SPECIAL REPORT

Internally Displaced Persons

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Abbreviations:
IASC = Inter-Agency Standing Committee
IDPs = Internally displaced persons
NGO = Non-governmental organizations
WHO = World Health Organization

Abstract

There were estimated to be over 20 million internally displaced persons (IDPs) at the end of 1999, a number that surpasses global estimates of refugees. Displacement exposes IDPs to new hazards and accrued vulnerability. These dynamics result in greater risk for the development of illness and death. Often, access of IDPs to health care and humanitarian assistance is excluded deliberately by conflicting parties. Furthermore, the arrival of IDPs into another community or region strains local health systems, and the host population ends up sharing the sufferings of the internally displaced. Health outcomes are dismaying.

From a health perspective, the best option is to avoid human displacement. WHO contributes to the prevention of displacement by working for sustainable development. Placing health high on the political agenda helps maintain stability, and thereby, reduce the likelihood for displacement.

Primary responsibility for assisting IDPs, irrespective of the cause, rests with the national government. However, where the government is unwilling or unable to provide the necessary aid, the international humanitarian community must step in, with WHO playing a major role in the health sector.

There is consensus among the partners of the World Health Organization (WHO) that, in emergencies, the WHO must: 1) take the lead in rapid health assessment, epidemiological and nutritional surveillance, epidemic preparedness, essential drugs management, control of communicable diseases, and physical and psychosocial rehabilitation; and 2) provide guidelines and advice on nutritional requirements and rehabilitation, immunisation, medical relief items, and reproductive health.

If the vital health needs of IDPs—security, food, water, shelter, sanitation and household items—are not satisfied, the provision of health services alone cannot save lives. Community participation is essential, and community participation implies bolstering the assets and capacities of the beneficiaries.

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"Protecting [internally displaced] persons.... is one of the most daunting challenges of our time. Whether the victims are forced into camps, choose to hide or merge into communities, they tend to be among the most desperate of populations at risk. Internal displacement .... denies innocent persons access to food, shelter and medicine and exposes them to all manner of violence."[4]

Introduction

Internally displaced persons (IDPs) are persons or groups of persons who have been forced or obliged to leave their homes or places of habitual residence, in particular as a result of or in order to avoid the effects of armed conflict, situations of generalized violence, violations of human rights, or other natural or human-made disasters' and who

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have not crossed an internationally recognized state border.[5] Hard data on the numbers of IDPs do not exist, and estimates are difficult. Depending upon the reasons that force people to flee, figures can seem surprisingly high, e.g., in most natural disasters, or amazingly low, e.g., in displacement due to civil strife. In the latter case, governments may be unable or even unwilling to acknowledge the existence of and the real numbers of IDPs.[6] Sometimes, the IDPs do not wish to be identified for fear of persecution.

Nonetheless, global estimates for the number of IDPs at the end of 1999 are enormous: the U.S. Committee for Refugees estimated that there were >20 million IDPs.[1] More than 10 million were in Sub-Saharan Africa, and 1.9 million were in South America, mainly in Colombia. Other countries with large internally displaced populations include Iraq (1 million), Afghanistan (750,000–1 million), and the Russian Federation (1 million).[7] Other persons are in an even more tenuous situation; they are not included in the numbers, but they sometimes are mentioned as internally displaced, e.g., in the Middle East, the Philippines, and South Africa[8] Worldwide, the number of IDPs surpasses the number of refugees.

Contrary to the status of refugees, IDPs enjoy no special status nor does any specific, legally binding instrument guarantee them protection and assistance. For example, a recent study found that U.S. legislation only "provides a minimal but not sufficient statutory basis" for government action on behalf of IDPs.[9] Thus, of the forced migrants, IDPs are among the most vulnerable. Furthermore, in most circumstances, it is the poorest and most vulnerable people who are forced to leave their homes or places of habitual residence by a natural or human-induced crisis.

As persons and citizens, though, IDPs are covered by the laws of their own country. International human rights law also remains applicable in cases of displacement. When the displacement occurs in the context of armed conflict, protection under international humanitarian law applies. Specifically, Article 3 and Additional Protocol II of the Geneva Conventions spell out the essential principles of treatment of civilians fleeing an internal armed conflict, including protection and care for the wounded and sick. Special protection is set out for women and children.[10] *The Guiding Principles on Internal Displacement*[5] set out the specific rights of protection and humanitarian assistance of IDPs and the obligations of governments in all phases of displacement. While not legally binding, these principles, along with humanitarian and human rights laws, provide a framework for action.

Especially tragic is the plight of those who remain inaccessible, and therefore, are not identified as IDPs; because of the location or the nature of the crisis, they get no public or institutional attention. This scenario is typical in complex emergencies, in which there is little or no information on large areas and populations due to inaccessibility. It is a frequent finding—from Mozambique[11] in the 1980s to contemporary D.R. Congo[12]—that before victims of war flee the most insecure areas, and thus get recognised as IDPs, they first try to cope by shuttling between their fields and houses during the day and hiding in the bush at night. Recent evidence suggests that this is a period of maximum risk.[12]

In these situations of collective distress, especially vulnerable are the elderly, infants, pregnant women, the disabled, the chronically ill, and, more in general, all of those who more recently have been displaced and have not yet found ways to cope with their new condition.

Issues of protection, vulnerability, and access are intimately linked. Additionally, for health and for the WHO, vulnerability is not a static condition. It is a complex process—in the case of IDPs, a very dynamic and rapid one. To approach and intervene in these dynamics, WHO suggests taking the IDPs' point of view on entitlement to protection and access to health.

Public Health Concerns

Public health for refugees, internally displaced persons, and other conflict-affected populations has evolved as a specialised field with its own policies, procedures, manuals, indicators, and reference materials.[13] Displacement of a population always affects health status and health care. In the epidemiological triad of host, agent, and environment interaction, displacement exposes IDPs to new hazard dynamics:

1. Infectious agents and vectors might be present in the new environment, to which IDPs may lack immunity and/or coping skills;
2. In general, poor quality of water and sanitation and overcrowding, as in temporary settlements, modify interaction with existing infectious agents;
3. Absolute and relative food shortages occur due to disruptions in the production and supply systems;
4. Psychosocial balance is disrupted by being uprooted, insecurity, lacking meaningful employment;
5. Displacement also can lead to an increase in hazardous behaviours (e.g., promiscuity and sexual and/or intrahousehold violence); and
6. Weather vagaries and other natural hazards may be present in the new environment.

These new hazards are compounded by accrued vulnerability due to a loss of assets and entitlements, as well as a loss of social networks and caring capacities, due to the disruption of households. This has a profound impact particularly upon women, children and the elderly.

Lack of knowledge and information about the new environment, decreased food security, dependence on external aid and often inadequate shelter, sanitation and access to safe water also compound their troubles.

Reduced access to health care facilities and health care services is yet another obstacle with which IDP's must cope. They lose access to the health services they knew and are at a disadvantage in cultural, financial, and functional terms, in accessing health services in areas of relocation.

Exposure to new hazards and greater vulnerability result in greater risks for illness and death for these populations. In most places, crude mortality rates for the IDPs are significantly higher than the baseline rates; in the most extreme case, Somalia, CMRs for internally displaced were 50 times the baseline.

In April 1999, Angola suffered the largest polio epi-

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demic ever recorded in Africa. After 30 years of war and destruction of the health infrastructure and services, massive population displacement and the consequent overcrowding, poor sanitation, and inadequate water supply created an ideal environment for the spread of the poliovirus (Figure 1).[14]

In Colombia, almost 2 million people have been obliged to move away from their places of origin to protect their lives. The situation is made more difficult by the fact that much displacement occurs "silently", and people simply merge unnoticed into the host population.[15] Only 22% are reported to have access to medical care.[16]

Access can be made difficult simply by the fact that IDPs lack information on the availability of health services, their location or costs. It can be argued that the high mortality rates often seen immediately after displacement (e.g., in Malawi in 1998), also are due to the time it takes for new arrivals to find out where the services are located and how to access them.[13] But, often IDP access to health care and assistance in general—and of humanitarian workers to the IDP—deliberately is excluded by parties in armed conflict.

Even in a best-case scenario, functional access is difficult, and the host population shares the sufferings of the internally displaced. The arrival of a large number of people can strain local health systems that are not sufficiently resilient. If the new arrivals are unexpected, or if information is uncertain and slow, as often is the case, personnel, supplies, and facilities rapidly become inadequate. This translates into reduced access to health care and poor health outcomes for all. Internally displaced persons and host communities also may need to compete for access to food, infrastructures, and environmental resources. In addition, IDPs may introduce diseases not normally present in the host population. Thus, the hosts may perceive the IDPs themselves as a hazard.

In countries in which armed conflicts are more prevalent and IDPs are more numerous, health outcomes are dismaying. An International Rescue Committee (IRC) survey in the eastern D.R. Congo noted that the fighting there resulted in at least 1.7 million excess deaths between January 1999 and May 2000, and concluded that, in such context, "war means disease", and that "violent deaths and nonviolent deaths are inseparable." The IRC elaborated that the majority of deaths were the result of a combination of violence, lack of services, extreme vulnerability, and "common" diseases, including trauma: the total number civilian deaths documented by the survey is "directly attributable to the warring parties and their backers", although in only 13% of the cases, "the mechanism of death was a man with a weapon."[2]

In Burundi, the under-5 year old child mortality rate increased from 108/1,000 in 1992 to 190/1,000 in 1998; in Afghanistan and Sierra Leone, maternal mortality rates are as high as 1,700 or 1,800/100,000 live births, respectively.[17] Polio eradication faces daunting challenges in all countries affected by conflicts or severe crises. Malaria is endemic in 80% of countries undergoing complex emergencies in Africa, Asia, and Latin America.[18] The interactions between social instability, violent conflicts, human displacement, and HIV/AIDS are of paramount concern. Sub-Saharan Africa, the region with the most IDPs is also home to the most persons severely affected by the HIV/AIDS pandemic, accounting for almost 70% of the HIV-positive people and 83% of cumulative deaths from AIDS.[19]

WHO and Internal Displacement

Health is a key factor in the growth of human capital, in disaster reduction, and social stability. As part of its fundamental mission, WHO contributes to the prevention of human displacement through advocacy and technical cooperation for *sustainable* health development. Equity of access to health services and preventive care is essential to the reduction in the number and types of hazards and factors of vulnerability. The WHO also assists national authorities in designing health systems that are more resilient to crises and in building capacities for preparedness, so that local health systems can better adapt to the arrival of IDPs, if displacement occurs.

This form of "health preparedness" can and should contribute to the prevention of human-induced crises. Placing social services high on the political agenda can help maintain societal cohesion, national unity, and stability. The WHO's cooperation with member countries includes assessing the capacities and vulnerability of the health sector and facilitating the development of consensus on priority public-health interventions that must be ensured for everyone, even or more particularly in a case of emergency.[20] Whatever these priorities, they must take into account the possibility of internal displacement and must be flexible enough to be readjusted according to its dynamics.

Primary responsibility for assisting IDPs, irrespective of the cause of the displacement, rests with their national government. Unfortunately, while the core needs of IDPs may be similar, the conditions under which assistance can be delivered, e.g. a drought, are far from those conditions that prevail during a war or a violent conflict.

Even in the case of natural disasters, especially in developing countries, the IDPs are the ones who suffer most. Most of the government's resources are absorbed by the emergency phase, leaving huge gaps when it comes to rehabilitation. Durable solutions for those displaced by the disaster may remain long unattended. In situations of natural disasters, the WHO is well placed to facilitate and support health coordination because of its long-term presence in the country. Particularly building on health sector and programme preparedness, WHO uses evidence-based public health advice to facilitate understanding between the country and its international partners, coordinating and complementing interventions for health relief, recovery, health development, and preparedness.[21]

Most massive population movements, though, are connected with armed conflicts, and in such circumstances, the authorities generally have very little capacity, and sometimes very little interest, to assist IDPs. They are considered a burden or an embarrassment, during and after a conflict. Even worse, they can become pawns in the tactics of combat or even "means of production" in the economy of war.[22]

In complex emergencies, the WHO, as a UN specialised agency and an intergovernmental organization, needs to reconcile its unique responsibilities in the health sector, the humanitarian imperative, and the mandate to

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assist its primary constituent, the member state. As a government feels undermined in its capacities and legitimacy, cooperation with ministries of health and local health actors can come under strain. In general, work with national counterparts, becomes more difficult, while access to national/local knowledge and capacities remains essential for effective action to occur.

When governments are unable or unwilling to provide necessary aid to the IDPs, some of the needs may be met by NGOs (local and international) and others by United Nations (UN) Agencies. Coordination by the UN may be facilitated by the Inter-Agency Standing Committee (IASC) through the system of humanitarian coordination. The WHO participates and has been a full member of the IASC since its beginning in the early 1990s. Through the country offices of the various IASC participants, coordination also may be assured within countries.

There is still much room for improvement. A recent review by the World Food Program (WFP),[23] identified three main gaps in humanitarian assistance to IDPs. First, gaps in protection exist in the absence of one agency with overall responsibility for the protection of IDP's. Secondly, nonfood sectors often are underfunded producing resource gaps. Thirdly, gaps in coordination arise along with the need to ensure a collaborative, coordinated approach to providing assistance to displaced persons.

Arguably, the first two gaps depend on variables that escape the direct control of those more closely involved. The "coordination gap", though, can and must be filled by national and international actors working together. Experiences from the late 1980s onwards indicate that, even in situations of displacement, highly effective outcomes may be achieved through active involvement of the host government, utilisation of local skills, and the insistence on accountability by relief agencies.[28]

The WHO mandate requires that it assist its member countries to attain and maintain the highest possible level of health for all their citizens, and displacement is not a qualifying variable in this respect. Importantly, in any specific country or situation, the World Health Organization also represents the collective presence of all the other WHO member countries, and particularly the views and capacities the health sector of these countries. A privileged relationship with the ministry of health is central to WHO's presence, continuity, and its function of global health exchange. However, in practice, the WHO recognises that the ministry of health is not necessarily the only or the most appropriate partner for its technical cooperation, particularly during emergencies. New partnerships are forged with other ministries, local or international NGOs, UN agencies, and the military during emergencies. The WHO's contribution is based upon its technical and moral authority and its special relationship with its member countries. Within the context of the IASC, this gives the WHO a specific advantage to advocate for and work toward having:

1. The existence and the health rights and needs of IDPs acknowledged;
2. IDPs identified and counted;
3. Humanitarian access ensured;
4. External resources mobilised for health;
5. Local health capacities identified and strengthened—be they institutional or community based; and
6. Public health best practices adopted.

For the WHO, the most important and urgent need is for dialogue between national/local actors and international partners in order to improve the understanding of health issues in IDP situations. As all primary humanitarian concerns are based essentially on survival and health issues, health concerns provide the best "lubricant" for intersectoral coordination.

Principles for Action

Population figures are key for the planning and monitoring of any relief operation, and are the essence of public health, which is a population-based discipline. All of the IDPs must be recognised and counted; this is not an easy task particularly when IDPs are integrated with host families. However, for example, the use of health records (e.g., a sudden increase in vaccination coverage) may help to identify "silent displacements". Simply by providing national data on the numbers and structure of the population and by applying vital statistics and epidemiological tools, WHO can facilitate the definition of the beneficiaries, estimating their numbers and needs, and establishing monitoring systems.

The health of the IDPs is preserved best through a community-based, preventive approach, which is dependent upon the satisfaction of vital health needs: security, water, food, shelter and sanitation, clothes/blankets and essential household items, and preventive/curative health care.

There is consensus among WHO's partners that, in emergencies, the organization must take the lead in the performance of rapid health assessments, epidemiological and nutritional surveillance, epidemic preparedness, essential drugs management, control of tuberculosis, HIV/AIDS, and sexually transmitted diseases, and physical and psychosocial rehabilitation. The organization must also provide guidelines and advice on nutritional requirements, rehabilitation, immunisation, medical relief items, and reproductive health.[24]

For other vital needs, the WHO is not primarily responsible. Nonetheless, as the technical agency of the United Nations (UN) responsible for health, the WHO must advocate that they be met by other agencies, lest preventable deaths occur. The organization also can provide the guidelines and information that may assist its partners in planning or measuring the effectiveness of their relief interventions. In all of these instances, WHO's action is consistent with its core corporate functions.*

*WHO core functions have been outlined as: articulating consistent, ethical, and evidence-based policy and advocacy positions; managing information to assess trends and compare performance, along with setting the agenda for and stimulating research and development; catalysing change through technical and policy support; negotiating and sustaining national and global partnerships; setting, validating, monitoring, and pursuing the proper implementation of norms and standards (best practise); stimulating and testing of new technologies and tools and guidelines for disease control, risk reduction, health care management and service delivery.

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Security

Security from violence as well as from hunger and disease is the IDPs' paramount need. Violence is a major cause of illness and death, directly and indirectly. War and other violence-related injuries must be included in epidemiological surveillance, and the WHO must advocate for proper care of the victims. For certain vulnerable groups such as the children and the elderly, security includes more basic requirements, e.g., family reunification, which in turn, impinges on programmes for mental health. Health education can include segments on violence, first aid training and injury prevention. Programmes for mine awareness and clearance, disarmament, and demobilisation contribute to security. All need a health component to be coordinated with national counterparts, and WHO can such provide support. Lastly, WHO has growing experience with programmes such as "Health Bridge for Peace" in support of conflict resolution, peace-building, and secure environments.*

Water

Adequate supplies of water are vital. In emergencies, ensuring at least 20 litres of potable water/person/day is central to any strategy. Water supply programmes must ensure an adequate number and distribution of water points—the more users of a source, the easier the contamination—and that the community be empowered to maintain the sources and the quality of the water, e.g., by education and provision of user-friendly pumps, spare parts, buckets, and chlorine.[13] Besides providing guidelines on water safety and in some instance being directly involved in improving water supply, WHO also has the scientific authority to bring to bear, so that health data, e.g., number of cases of diarrhoea and skin infections, are used to monitor the effectiveness of the assistance being provided.

Food

Minimum requirements for food exist (2,100 kcals/person/day) below which no "health" is possible. Internally displaced persons require the same quantity and the same range of nutrients required by all human beings. Supply-driven aid is ineffective and unethical. Food aid programmes must ensure that an adequate quality and quantity of food is available to the entire population affected (as well as pots and fuel to prepare it). Food is procured either by the IDPs (i.e., by foraging, trading, or market purchase), distributed through food aid or, most commonly, through a combination of both. Selective feeding provides only supplementary food to specific vulnerable groups and special food for those in need of nutritional rehabilitation; it cannot compensate for inadequate general rations. Ensuring that nutritional surveillance is in place, and that its information is used to monitor food distribution, is accepted universally as the WHO's responsibility.[3] Guidelines for therapeutic feeding are another of the WHO's responsibilities. Furthermore, disease consumes nutrients; only proper preventative and curative health care can optimise food aid.

Shelter, Sanitation, and Environment

Shelter, sanitation, and the environment are primary determinants of health. Exposure can be a fatal hazard, especially for weakened persons; IDPs must have shelter, blankets, and clothes. Shelter also has direct implications for the use of impregnated bed nets for the prevention of malaria, while hygiene and good environmental management generally are needed to control vectors of disease. As with water, there are minimum standards for sanitation that are essential for people's health and dignity.[25] Good programmes need the full support of the beneficiary community that should be given responsibility and the means to fulfil it according to local norms and cultural acceptability. Again, WHO can provide the technical guidelines and measures of effectiveness for activities that are the responsibility of sectors other than health, but that have an impact on the people's health status.

Health Services

If the other vital needs are not satisfied, the provision of health services alone cannot save lives. However, the provision of adequate health care is another primary concern; IDPs are at increased risk of illness and death. WHO must ensure that the public health component of assistance is technically sound. Some overarching principles apply:[26]

1. The absolute priority is to keep or to bring the daily crude mortality rate (CMR) below 1 per 10,000 persons, and the daily under-five-year-old mortality rate below 2 per 10,000 children who are less than five years old.
2. Appropriate decision-making for health and nutrition in IDP situations depends upon the availability of accurate and reliable information and a focus on disease prevention and health promotion.[13] The performance of rapid health assessments and epidemiological surveillance in such situations are responsibilities of the WHO.[3] Establishing surveillance systems in IDP camps is fairly easy. It is much more difficult when IDPs are hosted by friends, families, volunteers, etc., and often not properly registered. The WHO sees its responsibility as facilitating integration between the national health information system, those set in place by external partners (international NGOs) and local structures (the National Red Cross/Red Crescent Society.)
3. In the early 1990s, experience indicated that the most prevalent diseases in IDP situations mainly affect children and readily are preventable or treatable.[26] The events in the Balkans and the patterns of illness prevailing among IDPs in Europe and elsewhere, have triggered more thinking, especially in terms of public health

*The main purpose of the HBP programme is to identify and develop actions and strategies that can maximise the peace building effects of health programmes before, during and after conflicts.

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measures for victims of violence, chronic conditions, and equitable referral systems. HIV/AIDS and tuberculosis are infectious hazards common to any context and, together with malaria, are the most difficult to tackle. Reproductive health is gaining more and more ground as a primary need, as is mental health. Nonetheless, the fact remains that IDP situations occur mostly in developing countries and that major causes of mortality can be prevented by proven, low-cost, public health interventions. Measles immunisation is one of these priority interventions.[13]

4. Community participation in a coordinated health programme always is an advantage in the provision of health and nutritional support services, and has a value in itself, particularly in terms of mental health. Community participation implies identifying and bolstering the assets and capacities of the beneficiaries. All IDPs carry along their personal skills, and their coping strategies must be encouraged and supported. As a minimum practical step, the WHO can and will insist with national authorities and international partners that any health worker among the IDPs has her/his qualifications recognised and utilised, including proper remuneration.
5. Where those hosting the IDPs also are impoverished, in poor health, and lacking food, assistance should reach all, both the displaced and the surrounding community. Under the disaster reduction principle of *"doing the most for the most"*, it seems advisable first to address vulnerabilities by area and only subsequently target specific groups. Since the early 1990s, on the basis of experience gained in Central America and Southern Africa, WHO has been promoting community-based approaches that aim at empowering the host communities to assist IDPs.[27]

Operationalising Principles

Public health... can be effective only in as much as the security of victims of armed conflicts is guaranteed. Security embraces the sustainable satisfaction of needs and respects basic rights of human beings.[28]

As long as IDPs remain inaccessible and therefore not identified, nothing can be done to safeguard their health. In such contexts, and in IDP situations in general, WHO sees *advocating and negotiating for secure humanitarian access as integral parts of public health promotion.* Possibly the most important task for WHO is to support local non-governmental organisations (NGOs) on the basis of humanitarian principles, because generally they are the ones that have the best access to IDPs. The WHO's moral authority prompts it to act as an interface between the ministry of health and the local NGOs dealing with IDPs, minorities, and highly vulnerable groups.

A key element of preparedness planning and a priority for intersector/agency coordination is to identify trends, flows of displacement, points of passage, and the most suitable (or likely) areas of shelter. This will allow assistance to IDPs enroute and preparation of local health systems to assist the newcomers. Furthermore, all plans should make contingency provisions for sudden increases originating from inaccessible areas, i.e., new IDPs carrying along a "public health backlog" of missed opportunities for prenatal care, immunisations, etc.

Humanitarian coordination must bring UN agencies, national authorities, and the military together with the Red Cross (International Committee of the Red Cross (ICRC), International Federation of Red Cross/Red Crescent (IFRC), and national societies) and NGOs working in or near the conflict zones. It is at this stage that *protection, access and informed response* become critical elements for the survival of IDPs. Country expertise, situation analysis, human rights, vital health needs, and best public health practices must be combined to provide the basis for planning, humanitarian diplomacy, and for operational arrangements. Parties to the conflict—if that is the cause of the displacement—must be integrated into these processes. The WHO can contribute to humanitarian intelligence, negotiations, planning, and monitoring with data from the country's health profile, public health standards, needs assessments, epidemiological surveillance, and direct technical assistance.

At a certain point IDPs become accessible and "visible". In some cases, IDPs are brought to a first reception/transit centre by soldiers, such as after a military operation. Another scenario is that IDPs gather spontaneously, for example, near to a source of water, a road, or a city, and are met there by humanitarian workers. More often, individuals or small groups seek shelter with relatives or friends in a safer area; there they can be identified and assisted by volunteers, e.g., of the national Red Cross society. In most cases, they, at least, will be registered by local authorities for security purposes.

The WHO must engage actively with the actors who most likely are to be the first to meet the IDPs, because it is they who can provide immediate, lifesaving assistance. Preparedness is essential. Village health workers, Red Cross volunteers, local administrators, even party cadres can help to *pre-position assistance* close to inaccessible areas; at a bare minimum, they can inform IDPs about which health services are available and where and how to access them. Agencies such as the United Nations High Commission for Refugees (UNHCR), NGOs, and the military are the best placed to assist the IDPs in transit/reception centres. Those IDPs in spontaneous settlements can receive a degree of first, immediate health assistance, e.g., rescue teams can administer measles immunisation to all of the displaced children they encounter. The WHO advocates that health workers, who often are on the front lines of assistance to IDP's, have the knowledge and skills needed to insure not only IDP's health, but their right to security and protection as well. Therefore, in countries undergoing or at high risk of complex emergencies, the WHO's programme "Health as a Bridge for Peace" focuses on training health workers in humanitarian law, political analysis, and negotiation.

Health coordination, *in practice*, encourages working with national or local authorities, from health and from other sectors, with UN agencies, and with NGOs to ensure that all accessible areas can offer first health relief. It monitors that the relief provided fits the IDPs' needs and ensures that relief has adequate systemic follow-up and operational support. It also works for displaced persons to meet the security that comes from the sustainable satisfaction of needs and the respect of the basic rights of human beings.

Those IDPs concentrated in camps or in shanties

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around safe towns bring dramatic challenges to public health. As soon as possible, conditions of life must be improved by expanding and extending the existing health systems. Improved water supply, food, security, sanitation, housing and health care delivery are essential. Keeping in mind that the burden the newcomers can represent for the host community, the WHO needs to advocate for an integrated, area-based approach, rather than a vertical, vulnerable-group approach.

Also, historical evidence provides a warning that only cases of extreme emergency justify parallel structures. Even if very strongly represented at local level, all external interventions rely on national capacities—no matter how weak—for back-up and support, e.g., hospitals, cold-chain systems, or reference laboratories. For the WHO, it is clear that international aid can be detrimental by hiring away local workers, duplicating services, and creating a two-tier health system. In order to be immediately effective and then sustainable, external assistance needs to be coordinated, include local capacity-building, and be planned carefully so as into fit in the national systems.

Finally, if the medium-term perspective is to integrate IDPs into the host community, investment must include education and the creation of economic opportunities. If this cannot be done where the IDPs are concentrated, *then public health concerns justify that they are moved elsewhere.* Whether the crisis at the origin of the displacement is solved or not, decisions must be taken, lest the IDPs' plight is maintained indefinitely and, for example, they become political hostages in peace negotiations. The choice is between the IDPs returning home, which often will require rehabilitation in the area of origin, or resettlement, which will necessitate investment in a new area. These are politically-loaded decisions. Again, the WHO has a degree of responsibility to see that such decisions are taken and wants to contribute on the basis of public health principles and its technical authority.

In rehabilitation and reintegration, caution is needed. Restoring the original health system is not necessarily the right choice; arguably, what that was in place before the crisis—be it armed conflict or natural disaster—was part of the structural cause of the displacement itself. Rehabilitation must not recreate those same conditions. For example, rehabilitation must take into proper account the needs of previously underserved minority groups, and ensure more equitable and appropriate access to health services. Furthermore, *all major crises bring change*; this is true particularly for violent conflicts. Even if damage to the infrastructure is limited, demographic patterns change, new social structures emerge, and new economic options are needed. Even the natural environment may be changed permanently (e.g., by landmines). People will have new needs and, often, greater expectations. For some rural communities, the move into IDPs camps can represent an experience of forced, fast urbanisation; for some of them, the first contact with health services.

Conclusions

All institutions risk reducing reality to what is covered by their mandate, or to what they are able to deal with.[9] In WHO's view, its mandate gives it a comparative advantage in looking at internally displaced persons: health is for all, not only for vulnerable groups. The fact that it is easier to assist IDPs once and as long as they are concentrated in a camp should not overshadow their dynamic predicament: a progressive "loss of health", first as psychological and economic insecurity, then as increasing physical suffering that forces the person to flee. Internally displaced persons are individuals who must move to find new coping mechanisms in order to survive. All along this process, there are points at which health relief can be provided to complement the IDPs' coping strategies, while action is taken to find the durable solutions to which they are entitled.

No matter how dramatic or outright tragic, internal displacement is only a symptom of a wider public crisis. The challenges that instability pose to humanitarian and developmental work are many. Among them are: 1) loss of legitimacy of national institutions; 2) difficulty of identifying critical stakeholders and negotiating between them; 3) contradictions that may occur between transparency and neutrality; and 4) differing agendas of the international community, e.g., economic sanctions imposed upon societies already affected by structural crisis.[29]

In addition to international health information exchange and liaison, the WHO's mandate, at the country level, is to increase the resilience of local/national public health systems through the provision of technical cooperation. During crises, the WHO office within the country affected must remain functional and be ready to advise on and adopt the most suitable strategies. Arguably, a key indicator of WHO's corporate performance is the way its country programmes withstand the impact of crises and international relief efforts, and are able to accommodate new realities, such as IDPs.

Whatever the circumstances, WHO has the public health tools to ensure that the IDPs' vital needs are met, thus preventing further deterioration of their health status. The challenge for the WHO is to ensure that its country offices structure these instruments with strategies that are appropriate to the context at hand. Regional and country experiences provide some hints.[29] They point to the need for early intelligence and networking with a vast range of partners, for involving NGOs and civil society at-large in dialogue with health authorities, and making IDPs active stakeholders of health assistance. Another calls for the regearing of country technical cooperation, having all programmes remain active and collaborating to meet the needs of the IDPs, and to ensure that once a crisis is over, there will be no gap on the road to recovery. The WHO offices can and must make their role in health co-ordination tangible by providing partners with the "learning functions", i.e., documentation and health intelligence that some indicate as essential,[30,31] for informed response in emergency operations.

If it is true that, as the technical reference for health, the WHO can facilitate coordination of all aspects of assistance to IDPs, then its mandate must be supported by presence and proximity. Predictability, health intelligence, proactive networking, and services to its partners and constituents are at the core of how the World Health Organization exercises its responsibilities.

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References

1. At the request of the Inter-Agency Standing Committee, the Norwegian Refugee Council is developing a database of information to track the numbers and needs of internally displaced populations.
2. IRC: *Mortality in Eastern DRC-Results from Five Mortality Studies.* Prepared by Les Roberts, IRC Health Unit, 2000.
3. EHA consultation with donors and collaborating agencies on the role of WHO in complex emergencies, Geneva, March 1997
4. OCHA: *Handbook for Applying the Guiding Principles on Internal Displacement,* Geneva, WHO.
5. OCHA, *ibid* (p 6).
6. IFRC: *World Disasters Report, 2000.*
7. Norwegian Refugee Council Internally Displaced Persons Database. At the request of the Inter-agency Standing Committee, the Norwegian Refugee Council is developing a database of information to track the numbers and needs of internally displaced populations (http://www.idpproject.org/).
8. Save the Children: *War Brought Us Here,* 2000.
9. Kunder J: *The U.S. Government and Internally Displaced Persons: Present but Not Accounted For.* US Committee for Refugees, The Brookings Institution Project on Internal Displacement, November 1999.
10. Lavoyer JP: Refugees and internally displaced persons: International humanitarian law and the role of ICRC, ICRC, 1 March 1995.
11. Personal observation, Mozambique 1988. Also in Geffray R 1990 and Wilson K, 1991.
12. IRC: Mortality in Eastern DRC-Results from Five Mortality Studies. Prepared by Les Roberts, IRC Health Unit, 2000.
13. Toole M: Twelve Lessons for Public Health in Emergencies. Presented at FICOSSER, Paris 1999.
14. Outbreak of poliomyelitis – Angola 1999, *MMWR* 1999;48(16): 327-329.
15. Fabio Rivas Munoz, personal communication, June 2000.
16. PAHO: Basic Country Health Profiles for the Americas, Summaries, 1999.
17. WHO/FCH: A health sector strategy for reducing maternal and perinatal morbidity and mortality by WHO and partners. January 2000.
18. WHO/CDS: Partnership Meeting on Roll Back Malaria in Complex Emergencies, Geneva, June 2000
19. Inter-Agency Standing Committee-Sub-working group on HIV/AIDS in Complex Emergencies: *Controlling the Spread of HIV/AIDS in Complex Emergencies in Africa.* Geneva, May 2000
20. Planning Ahead for the Health Impact of Complex Emergencies, Draft Discussion Paper WHO/EHA, 8 Dec 1999.
21. WHO/EHA: *Emergency and Humanitarian Action—Disasters, Emergencies and WHO;* paper presented at the Second Meeting of the Global Programme Management Group: Geneva, 17 March 2000.
22. Rufin JC: Les economies de guerre dans les conflits de faible intensite, *Defense nationale* 1993.
23. WFP/IDP Review: *Experiences with Internal Displacement.* WFP, Geneva 16 March 2000.
24. EHA consultation with donors and collaborating agencies on the role of WHO in complex emergencies, Geneva, March 1997
25. The Sphere Project: *Humanitarian Charter and Minimum Standards in Disaster Response.* First final edition 2000.
26. University of Wisconsin – Disaster Management Center: First International Emergency Settlement Conference: New Approaches to New Realities, Emergency Settlements' April 1996.
27. WHO: *HEDIP-Health and Development for Displaced Populations, Emergency Relief Operations,* 1993.
28. Perrin P: War and public health: Extending the concept of public health for the victims of armed conflict. *Health in Emergencies,* Issue 3, EHA/WHO, 1998.
29. WHO/EHA: EHA Inter-Regional Retreat, Neemrana Fort Palace, 28 February-2 March 2000., April 2000.
30. Bhatt M, Reddick M: *Retrospective Model for Orissa Learning Office-Issues Raised and Lessons Learnt.* Draft report for discussion at ALNAP meeting, London 6-7 April 2000.
31. Pavignani E, Colombo S: *Health as a Bridge for Peace. National Health Systems and Protracted Humanitarian Emergencies.* Preliminary Findings from a Comparative Study on Angola and Mozambique. WHO/EHA, Geneva, June 2000.

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