This article is author version published as

Oommen, V.G., Brian, M., Komersee, M.A., and Stephen, D. (2008) *Refugee Health Management: An International Perspective*. In: Proceedings Diversity in Health Conference 2008 - Strengths and Sustainable Solutions, Sydney.

KEY WORDS: refugee; health; disaster; health promotion; program.

Author:
Dr Vinesh G Oommen
Senior Project Officer
Institute of Health and Biomedical Innovation
Queensland University of Technology
60 Musk Avenue
Kelvin Grove, Brisbane, QLD-4059
Australia
Email: v.oommen@qut.edu.au
Phone: 07 31386124

Co-authors:
Dr Mark Brian[1]
Dr Michelle A Komersee[1]
Dr David Stephen[1]
[1] TIHC Centre, Eastern Mediterranean Region.

Refugee Health Management: An International Perspective

Author: Vinesh G Oommen, Institute of Health and Biomedical Innovation, Queensland University of Technology, Queensland, Australia.
Co-authors: Brian, M., Komersee, M.A., and Stephen, D. TIHC Centre, Eastern Mediterranean Region.

ABSTRACT

In an era of uncertainty, a sudden war can bring disastrous consequences to any country where by an inflow of refugees can bring about a health crisis and social problems. Many healthcare systems in the world are neither designed nor prepared for such a calamity. It is no wonder that some say that wars are not respecters of international boundaries and occur at the least unexpected time.

The Persian Gulf War that lasted for a year (1990-1991) between Iraq and the rest of the coalition force countries brought a huge economic burden on many countries. One of the main reasons for this was the vast amount of people that fled from Iraq due to the consequences of war to the neighbouring countries. It was estimated that about 1.5 million people fled Iraq during this war to neighbouring countries.

The aim of this manuscript is to explain the various systems that were put in place by the World Health Organisation during the Persian Gulf War to help people integrate into the various communities and cultures of various countries where they had sought asylum. A breakdown of the various components that make up an effective system to deal with such situations will be outlined. In conclusion, the manuscript will give an example of a case study, which demonstrates that it is possible to promote the health and well being of refugees if appropriate components are used.

INTRODUCTION

Each day millions of people are affected around the world by disasters. For various reasons, it seems that people in developing countries tend to be hit especially hard by disasters. Catastrophic events like war shatter lives and societies with such force that survivors, facing an uncertain future sometimes envy the dead. Wars show no respect for international boundaries and transgress boundaries of every kind. Immense human migrations, fleeing forces that terrorize their lives, generate displaced populations of refugees who must struggle to stay alive in unknown and often hostile territories. Resident groups and the newly arrived refugees attempt to coexist in the face of cultural and linguistic differences, and the inescapable competition for status and resources. The losses endured by refugees vary in kind and enormity ranging from more substantial costs, such as lives and property, to relatively insubstantial assets such as identity, status and dignity.

The Persian Gulf War, which lasted for one year (1990-1991), between Iraq and the rest of the coalition force countries brought a huge economic burden to many countries. One of the main

reasons for this was the vast amount of people that fled from Iraq due to the consequences of war to the neighbouring countries. It was estimated that about 1.5 million people fled from Iraq during the '90-'91 war into neighbouring countries. Moreover, about 2 million foreign nationals that were working in Iraq and its neighbouring countries fled to nearby countries like Jordan and Yemen.

The World Health Organisation and the United Nations plays an important role in upholding basic human rights whenever disaster strikes. Article 25 of the Universal Declaration to Human Rights clearly states that "everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control" (Forsythe, 2000). While the International Committee of the Red Cross plays an important role in managing refugees, the United Nations High Commissioner for Refugees is the lead agency in responding to such a crisis.

No healthcare systems in any country are prepared for an influx of millions of refugees as it has serious economical and social consequences. In order to help people during the Persian Gulf War, a number of systems were put in place to help refugees integrate into the various countries where they had sought asylum. One of the big questions that governments usually ask during a crisis is what makes up an effective system to tackle such an enormous emergency? Some of the important components that make up an effective system include the following:

System One- Evaluating and examining the situation:

During any crisis the first thing that organisations need to do is to examine and evaluate the current situation. This includes undertaking a needs assessment to find out what are the current needs of the refugees. Some of the questions that need to be asked at this stage include:

a) Are the 'basic needs' of refugees met? That is, do they have the basic necessities of life (security, food, water, shelter and sanitation)?
b) What are the 'present health needs' of the refugees? That is, do they have any injuries or mental health problems due to traumatic events? Are there any pregnant women? Are there any children who are injured or who have displaced their parents?

System Two- Inter-organisational communication:

In disasters, communication difficulties are often hard to separate from coordination difficulties and the greatest coordination difficulties are inter-organisational. Therefore, many of the communication problems are those related to inter-organisational information sharing. Even though the means for communication exists, for a number of reasons people are hesitant to communicate with others outside their own organisation. This happens when people do not trust others that are not from their own organisation. During a humanitarian crisis there are hundreds of people that depend on various government and non-government organisations for relief assistance. In such situations, individuals should stop playing politics, which is often called the "blame game", and work together to help people who are facing adversity.

During a humanitarian crisis, the most crucial types of information that need to be shared are those related to:

- an ongoing evaluation of what the conditions are and what countermeasures need to be undertaken;
- an ongoing determination of what resources are needed to undertake the countermeasures, what resources are available, how they can be obtained, what is their capacity, and how long will it take for them to arrive;
- a determination of what persons and organisations will be responsible for the various tasks necessary to accomplish the countermeasures.

System Three- Coordinating to provide adequate health:

It is not possible for any single organisation to provide health to all people during a crisis. Multisectoral collaboration is the key to its success. There are three key elements to good multisectoral collaboration. These are trust, understanding and respecting differences. Moreover, the need for collaboration arises from the diverse nature of the problems that arise during a crisis. During a crisis it is important for people to collaborate and work together, which will increase the likelihood of success of the various initiatives that are put in place. Furthermore good collaboration will lead to:

- increased access to resources
- more efficient use of resources
- enhancement of accountability
- development of improvements in the various programs that are put in place
- broadened awareness of what is happening
- lasting relationships
- sustainable development of activities
- broad sharing of responsibility for different activities
- stronger ownership by stakeholders
- use of strengths of different partners
- sharing of knowledge, expertise and technology

System Four- Capacity building:

Refugees typically represent an unexpected increase in demands on resources. Capacity building can be defined as a community's current ability (as opposed to inherent ability) to respond to certain pressures. Capacity building “encompasses the country’s human, scientific, technological, organisational, institutional and resource capabilities. A fundamental goal of capacity building is to enhance the ability to evaluate and address the crucial questions related to policy choices and modes of implementation among development options, based on an understanding of environment potentials and limits and of needs perceived by the people of the country concerned" (Halpern, 1992).

One must keep in mind that capacity building is much more than training and includes the following:

- Human resource development: the process of equipping individuals with the understanding, skills, access to information, knowledge and training that enables them to perform effectively.
- Organisational development: the elaboration of management structures, processes and procedures, not only within organisations but also concerning the management of relationships between the different organisations and sectors (public, private and community).
- Institutional and legal framework development: making legal and regulatory changes to enable organisations, institutions and agencies at all levels and in all sectors to enhance their capacities.

System Five- Community integration and respecting cultural differences:

In a society where people from different ethnic backgrounds live, community integration becomes a challenge for many people. The main reason for this is because, as human beings, individuals tend to stick with their own ethnic group and the ingrained concept of "our race" takes over. One must understand that the way in which people care for others is influenced by the culture and social systems in which people live. Without respecting other cultures one cannot achieve the United Nations initiative of "Health for All". This is one of the main reasons why we still have health disparities even among developed countries like Australia, United States and other nations. Most of the time community integration becomes a nightmare to many organisations because of the various double-edged policies that various governments of different countries have composed for their people. In many countries refugees are seen as a big burden because of the amount of resources they draw on. Even though governments of many countries have a legal obligation under the 1951 United Nations Convention on the Rights of Refugees, only a few countries ever follow them.

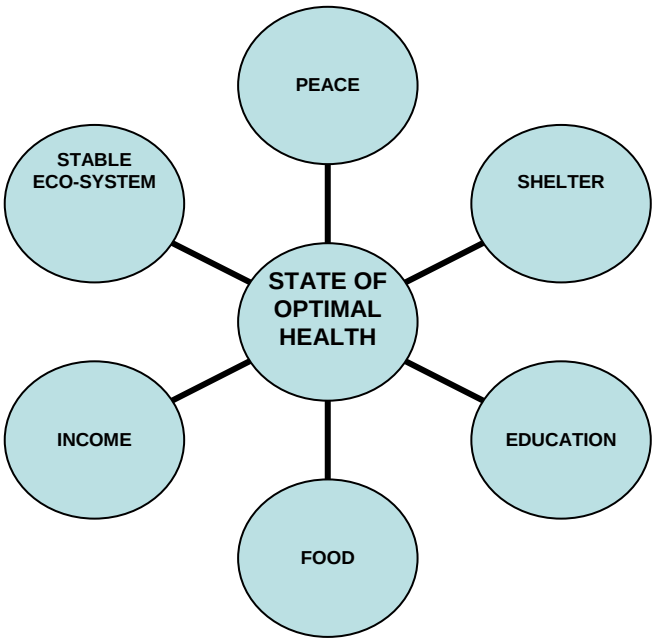
Providing culture-specific health is crucial in all societies. This attitude implies that, if people cannot tailor healthcare to the idiosyncratic needs of each culture represented in a community, then people should not tailor it to anyone. Certainly no individual healthcare professional can hope to understand how perhaps 40 or more different cultures relate to health and welfare; but it is not necessary that they should, if people just respected cultural differences and showed an attitude of willingness to learn about other cultures.

The importance of developing tolerant health services becomes obvious when people face up to the challenge of providing health services that are culturally sensitive. A health service that reflects just one ethos of healthcare cannot possibly satisfy the needs of a multicultural community. In addition, healthcare systems should also include the function of promoting health. Without this function, the health system becomes a system that exclusively relies on the care of illness and suffering rather than one that cares for health. A healthcare system that is based solely on scientific and medical knowledge cannot possibly function effectively and efficiently. A good healthcare system

is one that is culturally sensitive, orders care in different ways, comprehends different ways of communicating, provides different methods of healing, manages different responses to its attempts to heal and uses different mediums to promote health.

System Six- Satisfying the basic needs of life:

In any crisis management, all professionals should utilize the "Ottawa Charter of Health Promotion" as it is one of the most valuable frameworks that can be implemented to improve the health and well being of all people that are affected by calamites. The basic precept of the Ottawa Charter is that health promotion is a process to enable people to improve their health and well-being (World Health Organisation, 1995). In order to reach a state of complete physical, mental and social well-being, a person must be able to satisfy their basic needs as shown in the figure below:



In the Western biomedical model, illness is explained in terms of a patient's presenting pathophysiology. Sickness is often reduced to disease, and the focus is on the patient's body rather than on the whole person, where illness can be seen as the person's experience of being sick and is reflected in the person's thoughts, feelings and altered behaviours (Weston and Brown, 1989). Moreover, to understand a person's experience of illness, the healthcare professional must attempt to enter the patient's world to understand the patient's beliefs about what is wrong, why it happened, and what should be done about it. An equally important concept when working in culturally diverse settings is the need for a health professional to suspend their personal biases and judgements about those for whom he or she may be planning health programs. When people from various ethnic backgrounds live together in a community, it is imperative that one must be open to the possibility of encountering unfamiliar beliefs and concepts about health and disease and must be willing to cast aside any personal bias (Perrone, Sockel and Krueger, 1989).

Even though many countries had taken a huge amount of refugees during the Persian Gulf War, the number of countries that have actually implemented all the components that make up an effective system is questionable. Usually a good number of healthcare organisations that are entrusted with the various healthcare programs that deal with refugees fail to evaluate these programs due to the lack of resources that are available to them, or due to various political pressures.

Evaluation is critical to any healthcare program whether it be for refugees or for other people in the communities. The following case study that as explained below demonstrates the "Living a Harmonious Life" program that was developed for Iraqi refugees during the Persian Gulf War.

"Living a Harmonious Life" (LHL) program:

The LHL program was one of the many healthcare programs that were used by non-government organisations in Jordan to help people integrate into the various communities during the Persian Gulf War. Jordan is a small country compared to its neighbouring Arab countries with a population of about 5 million people. Jordan has the largest amount of refugees compared to the rest of the Arab countries; estimated to be about 1.5 million. The LHL program consisted of the following components:

- Community integration: this included helping people to integrate into the various Jordanian communities. This would enable people to live peacefully with other people in the communities.
- Basic life program:
    - this included helping people find jobs where by which they could earn a livelihood for their daily living;
    - providing culturally competent healthcare to people who are refugees;
    - providing education and skills development for adults and children;
    - providing security and housing.

In order to know if the program had made any difference, evaluation was incorporated into the program. When the program was initiated in 1999, the project team of this project evaluated about 934 people in a small community where this program initially commenced. Evaluation was conducted before and after two years of the program being implemented with the same group of people who were surveyed twice. The questionnaire items were translated from English to Arabic and then translated back to ensure the accuracy of translation as given by the World Health Organisation's process of translation and adaptation of instruments framework.

The sample population consisted of 934 people. All participants that were included in the survey were 18 years old or older. During the course of two years, 120 participants that had initially participated in the program had been relocated to other communities and others could not take part due to various other reasons. Hence, the final sample consisted of 814 people (males=420, females=394).

The questionnaire consisted of items in relation to demographic information (4 items), community living (7 items) and health (11 items). The questionnaire was developed based on community consultation with various stakeholders and community members. A 5-point Likert scale of '1=Strongly Disagree, 2=Disagree, 3=Uncertain, 4=Agree and 5=Strongly Agree' was used to assess the items on community living and health. The scales internal consistency was calculated using Cronbach Alpha on Statistical Package for the Social Sciences (SPSS). The alpha scores that were obtained for community living α=0.97 and health α=0.93. The scores that were obtained showed good internal consistency of the survey instrument.

The $\bar{x}$ age of the sample population during the pre-program survey was=32.80, SD=1.17 (minimum 18 years, maximum 57 years). Results of the analysis showed that there was a statistically significant change ($p<.001$) in people's health and well-being compared to before. Table 1 shows a detailed analysis of the results.

CONCLUSION

Humanitarian stakeholders, including government organisations, share values and interests that should improve prospects for collaborating towards commonly held aspirations. Nevertheless, it is a widely held perception that they often function with a greater emphasis on autonomy than on cooperation. It is unfortunate that humanitarian stakeholders would rather tolerate waste and duplication than pursue cooperative partnerships that might allow a more efficient division of efforts and responsibilities during any refugee crisis. In any crisis, especially when people flee to neighbouring counties, the first health interaction that occurs is between refugees and the various health organisations present. Refugee health is multifarious in nature, and to understand the health needs of people torn by war one must be able to put oneself in their shoes. The case study on Living a Harmonious Life program is a classic example of how it is possible to promote the health and well being of refugees provided the necessary components are put in place to achieve this desired outcome. In order to help refugees successfully integrate in today's societies, one must have all the necessary components that make up an effective system put in place. A failure of any one component can have an unhealthy outcome on the health and well-being of the person.

Table 1: Mean and Standard Deviation scores for Living a Harmonious Life Program (N=814)

		Time 1 (Pre)	Time 2 (Post)	
Community Living				t***
	I am happy in the community that I live in.	2.54 (0.80)	3.97 (0.63)	-39.57
	The community members know who I am.	3.67 (0.63)	3.95 (0.68)	-8.51
	I am treated equally to other members of the community.	2.74 (0.89)	3.95 (0.70)	-30.03
	The people in the community are concerned about my welfare.	2.61 (0.92)	3.96 (0.68)	-33.52
	I feel safe living in the community.	2.46 (1.07)	4.00 (0.68)	-34.35
	I am satisfied with my housing accommodation.	2.65 (1.05)	3.97 (0.66)	-29.59
	I know who to contact in case of an emergency.	2.57 (0.95)	3.97 (0.66)	-33.92
Health				
	I consider myself in good health.	2.51 (0.87)	3.96 (0.66)	-37.65
	I eat a healthy diet.	2.67 (1.07)	3.64 (0.71)	-29.13
	I know who to talk to when I have health problems.	2.99 (1.03)	3.98 (0.65)	-22.91
	Healthcare practitioners are able to understand my health problems.	2.54 (0.79)	3.65 (0.73)	-38.90
	Healthcare practitioners are able to understand my cultural beliefs.	3.61 (0.68)	3.68 (0.72)	-11.06
	I can manage my stress levels.	2.72 (0.92)	3.70 (0.70)	-30.93
	I feel quite healthy mentally.	2.60 (0.92)	4.00 (0.68)	-34.58
	I can handle most of my emotions.	2.49 (1.06)	4.05 (0.70)	-34.68
	I keep my worries to a minimum.	2.64 (1.07)	3.98 (0.66)	-29.60
	I manage my anger appropriately.	2.57 (0.95)	3.95 (0.68)	-33.27
	I have a positive attitude towards life.	2.51 (0.87)	3.99 (0.66)	-38.25

*Measured on a 5-point Likert Scale: 1=Strongly Disagree, 2=Disagree, 3=Uncertain, 4=Agree and 5=Strongly Agree.
*A Paired-Samples T-Test was done on SPSS to find out any change with the same group of people between time one and time two periods.
* *df= 813, p <.001*

REFERENCES:

Forsythe, D. P. (2000) *Human Rights in International Relations*, London: Cambridge University Press.

Halpern, S. (1992) *United Nations Conference on Environment and Development: Process and Documentation*. Geneva: Academic Council for the United Nations System.

Perrone, B., Stockel, H. H. and Krueger, V. (1989*) Medicine women, Curanderas, and Women doctors*. Norman: University of Oklahoma Press.

Weston, W. W. and Brown, J. B. (1989) The importance of patients' beliefs. In M. Stewart and D. Roter (Eds.), *Communicating with Medical Patients*. Thousand Oaks: Sage Publications.

World Health Organisation (1995) *Health Promotion: Ottawa Charter*, Ottawa: WHO.