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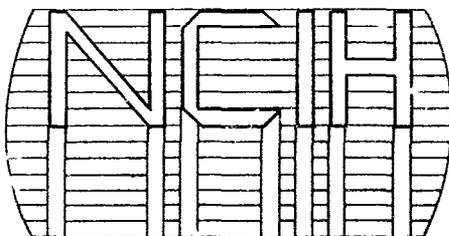
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Cambodian Refugee Relief: Lessons Learned and Future Directions

Report on June 9 through 10, 1980 Workshop



NATIONAL COUNCIL FOR
INTERNATIONAL HEALTH

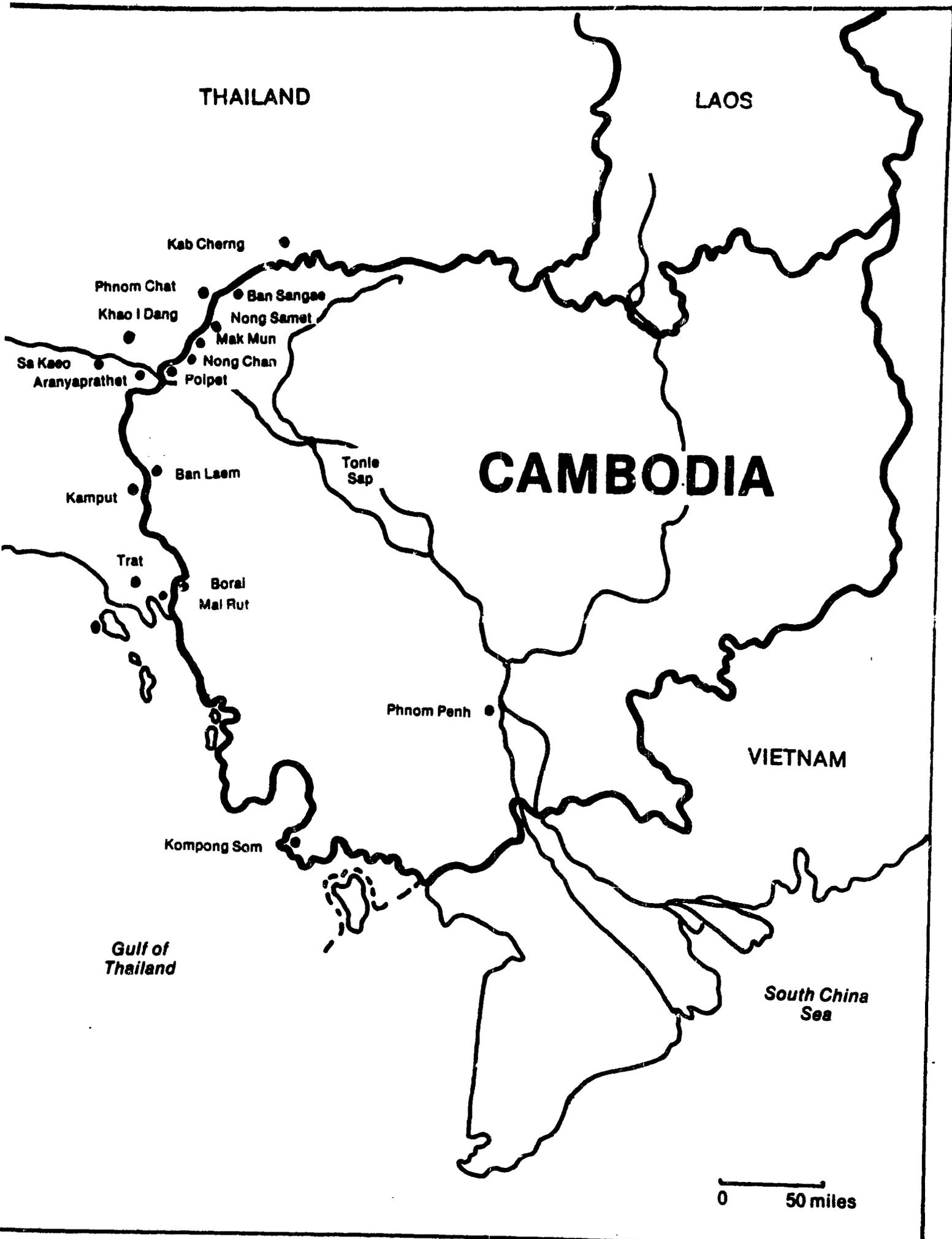
CAMBODIAN REFUGEE RELIEF:
LESSONS LEARNED AND FUTURE DIRECTIONS

Workshop Proceedings
June 9 - 10, 1980

Published by:

NATIONAL COUNCIL FOR INTERNATIONAL HEALTH
Cambodian Refugee Health Clearinghouse
2121 Virginia Avenue, N.W., Suite 303
Washington, D.C. 20037
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July 31, 1980



THAILAND

LAOS

CAMBODIA

VIETNAM

Gulf of Thailand

South China Sea

0 50 miles

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PREFACE

The National Council for International Health, established in 1971, works with private and voluntary organizations to promote primary health care activities in developing countries. NCIH serves as a link, gathering and disseminating information, providing technical assistance, and a forum where those involved in international health can meet and share ideas and experiences.

NCIH established the Cambodian Refugee Health Clearinghouse in November, 1979, with major funding from the Department of State. The Clearinghouse functions as a information service about the Cambodian refugee health situation, a data bank for volunteer medical personnel, and a referral agency of these qualified medical volunteers to meet the needs of the private and voluntary organizations providing relief for the Cambodians. Additionally, the Clearinghouse has acted as a disseminator of technical information for medical volunteers, and has sponsored several conferences designed to meet specific health needs of the refugee population in Thailand.

The following is a report of the workshop entitled "Cambodian Refugee Relief: Lessons Learned and Future Directions" held June 9 and 10, 1980 at George Washington University, Washington, D.C.

The National Council for International Health would like to acknowledge the support for this workshop given by the American Medical Association, the New Transcentury Foundation and the Office of International Health of the Department of Health and Human Services.

NOTE: The name "Cambodia" was changed to "Kampuchea" in 1976. Because of the lack of recognition of that name by the general public, we have maintained the use of the former name.

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INTRODUCTION

Like most of Southeast Asia, Cambodia has a history of centuries of colonization, notably by the Chinese and French, as well as conflict with her neighboring countries of Laos, Vietnam and Thailand.

In recent history, the Geneva accords of 1954 provided for a cessation of hostilities within Cambodia and the withdrawal of all foreign military operations. From that time until 1970, Prince Norodom Sihanouk maintained Cambodia's avowed neutrality, although Communist factions were allowed to exist in Cambodia. The National Assembly deposed Prince Sihanouk in 1970 and the new Prime Minister, Lon Nol, abolished the monarchy and established the Khmer Republic. During the period 1970-1975, the United States aided the Cambodians in their effort to rout the North Vietnamese and Viet Cong forces who were using Cambodia as a sanctuary to continue the war in Vietnam.

In April, 1975, the Lon Nol Government was overthrown by the Communist government of the Khmer Rouge, headed by Premier Pol Pot. A new Constitution established the People's Republic of Democratic Kampuchea. The Khmer Rouge held power in Kampuchea until 1979, when it was overthrown by a Vietnamese-backed Communist Government headed by Premier Heng Samrin. This Government continues to rule Kampuchea, although insurgent factions such as the Khmer Rouge and the Khmer Serei present challenges to that power.

Genesis of the Cambodian Exodus

The exodus of 700,000 plus Cambodians to the Thai-Cambodian border since the collapse of the Khmer Republic in 1975 derives from the chaotic conditions inside that country as a result of the policies of the Khmer Rouge in which the population was resettled on collective farms. Many Cambodians perished from malnutrition and disease while some fled Cambodia during the subsequent invasion of that country by Vietnam. Millions of Cambodians left the collectives for the cities, the hinterland or the Thai-Cambodian border.

The dislocation, warfare and near famine in Cambodia during 1975 - 1980 resulted in a severe loss of population and the disintegration of Cambodian society. It has been estimated, for example, that the population of Cambodia was about 8 million in 1974/5 but by 1980 had shrunk to about 5 million, of which approximately 2 million were casualties of disease, malnutrition and various kinds of military action. Almost another million became refugees or fled into the hinterland.

The social and economic fabric of Kampuchea suffered damage during these years. It is estimated that most of the Cambodian physicians, teachers,

senior civil servants and technicians either fled or died, leaving the society without the technical expertise to manage it. Similarly, it has been estimated that 90% of Cambodian roads and virtually all of the railroads were in an appalling state. (The few industrial plants that had existed were destroyed and the agricultural effort all but ceased.) For these reasons, hundreds of thousands of Cambodians sought escape from their nation and became refugees.

The first exodus of significant numbers from Cambodia to Thailand began in 1975 after the collapse of the Khmer Republic and the assumption of power by Premier Pol Pot. It has been estimated that by the end of 1975 over 74,000 Cambodians arrived in Thailand. In 1976 and 1977, the exodus continued but at a reduced rate so that it was estimated that about 70,000 more Cambodians reached Thailand during those two years. Toward the end of 1978, with the invasion of the Vietnamese troops, the exodus of Cambodians began to increase dramatically. By the end of May, 1979, it was estimated that between 80,000 and 90,000 Cambodians had escaped into Thai territory. The exodus continued through the rainy season so that by October, 1979, it was estimated that over 200,000 Cambodians had crossed into Thailand since the Vietnamese invasion of the previous year.

The mass movement of the Khmer population had a disastrous effect on food availability in Cambodia. The movement away from the agricultural lands along with the collapse of the rural cooperatives disrupted planting in May and June, 1979. Only about 10% of the arable land was planted for the August harvest. All of these disruptions resulted in severe malnutrition among the escaping refugees. By the end of October, 1979, between 2,000 and 3,000 Cambodian refugees were crossing into Thailand daily. By early November, it was estimated that approximately 560,000 Khmer refugees were in the vicinity of the Thai-Cambodian border north and south of Aranyaprathet. Within the next month it was believed that this number increased so that by the beginning of 1980 there were over 700,000 Khmer refugees along the border.

The physical and psychological condition of this indeterminate number of refugees upon their arrival along the Thai border revealed the nature of their tragic journey. Most of these refugees had been in transit for several months, many of them coming from the Mekong and Eastern provinces past the lowlands surrounding Tonle Sap, skirting Battambang and Siem Reap and thence to the Thai border. They had to live off the land which, due to wartime conditions, was producing very little rice and vegetables. Beyond this, they had to avoid the fighting between Vietnamese and Khmer Rouge troops.

Between 10% and 15% of the refugees, especially children and infants, suffered from malnutrition. When the refugees were tested in November, 1979, about 25% had malaria. A survey at one of the camps delineating causes of mortality among refugees from November, 1979 through January, 1980 revealed malaria at the top of the list followed by malnutrition, pneumonia, diarrhea, prematurity, combat wounds, anemia, septicemia, tuberculosis, meningitis, tetanus and measles. Nevertheless, several physicians were surprised at the survivability of the refugees given the arduous journey through Cambodia.

The vast exodus of Cambodian refugees in the latter part of 1979 brought forth a considerable international effort to provide both emergency and long-term care for the Cambodians. On November 1, 1979, the Royal Thai Government requested the United Nations High Commissioner for Refugees to prepare and obtain funding for a program to care for the Cambodian refugees then pouring into Thailand. Both the International Committee of the Red Cross and UNICEF had been providing food and materials to Cambodia for some time and the Thai Government now requested the ICRC to serve as the medical coordinator for all the Cambodian refugees arriving within its borders. A number of national Red Cross teams as well as medical teams from various voluntary organizations also began to arrive in Thailand to assist the refugees.

The assistance which had been organized in October and November began to have a decided effect upon the fleeing refugees in November and December. First, several U.N. holding camps were constructed and organized in Thailand not far from the Thai border. These included Khao I Dang, Sa Keo, Kamput and Mai Rut. On the other side of the border, the refugees established camps at Ban Sangae, Nong Chan, Poipet, Ban Laem, Borai, Non Mak Mun, Nong Samet and others.

Second, there was an unexpected response of volunteers to the several appeals for medical and technical personnel. By February, 1980 there were teams from 20 national Red Cross societies working in the camps on both sides of the border. Total Red Cross personnel working in Thailand and around the border numbered about 450. About the same number of medical personnel were also made available by about 40 voluntary organizations worldwide. (About 400 Americans have participated in the relief effort from November, 1979 through June, 1980.) The World Food Program (WFP) had already begun to provide food to the refugees crossing the border into Thailand early in 1979. The WFP obtained substantial funding from the Cambodian pledging conference in November 1979 in New York. As a result, the WFP launched a massive emergency food program to feed the refugees in both the holding centers and Cambodian refugee camps. It also launched a cross-border feeding program for Cambodians who came to the border to secure this food and then returned to their camps or villages. The WFP was able to purchase supplies of rice, dried fish, edible oil, beans and canned fish in Thailand.

This massive international relief effort undoubtedly saved hundreds of thousands of Cambodian refugees who otherwise would have perished from malnutrition, wounds, various diseases or outright starvation, which were the conditions existing among the refugees on the Thai border in October and November of 1979. As a result of this international assistance, however, the status of the refugees dramatically improved. The hospital admission rate at Kamput, for example, declined from 7.2 to 4.1 and from 3.8 to 0.6 at Khao I Dang. The neonatal mortality rate also declined dramatically at the several holding centers.

This improvement in the health status of the refugees resulted not only from the comprehensive medical care but also from the improved sanitary conditions and good water at the camps. Finally, the rate of flow of refugees across the border, which had been as high as 3,000 per day in November/December, 1979 also was reduced drastically. In May, 1980, for example, it was estimated that Khao I Dang had 120,000, Sa Keo about 30,000, Kamput 3,000 and Mai Rut about 10,000 refugees. Nong Samet across the border had 60,000 and Non Mak Mun about 55,000 refugees. Thus in May there were about 170,000 refugees in the holding centers and approximately 250,000 plus refugees in the camps along the Thai-Cambodian border.

The international organizations alone were unable to provide the necessary health care, food and shelter for the Cambodians and thus welcomed the assistance of a number of voluntary organizations (volags) from around the world.

The Committee for Coordination of Services to Displaced Persons in Thailand is a Bangkok-based committee of voluntary agencies providing assistance to the refugees in that country. Although they are not members of the CCSDPT, the international organizations, such as the ICRC, UNHCR, UNICEF, and WFP, and the Thai Government participate in the forum for mutual problem solving provided by the CCSDPT. On April 21, 1980, the CCSDPT held their annual meeting in Bangkok. Chairman Reginald Reimer told the participants: "Those of you who came today hoping or wishing that we would find some big solution to the refugee problem will go away disappointed. Those of you who are more realistic came today, I think, realizing that this meeting in itself is just part of a process. ..the fact that we are here today, together, spending the day, is an indication that we are committed to working toward a common solution.."

The same problems encountered by the UNHCR, ICRC, UNICEF and the many volags and the efforts to meet and solve these problems constitute the essence of this Washington workshop. From November, 1979 until the time of this workshop, the National Council for International Health has endeavored to respond to the needs of the various groups, both government and private, involved in the Cambodian relief effort. NCIH hopes that this workshop has served to promote a renewed association of government and voluntary professionals working in the refugee field, to present and analyze outstanding problems in refugee assistance as revealed by the Cambodian experience, and to gain a better understanding and clarification of the roles of interested governments, international organizations, and private relief agencies.

The following report is a compilation of the workshop, including a summary of all the workshop sessions, and speeches given by representatives of various international organizations, voluntary agencies, government specialists, and an independent journalist. Participants in the workshop were drawn from international organizations, voluntary agencies, government, relief workers, universities and professional associations. The National Council for International Health hopes that you will find the contents of this report useful in your work with the Cambodian refugees and in any future refugee work in which you participate.

KEYNOTE ADDRESS

KEYNOTE ADDRESS

FRUSTRATION AND PROGRESS IN COORDINATION

John Naponick, M.D.

I want to thank NCIH for the chance to speak today. I feel just a little bit stupid addressing such a distinguished audience. I should be asking you for advice but, as I have been asked to speak, I will.

I suppose that my claim to fame is that I was in Thailand for six months before the big influx of Cambodians in October and November, 1979. When all the confusion started, I knew what the initials stood for, so I was asked to be the medical coordinator for the Committee for the Coordination of Services to Displaced Persons in Thailand (CCSDPT). I have done this job since November.

I am going to address issues related to medical care for the refugees; I would like to avoid political issues. This conference may address some of the problems concerning medical care; whereas, political questions are outside of our domain

I would like to start with a description of the situation now in Thailand. The camps are now stable. Medical coverage is good. The death rates have fallen to the levels of pre-war Cambodia. The rates of hospitalization have fallen. For example, in Sa Keo there were initially 1200 patients; currently, there are fewer than 200. In addition to medical care in the hospitals and OPD's, we now have teams working in the community. Cambodian workers at all levels are being trained. Public health programs have been instituted. I don't think we have to worry too much about the refugees in the camps. The major concern now should be for the refugees along the border and inside Cambodia. Reports from Nong Chan indicate that the refugees coming to the land bridge are in poor condition. This is a deterioration of their health situation. We can probably expect another famine after the rainy season, just like last year.

At the beginning, I would like to pose what I consider to be a major question: Is this a relief effort or a development situation? I feel that initially when the situation was desperate in November and December it certainly was a relief effort, since the refugees were too weak and too sick to take care of themselves. Now they are back on their feet again and I feel we should be taking a more developmental approach. We have no idea as to the fate of these people, so it is in their best interests to be trained to be self-sufficient. There are volunteers and volunteers who still feel the refugees are like starving, helpless children and incapable of self-care. I think this attitude is inappropriate.

Dr. Naponick was the Medical Coordinator of the Committee for Coordination of Services to Displaced Persons in Thailand (CCSDPT) from November, 1979 until June, 1980.

I would like to congratulate the international community and all the agencies and workers in Thailand for the wonderful job they have done in this effort. There have been unbelievable improvements in the health status of the refugees. In the early days, Sa Keo was a muddy field of lifeless bodies--silent and eerie. Today, one would never recognize it as the same place or the same people. The improvement is remarkable. I want you all to remember that I have said something good about the effort! We have learned some major lessons from this experience:

1. Food: when people are starving, we have learned what value food has.
2. Epidemiology: has a place as the earliest tool that is needed in these efforts to define the problems.
3. Public Health: especially sanitation programs have shown their value.
4. Coordination: the effectiveness of its role has been demonstrated.

I would like to turn now to problem areas. This is in no way to detract from everybody's efforts or to criticize anyone. All of you have taken time from your busy schedules to attend this workshop; therefore, we should try to accomplish as much as possible. I have been to too many meetings where everybody claims to be friends and denies that problems exist. I think we are all aware that there are problems and I will elaborate on them. I feel fortunate that in the United States we have free speech, so I can say what I think.

To begin, I should present an organizational chart to identify the actors. Of course, the action is taking place in Thailand and all of the authority is in the hands of the Thais. The King and Queen are very influential and there is an elected civilian government. The Thai military plays an important role in the refugee problem, because the refugees along the border are in an insecure area. The Ministry of Public Health is responsible for health and the Ministry of Interior runs the old Lao and Vietnamese camps. Task Force '80 is in place at Aranyaprathet and has representatives from the Supreme Command, local military units, the international organizations and other Thai governmental units. It exercises on-the-spot control.

Working under the Thais are the international organizations (IO's). The International Committee of the Red Cross (ICRC) is responsible for medical care, tracing, and protection for the entire relief effort. They are now focusing on the border operations. The Thai Red Cross works with the ICRC, and, together, the group is called the Red Cross Task Force. The World Food Program (WFP) and UNICEF work on border and camp feeding. The United Nations High Commissioner for Refugees (UNHCR) is responsible for refugee protection, water, food, shelter and medical care in the holding camps.

In Thailand, the volags are represented by the CCSDPT. It is very important to note that the CCSDPT and the volags are never officially represented on any bodies that concern the refugees. We are always working under the umbrella of an IO, usually the UNHCR.

Let me give more specifics concerning each group. As I begin with the Thais, I should explain that this is not meant to be a personal or institutional attack. I like Thai people very much and have enjoyed working in Thailand. But, the Thais make it very hard for us and for the refugees. Thai politics being what they are, they make it difficult for us to plan. For example, the refugees are to be moved to a new camp soon, but the time tables are so vague that it is impossible to plan for redistributing medical volunteers. Not knowing the fate of these people, either resettlement or repatriation, also makes it hard to plan. The security in the camps is one of our major problems. The Ministry of Interior (MOI) could make our work easier by helping with customs, taxes and visas. The MOI's bureaucratic delays are world famous. For example, when the Nong Khai camp burned down several months ago, the US Embassy and the UNHCR gave the MOI several million baht to reconstruct the camp. So far, no construction has been done. Another example is drugs. The UNHCR pays the MOI who in turn pays the Thai Red Cross (TRC) to supply drugs to the camps. The last time I checked, the MOI was 9 million baht behind in payment, and the Thai Red Cross (TRC) was reticent about delivering more drugs. The Ministry of Public Health is charged with carrying out the public health duties in the camps. They do a good job of making sure no disease spreads from the camp to the Thai people, but otherwise they are not active in the camps.

The international organizations are sometimes referred to as the "gang of four". As I come from the volags, there aren't many bad things to say about WFP and UNICEF. They work well with us. I only question the decision by UNICEF to stop the rice seed distribution in June. Perhaps this can be discussed in the workshops.

The International Committee of the Red Cross was given the mandate by the Thais to coordinate the relief effort. To the ICRC this means control. They initially wanted to control the holding camps, but have since turned that responsibility over to the UNHCR and the volags. However, the ICRC refuses to allow the volags to participate on the border. I will not dwell on this, but I hope this topic is discussed in the workshops. This topic is a heated one in Bangkok. My other problem with the ICRC concerned their teams. They would tell me they were going to reduce and then would increase their teams. Also, there would be gaps in services. For example, a laboratory technician would be needed, and the people to do the job would be available through the volags. However, the ICRC would refuse the volag technician and call Geneva for one.

Let us consider the UNHCR. It is sad that their representative is not here today, but I suppose that is typical. In the camps, the UNHCR is responsible for protection, housing, food, water and sanitation. It is my belief that if the UNHCR would guarantee the services they pay for, then the rest of us could go home. Let me give you some examples. Food is one. The

UNHCR is paying to provide a basic daily ration of food: rice, meat and vegetables. I have been to camps where the refugees get 'x' grams of cooked rice per day instead of the 'y' grams of dry rice that the UN pays for. As you know, water is cheaper than rice. In the camps, the UN pays for 'xx' grams of meat, but the refugees get fat or bones. The UN pays so much for leafy green vegetables, but the refugees get vegetables with a high water content, such as cucumbers or marrows. Volags spend so much time and money on supplemental feeding because the UN does not deliver the basic rations. Another example of how the UN pays for, but does not receive, the service is the garbage collection in Sa Keo. The UN contracted to have it done for 500 baht. The man with the contract then subcontracted it out for 300 baht. Yet, the garbage is not collected. The UN goes to the original contractor who refers them to the subcontractor. The UN approaches the subcontractor who says "Who are you, UN? My contract is with the original contractor, not you." The volags then have to supply someone to collect the trash. Other examples concern construction. The UN paid to have a new section of a camp built. The only houses that were built had no water or drainage or toilet facilities, but the UN did nothing. One reason may be that the UN has a very strange auditing system. Finally, the UN will not back up the volags if it comes to that. One of our workers got into hot water over a family planning issue. He simply raised a few questions. I believe the UN could have defended him, but chose not to. Hopefully the UNHCR representative will be here tomorrow to answer some questions.

Lastly, I will discuss the CCSDPT and the volags. The CCSDPT has been in operation since 1975. The member volags each have a representative as do the IO's and Thai agencies. Meetings are usually held monthly. An Executive Committee of five members is elected. There are two subcommittees concerning medical care and transit camps.

The CCSDPT has some problems. The Chairmanship is an important position. Last year, for several months, the post was vacant because no one wanted the job. The people from the major volags were too busy with their own programs and didn't want to do it. Actually, these are the best people to do the job. I recommend to the volag representatives sitting in the audience that they should tell their people to show more of an interest.

In an effort to improve, the CCSDPT elected a medical coordinator, me, and an executive secretary. I was told to coordinate the services of 600 medical workers from 40 agencies and to represent the views of the CCSDPT to the IO's and Thai government. When I asked for a secretary and transportation, I was told the CCSDPT was not ready for that kind of an expenditure. I believe that the volags are ambivalent about coordination. I have now left the post of medical coordinator, but the CCSDPT has yet to pick someone to replace me. I believe it should have been important for me to overlap with my successor. It is as if the CCSDPT wants to have some confusion. A very important question is: "Who makes the decisions?". Volags send different people to the meetings each time and they feel they cannot make decisions. Many have to refer to their home offices. The Executive Committee is making more decisions. I hope this topic is discussed in the workshops. I will give you my impressions of

the voluntary agencies working in Thailand. It is difficult to make generalizations, but you will know when I am speaking of your group. It seems to me that communications between the home office and the field are not very good. For example, in several cases the field would request people or tell the home office to stop sending people, and the home office did just the opposite. You should all really try to get your act together.

Another major problem area is administration. Most of you pride yourselves in having such low administrative costs, but I think it would be better to try to concentrate on how much money is well spent in the field, not on how little is spent in administration. More often than not, your administrators could not tell me how many people you had in the field.

Money that was earmarked was another big problem for me, and I am sure it was for you too. For example, people could buy a car but had no money for gasoline. Or, people could only have the money if they spent it in two days. That is crazy. I have the greatest respect for one volag which turned down a sizeable sum because the money had too many strings attached.

Programs are another troublesome part of the relief effort. You all want to do something that is visible, you want to put your name on it. The most popular project is your own building with one of your workers pictured outside holding a starving child. This work has to be done, but you all can't do the same thing. Several groups are fighting over who will take care of well children! I know it is easier to raise funds to feed children than to do sanitation work, but always remember that all important aspects of the effort have to be covered.

Personnel is the next topic. I do not know what you tell your people who come out. Several times in March, people came who had quit their jobs in the U.S A. to take care of starving and dying people. They found the situation in the camps to be quite different from what they had expected. Also, I have had some teams who would take orders only from their home office, ignoring all efforts toward coordination.

Experts, please don't send me any experts. All they do is write reports, go shopping, and then go home. For example, at least six teams of experts surveyed Sa Keo and reached the same conclusion: sanitation was horrible. They did nothing. I then called on a team of sanitarians who promised me they were not experts. They cleaned up the place. Medical care in the refugee camps is not complicated. I believe that people with common sense, who are not too proud to do whatever is necessary, are the best volunteers. I have been really impressed with the paramedics, nurse practitioners, and, especially, nuns. I really like nuns. They work very hard, never cause any problems, and are never too proud to refuse to do a needed task. I have advised many groups to send as many nuns as possible.

The question is what kind of people should you be looking for? I hope that you will discuss this area in the workshops, but here are a few of my suggestions. They should be people willing to make a commitment of six

months. Short term people take a while to find out what is going on, to get over their diarrhea, to do their shopping, and then to plan their trip home. Previous overseas experience is valuable. Over there we are able to do only basic lab examinations with a microscope and a few X-rays, so medical people with strong clinical skills should be preferred. People must be flexible and have common sense. We need more people who do not have to work in the hospitals or outpatient departments. The real work to be done is in the community. We need fewer doctors and nurses who want to do curative services. We need more people who are interested in community health and public health, sanitation, training, and supervising, and, last but not least, education. Education includes basic health education to the training of the local medical workers.

The behavior of the volunteers is important too. A lot of workers seem to think that because they are doing something good, they can act any way they want to. Well, that's just not true. Thailand has very strict rules regarding conduct. I wish I could convince the workers that they are in Thailand. One volag administrator really impressed me because he made a doctor return to the house and dress properly after she had come to work wearing short pants. We need more discipline in the field.

Supplies are another problem. A lot of people send us ridiculous things. It takes so much time and effort, and it costs so much, to get supplies through customs that you should always consider if the articles are appropriate. Many items can be bought very cheaply in Thailand. This question of absurd supplies comes up during all emergencies.

The coordination effort among the agencies also leaves something to be desired. For most agencies coordination seems to mean that they do whatever they want to do and that the other agencies should do whatever else is left. I understand that most agencies recruit people to do a certain kind of project, usually hospital work. This means constructing a building, which is easily understood work and is good for fund raising purposes. But it must be realized that every agency cannot do this. I urge you to be serious when it comes to coordination, to really mean it, and not to pay just lip service to the concept. As far as the coordination I did is concerned, I was not endowed with the decision-making power to resolve disputes. Responsibility for who does what and where in the camps rests with the UNHCR. I was able to divide the jobs among the various agencies in the existing camps, and to plan for the anticipated movements to the new camps. However, my talks with the volags did not produce an agreement about assignments for Khao I Dang. KID is to be reduced from 125,000 to 50,000 people. Currently twenty agencies work there. Except for two, all the agencies wanted to stay and even to expand their presence. This was not feasible, and the UNHCR ultimately decided who would stay and who would leave. I think it would be better if the volags had been able to make these decisions themselves. I do believe that coordination by consensus is the best approach; however, at all times it is necessary to have some authority to settle disputes. Perhaps during the workshops you can discuss the power structure in Thailand.

Before I close, I would like to stress one more area that caused a lot of problems, sensitivity to Thailand. There are many aspects of the relief effort that are governed by the fact that it is taking place in Thailand. A major issue is the level of care. One must realize that in addition to the suffering of the refugees, there is a great deal of suffering among the Thai rural people. It is quite embarrassing to me, as well as to the Thai government, to see so much being done to help the refugees and so little to help the Thais. At this time, I would say the two populations are comparable in health status. The Thais have been telling us for a long time that we are doing too much for the refugees, and they finally have taken measures to stop it. There is now a list of items that cannot be taken into the camps. For example, if 100 meters of cloth go into the camp, the same must be given to the rural Thai people. It is also a shame that the Cambodian refugees are getting much more than the other refugees in Thailand. The workers must be made to understand the political sensitivity. The same idea applies to referral. Our workers frequently want to transfer patients to special referral centers. A referral system has been set up via the MOPH hospitals, and the Thais try to treat the refugees the same as the Thai village people. We should respect this system. Another problem area is drugs. The Thais have effective programs using cheap, locally available drugs. Many of our workers feel lost without fancy, expensive drugs. These are only some of the examples that point out that we must respect the culture of the refugees as well as that of Thailand. I think it is in our best interests to start developing programs for Thai people as well as for the refugees. This may not be our choice soon; we may be forced to do it if we wish to remain in Thailand.

I can only hope that this statement of problem areas will provoke a frank and open atmosphere for the workshops that follow.

Thank You.

SUMMARY OF WORKSHOPS

SUMMARY OF WORKSHOPS

During the course of the two day workshop, the participants met twice in small work groups. The first day's session was devoted to discussing the major lessons learned during the Cambodian relief effort and prioritizing problem areas. The problem areas identified by the participants were used as workgroup topics on the second day. Participants joined the group of their choice. The lessons, problems, and models developed in the workgroups are summarized in the following sections: coordination of the relief effort; the relief effort's relationship with Thailand, host country nationals, and Cambodian refugees; level and quality of services in the camps; and volunteer personnel.

Workshop 1: Coordination of the Relief Effort

Coordination, or the lack of it, generated more debate during the workshop than any other issue. It was agreed that coordination develops from need. In many disaster situations, coordination of volag activities probably is not necessary. However, in large scale disaster assistance or refugee relief, such as in Thailand now, a responsible and accountable organization is needed that can speak with one voice for all the voluntary agencies. In fact, the Coordinating Committee for Services to Displaced Persons in Thailand (CCSDPT) developed more from mandates from the host country and international organizations than from the cooperative effort of the volags. Support for the CCSDPT has not been total. At present, there is no central authority that the volags will listen to.

Workshop participants voiced doubts that the volags want to be coordinated. Each agency tends to do what it likes, rather than consider the common good. This has led to oversupply and duplication in some areas of personnel and services, while other worthwhile projects are neglected. A basic problem may be that the agencies have conflicting objectives and directions. There is no unified set of goals to which all have agreed. When in Thailand these varying missions are superimposed on the inevitable differences in individuals' perceptions, it is difficult to work together on the resolution of the larger issues. Talks and debates tend to center on smaller issues; these were characterized at the workshop as "turf" battles.

Models for Coordination in the Field

The workgroup on coordination presented three models for field coordination. The existing model, the CCSDPT, was the first described. Although noting the shortcomings of this committee, the group recommended that the appropriate model for the relief effort in Thailand is the CCSDPT and that it should be continued and strengthened. The group felt a strong point in favor of the CCSDPT is that decisions are reached by consensus of the member

volags. Because the voluntary agencies are so independent minded, this decision-making process allows them to retain their autonomy. The CCSDPT, with its full-time staff and periodic meetings, has functioned well as an information center. The workgroup recommends a larger role for the coordinating committee. It should be organizational rather than simply informational; it needs to be taken seriously by all the actors in Thailand; and it must have the authority to back its decisions. The recent reallocation of camp duties among volags by the UNHCR was brought up as a painful example of what happens when the volags do not reach decisions among themselves. Necessary tasks should be delegated by the coordinating committee if agencies will not take them on voluntarily. Especially during the early days of a relief effort, decisions about requirements for personnel and supplies must necessarily flow from the field to the volag home offices, rather than vice versa.

The second model described was the Action for Relief and Rehabilitation in Kampuchea (ARRK), a collaborative venture of six voluntary agencies for projects inside Cambodia. Constraints on number of personnel by the Heng Samrin government encouraged this coalition which is functioning successfully. The third model was a coordinating committee developed in Guatemala after the earthquake. That committee was able to purchase bulk supplies, such as drugs, for all the voluntary agencies.

Coordinating Functions

In order to succeed, any coordinating committee must have a clear purpose, the respect of all its members one for the other, and common agreement about the rules. The committee should act whenever the common good is involved, for example, assisting in the selection of camp sites. The committee can speak for all the volags when there are disagreements with the international organizations (IOs) or with the host country government. It may speed actions and responses if only one point of view is presented by the volags. An example in Thailand is the controversy over rice distribution. The committee must be active in areas of excess (cutting back when necessary) and scarcity (delegating or assigning duties). It could also function in such areas as purchasing supplies in bulk, identifying needs early, providing teaching materials, and compiling a list of acceptable drugs that are used in the camps. The committee should continue to be the hub of the information network. Finally, the coordinating committee should provide follow-up and continuity for the entire relief effort.

Coordination at Home

The CCSDPT needs a counterpart in the States. Budgetary decisions are usually made in the home office, and the degree of authority exercised by field administrators varies greatly. Many of the field administrators are young and inexperienced. Home offices must agree that they will cooperate and recognize the authority of the coordinating group in the field. This unfortunately has not occurred in the Cambodian relief effort. Agencies mentioned as possibly carrying out such a coordinating role in the U.S. include the American Council of Voluntary Agencies for Foreign Service, the

Cambodia Crisis Center, and the National Council for International Health. Ongoing outside evaluation of the entire relief effort should be encouraged as a way to achieve balance and completeness. If such data were available, the voluntary agencies could use them to revise and improve field programs.

Workshop 2: The Relief Effort's Relationship with Thailand, Host Country
Nationals and Cambodian Refugees

Participants at the workshop were concerned that a realistic evaluation be made of the future prospects of the Cambodian refugees. A better understanding between the international organizations and the host country government about the ultimate disposition of the refugees is needed. The political situation pervades the entire relief program.

Several participants pointed to the inefficiency, disinterest, and corruption of local authorities. Certainly, security in the camps was a major problem discussed. Confiscation of food was also noted. The consensus of opinion, though, was that the role of the volags is minimal with regard to the safety of the refugees. The volags have no official capacity in the camps. Volunteer workers should be sensitive to what is happening, but only act when they can be effective. Sensitivity to our own limitations in another country is very important.

Sharing Responsibility

No solution for the Cambodian refugees is imminent; it is highly unlikely that they will return to Cambodia in the near future. Therefore, the relief program must be geared to a long-term program. Successful relief programs inevitably bring the need for such long-term community medicine programs. The problems arise because the voluntary agency administrators do not plan soon enough for this transition from relief to development. Even in the earliest days, the refugees must be involved in their own and others care. Too often, the volags have underestimated the capacity of the refugees to act as problem solvers and as resources for development. Although we may be unwilling to let go and allow them to care for themselves, the whole purpose of the relief effort is to help the refugees move from dependency to self-sufficiency.

Involving Cambodian Refugees

The workshop recommended that health workers be trained from among the refugee population. Every medical volunteer should have a Cambodian counterpart, and the expatriate worker should never do anything alone. Health workers should be chosen from those who will remain in the camps for a long period of time, and not from those who might soon be resettled abroad. Refugees can be trained, too, by assisting on medical education programs or on public health teams. There should be greater use of training materials, such as the Khmer Medical Dictionary. Some of these materials can be obtained from

the Mahidol School of Public Health. Native health care providers already in the camp, even if they practice non-Western medicine, should be encouraged and utilized, and Western medical personnel should try to learn from them.

Involving Thais

It was stressed that the relief program will fail if Thais are not involved; it cannot be solely an American-European effort. Credit should be given the Thais when it is due, and we must learn to work with and consult the local physicians. There are a number of existing Thai groups, such as the Mahidol School of Public Health, which are willing and able to become involved. Contact could be made with provincial and other local health officials. Thai nationals should be employed in the camps whenever possible. Another way of collaborating would be for U.S. universities to establish exchange programs with their colleagues in Thailand.

Helping Thai Villagers

Tensions have arisen between the refugees and the local population. The countryside in Thailand is not unlike Cambodia; both are developing countries. The health status of the refugee population is now similar to that of the neighboring Thais. The volunteers must be cognizant of the impact of the relief program on the local Thai population and take care to minimize negative consequences. Workshop participants agreed that medical care and other programs should also be offered in the Thai villages.

Workshop 3: Level and Quality of Services in the Camps

During the early days of the relief effort, the kinds of services offered to the refugee population are different from those offered later during the community organization and development phase. Early on, the medical care given must be very basic. The problem is that there is no consensus on the kind or quality of medical care or on the medical policies for the camps. Although it is important to discuss these problems, we should not lose sight of the fact that the relief effort has succeeded in saving many lives.

During the Emergency Phase

A workgroup considered the needs of the refugees when they first arrived in the camps. The emergency phase of the relief effort is considered to last for about 10 to 12 weeks. At this stage, it is important to concentrate on the basic necessities: food, water, and housing. Getting sufficient food to the people is the highest priority. Sanitation should be considered in the camp's design, and potable water and disposal of solid and liquid waste must be provided for immediately. A triage system should be quickly instituted to identify those refugees who need immediate hospitalization or care in the outpatient facilities.

For the very ill refugees, a referral system can be developed, but medical specialists should not reside in the camps. An epidemiologist should be one of the first workers in the camp. A number of diseases can be prevented if appropriate monitoring systems are in place. Using indigenous personnel whenever possible, the data that should be collected during this initial phase include a rapid census of the population and ongoing collection of mortality, morbidity, and nutritional data. The volags must collaborate on the collection of these data. For certain data, for example census data, an individual should be selected to do the collection. For other data, uniform forms should be used by all personnel so that the data will be comparable and can be aggregated. Continuing assessment and surveillance should be incorporated into camp life so that present and future requirements for personnel and supplies can be determined. A system for the rapid evacuation of relief workers is also a necessity.

Medical and Public Health Services

The workgroup offered recommendations on minimum requirements or standards for services in the camps. For the hospitals, the group felt that the standards used in military field hospitals should be applied and that fire prevention plans should be made. Vector control and proper disposal of waste are important in the hospitals. Toilets should be placed next to each ward. Basic health education, such as how to clean themselves, should be given to the inpatient population.

The hospital laboratory should have the capabilities to do blood counts, hematocrit, routine urinalysis, malarial smears, smears for tuberculosis, and stool analysis for parasites. Refrigeration facilities and a microscope are minimal lab equipment.

Under public health services, control of communicable diseases is the primary activity. Vector control and proper sanitation (for example, covered toilets) are important early public health measures that should be taken throughout the camps. Screening can be done for tuberculosis and treatment given in either the hospitals or outpatient facilities. Refugee health workers should be trained for case finding and control. An immunization program should be started early. The minimum series should include: polio, measles, DPT, and DT for pregnant women. If indicated, treatment can also be given for typhoid, cholera, or parasites.

Administration and Other Services

The workgroup recommended that one full-time administrator be hired for each camp to solve problems on a day to day basis. The administrator should be multilingual and local, if possible. He or she should not be a physician. Strict financial records should be kept for the camp. Of course, a medical record system is also needed for the refugee patients. Good medical records improve the quality of care and are useful for epidemiological studies. If possible, all the refugees should be screened and given medical records that they can carry with them.

Ongoing evaluation of services should be undertaken by the camp administration. Periodic needs assessments to determine programs in all areas, including vocational, educational, and recreational, in addition to medical care and public health, are necessary.

Workshop 4: Volunteer Personnel

Participants at the workshop discussed the need for better screening and orientation for the volunteers going to work in Thailand. A few of the volunteers have caused problems in the camps. They refused to do the mundane tasks necessary to camp life, such as garbage clean-up. A few continued to argue their personal beliefs even when their ideas clearly conflicted with the Thai Government's policies. Some simply lacked the mental stability to withstand the rigors of refugee camp life. Although it would be impossible to avoid problems with volunteers completely, the group felt that improvements could be made in the recruitment, selection and orientation procedures so that problems can be minimized.

A trend noted at the workshop is that the agencies now prefer to send volunteers who can make long-term commitments (six months to one year) to development work in the refugee camps. The greater the cultural difference between the helper and the helped, the longer the helper needs to stay in order to adapt and to become useful. Short-term volunteers can also be useful, however, for specific assignments or tasks. For instance, they could work during the period of evaluation while it is being determined whether a project is worthwhile for ongoing agency involvement.

Recruitment

A number of different channels have been used for recruitment. Most of the voluntary agencies have contacts, established through the years, with their own religious groups or other associations, such as universities or medical schools. For example, the American Red Cross uses its chapters throughout the country as recruiting forums. Some of the voluntary agencies have contracts with university groups or other institutions to provide specific services in the camps. An example is the International Rescue Committee's arrangement with the Oregon health department to provide sanitation services. A third recruitment channel is the common data bank, such as the NCIH Cambodian Refugee Health Clearinghouse. The Clearinghouse's pool of qualified and available volunteers assures supply in a coordinated manner. It also eliminates the need for the volunteer to make duplicate applications with multiple agencies. The Clearinghouse has established contacts with numerous professional and educational associations so that special recruiting needs can be quickly met.

Selection Criteria

Recruiters employ various criteria in selecting the volunteers. Objective criteria include professional or technical credentials, experience in various kinds of medical settings, prior overseas experience, language capabilities, and commitment to long-term service (minimum of three months). Physicians and nurses who practice general medicine and primary health care are preferred over specialists. Experts tend too often not to listen to the lower level people in the field who may have needed practical solutions. Language skills are very useful to bridge cultural differences. Communication, even with the interpreters, was difficult for the volunteers.

The workgroup noted that subjective criteria for selecting volunteers are also important. If at all possible, candidates should have personal interviews scheduled. The recruiters are interested in the volunteers' attitudes toward the refugees and the host countries as well as in their reasons for volunteering. Because relief work is so stressful, an attempt should be made to evaluate the psychological stability of candidate volunteers.

Orientation

Orientation should stress sensitivity to the Khmer and Thai cultures. We cannot impose our philosophies on the refugees or the host country. For example, wearing inappropriate clothing can be very insulting. It would be impossible to train volunteers medically for the health problems they will find in the refugee camps, but they can be oriented to the conditions they will be living and working under. Volunteers should be informed about appropriate immunizations and common sense health practices for themselves.

The workgroup felt that the mechanisms for orientation should be formalized and that there should be greater sharing of information among volags. An "institutional memory" needs to be developed to facilitate the sharing of field experiences. Orientation ideally should have two stages: stateside sessions for two to ten days and in-country sessions for a day and a half. The participants believed that the UNHCR and CCSDP should provide better orientation courses than is now the case.

SPEECHES

ICRC AND FACING REALITY

Bjorn Zetterstrom, M.D.

I really think that you know already most of the International Committee of the Red Cross program in Thailand, so I will continue a little bit where we left off yesterday with our list of problems. The problems seem to be "why hasn't anything been done sooner?" There are, of course, many possibilities to go from that thought, I know. I have a suggestion, something like: please give me the strength to change to the better that which I can, please give me the courage to live with what I can't change and above all please let me realize the difference. That is something that could be applied everyday in your work abroad, and everyday, I am sure, in your work at home. Now, my feeling is that it is very, very difficult to speak about medical work in any developing country as the one and only item on the agenda, because so many things make differences. Above all, as we touched most of the subjects in groups yesterday, there are many differences in religion, culture and politics. The difference is between what you expect and the ability to face reality, which is something you could wish from every single individual, every single organization.

Now, let me tell you a small story, a true story, and a rather sad story about Afghanistan, where, as you know, there is an enormous percentage of malaria in the southern districts. In the beginning of the 1970's, there was about a thirty percent incidence of enlarged spleens in children under 12 years of age. Two organizations had started a malaria eradication program. They employed a number of nurses and they took them out to the villages to treat malaria with chloroquine. They rented a house in each of these districts and they agreed on a symbol for this project. The next step was that they brought the nurses to the districts with the drugs, of course, and they started advertising on TV, in the newspapers, and on the radio, and tried to get as many people as possible to the centers.

Now, nothing much happened. After about 3 months, the percent of people attending was about 2.5% of the population in these districts and, of course, far less than they expected. So it seems that at this point, they studied a little bit about Afghanistan in the different books that were available to them and they found that the average income was about \$64 and that the illiteracy rate at that time was over 97% for males and almost 1;00% for females, making it clear that TV was not a proper medium and that it was not even possible to reach the people through the

Dr. Zetterstrom was the medical coordinator for the Cambodian refugee camps in Thailand for the International Committee of the Red Cross.

newspapers. So they sat down and re-evaluated the situation and arrived at the decision that a poster would be the best thing to construct because that would reach everyone. So, the decision was to print the poster and divide it into three sections. They drew a room in which you could see a bed, a temperature chart going up and down, a man shivering and sweating in his bed, a lot of mosquitos buzzing around in the air, a window, a field in the background with two oxen hanging their heads and at the far end, a barn with just a couple of rats but nothing else. Now, the middle picture is with a beautiful nurse giving two tablets from her enlarged hand. The last picture on this poster showed this man running after the oxen, wheat and corn growing like mad and the barn absolutely full, the bed in the room empty, and, of course, the mosquitos dead on the floor.

The organizations displayed this poster on every tree, in every house in the district and everyone was happy for about two to three weeks until they started to count the patients again and found that not one single patient attended the centers because of the poster. Now this was, of course, really worrisome and so they brought in even more experts. The experts hadn't been there for many hours before they discovered that the language the people speak in Afghanistan is derived from ancient Persian, which is Arabic in a way, and even if you are illiterate, you read the same way literates do -- which in Arabic is backwards! This is no way to help people with malaria and it was never possible to repair this.

We make a lot of mistakes like that and we can give you many examples from Thailand. We misinterpret the situation. Say you have a young woman who has recently delivered a child with some kind of small defect that is not too impressive. You find that the mother rejects the child and, of course, we have seen such patients in our own countries. The diagnosis is rather fast and clear, so we call in our psychiatrists to try and help her out of this psychosis. Now, if the doctor had known a little bit more about Khmer culture, maybe he wouldn't have arrived at this diagnosis because he would know that the soul, according to the Khmer, will not settle into the body until 30 days after birth. The first month of the child's life the mother does not have the same kind of emotional attachment as we expect from mothers in the West.

This is only one side of it and there are many other examples of how things could go wrong. I would say that this is sometimes even more important than the knowledge of tropical medicine. To be interested, to try to learn as much as possible through the events you get on the spot as soon as possible and spend sometime on this because the time is well worth it and will make your work very much easier.

Thank you very much.

THE UNHCR VIEW

Gary Perkins

My name is Gary Perkins. I am in charge of the Washington Office of The United Nations High Commissioner for Refugees and again, as my colleague from ICRC, I think that most of you are well aware of what we are doing in Thailand. In many cases, ours is the easier program to manage. We are not working inside Cambodia. We are doing what we normally do, that is, to care for refugees across the border. This goes along with our definition of the refugee. We can assist in other circumstances when refugees are internally displaced and we have done that on a number of occasions. We don't face the problems of trying to bring our staff to Cambodia, as ICRC and Oxfam and others have. We have access to markets, we can purchase food in the area, and communications in Thailand are much easier. This is not to say that there are not a great number of problems in Thailand. I understand your comment yesterday about garbage contracts and corruption within the Thai government.

We have budgeted approximately \$98 million for our program in Thailand for the coming year. We are not hopeful that any kind of large movement of Cambodians will take place either on the basis of voluntary return to Cambodia or abroad. One would like to think that the international community would be scheduled to accept Cambodians abroad as they were of Vietnamese, but this is simply not the case. We do not have the financial nor the political support necessary to resettle Cambodians, with the exception of a few who have close relatives abroad.

We have been from the beginning criticized most justly in terms of the number of staff we have in Thailand. We now have more than 300 people on contract in Thailand. That represents for us a slightly bizarre situation. We have a total staff of 1,600 world-wide, and approximately 50% have been with UNHCR for less than a year and a half. To give you a further example of how the organization was expanded: since 1977, our entire budget was in the neighborhood of \$18 million; this year it will be half a billion. As you can see, this raises both internal and external problems for us. We have a large number of people brought in very recently, who don't know the UNHCR system. They bring with them a variety of skills, but these skills must be molded and be brought in, in some kind of coordinated fashion to the point where we can make maximum use of them. Now we are very cognizant of these difficulties but I would not want to raise any false hopes that UNHCR is going to continue to expand. We honestly feel that the 300 people that we have there are too many. They are involved in projects that should be done by the host government. We have a very large number of people that we care for in

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Thailand. We have an equal number of refugees in both Pakistan and Somalia. Our entire staff in Somalia is 37 people.

I spoke to the Asia Society last week. We talked for almost 2 hours on what will probably be the forthcoming decade of the refugee and, as one of the smaller points of preparation for that discussion, I picked up copies of the New York Times and encountered 22 stories on refugees or on situations which could produce refugees ranging from Afghanistan to Israel. In order to try and meet this tremendous challenge we have to mobilize and bring together a new consortium within UNHCR. It's extraordinary that, given budgetary cuts, the support has continued to come. In a conversation which the Secretary of State had with Dr. Waldheim, he advocated reduced budgetary allotments for the UN, with the exception of programs in international health. Now, we are pleased with that but we don't consider it carte blanche to carry on, and we are pleased that the support exists. However, we can no longer raise the funds that are necessary. We can no longer exist and continue to fund these programs in the hope that in January and February we will have one-third of the amount we asked for. When I talk of a consortium, I particularly think of the U.S. Unfortunately, it is happening elsewhere, but not in the U.S.

In October of last year, after he was in office for approximately one week, I went to see Ambassador Palmieri. We talked about a variety of things and it was certainly not a courtesy call. And he asked, "How do we go about taking care of the refugee situation in the future?" He also said that it is time to put forth a civilian disaster relief program. They do exist, especially in the military. The idea is that a standby group could put into the field approximately 10 - 12 experts in a very short space and time. I have spoken about this before and if you don't mind I would like to take two or three minutes to explain this for those of you who aren't aware of the concept.

When we are called upon to take over the responsibility for refugees, we normally have, if we have an office at all, a staff of about six, perhaps ten people. This is normal UNHCR operating policy and, as I have explained, we really cannot go beyond this on a long-term basis. Now refugee situations are such that one cannot point to a natural cause as cause for the displacement, very often of hundreds of thousands of people, so the only option is to point to ourselves. As a result, refugee situations tend to be dumped on UNHCR and other organizations. Things tend to happen very slowly. Governments do not create national bodies to take care of refugees. They will only do so after considerable pawing and pushing. The result yet again is that we find ourselves doing things and bringing in foreign personnel to work on problems which are not our real responsibility. We should be involved in coordination. We should be involved in protection. But, we find ourselves down at the docks to make sure that supplies don't disappear. We find ourselves doing a variety of things and paying very heavily for it, which should be the responsibility of the host government. That is precisely the situation in Thailand.

What we have seen in Southeast Asia is a breakdown of regional responsibility. We are spending somewhere in the neighborhood of 50% of our resources internationally on Southeast Asia. If you look at it from the eyes of an African government which has hundreds of thousands of refugees and has not insisted that they remain there only temporarily or that they move on, the imbalance becomes even more pointed. If you look at it from their eyes, the results are very clear. The results are less financial support.

We have to achieve a better balance in dealing with what I call civilian disaster relief. One of the main reasons this looked and continues to look like a very good idea was that if you can provide very quickly, literally within two weeks, a reasonable number of competent people who could get on with the job, you could derive some momentum. You will have, first of all, at the end of the first three weeks, a decent report, a decent plan of action which we can then take back to governments and which is worthy of their support. So right from the beginning we have a document that we can base our operations on. It's a document which our own office in that country would not be capable of producing because we have brought in 10 or 12 experts on anything ranging from health, sanitation, water, transportation, logistics, etc. At the end of that two weeks one would hope that the people would stay on and we could keep them in the field another month to establish continuity with the voluntary agencies to establish a reasonable schedule. Each agency could start bringing in their own people but also one would want to withdraw them long before the host government becomes used to the idea of international persons, who are terribly expensive and, as my colleague has mentioned, occasionally not totally aware of the customs and practices of that country.

Now I'd like to trace very quickly what has happened. It was felt that this was a very reasonable thing to get started, but it has come about to a very small extent in the U.S. We are now dealing with the Center for Disease Control (CDC) which has placed some teams in Somalia on contract with the U.S. Government. But this is really all we have to show for four or five months' effort. It really wouldn't cost that much. It is simply a matter of designating one or two agencies providing something in the neighborhood of sixty or seventy thousand dollars a year so that they could detail people who are available for this type of work, so that we could contact not only the voluntary agencies but private enterprise. If you want to drill a well in Thailand probably the best company to do it for you is Phillips Petroleum. If you want to establish computer lists, why not go to IBM; why not have a contact within IBM. They are willing to do it. Their personnel regard this as an interesting experience and for them personally it is a fulfilling exercise.

This sort of thing can be done. One would hope that the U.S. government would take a lead in this. I think there is a good reason they will. But having worked in the United States off and on for five years I must admit I am a little bit disappointed that we don't have this type of system operating. It is precisely what we all need and I speak of the voluntary agencies. In this country this kind of coalition isn't there. We were swamped with volunteers. We were all swamped with people, some of whom had only idealism

and enthusiasm to offer, some with tremendous background and training. To a certain extent, we were able to utilize these people, but to a large extent we were not.

Now I would like to leave you physically but with the problem which we have, I think, is a very real one: How, given responsibility but not authority, given very often funds but no real authority over how those funds are spent, you organize, in Thailand, some 30 voluntary agencies that are operating there, given the fact they differ in terms of size, program, in terms of particular political or religious concerns. How could you go about organizing? How would you coordinate --(it's a very nasty word, nobody wants to talk about coordination very much because no one wants to be coordinated) -- when everyone wants their own program and their own responsibility. We are criticized, occasionally applauded, concerned and we have the international mandate. The real authority to work with these people is not there and hopefully we can design a reasonable means of curing this, but someone has to be in control.

I think Thailand is probably the best and worst example of coordination. The first is how to best bring in new groups and how best to utilize old friends. The other is how to get everyone to work on these problems together. There is another series of options we have been trying and will continue to try. We tried and will continue to try to use volunteers, not only Peace Corps, but others, mixing enthusiastic people into an organization. It's not all that easy. We'd like to think that we can do it a little bit better than some of the other private and public bureaucracies. We'd like to think that this is because no matter how diplomatic or how polished the UNHCR representative is, sooner or later he is going to have a problem he simply cannot manage by discussing policy. He is going to have sixty to one hundred thousand people depend on him. We would like to think that this does separate the wheat from the chaff to a certain extent.

We are bringing people in; specialists on short-term contracts, volunteers. We would like to use individual agencies with particular expertise and have them operate under a UNHCR umbrella. UNHCR will provide support and funds as they are available. This has been done by individual agencies but we are looking more toward asking particular voluntary agencies. We are doing that in Europe. One of the interesting things one hears all the time in the U.S. is that this society's diversity is its strength. I think that is true, but nevertheless, at the core there must be some sort of central group to whom we can go and who can then reach us to tie together these very diverse groups of agencies.

Thank you.

POLITICS OF THE RELIEF EFFORT

William Shawcross

I haven't, I'm afraid, prepared a very formal speech of any sort, partly because I was a little concerned about the fact, which is obvious to me, that you all know a great deal more about the relief situation in Thailand and Cambodia than I do. I feel that I should be asking questions of all of you, rather than the other way around. I am hoping to write a book on the politics of the relief situation when I have collected material on it.

Perhaps I could start by giving a background of the political situation, what has happened in the last ten years, and what I think has been going on in the last few months and years that will determine what happens in Thailand. I personally feel extremely gloomy about the situation in Cambodia today. It is as bad or worse than it was a year ago, which is a horrible reflection on the extremely costly relief effort.

There is a story in the New York Times only this morning, which you may not have seen yet, by Henry Kamm, the Bangkok correspondent. The headline is "Cambodian Famine Said to Worsen Rapidly". The article goes on to say "the rice crop is used up and all indications point to a repetition of last year's catastrophic famine. The principal difference this year is the food appears to have run out even earlier than it did in 1979. The next harvest in Cambodia is not due until the end of the year, and indications are that it will be small." Kamm says Cambodians fear that they will have to abandon hopes of sowing their own crops and instead bring their families to the border for the rest of the year. It seems to me that the main thing we should be considering here for these two days is that this is not only an acute problem, but it is also a very long-term problem. It is not going to go away, in fact, it's going to get worse, both in Cambodia itself and in Thailand.

I'd like to go back briefly to the beginning and outline what is happening and suggest what might happen. As you all know, Cambodia until 1970 was at peace. It was a small country with seven million people. Nearly all of them were farmers and peasants who lived off the land and who celebrated their rituals of the year, the seasons, monarchy, and their church. The country was run by Prince Sihanouk rather effectively, and rather guilelessly. Some Westerners found him difficult to take seriously because he starred in his own movies, directed them, and had a rather well-publicized sex life.

He was very effective in playing off the Vietnamese and the United States which was the only way to keep Cambodia out of the Vietnam war, which expanded

Mr. William Shawcross is the author of Sideshow, a report of the American involvement in Cambodia, 1970 - 75.

through the sixties. The Cambodians, traditionally a tiny people, since the 14th century have been caught between Thailand and Vietnam. The Vietnamese came back from China and the Thais marched in from the West and gradually encroached upon what is now Cambodia. So by the middle of the 19th Century Cambodia would have virtually disappeared if the French had not arrived and imposed a protectorate, which lasted until 1954 when the French left Indochina. Cambodia was given independence and Vietnam was divided at the Geneva Conference into South Vietnam and North Vietnam. Sihanouk was ruling Cambodia in 1954 and continued to do so until 1970. He reckoned that the only way a country of six million people could keep out of the Vietnamese war was by not confronting the Vietnamese. He played off the Vietnamese (who numbered 48 million in those days) and the Americans by allowing the Vietnamese Communists to establish base camps across the border in Cambodia and allowing the Americans to conduct occasional hit-and-run attacks on those bases. This all changed in 1969.

It began to change when the Nixon Administration began a massive policy of bombing the base camps (illegally--this was not approved by Congress) and pushing the Communists somewhat further into the country. Sihanouk was overthrown by the right wing in March 1970. General Lon Nol, Prime Minister, brought Cambodia into the war on the American side against Hanoi. Over the next five years the problems spread right across the countryside. Mr. Nixon described the U. S. bombing of Cambodia as the "mad man" theory of war. He said, "I want the North Vietnamese to think there is a mad man in the White House, with his finger on a nuclear button and Ho Chi Minh himself will be in Paris in two days begging for peace." (Sideshow, p. 90) A problem with this theory is that reputations for irrationality have to be established, and that can be done only by irrational actions.

Throughout the period 1970-75, three to four million people fled from the countryside. They fled from agricultural systems to the towns, fled first from the bombings and then from the growing cruelty of the Khmer Rouge, a group which had not existed in any political sense in 1970. The Khmer Rouge was a group with about 4 thousand guerillas, led by a tiny clique of French educated Marxists,-- intellectuals educated in Paris in the 1950's-- who had come under the influence of the French Communist party, which was an extremely Stalinist organization in those days. They had gone back to Cambodia and found it impossible to live among the Sihanouk sympathizers. Gradually they had gone off into the countryside and formed a maquis. But only, as I say, about three or four thousand, with no hope of winning political power in 1970. They grew on the entrails of the war, as it were, and they came to power in 1975 rather like the Bolsheviks came to power in Russia in 1917 on the destruction of the war of the previous years. By the end of the war, half of the population were in cities as refugees with total dependence upon American food aid. Furthermore, before the war Cambodia had had a lot of food for export but by the end of the war the agricultural system had been completely destroyed by bombing and neglect.

The Khmer Rouge took over in 1975 and began to rule the country with a philosophy which is still of interest. In many ways, the atrocities were almost unbelievable. I'd like to read you one quote from a United States aide stationed in Phnom Penh. When the Americans left in 1975 this is what they recorded in their final termination report. "If ever a country needed to beat its swords into plowshares in a race to save itself from hunger, it is Cambodia. The prospects that it can do so or will do so, are poor. Slave labor, and starvation rations for half the nation's people will be a cruel necessity for this year, and general deprivation and suffering will stretch over the next two or three years before Cambodia can get back to rice and self-sufficiency." That was written in April, 1975 and it was an extraordinarily prescient report of the problems to come. None of us could foresee the awful cruelties. The Khmer Rouge would enter the cities at gunpoint and force the people back to the land, returning Cambodia, they said to year zero. Their aim was to create a totally new Communist agricultural society in which there would be no city life whatsoever. The only rational thing I can say about this plan is that they wanted to rebuild the agricultural system and then construct a new industrial society. How successful they were in rebuilding the agricultural system is still not known. Often their plans were absurdly grandiose, and they built huge dikes, dams, resevoirs, ditches and canals. Often, they were unconnected with each other and many of them were abandoned since the Vietnamese invasion. At any rate, however much rice they did begin to produce through the 1975 to '78 period, very little of it got to the people. It seems that almost 6 1/2 to 7 million people were living in Cambodia in 1975; maybe 1 or 2 million people died under the Khmer Rouge's executions (anyone associated with Lon Nol or Sihanouk), and of disease and starvation. This is an extraordinary mass execution, unequalled since World War II. Then, in January 1979, Vietnam invaded.

The Vietnamese, in the beginning of the 1970-75 period, had helped to build up the Khmer Rouge to fight Lon Nol and to fight the Americans. The Cambodian army in Cambodia helped to take pressure off of the Vietnamese themselves. By 1973, the ancient hatred between the Vietnamese and the Cambodians broke out between the two Communist parties. The Khmer Rouge (the maquis) matched them and began to slaughter anybody whom they suspected of being unpatriotic and sympathetic to Hanoi. Hanoi tried to impose its own Cambodian leadership upon the growing Cambodian Communist movement and failed completely.

One of the reasons for the evacuation of the people from the cities in 1975 was because the Khmer Rouge tried to protect themselves from Vietnam, and the possibility of Vietnamese infiltration. The Khmer Rouge, during the period 1975-79, attacked the Vietnamese across the border and treated the Vietnamese villagers across the border with the same contempt and disregard for life that they treated their own people. Vietnam finally invaded. The Khmer Rouge were allied with and supported throughout this period by China. China's own relationship with Vietnam got worse and worse from 1975 on. The Khmer Rouge were encouraged by the Chinese to attack the Vietnamese across the border. The Vietnamese finally invaded. There is no doubt, I think, that the

vast majority of the Cambodian people welcomed the Vietnamese invasion, after Pol Pot. The Vietnamese allowed people to find their own villages and tribes and retrace their steps from the gulags to which the Khmer Rouge had committed them. But as a result of this, very little planting was done last year. The planting season in Cambodia is from May through July. That's when the monsoons flood the countryside and a miracle, a natural wonder, takes place every year in Cambodia when the Mekong river reverses itself, and the great lake in the middle of the country overflows its banks and millions of acres are flooded and fertilized, and then the flood waters recede. This renders the country remarkably fertile, that is, when the country is used properly. But it wasn't last year. The planting was wretched; the crop was wretched. This was due to the Vietnamese invasion.

The Vietnamese and the government that they installed are run by Heng Samrin, a former Khmer Rouge colonel from the east of Cambodia, who was, I understand, a pretty brutal commissar himself, and who defected or was captured by the Vietnamese in 1978. They installed the government under him. They did not allow the international relief agencies to come into the country until July when ICRC and UNICEF were allowed to send one man each for three days. Finally, in September and October, 1979, ICRC and UNICEF began to set up the relief program in Cambodia and along the border of Thailand at the same time. As you recall, it was that period when masses began to stumble over the border to Thailand. Starving, listless, dying at enormous rates every day, they were taken to camps at Sa Keo and Khao I Dang. Meanwhile, Cambodia was totally devastated.

Since then there has been, as you know better than I do, twin relief programs run by the international organizations with the ICRC and UNICEF pushing food across the border to the Cambodians who come there. They are also pushing food through Phnom Penh. The Phnom Penh government was extremely reluctant to allow any food to be pushed across the border at first because that is where the Khmer Rouge had their installations. Last summer the Khmer Rouge had been pretty well defeated. There were only about 20,000 left. There were severe malaria conditions, and they were exhausted. Now, because of the international food aid across the border, they are rejuvenated and have over forty to fifty thousand people. They are well armed by the Chinese and by international food aid which is getting to the villages.

That is not to say that food across the border has not been important. It's been absolutely vital in keeping a large section of Cambodia alive -- the American Embassy in Bangkok says one million people. Whether it's one million or not, it is certainly several hundred thousand. The sad thing is that the Phnom Penh operation is still hopelessly inadequate. There are three problems, first of all that ICRC, UNICEF, OXFAM and other private organizations in Phnom Penh have not been allowed to send in very large teams. ICRC and UNICEF, for example, have 27 technical people in Phnom Penh at the moment, whereas in Bangladesh they had 140 people, with 300 to 400 local employees. OXFAM has about seven or eight in Cambodia. OXFAM went in with very high hopes at the beginning of the operation because they really played the Phnom Penh game and said they wouldn't move across the border into

Thailand. But UNICEF said they had to help both sides in the civil war and insisted on going across the border and, in the end, the Phnom Penh government accepted this. OXFAM hoped they would have greater access and greater possibilities of working in Cambodia by fitting more closely with the government's political demands. In fact, that hasn't happened. The OXFAM team, it seems, has become more depressed as time goes on.

Over the last couple of months Heng Samrin himself has been eclipsed somewhat within the government there and his place has been taken increasingly by the secretary of the communist party, Pen Sovan, a shadowy figure of whom little is known except that he is clearly more efficient than Heng Samrin (who had absolutely no administrative capabilities) and also more hard-line ideologically. He is a pro-Vietnamese bureaucrat. The organizations in Phnom Penh found their work a bit more difficult in the last few weeks as there is a new emphasis on political education. For example, the Director of Child Health was sent to East Germany and Moscow for three weeks of orientation on cooperative living and so forth. The entire staff of the Ministry of Health was sent off to Laos for two weeks in April for a solidarity session with their Laotian counterparts. The Ministry of Health, which is still one of the most inefficient organizations in the country, ground to a complete halt.

The Vietnamese and the Heng Samrin government have made the most of the fact that the Khmer Rouge murdered all but fifty of Cambodia's doctors, that there are only about fifty Cambodian doctors left in the country. This may be true, but if so, it makes it even more astonishing that they have refused to let in foreign doctors. There are a lot of medical organizations, as you well know, that want to send in medical personnel. It was only this February that they finally allowed ICRC to bring in a couple of teams of Russians and Hungarians and East Germans. They're talking about a few hundred Cuban and Vietnamese doctors. There are probably about 200 to 250 doctors in the entire country, which is ludicrous for a country with five million people that has suffered such extraordinary deprivation. At the same time, ICRC and UNICEF have been told they may have to replace their personnel with Eastern European and Soviet personnel.

There have been charges of fraternization. One OXFAM driver recently was called up before a Minister, if you can imagine, and was accused of driving the OXFAM team around Phnom Penh at night so that they could flirt with girls. It is these kinds of absurd allegations that are making the relief effort more and more difficult.

UNICEF put out a report in the beginning of May, 1980 in which they reckoned that 35,000 tons of food are needed every month. The truck capacity in the country is only about 15,000 tons. That's an enormous shortage in food alone, and it's not food alone that's needed. They have to distribute seed at this time as well. Food without seed means there will be no harvest this year. There is no way in which the 35,000 tons -- that is a minimum ration of 400 grams of rice a day -- is going to be met and it's not being met. Food is getting into the country, into Phnom Penh, and food is being brought in by ship to Kompong Som by a very good experienced group of Soviet stevedors. But

it isn't getting out into the countryside, partly because, as I said, of the still inadequate logistics. The roads have not been prepared at all since last year and the journey from Phnom Penh to Battambang takes about four days. It's chaotic still. Those numbers show inevitably that a) there is already and there will be increasing shortages of food and b) the harvest this year is going to be wretched also. I have here an OXFAM report from about the beginning of May about the nutritional status of children. The report says the figures for the nutritional status in the provinces are extremely alarming. From a total of 3,000 children examined, 26% were malnourished and 34% were on the borderline of being malnourished. This situation has been treated with great seriousness. There is a lot of underlying evidence that people in rural areas have not received their adequate food for months. Food is getting to the country, and it's getting to the cities and towns. But, for whatever reason, it is being given to the government workers, not to the peasants and the poor.

On the Thai border, as you know better than I, the situation is amazingly confusing. I was there in February and I was struck by the lack of coordination between the international organizations and the PVOs. There is warfare between the international organizations, the PVOs, and the American Embassy; these three groups are all at each others throats. The American Embassy uses the PVOs against the international organizations. The relationship between the American government now and UNICEF, in particular, and the UNHCR is atrocious. I talked to senior officials in Geneva last month. They spent a great deal of time attacking and abusing the head of UNICEF, Jim Grant, who I think it is true has been overly optimistic. Mr. Grant was a U.S. AID Administrator in South Vietnam in the sixties, who always saw the light at the end of the tunnel, and he seems to do the same with the North Vietnamese today. It is a remarkable transformation, in a sense, but he's too optimistic.

This leads to another question which I think all the organizations should be considering, both international and private organizations, because this will be a long term program and because, as The Washington Post pointed out today and yesterday, there are other disasters that require similar attention. That's a question of credibility. The international organizations, particularly, and OXFAM and possibly some of the American private organizations, I think, bent over backwards to minimize the problems. Certainly they did this at the end of last year when there were lots of stories coming out about the problems with food distribution. Through the 1975-79 period when the Cambodian refugees came out with horror stories, people wouldn't believe them at first. Now it turns out they were telling, if anything, less than the truth. The truth was more awful than they described it. They have been very reliable reporters, ever since last summer when they started coming out describing the shortages of food. Last December, just before Christmas, a senior official from the Cambodian Ministry of Commerce crossed the border and ended up in Khao I Dang. He had been in charge of the reception committee of international aid. He told Red Cross officials that at least part of the aid was being taken away and nobody was seeing it ever again, that about 40% was being stored, and only 5% was being distributed to

the population. Instead of doing anything about this; what happened was that the ICRC took him to UNHCR (this was done on a very high level) and he was spirited out of the country. He jumped all the lists, quotas, and he was taken out of the country, to Paris. The story was written up in a memo marked "confidential" and it was suppressed.

ICRC and UNICEF continued to demand little control. This was a very serious mistake. It raises the serious question of the credibility of the organizations. Given the claims of the rest of the world and the scarce resources of the relief organizations, the least the organizations can do is be candid with their contributors and supporters. I don't think that has happened.

TECHNICAL REPORTS

PUBLIC HEALTH/SURVEILLANCE ISSUES
IN CAMBODIAN REFUGEE SERVICE IN THAILAND

Phillip Nieburg, M.D.

TASKS PERFORMED BY CDC STAFF ASSIGNED TO
THE INTERNATIONAL COMMITTEE OF THE RED CROSS/THAILAND

November 1979 - February 1980

SURVEILLANCE: Collection, Analysis, Interpretation, (Response)

SURVEYS

INFECTIOUS DISEASE CONSULTATION

OUTBREAK INVESTIGATION(S)

SCREENING

INFORMATION DISSEMINATION: Local, to Bangkok, between Camps

PROGRAMS

Recommendations

Immunization, Tuberculosis, Malaria

Implementation

Sanitation, Nutrition, Education

Priorities

Dr. Nieburg is employed by the Center for Disease Control in Washington, D.C.
He worked as an ICRC epidemiologist in the Cambodian refugee camps.

SOCIOPOLITICAL AND HEALTH DATA - SA KEO, KAMPUT AND
KHAO-I-DANG KHMER HOLDING CENTERS, THAILAND

November 1979 - February 1980

<u>SA KAE0 (KAMPUT)*</u>	<u>CAMP(S)*</u>	<u>KHAO-I-DANG</u>
Khmer Rouge	Political group	Khmer Serei
55 km (8 km)	Distance from border	12 km
Military (?)	Community organization	Elected leaders
Barbed wire	Camp security	No fences
28,000 (2500)	Population (1 Feb.)	112,000
7% (<1)	% < 0-4 years	10%
6% (1)	% ≥ 45 years	-12%
1.05 → 0.02 (0.87 → 0.05)	Mortality rates (deaths/1000/day)	0.16 → 0.02
56 → <10 (?)	Deaths (%) outside hospital	0

16.1/1000	Crude birth rate	49.6/1000
	Fertility rate	
2,510	Mean birth weight (gram)	2810 through 12/16
170/1000	Neonatal mortality rate	50/1000

2.7 → 1.5 (9.3 → 8.0)	Admission rate (No./1000/day)	3.8 → 0.9
52% → 17% (71% → 14%)	<u>P. falciparum</u> prevalence (%)	4%
12% → 9% (?)	% Malnoursihed (< 80% ht/wt)	6% → 1%

* Data from Kamput are presented (in parenthesis) only if different from those of Sa Keo

AGE-SPECIFIC MORTALITY RATES* - SA KEO, KAMPUT, KHAO-I-DANG

November, 1979 - January, 1980

Age (Yrs)	<u>SA KEO</u>		<u>KAMPUT</u>		<u>KHAO-I-DANG</u>	
	8-18 Nov	8 Nov - 30 Jan	15 Nov - 28 Nov	15 Nov - 30 Jan	21-28 Nov	21 Nov - 30 Jan
0 - 4	1.11	0.42	1.42	0.26	1.08	0.17
5 - 14	0.28	0.07	0.36	0.11	0.05	0.01
15 - 44	0.18	0.06	0.75	0.15	0.03	0.02
≥ 45	0.87	0.31	-	1.13	0.22	0.05
All	0.30	0.10	0.74	0.76	0.76	0.03

* Deaths/1,000 people/day

ASPECTS OF NEONATAL MORBIDITY AND MORTALITY
SA KEO, KHAO-I-DANG

October 28 - December 16, 1979

<u>Camp</u>	<u>Period</u>	<u>Hospital Births</u>	<u>Mean B. Wt.</u>	<u>Deaths No.</u>	<u>%</u>
Sa Keo	28 Oct. - 16 Dec.	71	2.51*	12	17
Khao-I-Dang	25 Nov. - 16 Dec.	154	2.81	7	5

(p < 0.01)

* 7 infants who died were not weighed

RANDOM SURVEY OF STOOLS OF 200 CHILDREN 15*
AT KHAO-I-DANG

December 1979

Positive for at least one parasite	73.5%
Hookworm	59.5%
Ascaris	33.0%
H. Nana	11.0%
Trichuris	5.5%
Clonorchis Sinensis	1.0%

*Most 5 years

OUTPATIENT DIAGNOSIS IN KHAO-I-DANG, IN A THAI VILLAGE,
AND IN AN INDONESIAN REFUGEE CAMP

October 1979 - January 1980

Camp	<u>KHAO-I-DANG</u>	<u>THAI VILLAGE</u>	<u>INDONESIA*</u>
Date(s) No.	Jan 29-30, 1980 2122	Jan. 1980 90	October 1979 18000
<u>Diagnosis</u>	<u>%</u>	<u>%</u>	<u>%</u>
Upper Respiratory Infection	24	25	24
Skin Problem(s)	8	?	25
Fever Unknown Origin	8	} 6	-
Malaria	6		2
Diarrhea	8	7	18
Anemia	7	4	?
Nutritional disease	4	7	5
Allergy	<1	?	10
Tuberculosis	<1	?	<1
Parasites	3	?	<1

* data from Ahtone, J: Indochinese Refugees. Presented at CDC Epidemiology Seminar, 2/26/80.

Suggestions for Improvement

1. Prevention vs. Care

Cambodia/Thailand vs. U.S.

diarrhea/sanitation, nutrition (sterility), infant mortality,
vaccine preventable diseases
tuberculosis/malaria

2. Number/types of people

3. "Myths" and/or priority problems

- a) parasites
- b) multivitamins
- c) "milk" - infant formulas
powdered milks

4. Goal-oriented self assessment(s)

MENTAL HEALTH PROBLEMS,
CAMBODIAN REFUGEES AND PERSONS INVOLVED IN THEIR
RELIEF, REHABILITATION AND RESETTLEMENT

David N. Ratnavale, M.D

I cannot imagine that there is anyone in this room who disputes the existence of mental health problems among displaced persons and especially the refugees from Cambodia. Yet, as I listen to those of you who have spent time working in the camps I can't help feeling that there are more depressing problems among the groups responsible for the refugees than for the refugees themselves, and I was beginning to wonder if I should recommend some form of group therapy for the "Gang of Four"* and the CCSDPT* at least for a start.

The fact that interagency disputes are fierce does not strike me as surprising and I'm sure that such dissonance has its roots in emotion and tension. It is inevitable that tension and emotion will prevail in a setting such as the border zone between Thailand and Cambodia where people from different cultures with different loyalties attempt to work in concert under stressful conditions.

Actually, I would like to develop with you the idea that the mental health needs of the refugees can be significantly influenced by the attitude and psychological mindedness of those persons ostensibly involved in their relief, rehabilitation and resettlement.

Judging from the reports of personnel working in the camps and from the refugees themselves, there is agreement that mental health problems are considerable. But before I begin to discuss some of the psychological problems that refugees seem to be facing, it would be helpful to examine the impediments briefly to acknowledge that they exist and hence to the relative lack of services which address them.

Dr. Ratnavale, Professor of Psychiatry and Behavioral Science at Eastern Virginia Medical School, is a Distinguished Visiting Scientist at the National Institute of Mental Health (Department of Health and Human Services).

* Gang of Four - referred to by an earlier speaker to indicate key international agencies involved in refugee work in Thailand (UNHCR, ICRC, W.F.P. and UNICEF).

* C.C.S.D.P.T. - Committee for Coordination of Services to Displaced Persons in Thailand, which meets monthly.

Firstly, there is that common human tendency to deny the presence of emotional pain because it creates within us considerable anguish and a pressure to do something about it. When we are at a loss to know exactly what to do under such circumstances, it evokes a sense of helplessness which is far from comfortable. Then there is the well known tendency to believe that if one ignores a problem long enough it will cease to exist.

Regrettably, even medical workers are often ill-equipped to deal with the psychological crises occurring in their patients and have the tendency to medicate too quickly or to exaggerate the physical over the mental - which is after all just another way of overlooking the emotional issues.

Information concerning the mental health needs of persons under severe stress comes to us from a number of sources including our experiences with natural and man-made disasters, wars, famines and starvation. Furthermore, we have begun to take a more open and honest look at the whole meaning and experience of death and dying, as well as the psychological stresses inherent in the work being done in hospital emergency rooms, neonatal units, pediatric oncology wards, burn units and the like. Fortunately, the focus has been not only on the patients or victims undergoing serious stress but also on those persons who work with them under very trying and emotionally hazardous conditions.

We also have the benefit of our experience with other refugee movements and especially the refugees from Vietnam who have settled in the U.S. since 1975.

Several months ago the Alcohol, Drug Abuse and Mental Health Administration (ADAMHA) arranged a consultation with several mental health professionals who have had direct involvement in mental health service, training and research programs involving Indochinese refugees. Many of the consultants were refugees themselves offering insights not available to most of us.

In 1975, the National Institute of Mental Health (NIMH) dispatched two experts to Guam for the purpose of making an assessment of the mental health needs of the Vietnamese refugees who at that time were enroute to the U.S. for settlement. The experts came back with several recommendations focused on prevention and management of predictable mental stress. I regret to say that none of their recommendations were taken seriously, but all of their foreboding predictions came true.

The Indochinese consultants to ADAMHA came up with several observations and recommendations. They are all consistent with our own observations, and I will read out some of the important findings:

- Indochinese refugees in the U.S. are a high risk group from a mental health standpoint - and certain segments of their population are more vulnerable than others.

- Community support systems are essential for the maintenance of mental well being - for the group as a whole and for every individual in the group.
- The Indochinese refugees are experiencing difficulties in acculturation - as have all other "visible" ethnic and racial minorities.
- The Indochinese patients are not adequately utilizing the existing mental health systems and that culturally appropriate techniques need to be developed.
- The dispersion policy has led to a secondary migration within the continental U.S. This could have been anticipated.
- The training of outreach mental health workers to provide service to refugees in emotional distress is an essential need.
- Depression and depressive equivalents are common among Indochinese refugees as are anxiety syndromes, marital disharmony and intra-family conflicts.
- The refugees, especially the youth, are at great risk for finding diversion in drugs, alcohol and anti-social behavior.
- The spiritual needs are extremely important for people who are uprooted from their usual habitat.
- The refugees should be involved in developing service and training programs that would ultimately affect them.
- If one wants to really know about their mental health needs, ask them.

In late October of last year, ADAMHA set up a Task Force on Mental Health Needs of Refugees to explore the problems in general and specifically the situation in Southeast Asia. I was given the privilege of heading the Task Force and have worked diligently with some very dedicated and compassionate individuals.

The recommendations that we have made include: a systematic assessment of the problems which occur in the various short and long stay camps in Thailand and other countries of asylum. We also came to the conclusion that the ADAMHA Institutes could play a significant role in the following:

- (A) Providing consultation to the various federal and private agencies concerned with refugee mental health. (e.g., Office of Refugee Resettlement (ORR), Health Services Administration (HSA), and volags).
- (B) Conduct an in-depth survey and evaluation of programs already funded. (Earlier by Social Security Administration [SSA] but now by ORR).
- (C) Propose, develop and fund new programs for refugees related to service training and research.

- (D) Provide technical assistance to voluntary agencies.
- (E) Disseminate information regarding disaster assistance and emergency mental health services - crisis intervention, etc.
- (F) Provide training for professionals and paraprofessionals working with refugee populations here and overseas and help in developing innovative programs appropriate for these groups.

Though progress has been slow it is gratifying to see that more and more people in the administration are paying attention to mental health both from a preventative and curative angle.

When I inspected the new refugee camp in Bataan (Philippines), known as the "Refugee Processing Center", two weeks ago, I discovered that the UNHCR had actually assigned a senior social worker to assist the camp administrator and that other mental health oriented local and foreign staff were actively involved in camp life. I also found this to be the case in the Sham Shui Poh Camp in Hong Kong, run by the Hong Kong Christian Service - a very well run camp.

The focus, appropriately, is on morale, the mood of the refugee and the emotional climate (the psychological milieu) of the camp.

In some instances I learned that the people in charge seemed willing to overcome their individual biases and provide what was truly appropriate for the refugees (not their caretakers). For example, all the volunteer agencies involved in the resettlement of refugees in Bataan are Christian and naturally were more inclined toward building churches and spreading the Christian word. Despite resistance from some quarters the dwellers of the camp prevailed upon the administration and set about to erect a small Buddhist Temple on the camp grounds using wattle and daub for walls and thatch for a roof. The incumbent monks and other refugees shared with me their pleasure at this compassionate gesture - and even from my brief exposure I could see and sense that the temple served as a kind of magnet around which the people could gain some mental stability and peace of mind. According to the staff of the Sociocultural Affairs Unit of the Refugee Processing Center, the task of building the temple was one activity around which the three ethnic groups (Vietnamese, Lac, and Cambodians) worked collaboratively.

Such culturally relevant matters came up for discussion at a special session "Refugees and Mental Health" that I chaired at the Second Pacific Congress of Psychiatry held in Manila (May 12-18, 1980). The Session attracted mental health workers from Southeast Asia (Indonesia, Malaysia, Philippines, Taiwan and Japan) and helped to highlight the perceptions and recommendations of the people who lived in that region.

PSYCHIATRIC DISORDERS

Mental problems occurring in a refugee camp situation must be understood in the context of those which have pre-existed in certain members of the population manifesting in typical form, those which seem to have been aggravated by the new stressful and changing environment, and others still arising de novo or presumably precipitated by their present predicament.

It would certainly not be appropriate to label many of the emotional reactions of refugees as psychopathologic and requiring the services of a skilled psychiatrist - but unmistakably they are mental and emotional, involving the mind - and hence call for interventions that address them fairly and squarely.

There is, of course, the temptation to presume that many of the emotional reactions are transient and will pass after a while. The latter is partly true but the transient conditions require consciously articulated acknowledgement - for so often do we learn too late that the problems go underground so to speak, lead a subterranean life and stifle the mind of the person involved only to appear later in malignant form.

We can quickly dismiss (at least for today's discussion) the typical and common psychiatric syndromes - common it seems to all cultures - the psychoses: schizophrenia, affective disorder, mental retardation and organic syndromes - realizing of course, that all these conditions are worsened by the surrounding stress, lack of social and family support systems and in some instances the lack of maintenance therapy (as we are seeing in some of the Cuban ex-mental patients who have been sent here recently in boat loads).

As you well know, many chronic conditions are controllable in a community that is tolerant, accepting and therapeutic. Symptoms are fewer, less prominent and contained, because the patient has a place in that society and at least he has a sense of belonging. I need not explain why patients among the Cambodian refugees would feel unanchored and why their refugee status would seriously curtail their sense of safety and security.

There are also the 'culture bound' syndromes, mainly neurotic in nature - not uncommon in Southeast Asia - often described as exotic - but are far from incapacitating (with perhaps the exception of amok and koro, which are rare). In any event, the culture bound syndromes are contained within the culture, familiar to indigenous practitioners, usually transient and easily treated.

We need also consider the psychiatric syndromes that are secondary to medical and nutritional conditions. They would of course include the central nervous system infections, encephalitis, toxic states, typhoid, cerebral malaria, and the organic syndromes secondary to head trauma. There are also psychiatric manifestations of malnutrition, the vitamin deficiency diseases, the effects of various poisonous toxins and the like. Needless to say, few conditions occur in pure form, so that one would not expect to see pellagra or beri beri in their classical manifestations.

DISASTER RELIEF

The idea that disasters bring with them serious psychological stresses and reactions is neither new nor surprising. Relief workers are quite familiar with the emotional havoc that attends natural as well as man-made disasters and many are often quite adept at identifying reactions when they occur and providing effective psychological crisis intervention when necessary. Actually, a body of knowledge has been accumulating on the subject and many useful skills are being put into action every day by police, rescue squads, firemen and emergency room personnel. We also have available a fund of knowledge from wartime experiences and data that has been collected in some of the well publicized disasters including the Three Mile Island nuclear fallout crisis, airline crashes (Antarctic, Tenerife), persons held hostage, trapped in mines, school bus with children abducted - captives of all kinds.

The Jonestown tragedy in Guyana, the Nazi Holocaust, the Biafran war, mass refugee movements - Bangladesh, Cuba and Haiti are other examples, and it certainly looks as if there is no shortage of new crises that bring us face to face with human tragedy and especially the serious psychological sequelae. So it is no longer surprising to us when we learn that extreme psychological stress leads people to act in ways that are strange and/or seemingly inhuman. The phenomenon of cannibalism is one example, occurring in this decade among western people, worthy of note. Psychological stress would affect the Khmer as it would any of us but we cannot generalize about what one can expect in a given situation; how in fact is strain manifested in a given social group or for that matter, a particular individual? However, we are becoming increasingly knowledgeable about group and individual psychology and perhaps we are a little closer to learning skills and interventions which are preventative and prophylactic.

PERSONNEL AND VOLUNTEERS

No one doubts that personnel and volunteers working in the camps do so under some degree of stress despite their high motivation, dedication and initial enthusiasm. Yet attention to their own needs has not been taken seriously. Casualties are dismissed as being the 'rare case' or of no consequence.

One can understand why it is not easy for front line workers with a high sense of duty to acknowledge personal distress, and there is considerable resistance to the idea that we need a mental health plan for front line workers. After the San Diego air collision (1979) the fact that police and emergency workers needed counselling met with public outrage. They were told that as professionals, it was their job to work uncomplainingly and if it bothered them, they should be fired.

This might be an appropriate moment to focus on the question of the problems facing volunteer medical personnel working under the stressful conditions like those which exist in the camps. I do not mean here just the physical hardships of the lack of facilities that one is accustomed to,

rather, the psychological impact of the refugee situation on the persons involved in their care, support and treatment.

I have had some interviews with physicians and nurses who have worked in the camps in Thailand and have been struck by the psychological impact of their experiences. Those that I spoke to were fine, well adjusted individuals with no history of mental illness, nor did they have neurotic reasons for volunteering their services. They all acknowledged being mentally stressed while working in the camps, were open about their personal experiences and gave many clues to problems which might have been prevented, valuable pointers for persons involved in the selection of volunteer workers, without exception made a plea for more intensive orientation and training in psychological first aid. Very generously some of them shared with me their problems of "re-entry", that is, to their own accustomed social environment; which included sleep and eating disturbances, depression, suicidal thoughts, anxiety syndromes and obsessive rumination about what life was all about. This should certainly not surprise anyone.

Medical and other rescue workers are sometimes lulled into complacency because of a seeming calm in situations where one would expect crisis, and are themselves victim to the same denial and defensive mechanisms that all humans are prone to. Psychological wounds go deep - and one might not notice a surface scar. Rescue workers are therefore far more efficient in attending to gun-shot wounds, high fevers, and the obvious manifestations of food deprivation. For them there is something logical to do - a wound to sew, fluid to infuse into the veins, fractures to set.

But what of those psychological wounds that are slow to heal? Many rescue workers and those working with refugees know that they exist and have a normal human intuitive or emphatic sensitivity to what is going on and yet, often feel helpless to do anything tangible. When faced with more than one overwhelming situation their helplessness is heightened and in such circumstance one might expect that they can become more of a liability than an asset.

VOLUNTEERS

It should be emphasized at the outset that psychological disability among refugee relief workers varies from situation to situation. So much will depend on good screening, good orientation, and the availability of a therapeutic community on the scene of action, by which I mean good psychological support systems that all humans need for their mental well being.

Voluntary agencies have expressed some concern about their selection procedures and have reported some serious casualties. Not many, but enough to alert us. Some have in fact requested consultation from a few of us at NIMH. Others believe that we might offer workshops and courses in psychological first aid to all volunteers and especially to members of medical teams. Still others believe, as I do, that there is a definite place in the basic medical

team for a nurse or social worker specially trained in the area of mental health providing a counselling and supportive service to refugees as well as personnel.

I would strongly recommend the inclusion of the refugees themselves, provided that their needs do not pass unheeded.

Obviously the selection of effective volunteers is seen as a crucial matter. Almost everyone here has stressed it. It would be most interesting to know why people volunteer to work in disaster situations. We owe them a great debt. Yet many volunteers offer their service with unrealistic expectations and several expect to find a highly romanticized setting akin to what is depicted in the TV series M*A*S*H.

Some others seem to be responding to some exaggerated sense of guilt or other emotion and still others, believe it or not, operate out of a reaction formation to their sadism or have a ghoulish interest and curiosity in the aftermath of bloody violence and tragedy.

PROBLEMS FACING PERSONNEL: SOME OBSERVATIONS

- Exposure to gravely traumatized persons who are rendered helpless evokes in others a similar sense of helplessness.
- Helplessness can cause human beings to react with an array of responses which may be protective but may also be self-defeating or destructive.
- When overwhelmed by emotion which has been generated by witnessing fellow human beings who have been severely traumatized, there is a tendency to dehumanize them, to see them as different from us and thus to shield us from the pain which results from an empathic resonance with the feelings of those suffering persons. If the suffering persons appear at first glance to be different from us (in size, shape, color or feature) the tendency to dehumanize is further enhanced.
- Social support systems are necessary for the mental well-being of all members of society. Displaced and alienated people suffer from the lack of these support systems. This would be true not only for refugees but also for personnel working in settings unfamiliar to them, under stress and who to some extent experience a sense of being displaced and alienated.
- Personnel, being human, will manifest psychological stress in many disguised forms. This will be particularly prominent in persons who regard the acknowledgement of personal strain as being a sign of weakness or professionally unacceptable.
- A milieu that permits the acknowledgement by its members of experiencing mental strain is more likely to be therapeutic.

- Transient regressive behavior exhibited by personnel working under heavily stressful conditions is to be expected, regarded as normal and in the service of the ego.
- The impact of starving persons on people who have had no personal experience of food deprivation can be extremely profound.
- Personnel are more likely to acknowledge the need for mental health support sometime after the stressful experience is over. Their hindsight should be our foresight.
- Personnel who are not adequately oriented and have false expectations are more likely to become frustrated and disillusioned.

Therapeutic Approaches: Medical, Cultural, Spiritual

Dr. J.P. Hiegel, psychiatrist and Red Cross field coordinator in Thailand, has made an eloquent appeal for a serious assessment of the psychological problems facing the Khmer refugees, the need for front line mental health services and the importance of understanding their concepts of health and illness. In planning treatment procedures, he rightly advocates collaboration with traditional healers and recognizes the distinct advantage of clinical interventions which are a compromise between typically western approaches and those which are deeply rooted in the Cambodian culture. This of course requires a flexibility and sensitivity not readily found in western medical circles, where physicians are sometimes rigidly bound to a narrow focus or theory, have little or no exposure to ethnomedicine, to caste or class differences, or who are compulsively dependent on an array of back-up clinical and laboratory services available only in sophisticated and expensive academic settings.

One needs to pay attention to the special mental predicament of the displaced Khmers, their hopes, their fears and other psychological realities. We need to be clearer on what constitutes normality for these people and not be intolerant of ideas and beliefs which we do not share. We need to recognize the therapeutic value of certain social institutions which we take for granted in our own communities, such as the church, which addresses spiritual needs, and learn to translate them to communities where spiritual needs are addressed in different ways. In this context we should know that for the Cambodian people the Buddhist temple, the monks, the ceremonies and observances are significant supportive "structures" in their society.

We must help them recreate the social support systems so necessary for their mental well-being. We certainly need to be extremely cautious about labeling all behavior which transiently appears abnormal as being evidence of psychosis or as delusional, and we need to exercise restraint when it comes to prescribing tranquilizers, anti-psychotic and anti-depressive medications, bearing in mind also that when we do prescribe, the effective dose is lower than that needed for western patients.

At all costs one must support the family, or what's left of it, and other health-promoting social institutions, remembering that patients separated from their families are further endangered. We should bear in mind that "illness behavior" is culturally determined, that the language used to describe emotional distress may be focused on bodily functions - so that for instance, a complaint of "fire in the liver" might refer to anger and resentment and not to conditions which present with pain in the upper abdominal quadrants.

Cambodian patients, like their Southeast Asian cousins, tend to somatize their emotional stresses so that their aches and pains need careful assessment since they represent pain of mind and a disguised expression of emotional strain.

It must be realized also that hypochondriasis and somatization is not something contrived and aimed at fooling the doctor as some doctors tend to believe. Indeed it might just mean that the patient needs to make human contact - an excuse to be touched - a therapeutic pacifying and basic need familiar to all of us.

Above all our aim must be not to deprive the refugees of the technical skill which we possess but to adapt it to a system of health care delivery that is acceptable to the patient in his cultural milieu. This is entirely possible without having to compromise one's ethical values. We need only to be reminded of the efforts of the leadership in the People's Republic of China - where they have successfully blended traditional Chinese medicine with modern western medicine, where the traditional medicine practitioner has a status equal to his western medicine counterpart - and where the patients and the community at large are the beneficiaries of two sound medical traditions.

Now a final word about the trauma of starvation.

Starvation

It is well known that starved populations have an extraordinary impact on relief workers - the psychology of which deserves our close attention. Also, psychoanalytic explorations have amply demonstrated the significance of the early feeding experiences and their impact on human bonding, the development of basic trust and how feeding or withholding food can have far reaching psychological consequences.

The fact that very little scientific research has been conducted in the area of starvation and mental health signifies the resistance to such work. Animal studies provide some leads but the findings do not transfer easily to man. When one attempts to measure the impact of starvation on children, it is exceedingly difficult to separate food (nutritional) deprivation from maternal (emotional) deprivation.

Food/Reactions - Starvation

From a psychological standpoint, feeding and caring have equal value in our minds. This should surprise no one, since from the earliest moments of our life, being fed has represented attention to basic needs, to hunger and other pains - but above all to our sense of being wanted, worthwhile and deserving.

Hence it is no surprise that people who have suffered extreme food deprivation and have experienced all manner of trials in their search for food, are likely to demonstrate peculiar responses to food, feeding processes, and to those persons involved in providing and distributing food supplies.

There is a psychology about feeding that most Americans take for granted. For many Americans the question of three square meals a day is not a matter of conscious concern. Americans are constantly confronted with things to eat - if not in the grocery store window, then almost every ten minutes on the television screen informing them about what special foods they are missing or what one must eat to lose weight.

You will be interested to know that in 1979, nearly forty million American started on a food restriction diet.

In the affluent societies people don't have to line up for food though they may briefly stand in line to pay for it. For a great many people "what new dish shall I serve for dinner" is a real worry.

Is it any wonder then that American volunteers are deeply shocked when they see others who are nothing but skin and bone, the result of starvation?

As mentioned earlier, food exchanges are powerful symbols of communication - and "food-related behavior" is a clue to how one feels about oneself and those about them.

An example of "peculiar" food related behavior is the not uncommon finding that children who have been starved have episodes of food hoarding long after their food supplies have been re-established. Even with an abundant supply of food available to them and partaking of adequate regular meals, children stash away items of food under mattresses and in other hiding places. Such behavior has been seen in Vietnamese refugee children and children who survived the holocaust.

Starvation and malnutrition can have far reaching neuro-psychiatric complications. For example, it can be readily understood why malnutrition during pregnancy can complicate fetal growth and delivery. The child of a malnourished mother is usually born premature, suffers impaired brain development and a heightened susceptibility to disease. The malnourished mother has to cope with a "damaged child" but is ill-equipped to provide adequate psychological and nutritional care. Since lactation is usually curtailed under starvation conditions, nutritional needs and immunity to

infection (which breast milk affords) is further diminished, and the child is victim to all kinds of disease. Mother and child will also bring cognitive deficiencies into their relationship, disturbing the bonding processes so essential for mental growth.

The sequence just noted does not take into account other complicating circumstances like those which the Cambodian refugees have endured. Consideration should be given to such matters as the mood of the mother, the lack of social support systems, illness and injury which she might have suffered, her will to live and her reactions to the innumerable losses that she might have sustained. Quite apart from all of this, the child has so much to lose from his inability to evoke a satisfying response from his mother, when he wants to be caressed or when he experiences pain or hunger pangs. It seems likely that in such extreme conditions, the child is too weak to cry or the mother is too exhausted and preoccupied to respond.

We have no measures for assessing the psychological pain, helplessness and despair which a mother must feel as she watches her offspring wither away and die, especially if she has to bear the tragedy alone because family, social and religious supports are no longer available to her.

Embryologists, physiologists and developmental psychologists recognize that physical and mental maturation follows a predictable pattern and sequence and that there are critical periods in the human life-cycle when the organism is particularly vulnerable to damage. Any interruption of the sequentially programmed and predictable milestones distorts or delays mental and physical growth, and the earlier the interruption the more serious and long-lasting the consequences.

Researchers* have demonstrated that an interruption in the maturation of the central nervous system during the peak period of growth may leave deficits in psychomotor development which are not remediable even with adequate diet later on. They** have shown that malnutrition curtails cell division in the brain during the period of active cellular proliferation - prenatal and postnatal - usually from the second trimester of fetal life until the second birthday, and it is a widely held opinion that protein-calorie malnutrition at an early age is the principal cause of permanent retardation of mental development in children living in underprivileged parts of the world. This view is supported by evidence from animal experimentation - that food deprivation early in life irreversibly affects the physical growth and maturation of the brain cells which are in fact the material substrate of higher nervous activities determining mental capacity.

*Cravioto and Robles. **Winick.

Medical textbooks do not tell us how to treat starving patients and surely the psychological management of starvation victims is exceedingly complex. The spectacle of starving persons has an extraordinary psychological effect on those who behold it causing them to suffer anguish, anger, panic, guilt and a spectrum of emotions which can be incapacitating.

Rescue workers have noted that once the basic life-sustaining measures begin to take effect and the lifeless half-dead human organism starts to come alive, emerging from a mental state in which there appears to be no "ego" to address, to one where the individual begins to perceive a reality around him that he may react to his stark existential state with a peculiar mix of apathy and panic as he scans the surroundings for his human attachments. It is perhaps at this moment that emergency mental health nursing is required and that the first thing needed is the comfort of being held by human hands in a compassionate and caring manner. There is a need for a clearer understanding of these essential psychosocial emergency first aid measures, and we may have to go to the front line to learn about what is useful, effective and teachable.

Man stands supreme* among his cousins in the animal kingdom for cherishing his human attachments. He will go to any extreme to protect his loved ones or go to any length to make connection with them. He also makes attachments to pets and even inanimate possessions, regarding them narcissistically as an extension of himself or in some symbolic way his kinship between him and the universe.

As we sit here comfortably, we take our human attachments for granted. Only when we are faced with the prospect of separation, of goodbyes and loneliness as when lying in a hospital bed waiting for visitors do we stop to consider our special attachments.

We feel sad because the dog must go to the kennel when we take off a few days, and so we look for 'pet sitters' and even 'plant sitters'. We hate to give away old books and old clothes, old shoes, old saucepans, - and how we panic when we misplace that keepsake we received from a doting grandparent or first love. All of this is striking evidence of the attachments which provide the structure - the psychological base upon which we can move well-balanced, and in safety. These small, seemingly insignificant things add up to what we call home and life - our human and non-human environment. We can probably give up a great many of these things but when the chips are down, we realize that our personal attachments loom very large on the horizon revealing themselves as the lifeline carrying the electrical charge which generates our will to live.

* (and supremely vulnerable)

Conclusion

The Cambodian refugees have endured extreme pain and great sorrow. Some have lost nearly everything, yet somehow they seem to carry on living. We can marvel at their fortitude, but we must not forget that they have a lot of unfinished mourning to do; a lot of concealed rage to express, a lot of bitterness to dissolve - all this is a heavy mental load, extremely arduous and painful psychological work.

With the understanding and compassion that we possess we can appreciably assist them in this seemingly impossible task.

Just because we see them smile or even dance, let us not ignore or forget the psychological wounds which have not yet healed.

Thank you.

PUBLIC HEALTH AND SANITATION IN REFUGEE CAMPS

Michael McCracken

Introduction

Since the Oregon Public Health Officials' effort, which was one of the first groups to attempt to address public health problems in the Cambodian refugee camps in Thailand, we have gained much experience. Public health was totally neglected in the initial phases of these camps. As a result, the refugee population and the surrounding Thai population were exposed to potential large communicable disease outbreaks.

We found that, with good planning, minimal effort, utilization of available resources, and institution of simple public health measures, a complete personal health and environmental health change took place in the camp. The public health effort would have been much easier had it been a primary component of the original camp design and if it had been available when the camp first opened.

Public health must be given a high and immediate priority in refugee camps. The health of the majority of the refugees' health in a camp is dependent much more upon public health measures than direct individual medical care.

Examples:

1. There were many direct care providers in Sa Keo and little or no public health workers in the initial stages of the camp. As a result, privies were improperly constructed, garbage service was not organized, waste water disposal was not provided for, and drinking water was becoming contaminated. All of these things led to additional sickness and a tremendous fly problem.
2. Spraying of flies was looked upon as a solution. Unfortunately, the flies became resistant to all chemicals and, thus, basic sanitation measures had to be instituted. Obviously, this should have been done in the first place. As it was, if there would have been a major disease outbreak caused by this vector, there would have been no immediate measure available to kill the flies since they were resistant.

This report was prepared by Michael McCracken, Chairman of the Oregon Conference of Local Health Officials and Richard H. Swenson, a sanitarian who worked in the Cambodian refugee camps.

The original camp design must address public health considerations as they relate to the basic sanitation requirements and how they are constructed. Without looking at the entire camp and all the sanitary conditions together, the design of the camp will have major flaws that become very expensive to resolve.

Examples:

1. A non-public health person was in charge of sanitation for the hospital wards. Plumbing and sinks were installed with no regard for the disposal of waste water, thus causing more fly breeding.
2. Water bins were located throughout the camps without regard to the waste water generated from them, thus creating stagnant water and breeding more flies.
3. Bathing areas in the new section of the Camp were designed by an engineer. They were beautiful, but did not provide for waste water disposal. (He said that was the sanitarians' problem.)
4. A potable water system was constructed; however, the potable water became contaminated by sewage because one agency's responsibility did not match another agency's responsibility.
5. Without prompt and accurate epidemiological studies, disastrous consequences could occur, such as the incident in Khao-I-Dang. Young male adults were becoming ill and it was blamed upon the insecticide spraying. After epidemiological investigation it was found that they were experiencing beriberi because there was a problem with vegetable distribution in the camp.

Basic sanitation, communicable disease control and epidemiology must be funded by their own budget, and there must be a public health person in charge of all public health in the refugee camp including the hospital area. This person must report directly to the camp administrator.

Examples:

1. Cholera is present in many of the camps, but not yet in Sa Keo. The public health nurse is desperately trying to convince various officials to begin a mass cholera immunization to prevent such an outbreak, but she has not been successful. With separate funding for communicable disease control, the nurse could purchase the vaccine and implement the immunization program immediately.

2. When the flies became resistant to three of our chemicals and we needed a fourth, it took three weeks to obtain the chemical because agencies said they would buy it and never did. As a result, there was no way to have a quick kill of the tremendous fly population. With separate administration of the program, this could have been avoided.
3. One agency was willing to spend money on office equipment and fly paper rather than on improving the drainage system to reduce the fly population. Again, proper administration setting forth priorities could have helped the situation.

Public health issues must be addressed by persons knowledgeable in public and community health. Design of water systems, sewage systems, immunization programs, etc., are most effective when competent public health persons are in charge of the project. Public health people, because of their training and experience, tend to see the impact of systems upon one another rather than viewing a water system and a waste water system in isolation.

* * * * *

When there is a situation where refugees need to be located in a camp, the following actions should take place from a public health viewpoint.

1. A public health sanitarian would be a team member to help decide, along with government officials,
 - a. Where the camp is to be located, giving consideration to surface drainage, topographic features, accessibility and water supply.
 - b. The kinds of water systems, waste water disposal, garbage collection, etc., to develop.
2. Camp construction must begin by developing a housing area, a road system, construction of privies, and a water supply system.
 - a. It is crucial that privies and water supply be constructed before refugees enter the camp. Privies should be constructed in the ratio of one privy per 20 refugees, minimum, and they should be constructed under the supervision of the sanitarian to assure sanitary construction.
 - b. Garbage containers must immediately be purchased and altered so that they cannot be sold on the black market. The ration should be one garbage can per 40 refugees. A contract must be signed for the collection, removal and disposal of the garbage on a daily basis.

- c. Construct an incinerator or other safe facility to dispose of hazardous laboratory and hospital specimens and dressings.
 - d. Install a waste water and/or drainage system to eliminate standing water or sewage on the surface of the ground.
 - e. The public health sanitary engineer should oversee the construction and completion of the water supply system. There should be a minimum supply of 20 liters of water per refugee per day in hot climates.
 - f. Construct a rodent-proof facility to protect the camp food supplies.
3. A public health sanitarian and a public health nurse and, if possible, a public health doctor should establish a public health structure in coordination with the camp administrator to clearly identify its roles and communication links with the camp population, the camp administrator, the medical teams, the local government and agencies involved in the camp.
 4. The public health nurse should organize a system of screening refugees as they arrive and institute epidemiological and/or communicable disease measures as appropriate. Identification and medical record cards are to be given to refugees upon arrival. After the first screening, or during the first screening if time permits, appropriate immunizations are to be given. The public health nurse should keep an accurate population count for use by all agencies in such things as design of water system, sewer system, food supply needs for the population of the camp.
 5. Public health workers must have "hands-on" community development skills to organize the refugee population into specialized work crews. As soon as the refugee population is healthy enough, the refugees should be organized into crews for further camp development. Public health workers must have the support from the camp administrator in order to organize the refugees and to be able to offer an incentive to the workers (i.e., extra food, extra blankets, etc.). The refugee crews can work on things such as housing, construction of public buildings, etc. In addition, they can do maintenance operations such as testing water, cleaning and repairing privies, and general camp cleanup. The refugees could act as interpreters when possible, and all public health workers must be provided with a full-time interpreter and loud speakers so that information can be disseminated to the refugees.
 6. A minimum public health team should be maintained throughout the life of the camp. This team should consist of at least one public health sanitarian, one public health nurse and, if not otherwise available, one public health physician and one public health engineer. In the initial phases of the camp, of course, many more public health nurses and sanitarians would be needed.

Conclusion

Obviously, there is much turmoil, disorganization, and difficulty in planning and maintaining a refugee camp in order for it to be successfully operated. Since public health generally receives little attention, and yet is generally agreed that public health has a large contribution to make in these camps, international agencies should work toward having a responsible public health team.

This team should consist of at least two public health nurses, two public health sanitarians and, if possible, a public health physician and a public health engineer. The team should be available on call to go anywhere in the world with 24-48 hours' notice. The team doesn't necessarily need to serve on a long-term basis: it should be a response team. Long-term volunteers would then carry out the public health component in the on-going camp.