<i>D</i>
Feasibility				
Acceptance				
Cost				
Sustainability				
<b>TOTAL SCORE</b>				





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## Set Objectives to Reflect Possible Events

Set program objectives for program monitoring and evaluation

Short-term objectives

Longer-term objectives

Ensure objectives are SMART

**S**imple

**M**easurable

**A**ttainable

**R**ealistic

**T**ime-bound



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# Determine Strategy and Establish Monitoring System

Determine strategy and methods

Implement program

Use information system to monitor process, outputs and outcomes, as capacity allows





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## **Section D**

### ***Manner of Providing Health Services***



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# **In What Manner Should Health Services Be Provided.**

Health care is based on Primary Health Care principles

PHC seeks to do the following:

- Provide acceptable and affordable health care

- Provide optimum rather than maximum health care





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## Themes of PHC

Education about main health problems

Including prevention and control

Promotion of food supply and proper nutrition

Adequate supply of safe water and basic sanitation

Maternal and child health care, including family

planning

*Continued* 40

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## Themes of PHC

Immunization against major diseases

Prevention and control of locally endemic diseases

Appropriate treatment of common diseases/injuries

Provision of essential drugs



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# Different Levels of Health Care By Frequency of Needs



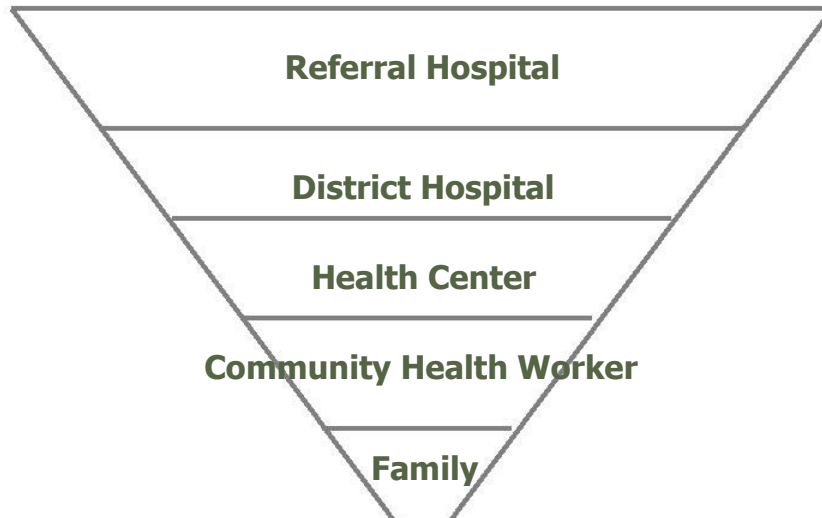
**at  
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# Resources Required to Provide Health Care







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## Section E

### *Making Specific Decisions*



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## Specific Decisions to Be Made

Establish new services vs. augment existing services

Where possible, the choice is to strengthen local services



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# Deciding Whether to Strengthen Local Services

<b><i>Hospital Level</i></b>	New facilities very costly
<b><i>Health Center Level</i></b>	New facilities often needed
<b><i>Health Post</i></b>	New facilities usually needed
<b><i>Community Services</i></b>	Specific for displaced populations



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# Setting Staff Requirements

Staff requirements depend on the following:

- Skills and capacity

- Main tasks to be done

- Resource requirements for each

Selection of staff

- Refugee vs. National vs. Expatriate

- Seconded government staff



*Continued* 47

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# Setting Staff Requirements

Need personnel policies for the following:

Job descriptions

Contracts

Disciplinary procedures



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## Establishing a Drug Program

Follow Essential Drugs Programme (1977)

Set drug procurement guidelines

Define drug selections for various levels of health care

Promote rational prescribing habits

Organizational practices

Host country policy



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## Drug Donations

Donated drugs often a disaster in themselves:

- Inappropriate or unknown medications

- Outdated

- Unreadable instructions

- Clutter up warehouses, take up personnel time



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## **New Emergency Health Kit**

Contains drugs and medical supplies for  
10,000 persons for three months

10 basic units for PHC workers

One supplementary unit for higher-level  
workers



*Continued* 51

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# New Emergency Health Kit

Does not cover all drug requirements

Chronic diseases

Psychotropic drugs



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## Section F

*How Much of What is Needed.*



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# First Referral Hospital

Capacity1:150,000300,000

Services provided

- Emergency surgery

- Emergency obstetrical care

- Blood banking

- Basic laboratory

*Continued* 54

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# First Referral Hospital

## Key staff

At least two medical officers

Adequate nursing staff (20+)





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## Health Center

Capacity: 30,000 or 10 km radius

Staffing: health care workers, nurses,  
medical officer, simple laboratory

May have inpatient beds and a maternity unit

Refer to 1st level hospital



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## Health Posts or Dispensaries

Capacity: 10,000 persons

Referral to the health center

Key staff: medical auxiliaries (primary health care workers)

Community Health Workers (CHWs) or home visitors



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## CHWs Work out of Health Posts

Often refugees 1:500 or 1:1000

Supervision from health post

Duties include the following:

- Health promotion

- Seek out and refer ill persons

- Treat common illness

- e.g., diarrhea

- Refer seriously ill

Refer seriously ill  
to hospital

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## How Health Services Are Utilized

Initially, may be a rush for treatment

Pent-up demand

Epidemics may be in progress

23% of population may use services/day



*Continued* 59

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## How Health Services Are Utilized

Steady state usually 1% of population  
visiting OPD services daily

1% of outpatient attendance will need  
inpatient care

1% of inpatients will need hospital referral



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# Factors Affecting Utilization

Utilization by geographic location

OPD attendance drops by 50% for every three km

*Continued* 61

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# Factors Affecting Utilization

## Utilization by age

Under-15s constitute 50% or more of most developing country populations

Under-5s constitute about 20% and represent 50-60% of outpatients



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## What Can Health Workers Do.

<i><b>HEALTH WORKER</b></i>	<i><b>POTENTIAL CAPACITY</b></i>
CHW or home visitor (community-based)	30 persons per day
Medical assistant or nurse (facility based)	50 persons per day
Medical Officer (doctor)	40 outpatients a day





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## Source of Staff

Refugee and host country nationals wherever possible

Have better understanding of refugee experiences

Potential for conflicts over pay are great

Establishing credentials of refugee staff may be difficult



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# Consider Down Time for Staff

Remember down time

Training

Vacation time

Sick leave and maternity leave

Rest and relaxation for expatriate staff

Consider staff turnover



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# Handing Over of Programs

Common after early phase to close down or hand over health services

To development-oriented NGOs

Sometimes to host country MoH

*Continued* 66

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# Handing Over of Programs

Imperative to design programs for long-term efficiency from the beginning

Monitoring of program effectiveness

Measured against set objectives

Goal to contribute to development of refugees and host country system



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# **Control of Communicable Diseases**

**Gilbert Burnham, MD, MPH  
Johns Hopkins University**



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## Learning Objectives

Know risk factors for communicable disease  
in emergencies

Understand the effects of disease outbreaks

- On the community

- On the health system

- On the host community

*Continued* 2

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## Learning Objectives

Know the common communicable diseases in refugee populations

And which may cause epidemics

Understand methods of disease prevention and control

Know tools for assessment and control

Be able to design control programs



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## Key Principles

1. The communicable disease cycle
2. Changing equilibrium
3. Risk factors
4. Effects of outbreaks
5. Disease prevention and control
6. Rapid assessment during disease outbreaks
7. Approach to childhood illness



## 8. Common communicable diseases

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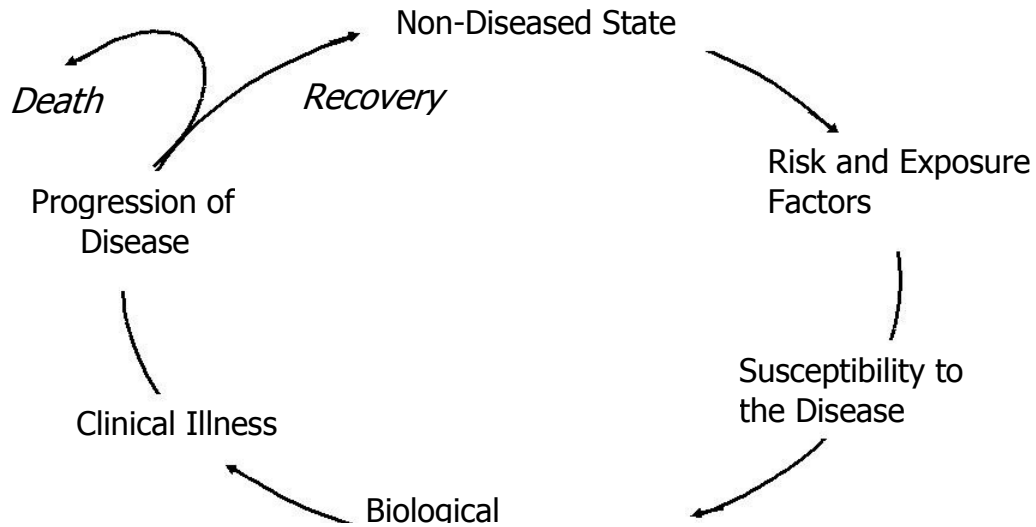
## **Section A**

### ***The Communicable Disease Cycle***



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# The Communicable Disease Cycle



Evidence of  
infection  
of

6

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## **Section B**

### ***Changing Equilibrium***



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# Changing Equilibrium

Changing equilibrium between population  
and environment

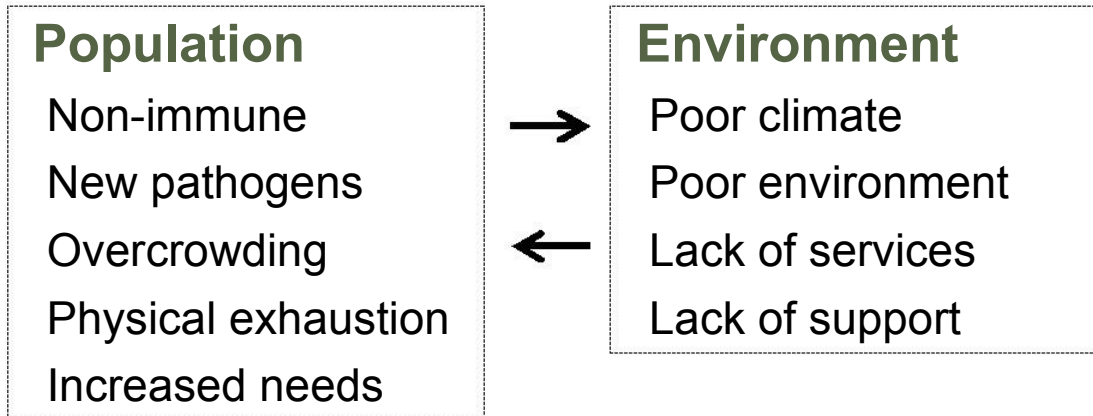
Changing equilibrium between needs and  
services





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# Changing Equilibrium between Population and Environment





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## Transmission of Disease

Outbreaks unusual after natural disasters

Organisms usually present in community

More likely if water and sanitation systems are poor or destroyed

*Continued* 10

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# Transmission of Disease

More common in displaced populations

Related to level dependency

Proven control measures may be less effective in refugee settings



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# Changing Equilibrium between Needs and Services

Major loss of equilibrium may occur

Needs may have increased dramatically

Services may not have capacity to meet needs or they may have decreased or ceased to function

*Problems      Resources Available =  
Unmet Needs*



*Continued* 12

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# Changing Equilibrium between Needs and Services

Loss of equilibrium manifest by . . .

Increased vulnerability by population

Increased individual susceptibility =  
populations at risk



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# Control of Communicable Diseases

Control of communicable diseases involves

Restoring this equilibrium

Reducing vulnerability and susceptibility

Decreasing the population risk

Strengthen services that will address  
outbreak of communicable diseases



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# Section C

## *Risk Factors*



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# Risk Factors

Risk factors for displaced populations

Risk factors for host populations





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# **Risk Factors for Displaced Populations**

Overcrowding

Physical exhaustion

High level of malnutrition

*Continued* 17

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# Risk Factors for Displaced Populations

Low personal hygiene and lack of soap

Inadequate quantity of water and poor water quality

Poor sanitation

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# Risk Factors for Displaced Populations

High percentage of children

Lack of immunity

Disruption of households

Increase vector breeding

Poor access to preventative or curative services



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# Risk Factors to the Host Population

Introduction of new pathogens

High presence of children as reservoir

Damage to the environment

Increase in vector-borne diseases



*Continued* 20

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# Risk Factors to the Host Population

Effect on nutrition from deforestation

Competition for resources

Poor or disrupted health services  
(overwhelmed)



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# Sexually Transmitted Infections

<i>Diseases Possible</i>	<i>Diseases Likely</i>
Ulcerative diseases Discharge Other STIs: HIV	Ulcerative diseases Discharge Other STI: HIV



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## Vector-Borne Diseases

<i>Diseases Possible</i>	<i>Diseases Likely</i>
Malaria	Malaria +++
Relapsing fever	Relapsing fever +
Yellow fever	Typhus +/-
Sleeping sickness	
Schistosomiasis	
Typhus	



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## Fecal or Fecal-Oral Diseases

<i>Diseases Possible</i>	<i>Diseases Likely</i>
Diarrhoea	Diarrhoea
Cholera	Cholera
Dysentery	Dysentery
Typhoid	
Amoeba	
Giardia	
Hepatitis	
Intestinal parasites	





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# Airborne Diseases

<i>Diseases Possible</i>	<i>Diseases Likely</i>
ARIs Measles Pertussis Tuberculosis Meningitis	ARIs Measles Pertussis Tuberculosis Meningitis



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## Section D

### *Effects of Outbreaks*



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# Effects of Outbreaks on Displaced Populations

Create fear and panic

Especially cholera and meningitis

*Continued* 27

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# Effects of Outbreaks on Displaced Populations

Health consequences

Loss of life



*Continued* 28

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# Effects of Outbreaks on Displaced Populations

Economic consequences

Social consequences population movement

Prolonged illness



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# Effects of Outbreaks on the Health System

Use up health resources

Cases overwhelm health system

Especially if already deteriorated

Create panic, rumors, and unrealistic demands



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## **Section E**

# ***Disease Prevention and Control***



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# Disease Prevention and Control

Several conceptual models

Natural cycle of disease

Preventive approach





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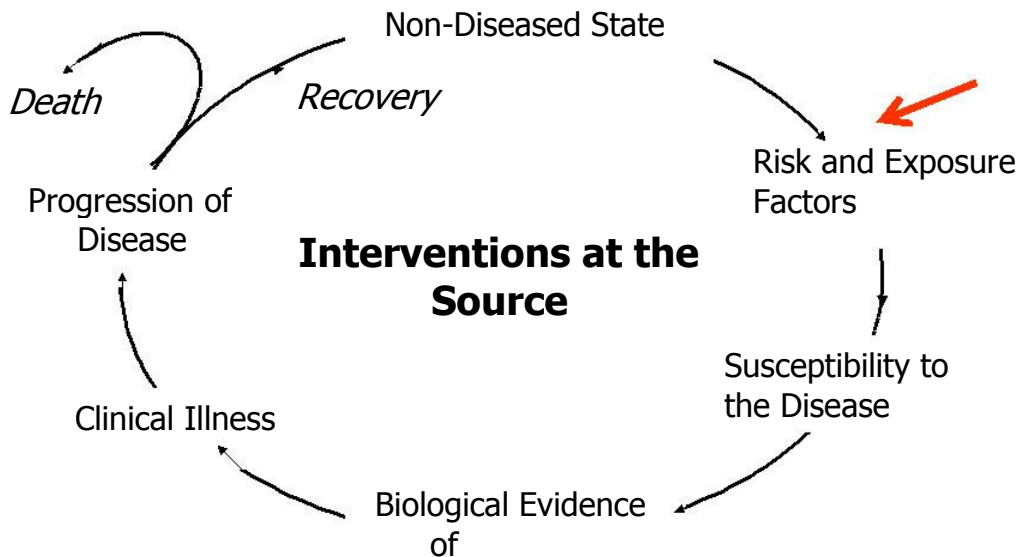
# Natural Cycle of Disease

## Intervention at several levels



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# Natural Disease Cycle

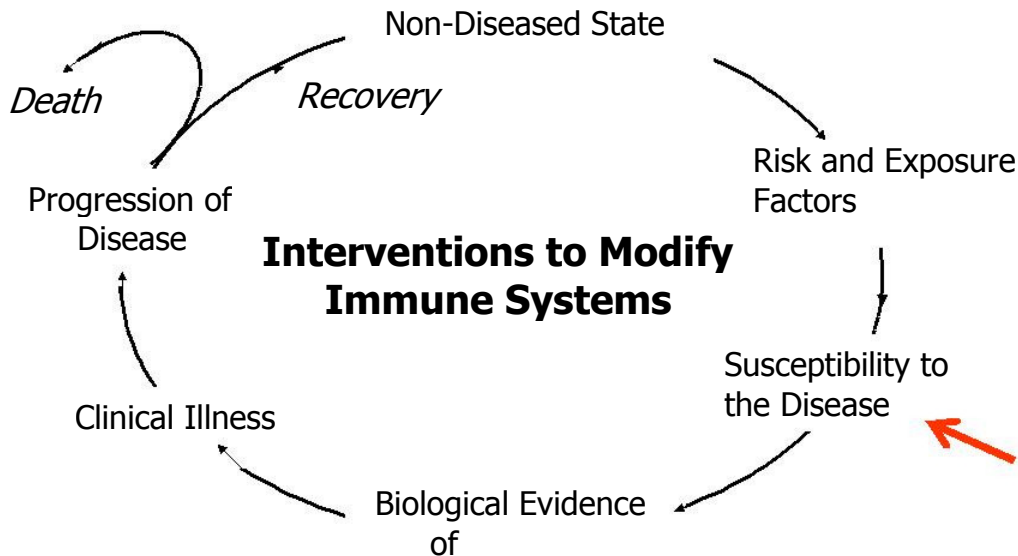


## Infection

*Continued* 34

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# Natural Disease Cycle

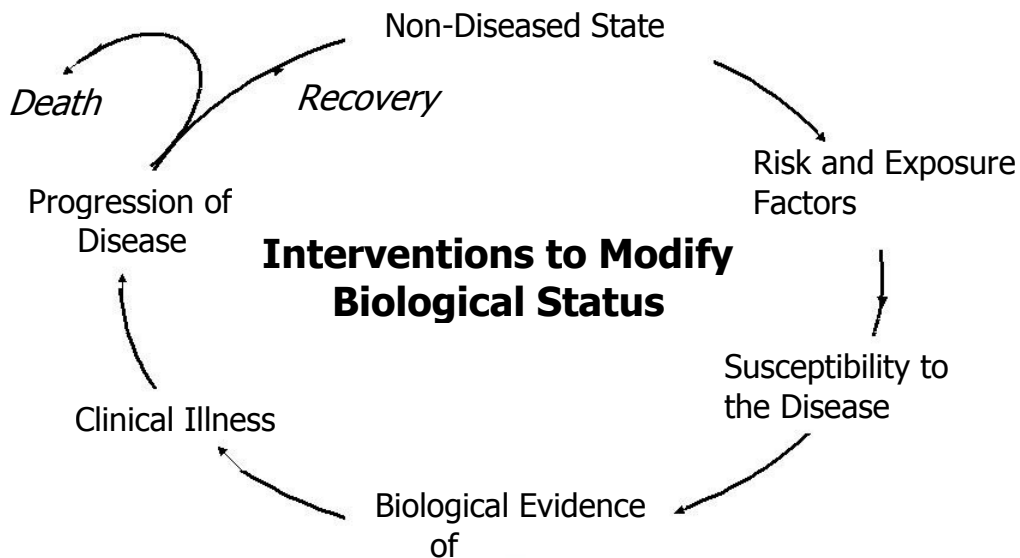


## Infection

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# Natural Disease Cycle





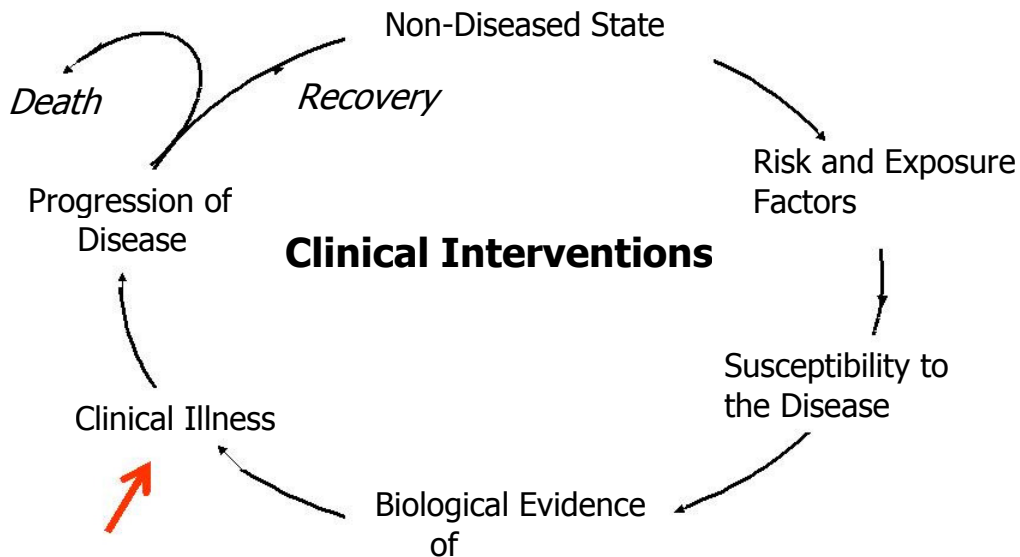
Infection



*Continued* 36

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# Natural Disease Cycle

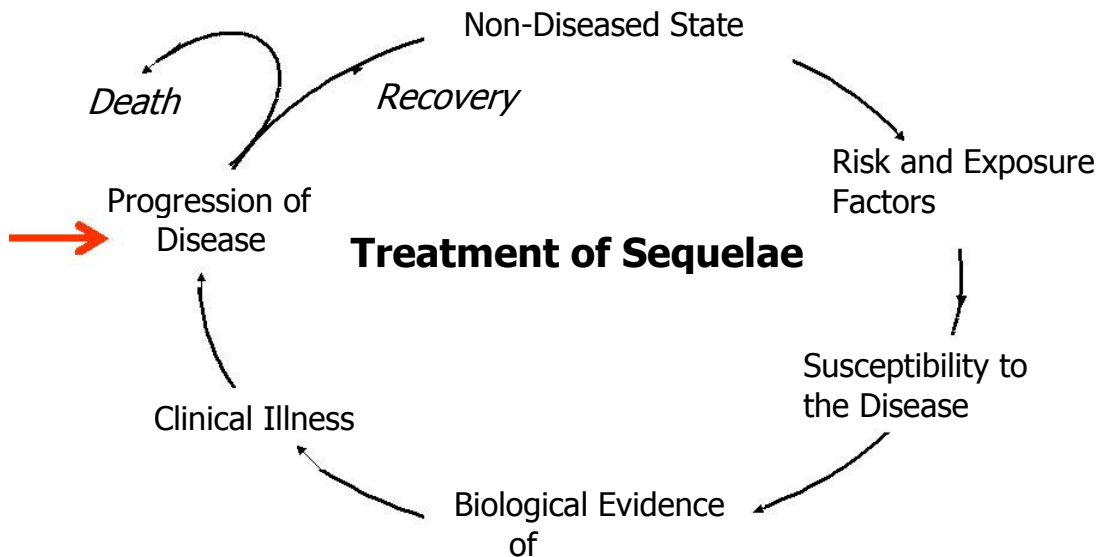


Infection

*Continued* 37

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# Natural Disease Cycle



## Infection

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# Preventive Approach

<b><i>Primary Prevention</i></b>	Preventing infection
<b><i>Secondary Prevention</i></b>	Preventing serious consequences of infections
<b><i>Tertiary Prevention</i></b>	Rehabilitation following a disease
<b><i>Curative</i></b>	<b>To stop disease transmission</b>



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## Section F

# *Rapid Assessment During Disease Outbreaks*





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# Steps for an Epidemic Investigation

1. Confirm the existence of an epidemic
2. Confirm the diagnosis
3. Determine the number of cases
4. Establish *time, place, and person*

*Continued* 41

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## Steps for an Epidemic Investigation

5. Determine who is at risk
6. Make and test hypothesis on transmission or risk factors
7. Document your findings
8. Establish disease control program



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## Sources of Death Information

In-depth interviews (verbal autopsy) of families with deaths

- Using checklist of common disease symptoms

- Using local names or descriptions

Health facilities simple data collection

Community health workers

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# Sources of Death Information

Information from burial grounds

Age and sex

Sometimes symptoms before death





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## **Section G**

### ***Approach to Childhood Illness***



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# Commonly a Symptomatic Approach

Clear case definitions for recording and treatment may need to develop

Use medical auxiliaries sometimes  
inadequate training and skills

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# Commonly a Symptomatic Approach

Integrated Management of Childhood Illness (IMCI) approach has been used in some emergencies

More thorough but time consuming



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# IMCI Approach

1. Check danger signs	6. Check for anemia and malnutrition
2. Ask about cough or difficult breathing	7. Check immunization status
3. Ask about diarrhea	8. Give vitamin A if needed
4. Ask about fever	9. Check for other problems
5. Is there an ear problem.	10. Schedule a return visit





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## **Section H**

### *Common Communicable Diseases*



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# Measles

A serious disease with high mortality

West Africa case fatality rate 12%

Displaced populations up to 30%

UK (1960) case fatality rate 0.02%

*Continued* 50

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# Measles

Low age of infection in developing countries

Risk begins at 56 months of age

>30% of children infected by age one year



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# Manifestations of Measles

## Eyes

Conjunctivitis, herpetic infection, corneal ulcers with vitamin A deficiency

Common cause of blindness



*Continued* 52

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# Manifestations of Measles

## Mouth

Child refuses to eat or drink due to buccal ulceration, *candida albicans*

Cancrum oris may develop

## Larynx

Hoarse voice, laryngo-tracheo-bronchitis  
(danger sign)

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# Manifestations of Measles

## Lungs

Pneumonia

## GI tract

Epithelial changes cause diarrhea and dehydration

## Skin

Desquamation leading to oozing, infected lesions

## RESULTS

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## **Risk Factors for Measles in Displaced Populations**

Often low measles-immunization coverage

Overcrowding promotes spread

Poor nutritional status increases risk of  
measles complications

*Continued* 55

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# Risk Factors for Measles in Displaced Populations

Measles makes bad nutrition worse

Major cause of weight loss

Recovery may take 34 months

Overt malnutrition often begins with measles



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# Risk Factors for Measles in Displaced Populations

Measles often followed by other disease

E.g., diarrhea

Vitamin A deficiency linked with high CFR and corneal changes



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# Importance of Prevention

Impact of a measles epidemic

- Can overwhelm services

- Can divert resources from critical preventive activities

- Often results in a large number of deaths

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## Importance of Prevention

Health managers aware of measles impact

Outbreaks less common than in 1970s and early 80s

Major cause of mortality in Sudan and Somalia

Uncommon in Rwanda and Bosnia



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# Measles Immunization

Decide if measles immunization needed

30 cluster survey for immunization carried out

Using history or card in a systematic sample



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# Measles Immunization

If high level measles coverage

Can establish a routine immunization (EPI) program

If uncertainty or low levels of measles immunization

Mass measles immunization program

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## Measles Immunization

Decide if measles only or full immunization appropriate

- Depends on resources

- Opportunity costs

In all situations, establish routine immunization program

- In due course



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# Acute Respiratory Infections (ARIs)

Often a major cause of death

Especially in cold areas

Coughing may be common in children

75% children may present with coughing

Most health care by nurses and auxiliaries



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## Diagnosis of ARIs

Differentiating between pneumonia and non-pneumonia

Lab and x-ray usually not available

Skill to make diagnosis by auscultation often absent

Over-treatment with antibiotics common



*Continued* 64

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## Diagnosis of ARIs

Alternative approach necessary depends on counting respiratory rate

Pneumonia if  $>50$  in child two to twelve months

Pneumonia if  $>40$  in 12 months to five years



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# Management of ARIs

For a successful program

Provide continuing support to sustain  
especially drugs

(Co-trimoxazole usually the standard drug)

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# Management of ARIs

For successful program

First build health facility capacity

Sensitize community health workers

Create awareness among mothers



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# **Sexually Transmitted Infections (STIs)**

Common in many developing countries

40% of population may have antibodies to syphilis (TPI)



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# Sexually Transmitted Infections (STIs)

Very common in displaced populations due to . . .

- Family separations

- Increase in female-headed households

- Lack of income-generating activities

- Abuse of vulnerable women



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# Risk Factors for Increasing STIs

Barriers to health care

Lack of access to health facilities

Poor health worker sensitivity common



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## Diagnosis of STIs

Symptoms less obvious in women

Diagnosis usually depends on laboratory

No training in syndromic approach

Partial treatment from local medications



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## Problems with Control of STIs

HIV increasing risk

Behavior change harder to establish  
among displaced populations

Few programs address problem of STIs

Not a relief issue

Population movement key factor





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# Approach to STI Treatment Programs

Based on syndromic approach to STIs

Requires community awareness

HIV control

Proper diagnosis of STIs

Condom availability and promotion

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# Approach to STI Treatment Programs

HIV control

Behavior change

Protection and support of vulnerable

Introduction into school curriculum



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# Meningitis

Epidemic meningitis caused by *Neisseria meningitidis*

Common in meningitis belt of Africa

Particularly during dry, dusty times

Droplet spread

Increased transmission in crowded situations



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# Meningitis Epidemics

Epidemic defined as

*>100 cases /100,000 people/week*

Outbreaks are episodic

Hard to predict their occurrence





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# Management of Meningitis (Treatment)

Critical choices when first cases appear

Treatment straightforward

Chloramphenicol in oil (Tifomycin), single dose,

Second dose given to 25% of cases



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# Meningitis Epidemics

Once an outbreak starts, it is hard to stop until it has run its course

- Follows classic epidemic curve

- Most exposed persons seldom show clinical disease

- Can overwhelm the health system

- Can create hysteria



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# Management of Meningitis (Mass Immunization)

Decision to immunize made when

Weekly incidence rises 24 fold

15 cases/100,000/week within two weeks

Start immunizations in affected areas

Mass chemoprophylaxis ineffective



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# Tuberculosis (TB)

Leading cause of preventable death in adults

Risk factors for TB infections

- Deteriorating health services

- National TB control programs are overwhelmed



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# Tuberculosis (TB)

## Risk factors for TB

Poor nutritional status

HIV co-infection increasingly common

Overcrowding



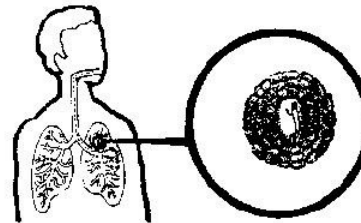
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## Prevalence of Pulmonary TB

Control measures concentrate on pulmonary tuberculosis

Urgent situation exists if prevalence of pulmonary TB exceeds 1%

Prevalence among many displaced populations is more than 4%





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## Drug Resistance in TB

Drug-resistant TB emerging threat in many situations worldwide

Partially or inadequately treated disease

Patients discontinue treatment when feeling better

Intermittent drug supplies

Patients leave treatment area

Drugs sold on open market

No TB control program in place

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# Guiding Principles for Treating TB in Refugee Populations

If it cant be treated correctly in a functional system, then it should not be started  
Basic capacities must be present





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# Basic Capacities Necessary for Treating TB in a Refugee Population

Capacity to Diagnose TB

Supply of uninterrupted/continuous TB treatment

Laboratory capacity

Regular follow-up of TB medication users

Tracing of treatment defaulters

Evaluation of TB program

Calculate a treatment completion ratio

Ultimately Can individuals be declared as cured.



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## When to *Starta* TB Program

After the emergency phase

Health system must be functioning

Populations must be stable

Agency must have capacity to run and evaluate program



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## When to *Stop* a TB Program

When populations become unstable

When health system is disrupted

When agency becomes unstable

When evaluation shows program is ineffective



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## Guidelines for TB Program

Start with careful planning

Concentrate on pulmonary TB

Ideally integrate into national program

- Same forms

- Same treatment protocol

- Same personnel

- Same training





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## TB Treatment Protocols

Basic principlesix, seven, and eight month programs in two phases

1. Intensive phase (first two months)
2. Maintenance phase (next four to six months)

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# TB Treatment Protocols

## 1. Intensive phase

Four drugs rifampicin, pyrazinamide, INH, ethambutol, or streptomycin

## 2. Maintenance phase

INH, rifampicin, other variations  
Thiacetazone is out



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# Malaria

Malaria is common in many displaced populations

Infection of Plasmodium four species

Benign malaria

*P. vivax*, *P. malariae*, *P. ovale*

Malignant malaria

*P. falciparum*

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# Malaria

Carried by Anopheline mosquitos  
Phenomenal vectorial capacity





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## Clinical Considerations

Most common cause of fever in endemic areas

Many persons self-treat

Repeated infections give partial immunity

Usually acquired by age three to five

Severe complications in non-immune

Massive hemolysis, cerebral malaria

Renal failure, malarial

# Renal failure, malaria lung (ARDS)

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# Malarial Immunity

## Partial immunity

- Protects against complications

- Uncomplicated febrile attacks common

- Requires regular parasitemia to maintain

- Immunity decreases in pregnancy  
(especially among primigravida)



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## Why Problems of Malaria Arise

Population is displaced from malaria-free area to malarious area

Immunity normally developed in childhood is absent

Population is displaced from a malarious area to a malaria-free area

Health system unprepared for malaria and its complication



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# Setting up a Malarial Control Program

Is this a priority.

What is the malaria problem.

Prevalence of parasites

Incidence of severe or complicated malaria  
in this population



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# Setting up a Malarial Control Program

How much effort can you devote.

What are the options/priorities.

Improve clinical services or

Comprehensive malaria program



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# Malaria Case Management

Coordinate with host government programs

Establish case definitions

Improve diagnostic/treatment skills

Of health workers and households

Ensure a regular supply of appropriate drugs

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# Malaria Case Management

Make drug supplies available outside the health system

Confirm a sample of malaria diagnoses parasitologically



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## Chemoprophylaxis for Malaria

A controversial issue appropriate for pregnant women, maybe correlated with miscarriage

Not necessarily appropriate for children

Appropriate for expatriate workers (who think they are not immune)



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## Vector Control

May combine any of the following

- Sanitation measures

- Drain breeding sites

- Other control measures

  - Spraying interior of houses

  - Fogging area

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# Vector Control

Other control measures

Bednets/curtains not always practical



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# Planning a Disease Control Program

The planning cycle

Assess the present situation

- Extent of problem or burden of disease

- Potential short-term and medium-term risk

- Present activities to address problem,  
if any

- Existing capacity to address problem

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# Planning a Disease Control Program

- Identify the problem
- Set the priorities
  - Consider alternatives
  - Choose solution
- Set goals and objectives
  - Choose indicators



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# Planning a Disease Control Program

Take actions

What strategy and methods.

What are potential constraints.

What are your contingency plans.

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# Planning a Disease Control Program

What resources you will require for a six-month program.

Supplies, personnel, equipment, transport

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# Planning a Disease Control Program

How will you conduct on-going monitoring of your activities.

At the end of six months, how is the program evaluated.



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# **United Nations High Commissioner for Refugees (UNHCR)**

## **Office of the United Nations High Commissioner for Refugees**





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# Section A

## *Overview of UNHCR and its Mandate*



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## UNHCR Statute

The United Nations General Assembly adopted the statute creating UNHCR on December 14, 1950

UNHCR had a temporary mandate renewed every five years, however in 2003 the United Nations General Assembly removed the time limitation on the continuation of the Office until the refugee problem is solved

**SOLVED.**

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# Refugee

## *1951 Convention and 1967 Protocol*

A person who, owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group, or political opinion, is outside the country of his or her nationality, and is unable to or, owing to such fear, is unwilling to avail himself of the protection of that country



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# Expanded Regional Definitions

## Organization of African Unity (OAU)

In 1969 included as reasons for refugee flight external aggression, occupation, foreign domination or events seriously disturbing public order

## Cartagena Declaration

In 1984 incorporated OAU definition PLUS massive violation of human



rights

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## OAU Convention

The term refugee shall also apply to every person who, owing to external aggression, occupation, foreign domination or events seriously disturbing public order in either part or the whole of his country of origin or nationality, is compelled to leave his place of habitual residence in order to seek refuge in another place outside his country of origin or

country of origin or  
nationality

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## Cartagena Declaration

Hence the definition or concept of a refugee to be recommended for use in the region is one which, in addition to containing the elements of the 1951 Convention and the 1967 Protocol, includes among refugees persons who have fled their country because their lives, safety, or freedom have been threatened by generalized violence, foreign aggression, internal conflicts, massive violation of human rights or other circumstances which have seriously

disturbed

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## Refugee vs. Immigrant

What is the difference.

A *refugee* is a person who owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular group, or political opinion, is outside the country of his or her nationality, and is unable to or owing to such fear, is unwilling to avail himself of the protection of that country



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# UNHCR Purpose

UNHCR was created to

Protect refugees

Assist refugees

Find durable solutions for refugees  
problems





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# Refugee Protection

Upholding the principle of non-refoulement

States may not return a refugee to a country where his or her life or freedom would be threatened

Safeguarding refugees basic human rights (including economic and social rights) in countries of asylum, and ensuring treatment as near as possible to that of

local  
citizens

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# Assistance May Include . . .



Food and Water

Medical Care



Photos provided by UNHCR



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Shelter

## Education



Photos provided by UNHCR



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# Health

Disease/epidemics (water, sanitation, shelter, vaccines)

Malnutrition

HIV/AIDS, other STDs

Maternal and child health

Psychological health (effects of trauma and grief resistance to disease)





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# Durable Solutions

## Voluntary repatriation

Refugees return home in safety and dignity

This is the durable solution preferred by most refugees

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# Durable Solutions

## Local integration

Refugees reach some level of self-sufficiency and remain in their country of first asylum, until repatriation becomes possible

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# Durable Solutions

## Resettlement

Refugees can neither return to their country of origin nor safely stay in their country of refuge

The only solution then is to resettle in a third country



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# **Section B**

## **UNHCR's Work**





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## UNHCR Works with . . .

Refugees

Returnees

Some Internally Displaced Persons (IDPs)

Some war-affected

In some operations, UNHCR may work with all these groups in the same place



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## Of Concern to UNHCR Today

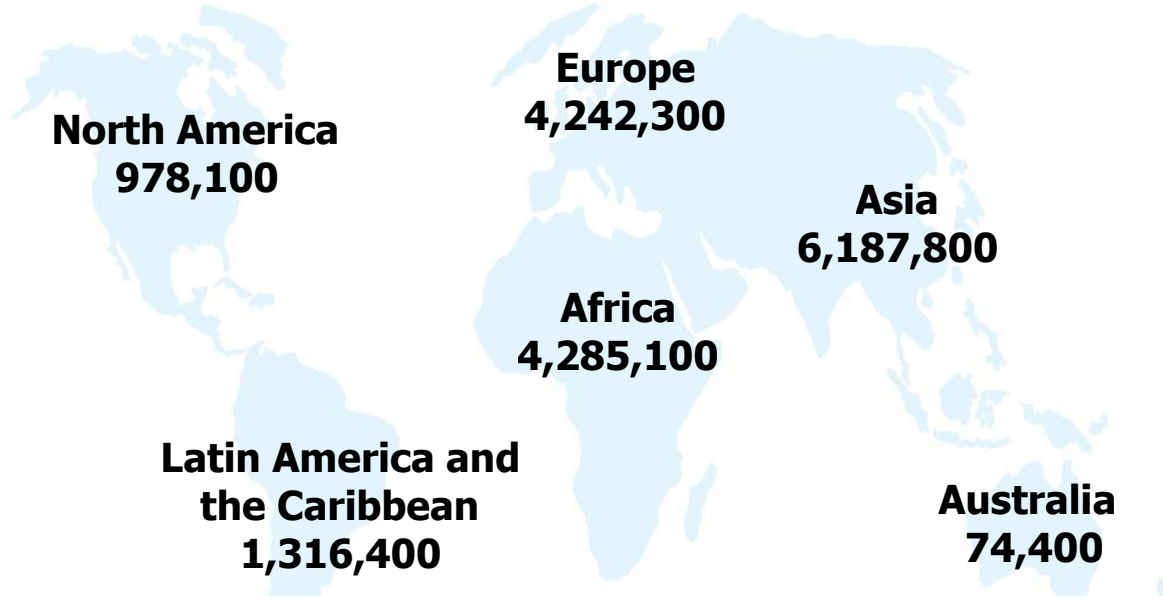
<b>Worldwide: 17.1 Million People</b>	
Refugees	9.7 Million
Returnees	1.1 Million
Asylum Seekers	985,500
Internally Displaced and Others of Concern	4.4 Million and 912,200



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# People of Concern to UNHCR

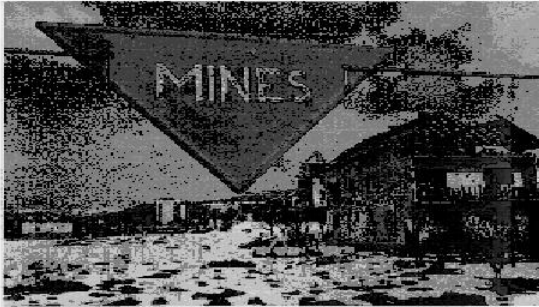
## *By Region*





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# Changing Humanitarian Circumstances



More internal conflict  
Civilians as targets of war/conflicts

Insecure, fragile  
working environment

Relief-development  
gap, even for  
returnees





Photos provided by UNHCR

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## Other Challenges/Dilemmas

Humanitarian fig leaf substitute for political will

Compassion fatigue

CNN factor (+ or -)

Working with the military

Globalization vs. localization



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# EMERGENCY RESPONSE



Provided by UNHCR

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## Origin of Largest Ten Refugee Groups in 2004

Afghanistan	2,136,000
Sudan	606,200
Burundi	531,600
Dem. Rep. Congo	453,400
Palestinians	427,900
Somalia	402,200
Iraq	368,500
Vietnam	363,200
Liberia	353,300
Angola	329,600

An estimated 4 million Palestinians who are  
separate by mandate of UNRWA are not included in this table

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## Top 10 Contributors to UNHCR (in millions of US\$) 2004

<b>United States</b>	309	<b>Norway</b>	49
<b>Japan</b>	91	<b>United Kingdom</b>	47
<b>EU Commission</b>	71	<b>Denmark</b>	39
<b>Netherlands</b>	57	<b>Germany</b>	33



<b>Sweden</b>	53	<b>Canada</b>	25
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## **Section C**

### ***Afghanistan at a Glance***



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# Afghanistan Refugee Emergency Preparations

UNHCR contingency planning

Open borders

Site identification in Pakistan, Iran, and  
other countries

Emergency teams and relief supplies in  
place

Special appeal to donors



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## Afghanistan Voluntary Repatriation

Large-scale return of more than 2.5 million  
refugees and IDPs in 2002

645,767 returned in 2003

375,526 of those returned in 2003 were  
from Pakistan

269,391 from Iran (2003)

82,000 IDPs (2003)

Up to 1 mil refugees anticipated to return  
in 2004 and another 778 000

in 2004 and another 770,000  
in 2005

*Continued* 28

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# Afghanistan Voluntary Repatriation

UNHCR will continue to provide transport and cash assistance to returning refugees and IDPs

The Ministry for Rural Reconstruction and Development (MRRD) and development actors such as UNDP, FAO, WFP, and ILO will provide leadership in addressing IDP problems



*Continued* 29

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# Afghanistan Voluntary Repatriation

UNHCR will maintain a total of 18 offices (two in Kabul) during 2005.

50 international staff and 470 national staff

Partnership between UNHCR and Afghan Independent Human Rights Commission will be intensified in 2005.

The field presence of UNAMA Human Rights Officers has been increased in 2004 and more strategic interaction with other human rights

actors is likely to take place

actors is likely to take place  
in 2005.

*Continued* 30

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## **Afghanistan Voluntary Repatriation**

UNHCR will monitor the situation of returnees and IDPs and ensure that their rights are protected

Facilitate the voluntary return of Afghan refugees with an initial reintegration package including a cash grant, food and non-food items

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## Afghanistan Voluntary Repatriation

Total UNHCR Budget for 2004: US\$ 1.13 billion

Afghanistans 2005 annual program budget is 64,191,028 USD

The 2005 budget for regional activities is another 850,000 USD which includes funds for repatriation of Afghans from various countries, scholarships for refugee students, and comprehensive solutions for

# displaced Afghans

*Continued* 32

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# Afghanistan Voluntary Repatriation

Further reduce its shelter program to  
10,000 units in 2005

Promote the return of desperately needed  
professionals, especially doctors and  
teachers

Increase in cash-for-work programs

Increase in income-generating activities for  
women and men



*Continued* 33

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# Afghanistan Voluntary Repatriation

Recent efforts to foster self-reliance will continue, with the majority of assistance given in the form of food-for-work

UNHCR will continue its program to enable the government to take responsibility for protecting and assisting returnees and IDPs



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# **Section D**

## ***Conclusion***



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# Funding

UNHCR is funded almost entirely through voluntary contributions



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# Opportunities and Obstacles

Current funding climate

Need expanding and contracting staff  
levels

Internships (ROW and overseasee  
website)



*Continued* 37

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# Opportunities and Obstacles

Junior Professional Officer Program (two years, U.S. citizens selected by Bureau for Population, Refugees, and Migration at Dept of State ([www.state.gov](http://www.state.gov)))

UN Volunteers

UNHCR partner organizations



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## Useful Characteristics

Masters in related field or law degree

Field experience

Languages (at least two of six UN languages +)

Flexibility, adaptability, cool under pressure

Commitment to refugees



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## For More Information

Updates, press releases, refugee law,  
research issues, program details, and more

[www.unhcr.ch](http://www.unhcr.ch)

[www.unrefugees.org](http://www.unrefugees.org)



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# **Mental Illness among Trauma-Affected Populations**

**Paul Bolton, MBBS, DTMH, MPH, MS  
Bloomberg School of Public Health**





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## **Section A**

### ***The Nature of Mental Illness after Trauma***



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# Leading Causes of Disability in the World

## 1990

1. Lower resp. infections
2. Diarrhoeal diseases
3. Perinatal conditions
4. Unipolar major depression
5. Ischaemic heart disease
6. Cerebrovascular disease
7. TB
8. Measles
9. Road traffic accidents
10. Congenital

## 2020

1. Ischaemic heart disease
2. Unipolar major depression
3. Road traffic accidents
4. Cerebrovascular disease
5. COPD
6. Lower resp infections
7. TB
8. War injuries
9. Diarrhoeal diseases
10. HIV

10. Congenital  
abnormalities

10. HIV

3

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# Conflict and Population Displacement

Global mental health issues receiving most attention are those due to conflict and population displacement



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# War Has Changed for Civilians

Battle of Gettysburg one civilian casualty

WW I 18% casualties civilian

WW II 60% casualties civilian

Currently 90% casualties civilian





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# Psychological Trauma

Civilians now commonly experience psychological trauma



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# Mental Results of Psychological Trauma

No effect

Sorrow, anger, hopeless, etc., but no illness

Mental illness

Directly caused by trauma

Increased incidence of other mental illnesses



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# What to Assess.

## *Issues*

### Importance

- Numbers affected

- Severity (suffering and dysfunction)

- Impact on community

### Measurability

- Assess problems requiring mental health expertise



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## Advantages of Assessing Mental Illness

Trauma-induced mental disorders are known to be common among refugees  
Cause intense suffering and dysfunction resulting in effects beyond individual  
Have well-defined diagnostic criteria  
Lessons learned in one population may be applicable to others  
Require specific mental health



# interventions

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## Disadvantages of Assessing Mental Illness

Do these mental illnesses occur across most cultures.

Evidence for some cultures

Others.

If so, are there differences.

May require focus on selected individuals

Lack of evidence for effective interventions



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# How Does Trauma Cause Mental Illness.

Severe challenge to a persons world view  
Failure to adapt      mental illness



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## Why Does Trauma Cause Mental Illness.

Loss of normal coping mechanisms      loss  
of sense of security/safety

Unless effective coping mechanisms/sense  
of security is restored, the following are  
permanently heightened:

Vigilance (anxiety disorders)

Despair (mood disorders)

Previous

mental  
illnesses

*Continued* 12

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# Why Does Trauma Cause Mental Illness.

Capricious trauma increases likelihood of  
mental illness





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# Causes of Psychological Trauma *Violence*

Injury/disability/disfigurement

Torture/imprisonment/deprivation

Witnessing atrocities and destruction

Living in contact with perpetrators

Living in contact with victims



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# Causes of Psychological Trauma *Violence*

## **Sexual Violence**

Common element of ethnic violence

Women and children

Used as a weapon/strategy

Humiliates

Bearing enemy children

Destabilizes families and communities

*Continued* 15

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# Causes of Psychological Trauma *Violence*

Domestic violence

Secondary to drug and alcohol abuse



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# Causes of Psychological Trauma *Losses*

Loved ones and friends

Physical capacity

Home and social institutions/support

Education, job, career, finances

Independence, identity

Loss of sense of security

Loss of a future





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# Causes of Psychological Trauma *Threats*

Threaten with violence or loss

Threat can be as damaging as the actuality



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# Mental Illnesses Resulting from War and Displacement

Anxiety disorders especially Post  
Traumatic Stress Disorder (PTSD)  
Mood disorders especially depression  
Socialization to violence  
Exacerbation of pre-existing disorders  
Psychoses  
Personality disorders



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# Post Traumatic Stress Disorder (PTSD)

Result of traumatic event

Disorder of heightened vigilance

Re-experience traumatic event

Increased arousal

Avoidance behavior

Numbing

Function affected

Lasts more than  
one month

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# Depression

Disorder of despair

Mood depressed

Loss of interest/pleasure (tired of life)

Change in appetite/weight

Problems sleeping

Psychomotor agitation/retardation and fatigue



*Continued* 21

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# Depression

Feeling worthless or guilty

Difficulty thinking

Recurrent thoughts of death or suicide

Function affected

Not due to bereavement or lasts more than two months



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# Socialization to Violence

Disorder of abnormal coping mechanisms

Especially child soldiers

Amoral behavior

Loss of empathy, sympathy

Dehumanized social relationships



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## Which Disorder.

Nature of trauma

Violence and threats      PTSD

Losses      depression

Chronic violence from childhood  
socialization



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# Section B

## *Interventions*





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# Non-Psychological Interventions

Reunification and family tracing

Work

Recreation

Build/rebuild infrastructure

Security

Reintegration (soldiers)

*Continued* 26

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# Non-Psychological Interventions

Spiritual support of religious leaders, elders

Physical health services

Justice and accountability

Self-determination

Decent environment



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# Psychological Interventions

Psycho-education and psychotherapy

Work through experiences

Assist local people to conduct their own  
healing processes

Drugs



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# Psycho-Education and Psychotherapy

Not much used (yet)

Need to adapt to local understanding of  
illness

Discussion of triggering events (debriefing)

Normalization of illness

Reinterpretation of events



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# Psycho-Education and Psychotherapy

Individual or group/family therapy or  
activities

Cognitive behavioral therapy

Interpersonal psychotherapy

Eye movement desensitization and  
reprocessing



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# Working through Experiences

Talking therapies

Story telling

Creative therapies

Drawing, collage

Play therapies

Drama, dance, play



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# Facilitate Local Approaches

Healing treatments

Healing ceremonies

Acceptance procedures



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# Drugs

Not currently used

Currently no long term role

Short term anxiolytics/sedatives may be beneficial





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## Section C

### *Issues*



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# Issues

Psychosocial vs. psychiatric  
Wellbeing model vs. disease model



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## Evidence for Mental Illness

Most is based on Western instruments

Are Western concepts of illness applicable across cultures.

How to assess function.



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# Guhahamuka

Failure to sleep  
Despair, hopelessness  
Anger  
Failure to eat  
Failure to talk  
Loss of intelligence  
Attempting suicide  
Confusion  
Acting crazy  
Fasilv

Mixed feelings and  
thoughts in your head at  
the same time  
Feeling extremely weak  
Absentmindedness  
Too many thoughts  
Feeling worthless  
Feeling you would be  
better dead  
Lack of concentration



—  
startled

*Continued* 37

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# Guhahamuka

Feel you have a cloud  
within

Feeling disconnected

Often falling sick

Keep dreaming of bad  
experiences

Fleeing from people and  
hiding

Lack of trust

Feeling like fighting

Being quarrelsome

Talking to anybody who  
comes by about your pain

Chaos in the mind  
(flashback)

Instability of the mind.

Feeling like you are having  
an epileptic episode  
(collapse).

Acting without thinking

Having nightmares about  
fighting.

De...

Excessive crying

Deep  
sadness  
that  
can  
lead

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# Agahinda

Isolation

Lack of self care

Loss of mind

Being very talkative

Not caring to work

Drunkenness

Feeling life is meaningless

Committing suicide

Dont feel like talking

Excessive alcohol drinking  
causing

Sadness

Being displeased with your  
living conditions/  
situation

Not pleased by anything

Inability to withstand  
whatever happens to you

Burying ones cheek in  
his/her palm (hopeless)

Difficulty interacting with  
others (poor relationships)

-----  
crazy  
behavior

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# Important Tasks in Rural Rwanda

## Men

- Wash
- Dress
- Advise the family
- Attend meetings
- Socialize
- Manual labor
- Earn money

## Women

- Wash
- Dress
- Cook
- Wash clothes
- Clean house
- Care for children
- Attend meetings
- Socialize

## Transmit culture

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JOHNS HOPKINS  
BLOOMBERG  
SCHOOL of PUBLIC HEALTH



# How to Distinguish Mental Illness from a Poor Environment





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## Little Evidence for Effectiveness

Impact of all post-disaster interventions  
unproven

Impact of most disease-specific  
interventions unknown in most developing  
countries



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## Recommendations

1. First focus on non-psychological interventions while studying the community (ethnographics)
2. Delay psych interventions until non-psych interventions have been implemented  
Adapt psych instruments and interventions to local situation
3. Assess for common major illness

*Continued* 43

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## Recommendations

4. Specific treatment with adapted psych interventions
5. Assess impact of psych interventions



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# Non-Mental Health Workers

What can a non-mental health person do about trauma if they are working in an area where this is happening.





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# Repatriation to Cambodia

**W. Courtland Robinson, PhD**  
**Johns Hopkins University**  
**Center for Refugee and Disaster Studies**



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## Section A

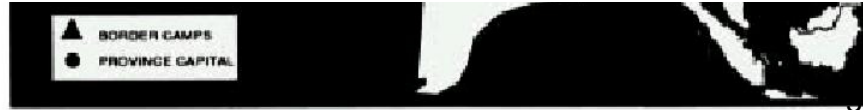
### *Cambodia, 1970-1990*



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Source: Robinson, W. C.  
 Double Vision: A History of  
 Cambodian Refugees in Thailand  
 Bangkok: Chulalongkorn  
 University, 1996  
 Double Vision: A History of  
 Cambodian Refugees in Thailand.  
 Bangkok: Chulalongkorn  
 University, 1996.





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## Cambodia, 1970-1975

1970: Prince Norodom Sihanouk  
overthrown in right-wing coup  
U.S. backs new leader, Gen. Lon Nol  
N. Vietnamese back Communist Party  
of Kampuchea, alias Khmer Rouge  
Five-year civil war kills 500,000 people  
and uproots an estimated 2 million





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## Cambodia, 1975

April 17, 1975: Khmer Rouge seize capital, Phnom Penh, and:

Force-march 4-5 million inhabitants into labor camps

Expel foreigners

Abolish markets and currency

Close Buddhist temples

Eliminate

state  
enemies

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## **Cambodia, 1975-1978**

**More than 2 million Cambodians die of execution, overwork, starvation, or disease**



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## Cambodia, 1978-1982

December 1978: Vietnamese forces invade Cambodia, oust Khmer Rouge, and install friendly Communist regime

1979: Khmer Rouge forces flee to the Thai-Cambodian border along with hundreds of thousands of refugees

1982: Formation of tripartite coalition government-in-exile with Khmer Rouge

..

and two non-  
Communist parties

7

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## Cambodia, 1978-1990

Two kinds of camps on the border:

1. Refugee camp (Khao-I-Dang) aided by UN High Commissioner for Refugees (UNHCR)
2. Displaced persons camps aided by UN Border Relief Operation (UNBRO) and administered by Cambodian resistance factions





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# **Cambodian Refugees in Thailand, 1979**

## **The walking dead**



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# Humanitarian Response

Extraordinary humanitarian response

Successful logistically

However, not a success politically  
as root causes not addressed

Hundreds of thousands of lives saved



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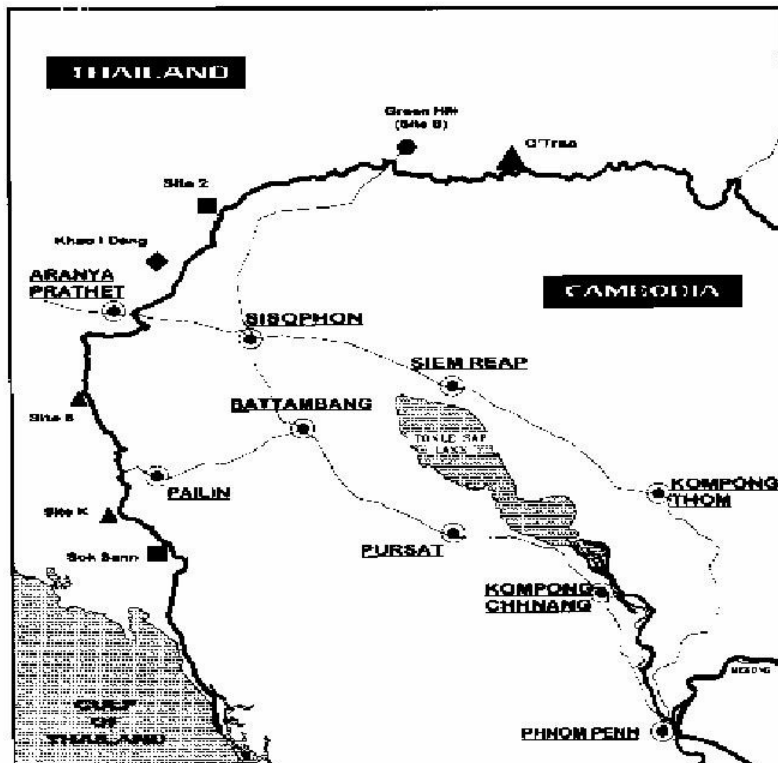
## **Humanitarian Response Bogged Down by Politics**

Aid relief effort split into two spheres

1. Agencies assisting people in Cambodia seen as sympathetic to government
2. Relief effort at Thai-Cambodia border seen to serve resistance factions



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*Map of Thai-Cambodian border camps, 1991*

- ▲ Democratic Kampuchea (Khmer Rouge)
- Khmer Peoples National Liberation Front (KPNLF)
- National United Front for an Independent, Neutral, Peaceful and Cooperative Cambodia (FUNCINPEC)
- ▲ UN High



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Source: Robinson, W. C. Double Vision: A History of Cambodian Refugees in Thailand Bangkok: Chulalongkorn University, 1996 Double Vision: A History of Cambodian Refugees in Thailand. Bangkok: Chulalongkorn University, 1996.



Commissioner  
for Refugees  
(UNHCR)

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# Cambodian Peace Agreement, October, 1991

Four warring parties sign peace  
agreement in Paris

Lay down weapons/canton troops

Submit to UN Transitional Authority  
in Cambodia (UNTAC) until  
national elections in 1993

Permit ~ 360,000 refugees to leave  
Thai camps and return to their

destination  
of  
choice

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## UNHCR Repatriation Plan

UN: Five preconditions for safe return

1. Overall peace and security
2. Provision of agricultural settlement land for returnees
3. Demining of settlement land
4. Repair of major roads and bridges
5. Strong funding support from donors



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## Agricultural Settlement Land

UNHCR promises two hectares (five acres) of agricultural land to each returnee family in destination of their choice

With 85,000 families in camps, UNHCR needed total of 170,000 hectares

*Continued* 15

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## Agricultural Settlement Land

UN land-identification mission in late 1991 found 231,000 hectares of potentially available arable land in western provinces





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## Demining of Settlement Land

Late 1991, UNHCR commissioned a survey of landmines in potential areas of returnee settlement

Of the first 70,000 hectares surveyed:

30,800 hectares probably clear of mines

28,000 hectares probably mined

11,200 hectares

heavily mined

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## Response to UNHCR Repatriation Plan

UNHCR survey in border camps found that 90% of residents wanted to return under UN plan

57% (~ 190,000 people) wanted to return to Battambang province

In Battambang, the most popular district was Rattanak Mondol, the destination of choice for nearly 27,000

people

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## Response to UNHCR Repatriation Plan

Popularity of Rattanak Mondol among the border camp residents was attributed to three things:

1. Rich agricultural heritage
2. Lay on a prosperous trade route with Thailand (gems, timber, etc)
3. Close to the Thai border





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## Group Work

Break into assigned groups:

Group 1 (or A): Returnees

Group 2 (or B): Rattanak Mondol  
District Office

Group 3 (or C): Non-Governmental  
Organizations (NGOs)

Group 4 (or D): UNHCR

*Continued* 21

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## Group Work

It is January 1992: Repatriation starts in two months. Each group should answer the following questions:

1. What are your concerns and expectations.
2. What do you need to know or do to be ready for repatriation.
3. What help do you expect from the

international  
community.

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## New Information

On the eve of repatriation, UNHCR learns new information:

Civil war has destroyed local economy, making Rattanak Mondol the poorest district in the province

Most of 4,700 residents are living in a displaced persons camp

Sporadic fighting between Khmer

# Rouge and government forces

*Continued* 23

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## New Information

Of seven potential settlement sites for returnees, a new survey finds that all are currently mined and will take a long time to demine

Prior to learning UNHCR registration results, provincial/district authorities report that Rattanak Mondol has no capacity to



capacity to  
absorb  
returnees

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## New Information: Questions for Groups

Each group to tackle specific questions:

*Returnees:* Do you go to Rattanak Mondol, go elsewhere in Cambodia, or stay in camps in Thailand.

*District Officials:* Do you continue to resist any return or seek to take advantage of international assistance.

*Continued* 25

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## New Information: Questions for Groups

*NGOs:* Do you revise your plans for Rattanak Mondol, move operations to another part of Cambodia, or call for a temporary halt to repatriation.

*UNHCR:* Do you revise repatriation plan, try to send returnees elsewhere, or order at least a temporary

temporary  
halt to  
return.

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## Section B

### *Revisions to the Plan and Aftermath*



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## Revisions to the Plan

May 1992: UNHCR offers returnees choice of assistance options

A: Farm land, house plot, building materials, food for 400 days

B: House plot, building materials, food for 400 days

C: Cash (\$50 per adult, \$25 per child under 12), food for 400 days



*Continued* 28

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## Revisions to the Plan

Options A and B required delays and were not available in all locations

87% of returnees chose Option C,  
reintegration money

*Continued* 29

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## Revisions to the Plan

Option C gave flexibility but raised concerns

How long could the money last.

What could it purchase.

Would people spend it wisely.

What should UNHCR do if returnees chose to return to areas still plagued by factional

conflict, or were inaccessible.  
with mines, or  
littered

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## No-Go Zone Policy

October 1992: UNHCR establishes policy of no-go zones

- Security risks

- Presence of mines

- Difficulty of access

- High incidence of malaria, other health hazards

- Lack of notable

## —lack of potable water, sanitation

*Continued* 31

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## No-Go Zone Policy

Refugees wishing to return to no-go zones would be advised of risks and counseled to go elsewhere

If refugees still insisted, UN would take them to nearest go zone where food would be distributed





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## Aftermath

64 districts in 20 provinces on no-go zones list

Rattanak Mondol was one of two districts in Battambang on the list

UNHCR began repatriation of 360,000 people in March 1992

About 6,000 returnees chose to settle in Rattanak Mondol, less than

25% of those  
initially registered

*Continued* 33

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## Aftermath

Rattanak Mondol remained on front-lines of the on-going fighting between Khmer Rouge and government forces  
In 1994, the entire district was forced to evacuate and live for several months in IDP camps



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## Landmine Casualties Remain High

One adult male in seven in the district killed or injured by a landmine in 1990s

One person in 90 is an amputee, four times the national average

Mines are the leading cause of disability and among top three causes of death in Rattanak Mondol



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## Landmine Victim in Rattanak Mondol







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## Outcome of Repatriation

Return to Rattanak Mondol was a disaster for the following reasons:

- Original plan did not work

- Insufficient information to plan and carry out repatriation

UNHCR deserves praise for timely revision of original repatriation plan to accommodate new needs



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## Outstanding Questions

Outstanding questions on repatriation

How far did reintegration money go.

Was the international response adequate.

Was repatriation to Cambodia a durable solution.



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## Conclusion

Cambodian repatriation hailed as a logistical and political success

Most returnees got back safely and in time to vote in the 1993 elections

Reintegration made difficult for all by:

Continued political instability

Poor economy

Several

...  
million  
mines

*Continued* 39

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## Conclusion

Cambodian per capita GNP is \$270

Under-5 mortality is 170 per 1,000





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## Lessons Learned

In conclusion, Rattanak Mandol shows

How not to carry out repatriation

What type of information is needed  
up front to plan repatriation

What should be known before  
making promises to returnees

What time should be provided for  
people to

# act responsibly

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# Health and Human Rights Principles for Refugee Health

**Robert S. Lawrence, MD**  
**Johns Hopkins University**



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## Section A

### *Origin, Definition, and Role of Human Rights*



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## Origin of Human Rights

The term *human rights* came into common use only after World War II and the founding of the United Nations in 1945





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## Origin of Human Rights

It replaces the concept of *natural rights*, which emerged from the philosophy of Greek stoicism

The concept of natural rights lost its utility when *natural law* became controversial in the 19th and early 20th centuries because of its misapplication in social Darwinism



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## Origin of Human Rights

Also replaces the Enlightenment concept of the Rights of Man

Which were not widely understood to include the Rights of Women

*Continued* 5

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## Origin of Human Rights

The horrors of Nazi Germany  
reaffirmed the basic idea of universal  
human rights

Human rights came into its own over  
the last 55 years



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## **Human Rights Definition: Five Basic Components**

1. Human rights represent demands of individuals and groups for the sharing of power, wealth and other values. Respect, reciprocal tolerance, and mutual forbearance are fundamental to human rights.

Human rights limit state power; states, through the rule of law, protect the rights of individuals but



do not convey or endow rights of  
individuals

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## Human Rights Definition: Five Basic Components

2. Human rights partake of both legal and moral orders; they express both the is and the ought in human affairs

Example of is: Legal proscription against torture

Example of ought: Rights in social, cultural, and economic

domain

*Continued* 8

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## **Human Rights Definition: Five Basic Components**

3. Human rights are universal, equally possessed by all humans everywhere

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## Human Rights Definition: Five Basic Components

4. Human rights are qualified by the limitation that the rights of any particular individual or group are restricted as much as is necessary to secure comparable rights of others

Sometimes designated as  
*prima facie* rights

*Continued*

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## Human Rights Definition: Five Basic Components

5. Human rights refer to *fundamental* rights as distinct from *nonessential* claims or goods

Some would limit human rights to core rights to life and equal freedom of opportunity and rule out mere wants





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## Role of Human Rights

While knowing the rules does not assure victory, the more they are known, the more likely they can protect those in greatest need

*J. Paul Martin, Executive Director  
Center for the Study of Human Rights  
Columbia University*

*Continued*

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## Role of Human Rights

The more we can communicate the rules that govern relationships between states and oversee the obligations of states to their citizens, the more opportunity we have to advance the rights of people everywhere



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## Section B

### *The United Nations and International Human Rights Laws*



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## Formation of the United Nations

Formed after World War II, where more than 60 million people were killed (about 6 million Jews in the holocaust)





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## United Nations Charter

*United Nations Charter* signed on June 26, 1945; which entered into force October 24, 1945

to reaffirm faith in fundamental human rights, in the dignity and worth of the human person, in the equal rights of men and women, and of nations large and small,

*Continued* 16

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## United Nations Charter

to establish conditions under which justice and respect for the obligations arising from treaties and other sources of international law can be maintained, and to promote social progress and better standards of life in larger freedom, and for these ends, to practice tolerance and live together in peace with one

peace with one  
neighbors as good

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## United Nations Charter

Generated a spirit of optimism and many believed that humans had learned the bitter lessons of intolerance

and were ready to embrace a new era of giving full recognition to human rights



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# Universal Declaration of Human Rights

Adopted by United Nations General  
Assembly on December 10, 1948

Represented aspirations of  
founders of the United Nations  
Staked out domain for human  
rights





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## Article 3

Everyone has the right to

Life

Liberty

And security of person



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## Article 22

Everyone, as a member of society, has the right to social security and is entitled to realization, through national effort and international cooperation and in accordance with the organization and resources of each state, of the economic, social and cultural rights indispensable for his dignity and the free

... dignity and the need  
development of his  
personality

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## Article 25

1. Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing, medical care, and necessary social services

*Continued* 22

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## Article 25

and the right to security in the event of unemployment, sickness, disability, widowhood, old age, or other lack of livelihood in circumstances beyond his control



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## Article 25

### 2. Motherhood and childhood are entitled to special care and assistance

All children, whether born in or out of wedlock, shall enjoy the same social protection



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## United Nations Covenants

*UN proposed two covenants on  
December 16, 1966*

1. International Covenant on Economic, Social, and Cultural Rights (not ratified by USA)

*Continued* 25

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## United Nations Covenants

### 2. International Covenant on Civil and Political Rights signed by USA

Gave people the freedom to vote, freedom of free movement, and freedom of assembly

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## United Nations Covenants

Several rights in the International Covenant on Economic, Social, and Cultural Rights are relevant to refugee and displaced populations, e.g.  
Article 12





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## Article 12

1. The States Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health

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## Article 12

2. The steps to be taken by the States Parties to the present Covenant to achieve the full realization of this right shall include those necessary for:
  - a. The provision for the reduction of the stillbirth rate and of infant mortality and for the healthy development of the child

*Continued* 29

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## Article 12

- b. The improvement of all aspects of environmental and industrial hygiene

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## Article 12

- c. The prevention, treatment, and control of epidemic, endemic, occupational, and other diseases



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## Article 12

- d. The creation of conditions which would assure to all medical service and medical attention in the event of sickness



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# Human Rights Laws and Displaced Populations

The International Covenant on Economic, Social, and Cultural Rights has given the world community the implicit obligation to protect and defend refugee populations

States that have signed this covenant have an obligation to protect and assist Internally Displaced Persons

— — — — —

The realities of mass  
displacement with human rights laws

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## Section C

### *Role of Health Workers and Human Rights Groups*



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# Health and Human Rights

Health professionals are often among the first witnesses of the physical and psychological harm that human rights violations cause to individuals and communities

Executions

Mutilations

Forensic examinations



*Continued*    **35**

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## Health and Human Rights

Health professionals exposed to complications and consequences of lack of food, security, decent shelter, etc., become advocates for affected populations without directly relating it to human rights

*Continued* 36

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## Health and Human Rights

For the past thirty years, the health care community has mobilized itself to

Protest violations of human rights

Document their health consequences

Examine its own role in perpetrating or ending these abuses



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# **Human Rights Violations by Health Professionals**

Situations where health professionals  
have been complicit with gross human  
rights violations

*Continued* 38

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# **Human Rights Violations by Health Professionals**

District Surgeons in South Africa watched  
Steve Biko die of wounds inflicted during  
torture

Exposed by Wendy Orr



*Continued* 39

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# Human Rights Violations by Health Professionals

Chilean physicians complicit in torture  
of victims

Four physicians later stripped of  
membership in Colegio Medico,  
ending their ability to practice



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## Human Rights Groups

Several human rights groups have emerged

Amnesty International

Human Rights Watch

*Medecins Sans Frontieres*

Physicians for Human Rights

Lawyers Committee for Human Rights

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# Physicians for Human Rights

The mandate of PHR is largely defined by the rights enunciated in the Universal Declaration of Human Rights and subsequent conventions and protocols

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## Physicians for Human Rights

PHR also uses Geneva Conventions of 1949 and Additional Protocols of 1977, which further define:

The protections and guarantees of medical neutrality

The protection of patients and health professionals

The right to access to care and



humane  
treatment of  
civilians

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## Origin of Geneva Conventions

In 1870, the Battle of Solferino in Northern Italy left many wounded and dying soldiers without aid

Henry Dunant, shocked by sight, on his return to Geneva called three colleagues and together formed the ICRC and articulated the first Geneva Convention



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## Geneva Conventions

<b>1<sup>st</sup> Convention</b>	Medical aid for wounded combatants and medical neutrality of participants
<b>2<sup>nd</sup> Convention</b>	Extended aid to sailors wounded in naval battle
<b>3<sup>rd</sup> Convention</b>	Protection and medical care for prisoners of war (POWs)
<b>4<sup>th</sup></b>	Protection and medical care

**Convention** | for  
| civilians  
|  
| in  
| armed  
| conflict

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## **Additional Protocols of 1977**

Four Additional Protocols later  
formulated and verbally honored by all  
nations

Frequently breached, e.g. the  
Balkans



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# PHR Philosophy

The decision to create an organization of health professionals to work on behalf of human rights arose from two insights





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## PHR Philosophy: First Insight

First was the recognition that many human rights violations had significant health consequences, which include:

*Continued* 48

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## PHR Philosophy: First Insight

Physical and psychological trauma  
of individual victims of violence,  
torture, and rape

Breaches of medical neutrality

Forced deportations

Use of indiscriminate weapons

Mass executions and other violent  
acts that affect

entire populations

*Continued* 49

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## PHR Philosophy: First Insight

the purposeful destruction of health facilities and essential civilian infrastructures leads to slower forms of death

From epidemic infectious disease

Untreated chronic disease

Or starvation



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## PHR Philosophy: Second Insight

Health professionals are uniquely situated to collect the medical documentation that provides concrete evidence of human rights violations

This ranges from physical examination of individuals to forensic exhumations of mass graves

PHR members H. Jack Geiger and



Robert  
Cook-  
Deegan

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## PHR Methods of Work

PHR conducts direct documentation through fact-finding missions (sent over 100 missions to 48 nations)

Provides advocacy

Reports, journal articles, press releases

Meetings with foreign government officials, U.S. state department

' ''

Letter-  
writing  
Coalition-building  
campaigns

*Continued* 52

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## PHR Methods of Work

PHR led the coalition to ban landmines, which led to the international law to ban landmines

Signed by over 100 countries  
(not U.S.)

PHR shared Nobel Peace Prize in 1998 with Jody Williams and five other NGOs

*Continued* 53

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## PHR Methods of Work

PHR conducts education and training and responds to challenge of making international human rights relevant to the health professional



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## Section D

### *Application of Human Rights Principles to Developing Policies and Procedures for Managing CHE*





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# Assessing Human Rights Impact

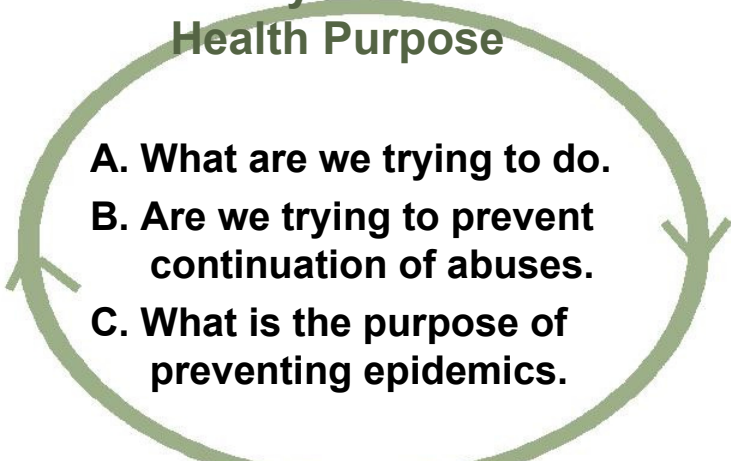
Guidelines for assessing human rights impact of any proposed policy or intervention have been developed by Lawrence Gostin and the late Jonathan Mann

*Continued* 56

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# Assessing Human Rights Impact

## Clarify the Public Health Purpose

- 
- A. What are we trying to do.**
  - B. Are we trying to prevent continuation of abuses.**
  - C. What is the purpose of preventing epidemics.**



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# Assessing Human Rights Impact

## Evaluate Policy Effectiveness

- A. Is magnitude well defined.**
- B. Will intervention work.**
- C. Consider alternatives.**



*Continued* 58

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# Assessing Human Rights Impact





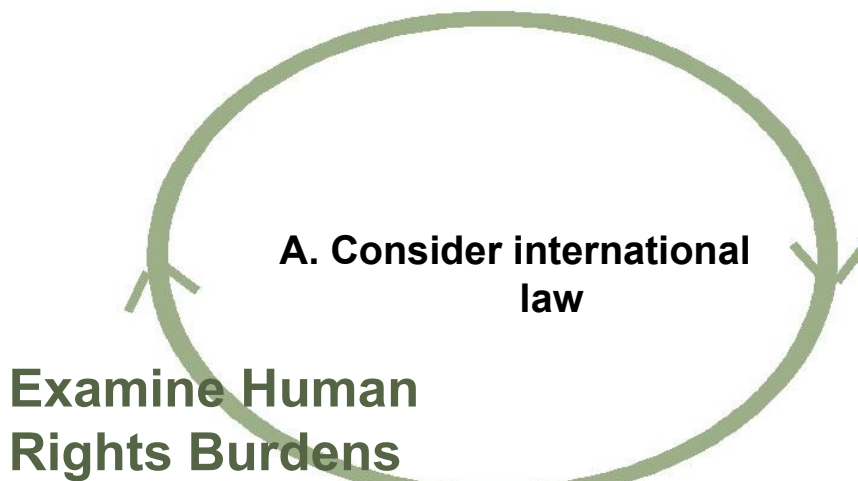


**Targeted.**

*Continued* 59

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# Assessing Human Rights Impact





*Continued* 60

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## Assessing Human Rights Impact

*Human rights divided into two categories:*

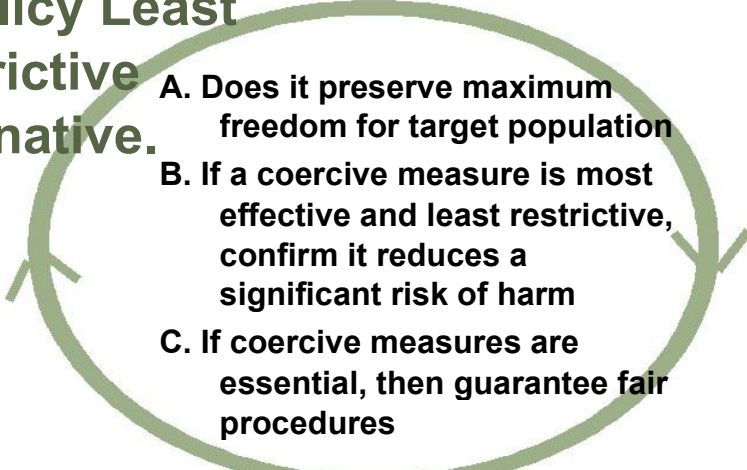
1. Derogable rights: Can be temporarily suspendede.g., freedom of movement can be removed during epidemics
2. Nonderogable rights: Constante.g., freedom of speech, freedom from torture

*Continued* 61

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# Assessing Human Rights Impact

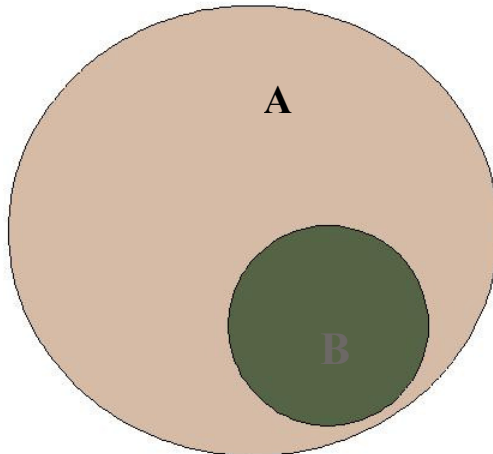
**Is Policy Least Restrictive Alternative.**

- 
- A. Does it preserve maximum freedom for target population**
  - B. If a coercive measure is most effective and least restrictive, confirm it reduces a significant risk of harm**
  - C. If coercive measures are essential, then guarantee fair procedures**



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## Permissible Under-Inclusion



**Population A = All adolescents at risk for STDs and unwanted pregnancy who could benefit from sex education and counseling**

**Population B = All adolescents in institutional settings e.g., prisons, foster**

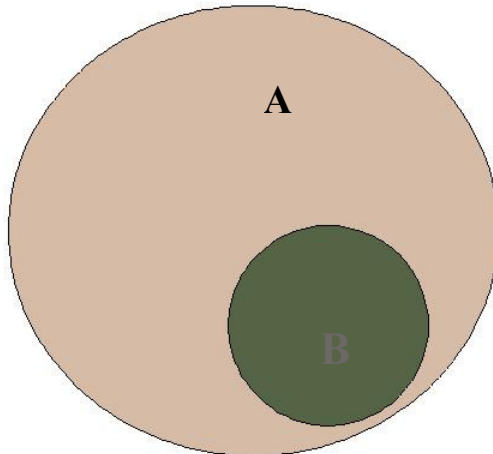


-----  
hospitals  
and  
mental

*Continued* 63

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## Permissible Under-Inclusion



**Proposed policy:**  
Provide  
comprehensive sex  
education and condom  
distribution only to  
Population B

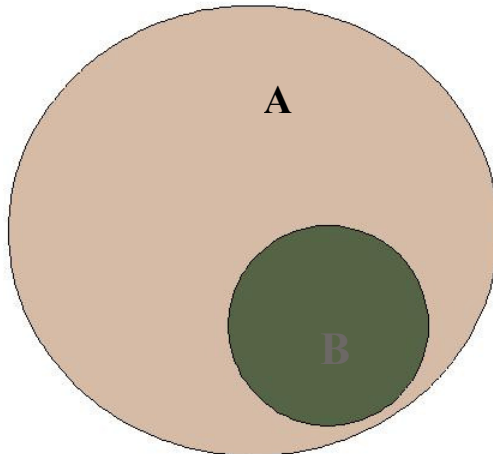
**Permissible since B  
represents subset of  
vulnerable**

vulnerable  
application risk

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## Impermissible Under-Inclusion

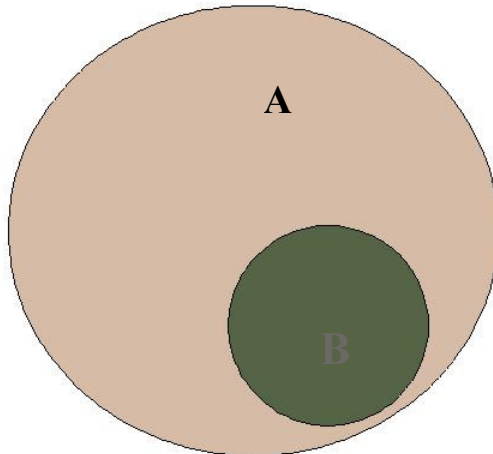


**Proposed policy:**  
Isolation during active phase of tuberculosis and DOT during the entire course of treatment of persons in Population B

*Continued* 65

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## Impermissible Under-Inclusion



**Population A** = All persons diagnosed with active tuberculosis

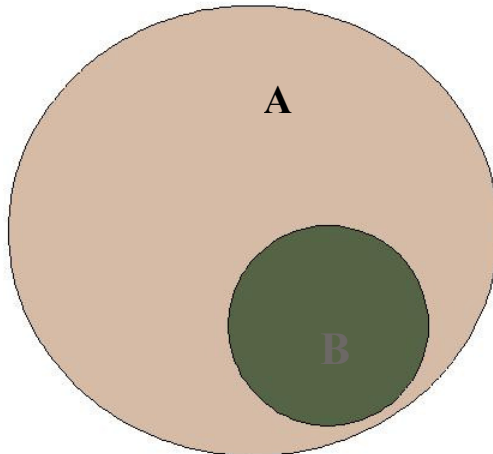
**Population B** = All persons without a permanent address diagnosed with active

## tuberculosis

*Continued* 66

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## Impermissible Under-Inclusion



**Proposed policy:**  
Isolation during active phase of tuberculosis and DOT during the entire course of treatment of persons in Population B

**Policy not permissible since anyone with active TB needs DOT to get**

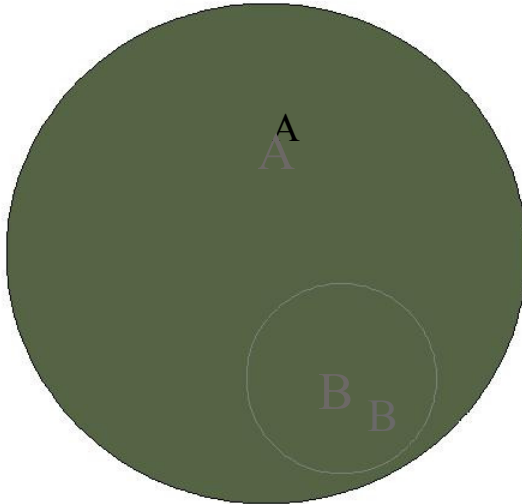


maximum  
benefit  
of

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## Over-Inclusion

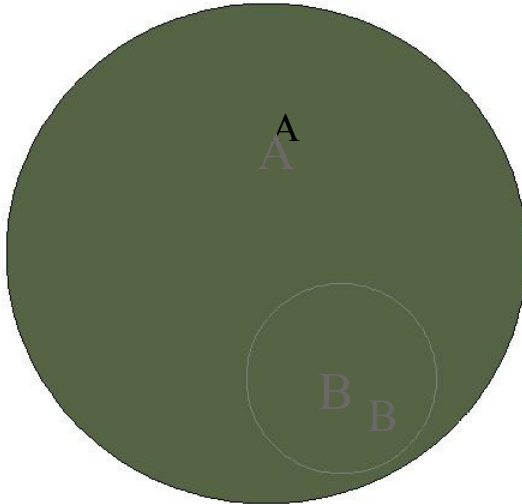


**Proposed policy:**  
Quarantine of all  
HIV-positive  
persons in the  
country

*Continued* 68

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## Over-Inclusion



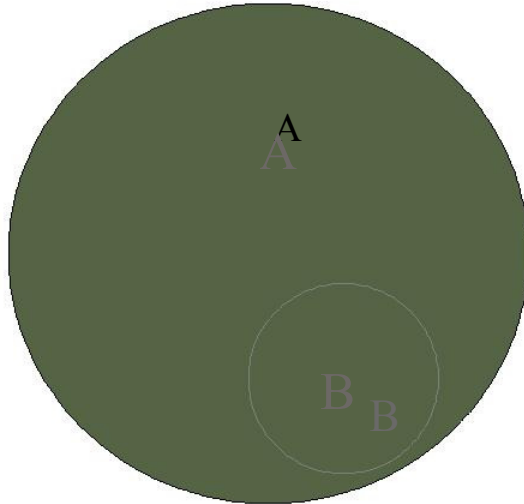
**Population A =**  
All persons with  
HIV in the country

**Population B =**  
All persons with  
HIV who engage  
in high-risk  
behavior



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## Over-Inclusion



**Proposed policy:**  
Quarantine of all  
HIV-positive persons  
in the country

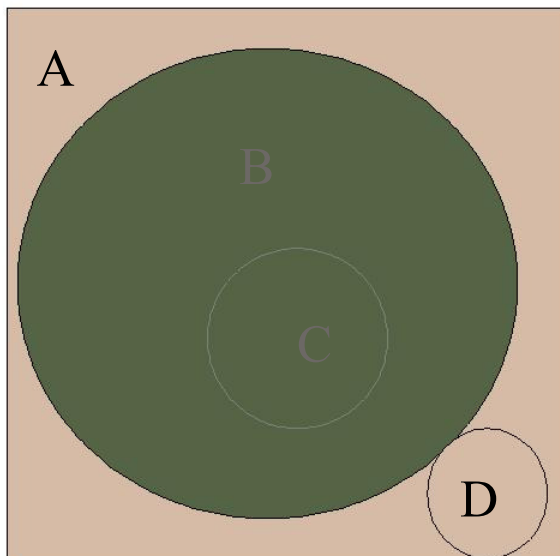
**Inappropriate uniform  
application of a policy  
that should only  
target the high-risk  
population**

population

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## Under and Over-Inclusion



**Proposed policy:**  
Screening and  
excluding those who  
test positive for HIV  
infection, targeted to  
Population B only

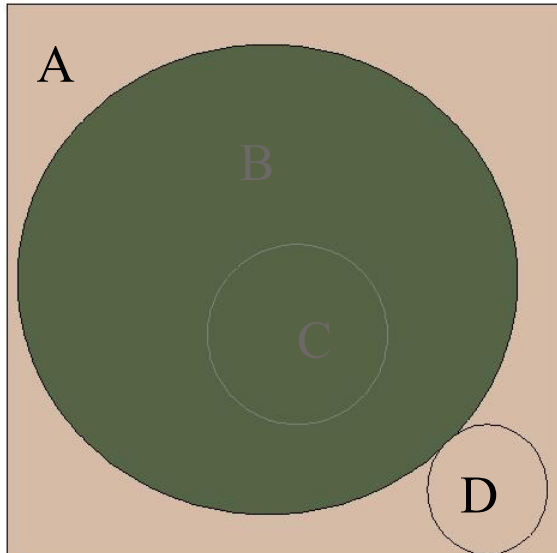




*Continued* 71

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## Under and Over-Inclusion



**Population A** = All foreigners entering the country

**Population B** = All foreigners from Region X

**Population C** = All foreigners from Region X with high-risk behaviors

**Population D** = All foreigners from outside Region

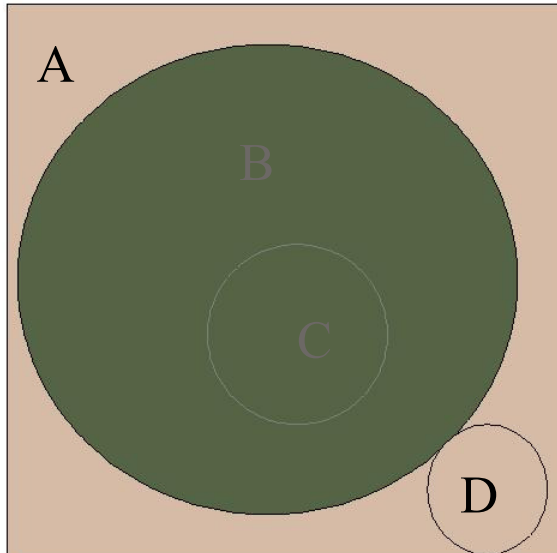


Region  
Behaviors  
with  
high  
-  
risk

*Continued* 72

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## Under and Over-Inclusion



**Proposed policy:**  
Screening and excluding  
those who test positive  
for HIV infection,  
targeted to Population B  
only

**Under-inclusion is D**  
**Over-inclusion is B;**  
**Policy**



I only  
Populations C and D  
should  
only  
target

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## Challenges of Refugees with Regard to Human Rights

Displaced people vulnerable to many problems: Lack of shelter, food, health, etc.

Problems compounded by breakdown of rule of law, power struggles within displaced population

Under threat from abusive government

Needs for human rights protection

greater than for stable  
population

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# AIDS Epidemic a Human Rights Challenge

Early AIDS victims included  
homosexuals, IV drug users, and their  
partners

All marginalized and stigmatized  
Vulnerable to neglect, abuse by  
society

Negative comments

They deserve



what they get  
God's retribution for sinful acts

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## Linking Health Status to Human Rights

In a situation where a disease can spread more easily in a marginalized population whose rights have been systematically denied, poor health status and failure to protect and recognize human rights are directly linked

*Continued* 76

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## Linking Health Status to Human Rights

While refugees differ from early AIDS victims, they are often marginalized, have same vulnerability to disease, same difficulty in access to basic needs

Direct link between special needs of refugees and special attention to protecting their human rights



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## Human Rights Web Sites

[www.un.org](http://www.un.org)

[www.hri.org](http://www.hri.org)

[www.hrw.org](http://www.hrw.org)

[www.phrusa.org](http://www.phrusa.org)

[www.hrweb.org](http://www.hrweb.org)

[www.ai.org](http://www.ai.org)

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JOHNS HOPKINS  
BLOOMBERG  
SCHOOL of PUBLIC HEALTH

# From Disasters to Development

**Pierre Perrin, MD, MPH**  
**Chief Medical Officer**  
**International Committee of the Red Cross**





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# Section A

## *Disasters and Development*



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# Disasters and Development

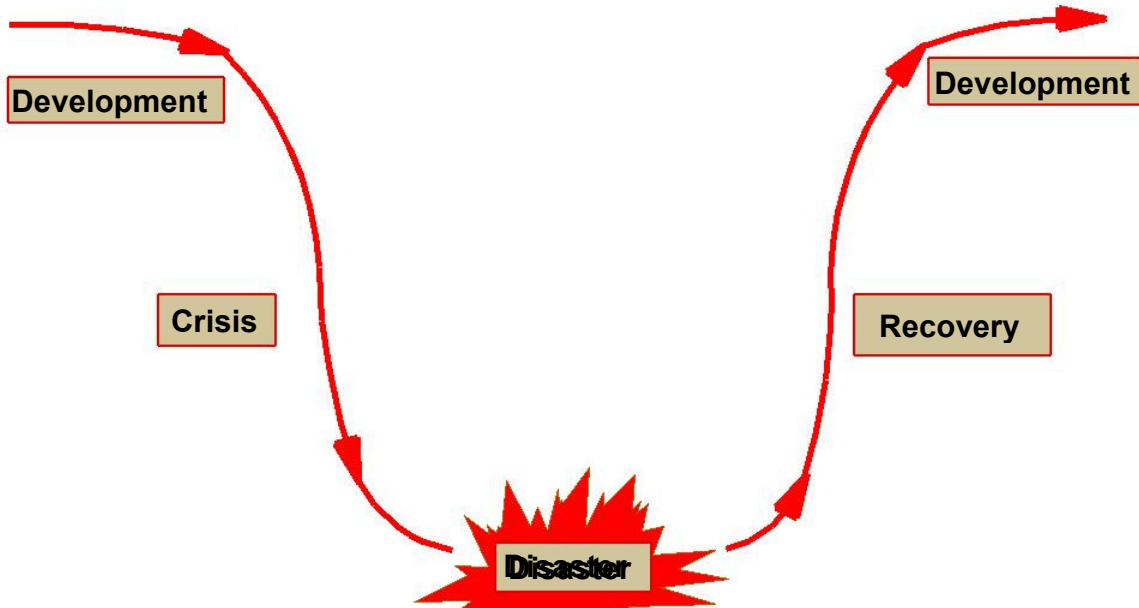
Let us define two concepts

1. What is a disaster.
2. What is development.



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# Disaster





*Continued* 4

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# Disaster

A *disaster* is a disruption in the normal pattern of life generating . . .

Suffering

Socioeconomic breakdown

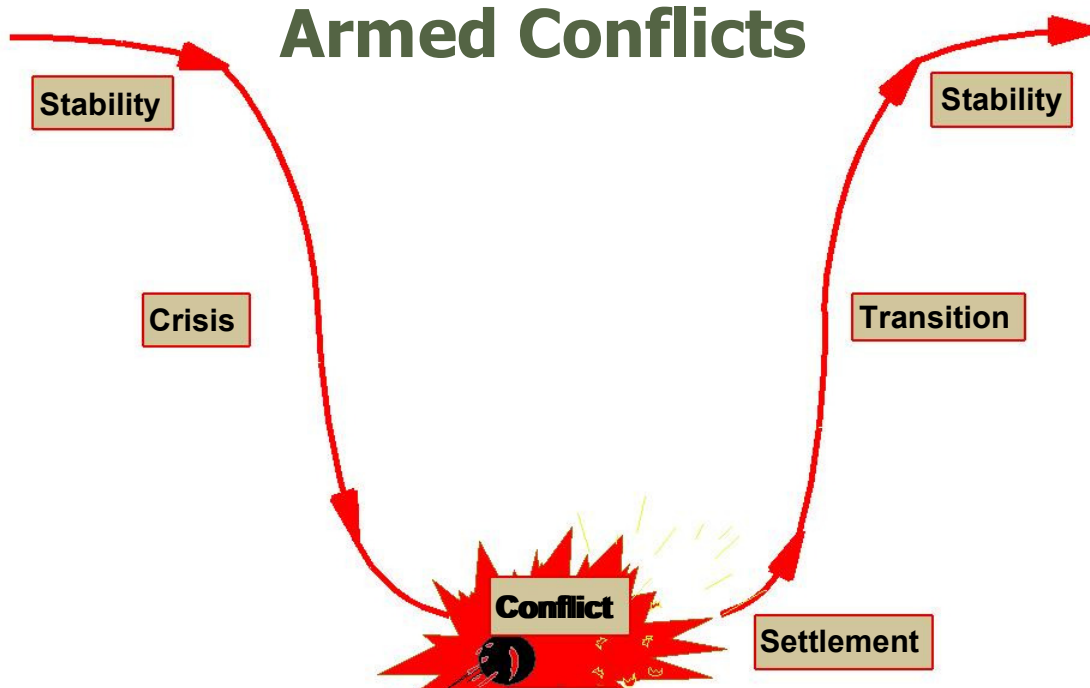
Modification of the environment

To such an extent that there is a need for assistance (PAHO)





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# Armed Conflicts Do Not Occur Unexpectedly

Behind the immediate factors that trigger conflicts, analysis reveals deeper causes, such as . . .

Territorial demands

Socioeconomic inequalities

Economic interests

The defense of political ideologies

*Continued* 7

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# Armed Conflicts Do Not Occur Unexpectedly

Behind the immediate factors that trigger conflicts, analysis reveals deeper causes, such as . . .

Burgeoning nationalism

The struggles of ethnic minorities

Racism and arms proliferation



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# Understanding Disasters

We want to understand

What causes a disaster

What the impact will be

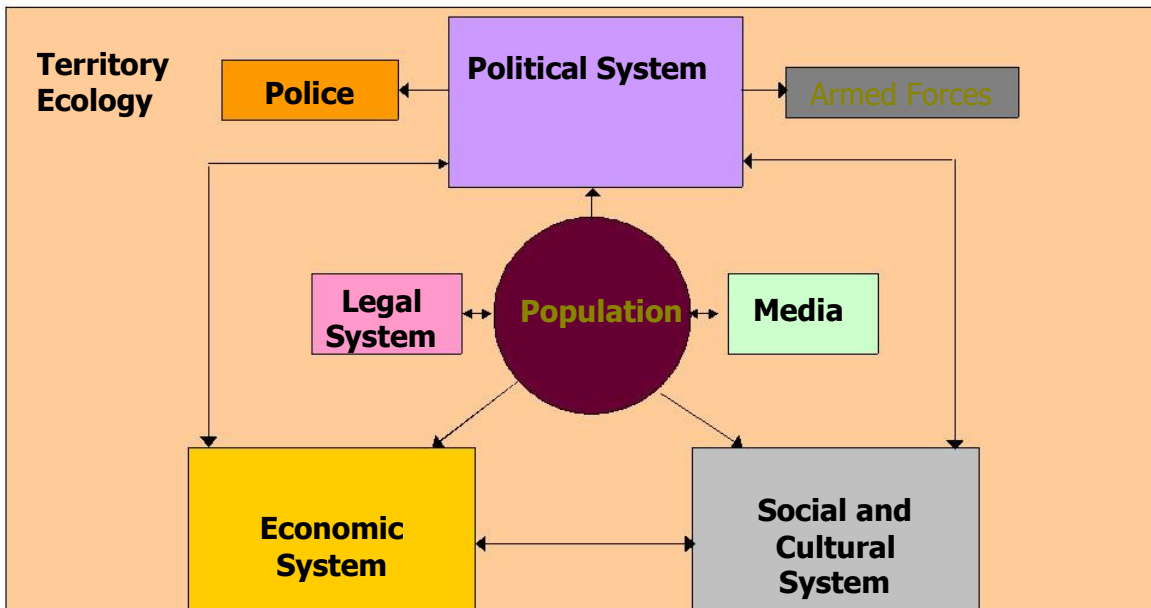
To do this, we need to define a frame that shows the functioning of a society





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# Society





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# Development

The interaction between the three systems can be called *development* when changes in any of them contribute to a better overall equilibrium

*Continued* 11

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# Development

Development is a comprehensive economic, social, and political process . . .

That aims at the constant improvement of the well-being of the population and all individuals

On the basis of their active, free, and meaningful participation in development

*Continued* 12

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# Development

Development is a comprehensive economic, social, and political process . . .

And in the fair distribution of benefits resulting therefrom

(UN Gen. Assembly, The Right to Development, 1986)





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# Reality of Development

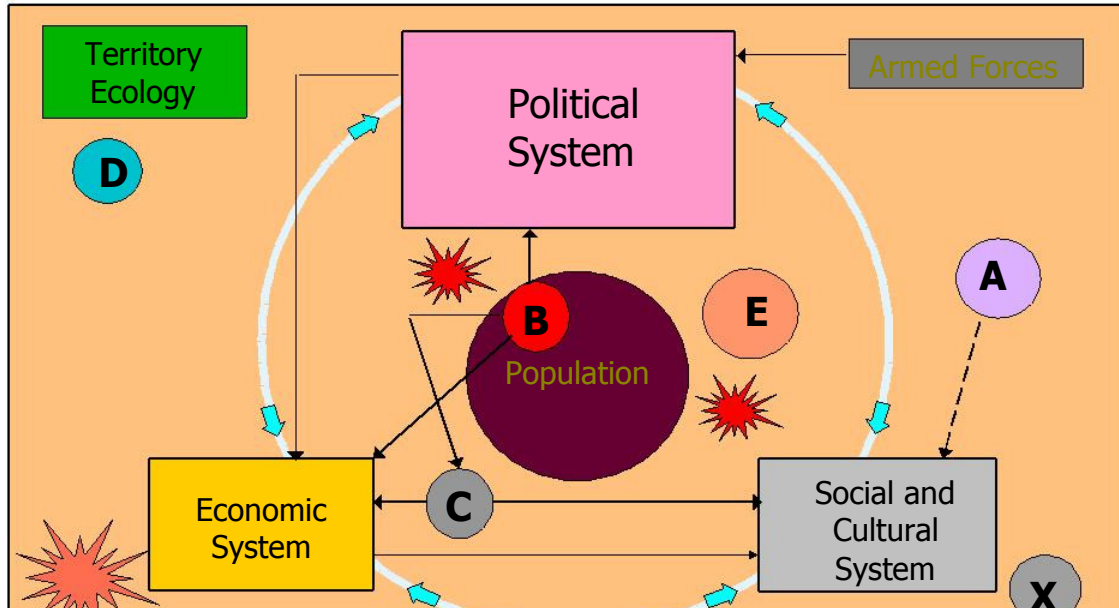
The reality is often far from the ideal view of a society

Dysfunction of society leads to inequalities among the people



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# Complex Reality

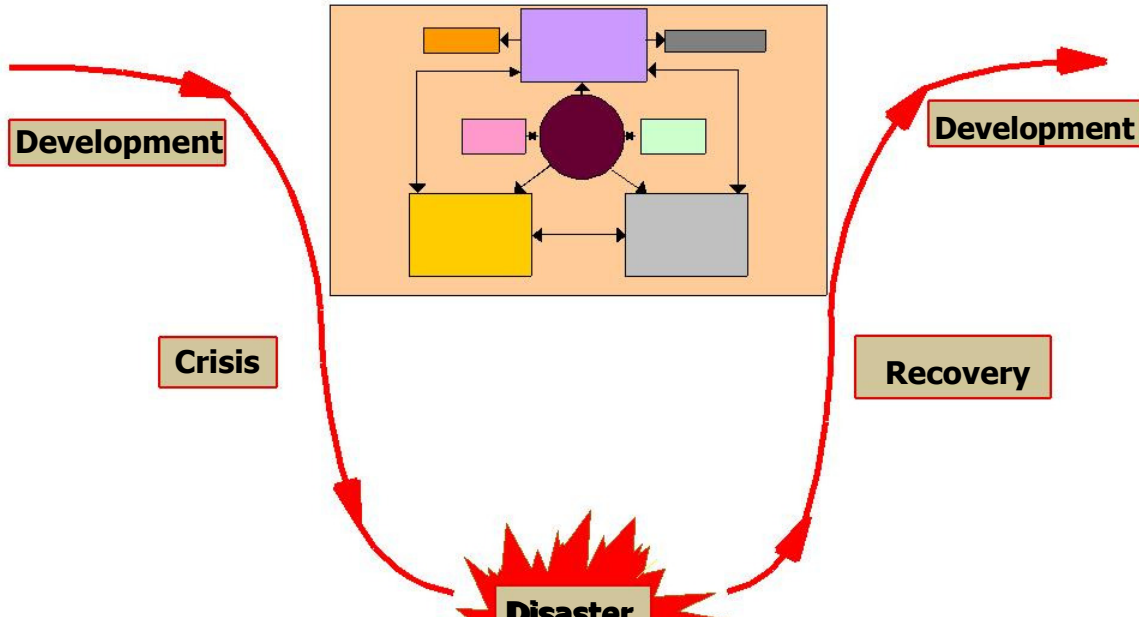




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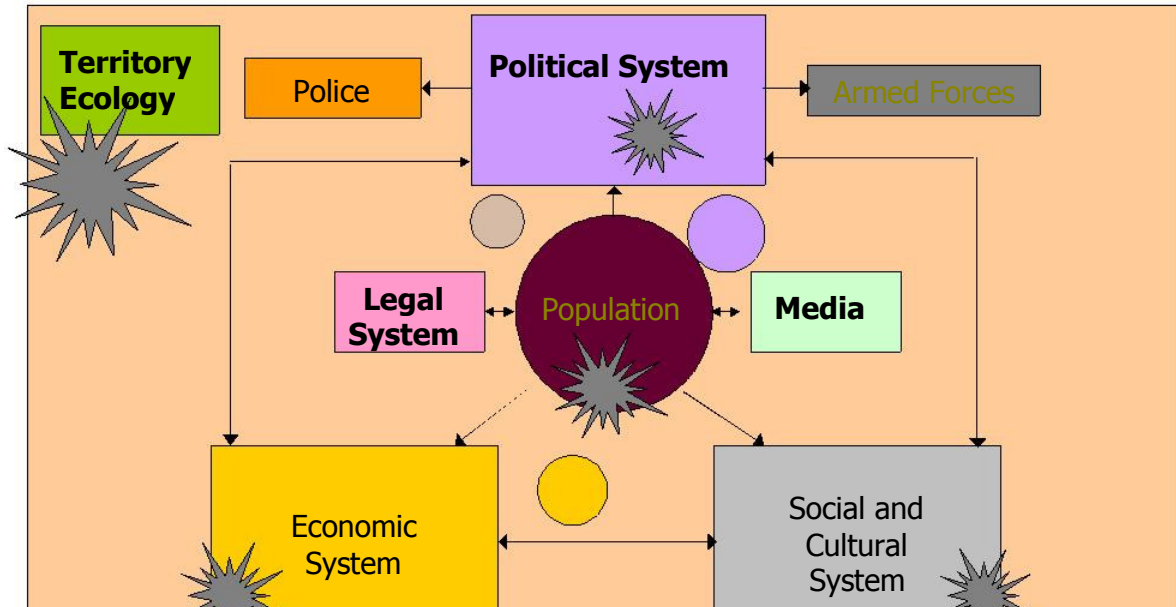
# Model in a Disaster Cycle





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# Impact of Drought

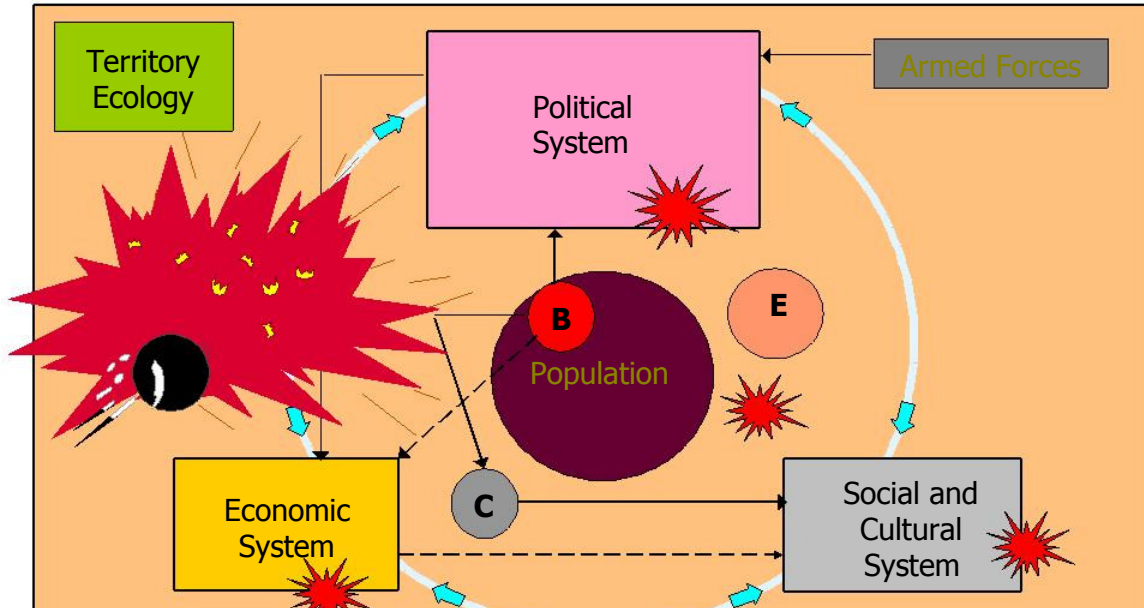






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# Impact of Armed Conflict





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# Vulnerabilities

Vulnerabilities are the weak points of a society

There are different levels

Ecological

Economic

Social

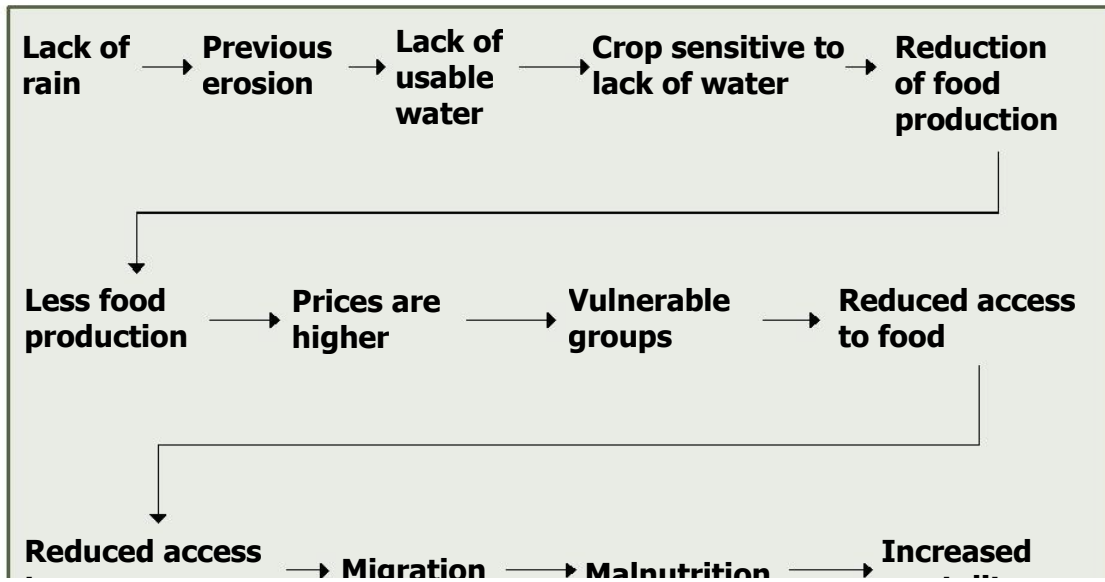
Human

Political



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## Vulnerabilities are Linked



to migration malnutrition mortality  
food

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# Effect of Vulnerability

**Aggressive Phenomenon**  $\times$  **Vulnerability**  $\longrightarrow$  **Negative Impact**





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# **Aim of Humanitarian Response**

For humanitarian organizations, the link between emergencies and development is clearly the reduction of vulnerabilities



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# Rural Populations Stricken by Drought

## Vulnerabilities

Economic

Environmental

Social



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# Environmental Vulnerabilities

## Environmental measures

Improve water storage system

Reduce erosion

Reforest



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# Economic Vulnerabilities

## Economic measures

Diversify the means of subsistence

Institute cooperatives

Improve methods of raising livestock

Encourage saving

Develop markets





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# Social Vulnerabilities

## Social measures

- Develop local aid organizations

- Respect traditional mechanisms of mutual aid



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## From Relief to Development

It is essential to analyze vulnerabilities exposed by a disaster

People have to define the systems (political, economic, socio-cultural) that they want to build after the disaster so that they will be less vulnerable to future disasters

*Continued* 27

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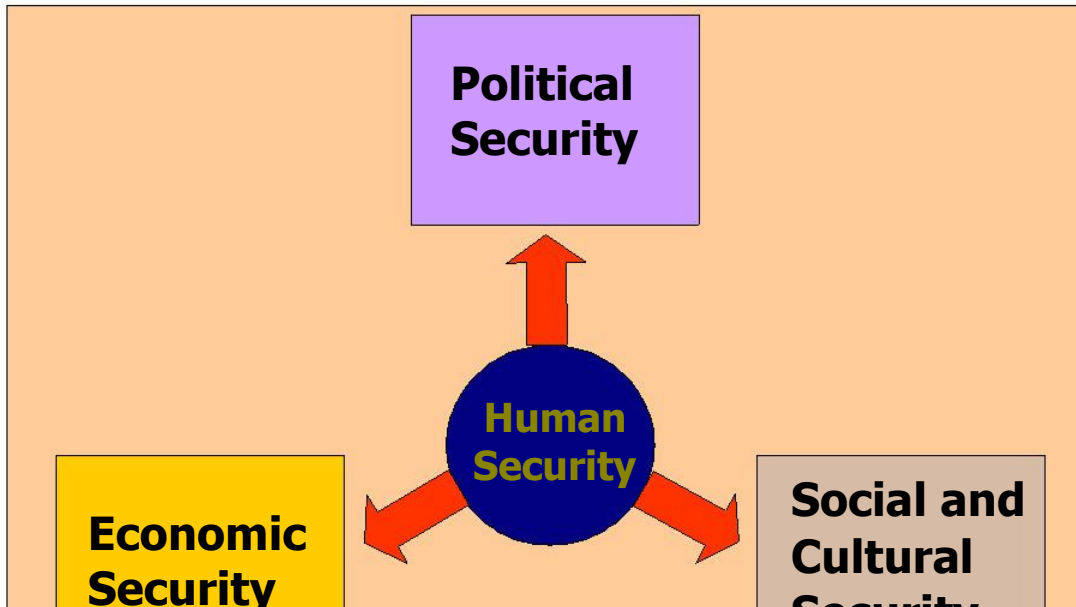
# From Relief to Development

When planning relief activities, always define long term objectives aimed at restoring the systems as defined by the people



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# Restoring Human Security







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## **Section B**

### ***Health, Ethics, Law, and Policies in Armed Conflicts***



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# Main Causes of Armed Conflicts

Fight for territories

Scarcity of resources

Competition for natural resources

Religious antagonism

Ethnic discrimination

Ideological struggle

Bad governance

-

# Arms availability

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## Civilians in Armed Conflicts

Civilians are victims of armed conflicts

In some cases, the objective of the war is the elimination of populations

Ethnic cleansing, genocide

In other situations, uncontrolled armed groups make their living by exploiting populations



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# Health Impact of Armed Conflicts



## **On Populations**

Malnutrition

High morbidity

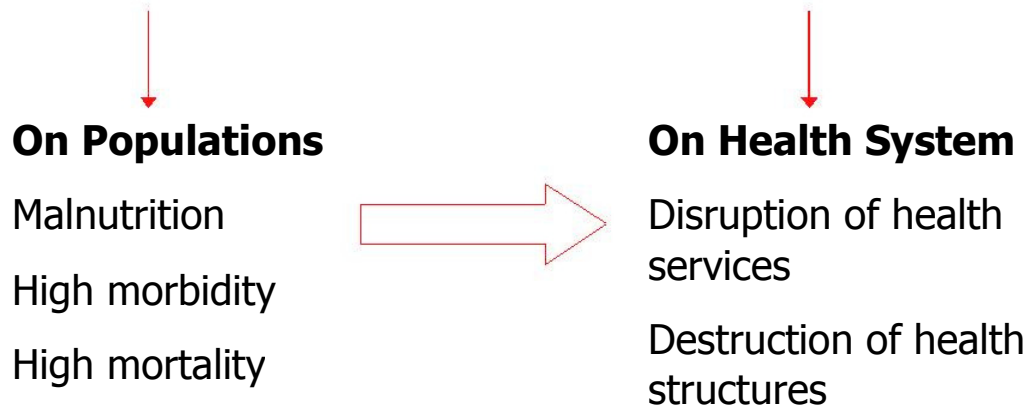
High mortality



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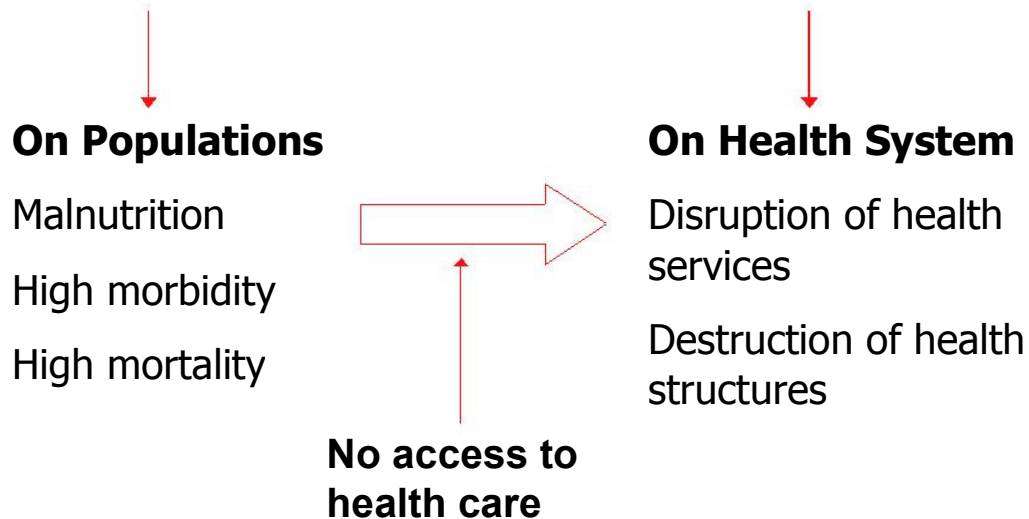
# Health Impact of Armed Conflicts



*Continued* 34

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# Health Impact of Armed Conflicts





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# Health and Human Rights

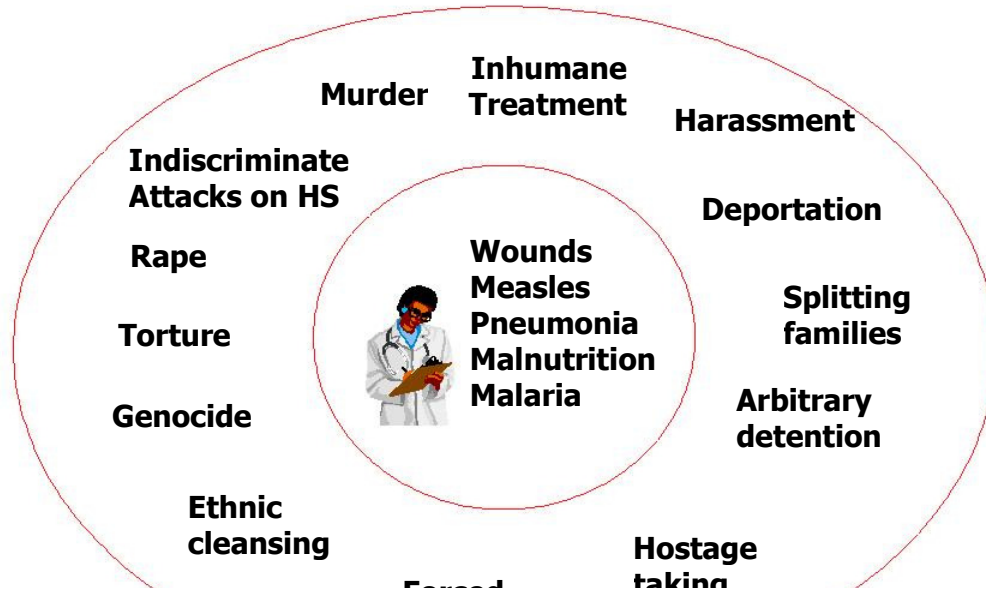




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# Health and Human Rights Are Linked



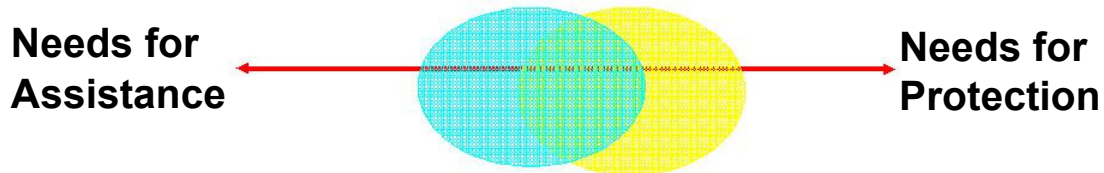




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## Assistance and Protection

In practice, assistance and protection of victims can not be dissociated



*Continued* 38

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## Assistance and Protection

At times, protection is assistance and vice versa

The ICRC provides protection

ICRC prison visits

Correct torture and mistreatment

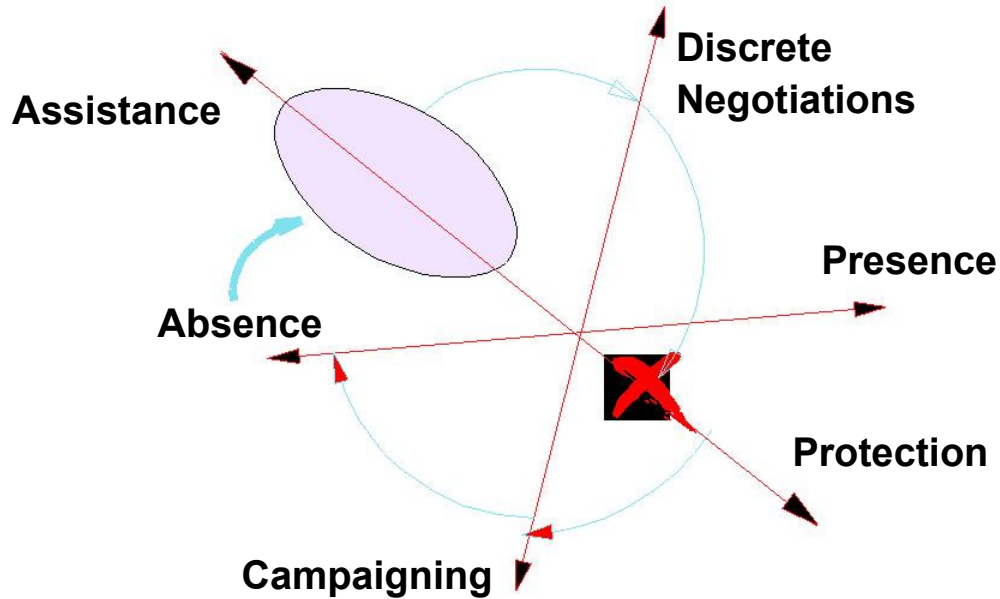
Distribute goods and medical services

*Source: David Forsythe, Choices More Ethical than Legal: The ICRC and Human Rights Ethics and International Affairs (1992)*

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# Humanitarian Strategy

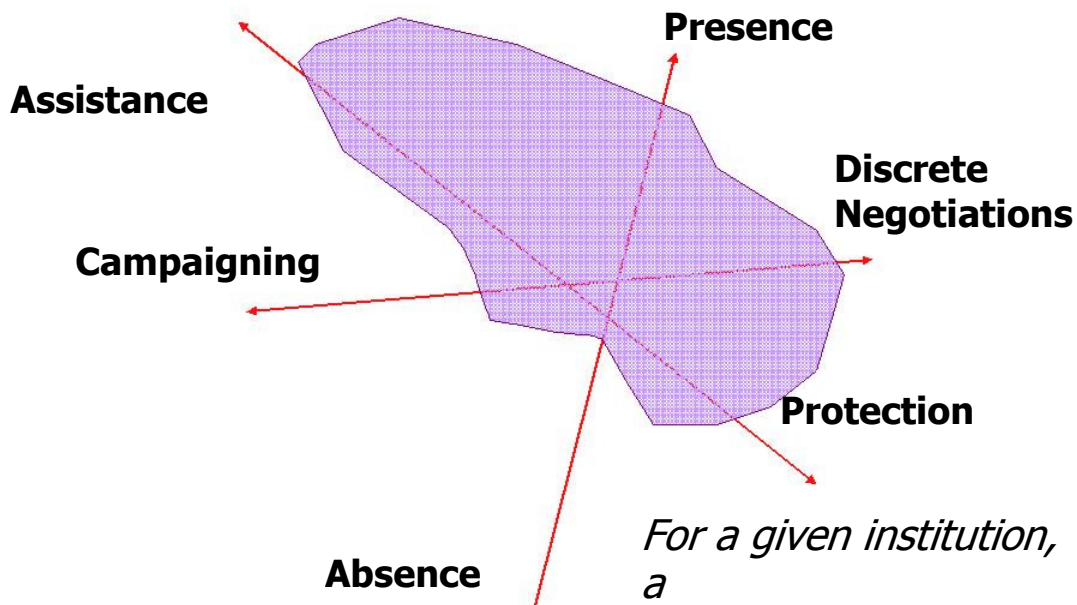


*The choice between options is difficult*

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# Institutional Strategy







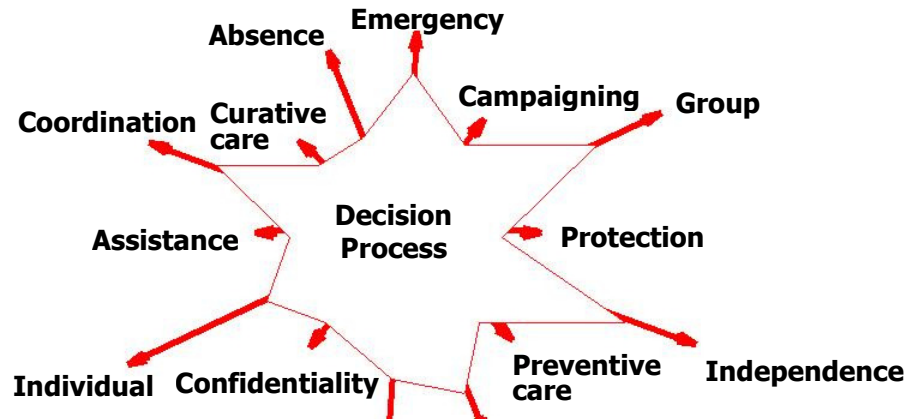
been  
strategies  
made  
be  
made

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# Institutional Strategy

To set a strategy, an organization must look at all issues





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# Ethical Decisions

Choices must be made on a strong ethical basis

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## Ethical Decisions

A good ethical decision tends to . . .

- Maximize all interests

- Minimize negative side effects

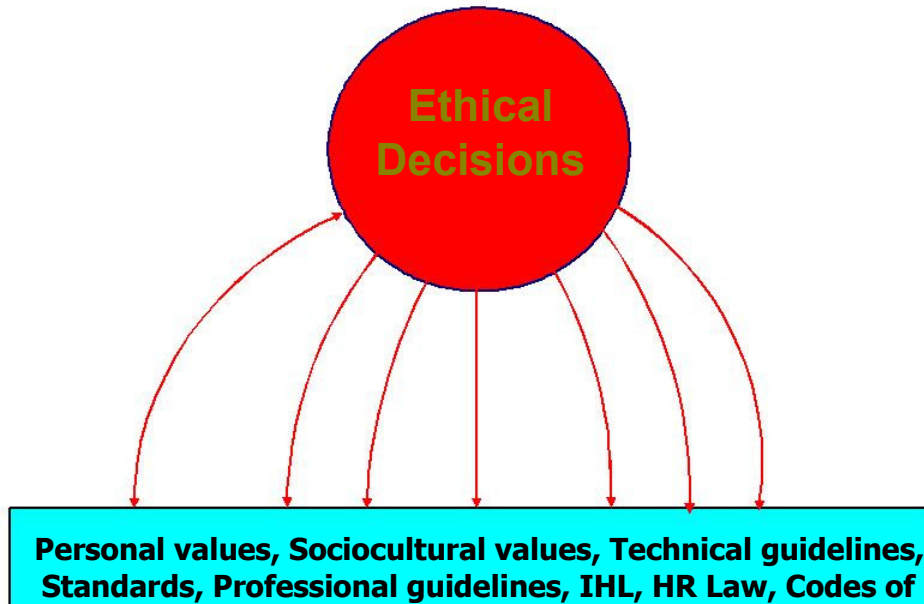
- Respect the values of victims, societies, and institutions

*Source: P. Lesage-Jarjoura, Nouveaux dfis professionnels pour le mdecin des annes 2000. Collge des mdecins du Qubec, 1998.*

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# Ethical Framework





**Conduct, Statutes, Mandates,  
Principles, Rules . . .**

*Continued* 45

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# Ethical Framework

Let us have a look at some issues involved in making a difficult decision in the field



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## Respect for the Values of Beneficiaries

Stripped of reality, the identity of these beneficiaries being the objects of humanitarian action undergoes a culturalist levelling. At worst, the beliefs, practices, and values of these victims no longer have any importance.

*Source: Bernard Hours, Lidologie humanitaire anthropophage de l'humanité, Journal des anthropologues, 7778, 1999.*

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# The International Humanitarian Law (IHL)

The existence of a large body of International Humanitarian Law and Human Rights Law is an important part of the moral landscape in which relief agencies make their moral decisions.

These international legal instruments often spell out what is right and wrong under law. In their decision making, relief agencies should be increasingly familiar with this body of law and be able to refer to relevant sections of it appropriately and abide by, wherever possible.

*Source: Hugo Slim. Doing the Right Thing: Relief agencies, moral dilemmas, and moral responsibility in political emergencies and war report, no. 6.*

*Continued* 48

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# The International Humanitarian Law (IHL)

The main rules of the IHL are contained in the following:

- The Geneva Convention of 1949

- The Additional Protocols to the Geneva Convention of 1977

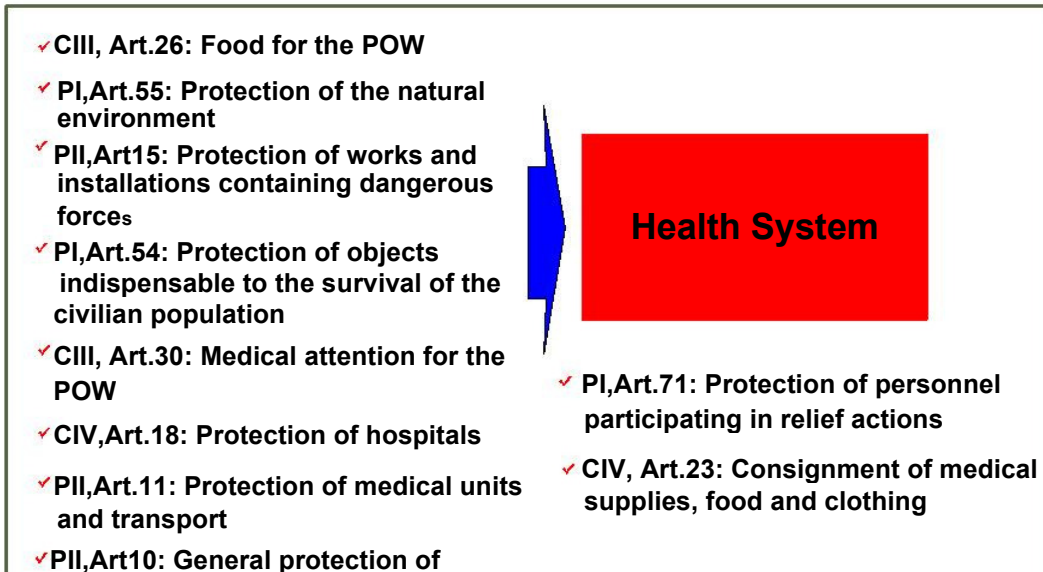
- The Law of War





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## Some Examples of Applicability of the IHL to Protection of Victims and the Health System

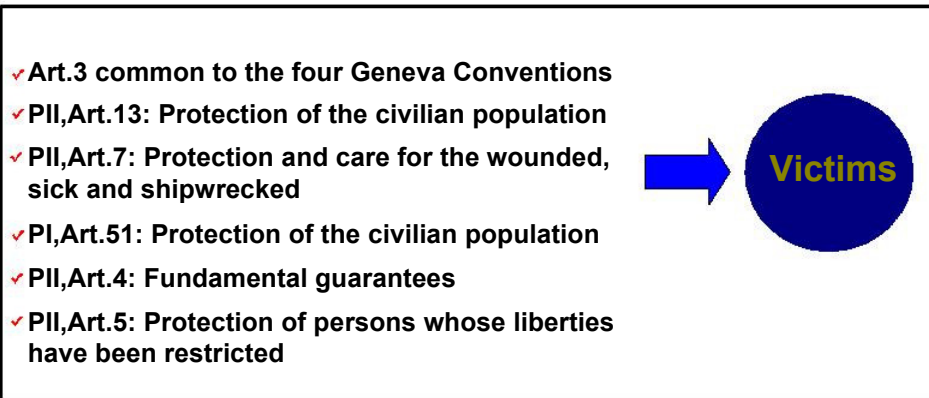


**medical duties**

*Continued* 50

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## Some Examples of Applicability of the IHL to Protection of Victims and the Health System





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# The Human Rights Law

## International instruments of the Human Rights Law

The Universal Declaration of Human Rights (1948)

The International Covenant on Economic, Social, and Cultural Rights (1966)

*Continued* 52

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# The Human Rights Law

## International instruments of the Human Rights Law

The International Covenant on Civil and Political Rights (1966)

The Convention relating to the Status of Refugees (1951)





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# Codes in Armed Conflicts

Examples of codes relevant in armed conflicts

The code of conduct for International Red Cross and Red Crescent Movement and Non-Governmental Organizations in Disaster Relief

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# Codes in Armed Conflicts

Examples of codes relevant in armed conflicts

People in Aid

Sphere project

RC/RC Principles



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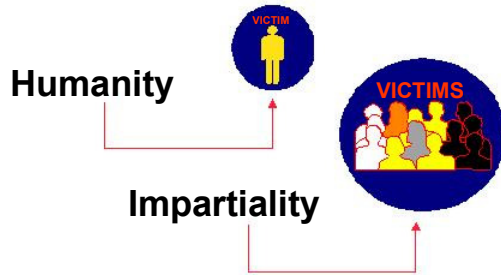
# The Red Cross and Red Crescent Principles



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# The Red Cross and Red Crescent Principles

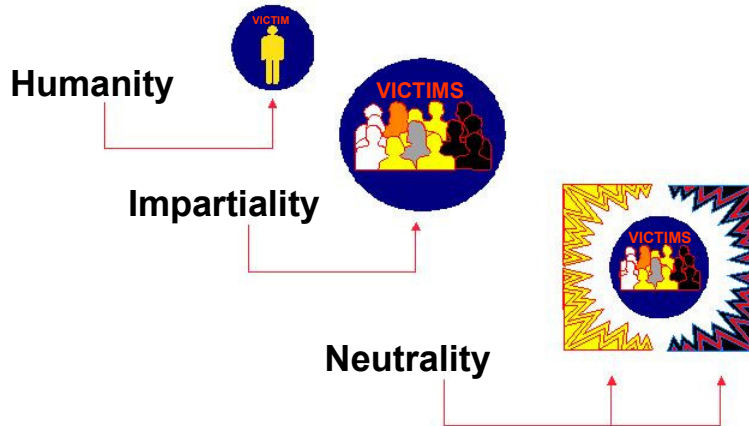




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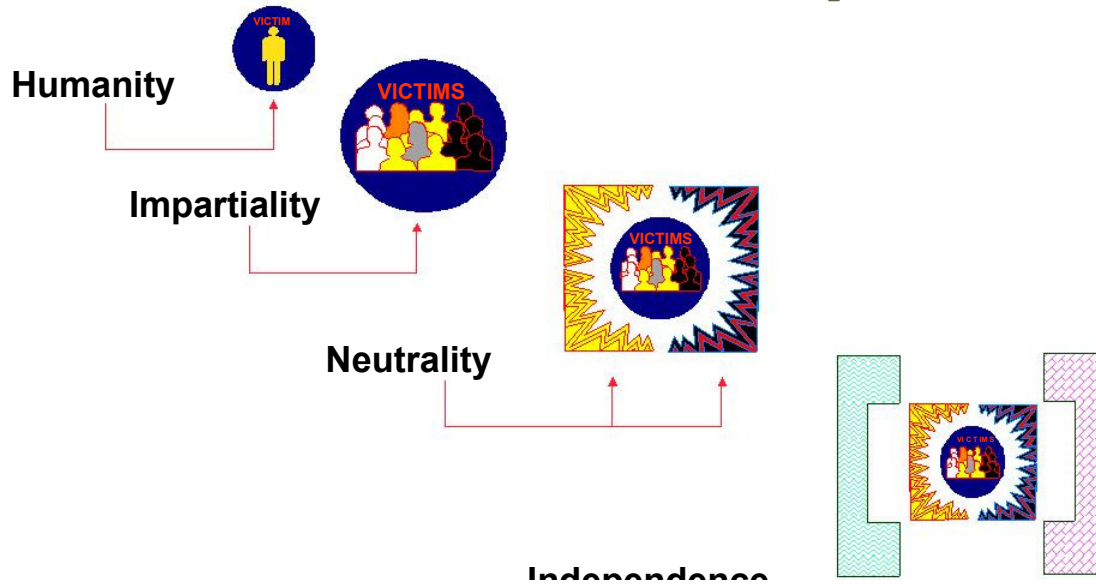
# The Red Cross and Red Crescent Principles



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# The Red Cross and Red Crescent Principles



independence



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# Professional Codes and Resolutions

## The Declarations of the World Medical Association

The Helsinki Declaration (1964) related to  
bioethics and biomedical research

The Statement on medical ethics in the  
event of disasters (Stockholm, 1994)

## The Resolutions of the International Council of Nurses



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# **Mandate and Statutes of Humanitarian Organizations**

Know the mandate and strategies of action of different humanitarian organizations to understand their complementarity



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# Mandate and Statutes of Humanitarian Organizations

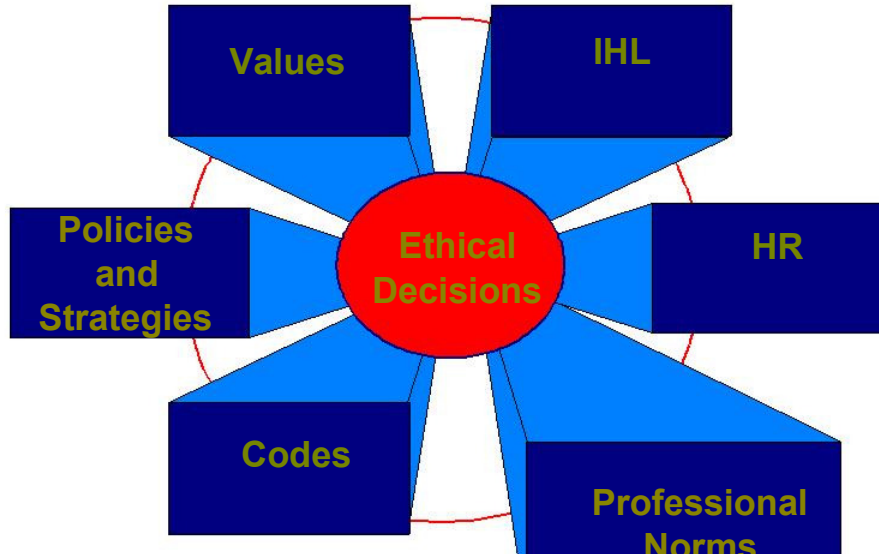
For example, the principle of *confidentiality* espoused by the ICRC should not be placed in opposition to the principles of denunciation adopted by other human rights agencies

The two approaches are complementary, and both are necessary



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# Decision Making



XXXXX  
(WMA)

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# Decision Making

*Quality assurance* is a tool for improving the quality of the decision-making process

Therefore, to prepare health care workers to make ethical decisions



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# Quality Assurance



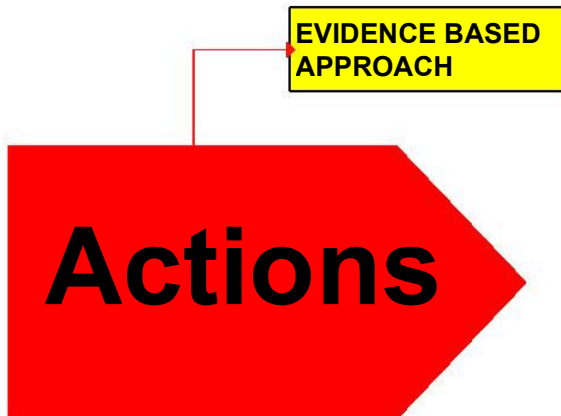
**Actions**



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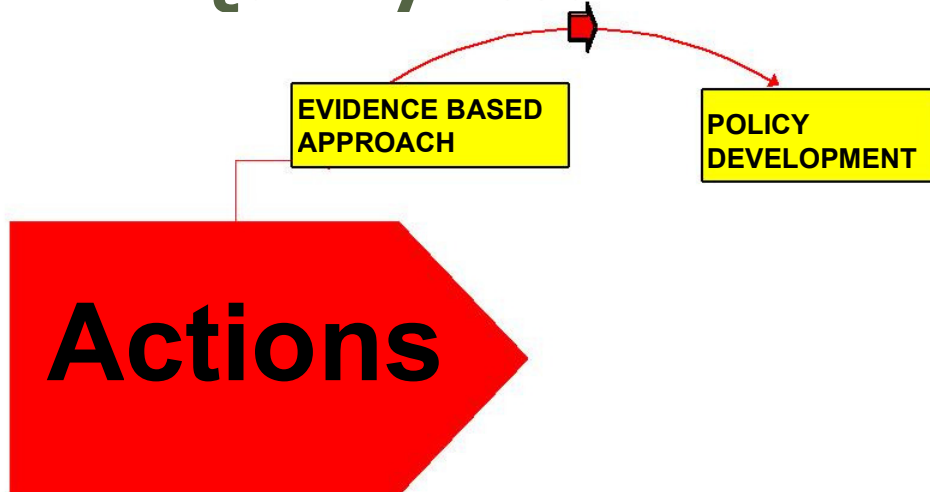
# Quality Assurance



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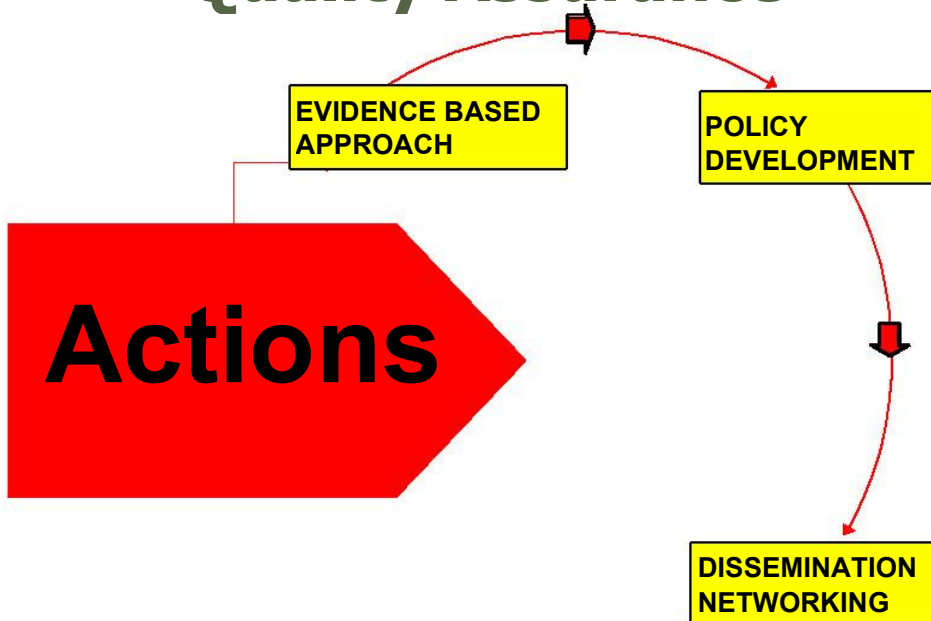
# Quality Assurance



*Continued* 67

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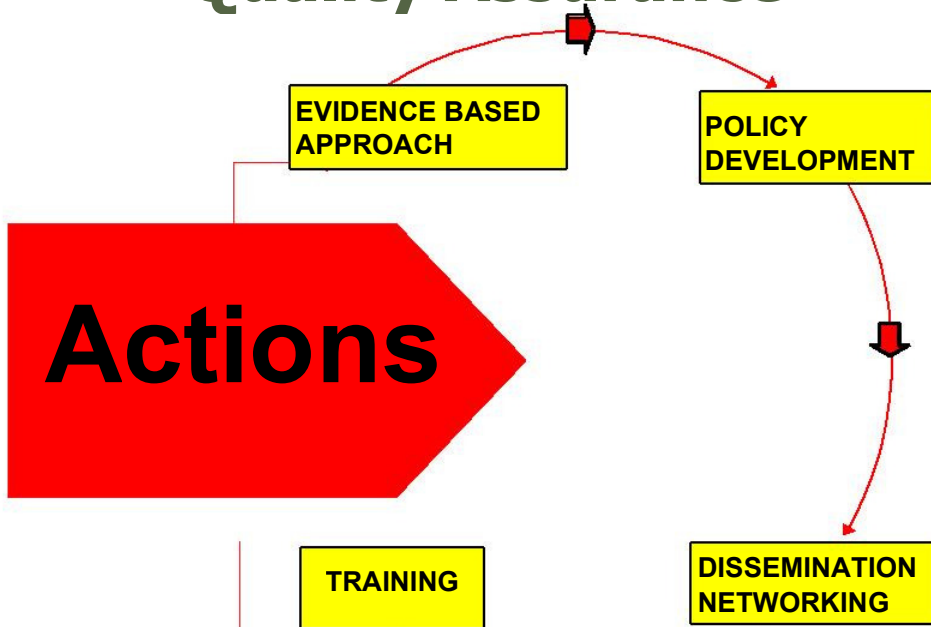
# Quality Assurance



*Continued* 68

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# Quality Assurance







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# Ethics and Research in an Emergency

An *Evidence-Based Approach*(EBA) may lead  
to research

*Continued* 70

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# Ethics and Research in an Emergency

Ethical considerations

Risk-benefit

Informed consent

Confidentiality

*Source: Adapted from J. Ovretveit. Evaluating Health Treatments Services and Policies. he Nordic School of Public Health, Goteborg.*

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## Summary

The bases for ethical decisions are as follows:

Learning from experiences

Respecting the values of people

Adhering to fundamental principles of action

Looking critically at codes, norms, etc.

Looking at choices systematically

Justifying options rationally

