GETTING IN ON THE ACT:

The multiplicity of agencies promoting the health of refugees,

with a case study of the Afghans in Pakistan, 1978-1988

Dissertation submitted in partial fulfilment of
the requirements for a Doctor of Philosophy Degree,
Faculty of Economics,
London School of Economics and Political Science,
University of London

March 1993

by
Nancy Godfrey

ProQuest LLC
789 East Eisenhower Parkway
P.O. Box 1346
Ann Arbor, MI 48106-1346

ACKNOWLEDGEMENTS

This thesis brings to a close over ten years of research and work in the field of refugee health care. I would like to thank the Overseas Development Administration of the UK Government, the Pew Charitable Trusts and Oxfam America for generously funding the work presented here as part of a larger programme of research investigating international and national health policies for refugees. I am also indebted to the London School of Hygiene and Tropical Medicine for giving me the opportunity to carry out this research.

I am especially grateful to Mercedes Juarez for sharing her own analytic approach and perspective; consequently, I have learned to think more creatively and to thoroughly enjoy doing so. It has also enabled me to interpret the findings of this research differently, moving my own understanding of the field in which I work forward. I would like to extend special thanks to Professor Brian Abel-Smith. His constant encouragement, insight and support have enabled me to learn so much: it is to him that this thesis is dedicated.

ABSTRACT

Over the past century and a half, an international system to assist refugees has evolved, which gives priority to health. This thesis looks at the processes by which policies for the health of refugees have been formulated and implemented in three historical periods. It begins with the Red Cross movement of the late 1800s when medical care was first organised for those wounded in war. Provision of basic medical care for entire populations affected by the World Wars is then reviewed, highlighting the creation of organizations by governments collectively for relief and aid.

The bulk of the analysis, however, focuses on the past forty years when western charities and inter-governmental organizations increasingly made medical and public health interventions available for refugee relief in poorer countries. Organizational policies, mandates and structures of the specialised agencies of the United Nations and the charitable agencies based in Europe and North America are examined. This places existing policies for the health of refugees within the context of the cultural and political environment in which they originate. It also identifies more general patterns in institutional responses, allowing their roles in particular relief operations to be anticipated.

Health policies for the Afghan refugees in Pakistan during the 1980s are then analyzed. Not only does this analysis validate earlier conclusions about international policies for refugee health, it reveals unbalanced relationships of power between internationally- and nationally-based organizations. In so doing, cultural dimensions of the policy process and the complexity of vested interests within national societies are found to have been neglected. Although recommendations can be made, the policy process indicates that they are unlikely to be put into practice.

Consequently, more general conclusions about the policy process, key policy issues and characteristics of existing policies for the health of refugees bring the analysis to a close. In particular, this research indicates that there is a coherent system through which health relief is provided. Health relief is not, however, promoted as a human right; instead it is provided as a humanitarian activity by powerful groups within national societies and globally. Sadly, many of the activities carried out under the *aegis* of relief appear to be symbolic since they do not alter existing balances of power. The intention of these policies to *promote the health of refugees* is, therefore, subject to debate.

GLOSSARY OF TERMS

AACC	All Africa Conference of Churches
ACBAR	Agency Coordinating Body for Afghan Relief
ACVAFS	American Council of Voluntary Agencies
AGFUND	Arab Gulf Programme for the United Nations Development Organization
AICF	Action International Contra la Faim
AMI	Aide Medicale Internationale
AVICEN	Afghanistan Vaccination/ Immunization Centre
BIA	Bureau Internationale de l'Afghanistan
BHU	Basic Health Unit
BRC	British Refugee Council
CAR	Commissionerate for Afghan Refugees (GOP provincial)
CARE	Cooperative for American Relief Everywhere
CCAR	Chief Commissionerate for Afghan Refugees (GOP federal)
CDC	Centres for Disease Control (US Govt)
CHREP	Christian Hospital Extension Programme
CHW	Community Health Worker
CIA	Central Intelligence Agency (US Govt)
CIMADEC	Ecumenical Aid Service
CRB	Commission for Relief in Belgium
CRED	Centre for Research on the Epidemiology of Disasters
CRS	Catholic Relief Services
CWS	Catholic World Service
DAC	Development Assistance Committee (OECD)
dai	Afghan traditional birth attendant
DOC	Division of Coordination (WHO)
ECOSOC	Economic and Social Council (UN)
EPI	Expanded Programme of Immunizations
EPR	Centre for Emergency Preparedness and Response (WHO)
ERO	Office for Emergency Relief Operations (WHO)
FAO	Food and Agriculture Organization (UN)
FATA	Federally Administered Tribal Areas (Pakistan)
FSMO	Field Supervisory Medical Officer (GOP)
GATT	General Agreement on Tariffs and Trade
GNP	Gross National Product
GOP	Government of Pakistan
IBRD	International Bank for Reconstruction and Development
ICARA I,II	International Conference on Assistance to Refugees in Africa (first and second)
ICC	Islamic Coordinating Council
ICD	Italian Corporation for Development (Govt of Italy)
ICEM	Inter-governmental Committee for European Migration
ICRC	International Committee of the Red Cross
ICVA	International Council of Voluntary Agencies
IGCR	Inter-Governmental Committee on Refugees

IMF	International Monetary Fund
IRO	International Refugee Organization
LHV	Lady Health Visitor (GOP)
LRCS/LORCS	League of Red Cross and Red Crescent Societies
LSHTM	London School of Hygiene and Tropical Medicine
LWF	Lutheran World Federation
LWR	Lutheran World Relief
MCH	Maternal and Child Health
MM	Medecins du Monde
MSF	Medecins Sans Frontieres
NATO	North Atlantic Treaty Organization
NGO	Non-Governmental Organiztaion
NGOIM	Non-Governmental Organizations interested in international migration
NWFP	North West Frontier Province (Pakistan)
QAS	Organization of American States
OAU	Organization for African Unity
OECD	Organization for Economic Cooperation and Development
OEEC	Organization for European Economic Co-operation
OEOA	Office for Emergency Operations in Africa (UN)
OXFAM	Oxford Famine Relief Committee
PAHO	Pan American Health Organization
PHC	Primary Health Care
PRCS	Pakistan Red Crescent Society
PDH	Project Director for Health (GOP)
PVO	Private Voluntary Organization
RHG	Refugee Health Group (LSHTM)
SAFRON	States and Frontiers Regions and Kashmir Affairs Division (GOP)
SCAWR	Standing Committee of Voluntary Agencies Working for Refugees
SCF	Save the Children Fund
SCN	Sub-Committee on Nutrition of the UN Administrative Committee on Coordination
SEATO	South-East Treaty Organization
SWABAC	South Western Agency Coordinating Body for Afghan Relief
TSS	Technical Support Service (UNHCR)
UK	United Kingdom
UN	United Nations
UNBRO	United Nations Border Relief Operation
UNDP	United Nations Development Programme
UNDRO	Office of the United Nations Disaster Relief Coordinator
UNECA	United Nations Economic Commission on Africa
UNEO	United Nations Environmental Organization
UNESCO	United Nations Education, Social and Cultural Organization
UNHCR	United Nations High Commissioner for Refugees
Unicef	United Nations International Children's Fund
UNIPAC	Unicef's Procurement and Assembly Centre
UNKRA	United Nations Korean Reconstruction Agency
UNNGLS	United Nations Non-Governmental Liaison Unit
UNRRA	United Nations Relief and Rehabilitation Administration

UNRWA	United Nations Reliefs and Works Agency for Palestine Refugees
US/USA	United States of America
USAID	US Agency for International Development
US$	United States dollars
USSR	United Socialist Soviet Republic
WCC	World Council of Churches
WFP	World Food Programme
WHA	World Health Assembly
WHO	World Health Organization
WWI	The first World War
WWII	The second World War
YMCA	Young Mens Christian Association

TABLE OF CONTENTS

Page

1 **TITLE PAGE**

2 **ACKNOWLEDGEMENTS**

3 **ABSTRACT**

4 **GLOSSARY OF TERMS**

7 **TABLE OF CONTENTS**

20 **INDEX OF FIGURES**

23 **INDEX OF TABLES**

24 **CHAPTER ONE Exegesis**

25 **1.1 Aims and objectives**

25 1.1.1 National health policies for refugees
26 1.1.2 International health policies for refugees

27 **1.2 Methods**

27 1.2.1 National health policies for refugees
27 1.2.1.1 Archival research
28 1.2.1.2 Individual interviews
28 1.2.1.3 Interviews with a brief schedule and conversation
28 1.2.1.4 Observation
29 1.2.1.5 Surveys
29 1.2.2 International refugee health policies

31 **1.3 An analytical framework: reflecting on policy processes**

31 1.3.1 Helping or hindering national efforts?
31 1.3.2 A rational or political process?
33 1.3.3 Seeking simple solutions?

33 **1.4 Policy redefined**

34 1.4.1 Analyzing the policy process
34 1.4.1.1 Refugee health relief as a historical concept
34 1.4.1.2 Institutions and institutional relationships through which health relief policy is created and practised

34 1.4.1.3 The dominant body of knowledge dictating the content of health relief policy
35 1.4.1.4 The experts who provide organizational and cultural leadership which directs and legitimises health relief policy

35 **1.5 Thesis structure**

36 **1.6 References**

38 **CHAPTER TWO The Red Cross movement - World War I: establishing international health relief as a humanitarian activity of nation-states**

38 **2.1 Legacies of the Red Cross movement**

38 2.1.1 Europe in the late 1800s
39 2.1.2 Health relief in law
40 2.1.3 Charitable agencies as conduits of health relief
41 2.1.4 A military or social welfare concern?
42 2.1.5 Health relief as a sub-specialty of medicine and surgery
43 2.1.6 Medical and surgical doctors organise and manage health relief

44 **2.2 The first World War: extending the scope and scale of health relief**

44 2.2.1 Medical concerns dominate the practice of health relief
48 2.2.2 Refugee relief: a charitable or governmental responsibility?
48 2.2.3 A new strategy of war
49 2.2.4 Comprehensive relief for entire populations
51 2.2.5 Paving the way for inter-governmental relief organizations

52 **2.3 International health relief as a policy of nation-states**

54 **2.4 References**

58 **CHAPTER THREE The second World War: establishing governmental structures for international health relief**

58 **3.1 Inter-governmental institutions as conduits of international health relief**

58 3.1.1 Legacies of the first World War (WWI)

59 3.1.2 The Health Committee of the United Nations Relief and Rehabilitation Administration (UNRRA)

60 3.1.3 The International Office for Public Health
61 3.1.4 The Health Organization of the League of Nations

62 **3.2 The United Nations (UN): a forum for international health relief as a humanitarian activity of national governments collectively**

64 3.2.1 The World Health Organization (WHO)
65 3.2.2 The United Nations Children's Emergency Fund (UNICEF)
67 3.2.3 The United Nations High Commissioner for Refugees (UNHCR)
71 3.2.4 The United Nations Relief and Works Agency for Palestine Refugees (UNRWA), The United Nations Korean Reconstruction Agency (UNKRA)
71 3.2.5 The Council for Europe and the Inter-governmental Committee for European Migration (ICEM)

72 **3.3 International health relief: a responsibility of governments collectively?**

75 **3.4 References**

77 **CHAPTER FOUR The United Nations High Commissioner for Refugees (UNHCR): a recent and increasingly significant participant in international health relief policy formulation and practice**

77 **4.1 The 1950s and 1960s: extending health relief world-wide**

77 4.1.1 Independence from colonial rule

83 **4.2 UNHCR: a forum for comprehensive refugee relief world-wide**

83 4.2.1 Refugee relief: a national or international responsibility?
83 4.2.1.1 Permanent or limited terms of office?
84 4.2.1.2 Universal or group definitions of a refugee?
84 4.2.1.3 Legal advocacy of material assistance for refugees?
85 4.2.1.4 International aid for individuals or groups of refugees?
85 4.2.1.5 Independent action or 'operational partners'?
86 4.2.2 Refugee relief becomes an international responsibility
86 4.2.2.1 Determining refugee status: The High Commissioner or the General Assembly of the UN?
87 4.2.2.2 Centralising decision-making for international refugee relief
87 4.2.2.3 From legal advocacy to comprehensive assistance
92 4.2.2.4 Financing international refugee relief

93 **4.3 The 1970s: International relief re-emerges as an aid priority**
98 4.3.1 The beginnings of bureaucracy

100 **4.4 The 1980s: UNHCR engages in health relief**

100 4.4.1 Health relief as a priority activity of UNHCR
101 4.4.1.1 An Emergency Health Kit
101 4.4.1.2 Assessing health and nutritional needs in emergencies
102 4.4.1.3 Guidelines on refugee health care for UNHCR managers
103 4.4.2 Building their own expertise in refugee health relief: medical doctors and nutritionists as staff members of UNHCR
103 4.4.2.1 International guidelines for refugee health care
104 4.4.2.2 Other standard kits or guidelines for international use
104 4.4.2.3 Appointing national or local refugee health coordinators: a focus for inter-agency competition
107 4.4.3 UNHCR: a coordinator and manager of refugee health relief?
107 4.4.3.1 Influencing national policies and practices for refugee health
112 4.4.3.2 Enhancing their credibility in refugee health
116 4.4.4 Moving beyond an advisory role
116 4.4.4.1 Centralised procurement of drugs and medical supplies
116 4.4.4.2 Proposing international standards for refugee health care
118 4.4.4.3 Co-sponsoring international conferences on refugee health care
119 4.4.4.4 Initiating international policies for refugee health care
119 4.4.5 Coordinating refugee health care: UNHCR or WHO?
119 4.4.5.1 Joint or independent health policies?
120 4.4.5.2 Collaboration or competition for roles in refugee health relief?

122 **4.5 Rationalising responsibility for refugee health relief: UNHCR or WHO?**

123 **4.6 References**

127 **CHAPTER FIVE The World Health Organization (WHO): a surprisingly insignificant participant in international health relief policy formulation and practice**

127 **5.1 1948 - 1975: a symbolic or substantial role in international health relief?**

127 5.1.1 Defining health relief: the prevention and control of epidemics of disease
128 5.1.2 Limited finances for providing emergency medical supplies
135 5.1.3 Opting for an advisory role

135 **5.2 1975 - 1980: organising to meet growing demands for relief**

135 5.2.1 Creating a separate unit for Emergency Relief Operations

136 5.2.2 Maintaining a supportive role
137 5.2.3 Continued financial dependency

137 **5.3 1980 - 1985: conferring legitimacy to health relief activities carried out by other organizations**

139 5.3.1 Forging links with other agencies engaged in international health relief
142 5.3.2 A guiding or rubber stamping role?

143 **5.4 1985 - 1990: bidding for a leading role?**

143 5.4.1 Strengthening WHO's response in health relief operations
144 5.4.2 Garnering support for a leading role
144 5.4.2.1 WHO as a centre of expertise
145 5.4.2.2 Forging links within the international aid regime
145 **Organizations within the United Nations**
146 **Private charitable organizations**
147 **Academic centres**
149 **Technical aid agencies of donor governments**

151 5.4.3 Organizational constraints to a leadership role in health relief
154 5.4.3.1 Insufficient members of staff
154 5.4.3.2 Insufficient funds
155 5.4.3.3 Centralised decision-making and bureaucratic procedures
157 5.4.3.4 Dependency on powerful national governments

172 **5.5 Rationalising responsibility for international health relief: UNHCR, WHO or Unicef?**

172 5.5.1 UNHCR?
175 5.5.2 WHO?
176 5.5.3 Unicef?

178 **5.6 References**

181 **CHAPTER SIX The United Nations Children's Fund (Unicef): the ideal organization to take the leading role in international health relief policy formulation and practice?**

181 **6.1 The 1950s: from relief to development**

184 **6.2 The 1960s: re-thinking an exclusive focus on development**

184 6.2.1 The challenge of more frequent and severe disasters
186 6.2.2 Opting for a role in rehabilitation and reconstruction
186 6.2.3 Capitulation: Unicef's unique role in relief

186 6.2.3.1 Relief based on tacit understandings only
187 6.2.3.2 Close collaboration with the Red Cross
187 6.2.3.3 Logistical expertise
187 6.2.3.4 Operational capacities
188 6.2.3.5 Ability to raise funds
193 6.2.3.6 Timely and authoritative decision making processes

193 **6.3 The 1970s: organising for a role in relief**

193 **6.4 The 1980s: adopting a low profile**

194 **6.5 The 1990s: resisting pressures to adopt a more influential role in relief?**

196 6.5.1 Strengthening relief capacities within Unicef
196 6.5.2 Maintaining a supportive role

196 **6.6 Planning relief for forced migrations: rhetoric or reality?**

197 6.6.1 Precedents for an expanded role
197 6.6.1.1 Supply and logistical capacities
198 6.6.1.2 Meeting basic needs for resources
198 6.6.1.3 The power of the purse
198 6.6.1.4 Meeting resource needs: a core component of relief
198 6.6.1.5 Timely and authoritative administration
199 6.6.2 A lack of support for an expanded role?
199 6.6.2.1 Widespread popular support
202 6.6.2.2 Dependency on powerful governments

214 **6.7 Responsibility for refugee health relief: a responsibility of governments collectively or civil societies?**

216 **6.8 References**

219 **CHAPTER SEVEN Beyond altruism: an expanded role for charitable organizations in the provision of foreign aid**

219 **7.1 Charities and WWII: responding to military strategies**

219 7.1.1 Supporting governmental strategies of war
220 7.1.2 Opposing governmental strategies of war

221 **7.2 The 1950s: partners in furthering foreign policies**

221 7.2.1 Cosy companions? Private Voluntary Organizations and the US Government

223 7.2.2 Promoting a more humane image of Europe: Non-governmental Organizations and post-colonial European foreign policy
224 7.2.3 An enlarged focus on the provision of technical and welfare aid

225 **7.3 The 1960s: An expanded role for charitable agencies in the provision of foreign aid**

225 7.3.1 PVOs and the exportation of the American dream
227 7.3.2 NGOs as advocates for social justice

229 **7.4 PVOs and NGOs in refugee relief: An essential institutional link in the new international health relief system**

229 7.4.1 Caring for European refugees
233 7.4.2 Locally based agencies in the developing world extend their services to refugees

237 **7.5 References**

240 CHAPTER EIGHT **Growth or partnership? Charitable organizations as 'the most vital component of the whole aid network' in the post-colonial era**

240 **8.1 The 1970s: Strengthening and consolidating partnerships with governments and inter-governmental agencies**

240 8.1.1 Private Voluntary Organizations and the 'New Directions' mandate
241 8.1.2 Non-governmental Organizations and the evolution of a Basic Human Needs strategy
243 8.1.2.1 Targeting basic needs
243 8.1.2.2 Generating popular support
244 8.1.2.3 Achieving goals for national expenditures on aid
244 8.1.2.4 Extending national influence abroad

244 **8.2 The 1980s: the decade of Private Voluntary Organizations and Non-Governmental Organizations**

244 8.2.1 The apolitical face of PVOs: Focusing on disaster relief and health care
245 8.2.1.1 Avoiding political associations
246 8.2.1.2 Fostering governmental support
246 8.2.1.3 Documenting their successes and comparative advantages
247 8.2.1.4 Scaling up
247 8.2.1.5 Working within governmental restrictions

248 8.2.2 Advocates for development: NGOs as important players in domestic politics

249 8.2.2.1 Generating substantial funds privately
250 8.2.2.2 Collaboration with inter-governmental agencies
250 8.2.2.3 Expanded governmental support
252 8.2.2.4 Responding to governmental incentives and punitive measures

254 **8.3 The new and pivotal role of relief for institutional growth: making the most of the sensational**

254 8.3.1 Refugees and displaced persons: a uniquely political disaster
255 8.3.2 Beyond the frontline: Charities as partners in official policy making processes for refugee relief
256 8.3.3 Justifying refugee relief on the basis of need
257 8.3.4 Aiding refugees confers international recognition
258 8.3.5 Working for, with or instead of agencies of the UN?
259 8.3.6 International recognition brings substantial profits
261 8.3.7 . . . and growth
263 8.3.8 . . . and greater influence

265 **8.4 References**

272 CHAPTER NINE **International health relief: a nefarious use of humanitarian resources?**

272 **9.1 Private, charitable organizations**

272 9.1.1 Essential providers of refugee health relief
274 9.1.2 Motivated by compassion or self-interest?
276 9.1.3 Roles played by charities in refugee health relief
277 9.1.4 Integral participants in the international refugee health regime

278 **9.2 Specialised agencies of the UN**

278 9.2.1 Supra-national powers or dependency on governments?
279 9.2.2 Dependency mechanisms
281 9.2.3 Strategies for surviving and thriving politically
282 9.2.4 Making symbolic gestures or substantial contributions?
284 9.2.5 Complementary and competitive roles in refugee health relief

287 **9.3 From clinical medicine to public health**

288 9.3.1 Priority public health interventions
290 9.3.2 Maintaining roles in meeting acute needs only

291 **9.4 References**

292 CHAPTER TEN **Health relief for Afghans in Pakistan, 1978-1982: Planning and organising a national refugee health service**

292 **10.1 Introduction**

292 10.1.1 Country Background
294 10.1.2 Afghan refugees in Pakistan
294 10.1.2.1 The Baluchis and Pathans: refugees in their own lands?
298 10.1.2.2 Seeking refuge from civil war
299 10.1.2.3 Seeking refuge among sympathetic hosts

301 **10.2 1978 - 1980: Organising relief for Afghans as refugees in Pakistan**

301 10.2.1 Responsibilities of the Federal Government: organising the distribution of essential goods
303 10.2.2 Responsibilities of the United Nations: securing needed resources
304 10.2.3 Responsibilities of the Provincial Governments of the North West Frontier and Baluchistan: organising and managing health relief
307 10.2.4 Establishing health services for the refugees: curative care or community health?
307 10.2.4.1 Basic curative services: management by refugee, Pakistani or foreign health personnel?
311 10.2.4.2 Sophisticated medical and surgical care: setting up separate facilities or building capacity in existing centres?
312 10.2.4.3 Disease control: extending national programmes

315 **10.3 1981 - 1982: Organising a national health service for Afghan refugees**

315 10.3.1 Management - a governmental affair
315 10.3.1.1 Planning for refugee health care nation-wide
316 10.3.1.2 Establishing federal and provincial structures
317 10.3.1.3 Planning for management of the refugee health programme locally
318 10.3.2 Creating a permanent medical service for Afghan refugees
319 10.3.2.1 The lack of a career structure for health staff
320 10.3.2.2 Hardship living conditions
320 10.3.2.3 Compensating for the lack of career opportunities and poor living conditions: financial incentives
321 10.3.2.4 National staff as care-givers: Restrictions on foreign personnel

322 **10.4 Comment**

328 **10.5 References**

332 CHAPTER ELEVEN **Closing the gaps between planning and practice: 1982 - 1984**

332 **11.1 Basic allopathic care and disease control: consolidating governmental responsibilities**

332 11.1.1 From *ad hoc* to routine service provision: establishing basic health units
338 11.1.2 Extending services to new arrivals in Mianwali District in the Province of Punjab
340 11.1.3 Strengthening management by the Provincial Governments
340 11.1.3.1 Setting up a system for local supervision
341 11.1.3.2 Grappling with the need to coordinate disparate health activities
344 11.1.3.3 Integrating disease control programmes
345 11.1.3.4 Setting technical standards

346 **11.2 Hospital services and community health: expanding roles for foreign interests**

346 11.2.1 Meeting the needs of those at war
351 11.2.2 Creating a community health programme

354 **11.3 Comment**

358 **11.4 References**

361 CHAPTER TWELVE **'Voluntary' agencies as providers of medical care, 1985 - 1988: Working for a charitable or political cause?**

361 **12.1 Fulfilling Governmental responsibilities for basic services in villages**

361 12.1.1 Achieving national targets for coverage of primary care
361 12.1.2 Confronting poor management of the refugee health services in Baluchistan
363 12.1.2.1 Moving beyond 'lame duck' management to leadership with authority

365 **12.2 Expanding roles for foreign voluntary agencies**

365 12.2.1 Foreign charitable agencies as providers of basic health services in refugee villages
365 12.2.1.1 From collaboration to competition: the Refugee Health Directorate and foreign charitable agencies in Baluchistan

368 12.2.2 Political parties and charitable agencies as providers of referral services in Pakistan and basic medical care in Afghanistan
368 12.2.2.1 Military or humanitarian priorities?
375 12.2.2.2 From coordination to anarchy in the North West Frontier
389 12.2.2.3 The refugee health programme in Punjab: a last remnant of coordinated national and international efforts?
393 12.2.2.4 Behind the scenes: the influence of the Government of the US

395 **12.3 Calling the shots: Pakistani authorities or foreign interest groups?**

398 **12.4 References**

402 CHAPTER THIRTEEN **Management of the refugee health programme, 1985 - 1989: by, with or instead of the Government of Pakistan?**

402 **13.1 Competing for the coordinating role: the Government of Pakistan, WHO and UNHCR**

402 13.1.1 Setting technical standards of care: specialised agencies of the UN move beyond an advisory role
403 13.1.2 Negotiating responsibility for refugee health within the UN system: the inadequacies of joint leadership
404 13.1.3 The power of the purse: UNHCR takes the leading role

407 13.1.4 Foreign aid agencies as managers of disease control programmes in collaboration with UNHCR
407 13.1.4.1 Management of an accelerated programme for immunizations
408 13.1.4.2 Management of the malaria control programme
409 13.1.4.3 Moving beyond concerns for effective care to considerations of efficiency
410 13.1.4.4 Initiating and carrying out a sanitation programme

411 13.1.5 Foreign aid agencies as managers of community-based health programmes in collaboration with UNHCR and Unicef

414 **13.2 Leadership within the refugee health programme: the Government of Pakistan, UNHCR or WHO?**

417 **13.3 The refugee health programme: in summary**

420 **13.4 References**

422 CHAPTER FOURTEEN **Getting in on the act: understanding the multiplicity of agencies promoting the health of Afghan refugees in Pakistan**

422 **14.1 The policy process: neglected dimensions of culture and discursive practices**

422 14.1.1 Policies for refugee health: synergistic or antagonistic to self- and community- health development?
424 14.1.2 Refugee health care: a demand driven response?
425 14.1.3 Cultural dimensions of health relief policy
426 14.1.4 Discursive practices and health relief

426 **14.2 National policies for refugee health: maintaining domestic stability**

426 14.2.1 Host governments: key or peripheral actors?
427 14.2.2 A significant influx of refugees: tens or hundreds of thousands?
428 14.2.3 Powerful symbols, but empty gestures?
428 14.2.4 Expanding official spheres of influence

429 **14.3 National or international policies for the health of Afghans in Pakistan?**

429 14.3.1 National and international publicity: delineating demand
431 14.3.2 Separate or integrated health services for refugees?
431 14.3.3 Expediency at the expense of efficient and sustainable services?
432 14.3.4 Health services for refugees: just basic?
433 14.3.5 Or referral too?
433 14.3.6 Humanitarian or strategic purposes?
434 14.3.7 Foreign charity - a solution to, or part of, the problem?
435 14.3.8 Seeking assistance from the UN: UNHCR, Unicef or *WHO*?
436 14.3.9 Management of refugee health by, with, for or instead of, national and local institutions?
438 14.3.10 Strengthening or undermining host capacities?

439 **14.4 Speculating about the future of the refugee health services in Pakistan**

439 14.4.1 The ideal policy option: integration
442 14.4.2 The likely reality: disintegration

444 **14.5 References**

445 CHAPTER FIFTEEN **Policies for the health of refugees: promoting human rights, compassion or self-interests?**

446 **15.1 Key findings**
446 15.1.1 A system for health relief globally
450 15.1.2 Health relief for Afghans in Pakistan, 1978 - 1988

453 **15.2 Recommendations: idealistic or realistic?**

455 **15.3 Policies for refugee health: promoting health or self-interests?**

455 15.3.1 The multiplicity of agencies: benevolent anarchy or a coherent system?
455 15.3.2 Many leaders, few followers
456 15.3.3 Charity or a human right?
456 15.3.4 Compassion or self-interest?
457 15.3.5 Power symbols, empty - even harmful - gestures

459 BIBLIOGRAPHY

INDEX OF FIGURES

Page	Figure	Title
78	4.1	Towards a third world: the twilight of the empires.
80	4.2	New states for old empires: independence 1945-57
81	4.3	New states for old empires: independence after 1957
82	4.4	New states for old empires: Africa
90	4.5	National governments with membership on the Executive Committee of UNHCR 1990: regional distribution
91	4.6	Governmental membership on the Executive Committee of UNHCR according to economic classification in 1990
109	4.7	Technical missions of UNHCR Geneva which included a health component, 1980-1989
110	4.8	Professional composition of technical missions of UNHCR Geneva which included a health component, 1980-1989
111	4.9	Health related missions of UNHCR Geneva by geographical region, 1980-1989
113	4.10	Recommendations for health care made by technical missions of UNHCR Geneva, 1980-1989
114	4.11	Management recommendations of UNHCR health missions: strengthening national or foreign management of refugee health?
115	4.12	Employment status of personnel undertaking health related technical missions for UNHCR Geneva, 1980-1989
117	4.13	Professional qualifications of personnel undertaking health related technical missions for UNHCR Geneva, 1980-1989
121	4.14	UNHCR's annual expenditure, 1967-1989
129	5.1	WHO's involvement in relief: disasters responded to since WWII
132	5.2	Types of disasters to which WHO responded before 1975
133	5.3	Type of assistance given by WHO for relief between 1948-1975
134	5.4	Type of assistance given by WHO for relief since WWII, 1948-1989
138	5.5	WHO's response to disasters by geographical region, 1948-1989
140	5.6	Types of disasters to which WHO responded, 1948-1989
141	5.7	WHO's participation in international health relief activities, 1980-1989
152	5.8	WHO disaster communication model
153	5.9	Actions of WHO and UN in disaster
159	5.10	Low, middle, high and nonmember economies represented on the Executive Board of WHO, 1948-1989
160	5.11	Continuity of representation on the Executive Board of WHO of lower income economies, 1948-1989
161	5.12	Continuity of representation on the Executive Board of WHO of higher income and nonmember economies, 1948-1989
162	5.13	Regional representation on the Executive Board of WHO, 1948-1989
163	5.14	Countries represented and seats occupied on the Executive Board of WHO by region, 1948-1989
164	5.15	Governments with membership on the Executive Board of WHO by region, 1948-1989

167	5.16	Continuity of African and Eastern Mediterranean representation on WHO's Executive Board, 1948-1989
168	5.17	Continuity of South East Asian and Western Pacific representation on WHO's Executive Board, 1948-1989
169	5.18	Continuity of American and European representation on WHO's Executive Board, 1948-1989
170	5.19	Governments with membership on WHO's Executive Board: financial contributions to the annual budget
173	5.20	Regional distribution of WHO member nation-states and those not represented on WHO's Executive Board
185	6.1	Unicef expenditure on emergency aid as a percentage of total programme expenditure, 1947-1985
195	6.2	Unicef expenditure on emergency aid in millions of US$, 1947-1985
200	6.3	Countries with Unicef National Committees by economic classification, 1990
201	6.4	Unicef National Committees by region in 1990
206	6.5	Regional representation of governments with membership on the Executive Board of Unicef, 1946-1989
207	6.6	Seats occupied on the Executive Board of Unicef by region, 1946-1989,
208	6.7	Income status of governments with membership on the Executive Board of Unicef, 1946-1989
209	6.8	Seats occupied on the Executive Board of Unicef by income status of member governments, 1946-1989
210	6.9	Representation of lower income economies on Unicef's Executive Board, 1946-1989
211	6.10	Representation of higher income economies on Unicef's Executive Board, 1946-1989
293	10.1	Provinces of Pakistan
295	10.2	Major Baluch and Pathan areas
297	10.3	Administrative organization of the territories of the Islamic Republic of Pakistan
300	10.4	Distribution of registered Afghan refugees in Pakistan between 1979-1987
302	10.5	Organization of the Disaster Preparedness and Relief Cell, Federal Government of Pakistan
305	10.6	Organization of health departments of the Provincial Governments of Pakistan
334	11.1	Health services provided for Afghans by private, charitable organizations in 1984
337	11.2	National base of private, charitable organizations involved in the Afghan relief effort, 1984
342	11.3	Organization of health services for Afghan refugees 31 December 1984
349	11.4	Organizations sponsoring hospital services for Afghans in Pakistan, 1984
369	12.1	Legal status in Pakistan of charities providing health care for Afghans from a base in Baluchistan, 1990
370	12.2	Registration in law of charities providing health care for Afghans from a base in Baluchistan, 1990

374 12.3 Involvement of charities in health care for Afghans from a base in Baluchistan, 1990
377 12.4 Charities providing health relief for Afghans from a base in the North West Frontier, 1980-1989
379 12.5 Charities involved in the provision of health care for Afghans from a base in the North West Frontier, 1990
380 12.6 Registration in law of charities providing health care for Afghans from a base in the North West Frontier, 1990
381 12.7 Legal status in Pakistan of charities providing health care for Afghans from a base in the North West Frontier, 1990
390 12.8 Registration in law of organizations providing referral services for Afghans in the North West Frontier, 1990
391 12.9 Organizations providing referral services for Afghans in the North West Frontier, 1990
406 13.1 The structure of the SCF Primary Health Care Programme

INDEX OF TABLES

Page	Table	Title
88	4.1	National governments with membership on the Executive Committee of UNHCR, 1951-1988
95	4.2	Disaster units in United Nations organizations
96	4.3	Disaster units established in major donor governments
108	4.4	Location of technical missions of UNHCR Geneva which included a health component, 1980-1989
131	5.1	The work of the ERO office of WHO, 1980-1989: Types of international health relief activities and the lead agency responsible for their implementation
165	5.2	Average number of seats occupied by low, lower-middle, upper-middle, high and nonmember economies represented on the Executive Board of WHO
165	5.3	Average number of seats occupied on the Executive Board of WHO by countries contributing <1%, 1-9.99% and 10+% of the annual regular budget
183	6.1	Unicef's participation in mass campaigns to control or eradicate diseases, 1947-1952
189	6.2	Unicef total income, 1947-1985
190	6.3	Emergency aid given UNICEF, 1948-1965
205	6.4	Ratio of seats occupied by national governments on Unicef's Executive Board between 1946-1989 according to their economic status and regional location
231	7.1	Charitable organizations working in the field of international migration and refugee relief, 1963
310	10.1	Voluntary agencies providing basic health services for Afghan refugees in 1980
313	10.2	Malaria prevalence among Afghan refugees and the local Pakistani populations in the North West Frontier
335	11.1	Charitable agencies recognised by Pakistani authorities for providing health care for the Afghans in 1984 (excluding hospital services)
350	11.2	Hospital services specifically established for Afghans living in Pakistan, 1984
371	12.1	Organizations providing health services for Afghans from a base in Baluchistan, 1989
375	12.2	Additional referral facilities established for Afghans in Baluchistan since 1984
382	12.3	Organizations providing health care for Afghans from the North West Frontier, 1989
386	12.4	Additional referral facilities established for Afghans in the North West Frontier since 1984
392	12.5	Organizations providing health care for Afghans in Punjab, 1989

CHAPTER ONE

Exegesis

Forced migrations of entire communities is a growing problem of our times. Most of the 20 million refugees in today's world[1] come from and seek asylum in the poorer countries in Africa, Asia and Latin America. Some of the poorest nations in the world host the largest refugee populations, although they have difficulty caring for their own people. Widespread conditions of systematic insecurity and oppression mean that voluntary repatriation will not be possible for many refugees; together with a growing reluctance to accept refugees for resettlement in more wealthy nations leaves long term refuge in Africa, Asia and Latin America the only remaining option. The Palestinians scattered throughout the Middle East since 1948 and the Tibetans in India since 1959 illustrate the indefinite or lengthy duration of such refuge today.

In response to refugees firstly of the World Wars and later of decolonization, a system evolved to provide international relief for refugees. In support of the numerous organizations in this system, several academic, research and consulting groups were formed to study the many problems encountered and to advise on policy and practice. Most of the prominent groups which specialised in refugee health care were formed in the 1970s and 1980s, for example at the School of Public Health at the University of California at Los Angeles, US, the Centres for Disease Control of the US Government, the Centre for Research on the Epidemiology of Disasters at the University of Louvain, Belgium and the Refugee Health Group at the London School of Hygiene and Tropical Medicine, UK. These groups and others studied the health problems of refugees and made recommendations of how best they could be addressed.

Throughout the published literature, and in many internal organizational reports, the questions under study and the recommendations offered generally focused exclusively on the health needs of refugees. Yet, when populations migrate, there are repercussions not only for those who move, but also for those communities into which

the refugees settle. But, in the health sector, international concern and relief efforts have focused almost exclusively on the problems of refugees thereby neglecting the consequences of an influx of refugees, and the resulting international relief operation, for host nations. In recognition of this gap in our understanding of refugee health relief, the London School of Hygiene and Tropical Medicine proposed to study the ways in which health policies are formulated and implemented in response to refugees, by both national governments and the international community[2]. The proposal was accepted for funding firstly by the Overseas Development Administration of the UK Government who generously funded the case study in Pakistan during 1987, 1988 and early 1989 and later by the Pew Charitable Trusts of the US who kindly funded the review of the policies and practices of the international community during 1989, 1990 and 1991[3].

1.1 Aims and objectives

1.1.1 National health policies for refugees

The original aim of this study was to identify the major health policy issues faced by host governments and to document the specific health policies adopted by them. It was thought that the ways in which national health policies for refugees were formulated and implemented could then be improved: it was also hoped that the lessons learnt could be generalised to other host nations. Thus, this research began with the case study of national health policies for Afghan refugees in Pakistan. The objectives of this study focused the research on:

1. Documenting health policies adopted by host governments and the factors which influenced the development of such policies.

2. Documenting the organization of health planning for refugees by host governments and the factors which influenced the evolution of organizational systems adopted.

3. Providing information on the most effective roles for international agencies, inter- and non-governmental, in providing support to countries responsible for large numbers of refugees.

1.1.2 International health policies for refugees

From the analysis of national health policy for refugees in Pakistan, it became clear that international agencies played a crucial role in many aspects of policy formation and implementation. In order to understand better the evolution and implementation of health policies for refugees in the national setting, it was then necessary to understand the policy process within which the international agencies operate and the extent to which they affect policy within countries. Subsequently, additional research on the policies, practices and roles of international aid agencies involved in refugee health care was undertaken; the objectives of reviewing health policies for refugees of international aid organisations were specifically:

1. To document the involvement of the United Nations High Commissioner for Refugees (UNHCR), the United Nations International Children's fund (Unicef) and the World Health Organization (WHO) in refugee health generally since their establishment in the 1940s.

2. To identify and analyze the mandates and health policies and plans for refugees of UNHCR, Unicef and WHO, with specific emphasis on their role in refugee health care and their relationships with each other, governments, private, charitable agencies and refugees.

3. To identify the types, mandates, structure and source of funds of charitable agencies assisting in refugee health care in Pakistan.

4. To document health policies for refugees of these charitable agencies and specific programmes, activities and other support provided by them for refugee health care.

5. To clarify the relationship of charities working in Pakistan with host governments, donor governments, agencies of the UN and the refugees.

6. To determine reasons for their involvement in relief operations for refugees in Pakistan and reasons for their withdrawal.

1.2 Methods

1.2.1 National health policies for refugees

An analysis of national health policies was undertaken in Pakistan during 1987, 1988 and 1990. Pakistan was chosen for the national case-study for several different reasons. Firstly, Pakistan has been host to the largest refugee population in Asia throughout the 1980s. Secondly, the Government of Pakistan has developed an extensive health service specifically for the Afghan refugees. Lastly, numerous charitable organisations and specialised agencies of the United Nations were involved in the Afghan refugee health programme; thus, the evolution of health policies for Afghan refugees illustrated the roles played by international aid agencies in the policy process.

Several different methods were used, mainly to reconstruct the historical development of refugee health policy and the ways in which it was expressed in practice. Most methods were qualitative and included the use of questionnaires, interviews, observation and archival research. These methods were supplemented by two surveys, based on structured questionnaires, which were administered personally.

1.2.1.1 Archival research

Written documents were reviewed, primarily national and regional files of the government, the main UN agencies involved in health and refugee relief, and private charitable organizations working with the refugees. Although these written documents are secondary sources, they were often the only remaining sources of information.

Since access was obtained to the records of several different organizations, it was possible to verify information obtained by more than one source.

1.2.1.2 Individual interviews

Open conversation was frequently used to uncover new facts and to validate information obtained from written sources. It was also used to elucidate the perspectives and views of individuals and the organizations they represented. This was especially important in understanding how different parties viewed particular problems, decisions taken and the effectiveness of actions implemented. Such conversations were held with general relief workers as well as with key informants within the refugee health programme at all levels.

1.2.1.3 Interviews with a brief schedule and conversation

Similarly, structured interviews were conducted, primarily with organizational representatives; for example, during the survey of private charitable agencies working in the refugee health programme. These interviews were important in determining common perceptions of problems and the relationships between the various institutions involved in providing health care, such as the government and UN agencies. In addition, these interviews allowed common interests and ways of working to be identified for this disparate group of organizations.

1.2.1.4 Observation

Nearly twelve months were spent in Pakistan, visiting the different offices, people and health facilities. This provided an opportunity to see how people, organizations and facilities were organized and how they communicated with each other. This was important because antagonistic relationships in particular are seldom documented in writing. Nor are individuals always willing to talk openly about conflict, competition or disagreements with others. Being able to observe some of the interactions among the different parties was an invaluable help in understanding why certain developments

occurred and others never materialised. In addition to the research, invitations to observe workshops and meetings were accepted whenever possible.

1.2.1.5 Surveys

Two different surveys were conducted. The first used a structured questionnaire of mainly closed questions to document the implementation of health policies. Because a structured questionnaire was used, the survey focused on material evidence of policy implementation in a sample of refugee camps, for example the presence of health facilities, drugs and supplies or personnel. The questionnaire did, however, also include some questions on management, in particular relationships with district, regional and national offices as well as with UN and charitable agencies working in the camp. Thirty camps were randomly selected and visited in Pakistan.

The second survey was of charitable agencies working in the refugee health programme. Again a structured questionnaire was used. Unlike the previous survey of camp health services, this questionnaire was given to the medical or health directors of a sample of agencies to complete. A structured interview was then conducted when the questionnaire was collected.

The data gathered from these two surveys is vast; an analysis and presentation of individual results has, therefore, not been included separately in this thesis; instead, the results have been incorporated into the narrative, both in making statements about historical facts as well as in drawing conclusions.

1.2.2 International refugee health policies

The analysis of international health policies for refugees was undertaken in 1990 and 1991. Archival research, interviews, questionnaires and reviews of published literature were again used. Questionnaires were used only for charitable agencies and have been described previously. Written documentation and interviews were the main sources of

information on the mandates, organizational structures, roles and activities of the UN agencies involved in health relief and the Red Cross. Visits were made to Geneva and New York where these agencies have their main offices, and published literature was reviewed in London and Oxford.

The use of these methods allowed a history of the development of national refugee health policies in Pakistan as well as international refugee health policies to be reconstructed. In such a complex phenomenon, there is no doubt that other facts and perspectives have been omitted, rendering the history, or in scientific parlance - the data, biased in one way or another. In an effort to validate the findings of the national case study, the various interest groups reviewed the summary and found it to be an acceptable representation of overall events. Perhaps more importantly, the summary was complete enough to reveal relationships between the various interest groups and policy issues of concern as well as the benefits or disadvantages of different options for the groups involved. To date, the findings on the roles and work of the specialised agencies of the UN and the Red Cross have only been shared with selected groups during academic presentations; the fact that the results have been well received and backed up by the provision of additional data are encouraging, even if such feedback is insufficient evidence of their validity.

as the benefits or disadvantages of different options for the groups involved. To date, the findings on the roles and work of the specialised agencies of the UN and the Red Cross have only been shared with selected groups during academic presentations; the fact that the results have been well received and backed up by the provision of additional data are encouraging, even if such feedback is insufficient evidence of their validity.

1.3 An analytical framework: reflecting on policy processes

1.3.1 Helping or hindering national efforts?

An analysis of the case studies in Pakistan and Somalia in 1989[5] led to several conclusions which extended the research to include international policies[6] and which suggested criteria for an analytical framework for the study as a whole. Firstly, it was noted that the original aims and objectives were biased, reflecting certain assumptions about refugees and policy-making. For example, they carried on the tradition of focusing almost exclusively on refugees by evaluating governmental response to refugees in order to improve those responses. More importantly, by seeking to understand and expose the strategies used by host governments to protect and promote their own interests in the wake of a large influx of refugees and international aid organizations, the purpose of the research had a sinister side to it. Such information would clearly be of use not only to those genuinely seeking to assist the governments and peoples of poorer nations who host refugees but also to those foreign organizations wanting to impose their own policies.

1.3.2 A rational or political process?

Secondly, the original proposal assumed that national policies were statements of intent, aims, ideals or plans of governments. Such a concept of policy is widely held and has been articulated by a variety of organizations and individuals. For example, the charitable agencies which had official relations with the World Health Organization in the late 1970s defined 'A National Health Policy [as] an expression

of the goals established for improving and sustaining the health situation, the priorities among these goals, and the main directions for attaining them'[7]. This definition of health policies suggests that they can be readily and easily identified, their implementation documented and, to some extent, their impact measured. It also suggests that the policy process 'for specifying health goals and priorities should follow the identification and careful analysis of health problems and the country's socio-economic capacity to deal with them'[8]. Furthermore, as such, the most influential reasons for their adoption could be deduced.

Policy as an expression of goals indicates an attempt to analyze policy rationally. In other words, it suggests that there would be logical steps in the policy process within which somewhat rational decision-making patterns could be identified and attributed to the needs or demand for care or to one or many social, economic or political interests of the groups involved. Such a popular concept of the policy process is based on the need or demand for services in its logic[9]. Yet, there are other factors which motivate institutions to provide health relief for a group of refugees, all of which further the interests of those supplying care somewhat irrespective of the need for care which is generated by the refugees themselves. Since the findings of this research show that health relief for refugees is based less on the needs of refugees than on those providing care, this analysis of health relief policy does not pivot around the demand for health care which is generated by the refugees themselves; instead, attention is focused on those who supply health relief services for refugees and specifically the ways in which refugee health relief furthers their own institutional interests.

The coherence of such an approach in analyzing and interpreting the findings of these studies highlights that the emphasis in the original objectives on identifying influential factors was naive. The factors which were found to influence policy are comprehensive, even 'infinite'[10], and they cannot, therefore, be singled out systematically or considered out of context. Clearly, the reality of a rational or normative process by which policy is formulated has not been borne out by this analytical study. It was also found, consequently, that health policies for refugees

could not be studied in isolation from the surrounding social, cultural, economic and political environment.

1.3.3 Seeking simple solutions?

Common to all of these assumptions inherent in the original proposal is an emphasis on technical interventions or solutions and on describing policy-making rather that explaining it. By using a more technical and descriptive focus, which it was hoped would lead to standards of care or administrative mechanisms which could be applied universally, the research was biased to benefit those conducting it and the organizations who could apply it universally - the international aid organizations. This technical and descriptive emphasis is characteristic of research and literature on refugee health relief generally. A review of published literature on refugee health care since 1948 found that nearly all documents were concerned with measuring primarily the extent of specific health or nutritional problems, the impact of specific interventions on the health status of refugee populations or, occasionally, the management of allopathic medical services for refugees. Published literature on national or international policies for health in response to an influx of refugees and the associated international relief operation is scant. Specific health policies in operation and the political processes behind their adoption are seldom stated. Instead, 'policy' decisions in the form of recommended technical or managerial standards and goals are frequently suggested following descriptions of refugee health conditions and services.

1.4 Policy redefined

Unlike more common perceptions of policy, which in the health sector are generally technical or administrative in nature, this analysis will conclude that *policies are the instruments through which an environment is ordered or regulated. Policies are the means through which power is managed. Thus, policies reflect relationships of power and the ways in which power is used - in other words for what ends.* In order to focus

this analysis of health policies for refugees, emphasis will be given to four key aspects of policy.

1.4.1 Analyzing the policy process

1.4.1.1 Refugee health relief as a historical concept

Although health and health relief are generally thought of as biological concepts, the meaning of health and health relief has, in fact, changed over time and differs within different cultures. This means that health relief must be considered historically as a concept which is defined culturally, economically and politically.

1.4.1.2 Institutions and institutional relationships through which health relief policy is created and practised

Secondly, health relief is a policy of institutions within national societies. As such, the analysis needs to focus on the role played by health relief for these institutions. To do this, the institutions and the ways in which they interact with each other to formulate health policies for refugees will be examined.

1.4.1.3 The dominant body of knowledge dictating the content of health relief policy

Thirdly, an official discourse has been developed for refugee health relief which defines the roles and shapes the identity of health care providers as well as perceptions of beneficiaries of health relief services. This discourse has institutional, political, social and scientific implications for defining health relief problems and the ways to solve them. In particular, it allows some kinds of knowledge which explain health relief issues to dominate the content of policy. This analysis will look at which body of knowledge is used to dictate the content of health relief policy.

1.4.1.4 The experts who provide organizational and cultural leadership which directs and legitimises health relief policy

Lastly, since the Red Cross movement of the late 1800s medical professionals have been the providers of health relief. Thus, medical professionals are endowed with the authority of the institutions for health relief and are generally recognised as experts. However, the training of these experts in specialised institutions is a process which inculcates ideological views and values in addition to scientific or technical knowledge. This means that their practice of health relief is also a practice of particular political and ideological views and values. Thus, it is important to identify and examine the group of experts who provide the organizational and cultural leadership which directs and legitimises policy.

1.5 Thesis structure

In order to understand the international context in which health relief is given as well as the policy environment in which the inter-governmental organizations and foreign private charitable agencies work, the evolution of the system for health relief worldwide is considered in Chapters 2 through 9. The formulation and practice of health relief policies for the Afghans living in Pakistan between 1978 and 1988 are then analyzed in Chapters 10 through 14. A discussion of the key policy issues and the characteristics of the policy-making process conclude the thesis in Chapter 15.

1.6 References

1. US Committee for Refugees (1992) World Refugee Survey. Washington DC, USA, US Committee for Refugees

   Cuenod J (1991) Report on refugees, displaced persons and returnees. Report to the Economic and Social Council of the United Nations. Geneva, Switzerland: the Economic and Social Council, the United Nations

2. Simmonds S, Vaughan P and Godfrey N (1986) Refugees and national health policies. A comparative study of the development of refugee and national health policies by host governments. London, UK: Evaluation and Planning Centre, London School of Hygiene and Tropical Medicine, 25 pp. plus appendices

3. Godfrey N and Mursal H (1990) International aid and national health policies for refugees: Lessons from Somalia. Journal of Refugee Studies 3(2):110-134

   Freyermuth Encisco G and Godfrey N (1991) Guatemalan refugees in Mexico: Living in a continuous state of emergency. Chiapas, Mexico and London, UK: El Centro de Investigaciones y Estudios Superiores en Antropologia Social del Sureste and the London School of Hygiene and Tropical Medicine, 50 pp.

4. Oxfam (1984) Health care to refugees. An assessment of needs and responses. in ICVA Timely solutions. Voluntary agencies and African refugees. Geneva, Switzerland: International Council of Voluntary Agencies, Working Group on Refugees and Migration, Subgroup on African Refugees, pp. 7-8

5. Godfrey N (1989) Refugees and national health policies. A comparative study of the development of national health policies for refugees in Pakistan and Somalia. Report to the Overseas Development Administration of the UK Government. London, UK: London School of Hygiene and Tropical Medicine, April, 41 pp.

6. Godfrey N and Vaughan P (1988) A modified proposal to enable an in-depth study to be carried out of the roles of inter- and non- governmental agencies and refugee organizations in the development and implementation of refugee health policies and plans. Research proposal submitted to the Pew Charitable Trust, USA. London, UK: London School of Hygiene and Tropical Medicine, 9 pp.

7. The Non-governmental Organizations Group on Primary Health Care (1981) The role of non-governmental organizations in formulating strategies for health for all by the year 2000. Geneva, Switzerland: World Health Organization, p. 12

8. The Non-governmental Organizations Group on Primary Health Care (1981), #7, p. 12

9. Cavallo S (1991) The motivations of benefactors. An overview of approaches to the study of charity. In: Barry J and Jones C Medicine and charity before the welfare state. London and New York: Routledge, pp. 46-62

10. Leichter HM (1975) A comparative approach to policy analysis. Health care policy in four nations. Cambridge, London, New York, Melbourne: Cambridge University Press, 281 pp. plus appendices

CHAPTER TWO

The Red Cross movement - World War I: establishing international health relief as a humanitarian activity of nation-states

2.1 Legacies of the Red Cross movement

2.1.1 Europe in the late 1800s

Although the Red Cross is only one of many organizations involved in international health relief for refugees today, many current perceptions of disasters and practices of health relief generally are legacies of the Red Cross movement of the 1860s. The Red Cross was founded in a world very different from today. Europe was the most densely populated part of the world, and together with Russia, it accounted for a quarter of the world's population[1]. Within Europe, peoples were divided. In central and eastern Europe a wide range of ethnic groups, which differed by language and customs but had common agricultural lifestyles, were incorporated into three large empires, the Austrian, Russian and Turkish empires.

In western Europe, the British, Belgian, Dutch, French, German, Italian, Portuguese and Spanish empires were undergoing industrialisation. Unlike the peoples to the east, most workers in the west were increasingly employed in industry. Growth of industry required a large, cheap and mobile labour force which was drawn from rural areas. The movement of large numbers of people from rural areas to urban centres meant that cities such as Amsterdam, Berlin, Brussels, London, Paris and Vienna had population increases of between 100 and 300 per cent in the latter half of the 1800s[2]. However, unlike the Austrian and Russian empires which were slower to industrialise or which had vast national resources, the needs of industry in western Europe soon exhausted national markets and resources. Western European empires then scrambled for colonies in Africa and Asia as new sources of cheap labour, raw materials and markets.

The growth of industrial economies in western Europe and North America brought profound changes in societies and the roles of national governments. Widespread poverty, overcrowding and appalling working conditions in cities and towns stimulated greater governmental intervention in industry and social services in the latter part of the 1800s, for example, in the areas of industrial legislation, education, health and social insurance[3]. These same conditions which prompted governments to take action to ensure healthy working and military populations and social stability, also acted as a catalyst for more general discussions and activities of a humanist nature throughout society.

Since the defeat of Napoleon in 1815, there was no war which involved all the major powers in Europe and North America (Austria, Britain, France, Germany (Prussia until 1871), Russia and the US). But there were numerous smaller wars as empires tried to extend their boundaries and influence and as groups of people tried to set up their own independent homelands and states. It was during one such conflict between the Italians and Austrians that Henry Dunant, a Swiss citizen, witnessed the Battle of Solferino in Italy in 1859. As a result he began a campaign to protect victims of war and to establish voluntary relief societies[4].

2.1.2 Health relief in law

Legal rules to protect those injured during war were first advocated by the Red Cross in the Geneva Convention of 1864. This Convention was signed initially by ten European governments. The Convention was later revised in 1906, 1929 and 1949 to include prisoners of war, refugees and civilians[5]. One-hundred-sixty-two countries had signed these Conventions by 1985[6]. Initially, the promotion and implementation of these Conventions was the work of the Geneva Committee, the founding fathers of the Red Cross. It originally consisted on only 5 members, all of whom were prominent citizens able to volunteer their time, resources and social status to nurturing the Red Cross movement: two distinguished surgeons, a retired army general, a lawyer active in social work and Henry Dunant[7]. The Geneva Committee was renamed in 1880 the International Committee of the Red Cross (ICRC) which continues today as a private

committee of between 15 and 25 Swiss citizens responsible for protecting and assisting victims of armed conflict.

Five of the ten articles of the first Geneva Convention gave neutrality to health workers and health facilities of national committees set up to assist those wounded in war. Ten such committees were established in Europe in 1863 and 1864[8], and health relief was their main activity. The designated roles and activities of these committees, later called national Red Cross or Red Crescent societies, established a pattern of dependency on national governments as well as an emphasis in health relief policy on the practice of clinical medicine and surgery which continued for nearly 100 years.

2.1.3 Charitable agencies as conduits of health relief

The two most important relationships which the Red Cross had were with Christianity and national governments. The relationship with Christianity was ideological, and the relationship with national governments was political and organizational. Both ensured acceptance of and support for health relief.

In the middle of the nineteenth century, Europe was under the influence of the 'revival' which imposed new rigour on prevailing Christian religions, especially Catholicism and Calvinism. In keeping with the times, the Dunant family were 'passionate followers of religious services'[9], and Henry was no exception. Less than ten years before the Red Cross was established, Henry Dunant had organised weekly meetings 'to bring about among the youth a reawakening to the cause of God'[10]. These meetings developed under Dunant's leadership into Young Men's Christian Unions and later, in 1855, into a World Federation of Young Men's Christian Association, known today as the YMCA. The similarities between the YMCA and national Red Cross societies were striking, both in their roles of providing assistance to the poor or needy and in their organization as federations of national groups.

The only institutional relationship which the newly formed national Red Cross societies had were with national governments. National societies were, and still are,

dependent on national governments in two ways. Firstly, national Red Cross societies can only be set up in nation-states whose governments have signed the Geneva Conventions. Moreover, only one such society can be created in any given nation-state; in other words, it must have a national orientation and character. Secondly, national societies were created to 'aid the wounded should the Military Medical Services prove inadequate' (emphasis added)[11]. Each society's duty is, thus, 'to assist Army Medical Services'[12]. To do this, each society 'shall get in touch with the government of its country, so that its services may be accepted'[13]. Not only must the government generally accept their national society, but voluntary medical personnel can only be sent to the battlefield 'on the request or with the consent of the military authorities'[14]. Clearly, national Red Cross societies depend on national governments not only to be allowed to act in times of war, but to exist at all. Moreover, health relief was originally under the control of military apparatuses of nation-states, even though it was carried out by private citizens working for private, humanitarian organizations.

2.1.4 Health relief: a military or social welfare concern?

Yet health relief could have been part of the social welfare apparatuses of nation-states. In the latter half of the 1800s, nation-states were well-established in Europe and were increasingly developing social welfare apparatuses in addition to more traditional apparatuses for national security (eg. the military and police), political administration and financing (eg. systems for public administration and taxation) and economic growth (eg. systems to enact and enforce legislation)[15]. After a relatively short period of laissez faire or non-interventionist policies at the turn of the nineteenth century, national governments in Europe increasingly accepted health as a concern of the state in response to the overwhelming effects and needs of industrialisation. They began to create state apparatuses to address health needs, particularly of the working class population. These apparatuses were first institutionalised in many European countries during the nineteenth century when governments began to provide free or inexpensive medical services for the poor as well as public health programmes to control specific diseases which were epidemic at the time, for example cholera, typhus and

smallpox[16]. Similarly, systems of government sponsored medical services were also set up in the African, Asian and Caribbean colonies of many European nations at the same time[17]. Later, in the first half of the twentieth century, national systems were created for health insurance and health services in most European countries[18],[19]. Clearly, health had become a priority of national governments in Europe and separate health institutions were being created for the delivery of health services as part of the social welfare apparatuses of nation-states.

There was a crucial difference between these national health systems and health relief. While national health systems addressed on-going social and economic needs, health relief met only the needs of soldiers wounded during war. In those times, wars were fought on battlefields by armies using firearms and seige tactics. In comparison with wars today, they had a distinct beginning and end, and many were only of short duration. Even at the beginning of World War II, most European governments were expecting a decisive battle based on the military strength of participants[20]. In addition, wars were fought only by able-bodied men, involving less than half of the population. Health relief was, therefore, a temporary activity; compared with wars and disasters today, it was only needed infrequently, over short periods of time and for a small proportion of the population.

2.1.5 Health relief as a sub-speciality of medicine and surgery

The initial tasks of national Red Cross societies all focused on providing timely medical and surgical care to those wounded in war, ranging from first aid to sophisticated surgical treatments. This emphasis on medical and surgical care is not surprising given that military medicine was a distinct occupation of the times. Numerous wars and internal conflicts in Europe since the 1400s had led to the development of military medicine, primarily surgical care of gun shot wounds[21]. Experiences on the battlefield were complimented greatly by, and were complimentary to, early developments in anatomy and surgery in the 1500s, physiology and chemistry in the 1600s, and bacteriology and the natural history of diseases in the 1700s. But it was not until the late 1800s that micro-organisms were accepted as the causes of

disease, establishing the framework within which medical and surgical research and practice have been based ever since. Nevertheless, by the end of the eighteenth century, medicine in Europe generally had evolved to such a degree that during the 1800s practitioners increasingly specialised in only one part of the body or age group, one type of disease(s) or one aspect of medical sciences (in the case of researchers and teachers)[22]. This applied equally to military medicine and surgery which remain today as sub-specialties within the fields of general medicine and surgery. Inadequacies of military medical services and advances in medicine and surgery generally provided a natural focus for humanitarian health relief priorities on the medical and surgical care of war casualties. Medical and surgical care of individuals wounded during armed conflict was one of the main activities of voluntary relief agencies, especially the Red Cross. Even today, the International Committee of the Red Cross (ICRC) continues to specialise in war surgery.

2.1.6 Medical and surgical doctors annex the field of health relief

The application of positivist science to medicine not only had benefits for the effectiveness of medical and surgical practices, but it also allowed doctors to take the lead in and control of the healing professions generally. It did this in several ways.

> 'It increased the technical effectiveness of doctors, providing a basis for increasing public confidence in the profession. The need for research and the teaching of medical sciences created a whole new category of academic medicine. It united the interests of these academic physicians, who sought total victory for scientific medical schools over less adequate ones, with the interests of elite practitioners, who wanted to reduce production of and competition among doctors in order to raise their income and status. The requirements of scientific medical education strained the resources of 'commercial' medical education to the breaking point, closing down many medical schools and reducing the production of physicians. It also provided the rationale for requiring extensive preliminary education of medical school applicants, forcing the poorer classes out of medicine and thereby raising the social class base of the profession. Furthermore, scientific medicine undermined sectarian medicine, uniting most of the divided profession under the banner of 'nonsectarian' scientific medicine. Finally, it provided a basis for further decreasing competition within the profession through the development of specialization. Thus, scientific medicine helped complete the professionalization of medicine'[23].

Not surprisingly, while the Red Cross initially accepted voluntary assistants to help in their relief work, medical and surgical doctors were to organise and manage health relief practice, using accepted practices and standards of medicine and surgery. Two distinguished surgeons were members of the Geneva Committee and its successor the International Committee of the Red Cross (ICRC). Both of these surgeons had reputable practices as well as professional links with medical societies and schools. They were able to make use of and contribute to new advances in scientific medicine generally as they developed the practice of war surgery for the Red Cross. By 1867, significant advances in war surgery practices led them to insist that the Red Cross train nurses and medical orderlies in times of peace rather that relying on volunteers who were instructed on site[24]. Later in this century, when the medical profession had secured its place as the dominant healing profession in industrialised countries, national Red Cross societies and other charitable agencies were able to recruit and send entire teams of medical and nursing personnel to relief operations. Whether as employees of charitable agencies or as volunteers, medical and surgical doctors were recognised as the experts in health relief practice. Since its inception, the content of international health relief policy and its practice has always been dictated by the medical profession.

2.2 The first World War: extending the scope and scale of health relief

2.2.1 Medical concerns alone dominate the practice of health relief

The process of attaining professional status was largely complete by World War I[25], bringing with it a new set of institutions which organized and carried out medical education and practice, a new body of scientific and medical knowledge which dominated health policy, and a new group of experts in health - medical doctors. This new medical system which had initially benefited from the support of industry and private philanthropies, now had substantial interests in, and a considerable base of support for, expanding the private organization and practice of medicine. Whereas public health policy priorities in the 1800s had been to regulate and improve the environment, for example by improving wages and working conditions, preventing or

alleviating unemployment and reducing the effects of poverty through pensions, education, improved nutrition, housing and sanitation, by the 1920s health and medical care policy had become synonymous[26]. Health policy was then dominated by questions of how best to organize and finance medical services. Conflicts of interest arose between those who wanted to ensure that medical care was readily available and affordable to the general public and those who wanted to ensure profitable and prestigious practices. There was extensive debate and political interest in the policy processes for health by at least nine different groups.

- **national governments** - whose interests in promoting a thriving national economy, a strong military and social consensus generally had led to the creation of separate state apparatuses specifically for health in the form of national ministries or departments of health and government sponsored health services for special groups[27];

- **private philanthropies and industry** - whose interests in maximising the health of the working class had led them to establish their own medical institutes and trusts, mainly for research but also for teaching and the organization of practice[28];

- **hospital administrators** - whose interests were to secure funding for hospital services and to maintain control over their organization;

- **insurance groups (either voluntary, commercial, industrial or philanthropic)** - who wanted to preserve their role in financing, and to some extent controlling, medical practice as well as ensuring that such a role was profitable[29];

- **medical academics and specialists/consultants** - who wanted to control research, teaching and practice generally but who were dependent on outside sources of funding for research facilities and technologies[30];

- **general medical practitioners** - who wanted to manage primary medical care and control its funding as well as referrals to hospitals[31],[32];

- **public health doctors** - who wanted to preserve and elevate their position within the profession by controlling and managing all medical services in their geographical area[33].

The main issue of concern to all of these groups throughout the first half of this century was how best to organise and finance medical services so as to protect and further their own interests. None of these groups contested the merits of the new and advancing medical sciences as the solution to problems of illness, disability and premature death. Very early in this century, health and medical care policies became synonymous, focusing on the provision of medical services as the best way for promoting health. In other words, there was general agreement on the content of health policy, even though the various interest groups had conflicting or competing views over the organization and funding of medical care.

Although there were numerous compromises and solutions which were adopted in different industrialised countries, there were common characteristic features in their medical service systems which influenced the organization and practice of health relief. Firstly, hospitals were the centres for practice, teaching and research since they provided increasingly sophisticated facilities and equipment essential to the practice and further development of the medical sciences. Consensus on the pivotal role of hospitals meant that medical services were organised hierarchically: the most sophisticated services were provided by relatively few teaching hospitals, while more general care was given in smaller hospitals in each region. The point of contact with the public was through individual practices of doctors, who could then refer individuals to hospital for additional care if needed. Medical services were organized hierarchically and regionally[34].

The pharmaceutical revolution of the 1930s later gave medical practitioners access to a wide range of effective and quick acting treatments for the most common illnesses. Pharmaceuticals not only boosted the prestige and profitability of medical practice - especially after prescriptions were required, they brought a new interest group to health politics - the pharmaceutical industry. As medical practice relied increasingly on pharmaceuticals as the core of nearly all therapeutic regimes, the pharmaceutical industry would become one of the most powerful interest groups in health, having acquired considerable financial profits and widespread popular and professional support for their products. Nevertheless, during the first half of this century and beyond, it was the medical doctors who dictated the content of health policy since it continued to be concerned primarily with medical service issues and they controlled its practice.

One can hardly be surprised that medical care remained the dominant concern of health relief policy and practice throughout the first half of the twentieth century. On the one hand, priority was given to military medicine during both World Wars. National militaries greatly expanded their medical services both at the battlefield and at home. On the other hand, civilians were also in urgent need of emergency and on-going care during both wars in many European countries. Their needs were met by governments and charitable agencies, often in collaboration with inter-governmental organizations.

Yet the priorities were the same. Emergency and basic medical services were provided and medical practitioners expanded their clinical interests to include the effects of war. For example, malnutrition and its treatment were dominant concerns in countries under seige or experiencing famine as a result of agricultural disruption or 'scorched earth' policies[35]. Mental disturbances were another prevalent problem which medical practitioners increasingly documented in the literature[36]. Similarly, the biologic effects of the atomic bomb on health were prominent subjects of study in many medical journals after the second World War[37]. Others documented their experiences and efforts more generally[38]. The provision of emergency and basic medical services

for both combatants and civilians was the prevailing practice in relief operations, and medical relief was organized and carried out under the direction of medical doctors.

2.2.2 Refugee relief: a charitable or governmental responsibility?

Throughout the remainder of the nineteenth century, the Red Cross provided relief in 14 international wars and 11 internal conflicts[39]. During this period, the Red Cross established itself as an organization with expertise in international humanitarian law and in war surgery and emergency medical care. As a federation of the International Committee of the Red Cross (ICRC) and 36 national societies by 1900[40], the Red Cross was organised and worked within a political perspective where nation-states were dominant: its work was under the control of the apparatuses of nation-states, and its presence in many different countries made its work part of the relationships between them, inter-national.

The Red Cross first extended its services to refugees in 1913. The Armenian, Bulgarian and Turkish Red Cross societies, for example, assisted Armenian, Bulgarian, Ottoman and Russian refugees between 1913 and 1925. Yet their involvement was temporary, and they advocated for a longer-term programme of relief and rehabilitation by governments. Their first contacts with refugees set two precedents: firstly, that the Red Cross 'undertakes emergency measures for refugees until other agencies can take over'[41] and secondly, that refugee relief be a responsibility of the newly created inter-governmental organizations. The latter would in turn set a precedent that inter-governmental organizations, especially the United Nations High Commissioner for Refugees (UNHCR), would provide the bulk of finances needed for the Red Cross to participate in refugee health relief.

2.2.3 A new strategy of war

At the beginning of this century, Britain, France and Germany in Europe and the United States in North America were the leading industrial and imperial powers in the world. The very technologies which had enabled these powers to thrive and expand

greatly changed the way in which the World Wars were fought. Similarly, improved systems of transport and communication and large industries for mass production of material goods changed the way in which relief was organized as well as the scope of relief provided, since massive quantities of food, equipment, supplies and other resources could be mobilised and moved quickly. During World War I, industries were re-oriented to support the war, producing vast quantities of weapons and ammunition. Extensive railways enabled these armaments along with men, food and other supplies to be delivered speedily to war fronts. Since both sides were equally equipped, this resulted in most battles of World War I ending not in victory or defeat, but in exhaustion[42]. Thus, the war went on and more nation-states became involved. But not until it had dragged on for several years and had consumed nearly all of the national resources of most European governments.

Relief was desperately needed in the first six months of World War I. Following the German occupation of Belgium in 1914, some 7-9 million people faced starvation, since most industries stopped working, agricultural production was disrupted and access to outside sources of supply was cut off. Local relief groups were formed but they needed governmental assistance to take supplies through the British blockade. Belgian businessmen approached the Ambassadors of the US for Belgium and Great Britain in London. The Embassy of the US in London then asked Herbert Hoover, a prominent and wealthy businessman known for his ability to organise and manage successful ventures, to oversee a large relief effort for occupied Belgium[43].

2.2.4 Comprehensive relief for entire populations

Faced with urgent needs to gather, transport and distribute ultimately more than 5 million tons of food to 11 million people in Belgium and northern France, and convincing both sides that relief should be provided, as well as locating enormous sums of money to finance this work, Herbert Hoover formed the American Committee for the Relief of Belgium in 1914, soon renamed the Commission for Relief in Belgium (CRB)[44]. By convincing each side that relief was in their interests, the Commission for Relief in Belgium was able to obtain sponsorship from the

Governments of the US, UK, Germany, Belgium, the Netherlands and Spain, and offices were set up in London, Rotterdam, Brussels and New York[45]. Funds were drawn from Belgian deposits overseas, loans were obtained from the Governments of Great Britain, France and the US, and private donations of more than 52 million US$ in total were solicited. The financial costs of the Commission for Relief in Belgium effort ultimately reached 25 million US$ per month, and at its closure in 1919, the Commission for Relief in Belgium had distributed supplies worth 1 billion US$[46]. Through local civilian committees, the Commission for Relief in Belgium distributed essential supplies - mostly food and clothing, supported some welfare services financially and materially and revived some sectors of the economy between 1914 and 1918[47]. The Commission for Relief in Belgium was, thus, the first organization to provide general relief on a large scale.

The Commission for Relief in Belgium has been described as 'an organization without precedent in international relations'[48], partly because of its success in maintaining several million people throughout the war, partly because of the cooperation it obtained from warring governments and partly because it had many characteristics and privileges of national governments. In contrast to the Red Cross which worked under the direct supervision of national militaries, the Commission for Relief in Belgium operated in a manner similar to national governments. The Commission for Relief in Belgium dealt directly with governments at the highest levels. It had a wide remit which was determined partly by sponsoring governments and partly by the hundreds of volunteers who worked for it. As a result, it carried out a wide range of activities - many of which were in the traditional domain of national governments, from the provision of essential supplies and services to the rehabilitation of basic economic sectors. It had its own flag and passports with accompanying privileges of independent authority and mobility, and it had vast resources for maintaining a nation throughout the war. The work of the Commission for Relief in Belgium set two important precedents. Firstly, comprehensive relief for entire populations could be provided and maintained for several years - the technologies and resources needed were available and governmental cooperation was possible, even from those at war with each other. Secondly, civilians who could be distinguished clearly from combatants had a right

to relief. This right was subsequently incorporated into the legal conventions of the Red Cross in 1949[49].

2.2.5 Forerunners of inter-governmental relief organizations

Both the Red Cross and the Commission for Relief in Belgium were created with the approval of concerned national governments, and both depended on these governments for legitimate authority to carry out their work. Furthermore, both were organizations which relied partly on charity or voluntary contributions for many of their resources. Their charitable status enabled them to be more generally acceptable to, and worthy of support from, the general public and individual governments. However, unlike the Red Cross which aimed to establish a permanent movement for peace and humanitarian assistance somewhat independent of national governments, the Commission for Relief in Belgium was created as a temporary organization for relief in occupied Belgium on the initiative of national, allied governments.

The Commission for Relief in Belgium was a landmark in the history of relief organizations. The Commission for Relief in Belgium extended the tradition of international relief as an activity under the direct control of national governments instead of religious, philanthropic and charitable agencies. It is misleading to think of the Commission for Relief in Belgium solely as a private or charitable organization because it assessed relief needs and determined its programme of work jointly with the governments concerned and it relied on these governments for most of its resources - especially money and food. The concurrence of the various governments is somewhat easily understood since all gained from the Commission for Relief in Belgium's work. For example, the Belgian government ensured the survival of its people and the preservation of existing infrastructures. The Allies strengthened their links with the Belgian Government and people, ideologically and economically, and the Germans maintained the Belgian people at the expense of the Allies. In many ways, the Commission for Relief in Belgium was organised and worked more like an inter-governmental organization, such as the United Nations (UN) today.

Singling out the Commission for Relief in Belgium is not meant to imply that it was the only organization involved in the relief operation. It was not. Many religious and philanthropic agencies extended their work to assist relief efforts during and after the war, for example the YMCA, the Society of Friends and the Rockefeller Foundation[50],[51]. In addition to existing private agencies, new charities were also created, for example the American Friends Service Committee in 1917[52] and the Save the Children Fund in 1919 - which has become one of the largest and most active charitable organizations in health relief today[53]. In these examples, we see the beginnings of a pattern which continues today. With each new crisis and subsequent international relief operation, private charitable organizations are created. Many continue after the operation has ended, usually those which have other roles and purposes and those which adopt new priorities, such as the Commission for Relief in Belgium which became the American Relief Commission in Russian during the famine of the 1920s[54]. Others cease to exist.

2.3 International health relief as a policy of nation-states

The Red Cross movement of the late 1800s marked the beginning of health relief as a humanitarian activity of nation-states. This policy was formulated and implemented through charitable societies ostensibly established independent of national governments, even though they had a national orientation and character. As private, charitable agencies these institutions drew heavily on Christian and humanist ideologies of helping those in need. This religious-cum-humanist framework promoted relief as a humanitarian activity worthy of popular support and legitimised the provision of relief to all in need regardless of nationality or political affiliation. It also allowed relief to be given without questioning war itself, since fighting for ones liberties and freedoms has long been a Christian practice. Yet as institutions in a political system of nation-states, these charitable agencies depended on national governments for political authority to act in times of war; ironically, the Red Cross even worked directly under the auspices of national militaries. Clearly, national governments benefited greatly by the relief work of these agencies, both the care given to their militaries and the popular support generated for relief work.

The success of this policy, however, also depended on perceived and real improvements in the care given to those injured during war. Deficiencies in military medical services and rapid advances in medicine and surgery generally focused humanitarian relief priorities on the medical and surgical care of war casualties. Medical and surgical care of individuals wounded during armed conflict was, therefore, one of the main activities of charitable relief agencies. The increasing effectiveness of medical and surgical practices had contributed greatly to the lead taken by medical doctors and surgeons in the healing professions generally, and health relief was no exception. Medical and surgical doctors, as the experts in health, also organised and managed health relief. Thus, since its inception, the content of international health relief policy and the organization and management of its practice has always been dictated and managed by the medical profession.

Despite strong links with health policies and practices generally, health relief was provided separately from on-going health services. Institutions providing health relief were not those providing health services as part of social welfare activities. Nevertheless, the continuing development of the practice of allopathic medicine and its adoption as the means for promoting health meant that health relief policy, like health policy generally, was synonymous with medical care.

New strategies of war employed in the first World War extended the scope and scale of health relief needed and instead of caring only for individuals wounded during armed conflict, health relief then aimed to maintain the health of entire populations by providing emergency and basic medical care as well as public health interventions for the control of epidemics of disease. Medical doctors continued to act as the experts who organized, guided and provided medical relief services, and health relief remained a sub-speciality of medical practice generally. Charitable or private organizations continued to act as conduits for international health relief, although governments of the recipient populations were increasingly involved in providing much of the care given through their own local or national health services. The vast scale of relief needed then led many agencies to advocate that governments accept responsibility for international health relief efforts in future.

2.4 References

1. Howarth T and Brooman J (1987) Twentieth century history. The world since 1900. London, UK and New York, USA: Longman Group, 308 pp.

2. Howarth T and Brooman J (1987), #1

3. Leichter HM (1979) A comparative approach to policy analysis. Health care policy in four nations. Cambridge, London, New York, Melbourne: Cambridge University Press, 309 pp.

4. Gagnebin B and Gazay M (1963) Encounter with Henry Dunant. Geneva, Switzerland: Libraire de l'Universite, GEORG and Cie, S.A., 118 pp.

5. Macalister-Smith P (1985) International humanitarian assistance. Disaster relief actions in international law and organization. Dordrecht, Germany; Boston, USA and Lancaster, UK: Martinus Nijhoff Publishers, 230 pp.

6. ICRC (1986) Presenting the ICRC. Geneva, Switzerland: The International Committee of the Red Cross, 19 pp.

7. Boissier P (1985) From Solferino to Tsushima. History of the International Committee of the Red Cross. Geneva, Switzerland: the Henry Dunant Institute and the International Committee of the Red Cross, 384 pp.

8. Gagnebin B and Gazay M (1963), #4

9. Boissier P (1985), p. 9, #7

10. Gagnebin B and Gazay M (1963), p. 18, #4

11. ICRC and LORCS (1983) International Red Cross Handbook. Geneva, Switzerland: the International Committee of the Red Cross, the League of Red Cross and Red Crescent Societies and the Henry Dunant Institute, p. 547

12. ICRC and LORCS (1983), p 547, #11

13. ICRC and LORCS (1983), p 547, #11

14. ICRC and LORCS (1983), p 548, #11

15. Leichter HM (1979), #3

16. Rosen G (1958) A history of public health. New York, USA: MD Publications, 551 pp.

17. Brockington F (1975) World health. Edinburgh, London and New York: Churchill Livingston, pp. 117-181

18. Fox DM (1986) Health policies, health politics. Princeton, New Jersey, USA: Princeton University Press, 226 pp.

19. Leichter HM (1979), #3

20. Taylor AJP (1954) The struggle for mastery in Europe, 1848-1918. Oxford University Press, 601 pp.

21. Singer C and Underwood EA (1962) A short history of medicine. Oxford, UK: Clarendon Press, 755 pp.

22. Singer C and Underwood EA (1962), #21

23. Brown ER (1979) Rockefeller medicine men. Berkeley, Los Angeles, USA: University of California Press, pp. 94-95

24. Boissier P (1985), #7

25. Brown ER (1979), #23

26. Fox DM (1986), #18

27. Fox DM (1986), #18

28. Brown ER (1979), #23

29. Abel-Smith B (1988) The rise and decline of the early HMOs: Some international experiences. The Milbank Quarterly 66(4): 694-719

30. Brown ER (1979), #23

31. Fox DM (1986), #18

32. Brown ER (1979), #23

33. Lewis J (1986) What price community medicine? The philosophy, practice and politics of public health since 1919. Brighton, England: Wheatsheaf Books Ltd., 164 pp.

34. Fox DM (1986), #18

35. Salisbury H (1969) The 900 days. The seige of Leningrad. London, UK: Macmillan Publishers Ltd., 596 pp.

36. Ziferstein I (1967) Psychological habituation to war: a sociopsychological case study. American Journal of Orthopsychiatry 37(3):457-468

37. Bizzozero OJ Jr, Johnson KG and Ciocco A (1966) Radiation-related leukaemia in Hiroshima and Nagasaki, 1946-1964. New England Journal of Medicine 274(20):1095-1101

Wada S, Yamashita Y, Miura M, Matsuura N, Yamakido M (1964) Studies on age of onset of diabetes mellitus in relation to atomic bomb exposure. Hiroshima Journal of Medical Science 13(3):265-275

38. Antonov AN (1947) Children born during the seige of Leningrad in 1942. The Journal of Pediatrics 30:250-259

Kranzler D (1972/73) The Jewish refugee community of Shanghai, 1938-1945. Wiener Library Bulletin 26(3/4):28-37

Sovetov SE (1965) (Protection of the health of children and adolescents during World War II.) Gig-Sanit 30(6):45-48

Milashkin AG (1965) (Study of the effectiveness of antibiotics during World War II.) Voen-Med-Ah 11:80-82

Volovik AB (1967) (Leningrad paediatrician during the war and blockade.) Vopr-Okhr-Materin-Det 12(9):58-61

39. Boissier P (1985), #7

40. Gagnebin B and Gazay M (1963), #4

41. League of Red Cross Societies (1979) Red Cross and refugees. Disasters 3(4):357-358 (p. 357)

42. Howarth T and Brooman J (1987), #1

43. Smith RN (1984) An uncommon man. The triumph of Herbert Hoover. New York, USA: Simon and Schuster, 435 pp.

44. MacAlister-Smith P (1985), #5

45. Smith RN (1984), #43

46. Smith RN (1984), #43

47. MacAlister-Smith P (1985), #5

48. MacAlister-Smith P (1985), #5

49. ICRC and LORCS (1983) International Red Cross handbook. Twelfth edition, Geneva, Switzerland: The International Committee of the Red Cross, the League of Red Cross Societies and the Henry Dunant Institute, 707 pp. plus annexes

50. Black M (1986) The children and the nations. The story of Unicef. New York, USA: the United Nations Children's Fund, 496 pp.

51. Brown ER (1979), #23

52. Bolling LR and Smith C (1982) Private foreign aid. US philanthropy for relief and development. Boulder, Colorado, USA: Westview Press, 294 pp.

53. Freeman K (1965) If any man build. The history of the Save the Children Fund. London, UK: Hodder and Stoughton, 156 pp.

54. Bolling LR and Smith C (1982), #52

CHAPTER THREE

The second World War: establishing governmental structures for international health relief

3.1 Inter-governmental institutions as conduits of international health relief

3.1.1 Legacies of the first World War (WWI)

The extensive destruction of European societies during and after the first World War (WWI) and the precedent set by the quasi-governmental nature of the Commission for Relief in Belgium in providing massive relief in Belgium and northern France, led the Allies (primarily the governments of the US and Great Britain) to begin planning and preparing for the relief and rehabilitation of Europe early during the second World War (WWII). These early planning efforts were carried out by the Inter-Allied Post-war Relief Committee and the US Office of Foreign Relief and Rehabilitation between 1941 and 1943. But they were not immediately implemented. It was not until late in 1942 that the US Government first took steps to set up the new United Nations Relief and Rehabilitation Administration (UNRRA) by appointing a director[1,2,3,4]. The UNRRA was subsequently established in November of 1943 by 43 nations. By 1944, widespread support in the US for relief for occupied Europe led both houses of the US Congress to approve a resolution urging the US Administration to actively promote such work.

However, initial attempts by UNRRA were hampered by bottlenecks in transportation within Europe, by changing governments in many European countries and by the chaos generated by millions of people on the move. The US President then undertook additional measures beginning in 1945 to assess needs, to negotiate relief provisions and to appropriate resources needed. Such measures included the involvement of the US and Allied Armies in organizing and distributing relief supplies, the establishment of a separate Famine Emergency Committee in the US Government for Western

Europe under the chairmanship of Herbert Hoover in 1946 and the creation of the Cooperative for American Relief Everywhere (CARE) as a private charitable agency in the autumn of 1945 to distribute Army surplus food and contributions from other US charities[5]. Despite these additional efforts, UNRRA alone ended up working in 25 different countries, mainly in central and eastern Europe but also in China, Ethiopia, Korea and the Philippines. During 1945 and 1946, at the peak of its operation, UNRRA employed 15 000 international and 35 000 local staff and spent nearly 4 billion US$D on aid, 90% of which came from the US, UK and Canada[6].

3.1.2 The Health Committee of the United Nations Relief and Rehabilitation Administration (UNRRA)

Although no specific mention is made of the health work of the Commission for Relief in Belgium, both the Inter-Allied Post-War Relief Committee and UNRRA had sub-committees to deal with health problems. Unlike the medical committee of the Inter-Allied Committee which was purely a planning forum which focused firstly on formulating a standard list of essential medical supplies for relief, the health committee of UNRRA undertook to revive national health services, to revise and administer existing international conventions for the prevention and control of communicable diseases, to supervise and provide health care for persons displaced by war - in centres, camps, and on-route to new or old homes, and to train health professionals in health relief and rehabilitation.

The health work of UNRRA has been described as one of its most successful and least controversial activities[7]. Its success was largely due to widespread governmental support: financially - the total expenditure for health was 168 million US$ between 1943 and 1947; politically - 43 nation-states participated from the beginning and both existing international health organizations collaborated; operationally - by facilitating transportation and access to supplies and people; and legally - by formalising its status and rights in a multilateral agreement as well as in operating agreements with individual governments. Its success was also due, undoubtedly, to the substantial

efforts of a number of charitable agencies who provided much of the care for people displaced by the war, for example, the Red Cross.

3.1.3 The International Office for Public Health

Yet again, health relief for post-war Europe could have been the responsibility of either of two existing inter-governmental health organizations rather than UNRRA. In the first decade of this century, European and North American governments had created regional inter-governmental organizations to prevent, monitor, control and study plague, cholera, yellow fever, typhus and smallpox (commonly known as the 'big five'): specifically, the International Office for Public Health in Paris in 1907 and the Pan American Sanitary Bureau in Washington in 1902. The Paris Office was later designated the centre for the entire world with the office in Washington being the regional centre for the Americas. Other regional offices were established in 1926 in Singapore for the Far East (the Far Eastern Bureau of the League of Nations) and in Alexandria for the Middle and Near East (the Quarantine Council of Egypt).

Despite the creation of the Health Organization of the League of Nations in 1923, the 'Office' (as it has generally been called) retained responsibility for world-wide epidemiological intelligence work until the creation of the World Health Organization (WHO) following WWII. However, during WWII the Office was unable to carry out some of its activities and others were transferred to the regional office in Washington because of the occupation of Paris by the Germans and the proposal by the Germans to transfer the office to Berlin with the subsequent block on funds by the Allies in the temporary offices in London and New York. After WWII, possibilities to re-establish, let alone expand, the Office were quickly overwhelmed and subsumed by the movement to create one world-wide organization for health as part of the United Nations[8].

3.1.4 The Health Organization of the League of Nations

Unlike the Office which enjoyed the respect and support of all powerful governments in Europe and North America, the Health Organization of the League of Nations was handicapped since its creation because the governments of the US, Germany and Russia participated only sporadically[9]. Yet, there were serious health problems following WWI which required urgent action on an international scale, for example the typhus epidemic in Eastern Europe during 1919 and 1920. Not surprisingly a compromise was reached wherein the Permanent Committee of the Paris Office became the General Advisory Health Committee to the League's Health Organization, and the Health Committee which planned and supervised the technical work of the League's Health Organization was made up of 10 members elected by the Office, 6 members elected by the League's Council and 4 members chosen by the Health Committee itself.

This compromise enabled the Health Organization of the League to function, and work was subsequently undertaken in five functional areas[10]. Epidemiological intelligence services were carried out, first to manage the epidemic in Eastern Europe and later to deal with diseases which were not included in the international conventions, such as meningitis, polio, dysentery and enteric and scarlet fevers. Health care was provided for displaced persons. Technical studies were commissioned and conferences held in order to establish international standards, for example for the control and treatment of major diseases - such as malaria and cancer, for the classification of deaths and diseases, for the control of drugs - particularly narcotics, and for maintaining and promoting good nutritional status. Direct assistance was given to governments and, beginning in 1929 in China, this took the form of experts taking up residence in-country to work with governments directly. Lastly, fellowships, publications and study tours were made available to educate health professionals primarily, but also the general public.

Clearly, the League's Health Organization had the experience to provide relief in Europe during and after the WWII since it had cared for refugees and displaced

persons, it had managed epidemics and epidemiological surveillance and it had advised and worked with governments. But, laudable though these activities were, their effects were limited early on by insufficient funding - the largest annual budget was only 414 000 US$ in 1931, and later on by the loss of influence, prestige and membership of the League generally after 1936 when it was unable to prevent aggression and hostilities between member nations. Furthermore, WWII made communications difficult and, although some work continued throughout the war, the Health Organization's role after 1939 increasingly became one of collaboration with the Inter-Allied Post-War Relief Committee and the US Office of Foreign Relief and Rehabilitation[11].

3.2 The United Nations (UN): a forum for international health relief as a humanitarian activity of national governments collectively

The devastation of WWII was great; half of the total casualties were among civilians, with estimates of deaths ranging from 40 to 50 million people, mostly in Eastern Europe[12]. When hostilities ceased in 1945, more than 20 million soldiers, evacuees and refugees were on the move, food was desperately scarce and many political administrations were disorganized or inexperienced. In Tokyo, Warsaw, Budapest, Vienna and numerous other cities and towns, primarily in Eastern Europe and Japan, thousands of people faced famine and accompanying disease, such as tuberculosis, typhoid and dysentery[13]. Prospects of falling production in industry and increasing unemployment brought fears in the US, the economy least damaged by the war, that 'there would be ushered in the greatest period of unemployment and industrial dislocation which any economy has ever faced'[14]. But these problems could be solved fairly rapidly if sufficient resources were made available to restore production in Europe, especially food, fuel and transportation.

Capitalist governments in the US and Western Europe were more concerned that the precedent of the Bolshevik revolution in Russia in 1917 during the chaos and hardship of WWI would be repeated. Organized labour had been strengthened in many of the Allied countries before and during WWII and demands for improved social and

economic conditions were increasing. The USSR emerged from the war with increased prestige, a strong industrial economy and extended geographical influence[15]. Under the banner of 'communism', the USSR posed an alternate social order to people dissatisfied with previous regimes of fascism, periods of severe economic depression and the devastation of war.

Fears of postwar depression and social unrest resulted in postwar policies of the Allies which ensured the preservation and growth of capitalist ideologies and systems. As early as 1943, such policies were reflected in plans for the postwar monetary and trading system drawn up by the US Government. These plans were based on the central role of the US$ in the world economy and on reducing balance of payments and trade restrictions in order to secure access to raw materials and large markets for exports and investments abroad. Towards the end of the war, concerns within the US that rehabilitation in Europe might renew immediate economic competition led the US Congress to rule out any medium-term reconstruction aid as a role for UNRRA as well as to plan for its termination.

This in turn coincided with the formation of four other inter-governmental organizations by the Allies, under the leadership of the US, between 1944 and 1947[16]. These organizations were the institutions through which global economic and social policies could be formulated and implemented, both for immediate relief and for the longer-term. Ostensibly, the United Nations Organization (UNO) was created to maintain international peace and well-being, the International Monetary Fund (IMF) to lend money in order to stabilise exchange rates and therefore the international economy, the International Bank for Reconstruction and Development (IBRD or the World Bank) to lend money to re-build Europe as well as to develop poor nations, and the General Agreement on Tariffs and Trade (GATT) to promote trade between nations [17]. These inter-governmental institutions were mainly concerned with ensuring a thriving world economy dominated by industrial powers in Europe and North America. The exception was the United Nations (UN). While economic issues were clearly of concern to the UN, its primary purpose was to maintain and promote international peace and well being. Within this broad mandate, three institutions were

created between 1946 and 1947 which had roles in international health relief - the World Health Organization, the United Nations Children's Fund and the United Nations High Commissioner for Refugees.

3.2.1 The World Health Organization (WHO)

At the end of WWII, there were three inter-governmental organizations working in the health sector - UNRRA, the League of Nations and the Office. Neither the League or UNRRA were constitutionally or organizationally able to maintain peace or to promote the economic and social revival of European societies devastated by war. Similar to development efforts in poor countries today, economic and social concerns generally towered above those for health specifically and health was not included in the original draft for a new United Nations Organization[18]. But the relative inactivity of both the League's Health Organization and the Office during the war and the constitutional limits of UNRRA as a temporary organization solely for relief and rehabilitation were unsatisfactory mainly to doctors working within health ministries of national governments or health departments of existing inter-governmental organizations. Thus, in the UN Conference on International Organization at San Francisco in 1945, the Brazilian and Chinese delegations succeeded in having health included as a concern of the UN. One world-wide health organization was to be created as a specialised agency under the Economic and Social Council of the UN. Subsequently, a constitution was drafted by a Preparatory Committee in New York in 1945, accepted by 62 nations in 1946 and implemented by an Interim Committee between 1946 and 1948.

By the time the World Health Organization (WHO) convened its first World Health Assembly in 1948, its programme of work and methods for carrying out its responsibilities were fairly well-established. Not surprisingly most activities were inherited from its predecessors: conducting epidemiological intelligence work, formulating international standards, assisting government health services, sponsoring health education in its broadest sense and coordinating health research[19]. It also inherited a minor role in health relief, which at that time was primarily caring for the

millions of refugees and displaced persons in Europe. In other words, health relief generally was one of the constitutional activities of WHO, but it was not a dominant or priority activity. Nor was the role and work of WHO in relief operations clearly defined and detailed. In fact, until the 1970s, health relief was not the specific responsibility of any one unit or division in WHO. Nor was it a line item in the annual budget[20].

3.2.2 The United Nations Children's Emergency Fund (Unicef)

Similar to WHO, historical developments which led to the creation of a children's fund within the UN go back many years. Governmental concern for the welfare of children was institutionalised around the turn of this century, largely in response to appalling conditions in overcrowded and poorly developed urban centres and to practices within industry which exploited child labour. In the US, for example, a Children's Bureau was established in 1912 to advise the government on policies and legislation involving children[21].

Concern for children affected by war, particularly those who had been abandoned or who had suffered emotionally, first became a priority relief activity during WWI. In fact, some private relief agencies were created during the war specifically to care for such children, such as the Save the Children Fund in 1919 and its international federation, the Save the Children International Union in 1920[22]. Their work continued after the war ended, partly because some 4-5 million children in Europe were still homeless in 1920[23], and partly because they adopted a wider remit to care for children generally. Immediately after the war, the primary concerns of agencies working with children were to reunite homeless children with their families which was done in collaboration with the Red Cross, to resettle those children without homes or families which was done in collaboration with national governments and to restore and maintain good nutritional status which was done through soup kitchens and other food supplementation programmes in collaboration with UNRRA and charitable agencies.

The continuation of this work was advocated by the Governing Council of UNRRA and by Ludwik Rajchman - the former head of the League of Nation's health division and a renown Polish medical doctor and public health specialist-cum-diplomat. After having his involvement in WHO rejected by the WHO Interim Commission in 1946, Rajchman obtained support for a separate children's fund from the US Children's Bureau who helped write the proposal and lobby for support from the US Government generally and from the US State Department whose financial support was particularly essential[24]. Even so, the United Nations Children's Emergency Fund (Unicef) was only established in 1946 as a temporary body (for three years) mainly for post-war reconstruction. The main tasks of Unicef were to help children and adolescents suffering from the war and to promote child health generally. Thus, Unicef's initial mandate retained a significant focus on relief and allowed more involvement in health generally. Its first programmes were in Europe where it provided supplementary food rations of mainly milk to 4.5 million children in some 30 000 locations in twelve countries. Similar to its sister organizations in the UN, such as the FAO and WHO, Unicef worked with national governments, mainly in Eastern European countries, to provide these services.

Unlike the other UN agencies which received their funds from member states as part of membership dues or which were required to seek approval from member states for the use of financial contributions, Unicef was free to receive voluntary contributions from any source and to spend these primarily as they thought best[25]. The UN Secretariat would provide staff and facilities, and other specialised agencies of the UN, in particular WHO, were to provide specialists, professional advice and technical support in order to keep staffing and resource requirements to a minimum[26].

The relationship between Unicef and WHO was formalised in 1948 when Unicef requested technical advice from WHO on medical programmes. Although Unicef's involvement in health programmes created tensions between the two organizations, Unicef's participation was justified partly on the grounds that the immunization campaign against tuberculosis was an urgent post-war need and partly because WHO was unable to provide relevant supplies and services. Subsequent involvement in

health services for mothers and children and other mass campaigns against common diseases set a precedent for the involvement of both Unicef and WHO in international health programmes. WHO generally provided technical guidance and advice while Unicef contributed needed supplies or funds or both, and joint planning and administration of health projects was intended to be ensured by a Joint Committee on Health Policy which was set up in the summer of 1948.

3.2.3 The United Nations High Commissioner for Refugees (UNHCR)

Inter-governmental organizations for refugee relief also had their beginnings in the work of private charitable agencies during WWI. At the end of the war, however, the workload and needs increased well beyond the capacities of the charitable agencies. The sheer numbers of Russian refugees was less of a problem than their lack of legal status. Thus, a group of private relief agencies appealed to the League of Nations, through the International Committee of the Red Cross, to take responsibility for defining the status of refugees, for coordinating assistance to them and for securing their repatriation or resettlement. This proposal was accepted by the League and a High Commissioner for Russian Refugees was appointed on two conditions: firstly, that the League had no responsibility for organizing and financing refugee relief and, secondly, that the work was temporary[27]. With private agencies to provide relief and the International Labour Organization to provide assistance with employment, this High Commissioner's job was limited to legal and political matters.

However, some 200 000 refugees were still in need of assistance in 1928 and a new, independent and more comprehensive organization was created for refugees under the direction of the League with a seven year tenure, the International Nansen Office for Refugees. Through a Governing Body, this office continued to work closely with the International Labour Organization, private agencies, the Secretary-General of the League and the Inter-Governmental Committee on Refugees (IGCR). The IGCR was another inter-governmental organization which had been created on the initiative of President Roosevelt of the US during the Evian Conference of 1938 to address the problems of refugees coming from Germany and Austria. It was headed by the High

Commissioner for Refugees of the League and represented many governments within the Allied bloc.

Instead of resolving refugee problems, however, the needs of refugees were increasing with the world-wide economic recession and the policies of the German Reich under Hitler. At the same time, the efforts of the Nansen Office were constrained by the admission of the Soviet Union to the League (which affected activities for Russian refugees) and the loss of prestige and influence of the League generally (following its inability to resolve conflicts between the Chinese and Japanese and the Italians and Ethiopians). This contributed to the amalgamation of the two High Commissioners' offices from 1938-1946. Nevertheless, the creation of separate High Commissioners for Russian and German Refugees within the League illustrates that international assistance for refugees was dealt with on a group-by-group basis; national governments refused to agree on universal rights for refugees as well as international responsibilities to oversee their implementation.

During WWII, therefore, there were three separate inter-governmental organizations providing relief for refugees and displaced persons, the High Commissioners of the League, the Inter-governmental Committee for Refugees and UNRRA. While the League and the Inter-governmental Committee for Refugees were principally concerned with establishing and ensuring legal rights for refugees as well as assisting them to find permanent settlement elsewhere, UNRRA along with over sixty private agencies provided a wide range of services for persons displaced by war.

The liquidation of the League in December of 1946 and of UNRRA and the Inter-governmental Committee for Refugees in July of 1947 led to the creation of a new International Refugee Organization (IRO) as a temporary, specialized agency outside the new UN[28]. The foundation of the International Refugee Organization for three years was based on three principles. Firstly, refugee problems were 'international in scope and nature'. Secondly, there should be no forced repatriation. Thirdly, repatriation should be pursued and assisted[29]. Interestingly, only 18 of the 54 members of the UN joined the International Refugee Organization. Moreover, these

18 were all allies of one another. The USSR and Comintern countries opposed the International Refugee Organization and advocated the repatriation of displaced persons, most of whom were fleeing from their countries into Western Europe. To encourage repatriation, they called for an end to international aid to refugees.

When the International Refugee Organization was created, the needs of refugees and displaced persons were great. The International Refugee Organization undertook to provide temporary relief activities for the 'care and maintenance' of those in temporary accommodation, to move these people out of the countries of temporary asylum by repatriation or resettlement and to establish citizenship for refugees in order for them to have legal protection and rights as well as a means of earning a living. This required a massive operation of which health care was an integral part. A division of health was responsible for health care in camps or centres and on-route to new or old homes. In addition, the health division ensured and certified good health status of immigrating refugees. This division was headed by the former director of UNRRA's health department, and close collaboration was maintained with WHO[30].

Although the tenure of the International Refugee Organization was due to end in 1950, several needs of refugees remained. Most important was the lack of universally agreed legal rights and protection of refugees and displaced persons. In addition, there were still large numbers of refugees, mainly in Europe, who would not be absorbed into the communities where they took refuge, and other refugees were still coming from Eastern European countries. These concerns were acknowledged and in 1949 the UN decided to establish a High Commissioner for Refugees. However, this new High Commissioner was controversial and it took two years of debate before agreement was reached over the role, functions and organization of his office.

Larger political and economic interests of nation-states and their regional allies gave rise to at least three important conflicts which affected the mandate and structure of UNHCR[31]. Tensions between the East and the West grew during the latter half of the 1940s, and by 1950 the US Congress vetoed the use of US funds for any international organization which included Iron Curtain countries. The US policy to give billions of

US$ directly to Western European governments under the Marshall Plan further compounded the difficulties of obtaining US funds for UN work. Since the US Government had taken the lead in creating and funding the UN and its specialised agencies, this change in foreign policy from supporting the UN to supporting bilateral initiatives had serious financial repercussions for the UN.

In addition to the conflicts between East and West and between US funding for bilateral or UN activities, there was a growing difference of interest in and support for international material assistance for refugees between those countries hosting the refugees, for example in Western Europe, and those available only for resettlement overseas, for example the US and Australia. Obviously, the societies and economies of the former were strained by large numbers of refugees, but it was the latter who funded most of the material assistance which benefited both the refugees and their hosts. This became acute by 1950 when the overseas economies had their own sufficient labour markets following the return of soldiers and initial influxes of refugees immediately after hostilities ceased. It was the Western European countries which continued to need international help throughout the 1950s and well into the 1960s for the care and maintenance of refugees while the countries of resettlement overseas were increasingly reluctant to fund such programmes or to accept additional refugees as immigrants.

Two functions for the High Commissioner were finally agreed: to provide international protection and to seek permanent solutions for refugees. Despite the possibilities for an extensive structure and programme of work these functions might suggest, UNHCR was to be a non-operational agency with only a small staff and limited funds. Direct services were to be provided mainly by governments and private agencies, but also by other inter-governmental organizations. UNHCR's role was to ensure that care provided was adequate and humane. Clearly, unlike the International Refugee Organization or UNRRA, the new UNHCR had no direct involvement in health relief. Similar to Unicef, UNHCR was to rely on WHO, national governments and charitable agencies for health care of refugees.

3.2.4 The United Nations Relief and Works Agency for Palestine Refugees (UNRWA), The United Nations Korean Reconstruction Agency (UNKRA)

It would be much simpler if the above specialised agencies of the UN were the only inter-governmental institutions working in international health relief operations. But they were not. The practice of setting up new organizations within the UN to deal with particular relief needs continued. Although the International Refugee Organization was established in 1947 and its successor the UNHCR in 1949, their preoccupation with refugees of WWII in Europe and the Far East led to the creation of two additional specialised agencies of the UN for Palestinian refugees in 1949 and Korean relief in 1950 - the United Nations Relief and Works Agency for Palestine Refugees (UNRWA) and the United Nations Korean Reconstruction Agency (UNKRA). Both were created on a temporary basis to provide international assistance to refugees of the Arab-Israeli and Korean wars.

3.2.5 The Council for Europe and the Inter-governmental Committee for European Migration (ICEM)

After Germany and Japan had been defeated, different political ideologies and economic interests of the Allied governments quickly divided the world into two power blocks, one centre being in the US and the other in the USSR - then the two greatest industrial and military powers in the world. The ensuing conflict, commonly known as the 'Cold War', led to the creation of additional inter-governmental organizations by the US and her allies: in Western Europe in 1948 and 1949 - the Organization for European Economic Co-operation (OEEC) and the North Atlantic Treaty Organization (NATO), in Latin America in 1948 - the Organization of American States (OAS), in South East Asia in 1954 - the South-East Treaty Organization (SEATO) and in the Middle East in 1955 - the Baghdad Pact. Similar alliances were established between the Soviet Union and her allies in Eastern Europe and China[32]. Within Europe, two inter-governmental organizations were created to deal with problems created or exacerbated by the war, namely the Council of Europe and the Inter-governmental Committee for European Migration (ICEM).

The Council of Europe, which was formed in 1949 by nine Western European and Scandinavian governments, was particularly concerned with the inability of several European economies to absorb large populations of refugees and displaced ethnic groups since domestic economic resources were limited and possibilities for emigration were greatly reduced[33]. Their focus on these 'national refugees' reinforced the prerogative and responsibility of national governments to manage assistance to refugees and persons displaced within their own countries; international assistance for refugees remained the concern of UNHCR, but only in collaboration with national governments. Concerns with excess populations also led to the creation of a separate agency to assist refugees and European nationals in migrating to other countries - the Inter-governmental Committee for European Migration (ICEM). Obviously, ICEM also worked in close collaboration with UNHCR.

3.3 International health relief: a responsibility of governments collectively?

The vast and comprehensive needs for relief in Europe following the two World Wars and the associated implications for political and strategic alliances between nation-states encouraged the direct involvement of national governments in relief operations. Subsequently, national governments set up their own institutions for relief collectively in addition to the private or charitable agencies. These inter-governmental organizations were able to draw resources from a variety of national governments, enhancing their income without taxing any one government excessively. Similarly, membership of several governments minimised the more overt political biases, facilitating the provision of needed care. And importantly, as institutions of governments collectively, these inter-governmental organizations were able to provide relief on the scale needed - a scale far beyond the capacities of any existing private or charitable organization. Yet, these inter-governmental organizations had similar characteristics to private or charitable agencies.

Firstly, many inter-governmental relief agencies were transient since they were created for only one relief operation, for example, UNRRA and the United Nations Korean Reconstruction Agency (UNKRA). Others found additional on-going purposes or were

succeeded by more permanent institutions in which relief was only one, usually low, priority, for example UNHCR and Unicef.

Secondly, inter-governmental organizations engaged in relief varied immensely from each other. Variations in structures, purposes and forms together with the fluidity with which they were set up, altered, merged or discontinued created an image that they were separate from one another and, to a great extent, from national governments. Even today many consider the specialised agencies and funds of the United Nations supra-national organizations which are independent of national governments. The impression conveyed in relief operations, at first glance, was one of benevolent organizational anarchy.

However, many of these inter-governmental institutions were created on the initiative of national governments or they were dependent on them for political authority or resources or both. Thus, the inter-governmental agencies provided the legal and administrative structures for large-scale, international relief while private or charitable agencies mobilised popular opinion, support and resources and actually did they work. This then suggests that there was a coherent system for relief: one which was generated and controlled by the more powerful national governments, and one which did not interfere with existing economic and social policies for the longer-term.

This hypothesis is further supported by the separation, both institutionally and in practice, of relief from rehabilitation and development and by the focus of relief on acute survival needs only. Relief during and after the World Wars had expanded to include any activity or the provision of material goods which were essential for survival, and its provision had been made the responsibility of separate, often temporary or specialised institutions. Relief was a temporary, short-term, minimalistic activity which was isolated from social and economic rehabilitation and development.

International health relief was not exception; institutions providing international health relief were rarely those providing health services as part of national or international social welfare activities. Nevertheless, international health relief had expanded from

caring for wounded soldiers to maintain entire populations. This was achieved by providing emergency and basic medical care as well as public health interventions for the control of epidemics of disease. These relief services continued to be organised and provided by medical doctors, usually under the direction of national or local governmental health authorities although they were often carried out by private or charitable agencies.

3.4 References

1. Barros J (1972) The United Nations past, present and future. New York, USA: The Free Press, 266 pp.

2. Twitchett KJ (ed) (1971) The evolving United Nations: A prospect for peace? London, UK: Europa Publications, 190 pp.

3. Luard E (1966) The evolution of international organizations. London, UK: Thames and Hudson, pp. 25-41

4. Smith RN (1984) An uncommon man. The triumph of Herbert Hoover. New York, USA: Simon and Schuster, 435 pp.

5. Smith RN (1984), #4

6. Black M (1986) The children and the nations. The story of Unicef. New York, USA: The United Nations Children's Fund, 496 pp.

7. Goodman NM (1952) International health organizations and their work. Edinburgh and London, UK: Churchill Livingston

8. Goodman NM (1952), #7

9. Walters FP (1966) The League of Nations. In: Luard E The evolution of international organizations. London, UK: Thames and Hudson, pp. 25-41

10. Goodman NM (1952), #7

11. Goodman NM (1952), #7

12. Howarth T and Brooman J (1987) Twentieth century history. The world since 1900. London, UK and New York, USA: Longman Group, 308 pp.

13. Black M (1986), #6

14. Armstrong P, Glyn A and Harrison J (1984) Capitalism since World War II. The making and breaking of the great boom. London, UK: Fontana Paperbacks, 482 pp.

15. Armstrong P et al (1984), #14

16. Armstrong P et al (1984), #14

17. Howarth T and Brooman J (1987), #12

18. Goodman NM (1971) International health organizations and their work. Edinburgh and London, UK: Churchill Livingston, 2nd edition, 398 pp.

19. Berkov R (1957) The World Health Organization: A study in decentralized international administration. Paris, France: Etudes d'Histoire Economique, Politique et Sociale, 162 pp.

20. Goodman NM (1971), #18

21. Black M (1986), #6

22. Freeman K (1965) If any man build. The history of the Save the Children Fund. London, UK: Hodder and Stoughton, 146 pp. plus annexes

23. Black M (1986), #6

24. Black M (1986), #6

25. Black M (1986), #6

26. Black M (1986), #6

27. Holborn LW (1975) Refugees: A problem of our time. The work of the United Nations High Commissioner for Refugees, 1951 - 1972. Metuchen, New Jersey, USA: The Scarecrow Press, Inc., 2 volumes, 1446 pp.

28. Gallagher D (1989) The evolution of the international refugee system. International Migration Review 23(3):579-598

29. Holborn LW (1975), #27

30. Goodman NM (1971), #17

31. Holborn LW (1975), #27

32. Howarth T and Brooman J (1987), #12

33. Holborn LW (1975), #27

CHAPTER FOUR

The United Nations High Commissioner for Refugees (UNHCR): a recent and increasingly significant participant in international health relief policy formulation and practice

4.1 The 1950s and 1960s: extending health relief world-wide

Two changes since the second World War (WWII) have greatly influenced the evolution of the international health relief system; firstly, independence from colonial rule of countries in Africa, Asia, the Caribbean and Latin America beginning in the 1950s, and secondly the re-emergence of disasters as an international priority in the 1970s.

4.1.1 Independence from colonial rule

WWII altered power relations between nation-states around the world. The US and the USSR quickly emerged as the two greatest military powers since the size and capacity of their armed forces greatly exceeded that of other warring nations. In contrast to these two, Western and Eastern European nations were devastated. They were now dependent on the US and USSR for economic aid to finance reconstruction and to pay off their war debts, and in the west for military support to prevent the spread of Russian dominated communism from the east. Not only were the Western European nations in a weaker position in relation to the US and the USSR, they were no longer in a position to maintain their rule in many colonies in Africa, Asia and the Caribbean.

Although the decline of Western European empires began early in this century with the break up of the German and Austrian empires following the first World War (WWI), it was not until after WWII that colonial rule in Africa, the Caribbean and Asia by Britain, France, the Netherlands, Belgium, Spain and Portugal was challenged successfully (Figure 4.1). Immediately after the war, Britain, France and the

Canada, Australia, New Zealand South Africa and the Irish Free State had their independence (within the British Commonwealth) recognised formally by the Statute of Westminster, 1931

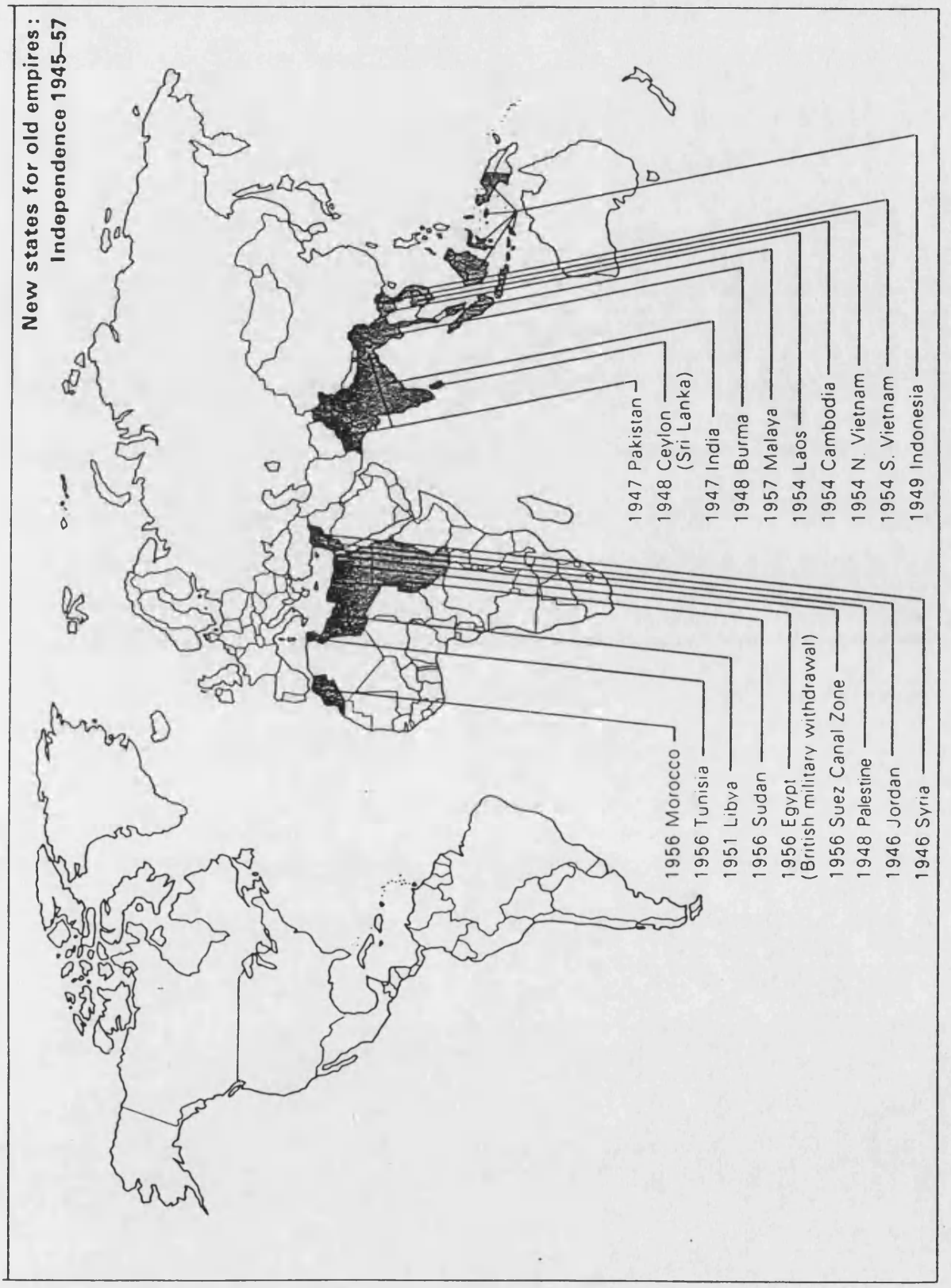
FIGURE 4.1

Netherlands in particular were less able to maintain their rule - they simply did not have the financial or military resources. Nor were they able to seek support from the US who openly disapproved of the imperialism of old Europe. Consequently, between 1945 and 1957, many of their colonies were granted independence (Figure 4.2). In Asia, India and Pakistan became independent in 1947; Ceylon (Sri Lanka) and Burma in 1948; Indonesia in 1949; Malaysia in 1957; and Vietnam, Laos and Cambodia in 1954. In the Middle East, Jordan and Syria became independent in 1946; Palestine in 1948; Libya in 1951; and Morocco, Tunisia and Sudan in 1956[1].

Many of the colonies which were granted independence soon after WWII had been self-governing for some time and most continued to have economic and political ties with Western Europe after independence. These links were formalised firstly through allegiances between individual European nations and their former colonies, for example the British Commonwealth of Nations and the French Union, and later through agreements between the West European community and newly independent nations collectively, for example the Lome Conventions of 1975, 1981 and 1985.

European assumptions that colonies in Africa and the Caribbean were incapable of self-government, because their economies were weak and their populations had poor levels of illiteracy and were ethnically diverse, were challenged violently in the 1960s (Figure 4.3). In addition to support from the US and the USSR, colonies struggling for independence were supported by newly independent nations who were an increasingly vocal and large group in international forums such as the United Nations (UN). World opinion was less important, however, than the growing strength of national liberation movements and the vast resources needed for their containment. For example, by the 1970s, Portugal (one of the last European countries to grant independence to her African colonies) was spending 40 per cent of its national budget on defense and security costs to suppress guerilla movements in her African territories[2]. Moreover, some Western European nations had been defeated despite extensive military efforts, for example the French in Indochina in 1954 (Figure 4.4).

FIGURE 4.2


New states for old empires:
Independence 1945–57
1947 Pakistan
1948 Ceylon (Sri Lanka)
1947 India
1948 Burma
1957 Malaya
1954 Laos
1954 Cambodia
1954 N. Vietnam
1954 S. Vietnam
1949 Indonesia
1956 Morocco
1956 Tunisia
1951 Libya
1956 Sudan
1956 Egypt (British military withdrawal)
1956 Suez Canal Zone
1948 Palestine
1946 Jordan
1946 Syria

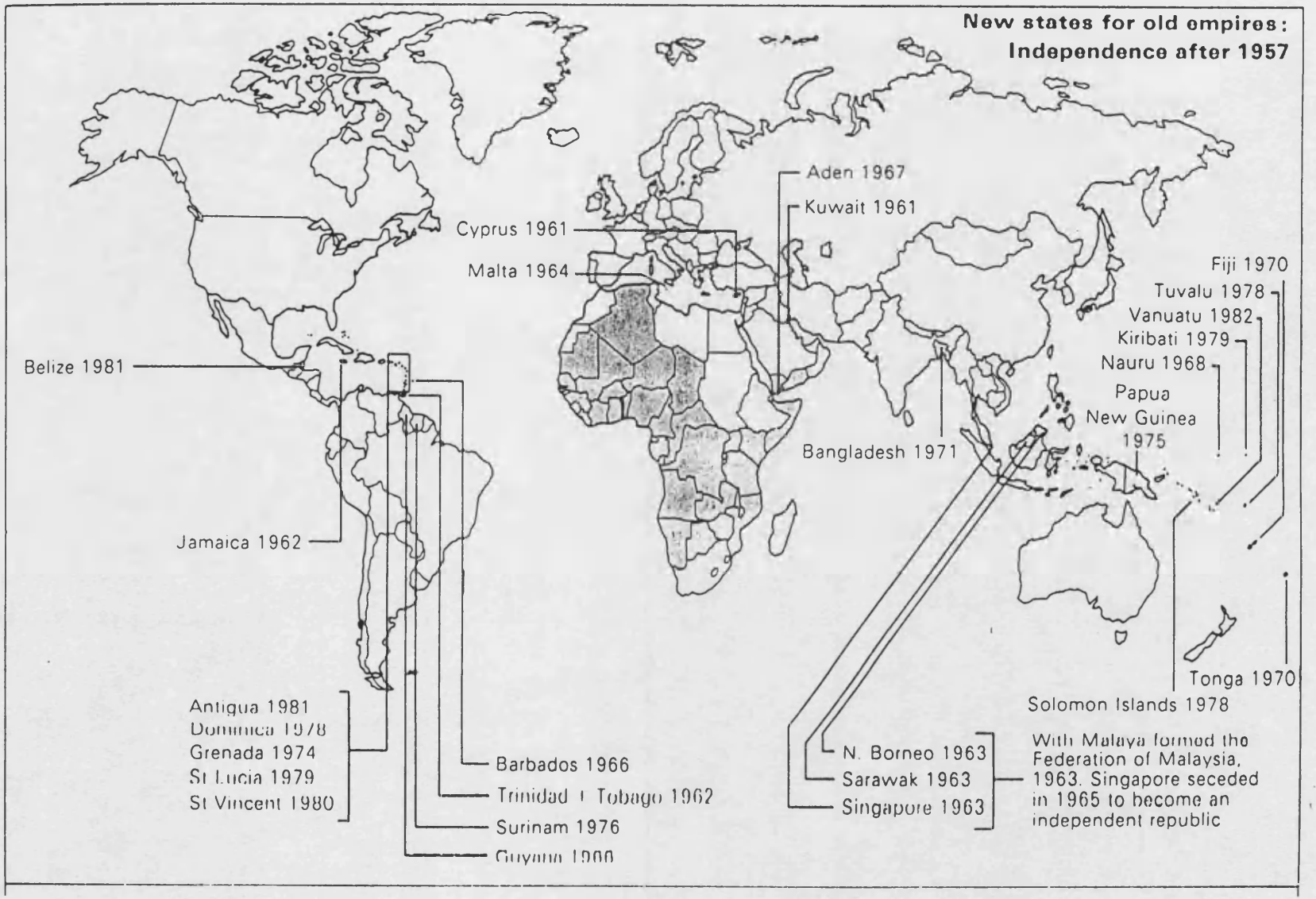

New states for old empires:
Independence after 1957
Aden 1967
Kuwait 1961
Cyprus 1961
Malta 1964
Fiji 1970
Tuvalu 1978
Vanuatu 1982
Kiribati 1979
Nauru 1968
Papua
New Guinea
1975
Belize 1981
Bangladesh 1971
Jamaica 1962
Tonga 1970
Solomon Islands 1978
Antigua 1981
Dominica 1978
Grenada 1974
St Lucia 1979
St Vincent 1980
Barbados 1966
Trinidad + Tobago 1962
Surinam 1976
Guyana 1966
N. Borneo 1963
Sarawak 1963
Singapore 1963
With Malaya formed the Federation of Malaysia, 1963. Singapore seceded in 1965 to become an independent republic

FIGURE 4.3

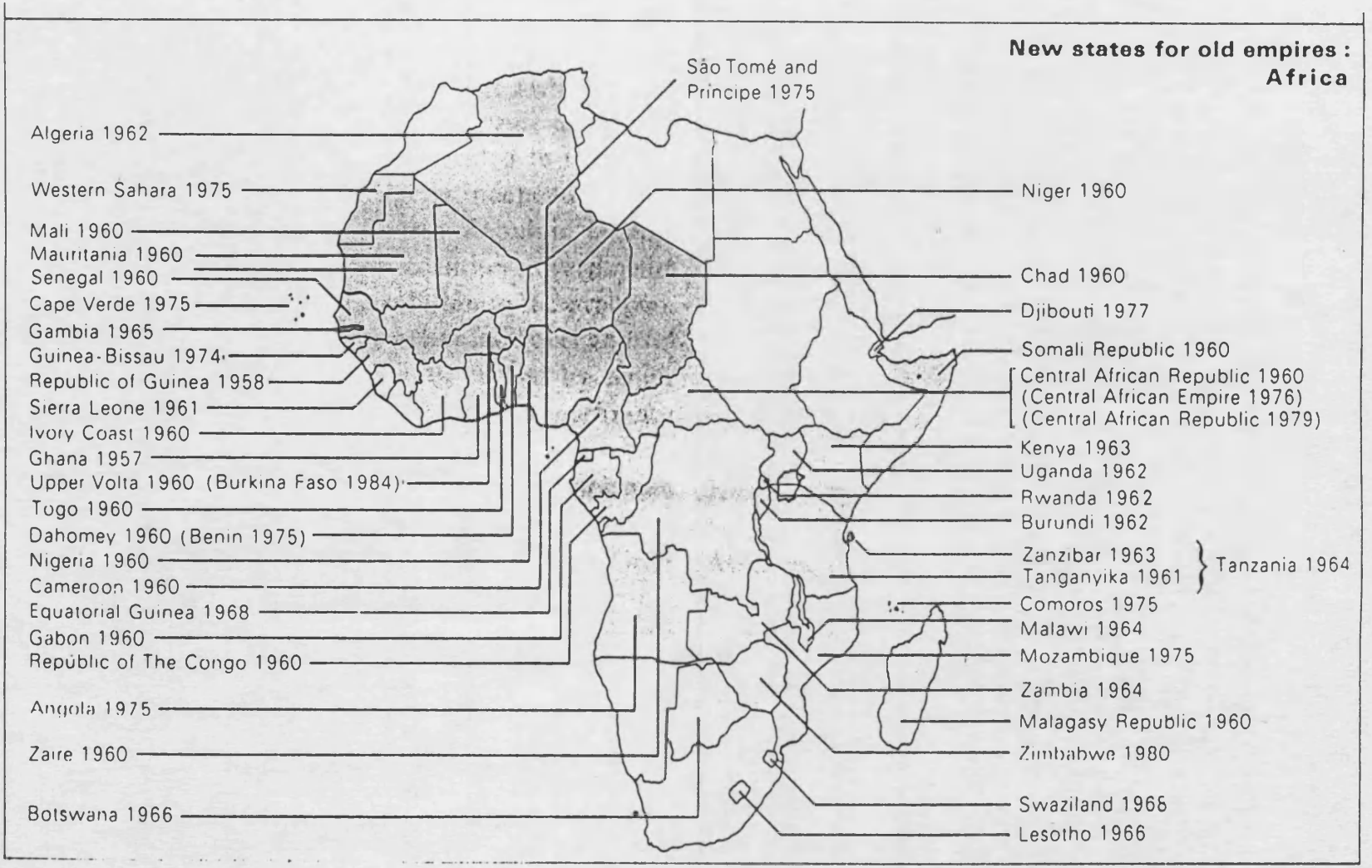

New states for old empires :
Africa
São Tomé and
Principe 1975
Algeria 1962
Western Sahara 1975
Mali 1960
Mauritania 1960
Senegal 1960
Cape Verde 1975
Gambia 1965
Guinea-Bissau 1974
Republic of Guinea 1958
Sierra Leone 1961
Ivory Coast 1960
Ghana 1957
Upper Volta 1960 (Burkina Faso 1984)
Togo 1960
Dahomey 1960 (Benin 1975)
Nigeria 1960
Cameroon 1960
Equatorial Guinea 1968
Gabon 1960
Republic of The Congo 1960
Angola 1975
Zaire 1960
Botswana 1966
Niger 1960
Chad 1960
Djibouti 1977
Somali Republic 1960
Central African Republic 1960
(Central African Empire 1976)
(Central African Republic 1979)
Kenya 1963
Uganda 1962
Rwanda 1962
Burundi 1962
Zanzibar 1963
Tanganyika 1961
Tanzania 1964
Comoros 1975
Malawi 1964
Mozambique 1975
Zambia 1964
Malagasy Republic 1960
Zimbabwe 1980
Swaziland 1968
Lesotho 1966

FIGURE 4.4

The emergence of newly independent nations throughout Africa, Asia and the Caribbean in the 1950s and the 1960s meant that membership of the UN swelled from 51 in 1945 to 127 in 1971[3]. The admission of these new states to the UN changed the character and focus of its work. It soon became a forum for these numerically greater but poorer nations of the world to make their needs and perspectives known. As relief and rehabilitation needs in Europe were met and as regional alliances divided Europe in support of either the US or the USSR, the vast economic and social problems of African, Asian and Latin American countries provided a new and endless *raison d'etre* for many of the specialised agencies of the UN, especially those which were set up originally on a temporary basis, including UNHCR and UNICEF.

4.2 UNHCR: providing selective or comprehensive refugee relief world-wide?

4.2.1 Refugee relief: a national or international responsibility?

4.2.1.1 Permanent or limited terms of office?

UNHCR was created in 1951 only after two years of debate in the General Assembly of the UN and after numerous compromises had been reached, mainly between the US and other nations. Although UNHCR was originally set up on a temporary basis to ensure international protection and settlement of refugees from WWII, several provisions in the original resolutions allowed UNHCR to take advantage of changes in global economic and political systems during the 1950s and 1960s to extend its purpose and existence indefinitely. For example, although the new High Commissioner for Refugees was originally given a limited term of three years, a provision was included in the resolution which allowed for extensions by the General Assembly. Possibilities for extending the life span of the organization later became important only because other provisions allowed the High Commissioner to expand his scope of authority to include other refugees and to provide material assistance for refugees and their hosts.

4.2.1.2 Universal or group definitions of a refugee?

Determining which people qualified for help from the UNHCR was a significant area of debate and eventual compromise in the General Assembly. Refugees, displaced persons and stateless individuals were distinguished clearly from one another, and UNHCR was given responsibility for refugees and displaced persons who:

> 1) had already been designated refugees under the Constitution of its predecessor the International Refugee Organization (IRO), or other previous international agreements, or
>
> 2) were outside their country of nationality or habitual residence and were unable or unwilling to return to it because of a well-founded fear of persecution.

This broad definition represented a significant victory over those national governments led by the US who had fought for an *ad hoc* approach to refugees through definition by category. In other words, the US Government had wanted each group of refugees or displaced persons to be recognised only after their case had been debated in the General Assembly, similar to the first group of people under the mandate of UNHCR[4]. Clearly, they wanted to retain control over which groups of people would be assisted, in what ways, when and by whom. The inclusion of the second group, however, gave UNHCR the right to act on behalf of future refugees and displaced persons who met the criteria specified above somewhat independent of national governments.

4.2.1.3 Legal advocacy or material assistance for refugees?

Another way in which some national governments sought to limit the scope of the High Commissioner's influence was to restrict his responsibilities to those concerned with providing international legal protection. Yet again, other governments opposed such a limitation and extended UNHCR's responsibility to include 'seeking permanent

solutions for the problems of refugees by assisting governments . . . to facilitate the repatriation of such refugees, or their assimilation within new national communities'[5]. Having failed to eliminate more general assistance to refugees and their hosts as one of the functions of UNHCR, three other criteria were originally attached to this work by governments who wanted to restrict the work and influence of UNHCR.

4.2.1.4 International aid for individuals or groups of refugees?

UNHCR was to be a non-operational agency with a small staff and limited budget. In order to ensure that the office remained small and did not require (or have access to) large sums of money, UNHCR was to concern itself with groups of refugees rather than individuals. This, it was thought, would negate the need for an elaborate and expensive bureaucracy to assess individual claims as well as to address individual needs for help.

4.2.1.5 Independent action or 'operational partners'?

Another tactic to limit the size, costs and scope of UNHCR was to require that it work through governments, private charitable agencies or other specialised agencies of the UN in caring for refugees. Specifically, the High Commissioner was to seek permanent solutions by assisting governments, or with the approval of concerned governments by assisting private organizations. In addition to being an attempt to keep the office small and the scope of work restricted, this requirement reflected governmental concern that refugee relief remain under the control of national governments. The desire to keep refugee relief a national, governmental responsibility was also reflected in limitations on the financial resources of UNHCR. Only administrative expenses of the office could be paid for by the UN budget. All other work had to be financed by voluntary contributions. Yet initially, provisions were introduced by the US Government and accepted by the General Assembly which prevented the High Commissioner from seeking additional funds from governments or individuals without the prior approval of the General Assembly. Thus, although compromises were reached which gave UNHCR the authority to promote longer term

solutions for refugees and their hosts, the office lacked the resources, and the autonomy to seek additional resources, to do so.

At the end of the first year, there were 33 professional officers working with the High Commissioner in Geneva. By the end of 1953, UNHCR had a staff of 99 people, half of whom were professional officers and half secretarial personnel. In contrast with the first year, however, only 40 per cent were employed in the headquarters in Geneva. The remaining 60 per cent worked in branch offices set up in 11 countries: Austria, Germany, Greece, Italy Belgium, France, Great Britain, Columbia (for Latin America), the US and Hong Kong. This distribution of branch offices clearly reflects the initial emphasis on European and North American concerns after WWII. Similarly, membership in the first Advisory Committee, later renamed the Executive Committee, reflected European and American concerns at the end of WWII: overseas countries which were represented included Australia, Brazil, US, Israel and Venezuela; European countries represented were Austria, Belgium, Denmark, Federal Republic of Germany, France, Italy, Switzerland, Turkey, UK and the Holy See[6] (Table 4.1).

4.2.2 Refugee relief becomes an international responsibility

Over the next thirty years, nearly all of the restrictions initially placed on UNHCR's size, budget and scope of work were removed or gradually reduced. For example, the High Commissioner's term of office was renewed regularly beginning in 1953 and every five years thereafter; yet, his organization ostensibly remained a temporary one because it was subject to renewal by the General Assembly every 5 years.

4.2.2.1 Determining refugee status: The High Commissioner or the General Assembly of the UN?

Perhaps the most significant change came in the early 1960s when the General Assembly passed resolutions which authorised UNHCR to assist refugees regardless of their legal position as refugees under UNHCR's Statute. In other words, beginning with the Chinese refugees in Hong Kong in 1957 and Algerian refugees in Tunisia and

Morocco in 1958, UNHCR was authorised to assist refugees who did not qualify in law for refugee status within the UN or who could not be brought under the UN mandate because of the political sensitivities of member governments. The General Assembly passed resolutions which gave the High Commissioner this authority generally in 1961 as well as the right to use emergency funds and voluntary contributions for such refugees. This meant that the High Commissioner, in consultation with his Executive Committee, was free to assist a much wider range and more vaguely defined group of refugees independent of the General Assembly of the UN.

4.2.2.2 Centralising decision-making for international refugee relief

Clearly, the selection of refugees to be assisted by UNHCR was now in the control of the High Commissioner and a select group of national governments who were represented on the Executive Committee. The first Executive Committee was established in 1951 and consisted of 15 representatives. Membership later expanded, mostly after 1960, to include other governments involved in major refugee migrations (Table 4.1). With few exceptions (for example, Namibia, Nicaragua and Yugoslavia), these governments had political and economic alliances with one another - few communist or socialist regimes associated with the USSR have been represented. Furthermore, even with the addition of 18 new members between 1960 and 1990, governments of wealthier nation-states, primarily located in Europe and North America, continue to occupy 50% or more of the positions on the Executive Committee (Figures 4.5 and 4.6).

4.2.2.3 From legal advocacy to comprehensive assistance

This shift in the selection of refugees for assistance from the UN to the High Commissioner and his Executive Committee was accompanied by a shift in the type of aid given by UNHCR. Previously, the absence of national and international legal instruments to guarantee basic human and political rights of refugees as well as a critical shortage of funds meant that during the 1950s the work of UNHCR focused

TABLE 4.1

National Governments with membership on the Executive Committee of the United Nations High Commissioner for Refugees[1]

YEAR	REGIONS Europe	North America	Other[2]	Africa	Asia	Latin America
1951[3]	Austria	USA	Australia			Brazil
	Belgium		Israel			Venezuela
	Denmark					
	Fed Rep Germany					
	France					
	Italy					
	Switzerland					
	Turkey					
	UK					
	Holy See					
1955[4]	Greece				Iran	Colombia
	Netherlands					
	Norway					
1957		Canada				
1958[5]	Sweden					
	Yugoslavia			Tunisia	China	
1963				Algeria	Lebanon	
				Madagascar		
				Nigeria		
				Tanzania		
1967				Uganda		
1979	Finland			Lesotho	Japan	Argentina
				Morocco	Thailand	Nicaragua
				Sudan		
				Zaire		
1982				Namibia		
1988				Somalia	Pakistan	

YEAR	Europe	North America	Other	Africa	Asia	Latin America
TOTAL	16 (37%)	2 (5%)	2 (5%)	12 (28%)	6 (14%)	5 (12%)

1. Source: UNHCR (1990) Information paper. Geneva, Switzerland: United Nations High Commissioner for Refugees, 18 pp.

2. Other high income economies

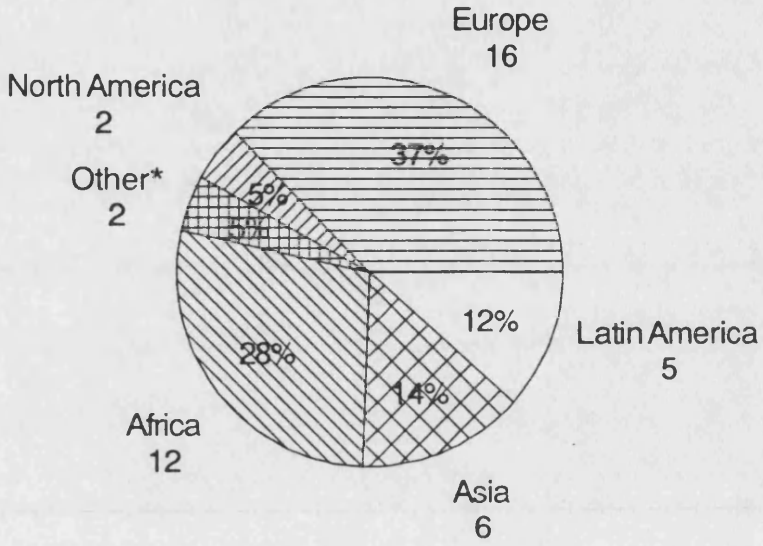
3. UNHCR Advisory Committee established in 1951.

4. UNREF Executive Committee established in 1955.

5. Executive Committee of UNHCR established in 1958.

Figure 4.5

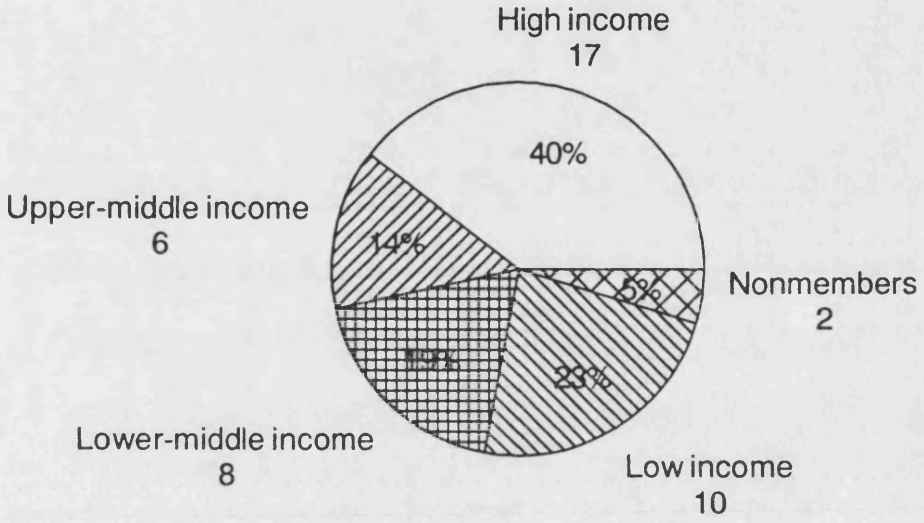
National governments with membership on the Executive Committee of UNHCR 1990: regional distribution



*Other high income economies

Figure 4.6

Governmental membership on the Executive Committee of UNHCR according to economic classification* in 1990



*According to the World Bank Development Report 1990.

on encouraging and assisting national governments in Europe to establish laws to protect refugees. Services and material assistance for refugees throughout Europe after WWII were provided by national and local governments and by charitable organizations, with their own funds or with funds from other governments channelled bilaterally or through UNHCR. UNHCR's main preoccupation had been to protect and find new homes for refugees in Europe. This was not successfully completed until the late 1960s; camps in Europe were only closed in 1966, and some refugees still required financial or legal assistance after they had been resettled. It was not until 1971 that UNHCR reported that none of the remaining 650 000 refugees in Europe required further assistance from the UN[7].

However, in the 1960s the greatest and most urgent needs of refugees of concern to UNHCR were in Africa and Asia and were basic. Assistance was, therefore, usually material and often did not include a legal component since many of these refugees were not given legal refugee status under UNHCR's Statute. This practice of giving material assistance to a more disperse group of refugees contributed to the expansion of branch offices from 15 in 1962 to 34 in 1971. It also accounted for the work of more than half of the 350 staff by 1970[8]. Thus, during the 1960s and especially the 1970s, UNHCR increasingly became an inter-governmental organization which organised and managed aid from wealthier nations in North America and Western Europe for basic relief for refugees and their hosts - nearly all of whom now lived in poorer countries in Africa and Asia, and to a lesser extent in Latin America.

4.2.2.4 Financing international refugee relief

But material assistance required money. During the 1950s and 1960s, UNHCR developed a system for obtaining voluntary contributions from governments and private sources in addition to its UN budget for administrative expenses which ranged from only 2.5 to 5.4 million US$ annually between 1963 and 1971[9]. Although the need for voluntary contributions was first recognised when UNHCR was created and a special refugee fund had been established, an appeal could only be made for emergency aid. Furthermore, the response to these emergency appeals in the early

1950s was so poor that the High Commissioner felt it 'had made him what might be called an international beggar'[10]. It was not until 1954 that the General Assembly authorised the High Commissioner to appeal for funds to finance temporary care and permanent solutions of refugees generally, and not until 1961 that the General Assembly authorised the High Commissioner and the Executive Committee to determine the use of such funds independently. But like the selection of refugees, fund raising by the High Commissioner was to be done with the approval of his Executive Committee. In addition, an emergency fund, initially of not more than 500 000 US$, was created in 1957 to meet acute needs. It too was to be used by the High Commissioner under the direction of the Executive Committee.

Other funds were donated for specified purposes. Many of these were administered as trust funds, for example, between 1956 and 1972 nearly 40 million US$ were donated to UNHCR special trust funds. Thus, the lack of financial support from governments which plagued UNHCR in the early 1950s began to disappear in the 1960s when the focus and nature of its work changed to meeting the basic needs of refugees and their hosts in poorer countries. Some 85 governments contributed to UNHCR in 1971 in comparison with only 50 in 1966. Voluntary contributions from governments totalled between 2.6 and 4.6 million US$ annually between 1959 and 1970, excluding special trust funds. Voluntary contributions from private sources during the same period totalled between less than 100 000 US$ to 1.5 million US$ annually[11].

4.3 The 1970s: international relief as an aid priority

Colonial independence was not followed by periods of peace and prosperity as had been hoped. Instead, national unity was soon followed by ethnic and tribal tensions. In light of the gap between stated goals for equitable growth and available resources to meet these goals[12], the leaders of these increasingly fragile nations sought for better concessions on trade and aid with northern states. They did this firstly by forming regional groups, such as the Organization for African Unity in 1963, as well as political groups, such as the non-aligned movement in 1955 and the Group of 77 in 1963. Given their numerical weight in international forums, these blocs of southern

states then pressed for reforms, for example through the UN Conference on Trade and Development in 1964 and the Lome Conventions of 1975, 1981 and 1985.

Heightened attention worldwide to the longer-term problems of underdevelopment was accompanied by a greater awareness of the persistent and erosive character of disasters. The civil war between Nigeria and Biafra of 1967-1970 marked the beginning of a new era for international relief; it was the first large scale disaster of the 1970s which was publicised by television throughout North America and Europe. It was immediately followed by a cyclone and civil war in East Pakistan (1970-1971), civil war in southern Sudan and severe drought and famine in Sub-Sahelian Africa (1973-75). These experiences were catalytic in defining disasters as a distinct area of international concern which demanded more attention by international aid agencies[13].

Thus, disasters again became a priority of international aid organizations. Beginning in the 1960s, many such organizations created special offices or departments solely for the problems created by disasters and associated needs for relief (Tables 4.2 and 4.3). While the humanitarian needs caused by disasters were acute and extensive, this was not the primary reason for institutional concern.

> 'More pragmatically, however, the more such suffering was presented to the public in the developed world, the greater was the pressure on institutions with relevant roles and resources to respond. Disaster relief - the way in which an organization could mobilize its responses - became linked even more than in the 1950s to the way that an organization was assessed by potential supporters. Disasters provided organizations, non-governmental and inter-governmental organizations alike, a battlefront over which they could wave their institutional banners. Increasingly, it became important not only to be in the forefront of relief . . . . where the cause was popular, but also to be seen to be there. The resources that organizations possessed to pursue their longer-term goals and to ensure their very survival and growth were intertwined with the new attention that disasters were receiving.' [14]

Along with the creation of separate offices or departments for relief within existing institutions, new organizations were also formed specifically for relief. Within the UN system, two agencies were set up in the 1960s and 1970s which reveal organizational relationships and characteristics similar to those of their predecessors. The World Food Programme (WFP) was set up jointly by the UN and the Food and Agriculture

TABLE 4.2

Disaster units in United Nations Organizations

Organization	Unit/ function	Date
Food and Agriculture Organization	Office for Special Relief Operations (arose out of the Office for Sahelian Relief Operations-1973)	1975
United Nations High Commissioner for Refugees	Emergency Office	1980
United Nations Children's Fund	Office of the Emergency Operations Coordinator	1971
World Food Programme	Emergency Unit	1975
World Health Organization	Emergency Relief Operations Office	1974
United Nations Development Programme	Role of Resident Representatives to coordinate relief operations on country level designated in UN Res. 2816 (XXVI) December	1971
United Nations Disaster Relief Office	Main activity to mobilize, direct and coordinate relief activities of UN system as stipulated by UN Res. 2816 (XXVI) December	1971
Pan-American Health Organization	Emergency Preparedness and Disaster Relief Coordinator	1977
United Nations Office of the Coordinator for Special Economic Assistance	Concerned with economic emergencies threatening economic viability of member states	1977

* Copied from Kent (1987), page 52.

TABLE 4.3

Table 2.3 Disaster units established in major donor governments

Country	Name of unit & ministry	Date Establishec
Belgium	Section C-25, Service Catastrophes Naturelles Service du Confinancement et de l'Aide d'Urgence Ministry of Foreign Affairs	197 198
Canada	International Humanitarian Assistance Division, Canadian International Development Agency	197
Denmark	DM-1-DANIDA, Ministry of Foreign Affairs [Disaster relief was part of DANIDA's main role when it was established in 1962. DM-1 resulted from reorganization which took place in 1986]	1962/8
France	La Cellule d'Urgence et Veille, Ministry of Cooperation	198
Great Britain	Disaster Unit, Overseas Development Administration	197
Netherlands	Emergency and Humanitarian Aid Section, Ministry of Foreign Affairs	197
Norway	Coordination of Disaster Relief Section, Ministry of Foreign Affairs	
Sweden	Section for Emergency Relief Assistance, Swedish International Development Authority	197
Switzerland	Directorate for Cooperation Assistance and Humanitarian Aid, Federal Department of Foreign Affairs	197
United States	Office of US Foreign Disaster Assistance, Agency for International Development	1964
West Germany	Section 301, Ministry of Foreign Affairs	1978

* Copied from Kent (1987), page 53.

Organization in 1963 to provide food for relief and development. Yet like many of the agencies before it, the World Food Programme (WFP) soon devoted most of its resources and efforts to development because of the institutional security such a focus provided[15].

In contrast, the Office of the United Nations Disaster Relief Coordinator (UNDRO) was set up by the UN Secretariat to coordinate the array of UN agencies involved in relief work in 1971. The creation of a UN Disaster Relief Coordinator occurred only after a decade of negotiation and compromise between the UN Secretariat who were keen to improve the image, work and support base of the UN generally but were unwilling to take on additional roles beyond those they already had, while the specialised agencies of the UN themselves were unwilling to relinquish responsibility for such an increasingly profitable and popular area of work. Major donor governments were reluctant for the UN to take a leadership or coordinating role which might override their authority or autonomy - either as donors or recipients of relief aid. To a lesser extent, many of the charitable organizations saw a need for greater coordination but had their own coordinating bodies or close relationships with other specialised UN agencies involved in relief.

This resulted in the creation of an agency which was given very limited resources. For example, the UN Disaster Relief Coordinator's trust funds were increased in 1982 to provide a higher ceiling for responding to individual disasters; yet an allocation of only 50 000 US$ at most would only be, in practice, a symbolic gesture[16]. Furthermore, it was only after seven more years (and several devastating disasters) that an agreement was reached with the United Nations Development Programme (UNDP) which gave the UN Disaster Relief Coordinator an organizational structure for responding to individual disasters: Country Resident Representatives of the UN Development Programme (UNDP) were to be the disaster coordinators in each country, acting on behalf of the UN Disaster Relief Coordinator. Even then, the UN Disaster Relief Coordinator had little, if any, independent operational ability. Instead, it was confined to a role of clearing information which would then be used (or ignored) by other organizations - within the UN system, the charitable sector or aid

organizations of individual national governments. Clearly, the UN Disaster Relief Coordinator was another agency for relief whose work was tightly controlled; but this time, measures to control its work were supported and enforced by the array of actors already working within the international relief system.

The establishment of these various institutional structures specifically for relief did not mean, however, that the obvious links between disasters and development were addressed by the international community. In fact, the creation of separate units or agencies maintained the political distinction between relief and development - between socioeconomic development and immediate survival. For refugees, relief aid was available only in cases of acute, political persecution. Refuge from systematic, economic exploitation was excluded. In other words, it excluded the masses of poor and powerless people in the southern states[17]. Refugee relief continued to avoid underlying socioeconomic issues.

Nevertheless, this did not result in less work for refugee relief agencies. On the contrary, the massive influx of nearly 10 million Bengalis into India in the early 1970s and several hundred thousand Indochinese throughout Southeast Asia later that decade were indicators of the magnitude of refugee populations and displacements yet to come. They were followed by massive movements - nearly continuously - during the 1980s, for example, the Afghans in Iran and Pakistan, the various Ethiopian ethnic groups in Somalia and Sudan, and the Mozambicans in Malawi and Zimbabwe. All generated unmeasurable suffering, added to the economic, social and political complexities facing southern nations-states and created space for aid agencies to assume substantial roles in international relief.

4.3.1 The beginnings of bureaucracy

Despite an increasing and substantial workload throughout the 1960s, primarily in Africa, it was not until the 1970s that UNHCR expanded and reorganised itself as a large bureaucracy. Beginning with the mass migration of some 10 million refugees from Bangladesh into India in 1971, UNHCR's staff, budget and programmes of

assistance grew astronomically. By 1980 its staff had tripled, totalling some 1000 of whom one third were based in Geneva, and its programmes of assistance cost over 250 million US$ in comparison with just over 8 million US$ ten years earlier. The main office in Geneva had been reorganised in 1972 by geographical regions of the world, and branch offices which had previously been staffed by only one professional officer were enlarged[18].

This expansion did not, however, alter substantially the way in which UNHCR worked. By the end of the second World War nearly all of the principal organizations involved in international relief had well-defined and well-established roles. Not surprisingly, as one of the specialised agencies of the UN, UNHCR's main roles were:

1. to encourage and assist host governments to care for refugees, especially to promote long term solutions, such as settlement or repatriation, and

2. to elicit and channel aid from other governments and private sources for these purposes.

Despite the shift from Europe to poorer countries in the South in the 1960s and 1970s and the increasing emphasis on general aid, UNHCR did not get involved in providing services or material assistance directly. Instead, it was an institutional structure through which the needs of refugees and their hosts could be assessed and made known to wealthier nations and through which aid from those nations was channelled for relief of selected groups of refugees. Thus, in a review of programmes for refugees in some 20 countries in Africa and Asia before 1980[19], the main activities of UNHCR were:

a) to assess the need for and desirability of international assistance for refugees and their hosts,

b) to work directly with host governments for the acceptance and implementation of internationally supported programmes of assistance for refugees,

c) to collect and disperse funds for such programmes,

d) to monitor and disseminate information on refugee needs and internationally supported relief programmes, and

e) to elicit and support the involvement of national governments, private charitable agencies and other specialised agencies of the UN in refugee relief programmes.

In addition, UNHCR worked with governments to obtain agreements which allowed either repatriation or permanent settlement in neighbouring countries. Direct care was given through existing governmental or charitable services and programmes or through additional projects set up by governments or charitable agencies especially for refugees.

4.4 The 1980s: UNHCR engages in health relief

4.4.1 Health relief as a priority activity of UNHCR

Although UNHCR was by definition a relief agency, the changes in the environment in which relief needs were created and responded to had a great impact on the organization. The prominence and visibility of relief work, as well as the vast resources available to support it, led UNHCR to compete for an expanded role in refugee relief, including health care - but not substantially until the 1980s. In general, the agency then expanded its role in two directions: firstly in their involvement in acute or emergency relief work, and secondly in providing technical and material assistance for relief and rehabilitation. Both of these areas included a role in health relief.

Beginning with the newly formed Emergency Unit of UNHCR in 1980 and continuing with the Technical Support Unit since 1983, health and nutritional relief became distinct priorities of UNHCR's head office in Geneva. The Emergency Unit immediately undertook three activities for refugee health relief: the creation of an Emergency Health Kit, the production of a manual for UNHCR staff on the

management of refugee relief operations and the establishment of standing arrangements for rapid assessments of refugee health and nutritional needs.

4.4.1.1 An emergency health kit

In 1980, the Emergency Unit requested the Office for Emergency Relief Operations of WHO to assist with these three activities[20]. It was agreed that WHO would draw up a standard list of basic drugs and supplies which would be needed in emergencies in order to stock supplies in advance. WHO used the funds for this work to pay the Refugee Health Group in the Ross Institute of the London School of Hygiene and Tropical Medicine to prepare such a list. The list was eventually published in the form of a paperback book by WHO[21], and a kit which contained three months supplies of drugs and equipment was packaged and stored by Unicef's office in Copenhagen, Denmark. Subsequently, the Emergency Unit of UNHCR also agreed to contribute financially to a manual on the health needs of refugees which was being prepared by the London School in collaboration with WHO which was eventually produced as a book on Refugee community health care[22,23].

4.4.1.2 Assessing health and nutritional needs in emergencies

WHO suggested that arrangements for the rapid epidemiological assessment of health and nutritional needs of refugees be made with the Centres for Disease Control (CDC) of the US Government's Public Health Service directly since they had gained considerable expertise in this area, firstly in the Nigerian civil war of 1967-1970[24] and more recently in the Cambodian crisis of 1979[25,26,27]. Consequently, negotiations were carried out directly between CDC and UNHCR. An institutional agreement in which CDC provided epidemiological experts to carry out such assessments for UNHCR who funded most of the expenses incurred was reached in principal in 1981[28,29] but was not formalised in a Memorandum of Understanding until 1989[30]. Thus, CDC was one of the first agencies outside of the UN system to act directly as a resource of health expertise and personnel for UNHCR.

4.4.1.3 Guidelines on refugee health care for UNHCR

Concurrently, the Emergency Unit convened meetings of various professionals to draft management guidelines for staff of UNHCR to use in refugee relief operations, which were eventually published in 1982[31]. All of the principal sectors were included, and health and nutrition were no exception. Those professionals who contributed to these technical guidelines for refugee health relief represented the most prominent governmental, UN and charitable organizations involved in refugee relief or in health. These included WHO and the Pan American Health Organization (PAHO) as the global and American inter-governmental organizations responsible for health and nutrition, the Centres for Disease Control (CDC) as the public health agency of the US Government - who was and is the largest contributor to UNHCR's resources, the London School of Hygiene and Tropical Medicine which had technical experts in tropical public health - some of whom were developing expertise in refugee health issues, and the League of Red Cross and Red Crescent Societies, Oxfam UK, Save the Children Fund and Medecins Sans Frontieres, France as the largest, better organized and most widely known charitable agencies providing health care for refugees.

The main reason for involving such a wide range of agencies was to ensure the acceptance of the manual and its practices internationally[32]. In other words, to generate an international support base for the technical standards and activities proposed as well as a role for UNHCR in determining and carrying out such practices. Clearly, the involvement of health professionals from internationally renown institutions, such as WHO, the Pan American Health Organization, and the London School, enhanced the credibility and global acceptance of the technical contents of the proposed guidelines. The involvement of the most important donor government and several popular and active charitable agencies ensured support for the implementation of such practices. Moreover, acceptance of this manual by these agencies implied an acceptance of UNHCR in the process of determining and carrying out refugee health policies and practices. It was in this way that UNHCR formally entered the international health relief policy arena.

4.4.2 Building their own expertise in refugee health relief: medical doctors and nutritionists as staff members of UNHCR

Shortly after the Emergency Unit was formed, UNHCR created another unit in 1981 to provide the technical expertise needed in programmes giving material assistance. By 1986 this Technical Support Unit was made up of eight professionals: a rural settlement specialist (Head), an agronomist, an agricultural planner, a water development expert, a health and nutrition adviser, a physical planner, an income-generating expert and a socio-economist[33]. Three of these professionals were senior officials seconded to UNHCR by other agencies within the UN system, including the health and nutrition adviser who had been seconded from the Office for Emergency Relief Operations of WHO since 1983. UNHCR gave funds to WHO to cover all costs associated with this post.

4.4.2.1 International guidelines for refugee health care

Between 1983 and 1987, the health and nutrition adviser gave technical advice to several different refugee programmes and undertook to rewrite the guidelines on health and nutritional care. As before, he convened a group of experts from the most important agencies in the international relief or health sectors. Many of the same agencies participated, namely WHO, CDC, the International Committee of the Red Cross (ICRC), the League of Red Cross and Red Crescent Societies (LORCS), the Refugee Health Group of the London School of Hygiene and Tropical Medicine, Medecins Sans Frontieres France and Save the Children Fund UK. In addition, two consultants were invited to contribute, one who had previously worked for UNHCR in several different relief operations and another who was at the School of Public Health at the University of California at Los Angeles (which had been involved in refugee health care since the early 1980s). Other key agencies were invited to review drafts and make comments for change or modification, for example the Pan American Health Organization and Oxfam UK. Also similar to the first guidelines, this edition focused on technical standards and interventions, but in much greater detail. So much detail that the three tomes totalled nearly 500 pages altogether[34],[35],[36]. Yet, neither

the first or second versions addressed policy issues, such as finance, organization of health services or human resource management. However, unlike its predecessor, the revised version was intended for more general use and was not limited to staff of UNHCR. Although the work first began in 1986, drafts were not circulated until 1987. A final version has not yet been produced of the general health and selective feeding guidelines. The essential drugs policy was finalised and published in 1989[37].

4.4.2.2 Other standard kits or guidelines for international use

In addition to advising individuals working in refugee relief programmes and drafting new guidelines for international use, the health and nutrition adviser supported the creation of an emergency immunization kit together with Oxfam UK and WHO, a practical guide for the use of disinfectants in refugee camps and a video on the management of supplementary feeding programmes as well as a review of the emergency health kit jointly with WHO[38].

4.4.2.3 Appointing national or local refugee health coordinators

The effects of these various activities undertaken by UNHCR within the international health relief community since 1980 would have been limited to one of generating and disseminating expert advice unless additional personnel were appointed within UNHCR country programmes to put these decisions into practice. Not surprisingly, UNHCR then looked to obtain financial and political support for appointing national health or nutrition coordinators within UNHCR itself[39]. This was less easy since it clashed openly with management by national government officials who had a sovereign right to such a role and by WHO who had a history of and mandate for providing advisers to national governments in the field of health. To a lesser extent, it created conflict with some charitable agencies who had been running many of the internationally supported refugee health programmes for several years; some of these agencies were not keen for UNHCR to take over decision making within countries or individual refugee health programmes.

A coordinator for refugee health services within the UN system was first appointed at national level in Thailand in 1979. This position began as a series of consultancies 'to study, promote and establish emergency and other health measures in refugee camps and surrounding populations'[40]. It was requested by the UNHCR office in Thailand in response to the emergency created by a large and continuing influx of Cambodians. The request was made to WHO who then proceeded to recruit a medical doctor with funding from UNHCR, firstly for 2 and then 3 months and later throughout 1980, 1981, 1982 and half of 1983. The arrangement was then discontinued and a public health nurse took over the work with funding from one of the charitable organizations working in the programme.

The reasons for WHO's disillusionment with this arrangement are not clear. Other health coordinators were later appointed by WHO in Somalia (1981), Pakistan (1983), Sudan (1985), Ethiopia (1985), Iran (1986) and Afghanistan (1988); only those appointments in Somalia, Pakistan and Iran were joint with UNHCR. In fact, WHO had requested in 1982 that the Thai post be a full-time position, funded by UNHCR. Perhaps the administrative procedures for consultancies were cumbersome or the dual lines of accountability too contentious. Perhaps the incumbent's recommendations were taken to heart - that the coordinating committee of the charitable agencies could provide the leadership and coordination which was needed along with a public health nurse to monitor public health concerns and advise UNHCR's programming officers on technical issues. For whatever reasons, terminating this position was consistent with WHO's historical involvement, or rather non-involvement, in the medium- or long-term, in relief (see chapter five on WHO which follows).

UNHCR's inability or unwillingness to change the agreement probably reflected their own financial uncertainties, in other words, that their budget was planned and approved on a yearly basis only. In addition, they had only recently begun to address technical issues within their own institution; at that time, for example, they did not have a health or nutritional professional on their staff. Clearly, UNHCR needed to ensure that health and nutritional programmes were effective. Their renewal of the contract and continued funding for the post were evidence that they were satisfied

with the arrangement. The withdrawal of WHO in 1983 did not change this. Instead of working with WHO, UNHCR then arranged for one of the charitable agencies to second a public health nurse to them for health and nutritional expertise. Such a shift reflected in part growing collaboration between UNHCR and charitable agencies more generally[41].

Thus, it was WHO which provided technical experts on secondment to UNHCR initially. Later these coordinators were either professionals seconded from charitable agencies (with funding from UNHCR) or professionals employed by the programming section of UNHCR itself. UNHCR first employed their own professionals for country programmes in 1984 for eastern Sudan. Similar to the coordinator in Thailand, health coordinators in Pakistan and Somalia were originally employed by WHO or charitable agencies; it was not until 1986 and 1987 respectively that UNHCR created their own positions for these coordinators[42]. UNHCR has since appointed their own health coordinators in Malawi (1987) and Ethiopia (1988), for example. Or they have continued to rely on charitable agencies to second these coordinators or other health-related professionals to them, for example in the Philippines and Malawi or in the regional offices in Pakistan and eastern Sudan[43]. The charitable agencies who are assisting UNHCR in this way are many of the same ones who worked closely with UNHCR in drawing up their standards and guidelines, specifically Medecins Sans Frontieres France and Save the Children Fund UK.

Increasing, rather than decreasing, health and nutritional problems among refugees under UNHCR's care and the global publicity given to many of these problems, eventually contributed to the appointment of additional health and nutritional professionals in the head office. Additionally, in 1987 the new High Commissioner promised to improve the performance of UNHCR's technical assistance and particularly singled out health care (which was not surprising since he previously worked for the International Committee of the Red Cross). In fact, shortly after he was appointed, the Technical Support Unit was promoted to the level of section which reported directly to the Deputy High Commissioner within the Office of the High Commissioner. The scope of the work of the Technical Support Services was also

expanded in 1988, incorporating the Emergency Unit and Social Services[44]. Pressure to improve their health and nutritional aid and support for an expanded technical role from the new High Commissioner were two factors leading to the appointment of a nutritionist and a second public health doctor in 1987. With a full time staff of three and the availability of funds for consultants, the work of UNHCR in health relief expanded.

4.4.3 UNHCR: a coordinator and manager of refugee health relief?

4.4.3.1 Influencing national policies and practices for refugee health

The most notable expansion was in missions undertaken for health and nutritional concerns (Figure 4.7). A health or nutritional component was part of some 51 missions to 24 different countries in Africa, Asia and Latin America during the 1980s. Although most were undertaken by health and nutrition professionals in only 16 (1/3 or 31%) were health concerns a part of more general assessments (Figure 4.8). The majority of missions were carried out in Africa where the largest refugee population was situated (Figure 4.9). Table 4.4 shows that of the 24 countries visited in Africa, Asia and Latin America, at least half were visited only once. An analysis of those countries visited twice or more (Appendix IV) illustrates that most of the missions to these countries were carried out by different professionals, for different purposes or among different groups of refugees. Thus, they too could be counted separately since there was no purposeful link between them. In only five countries, (5/24 (21%), Honduras, Indonesia, Mexico, Philippines and Somalia, were at least two of the visits undertaken by the same person among the same group of refugees. It is not possible, therefore, to conclude that UNHCR's head office had regular, consistent or frequent contact with more than a few individual refugee relief operations.

TABLE 4.4
Location of technical missions of UNHCR Geneva which included a health component, 1980 - 1989

Number of missions undertaken by country					
One	**Two**	**Three**	**Four**	**Five**	**Six**
Algeria	Indonesia	Malawi	Ethiopia	Honduras	Philippines
Cameroon	Rwanda	Zaire	Pakistan	Sudan	
China	Thailand	Mexico	Somalia		
Costa Rica					
Djibouti					
Iran					
Malaysia					
Sri Lanka					
Tanzania					
USA					
Yemen					
Zimbabwe					
TOTAL 12	**3**	**3**	**3**	**2**	**1**

Figure 4.7

Technical missions of UNHCR Geneva which included a health component, 1980-1989

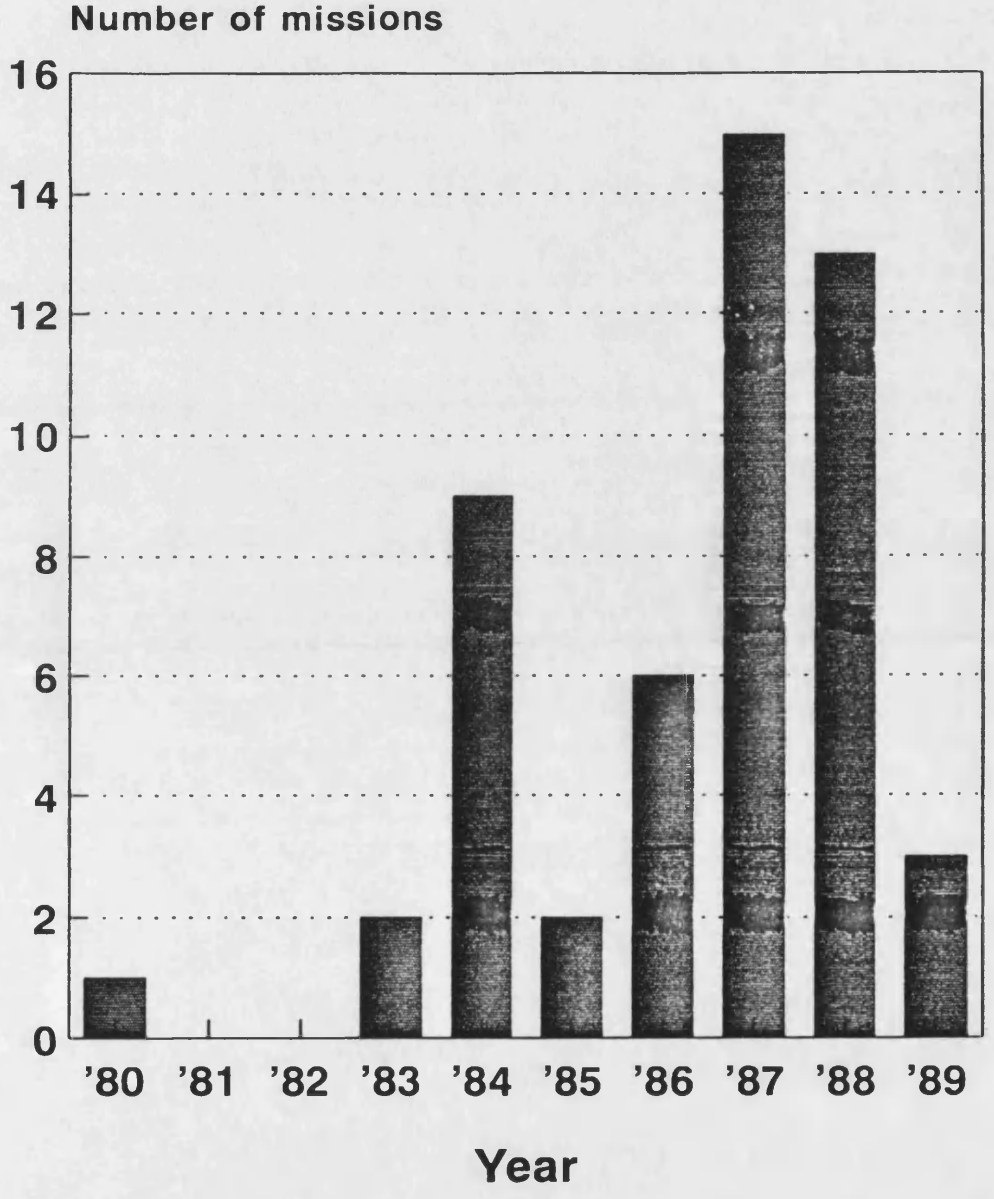


Figure 4.8

Professional composition of technical missions of UNHCR Geneva which included a health component, 1980-1989

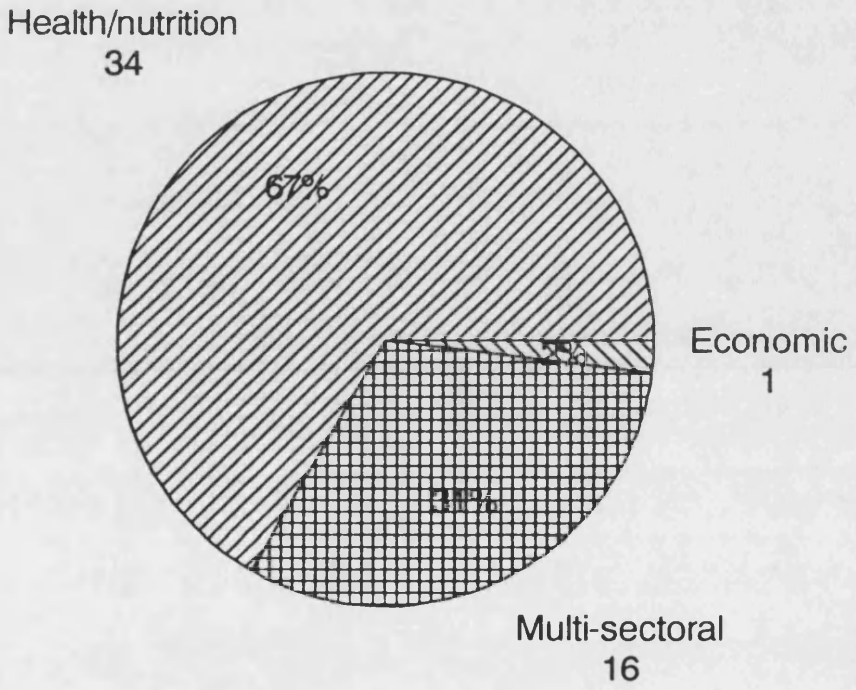
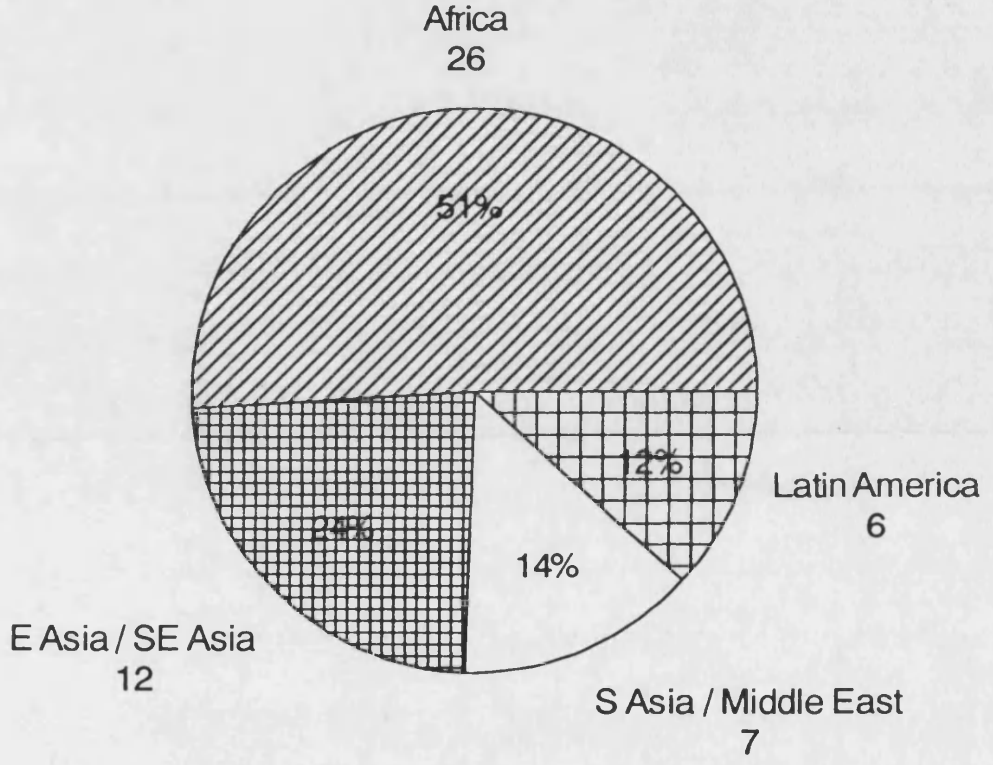


Figure 4.9
Health related missions of UNHCR Geneva by geographical region, 1980-1989



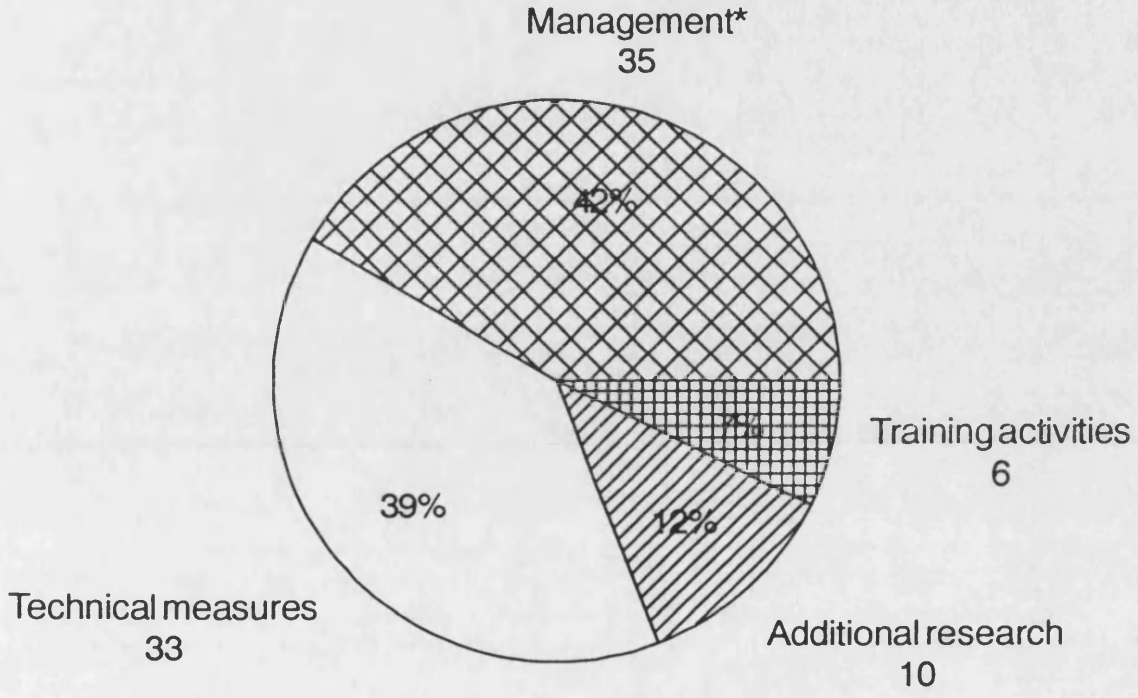
Despite the seemingly *ad hoc* nature of these technical health missions, there is near uniformity in the type of recommendations made. Not surprisingly, many were technical in nature. In other words, specific activities, interventions or technical standards were recommended for use in one third of the missions (Figure 4.10). Most of these recommendations were consistent with the activities and interventions being promoted worldwide under the banner of Primary Health Care. The most frequent type of recommendation, however, made some comment on the management of refugee health services. In particular, attention was given to which organization should be the lead agency or coordinator. Appendix V classifies each recommendation for the management and organization of refugee health services according to its orientation - whether it addresses the relationship between refugee and national health services, roles of foreign professional and agencies other than UNHCR or roles specifically for UNHCR. Figure 4.11 summarise these recommendations numerically, highlighting the preoccupation with <u>who</u> manages refugee health programmes and UNHCR's preference for management by European, North American or international agencies. In other words, what might be labelled as UNHCR's territorial concerns for an expanded and clearly defined role in international refugee health relief led them to promote, and at times insist (when they held the purse strings), that they or an agency of their choice be the lead or coordinating body in a given refugee health operation. Not only were they providing technical support and guidance, UNHCR was now lobbying for an active role in determining refugee health policy and practice at both international and national levels. This shift from 'non-operational' roles to more active participation in all aspects of refugee relief operations appeared to be a more general one. For example, since 1983 in Sudan UNHCR has had to 'try' to remain operational[45].

4.4.3.2 Enhancing their credibility in refugee health care

The strength and potential success of the efforts of UNHCR's head office to promote and obtain a leading role in refugee health care depended in large part on the perceived credibility of the organization to carry out the work successfully. Thus, whether staff were employed by UNHCR or were consultants (Figure 4.12) was only

Figure 4.10

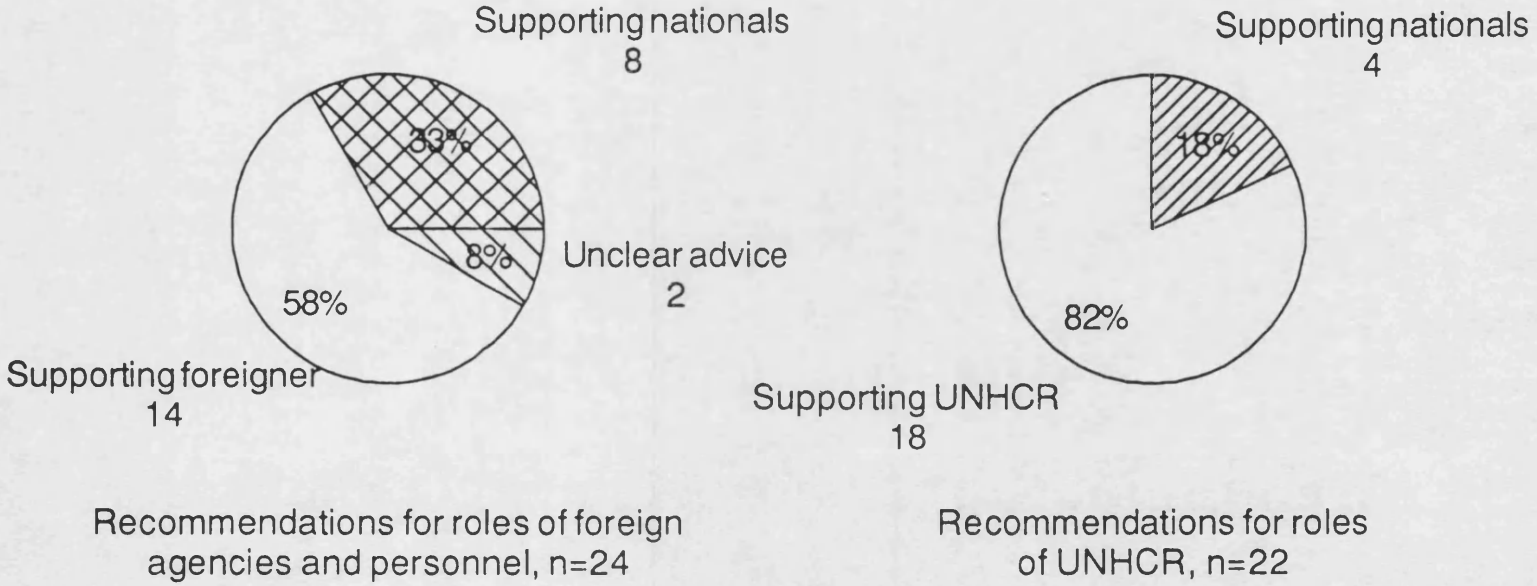
Recommendations for health care made by technical missions of UNHCR Geneva, 1980-1989



***Includes management mechanisms, organizational structures and systems**

Figure 4.11

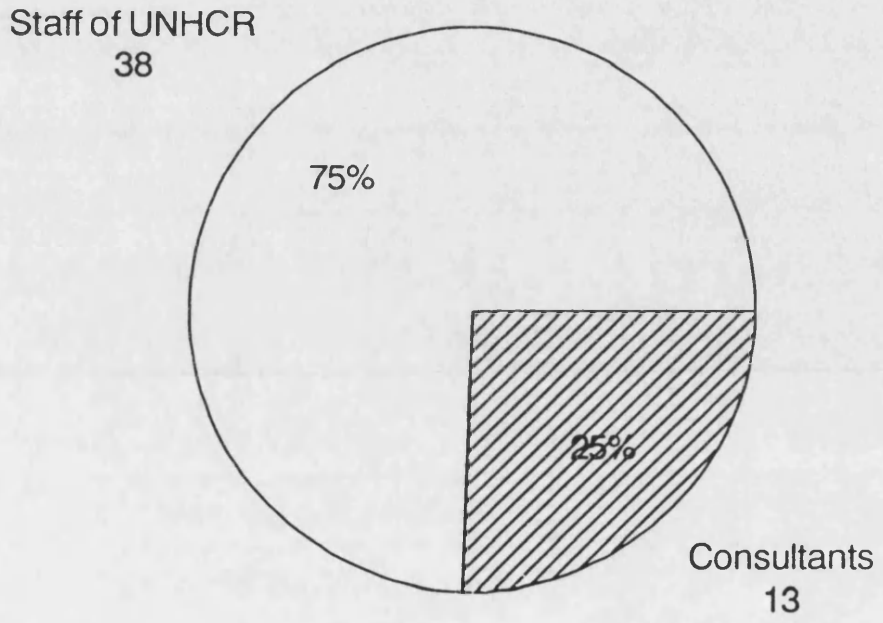
Management recommendations of UNHCR health missions*: Strengthening national or foreign management of refugee health?



*Health related technical missions of UNHCR Geneva, 1980-1989

Figure 4.12

Employment status of personnel undertaking health related missions for UNHCR Geneva, 1980 - 1989



one important consideration. Of greater concern was their professional qualifications. Nearly all of these missions were undertaken by a medical doctor who had additional training in public health (Figure 4.13). Those which dealt specifically with food and nutrition issues were increasingly carried out by nutritionists during the latter half of the decade. It is clear that the use of medical doctors primarily, and nutritionists to a lesser extent, enhanced the credibility of the technical recommendations given as well as lending legitimacy to UNHCR as the organization under whose aegis this work could be managed. Of course the latter was enhanced greatly by the employment of three professionals, two public health doctors and one nutritionist, on a full time basis at the head office as well as the appointment of national health coordinators since 1984.

4.4.4 Moving beyond an advisory role

4.4.4.1 Centralised procurement of drugs and medical supplies

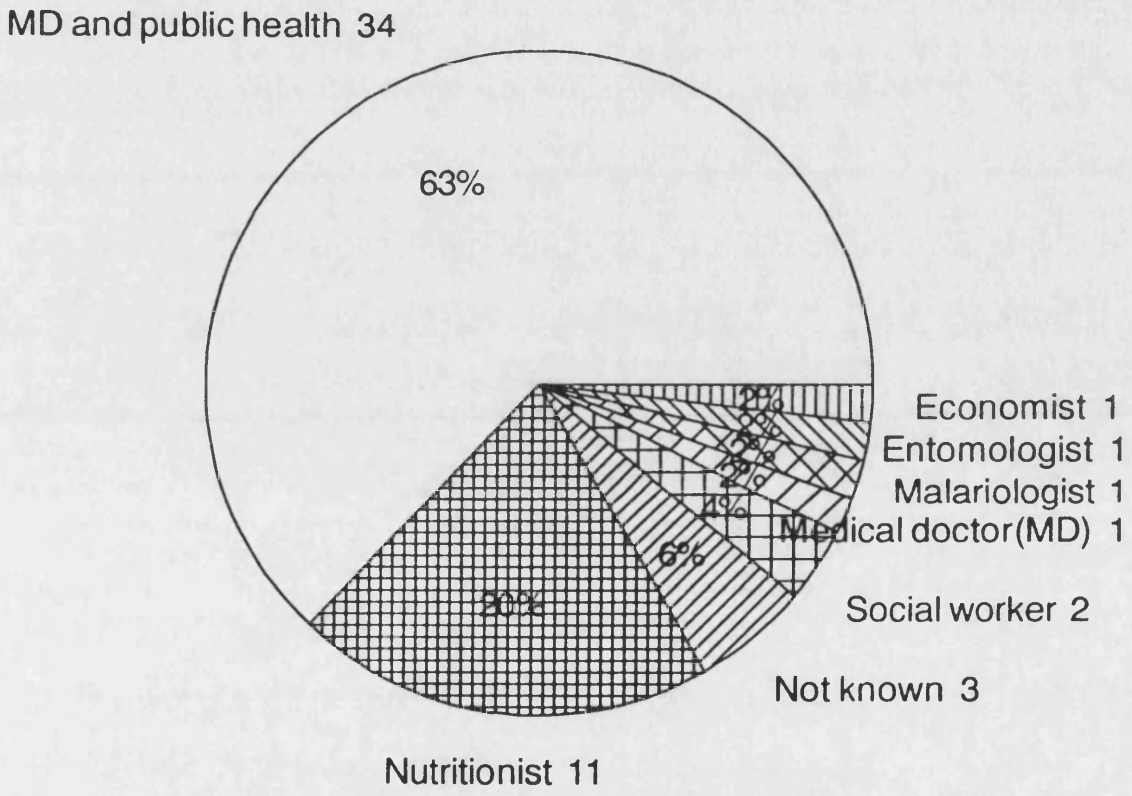
UNHCR's efforts to create a role for themselves in refugee health relief extended beyond the giving of expert advice and guidance world-wide and for national programmes. Beginning in 1984, the first health and nutrition adviser recommended that the procurement of drugs and medical supplies for at least 4 country programmes be carried out by the Procurement Unit of UNHCR's head office in Geneva. Clearly, this gave UNHCR control over the types, quantities and quality of medicines used in country programmes. Such a practice gave UNHCR the ability to enforce their own drug policies, since UNHCR usually paid for drugs and medical supplies in refugee relief operations.

4.4.4.2 Proposing international standards for refugee health care

There are other indications that UNHCR's health unit wanted to take the lead role in refugee health relief generally. The first was the publication of health and nutritional standards and activities in firstly the quarterly newsletter of the Emergency Section beginning in 1987[46] and later in the newsletter of the Technical Support Service

Figure 4.13

Professional qualifications of personnel undertaking health related missions for UNHCR Geneva, 1980-1989



beginning in 1988. This activity is further evidence of their efforts to formulate standards generally and to distribute them widely.

Secondly, the health unit wrote separate documents for developmental plans of the unit[47],[48]. The language used in the developmental plan of 1987 in particular highlights the central issue of power or control that accompanies leadership positions. For example, this plan states that 'the main objective of .. training activity is to improve the ability of UNHCR officers to exercise adequate control over implementing agencies'[49]. In fact, in that plan priority training activities were targeted to UNHCR programme officers and heads of offices. Similarly, training activities for technical staff aimed to 'standardise training . . that reflect UNHCR health policy and can be used by their main partners for their own in-house training'[50]. Moreover, they go on to propose that the health unit 'be given authority to recommend for or against the assignment (or the continuation) of an agency in a given programme'[51]. Clearly, their ability to do so would be limited by the financial and political autonomy of the agencies concerned. But since UNHCR is often used by donor governments as a conduit for funding, such a proposal potentially increases substantially the control UNHCR's health unit would have over the work of other agencies, especially national ones dependent on international sources of aid.

4.4.4.3 Co-sponsoring international conferences on refugee health care

The health unit also undertook to sponsor international conferences on important health or nutritional problems, such as Nutrition in Times of Disasters in 1988 jointly with the Sub-Committee on Nutrition of the UN Administrative Committee on Coordination and WHO[52] or Health Care for Displaced Persons and Refugees: an International Symposium which was organized primarily by Georgetown University and the Refugee Policy Group in the US in 1988[53]. These two conferences aimed to review key issues and problems in the provision of general food rations or health services generally respectively among refugee or displaced populations. Both conferences attracted participants from most of the prominent relief and health

organizations and both were used to produce statements[54] or recommendations on the practice of health and nutritional relief which would then be accepted worldwide.

4.4.4.4 Initiating international policies for refugee health care

Efforts by this health unit to establish a leadership role for UNHCR in health relief also extended to international policy creation and practice. In 1988 and 1989, the head office in Geneva issued two policy statements concerning health and nutrition. The Deputy High Commissioner first detailed UNHCR's position on the problem of AIDS among refugees and steps to be taken for its prevention and control as well as for the protection of individual human rights in 1988[55]. A second policy was proposed in 1989 against the use of powdered milk in refugee camps - a controversy that has been and still is raging[56]. Both of these statements differed markedly from previous health and nutritional guidelines in that each tackled political issues as well as technical ones, often unpopularly. In addition, both statements have been widely publicised, the AIDS policy, for example, being promoted during the conference at Georgetown and the policy on milk powder was discussed by the Sub-Committee on Nutrition of the Administrative Committee on Coordination of the UN. This practice implies that these strategies were meant to be adopted globally.

4.4.5 Coordinating refugee health care: a role for UNHCR or WHO?

4.4.5.1 Joint or independent health policies?

In contrast with most of these activities which were carried out in collaboration with other agencies, the publication of the Essential Drugs Policy in 1989 was done independently of WHO - even though WHO had worked out a detailed policy and programme for essential drugs from 1984 onwards. This happened despite the joint production of the first version (the Emergency Health Kit) in 1984, a joint review of the Emergency Health Kit in 1986 which was carried out by the London School[57] and a second evaluation in 1987 of the same by the Drug Action Programme of WHO. In fact, WHO has since published The New Emergency Health Kit in 1990[58].

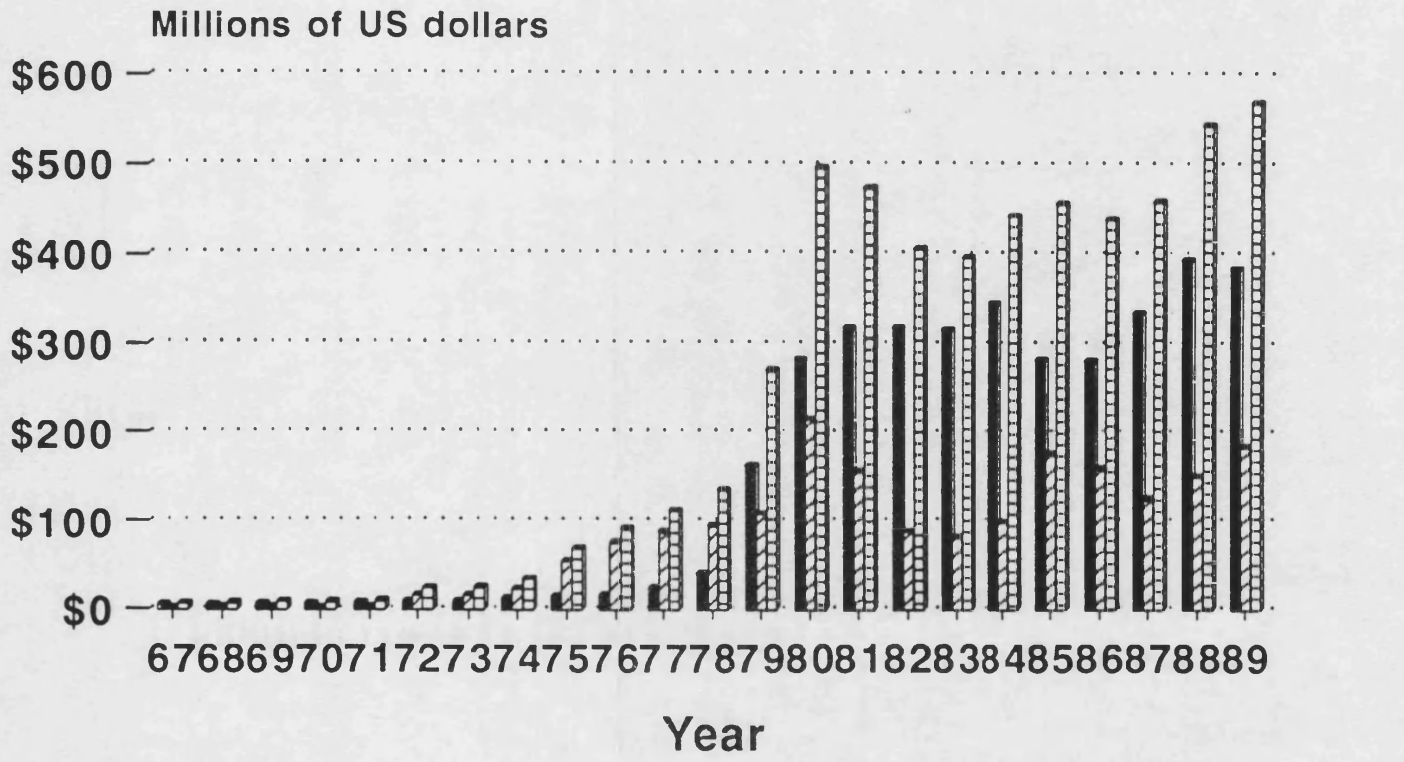
Clearly, collaboration was beneficial but had its limits; UNHCR now appeared to be working independently, even in direct competition mainly with WHO, Unicef and charitable agencies, for the leading role in refugee health relief internationally.

4.4.5.2 Collaboration or competition for roles in refugee health relief?

Moreover, there are more fundamental issues which were raised in a memorandum of understanding between UNHCR and WHO in 1987[59]. In this memorandum, consideration is given to ministries of health as potential 'operational partners to be employed by UNHCR'. Such employment could mean that UNHCR intended to make policy, plan, monitor and evaluate refugee health care leaving ministries of health and other operational partners solely to implement UNHCR programmes - with little, if any, involvement in the management of refugee health services. Similarly, the role of WHO now appears to be limited mainly to providing technical advice, primarily in refugee health projects which are to be integrated within national services. Since health relief for refugees is often established separately from national health services, and since UNHCR increasingly has its own professional health staff, such a limited role may, in fact, exclude WHO.

Interestingly, the negotiation and agreement for this understanding occurred at a time when WHO was not in a position to provide an alternative. In contrast with UNHCR whose overall expenditure increased since 1983 (Figure 4.14), beginning in 1986 and continuing in 1987, the US Government paid only a fraction of its financial dues to WHO[60]. For a variety of reasons, including 1) general dissatisfaction among the Reagan Administration with the work of the UN agencies generally, 2) resentment among some members of Congress over their lack of influence within WHO proportional to their financial contributions[61] and 3) the adoption by WHO of policies and activities in conflict with US economic interests - regarding pharmaceuticals and tobacco for example, the loss of up to 25% (or 63 million US$ in 1986-87 alone) of their regular budget and additional monies for specific programmes (or 8 million US$ annually) meant that WHO lacked the resources to carry out the work itself.

Figure 4.14
UNHCR's annual expenditure*, 1967-1989



*Presented in US dollars

4.5 Rationalising responsibility for refugee health relief: UNHCR or WHO?

There are advantages in support of more independent and direct action by UNHCR. For example, appointing national coordinators jointly with other organizations meant that individuals were accountable to two agencies with very different mandates and organizational characteristics. Similarly, organising services in collaboration with other agencies meant that planning and managing such services engaged two separate bureaucracies. This often resulted in a duplication of administrative work, such as reporting or seeking approval for programme goals, objectives, methods and reviews. Clearly, it also meant that policies, plans, methods of work and evaluations had to be agreed by two separate bureaucracies and that competition ensued over decision-making authority. This was time consuming and often led to conflict, confusion or simply lengthy delays. The assignment of responsibility to one agency only was clearly advantageous generally, but even more so during an emergency when needs were acute.

But should UNHCR be the agency to take responsibility for the coordination and management of refugee health care? Could or would WHO take this responsibility?

4.6 References

1. Howarth T and Brooman J (1987) Twentieth century history. The world since 1900. London and New York: Longman Group, 308 pp.

2. Kay DA (1972) The United Nations and decolonization. In: Barros J (ed) The United Nations: Past, present and future. New York, USA: The Free Press / London, UK: Collier-MacMillan Ltd., pp. 143-170

3. Twitchett KJ (ed) (1971) The evolving United Nations: A prospect for peace? London, UK: Europa Publications, 190 pp.

4. Holborn LW (1975) Refugees: A problem of our time. The work of the United Nations High Commissioner for Refugees, 1951 - 1972. Metuchen, New Jersey, USA: The Scarecrow Press, Inc., 2 volumes, 1446 pp.

5. Holborn LW (1975), #4

6. Holborn LW (1975), #4

7. Holborn LW (1975), #4

8. Holborn LW (1975), #4

9. Holborn LW (1975), #4

10. Holborn LW (1975), p. 139, #4

11. Holborn LW (1975), #4

12. Kent RC (1987) The anatomy of disaster relief. The international relief network in action. London, UK: Pinter Publishers, 183 pp.

13. Kent RC (1987), #14

14. Kent RC (1987), pp. 45-46, #14

15. Kent RC (1987), #14

16. Kent RC (1987), #14

17. Suhrke A (1983) Global refugee movements and strategies of response. In: Kritz M (ed) US immigration and refugee policy. Lexington, Massachusetts, USA: Lexington Books, D.C. Heath and Company, pp. 157-173

18. UNHCR (1980) UNHCR: The last ten years. Geneva, Switzerland: United Nations High Commissioner for Refugees, 88 pp.

19. Holborn LW (1975), Parts VI and VIII, pp. 655 - 822 and 957 - 1396, #4

20. Chief, Emergency Unit, UNHCR (1980) Note for the file. EU/39/B, 21 November 1980, 2 pp.

21. WHO (1984) WHO Emergency Health Kit. Standard drugs and clinic equipment for 10 000 persons for 3 months. Geneva, Switzerland: World Health Organization, 27 pp.

22. Simmonds SP, Vaughan JP and Gunn SW (eds) (1983) Refugee community health care. Oxford, UK: Oxford University Press, 250 pp.

23. Chief, Emergency Unit, UNHCR (1980) Letter to the Responsible Officer, Office of Emergency Relief Operations, World Health Organization, 18 December 1980, 1 p.

24. Western KA (1971) The epidemiology of natural and man-made disasters. The present state of the art. Report submitted for the Diploma in Tropical Public Health. London, UK: London School of Hygiene and Tropical Medicine, 108 pp.

25. Allegra DT et al (1980) Emergency refugee health care - a chronicle of the Khmer refugee-assistance operation. Atlanta, Georgia, USA: Centres for Disease Control, Public Health Service, Department of Health and Human Services, Government of the USA, 188 pp.

26. Chief, Emergency Unit UNHCR (1980) Letter to the Responsible Officer, Office of Emergency Relief Operations, World Health Organization, 21 November 1980, 1 p.

27. Responsible Officer, Emergency Relief Operations, WHO (1980) Letter to the Chief, Emergency Unit UNHCR, 3 December 1980, 2 pp.

28. Assistant Director, International Health, CDC (1980) Letter to the Deputy High Commissioner and the Deputy Chief Programming Section, UNHCR, 10 June 1980, 2 pp.

29. Deputy Chief, Programming Section, UNHCR (1980) Note for the file. Centres for Disease Control, USA: Possible assistance to UNHCR. Reference number 118, 22 May 1980, 2 pp.

30. Technical Support Service, UNHCR (1989) Memorandum of Understanding between UNHCR and CDC. Rapport 7/8:10, Newsletter of the Technical Support Service, United Nations High Commissioner for Refugees, Geneva, Switzerland

31. UNHCR (1982) Handbook for emergencies. Geneva, Switzerland: United Nations High Commissioner for Refugee, 189 pp.

32. Chief, Emergency Unit, UNHCR (1982) Letter to the Research Fellow and Head of the Refugee Health Group, London School of Hygiene and Tropical Medicine, 22 February 1982, 1 p.

33. Technical Support Service, UNHCR (1987) Developmental plan. Provisional document. Geneva, Switzerland: Technical Support Section, United Nations High Commissioner for Refugee, 17 pp.

34. Technical Support Service, UNHCR (1987) UNHCR guidelines for the use of imported food items in selective feeding programmes. Geneva, Switzerland: United Nations High Commissioner for Refugees, 151 pp.

35. Technical Support Service, UNHCR (1987) UNHCR operational guidelines for health and nutritional care in refugee settings. Geneva, Switzerland: United Nations High Commissioner for Refugees, 207 pp.

36. Technical Support Service, UNHCR (1987) UNHCR essential drugs policies. Geneva, Switzerland: United Nations High Commissioner for Refugees, 118 pp.

37. UNHCR (1989) UNHCR Essential drugs manual. Guidelines for use of drugs in refugee settings and UNHCR list of essential drugs. Geneva, Switzerland: Technical Support Section, United Nations High Commissioner for Refugees, 89 pp.

38. Technical Support Service, UNHCR (1987), #33

39. Health Unit UNHCR (1987) Development plan. Health unit, Technical Support Services. Geneva, Switzerland: United Nations High Commissioner for Refugees, 4 pp.

40. Acting Director, Assistance, UNHCR (1979) Project 79/AP/THA/SA/14 - Provision of health coordinator by the World Health Organization (WHO) for refugees in Thailand. Letter to Responsible Officer, Emergency Relief Operations, World Health Organization, 21 December 1979, 2 pp.

41. UNHCR (1980) UNHCR and the Voluntary Agencies. News from the United Nations High Commissioner for Refugees 5/6, December 1979/January 1980, 14 pp.

42. Technical Support Service, UNHCR (1987), #33

43. Technical Support Service, UNHCR (1989) UNHCR staff in health and nutrition. Rapport 7/8:9-10, Newsletter of the Technical Support Service, United Nations High Commissioner for Refugees, Geneva, Switzerland

44. Technical Support Service, UNHCR (1988) Social services and emergency unit join TSS. Rapport 2:2. Newsletter of the Technical Support Service, United Nations High Commissioner for Refugees, Geneva, Switzerland

45. Zollner M-I (1983) UNHCR tries to remain non-operational. Refugees 19, May

46. Emergency Section, UNHCR (1987) Emergency managers update. Geneva, Switzerland: United Nations High Commissioner for Refugees

47. Health Unit, UNHCR (1987), #39

48. Health Unit, UNHCR Briefing notes: UNHCR health programmes. Geneva, Switzerland: United Nations High Commissioner for Refugees, 3 pp.

49. Health Unit, UNHCR (1987), #39

50. Health Unit, UNHCR (1987), p. 2, #39

51. Health Unit, UNHCR (1987), p. 3, #39

52. Technical Support Service, UNHCR (1988) Announcement. Rapport 2:2 The newsletter of the Technical Support Section of Office of the United Nations High Commissioner for Refugees in Geneva, Switzerland

53. Georgetown University Medical Centre (1988) Health care for displaced persons and refugees: An international symposium. Washington, D.C., USA: 4-7 December 1988

54. Kuntz D, Forbes Martin S and Clark L (1990) Ensuring the health of refugees: Taking a broader vision. Washington, D.C., USA: Refugee Policy Group, 39 pp.

55. Technical Support Service, UNHCR (1988) AIDS. Rapport 3:3 The newsletter of the Technical Support Section of Office of the United Nations High Commissioner for Refugees in Geneva, Switzerland

56. Gillespie S (1989) Use of dried skim milk powder in refugee programmes. SCN News 4:22. Report of the meeting on DSM, 7 April 1989, in the newsletter of the Sub-Committee on Nutrition, the Administrative Committee on Coordination, United Nations

57. Mamdani M and Simmonds S (1986) Evaluation of the World Health Organization's Emergency Health Kit: Standard drugs and clinic equipment for 10 000 persons for 3 months - first phase. London, UK: London School of Hygiene and Tropical Medicine, 26 pp.

58. Drug Action Programme, WHO (1990) The new emergency health kit. List of drugs and medical supplies for a population of 10 000 persons for approximately 3 months. Geneva, Switzerland: The Drug Action Programme, World Health Organization, 42 pp.

59. Mahler H and Hocke JP (1987) Memorandum of understanding governing collaboration and coordination between the United Nations High Commissioner for Refugees and the World Health Organization. Geneva, Switzerland: United Nations High Commissioner for Refugees / the World Health Organization

60. Mingst KA (1990) The United States and the World Health Organization. In: Karns MP and Mingst KA, The United States and multilateral institutions. Patterns of changing instrumentality and influence. Boston, USA: Unwin Hyman, pp. 205-230

61. Williams D (1987) The Specialised Agencies and the United Nations. The system in crisis. London, UK: C. Hurst and Company, 269 pp.

CHAPTER FIVE

The World Health Organization (WHO): a surprisingly insignificant participant in international health relief policy formulation and practice

5.1 1948 - 1975: opting for a symbolic or substantial role in international health relief?

The World Health Organization's (WHO) involvement in health relief generally and refugee relief particularly has been sporadic and limited. This can be understood partly by the definition of an 'emergency' or 'disaster' which was adopted by the organization, partly by its mandate and the structure of the organization and partly by the financial resources available to it.

5.1.1 Defining health relief: the prevention and control of epidemics of disease

The WHO was created as a permanent institution to promote 'the attainment by all peoples of the highest possible level of health'[1]. Health was similarly defined very broadly as 'a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity'[2]. The Constitution further specified that governments were responsible for the health of their peoples. Such far reaching goals were to be achieved in 22 distinct ways, one of which was 'to furnish appropriate assistance and, in emergencies, necessary aid upon the request or acceptance of Governments'[3]. Despite this constitutional basis for a substantial role in health relief, WHO chose in 1948 to adopt a narrow and technical definition of emergencies requiring relief and to give assistance which was very limited in scope, quantity and duration.

Given that there were several other agencies within the UN system which specialised in relief, such as the United Nations Relief and Rehabilitation Administration (UNRRA), the United Nations Children's Emergency Fund (Unicef) and the United

Nations High Commissioner for Refugees (UNHCR), and that the resources needed for relief were vast, as well as the fact that the primary concerns of the organization were with on-going health priorities, such a practice was not questioned at the time or during the first twenty-five years of the organization's existence. Moreover, a special programme of advisory and demonstration services was set up for countries facing the rehabilitation of their health services immediately following the second World War, subject to the approval of the World Health Assembly and the provision of needed funds by individual member governments[4].

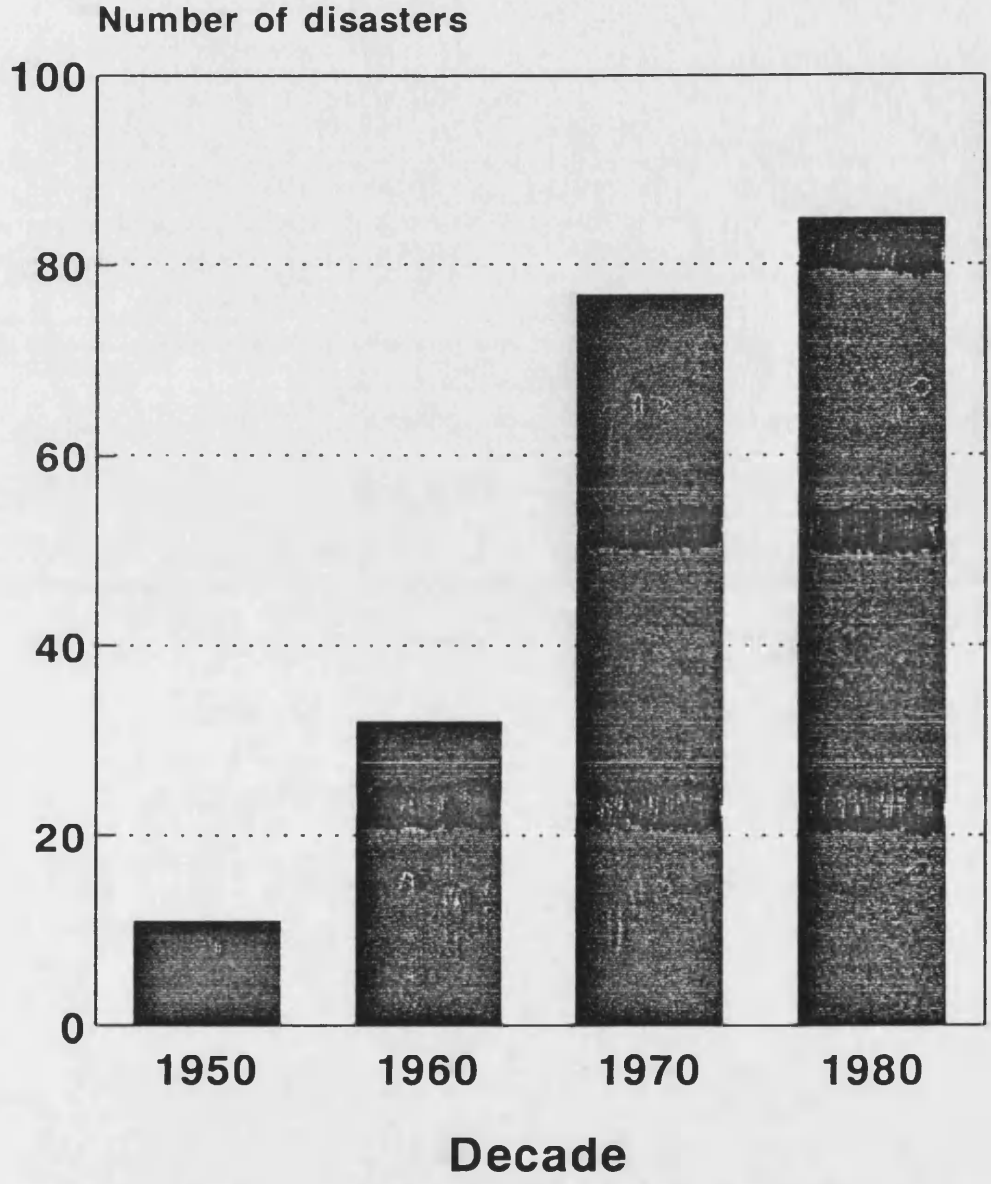
Although the constitution of WHO established a role in relief (Articles 2,28 and 58), it did not define clearly an emergency or disasters; nor the way in which the organization should respond. It was the First World Health Assembly (WHA) who defined emergencies as epidemics of disease and relief as the provision of supplies and services[5]. WHO was to be the first source of assistance to countries experiencing an epidemic which required international help. This definition of an emergency is a medical one, and the solution a technical one. Both have their base in allopathic medical practice which emphasises the control and cure of disease and the use of pharmaceuticals as the core therapy. They also reflect the traditional concern of inter-governmental health organizations with epidemics of disease since the 1800s.

5.1.2 Limited finances for providing emergency medical supplies

It was on the basis of this concern with epidemics that WHO initially provided medical supplies to several governments coping with problems of flooding, earthquakes or other acute disasters. Over time, however, medical supplies were provided in response to disasters regardless of the actual existence or imminent fear of an epidemic. Such assistance was given increasingly in the 1960s and 1970s (Figure 5.1). In most cases, requests were made by government health authorities directly to the Director-General who used funds from the Working Capital Fund to purchase needed medical supplies for the government concerned. The funds used were later reimbursed by recipient governments. In some cases, the Director-General used money from the Executive Board Special Fund which was subsequently reimbursed by either

Figure 5.1

WHO's involvement in relief: disasters responded to since WWII



the regular budget the following year or by funds given to WHO by UNRRA at the close of its operations. These were the only sources of funding for emergencies which were originally established within WHO. Both had limited sums available for emergencies and both required reimbursement.

In the majority of relief efforts undertaken by WHO between 1948 and 1975, including responses to refugees, famine and war (Figure 5.2), the provision of medical supplies was a substantial component, often the only one, of aid given (Figure 5.3). This meant that emergency relief within WHO was dealt with by the Director-General's office and the Medical Supply Service. There was no individual, unit or department with specific responsibility for relief.

The practice of providing medical supplies during emergencies was not, however, limited to epidemics or acute disasters. Figure 5.2 shows that WHO was often involved in relief efforts for refugees and populations affected by civil war or famine. There are several interesting practices currently in use in refugee health relief which can be traced back to these early relief operations. Firstly, WHO has continued to give priority to the provision of medical supplies as relief aid (Figure 5.4). In most cases, this was the only type of assistance given, similar to relief for epidemics or natural disasters. This implies that WHO did not discriminate by type of emergency and instead responded in a somewhat standard fashion. Secondly, WHO's involvement in relief for refugees, famine or war was usually at the initiative of other agencies within the UN who needed help in assessing needs, planning responses and overseeing relief work (Table 5.1). Although WHO's constitution allows it to initiate a response, there were no cases of it doing so during that period. Instead, WHO involvement was at the request of other UN bodies who provided the financial resources to support such involvement.

TABLE 5.1
The work of the ERO office of WHO, 1980-1989:
Types of international health relief activities and
the lead agency responsible for their implementation

LEAD AGENCY> / ACTIVITY	ERO, WHO/HQ	WHO, other office	UN agency/ ICRC	CCs[1] of ERO WHO /HQ	Others	Not known	TOTAL	Total 1980-1985	Total 1986-1989
Publication	4 [1][2]	1 [1]	0	0	0	0	**5** (5%)	**2** -40% (7%)	**3** -60% (4%)
Training	1	34 [9]	4 [9]	12	0	0	**51** (53%)	**18** -35% (69%)	**33** -65% (47%)
Meetings /Consulta-tions	7	9	4	0	2	3	**25** (26%)	**0**	**25** -100% (36%)
Technical evaluation or standard	2 [2]	1	1 [1]	4	1	0	**9** (9%)	**3** -33% (12%)	**6** -67% (9%)
Management support	1	0	5 [3]	0	0	0	**6** (6%)	**3** -50% (12%)	**3** -50% (4%)
TOTAL	**15** (16%)	**45** (47%)	**14** (15%)	**16** (17%)	**3** (3%)	**3** (3%)	**96**	**26** (27%)	**70** (73%)
Total 1980 - 1985	**3** -20% (12%)	**10** -22% (38%)	**4** -29% (15%)	**9** -56% (35%)	**0**	**0**	**26** (27%)		
Total 1986 - 1989	**12** -80% (17%)	**35** -78% (50%)	**10** -71% (14%)	**7** -44% (10%)	**3** -100% (4%)	**3** -100% (4%)	**70** (73%)		

1. Collaborating Centres

2. Numbers in brackets indicate activities undertaken between 1980-1985

Figure 5.2
Types of disasters to which WHO responded before 1975

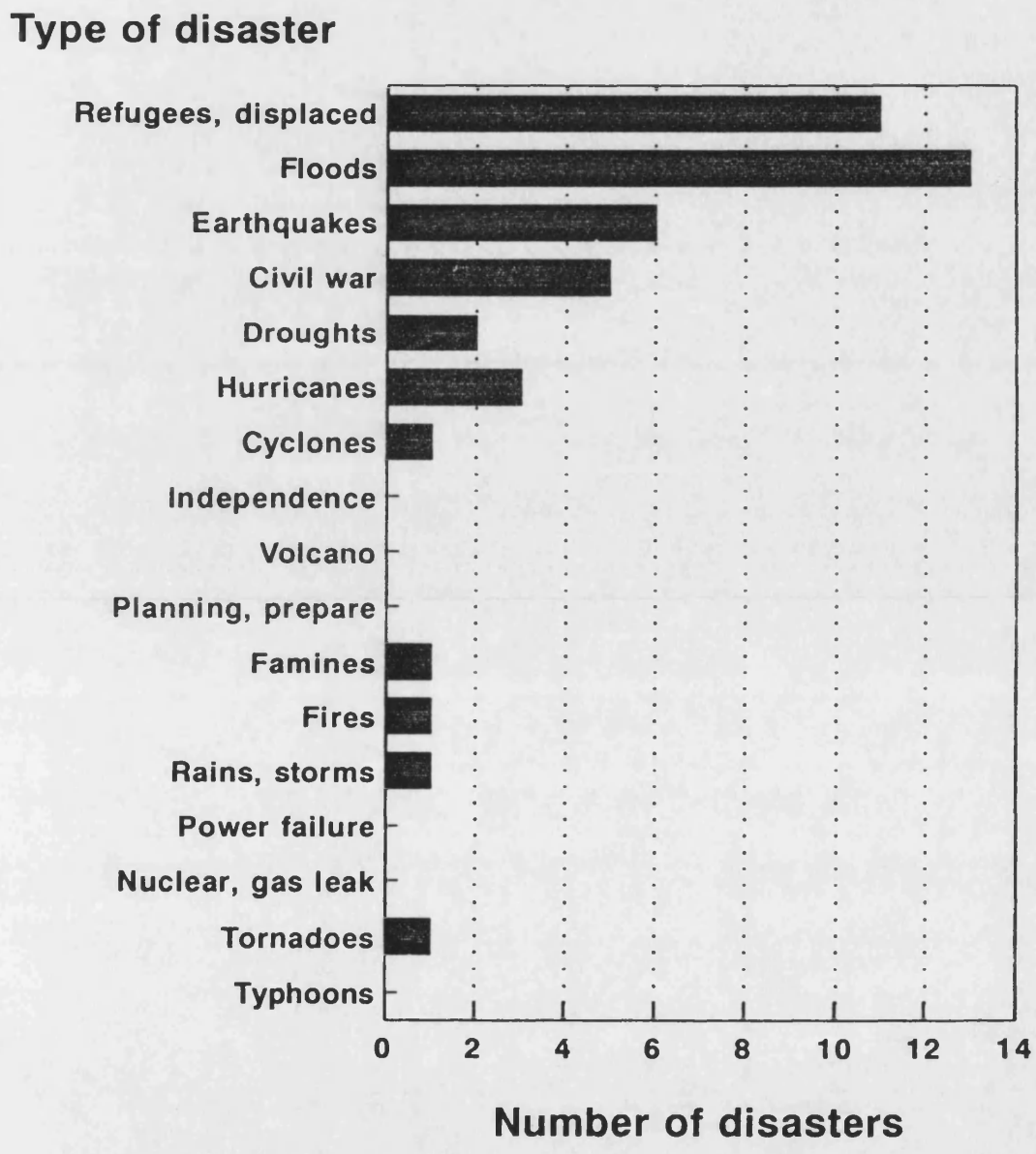


Figure 5.3
Type of assistance given by WHO for relief between 1948-1975

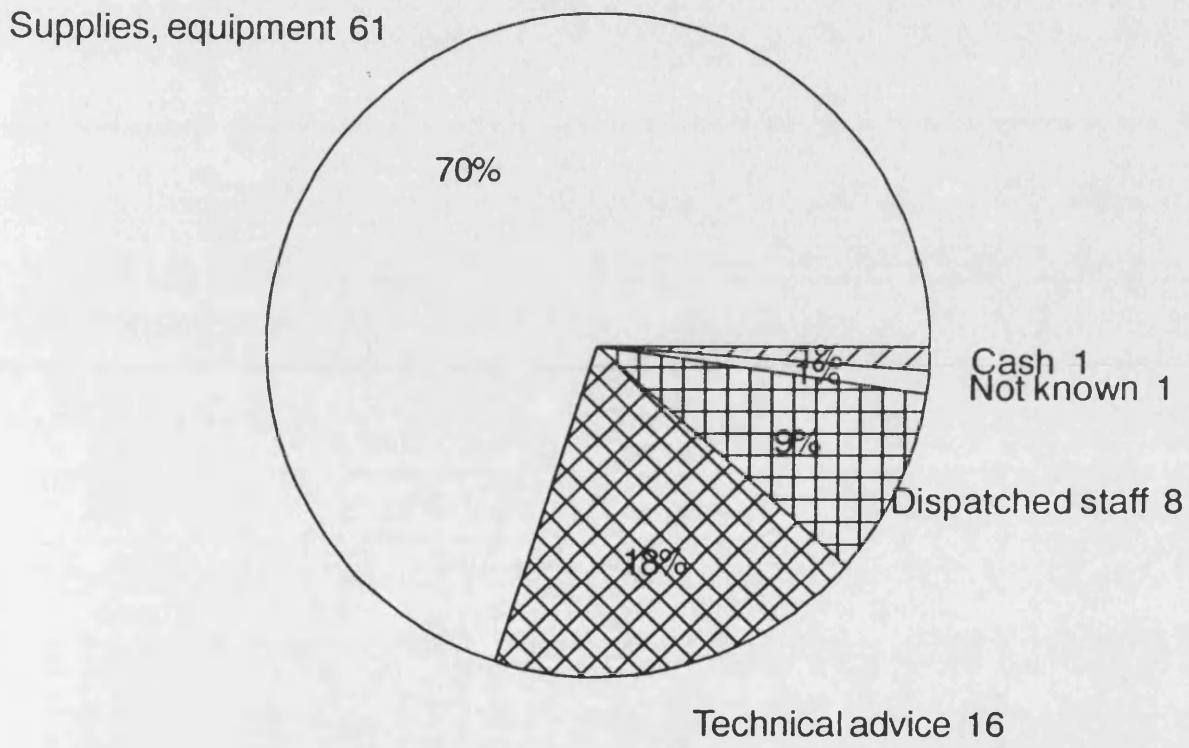
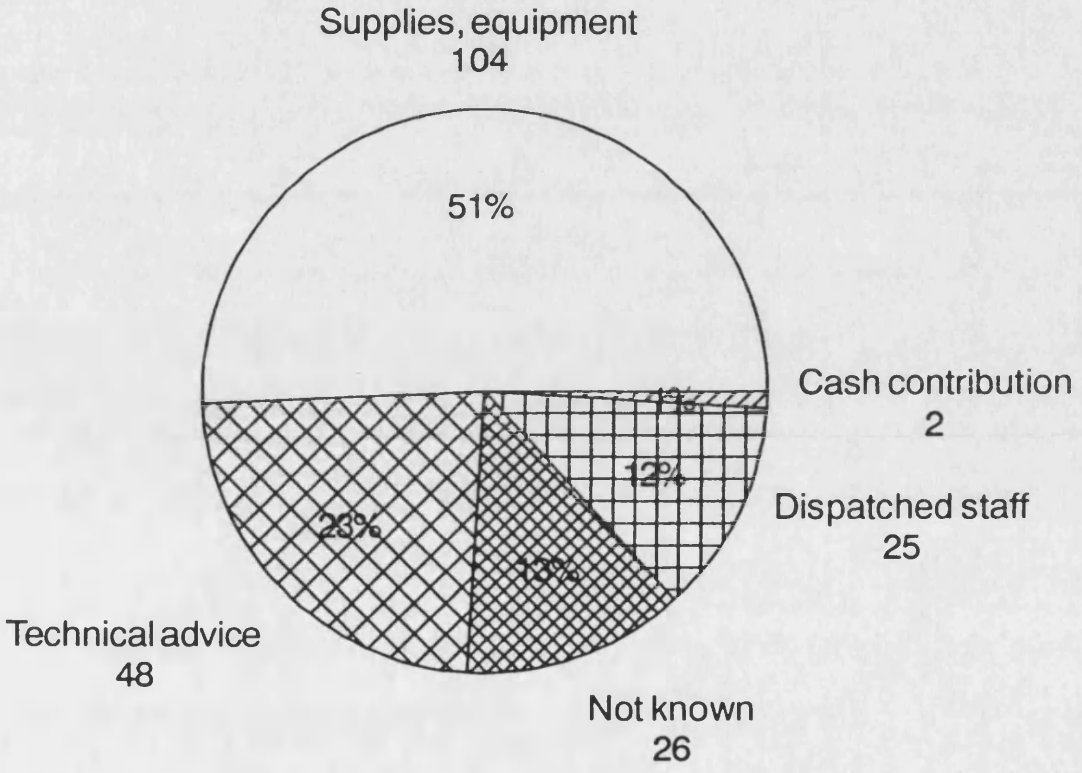


Figure 5.4
Type of assistance given by WHO for relief since WWII, 1948-1989



5.1.3 Opting for an advisory role

Thirdly, in addition to medical supplies, WHO often provided technical advice and management support through the secondment or recruitment of health professionals to other agencies within the UN. In the Middle East, WHO retained responsibility for appointing and supervising senior health officials who worked for the United Nations Relief and Works Agency for Palestine Refugees (UNRWA), but in Korea, these officials worked exclusively for the United Nations Korean Reconstruction Agency (UNKRA) after 1951. In both of these examples, these health officials were administratively responsible to another agency within the UN system which was set up specifically for a particular relief effort and not to WHO. This was also true in the relief operations for refugees during the 1960s and 1970s which were managed by UNHCR. Thus, throughout the first two and one half decades, WHO mainly provided technical support to governments and other UN organizations managing relief operations. This was true not only for the provision of material goods but also for the placement of health professionals as advisers or managers of health relief services. WHO did not set up their own organizational structure for health relief; nor did they retain responsibility or accountability for health relief in most cases.

5.2 1975 - 1980: organising to meet growing demands for relief

5.2.1 Creating a separate unit for Emergency Relief Operations

WHO's policy of limited involvement in health relief was first challenged in the 1970s, partly by newly independent governments of poorer countries who increasingly faced natural disasters, refugees, famine and war as well as rehabilitation needs following independence, partly by other agencies within the UN system whose role and involvement in relief were growing in response to large, devastating disasters in these countries and partly by governments in Europe and North America who were establishing geopolitical and economic links with these newly independent countries. Similar to other agencies within the UN, donor governments and private charitable

agencies who created specialised relief cells or departments for relief from the early 1960s throughout the 1970s, WHO then responded by creating a separate office for Emergency Relief Operations (ERO) in 1974.

Responsibility for Emergency Relief Operations was originally assigned to one medical doctor in the Division of Coordination (DOC) at headquarters in Geneva in the autumn of 1974. This doctor was also responsible for assistance to national liberation movements recognised by the Organization for African Unity (OAU). In order to support this officer, a task force of 6 representatives from relevant departments was created. One of the task force members was from the medical supplies service - the department most involved in emergency assistance to date. Beginning in July of 1975, the officer who was responsible for Emergency Relief Operations reported directly to the Director-General and was, thus, attached to his office. At the same time, a management survey was carried out of the work of WHO in relief between 1970 and 1975[6].

5.2.2 Maintaining a supportive role

This survey found that WHO's relief work was limited to the provision of medical supplies (which occupied half of each working day of one medical supply officer) and the provision of technical advice (either directly or through the recruitment of health personnel for other agencies within the UN system). Both of these roles explain the original designation of an officer in the Division of Coordination as responsible for relief work. The main priorities of the Division of Coordination revolved around liaison with other organizations, especially within the UN system but also with non-governmental organizations. The organizations for which WHO procured supplies and provided technical advice frequently included the United Nations Relief and Works Agency for Palestine Refugees (UNRWA), the United Nations Children's Emergency Fund (Unicef), the United Nations High Commissioner for Refugees (UNHCR), the Food and Agriculture Organization (FAO), the United Nations Disaster Relief Office (UNDRO) (which was created in 1972), the United Nations Environmental Organization (UNEO) and the League of Red Cross Societies (LORCS). Even the

establishment of a separate, specialised office did not, therefore, mean that WHO was prepared to undertake responsibility for health relief operations. Instead, it tried to strengthen its ability to provide technical advice and supplies to other agencies within the UN system or, in the case of natural disasters, to national governments.

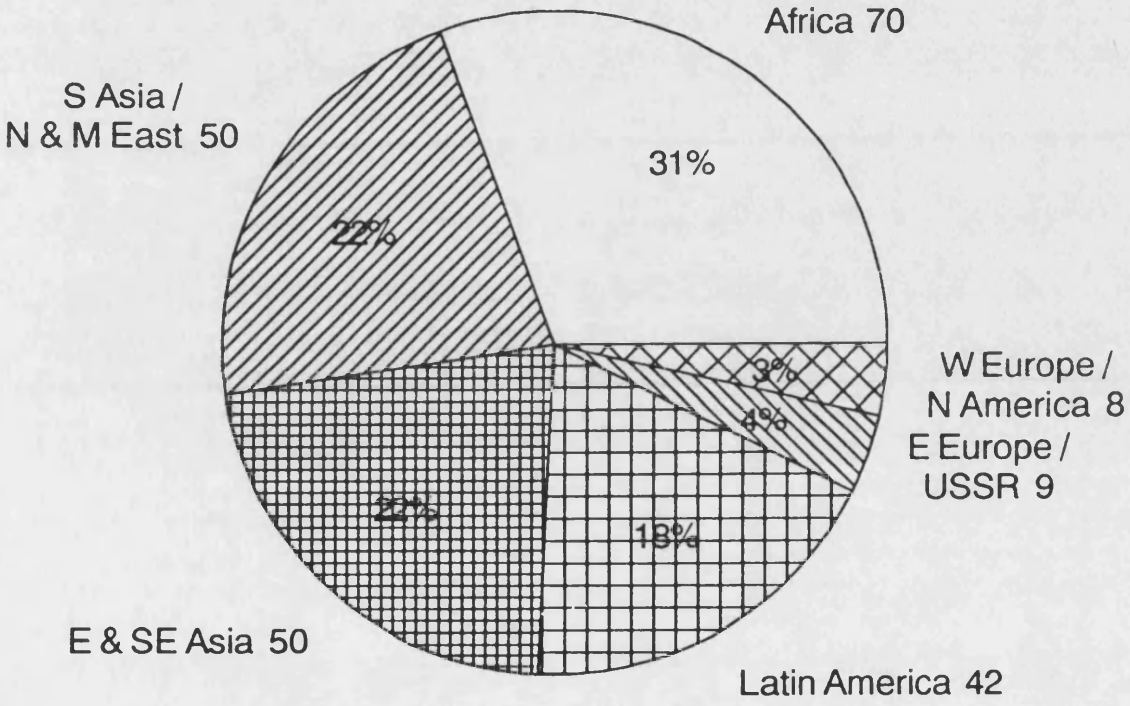
5.2.3 Continued financial dependency

This arrangement did not require additional finances on a large scale since WHO could then continue to rely on the use of reimbursable funds within the organization or on funds provided by other organizations of the UN (for example, trust funds managed by UNDRO, UNHCR, FAO and UNEO). Similar to the United Nations Secretariat which established a separate fund of 100 000 US$ per annum for relief in 1965, with a maximum contribution of 20 000 US$ for any single disaster, WHO eventually established a special account for 'disasters and other natural catastrophes' in 1975 within the Voluntary Fund for Health Promotion[7]. Yet by the end of 1975, this account had less than 200 000 US$ in it[8], indicating the limited size of donations by governments in support of, as well as the limited possibilities to practice, independent responses for relief by WHO. Thus, the practical impact was generally symbolic[9].

5.3 1980 - 1985: conferring legitimacy to health relief activities carried out by other organizations

Although the medical officer responsible for Emergency Relief Operations first proposed that WHO extend its involvement in relief to include disaster prevention, preparedness and rehabilitation in December of 1977[10], it was not until the 1980s that such work began. Even then, WHO was slow to expand its role in health relief. Although WHO has responded to three times as many individual disasters (Figure 5.1) in Africa, Asia and Latin America (Figure 5.5) since 1975, assistance given continued to be mainly in the form of medical supplies and equipment and, to a lesser extent, technical advice (Figure 5.4). Yet, similar to the period between 1948 and 1975, the types of disasters to which WHO responded included a mix of those traditionally

Figure 5.5
WHO's response to disasters by geographical region, 1948-1989



types of disasters to which WHO responded included a mix of those traditionally grouped as natural or man-made but refugees continued to be one of the groups most frequently needing relief (Figure 5.6).

5.3.1 Forging links with other agencies engaged in international health relief

In contrast with aid given for individual disasters which did not change significantly, the office for Emergency Relief Operations began to involve themselves in international health relief activities in the 1980s - but especially after 1985. They participated in 3 or 4 international activities on average per year between 1980 and 1985 (Figure 5.7), including publications, training activities, technical evaluations, global guidelines and meetings, conferences and expert consultations. During the first half of the 1980s, the office for Emergency Relief Operations of WHO was the lead or responsible agency in at most 3 of the 15 (20%) international activities in which they participated (Table 5.1). All of the other activities were organised by the regional offices of WHO in Europe and North America, by UNHCR's head office in Geneva and by two academic centres in Europe which were designated in 1980 and 1984 as official collaborating centres of WHO - the Centre for Research on the Epidemiology of Disasters (CRED) at the University of Louvain in Belgium, and the Refugee Health Group (RHG) of the London School of Hygiene and Tropical Medicine in the United Kingdom respectively. Of the three activities credited to Emergency Relief Operations before 1985, two were concerned with the production of the first emergency health kit whose design had been initiated by UNHCR in collaboration with the Refugee Health Group of the London School of Hygiene and Tropical Medicine. In practice, WHO initiated only one activity in international health relief between 1980 and 1985.

There are several conclusions which can be drawn about the role of WHO during this period. Firstly, the office for Emergency Relief Operations unit continued to provide medical supplies and technical advice for disaster relief upon the request of national governments or other agencies within the UN. In addition to responding to requests for medical supplies or technical advice for individual disasters (Figure 5.4), they

Figure 5.6
Types of disasters to which WHO responded, 1948-1989

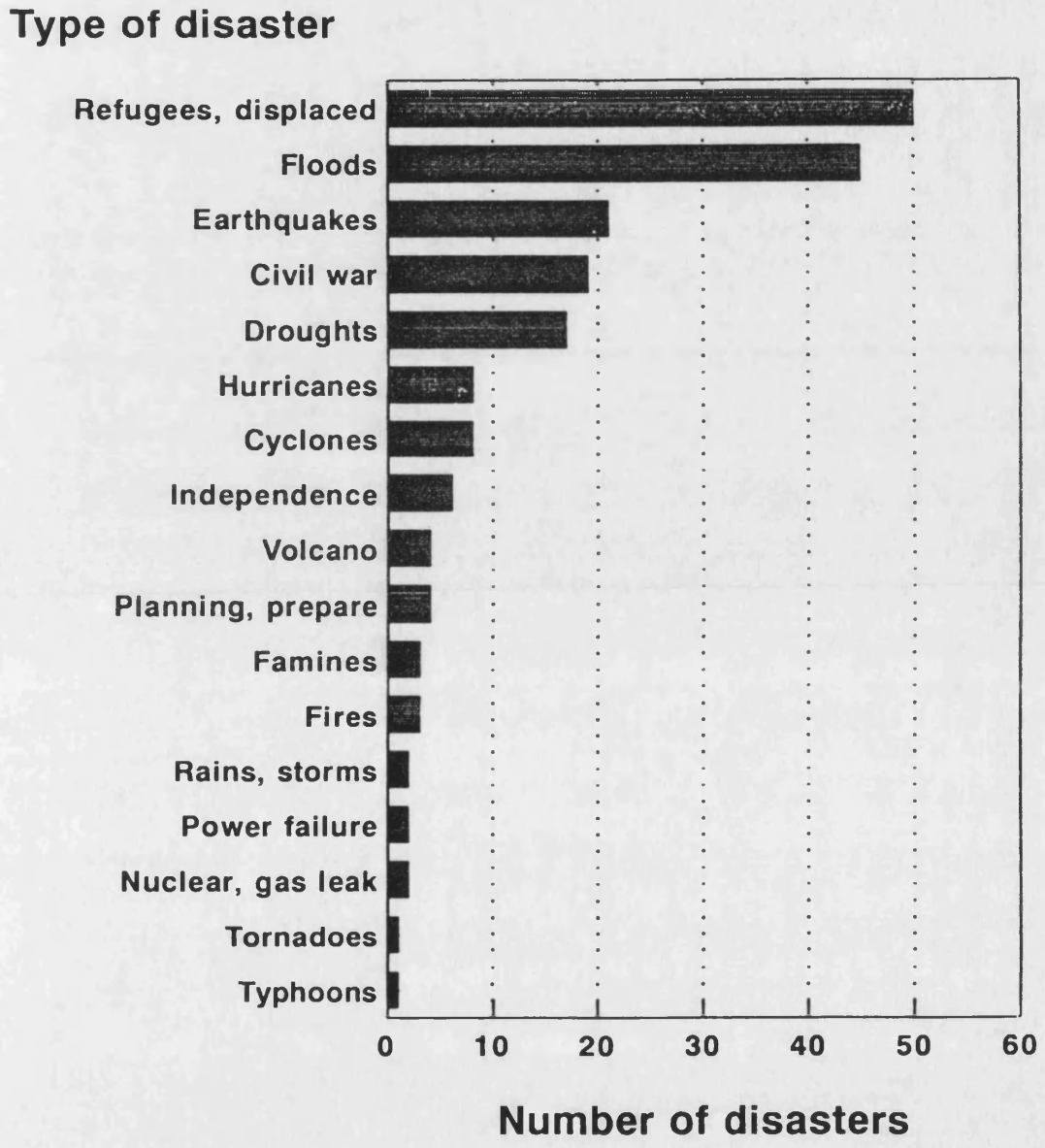
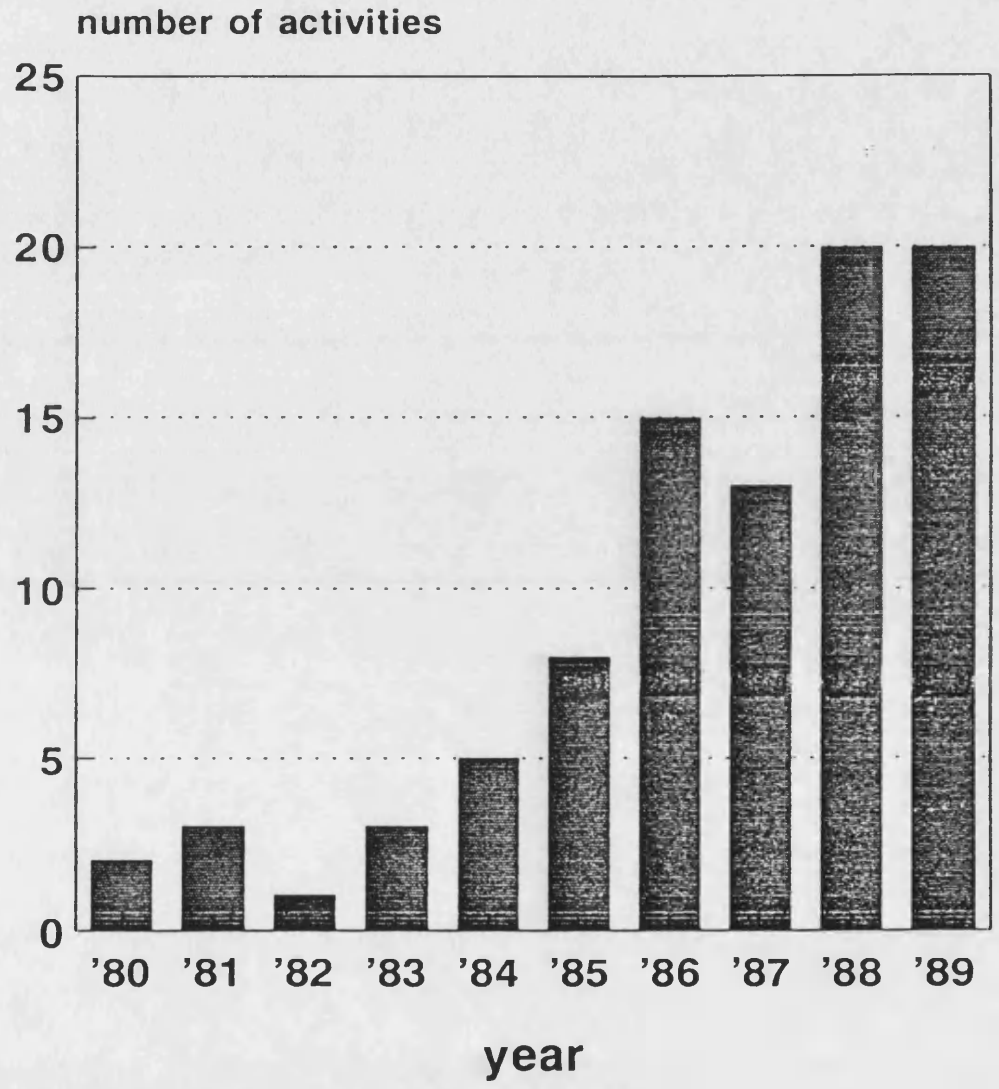


Figure 5.7

WHO's participation in international health relief activities*, 1980-1989



*publications; training; meetings, consultations, conferences; technical evaluations, standards; management

advised the regional offices of WHO in Africa, Asia, the Eastern Mediterranean and Western Pacific on five occasions during the early 1980s. In contrast with this technical supply and advisory role, the office for Emergency Relief Operations established relationships with other organizations involved in health relief internationally, independent of a specific disaster. This marked the beginning of more active participation by WHO in international health relief policy creation and practice.

5.3.2 A guiding or rubber stamping role?

However, before 1985, collaboration with the Pan American Health Organization (PAHO), the regional office of WHO for Europe, UNHCR, the Centre for Research on the Epidemiology of Disasters (CRED) at the University of Louvain in Belgium and the Refugee Health Group (RHG) of the London School of Hygiene and Tropical Medicine in the United Kingdom was usually initiated by these agencies and not WHO (Table 5.1). Similarly, it was these agencies who carried out technical analyses, drew conclusions and made recommendations on future standards and practices of health relief. One reason for including WHO in these activities was to influence international health relief policy by gaining the approval and support of WHO for their proposals and work. WHO's participation, often in the form of co-sponsorship, was a means of legitimising the activities and status of other agencies involved in international health relief policy formulation and practice.

Not only did these agencies seek to influence the policies for and practices of health relief generally, they specifically sought to influence the policies and practices of WHO since it had been designated as the lead agency in international health. Given that these agencies had quantitatively and qualitatively more experienced personnel and substantial financial resources for their work, as well as their own institutional backing and support from constituencies in common with WHO, it is not surprising that they were successful in determining most of the international work of WHO in health relief: during the first half of the 1980s WHO initiated, at most, only one of the international activities in which they participated.

Nevertheless, WHO's official mandate for international health meant that the work of the agencies was often promoted under WHO's name and that the final standards and technical products were published or produced by WHO, not the agency which initiated and carried out the work. An example of the latter practice was the production of the first emergency health kit (which was designed by the Refugee Health Group of the London School of Hygiene and Tropical Medicine at the request of UNHCR). An example of the former practice was the training courses run by the collaborating centres which were promoted partially as WHO activities. Even though the technical content of health relief policy was decided by a variety of institutions, the formal expression of the technical standards and practices was often done by or through WHO. WHO, therefore, had a role not only to legitimise the activities and work of other organizations involved in international health relief but to legitimise the standards and practices which they proposed for global use. This did not entail, however, that WHO develop an interest or an ability to play an extended and independent role in health relief themselves. Thus, the relationships between WHO and these agencies were of benefit to both parties.

5.4 1985 - 1990: bidding for a leading role

The only activity in the early 1980s which the office for Emergency Relief Operations initiated and carried out independently, (the drafting of guidelines for country representatives), gives one clue or reason for WHO's extended involvement in health relief during the following four years, namely a change in personnel. In 1985 a senior medical officer who had been working as an advisor in Primary Health Care and refugee health relief in Somalia and Pakistan was appointed to be the responsible officer or head of Emergency Relief Operations.

5.4.1 Strengthening WHO's response in health relief operations

During his tenure, WHO extended its role in health relief both within WHO itself and within the international relief system (Table 5.1). Unlike previous years, WHO was involved in 70 activities concerned with international health relief between 1986 and

1989, in sheer numbers a doubling from the first half of the 1980s (Figure 5.7). Not only did the overall scale of involvement change, but there was a definite shift in priorities. Instead of participating in and co-sponsoring activities initiated and carried out by other agencies within the UN system and academic centres - which accounted for one half of WHO's international relief work between 1980 and 1985, priority was given to initiating and promoting health relief within WHO itself. This meant that training became one of the main components of the Emergency Relief Operations programme of work. However, in contrast with the years before when training was organised and carried out primarily by the two academic collaborating centres for health professionals generally, training was now organised and conducted by the office for Emergency Relief Operations for regional and country offices of WHO. The most important change in WHO's work during these five years was in their efforts to strengthen their own responses at regional and country levels.

5.4.2 Garnering support for a leading role

5.4.2.1 WHO as a centre of expertise

Concurrently, the office for Emergency Relief Operations began to establish an independent role in international health relief within the international relief system. This was most apparent in their participation in international meetings, conferences and expert consultations which was the other priority activity along with training (Table 5.1). In fact, the office for Emergency Relief Operations initiated and convened one third (8/25) of these meetings. Thus, WHO began to lobby for support for their own place in relief work, similar to other prominent organizations before them. The meetings and informal consultations which were convened by the office for Emergency Relief Operations brought together two groups of actors which influenced what WHO could and would do. Firstly, representatives from other departments within WHO were invited. Most came from units concerned with prominent diseases associated with disasters or with public health practices and the organization of health services - for example, the food aid programme, malaria action programme, nutrition, communicable diseases, media service, control of diarrhoeal diseases, environmental

health, global epidemiological surveillance and health situation assessment, human resources management and information systems support. Clearly, support from these units strengthened the scientific basis and legitimacy of technical standards and practices for health relief as well as the internal acceptance and support for involvement of WHO in relief.

5.4.2.2 Forging links within the international aid regime

The second group of organizations which were invited and consulted included other inter-governmental and charitable organizations involved in relief, technical organizations of donor governments and academic institutions. By bringing these different agencies together, the office for Emergency Relief Operations garnered international support for their own work as well as establishing WHO as a potential leader and coordinator of health relief internationally.

Organizations within the United Nations

The Regional Office of WHO for the Americas is a part of The Pan American Health Organization (PAHO). PAHO is an independent (inter-governmental) organization based in the US with its own sources of funding which was able to establish itself as a leading agency in relief for natural disasters during the 1970s and 1980s. In response to numerous natural disasters during the 1950s and 1960s, in the US in particular, a new speciality developed within medicine for disaster relief. Detailed knowledge of natural disaster characteristics as well as the effects on health and health services, contributed to the creation of a separate unit for emergency preparedness and response in PAHO in the late 1970s. This unit has been led by a former member of the Centre for Research on the Epidemiology of Disasters (CRED), and has generated several technical evaluations and standards for health relief associated with natural disasters as well as training courses and conferences for national health officials in preparing for and managing relief. During the first half of the 1980s, for example, it published a series of manuals on disaster relief and health, such as Emergency vector control after natural disaster, Epidemiological surveillance

after natural disaster and Environmental health management after natural disasters[11],[12],[13].

The Regional Office of WHO for Europe was the first regional office outside of the Americas to conduct workshops and training courses on health relief at regional and country levels. While not a regional activity, the first course in health relief was organized in Belgium in 1980. Regional workshops were then held in 1981 and again in 1984. In the interim, a regional meeting was convened to discuss disaster relief and preparedness. It was during this first European regional meeting on health relief that guidelines for health relief were first proposed by the Italian Government. Thus, the European regional office was the first to provide the organizational umbrella under which the Italian Government could fund and carry out such work. These guidelines were modified and finally published jointly with the League of Red Cross Societies in 1989 as a book on Coping with natural disasters: the role of local health personnel and the community[14].

There were only two other agencies within the UN with whom WHO established an extended working relationship in international health relief policy and practice, in comparison with those agencies for whom it provided advice and supplies generally. These agencies were Unicef and UNHCR. Their roles and activities are discussed separately elsewhere.

Private charitable organizations

Oxfam UK, **Save the Children Fund** UK and **the League of Red Cross Societies** were three agencies actively working in international health relief who established an extraordinary consultative relationship with WHO. All had considerable experience and were formulating their own standards of practice for health relief. For example, the League of Red Cross Societies first published an International disaster relief manual in 1959[15]; additional guidelines were produced in the 1970s, for example the Red Cross disaster relief handbook[16]. Oxfam UK was one of the first charitable agencies to produced their own Practical guide to refugee health care in 1983[17]. In

each case, these guidelines not only provided technical ideals, but they also articulated roles for the charitable agencies themselves and other foreign organizations, such as the UN, as well as promoting ways in which relief aid should be given. Importantly, these agencies had substantial popular backing and their own resources. They were an important source of support for WHO, both in providing relief directly and in generating support for WHO's work in setting standards for practice and management. In addition to collaborating with WHO, these agencies were also working closely with UNHCR in providing relief for refugees.

Academic centres

The Centre for Research on the Epidemiology of Disasters (CRED) is a unit within the School of Public Health of the University of Louvain. It was established in 1973 in response to growing awareness of disasters and the need to analyze their effects on the health and nutritional status of entire populations. Initially the centre collaborated with PAHO since PAHO's director of Emergency Relief Operations was formerly a staff member of the centre. In 1979, collaboration with the office for Emergency Relief Operations of WHO in Geneva was initiated by the centre when they requested co-sponsorship of their first international course on health relief. The centre subsequently requested recognition of their relationship and support for their work from WHO.

In 1980, the centre became the first Collaborating Centre to the office for Emergency Relief Operations of WHO in 'the epidemiology of natural disasters'. Even though such status also included financial support from WHO, the money was given to WHO by the Government of Belgium who had funded the centre since its foundation. Thus, the centre did not place demands on the limited financial resources of WHO but instead brought in additional funds as well as expanding the work carried out under the aegis of WHO. The centre has offered a course on health relief in Belgium in collaboration with WHO first in 1980 and again in 1988 and 1989. In addition, they have assisted in country workshops in Botswana, Mozambique and Indonesia in 1987 as well as providing consultants for Emergency Relief Operations on a number of

occasions. They have also developed early warning and management systems for use by WHO, among other technical evaluations and consultations.

The Refugee Health Group (RHG) was a unit in the London School of Hygiene and Tropical Medicine of the University of London. It was first set up in 1979 by staff who had previously worked in refugee relief in Ethiopia. Collaboration with WHO was initiated by the group in 1980 when it informed WHO of its forthcoming course on refugee community health care. Co-sponsorship of this annual course began in 1981, and the group was named another Collaborating Centre to the office for Emergency Relief Operations of WHO in 1984 for 'the health of refugees and other displaced communities'. In the interim, the group undertook to edit a book on Refugee community health care jointly with the head of the office for Emergency Relief Operations[18]. They helped WHO to co-sponsor a workshop on the Educational aspects of health in disasters in cooperation with the Council of Europe in Strasbourg in the spring of 1982[19] In addition they designed an emergency health kit for UNHCR which was then produced by WHO and Unicef[20]. During the following four years, the group reviewed the literature on mental health of refugee and famine populations[21] and undertook an evaluation of the Emergency Health Kit for Emergency Relief Operations. Staff of the group also acted as consultants for WHO in Pakistan (1981 and 1985), Lebanon (1983), Tanzania (1984), Ethiopia (1984, 1985, 1986, 1987), Botswana (1986), Lesotho (1986) and Sudan (1987). The group ended its relationship with the office for Emergency Relief Operations of WHO as a Collaborating Centre in 1988. The group was funded primarily by a large research grant from the Edna McConnell Clark Foundation; a small sum was also provided by WHO for work done for the office for Emergency Relief Operations.

The Centre for Emergency Preparedness and Response at the Public Health Institute in Kuopio, Finland was named an official collaborating centre to the office for Emergency Relief Operations in 1988. Since 1985, this institute expanded its involvement in disaster relief, specialising in technological disasters. Similar to other centres, the Finnish centre has provided consultants for individual disaster relief operations, prepared training courses for national and international health professionals

and produced guidelines on technical interventions for health relief. Similar to the Centre for Research on the Epidemiology of Disasters (CRED), the Centres for Disease Control of the US Government (CDC) and the centre within the Italian Government, the work of the Finnish centre in health relief is funded largely by their own government.

On occasion other centres were invited to participate in international health activities sponsored by WHO, such as **the University of Geneva, the Tulane Medical Centre, the European Centre for Disaster Medicine** and **the Asian Institute of Technology**.

Technical agencies of donor governments

The Centres for Disease Control of the US Public Health Service has been involved in disaster relief since the 1950s. As the national public health authorities in the US, CDC was first involved in disaster relief within the US, occasionally assisting in relief abroad. But beginning with the Nigerian civil war of 1967-1970, the Centres extended their involvement in international health relief substantially. During that civil war, the Centres sent more than 25 medical doctors with additional training in epidemiology to assist relief efforts. The Centres were subsequently involved in relief for the earthquake in Peru (1970) and the floods and civil war in Bangladesh (1972)[22].

The Centres have always liaised with WHO; their services are often provided to WHO as a bilateral contribution. There is little evidence, however, to suggest that the Centres worked closely with the office for Emergency Relief Operations before 1985. In contrast with this infrequent and ad hoc liaison, the Centres regularly participated in many of the international health relief activities during the 1980s, especially after 1985. Thus, it is not surprising that in 1988, they set up their own unit for Emergency Preparedness and Response which was designated as a Collaborating Centre for the office for Emergency Relief Operations of WHO. This collaborating centre specialises in epidemiological assessment and surveillance for disaster relief. Their first contribution as a collaborating centre has been to draft a protocol for rapid health assessments in response to disasters[23]. They will no doubt continue to provide

consultants for individual relief operations as well as producing technical evaluations and guidelines.

The Centre for Disaster Preparedness and Management at the Corporation for Development of the Ministry of Foreign Affairs of the Government of Italy has been actively involved in international health relief activities since the early 1980s. They were the first group to propose that guidelines be written for health relief and to undertake writing these guidelines which were published in 1989 jointly with the League of Red Cross Societies as a book on Coping with natural disasters: the role of local health personnel and the community[24]. Much of their work has been with the Regional Office for Europe of WHO, supporting training courses, regional meetings and drafting WHO/EURO Guidelines on action to be taken at the time of disaster in 1987.

In 1987, this centre was named a collaborating centre to the office for Emergency Relief Operations in Geneva with responsibility for supporting global training activities, publications and the production of guidelines as well as supporting particular programmes or activities in individual countries. The most significant programme which the Italian Government supports is the Pan African Centre for Emergency Preparedness and Response[25]. This WHO regional centre serves all of Africa from a base in Addis Ababa in Ethiopia and is financed by the Italian Government. The Italian Collaborating Centre has specific responsibility for supporting this African centre by providing staff, funds and supplies. In addition, the Italian Government supports comprehensive emergency preparedness and response programmes for some countries in South East Asia, Africa and Central America.

The meetings which were convened by WHO provide the most direct evidence of the prominent organizations involved in health relief internationally. By prominent is meant that in practice these were the agencies which were determining and disseminating the technical standards and components of health relief policy. Despite the office for Emergency Relief Operations willingness and efforts to expand their own involvement in this process after 1986, there is little evidence that they were able

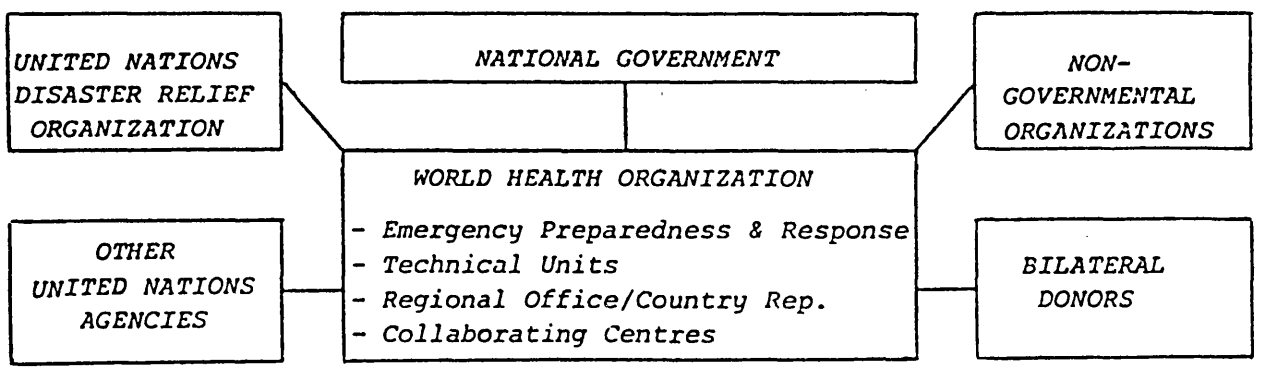
to take the leadership or a coordinating role internationally. Instead, they became yet another organization actively determining technical standards and practices for health relief, often in competition with other agencies - for example, UNHCR.

In fact, the change in name in 1985, from Emergency Relief Operations to Emergency Preparedness and Response (EPR), reflected the nature of their international work which continued to emphasize the provision of expert advice, usually through the production or legitimisation of technical standards or guidelines for international use. This role is clearly illustrated in a working paper prepared by the office for Emergency Preparedness and Response in 1989. In this paper, an organogram illustrates the intended structure of communications within WHO for health relief purposes (Figure 5.8)[26]. This diagram places the office for Emergency Preparedness and Response at the centre, accurately reflecting the role it often plays in conferring legitimacy and in providing expert advice. On the other hand, any attempt to use this model for leadership channels or the implementation of relief activities would be a gross overestimation of WHO's role in policy formation and practice. Instead, an earlier organogram adopted by the office for Emergency Relief Operations in 1981 more accurately portrays WHO as one of many organizations involved in international health relief (Figure 5.9)[27].

5.4.3 Organizational constraints to a leadership role in health relief

Laudable though it was to attempt to expand their work in international health relief, WHO did not generate sufficient additional resources or create structures which would allow an extended role in relief management. Nor did they extend their scope of work to include the day-by-day running of a relief operation. Thus, WHO was simply not in a position to take the leadership or coordinating role. Nor would they be able to do so in future. There are several indicators within WHO itself which support such a conclusion.

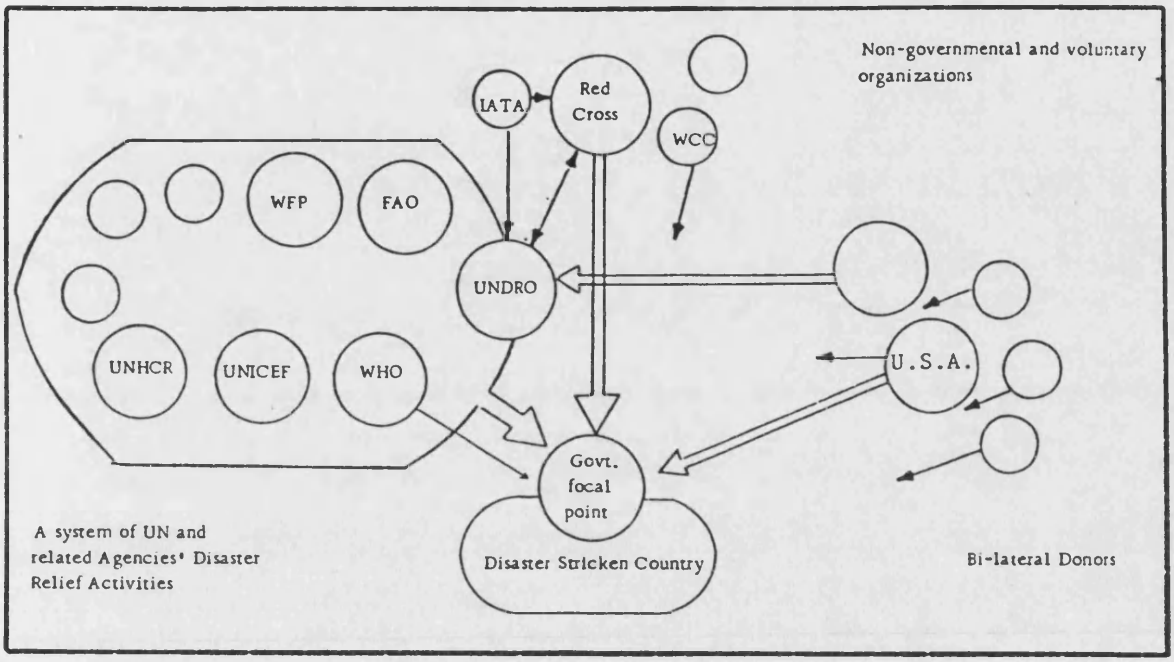
WORLD HEALTH ORGANIZATION DISASTER COMMUNICATION MODEL



Source: EPR, WHO (1989) Emergency preparedness and response 1989-1991. Unofficial planning document. World Health Organization, Geveva, Switzerland, 9pp.

FIGURE 5.8

FIGURE 5.9



Source: Head, EPR, WHO (1981) The action of the United Nations and the World Health Organization in disasters. Paper presented at the Ross Institute, London School of Hygiene and Tropical Medicine, London UK, 8pp.

5.4.3.1 Insufficient members of staff

Within WHO itself, the office for Emergency Relief Operations lacks the human resources, finances and authority to coordinate international health relief efforts. Since its inception in 1975, the office for Emergency Relief Operations has never been staffed by more than four people, which included two secretaries. Although up to three additional professionals have been attached to the office for Emergency Relief Operations as Associate or General Professional Officers with funding from individual donor governments, and other professionals have been brought in as consultants, a core staff of only two prevents the allocation of sufficient time and effort to coordinate continuously the work of a variety of organizations dispersed throughout Europe and North America in addition to strengthening relief responses of WHO offices at country, regional and global levels.

5.4.3.2 Insufficient funds

Not only does the office for Emergency Relief Operations lack the human resources needed for a leadership role, it lacks sufficient funds - even for its current programme of work[28]. In the programme plan for emergency preparedness and management between 1986 and 1989 inclusive, a budget of 3 286 000 US$ was thought to be needed to cover only international health relief work[29]. Yet the regular budget available to Emergency Relief Operations within WHO was less than 300 000 US$ per year or 800 000 US$ for the four years in question: only 24% of the total requested. Clearly, additional contributions were essential for the work which was undertaken during this period. Nevertheless, the extra-budgetary contributions of individual donor governments were small in comparison to the need, ranging between 98 000 and 400 000 US$ in 1986, for example. Furthermore, these extra-budgetary contributions were uncertain and, thus, their generation required the ongoing attention of core staff of Emergency Relief Operations.

5.4.3.3 Centralised decision-making and bureaucratic procedures

The last constraint within WHO itself was a lack of authority and limited access to authority to take decisions about health relief. Although the office for Emergency Relief Operations had been attached to the Director General's office shortly after its creation, ten years later in 1985, the office was made a part of the Division of Coordination (DOC) once again. Such an organizational structure prevented direct access to the Director General's office and, instead, added an additional layer of bureaucratic procedures and processes to decision making for relief within WHO. While important, the extra time and work which was involved in a decision making process that encompassed additional levels or units of authority and specialisation, it was less of a problem than the lack of direct access to the Director General.

The Director General of WHO has vast power over the work of the organization as well as being the organization's link with other agencies of the UN, donor and member governments and the public at large. The Director General not only appoints staff and acts as the secretary to the Executive Board, he prepares and approves the annual programme of work and budget - relatively independently. Similar to the staff of WHO who prepare and propose the annual work plans and budgets, the Executive Board can examine, discuss and even question the proposed plans, but authority to approve it rests with the Director General. Yet, while the Director General directs the work of both the staff of the organization itself and the Executive Board, he does not depend heavily on either one for his power base. Nominations for the Director General position are put forward by members of the Executive Board who elect one whose name is then submitted to the World Health Assembly. Thus, the staff of the organization, while being accountable to him, are excluded from the election process (which is limited to representatives of member governments). Similarly, while the Executive Board controls the election process, they have no responsibility for the staff and work of the organization directly. The Director General, therefore, has a central power base from which to take and enforce decisions.

More routine decisions must be processed through a structure which is complex and whose membership changes from year to year. Unlike UNHCR which has a relatively simple decision making structure consisting of an elected Executive Head and an Executive Board made up of permanent member governments, there appears to be an incestuous and complex set of relationships between the leadership of the Health Assembly, the various committees of the Health Assembly, the Executive Board and the Director General despite an ostensibly democratic election procedure. Since each member nation-state can send three delegates to the Health Assembly, several committees have been formed to expedite the selection and work of the Health Assembly, the Executive Board and the Director General.

The Committee on Nominations is central in the electoral process. At the beginning of each Health Assembly, the President of the Health Assembly submits a list of 24 members to form a Committee on Nominations. Any member of the Health Assembly can add to this list which is then voted upon by the Health Assembly as a whole. This newly elected Committee on Nominations in turn proposes nominations for the offices of President and five Vice Presidents, for the chairs of the Main Committees and for the members of the General Committee. In suggesting nominees, the Committee on Nominations is to take the geographical representation in particular and the personal experience and competence of individual delegates into account. The Health Assembly then votes on these proposals, electing a President and Vice Presidents, who together with the Director General constitute the Secretariat of the Health Assembly, as well as the members of the General Committee and chairs of the Main Committees. As already stated, it is the President who then suggests nominees for the Committee on Nominations the following year.

There are currently two Main Committees of the Health Assembly which discuss and vote on the various agenda items, dividing them into programme or budget matters and administrative, financial or legal matters. Originally there were five Main Committees in 1948 but this was reduced to three in 1942 and two in 1950 in order to streamline and consolidate the work of the Health Assembly. Members chairing these committees are also members of the General Committee, in addition to the

President, Vice Presidents and other delegates of the Health Assembly up to a total of 24 members. The President of the Health Assembly convenes this General Committee which plans the meetings of the various committees and the Health Assembly in detail in consultation with the Director General. In addition, the General Committee submits a list of members, indicating preferences, to the Health Assembly for membership on the Executive Board. Similar to the offices of President, Vice Presidents', chairs of the Main Committees and membership on the Committee on Nominations, this list is then voted on by the Health Assembly. Thus, there is a somewhat circular and closed structure within which key leadership positions are filled. This is true despite the appearance of a democratic electoral system, since nominees are in general determined by smaller, related groups.

5.4.3.4 Dependency on powerful national governments

The Executive Board originally consisted of 18 members with a tenure of three years; currently it is made up of 31 members, each of whom has a three year tenure. Every year one third of the membership changes and no member government can be re-elected while serving on the Executive Board. Nevertheless, an informal agreement was reached when WHO was first set up amongst the 'Big Five' - the United States, United Kingdom, Soviet Union, China and France - that each would only be off the board for the one required year between three year terms[30]. The Executive Board meets twice each year to consider the programme of work and budget prepared by the Director General. Yet, it cannot amend the Director General's proposals directly. It has several committees which consider individual activities, such as malaria control, relationships with other organizations, such as Unicef and charitable agencies, and administrative processes, such as financial audit and outstanding contributions. Similar to the Health Assembly, it is managed by a Chair and three Vice Chairs and the Director General acts as secretary.

Despite an emphasis on an equitable geographic representation among member governments, wealthy governments in Western Europe and North America have had disproportionately high representation. This can be seen in an analysis of their Gross

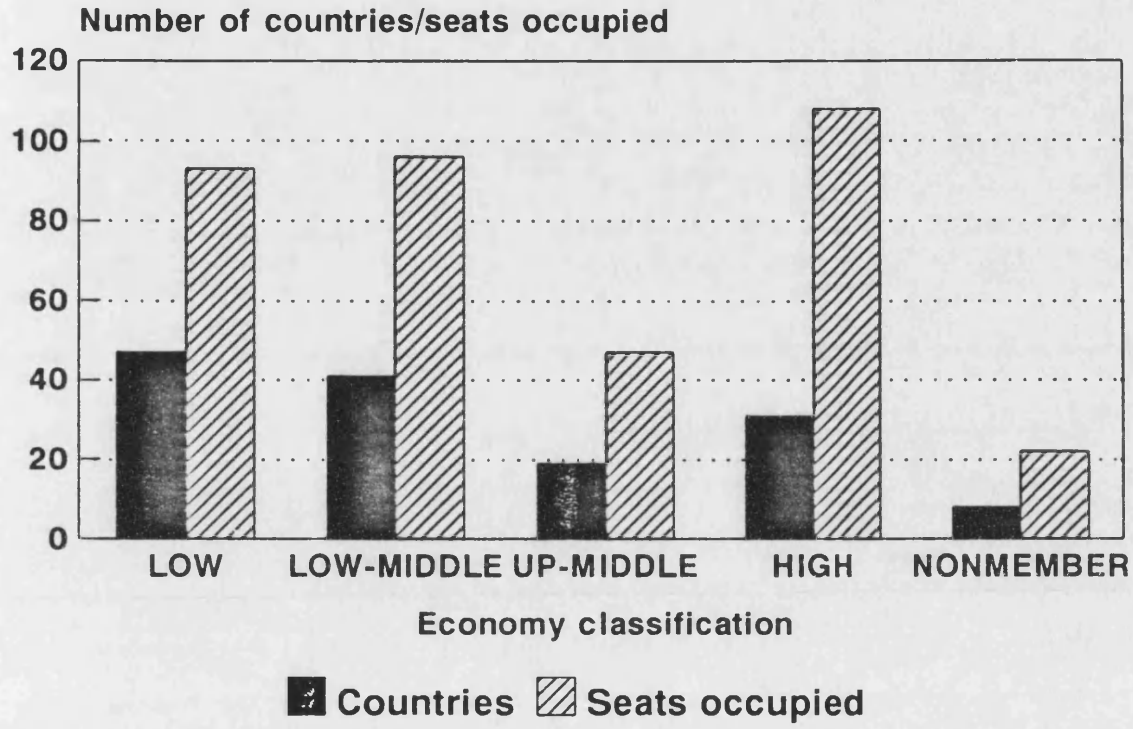
National Product (GNP) per capita in 1990 according to the World Bank[31], their geographical location and their financial contribution to the annual, regular budget of WHO of member governments who have been elected to serve on the Executive Board. Figure 5.10 summarises the numbers of low, lower-middle, upper-middle, high and nonmember income economies represented on the Executive Board as well as the number of seats they occupied (since some countries have occupied more than one seat). Clearly, while low and lower-middle income economies are numerically the largest group of countries represented on the Executive Board (88 or 60%), higher income economies occupied one half of the positions or seats on the Executive Board.

This contrast is most stark between low income economies who occupied two seats each on average and high income economies who occupied 3.5 seats each on average (Table 5.2). Another way of looking at this is to graph the number of countries elected to the Executive Board according to the total number of seats they occupied. Figures 5.11 and 5.12 show several differences between lower and high income economies. Firstly, less than five lower income economies were elected to the Executive Board more than three times, and none were elected more than seven times; most lower income economies were elected to the Executive Board only once or twice (69%) over the past 40 years. In contrast, six high income and nonmember economies have been elected six or more times - up to 12 times for two countries (the US and UK). Obviously, the informal agreement has been modified in response to changing political relationships. For example, Canada and Japan have both been represented more frequently than China. Thus, while the proportional representation of economies on the Executive Board is almost equal to their distribution in the world generally (Figure 5.13), higher income economies occupied disproportionately higher numbers of seats or positions on the Board than their numbers would suggest. Thus, they had a more regular or continuous presence in decision making processes throughout the past forty years.

Figures 5.14 and 5.15 summarise the distribution of member governments elected to the Executive Board and the seats they occupied according to geographical regions of WHO. Figure 5.14 in particular highlights the high proportion of both countries

Figure 5.10

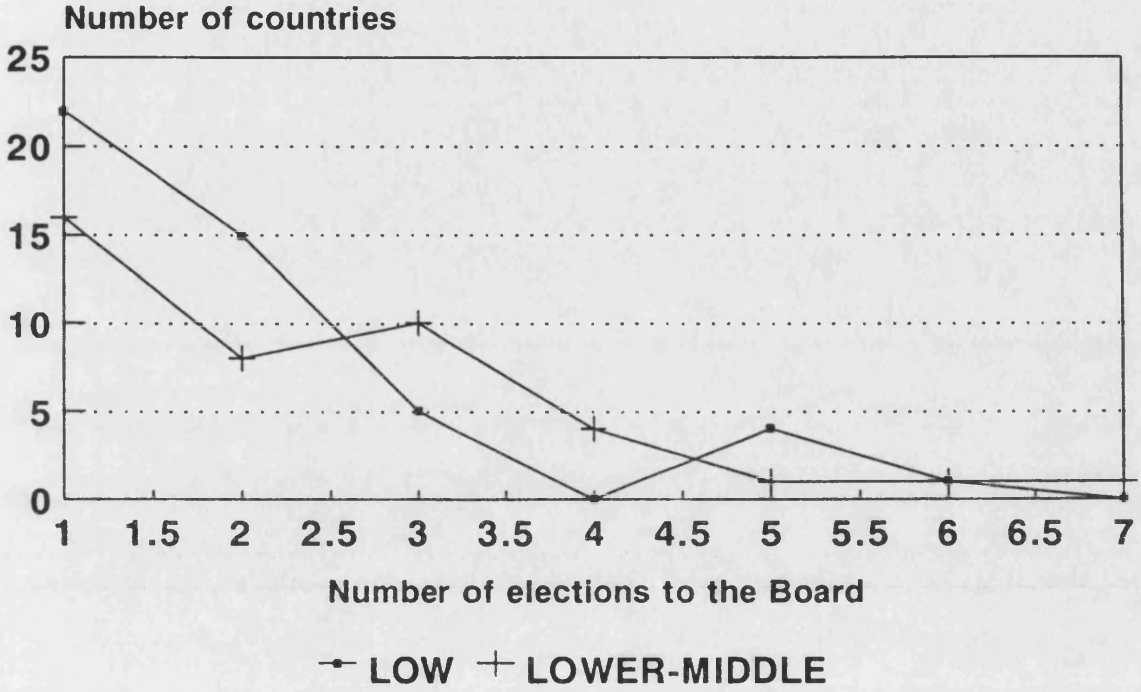
Low, middle, high and nonmember economies* represented on the Executive Board of WHO, 1948-89.



*Classified according to the World Bank Development Report for 1990

Figure 5.11

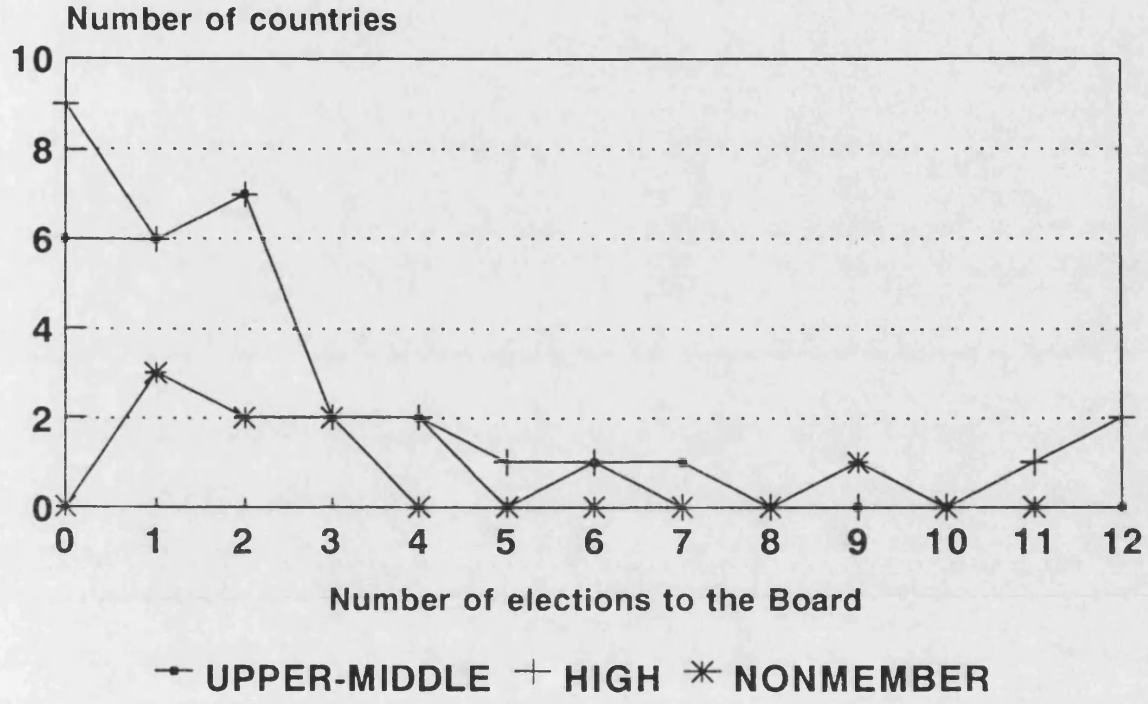
Continuity of representation on the Executive Board of WHO of lower income economies*, 1948-1989



*Low income economies generate <500 USD GNP per capita; lower-middle income economies generate 500-2200 USD

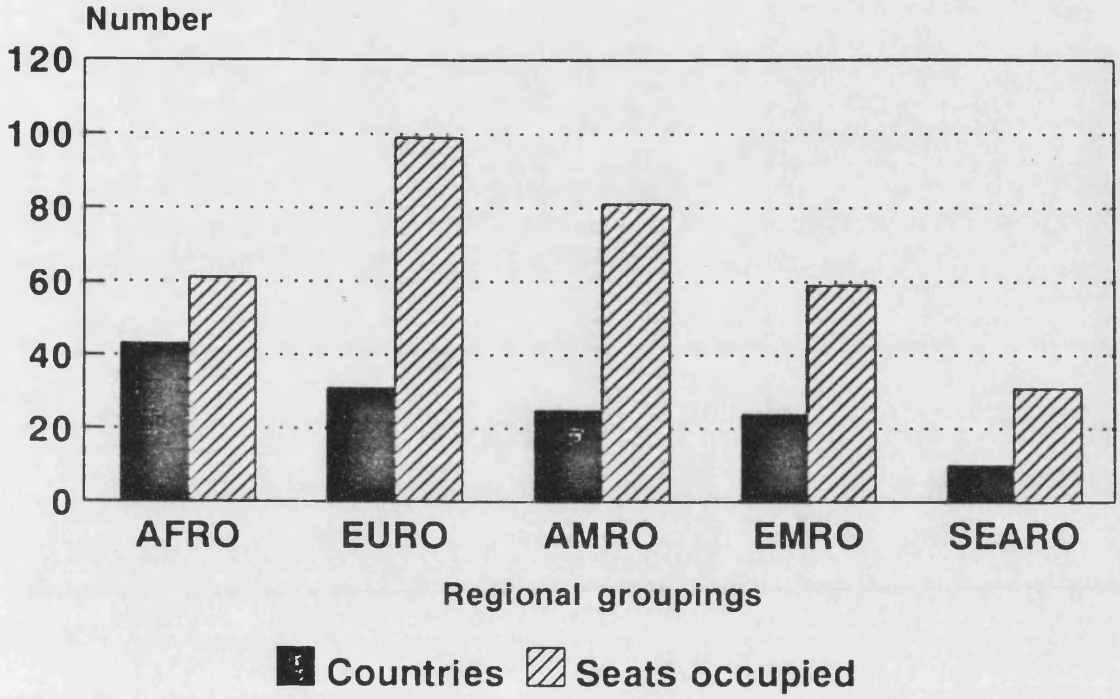
Figure 5.12

Continuity of representation on the Executive Board of WHO of higher income and nonmember economies, 1948-1989



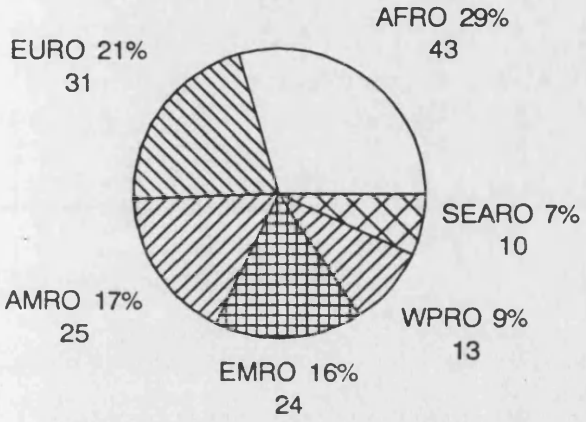
Upper-middle = 2200-6000 USD GNP per capita; High = 6000+ USD GNP per capita; Nonmember = not known.

Figure 5.13
Regional representation on the Executive Board of WHO, 1948-1989

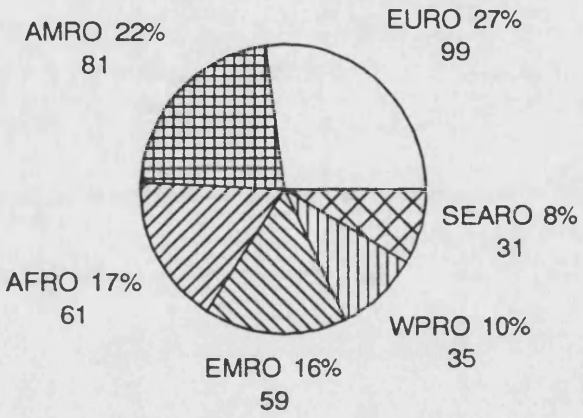


Areas: Africa (AFRO); American (AMRO); European (EURO); Eastern Mediterranean (EMRO); South East Asia (SEARO); Western

Figure 5.14
Countries represented and seats occupied on the Executive Board of WHO by region, 1948-1989

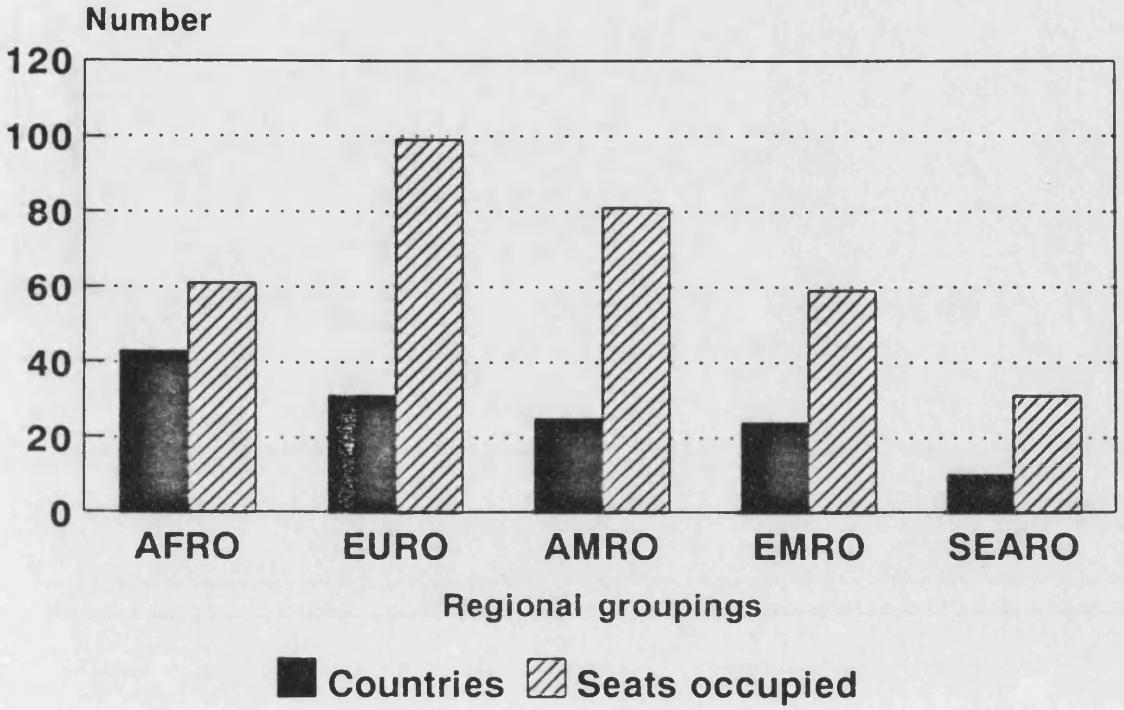


Regional distribution of countries represented on the Board.



Number of seats occupied by countries in the regions on the Board.

Figure 5.15
Governments with membership on the Executive Board of WHO, 1948-1989



Areas: Africa (AFRO); American (AMRO); European (EURO); Eastern Mediterranean (EMRO); South East Asia (SEARO); Western

TABLE 5.2

Average number of seats occupied by low, lower-middle, upper-middle, high and nonmember economies represented on the Executive Board of WHO

ECONOMY	SEATS OCCUPIED	NUMBER OF COUNTRIES	AVERAGE SEATS PER COUNTRY
LOW	93	47	2.0
LOWER-MIDDLE	96	41	2.3
UPPER-MIDDLE	47	19	2.5
HIGH	108	31	3.5
NONMEMBER	22	8	2.8
TOTAL	366	146	2.5

TABLE 5.3

Average number of seats occupied on the Executive Board of WHO by countries contributing < 1%. 1 - 9.99% and 10+ % of the annual, regular budget

CONTRIBUTION	SEATS OCCUPIED	NUMBER OF COUNTRIES	AVERAGE SEATS PER COUNTRY
< 1 %	273	130	2.1
1 - 9.99 %	66	13	5.1
10 + %	27	3	9.0
TOTAL	366	146	2.5

represented from the European and American regions (38%) and seats occupied by them (49%). This figure further suggests that the high proportion of seats occupied by the American and European regions is at the expense of Africa since the Eastern Mediterranean, South East Asian and Western Pacific regions account for the same proportion of seats as countries. This conclusion if further borne out in Figures 5.16, 5.17 and 5.18 in which most African countries (93%) are clearly shown to have been elected only once or twice. These figures also indicate that countries within the American and European regions had the most regular or continuous presence on the Executive Board - a finding consistent with the analysis by economy since the highest income economies are located mainly in these regions.

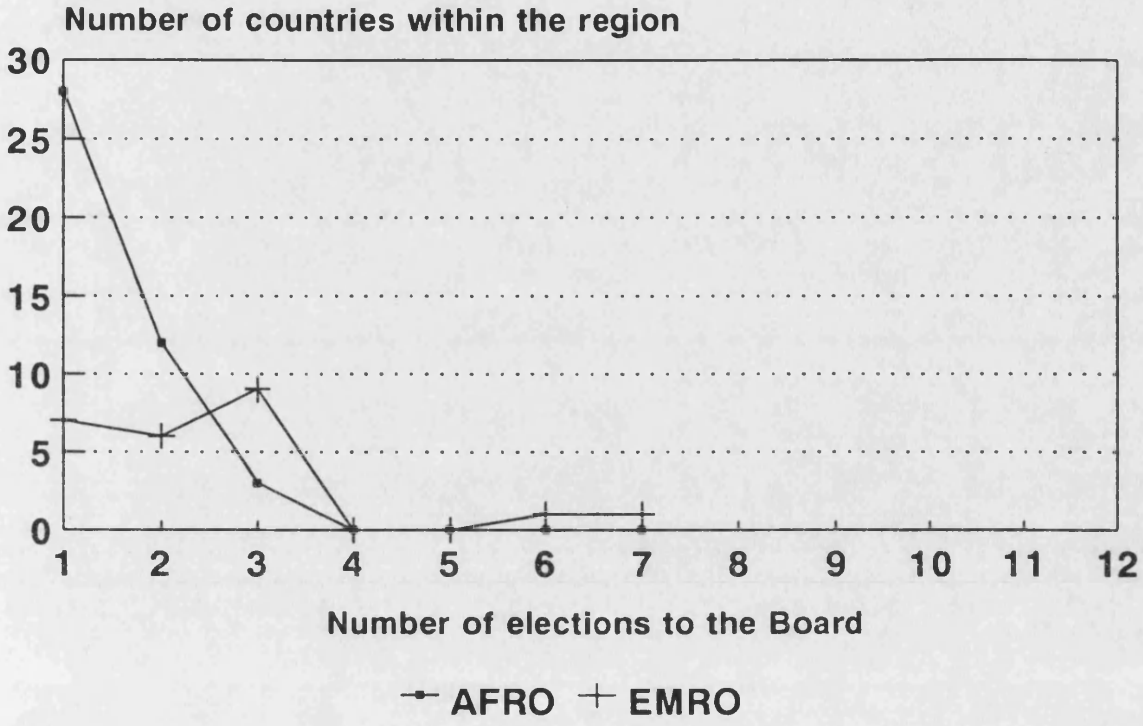
Lastly, member governments which have been represented on the Executive Board were analyzed and summarised in Figure 5.19 according to their financial contribution to the regular, annual budget of WHO[32]. The three countries currently contributing 10% or more of the regular budget (Japan, US and USSR) occupied 27 seats (7%) or 9.0 seats per country on average (Table 5.3). Of the 14 countries contributing between 1 and 10%[1], 13 occupied 66 or 18% of the seats on the Executive Board or 5.1 seats per country on average. The majority of countries represented on the Executive Board contributed less than 1% of the annual budget; although they occupied 273 or 75% of the seats, they occupied only 2.1 seats per country on average. Again, wealthy governments who are able to make larger contributions to the annual budget, mainly in Europe and North America, were found to have a disproportionately high representation - more frequently and regularly than their numbers would suggest.

Similarly, an analysis of member governments who have not been elected to the Executive Board further substantiates the above findings and reinforces the conclusion that the most powerful nation-states in the world are those that are most frequently and regularly represented in WHO's decision making bodies. The Ukrainian SSR is

[1] Including: Australia, Belgium, Brazil, Canada, France, German Democratic Republic, German Federal Republic, Italy, Netherlands, Spain, Sweden, Switzerland, Ukrainian SSR and the United Kingdom.

Figure 5.16

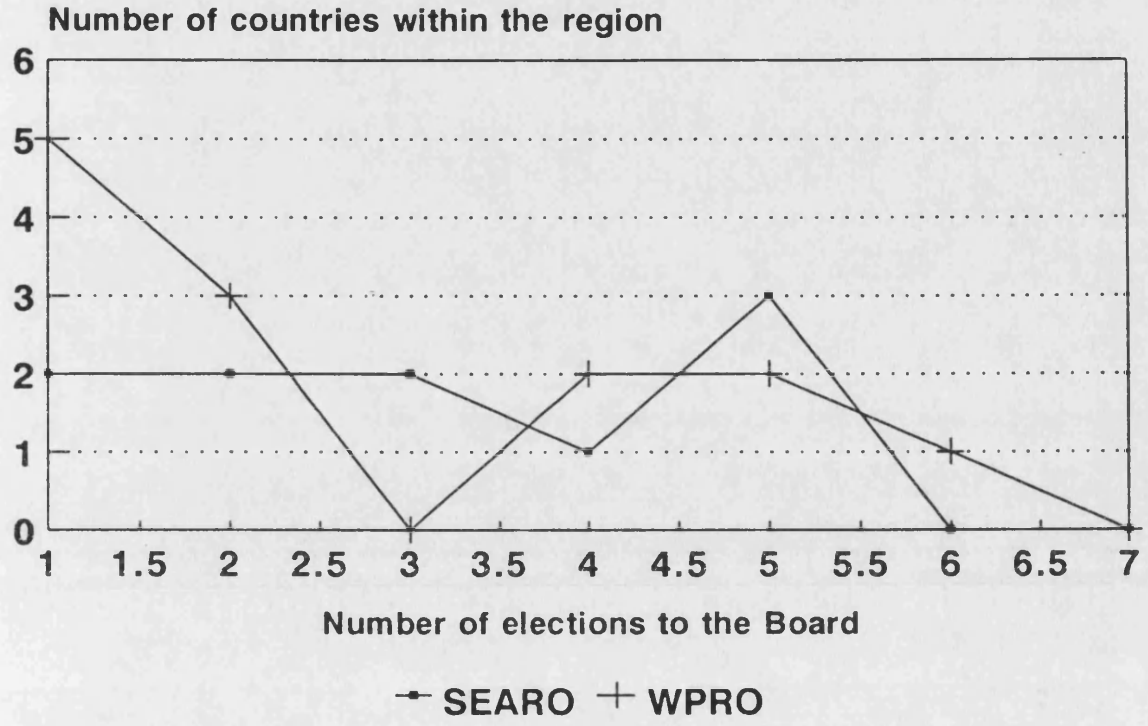
Continuity of African and Eastern Mediterranean representation on WHO's Executive Board, 1948-1989



AFRO - African region;
EMRO - Eastern Mediterranean region.

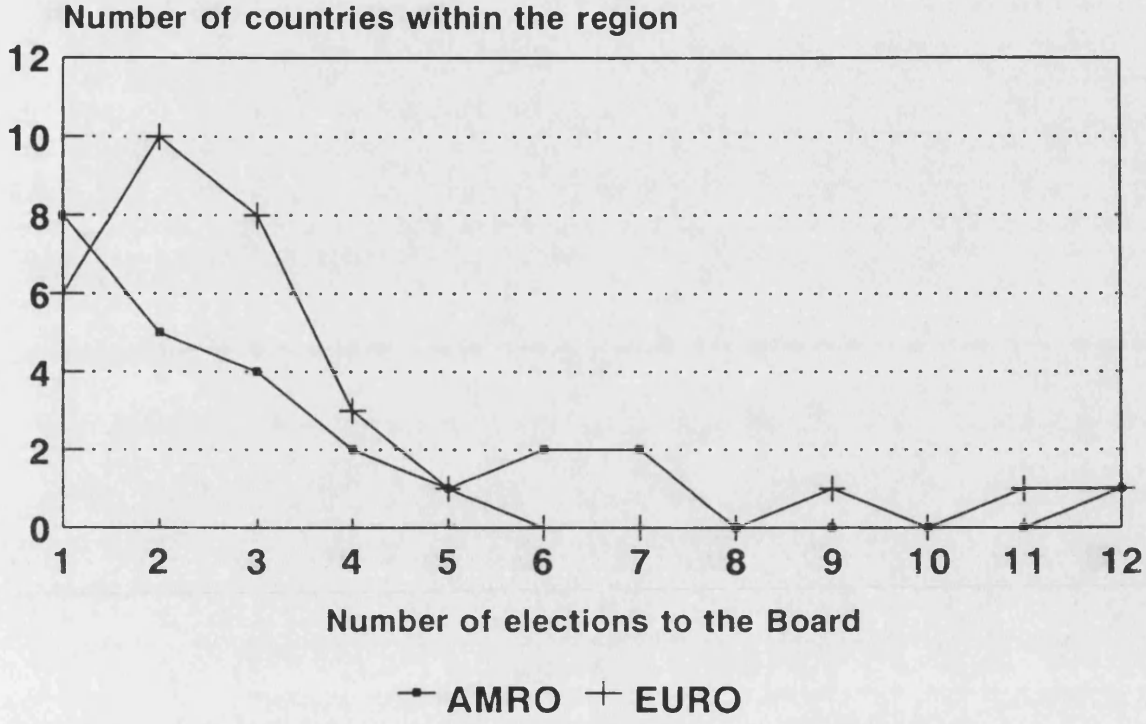
Figure 5.17

Continuity of South East Asian and Western Pacific representation on WHO's Executive Board, 1948-1989



SEARO - South East Asia region;
WPRO - Western Pacific region.

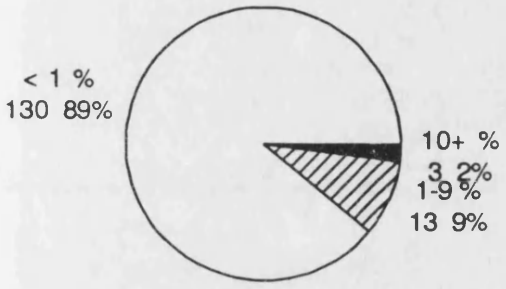
Figure 5.18
Continuity of American and European representation on WHO's Executive Board, 1948-1989



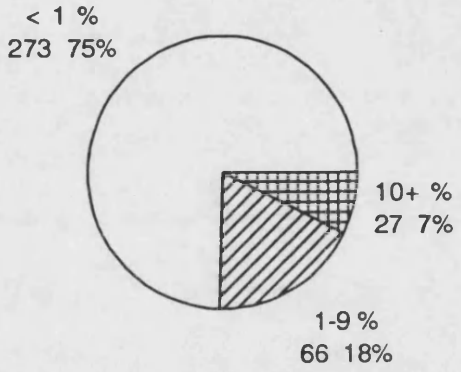
AMRO - American region;
EURO - European region.

Figure 5.19

Governments with membership on WHO's Executive Board: financial contributions* to the annual, regular budget



Number of governments elected to membership on the Board, n=146.



Seats occupied on the Board by these governments, n=366.

***Those contributing < 1%, 1 - 9.99% and 10+ % of the annual, regular budget.**

the only country contributing more than 1% of the annual budget which has not been a member of the Executive Board. All other governments who have not had membership contributed less than 1% of the budget. Likewise, although the largest proportion of countries not represented are from the American (34%), Western Pacific (31%) and European (16%) regions (Figure 5.20), within the Americas it is only countries south of the US who have been excluded; within Europe, it is only the very small countries which have not been elected to the Executive Board; being made up of 23 small islands, it is not surprising that the Western Pacific region had several members who have been excluded from membership on the Executive Board.

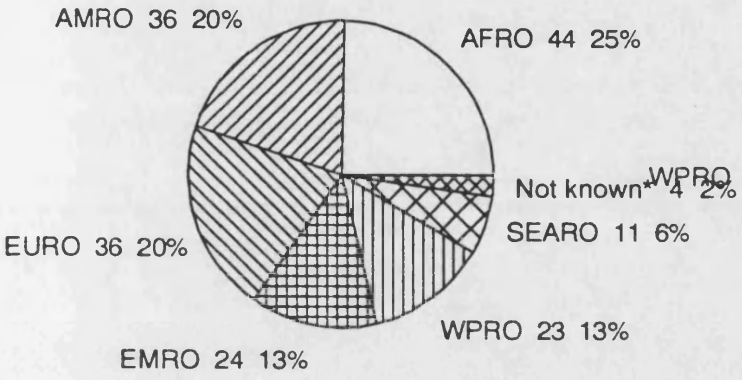
5.5 Rationalising responsibility for international health relief within the UN: UNHCR, WHO or Unicef?

5.5.1 UNHCR?

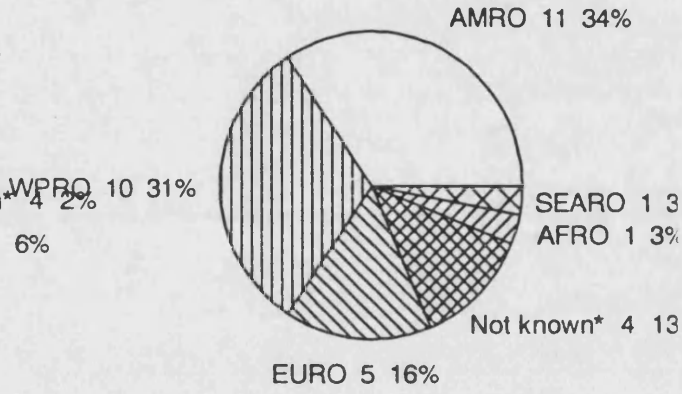
Holborn[33] describes the way in which the various components of the UN system worked with UNHCR, including WHO: the seconding of experts, exchanges of information and documents, mutual representation at meetings, joint fund raising efforts and the provision of technical advice, equipment or other materials. In health, this meant that until UNHCR created their own institutional expertise in health relief in the 1980s WHO was often asked to assess refugee health needs, to plan refugee health services, to advise on the suitability of sites chosen for settlements and to determine what assistance should be provided internationally - usually in the form of money or material goods. There are at least four issues which suggest that UNHCR may not be the most suitable organization to take over these roles and to provide the leadership in refugee health relief programmes.

Firstly, the mandate to advise and assist governments in the provision of health care lies with WHO, not UNHCR. Historically, WHO has been asked to provide the technical expertise directly or indirectly. Furthermore, increasing evidence of the long-

Figure 5.20
Regional distribution of WHO member nation-states* and those not represented on WHO's Executive Board



Member nation-states of WHO according to geographical regions, n=178



Regional distribution of countries which are not represented on the Board, WHO

***Includes: Holy See; Vatican City; UK and French Overseas Territories**

term or developmental nature of refugees since the 1970s suggests that short-term, temporary responses are not appropriate, lending support for WHO, as a developmental agency, to take responsibility for refugee health relief.

Secondly, the role of medical or nutritional advisers in UNHCR appears to have been somewhat loosely defined. The primary duties focus on monitoring UNHCR funded programmes[34], specifically budgeting, and writing and reviewing reports and proposals. In addition, they provide technical advice to programme coordinators and other senior staff members of UNHCR. Yet, their professional advice is not necessarily translated into policy or even guidelines. As we have seen earlier, such decisions are made in the head office by senior staff in conjunction with the Office of the High Commissioner who confers with the Executive Board. Even on more practical issues, technical staff usually have to seek the approval of the regional bureaus in the head office or the programme coordinators of national or regional offices.

Thirdly, UNHCR's practice of renewing employment contracts on a yearly basis and the use of different organizations to second health professionals has meant that the continuity and quality of staff has varied. Depending on charitable agencies in particular to provide expert advisers does not ensure, or at times even suggest, that staff with appropriate training and experience will be appointed. This is especially relevant for management since experience in the management of health or relief at national or regional levels is very different from directing individual projects for a charitable agency. Moreover, unlike the first health and nutrition adviser in UNHCR's head office and the first Senior Health Coordinators in Thailand, Somalia and Pakistan who were senior members of WHO's staff, recent health or nutrition advisers have been appointed at junior levels[35], limiting their authority within the institution itself as well as the possibilities for recruiting highly experienced and qualified personnel.

Lastly, national governments have the sovereign responsibility for health care of those living on its territory, at least according to WHO's Constitution. As such, it should have the authority to establish and enforce policies and to coordinate the various

agencies and activities. UNHCR as the source of funds is able to direct, to some extent, the activities of recipient organizations. They are not, however, in a position to be the main coordinating body in refugee health. This is the responsibility of the government and advising governments on health issues is the role of WHO. And most important, they have no jurisdiction over separately funded programmes.

5.5.2 WHO?

However, within WHO itself, a very narrow paradigm for perceiving and defining problems to be tackled, a complex and entrenched bureaucratic structure through which decisions are taken and acted upon, and a rigid dependency on donor governments for financial resources will continue to sabotage any meaningful efforts to provide relief.

Even though the Emergency Unit has tried to extend its concerns beyond epidemics of disease which are associated with disasters, WHO's expertise more generally and their input to disasters specifically remains much the same. In response to disasters, WHO continues to purchase and distribute very limited quantities of drugs or other medical supplies for governments, and they continue to provide technical advice to governments or other UN agencies. Even their more recent involvement in establishing global standards for health relief is consistent with a limited focus, addressing primarily only the needs for technical, medical care. Such a focus on medical care ignores the underlying determinants of health, many of which are now being addressed by other agencies - for example needs for water supplies and sanitation facilities which are being constructed by Unicef. Unless WHO can expand its scope of work beyond traditional medical activities, there is little evidence that they could lead the way to improving health and well-being in circumstances where environmental factors are central.

Despite the Emergency Unit's efforts to play a leading role in some of the most recent, large relief operations, for example for Afghanistan, their involvement continues to depend on others. Mainly for money. Two professional staff members

will not be able to be involved directly in field work; nor will they be able to undertake time-consuming roles within the international relief community. Similarly, an annual budget of less than one million US dollars will cover only a few, smaller projects. Thus, WHO's involvement will continue to depend on requests from or the support of other governments or UN agencies who will fund their participation. This will continue to preclude long-term planning and on-going involvement since they will need to raise the required resources repeatedly. Furthermore, the funds which have been secured are minuscule for the magnitude of needs which already exist, let alone those which will inevitably be generated in future. WHO simply lacks the resources to make more than a symbolic gesture of good will in relief.

Those familiar with WHO are acutely aware that even with a more flexible mandate and vast resources, WHO's ability to respond to disasters efficiently and effectively is questionable. Not only do decision-making procedures within headquarters take time but they are vulnerable to the interests and influence of many parties; this is even more true for relations with regional offices which enjoy a high degree of autonomy and often resources. Sheer bureaucracy which 'comes to live too greatly for itself, multiplying special units according to bureaucratic whim, so that the sight of the wood is lost in the trees' was recognised in WHO nearly two decades ago[36]. Hence, the establishment of direct lines of authority for relief within WHO, which minimise delay and outside influence, is unlikely.

The lack of support within WHO itself for a leading role in health relief must surely reflect a lack of support for such a role by its donors. Dependency on a few, powerful national governments means that support is often only forthcoming when it furthers donor interests.

5.5.3 Unicef?

Clearly, WHO appears to be in a weak position to undertake an expanded role in international health relief. Even the most recent attempts (since 1990) of the newly created Emergency Unit to keep pace with other organizations who are formulating

and implementing health relief policy have done little to alter more fundamental limitations on WHO's contribution. Moreover, the more traditional roles of the past no longer apply; the creation of separate units for relief and for health within other organizations within the UN negates the need for WHO to participate in the ways they have previously. Similarly, many other organizations are increasing able to provided the resources needed for health relief operations. Unicef in particular has often contributed money, medical supplies, drugs, vaccines or special equipment for government or charitable health services for relief. Mass migrations within nation-states has often led Unicef to adopted a leading role in associated relief operations. Perhaps Unicef, which has a mandate covering both health and relief, is better suited to take responsibility for international health relief for refugees.

5.6 References

1. WHO (1982) Basic Documents. Geneva, Switzerland: the World Health Organization, p. 1

2. WHO (1982), p. 1, #1

3. WHO (1982), pp. 2-3, #1

4. Director-General WHO (1951) Official records of the World Health Organization 14:48, Annex 9

5. Director-General, WHO (1962) The role of WHO in emergencies. Official Records of the World Health Organization 124:50-53

6. Hata K (1975) Management survey on emergency relief operations. Geneva, Switzerland: the World Health Organization, Management Survey Report No. 137, October 1975, 28 pp.

7. World Health Assembly, WHO (1975) Assistance to newly independent and emerging states in Africa. World Health Assembly resolution WHO28.78. Official Records of the World Health Organization 226:44

8. Hata K (1975), #6

9. Kent RC (1987) The anatomy of disaster relief. The international relief network in action. London, UK: Pinter Publishers, 183 pp.

10. Responsible Officer, Emergency Relief Operations, WHO (1977) Memorandum to the Director-General, 5 December 1977, 2 pp., Geneva, Switzerland: the World Health Organization

11. PAHO (1982) Emergency Vector Control after Natural Disaster. Washington D.C., USA: Pan American Health Organization, Scientific Publication No. 419

12. PAHO (1982) Epidemiologic surveillance after natural disaster. Washington DC, USA: Pan American Health Organization, Scientific Publication No. 420

13. PAHO (1982) Environmental health management after natural disasters. Washington DC, USA: Pan American Health Organization, Scientific Publication No. 430

14. WHO and LORCS (1989) Coping with natural disasters: the role of local health personnel and the community. Geneva, Switzerland: the World Health Organization and the League of Red Cross and Red Crescent Societies, 62 pp.

15. LORCS (1959) International disaster relief manual. Geneva, Switzerland: League of Red Cross and Red Crescent Societies

16. LORCS (1970) Red Cross disaster relief handbook. Geneva, Switzerland: League of Red Cross and Red Crescent Societies

17. Oxfam (1983) Oxfam's practical guide to refugee health care. Oxford, UK: Oxfam Medical Unit, Oxfam Working Paper No. 2.

18. Simmonds SP, Vaughan JP and Gunn SW (1983) Refugee Community Health Care. Oxford, UK: Oxford University Press, 250 pp.

19. Division for Higher Education and Research, Council of Europe (1982) European workshop on the educational aspects of health in disasters, 2-5 March 1982, Strasbourg, 48 pp.

20. WHO (1984) WHO Emergency Health Kit. Standard drugs and clinic equipment for 10 000 persons for 3 months. Geneva, Switzerland: World Health Organization

21. Simmonds S and Ryding D (1986) Refugee mental health - a bibliography. London, UK: Refugee Health Group, London School of Hygiene and Tropical Medicine

22. Western KA (1972) The epidemiology of natural and man-made disasters. The present state of the art. Dissertation submitted for a Diploma in Tropical Public Health, London, UK: the London School of Hygiene and Tropical Medicine, 107 pp.

23. Emergency Relief Operations, WHO (1989) Annual Report 1989. Geneva, Switzerland: the World Health Organization

24. WHO and LORCS (1989), # 14

25. Emergency Relief Operations, WHO (1989) Annual Report 1989. Geneva, Switzerland: the World Health Organization

26. Emergency Preparedness and Response, WHO (1989) Emergency Preparedness and Response 1989 - 1991. Geneva, Switzerland: the World Health Organization, PCO/EPR/89.5, 8 pp.

27. Hata K (1975), Annex 7, #6

28. Emergency Relief Operations WHO (1989), #23

29. Emergency Preparedness and Response, WHO (1986) Review of the United Nations system-wide emergency situations preparedness and its coordination aspects and links to longer-term development in the light of the experience gained from the emergency operations in Africa. Background paper prepared for the joint meeting of CPC/ACC, Geneva, 1-2 July 1986

30. Mingst KA (1990) The United States and the World Health Organization. In: Karns MP and Mingst KA The United States and multilateral institutions. Patterns of changing instrumentality and influence. Boston, USA: Unwin Hyman, pp. 205-230

31. World Bank (1990) World Bank Development Report. New York, USA: Oxford University Press, 260 pp.

32. Williams D (1987) The specialised agencies and the United Nations. The system in crisis. London, UK: C Hurst and Company, 269 pp.

33. Holborn LW (1975) Refugees: A problem of our times. The work of the United Nations High Commissioner for Refugees, 1951 - 1972. Metuchen, New Jersey, USA: The Scarecrow Press, Inc., 2 volumes, 1446 pp.

34. Chief, Emergency Preparedness and Response, WHO (1989) Note for the record. UNHCR/WHO collaboration in the Islamic Republic of Iran. 9 September 1989. Geneva, Switzerland: Emergency Preparedness and Response, World Health Organization, 3 pp.

35. Technical Support Service, UNHCR (1987) Developmental plan. Provisional document. Geneva, Switzerland: Technical Support Section, United Nations High Commissioner for Refugee, 17 pp.

36. Brockington F (1975) World Health. Edinburgh, London and New York: Churchill Livingston, p. 180

CHAPTER SIX

The United Nations Children's Fund (Unicef) the ideal organization to take the leading role in international health relief policy formulation and practice?

Unlike the United Nations High Commissioner for Refugees (UNHCR) whose organization, funding and work changed relatively little when they first shifted their activities to countries in the southern hemisphere during the 1950s and 1960s, the indefinite extension of the United Nations International Children's Emergency Fund (Unicef) mandate in 1953 formalised marked changes institutionally[1]. Changes have occurred in the organization of Unicef, its funding and its focus. It has grown from a small centralised agency based in North America and Europe in the 1950s to one managed largely by regional and national offices in 128 countries and territories world-wide in 1990[2]. From an annual budget of less than 10 million in the early 1950s its finances exceeded over 800 million US$ in 1990[3]. And importantly its focus shifted from working primarily in emergency relief to addressing problems confronting children's well-being in the longer-term.

6.1 The 1950s: from relief to development

This transformation was greatly facilitated in the 1950s by a mandate for child health generally and international health policies which gave priority to eradicate tropical diseases through mass campaigns - with vaccines, drugs or pesticides, for example. These campaigns were similar to relief work in many ways. The widespread application of a vaccine, drug or pesticide in a population for an intense period of time meant that programmes to eradicate or control common diseases in the tropics were thought to be needed only in the short-term since only one treatment or limited applications were required[4], and they were visibly popular and thought to be highly effective and beneficial.

Successes following the world wars in Europe, particularly in eradicating malaria in southern Europe after the second World War (WWII), the development of new and cheaper drugs, vaccines and other compounds as well as improved communication and transport systems were sufficient justification to extend campaigns to newly independent countries. Together with the newly created alliance of central and eastern European states with the USSR and the new People's Republic of China headed by Mao's communist government in 1950 which limited further relief and rehabilitation work in these countries, growing concern for global eradication of common diseases meant that Unicef's involvement in disease control or eradication shifted from emergency programmes in Europe to endemic problems in the southern hemisphere as early as 1949 (Table 6.1). Thus, by 1953 the word 'emergency' was dropped from Unicef's name even though the acronym was retained[5].

Not only did the priority given to mass campaigns facilitate a smooth transition to working in health development, but the high costs associated with such campaigns made Unicef's participation somewhat of a necessity. The limited financial resources of WHO in the 1950s and the 1960s, whose primary income came from assessed contributions which grew from a total of only 13.4 million US$ to 49.8 million US$ between 1958 and 1967[6], together with restrictions on its extra-budgetary fund-raising meant that the provision of supplies and equipment by Unicef was a much needed contribution. For example, by the latter half of the 1960s WHO spent one-sixth of its total budget on malaria control only[7]. The need for Unicef's support and the priority given to the campaigns within Unicef itself was reflected in the allocation of nearly one-half of their budget, 12.2 million of 25 million US$ annually, to these campaigns by the end of the 1950s[8].

Short-comings with this approach were, however, becoming more and more apparent. For example, the potency, sensitivity and specificity of vaccines, tests and treatments were in question, and the immunity of disease organisms and vectors was much greater than had previously been thought. Nevertheless, Unicef had also involved themselves in other health and nutrition activities, such as the supply of hospitals,

TABLE 6.1

Unicef's participation in mass campaigns to control or eradicate diseases, 1947-1952

YEAR	FOCUS	TARGET GROUP	LOCATION	CONTRIBUTION
1946-50	malnutrition	young children	Europe, China	Supplied dried milk, fats, grains
1948-49	tuberculosis	all ages	Europe	Supplied vaccines; supported medical teams to screen and treat
1948-49	syphilis	all ages	Europe	Supplied penicillin
1948-49	training health personnel	middle-school graduates	China	Supplied drugs, equipment, funds
1948-50	malnutrition	refugees	Palestinian	Supplied foods, blankets, other essentials
1948	general child health, diseases	children	Israel	Sent X-ray units, drugs, vaccines
1949	tuberculosis	all ages	Egypt, Syria, Lebanon, India, Israel	Supplied vaccines, drugs
1949	malaria	all ages	India, Pakistan, Thailand	Supplied DDT
1949	yaws	all ages	Haite, Indonesia, Thailand	Supplied drugs, vaccines, vehicles, equipment, costs of training and salaries of experts
1949	malnutrition	children	Latin America	Supplied powdered milk, equipment, supplies
1950	tuberculosis	all ages	Latin America	Supplied tuberculin tests, vaccines and supported medical teams
1950	malaria	all ages	eight Carribean countries	Supplied DDT
1950	syphilis	all ages	eight Carribean countries	Supplied penicillin
1950	yaws	all ages	Carribean	Supplied penicillin
1950	mother and child health care	mothers and children	Carribean	Supplied equipment for facilities and factories for vaccines
1952	trachoma	all ages	Morocco, Taiwan	Supplied eye ointments
1952	Leprosy	all ages	Nigeria	Supplied drugs

health centres and training institutions, the production and distribution of milk locally, the establishment of child feeding programmes, the training and supply of midwives and other health workers, and planning within national, regional and district health authorities.

In 1963, health programmes accounted for 60% of all programme allocations[9]. Furthermore, by the beginning of the 1960s, Unicef began to broaden the scope of their work to include education and community development more generally. But it was not until the end of the UN's first development decade that Unicef was recognised primarily as a developmental rather than a humanitarian agency. For example, it was not until 1972 that Unicef first began to report to the Second Committee of the Economic and Social Council (ECOSOC) on Economic and Financial Questions rather than the Third Committee on Humanitarian and Social Affairs[10].

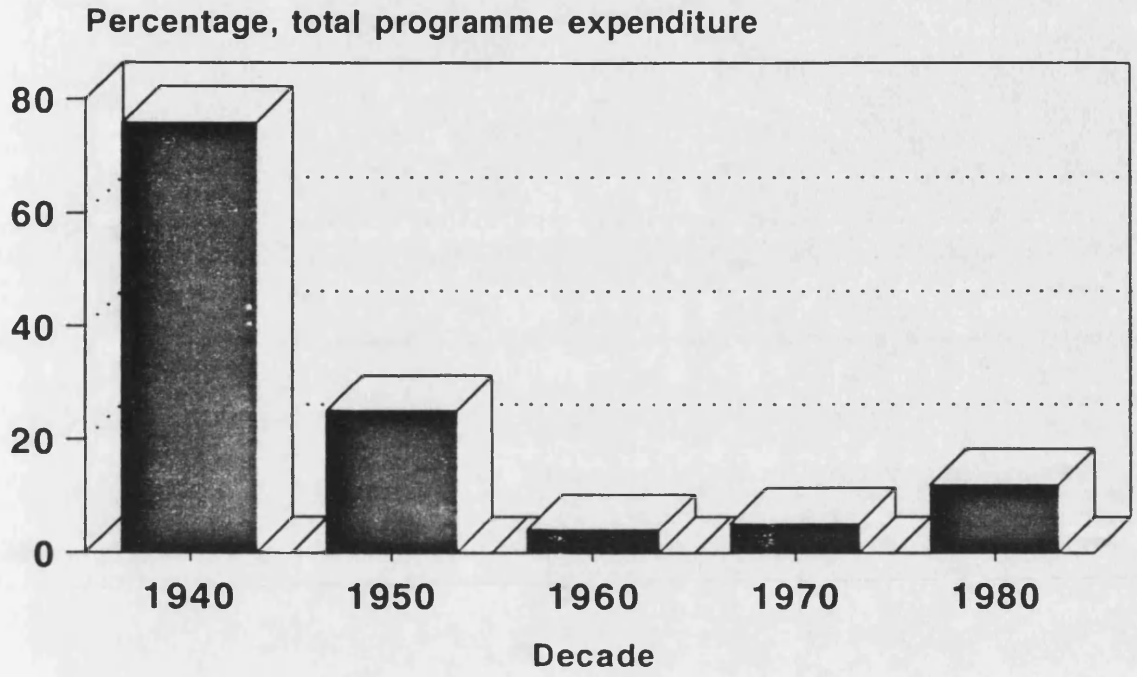
6.2 The 1960s: re-thinking an exclusive focus on development

6.2.1 The challenge of more frequent and severe disasters

By the mid-1960s, Unicef had successfully extracted themselves from relief work generally, spending less than 2% of their budget on emergency aid (Figure 6.1) and sending only 7% of their donations of goods overseas for relief[11]. But this position was viewed with ambivalence by those experiencing disasters and the devastating consequences for their daily lives, by field staff who saw firsthand the vast and urgent needs for relief assistance, by the general public who were horrified and moved to action as media coverage became more routine and vivid, by staff based at the head office who were pressured by supporters and donors to take action, and often by host and donor governments who were encouraged by their constituencies to take part in managing or supporting relief efforts.

Figure 6.1

Unicef expenditure on emergency aid as a percentage of total programme expenditure, 1947-1985



Source: Black 1986, pg 494
*Excludes expenditure for rehabilitation of facilities damaged during emergencies

6.2.2 Opting for a role in rehabilitation and reconstruction

Beginning with the earthquake at Agadir Morocco in 1960 and continuing throughout the crisis associated with colonial independence in the Congo in 1960-62, the increasing prominence of disasters influenced Unicef to articulate an alternative policy for relief. In 1965, the Executive Board decided that Unicef would participate mostly in rehabilitation and reconstruction of permanent services for mothers and children following disasters[12], thereby avoiding the diversion of scarce resources for emergencies - whenever possible[13]. This policy was consistent with decisions taken in the following years to reduce their involvement in disease control programmes and to increase their support for basic health services[14].

6.2.3 Capitulation: Unicef's unique role in relief

But this policy was immediately challenged by severe drought and famine in the Indian States of Bihar and Uttar Pradesh in 1965-66, the civil war in Nigeria from 1967-70 and the civil-cum-regional conflict in Vietnam. The constraints inherent in addressing needs in such polarised and acutely political environments meant that Unicef's response built upon their experiences in China and the Middle East in 1948, consolidating a strategy for their involvement in future relief efforts throughout the 1970s and 1980s.

6.2.3.1 Relief based on tacit understandings only

Firstly, the clause in Unicef's mandate which ensures the provision of aid to all children regardless of, among other things, nationality or political beliefs was used to justify relief in the absence of an invitation from the recognised government of the country in question. This meant that Unicef was not held to the standards set for other agencies of the UN which required official consent in recognition of sovereignty. Instead, Unicef worked for a tacit understanding whereby the lack of an invitation did not impede its relief work[15]. Not surprisingly, this meant that Unicef often worked

to provide relief on both sides of armed conflict and that it was often able to work in areas where other agencies of the UN could not.

6.2.3.2 Close collaboration with the Red Cross and charitable agencies

Secondly, such a position was somewhat similar to that adopted by the International Committee of the Red Cross (ICRC), and Unicef collaborated closely with them in responding to armed conflicts. This collaboration was largely built upon the acceptability of the Red Cross in, as well as its ability to respond to, such crisis and Unicef's willingness to strengthen and support their efforts. During the Nigerian civil war for example, relief supplies from Unicef were channelled primarily through ICRC. More generally, Unicef established forums through which they created and maintained close relationships with a variety of charitable organizations; this is evident, for example, by the NGO-Unicef Forum and its production of the newsletter Ideas Forum on a monthly basis.

6.2.3.3 Logistical expertise

Thirdly, similar to its collaboration with WHO in programmes for health development, Unicef's main contribution to relief operations continued to be the provision of needed supplies and material goods. For example, Unicef's Procurement and Assembly Centre (UNIPAC) in Copenhagen became the main purchasing and sending agency in the Nigerian relief operation. In many ways Unicef's involvement ensured that logistical considerations - which are so essential to any relief effort where scarcity is a fundamental concern - were addressed. It also meant that the seemingly less glamorous procurement and dispatch of substantial quantities of needed goods was undertaken.

6.2.3.4 Operational capacities

Lastly, Unicef became operational in some circumstances, for example in re-building Biafra after the war. Unlike most agencies within the UN system which are confined to working through governments or charitable agencies for both relief and

development, exceptionally great needs and the lack of administrative infrastructure led Unicef not to only provide needed goods for Biafra's reconstruction but to take responsibility for their distribution and use, relatively independent of the government or other agencies. Thus, Unicef also set a precedent for setting up its own programmes in response to disasters similar to the Red Cross or the charitable agencies.

6.2.3.5 Ability to raise funds

There were at least two other factors which influenced the way Unicef responded to these disasters. Since it was first set up after WWII, Unicef has relied on voluntary contributions for its work. Only the office requirements and core staff of the head office were funded by the UN Secretariat. All other costs had to be covered by voluntary rather than assessed contributions from governments, private organizations or individuals. As a result of this funding scheme, Unicef quickly set up an extensive network of support groups, largely through national committees, which generate funds and lobby governments and private organizations to support Unicef. Initially funding was uncertain, but over the years there has been a steady increase in Unicef's annual income - excluding special appeals for major relief efforts (Table 6.2). The existence of such an extensive network of supporters meant that Unicef had greater flexibility in seeking additional funds than most agencies within the UN system. This enabled it to respond quickly to disasters and to raise needed funds on its own initiative.

This ability to seek additional funds was particularly important because the creation of a fund for emergency relief in 1969 authorised the Executive Director to draw only 100 000 US$ for any given crisis. Even with the allowance for a further 100 000 US$[16], such funds would hardly cover anything but the most basic and initial response. In other words, the emergency fund of Unicef was similar to those created within the UN Secretariat, UNHCR and WHO during the same period - very small in comparison with the needs and total expenditures (Table 6.3). Later it was possible to use other programme funds for emergencies, either when the on-going programme could not be continued or when relief needs were urgent.

TABLE 6.2

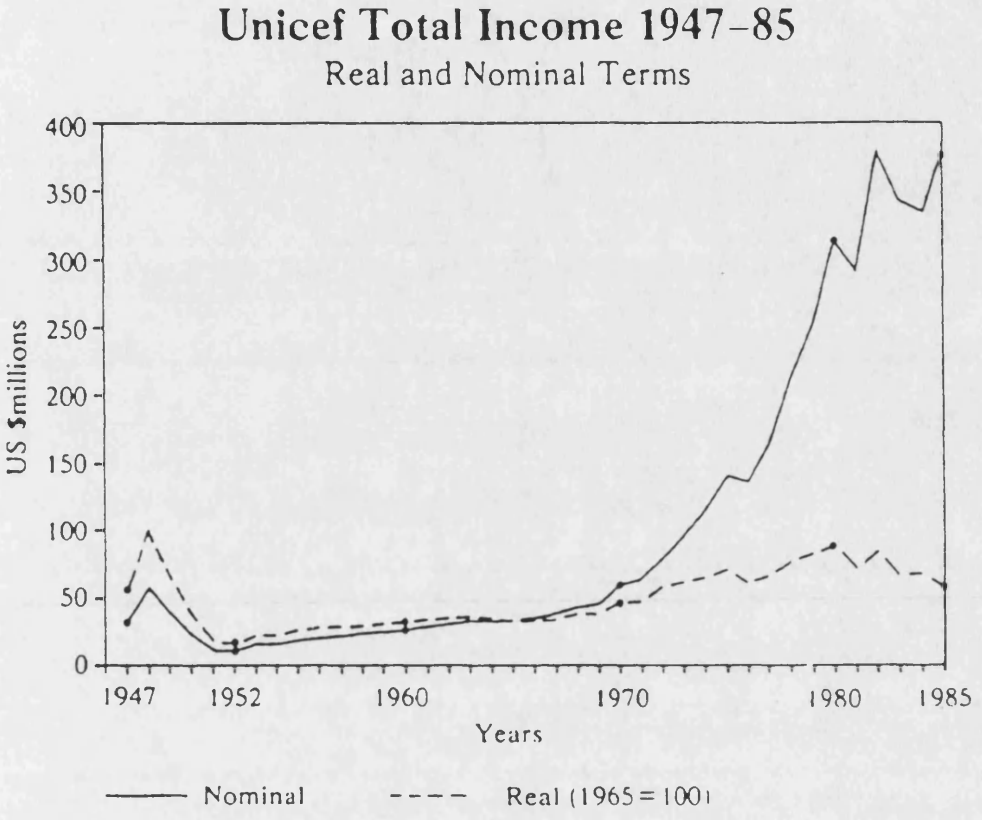

Unicef Total Income 1947–85
Real and Nominal Terms
US $millions
400
350
300
250
200
150
100
50
0
1947
1952
1960
1970
1980
1985
Years
Nominal
Real (1965 = 100)

TABLE 6.3
Emergency aid given by UNICEF
1948-1965[1]

YEAR	COUNTRY	TYPE OF DISASTER[2]	VALUE OF RESPONSE[3]
1948	Middle east	refugees, Palestinian	around 15 million US$, 1948-53
1952	Egypt, Jordan	refugees	not known
1952	Brazil, India	drought	not known
1952	Philippines	volcano	not known
1953	India, Korea, Pakistan, Japan	drought and famine, war	1 722 000 US$
1953	Greece	earthquake	100 000 US$
1953	Japan	floods, typhoon	132 000 US$
1954	India	food shortages	900 000 US$
1954	Iraq	floods	53 000 US$
1954	Tanzania	drought and famine	120 000 US$
1954	Haiti	hurricane	115 000 US$
1955	Pakistan	floods	15 000 US$
1955	India	(stocks)	51 000 US$
1955	Korea	(feeding programme)	628 000 US$
1955	Maldives	hurricane	15 000 US$
1956	Pakistan	floods	594 000 US$
1956	Korea	(feeding programme)	800 000 US$
1956	Japan	crop shortages	28 000 US$
1956	India	(drug stocks)	55 000 US$
1956	Port Said	evacuation	110 000 US$
1956	Austria, Hungary	evacuation	700 000 US$
1957	Jordan	(feeding programme)	363 727 US$
1957	Egypt	refugees	22 677 US$
1958	Tunisia	refugees	not known
1960	Congo	independence, famine	536 000 US$
1960	Mauritius	cyclones	55 000 US$

YEAR	COUNTRY	TYPE OF DISASTER[2]	VALUE OF RESPONSE[3]
1960	Pakistan	cyclones	647 045
1960	Chile	earthquakes	356 000 US$
1960	Iran	earthquakes	not known
1960	Morocco	earthquakes	300 000 US$
1960	Mauritania	drought, food shortages	31 000 US$
1960	Jordan	(feeding programme)	373 000 US$
1960	Morocco	refugees	not known
1960	Tunisia	refugees	207 000 US$
1960	Korea	not known	109 000 US$
1960	Somalia	not known	78 082 US$
1961	Congo	famine prevention	471 000 US$
1961	Morocco	refugees	216 000 US$
1961	Tunisia	refugees	402 500 US$
1961	Jordan	(feeding programme)	242 000 US$
1961	British Honduras	hurricane	105 000 US$
1961	Vietnam	floods	85 500 US$
1962	Iran	earthquake	not known
1962	Somalia	flood	not known
1962	Algeria	resettlement of refugees	not known
1962	Philippines	cholera epidemic	not known
1962	Jordan	(feeding)	not known
1962	Chile	not known	not known
1962	China	not known	not known
1962	Congo	rehabilitation	1 370 000 US$
1963	Yugoslavia	earthquake	NK
1963	Carribean	hurricane	NK
1963	Algeria	NK	NK
1963	Cuba	NK	NK
1963	Haiti	NK	NK
1963	Jordan	NK	NK
1963	Korea	NK	NK

YEAR	COUNTRY	TYPE OF DISASTER[2]	VALUE OF RESPONSE[3]
1963	Morocco	NK	NK
1963	Trinidad and Tobago	NK	NK
1963	Uruguay	NK	NK
1964	Cuba	hurricane	NK
1964	Haiti	hurricane	NK
1964	Trinidad and Tobago	hurricane	NK
1964	Costa Rica	volcano	NK
1964	Vietnam	typhoons, floods	NK
1964	Jordan	NK	NK
1964	Korea	NK	NK
1964	Uruguay	NK	NK
1964	Congo	rehabilitation	549 000 US$
1965	Jordan	(feeding programme)	NK
1965	Vietnam	NK	NK

1. Source: UN (1948-1965) Yearbook of the United Nations. Lake Success, New York, USA: United Nations, Department of Public Information

2. NK - not known

3. NK - not known

6.2.3.6 Timely and authoritative decision making processes

Not only was Unicef able to mobilise vast resources for relief more quickly and independently than other agencies of the UN, the small size of the organization and the dynamic and outgoing role adopted by its Executive Directors meant that decisions were taken at the highest levels, avoiding lengthy delays. In particular, the Executive Director was personally involved throughout these relief operations, negotiating directly with the authorities concerned as well as overseeing the planning and response of the organization itself. Relief coordinators who were based on site were often appointed, but they too were accountable directly to the Executive Director. Obviously, this increased the flexibility with which responses could be made since they were authorised and supported at the highest levels. Clearly, decision making processes within Unicef meant that lengthy bureaucratic procedures and managerial indifference were avoided.

6.3 The 1970s: organising for a role in relief

The need to respond more formally to disasters was incorporated in the organization in 1971 with the creation of an Office of the Emergency Operations Coordinator. Nevertheless, the policy did not change. Unicef continued to use around 5% of its annual budget in the 1970s to respond to several, relatively small disasters each year (Figure 6.1), as well as appealing for additional funds to participate in the larger, widely publicised international relief operations. For example, it responded to the cyclone and tidal wave in the Bay of Bengal in 1970, the civil war in East Pakistan in 1971, the millions of Bengali refugees who fled to India in 1971-1972, the war and reconstruction in Indochina and the massive drought and famine in the Sahel in 1972-75.

6.4 The 1980s: adopting a low profile

It was not until the repressive regime of Pol Pot in Kampuchea came to an end in 1979 that Unicef again took on an extensive and leading role in a relief effort[17] - a

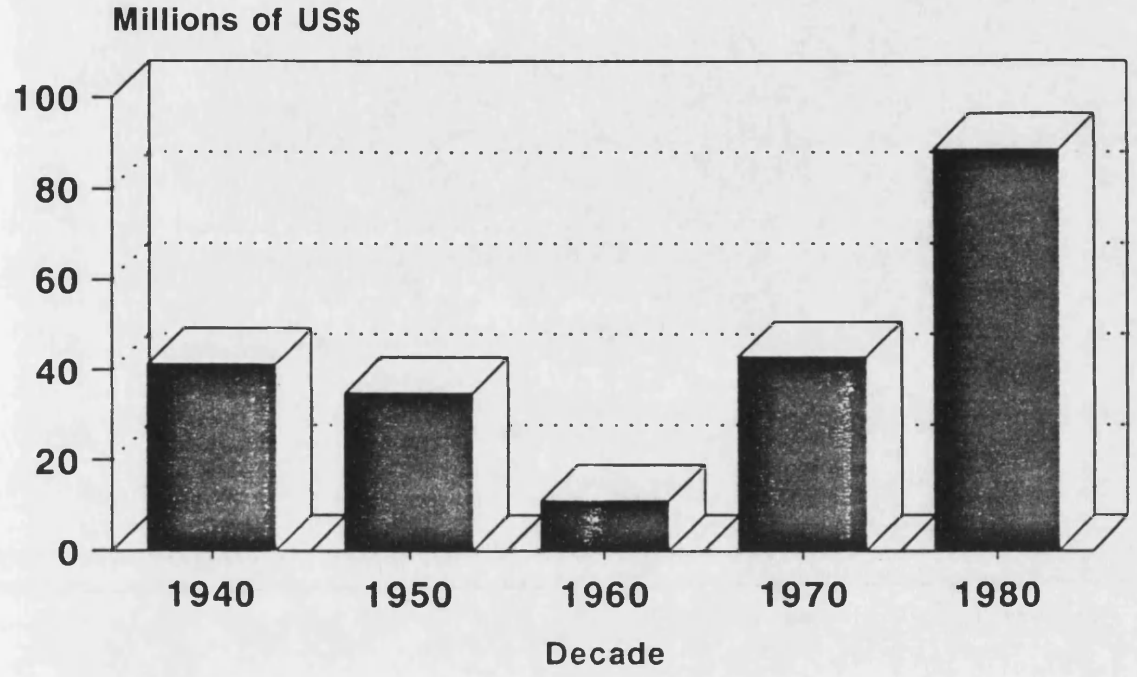
role nearly identical to that adopted in the Nigerian civil war relief effort. Yet their involvement was again quickly replaced by rehabilitation and on-going programmes in the various countries of the region as early as 1981. The conclusion of Unicef's relief programme for Kampuchea brought to an end one of the most stormy and difficult times for the organization - operationally, financially and politically[18].

At that time, the Executive Director proposed that Unicef avoid, whenever possible, the role of lead agency[19] - a decision successfully followed throughout the remainder of the 1980s. They then returned to supporting individual components of relief and rehabilitation programmes on a smaller scale. But during the 1980s, more frequent and devastating disasters meant that some 10% of the programme budget was spent on emergency aid during the first half of the decade, or 177.2 million US$ (figures 6.1 and 6.2). For example, for the Afghan refugees in Pakistan, the Ethiopian refugees in Somalia, the famine in much of Africa in 1983-86 and civil wars in Angola, Ethiopia, Liberia, Mozambique, Somalia, Sri Lanka and Sudan.

6.5 The 1990s: resisting pressures to adopt a more influential role in relief?

The end of the 1980s were characterised by the need for several massive relief and rehabilitation operations. The UN appealed for funds to mount multi-agency, multi-sectoral operations in many regions of the world, such as for Afghanistan (Operation Salaam), southern Sudan (Operation Lifeline) and southern Africa (Children on the Frontline). Moreover, the 1990s were designated as the International Decade for Natural Disaster Reduction. The declaration of war by several North American, European and Middle Eastern nations against Iraq, massive flooding in Bangladesh, widespread famine and escalating armed conflict in many African nations, a large earthquake in the Philippines and global pollution and environmental degradation were only a few of the widely publicised and better known tragedies which marked the beginning of the 1990s. The severity of these disasters and their consequences again made relief a priority on many political agendas.

Figure 6.2
Unicef expenditure on emergency aid* in millions of US$, 1947-1985



Source: Black 1986, p. 494
*Excludes rehabilitation expenditures for facilities damaged in emergencies.

6.5.1 Strengthening relief capacities within Unicef

Once again, Unicef was asked to improve its response. Similar to the creation of the emergency unit in 1971, Unicef's strategy focused on strengthening their own capabilities with little change in policy. Thus, in 1990 a Director for Emergency Programmes was appointed, a regional office for Africa was created and a strategy was outlined for Unicef policy and practice in the 1990s[20]. The remit of the new Director was 1) to 'rationalise, streamline and improve Unicef response capabilities to the needs of women and children caught in emergency situations and 2) to enhance Unicef support of overall United Nations efforts aimed at facilitating the provision of humanitarian assistance to all civilians caught in such situations'.

6.5.2 Maintaining a supportive role

These objectives highlight the perceived need and donor support for Unicef to involve themselves further in relief and rehabilitation, as well as a decision to maintain their existing policy not to take the lead role in international relief efforts. In specifying tactics to achieve these goals[21], nearly all (12/13) of the measures identified aimed to improve Unicef's capacity institutionally, for example to prepare and support staff in managing emergency programmes and to mobilise resources for such work. Priority continued to be given to rehabilitation and development with emergency programmes being linked or converted quickly to them. Furthermore, Unicef support would be an integral component of a UN response, in other words under the direction of the UN or other designated lead agency.

6.6 Planning relief for forced migrations: rhetoric or reality?

Within this context, Unicef also articulated a position for working for people displaced by war, famine or other life-threatening events. In the strategy for the 1990s, the plight of millions of refugees and people displaced within their own countries was recognised and an action plan was written for the African continent[22]. A further statement was issued in 1991 following an agreement to collaborate between the

Executive Director of Unicef and the High Commissioner of UNHCR[23]. They agreed that for some refugees, mutually supportive programmes would be set up in the fields of 'water and sanitation, primary health care including immunizations and basic education'.

While the implications of this agreement and plan for refugee health will only be clarified in time, the possibilities most likely range from no change in policy or practice to a leading role in refugee health relief. The likelihood of these positions maturing in future can best be evaluated by looking briefly at the way in which Unicef works - both in relief and development, by the competition for such roles - both by other agencies of the UN and charitable organizations, and by the support available for this work - both in their decision-making bodies and donor network.

6.6.1 Precedents for an expanded role

6.6.1.1 Supply and logistical capacities

Since its inception, the transfer of primarily material or financial resources, and to a lesser extent knowledge and skills, has been the main form of aid provided by Unicef. This has been true in both emergency and on-going health programmes. Its origins lie in aid given to European nations after WWII which was based on the assumption that such inputs would enable governments to rebuild and restore their societies within a few years time[24]. The subsequent application of this approach to development in poorer countries has since been discredited, as it fails to address underlying problems of poverty or to facilitate and enhance processes leading to self-reliance - economically, politically, culturally or socially. By nature, it is short-term and a factor in continued dependency unless there are simultaneous efforts to address limits to self-reliance. Moreover, the provision of resources which have been developed within the culture and economy of industrialised nations means that by its nature aid imposes a western way of doing things on its recipients. Notwithstanding these limitations, this approach is characteristic of relief aid. If such an approach continues to be adopted, Unicef would appear to be an ideal agency for filling this role in relief operations.

6.6.1.2 Meeting basic needs for resources

The ability and willingness to provide such resources has several implications for Unicef. Firstly, it facilitates and enhances the welcome given to Unicef, especially when resources are needed or desired. Together with its policy of providing relief without official consent from the government concerned, Unicef is in a position to work in some areas of conflict where other agencies of the UN cannot or where charitable agencies are unable to provide the vast resources needed.

6.6.1.3 The power of the purse

Secondly, being a provider of resources empowers Unicef to make decisions about how these resources will be used. In other words, it could be used to justify a leading role in decision-making and management. Such a leadership role is potentially strengthened when other agencies working in the area of relief or health lack similar resources - which is currently the case with UNHCR and WHO. Hence, it would appear that Unicef could take a leading role in refugee health relief.

6.6.1.4 Meeting resource needs: a core component of relief

Lastly, Unicef's willingness and proven abilities in handling the logistics of supply and distribution of large quantities of goods enhances - what might be called - Unicef's candidacy. This is an essential task, frequently neglected or underdeveloped by other relief organizations. Thus, Unicef's existing structure could be an important asset in any relief operation.

6.6.1.5 Timely and authoritative administration

Not only does Unicef's Procurement and Assembly Centre (UNIPAC) provide a somewhat unique structure within the UN system for the rapid distribution of non-food supplies, Unicef's general administrative procedures enhance local decision-making and response within policy priorities agreed at the highest levels. Despite the existence

of two head offices in New York and Geneva, six regional offices in Africa (2, 33%), Asia (2, 33%), Latin America (1, 17%) and the Middle East (1, 17%) and field offices in 128 countries in Africa (44, 34%), Asia (34, 27%), Latin America (35, 27%), the Middle East and North Africa (15, 14%) and Central and Eastern Europe (<1%)[25], administrative costs were less than 10% of total expenditure until the early 1980s when they accounted for 11% of all expenditure[26]. In 1990, administrative costs were 9% of all expenditure[27].

The conclusion that low administrative costs are indicative of fewer bureaucratic complexities and procedures is further supported by the distribution of three out of every four staff members in field offices, rather than in regional or head offices[28]. Moreover, in reporting on their involvement in major relief operations during the past 40 years, no mention has been made of decisions processed through regional offices. Instead, decisions were based on needs which were determined on-site together with an assessment of the international context by the Executive Director and other senior staff in the head office. Communications between field staff and senior officials were direct, thereby avoiding lengthy delays, managerial indifference or political interference within Unicef itself. This institutional ability to take action quickly and with authority would be essential for leading or coordinating relief efforts.

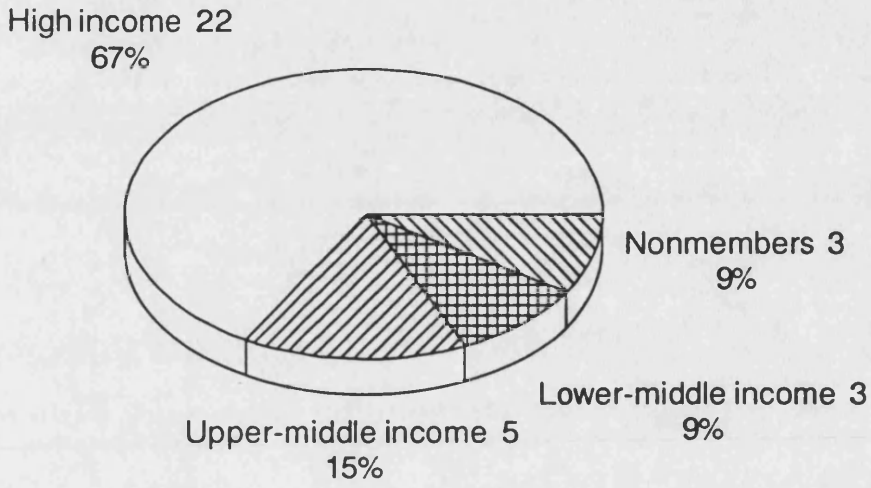
6.6.2 A lack of support for an expanded role?

So why has Unicef consistently gone to great lengths to avoid a significant focus on relief? Surely, fears about their ability to manage an expanded role and the acceptability of this depend largely on the attitudes and support of their donors.

6.6.2.1 Widespread popular support

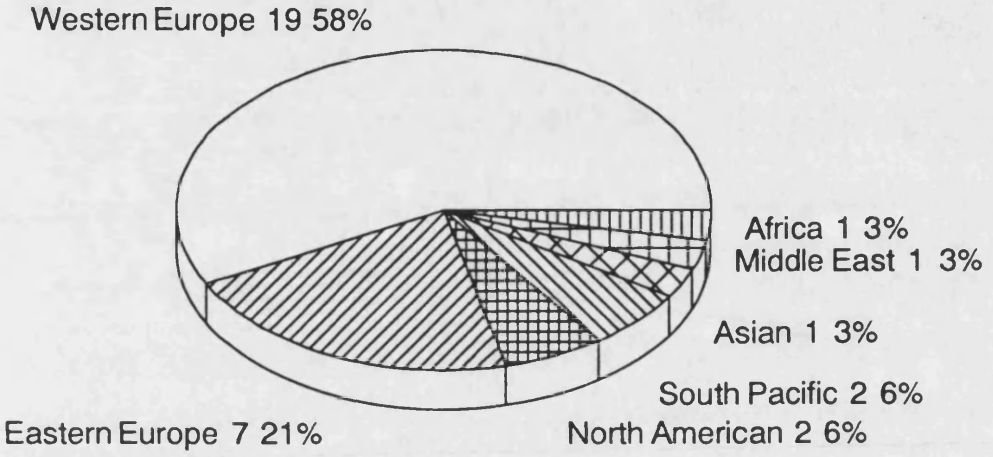
Since Unicef is the only UN agency to receive funds directly from the public, it is interesting that most of this money comes through 33 national committees which are based in high income economies (Figure 6.3) or in Europe (Figure 6.4). These national committees work primarily within industrial societies, especially those affiliated with

Figure 6.3
Countries with Unicef National Committees by economic classification* 1990



Source: Unicef (1991) Unicef at 40
***World Bank Development Report 1990**

Figure 6.4
Unicef National Committees by geographical region in 1990



Source: Unicef (1991) Unicef at 40

the political views, policies and practices of the USA since WWII (79%). Although the publicity and general support which is elicited by these committees can influence decisions taken - both within Unicef itself and by major donors, non-governmental income has accounted for only a quarter or less of total income (Table 6.2). Furthermore, sales of greeting cards have been a significant proportion (44% between 1947-1985) of this contribution throughout the past forty years[29].

Non-governmental contributions totalled an estimated 198.7 million US$ in 1990 or 24% of all income. Of these non-governmental contributions, the largest donations, of 10 million US$ or more, came from only seven countries where there are national committees, including the USA (32.1 million), West Germany (23.5 million), the Netherlands (20.7 million), France (18.6 million), Japan (15.9 million), Switzerland (13.3 million) and Canada (11.9 million). The contributions of these societies accounted for 68% (136/198.7 million US$) of all non-governmental income or 17% of all income[30].

6.6.2.2 Dependency on powerful governments

The main source of income is national governments, accounting for three-quarters of the annual budget (Table 6.2). Similar to non-governmental income to which the US group has been the largest contributor[31], the Government of the US has been the largest governmental contributor to the regular budget. In the 1950s, the US Government provided over 60% of all governmental contributions to the regular budget; this proportion declined gradually and ranged between 15-20% in the 1980s[32]. In 1990, for example, of the contributions from 119 governments or inter-governmental organizations, such as the European Economic Community and the Arab Gulf Fund, the contribution of the US Government accounted for 17% of all governmental contributions to the regular budget (65.4/394.1 million US$), 13% of all governmental income (77/608 million US$, including supplementary or emergency funds) or 9% of total income (77/821 million US$)[33].

Other governments which have made large contributions are also representative of wealthy countries located primarily in North America and Europe, including Canada, Denmark, Finland, Italy, Japan, Netherlands, Norway, Sweden, Switzerland, UK, USSR and West Germany. In 1990, these governments together with the US Government (who accounted for 11% of all governmental donors) provided 94% of all governmental contributions to the regular budget or general resources, 89% of all governmental contributions to supplementary or emergency funds, 92% of all governmental income (general resources and supplementary or emergency funds) or 68% of all income[34].

Only seven of these main donors (from USA, Sweden, Italy, Norway, Finland, USSR and Japan) contributed 20 million US$ or more to the regular budget, accounting for 72% of governmental contributions to the regular budget or 56% of total income for the regular budget. Six of these main donors (from Sweden, Canada, Denmark, Netherlands, Norway and the USA) provided 10 million US$ or more for supplementary or emergency funds, accounting for 73% of governmental contributions to such funds or 55% of total income for these funds. Large donations for supplementary or emergency funds meant that in 1990 the Government of Sweden made the largest governmental contribution overall, some 119.2 million US$ for general resources and supplementary or emergency funds, accounting for 20% of governmental income or 15% of the total income (Appendix VI).

Not surprisingly, the governments of these same countries greatly influence policies and practices through membership on Unicef's Executive Board. The first Executive Board was nominated by the Economic and Social Council of the UN to serve for three years[35]. The indefinite extension of Unicef's mandate in 1953 followed a reorganisation of the Executive Board in 1951. At that time, national governments who were members of the Social Commission of the Economic and Social Council were made ex officio members of Unicef's Executive Board. An additional eight members were nominated with due regard to geographical distribution and major donor and recipient governments[36]. This brought the original, annual membership to 26. In 1990, there were 41 members - 9 each from Africa and Asia, 12 from Western Europe

and other areas, 6 from Latin America, 4 from Eastern Europe and one seat which rotated between the regions.

Unlike UNHCR's Executive Committee which consists of permanent member governments, one-third of Unicef's Executive Board changed each year as member governments completed their three year term of office. Although this is nearly identical to the Executive Board of WHO, the occupation of two-thirds of the membership by a commission of the Economic and Social Council (the body to which both Unicef and WHO are accountable) is unique.

Between 1946 and 1989, 107 governments have been members of Unicef's Executive Board (Figure 6.5). Of these governments, nearly three-quarters come from the poorer regions, such as Africa, Asia, Latin America and the Middle East. However, Figure 6.6 shows that the governments from poorer regions occupied only half of the seats available on Unicef's Board. In other words, they had only half of the votes. Similarly, the distribution of high, upper-middle, lower-middle, low and nonmember economies (Figure 6.7) shows that governments of poorer countries account for nearly three-quarters of all governments represented. Again, however, these governments only held less than half of the seats available (Figure 6.8). In other words, governments of higher income economies or of countries located in North America, Europe or the South Pacific occupied over twice as many seats or had twice as many votes per country as those of poorer economies (Table 6.4).

Figures 6.9 and 6.10 further highlight that not only did wealthier, northern based governments have more votes, but that their representation was more continuous. None of the African governments and less that half of the Asian (46%), Latin American (44%) or Middle Eastern (14%) governments were elected to the Executive Board five times or more. In contrast with infrequent nominations, more than half of the governments of higher income economies were elected five times or more (on average 62%). Furthermore, one-third of these governments were elected more than ten times - accounting for 71% of all governments elected so frequently. The other four

TABLE 6.4

Ratio of seats occupied by national governments on Unicef's Executive Board between 1946-1989 according to their economic status and regional location

ECONOMIC STATUS	NUMBER OF COUNTRIES	NUMBER OF SEATS	AVERAGE SEATS PER COUNTRY
HIGH	21	162	7.7
UPPER-MIDDLE	16	52	3.3
LOWER-MIDDLE	28	112	4.0
LOW	35	92	2.6
NONMEMBER	7	34	4.9
TOTAL	7	34	4.9

REGION	NUMBER OF COUNTRIES	NUMBER OF SEATS	AVERAGE SEATS PER COUNTRY
AFRICA	39	67	1.7
ASIA	14	82	5.9
LATIN AMERICA	18	73	4.1
MIDDLE EAST	7	19	2.7
SUB-TOTAL	78	241	3.1
WESTERN EUROPE	15	115	7.7
EASTERN EUROPE	10	56	5.6
NORTH AMERICA	2	28	14.0
SOUTH PACIFIC	2	12	6.0
SUB-TOTAL	29	211	7.3
SUB-TOTAL	107	452	4.2

Figure 6.5

Regional representation of governments with membership on the Executive Board of Unicef, 1946-1989

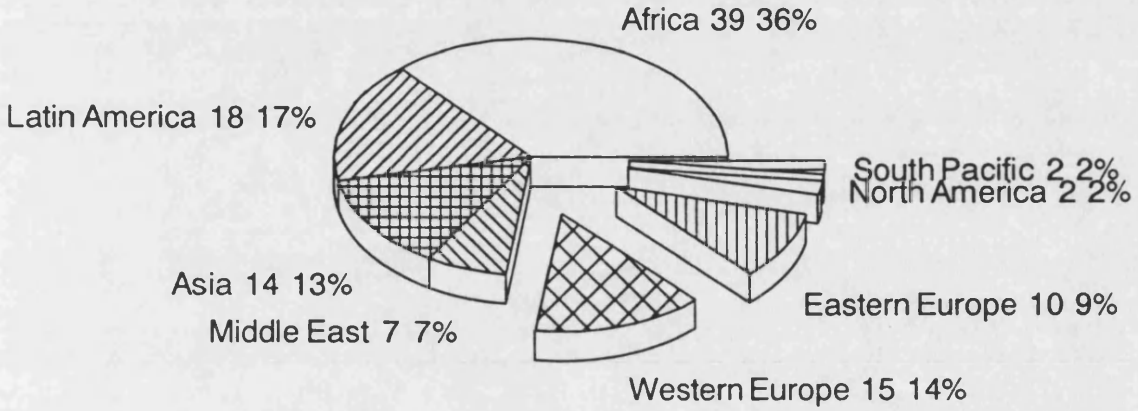


Figure 6.6
Seats occupied on the Executive Board of Unicef by region, 1946-1989, n=452

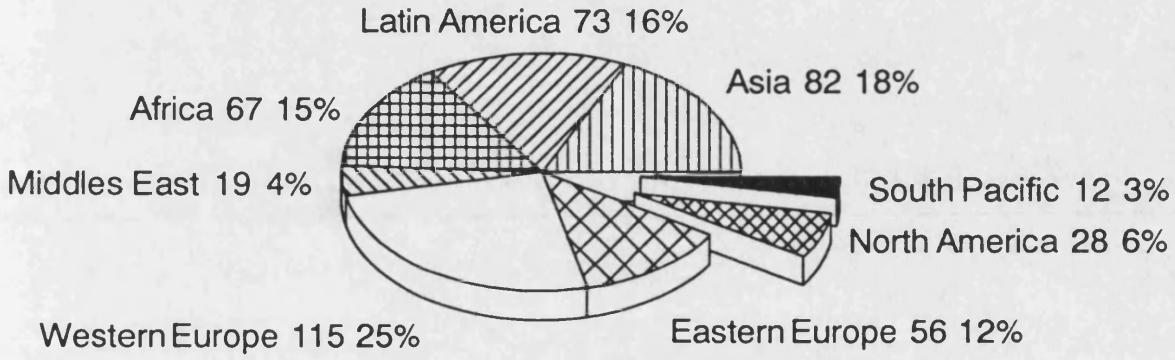
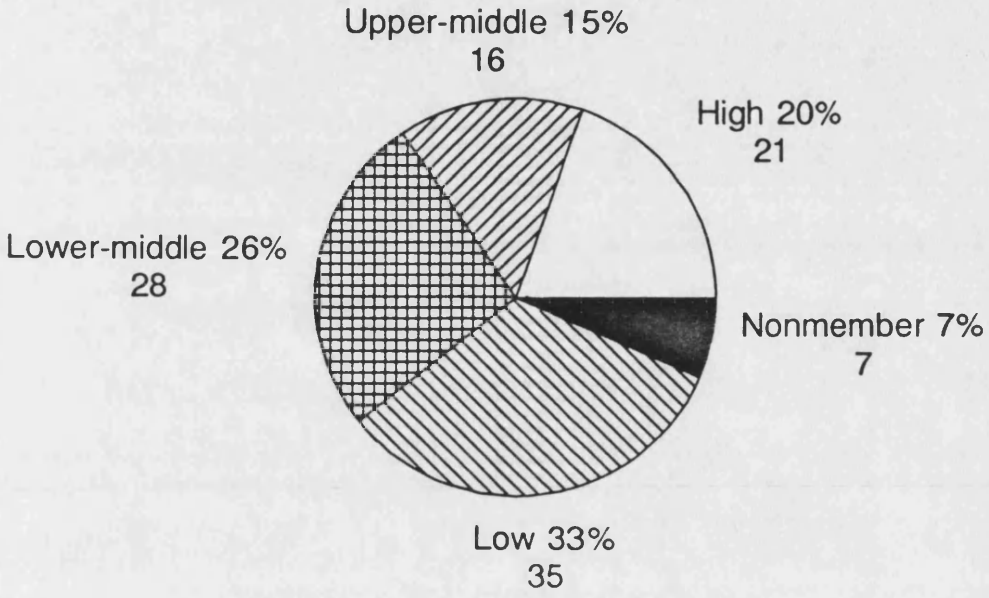


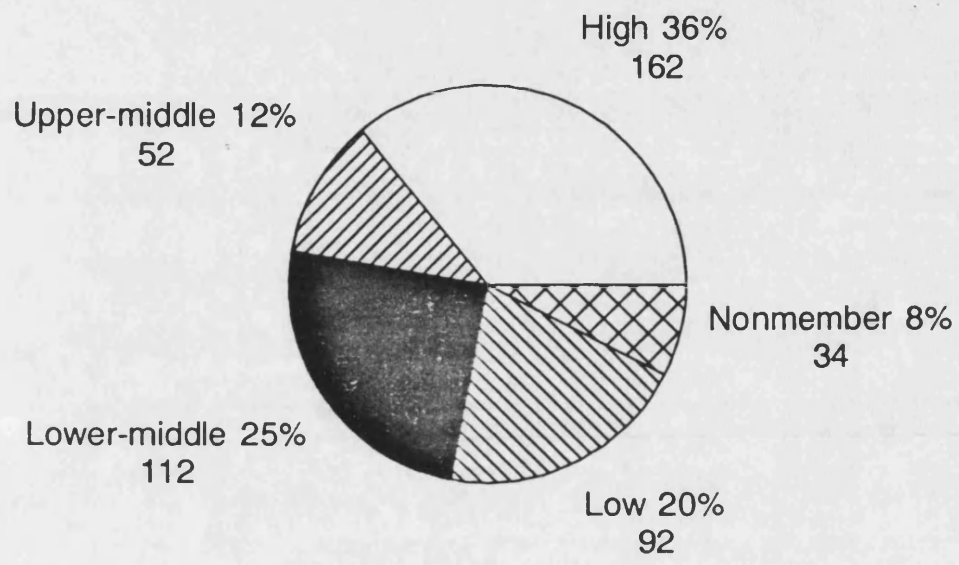
Figure 6.7
Income status* of governments with membership on the Executive Board of Unicef, 1946-1989



*Based on the World Bank Development Report for 1990

Figure 6.8

Seats occupied on the Executive Board of Unicef by income status* of member governments, 1946-1989



*Based on the World Bank Development Report for 1990

Figure 6.9

Representation of lower income economies on Unicef's Executive Board, 1946-1989

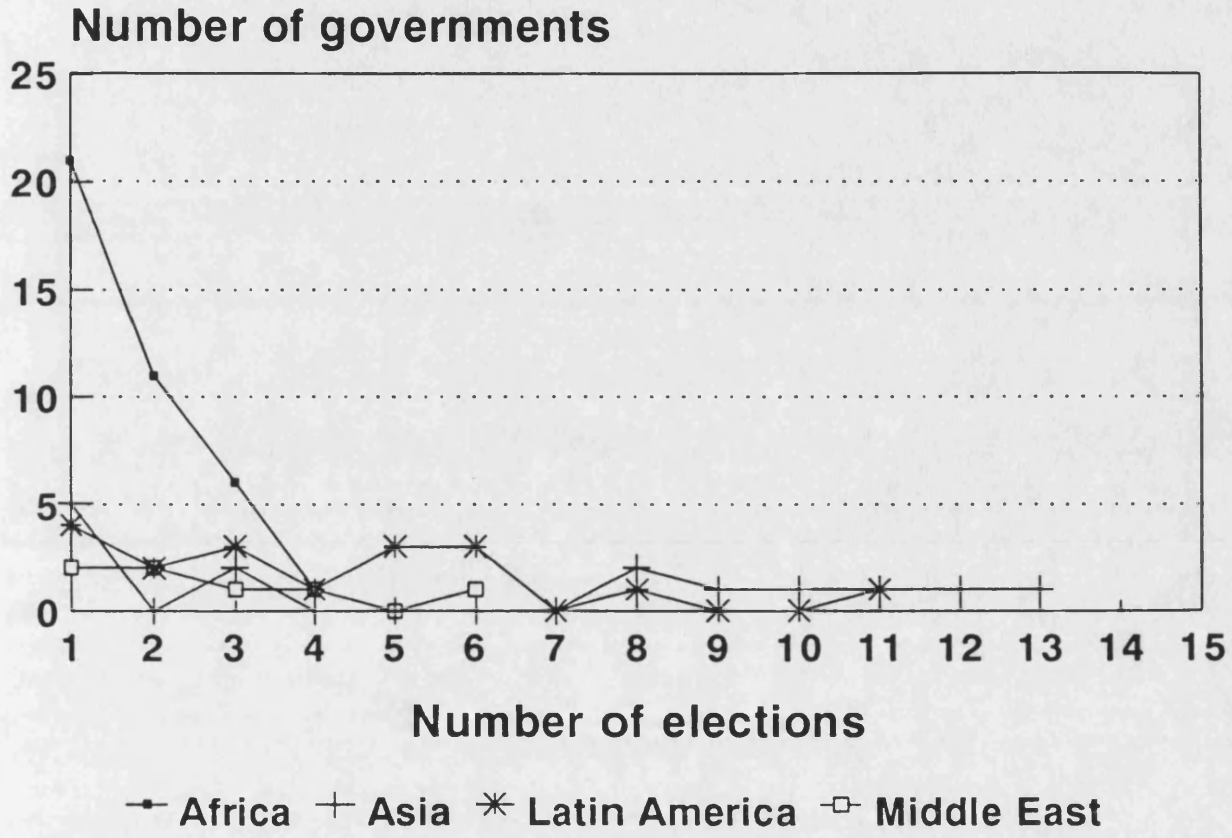
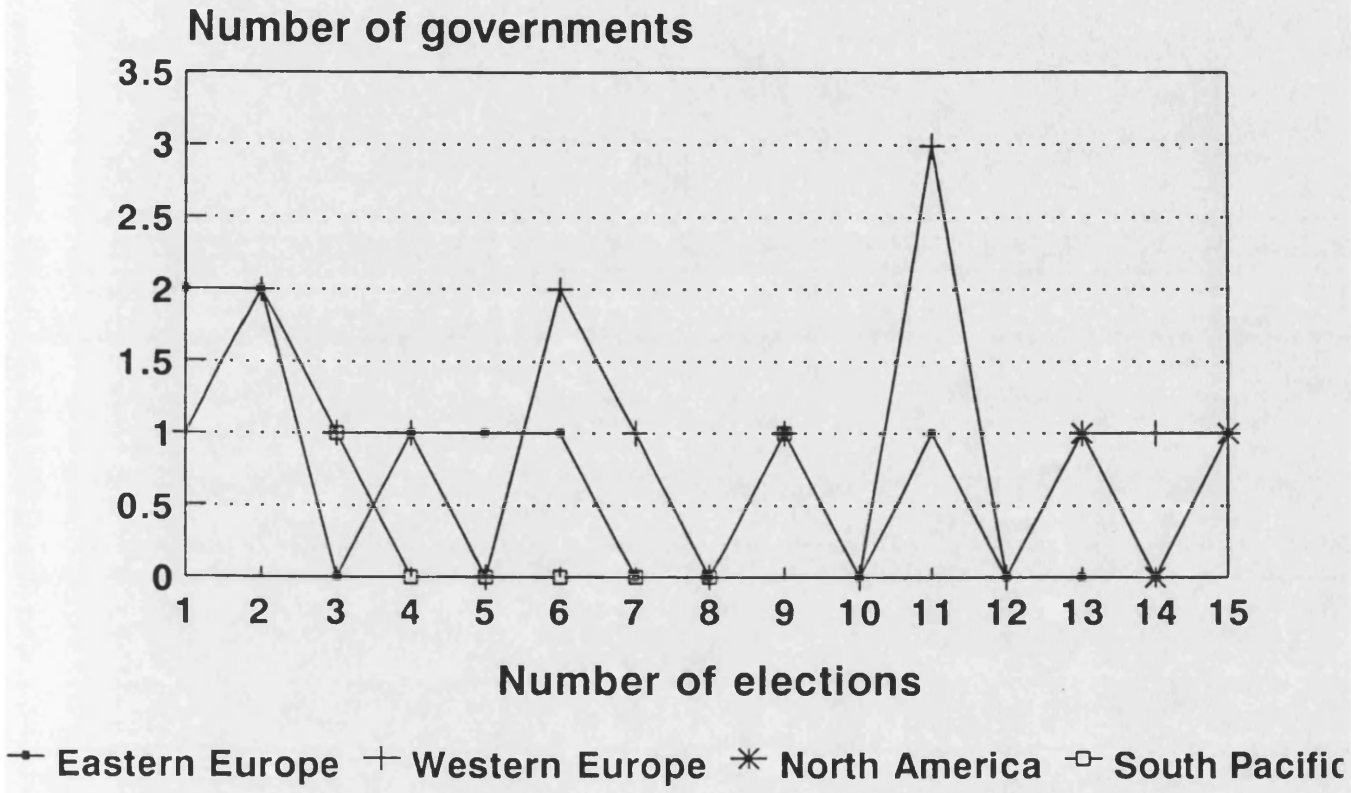


Figure 6.10

Representation of higher income economies on Unicef's Executive Board, 1946-1989



governments to enjoy such continuous representation were Brazil, China, India and Pakistan. Thus, the majority of governments who represented the recipients of Unicef aid (77/107, 72%) were elected five times or less, while a small minority - mainly their generous donors - (12/107, 13%) had a continuous influence on decision-making.

There is little historical evidence that influential donor governments would support an extended role in relief. Moreover, Unicef's recent policy not to take the leading role in relief operations suggests that to carry on as they had done in India, Nigeria, the Sahel and Indochina was an equally unacceptable proposal. Plans to adhere to this policy are clearly stated in the strategy paper of 1991 in which the United Nations Development Programme (UNDP) country representatives or other coordinators appointed by the Secretary-General of the UN are identified as the leaders within the UN system[37]. The strategy paper further states that Unicef prefers that needs assessments and special appeals for resources also be carried out as part of an effort by the UN system more generally. In brief, Unicef no longer appears to be willing to initiate and follow through relief work independent of the UN system.

Similarly, proposed mechanisms for funding relief activities remain the same as they have been throughout the 1980s. There are six different mechanisms for securing funds. Four of these mechanisms draw upon the regular budget or general resources[38]. Firstly, field representatives may divert up to 25 000 US$ in funds and supplies from existing programmes for an emergency. Such a diversion must be agreed to by the government concerned, but it does not require the approval of the head office. Secondly, resources for regular programmes can be reallocated but only when approval has been given by both the government concerned and the head office. In 1990, these two uses of regular programme resources for emergencies accounted for only 3% of all expenditure on emergencies[39]. Most of these emergency projects (11/15, 73%) were valued at less than 100 000 US$.

Thirdly, there is an Emergency Reserve Fund of 4 million US$ annually in the regular budget for meeting 'requirements in relatively minor situations or to meet initial

operations in larger emergencies while additional resources are being sought'[40]. In 1990, 17 projects were funded from this reserve, accounting for 10% of all expenditure on emergencies. Somewhat similar to the emergency projects funded by diverting or reallocating regular resources within a country, most projects funded from the reserve (14/17, 82%) were valued at 500 000 US$ or less. However, unlike the use of country programme funds, the use of reserve funds requires a proposal from the field which must then be approved by both the emergency unit and the concerned geographical section in the head office.

Lastly, the Executive Board may approve the use of other regular resources when other funds are insufficient to meet acute needs or when 'the situation is of major international concern'[41]. But surely these funds would be zealously guarded by the programmes concerned and, again, only relatively small sums of money would be made available. Not surprisingly, no mention is made of such funding of emergency projects in 1990[42].

Obviously, any substantial involvement in relief requires that other resources are solicited in addition to the regular budget. Special Purpose Contributions can be sought by the Executive Director without prior approval from the Executive Board - but only for 'specific emergency assistance projects'[43]. Supplementary Funds, however, must be approved by the Executive Board and are usually generated for on-going relief or rehabilitation programmes. Projects funded by the latter are often listed under regular programmes rather than emergency assistance.

In 1990, Special Purpose Contributions accounted for 86% (30.6/35.7 million US$) of all emergency expenditure[44]. Most contributions (9/14) were for projects valued at one million US$ or more; four such projects were valued at more than 3 million US$. Furthermore, these contributions were also used to replenish any over-spent funds from the Emergency Reserve Funds, totalling 2 226 266 US$ in 1990[45]. Similar to the regular budget of which 74% is provided by national governments, at least three-quarters of all supplementary and emergency funds were contributed by national governments in 1990[46]. In fact, 86% of emergency resources were provided

by governments in 1990[47]. Thus,funds to engage in any meaningful relief work require that special appeals be made, primarily to national governments in Europe and North America.

6.7 Responsibility for refugee health relief: a responsibility of governments collectively or civil societies?

Within the UN system, Unicef appears to be the ideal candidate for managing health relief. Well-established practices of working with only informal or tacit agreements, of making decisions and commitments at the highest levels of authority, of distributing needed resources quickly, and of actively participating in some relief and rehabilitation programmes are unique characteristics so essential to any meaningful relief effort. But such optimism is counter-balanced by similarities with relief undertaken by UNHCR and WHO. Similar to WHO, Unicef routinely provides only relatively small sums of money or other material goods in response to disasters. Only a very few permanent personnel, organizational structures and resources have been created for relief work. Similar to UNHCR, relief work by Unicef is only undertaken for the shortest period of time possible. Substantial participation by Unicef in relief has been limited to crises which affect large numbers of people, which were widely publicised and patronised by the international media and which furthered the interests of the main donors.

Any significant participation in relief was, therefore, exceptional; Unicef was engaged in relief on an ad hoc basis and their work was limited to meeting only immediate needs - largely through the transfer of massive quantities of material goods. Moreover, Unicef's relief policy for the 1990s continues to be one of restraint. In spite of increasingly widespread and acute needs throughout much of the world, or growing fears of financial and political bankruptcy for health relief work by UNHCR and WHO, Unicef appears to plan not to undertake roles and commitments in large-scale relief efforts, at least not outside of responses made by the UN more generally. This is true even though Unicef has several organizational characteristics which enable it to intervene in a timely and effective manner. Unicef shares other organizational characteristics with UNHCR and WHO which limit its ability to do so in practice. In

particular, dependency on powerful national governments for its political and financial resources constrain opportunities to take advantage of fewer bureaucratic procedures, impressive logistical capacity, widespread popular support for a role in relief. Instead, institutional survival requires that roles undertaken enhance the organizations growth and political status within the political and economic environment in which it exists.

Clearly, the complexities of relationships between nation-states as well as those between interest groups within the individual societies which have an interest in inter-state interactions influence greatly the environment in which inter-governmental organizations work. Coupled with the sensitivities inherent in any conflict and associated relief operations, less official conduits of aid for relief may well be preferred by governmental authorities. Have private, charitable organizations built upon the traditional roles of the Red Cross to initiate, organise and provide health relief?

6.8 References

1. Black M (1986) The Children and the Nations. The story of Unicef. Sydney, Australia: P.I.C. Pty Ltd for Unicef, 496 pp.

2. Unicef (1990) Facts and figures. New York, USA: United Nations Children's Fund

3. Unicef (1991) Unicef Annual Report. New York, USA: United Nations Children's Fund, 60 pp.

4. Brockington F (1975) World health. Edinburgh, London and New York: Churchill Livingston, pp. 117-181.

5. Black M (1986), #1

   UN (1953) Yearbook of the United Nations. Lake Success, New York, USA: United Nations, Department of Public Information, pp. 461-468

6. WHO (1986) The second ten years of the World Health Organization. Geneva, Switzerland: World Health Organization, p. 57

7. Brockington F (1975), #4

8. Black M (1986), #1

9. UN (1963) Yearbook of the United Nations. New York, USA: United Nations, Department of Public Information

10. Black M (1986), #1

11. Black M (1986), #1

    UN (1946-85) Yearbook of the United Nations. Lake Success, New York, USA: United Nations, Department of Public Information, see relevant years discussed.

12. UN (1965) Yearbook of the United Nations. Lake Success, New York, USA: United Nations, Department of Public Information, pp. 419-27, 852

13. Black M (1986), #1

14. UN (1966) Yearbook of the United Nations. Lake Success, New York, USA: United Nations, Department of Public Information, pp. 383-92, 1121

    UN (1967) Yearbook of the United Nations. Lake Success, New York, USA: United Nations, Department of Public Information, pp. 460-70, 986

15. Black M (1986), #1

16. UN (1969) Yearbook of the United Nations. Lake Success, New York, USA: United Nations, Department of Public Information, pp. 455-65, 1011

17. Shawcross W (1984) The quality of mercy. Cambodia, holocaust and modern conscience. London, UK: Andre Deutsch Ltd., 433 pp.

ICRC and UNICEF (1981) Kampuchea. Back from the brink. Geneva, Switzerland: The International Committee of the Red Cross, 40 pp.

18. Black M (1986), #1

19. Black M (1986), #1

20. UNICEF (1991) Emergency operations in 1990. New York, USA: United Nations Children's Fund, Report to the Executive Board 1991 session. Document E/ICEF/1991/11, 7 February 1991, 29 pp.

21. UNICEF (1991), #20

22. UNICEF (1991) Unicef action plan for complex emergency situations in Africa 1991. New York, USA: United Nations Children's Fund, Emergency Unit

23. UNICEF (1991) Unicef role in situations involving refugees, returnees and displaced persons. New York, USA: United Nations Children's Fund, Emergency Unit working paper, 1 p.

24. Kent RC (1987) Anatomy of disaster relief. The international network in action. London, UK: Pinter Publishers, 183 pp.

25. Unicef (1991) Unicef at 40. Unicef news. New York, USA: United Nations Children's Fund, 44 pp.

Unicef (1991) Unicef Annual Report 1990. New York, USA: United Nations Children's Fund, 60 pp.

26. Black M (1986), #1

27. Unicef (1991) Unicef Annual Report 1990, #25

28. How is Unicef organised? Why Unicef? Geneva, Switzerland: United Nations Children's Fund, p. 5

29. Black M (1986), #1

UN (1946-85), #11

30. Unicef (1991) Unicef annual report 1990, #25

31. Unicef (1991) Unicef annual report 1990, #25

32. UN (1946-1985), #11

33. Unicef (1991) Unicef annual report 1990, #25

34. Unicef (1991) Unicef annual report 1990, #25

35. UN (1946) Yearbook of the United Nations. New York, USA: United Nations, Department of Public Information

36. UN (1950) Yearbook of the United Nations. New York, USA: United Nations, Department of Public Information

37. Unicef (1991) Emergency operations in 1990, #20

38. Unicef (1991) Emergency operations in 1990, #20

39. Unicef (1991) Emergency operations in 1990, #20

40. Unicef (1991) Emergency operations in 1990, p. 14, #20

41. Unicef (1991) Emergency operations in 1990, p. 14, #20

42. Unicef (1991) Emergency operations in 1990, #20

43. Unicef (1991) Emergency operations in 1990, #20

44. Unicef (1991) Emergency operations in 1990, #20

45. Unicef (1991) Emergency operations in 1990, #20

46. Unicef (1991) Unicef annual report 1990, #25

47. Unicef (1991) Emergency operations in 1990, #20

CHAPTER SEVEN

Beyond altruism: an expanded role for charitable organizations in the provision of foreign aid

7.1 Charities and WWII: responding to military strategies

Similar to many of the wars before, urgent needs for relief during the second World War (WWII) quickly engaged existing charitable organizations and stimulated the creation of new ones. On the eve of the first World War (WWI) 344 European and North American charitable agencies were engaged in some form of activity overseas. But during the first year of WWII alone, 362 new relief agencies registered under the Neutrality Act of 1939[1], and between 1939 and 1941 (the two year period of US neutrality in WWII) 545 charitable agencies based in the US registered with the US Government to undertake relief work abroad[2]. Kent[3] quotes lower figures for the formation of new charities between the beginning of WWII and 1949 - only 192. Regardless of the exact numbers, the two World Wars clearly stimulated the formation of many new charities whose first responsibilities were for relief.

7.1.1 Supporting governmental strategies of war

Unlike previous years when the US Government rarely provided financial subsidies to charitable agencies, during the first few years of WWII nearly 30% of all aid sent abroad by US charities came from the US Government. Nevertheless, these financial contributions were less significant than legal tools in linking the work of these charities with the war objectives of the US Government. Legal regulation of the overseas work of charities became firmly established with the creation of the War Relief Control Board by President Roosevelt in July of 1942[4]. This Board was given responsibility for monitoring the overseas work of all non-profit organizations, for registering them and coordinating their fund-raising efforts, and even for merging or eliminating agencies for greater efficiency[5]. Moreover, in order for the US to be

credited with the work of these agencies, the Board put pressure on agencies to incorporate the word 'American' into their names.

The result of the Board's efforts led to reduced administrative expenditures by these charities - from 10.6% in 1942 to 4.8% in 1944, and to a smaller number of agencies sending aid abroad - from 545 in 1939, to 223 in 1942, to 61 in 1945[6]. This did not, however, mean that the value of aid sent by charities overseas declined. On the contrary, these agencies were sending a total of 1.4 billion US$ abroad annually in 1945 compared with 615 million US$ in 1941[7]. In order to ensure continued support for private foreign aid after the war ended, 19 US charities agreed to form a federation in 1943, the American Council of Voluntary Agencies (ACVAFS). The creation of this federation was initiated largely by the Board so that the charities would continue to work in a coordinated way with the US War Department and the United Nations Relief and Rehabilitation Administration (UNRRA) who would continue to have jurisdiction over them.

7.1.2 Opposing governmental strategies of war

In contrast with charities based in the US whose work was increasingly linked with foreign policies of their government, some new European charities disagreed with the policies of their own governments. The Ecumenical Aid Service (CIMADE) was established in France in 1939 by protestant churches to assist refugees of Nazism. Over the coming years, it protested against the Vichy Government's treatment of captives and it assisted Jews in avoiding deportation to Germany. Similarly, the Oxford Famine Relief Committee (OXFAM) which was set up in England in 1942 opposed the British Government's policy of total war which called for a blockade of countries under Nazi rule, ruling out aid to their civilians. Despite refusal of their petition, the Committee supported the Greek Red Cross in caring for civilians under siege. The efforts of these two agencies are thought by Smith[8] to have set the precedence for European and Canadian charities to be involved in wider domestic political movements which dissent from official policies for the third world.

In an analysis of the roles played by charitable organizations based in the North Atlantic region in the provision of private foreign aid, primarily since the end of WWII, Smith[9] separates those originating in the US from those based in Europe and Canada. In brief, his analysis focuses on differences in the societies within which these organizations were formed. In so doing, he highlights that these agencies are institutions of civil society and he concludes that their work serves largely to maintain the *status quo* of existing power relationships. Thus, his work provides a useful, even essential, perspective of the context within which charitable agencies contribute to the formulation of international health relief policy and its practice. Furthermore, his framework allows the vast literature on charitable organizations to be put into the context of the provision of foreign aid generally. Within such as analysis, charitable aid for refugees can then be better understood[1].

7.2 The 1950s: partners in furthering foreign policies

7.2.1 Cosy companions? Private Voluntary Organizations and the US Government

In order for US charities, commonly known as Private Voluntary Organizations (PVOs) in the US, to continue to provide relief overseas following the end of armed conflict in 1946, President Truman appointed representatives from PVOs and the Government to act as an Advisory Committee on Voluntary Foreign Aid to the Department of State. Agreements were reached through this Advisory Committee which ensured that detailed financial and operational reports of PVO activities overseas would continue to be provided to the Government, now voluntarily. In return, PVOs became eligible to receive governmental monies and goods; the supply of food and other essential commodities and money for transporting them abroad continued

---

[1]. Unless otherwise indicated, the information about the general work of PVOs and NGOs during the 1950s and 1960s is based on: Smith BH (1991) More than altruism. The politics of private foreign aid. Princeton, New Jersey, USA: Princeton University Press, 284 pp.

to be given by the Government to PVOs for relief during the years immediately following the end of WWII.

Interest in continuing and strengthening a cooperative relationship between the PVOs and the US Government were mutual. PVOs wanted an expanded role for themselves in working abroad and they needed government subsidies to do so. The US Congress was keen to improve and maintain a positive, highly visible image of the US in order to generate domestic support for foreign assistance programmes; foreign assistance programmes were thought to further US security interests in checking Soviet expansion - primarily in Europe but also as many colonies achieved independence, as well as economic interests in establishing alliances with these newly independent countries[10]. Furthermore, for the most part PVOs were free to bypass other governments and inter-governmental organizations. This was desirable to those who felt that the policies and practices of the inter-governmental agencies were unduly biased by inputs from the Soviet Union and her allies or by those who viewed recipient governments as corrupt or inept.

This close relationship between PVOs and the US Government was strengthened in the 1950s, firstly by the establishment in 1949 of a programme for technical assistance for economic development in foreign nations which incorporated cooperation between the Government and PVOs[11], and secondly by the creation of the US Technical Cooperation Administration in 1950 which was set up to coordinate longer-term foreign aid to the newly independent nations. Between 1952 and 1956, 917 million US$ were given by the Technical Cooperation Administration to private organizations for technical aid overseas; over one-half of this was granted to non-profit service organizations. Not surprisingly, these grants were for countries considered within US foreign policy to be security priorities and conditions were attached. For example, PVO programmes had to be non-sectarian and free of any proselytising activities. Host governments had to request a PVO's service and the PVO must coordinate their work with other technical aid given through US bilateral programmes. The extent and success of this cooperation can be seen in the creation of the US Peace Corps of the Department of State in 1961, largely on the basis of the work of volunteers in

education, housing, health, sanitation and agriculture which had been coordinated by church-affiliated PVOs since 1953 under the International Voluntary Service.

Pressures on the US Congress to maintain domestic prices of agricultural products led to one of the most important events in the history of PVOs. The passage of the Agricultural Trade, Development and Assistance Act in 1954, most commonly known as Public Law 480, authorised expanded distribution of surplus food overseas. PVOs were then able to expand their food distribution programmes since greater quantities and varieties were available and since domestic and sea transport cost were paid by the Government. By 1956, 610 000 tons of food had been shipped overseas by PVOs compared with only 140 000 three years previously.

7.2.2 Promoting a more humane image of Europe: Non-governmental Organizations and post-colonial European foreign policy

Several new charities were also created in Europe and Canada immediately after WWII. Similar to PVOs who were subsidized by the US Government to provide assistance for the rehabilitation and reconstruction of Europe after WWII, European and Canadian charities, commonly known as Non-governmental Organizations (NGOs), were also subsidized by their governments during the same period, but not on the same scale as in the US. Nor were these subsidies increased over the decade.

Unlike the US Government which had food surpluses and monies for its shipment overseas, European governments lacked resources generally, including food. Moreover, relief for the developing world could be administered through colonial administrations; this was especially desirable since it allowed ruling governments to keep control during the time when movements for independence were growing. Unlike the US Government which created the Technical Cooperation Administration in 1950, many European governments did not create separate agencies for foreign aid to developing countries until the 1960s - when many countries had already achieved their independence and others were close to doing so. Furthermore, the political priorities in Europe differed greatly from those of the US; at home, concerns were not

dominated by fears of communism, and abroad, European nations were looking for ways to maintain their influence in their former colonies rather than in establishing it.

The lack of significant governmental support to NGOs did not mean that they did not continue or attempt to expand their efforts, but rather that they did so with private funding. Even before Europe had recovered economically from WWII, several NGOs had begun to work overseas, especially in areas where colonial links were strong. Fighting in China, India, Israel and Pakistan, for example, engaged British and French NGOs in relief work in the late 1940s. Throughout the 1950s, NGO involvement in overseas relief operations expanded, partly in response to the urgent needs associated with the process surrounding independence and partly as a means of maintaining the links between Europe and their former colonies. The work of the NGOs not only maintained a European presence in these newly independent nations but it helped to create a new and different image of Europe, a more humane one. Thus, as in the US experience, the overseas work of the NGOs was seen by their own governments to be furthering foreign policy objectives.

7.2.3 An enlarged focus on the provision of technical and welfare aid

The processes associated with attaining national independence were often characterised by strong feelings of nationalism. For many charities, this required a shift in focus in order to ensure that they would continue to be relevant and useful in newly created nation-states. This was especially true for those with religious affiliations since many had acted as the educational, social and cultural means through which European policies had been promoted and legitimised during colonial times. Thus, many of the new relief agencies which were set up during and after WWII by the churches, such as Catholic Relief Services (CRS), Catholic World Service (CWS) and Lutheran World Relief (LWR), were organised as service agencies for all needy people irrespective of their religious beliefs. These agencies were not controlled by church boards as the older missionary societies had been and priority activities stressed training for technical skills development, disease control programmes and improved agricultural techniques, for example. In the US, these church-affiliated agencies came

to dominate the field of voluntary foreign aid quickly, and between 1946 and 1953 they administered nearly two-thirds of US Governmental assistance to PVOs.

7.3 The 1960s: An expanded role for charitable agencies in the provision of foreign aid

7.3.1 PVOs and the exportation of the American dream

During the 1960s, the first Development Decade of the UN, the central role of food in aid provided by PVOs was consolidated when foreign policy gave priority to development. Public Law 480 was amended in 1961 to allow PVOs to use surplus food for development and by the end of the decade PVOs had distributed some 20 million tons of food, bringing the total since 1954 to over 30 billion. By the early 1970s, food aid accounted for nearly two-thirds of all contributions from the US Government to PVOs. However, over 90% of food sent abroad was distributed by only two agencies throughout the 1960s and 1970s - Cooperation for American Relief Everywhere (CARE) and Catholic Relief Services (CRS)[12].

Three other developments of equal, yet more subtle, importance also occurred in the 1960s. Mass violations of civil and political rights stimulated the formation of a new group of organizations, in Europe as well as the US, which aimed to promote and protect human rights[13]. Some of these new PVOs/NGOs adopted a global clientele, such as Amnesty International in London, The International Federation of Human Rights in Paris and The International League for Human Rights in New York. National offices or affiliates were often created within individual countries, and several groups of intellectuals, professionals and political activists within their own countries set up their own national agencies. These newly formed human rights organizations had a distinct and well-defined concern - governmental abuses of personal security, discrimination and basic rights to participate in political processes. Their role was one of investigating, monitoring and publicising the nature and number of individual violations.

Over the years, however, this narrow conception of human rights would be challenged, especially by nationals of developing countries who increasingly paid more attention to the structures and systems of power which led to violations - including social, economic and cultural rights. Nevertheless, throughout their history, none of these organizations have engaged in struggles for social, economic and political rights of *groups* of people, including refugees. Nor would this gap be filled by their peers who provided social and economic assistance: these latter agencies frequently avoided any association with 'human rights' since many thought it could hinder their work. Moreover, several of the Human Rights organizations have been denied charitable status in law, for example Amnesty International in Britain[14], presumably because of the overtly political nature of their work.

The Civil Rights Movement and the passage of the Economic Opportunity Act in 1964 also generated concern among prominent US Congressional leaders that various institutions of civil society, such as trade unions, cooperatives and other social or community organizations, be adequately involved in government sponsored programmes. Legislation was then enacted in 1966 and 1967 to assure 'maximum participation in the task of economic development on the part of the people of the developing countries, through the encouragement of democratic, private and local governmental institutions'[15]. This legislation reflected different interests: those who wished to strengthen private organizations and initiatives, those who wished to promote and support local democratic processes (both domestic and abroad) and those who wished to 'promote stable and responsible governmental institutions at the local level'[16].

PVOs were identified as one of the key mechanisms through which these goals could be achieved. Even in countries where US bilateral assistance was limited or did not exist, PVOs 'could become an American sponsored and locally recognized substitute for a US public foreign aid program and could help directly in advancing Title IX goals'[17]. Furthermore, 'the US might ... choose to dissociate itself from a regime by withdrawing or sharply curtailing its presence, including aid, but might seek to maintain NGO activities as a connection with the national Title IX allies who some

day might change the country's direction'[18]. Clearly, the potential for PVOs to promote the foreign policy objectives of the US was recognised by governmental and other influential leaders in US society. Moreover, the emphasis on private initiatives and democratic processes reflected the history and ideology of the US, leading Smith to conclude that they were aiming to export the American dream.

7.3.2 NGOs as advocates for social justice

Although both PVOs and NGOs established close relationships with the United Nations, this was especially prominent with many European NGOs. Often collaboration with the UN acted as a catalyst for generating greater interest and support for their own work among European publics and private institutions. Beginning with the United Nations Appeal for Children in 1948 to support the newly created United Nations International Children's Fund (UNICEF) and continuing with the Food and Agriculture Organization's (FAO) Freedom From Hunger Campaign in the late 1950s and early 1960s to support their programmes for the alleviation of hunger, NGOs made use of these events to educate European publics about the problems facing the developing world. In so doing, they generated support for both the UN agencies and themselves.

In the case of the Appeal for Children, NGOs kept a share of the funds raised. In the case of the Freedom From Hunger Campaign, their rewards were more substantial. In addition to boosting their fund-raising efforts, the focus on hunger quickly shifted attention away from short-term solutions, such as feeding, to longer-term measures for the alleviation of poverty. This emphasis on political causes led to the creation of new NGOs and enlisted new supporters for existing ones. Many of these supporters had been members of Freedom From Hunger Campaign committees and were active in trade unions, political parties, professional associations and church groups. Many NGOs then began to call for more just and equitable policies towards the developing world. In support of these political objectives, several engaged in education campaigns at home, and development became the priority instead of relief. Thus, many NGOs

became part of political movements in their own societies, together with other labour, political, social and religious groups.

Pressures on European governments to provide more aid to developing countries began to mount in the latter half of the 1950s. In 1954, the US Congress passed the Mutual Security Act which requested European governments to increase their programme of assistance to developing countries in order to prevent further advances of communism. In 1960, the creation of the Organization for Economic Cooperation and Development (OECD) by national governments in the Northern Atlantic region incorporated a Development Advisory Group, renamed the Development Assistance Committee (DAC) in 1961, partly in response to demands of the US Government that European nations expand their aid to developing countries. These requests coincided with a period of economic growth in Europe as well as an acceleration in the granting of national independence in much of Africa, Asia and Latin America. Expanding foreign aid programmes to these new nation-states was appealing to European governments who wanted to maintain their economic and political influence and to inter-governmental organizations whose membership was increasingly dominated by these new countries. Subsequently, a resolution was passed by the UN in 1963 which not only called for more aid but specifically endorsed the work of the NGOs, both overseas and at home, and governmental subsidies to NGOs began to increase.

The rapid demise of colonial rule during the 1960s also brought increasing pressure on many churches to expand their assistance programmes to address the socioeconomic needs of members in the developing world. In response to calls from new member churches in Africa, the World Council of Churches proposed in 1958 that all North Atlantic countries send 1 per cent of their individual incomes as aid to the developing world. This resolution was adopted by the General Assembly of the UN three years later. Within the churches, influential committees, such as the Second Vatican Council, individual leaders, such as the Pope, and returning missionaries supported similar movements for more just policies towards the developing world. In response, new NGOs were created with private funds raised during special church

collections exclusively to meet socioeconomic needs, for example in the Netherlands and West Germany.

7.4 PVOs and NGOs in refugee relief: An essential institutional link in the new international health relief system

7.4.1 Caring for European refugees

It is difficult to document the exact numbers, names and histories of charitable organizations involved in refugee relief during WWII since their formation and involvement was often a fluid process. Moreover, analytical historical accounts of their combined work are very limited, excepting the numerous descriptions which focus on developing different categories or classifications of them. Original records which must be available are widely dispersed, addressing the work of individual agencies only.

Lador-Lederer, in a review of international NGOs in 1963, used European refugees as a case-study to show the types of NGOs which were involved and the ways in which they worked with each other and inter-governmental organizations[19]. Even though he only gives a sketchy and poorly documented account, he does list 58 agencies who were members of the Standing Committee of Voluntary Agencies Working for Refugees (SCAWR) or who were interested in international migration (NGOIM). The Standing Committee was formed by NGOs working under the umbrella of the United Nations Relief and Rehabilitation Administration (UNRRA), originally only a dozen or so agencies in 1944. It was given consultative status with the Economic and Social Council of the new UN as well as with the Executive Committees of many specialised agencies of the UN, for example UNHCR. Such status meant that the Committee was able to send representatives to observe meetings of the Council and its committees, to review and comment on the provisional agenda of such meetings, to express views on subjects of concern to both the Council and the agencies and to gain access to documentation of the UN and to meetings and conferences of mutual concern[20].

Lador-Lederer's list of member agencies is reproduced in Table 7.1. It does not represent all NGOs working in relief at that time since many well known agencies are not included, for example Oxfam, national Red Cross societies and Quaker groups. However, his list of agencies does highlight that nearly all these private charitable agencies were based in North America or Western Europe (56/58), many were affiliated with religious groups (26/58) or aimed to help targeted groups of people (such as persecuted ethnic groups, children or women) and several were international in focus or composition (29/58). Moreover, more than half still existed in 1989 and were listed in UNHCR's directory of NGOs (29/58)[21].

Lador-Lederer's list also illustrates the beginnings of a new development in the organization of charitable or private agencies internationally. At least one-third of those agencies on his list were new organizations formed after WWII by groups of agencies. For example[22], the World Council of Churches was formed in 1948 as a cooperation of over 280 Protestant, Anglican and Orthodox Churches. The Lutheran World Federation was founded in 1947 as an association of Lutheran Churches. Caritas International was established in 1950 as a federation of Catholic organizations involved in charitable or social work. These examples of some of the most prominent international charitable agencies in refugee relief work also highlight the religious base of many of the oldest and most well-established agencies. Such large global bodies not only facilitated fund raising, greater representation among governments and inter-governmental organizations and increased international support for the work of member agencies individually, these new organizations provided an institutional structure through which charitable agencies could actively participate in formulating international relief policies and putting these policies into practice. This institutional structure would be more firmly established for charitable agencies as a whole a decade later when members of the Standing Committee, those interested in migration (NGOIM) and other individual agencies joined together in 1961 to form the International Council of Voluntary Agencies (ICVA).

Table 7.1

Charitable organizations working in the field of international migration and refugee relief, 1963[23]

NGOIM: Non-governmental organizations interested in international migration
SCAWR: Standing Committee of Voluntary Agencies Working for Refugees

AGENCY **Name and location**	**NGOIM**	**SCAWR**
1.Agudas Israel World Organization	X	
2.Aide aux Israelites victimes de guerrel, Brussels		X
3.American Federation of International Institutes	X	
4.American Friends Service Committee, Philadelphia	X	X
5.American Fund for Czechoslovak Refugees, New York	X	X
6.American Joint Distribution Committee, New York - Paris	X	X
7.American Polish War Relief, Geneva		X
8.Brethren Service Commission, Geneva	X	X
9.Catholic International Union for Social Service	X	
10.Church World Service	X	
11.Commission of the Churches on International Affairs	X	
12.Common Council for American Unity	X	
13.Consultative Council of Jewish Organization, New York	X	
14.Coordinating Goard of Jewish Organizations, New York	X	
15.Emigratiesticking van de KNBTB	X	
16.Friend's World Committee for Consultation	X	
17.Hebrew Immigrant Aid Society	X	X
18.International Catholic Girls Society	X	

AGENCY Name and location	NGOIM	SCAWR
19.International Catholic Migration Commission, Geneva	X	X
20.International Committee of the Red Cross, Geneva	X	
21.International Confedration of Free Trade Unions	X	
22.International Conference of Catholic Charities, Rome		X
23.International Council of Catholic Charities	X	
24.International Council of Women	X	
25.International Federation of Agricultural Producers	X	
26.International Federation of Christian Trade Unions	X	
27.International Federation of Friends of Young Women	X	
28.International Labour Assistance, Brussels	X	X
29.International Legal Assistance	X	
30.International Relief Committee for Intellectual Workers, Geneva	X	X
31.International Rescue Committee, Geneva	X	X
32.International Social Service, Geneva	X	X
33.International Union for Child Welfare	X	
34.Jewish Agency for Paliestine, Jerusalem-Geneva		X
35.Lutheran World Federation, Geneva	X	X
36.National Catholic Welfare Conference, Geneva - New York	X	X
37.Oeuvre de Protection des Enfants Juifs, Paris		X
38.Pax Romana	X	
39.Refugee Service Committee for Greece, Athens		X
40.Secours Catholique	X	
41.Secours International de Caritas Catholica, Brussels	X	X
42.Service Social c'Aide aux Immigrants, Paris		X

AGENCY Name and location	NGOIM	SCAWR
43.Swiss Aid to Europe, Berne	X	X
44.Swiss Central Office for Aid to Refugees, Zurich		X
45.Tolstoy Foundation, Munich		X
46.Unitarian Service Committee, Massachusetts		X
47.United HIAS Service, Paris-New York: see #17	X	X
48.United Lithuanian Relief Fund of America		X
49.United Service for New Americans, New York	X	
50.United Ukrainian American Relief Committee, Munich		X
51.World Alliance of YMCA/YWCA (World's YMCA/YWCA Service for Refugees)	X	X
52.World Assembly of Youth	X	
53.World Council of Churches, Geneva	X	X
54.World Jewish Congress, Geneva - New York	X	
55.World ORT Union, Geneva	X	X
56.World OSE Union, Paris	X	X
57.World Union of Catholic Women's Organizations	X	
58.World University Service, Geneva	X	X
Total = 58 agencies	**46**	**32**

7.4.2 Locally based agencies in the developing world extend their services to refugees

With the exception of Palestinian refugees in the Middle East who were initially cared for by charitable agencies, for example the American Friend's Society which took full responsibility for refugees in Gaza in 1949 at the request of the UN[24], most charitable agencies which worked with refugees in the 1950s and 1960s did so in Africa where the largest concentration of refugees were living. Instead of ushering in

peace and prosperity, independence from colonial rule was frequently accompanied by the creation of borders which divided ethnic, cultural and social groups, by a shift in power to yet another foreign force or by mass violations of human rights as conflicts between different groups flared up. Together with liberation and separatist movements or newly sparked armed conflicts within nations, Africa housed the largest, growing refugee population in the world. There were an estimated 400 000 in 1964 and nearly 1 million three years later when the Nigerian civil war erupted, displacing 4.5 million civilians in only a years time. Thirty-five of 41 African nation-states hosted refugees by 1968, 11 of which were located in the Sahel. Furthermore, these Sahelian nations frequently hosted refugees from more than one country simultaneously.

Concerns were understandably growing and this focused attention within governments and the UN on Africa[25]. The UN, through the Economic Commission on Africa (UNECA) and the High Commissioner for Refugees (UNHCR), together with the Organization of African Unity (OAU) and the Dag Hammarskjold Foundation in Sweden consequently sponsored the first African conference on the legal, economic and social needs of refugees in 1967. Important outcomes of this conference included the adoption of the OAU Refugee Convention of 1969 and the creation of the OAU Bureau for the Placement and Education of African Refugees to coordinate assistance to African refugees[26].

Charitable agencies, while not participating in the 1967 conference, played a key role in the delivery of care. Most who aided refugees were associated with Christian religions based in Europe or North America. In fact, the church-based agencies were perceived as the only African institutions working to solve the practical problems of refugees[27]. Many were linked to missions and had programmes extending beyond religious schooling to developing primary school education and health services for the communities in which they worked. These agencies were, therefore, often the first to help refugees. Their knowledge of local languages and customs as well as good

relations with many governments and the existence of on-going social programmes in education and health meant that some were ideally suited to expand their services to include refugees or to set up new ones. Others, whose infrastructure and programme of work could not easily accommodate a large number of additional beneficiaries, often provided an entry for larger denominational agencies who could then set up relief and resettlement services specifically for refugees.

In many of the programmes for refugees during the 1950s, 1960s and early 1970s, it was the latter group - the international denominational agencies - which acted as the implementing or 'operational partner' of UNHCR[28]. As such, the Lutheran World Federation (LWF), Catholic Relief Services (CRS), World Council of Churches (WCC), Caritas, YMCA and Quaker organizations took responsibility for the management and implementation of a variety of programmes for refugees in Africa, ranging from running hospitals and first aid stations to clearing land for agricultural settlements. In addition, most provided funds, materials and personnel from their own resources, even for programmes run by governments or other local charitable organizations. The All Africa Conference of Churches (AACC), with support from the World Council of Churches, set up an Ecumenical Programme for Emergency Action in Africa in 1965 to meet the basic and longer-term needs of refugees through existing church and governmental structures[29]. The Lutheran World Federation even created separate national organizations specifically to manage and provide services for refugees in Tanzania and Zambia under an agreement with UNHCR and the governments concerned.

The other charitable agencies most involved in refugee health relief during that period were the Red Cross societies. The League of Red Cross and Red Crescent Societies, which had been founded in 1919 'to encourage and promote the establishment and cooperation of duly authorized charitable national Red Cross organizations having as purposes the improvement of health, the prevention of disease and the mitigation of

suffering throughout the world'[30] had provided extensive assistance and leadership in relief efforts in Europe during and after WWII. It was, therefore, often asked by UNHCR to work in African refugee programmes. For example, in Burundi (1962-63 and 1972), the Central African Republic (1969), Senegal (1965-66), Tanzania (1963-64), Togo (1962), Uganda (1972) and Zaire (1961-64)[31].

African Red Cross societies were also significant providers of care, though usually in collaboration with either the League or another national society from Europe or North America. However, in practice the Red Cross was not the most suitable partner for UNHCR since its mandate was limited to short-term relief and did not include longer term rehabilitation or resettlement. Near the end of the 1960s, therefore, the League and UNHCR agreed that other agencies would be asked to assist in resettlement or rehabilitation schemes for refugees[32]. Thus began the decline of the Red Cross from a leading role in refugee health policy formulation and programme implementation[33] since it was unable or unwilling to adapt to the changed context in which refugee relief was needed and provided. Nevertheless, continuing and growing needs for disaster relief led the League of Red Cross and Red Crescent Societies to establish a Steering Committee for Disasters in 1972, jointly with charitable organizations playing key roles in health relief, including Caritas International, Catholic Relief Services, Lutheran World Federation, Oxfam UK and the World Council of Churches. This Committee provided a forum through which information was exchanged and published and the spirit of cooperation was fostered[34].

7.5 References

1. Bolling LR and Smith C (1982) Private foreign aid. US Philanthropy for relief and development. Boulder, Colorado, USA: Westview Press, 294 pp.

2. Smith BH (1990) More than altruism. The politics of private foreign aid. Princeton, New Jersey, USA: Princeton University Press, 284 pp.

3. Kent RC (1987) Anatomy of disaster relief. The international relief network in action. London, UK: Pinter Publishers, 183 pp.

4. Holborn LW (1975) Refugees: A problem of our time. The work of the United Nations High Commissioner for Refugees, 1951-1972. New Jersey, USA: Scarecrow Press Inc., 2 volumes, 1446 pp.

5. Smith BH (1990), #2

6. Holborn LW (1975), #4

   Smith BH (1990), #2

   MacAlister-Smith P (1985) International humanitarian assistance. Disaster relief actions in international law and organization. Dordrecht, Boston, Lancaster: Martinus Nijhoff Publishers, 197 pp.

7. Smith BH (1990), #2

8. Smith BH (1990), #2

9. Smith BH (1990), #2

10. Bolling LR and Smith C (1982), #1

11. Holborn LW (1975), #4

12. Bolling LR and Smith C (1982), #1

13. Steiner HJ (1991) Diverse partners: Non-governmental Organizations in the human rights movement. The report of a retreat of human rights activists. Cambridge, Massachusetts, USA: Harvard Law School, Human Rights Programme, and Human Rights International, 82 pp.

14. Burnell PJ (1991) Charity, politics and the Third World. London, UK: Harvester Wheatsheaf, 286 pp.

15. Foreign Assistance Act of 1966, Public Law 89-583 (80 stat. 795)ll, part 1, chapter 2, title 9, section 281; cited in Smith BH (1990), p. 59, #2

16. Foreign Assistance Act of 1962, Public Law 87-565 (76 Stat. 225) Part 1, Chapter 6, Section 461; cited in Smith BH (1990), p. 59, #2

17. Hapgood D (ed) (1968) The role of popular participation in development. MIT Report No. 17, Cambridge, Massachusetts, USA: Center for International Studies, Massachusetts Institute of Technology, p. 176, cited in Smith BH (1990), p. 61, #2

    Minear L (1984) Reflections on development policy: A view from the private voluntary sector. In: Gorman RF (ed) Private Voluntary Organizations as agents of development. Boulder, Colorado, USA and London, UK: Westview Press, chapter 2, pp. 13-40

18. Hapgood D (ed) (1968), p. 176, #17

19. Lador-Lederer JJ (1963) International Non-Governmental Organizations and economic entities. AW Sythoff-Leyden, 384 pp.

20. Lador-Lederer JJ (1963), #19

21. UNHCR (1989) Directory of non-governmental organizations. Geneva, Switzerland: Liaison Unit with Non-Governmental Organizations, United Nations High Commissioner for Refugees, 144 pp.

22. MacAlister-Smith P (1985), #6

23. Taken from: Lador-Lederer JJ (1963), pp. 227-230, #19

24. Bolling LR and Smith C (1982), #1

25. Gallagher D (1989) The evolution of the international refugee system. International Migration Review 23(3):579-598

26. Ericksson L-G, Melander G and Nobel P (eds) (1981) An analysing account of the Conference on the African Refugee Problem. Arusha, May 1979. Uppsala, Sweden: Scandinavian Institute of African Studies, 226 pp.

27. Ericksson L-G, Melander G and Nobel P (eds) (1981), #25

28. Holborn LW (1975), #4

29. AACC (1983) Handbook for refugee workers. Nairobi, Kenya: All Africa Conference of Churches, Refugee Service

30. MacAlister-Smith P (1985) p. 18, #6

31. Holborn LW (1975), #4

32. Holborn LW (1975), #4

33. Bolling LR and Smith C (1982), #1

34. LRCS The role of international organizations in disaster relief coordination. Geneva, Switzerland: International Federation of National Red Cross and Red Crescent Socities, 19 pp.

CHAPTER EIGHT

Growth or partnership?
Charitable organizations as 'the most vital component of the whole aid network'[1] in the post-colonial era[1]

8.1 The 1970s: Strengthening and consolidating partnerships with governments and inter-governmental agencies

8.1.1 Private Voluntary Organizations and the 'New Directions' mandate

Although the proportion of Private Voluntary Organization (PVO) income provided by the US Government had risen substantially from 10.5% in 1953 to 20.2% in 1964 and to 27.5% in 1973, in 1972 PVOs received only 1.5% of the budget of the US Agency for International Development (USAID). Concerns for greater popular participation in development programmes were followed in the early 1970s by criticisms of foreign aid policies and practices by many scholars as well as growing opposition to prolonging the involvement of the US in the Vietnam War. Within this political context, Congressional leaders attempted to refocus foreign aid priorities on economic and humanitarian assistance as well as an expanded role for PVOs. In 1973, a 'new directions' mandate was formulated for US development assistance which matched closely the stated realm of PVO expertise.

> 'Private and voluntary organizations and cooperatives ... embodying the American spirit of self-help and assistance to others to improve their lives and income, constitute an important means of mobilizing private American financial and human resources to benefit poor people in developing countries. The Congress declares that it is in the interest of the United States that such organizations and cooperatives expand their overseas development efforts without compromising their private and development nature. The Congress further declares that the financial resources of such organizations and cooperatives should be supplemented by the contribution of public funds for

[1]. Similar to the previous chapter, unless otherwise referenced, the information in this chapter has been taken from: Smith BH (1991) More than altruism. The politics of private foreign aid. Princeton, New Jersey, USA: Princeton University Press, 284 pp.

the purpose of undertaking development activities in accordance with the principles set forth in the [Foreign Assistance Act]'.[2]

Despite the potential for these shifts in policy to be interpreted by some as promoting socialist movements or encouraging poorer people to put pressure for a redistribution of wealth, the aims of this legislation were to generate renewed confidence among US and foreign publics as well as the Governments of recipient countries that US foreign aid emphasized the alleviation of poverty and more equitable economic development. In other words, it was not to be seen as a means for interfering in others' political affairs. In 1974, the Office for Private and Voluntary Cooperation was created within USAID specifically to work with PVOs, and throughout the remaining years of that decade government funding of PVOs expanded, accounting for 38.95% of total PVO income and for 14.3% of the USAID budget in 1982. In 1981, this amounted to more than 700 million US$[3]. Moreover, since 1973 USAID has made funding commitments for up to three years, facilitating more stable financial planning.

Increased governmental funding for PVOs was essential for continued growth within individual agencies as well as in the PVO sector as a whole. Between 1973 and 1983, private contributions to PVOs fell sharply, from 1.6 billion US$ to 1.36 billion US$ - a decline of 19.5% in real value. As a percentage of Gross National Product (GNP), private contributions for foreign assistance fell from 2.01% in 1972 to 1.83% in 1981. Moreover, nearly two-thirds of private donations to PVOs were given to the largest PVOs, leaving smaller agencies to compete for small sums. For many PVOs, the administrative costs associated with intensive fund-raising efforts may well have offset the gains of funds raised privately.

8.1.2 Non-governmental Organizations and the evolution of a Basic Human Needs strategy

At the end of the 1960s, student movements in Europe took up various foreign policy issues, and aid to developing countries became a more central concern in many debates. Unlike similar movements in the US during the 1960s which were somewhat

narrowly focused on discriminative practices and mandatory conscription during the Vietnam War, movements in Europe during the late 1960s and early 1970s were overtly ideological with many left perspectives gaining in popularity. For example, some Catholic and labour groups in France broke with the Catholic Church in order to support fairer trade policies, the suspension of the sale of arms to developing countries and the end of privilege for former colonies and territories. Moreover, centre-left parties held power in several European countries which were sympathetic to Third World causes, for example in Austria, Belgium, Denmark, Great Britain, The Netherlands, Portugal and Sweden. Many centre-right parties also felt that more help should be given to developing countries.

Yet, aid as a percentage of GNP from countries with membership in the Organization for Economic Cooperation and Development (OECD) had been declining, from 0.42% in 1967 to 0.29% in 1973. Widespread poverty and low levels of expenditure on foreign aid prompted a series of initiatives throughout the 1970s which called for profound changes in existing economic and political policies of wealthy nations towards their peers in the developing world. These initiatives had their origins in Europe and all went far beyond the 'New Directions' mandate in the US, emphasising 'equity, equality, sovereignty, interdependence, common interests and cooperation among all'[4]. Nonetheless, economic considerations remained the central concern[5]. Calls for a New International Economic Order (NIEO) by the UN General Assembly in 1974 stimulated extensive discussions by the UN in 1974, the Club of Rome in the same year, the OECD in 1975 and 1977, the International Labour Organization in 1976 and the Brandt Commission in 1978. Many of these discussions, however, failed to end with concrete agreements on a way forward or they failed to be specific and realistic enough to have any impact in practice.

There were, nonetheless, distinct effects on aid practices. Many European governments increased aid to Non-governmental Organizations (NGOs) along with some inter-governmental organizations. The Government of the UK, for example, set up a Disaster Unit within the Overseas Development Ministry (ODM) in 1974 to work with prominent NGOs, especially members of the Disaster Emergency Committee - a joint

effort of some of the main NGOs since 1963 to lobby for greater support[6]. In response to the New International Economic Order, the UN established a Non-governmental Liaison Service (UNNGLS) in Geneva in 1975 to support networking and information services by NGOs as well as their programmes for development education and policy advocacy[7]. The European Economic Community (EEC) created a NGO Liaison Committee in 1976 when they began to co-fund NGO projects. In 1979, co-funding was extended to include domestic educational activities about development issues and the provision of food and emergency aid[8]; by 1983 the EEC provided 13 million Ecu for emergency aid and 24 million Ecu for development, excluding food aid which had a separate budget of 52 million Ecu. Overall, public aid which was channelled through NGOs increased dramatically, 425% in constant value, from 160 million US$ in 1973 to 680 million US$ in 1983. The percentage of NGO income from governments rose from 16% to 36% during the same period.

8.1.2.1 Targeting basic needs

This interest in supporting NGOs was an outcome of at least five developments. Firstly, the 1977 policy paper of the OECD, Development Cooperation for Economic Growth and Basic Human Needs, gave priority to programmes which met basic survival needs of the poor in developing countries. Like PVOs who were thought to be best placed to carry out the 'New Directions' mandate, NGOs were thought to be better suited to meet Basic Human Needs (BHN) because of their ability to engage in technical and welfare programmes at local levels and because widespread beliefs held that they carried them out more efficiently (not necessarily democratically)[9] than inter-governmental or bilateral agencies.

8.1.2.2 Generating popular support

Secondly, governmental grants were thought to encourage NGOs to continue and expand their fund-raising efforts among private individuals and institutions. Privately donated aid was seen as a means for increasing the total amount[10], but more importantly the impact, of foreign aid without additional cost to governments. In 1981

European NGOs sent over 600 million US$ abroad from their own resources; private donations accounted for more than 90% of the total income of 42% of NGOs surveyed in 1982 while contributions from national governments provided less than 10% of the total income of 72% of agencies surveyed[11].

8.1.2.3 Achieving goals for national expenditures on aid

Thirdly, this also helped governments in achieving higher percentages of expenditure on aid - set at 0.7% of GNP in 1971. Aid as a percentage of GNP which was sent through NGOs in 11 European countries rose from a low of 0.034 (in the UK) in 1973 to 0.25% (in Switzerland) in 1982; total aid to developing countries by NGOs in five European countries (Belgium, Finland, Netherlands, Norway and Sweden) accounted for more than 10% of official development assistance during the same year[12].

8.1.2.4 Extending national influence abroad

Fourthly, by the end of the 1970s, NGOs were working in over one hundred countries; to match such widespread influence independently, governments would have had to set up many new missions and offices overseas - a costly undertaking. Lastly, NGOs themselves were lobbying for governmental subsidies since the economic crises associated with dramatic rises in the price of oil in 1973 and again in 1978 had reduced the rate of growth in private donations.

8.2 The 1980s: the decade of Private Voluntary Organizations and Non-Governmental Organizations[13]

8.2.1 The apolitical face of PVOs: Focusing on disaster relief and health care

The evolution of PVOs in US society has been characterised since the second World War (WWII) by increasingly close cooperation with and support from the US Government. The links between PVOs and their Government, however, go beyond financial dependency. During the 1980s, many of the characteristics of US society

which had contributed to an expanded role for PVOs in foreign aid programmes led to the emergence of disaster relief and health care as favoured overseas activities for PVOs.

8.2.1.1 Avoiding political associations

While the US Government was preoccupied with using food surpluses to expand the market for domestic agricultural products and with supporting programmes in countries where alliances were thought to further security and economic interests, the US public was in favour of aid which was more technical in nature and which relieved suffering immediately[14]. Surveys in the 1970s and 1980s found that US citizens were ignorant about development issues and that, unlike their European counterparts, few PVOs had initiated campaigns to educate their own public before the mid-1980s. Widespread ignorance and disinterest in a society without any significant following for more left political perspectives meant that many PVOs avoided associating themselves with political activities and causes. Those which were engaged in programmes with political overtones down played this work in their public image. Thus, PVOs failed to attract individuals actively working for change in political policies and practices; nor did they establish links with politically active organizations.

Instead, many tailored their aid programmes, or at least their presentation to the public, to emphasise disaster relief and health care activities, which were favoured by over 70% and 60% respectively of US citizens in surveys carried out in 1972 and 1986. Educational efforts by PVOs among their own public in general did not incorporate political analyses or explanations; rather, they drew upon more emotional or sentimental responses to urgent needs, such as images of stark starvation[15]. The provision of governmental funds since 1981 for education of the US public in development issues reinforced these tendencies by prohibiting the presentation of politically partisan views.

8.2.1.2 Fostering governmental support

Like their efforts to influence public perceptions, efforts by PVOs to influence governmental policies have been somewhat narrow in scope. Despite attempts by the American Council of Voluntary Agencies (ACVAFS) and Private Agencies in International Development (PAID - a federation of many of the new and smaller agencies) in 1983 to advocate (unsuccessfully) for a separation of economic and military assistance[16], collective efforts of the American Council for Voluntary International Action (INTERACTION - formed in 1984 by the merger of the American Council of Voluntary Agencies (ACVAFS) and Private Agencies in International Development (PAID)) or attempts by individual agencies to influence governmental policies have been limited in scope. Priority has often been given, for example, to lobbying for increased governmental subsidies for PVOs or greater flexibility in governmental regulation of PVO activities[17]. Concern for their own institutional preservation and growth appears to have been paramount.

8.2.1.3 Documenting their successes and comparative advantages

Substantial governmental funding of PVOs in the 1980s has had at least three additional benefits for PVOs which have further consolidated and expanded their roles in foreign aid programmes. Firstly, governmental requirements for evaluation of existing projects and the provision of resources needed to carry them out have enabled PVOs to document empirically their achievements. Despite controversy about the quality or scope of review of evaluations undertaken[18], evidence has been gathered that not only are some of their programmes technically sound but that PVOs have comparative advantages over governmental and inter-governmental organizations. Even the identification of weaknesses has benefited PVOs, by highlighting faults in project designs and institutional needs for better project management, for example. The correction of such weaknesses promises greater success, generating more support for both solving existing problems and continuing modified programmes.

8.2.1.4 Scaling up

Secondly, scaling up governmental funding has allowed PVOs to develop their professional capabilities and to undertake larger and more complex programmes. This has been accompanied by management by professionals and by involvement in more diverse activities. In creating a new social role for professionals, Cumper[19] concluded that it was possible because of the expanding resources and spheres of influence. In turn, leadership by professionals reoriented charitable agencies towards further expansion, but at the expense of traditional administrators. Current conflicts between administrative and professional staff in most charities may well indicate an on-going struggle for power within the agencies, rather than a clear decision in favour of one or the other.

Thirdly, greater professional characteristics and access to vast resources has enabled some PVOs to work with recipient governmental agencies, for example ministries of health. Without large sums of money and technical expertise, collaboration with PVOs in the delivery of national social services would not be taken seriously by receiving governments or by aid agencies of donor governments.

8.2.1.5 Working within governmental restrictions

Disadvantages are obvious. At times, certain countries have been excluded, such as Cuba, Nicaragua, North Korea and Vietnam. Other countries in less need have instead been targeted, for example Israel and Egypt received over one-half of USAID's total assistance budget in 1980[20]. The types of projects have similarly been limited, for example the reliance on food aid in order to create markets for US grain and dairy products precluded some projects to promote local agricultural growth. Relationships with local and national colleagues were often strained as a result. Some PVOs have refused governmental funds in principal, such as OXFAM America, the American Friends Service Committee and World Neighbours[21], or for selected countries or projects. Others have made their concerns known to government officials. Yet, they do so with a government which has not hesitated in the past to impose legal or

financial restrictions to ensure that PVO activities are compatible with foreign policy objectives. Congressional legislation has been used to prevent shipment of seeds and tools to Nicaragua, for example, and official approval of other PVO aid to 'blacklisted' countries has been excessively delayed[22]. Many other PVOs have slowly, but surely, assimilated the views and policies put forward by their Government.

8.2.2 Advocates for development: NGOs as important players in domestic politics

In contrast with US PVOs which placed disaster relief and technical aid foremost on their institutional agendas, NGOs in Europe and Canada continued to give developmental needs highest priority throughout the 1980s. In so doing, they continued to espouse more overtly political objectives than their US counterparts. One effect was an increasing emphasis on programmes rather than individual projects as well as the need to advocate for more just policies, both nationally and internationally[23]. One of the key strategies adopted by NGOs was to educate their own publics about the structural injustices in the global political economy which underlie poverty. Unlike PVOs which did not substantially engage in domestic educational campaigns before the mid-1980s, most NGOs had made significant efforts to do so in the late 1970s and early 1980s. Later in the 1980s, for example, British NGOs took up the need to resolve conflicts in Central America as well as the need to reschedule or write off mounting foreign debts in many developing countries[24].

Their efforts built upon a long history of colonial associations with the developing world[25]. These efforts were made in a political context which highlighted the links between conditions in developing countries and the policies and practices of industrialised nations: for example, fluctuating terms of trade, widespread civil and international armed conflict, growing populations, extensive movements of large groups of people and mounting stresses within an international financial system plagued with a debt crisis[26]. To Cumper's list, the varied components of macro-economic structural adjustment programmes need to be added, especially growing

support for privately organised and managed initiatives[27]. Understandably, by the mid-1980s, surveys found that most Europeans (60%-80%) attributed poverty to global injustices which sanctioned the exploitation of people living in the developing world by industrial countries or wealthy elites within their own societies.

The focus on development was not only supported by well-educated and professional segments of European publics[28] but also by other private organizations who had links with political groups or who were themselves advocating political change. Many of the latter were officially represented on governing boards, influencing the direction taken by NGOs. The adoption of more politically determined strategies was also influenced greatly by the political orientation of staff members. Unlike staff of PVOs who had previously held positions in business or other PVOs, or who had worked for the US Government, executives of NGOs rarely came from backgrounds in government or business. Instead, many had significant academic experience and they maintained close links with institutions specialising in development issues. Others had been active in political movements - especially those with leftist perspectives. Those who worked for church-based NGOs frequently had served as missionaries in developing countries. In general, previous experience which gave greater attention to the politics of development engendered more critical attitudes and awareness among NGO executives and staff. Thus, many NGOs are characterised by their political convictions about development policies and their ability to sway segments of public opinion in support of their views.

8.2.2.1 Generating substantial funds privately

The popular appeal of NGOs grew and along with it financial contributions from a variety of sources. For example, donations from private sources which were used overseas by NGOs in countries with membership on the Development Assistance Committee (DAC) totalled over 4 billion US$ in 1986[29], an increase of 100% from figures quoted by Burnell[30] for 1980. Yet, these private grants comprised a mere 5 - 15% of official development assistance from DAC countries[31] and over half came from the US[32]. Unlike van Heemst's[33] findings in 1982 in which private donations

constituted a very large proportion of NGOs income, Burnell quotes a much lower figure of just over one-half for the top 400 charities in Britain in 1991. Nonetheless, 256 million US$ in the UK alone was a significant sum in 1989, especially when compared with 34 million US$ in 1970 and 120 million US$ in 1980[34].

8.2.2.2 Collaboration with inter-governmental agencies

Inter-governmental organizations also set up or expanded closer cooperation with NGOs. In 1979, for example, the DAC of OECD met with the International Council of Voluntary Agencies (ICVA) in the first of a series of meetings which eventually led to permanent arrangements for consultation between NGOs and their governments in some member countries. The World Bank set up a liaison committee in 1982 and has since employed NGOs as advisors or subcontractors on some of its projects[35]. Specific guidelines for collaborating with NGOs were later written by the Bank in 1988. Similarly, NGOs have been recognised as 'an integral part of [European] Community policy in the field of development cooperation'[36], and by the late 1980s, nearly 10% of the European Commission's funds for development cooperation were spent through NGOs. By 1987, 2500 development projects in over 100 countries were implemented by more than 300 NGOs which were co-funded by the European Commission[37].

8.2.2.3 Expanded governmental support

Concurrent with continued growth in private and inter-governmental support, European and Canadian Governments increased their grants to NGOs. Some did so substantially, such as the Governments of Belgium, the Netherlands and West Germany who gave their NGOs 6% of official development assistance in 1985; others were less generous, such as the Governments of France and the UK who gave less than 2% of their official development assistance to NGOs in the same year[38]. Like USAID, many approved grants for several years and some provided block grants which could be used at the discretion of the NGO. Similar to PVOs, governmental funding led to improved evaluation of NGO projects, highlighting lower costs associated with NGO

programmes, some success in reaching the poorest, the value of raising awareness among local participants, and improvements in health services, water supplies and subsistence food production.

NGOs continued to be seen by their governments as alternate channels of influence abroad[39]. In countries governed by repressive regimes, aid sent through NGOs was viewed as a symbolic gesture of support to the people. Somewhat similarly, NGOs were a vehicle through which support could be given to liberation movements without challenging official policies. In some regions, such as Central America, aiding NGOs helped to create an image of Europe which was independent of US objectives[40] - again without challenging official policies.

In cases where official development policies may have detrimental effects on minorities, an NGO's presence and their provision for basic needs may be seen on the one hand to counter-balance unwanted consequences, for example, macro-economic structural adjustment policies and large scale commercial development of environmental resources. On the other hand, they may also be the means through which official policies of foreign entities may be influenced, including those of governments. Similar to their US peers, NGOs have increasingly been viewed as a means to promote private initiatives - not only abroad but at home in a climate of conservative policies stressing private mechanisms, even for aid[41]. Ideologically, NGOs are thought to be tangible evidence of the merits of liberal societies and democratic polities[42]. NGOs also provide additional eyes and ears, gathering information about local events and perceptions which may not be readily accessible otherwise. The private and autonomous status of NGOs in law served as a buffer for European governments.

At home, the political character of NGOs and their appeal to significant segments of European and Canadian societies has meant that they have played an equally important role in domestic politics[43]. Governmental co-funding of NGOs has allowed parties in power to meet popular and opposing party demands that aid be given to the poor in developing countries. Enthusiasm within official circles for the Joint Funding

Scheme in Britain was so great that the budget quadrupled between 1981-82 and 1989-90, and 70% of it was given in the form of block grants to selected NGOs by 1987[44]. Thus, in Britain, the Government met demands for aid at very low cost - only 0.27% of official development aid in 1983; during the 1980s, the UK Government's aid fell both in real terms and as a percentage of GNP, from 0.44% in 1977 to 0.31% in 1989. Moreover, the increasing use of government-assisted volunteers enabled the Overseas Development Administration of the UK to reduce the number of publicly financed technical cooperation personnel, from over 17 000 in 1970 to just over 3000 in 1988[45].

Governmental support for NGO projects in particular countries, for example those excluded from bilateral assistance or those known to abuse human rights, may be used to appease those who oppose official policies of isolation or preferential treatment of selected regimes. Others claim that supporting NGOs is a way in which governments have avoided giving greater priority to the needs of developing countries and the commitments it would then entail. Despite a substantial following, supporters of overseas aid are a minority in many countries and NGOs are one way in which their demands have been satisfied[46].

8.2.2.4 Responding to governmental incentives and punitive measures

But like the US Government which has used legal and financial restrictions to control PVO activities abroad, European governments have also used incentives and punitive measures to direct the overseas work of NGOs. For example, the Overseas Development Administration (ODA) of the UK Government has kept close watch on certain projects and has delayed approving others, especially in Nicaragua, Korea and Vietnam. Governmental grants have been diverted from troublesome NGOs to those with more compatible views, for example diminished grants to Oxfam in Belgium and the UK for their work among Palestinians or their attempts to inform and mobilised the British public respectively. Governmental grants have also been limited to certain types of projects or to certain countries. For example, only 22% of grants to NGOs from the Belgian Government between 1976 and 1981 were for projects to mobilise

and raise awareness among local people[47]; the UK Government prefers to fund projects in countries which are members of the Commonwealth and has, at times, denied funding for work in Afghanistan, Cambodia, Ethiopia, Guatemala and Vietnam[48].

Tax exemptions are confined in Britain and Canada, for example, to only those agencies which do not engage in politically partisan activities[49] and they can be withdrawn at any time. Governmental funding of a project or NGO can also be withdrawn or refused. Lastly, the option to fund directly local development organizations in developing countries has been experimented with by US Foundations, governmental aid agencies and the World Bank, for example[50]; this poses the possibilities of a new set of relationships which may render many roles of NGOs superfluous, especially since such local organizations have proliferated in recent years more rapidly and extensively than their counterparts in Northern Atlantic countries[51].

However, these mechanisms have been used most often in more subtle ways since there is little evidence that the work of NGOs is significantly affecting opinions in societies at home or abroad. The lack of widespread popular criticism of foreign policies has meant that NGOs have only influenced change in less prominent issues or at the margins of fundamental policies. Moreover, the political orientation of many NGOs has been countered in recent years by the emergence of new NGOs with opposing points of view. For example, the creation of Medecins Sans Frontieres (MSF) in France provided the means to denounce left-wing criticisms which were articulated by older, leftist NGOs - by a peer rather than by the Government who was the target of much of the critique. Thus, French NGOs have become obvious and significant players in various domestic political battles. Not only did this allow officials to distance themselves from some sensitive issues, but it divided the NGO community, weakening its ability to lobby government and other powerful institutions effectively.

8.3 The new and pivotal role of relief for institutional growth: making the most of the sensational

8.3.1 Refugees and displaced persons: a uniquely political disaster

Similar to previous decades, Africa continued to host the largest concentration of refugees and displaced persons throughout the 1970s. By 1981, one of every two refugees in the world were African and more than five million of them were living in Africa[52]. During the 1970s forced migrations took place on an unprecedented scale, beginning with the tragedies surrounding the civil war between the Federal Government of Nigeria and the Regional Government of Biafra and continuing with the fight for an end to white rule in southern African nations and the severe famine in the Sahelian countries between 1972 and 1975.

The Nigerian civil war, Bangladesh's cyclone and war of independence and the famine in the Sahel invoked the largest relief operations since WWII. They illustrated the highly political nature of forced migrations and any attempt to aid those affected by them. Partly because of their highly charged character and partly because newly developed technologies enabled them to be publicised instantaneously around the world, attempts to provide relief were dominated by the political interests of those involved, challenging previous practices of giving responsibilities for relief to official bodies - especially those affiliated with governments[53]. This not only created the possibilities for charitable organizations to expand their roles in relief, it actively encouraged them to do so. This was true partly because of their non-governmental image and partly because no single agency had been able to provide relief in a timely and equitable way, especially to both sides of warring factions. As a result, refugee relief would become a pivotal activity for the growth and well-being of the charitable sector during the 1970s but especially during the 1980s.

8.3.2 Beyond the frontline: Charities as partners in official policy making processes for refugee relief

Unlike the first African conference on refugee affairs in 1967 which was an undertaken by governmental and inter-governmental bodies, the second conference was proposed, prepared and attended by charitable agencies working with African refugees. It was the All Africa Conference of Churches (AACC) which called for a Consultation on the Rights and Problems of Refugees in Independent Africa in 1977 and which formed a planning committee for it together with the International University Exchange Fund, the Lutheran World Federation, the World Council of Churches and the Scandinavian Institute of African Studies.

Recognising the need for governmental support and subsequent action, the Organization of African Unity (OAU), the United Nations High Commissioner for Refugees (UNHCR) and the United Nations Economic Commission for Africa (UNECA) were then invited to sponsor the Pan-African Arusha Conference on the African Refugee Problem. The Tanzanian Government subsequently hosted this conference in 1979, when estimates for the previous year (1978) placed the current refugee population in Africa above 4 million and when UNHCR alone had spent 54 million US$ to assist more than 23 African nations to care for them. Of the 37 charitable agencies which attended this conference, only four were genuinely African and, like nearly half of the other agencies participating, they were affiliated with Christian churches. Some organizations were primarily funding agencies and others had more narrowly defined interests in refugee relief, such as the Ford Foundation, the Danish and Norwegian Refugee Councils and Amnesty International[54]. Irrespective of the particular interests of individual agencies, their collective efforts to organise and participate in the conference laid the foundations for a new role in the policy making arena of refugee relief.

8.3.3 Justifying refugee relief on the basis of need

Growing concerns about the numbers and plight of refugees were, unfortunately, well founded. The advent of the 1980s was marked by the creation of millions of new refugees in each continent of the developing world. Vivid images of people on the verge of death or forced into exile began in 1979 with the horrors of famine, torture and systematic oppression in Cambodia and continued in 1980 and 1981 with the escalation of armed conflict between the Soviet-allied Government and US-backed rebels in Afghanistan, the defeat of the US-supported Somali forces attempting to reclaim the Ogaden from the Soviet-backed Government of Ethiopia, and the devastation from scorched earth policies, widespread torture and violence by the US-backed regime in Guatemala against rebel groups and Indian communities in rural areas. These four crises generated the largest officially recognised refugee populations in their respective continents of Africa, Latin America, South Asia and Southeast Asia in the 1980s.

Needs were desperate and acute, and global publicity evoked responses from all. During a visit to the Philippines in 1981, Pope John Paul II said that 'of all the human tragedies of our day, perhaps the greatest is that of refugees'[55]. Unlike those displaced during struggles for colonial independence in the 1950s and 1960s, the numbers of people who were displaced forcibly and the period of time they required care and assistance rose at a staggering pace. By 1981, estimates placed the global refugee population at over 8 million and the number of additional people displaced over 4.5 million[56]. The nature of the wars, armed conflicts and violations of human rights from which many of the officially recognised refugees in particular had fled, together with the interests of others in exploiting their exile for political purposes[57], meant that it was unlikely that they would be able to return to their homes in the foreseeable future. Increasingly lengthy periods of asylum were compounded by the large numbers of people fleeing as a group[58]. Hundreds of thousands, even millions, of an ethnic, political or religious group of people seeking refuge together was increasingly widespread.

8.3.4 Aiding refugees confers international recognition

Similar to the Nigerian civil war and the famine in the Sahel in the 1970s, the highly political nature of these refugee crises in early 1980 was again evident. Sir Robert Jackson, for example, said of relief efforts in Cambodia, 'no humanitarian operation in this century has been so totally and continuously influenced by political factors'[59]. In fact, Coles[60] observed that the Indochinese conflict made refugees an 'in' cause among wealthy nations for the first time since the cold war. In support of this analysis she noted that the second granting of the Nobel Peace Prize to UNHCR came in 1981; the first such award was granted in 1954. Not surprisingly, the charities were quickly and prominently engaged in these relief operations.

No doubt the efforts of the charitable agencies in the relief operations in the late 1970s and early 1980s in particular influenced their role in the first International Conference on Assistance to Refugees in Africa (ICARA I). Held by the United Nations and the OAU in Geneva in 1981 in response to concerns about the African refugee problem raised by the General Assembly of the UN, this conference provided a forum through which charitable agencies were acknowledged and accepted by official institutions as legitimate and equal participants in not only international relief operations but also development programmes more generally. According to Michael Harris , a former director of Oxfam UK's Overseas Department, the first International Conference on Assistance to Refugees in Africa (ICARA I) 'was a major breakthrough in the recognition of NGOs.'[61]

The important roles played by charitable agencies in caring for refugees was acknowledged most readily by recipient governments. In 1981, for example, the Organization of African Unity (OAU) Council of Ministers requested 'a meeting of all the charitable agencies having refugee programmes in Africa in order to develop a coordinated strategy and map out further action'[62]. This meeting was again organised by many of the same organizations; the OAU, UNHCR and UNECA represented African Governments and the UN while Caritas International, Catholic Relief Services, the International Council of Voluntary Agencies, Lutheran World

Federation and World Council of Churches/All African Conference of Churches represented the charitable sector.

The numbers of agencies which took part in this meeting was larger and their particular roles in refugee relief were more varied than before. This was partly because needs were so great and partly in preparation for the second International Conference on Assistance for Refugees in Africa (ICARA II) which was being planned for the following year. There were 68 charitable agencies which attended this meeting along with six agencies of the UN and several branches of the OAU. Of these 68 agencies, only half were explicitly affiliated with churches. Like before, others were funding agencies or had a particular concern, including a growing interest by academics. At least 8 participants represented research or consulting institutions. In contrast, there were only two governments represented, Canada and the US, although the Commonwealth Secretariat also participated.

8.3.5 Working for, with or instead of agencies of the UN?

Like African Governments, specialised agencies of the UN also sought to strengthen their links with charitable agencies. In 1983, the United Nations Relief and Works Agency for Palestinian Refugees in the Near East (UNRWA) hosted its first annual consultation with charitable agencies. In the second such consultation in 1984, 30 agencies participated, representing organizations affiliated with churches, universities, unions, refugee councils and international movements for migration, development and relief. The United Nations Relief and Works Agency for Palestinian Refugees in the Near East (UNRWA) stated reasons for creating and continuing this liaison highlighted the valuable role of the charitable agencies in publicising the needs of refugees and in raising increasing sums of money for their own programmes as well as those of the UN[63]. Similarly, close relationships were established between the special Office for Emergency Operations in Africa (OEOA) of the UN and charitable agencies during the relief effort for the famine in the Horn of Africa between 1984 and 1986[64]. Like other UN agencies, the United Nations Relief and Works Agency for Palestinian Refugees in the Near East (UNRWA) and the special Office for Emergency

Operations in Africa (OEOA) responded not only to popular recognition of charitable agencies as key partners in refugee relief but also to pressures from the charitable agencies themselves for greater influence in the policy process[65].

The extent to which refugee relief was recognised as a particular speciality of charitable agencies became clear in 1984 when the second International Conference on Assistance to Refugees in Africa (ICARA II) concluded that they were best suited to implement most of the newly proposed developmental projects, worth 362 million US$, which were needed to care for refugees and their hosts[66]. This was especially significant since this new developmental approach and related projects had been designed and proposed mainly by the UN, both UNHCR and the United Nations Development Programme (UNDP). Clearly, donor governments were also in favour of an expanded and significant role for the charitable agencies in refugee relief.

8.3.6 International recognition brings substantial profits ...

Several analysts[67] have concluded that until the end of the 1970s, charities experienced stagnant or slow growth in their income, but beginning with the emergency in Cambodia, there has been a 'spectacular rise in income'[68]. In Britain, the plight of the Indochinese led charities to increase their expenditure overseas by 76%, or 54% in real terms[69]. For example, the media's publicity of Oxfam's success in negotiating an agreement with the Cambodian Government in 1979 generated widespread and generous popular support, especially since the UN and the Red Cross had been unsuccessful so far and the Foreign and Commonwealth Office of the UK Government opposed official aid for the Cambodian regime. Between 1979 and 1981, charitable contributions of 110 million US$ in total were sent to Cambodia. Nearly half of it was channelled through a consortium of 32 charitable agencies led by Oxfam who provided one-third of aid given by the consortium[70].

While this represented a substantial sum of money for these charitable agencies, it accounted for only an estimated 10-15% of aid sent[71]. Similarly, charitable aid for refugees in Somalia, which totalled 20 million US$ at the end of 1981, was only 8%

of the estimated 230 million US$ sent overall. Estimated expenditures on Afghan refugees in Pakistan during 1980-1981 amounted to 250 million US$, less than 3% of which came from charitable contributions[72]. Clearly, charitable donations for relief have been substantial sums for the charitable sector but they amount to only a small proportion of the resources expended overall. In 1980, for example, the ten largest contributions for assisting refugees through five UN agencies totalled 461 million US$. Even though the United States gave more than double the actual amount of any other nation, 11 other countries donated more per capita. Nevertheless, less than 20 million US$ or 4% was raised voluntarily[73].

Increased levels of spending abroad by charitable agencies were maintained throughout the mid-1980s by additional income raised in response to famine in Ethiopia and many other Sahelian countries. This disaster brought an increase of 163% in the voluntary income of charitable agencies in real terms[74]. For example, aid from US PVOs to Africa totalled some 800 million US$ at the end of 1986 compared with 486 million two years earlier[75]. In the UK, Oxfam's income more than doubled following appeals in 1985, from some 20 million pounds sterling in 1983-1984 to over 51 million[76].

The availability of large sums of money for relief continued to characterise disaster relief throughout the 1980s. For example, in the fiscal year for 1988-89, the Overseas Development Administration of the UK Government gave 30 million pounds sterling to UK NGOs for disaster relief, caring for refugees and distribution of food aid; just one year earlier, when severe famine displaced hundreds of thousands of people in the Horn of Africa, 33 million pounds sterling had been granted to the Disasters Emergency Committee for refugees alone. Despite declining income in the years immediately after this famine, UK charities again expanded their overseas expenditures in response to new disasters at the end of the 1980s - in Bangladesh, Ethiopia and Sudan, for example[77].

Other authors[78] reinforce the importance of disasters in raising funds by pointing out that mass campaigns generate the largest sums; covenants, legacies, gifts and employee income deduction schemes raise smaller amounts. Hence, charities

dependence on the mass media. In fact, this dependence is greatest on journalists and broadcasters since their own publicity efforts reach only a limited audience, many of whom already give support, and since publicity in the mass media is extremely costly otherwise. In some countries, legal restrictions prevented NGOs from advertising through the mass media independently, for example, the use of television was only granted to NGOs in Britain in 1990[79]. Thus, even though there have been widespread calls in recent years for more realistic and just presentation of the context and nature of refugee relief needs, the 'pornographic'[80] presentation of developing country peoples in emergencies has in fact been at the heart of the dramatic growth in the charitable sector during the 1980s.

This financial reality facilitated the emergence of 'the charities' charities'[81]. Beginning in 1984 when drought, famine and armed conflict threatened the lives of millions of people in the Horn of Africa, new organizations were set up to raise money for charitable agencies to respond to acute needs. Band Aid, for example, raised over 100 million pounds sterling worldwide between 1984 and 1988[82]. Similarly, Comic Relief raised some 70 million pounds sterling, primarily from their 'red nose' days in 1987, 1989 and 1991. Drawing largely upon the concerns of entertainers, fund raising campaigns mounted by these two organizations have reached much larger audiences, especially groups previously untapped - such as children, teenage youth and entertainers themselves. Both have also tried to raise awareness among the general public, succeeding impressively in making the problems and needs widely known but less so in conveying an understanding of the underlying issues. Nonetheless, they are a further expression of the charitable sector's expanding role in relief, both as participants themselves and as a means for generating more resources for the sector as a whole.

8.3.6 . . . and growth

Not only did existing charities benefit financially from their expanding role in refugee relief, but each new influx of refugees enabled new charities to be set up. Evidence that the charitable sector has grown as a result of refugee relief is somewhat

speculative. But growing numbers of charities involved in the developing world, and the central role of relief in expanding their roles and influence in international aid, have been well documented. In the UK, for example, Burnell[83] cites the creation of only nine new charities with an overseas focus over the 200 years preceding this century in contrast with the establishment of between 11 and 36 such agencies in each decade since WWII.

The numbers of charitable agencies engaged in aiding refugees has grown phenomenally during the 1980s. Official policy dialogues about African refugees only engaged charitable agencies as equal participants in 1979, when 37 of them attended the second Pan-African Conference on the African Refugee Problem. Four years later, the number of charitable agencies participating in similar meetings had nearly doubled (68). A survey of 289 charitable agencies was undertaken by the International Council of Voluntary Agencies (ICVA) in 1984 which found that at least 98 agencies were working with African refugees[84]. During the 1980s, the number of agencies collaborating with UNHCR increased five-fold; from only one-hundred or so agencies in the early 1980s[85], the Liaison Unit with Non-governmental Organizations of UNHCR listed 546 agencies in their directory in 1989[86]. Of these 546 agencies, less than a quarter (119, 22%) were based in the developing world and many of them were affiliated with Christian churches. Nearly two-thirds (330, 60%) had their headquarters in one of seven countries: Switzerland (88, 16%), US (69, 13%), UK (46, 8%), France (40, 7%), Germany (32, 6%), Canada (29, 5%) or Belgium (26, 5%). Apparently, the growth in the size of the charitable sector engaged in refugee relief occurred mainly in the wealthy societies of the North Atlantic region.

Moreover, it occurred sporadically with each new influx of refugees engaging the services of a wider range of existing agencies, such as those working with a particular group - women or children, with a particular issue - human rights or migration, or in a particular region - the Middle East or Africa. A new influx also generated the formation of new charitable agencies, for example the Comite medical belge pour les refugies en Somalia, the Comite national d'entraide franco-vietnamien, franco-

cambodgien, franco-laotien, the Ecumenical relief and development group for Somalia and the Afghan medical aid.

The opportunities for institutional growth which are created by new groups of internationally publicised refugees has also meant that many charitable agencies will insist on taking part in the relief operation. In nearly all of the large relief operations undertaken for refugees in the 1980s, 'the extent of international competition between charitable agencies has been such that no one charity is indispensable'[87]. This competition has been interpreted by some as 'simply a recent manifestation of the scramble for Africa'[88]. However, if the financial gains, widespread popularity and expanding spheres of influence continue to grow at the astonishing pace of the 1980s, the scramble is surely not for Africa, but for the benefits at home from being involved in refugee relief in the developing world.

8.3.7 . . . and greater influence

As their popularity and resource base grew, the spheres of influence of charitable agencies in refugee relief also expanded. Although the preservation of life and the maintenance of health had always been a significant part of refugee relief operations, health became a central focus for many charitable agencies during the 1970s but especially during the 1980s. Oxfam, for example, created a specialised unit for health in 1979 together with units for emergency relief and technical assistance[89]. Other agencies, like Save the Children Fund UK, recruited health professionals as permanent members of staff at their headquarters. Some agencies which were set up by health professionals continued to require their presence on boards of trustees or within the offices of senior management. For example, in 1991 eight of the 12 senior posts in Medecins Sans Frontieres France were filled by medical doctors who had worked previously for them in developing countries[90]. The importance of having expertise in health can be seen in individual relief operations; the majority of charitable agencies in any given refugee relief effort will be providing some assistance in the health sector.

Suggestions for improving the quality of health relief provided for refugees in the developing world began to appear in the academic literature after the Nigerian civil war[91]. However, it was not until the 1980s that the charitable agencies began to articulate their own strategies and guidelines for refugee health care independently. The publication of its Practical guide to refugee health care in 1983 put Oxfam UK[92] on par with UN agencies[93] and academic centres[94] who were promoting their own strategies worldwide for providing health care in refugee *camps* in the developing world. It was soon joined by other charitable agencies, such as the All Africa Conference of Churches who put together a Handbook for refugee workers in 1983[95] and Medecins Sans Frontieres Belgium who produced their own guidelines in 1987[96].

The fact that many of those responsible for putting these documents together had worked closely together, individually and institutionally, did not diminish the impact of these documents in official circles. The charitable agencies now had considerable expertise and they had the power base within the international relief system to put forward alternative strategies for meeting the health needs of refugees. Their efforts to formulate their own policy statements and practical guidelines further enhanced their role in advising policy makers within governmental and inter-governmental organizations. Thus, charitable agencies were no longer auxiliaries in policy dialogues; instead they were often taking the leading role. They were widely recognised not only for the health services they provided directly among refugee communities, but also for their growing expertise in which interventions should be given priority and the technicalities of carrying them out.

8.4 References

1. Gill P (1986) A year in the death of Africa. Politics, bureaucracy and the famine. London, UK: Paladin, p. 82

2. Foreign Assistance Act of 1973, Public Law 93-189 (87 stat. 714), part 1, Chapter 1, Section 123; cited in Smith BH (1990) More than altruism. The politics of private foreign aid. Princeton, New Jersey, USA: Princeton University Press, p. 68

3. Bolling LR and Smith C (1982) Private foreign aid. US Philanthropy for relief and development. Boulder, Colorado, USA: Westview Press, 294 pp.

4. Cited in Smith BH (1990), p. 98, #2: taken from a summary of the UN Special Sessions in 1974 and 1975 in Tinbergen Reshaping the international order, pp. 48-49

5. Lewis DE (1991) Non Governmental Organizations (NGOs) and alternative strategies in the 1990s: Bridging the development gap between Central America and the Caribbean. Paper presented at the Conference on **Alternatives for the 1990s Caribbean** of the Institute of Commonwealth Studies and the Institute of Latin American Studies - Caribbean Studies Programme, London University, 9-11 January 1991, 26 pp.

6. Burnell PJ (1991) Charity, politics and the Third World. London, UK: Harvester Wheatsheaf, 286 pp.

7. Burnell PJ (1991), #6

8. van Heemst JJP (1985) European NGOs and the Third World: A background analysis. In: Stevens C and van Themaat JV (eds) Pressure groups, policies and development. The private sector and EEC-Third World Policy. London, UK: Hodder and Stoughton, chapter 2.

9. Lewis DE (1991), #5

10. Green A (1987) The role of non-governmental organizations and the private sector in the provision of health care in developing countries. International Journal of Health Planning and Management 2:37-58

11. van Heemst JJP (1985), #8

12. van Heemst JJP (1985), #8

13. Green A (1987), #10

    Hellinger D (1987) NGOs and the large aid donors: changing the terms of engagement. World Development 15, Supplement

14. Bolling LR and Smith C (1982), #3

15. Bolling LR and Smith C (1982), #3

16. Bolling LR Smith C (1982), #3

17. Roberts HR (1984) The domestic environment of AID-registered PVOs: Characteristics and Impact. In: Gorman RF (ed) Private Voluntary Organizations as agents of development. Boulder, Colorado, USA and London, UK: Westview Press, 256 pp.

18. Green A (1987), #10

    Downs C and Solimano G (1989) Toward an evaluation of the NGO experience in Chile: Implications for social policy and future investigation. In: Downs C, Solimano G, Vergara C and Zuniga L (eds) Social policy from the grassroots. Nongovernmental organizations in Chile. Boulder, San Francisco and London: Westview Press, 212 pp.

19. Cumper GE (1986) The changing role of NGOs: no longer the eunuch in the harem? Health Policy and Planning 1(4):335-344

20. Bolling LR and Smith C (1982), #3

21. Burnell PJ (1991), #6

22. Burnell PJ (1991), #6

23. Cumper GE (1986), #19

24. Cumper GE (1986), #19

25. Burnell PJ (1991), #6

26. Cumper GE (1991), #19

27. Twose N (1987) European NGOs: Growth or partnership? World Development Forum 15, Supplement:7-10

28. Burnell PJ (1991), #6

29. Lewis DE (1991), #5

30. Burnell PJ (1991), #6

31. Burnell PJ (1991), #6

    Lewis DE (1991), #5

32. Gorman RF (1984) Introduction. In: Gorman RF (ed) Private Voluntary Organizations as agents of development. Boulder, San Francisco and London: Westview Press, pp. 1-12

33. van Heemst JJP (1985), #8

34. Burnell PJ (1991), #6

35. Bolling LR and Smith C (1982), #3

36. Cited in Burnell PJ (1991), p. 28, #6

37. Burnell PJ (1991), #6

38. van Heemst JJP (1985), #8

39. Stevens C and van Themaat JV (1985) Non-governmental influences on Euro-South relations. In: Stevens C and van Themaat JV (eds) Pressure groups, policies and development. The private sector and EEC-Third World Policy. London, UK: Hodder and Stoughton, chapter 1

40. Stevens C and van Themaat JV (1985), #39

41. Burnell PJ (1991), #6

42. Clark J (1991) Democratizing development. The role of voluntary organizations. London, UK: Earthscan, 253 pp.

43. Stevens C and van Themaat JV (1985), #39

44. Burnell PJ (1991), #6

45. Burnell PJ (1991), #6

46. Burnell PJ (1991), #6

47. Smith BH (1990), #2

48. Burnell PJ (1991), #6

49. Burnell PJ (1991), #6

50. Minear L (1984) Reflections on development policy: A view from the Private Voluntary Sector. In: Gorman RF (ed) Private Voluntary Organizations as agents of development. Boulder, San Francisco and London: Westview Press, pp. 13-40

Bolling LR and Smith C (1982), #3

51. Burnell PJ (1991), #6

52. Arrupe P (1985) The refugee crisis in Africa: Opportunity and challenge for the Church. Migration News 4:47-48

53. Davis M (ed) (1976) Civil wars and the politics of international relief. Africa, South Asia and the Caribbean. Praeger International Studies in International Politics, 103 pp.

54. Ericksson L-G, Melander G and Nobel P (eds) (1981) An analyzing account of the Conference on the African Refugee Problem. Arusha, May 1979. Uppsala, Sweden: Scandinavian Institute of African Studies, 226 pp.

55. Cited in: Arrupe P (1985), pp. 47-48, #52

56. USCR (1981) 1981 World refugee survey. New York, USA: The United States Committee for Refugees, printed by Hudson Press, 62 pp.

57. Coles G (1989) Approaching the refugee problem today. In: Loescher G and Monahan L (eds) Refugees and international relations. Oxford University Press, pp. 373-410

58. An example of the focus on numbers can be found in Chambers R (1985) Memorandum to the House of Commons Foreign Affairs Committee. Sussex, UK: Institute of Development Studies, 4 pp. plus 6 pp. of notes

59. Burnell PJ (1991), #6

60. Coles G (1989), #57

61. Cited in Kent RC (1987) The anatomy of disaster relief. The international relief network in action. London, UK: Pinter Publishers, p. 97

62. Nobel P (1983) Meeting of the OAU Secretariat and Voluntary Agencies on African Refugees. Arusha, March 1983. Uppsala, Sweden: Scandinavian Institute of African Studies, 36 pp.

63. UNRWA and ICVA (1984) Report of the second consultation between Non-governmental Organizations and the United Nations Relief and Works Agency for Palestinian Refugees in the Near East. Vienna, Austria: UNRWA, 6 pp. plus ten annexes.

64. Strong MF (1986) Relations between the OEOA and the private sector including NGOs/PVOs and private donors. New York, USA: The UN Office for Emergency Operations in Africa, Report No. OEOA/3/15, 70+ pp.

65. Gordenker L (1987) Refugees in international politics. London, UK and Sydney, Australia: Croom Helm, 214 pp.

66. Brown MM (ed) (1984) The rise and rise of the volag. The Economist, Developmental Report, August, pp. 1-2

67. Burnell PJ (1991), #6

Hancock G (1989) Lords of poverty. London, UK: Mandarin Paperbacks, Octopus Publishing Group, 193 pp.

68. Burnell PJ (1991), p. 31, #6

69. Burnell PJ (1991), #6

70. Hingson LL (1981) The role of private international assistance in response to major disasters. Disasters 5(4):407-410

71. Hingson LL (1981), #70

72. Hingson LL (1981), #70

73. USCR (1981) 1981 World refugee survey. New York, USA: the United States Committee for Refugees, printed by Hudson Press, 62 pp.

74. Burnell PJ (1991), #6

75. Smith BH (1990), #2

76. Hancock G (1989), pp. 3-33, #67

77. Burnell PJ (1991), #6

78. Cumper GE (1986), #19

Burnell PJ (1991), #6

79. Burnell PJ (1991), #6

80. Lissner J (1976) The politics of altruism. Geneva, Switzerland: Lutheran World Federation, Department of Studies; cited in Burnell PJ (1991), p. 19

81. Tewson J (1991) Interview with the Director. More than a mission... Charity Projects Annual Review 90-91. London, UK: Charity Projects, pp. 14-15

82. Burnell PJ (1991), #6

83. Burnell PJ (1991), #6

84. ICVA (1984) Assistance to African Refugees by Voluntary Agencies. Geneva, Switzerland: International Council of Voluntary Agencies, May, 113 pp.

85. Jaeger G (1982) Participation of Non-governmental Organizations in the activities of the United Nations High Commissioner for Refugees. In: Willett P (ed) Pressure groups in the global system. London, UK: Francis Pinter, pp. 171-178

86. Liaison Unit with Non-governmental Organizations (1989) Directory of Non-governmental Organizations. Geneva, Switzerland: United Nations High Commissioner for Refugees, 144 pp.

87. Burnell PJ (1991), p. 37, #6

88. Harrell-Bond B (1986) Imposing Aid. Emergency assistance to refugees. Oxford, UK: Oxford University Press, p. 221.

89. Oxfam (1989) A brief history of Oxfam. Information from Oxfam. Oxford, UK: Oxfam Information Department, September, 4 pp.

90. Dodd R (1991) The marketing of mercy. A review of the emergency response of the League of Red Cross and Red Crescent Societies and of other agencies. Geneva, Switzerland: League of Red Cross and Red Crescent Societies, May, 45 pp.

91. Aall C (1970) Relief, nutrition and health problems in the Nigerian/Biafran war. Journal of Tropical Paediatrics 16:70-90

Bennett FJ, Jelliffe DB, Jelliffe EDP and Moffat M (1968) The nutrition and disease pattern of children in a refugee settlement. East African Medical Journal 45:229-246

Gardner P, Rohde JE and Majumdar MB (1972) Health priorities among Bangladesh refugees. The Lancet 1:834-836

Hickman R (1971) Deteriorating health of refugee children in India. The Lancet 2:917-918

Ifekwunigwe AE (1976) Emergency assistance. The nature and organization of disaster relief. Food and nutrition (Roma) 2:6-13

Seaman JA (1972) Relief work in a refugee camp for Bangladesh refugees in India. The Lancet 2:866-870

92. Oxfam Medical Unit (1983) Oxfam's practical guide to refugee health care. Oxford, UK: Oxfam

93. UNHCR (1982) Handbook for emergencies. Geneva, Switzerland: United Nations High Commissioner for Refugees

Ockwell R (1986) Assisting in emergencies. A resource handbook for UNICEF field staff. Geneva, Switzerland: United Nations Children's Fund

94. Entire editions of the journal Disasters were devoted to the needs of refugees generally in 1979 (volume 3, number 4) and to the health needs of refugees specifically in 1981 (volume 5, number 3)

Jelliffe DB and Jelliffe EDP (1981) Refugee medicine: the need for new approaches. Sciences 21:14-15, 18-19

Simmonds SP, Vaughan PJ and Gunn W (eds) (1983) Refugee community health care. Oxford, UK: Oxford University Press, 250 pp.

95. AACC (1983) Handbook for refugee workers. Nairobi, Kenya: AACC Refugee Service

CICARWS (1981) Recent WCC statements concerning refugees. Refugees. Oikoumene. Geneva, Switzerland: Refugee Service of the Commission on Inter-Church Aid, Refugee and World Service, World Council of Churches, September, 9 pp.

96. Centre de Recherche sur l'Epidemiologie des Desastres and Medecins Sans Frontieres Belgique (1988) Organization d'un camp de refugies. Guide operationnel pour la phase d'urgence. Modules 1-4. Fiches techniques and annexes. Brussells, Belgium

CHAPTER NINE

International health relief: a nefarious use of humanitarian resources?

Both World Wars, but especially the second, prompted more active involvement in international health relief by both national governments and organizations having their roots primarily in civil society throughout the western world. Inter-governmental organizations and private, charitable agencies became the primary means through which the concerns and interests of individual groups within these societies which were affiliated with armed conflicts and relief operations were expressed.

9.1 Private, charitable organizations

9.1.1 Essential providers of refugee health relief

The Second World War engaged charitable organizations as essential partners in the provision of international health relief for refugees. This role has been largely overlooked by most analysts who are preoccupied with identifying descriptive categories or normative protocols for charitable agencies. Their focus reflects but fails to acknowledge the infinite types of agencies which exist at any moment and the fluidity with which they are formed, merged or disbanded. The stated and covert purposes of these organizations, their sources of funding and ideological and political support, the types of activities they engage in or the services they render, and the organizational structures they adopt all vary widely; this suggests that descriptive categories are somewhat superfluous. Instead, an understanding of the relationships which these organizations have with national governments, general publics and other organizations within the societies where they work is more enlightening.

Beginning with the Red Cross in the latter half of the nineteenth century and the Commission for Relief in Belgium (CRB) during the first World War charitable organizations have traditionally been labelled as 'non-governmental' or 'private,

voluntary'. Yet these organizations have been dependent on their own national governments for their very existence - legally, financially and politically, and most have incorporated and practised only those policies determined or approved by these same governments. Direct governmental influence, however, has usually been transmitted only at the highest levels of appointments and decision-making. The lack of official governmental representation on the staff of individual agencies and their lack of involvement in the day-to-day management of agency affairs or relief operations has enhanced an image of organizational autonomy. Such an image was consistent with the emphasis given to promoting the charitable nature of the work which in turn generated substantial support from the public at large or from individual groups within society. Furthermore, most relief workers and middle managers of charitable agencies were civilians volunteering their time and services or working for very low wages. Those who were unable to volunteer directly, were often kept informed by the media - at that time through radio and press - or were involved in frequent, *ad hoc* campaigns for donations - of money, food or clothing, for example. To the general public, donors and recipients alike, these organizations were non-governmental or private, and they were seen to be earning the support and respect of governments and inter-governmental organizations through their charitable, hard work.

Inter-governmental organizations and national governments not only controlled the financial, legal and political environment within which these agencies existed, they depended on these organizations to set up and manage refugee relief programmes. Without these agencies, the bureaucratic and diplomatic machinery of inter-governmental organizations would have had little effect in practice. Similarly, disorganized and inexperienced governments could not have undertaken the work themselves, neither in many European countries during and after the second World War, or in many developing countries during and immediately after wars of independence. While national governments and inter-governmental organizations paved the way for international relief work by negotiating political and legal agreements, by securing enormous sums of money and quantities of material goods and by setting general policies and often individual standards of practice, it was the charitable agencies who actually did the work. Charitable agencies, and their newly formed

international organizations, were an essential institutional link which ensured that relief policies were put into practice.

9.1.2 Motivated by compassion or self-interest?

Despite the emphasis on resettlement and repatriation schemes for refugees in Africa during the 1950s and 1960s, as well as stated preferences by international aid agencies to be involved primarily in longer-term assistance programmes for development since the late 1960s, refugee relief not only remained an important activity of charitable organizations throughout the 1970s and 1980s but it increasingly became the means through which the growth and well-being of the charitable sector was ensured. Arguments put forward in support of a continued and expanded role in refugee relief have almost always been based on increasing demand. In particular, the growing numbers of people seeking refuge and the increasingly lengthy period of time they require assistance has risen on a large scale throughout the 1970s but especially the 1980s.

But surely, the logical extension of this demand-driven rationale begs many questions: most importantly why such relief is needed in the first place, why temporary periods of asylum which follow are increasingly prolonged and which responses are most appropriate given the 'temporarily permanent'[1] status of most refugees. Even though obvious requirements for lasting solutions have led many specialists and agencies to advocate for a developmental approach in caring for refugees, refugee relief has been undertaken in isolation from development programmes and within what many would consider an out-dated framework of providing welfare services temporarily. The contradiction between the rhetoric of refugee relief and the reality of its provision, together with the pivotal role of relief in the growth of the charitable sector over the past two decades, suggest that the appeal in aiding refugees lies primarily in the supply-side of the equation.

Engaging in refugee relief operations is a strategy which guarantees the charitable sector substantial popular and governmental support, particularly within Europe and

North American societies. This is true because the provision of relief for refugees addresses the concerns of both the general public who want to help for humanitarian reasons - genuine or tinged by guilt or other self-interests, and governments who want to promote and protect the political and economic interests of their societies. The act of seeking asylum by thousands or millions of an ethnic, social or political group brings to light conflicts with existing groups in power - within their own societies and those which act as hosts to them as well as within societies with which they have political and economic links. Aiding refugees thus becomes an arena where struggles for power, nationally and internationally, are played out. The uniquely sensitive and complex nature of any action taken in such circumstances means that official bodies may be more constrained in the scope and form of their responses. In combination with the vivid and far reaching publicity of the horrific and life-threatening conditions of those seeking refuge, an institutional space is created which allows charitable agencies to play a much needed and significant role.

In undertaking to fill this institutional gap, charitable agencies benefit enormously. Far greater than the satisfaction of helping those in need, huge sums of money, favourable publicity, access to new groups of people and geographical areas and opportunities for greater decision-making responsibilities make refugee relief a highly profitable market for the charitable sector. Moreover, these benefits have only begun to be exploited. On the one hand, for example, the phenomenal success of entertainers in raising funds from the general public has only been institutionalised in the form of the charities' charities in the latter half of the 1980s. On the other hand, only a small proportion of governmental funds for relief have been channelled through charitable agencies to date although there is growing interest within governmental aid agencies to support charitable agencies.

Similarly, charitable agencies have only begun to exercise their voice in policy-making dialogues, and their responsibilities have increasingly extended beyond the provision of direct care among refugee communities, incorporating the planning, organization and management of health services for refugees locally, regionally and nation-wide. Charitable agencies are now able to offer technical, professional and managerial

expertise on par with, if not better than, that made available through bilateral and multilateral structures.

9.1.3 Roles played by charities in refugee health relief

No wonder every book or article which considers the characteristics and roles of the charitable sector contains a distinct and substantial discussion of its roles in relief, and particularly relief for refugees. Even though only a few of these analyses consider the reverse: in other words the role of relief in the growth and well-being of the sector. Notwithstanding analytical biases towards a demand driven rationale for relief, these trends convey a general picture of what can be expected in any given relief operation for a group of refugees.

Firstly, many charitable agencies will be involved; the charitable sector will be represented by not one or two agencies but by tens or hundreds. Secondly, there will be many well-established agencies and there will also be agencies created specifically for the crisis at hand. Thirdly, most agencies - new and older - will have their base in the political and economic links of societies in the North Atlantic region with those of either the refugees or their hosts. While several will be affiliated with Christian churches, few will be an expression of concern by nationals of affected groups living abroad[2].

Fourthly, many agencies will have a role in the health sector because of its popularity, and therefore profitability, with donor publics and governments. Fifthly, most charitable agencies will provide care directly but some will also be involved in planning and managing health programmes which cover large geographical areas or which care for refugees nation-wide. In such a capacity, charitable agencies will not necessarily be acting as auxiliaries to governments or UN agencies but as equal partners or competent competitors.

Sixthly, new federations or forums for collaboration may be set up by several charitable agencies in an effort to negotiate and strengthen their role *vis-a-vis*

governmental and inter-governmental organizations. Seventhly, some agencies may bypass bureaucratic procedures and diplomatic protocol when entering an area where refugees have come to set up their own system of services or to co-opt state structures[3]; in so doing they will be exploiting a period of intense social disruption, their humanitarian *raison d'etre*, current publicity of urgent needs and widely accepted notions that the international community has responsibility for refugees to enhance their own institutional growth.

Thus, eighthly, unlike many on-going health programmes in the developing world which are run by charitable agencies in cooperation with local governments or community groups, health services for refugees may well be planned, managed and financed independent of national health authorities or local practitioners. In so doing, charitable agencies may assume responsibilities normally assigned to governments or private providers of care.

9.1.4 Integral participants in the international refugee health regime

The creation of separate, temporary health services for refugees by charitable agencies is another stark reminder that these organizations are institutions of civil societies in Western Europe and North America. They are elite institutions which are often managed by intellectuals, activists or naive but well-meaning citizens of western societies. Consequently, they are isolated from their constituencies at home and abroad culturally or socially or both. Their composition and the type of work they undertake reflects domestic political debates at home about foreign policies, including those for aid - developmental and relief. This reality can hardly be disputed for relief given the US Secretary of State's announcement in 1976 that 'disaster relief is becoming increasingly a major instrument of our foreign policy'[4].

Charitable agencies are an integral structure within the supply-side of the international aid system - the so called 'private arm', together with key donor governments, inter-governmental agencies and general publics of western societies. Multiple agendas are pursued through charitable agencies but they are unlikely to be the source of radical

reforms, partly because they do not challenge differentiations of social class and partly because their presence and efforts alleviate pressures for fundamental change. Thus, charitable agencies enhance political stability at home and abroad, maintaining the *status quo*[5]. No doubt most charitable agencies will continue to try to get in on the act in order to ensure their own institutional growth and well-being.

9.2 Specialised agencies and funds of the United Nations

9.2.1 Supra-national powers or dependent on governments?

Contrary to popular beliefs today that the UN is a supranational organization for world peace and prosperity, the UN is one of many inter-governmental organizations set up by powerful governments in North America and Western Europe originally in response to the relief and rehabilitation needs created by the second World War. Many different agencies were created under the aegis of the UN to deal with a wide range of concerns associated with restoring a thriving capitalist economy after the war, from economic interests (for example the International Monetary Fund (IMF), the International Bank for Reconstruction and Development (IBRD or the World Bank) and the General Agreement on Tariffs and Trade (GATT)) to social and cultural issues (for example, the World Health Organization (WHO) and the United Nations Education, Social and Cultural Organization (UNESCO)). In founding various, largely autonomous agencies within the UN system, national governments in North America and Western Europe were careful to safeguard their own economic and social interests.

Extensive governmental influence has always been present as evidenced in 1950 by the Soviet Union's perception of the United Nations as another of the many institutions dominated and used by the US and Western Europe for their own interests when Mao's communist government was refused recognition by the UN. In response, the Soviet Union and Eastern European nations boycotted the UN, but not for long. The absence of the Soviet Union's delegate during the Korean War led to the endorsement by the UN of the position and activities of the US and her allies[6]. Opportunities to use the UN to sway world opinion were greatly increased with the

addition of 87 new nation-states to the UN by 1955[7] from the poorer, but rich in resources, southern hemisphere. Thus, the UN increasingly became a forum not only to influence world opinion but to garner support for policies which benefited particular nation-states. Not surprisingly, the Soviet Union and her allies renewed their membership in 1955.

9.2.2 Dependency mechanisms

The creation of several specialised agencies within the UN and the creation of separate, additional inter-governmental organizations reflected the unwillingness of national governments, primarily of the US, to relinquish control over the activities of inter-governmental organizations. By restricting the political authority and scope of inter-governmental agencies as well as their resource base, powerful national governments were able to manipulate and control the work of the individual inter-governmental organizations to benefit their own political and economic interests. They did this in several ways.

One way was to limit the responsibilities or tasks of an agency, which meant that separate or temporary agencies were established for individual issues or concerns. This technique has continued in relief with, for example, the creation of the United Nations Border Relief Operation (UNBRO) to manage relief for Cambodians living along the border between Thailand and Cambodia since 1982[8] and the Office for Emergency Operations in Africa (OEOA) to coordinate relief in the Horn of Africa between January 1985 and October 1986. Such narrowly defined mandates prevented individual agencies from getting involved in issues beyond those agreed to by member governments. Control over the work of the agencies was further enhanced by organizational structures and protocols which gave powerful governments considerable influence in policy-making processes. For example, establishing executive committees or boards for policy-making which consisted of a few key member governments, appointing certain nationals as heads or executive directors, or requiring an agency to obtain the approval of the General Assembly on proposed policies and programmes of work.

The general independence of the agencies from one another and from the UN Security Council, General Assembly and Economic and Social Council allowed national governments to exert their influence within each individual agency (divide and rule) as well as to fragment the power base of the UN, preventing it from becoming a supra-national institution capable of imposing and enforcing its own policies among member nations. Economic dependency, mainly on the US, for the enormous sums required to run the Secretariat and the specialised agencies and funds and to pay for their work, further enhanced the position of certain national governments. In fact, according to Duke[9], the UN Secretariat has borne the largest proportion of the financial shortfall since the late 1980s; it too depends on only 14 of some 102 member governments for 84% of its regular budget. Thus, the UN was a forum for European and North American governments primarily to negotiate policies on a wide range of subjects, to initiate and sponsor joint activities and to garner international support for their own policies and positions.

The pattern of creating short-lived, all-purpose and fully-resourced organizations for acute relief needs, such as the Commission for Relief in Belgium and the United Nations Relief and Rehabilitation Administration (UNRRA), and of replacing these organizations very quickly with numerous other inter-governmental ones for the longer-term development of specified sectors or areas of concern, such as the specialised agencies of the League of Nations and the UN, highlights the political sensitivity of relief work. In order to maintain greater control over economic and social policies and practices in the longer-term, national governments isolated relief from development. They limited relief to meeting only basic survival needs for no more than a few years.

Within the UN, for example, the four agencies originally designated substantial mandates and roles in relief - the United Nations High Commissioner for Refugees (UNHCR), the United Nations International Children's Emergency Fund (Unicef), the United Nations Relief and Works Agency for Palestine Refugees (UNRWA) and the United Nations Korean Reconstruction Agency (UNKRA) - were set up on a temporary basis for three years. Furthermore, the actual implementation of relief

programmes was often left to charitable agencies which ensured, for the most part, that they were small in scale, limited in scope, short in duration and targeted to groups in alliance with donor nations. Such practices allowed national governments to ensure that many acute needs were met or were at least seen to be being met and that relief did not interfere with longer-term economic and social policies.

9.2.3 Strategies for surviving and thriving politically

Masked by humanist ideology, current advocates for a developmental, or longer-term, approach to relief work are naive, at best. By exclusively stressing the very real and inseparable links of disasters, relief and development in the lives of individuals and societies and the logical demand for more coherent approaches to relief and developmental aid, they ignore political realities which benefit from separating relief as a minimal set of activities for survival in the short-term and development as the longer-term growth and functioning of economic and social systems in the world. Instead, thoughtful consideration of these realities enables the roles adopted by these inter-governmental institutions in refugee health relief to be understood.

For example, Unicef's determination not to undertake any significant role in relief, in spite of increasing devastation and destitution associated with disasters, would otherwise be puzzling because of their past successes and organizational assets which are essential for making timely responses. Unlike the policies of Unicef which appear to acknowledge limited donor support for an extended role in relief, WHO's involvement in relief is further constrained by its adoption of excessive and complex bureaucratic procedures as well as a narrow framework for defining acceptable work. Similarly, UNHCR is only able to plan and budget on an annual basis, limiting their interventions to *ad hoc* and temporary activities in the shorter-term. Within WHO and UNHCR, professionals responsible for health relief often lack authority within their own organization to influence policy and its practice; partly because of their position within the organization, partly because of decision-making procedures and, often, because they lack previous experience or relevant qualifications in health relief. Moreover, all three agencies lack sufficient financial resources in their regular budget

to initiate substantial relief efforts independently. Yet, surely these organizational and financial constraints could be remedied if there was the will and commitment to do so. Herein must lie the explanation for the failure of these agencies to consider relief needs seriously within existing mandates, structures and programmes of work, in particular what stifles aspirations or efforts to improve their responses.

There are other similarities in the organization and practice of health relief by UNHCR, Unicef and WHO which highlight equally disturbing tendencies. In response to increasingly frequent and destructive disasters since the late 1960s, most agencies within the UN system have set up their own units for relief. UNHCR, Unicef and WHO were, obviously, no exception. Between 1971 and 1981, each created a separate unit for relief. Moreover, UNHCR which had previously concerned itself with legal and advocacy issues, set up a separate unit to expand and incorporate contributions from the more technical specialities in 1981, including health and nutrition in 1983. Clearly, relief has been distinguished and separated from 'development', even though such a distinction makes no sense for those experiencing disasters and their repercussions, or for those working to reduce vulnerabilities which underlie needs for relief in the first place. There must be benefits for some groups from this seemingly illogical policy.

9.2.4 Symbolic gestures or substantial contributions?

Furthermore, in the head offices of all three agencies, health relief has been a responsibility of only one, two or at most three permanent staff members. Regular financial resources for relief generally have also been minimal, currently ranging between only one million US$ per year in the case of WHO and twenty million US$ per year in the case of UNHCR for global needs; most funds for relief have been raised through special or additional appeals. Given the certainty with which these agencies have been confronted with increasingly vast relief needs, there has consistently been a lack of regular resources which would enable the agencies to respond quickly and independently.

Nevertheless, meagre resources for relief, which are planned for and approved on a regular basis, have allowed the agencies to respond routinely, but in a very limited way. Firstly, disasters which have generated responses routinely have most often been those classified as 'natural' and whose effects are relatively circumscribed. For example, earthquakes, hurricanes and floods have routinely generated one-time donations or loans from the agencies whose value ranged between only tens and hundreds of thousands of US$.

On the other hand, responses to 'man-made' disasters, such as war and famine, or those which have generated widespread devastation and destitution, such as flooding in Bangladesh, have depended on obtaining additional support, including vast sums of money, material goods or services. Thus, their responses to these disasters have been on a somewhat ad hoc basis even though all three agencies have consistently engaged in relief where needs were widely publicised by the international media. The agencies have consistently distinguished between 'natural' and 'man-made' disasters, and have responded more routinely to natural disasters in contrast with their seemingly uncertain, yet consistent and often extensive involvement in responding to 'man-made' disasters.

Secondly, the responses of the agencies has often been limited to the provision of expert technical advice or the provision of material goods. In other words, they were often asked which goods or interventions were most needed and appropriate and to help provide resources whenever possible, for example drugs and other medical supplies. Although they frequently carried out assessments of health and nutrition needs and service requirements - initially, as part of on-going planning exercises or in anticipation of terminating relief programmes, additional funds were usually obtained for this. Similarly, the convening of expert committees to determine international standards or the organisation of training courses in preparation for future relief are examples of international relief efforts which were also usually funded through special or additional appeals. Nevertheless, these activities sought to improve international responses to relief needs within the framework of providing material goods or emergency services or of recommending technical interventions, for example,

the creation of emergency kits for essential drugs and immunization campaigns, the organization of emergency medical screening, first aid and referral or the establishment of special feeding programmes and mass vitamin supplementation. Policies of the agencies have emphasized only the technical aspects and immediate material needs of health relief operations.

9.2.5 Complementary and competitive roles in refugee health relief

Like the charitable agencies, consideration of the work of the specialised agencies and funds of the UN over time and within the larger political and economic environment conveys a scenario of what can be expected from these inter-governmental organizations in any refugee health relief operation.

Firstly, several specialised agencies and funds of the UN will be involved. UNHCR, Unicef and WHO will be among those participating even though their roles may differ by place and time. Some conflicts and the relief efforts associated with them will lead to the creation of organizations specifically for that particular crisis, although this tendency is less likely within the UN than within the charitable sector since acceptance and support for such an organizational response by many governments collectively is less easily secured. Those with on-going terms of office and those created for specific relief needs will be dependent on wealthier governments in Europe and North America for their political and financial authority.

Fourthly, UNHCR, Unicef and WHO will all have a role in refugee health relief services, partly in carrying out their stated mandates and partly in response to the popularity of such services among prominent donor publics and governments. Their involvement will be primarily in planning, managing and financing health relief programmes, especially at national and regional levels. Only rarely will these organizations become involved in the provision of health care directly. They will, therefore, be in close contact with the charitable agencies which will be providing much of the care and governmental health authorities which ostensibly have responsibility for health within the geographical areas of concern.

The international nature of refugee relief may well mean that existing governmental health services or responsibilities for them will be co-opted by these inter-governmental organizations individually or collectively. Thus, refugee health services may be planned, managed and financed independent of national health authorities. Along with charitable agencies, the UN may then assume responsibilities for health which are often assigned to governments or private providers of care.

The governmental and global membership of the UN may isolate those working for it from their constituencies culturally or socially or both. Yet, in spite of their international composition, their work will reflect political and military policies of the wealthier governments in Europe and North America, which encompass those for developmental and relief aid. Multiple agendas will be pursued through these inter-governmental organizations which act as the official structure within the supply-side of the international system of aid for refugee health relief. Thus, their own institutional growth and well-being will be enhanced through their participation in refugee health relief.

WHO is likely to provide expert advice, either to government health authorities or other agencies within the UN system. In light of WHO's mandate to work with national governments, it would be surprising to find it collaborating closely with charitable agencies except through national health authorities or other UN agencies. Advice may be given in the form of internationally recommended technical standards of care, lists of drugs, supplies or equipment which will be needed, recommended priorities for interventions among displaced populations or the secondment of senior health professionals to support the organization and management of care on a daily basis. These advisory services will, however, no doubt be subject to the perceived need for them among donor governments and other UN agencies who must finance their provision. The lack of financial and human resources may well be the fundamental constraint to additional initiatives or prolonged participation by WHO - by the head, regional and country offices alike.

UNHCR is likely to initiate and fund the provision of health care throughout a refugee relief operation. The recent employment of health professionals as programme officers in the head office and within specific national or regional operations will create an image at the very least and a foci of power at most for decision-making and management. UNHCR may well be the authority for making policy, planning and managing health services for refugees. The extent to which this is true will depend less on the contributions of other UN agencies and more on the roles adopted by private, charitable agencies and concerned national governments - especially those supporting the programmes.

Regardless of their role in managing refugee health services, UNHCR will be a significant provider of resources. While the yearly programming cycle precludes any commitment or preparation beyond a year or two at a time, special appeals made by it will generate the vast resources needed to create a system of medical services for large refugee populations. Despite an ability to raise considerable quantities of money, human and material resources as well as widespread popular support for relief efforts, the temporary involvement of UNHCR may well mean that consideration of longer-term health needs and the features of sustainable and appropriate systems of care will be neglected. Instead, acute survival needs will be given priority, even focused upon exclusively.

Such an approach together with UNHCR's efforts to play a more significant role in the formulation of health policies for refugees may also mean that UNHCR supports private, charitable agencies from Europe and North America in setting up and offering health services at the expense of national and local organizations. UNHCR may well act as financier of refugee health programmes which are established and run by the charitable sector, either in collaboration with national or local authorities or in isolation from them. The efficiency with which foreign charities can put together a response, arrive with needed resources and manage services acceptable to donors may well lead UNHCR to rely almost solely on them. This may especially be true where national health systems are bureaucratic, lethargic, grossly under-resourced or poorly developed (encompassing most low and middle income economies). Obviously, this

will compliment and enhance a focus on the provision of services for acute, survival needs in the immediate future.

Unicef is likely to involve itself in selected programmes or activities rather than the organization and management of a system of health services generally. Its ability to provide needed supplies quickly, in good condition and of acceptable quality will undoubtedly lead it to provide supplies for health care, such as drugs and vaccines. Their ability to divert existing funds or to raise additional monies quickly will almost certainly lead Unicef to finance programmes of particular interest to it, most likely those they fund on an on-going basis for children - for example, immunization activities.

Unicef has always collaborated with national governments and charitable agencies. Thus, they may support the involvement of either in relief programmes, especially when needs are acute or when the agency or governmental department specialises in the provision of care which is a priority for Unicef.

The involvement of UNHCR, Unicef and WHO will vary with time within a given relief effort. This will reflect shifting priorities within the organizations themselves, pressures and support from donors for them to be involved or withdraw and the extent to which private, charitable contributions to relief meet existing needs, either collectively or independently.

9.3 From clinical medicine to public health

Refugee health relief continues to consist of technical measures which are designed and justified within a medical model, even though they now emphasise public health interventions. Similar to clinical medicine, public health had its origins in the industrial revolution and in the efforts of national governments to control fatal epidemics of diseases, such as cholera and plague, which raged through Europe in the eighteenth and nineteenth centuries. Public health was, as a result, also preoccupied with preventing and controlling diseases - primarily in cities or along main trading

routes. Like the provision of medical care, public health then became a social welfare activity of national governments in the latter part of the nineteenth century. In particular, public health aimed to improve environmental sanitation, housing and nutrition within nation-states, while international public health was organised as inter-governmental collaboration in quarantine practices to control the spread of the 'big five' diseases - cholera, plague, yellow fever, typhus and smallpox.

Following the advent of the germ theory of disease and the rapid advances in medical sciences generally around the turn of the century, public health increasingly became a sub-speciality of scientific medicine. In addition to overseeing environmental sanitary and housing improvements, public health doctors began to provide basic medical advice and care under the name of preventive medicine. This distinction between preventive and curative medicine was an attempt by those medical doctors who specialised in public health to establish a separate, credible area of work in comparison with private general practitioners. In England, for example, such a distinction was very real politically since salaried public health doctors working for local governments posed a threat to the professional and financial autonomy of private medicine[10]. Yet there was clearly considerable overlap in the work of clinical and public health doctors. This became apparent in England, for example, in the 1930s when public health departments took over the management of some hospitals, which meant that public health doctors managed a wide range of medical services within a large geographical area.

9.3.1 Priority public health interventions

Public health has matured since the second World War, assuming a leading role within the planning and management of health services. Since the 1970s when entire populations in poorer countries needed health relief, for example in southern Sudan, northern Ethiopia or among Afghans in Pakistan and Iran, health relief increasingly looked to the discipline of public health for leadership. At first, this new focus of health relief on public health was included under the 'basic needs' concept originally promoted by the International Labour Organization in the 1970s. It was further

developed within the concept of Primary Health Care which was promoted by WHO and Unicef in the 1980s. Seven community health interventions in particular were identified and given priority in both policies and practice. These interventions are likely to dominate the content of health relief policies in any given relief effort for refugees, including:

1. Environmental improvements: adequate shelter, sufficient water supply, disposal of refuse, sanitation systems.

2. Nutritional activities: general and selective food rations, vitamin or mineral supplements.

3. Epidemic control: vaccination programmes, vector control, medical screening.

4. Basic medical care: essential drugs for common diseases, provision of medical centres and clinics.

5. Epidemiological assessment and surveillance: cross sectional surveys, record keeping and reporting by services.

6. Security measures: location of settlements, international protection, monitoring and advocacy.

These priorities continued to emphasise the provision of technical or material interventions, and they have increasingly been articulated in the form of guidelines. Most of the main agencies, whether they be within the UN system or the charitable sector, have produced their own set of technical standards or guidelines[11] advocating these interventions as priorities. Thus, health relief no longer limits intervention to emergency and basic medical care but gives increasing attention to the most common health needs of entire populations. This means that, like health services within

industrialised countries, medical doctors with additional training in public health now provide the organizational and cultural leadership in health relief operations.

9.3.2 Maintaining roles in meeting acute needs only

In spite of the focus on population-wide health needs, the provision of leadership and care principally by international relief agencies suggests that current approaches still fail to consider issues related to the provision of health services in the longer term as well as the problems created for the host societies and governments. Moreover, giving priority to technical interventions which continue to be justified within a medical paradigm suggests that it also fails to address underlying social, economic and political determinants of poor health and nutrition as well as strategies for the organization of self-care in the longer-term. Thus, it would appear that health relief continues to be provided temporarily for immediate needs; interventions act as stop-gap measures which will inevitably reinforce the need for themselves as well as development.

9.4 References

1. Simmonds SP (1980) Seminar on health and health-related needs of refugees: National Office of the Commissioner for Refugees, Somalia. Disasters 4(2):129-132

2. Burnell PJ (1991) Charity, politics and the Third World. London, UK: Harvester Wheatsheaf, 286 pp.

3. Allen T (1990) Putting people first again: Non-governmental organizations and the 'new orthodoxy' for development. Disasters 14(1):63-68

4. 'State/AID response to General Accounting Office's draft to the Congress: "Need to build an international disaster relief agency"', Appendix II, Comptroller-General of the United States, Need for an International Disaster Relief Agency, Washington DC, General Accounting Office, 1976, pp. 19; cited in Kent RC (1987), p. 81

5. Smith BH (1991) More than altruism. The politics of private foreign aid. Princeton, New Jersey, USA: Princeton University Press, 284 pp.

6. Howarth T and Brooman J (1987) Twentieth century history. The world since 1900. London, UK and New York, USA: Longman Group, 308 pp.

7. Kent RC (1987) The anatomy of disaster relief. The international relief network in action. London, UK: Pinter Publishers, 183 pp.

8. Shawcross W (1984) The quality of mercy. London, UK: Andre Deutsch, 433 pp.

9. Duke S (1992) The UN financi crisis: A history and analysis. International Relations 11(2):127-150

10. Lewis J (1986) What price community medicine? The philosophy, practice and politics of public health since 1919. Brighton, UK: Wheatsheaf Books Ltd., 164 pp.

11. For example, a) UNICEF (1986) Assisting in emergencies. A resource handbook for UNICEF field staff. Geneva, Switzerland: United Nations Children's Fund. b) UNHCR (1982) Handbook for emergencies. Geneva, Switzerland: United Nations High Commissioner for Refugees. c) UNBRO (1988) Medical guidelines for the Thai-Kampuchean border. Aranyaprathet, Thailand: United Nations Border Relief Operation. d) Oxfam (1983) Oxfam's practical guide to refugee health care. Oxford, UK: Oxfam. e) MSF (1988) Organization d'un camp de refugies. Guide operationnel pour la phase d'urgence. Modules 1-4, Fiches techniques and annexes. Bruxelles, Belgium: Medecins Sans Frontieres Belgique and the Centre de Recherche sur l'Epidemiologie des Desastres

CHAPTER TEN

Health relief for Afghans in Pakistan, 1978-1982: Planning and organising a national refugee health service

10.1 Introduction

10.1.1 Country Background

The Islamic Republic of Pakistan is a relatively new nation-state located in the northwest of the Indian sub-continent. Pakistan has common borders with Afghanistan, India and Iran as well as a coastline on the Arabian Sea (Figure 10.1). The population of Pakistan is multi-ethnic and was estimated to be 96.2 million in 1985[1]. The main ethnic/linguistic groups are Punjabi and Sindhi: 79% reported Punjabi or Sindhi as their mother tongue in 1961. The rest of the population belong mostly to the Baluch and Pathan ethnic/linguistic groups - estimated to be 16% in 1961[2]. The majority of the population live in the eastern provinces of Punjab and Sind; only a relatively small proportion live in the provinces of Baluchistan and the North West Frontier or in the Federally Administered Tribal Areas. Thus, it is not surprising that the latter are the most poorly developed areas of the country. The proportion of the population living in urban areas has remained relatively the same since 1965 with over 70% living in rural areas[3].

The gross national product per capita was US$ 380 in 1985 with an average annual rate of growth estimated at 2.6% between 1965 and 1985. Though the majority of the population live in rural areas, only 55% of the working population is employed in agriculture: 16% are employed in industry and 30% are employed in service organizations. Furthermore, industry produced a larger proportion (48%) of the gross domestic product (GDP) than agriculture (25%) in 1985. This contrasts with production in 1965 when agriculture contributed 40% and industry 34% of the GDP which suggests a greater degree of industrialisation than before[4].

FIGURE 10.1

PROVINCES OF PAKISTAN

Most of the health status indicators for Pakistan are typical of a poor country. Infant and child mortality rates were 115 and 16 per thousand and life expectancy at birth was 52 and 50 years for males and females respectively in 1985[5]. Leading causes of illness, disability and death are those commonly associated with poverty, such as diarrhoeal diseases, malaria, nutritional deficiencies and complications during pregnancy and birth. Despite these indicators of poor health and nutritional status, the World Bank[6] estimated that health received only 1.1% of central government expenditure in 1985.

10.1.2 Afghan refugees in Pakistan

10.1.2.1 The Baluchis and Pathans: refugees in their own lands?

The influx of Afghan refugees and the responses of the Federal and Provincial Governments of Pakistan are most easily understood in the context of the historical development of the Baluch and Pathan ethnic groups[7]. Both the Baluchis and Pathans are ancient peoples with histories going back over 2000 years. They were originally settled further north and west than their current locations in southeastern Afghanistan and Iran and western Pakistan (Figure 10.2). Despite attempts by the Persians, Sindhis, Afghans, Sikhs, Moguls and British to subjugate the Baluchis or Pathans since the 13th century, permanent or complete control has eluded them all. In addition, rivalries among the various clans, especially the Baluchis, has limited efforts to create and maintain tribal unity.

The influx of Afghan refugees and the responses of the Federal and Provincial Governments of Pakistan are most easily understood in the context of the historical development of the Baluch and Pathan ethnic groups[8]. Both the Baluchis and Pathans are ancient peoples with histories going back over 2000 years. They were originally settled further north and west than their current locations in southeastern Afghanistan and Iran and western Pakistan (Figure 10.2). Despite attempts by the Persians, Sindhis, Afghans, Sikhs, Moguls and British to subjugate the Baluchis or Pathans since the 13th century, permanent or complete control has eluded them all. In addition, rivalries

FIGURE 10.2

Source: Wirsing 1981

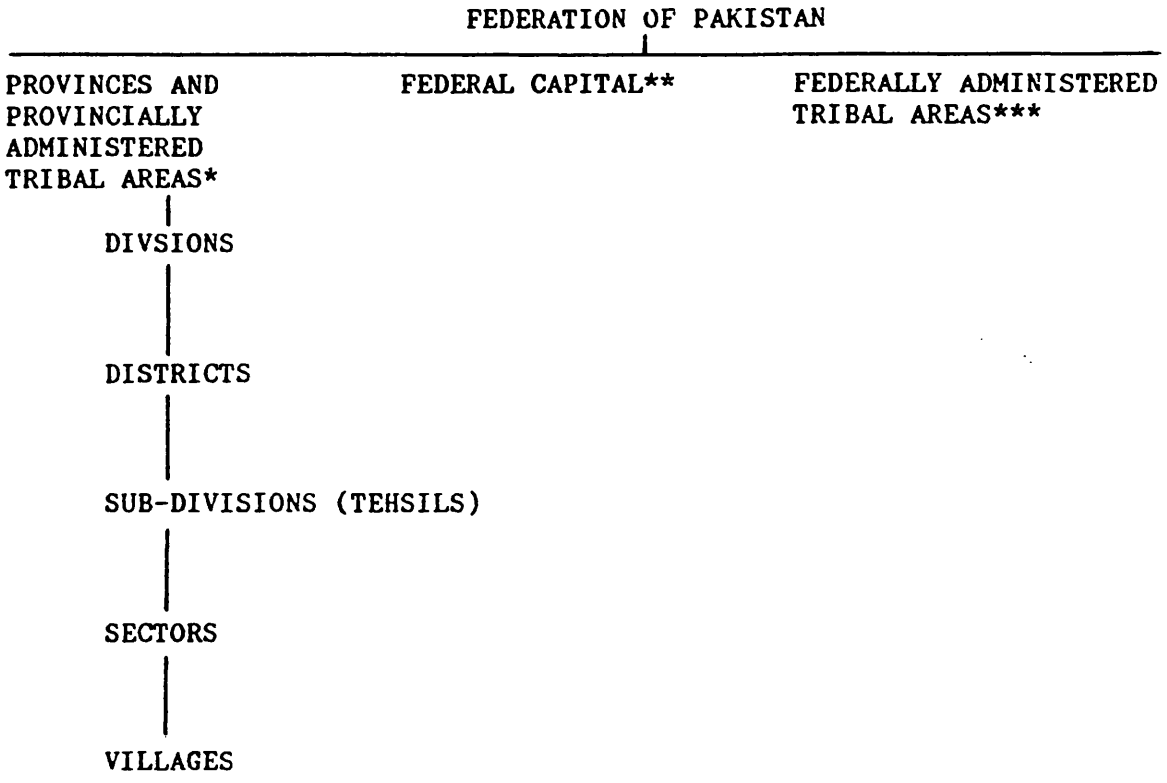
among the various clans, especially the Baluchis, has limited efforts to create and maintain tribal unity.

The fiercely independent nature of these people has always been recognised by the Federal Government of Pakistan. Beginning in 1947 during the creation of modern Pakistan, some of the Baluch and Pathan tribal areas were given semi-autonomous status. This status continued in 1955 although parts of Baluchistan (British) and the North West Frontier Province (NWFP) were absorbed into the single province of West Pakistan. With the restoration of the separate provinces of Baluchistan, the North West Frontier, Punjab and Sind in West Pakistan in 1970, the semi-autonomous tribal areas of the Baluchis were combined as Provincially Administered Tribal Areas with British Baluchistan into the province of Baluchistan. The tribal areas of the Pathans in the North West Frontier, however, remained separate and were grouped together for administrative purposes by the Federal Government to form the Federally Administered Tribal Areas (FATA) (Figure 10.3). Thus, throughout the history of Pakistan, many of the Baluchis and Pathans have retained their relatively independent status. Moreover, administrative groupings within the provinces of Baluchistan and North West Frontier and the international boundary between Afghanistan and Pakistan artificially divide peoples with shared kinship and ethnic identity.

The exact size and distribution of the Baluchis and Pathans in Pakistan is largely unknown. Estimates have been based primarily on three census counts undertaken in 1951, 1961 and 1972. The Baluch population was estimated at 2.8 million or 3.5% of the total population of Pakistan in 1979. Most (over 57%) were living in the provinces of Punjab and Sind as minorities. Moreover, large numbers of Pathans, Punjabis and Sindhis residing in the province of Baluchistan meant that ethnic Baluchis are also likely to be a minority in the province of Baluchistan. The Pathan population was estimated in 1979 to be at least 12 million people or 15% of the country's population. Thus, they are a much larger group than the Baluchis and are a majority in the North West Frontier, the Federally Administered Tribal Areas and parts of Baluchistan.

FIGURE 10.3

Administrative organization of the territories of the Islamic Republic of Pakistan



*Provinces: Baluchistan, North West Frontier, Punjab and Sind

Provincially administered tribal areas:

BALUCHISTAN: Zhob and Loralei Districts; Dalbandin Tehsil of Chagai District; tribal areas of Marri and Bugti of Sibi District.

NORTH WEST FRONTIER: Chitral, Dir and Swat Districts; Previous State of Amb; Malakand Protected Area; tribal area adjoining Mansehra.

**Federal Capital: Islamabad Capital Territory.

***Federally Administered Tribal Areas: Bajour, Orakzai, Mohamand, Khyber, Kurram, North and South Waziristan and tribal areas adjoining Peshawar, Kohat, Bannu, Dera Ismail Khan.

The size of the Pathan group and their control over the Federally Administered Tribal Areas, much of the North West Frontier and parts of Baluchistan has been of particular concern to the Federal Government of Pakistan because of the movement for a separate Pathan state, "Pashtunistan", since the creation of Pakistan[9]. The call for Pashtunistan was most recently put forward in 1976 by Abdul Ghaffar Khan in an attempt to mobilise Pathan popular opinion for the *Khudai-Kidmatgars* organization. An independent Pathan state, or alternatively the incorporation of the Pathans in Afghanistan (where Pathans are the single largest group in the country and probably half of the population), was supported at that time by the Afghan Government in Kabul[10]: one reason for giving support was Afghanistan's need for access to the Arabian Sea.

Between 1947 and 1949, the Afghan Government voted three times in favour of Pashtunistan. In addition, they voted against Pakistan's application to the UN, their parliament declared the Durrand and other Anglo-Afghan boundary agreements null and void, and they supported tribal dissidents who tried to form a Pashtunistan Government. Again in 1955, sympathy for Pashtunistan was expressed by the Afghan Government and leaders of the Soviet Union in response to the formation of a single province in West Pakistan. Support for Pashtunistan was most recently given by Daoud Khan's regime during 1973-78; this regime also supported the creation of a 'Greater Baluchistan' in addition to a separate Pathan state.

10.1.2.2 Seeking refuge from civil war

Refugees from Afghanistan first arrived in Pakistan following the overthrow of King Zahir Shah by Mohammad Daoud Khan in 1973. However, they did not begin to arrive in substantial numbers until Daoud Khan was assassinated in April 1978 during a Marxist coup. Daoud Khan's new Communist regime had embarked upon an ambitious programme of reforms of land tenure and the rights of women which were perceived by the rural population as a threat to the Islamic basis of their society. Thus, these reforms provoked intense opposition and the emergence of armed resistance[11]. Subsequent to Daoud Khan's fall, a revolutionary council was formed and headed by

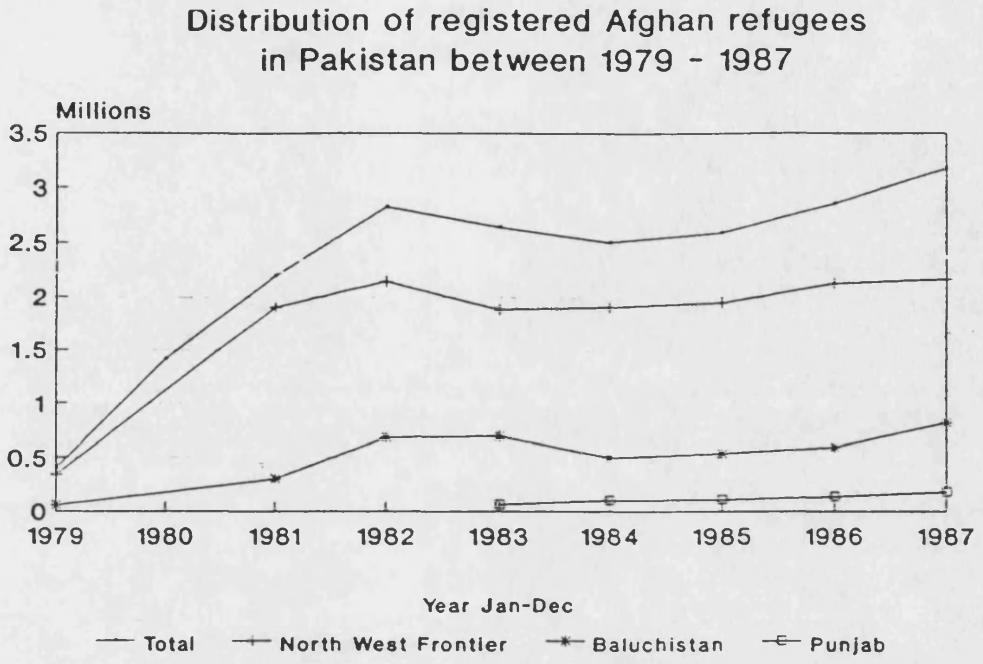
Nur Mohammad Taraki in Kabul for the newly established Democratic Republic of Afghanistan. In September 1979, the Taraki Government was overthrown by Prime Minister Hafizullah Amin. The Amin Government began to strengthen military capacity in Kabul and the northern areas of Afghanistan, and sporadic fighting began between government forces and rebel groups. Nevertheless, the Amin Government only survived three months and in December 1979 *Parcham* leader Babrak Karmal took over the presidency with the help of the armed forces of the Soviet Union[12].

10.1.2.3 Seeking refuge among sympathetic hosts

The most dramatic influx of Afghans into Pakistan occurred after the Soviet intervention, with some two million Afghans arriving during 1980 and 1981 (Figure 10.4). Most of the Afghans (80%) who fled into Pakistan concentrated in the North West Frontier, with the rest settling primarily in Baluchistan. Only a small number of people settled in the Northern Areas (between 1 and 2%). This distribution of the refugees reflects the asylum and hospitality provided to near and distant kin in Pathan culture.

Afghans crossed a disputed international border to seek asylum among kindred in lands long familiar to them. Peshawar, the capital of the North West Frontier, was previously known as the winter capital of Afghanistan. Afghans sought refuge in Peshawar and other villages close to the border where they were first assisted by local people. The welcome and assistance given to them by local people was not only a reflection of shared kinship and ethnic identity, but it was also an expression of shared opposition to the political conditions from which they were fleeing[13].

FIGURE 10.4


Distribution of registered Afghan refugees
in Pakistan between 1979 - 1987
Millions
3.5
3
2.5
2
1.5
1
0.5
0
1979
1980
1981
1982
1983
1984
1985
1986
1987
Year Jan-Dec
Total
North West Frontier
Baluchistan
Punjab

10.2 1978 - 1980: Organising relief for Afghans as refugees in Pakistan

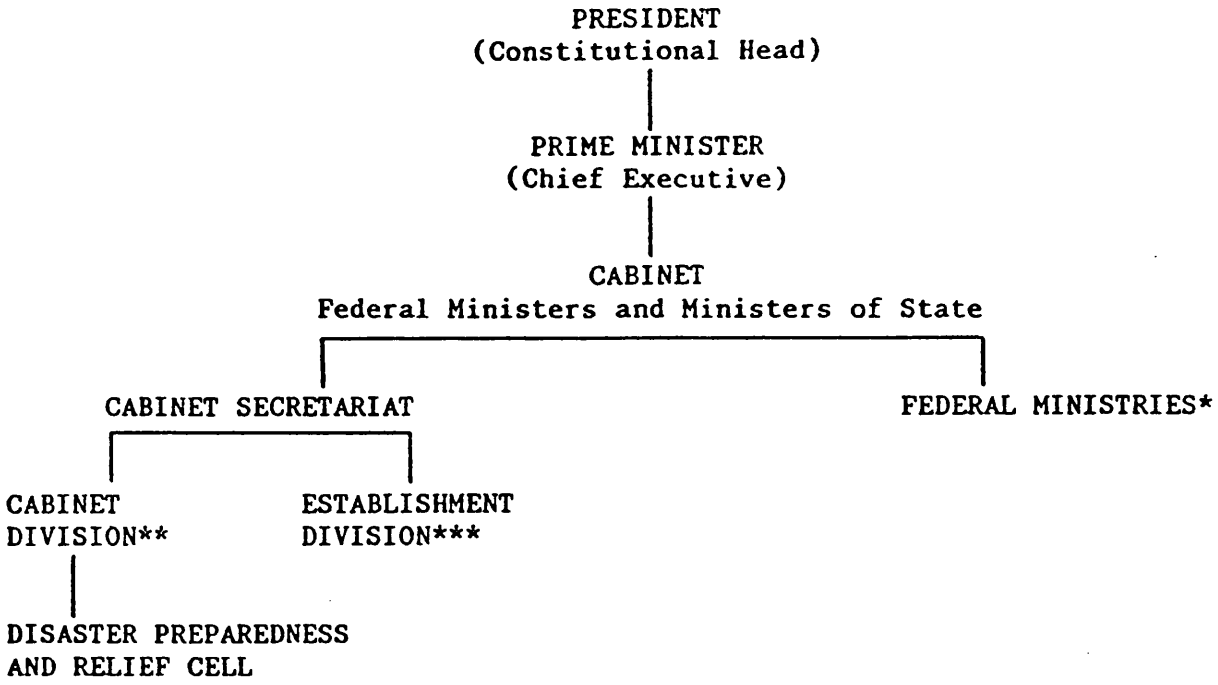
10.2.1 Responsibilities of the Federal Government: organising the distribution of essential goods

The Federal Government first began providing relief to Afghans in September 1978 through the Disaster Preparedness and Relief Cell of the Cabinet Division of the Federal Secretariat (Figure 10.5). This relief cell had originally been set up in the early 1970s following the cyclone in East Pakistan (now Bangladesh) and the extensive relief operation which was subsequently required[14]. The responsibilities of the Disaster Preparedness and Relief Cell were to co-ordinate the logistics of relief activities of relevant ministries and departments of the Federal Government and the international community: for example, by receiving donations and arranging the storage and transport of supplies. Efforts by the Disaster Preparedness and Relief Cell were primarily intended to augment those of the Provincial Governments which were responsible for making policies and plans for disaster relief as well as implementing relief activities.

Relief supplies, such as food, tents and money, were first sent by the Disaster Preparedness and Relief Cell to relevant federal ministries in the autumn of 1978 in response to requests from local administrators. In addition, other relevant federal bodies were informed as well as representatives of the United Nations who were working in Pakistan. Within the Federal Government, the States and Frontier Regions and Kashmir Affairs (SAFRON) Division became the focal point since it was responsible for the political and military administration of the geographical areas in which Afghans were settling. The Disaster Preparedness and Relief Cell continued to be involved in the relief programme for Afghan refugees until the spring of 1980 at which time responsibility for coordinating the logistical aspects of the programme was assumed by the newly established Chief Commissionerate for Afghan Refugees (CCAR) within the States and Frontier Regions and Kashmir Affairs Division[15].

FIGURE 10.5

Organization of the Disaster Preparedness and Relief Cell, Federal Government of Pakistan



*Federal Ministries: Commerce; Communications; Culture, Archaeology, Sports and Tourism; Defence; Education; Finance and Economic Affairs; Food, Agriculture and Co-operatives; Foreign Affairs; Health and Population; Housing and Works; Information and Broadcasting; Interior; Justice and Parliamentary Affairs; Labour and Manpower; Local Government and Rural Development; Petroleum and Natural Resources; Planning and Development; Production; Railways; Religious and Minorities Affairs; Science and Technology; States and Frontier Regions, Kashmir Affairs and Northern Affairs; Water and Power.

**Cabinet Division: Provides secretarial services to Federal Cabinet, inter-provincial conferences and National Economic Council. Concerned with the implementation of Presidential Directives, decisions of the Federal Cabinet and other bodies mentioned above. Also deals with flood and earthquake relief. Provides guidance to Federal Bureau of Intelligence.

***Establishment Division: Concerned with all matters related to public services, recruitment to senior positions, civil awards, and staff welfare. Monitors government offices for efficiency.

This separate Commissionerate, the CCAR, was first established as a temporary organization solely to co-ordinate relief for Afghan refugees and, thus, its responsibilities were similar to those of the Disaster Preparedness and Relief Cell but specific to the Afghan programme. The Chief Commissionerate for Afghan Refugees (CCAR) was headed by a Chief Commissioner who was assisted by two-to-three Programme Officers, one of whom was a medical doctor[16]. Thus, the role of the Federal Government in managing health relief was initially limited to one of logistical co-ordination of donations, storage and transport of medical supplies and equipment and of medical cover provided by government hospitals.

10.2.2 Responsibilities of the United Nations: securing needed resources

In April 1979, the Federal Government asked the United Nations High Commissioner for Refugees (UNHCR) and the World Food Programme (WFP) of the United Nations Food and Agriculture Organization (FAO) to assist Afghan refugees in Pakistan. Subsequently, two missions were sent to Pakistan in May and August of 1979. In response to their findings, an initial donation of US$ 190 000 was made from the Emergency Fund of the High Commissioner for Refugees. These funds were used to procure and distribute 1194 tents in the North West Frontier and 4868 blankets in Baluchistan. A plan for a more comprehensive programme of assistance was written in August 1979 by officials of the UNHCR and Provincial and Federal Governments. This *UNHCR Humanitarian Assistance Programme to Afghan Refugees in Pakistan* provided for some 185 000 refugees during the coming year, between 1 October 1979 and 30 September 1980, at a cost of US$ 10.3 million[17]. An official agreement to this programme of assistance was signed by the UNHCR and the Government following approval by the Executive Committee of the UNHCR in October 1979.
Officials of the WFP also took part in the missions undertaken by UNHCR in 1979. Based on the recommendations of these missions, the Federal Government submitted a request for food assistance to the Director General of the Food and Agriculture Organization on 13 December 1979, and approval was granted on 20 December 1979 for food commodities valued at US$ 5 383 000.

The on-going influx of Afghans into Pakistan following a third *coup-de-etat* in Afghanistan in December 1979, and the subsequent intervention by the Soviet Union[18], led the UNHCR to revise their programme of assistance. In January 1980 the High Commissioner launched an international appeal for US$ 55 million to cover the relief needs of the Afghans in Pakistan during 1980. Similar to the contribution of UNHCR, the WFP programme of assistance was expanded several times bringing the total contribution in 1980 to US$ 39 882 900. Under the agreement which WFP had with UNHCR, the WFP was responsible for the co-ordination and monitoring of all food commodities donated to the *UNHCR Humanitarian Assistance Programme to Afghan Refugees in Pakistan*[19].

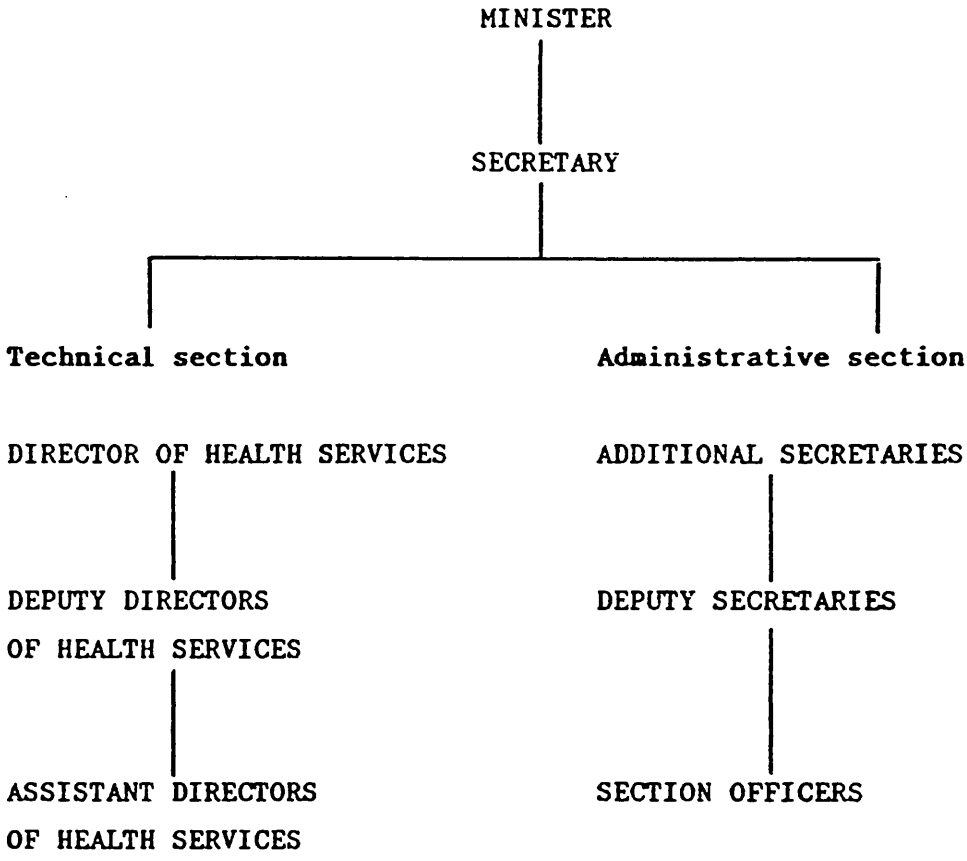
10.2.3 Responsibilities of the Provincial Governments of the North West Frontier and Baluchistan: organising and managing health relief

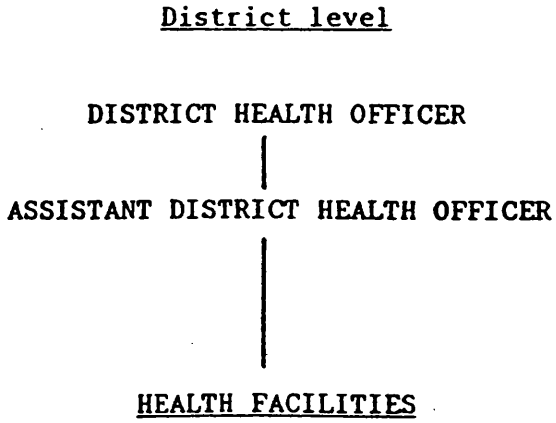
Although the Federal Government took responsibility for securing and distributing needed supplies, it was the Provincial Governments of Baluchistan and the North West Frontier which undertook to organise, manage and implement health care for the refugees in the autumn of 1979. Responsibility for health care of Afghan refugees was first given as an additional task to a Deputy Director of Health Services in the Provincial Health Department of the North West Frontier in October 1979 (Figure 10.6)[20]. Health care for the refugees at that time was provided by existing government health facilities to which the Afghans were given access, such as hospitals, rural health centres, clinics and dispensaries. Early in 1980 the first plans for a comprehensive refugee health programme were drawn up by the Provincial Health Department of the North West Frontier in collaboration with the World Health Organization (WHO) which had been working in Pakistan since the 1950s, the United Nations High Commissioner for Refugees (UNHCR) which had begun to assist Afghan refugees in October 1979 and the United Nations Children's Emergency Fund (UNICEF) which had also been working in Pakistan for several years[21].

The plan for the North West Frontier called for a separate 'Health Directorate' within the Health Department to manage and implement the refugee health programme.

FIGURE 10.6

Organization of health departments
of the provincial governments of Pakistan





However, this Health Directorate for Afghan refugees in the North West Frontier was not approved by the States and Frontier Regions and Kashmir Affairs of the Federal Government until September 1980. Furthermore, it was then established within the newly formed Provincial Commissionerate for Afghan Refugees in the Home Department and not the Health Department as had originally been planned. Unlike health, the education programmes, veterinary services, income generation schemes and skills training projects were initially implemented by the relevant departments within the Provincial Government. Health was the only social sector in which a separate administrative structure was created for refugee services. Furthermore, it was the first sectoral programme to be established within the Provincial Commissionerate for Afghan Refugees.

The decision to establish a separate management structure within the Home Department was influenced by several factors. Firstly, there was a rapid and continuing increase in the number of refugees; the Afghan population in Pakistan increased from 100 000 in September 1979 to 400 000 in December 1979 and reached one million in mid-1980 - approximately 100 000 new arrivals each month which continued throughout 1980. Secondly, the health needs and potential problems associated with this rapid increase in population quickly exceeded the capacity of existing health services. Thirdly, assistance from international organizations placed additional managerial demands on the Provincial Governments. Lastly, urgent and growing needs for relief required that lengthy bureaucratic procedures and political processes within government be bypassed. For example, health officials needed to be able to recruit and discipline workers hired temporarily as well as to control the use of donated funds and supplies. The creation of a separate structure for refugee relief generally, and health relief specifically, was one way government officials created and protected their autonomy to make decisions quickly and to use available resources to carry them out.

10.2.4 Establishing health services for the refugees: curative care or community health?

Throughout the formation of the Refugee Health Directorates to set up and manage separate health services for the refugees, a system of 'basic health services' was developed to provide curative care and disease control activities in the refugee villages. Until 1980 Afghans were given access to existing government facilities. With over 400,000 Afghans registered in January 1980 and a continuing influx of some 100,000 per month since October 1979, the plans for a comprehensive refugee health programme early in 1980 called for[22]:

- mobile teams staffed by a medical doctor, paramedic and lady health visitor (LHV) to visit the refugee villages on a regular basis.

- dispensaries staffed by a paramedic and lady health visitor to be located in the refugee villages.

- Afghan women to be employed as 'female scouts' to screen for health problems in the villages and refer people to the dispensaries and mobile teams.

- malaria control activities and immunizations to be provided by the relevant provincial departments.

- a health centre to be set up in Peshawar with an outpatient department, 25 beds for more serious cases and minor operating facilities.

10.2.4.1 Basic curative services: management by refugee, Pakistani or foreign health personnel?

With the exception of 'female scouts', these components of the refugee health programme were first implemented in 1980. Ten mobile teams and 15 dispensaries were set up in 1980 by the Health Department in Baluchistan to cover the 249,424

registered refugees living there[23]. Forty mobile teams and 88 dispensaries, of which 20 teams and 42 dispensaries were provided by the Refugee Health Directorate, had been established in the North West Frontier by the end of 1980[24]. The use of mobile teams and dispensaries in the villages reflects the priority given to medical care and the need to provide such care for large numbers of refugees, many of whom were initially living with family or friends or were scattered throughout the countryside. Organized settlements for the refugees were established early in 1980 in order to discourage integration with the Pakistani people, and consequently long-term settlement in Pakistan, and to facilitate the distribution of relief services. These settlements which were to accommodate 500 families or 5000 individuals led to the inclusion of dispensaries in addition to mobile teams in the plans for refugees health care[25]. Moreover, the use of mobile teams and dispensaries was consistent with the national disaster plan which specified the use of existing government health facilities, mobile first aid teams and dispensaries on-site for health relief[26].

These health units in the North West Frontier were originally employed by UNHCR on an exceptional basis, and as a short-term measure, until the Refugee Health Directorate was established in September 1980. Medical doctors for these teams were initially recruited from the *Society for Doctors and Other Health Professionals outside of Afghanistan* which had been formed by Afghans living in the North West Frontier who were associated with moderate Islamic political parties[27]. These interim arrangements did not work well since there was no co-ordination between refugee medical teams and local health authorities, drugs were not re-supplied to the teams, living facilities were not provided for the doctors and payment of salaries was often delayed. In addition, this society of Afghan health professionals had proposed that they be responsible for the management of all Afghan health staff with the Government and UNHCR providing salaries, equipment and supplies. This proposal was unacceptable to government officials who felt that management of the refugee health programme was the prerogative of the Government. Thus, the society was dissolved when health staff were employed in November 1980 by the Refugee Health Directorate directly.

In addition to the UN agencies which were already working in the country (WHO and UNICEF) or which had begun to assist the Afghan refugees in 1979 (UNHCR and WFP), several charitable agencies began to provide basic health services for the Afghans in 1980. The International Committee of the Red Cross (ICRC) and Medecins Sans Frontieres (MSF) France were two of the first foreign charitable agencies to take part in providing health care for the Afghan refugees. In keeping with its mandate, the ICRC concentrated on organizing the provision of first aid and medical and surgical care for those wounded during armed conflict. MSF sent a small team to assess needs in January of 1980 and their findings and recommendations concurred with governmental plans to provide care through mobile teams. However, MSF recommended that the mobile teams be staffed by two medical doctors, one male and one female, as well as two nurses; it is unclear whether they envisaged that foreign, Pakistani or Afghan nationals would fill these positions. Nevertheless, MSF and two other French medical aid organizations, Aide Medicale Internationale (AMI) and Medecins du Monde (MM), choose to work in Afghanistan where they established permanent clinics staffed by two medical personnel who rotated every four or six months. Since these agencies had no permanent base in Pakistan and since they maintained a discreet silence about their route into Afghanistan, these agencies were officially ignored by Pakistani authorities[28].

Notwithstanding the decision of the three French medical aid organizations to work in Afghanistan instead of Pakistan, by the end of 1980 there were ten charitable agencies financing and supervising 21 mobile teams and 24 dispensaries for Afghans in Pakistan[29]. In Table 10.1 it can be seen that six of the ten charitable agencies were based outside of Pakistan, with five being registered in Europe or North America and one in Saudi Arabia. Only four agencies were Pakistani; one was a charitable agency set up by Pakistanis, one was affiliated with branches of Protestant churches whose head office was in the US, one was a branch of a US charitable agency and the other one was affiliated with a political party of the Islamic faith. Two of the agencies registered in Europe were managed and staffed primarily by Afghans; both of these organizations were formed in response to the recent influx of Afghans into Pakistan and at least one had close links with one of the Afghan political parties. In addition

TABLE 10.1

Charitable agencies providing basic health services for Afghan refugees in 1980[30]

AGENCY	COUNTRY OF LEGAL REGISTRATION	SERVICES PROVIDED
North West Frontier		
International Committee of the Red Cross (ICRC)	Switzerland	4 mobile teams
Inter-Aid Committee	Pakistan/United States of America	2 mobile teams
CARE-Pakistan	Pakistan/United States of America	Potable water supply
International Rescue Committee	United States of America	4 mobile teams; 20 dispensaries
Save the Children Fund	United Kingdom	1 mobile team; 3 dispensaries
Union Aid for Afghan Refugees	West Germany	2 mobile teams
Pakistan Medico International	Pakistan	2 mobile teams
Austrian Relief Committee for Afghan Refugees	Austria	2 mobile teams; 1 health clinic
Edara Ahya-ul-Uloom	Pakistan	1 mobile team
Saudi Arabian Red Crescent Society	Saudi Arabia	2 mobile teams
Baluchistan		
Pakistan Medico International	Pakistan	1 mobile team
10 Agencies	**7 Countries**	**21 mobile teams; 24 dispensaries or clinics; one water supply project**

to providing care directly, some of the foreign agencies seconded medical doctors and nurses to the sub-offices of UNHCR in Peshawar and Quetta. For example, one nurse assessed the nutritional status and needs of the refugees and a medical doctor advised officials in charge of the programme in the North West Frontier.

10.2.4.2 Sophisticated medical and surgical care: setting up separate facilities or building capacity in existing centres?

A health centre for Afghan refugees was set up by the Health Department of the North West Frontier in Peshawar in May of 1980 with funds from UNHCR. But it only offered basic care on an outpatient basis and it only functioned for four months. Similar to many of the mobile teams and local dispensaries, this health centre was staffed by medical doctors who were members of the *Society for Doctors and Other Health Professionals outside of Afghanistan.* Disputes with provincial health authorities over salaries and managerial responsibilities contributed to the early closure of this centre[31].

Beginning in 1981, some foreign and local charitable agencies and several Afghan and Pakistani political parties began to establish separate referral facilities and specialty services for the Afghans, mainly in Peshawar in the North West Frontier. These hospitals were funded and managed by organizations other than the Government of Pakistan and UNHCR, and they were set up specifically to care for Afghans wounded during armed conflict. Not surprisingly, many were associated with particular political parties of the Afghan Mujahideen who were at war with their own Government. For example the *Society for Doctors and Other Health Professionals outside of Afghanistan* set up their own hospital to care for those wounded in conflict, ill members of their party, other supporters and their families[32]. Support from the Government of Pakistan to these hospitals was limited at that time to the provision of some ambulances to transport patients from the border areas to the hospitals. Instead, provincial health authorities and officials of UNHCR were concerned mainly with providing basic medical care through mobile teams and local dispensaries and, to a

lesser extent, with enabling existing governmental hospitals in the districts and regions to extend their services to Afghans in need of care.

10.2.4.3 Disease control: extending national programmes

Control activities for malaria and tuberculosis and vaccination programmes were high priorities in the health plans and services of Pakistan and vertical programmes were well-established. For example, malaria control activities first began in the 1950's as part of the WHO malaria eradication programme. The inclusion of these activities in the refugee health programme was a logical extension of national and international health priorities and services. Thus, specific measures to control priority diseases were promoted and initiated mostly by the Government, with support from WHO and UNICEF.

Beginning in 1980, spraying of insecticides and testing samples of blood for the malaria parasite were begun among refugees living in the North West Frontier by the Provincial Malaria Control Programme of the Health Department. From the beginning and continuing throughout the refugee health programme, the percentage of blood samples in which the malaria parasite was found was higher among refugees than the local populations (Table 10.2)[33]. These findings led many people to believe that the refugees might increase the incidence of malaria, either as a result of increased foci brought by Afghans since many were coming from malarious areas of Afghanistan or of epidemics within non-immune communities since many camps were located in malarious areas of the North West Frontier. Furthermore, publication of these findings in the local and international press created additional pressure to implement control measures. Spraying insecticides prior to, and after, the season of transmission and screening for cases by collecting samples of blood were common components of both programmes in addition to the treatment of cases by staff in the mobile units and dispensaries. With funds from UNHCR, these activities were implemented in the camps by separate mobile teams and staff of the provincial disease control programmes. These plans for malaria control among Afghan refugees were written in both Baluchistan and the North West Frontier during 1981[34].

TABLE 10.2
Malaria prevalence among Afghan refugees and local Pakistani populations in the North West Frontier

Year	Afghan refugees			Local population		
	Total examined	Number positive	Prevalence (%)	Total examined	Number positive	Prevalence (%)
1979	12156	235	1·9	583824	1815	0·3
1980	52464	2562	4·9	612580	1982	0·3
1981	177537	11255	6·3	601508	3987	0·7
1982	268083	18087	6·8	603602	4437	0·7
1983	51843	4761	9·2	569819	5357	0·9
1984	131615	20808	15·8	667188	9558	1·4
1985	183725	40820	22·2	488490	17111	3·5
1986 (Jan. to July)	114470	27326	29·1	252561	12661	5·0

Source: Provincial office of Malaria Control Department and Project Directorate of Health for Afghan refugees NWFP.

Similar to malaria control, vaccines against cholera and typhoid were first given to the refugees early in 1980 by the Provincial Expanded Programme of Immunizations (EPI) of the Health Department. Later in that year, the vaccines given were changed to those against diphtheria, pertussis, tetanus, polio and measles in accordance with international standards. With support from UNICEF, the Provincial EPI Programme in the North West Frontier established vaccination centres for refugees in five tribal agencies and four settled districts, and in Baluchistan mobile teams were formed. Despite organizational differences, an evaluation of the programme in December 1980 found that vaccinations were provided mostly on an *ad hoc* basis in response to reported outbreaks[35]. These crash programmes were creating a tremendous burden on the provincial programmes since coverage in the local and international press necessitated prompt responses to reported outbreaks among the refugees and, thus, local staff and supplies were being diverted to care for the refugees. In addition, *ad hoc* services lacked continuity which made follow-up visits and doses difficult to provide. As a result of the evaluation, separate mobile vaccination teams were then formed, beginning in 1981, by the Health Department in Baluchistan and the Refugee Health Directorate in the North West Frontier.

Unlike vaccinations and malaria control activities, tuberculosis control was not organised as a separate programme in isolation from basic curative care due to the nature of the disease and its control. Responsibility for diagnosing and treating cases (the main control measures) was given to the staff of mobile units, dispensaries and, later, basic health units. However, the lack of laboratory facilities for sputum analysis and systems to follow-up suspected and confirmed cases greatly limited the effectiveness of the programme. The lack of laboratory facilities was equally a problem for malaria control, a priority of which was detection of cases through testing samples of blood. These problems were highlighted in an evaluation of the refugee health programme generally by WHO mid-1981[36]. In this evaluation, the additional problems of a somewhat haphazard implementation of insecticide spraying and low coverage of vaccinations were also noted.

10.3 1981 - 1982: Organising a national health service for Afghan refugees

10.3.1 Management - a governmental affair

10.3.1.1 Planning for refugee health care nation-wide

In response to the request of the Provincial Government of the North West Frontier in 1980 for a separate administrative structure for the health relief programme for the Afghan refugees, the Federal Government not only gave approval but expanded and formalised the organization at national, provincial and district levels. On 17 December 1980, the President issued a Directive (No 57/1/CMLA) regarding the administration of Afghan refugee camps. In this Presidential Directive, the organization of health services for Afghan refugees was established to include[37]:

NATIONAL LEVEL	One Director of Health Services within the Chief Commissionerate for Afghan Refugees (CCAR), the States and Frontier Regions and Kashmir Affairs Division of the Federal Government. This Director was to arrange for, and centrally control, medical supplies and equipment. Distribution was to be conducted by the Provincial Health Directorates for Afghan Refugees.
PROVINCIAL LEVEL	One Project Director for Health within the Provincial Commissionerate for Afghan Refugees. The Director was to be assisted by two Deputy Directors.
DIVISIONAL LEVEL	Divisional hospitals were to be expanded by 30 beds. Additional staff were to be hired.
DISTRICT/TRIBAL AGENCY LEVEL	Existing staff at the district and tribal agency level were to be reinforced and used for the supervision and co-ordination of the refugee health programme in their

respective areas. Separate medical facilities were not to be established within the districts and tribal agencies. Honoraria were to be given to health staff.

VILLAGE LEVEL Refugee villages were to be provided with dispensaries which included five inpatient beds, an ambulance for transporting emergency cases to referral facilities and residential accommodation for staff. The medical officer of the dispensary was further designated as the health officer of the camp.

10.3.1.2 Establishing federal and provincial structures

Subsequently, in February 1981, a Director of Medical Services was appointed in the Chief Commissionerate for Afghan Refugees (CCAR)[38] and a Deputy Director of Health Services of the Health Department in Baluchistan was given responsibility for refugee health care. Unlike the Health Directorate for Afghan refugees in the North West Frontier, the Directorate in Baluchistan was initially established within the Health Department in October 1981. However, there were problems in managing the refugee health programme in Baluchistan as a result of this arrangement which were similar to those encountered in the North West Frontier, including[39]:

- government procedures for recruiting and terminating health staff were lengthy processes which caused delays in filling posts and in disciplining staff.

- dual accountability of staff to the Health Department and the Refugee Health Directorate weakened the authority of the Refugee Health Directorate largely because the Health Department could offer career positions in future.

- procedures for requesting and obtaining funds from the Government were also lengthy processes which caused delays in getting financial approval for projects and in paying bills.

The resulting delays in implementing some health activities in Baluchistan and the poor quality of many of those which had already been initiated led to the relocation of the Refugee Health Directorate in the Provincial Commissionerate for Afghan Refugees of the Home Department at the end of 1981 - similar to the organization in the North West Frontier. Thus, by the end of 1981 both Provincial Governments which were hosting Afghan refugees had assumed responsibility for managing and implementing refugee health services, and they had created separate political and administrative structures within their Home Departments to do so.

10.3.1.3 Planning for management of the refugee health programme locally

The need for separate supervisors within the districts and tribal agencies was first suggested in January 1981 by the foreign Medical Advisor to the UNHCR Sub-office in Peshawar in response to delays and difficulties in implementing the planned health activities, namely the provision of dispensaries and basic health units in the camps and the implementation of the immunisation, malaria control and sanitation programmes. During 1980/81 problems with District Health Officers and Agency Surgeons had been encountered by the Refugee Directorate for Health. Moreover, responsibility for some 2 million refugees as well as one million local Pakistanis was felt to be an unreasonable task for the regular government health officials[40]. Furthermore, it was no longer possible for the Project Director of Refugee Health to continue to supervise personally and co-ordinate the medical officers and other staff of the refugee health programme which had expanded to cover 1, 148 746 refugees living in 11 different districts and tribal agencies.

Initially, field supervisors were proposed to be attached to the District Health Officer or Agency Surgeon but responsible to the Refugee Directorate for Health. The foreign Medical Advisor to UNHCR originally suggested the use of foreign staff but this was never discussed with the Project Director of Refugee Health. In August 1981, the Project Director of Refugee Health and UNHCR agreed to request six Field Supervisory Medical Officers (FSMO) in an attempt to exercise greater control over staff of the refugee health programme. Specifically these Field Supervisory Medical

Officers (FSMOs) were to oversee the tuberculosis control, malaria control and immunisation programmes.

10.3.2 Creating a permanent medical service for Afghan refugees

The distribution of mobile teams and dispensaries was revised in the spring of 1981 in order to comply with the Presidential Directive which stated that one dispensary in a permanent structure was to serve 10,000 people. In addition, a medical doctor was to be a regular staff member of each dispensary. The first criteria mirrored the national health plan for 1976-1981 which called for one basic health unit (BHU) for every 10,000 persons[41]. However, this national plan specified that staff of basic health units were to be paramedical rather than medical doctors. Placing doctors in national basic health units was first recommended in November of 1981 by a special committee appointed by the President to investigate the surplus of medical doctors. Thus, beginning in 1981 and to a greater extent during 1982, the number of dispensaries in refugee villages was increased and medical doctors were increasingly employed in them, thereby upgrading them to basic health units. By the end of 1981, the Refugee Health Directorates in Baluchistan and the North West Frontier were providing 10 and 31 (61%) of the 61 (10 and 51 respectively) mobile teams as well as 15 (75%) and 74 (65%) of the 134 (20 and 114 respectively) dispensaries for Afghan refugees[42].

The implementation of this policy was not without difficulty. The main problems were in recruiting and retaining staff, particularly medical doctors and women - both doctors and lady health visitors - since there were shortages of these workers in both Baluchistan and the North West Frontier despite a nation-wide surplus of medical doctors. In the North West Frontier, for example, some 150 posts for physicians, particularly those for women, and 80 posts for lady health visitors were vacant at that time. In addition to shortages of health staff within the provinces generally, frequent vacancies in refugee health positions were due to insufficient and unacceptable accommodation facilities in rural areas, frequent delays in payment of salaries and inadequate supervision. In order to overcome some of these problems, specific

personnel polices were adopted regarding the employment and remuneration of health workers in the refugee camps.

10.3.2.1 The lack of a career structure for health staff

A group of Pakistani physicians which offered to work for the refugee health programme in the North West Frontier in May 1980 requested that their work with the refugees be considered as a secondment from the Provincial Government. Their request was refused for at least two reasons. Firstly, such a system had been unsuccessfully tried in Baluchistan. The system of taking staff on deputation from the Provincial Department of Health created confusion about accountability since staff answered to both the Health Department and the Refugee Directorate for Health in the Commissionerate for Afghan Refugees. This undermined the authority of the Refugee Directorate for Health, making control of staff difficult since they responded primarily to the Health Department. Initially, the Director of Refugee Health of the North West Frontier, and later the Director of Refugee Health of Baluchistan, felt that control over staff was essential to implement the programme successfully. Thus, senior health staff of the refugee programme continued to be appointed by the Health Department, but the Field Supervisory Medical Officers (FSMOs) and staff of the basic health units were later hired and supervised directly by the Refugee Directorates for Health beginning in 1980 in the North West Frontier and in 1985 in Baluchistan.

Secondly, graduates of medical doctor and lady health visitor training programmes which were subsidised by the Government were required to work in provincial health facilities for between six months and three years following completion of their training. This work was not recognised as government service. Thus, neither work in the refugee health programme nor work as an obligation for training was recognised as government service. There was, however, an agreement with the Health Department in the North West Frontier that lady health visitors could defer their two year obligation while working for the refugee health programme.

10.3.2.2 Hardship living conditions

Insufficient or inadequate accommodation was a problem less easily solved than levels of salaries. The lack of accommodation facilities was most serious for female staff who in Pakistani culture must live separate from men and preferably not on their own. Obviously, the difficulty in recruiting and retaining female staff was most acute in remote areas, such as Baluchistan and the tribal agencies in the North West Frontier. The possibility of constructing separate accommodation facilities was considered and rejected in the North West Frontier in 1982. It was felt that the provision of separate accommodation facilities was too costly and unnecessary given the compensatory increase in salary[43]. In Baluchistan, accommodation facilities were provided to some extent in the basic health units; there were few other options since many of the camps were a considerable distance from Pakistani villages and towns.

10.3.2.3 Compensating for the lack of career opportunities and poor living conditions: financial incentives

From the beginning of the refugee health programme, the Project Director of Refugee Health in the North West Frontier (at that time a Deputy Director for Health Services in the Health Department) requested that higher salaries be paid to staff working with the refugees. A financial incentive was felt to be necessary to recruit and retain health staff because:

- the demands of the job were felt to be greater than in government posts or private practice. The refugees were located in remote areas which required that staff live in areas away from the conveniences of more developed villages and towns and away from family and friends. In addition, many refugees were living in the tribal agencies where the safety of staff could not always be guaranteed. Lastly, the Afghans had different cultural beliefs and practices regarding health which required different approaches by health staff.

- unlike the health programme of the Provincial Government, accommodation was not provided for health staff working with the refugees. (Some accommodation facilities were provided in Baluchistan since many camps were a considerable distance from Pakistani villages and towns.)

- there were no career possibilities in the refugee health programme; all posts were temporary and work with the refugees was not credited towards government service.

- there was a shortage of health staff

A financial incentive was intended to compensate for these disadvantages of working in the refugee health programme. The Commissionerate for Afghan Refugees in the North West Frontier referred this request to the Provincial Department of Finance which recommended that approval be sought from the Federal Government. Subsequently, the request was referred to the States and Frontier Regions and Kashmir Affairs which requested approval from the Ministry of Finance. The Ministry of Finance rejected salaries in excess of those paid for government service in September 1980. The Commissionerate persisted in their request for the above reasons to which the Federal Government finally agreed in 1981. Although the Project Director of Refugee Health initially requested a monthly salary of rupees 6000 for medical officers, the salary was set at rupees 4500 per month - three times the salary for medical officers in the government health service[44]. Monthly salaries for other health staff were also higher than their counterparts in the government health services.

10.3.2.4 National staff as care-givers: Restrictions on foreign personnel

Despite the many difficulties faced by the Government in recruiting and retaining local staff in the refugee health programme from 1981, the Government maintained a policy that limited foreign personnel to working in settled areas, in other words in districts rather than tribal agencies. Prior to that time, several international agencies were either working in, or had proposed to work in, tribal agencies. However, one foreign staff

member of an inter-governmental organization did not abide by the agreement the agency had with the Government. Due to associated security problems, the Federal Government, upon the recommendation of officials of the provincial refugee programme in the North West Frontier, barred all foreigners from working in the tribal areas in July of 1981. In future, foreign workers and agencies were to finance and supervise medical teams of Pakistan and Afghan nationals in settled areas; the Government would provide services in the tribal agencies. As a result, foreign personnel of the International Committee of the Red Cross were re-assigned to Peshawar (from Kurram and North Waziristan Agencies) and the Austrian Relief Committee and the International Rescue Committee were reassigned to cover Mardan and Kohat Districts rather than Bajour and Dir Tribal Agencies respectively.

Another result of the increasing involvement of foreign health staff in relief efforts for the Afghans, both in Afghanistan and Pakistan, was a growing concern among government officials for national security. Further restrictions were then placed on foreign personnel which limited them to administrative or advisory roles: they were not to be working in the refugee villages and they were not to be providing basic care directly. Similar to the requirement that foreigners work only in settled districts, this restriction was also established because of concerns for security by the Government. In addition to these restrictions, all health staff earning more than rupees 1500 per month were required to obtain security clearance from the Federal Government as well as consent from the Provincial Refugee Health Directorates to work in the refugee health programme[45]. These practices limited the roles and activities of international staff and ensured, to some extent, that services provided by international agencies complimented those provided by the Government.

10.4 Comment

The escalating influx of hundreds of thousands of Afghans into Pakistan between 1979 and 1981 was followed by a massive relief operation. The initial relief effort was distinguished by national and international policies which recognised all Afghans as refugees, entitling them to national and international assistance. Relief activities were

initiated for a relatively small number of refugees, less than five per cent of the refugee population registered with the Government and UNHCR in 1988. Though several thousand people in need pose obvious problems for governments to provide for their food, shelter and other basic needs, they also create additional political concerns. Large numbers of refugees may be seen as a threat to internal order by national governments. The independent nature of Pathans, which had previously been expressed in the movement for a separate Pathan state, the considerable degree of autonomy enjoyed by Provincial Governments in Pakistan and the existence of a majority of Pathans in the North West Frontier and Baluchistan meant that the arrival of several hundred thousand additional Pathans as refugees had the potential to upset the already delicate, and at times strained, relationship between the Federal Government and the local governments and people of the North West Frontier and Baluchistan. Thus, there were concerns for domestic political stability which incorporated the effect of several thousand refugees on ethnic composition, employment markets and scarce environmental resources. Clearly, it was not in the interest of the Federal Government to ignore the needs of the refugees and their local hosts.

The arrival of several thousand refugees may also pose a threat to national security, particularly when there is potential for armed conflict between the government from which the refugees are fleeing and either the government hosting the refugees or the refugees themselves. These fears were partially realised but not until February and March of 1987 when refugee villages were bombed by aircraft of the Afghan Government's military forces[46]. Host governments may fear infiltration by agents of the opposing government under the guise of being refugees or they may fear retaliation from the opposing government for hosting active rebels - both of which may undermine government structures and services as well as support for the government by local people. For example, some attributed the frequent bombings of local businesses, government offices or public markets to agents of the Afghan Government's secret intelligence service, KHAD. Similarly, the threat of refugees on the national security of host governments is of concern to other states, particularly those who have strategic interests in the country. Thus, although large numbers of

refugees are a humanitarian concern, their effect on existing relationships within and between nation-states may be of equal, if not greater, political concern to host and allied governments.

Governmental relief activities for Afghans were first initiated in 1978 by local government authorities. Relief priorities centred on meeting basic needs for water, food and shelter. The activities undertaken were extensions of existing or previous relief programmes; they were organised and implemented through an existing relief structure, namely the Disaster Preparedness and Relief Cell of the Cabinet Division. Clearly, previous experience with, and preparedness for, disasters affects contemporary responses of governments - both the priorities and organization of relief provided. However, a lack of resources and a poorly developed relief organization led to the *ad hoc* distribution of food and other supplies in practice.

Very early on policies designated the Government of Pakistan as the institution through which health relief would be provided for the refugees. Inevitably, health relief for the refugees was initially provided by existing health facilities or extensions of existing services. Yet in Pakistan, rural health services lacked sufficient resources, were poorly developed or did not exist at all in the areas where the refugees settled. Nonetheless, in the plans for relief, Afghans were initially given access to rural health centres, clinics and dispensaries. Many of these facilities lacked supplies and personnel or were frequently closed; they were inadequate to meet the needs of local people, let alone thousands of refugees. This meant that health care was provided on an *ad hoc* basis in practice and was insufficient to address the health problems of the refugees.

Additional policies were then formulated which authorised the creation of a separate, parallel system of health services nation-wide in which decision-making and managerial responsibilities were granted to governmental health and political authorities. The creation of the refugee commissions allowed refugee health care to either be the responsibility of these commissions or the Ministry of Health. In Pakistan, a somewhat unusual arrangement was adopted with a combination of military

and government health officials being seconded to national and provincial refugee commissions respectively for refugee health care.

Choosing to place the management of refugee health care in the refugee commissions was a response to urgent needs for relief which required that bureaucratic procedures and lengthy political processes within government be bypassed. In other words, officials in charge of refugee health care chose to work within the organization which offered them greater autonomy. They needed to be able to recruit, retain and discipline health workers and to obtain and control the use of funds and other supplies. Thus, in Pakistan, the creation of a separate directorate for refugee health care was one mechanism through which the autonomy to make decision, and to control the resources needed to implement them, was made available.

Curative allopathic care, both medical and surgical, was the priority and efforts were made to make it widely accessible through the use of mobile teams and facilities sited locally. The priority given to curative medicine and disease control in Pakistan clearly mirrored health priorities in national disaster plans and health services. These were also the health relief priorities of many charitable agencies and inter-governmental organizations which were involved in the Afghan relief effort. Thus, medical and surgical care as priorities were supported by the United Nations, charitable agencies and host and donor governments alike.

The Government was supported in these roles by specialised agencies of the United Nations and both foreign and domestic charitable agencies. UNHCR provided vast financial resources to set up and maintain a system of refugee health services. Unicef gave money, vaccines and other supplies so that immunization and water would be accessible to the Afghans. WHO advised the Government on disease control strategies, primarily for malaria and tuberculosis, but relied on UNHCR to secure the resources needed to put them into practice. Foreigners were excluded from positions in management and in the provision of care directly; Pakistani medical doctors were enticed with higher pay and other benefits both to staff and to manage the refugee health services within districts and refugee villages. Thus, charitable agencies provided

resources for mobile teams and clinics to care for the refugees in their villages; in addition, some seconded professionals to advise UNHCR on the organization and management of curative services or community health concerns, such as nutrition. In so doing, each of these agencies, as conduits for international aid, undertook roles traditionally held by them in refugee relief operations. But in Pakistan, they initially did so under the skilled leadership of Pakistani authorities and within policies and plans determined by them.

To understand why Pakistanis were able to take and enforce leadership at all levels of the health relief operation is beyond the scope of this analysis since any meaningful explanation would need to delve deep into Pakistan's recent and colonial past. Policies of key donors and other political allies would also need to be explored in detail. Notwithstanding the short-comings of reviewing historical influences more superficially, at least two factors made a notable contribution. Firstly, throughout their recent and colonial past, Pakistan officials have gained considerable expertise in providing political leadership. They were skilled in dealing with the different interests and complexities which characterise a multi-ethnic society as well as pressures exerted from abroad - both near and far. Thus, their leaders were very much aware of the circumstances within which events occurred as well as the implications for existing balances of power. This was no small feat since groups with vested interests were many and varied, ranging from the two most powerful governments in the world to local factions of the Islamic faith.

Secondly, Pakistani officials were skilled in planning and organising public services. With a long exposure to allopathic systems of medical care, Pakistan not only had extensive systems of public and private health facilities when the Afghans first arrived, they had a surplus of some 10 000 medical doctors who were unable to find work. The need to consider the interests of the medical profession weighed heavily on both public health authorities who not only were members themselves but who genuinely supported medical doctors in the leading role as legitimate providers of health care, and political officials who could ill afford to lose the support of one of the most wealthy, politically-active and influential groups in society. Thus, in addition to their

concerns for the well-being of the Afghans, their ability to plan and organise a separate system of health services based on the practice of allopathic medicine by medical doctors also ensured the well-being of the medical profession's position within the health sector in Pakistan.

10.5 References

1. World Bank (1987) World Development Report 1987. Oxford, UK: Oxford University Press, 285 pp.

2. Wirsing RG (1981) The Baluchis and Pathans. London, UK: Minority Rights Group, Report No. 48, 23 pp.

3. World Bank (1987), #1

4. World Bank (1987), #1

5. World Bank (1987), #1

6. World Bank (1987), #1

7. See Wirsing RG (1981), #2

8. See Wirsing RG (1981), #2

9. Cheema PI (1983) The Afghanistan crisis and Pakistan's security dilemma. Asian survey 23(3):227-243

10. Wirsing RG (1981), #2

11. York S and Grant K (1980) Afghan refugees in Pakistan. A preliminary report 5th September 1980. London, UK: International Disaster Institute, 23 pp.

    BRC (1987) Afghanistan: The Human Tragedy. London, UK: British Refugee Council, 27 pp.

12. Wirsing RG (1981), #2

13. Zaman S (1987) Humanitarian assistance programme for Afghan refugees in North West Frontier Province. Peshawar, Pakistan: Afghan Refugee Commissionerate NWFP, Public Relations Unit, January, 72 pp.

14. Khan AU (1987) former Deputy Secretary, Emergency Relief Cell, Cabinet Division, Federal Government of Pakistan. Interview 26 July 1987, Rawalpindi, Pakistan

15. Shafique A (1987) Deputy Secretary Emergency Relief Cell, Cabinet Division, Federal Government of Pakistan. Interviews 16 and 26 July 1987, Rawalpindi, Pakistan

16. Khan AR (1988) Director Medical Services, Chief Commissionerate for Afghan Refugees, States and Frontier Regions Division, Federal Government of Pakistan. Interview 6 January 1988 Islamabad, Pakistan.

17. UNHCR (1980) UNHCR Humanitarian Assistance Programme to Afghan Refugees in Pakistan. Period under review - 1980 Calendar Year. Report No. 9. Islamabad,

Pakistan: Office of the Chief of Mission, United Nations High Commissioner for Refugees, 83 pp.

18. UNHCR (1983) UNHCR Sub-office in Peshawar. Afghan refugees in NWFP. Peshawar, Pakistan: United Nations High Commissioner for Refugees, 5 pp.

19. UNHCR (1980), #16

20. Khan AS (1987) former Project Director For Health for Afghan Refugees, Provincial Government of NWFP. Interviews 24 and 30 August 1987, 2, 15, 19, and 20 September 1987, Peshawar, NWFP, Pakistan

21. UNHCR (1980), #16

22. UNHCR (1980, #16

23. Programme Officer UNHCR (1981) Self-evaluation report on the health sector 1981 programme. Quetta, Baluchistan, Pakistan: United Nations High Commissioner for Refugees, 9 pp.

24. Khan AS Medical cover - Afghan refugees in NWFP. Peshawar, NWFP Pakistan: Commissionerate for Afghan Refugees, Government of NWFP, 8 pp.

25. Khan AS Health cover for Afghan refugees in NWFP. Paper of Project Director for Health Afghan refugees in NWFP. Peshawar, Pakistan: Commissionerate for Afghan Refugees NWFP, 3 pp.

26. Cabinet Division National Disaster Plan. Islamabad, Pakistan: Disaster Preparedness and Relief Cell, Cabinet Division, Government of Pakistan, 20 pp.

27. Khan AS (1987) former Project Director For Health for Afghan Refugees, Provincial Government of NWFP. Interviews 24 and 30 August 1987, 2, 15, 19 and 20 September 1987, Peshawar, NWFP, Pakistan.

28. Magnus RH (1987) Humanitarian responses to an inhuman strategy. In: Farr GM and Merriam JG Afghan resistance. The politics of survival. Boulder, Colorado, USA and London, UK: Westview Press, pp. 191-212

29. UNHCR (1980), #16

30. UNHCR (1980), #16

31. UNHCR (1980), #16

32. Magnus RH (1987), #27

33. Suleman M (1988) Malaria in Afghan refugees in Pakistan. Transactions of the Royal Society of Tropical Medicine and Hygiene 82(1):44-47

34. Provincial Chief Malaria Control Programme (1981) Malaria control activities in the Afghan refugees camps. Quetta, Baluchistan, Pakistan: Malaria Control Programme, Government of Baluchistan, 5 pp.

Provincial Chief Malaria Control Programme (1982) Working paper for 9th meeting of the provincial co-ordination committee meeting. Peshawar, NWFP, Pakistan: Malaria Control Programme, Department of Health, Government of NWFP, 4 pp.

35. WHO (1980) Expanded programme on immunization Pakistan. Suggested plan of action for Afghan refugees. Quetta, Baluchistan, Pakistan: United Nations High Commissioner for Refugees, 10 pp.

36. Simmonds SP (1981) Assignment report. The health of the Afghan Refugees in Pakistan. Geneva, Switzerland: the World Health Organization, Emergency Relief Operations, 17 pp.

37. SAFRON (1981) Medical cover plan for Afghan refugees. Islamabad, Pakistan: letter to Chief of Mission, UNHCR, 22 June 1981, 6 pp.

38. Khan AR (1988), #15

39. Programme Office UNHCR (1982) Self-evaluation report on the health sector - No.11. Extended 1981 programme. 1982 programme up to 30 June 1982. Quetta, Baluchistan, Pakistan: United Nations High Commissioner for Refugees, 18 pp.

Tareen AR (1988) Project Director for Health of Afghan Refugees, Commissionerate for Afghan Refugees, Provincial Government of Baluchistan. Interview 4 January 1988, Quetta, Baluchistan, Pakistan.

40. Medical Advisor UNHCR (1981) Annual self-evaluation report of 'Humanitarian assistance to Afghan refugees in Pakistan, general health care, NWFP, 1 January-31 December 1981'. Peshawar, NWFP, Pakistan: United Nations High Commissioner for Refugees, 7 pp.

41. Planning and Development Division (1986) Rural health programme of Pakistan, 1986 - 1990. Islamabad, Pakistan: Planning and Development Division, Federal Government of Pakistan, 114 pp.

42. Khan AR and Elo O (1984) Annual report 1984, Afghan Refugee Health programme. Islamabad, Pakistan: Chief Commissionerate for Afghan Refugees, Government of Pakistan/United Nations High Commissioner for Refugees, 184 pp.

43. Chief Sub-office Peshawar UNHCR (1982) Letter to Chief of Mission, UNHCR, 21 September 1982. Peshawar, NWFP, Pakistan: United Nations High Commissioner for Refugees, 1 pp.

44. Chief Sub-office Peshawar UNHCR (1982), #42

45. Chief of Mission UNHCR (1981) Letter to Joint Secretary, States and Frontier Regions Division, Government of Pakistan, 28 May 1987. Islamabad, Pakistan: United Nations High Commissioner for Refugees, 1 pp.

46. UNHCR (1987) News in brief. Pakistan: bombings. Refugees, April, p. 7

CHAPTER ELEVEN

Closing the gaps between planning and practice: 1982 - 1984

The presence of some 2.5 million Afghans in Pakistan at the beginning of 1982 enhanced coverage of their plight in the international press. Together with waning interest among western publics in other groups of refugees - particularly in Indochina - who also fled in large numbers at the end of the 1970s[1], the Afghans became an increasingly common focus of concern among the international community. This created additional pressures on the Government of Pakistan in particular to not only plan and organise needed care but to provide it in practice.

11.1 Basic allopathic care and disease control: consolidating governmental responsibilities

11.1.1 From *ad hoc* to routine service provision: establishing basic health units

Despite a continuing increase in the numbers of mobile teams and local dispensaries throughout 1980 and 1981, the coverage of health services among the Afghan refugees fell short of the targets established in the Presidential Directive. With some two million refugees in the North West Frontier at the end of 1981, 200 teams or dispensaries were needed in that province alone and more Afghans continued to arrive each month. In order to better cope with the rapidly increasing refugee population, mobile teams were converted or reassigned to work in dispensaries and dispensaries were upgraded to basic health units. By the end of 1982, the Provincial Governments of the North West Frontier and Baluchistan were providing 85 (66%) and 40 (89%) of the 164 (129 and 45 respectively) basic health units for Afghan refugees. Two years later, at the end of 1984, they were operating 95 (70%) and 47 (90%) of the 191 (139 and 52) basic health units for the refugees. Additional basic health units and sub-health units (those without medical doctors on the staff) were created in the following years when newly arrived Afghans needed care, and in 1984, the basic salaries of all health staff were reviewed and increased in order to maintain a financial incentive.

Both Provincial Governments continued to be assisted by foreign and domestic charitable agencies. In 1984, UNHCR and the Government of Pakistan reported that 18 agencies were providing basic or specialty health care for the Afghans in addition to those providing hospital services (Table 11.1). Ten of these agencies supported basic health units; others provided first aid or other specialty services, such as eye care, and a few focused exclusively on raising and dispersing funds. Only one of the agencies listed below gave its sole support to medical relief efforts inside Afghanistan (Figure 11.1). The Swedish Committee for Afghanistan began to fund and supply six clinics inside Afghanistan which were being set up and run by the *Society for Doctors and other Health Professionals outside of Afghanistan* in 1982 - 1983. Divisions within this union of doctors, who were members of the alliance of moderate Islamic and political resistance parties, however, prompted the Swedish Committee to work with individual medical doctors and other paramedical personnel instead of the union or the parties. By 1984, the Swedish Committee had supported 44 medical doctors, 67 other trained health professionals and 383 paramedical personnel[2].

Even though the Swedish Committee was the only agency on the official list which was working exclusively in Afghanistan, other agencies began to support relief work inside Afghanistan in 1983 - particularly those from the United States of America (US). Following a visit to Pakistan by the Vice President of the US (George Bush) in May of 1984, US and Pakistani policies which restricted the involvement of groups from the US were reversed. Previously, fears of Soviet charges that such groups were fronts for the Central Intelligence Agency (CIA) of the US Government and desires by the Carter and Reagan administrations not to portray the conflict as a confrontation between the Soviet Union and the US had led the Governments of Pakistan and the US to restrict the involvement of US groups in relief efforts. Aid for relief which came from the US Government, and amounted to one-third of all resources provided, had been channelled primarily through the United Nations[3]. Such a large contribution was consistent with previous patterns of foreign assistance received by Pakistan more generally; between 1951 and 1960, when Pakistan was creating its own national

Figure 11.1

Health services provided for Afghans in Pakistan by charitable organizations, 1984

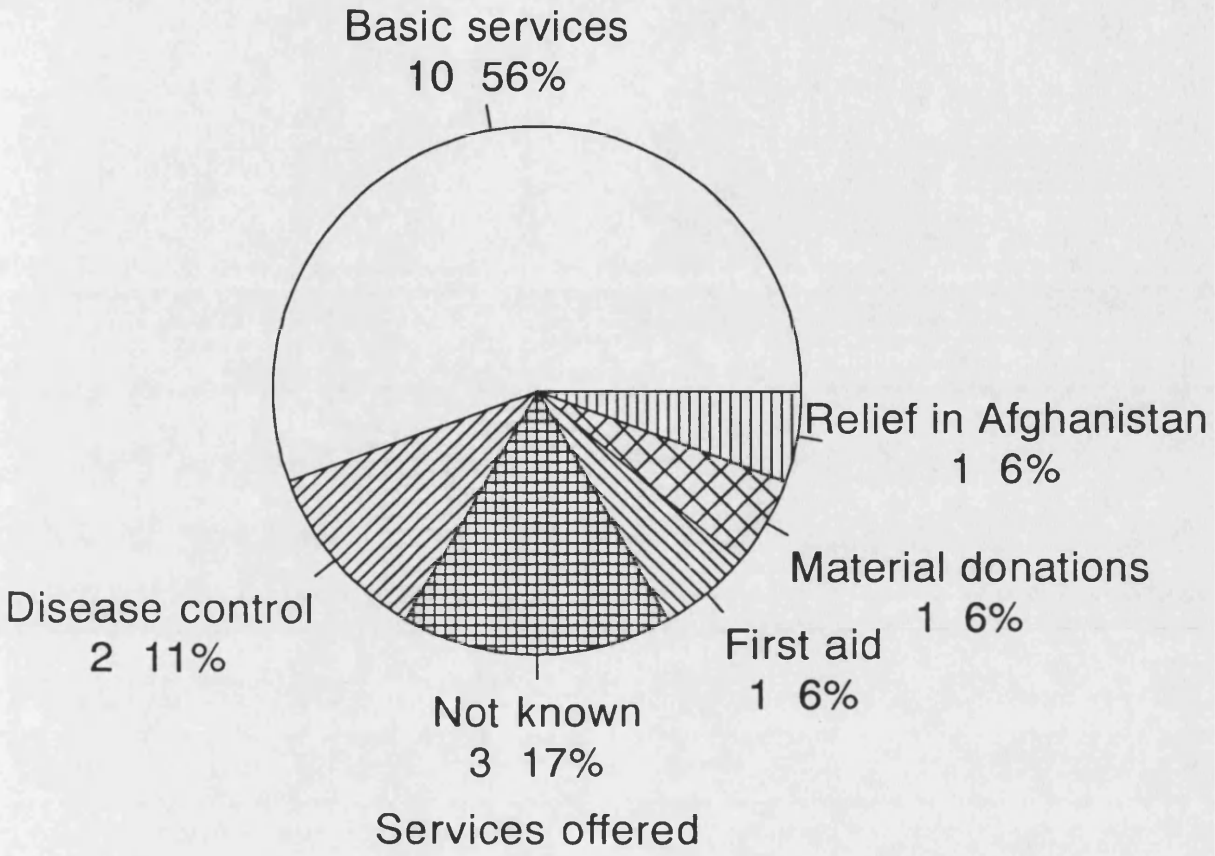


TABLE 11.1

Charitable agencies recognised by Pakistani authorities for providing health care for the Afghans in 1984[4] (excluding hospital services)

AGENCY	COUNTRY OF LEGAL REGISTRATION	HEALTH SERVICES PROVIDED
North West Frontier		
Austrian Relief Committee for Afghan Refugees	Austria	2 basic health units
CARITAS Pakistan	Pakistan/Holy See	donations of food and other material goods
German Agency for Technical Cooperation	West Germany	not specified
Inter Aid Committee	Pakistan/United States	7 basic health units
International Committee of the Red Cross	Switzerland	first aid posts
International Rescue Committee	United States	6 basic health units
Islamic African Relief Agency	Sudan	not specified
Italian Cooperation for Development	Italy	management and funding of tuberculosis control programme (NWFP)
Kuwait Red Crescent Society	Kuwait	3 basic health units
Norwegian Refugee Council	Norway	not specified
Pakistan Red Crescent Society	Pakistan	1 basic health unit; specialty care
The Salvation Army	United Kingdom	3 basic health units
Saudi Red Crescent Society	Saudi Arabia	8 basic health units
Save the Children Fund	United Kingdom	3 basic and sub- health units; training

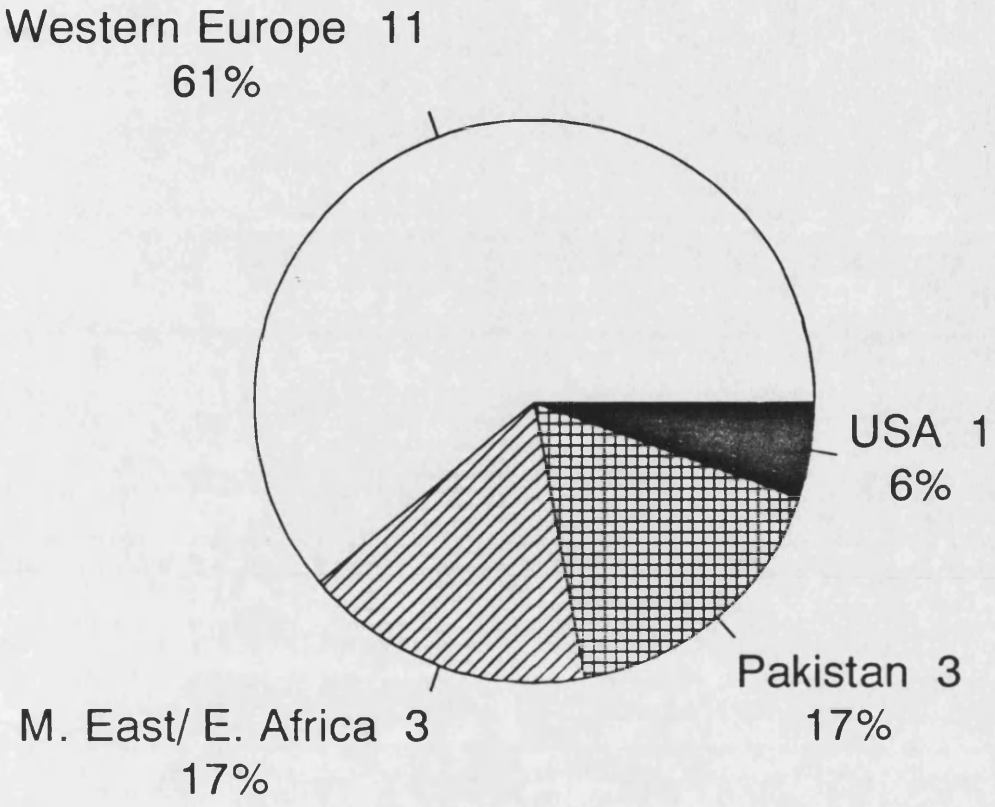
AGENCY	COUNTRY OF LEGAL REGISTRATION	HEALTH SERVICES PROVIDED
Swedish Committee for Afghanistan	Sweden	not specified
Serving Emergency Relief and Vocational Enterprises (SERVE)	United Kingdom	eye clinic
Union Aid for Afghan Refugees	West Germany	17 basic and sub- health units
Baluchistan		
Action International Contre La Faim	France	2 basic health units
Inter Aid Committee	Pakistan/United States	3 basic health units
International Committee of the Red Cross	Switzerland	2 first aid posts
Pakistan Red Crescent Society	Pakistan	not specified
Saudi Red Crescent Society	Saudi Arabia	3 basic health units
Punjab		
Austrian Relief Committee for Afghan Refugees	Austria	sanitation
18 Agencies	**14 countries**	**58 basic and sub- health units; first aid; specialty care; funds; information**

character and system of government, the US Government contributed nearly four-fifths of all foreign assistance - over 75% of which came in the form of surplus agricultural commodities[5].

Thus, only one of the 18 charitable agencies officially recognised in the relief effort in Pakistan was registered as a charity in law in the US (Figure 11.2). Although one charitable agency was set up in the US which subsequently sent medical supplies in support of relief efforts inside of Afghanistan beginning in 1983, it did not receive any

Figure 11.2

National base of charitable organizations providing health care for Afghans in Pakistan, 1984



support from the US Government, financially or politically, until 1984. Nor did it establish a base in Pakistan. In 1984 other charitable agencies from the United State began to set up relief programmes for Afghans living in Afghanistan from a base in Pakistan. For example, the International Medical Corps first sent teams of American medical personnel to Afghanistan in 1984. Notwithstanding the significant potential of this change in policy, the number of charitable agencies actively involved in relief programmes for the Afghans - in Pakistan and Afghanistan - remained relatively small at the end of 1984.

11.1.2 Extending services to new arrivals in Mianwali District in the Province of Punjab

The pressure of some 2.5 million Afghans and the continuing arrival of thousands more led the Provincial Governments of the North West Frontier and Baluchistan to advocate a policy limiting further settlement in these provinces by newly arriving or unregistered Afghans in 1982. The Federal Government then established a policy to settle new refugees in Mianwali District of the Province of Punjab. Mianwali was located in close proximity to the North West Frontier - it had been a part of the North West Frontier until 1901[6]. Although Mianwali was administered as part of the wealthy province of Punjab, the sites selected were located in an area subjected to stifling heat, 125 F or 54 C, during the summer months. This eventually led the refugees to migrate to cooler regions of tribal agencies during this season each year. Employment opportunities were scarce in Mianwali and the stony scrub-land was infertile, offering few hopes for agricultural initiatives or even the production of needed materials for firewood. Furthermore, all land was owned privately by peoples of different ethnic groups, languages and customs[7]. Despite these unfavourable conditions, an agreement was finally reached between the Government and UNHCR, and the first groups of Afghans to be settled there arrived in 1982.

Overall responsibility for Afghans in the Punjab was first given as an additional task to the Commissioner for Sargoda Division - the geographical area in which the refugees were located - who was answerable to the Home Secretary of the Provincial Government. The Commissioner for Sargoda Division involved seven departments of the Provincial Government in planning, building and staffing these new refugee camps. The departments for Highways, Education, Health and Small Industries took part in the relief effort less extensively than those for Housing and Physical Planning, Public Health Engineering and Revenue. Although an Administrator had been appointed in Mianwali District to work in the refugee programme, the Commissioner for Sargoda Division specifically requested the Deputy Commissioner of Mianwali District to be involved in the relief programme. The Deputy Commissioner had access to all Departments in the District Government, including the District Health Office which was initially requested to provide staff and supplies for a dispensary in the camp.

A Director of the refugee health programme was first appointed by the Provincial Health Department in 1982. However, the post was vacant four months later in spring 1983. It is likely that the first Director was a provincial health official who was given the responsibility for health care for Afghan refugees as an additional task, since a separate Commissionerate for Afghan Refugees was not established until mid-1983 - six months after the refugees were settled in Mianwali District. When the post was filled in October 1983, the Director was a member of the Commissionerate for Afghan Refugees in Lahore. Like the Director in the North West Frontier, he was responsible to the Commissioner for Afghan Refugees in Punjab and the Director for Medical Services of the CCAR in Islamabad. Also similar to the health programme of the North West Frontier refugee relief effort, the health programme in Punjab was the first sectoral programme to be established in the Commissionerate for Afghan Refugees in Punjab.

Health care for the Afghan refugees arriving in Mianwali in early 1983 was carried out by officials of the District. A transit centre was initially established for registration

of the refugees before moving to Kot Chandna camp and one dispensary was set up in the camp by health staff who were seconded on a temporary basis from the District Health Office. Furniture, equipment and drugs were supplied by the District Health Office with some assistance from the Pakistan Red Crescent Society. The medical officer and other health staff also formed a mobile team in the afternoons to provide curative services at the transit centre and to other areas of the camp. From March 1983, separate out-patient clinics had been established for males and females and tuberculosis patients were being registered and treated. Immunisations were being provided by a team from the District Health Office 4 days per week. Malaria control activities had not been started and laboratory facilities had not been established.

11.1.3 Strengthening management by the Provincial Governments

11.1.3.1 Setting up a system for local supervision

Between 1980 and 1982, problems with staff of the District Health or Agency Surgeon Offices, poor communications with the camps and the continuing influx of refugees, had led the Government and UNHCR to agree that separate field supervisors would be responsible for refugee health in a given district or tribal agency[8]. Between 1982 and 1983 the first ten Field Supervisory Medical Officers (FSMO) were appointed in the North West Frontier to oversee the refugee health programme in 16 districts and tribal agencies. Unfortunately, the delays in establishing the Refugee Health Directorate in Baluchistan also affected the establishment of supervisory posts in the districts and tribal agencies. These posts were not approved in Baluchistan until 1983 at which time there was a lack of medical officers with sufficient experience: it was not until 1984 that Field Supervisory Medical Officers (FSMOs) began to be appointed for the 5 districts and tribal agencies of Baluchistan which hosted Afghan refugees.

Since the Afghan refugee health programme in Punjab was much smaller, no Deputy Directors, Field Supervisory Medical Officers (FSMOs) or supervisors for disease

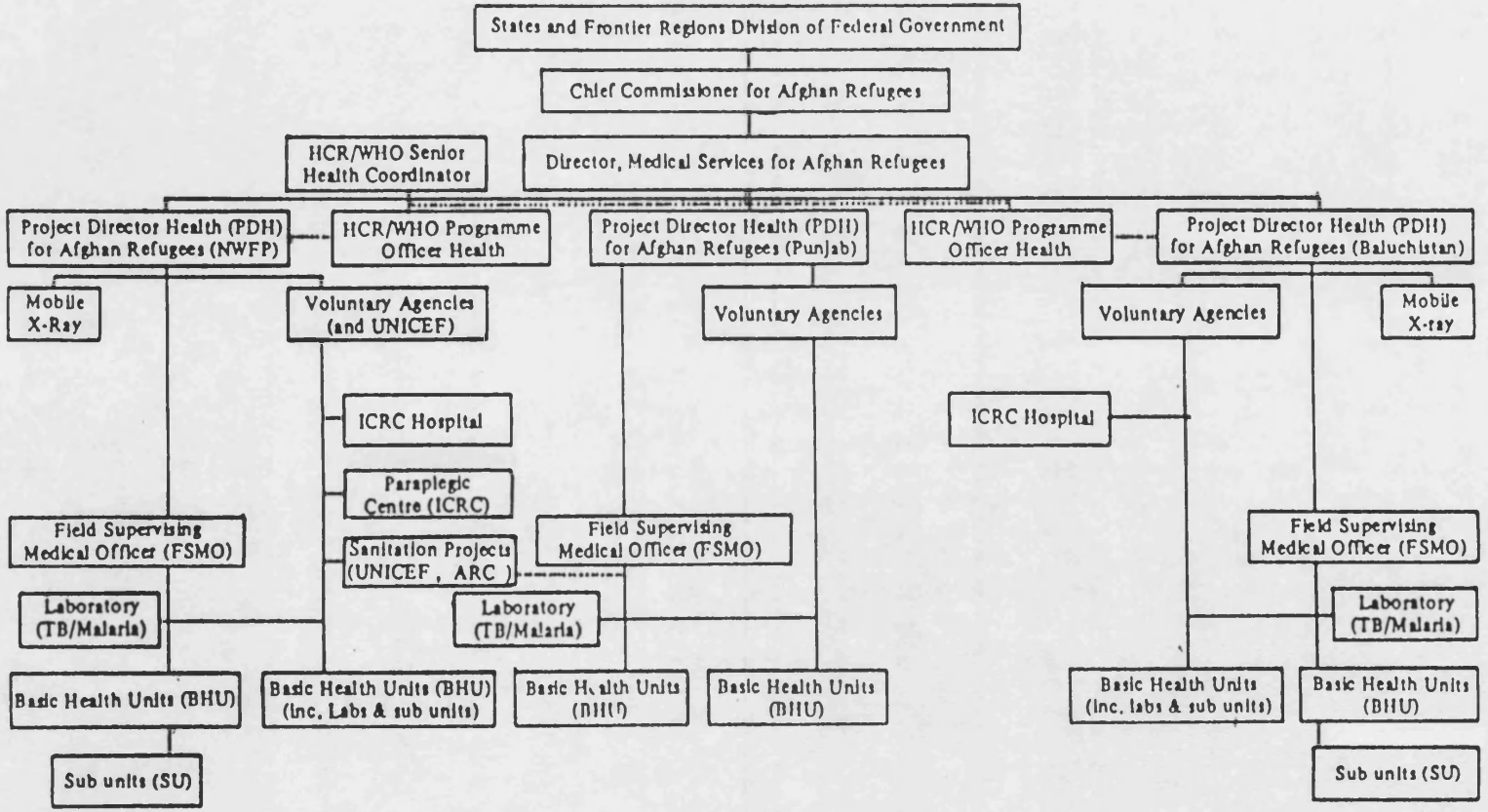
control programmes were appointed. The responsibilities of the Director were comprehensive since he was expected to spend half of his time in the field. This arrangement proved to be inadequate, largely because of the distance between Lahore and Mianwali (approximately a 7 hour drive). Subsequently, one of the medical officers in Kot Chandna camp was appointed as FSMO in 1984. Thus, it was not until the end of 1984 that separate organizations for the management of refugee health services had been established, and were fully functioning, in the provinces of the North West Frontier, Baluchistan and Punjab (Figure 11.3).

11.1.3.2 Grappling with the need to coordinate disparate health activities

Central to many of the problems faced by the Provincial Governments in attempting to set up and manage health services for the Afghan refugees was a lack of coordination of the various components of the refugee health programme. In order to facilitate better coordination, an external evaluator recommended to WHO in 1981[9] that a post for a Senior Health Coordinator be created and based from the office of the Chief of Mission of UNHCR in Islamabad. This post was to be a special programme of the WHO Emergency Relief Operations Unit in Geneva, similar to relief programmes for refugees in Somalia and Thailand. In addition, provincial health advisors were to be appointed and based in the sub-offices of UNHCR in Peshawar and Quetta. The latter suggestion was not new since medical doctors and nurses had been seconded to the sub-offices by charitable agencies since 1980.

A staff member of WHO was subsequently appointed as the Senior Health Coordinator for WHO/UNHCR in the spring of 1982. This new post for a Senior Health Coordinator was funded by UNHCR even though he was recruited on the staff of WHO and placed on secondment from WHO to UNHCR. Within these arrangements he was accountable to the Country Representative of WHO in Islamabad as well as the Chief of Mission of UNHCR in Islamabad. His duties were similarly divided, incorporating an advisory role to government officials of the refugee health

ORGANISATION OF HEALTH SERVICES FOR AFGHAN REFUGEES 31 DECEMBER 1984



Source: Khan and Elo 1984

FIGURE 11.3

programme in formulating health policies and plans and a consultative role to UNHCR on the technicalities of health matters[10]. In addition, he was designated as a focal point for coordinating the various organizations involved in the refugee health programme.

Based upon earlier evaluations and his own observations, the Senior Health Coordinator suggested strategies for the refugee health programme generally in October of 1982 which partially aimed[11]:

1. "To provide a full range of basic health services, both preventive, promotive and curative, in the basic health services outside refugee villages for specialised medical care."

2. To integrate "all vertical projects ... within the refugee health service structure, including malaria control and immunisations. This would mean demolishing separate teams in the refugee villages to form one team, on district level annexing the mobile teams as part of the Field Supervisory Medical Team and rationalising their activity."

3. "Preparing and introducing adequate community involvement ..., increasing collaboration with the traditional health workers among refugees and training different categories of health workers".

4. "Standardizing to the extent possible the service structure, staff, salaries, supplies and equipment in the health units."

Many of these strategies restated policies first established in the Presidential Directive of 1980. However, these strategies expanded and further developed existing policies as well as stating new directions. Moreover, they were a policy statement of the inter-governmental agencies mostly closely involved in the refugee health programme,

WHO and UNHCR, and specifically in its finance and management. These strategies were presented and accepted during the first health workshop of the refugee health programme held in Islamabad in November 1982[12].

11.1.3.3 Integrating disease control programmes

Obviously, the greatest impact of these strategies was on the disease control programmes. As a result, one vaccinator was appointed in each basic health unit, and field supervisors for immunizations were appointed in each district and tribal agency; mobile vaccination teams were discontinued in 1983 and 1984 in the North West Frontier and Baluchistan respectively. Simultaneously, the provincial Refugee Health Directorates, with funds from UNHCR, assumed responsibility for procuring, storing and distributing vaccines and supplies. Vaccines and related supplies had previously been provided by the Provincial EPI programmes with support from UNICEF. In addition, the provincial health official responsible for vaccination of Afghan refugees became a deputy director in the Refugee Health Directorate of Baluchistan. These changes brought improvements in coverage though not until 1984 and 1985. Even then drop-out rates between the first and second doses and between the second and third doses remained high, for example 50% and 66% respectively in the North West Frontier in 1984[13].

Integration of the malaria control programme into the refugee health services was also begun in 1983 along with immunizations, but was not completed until 1984. By the end of 1984, 34 laboratories had been established throughout Baluchistan and the North West Frontier specifically for the refugee health programme[14]. This greatly facilitated diagnosis, treatment and follow-up of cases of both malaria and tuberculosis by the basic health units. Similar to immunizations, field supervisors for malaria control were appointed at that time in each district and tribal agency and the provincial officials in charge became deputy directors in the Refugee Health Directorates.

Beginning in 1983, tuberculosis control was also established as a separate priority programme with the appointment of a deputy director in the provincial Refugee Health Directorates. Shortly after the post for a deputy director was created, a bilateral agreement was signed with the Government of Italy for the Italian Corporation for Development to organize and manage the study, diagnosis and treatment of tuberculosis among Afghan refugees and local populations living near the camps in the North West Frontier. Specifically, they were to train local health staff, to promote and organize health education activities, to provide drugs, supplies and equipment which were needed and to provide salaries for staff employed full-time in tuberculosis control[15]. Similarly, a consultant from WHO trained refugee health staff and organized tuberculosis control activities in Baluchistan during 1984 with special funding from the Arab Gulf Programme for the United Nations Development Organization (AGFUND)[16].

11.1.3.4 Setting technical standards

During the establishment of the tuberculosis control programme, basic strategies and guidelines were written by the Senior Health Coordinator of WHO/UNHCR, in collaboration with the Director of Medical Services of the Chief Commissionerate for Afghan Refugees, the provincial refugee health officials and officials of the relevant national programmes in order to standardise control activities. These guidelines restated the priority activities, namely to diagnose and treat cases presenting at the basic health units and to prevent tuberculosis in children by vaccination with BCG[17]. Similar guidelines were written at the same time for malaria control and immunization activities which also restated priority activities as previously described[18]. These plans were distributed to all of the basic health units as well as district and provincial supervisors.

Clearly, efforts were made to establish an infrastructure through which all health services for the Afghans could be managed. Yet, the many layers of management

personnel and the employment of numerous staff who were responsible for a limited number of tasks raises questions about the effectiveness and efficiency of such a bureaucratic empire. Notwithstanding the apparent confusion over the need for an infrastructure instead of a focus on formulating policies, many of the measures taken during these two years consolidated power in the refugee health programme as opposed to the Provincial Departments. Not only were responsibilities clearly defined and controlled by officials of the refugee health programme, but technical standards were now determined by them independently. Despite these achievements, the failure to formulate both broad and specific policies which encompassed the organization and management of all health services provided for the refugees created opportunities for foreign agencies to expand their roles in order to better meet their own interests.

11.2 Hospital services and community health: expanding roles for foreign interests

11.2.1 Meeting the needs of those at war

The decision to give priority to basic medical care rather than sophisticated treatments was first articulated in writing by the Senior Health Coordinator of WHO/UNHCR in October of 1982. In his report on field visits to the North West Frontier, Baluchistan and Punjab, existing hospital facilities which were outside the refugee villages would be relied on for specialised medical and surgical care. This policy did not, however, go on to specify who was responsible for these services; nor did it detail which interventions were needed, which should be given priority or how they might best be made available to the majority of refugees. Instead, initial plans focused vaguely on expanding and strengthening existing district and provincial hospitals.

In Baluchistan, for example, funds were made available by UNHCR in 1981 for the construction and running of 10 bed wards in four district and tribal agency hospitals. The funds for these wards were in addition to those provided for the supply of

medicines and equipment to hospitals caring for the refugees. The construction of the wards was not begun until March and April of 1982 and was therefore not completed until mid-1982. Similarly, the refugee health plan for Baluchistan in 1982 included the construction of 10 bed wards for children in Pishin District and Sandeman Provincial hospitals. These efforts were supplemented by a French charitable agency which provided for two additional wards. The contribution of this agency allowed funds from UNHCR to be used for two wards in Dalbandin, Chagai District, which were to be completed by March 1983.

During the visit of the Senior Health Coordinator of WHO/UNHCR and the Director for Medical Services of the Chief Commissionerate in Islamabad to the refugee health programme in Punjab in March 1983, the plans prepared by the provincial and district officials for the expansion of the health services were reviewed. These plans included the construction of a health centre by the Public Health Engineering Department which was to be of hospital standard and was to be located outside the immediate refugee village and areas of planned expansion. This hospital was given low priority by the Senior Health Coordinator of WHO/UNHCR and preference was given to the expansion of one of the basic health units in the camp to form a central health unit if referral services were needed. Instead, the Kalabagh Civil Hospital was designated as the primary referral centre for Afghan refugees due to its close proximity to Kot Chandna camp and 24 beds were set aside for secondary referrals in the District Hospital in Mianwali. Financial and material assistance was donated by UNHCR to the Government for the services provided by these hospitals.

Shortly after this mission, a proposal was submitted by the Punjab branch of the Pakistan Red Crescent Society to provide 3 basic health units and hospital services within Kot Chandna camp. Funding was requested for the duration of the programme from UNHCR. UNHCR responded that funding was available for 1983 but the Pakistan Red Crescent Society would be expected to secure their own funding from 1984 onwards since such a take-over by the Pakistan Red Crescent Society was

thought to negate the need for a governmental programme in Punjab. The negotiations which followed became tense and complex. Subsequently, the Pakistan Red Crescent Society gave priority to providing hospital services. Consequently, the Commissionerate for Afghan refugees in Punjab retained responsibility for the basic health units in Kot Chandna. The refugee population of Kot Chandna was approaching 100 000 in 1984 and the need to make other arrangements for specialised medical care became acute. The District Hospital was already overcrowded and could not accommodate an increase in need among the refugees. However, since space was available in the two neighbouring civil hospitals, in Isa Khel and Kalabagh, UNHCR continued to refuse to fund a separate hospital, even if the Provincial Government was unwilling to allow these civil hospitals to be used.

Notwithstanding these efforts to strengthen governmental hospitals in the districts and tribal agencies where Afghans were living, two Red Cross and Red Crescent organizations and five Afghan political parties had constructed and were running their own hospitals for the Afghans living in Baluchistan[19] in 1983 along with seven charitable agencies and three political parties or political alliances who were running eight hospitals specifically for the Afghans in the North West Frontier (Table 11.2). By 1984, 22 hospitals specifically catering for Afghan refugees were officially recognised by the Government and UNHCR[20].

The provision of sophisticated medical and surgical care was clearly a priority of many Red Cross and Red Crescent societies and political parties. Political parties affiliated with the Afghan resistance operated 13 (59%) of these hospitals while the International Committee of the Red Cross and several Red Crescent societies from sympathetic Islamic nations sponsored and managed another eight (38%) hospitals. Only one clinic-cum-hospital was set up by a foreign charity with funds from its own government - the US (Figure 11.4). These hospitals were surely an expression of solidarity with the Mujahideen. But their establishment may also have been influenced

Figure 11.4

Organizations sponsoring hospital services for Afghans in Pakistan, 1984

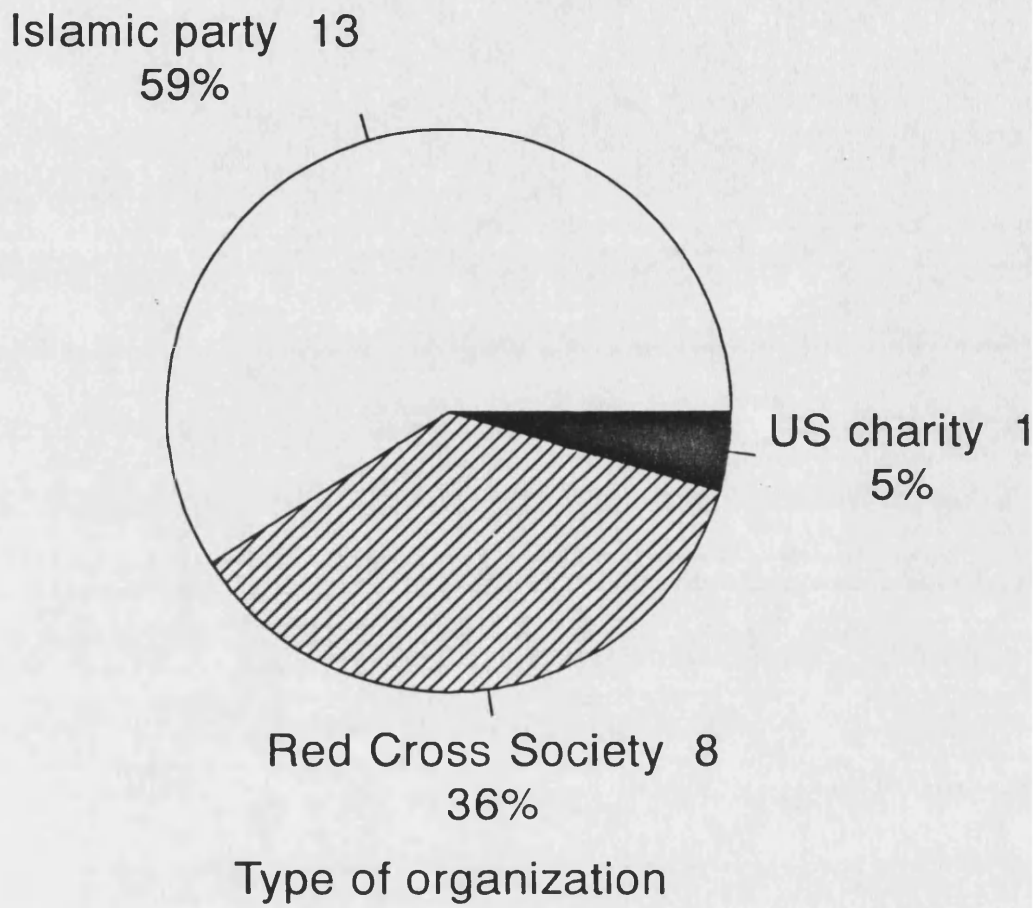


TABLE 11.2

Hospital services specifically established for Afghans living in Pakistan, 1984

HOSPITAL	SPONSORING AGENCY	COUNTRY OF LEGAL RECOGNITION
North West Frontier		
1.Afghan Surgical Hospital	Idara Ahya-ul-Uloom	Pakistan
2.Afghan Gynaecological Hospital	Idara Ahya-ul-Uloom	Pakistan
3.Ibn-Sina Surgical Hospital	Islamic Alliance for the Liberation of Afghanistan	Afghanistan
4.Ibn-Sina Medical Hospital	Islamic Alliance for the Liberation of Afghanistan	Afghanistan
5.Ittehad Surgical Hospital I	The Islamic Alliance	Afghanistan
6.Ittehad Surgical Hospital II	The Islamic Alliance	Afghanistan
7.Jihad Hospital	The Islamic Alliance	Afghanistan
8.Surgical Hospital	International Committee of the Red Cross	Switzerland
9.Paraplegic centre	International Committee of the Red Cross/ Pakistan Red Crescent	Switzerland, Pakistan
10.Orthopaedic centre	International Committee of the Red Cross	Switzerland
11.Eye Hospital	Pakistan Red Crescent Society/ League of Red Cross and Red Crescent Societies	Pakistan, Switzerland
12.Surgical and Orthopaedic Hospital	Kuwait Red Crescent Society	Kuwait
13.Orthopaedic workshop	Kuwait Red Crescent Society	Kuwait
14.Afghan Obstetric and Gynaecology clinic	International Rescue Committee	United States

HOSPITAL	SPONSORING AGENCY	COUNTRY OF LEGAL RECOGNITION
Baluchistan		
1.Al Khidmat Hospital	Al Khidmat Welfare Society	Afghanistan
2.Al Jehad Hospital		
3.Ansari Hospital for Afghan Mujahids and Refugees		
4.Hakim Sanai Hospital		
5.Ittehad Hospital	The Islamic Alliance	Afghanistan
6.Islamic Aid health centre		
7.Hospital for War Wounded	International Committee of the Red Cross	Switzerland
8.Al Salam Hospital	Saudi Red Crescent	Saudi Arabia
22 hospitals	**10 or more organizations**	**6 or more countries**

partly by the restrictions on the involvement of charitable agencies and political parties in health care provided in the camps, partly by the lack of official plans for the provision of specialty and sophisticated medical care and partly by widely accepted beliefs in the merits of medical and surgical care. Stated policies of the Government of Pakistan and UNHCR were generally silent on the organization and management of referral services for the Afghan refugees; requests that funds, drugs, supplies and equipment be given to government hospitals locally and regionally were the only exception. Official endorsement and support appears to have been given to charitable agencies and political parties to organise and manage such services independently.

11.2.2 Creating a community health programme

Unlike the system of basic health units and the control programmes for priority diseases, the strategy to train lay health workers had no existing foundation on which to build. Concern for the health of women and young children in 1980 had led to the

proposals for 'female scouts' to work in the refugee villages and to the inclusion of lady health visitors in the staff of mobile teams and dispensaries. The health of women and young children was of particular concern because of the cultural and religious practice among Afghans of 'purdah' - or the seclusion of women. The practice of purdah limited the movements of women in the villages and their contacts with men, with implications for the use of health facilities and consultations with male members of health staff.

The difficulty of implementing the 'female scout' programme in a society which practised purdah had instead led the Refugee Health Directorate in the North West Frontier to create an additional post in the mobile teams for a traditional birth attendant, a 'dai'. The use of community-based health workers was only considered seriously at the end of 1981 by a foreign medical doctor who was advising the UNHCR sub-office in Peshawar (on secondment from a charitable agency), health advisors of UNICEF and several foreign charitable agencies[21]. They then held a seminar in December 1981 to discuss specific proposals to train Afghan women as 'basic health workers'. However, their conclusion was that such a programme was 'almost impossible' because of the unwillingness of the Afghans to allow their women to participate in activities which were not associated with their own household. Instead, health education activities in the basic health units were to be strengthened, particularly by Pakistani lady health visitors.

Beginning in 1982 and continuing in 1983 plans to implement a community-based health worker (CHW) programme were revived and discussed, mostly by the health advisors of UNHCR and UNICEF. Much of the design of the programme came from a proposal originally written by UNICEF for the seminar in December 1981 which aimed to provide 'a structure for primary care ultimately to all refugee camps'[22]. This Primary Health Care (PHC) programme was to be sponsored by UNHCR and was to involve and co-operate with charitable agencies, WHO and UNICEF. The first step was to consolidate the experience of agencies who had established similar programmes

among the refugees and to conduct a survey to gather information needed to design a training programme. This training course was then to be piloted in one camp by a charitable agency. Following an evaluation and subsequent modifications, training could then be undertaken by the charitable agencies and the Government in their respective areas.

This plan was approved by the States and Frontier Regions and Kashmir Affairs in June 1983 and work began in November by the Save the Children Fund (SCF), UK[23]. Despite delays with implementation, considerable progress was made by the Save the Children Fund during 1984, primarily in establishing a training-cum-management structure[24], namely:

- establishing a training centre and accompanying curricula, manuals and other aids.

- training trainers to train and supervise community health supervisors in the basic health units.

- creating a team to survey the targeted communities and to motivate and assist community leaders to establish health committees.

- establishing posts in the basic health units for community health supervisors, at a ratio of 1:7500 refugees, as mid-level managers to facilitate integration with existing refugee health services.

- training community health workers at a ratio of 1:30 refugee families.

- developing systems of reporting, referral and supply.

However, rather than training women, these community health supervisors and community health workers were men. The original goal to train women had not been forgotten and plans for a similar programme to train 'dais', traditional birth attendants, were first written at that time[25]. In addition, training of medical and administrative staff of the refugee health programme was also planned in order to prepare them to assume responsibility for the project[26].

11.3 Comment

Although scant information was found in Pakistan to document retrospectively the role of the media, general coverage which was given to the Afghans in the first half of the 1980s is fairly well-known. The media played a key role in bringing the needs and problems of the Afghans to the attention of the international community in general and western publics in particular. This in turn established international support for them and for efforts to assist them. It also created a system of accountability of the Government of Pakistan and international aid agencies to the international community at large.

Thus, from 1982 through 1984, considerable effort was made to close the gaps between the plans for health care and the reality of its provision. Governmental authorities modified existing plans for the provision of basic medical care to cater regularly for millions of Afghans living in remote and dispersed areas of the North West Frontier, Baluchistan and Punjab. They were supported in their efforts to make such care widely and equitably available by domestic and foreign charitable agencies. The strengthening of their capacity to manage this new system of basic primary care services was facilitated greatly by the specialised agencies of the United Nations, especially WHO which arranged for senior health professionals to advise both the Government and UNHCR at national and provincial levels. In order to ensure that services were delivered more effectively, great emphasis was placed on establishing an infrastructure which integrated all health activities under one management structure

and which made activities of a similar nature and standard available in all areas where Afghans were living.

While significant achievements in extending the coverage of primary care and improving the quality of services provided through basic and sub-health units were achieved with only moderate refinements, inefficiencies and limited effectiveness of disease control measures led to a major reorganization which integrated them into the refugee health programme. Separate management structures were created in the provincial Refugee Health Directorates in the North West Frontier and Baluchistan and separate workers were posted in the villages. This gave refugee health officials greater control over disease control activities and personnel. But it also meant that national programmes lost funds - which meant supplies and salaries. Not all governmental departments were happy with the transfer of responsibility. But because this reorganization of disease control activities was initiated, promoted and enforced by foreign medical advisors acting as health coordinators for WHO/UNHCR at national and provincial levels, they were realised. It is important to recognise that these advisors controlled the allocation of international funds for these activities which enabled them to take and enforce these decisions even though they were unpopular with branches of the Government.

Similarly, it was not until a Senior Health Coordinator had been appointed by WHO/UNHCR in 1982 that standards were written for the organization and implementation of health care for Afghan refugees nation-wide. These standards were policy statements on the organization of care which also provided guidance on the clinical management of specific health problems. In combination with existing governmental policies restricting foreign health workers to administrative and advisory roles, the organization and delivery of care was standardised between districts and provinces in Pakistan.

This system of basic health services did not, however, address the needs of those at war. In particular, needs for first aid and sophisticated surgical and medical treatments were acute among those wounded during armed conflict. Vague plans of the Government and UNHCR to strengthen governmental hospitals were insufficient, and special facilities were set up and managed by various political parties and alliances as well as sympathetic Red Cross and Red Crescent societies. Despite the rapid and disorderly proliferation of such facilities, no further plans were formulated for the provision of referral services for the Afghans by officials of the refugee health programme. Policies, though unspoken, clearly condoned the establishment of new referral facilities by those with a vested interest in the war - independent of the refugee health programme. Consequently, there were comparatively few benefits for the development of Pakistani referral services.

While the Government of Pakistan went to great lengths to consolidate their responsibilities for managing and providing basic health services for Afghans living in Pakistan, they appeared to dissociate themselves from relief efforts undertaken for those civilians remaining in Afghanistan and those engaged in the war. While several foreign groups subsequently set up various referral centres in Pakistan, a few others began to organise teams to work in Afghanistan. No detailed policies and plans were formulated for such activities by officials of the refugee health programme. Instead, an unspoken policy left them alone to carry out the work they deemed necessary in whatever way they wished. Silence and discretion on the nature and work of these organizations appeared to be the only requirements of Pakistani authorities.

In contrast with the new referral centres which were run primarily by foreign Islamic groups and the teams of medical personnel which were organised and sent to work in Afghanistan by foreign charitable agencies independent of the refugee health programme, community health activities which were started during the same period were ostensibly a component of the refugee health programme. The community health programme aimed to meet common health needs of those living in villages in

Pakistan, especially Afghan women and children. Notwithstanding the attempts to plan the community health programme as a component of the Government's refugee health programme, it was also initiated and carried out by foreign agencies; in practice the preparations and pilot activities were organized and implemented by a British charity with support from UNHCR and Unicef. Without support from these international aid agencies, the training of refugees as community health workers would not have been incorporated into national policies and plans; nor would training programmes have been implemented. Yet, in practice, these initiatives were carried out in isolation from the Government's system of refugee health services - both the delivery of care and its management. Thus, in Pakistan, specialised agencies of the UN and foreign charitable organizations also began to expand their roles by focusing on community health priorities within the refugee health programme, especially the unmet needs of women and children.

11.4 References

1. Loescher G and Scanlan LA (1986) Calculated kindness. Refugees and America's half-open door policy, 1945 - present. New York, USA and London, UK: The Free Press, Macmillan, 272 pp.

2. Magnus RH (1987) Humanitarian responses to an inhuman strategy. In: Farr GM and Merriam JG Afghan resistance. The politics of survival. Boulder, Colorado, USA and London, UK: Westview Press, pp. 191-212

3. Magnus RH (1987), #2

4. Khan AR and Elo O (1984) Annual report 1984, Afghan Refugee Health Programme. Islamabad, Pakistan: Chief Commissionerate for Afghan Refugees, Government of Pakistan / United Nations High Commissioner for Refugees, 184 pp.

5. Alavi H and Khusro A (1962) Pakistan: The burden of US aid. New University Thought 2(4), 16 pp.

6. Zia-ul-Haq M (1986) Afghan refugees camp. Kot Chandna. Lahore, Pakistan: personal paper of M Zia-ul-Haq, 9 pp.

7. D'Souza F (1984) A new camp for vintage refugees? Disasters 8(1):11-12

8. Medical Advisor UNHCR (1981) Annual self-evaluation report of 'Humanitarian assistance to Afghan refugees in Pakistan, general health care, NWFP, 1 January-31 December 1981'. Peshawar, NWFP, Pakistan: United Nations High Commissioner for Refugees, 7 pp.

9. Simmonds SP (1981) Assignment report. The health of the Afghan refugees in Pakistan. Geneva, Switzerland: World Health Organization, Emergency Relief Operations, 17 pp.

10. Ahtone J, Berends P and Khan AR (1985) Annual report 1985. Afghan refugee health programme Pakistan. Islamabad, Pakistan: Chief Commissionerate for Afghan Refugees, Government of Pakistan/United Nations High Commissioner for Refugees, 124 pp.

11. Senior Health Coordinator WHO/UNHCR (1982) Report of field visits, date 25 October 1982. Quetta, Baluchistan, Pakistan: United Nations High Commissioner for Refugees, 3 pp.

12. Khan AR and Elo O (1984), #5

13. Khan AR and Elo O (1984), #5

14. Khan AR and Elo O (1984), #5

15. Protocol between the Governments of the Republic of Italy and the Islamic Republic of Pakistan concerning the tuberculosis control programme among the Afghan refugees in the North West Frontier Province of Pakistan (1983) Islamabad, Pakistan: Economic Affairs Division, Government of Pakistan/Italian Embassy, Government of Italy

16. Ahtone J, Berends P and Khan AR (1985), #10

17. Afghan Refugee Health Programme (1984a) Tuberculosis control programme for Afghan refugees in Pakistan. Plan of operation. Islamabad, Pakistan: Chief Commissionerate for Afghan Refugees, Government of Pakistan/United Nations High Commissioner for Refugees, 12 pp.

18. Afghan Refugee Health Programme (1984b) Malaria control. Plan of operations. Islamabad, Pakistan: Chief Commissionerate for Afghan Refugees, Government of Pakistan/United Nations High Commissioner for Refugees, 12 pp.

Afghan Refugee Health Programme (1984c) Expanded Programme for Immunization (EPI). Plan of Operations. Islamabad, Pakistan: Chief Commissionerate for Afghan Refugees, Government of Pakistan/United Nations High Commissioner for Refugees, 11 pp.

19. Afghan Refugee Health Programme (1984) Annual report 1983 (Strategies for 1984). Islamabad, Pakistan: the Chief Commissionerate for Afghan Refugees, States and Frontier Regions and Kashmir Affairs Division, Federal Government of Pakistan and the World Health Organization, Emergency Relief Operations, 24 pp. plus annexes

20. Khan AR and Elo O (1984), #5

Ahtone J, Berends P and Khan AR (1985), #10

Khan AR and Nesbit R (1987) Annual report 1986. Afghan refugee health report 1986. Afghan refugee health programme Pakistan. Islamabad, Pakistan: Chief Commissionerate for Afghan Refugees/United Nations High Commissioner for Refugees, 129 pp.

21. Medical Advisor UNHCR (1981a) How to start with a Basic Health Programme. Peshawar, NWFP, Pakistan: United Nations High Commissioner for Refugees, 3 pp.

Medical Advisor UNHCR (1981b) Second paper on "Basic" preventive health care for Afghan refugees. Peshawar, NWFP, Pakistan: United Nations High Commissioner for Refugees, 3 pp.

22. Griffith M (1981) Training of Afghan community health workers. Peshawar, NWFP, Pakistan: United Nations Children's Fund (UNICEF), 3 pp.

23. Cutts F (1984) Training community health workers in refugee camps: a case study from Pakistan. Disasters 8(3):198-205

24. UNHCR (1984) Project self-evaluation. Primary health Care to Afghan Refugees in NWFP. 1 July 1984 - 31 December 1984. Peshawar, NWFP, Pakistan: United Nations High Commissioner for Afghan Refugees, 3 pp.

25. PHC Advisor SCF/UNICEF (1985a) Proposal to train community and family dais. Peshawar, NWFP, Pakistan: Save the Children Fund, 6 pp.

26. PHC Advisor SCF/UNICEF (1985b) Development of Primary Health Care in Afghan refugee villages. Interim report 1 November 1984 - 31 January 1985. Peshawar, NWFP, Pakistan: Save the Children Fund, 4 pp.

CHAPTER TWELVE

'Voluntary' agencies as providers of medical care, 1985 - 1988: Working for a charitable or political cause?

12.1 Fulfilling Governmental responsibilities for basic services in villages

12.1.1 Achieving national targets for coverage of primary care

In keeping with their policy to provide a full range of health services in the basic health units while relying on regular health services outside the refugee villages for specialised care, the Government of Pakistan focused on improving the coverage and quality of care given in the basic health units from 1985 through 1988. By the beginning of 1987, the Provincial Government of the North West Frontier had set up two additional basic health units and 22 new sub-health units to cater for Afghans according the national targets of one centre for every 15, 000 people. Similarly, in Punjab permanent structures were built for existing basic health units in Kot Chandna camp and one new basic health unit was constructed in the new camp of Dara Tang for Afghans settled in Mianwali since the autumn of 1985.

12.1.2 Confronting poor management of the refugee health services in Baluchistan

Unlike the refugee health programmes in the North West Frontier and especially the Punjab which continued to expand, no new basic health units were established in Baluchistan since few additional refugees were registered there. Instead, there was a crisis of management which led to substantial reforms beginning in 1985. Throughout the first five years of the programme, between 1980 and 1985, the reports suggest that health services for Afghan refugees in Baluchistan were more a reality on paper than in practice. Several problems plagued the programme which were similar to difficulties faced by the Provincial Health Department in providing health services to nationals.

Firstly, vacancies were common, especially in positions for medical doctors and female staff, and staff were frequently absent. These problems had been compounded by the decision of the Provincial Health Department to end the practice of seconding staff to the refugee programme in 1982. The 'scarcity of good health staff in Baluchistan' was the reason given at that time, which also supports reported difficulties in recruiting health staff by the refugee health programme[1].

Secondly, transportation to and from the refugee villages was insufficient which caused the supply of medicines and equipment to be irregular and supervision to be inadequate. Within the villages, there was a lack of accommodation facilities. Together with frequent delays in payment of salaries, conditions of work deterred rather than enticed potential health workers and invited delinquent behaviour among those employed[2].

Due to the problems in the refugee health programme in Baluchistan, the second Senior Health Coordinator of WHO/UNHCR undertook a review of the programme in June of 1985[3]. Chronic problems with staff and the lack of implementation of planned activities needed to be rectified. The problems highlighted in his review were further substantiated by three separate missions of the WHO in 1981 and 1985[4]. Although three factors were singled out, all pointed to poor management and planning.

. 'no delegation of powers to health supervisory staff to actually control the health programme by the Commissioner for Afghan Refugees in Baluchistan;

. inadequate health infrastructure to support a comprehensive health programme;

. chronic vacancies in health positions.'[5]

Consequently, the Senior Health Coordinator of WHO/UNHCR recommended that a 'smaller' programme be implemented by the Government. Specifically, the plan was to[6]:

1. re-allocate health units with more reliance on sub-health units (those without medical doctors on the staff) and closure of inappropriately assigned units.

2. reduce staff assigned to the health units. Job descriptions in which individual staff perform more than one task were put forward, and positions for programmes not implemented to date were to be terminated.

3. review and reduce medicines and equipment to reflect a more 'compact' programme and that the programme was no longer in an 'emergency phase'.

The re-allocation of basic health units and sub-health units was not implemented until 1986 after a new Director was appointed for the refugee health programme at the end of 1985[7]. The Provincial Government then reduced the number of basic health units from 40 to 24 by downgrading 13 basic health units to sub-health units and eliminating the others. Yet, there were 37 basic health units and 13 sub-health units for 592 716 refugees living in 62 camps one year later[8]. Due to the continuing arrival of refugees in 1987, the number of Government basic health units was again increased by 12 and 2 mobile teams were also added. By 1988, there were 49 basic health units, 13 sub-health units and 2 mobile teams providing basic medical care to the 818 000 refugees living in Baluchistan[9].

12.1.2.1 Moving beyond 'lame duck' management to leadership with authority

In the annual report of UNHCR for 1986, a vast improvement in the basic services in Baluchistan was noted[10]. Much of this was attributed directly to the new Director who controlled absences among staff and filled posts to a greater degree that his predecessor. Without strong leadership under new lines of accountability, the re-allocation of services among the refugee population and the re-assignment of duties among staff would not have made as great an impact on many of the problems. Even though an agreement had been reached in 1981, by the Secretary for Health, the Commissioner for Afghan Refugees and UNHCR, that the Health Directorate for the refugee health programme would function within, and be responsible to, the

Commissionerate for Afghan Refugees, and that assistance from the Health Department would, in future, be limited to technical matters only, the Refugee Health Directorate continued to function somewhat as a 'lame duck'. This state of affairs was attributed to[11]:

- the lack of a job description with accompanying confusion about his responsibilities and delegation of power;

- the relationship of the Refugee Health Directorate with the Commissionerate for Afghan Refugees and the Provincial Health Department continued to be poorly defined;

- the lack of authority delegated to the Director to implement health activities.

However, it was not until 1985 that these problems were overcome. Although the process of clarifying the relationships of the Refugee Health Directorate Health with the Commissionerate for Afghan Refugees and the Provincial Health Department was revived in 1983, it was not decided until 1985 that the Director was on secondment to the refugee health programme from the Provincial Health Department but that his office functioned independently since he was responsible to the Commissionerate for Afghan Refugees.

Independence from the Health Department was more firmly established in the autumn of 1985 when the process for recruiting and terminating staff of the refugee health programme was changed. Prior to September 1985, all health staff were hired and terminated according to the procedures for government employees. For example, health staff of the refugee programme were selected by representatives of UNHCR, the Director of the refugee health programme and the Provincial Secretary for Health. Approval was given by the Governor. This system had two main disadvantages. It was a lengthy process which caused delays in filling posts and in disciplining staff, and it did not make staff accountable to the Director of the refugee health programme. The latter consequence was compounded by the lack of a career structure within the

refugee health programme, and not surprisingly loyalties were placed with the Health Department which could offer positions in future. The new Director of the refugee health programme, therefore, obtained responsibility for recruiting and terminating staff in 1985.

The relationship of the Refugee Health Directorate with the Commissionerate for Afghan Refugees also changed in 1985. However, unlike the change in personnel management, the change in financial procedures decreased the autonomy of the Director. Prior to 1985, expenditures were approved by the Directors of education, health and water supply. In response to an audit in 1985 which revealed misappropriation of funds in a water supply project, the Commissionerate limited independent expenditures to 5000 rupees or less. All other expenditures had to be approved by the Commissionerate.

12.2 Expanding roles for foreign voluntary agencies

12.2.1 Foreign charitable agencies as providers of basic health services in refugee villages

12.2.1.1 From collaboration to competition: the Refugee Health Directorate and foreign charitable agencies in Baluchistan

In addition to changes in the allocation of health services and the organization of its management, recommendations of the Senior Health Coordinator for strengthening the programme in Baluchistan emphasised a need to use charitable agencies, particularly as a short-term solution to strengthen the medical infrastructure and development of a preventive programme tailored to Baluchistan[12]. The advantages of using charitable agencies which were stated included:

- 'private funding for part or all of their project, allowing some relief for UNHCR;

- closer supervision/monitoring of programme, allowing greater freedom to make personnel changes and modifications as needed;

- a chance to utilise different approaches to achieve preventive programmes and health education;

- an ability to recruit individuals, possibly expatriates, in remote places that the Government has not been able to do thus far;

- to allow the Government to concentrate on remaining programmes and the development of long-term preventive programmes which they can manage.'[13]

This recommendation indicated a substantial change in the policy on the roles of foreign charitable organizations in the refugee health programme[14]. Following the departure in 1985 of both the first Director of the refugee health programme in the North West Frontier and the first Senior Health Coordinator of WHO/UNHCR, greater involvement of charitable agencies was encouraged and supported. Expansion subsequently occurred, mostly in cross-border operations or other war-related relief efforts and mostly with support from the US Government and UNHCR.

In Baluchistan, there was also an increasing use of charitable agencies within the refugee health programme which was promoted solely by UNHCR and the concerned foreign charitable agencies. Between 1985 and 1987 there were two attempts to take over basic health units run by the Government, one of which was successful. Medecins Sans Frontier (France) assumed responsibility for four basic health units in Chagai District in early 1986 despite opposition from the Refugee Health Directorate. Ironically, these basic health units were returned to the Government two years later in October 1987 following a change in the policy of Medecines Sans Frontier; they had decided to provide technical advice to officials of the Government in Chagai District rather than implementing basic health units[15].

The transfer of these basic health units first to Medecins Sans Frontier and later back to the Refugee Health Directorate highlighted an interesting discrepancy between programmes run by charitable agencies and those of the Government. Medecins Sans Frontier was allowed to hire additional health staff with funds from UNHCR during their management of the basic health units. Following the return of the basic health units to the Refugee Health Directorate, UNHCR informed the Director that these five additional staff were to be terminated[16].

Again in 1986, an attempt was made to take over the basic health units in Zhob and Loralei Districts of Baluchistan. This time the charitable agency was Catholic Relief Services (US), and again support was provided by UNHCR. Catholic Relief Services had been providing sanitation facilities and health education in these two districts since January of 1986. They had been assisted by the Refugee Health Directorate which had seconded 2 physicians and a lady health visitor, provided living facilities for staff and loaned 3 vehicles to the programme. The new proposal of Catholic Relief Services to provide supervision of preventive and curative care in the basic health units was not accepted since supervision responsibilities rested with the Commissionerate for Afghan Refugees. Instead, the Director recommended that any additional projects focus on establishing training centres for existing staff[17].

Yet again, in 1987, a proposal was submitted by Action International Contra la Faim (France) to be involved in the basic health units in Zhob/Loralei Districts. Unlike the Medecins Sans Frontier and Catholic Relief Services proposals, Action Internationale Contra la Faim offered to assist in training basic health unit staff in mother and child health care[18]. Nevertheless, the initiative came from the agency with support from UNHCR and thus was initially treated with suspicion by officials of the Refugee Health Directorate[19].

12.2.2 Political parties and charitable agencies as providers of referral services in Pakistan and basic medical care in Afghanistan

12.2.2.1 Military or humanitarian priorities?

In addition to these attempts to take over existing basic health units in some refugee villages (by agencies with programmes in Pakistan as well as those without any involvement in the refugee health programme to date), other charitable agencies and political parties also set up other health services for Afghans from a base in Baluchistan. Table 12.1 indicates that by 1990, there were at least 17 organizations providing health care for Afghans from a base in Baluchistan. Fourteen (82%) of these organizations were recognised by officials of the refugee health programme and, together with one other Germany agency, had been granted registration in law by the States and Frontier Regions and Kashmir Affairs Division (SAFRON) of the Federal Government to work in Pakistan (Figure 12.1). Only three of the 14 agencies (21%) which were recognised by officials of the refugee health programme were registered as charities in law in Pakistan, and all three of these agencies were affiliated with Christian or humanitarian movements which originated in western Europe and North America. Ten of the remaining 11 agencies were based in western Europe (4), the US or Canada (3) and Islamic nations of the Middle East (3) . Only two of the 17 agencies were Afghan (Figure 12.2).

The three agencies which were not recognised in the records of the refugee health programme were involved with the provision of health care inside Afghanistan. Even though two organizations acknowledged that some of their work took place in Pakistan, their activities were in support of cross-border operations - the provision of health care in Afghanistan itself. Even though one agency did not register with the Government of Pakistan and did not acknowledge working in Pakistan, they too were known to be using their base in Quetta to train and support health workers to work in rural Afghanistan.

Figure 12.1

Legal status in Pakistan of charities providing health care for Afghans from a base in Baluchistan, 1990

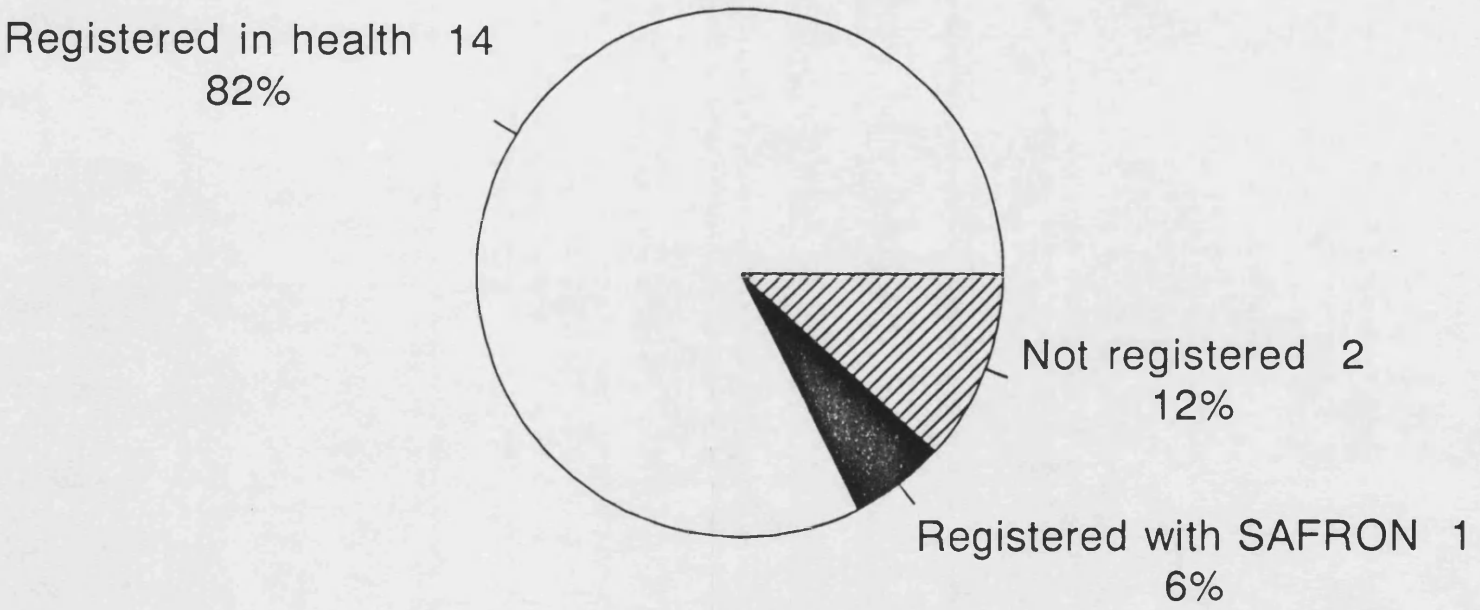


Figure 12.2

Registration in law of charities providing health care for Afghans from a base in Baluchistan, 1990

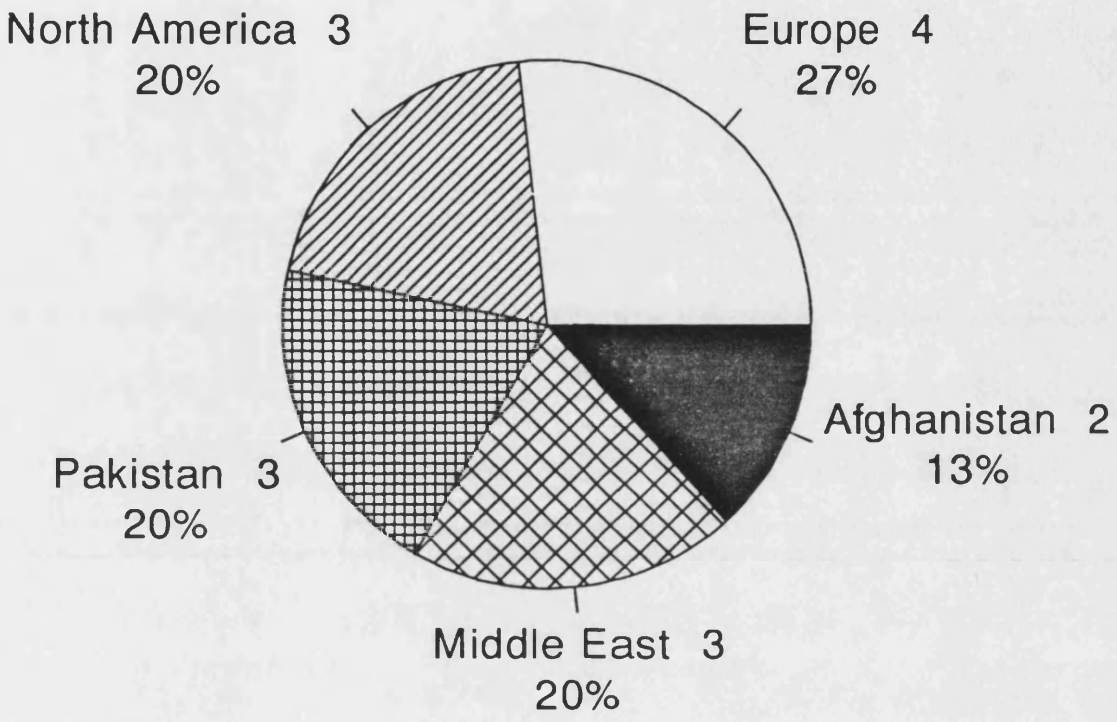


TABLE 12.1
Organizations providing health services for Afghans from a base in Baluchistan, 1989

AGENCY	NATIONALITY	BEGAN	HEALTH PROJECTS	1	2	3
1.Action International Contra la Faim	France	3/81	Sanitation, BHU support, training, inpatient care, MCH, laboratories	P	Y	Y
2.Inter-Church Aid	Pakistan	/83	BHU support, first aid, inpatient care	B	Y	Y
3.Handicapped International	Belgium	9/85	Rehabilitation	B	Y	Y
4.Catholic Relief Services	US	9/85	Sanitation, training	P	Y	Y
5.Medecins Sans Frontiers	France	1/87	BHU provision, training	B	Y	Y
6.International Committee of the Red Cross	Switzerland	/83	First aid, inpatient and outpatient care, training	B	Y	Y
7.Kuwait Red Crescent Society	Kuwait	/85	Hospital care	?	Y	Y
8.Saudi Red Crescent Society	Saudi Arabia	/84	Hospital care, BHUs	B	Y	Y
9.Pakistan Red Crescent Society	Pakistan	/80	First aid, PHC project	P	Y	Y
10.Christian Hospital Extension Programme (CHREP)	Pakistan	/83	Hospital care, BHU support	P	Y	Y
11.Human Concern Relief Fund Society	Canada	/83	Hospital care, outpatient care	B	Y	Y
12.Afghanistan Nothilfe	Germany	11/86	Outpatient care, EPI, training	B	N	Y
13.Islamic Aid Health Centre	Afghanistan	2/81	Outpatient care, EPI, training	B	Y	Y

AGENCY	NATIONALITY	BEGAN	HEALTH PROJECTS	1	2	3
14.Welfare and Relief Committee for Afghan Refugees	Afghanistan	9/89	Outpatient care, training	B	N	N
15.Mercy Corps International	US	5/87	In- and out-patient care, first aid, mobile teams	B	Y	Y
16.Lajna Al-Dawa Al-Islamia	Kuwait	/87	Training, MCH	B	Y	Y
17.Health Unlimited	United Kingdom	10/84	Training	B	N	N
17 agencies	**11 or more countries**	**1980 - 1989**	**Varied**	B= 13	Y= 14	Y =15

1.Location of projects: Pakistan (P), Afghanistan (A) or both (B)
2.Recognised by officials of the refugee health programme: Yes (Y) or No (N)
3.Registered with the Government of Pakistan: Yes (Y) or No (N)

Most agencies which supported health relief in Afghanistan increasingly offered training to medical and paramedical workers from a base in Pakistan. The attention given to training reflected general agreement with the position adopted by the Swedish Committee for Afghanistan in 1985. In 1985, the Swedish Committee came to the conclusion that their efforts to support existing medical personnel inside Afghanistan would soon reach its limits because only 50 of the 200 medical doctors in Afghanistan worked in the rural areas[20]. Such a strategy was also consistent with widely held beliefs that one tactic of the Soviet and Afghan Governments' for defeating the resistance was to prevent medical personnel from caring for the wounded, sick or malnourished[21]. Hence, priority was given to training medical and paramedical personnel in first aid, basic primary care and some preventive measures. Numerous training facilities were set up in Pakistan, and many agencies provided their newly trained staff with drugs, supplies and equipment when they returned to Afghanistan.

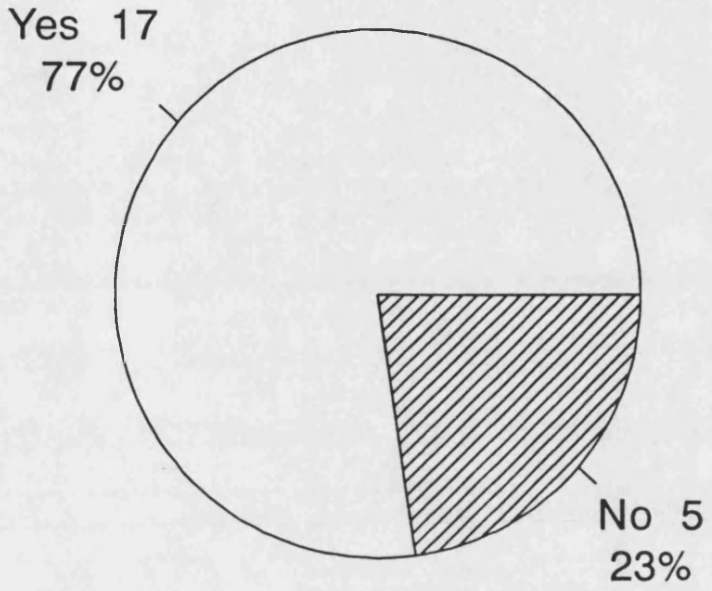
Some agencies also sent teams of foreign medical personnel to supervise the work of these medical doctors and paramedical staff. Others provided support and supervision from a base in Pakistan only.

In addition to training courses, many of these agencies also ran clinics for outpatient care or inpatient facilities for more sophisticated medical and surgical care for Afghans in Pakistan. Table 12.2 lists five new referral facilities for Afghans which were set up in Baluchistan since 1984. Together with the eight facilities established between 1980 and 1984, there were at least 13 referral facilities on record which were specifically for Afghans in Baluchistan and which were organised and managed independently from government health services - for nationals or refugees alike.

Irrespective of their status within the refugee health programme, nearly all agencies providing health care from a base in Baluchistan were active in both Pakistan and Afghanistan (13/17, 76%); by this time only four of these agencies worked solely in Pakistan. Moreover, there were only five other agencies aiding the Afghans in fields outside of the health sector, for example in building systems of water supply or creating schemes for employment. Clearly, most charitable agencies and political parties had some involvement in the provision of health services for the Afghans (17/22, 77%) (Figure 12.3). Obviously, health care was of great importance to those with humanitarian and military missions alike.

Interestingly, two of the four agencies which were active in health relief in Pakistan only, Catholic Relief Services and CHREP, had a long history of involvement in Pakistan through local branches of Christian churches. A different two of the four agencies which were involved in health relief efforts in Pakistan only, CHREP and Action International Contra la Faim (France), had been participating in the refugee health programme since the early 1980s. One might conclude that those without any

Figure 12.3
Involvement of charities in health care for Afghans from a base in Baluchistan, 1990



Participation in health services, n=22

TABLE 12.2
Additional referral facilities established for Afghans in Baluchistan since 1984

FACILITY	SPONSORING AGENCY	AGENCY NATIONALITY
1.Christian Hospital Extension Programme	Mission Hospital/ Inter Aid Committee	Pakistan
2.Inpatient care: Chagai & Chaman districts	Human Concern Relief Fund	Canada
3.Inpatient care	Action Internationale Contra la Faim	France
4.Mekkah Mukarsma Hospital	Saudi Arabian Red Crescent Society	Saudi Arabia
5.Malaria Hospital for Women and Children Afghan Refugees	Not specified	Not specified
+ eight existing facilities,+ 4 or more organizations		**+ 3 or more countries**
13 referral facilities	**7 or more organizations**	**6 or more countries**

existing affiliations with groups in Pakistan and those arriving as the civil war in Afghanistan escalated had an interest in the outcome of the war which was equal to or greater than their interest in humanitarian relief for the refugees on its own.

12.2.2.2 From coordination to anarchy in the North West Frontier

The growing participation of foreign aid agencies and Islamic political parties in health relief operations for Afghans from a base in Baluchistan was small in scale and relatively orderly in comparison with developments in the North West Frontier. Compared with only 17 agencies at the end of 1984, officials of the refugee health programme acknowledged the participation of 32 'voluntary' agencies in the North

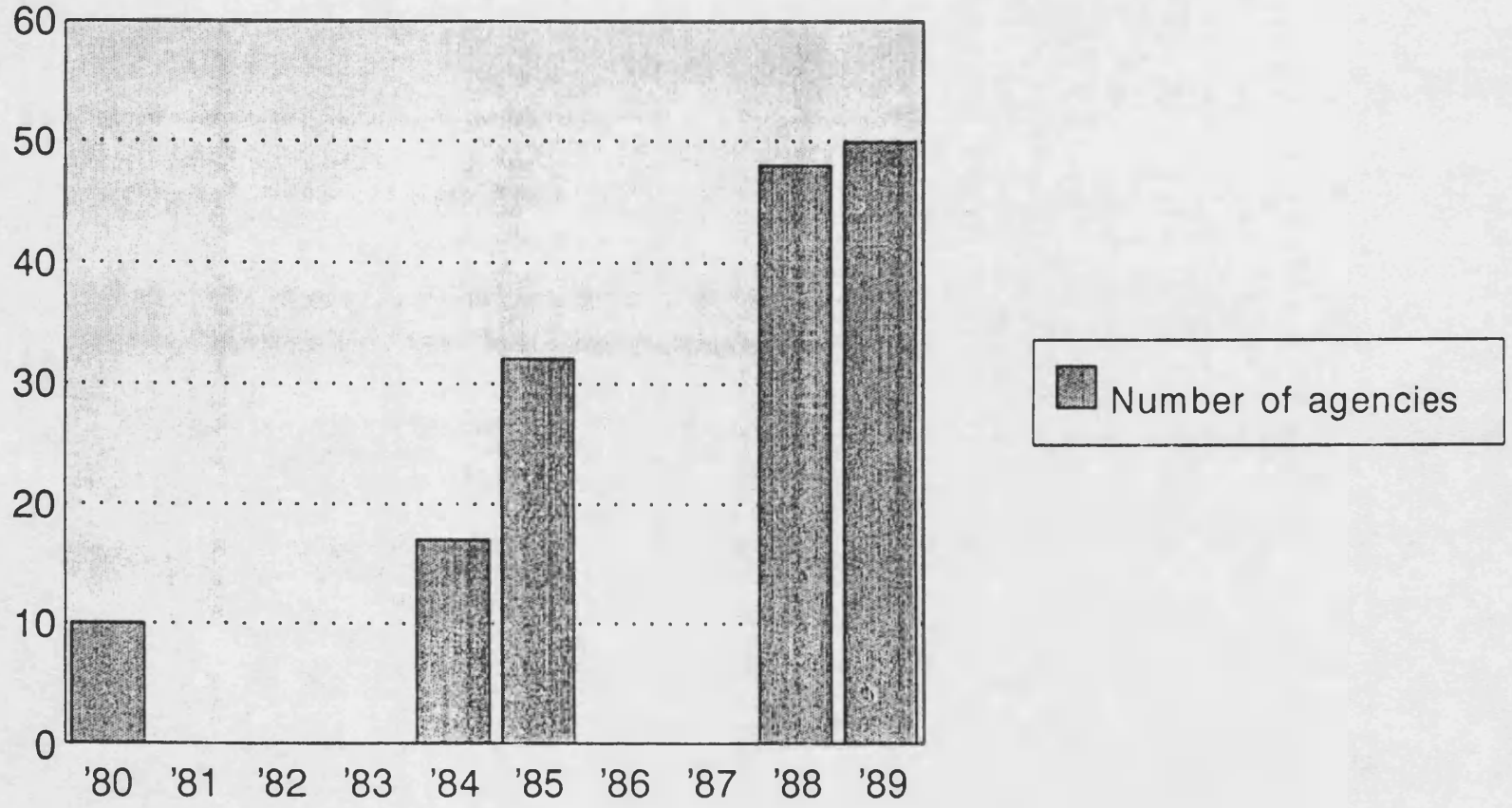
West Frontier alone only one year later. At the end of 1988, this figure had risen to 48 and in 1989 the total reached 50 or more (Figure 12.4).

The Agency Coordinating Body for Afghan Relief (ACBAR) was set up in 1989 to represent the collective interests of private, charitable agencies in the North West Frontier and a similar organization, SWABAC, was established in Baluchistan. ACBAR and SWABAC were, however, representative of those agencies based in North America or Europe. Agencies from Islamic nations set up their own coordinating body, the Islamic Coordinating Council (ICC), which was chaired by the Islamic Relief Agency. The directories of ACBAR for 1989[22] and the combined database of ACBAR and SWABAC of 1989[23] provide a great deal of information on the work of more than 65 agencies while mentioning five others which did not make entries. Differences between draft and final editions along with other lists of agencies involved in the refugee health programme[24] indicate that no one list was complete. In other words, the exact number of agencies contributing to relief efforts was not known. Nor was the nature of their work documented and verified systematically. Similarly, the monetary value of these agencies' contribution to the health programme was not routinely assessed or recorded. Moreover, numerous sources of funding, including general publics, national governments, private corporations, churches, foundations and specialised agencies of the UN, together with only vague notions about which agencies participated and the services they offered, means that the costs associated with their work would be extremely difficult, if not impossible, to assess.

Other published accounts of the relief efforts and related events frequently mention agencies not included in the above sources, such as the Bureau Internationale de l'Afghanistan (BIA) of France, American Aid for Afghans of the US and Afghanaid of the UK who supported teams of medical personnel in Afghanistan[25]. Some accounts detail the work of agencies within North America and Western Europe to generate moral, material and financial support for the Afghan resistance and associated humanitarian assistance programmes[26]. Previous reports also cite agencies not listed in current editions or official records, such as Oxfam UK and World Vision

Figure 12.4

Charities providing health relief for Afghans
from a base in the North West Frontier, 1980-1989



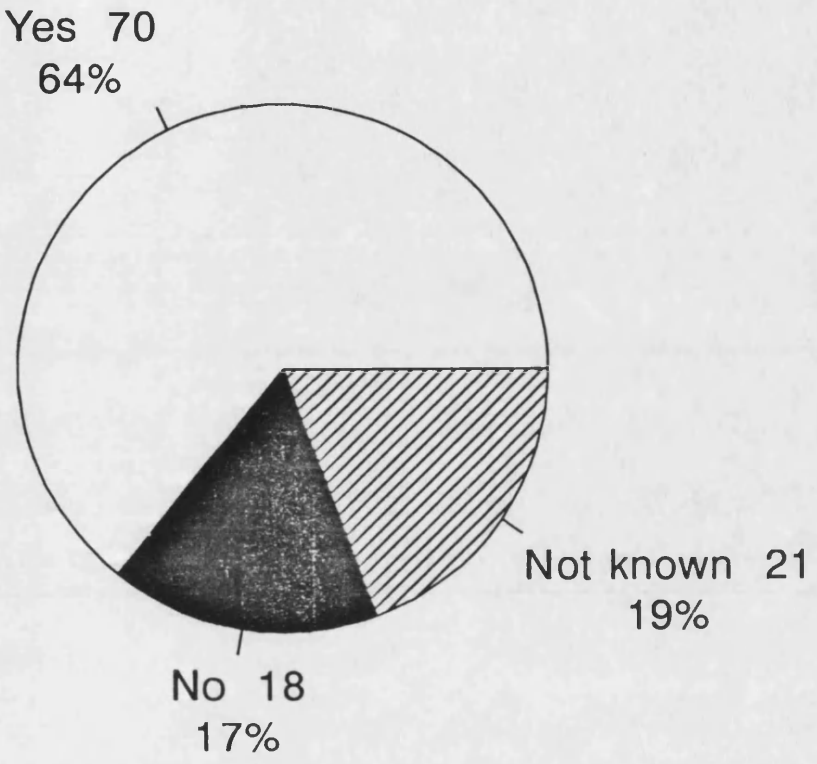
of the US[27]. Baitenmann, for example, claims that 265 non-governmental organizations had a role in the Afghan civil war. Over 100 of these agencies worked with Afghans seeking refuge in Pakistan, over 50 agencies carried out cross-border operations from a base in Pakistan (with at least 27 other agencies supporting these operations from other countries) and over 70 agencies advocated the Afghan cause (60 from a base in the US or Western Europe and 10 from a base in Pakistan).

From sources available in Pakistan, at least 70 agencies were found to providing health care for Afghans from a base in the North West Frontier between 1985 and 1989 (Table 12.3). In addition to these 70, there were 18 agencies who were assisting in fields other than health and another 21 had applied for registration with the Government even though no details were given about their intended activities. At least some of the latter were planning to offer health care, for example the German and Iranian Red Cross and Red Crescent Societies. Agencies involved in health relief accounted for at least 80% (70/88) of those for whom their activities were known, and they accounted for at least 64% of all agencies identified (70/109, 64%) (Figure 12.5).

Thirty-two of the agencies, or 46%, involved in health relief were registered as charities in law in Western Europe in comparison with only 10 (14%) from the US and Canada, 2 (3%) from Australia and Japan and 6 (9%) from the Middle East. Eight charities were registered in Pakistan (11%) and another eight were Afghan (11%) (Figure 12.6). Clearly, most agencies were from the wealthy nations of the North Atlantic region, 63%. Nearly one-third, 21/70 or 30%, of these agencies were not registered with the Government of Pakistan, most of which were involved in cross-border operations (Figure 12.7). However, many other agencies were working in both Afghanistan and Pakistan, bringing the total to at least 39 of the 70 agencies (56%) but probably closer to 50, or 71%, when those claiming to work only in Afghanistan and those for which the location of their work was not specifically documented are included.

Figure 12.5

Charities involved in the provision of health care for Afghans from a base in the North West Frontier, 1990



Participation in health services, n=109

Figure 12.6

Registration in law of charities providing health care for Afghans from a base in the North West Frontier, 1990

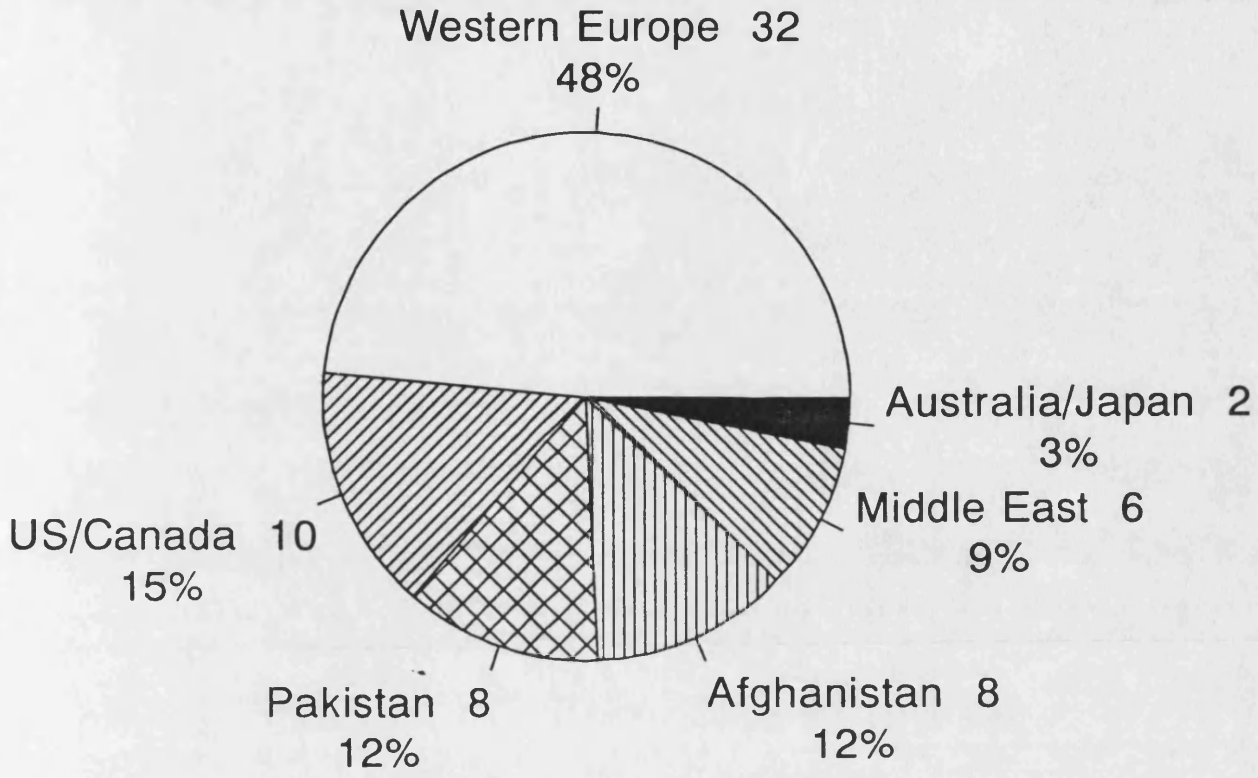
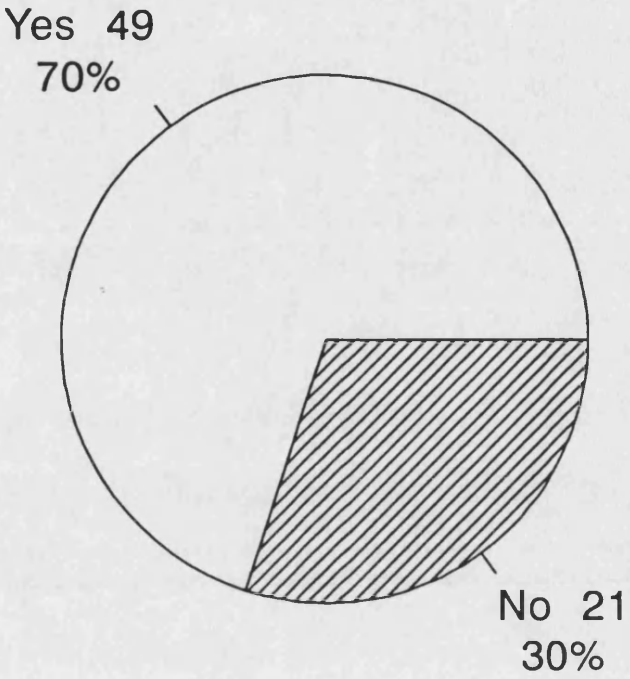


Figure 12.7

Legal status in Pakistan of charities providing health care for Afghans from a base in the North West Frontier, 1990



Registered with the Government of Pakistan

TABLE 12.3

Organizations providing health care for Afghans
from the North West Frontier, 1989

AGENCY	NATIONALITY	BEGAN	1	2	3
1.Afghan Refugee Leprosy Service	UK	/86	N	N	P
2.Afghan Health and Social Assistance Organization	Germany/ Netherlands/ Afghanistan	1/87	Y	Y	B
3.Afghan Medical Aid	Pakistan	11/89	Y	Y	B
4.Afghanistan Nothilfe	Germany	1/87	N	N	B
5.Aide Medicale Internationale	France	9/85	N	Y	B
6.Afghan OB/GYN clinic	Afghanistan	11/84	Y	Y	B
7.Austrian Relief Committee for Afghan Refugees	Austria	1/80	Y	Y	B
8.Afghan Relief Foundation	Afghanistan	/87	N	N	B
9.Afghanistan Vaccination/ Immunization Centre (AVICEN)	France	9/87	Y	Y	B
10.Afghan Refugees Humanitarian Unity	Afghanistan	7/85	Y	N	?
11.Afghan Welfare Centre	?	/86	N	N	?
12.CARITAS Pakistan	Pakistan	/80	Y	Y	P
13.Catholic Relief Services USCC	US	/85	Y	Y	P
14.Christian Hospital Extension Programme (CHREP)	Pakistan	/85	Y	Y	P
15.Committee for a Free Afghanistan	US	/86	Y	Y	P
16.Danish Committee for Aid to Afghan Refugees	Denmark	1/84	Y	Y	P
17.Dental Clinic for Afghan Refugees	Afghanistan	1/84	N	N	B

AGENCY	NATIONALITY	BEGAN	1	2	3
18.Dorsch Consult	?	/86	N	N	P
19.Freedom Medicine	US	2/86	Y	Y	B
20.German Afghanistan Committee	Germany	8/85	Y	Y	B
21.German Afghanistan Foundation	Germany	7/87	Y	Y	B
22.German Technical Cooperation GTZ	German	/85	Y	Y	P
23.Hayat Services	?	/85	Y	Y	?
24.Human Concern International	Canada	1/89	N	N	B
25.Human Concern Relief Fund	Canada	/85	Y	Y	?
26.Help the Afghans Foundation	Netherlands	/85	Y	Y	B
27.Help Organization of West Germany	Germany	/86	Y	Y	P
28.Inter-Church Aid	Pakistan	11/79	Y	Y	B
29.Idara-e-Ahya-ul-Uloom	Pakistan	/80	Y	Y	?
30.International Committee of the Red Cross	Switzerland	/80	Y	Y	B
31.International Medical Corps	US	11/85	Y	Y	B
32.International Rescue Committee	US	6/80	Y	Y	B
33.Islamic Relief Agency	Sudan	/84	Y	Y	B
34.Italian Cooperation for Development	Italy	/84	Y	Y	P
35.Kuwait Red Crescent Society	Kuwait	/84	Y	Y	P
36.Japan Afghan Medical Service	Japan	/86	N	N	P
37.Lajna Al-Dawa Al-IslamiP	uwait	/87	Y	Y	B

AGENCY	NATIONALITY	BEGAN	1	2	3
38.League of Red Cross and Red Crescent Societies	Switzerland		Y	Y	P
39.Medecins Sans Frontiers	Belgium	11/88	Y	Y	B
40.Medecins Sans Frontiers	France	1/87	Y	Y	B
41.Medical Refresher Course for Afghans	France	9/85	Y	Y	P
42.Management Sciences for Health	US	11/87	N	N	B
43.Muslim Aid	UK	6/86	Y	Y	B
44.Mercy Fund	US	7/87	Y	Y	B
45.Muslim World League	Saudi Arabia	/86	Y	N	?
46.Norwegian Refugee Council/ Norwegian Church Aid	Norway	/80	Y	N	B
47.Pakistan Red Crescent Society	Pakistan	/80	Y	Y	P
48.PP-German Basic Education	Germany	/86	N	N	P
49.Psychiatry Centre for Afghan Refugees	?	?	Y	Y	P
50.Rabita Al-Alam Al-Islami	Pakistan	/88	Y	Y	P
51.Saudi Arabian Red Crescent Society	Saudi Arabia	/80	Y	Y	B
52.Swedish Committee for Afghanistan	Sweden	1/84	Y	Y	B
53.Save the Children Fund	UK	/80	Y	Y	P
54.Sandy Gall Afghanistan Appeal	UK	4/88	Y	Y	?
55.Shelter Now International	Australia/ Sri Lanka	10/88	Y	Y	B
56.Serving Emergency Relief and Vocational Enterprises (SERVE)	UK	9/80	Y	Y	B
57.Salvation Army	UK	/84	Y	Y	B

AGENCY	NATIONALITY	BEGAN	1	2	3
58.Seventh Day Adventists	Pakistan	/86	Y	Y	P
59.Society of Afghan Doctors and Other Health Professionals outside of Afghanistan	Afghanistan	/80	N	N	B
60.Solidarites Afghanistan	Belgium	6/84	Y	Y	B
61.Solidarites Afghanistan/Guilde de Raid	France	/86	N	N	B
62.Union Aid for Afghan Refugees	Germany	/80	Y	Y	B
63.Union Aid of Afghan Mujahid Doctors	Afghanistan		Y	Y	B
64.United Arab Emirates Red Crescent Society	UAE	/88	Y	Y	?
65.United Medical Centre of Afghan Mujahid Doctors	Afghanistan	/82	N	N	B
66.Welfare and Relief Committee for Afghan Refugees	Afghanistan	9/87	N	N	B
66 Agencies					
Agencies which acknowledge work in Afghanistan only					
1.Action Internationale Medicale Estudiante	France	8/81	N	N	A
2.Mercy Corps International	US	5/87	N	N	A
3.Medecins du Monde	France	2/80	N	N	A
4.Norwegian Committee for Afghanistan	Norway	3/85	Y	Y	A
4 Agencies	**3 countries**	**1980 - 87**			
70 Agencies in health					

1.Location of projects: Pakistan (P), Afghanistan (A) or both (B)
2.Recognised by officials of the refugee health programme: Y (Y) or No (N)
3.Registered with the Government of Pakistan: Y (Y) or No (N)

Thus, between 1985 and 1989, the North West Frontier became the base for a massive groups of charitable agencies and political parties. Most agencies provided health care and most worked in both Afghanistan and Pakistan even though priority was clearly given to cross-border and war-related relief efforts. Few agencies were national or local in character and instead represented societies from wealthier countries in the North Atlantic region.

The growing interest in the Afghan relief programme also affected the provision of sophisticated medical and surgical care in the North West Frontier. Table 12.4 lists 41 new referral facilities which were established for Afghans since 1984. Unlike cross-border operations which were set up primarily by western groups, new referral facilities were established and managed mainly by Islamic groups - 28 of the 41 facilities, or 68%, were affiliated with an Islamic organization even though many

Table 12.4
Additional referral facilities established for Afghans in the North West Frontier since 1984

FACILITY	SPONSORING AGENCY	AGENCY NATIONALITY
1.Mission Hospital, Peshawar	Christian Hospital Extension Programme	Pakistan
2.Christian Hospital, Tank	Christian Hospital Extension Programme	Pakistan
3.Afghan Female Surgical Hospital	Idara-e-Ahya-ul-Uloom	Pakistan
4.Kuwait Red Crescent Hospital, Jehangirabad	Kuwait Red Crescent Society	Kuwait
5.Miranshah Hospital	Kuwait Red Crescent Society	Kuwait
6.Female and Children Hospital, Peshawar	Kuwait Red Crescent Society	Kuwait
7.Eye Hospital	SERVE	UK

FACILITY	SPONSORING AGENCY	AGENCY NATIONALITY
8.Abdul Manon Shaheed Hospital, Peshawar	Harka-e-Inqilab-e-Islamia	Afghanistan
9.Barakai Hospital	Union Aid	Germany
10.Tuberculosis Hospital in Kacha Garhi	Saudi Red Crescent Society	Saudi Arabia
11.Physiotherapy Hospital, Peshawar	Saudi Red Crescent Society	Saudi Arabia
12.Afghan General Hospital, Jalozai	Saudi Red Crescent Society	Saudi Arabia
13.Umar Shaheed General Hospital, Peshawar	The Islamic Alliance	Afghanistan
14.Al Hijra-wal-Jehad General Hospital, Peshawar	Hazbi Islami	Afghanistan
15.Badeer Rooghton (Al Fauuzan) Hospital, Peshawar	Human Concern Relief Fund	Canada
16.Hospital Khulfa-e-Rashideen	?	?
17.Leprosy Department Mission Hospital, Peshawar	Mission Hospital, Christian Hospital Extension Programme	Pakistan
18.Marie Adelaide Leprosy Centre	Manghopir Leprosy Hospital	Pakistan
19.Border Hospitals	Human Concern International	Canada
20.Inpatient facilities: Abbottabad, Bannu, Chitral	Islamic Relief Agency	Sudan
21.Inpatient facilities: Chitral	Medecins Sans Frontieres	France
22.Inpatient facilities: Mardan	Union Aid for Afghan Refugees	Germany
23.Inpatient facilities: Peshawar	Afghan Health and Social Assistance Organization	Afghanistan
24.Inpatient facilities: Peshawar	Afghanistan Northilfe	Germany

FACILITY	SPONSORING AGENCY	AGENCY NATIONALITY
25.Inpatient facilities: Peshawar	Medical Refresher Courses for Afghan Refugees	France
26.Inpatient facilities: Peshawar	Welfare and Relief Committee Fund	Afghanistan
27.Freedom Medicine Hospital, Kohat	Freedom Medicine	US
28.Freedom Medicine Hospital, Chitral	Freedom Medicine	US
29.Shaheed Syed Abdullah Hospital	Jamiat-e-Islamia	Afghanistan
30.Shaheed Saifullah Hospital	Jamiat-e-Islamia	Afghanistan
31.Shaheed Syed Jamaluddin Hospital	Jamiat-e-Islamia	Afghanistan
32.Shaheed Abdul Latif Hospital	Jamiat-e-Islamia	Afghanistan
33.Shaheed Ghulam Haider Hospital	Jamiat-e-Islamia	Afghanistan
34.Jamiat-e-Islami Afghan Refugees Hospital	Jamiat-e-Islamia	Afghanistan
35.Shaheed Shah Wali Hospital	Jamiat-e-Islamia	Afghanistan
36.Al-Hirja Wal-Jihad Hospital (male)	Hizbe Islami (Khalis Group)	Afghanistan
37.Shakoor Shaheed Hospital	Islamic Alliance of Mujahideen	Afghanistan
38.Umar Shaheed Hospital	Islamic Alliance of Mujahideen	Afghanistan
39.Artificial limb centre: Lady Reading Hospital	CARITAS	Pakistan
40.Artificial limb centre: Khyber Hospital	GTZ	Germany
41.Paraplegic centre	Kuwait Red Crescent Society	Kuwait
41 referral facilities	**23 agencies**	**10+ countries**

were sponsored by charitable organizations (Figures 12.8 and 12.9). These facilities functioned independently of government health services - for nationals and refugees alike. Similar to the early years of the refugee health programme, the provision of sophisticated medical and surgical care continued to be an area in which foreign groups expressed and supported their own interests.

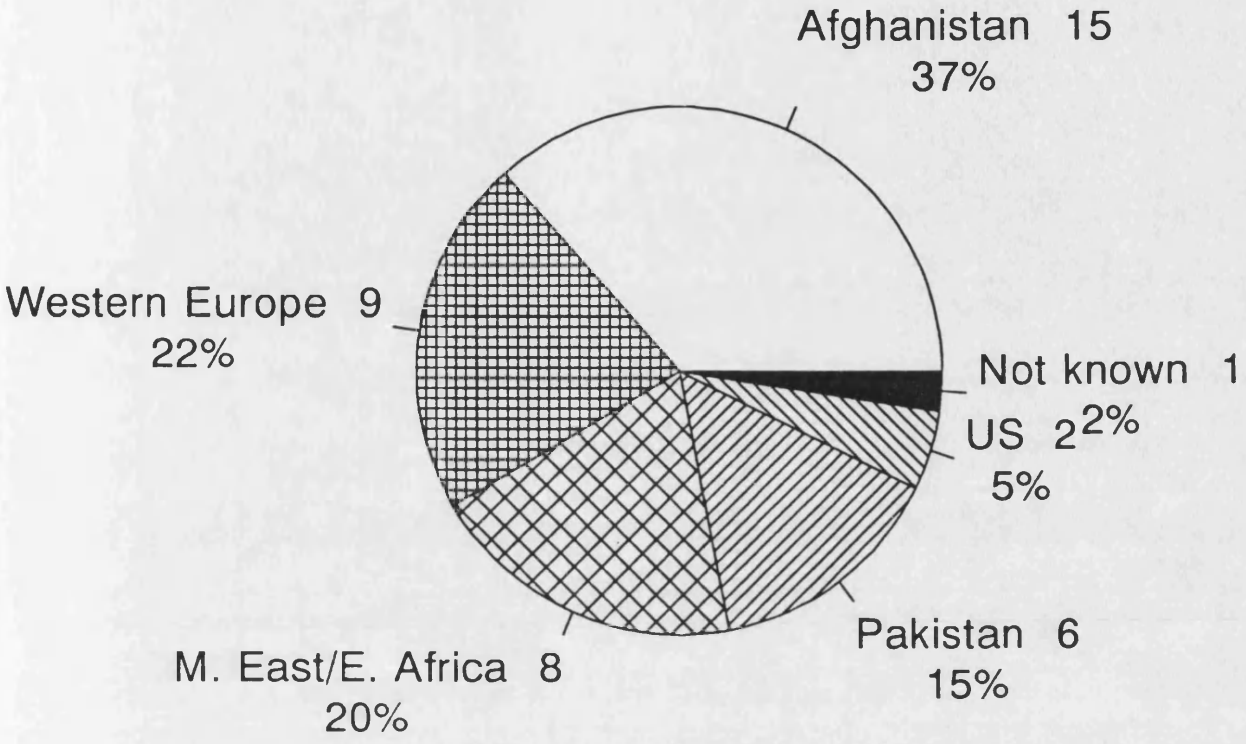
12.2.2.3 The refugee health programme in Punjab: a last remnant of coordinated national and international efforts?

Despite the relatively small Afghan population in Mianwali (less than 200 000 people) and their location a considerable distance from Afghanistan, charitable agencies also began to take part in providing health services for refugees in Punjab in 1985. Unlike Baluchistan where some foreign charitable agencies began to compete with health officials of the Commissionerate for Afghan Refugees to provide basic primary care in the camps, foreign charitable agencies which worked in Kot Chandna and Dara Tang camps did so in a complimentary and supportive way. In Table 12.5 it can be seen that no more than four agencies worked directly in the camps and that they worked to strengthen services offered by the basic health units through training programmes and laboratory support, or by focusing on activities which had not been implemented adequately to date, such as immunizations and other community health interventions. In combination with strong leadership by government officials, pleasant and productive working relationships were established.

Unlike the provision of basic care for which strategies and plans were mutually agreed upon, the provision of hospital care continued to engage the Pakistan Red Crescent Society, UNHCR and government officials of the refugee health programme in debate. In 1984 a delegation from the League of Red Cross and Red Crescent Societies in Geneva visited Pakistan and formulated a proposal together with the Pakistan Red Crescent Society to establish a hospital for the refugees in Kot Chandna camp. This proposal was submitted by the Pakistan Red Crescent Society to SAFRON and approval was granted in February 1985. UNHCR was apparently not

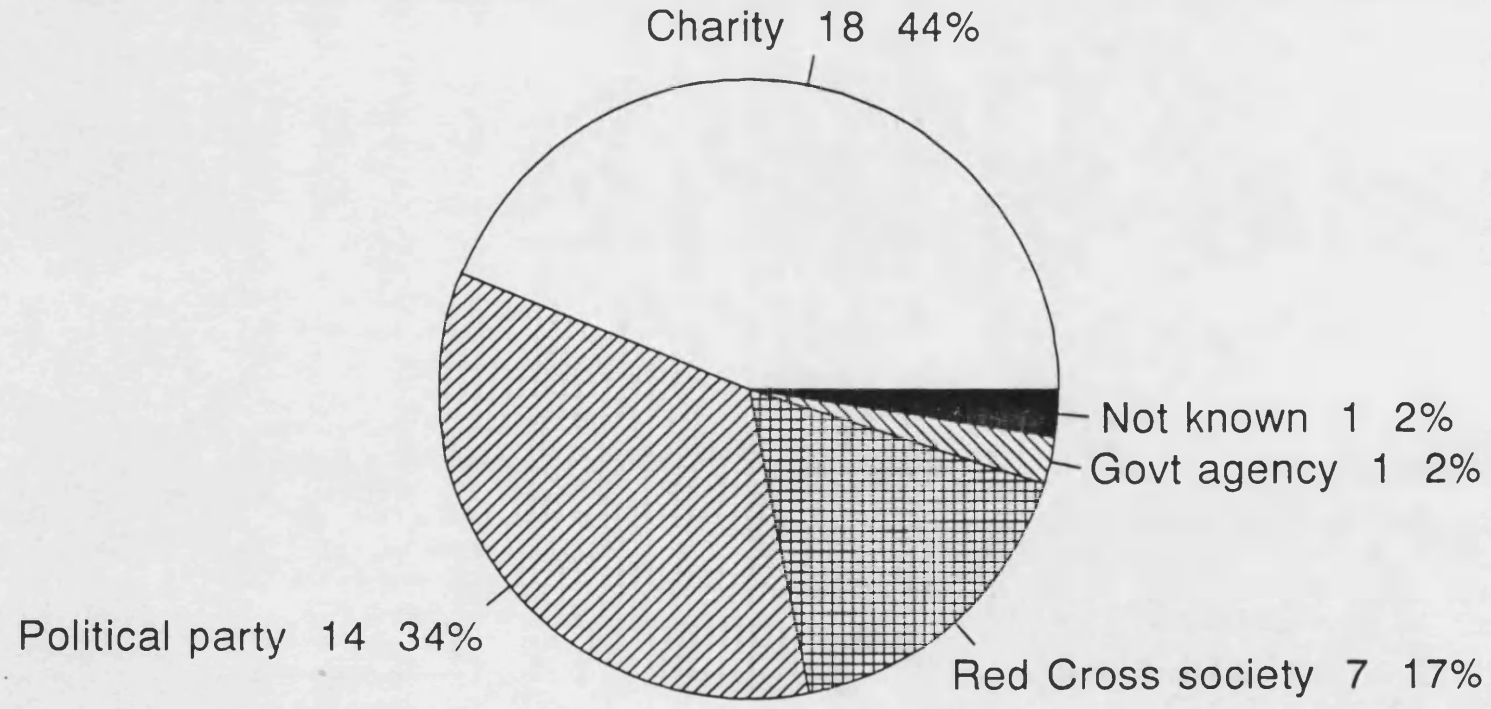
Figure 12.8

Registration in law of organizations providing referral services for Afghans in the North West Frontier, 1990



Country of registration, n=41

Figure 12.9
Organizations providing referral services for Afghans
in the North West Frontier, 1990



Type of organization, n=41

TABLE 12.5
Organizations providing health care for Afghans in Punjab, 1989

AGENCY	NATIONAL-ITY	DATE BEGAN	HEALTH PROJECTS	1	2	3
1.Catholic Relief Services	US	8/86	Training	Y	Y	P
2.Church World Service	Switzer-land	/85	?	Y	Y	P
3.Hayat Services	?	/85	Funds	Y	Y	?
4.Medecins Sans Frontieres	Belgium	6/88	Immunizations, laboratory, training, sanitation	Y	Y	B
5.Pakistan Red Crescent Society	Pakistan	/85	Hospital care	Y	Y	P
6.League of Red Cross Societies	Switzer-land	/85	Hospital care	Y	Y	P
7.Salvation Army	UK	/86	?	Y	Y	P
8.Save the Children Fund	UK	/86	Community health	Y	Y	P
8 Agencies, 5 or more countries, 1985-1988, Varied				**All**	**All**	

1.Location of projects: Pakistan (P), Afghanistan (A) or both (B)
2.Recognised by officials of the refugee health programme: Yes (Y) or No (N)
3.Registered with the Government of Pakistan: Yes (Y) or No (N)

notified until June 1985 at which time they expressed the same concerns as before and reaffirmed their previous position.

A meeting was convened in August 1985 at which time it was decided that the Commissionerate for Afghan Refugees would continue to provide basic health units for the refugees in Mianwali, including Dara Tang camp. SAFRON honoured their commitment to the Pakistan Red Crescent Society and granted approval to them to provide hospital services with the support of the League of Red Cross and Red Crescent Societies. The Government did, however, express their preference that the

hospital should not be located in the camp. As a result of this decision, UNHCR support to local hospitals was withdrawn as it was no longer needed.

Preparations were made and the Kalabagh Referral Hospital officially opened in August of 1986[28]. Services provided to the refugees and the local population included general medical and surgical care, X-ray and laboratory examinations and an outpatient department - originally established to screen referred patients. All cases, except emergencies, had to be referred by the basic health units in the camp or, in the case of local people, the medical officer of the Civil Hospital. Medical needs which were beyond the scope of the Kalabagh Referral Hospital were referred to Lahore. Thus, similar to refugee health programmes in Baluchistan and the North West Frontier, the refugee health programme in Punjab now incorporated a variety of charitable agencies which provided both basic and sophisticated treatments.

12.2.2.4 Behind the scenes: the influence of the Government of the US

Despite the overwhelming representation of agencies from Western Europe, the key donor who influenced and supported policies to use charitable or other private agencies to implement health care was the Government of the US. Of the more than 400 million US$ required to fund the assistance programme for Afghan refugees in Pakistan each year, the largest donor was the US Government. The US Government provided nearly one-third of all costs through bilateral channels and gave additional funds through specialised agencies of the UN and, since 1984, the charitable agencies and political parties. For example, in 1984, the US contribution to UNHCR represented 35% of their budget. At that time, they also provided about 50% of the food donation given through the World Food Programme[29].

Before the autumn of 1984, Pakistan's policy required that US-owned rupees could fund only UNHCR and ICRC. In response, support from the US Government for the work carried out by Inter-Church Aid, CARE, Catholic Relief Services, Church World Service, the International Rescue Committee and the Salvation Army was channelled through UNHCR. UNHCR then became not only the conduit for funds but the

umbrella for health activities more generally. In addition to directing UNHCR to support these agencies, the US Government also encouraged other donors to support these agencies[30].

The US Government began to support the agencies directly in August of 1984 when appropriations were made to Americares from the civilian disaster relief fund of the Department of State[31]. In addition to funding relief for refugees in Pakistan through the Department of State, funds were also allocated for a 'Cross-Border Humanitarian Assistance Programme'. This cross-border programme was administered by USAID and drew resources from 1) Public Law 480, Title II Assistance which donated food commodities, 2) the Humanitarian Relief Programme of the Department of Defense which distributed excess defense stocks of food, medicines and other goods and which arranged free medical treatment for those wounded in war in facilities in the US, Europe or the Middle East, and 3) a new 'Humanitarian Assistance Programme' of USAID which channelled 8 million US$ to charitable agencies in 1985 and 45 million US$ in 1988. Medical aid and cash-for-food were also provided through a new Afghanistan Programme of USAID's Office for Disaster Assistance. The US Government became the largest single funder of cross-border relief; their contribution totalled some 250 million US$ between 1985 and 1989[32].

The availability of new and sizable sums of money accounts for much of the proliferation of charitable agencies in health relief operations. Perhaps surprising to some, funds from the US Government supported more European agencies than those from North America. This was consistent with policies adopted before 1985 which aimed to avoid the appearance of a confrontation between the US and Soviet Union. In order to fund a wide range of agencies and activities which were under the control of various leaders and political parties in many parts of rural Afghanistan, USAID used the International Rescue Committee as a conduit. By 1989 the International Rescue Committee had a substantial programme of refugee and cross-border projects and was the largest US programme in Pakistan[33].

Baitenmann, among others, believes that those charitable agencies which were involved in cross-border efforts were 'integral to the US strategy of low-intensity conflicts against communist forces'[34]. He further substantiates this interpretation of the political and military roles played by the cross-border health relief programme in his analysis of the 70 charitable agencies advocating the Afghan cause. Not only does he point out that most were based in the US or Western Europe (60/70, 86%), but he also noted that all were members of a 'web of right-wing organizations, which includes think tanks, funders, activists, church representatives, university intellectuals, soldiers of fortune, retired US generals and high government officials' of which 'anti-communism is the glue that holds these groups together'[35]. Furthermore, his chronology of events clearly linked the escalation of armed conflict and the provision of US Stinger anti-aircraft missiles to the Mujahideen with expansions in the cross-border humanitarian programme.

12.3 Calling the shots: Pakistani authorities or foreign interest groups?

Links between an expanded humanitarian programme of assistance and military and political strategies of low-intensity conflict in support of armed resistance call into question the ability of Pakistani health authorities to formulate and enforce policies independently for the roles of foreign aid and political organizations in a health relief programme. Instead, it may well have been that initial policies which limited the participation of foreign charitable agencies in the refugee and relief programmes were tolerated largely because they concurred with those of the most powerful donor - the Government of the US.

The arrival of foreign charitable agencies shortly after the specialised agencies of the UN became involved and after the plight and needs of the refugees were first publicised in 1980 was an important challenge to the Government. Support for the involvement of the charitable agencies came primarily from UN agencies, donor governments and the international public at large. Charitable agencies were seen to be a means to implement emergency services quickly, especially since health professionals, equipment and supplies were not readily available to meet the needs of

the refugees. Not only could charitable agencies provide needed resources quickly, their organization allowed lengthy bureaucratic and diplomatic procedures to be bypassed without further delay in implementing services. Moreover, supporting charitable agencies provided an alternative to the Government who, some fear, may divert funds and other resources for their own purposes[36].

In Pakistan, governmental support for charitable agencies between 1980 and 1984 was equivocable, and for good reason. Their previous experiences with foreign charitable agencies had shown that humanitarian work was often less important that other activities - ranging from tourism to intelligence work. Although the Government recognised the value of the resources which these agencies could provide, they were concerned about the effects these agencies would have on the already complex relationships between groups within Pakistan and between Pakistan and other nation-states. Notwithstanding these concerns, the Government increasingly felt compelled to accept charitable agencies in the relief programme. Otherwise, they could have been accused of refusing international assistance, thereby denying the provision of essential services for the refugees or jeopardising other sources of international aid.

Although domestic and foreign charitable agencies began working with the Afghans very early in the relief operation, it was not until the mid-1980s that they began to arrive in mass. The escalation of armed conflict at that time, which included the provision of additional weapons directly from the US Government for the first time[37] and the need to care for those engaged in combat specifically or those supporting the resistance movement generally, entailed a large scale health relief effort. In attempting to expand health relief efforts within existing humanitarian programmes for the refugees or within the newly created humanitarian programme for cross-border operations (rather than those of an overtly military nature), private and charitable agencies became the institutional conduit for delivering health care. Such a strategy was consistent with existing policies which aimed to preserve the presentation of the war as a civil one between various groups within Afghanistan. Furthermore, it allowed this form of support to be presented as a humanitarian or technical intervention rather than one with overtly political motivations. As such, it also avoided a direct

association between health relief efforts and military strategies and instead emphasised the provision of care for 'innocent' victims - a cause which would be difficult to dispute on ethical grounds. This tactic would also be widely accepted by the general public of donor nations and thus was more easily justified.

Such a strategy required new policies within the refugee health programme. Beginning in 1985, 'voluntary' agencies were 'encouraged to assist in delivering health care to the Afghan refugees'[38], and in 1986 specific guidelines for their participation were issued jointly by UNHCR and the Director of Medical Services of the Chief Commissionerate for Afghan Refugees of the Federal Government[39]. These guidelines acknowledged that charitable agencies already provided one-third of the refugee population with health care. Criteria for their participation in the programme emphasised lines of accountability through provincial and national offices of the Government's refugee health programme as well as UNHCR. Adherence to standards of care determined by the Government and UNHCR were another recurring theme, including salaries paid to various health workers, patterns of staffing services and the types of medicines and treatments to be given. Even though the charitable agencies were admonished repeatedly to coordinate their work with UNHCR and the Government, and to adhere to policies and plans determined by them, they were also told to 'try innovative approaches to health care problems and implement pilot projects using new strategies to enhance their effectiveness'[40]. In practice, therefore, they were increasingly given considerable scope to set up and run their own projects, and by 1989 'the Pakistan Government had adopted a liberal policy towards charitable agencies to undertake relief work in refugee areas in sectors that they wish to supplement'[41].

12.4 References

1. Khan AR and Elo O (1984) Annual report 1984, Afghan Refugee Health programme. Islamabad, Pakistan: Chief Commissionerate for Afghan Refugees, Government of Pakistan/United Nations High Commissioner for Refugees, 184 pp.

   Ahtone J, Berends P and Khan AR (1985) Annual report 1985. Afghan refugee health programme Pakistan. Islamabad, Pakistan: Chief Commissionerate for Afghan Refugees/ United Nations High Commissioner for Refugees, 124 pp.

   Programme Officer UNHCR (1981) Self-evaluation report on the health sector 1981 programme. Quetta, Baluchistan, Pakistan: United Nations High Commissioner for Refugees, 9 pp.

2. Programme Officer UNHCR (1981), #1

   Khan AR and Elo O (1984), #1

   PDH Baluchistan (1982) Narrative report on the implementation of health projects under the UNHCR assistance programme for the year 1982 as it stood on 31.12.82. Quetta, Baluchistan, Pakistan: Project Directorate for Health for Afghan Refugees, Government of Baluchistan, 6 pp.

3. Senior Health Coordinator WHO/UNHCR (1985). Draft: Health services - Baluchistan. Quetta, Baluchistan, Pakistan: United Nations High Commissioner for Refugees, 6 pp.

4. Simmonds SP (1981) Assignment report. The health of the Afghan refugees in Pakistan. Geneva, Switzerland: World Health Organization, Emergency Preparedness and Response, 17 pp.

   Simmonds SP and Hussain M (1986) The health of Afghan refugees in Pakistan. Alexandria, Egypt: World Health Organization, Regional Office for the Eastern Mediterranean, 19 pp.

5. Senior Health Coordinator WHO/UNHCR (1985), #3

6. Senior Health Coordinator WHO/UNHCR (1985), #3

7. PDH Baluchistan (1985) Letter to the Commissioner for Afghan Refugees in Baluchistan, 25.12.82. Quetta, Baluchistan, Pakistan: Project Directorate for Health for Afghan Refugees, Government of Baluchistan, 3 pp.

   Ahtone J, Berends P and Khan AR (1985), #1

8. Khan AR and Nesbit R (1987) Annual report 1986. Afghan refugee health programme Pakistan. Islamabad, Pakistan: Chief Commissionerate for Afghan Refugees/United Nations High Commissioner for Refugees, 129 pp.

9. PDH Baluchistan (1987) Report on the Afghan refugee health programme in Baluchistan for 1987. Quetta, Baluchistan, Pakistan: Project Directorate for Health for Afghan Refugees, Government of Baluchistan, 5 pp.

10. Khan AR and Nesbit R (1987), #8

11. Programme Officer UNHCR (1982) Self-Evaluation report on the health sector - No.11. Extended 1981 programme. 1982 programme up to 30 June 1982. Quetta, Baluchistan, Pakistan: United Nations High Commissioner for Refugees, 18 pp.

SAFRON (1985) Letter to Chief of Mission, UNHCR, 11 November 1985, 1 p.

12. Senior Health Coordinator WHO/UNHCR (1985), #3

13. Senior Health Coordinator WHO/UNHCR (1985), #3

14. Senior Health Coordinator WHO/UNHCR (1985). Draft: Health services - Baluchistan. Quetta, Baluchistan, Pakistan: United Nations High Commissioner for Refugees, 6 pp.

15. Administrator MSF (1987) Letter to Chief Sub-office UNHCR, 14 July 1987. Quetta, Baluchistan, Pakistan: Medecins Sans Frontier

16. Chief Sub-office UNHCR (1987) Letter to Project Director for Health for Afghan Refugees, Government of Baluchistan, 14 October 1987. Quetta, Baluchistan, Pakistan: United Nations High Commissioner for Refugees

17. PDH Baluchistan (1986) Letter to Commissioner for Afghan Refugees, Baluchistan, 2 June 1986. Quetta, Baluchistan, Pakistan: Project Directorate for Health for Afghan Refugees, Government of Baluchistan

PDH Baluchistan (1987), #9

18. Chief of Mission AICF (1987) Letter to Commissioner for Afghan Refugee in Baluchistan, 11 November 1987. Quetta, Baluchistan, Pakistan: Action International Contra la Faim

19. FSMO Zhob/Loralei Districts (1987) Letter to Project Director for Health of Afghan Refugees, Government of Baluchistan, 21 November 1987. Quetta, Baluchistan, Pakistan: Project Directorate for Health of Afghan Refugees, Government of Baluchistan

PDH Baluchistan (1987) Letter to Chief of Mission AICF, 22 November 1987. Quetta, Baluchistan, Pakistan: Project Directorate for Health of Afghan Refugees, Government of Baluchistan

20. Magnus RH (1989) Humanitarian response to an inhuman strategy. In: Farr GM and Merriam JG Afghan resistance. The politics of survival. Boulder, Colorado, USA and London, UK: Westview Press, pp. 191-212

21. Baitenmann H (1990) NGOs and the Afghan war: the politicisation of humanitarian aid. Third World Quarterly 12(1):62-85

Brownfeld AC (1986) Just what is our policy toward Afghan rebels? Human Events, 16 August, 10:706

22. Agency Coordinating Body for Afghan Relief (1989a) ACBAR directory of members. Islamabad, Pakistan: Pan Graphics Ltd, November, 133 pp.

ACBAR (1989b) Directory. Draft edition for members. Peshawar, Pakistan: Agency Coordinating Body for Afghan Relief, June

23. Regional Coordination Department, ACBAR (1989) ACBAR/SWABAC database. Regional coordination for Afghanistan and Pakistan. Second Edition, November. University Town, Peshawar, Pakistan: Agency Coordinating Body for Afghan Relief, 213 pp.

24. Khan AR and Elo O (1984), #1

Ahtone J, Berends P and Khan AR (1985), #1

Khan AR and Nesbit R (1987), #8

CCAR/GOP (1984) Humanitarian assistance programme for Afghan refugees in Pakistan. Islamabad, Pakistan: Chief Commissionerate for Afghan Refugees, Government of Pakistan, 28 pp.

UNHCR (1987) UNHCR activities for 1986 -1987 and programme for 1987 - 1988. Report. Islamabad, Pakistan: United Nations High Commissioner for Refugees, 3 volumes

Zaman S (1987) Humanitarian assistance programmes for Afghan refugees in North West Frontier Province Pakistan. Peshawar, Pakistan: Public Relations Cell, Afghan Refugee Commissionerate, Government of Pakistan, January, 72 pp.

25. Magnus RH (1989), #20

26. Baitenmann H (1990), #21

27. ACBAR (1989b), #22

28. PRCS (1986) Inauguration ceremony of the Red Crescent Referral Hospital, Kalabagh, for Afghan refugees. Newsletter 1(3):4-5, Punjab Provincial Branch of the Pakistan Red Crescent Society

29. Karp C (1984) A five year summary. Afghan resistance and Soviet occupation. Washington DC, USA: US Department of State, Bureau of Public Affairs, December, 4 pp.

30. Baitenmann H (1990), #21

31. Magnus RH (1989), #20

32. Baitenmann H (1990), #21

33. Baitenmann H (1990), #21

34. Baitenmann H (1990), p.74, #21

35. Baitenmann H (1990), p. 81, #21

36. Kent RC (1987) The Anatomy of disaster relief. The international network in action. London, UK: Pinter Publishers, 183 pp.

37. Merriam JG (1989) Arms shipments to the Afghan resistance. In: Farr GM and Merriam JG Afghan resistance. The politics of survival. Boulder, Colorado, USA and London, UK: Westview Press, pp. 71-101

38. Ahtone J, Berends P and Khan AR (1985), p. 18, #1

39. Khan AR and Nesbit R (1987), pp. 118-120, #8

40. Khan AR and Nesbit R (1987), p. 120, #8

41. CCAR (1989) 3.27 Million Uprooted Afghans in Pakistan. Islamabad, Pakistan: Chief Commissionerate for Afghan Refugees, States and Frontier Regions and Kashmir Affairs Division, Federal Government of Pakistan, p. 9 of 16

CHAPTER THIRTEEN

Management of the refugee health programme, 1985 - 1989: by, with or instead of the Government of Pakistan?

13.1 Competing for the coordinating role: the Government of Pakistan, WHO and UNHCR

13.1.1 Setting technical standards of care: specialised agencies of the UN move beyond an advisory role

The guidelines which the Federal Government and UNHCR formulated in 1986 for charitable agencies represented only a fraction of the standards being set for the refugee health programme. Beginning in 1985 the second Senior Health Coordinator of WHO/UNHCR began to compile an Operations manual for the Afghan Refugee Health Programme in Pakistan[1]. This manual brought together guidelines for each of the disease control programmes as well as the provision of basic primary care, community-based activities, referral services and emergency assistance. The roles of various organizations and protocols for management were also included. Despite the substantial amount of time put into the preparation of this manual by the Senior Health Coordinator and many other health professionals of WHO, it was never distributed to staff of the basic health units. Instead, its publication in 1987 coincided with the arrival of the fourth Senior Health Coordinator who had different views on standards to be adopted. This meant that further dissemination or enforcement of stated plans were not pursued. Revisions were begun and it was not until 1989 that guidelines were issued; yet again, these guidelines were for specific programmes and were issued as separate documents, for example for environmental health services[2] and maternal and child health care[3].

13.1.2 Negotiating responsibility for refugee health within the UN system: the inadequacies of joint leadership

Notwithstanding the failure to distribute and enforce the standards proposed in the operations manual, the process by which they were formulated characterised more radical shifts in power between the Government, WHO and UNHCR. Policies and plans originally gave responsibility for policy-making, planning and managing health services for the Afghans to government officials. The arrival of the first Senior Health Coordinator of WHO/UNHCR did not significantly alter existing structures within the refugee health programme since he acted in an advisory and supportive role to government officials at national and provincial levels.

The creation of the position of a Senior Health Coordinator did, however, alter the roles of both WHO and UNHCR. Through the Senior Health Coordinator, WHO provided leadership on refugee health-related issues within the UN system. They also fulfilled their mandate to provide expert advice and assistance to member governments. The first two Senior Health Coordinators were recruited on to the staff of WHO through the Emergency Preparedness and Response Unit in Geneva and seconded to UNHCR which provided funds for all associated costs. As staff of WHO, they made extensive use of the various resources of WHO, primarily by engaging the services of experts to guide all aspects of the programme. For example, the two evaluations of the refugee health programme overall, which were undertaken in 1981 and 1985, were carried out under the auspices of WHO[4], and specific disease control programmes were evaluated by officials of the relevant departments in WHO, such as for tuberculosis and malaria control[5]. Advisors to national programmes were also engaged in the formulation of related policies and plans for the refugee programme[6], for example in generating a list of essential drugs for the refugee health programme.

Not only did the first two Senior Health Coordinators draw upon expertise within WHO, they invited other agencies with expertise in international health to assist officials of the refugee health programme. For example, the first Senior Health Coordinator arranged for the Centres for Disease Control of the US Government to

assess the rates of infant mortality and poor nutritional status among Afghan refugees in 1984[7]. This assessment provided important indicators about the effectiveness of existing interventions as well as unmet needs for care, and it was subsequently carried out by the Centres for Disease Control for UNHCR each year.

Although the Senior Health Coordinator's position within both WHO and UNHCR appeared to facilitate the work of both agencies, there were serious managerial constraints with this arrangement. Most importantly, the Senior Health Coordinator in Islamabad and the Health Coordinators in the North West Frontier and Baluchistan were accountable to two agencies. This meant that they had to report to both agencies separately. Obtaining official approval for policies and plans was a lengthy and, at times, confused process. Different views on priorities to be adopted and actions to be taken were not uncommon, requiring additional effort on the part of the Senior Health Coordinator to negotiate and mediate between WHO and UNHCR - let alone with the Government and numerous charitable and private agencies.

13.1.3 The power of the purse: UNHCR takes the leading role

Consequently, in 1985, UNHCR decided to create a position within the Office of the Chief of Mission in Islamabad for a Senior Health Coordinator. This move consolidated decision-making powers within UNHCR when it was implemented in 1986, and it ended the direct involvement of WHO in the refugee health programme. The Health Coordinators in the North West Frontier and Baluchistan continued to be seconded to UNHCR but no longer from WHO. Beginning in 1986, these advisors were provided by the Save the Children Fund under an agreement similar to the one previously held with WHO. Such an agreement allowed UNHCR to continue to benefit from the presence of foreign medical professionals, but without creating additional posts within UNHCR and at significantly less cost since these professionals were recruited and paid as staff of the Save the Children Fund (UK). Nevertheless, the dual accountability of these two Health Coordinators created tensions between UNHCR and the Save the Children Fund at times; the Save the Children Fund also

considered these coordinators members of their staff under their jurisdiction (Figure 13.1).

In 1986, UNHCR further strengthened their own capacity to coordinate and manage the refugee health programme by appointing three specialists in nutrition/maternal and child health, sanitary engineering and health programming. With the addition of these three professionals in Islamabad UNHCR now had their own health unit. The role of UNHCR then extended far beyond funding 'to provide guidance and coordination'[8]. In order to better manage the refugee health programme, UNHCR also took responsibility, 'on behalf of the Government', for 'the procurement of vaccines, insecticides, vehicles and other specialised medical supplies'[9] through their procurement unit in Geneva. Taking responsibility for providing leadership and for the provision of essential supplies not only placed UNHCR as the lead agency within the UN system for refugee health matters but also within the refugee health programme itself.

Not surprisingly, many officials of the Government's refugee health programme resented UNHCR's dominance in policy-making, planning and managerial processes as well as the credit given to them for health care provided. Nevertheless, UNHCR consolidated their leadership throughout the following years. The agreements which they reached with charitable and private agencies to manage and provide basic care in the camps was one mechanism which further strengthened UNHCR's position within the refugee health programme - even though at times it was at the expense of the Government. Similarly, the appointment of foreign aid agencies as advisors and managers within specific disease control and community health programmes was another.

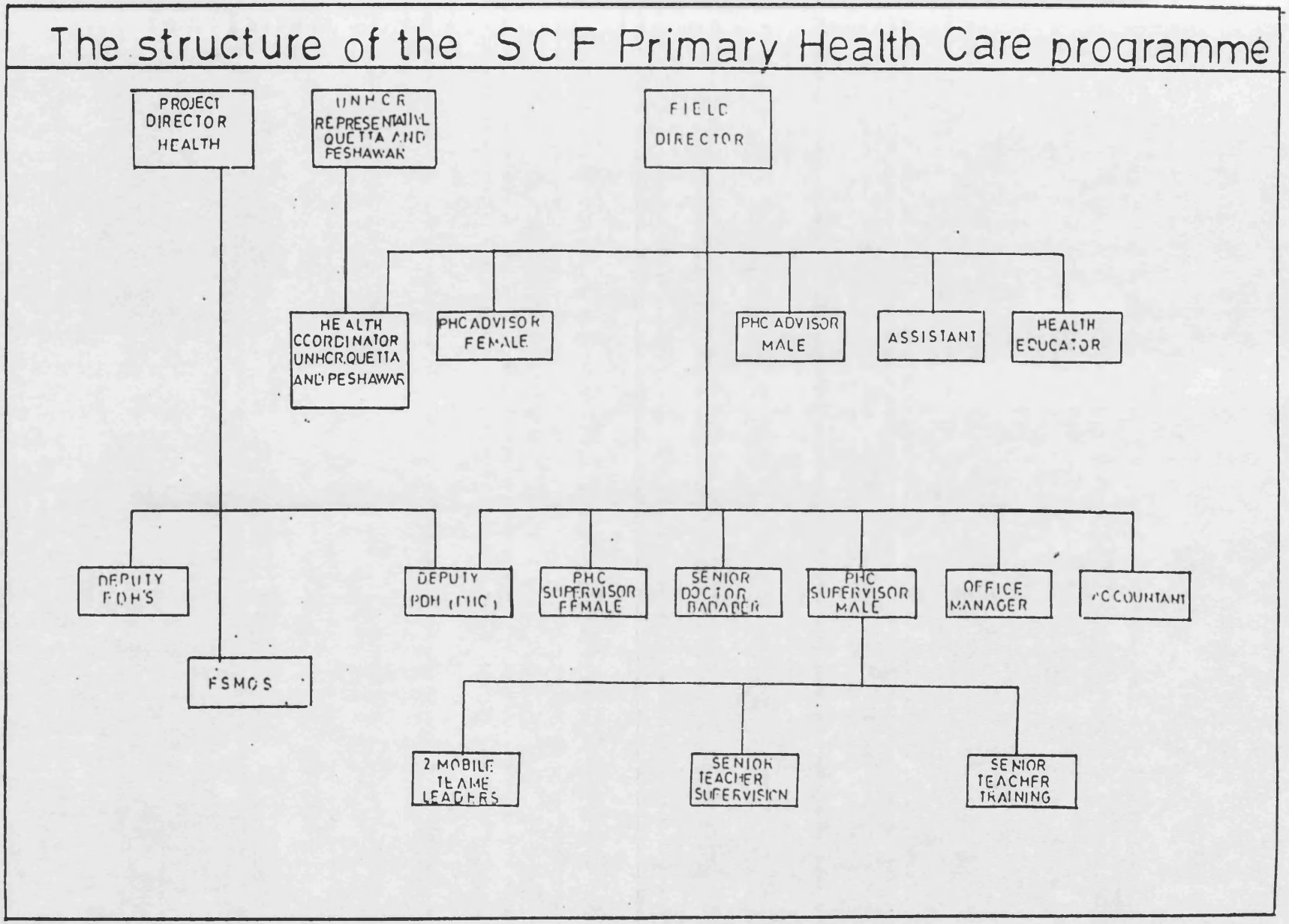

The structure of the SCF Primary Health Care programme
PROJECT DIRECTOR HEALTH
UNHCR REPRESENTATIVE QUETTA AND PESHAWAR
FIELD DIRECTOR
HEALTH CCORDINATOR UNHCR QUETTA AND PESHAWAR
PHC ADVISOR FEMALE
PHC ADVISOR MALE
ASSISTANT
HEALTH EDUCATOR
DEPUTY PDH'S
DEPUTY PDH (PHC)
PHC SUPERVISOR FEMALE
SENIOR DOCTOR BADABER
PHC SUPERVISOR MALE
OFFICE MANAGER
ACCOUNTANT
FSMOS
2 MOBILE TEAME LEADERS
SENIOR TEACHER SUPERVISION
SENIOR TEACHER TRAINING

FIGURE 13.1

13.1.4 Foreign aid agencies as managers of disease control programmes in collaboration with UNHCR

With the delegation of responsibility for each disease control programme to medical officers working in the two camps in Punjab in 1985, control programmes for malaria, tuberculosis and vaccine preventable diseases became an integral part of the refugee health programme in all three provinces. Building upon the efforts to formulate national standards for disease control among the Afghans, which had first been undertaken by the Senior Health Coordinator of WHO/UNHCR in 1984, work carried out between 1985 and 1987 focused on improving the coverage of chosen interventions and the efficiency with which they were provided.

13.1.4.1 Management of an accelerated programme for immunizations

Within the immunization programme, for example, Pakistani lady health visitors and Afghan midwives were given responsibility for vaccinating women between the ages of 15 and 45 in the basic health units in 1985. Crash programmes of tent-to-tent visits by female staff, vaccinators or outreach workers were also carried out in areas where coverage was especially poor in the spring and autumn of 1985. Notwithstanding these efforts, coverage had improved little by 1987. Consequently, an accelerated programme was designed and implemented under the direction of UNHCR in collaboration with Unicef, John Snow Incorporated of the US and the Afghanistan Vaccination/ Immunization Centre (AVICEN) of France.

Technical measures which were undertaken focused on improving the cold chain and procedures for using one sterile syringe for each vaccination or for sterilising syringes which were to be used more than once. Organizational changes took responsibility for vaccinating women and children away from fixed centres and gave it to mobile teams or outreach workers. The effectiveness of these efforts were to be monitored and assessed through coverage surveys in each district and tribal agency.

Management was strengthened, primarily by engaging the advice of a consultant from John Snow Incorporated[10] who worked closely with officials of the refugee health programme and charitable agencies. He was assisted by AVICEN, a French charitable agency providing immunization services in Afghanistan, which organised training courses in vaccination for health workers. The success of these strategies which were adopted in 1988 led UNHCR to engage the services of two full time advisors from John Snow Incorporated for the following year[11]. Like the control programme for tuberculosis which was the joint responsibility of the Italian Corporation for Development and the Government, the organization and management of the programme for immunizations became the responsibility of foreign aid organizations in collaboration with UNHCR, even though overall responsibility ostensibly remained with the Government.

To some extent, John Snow acted as the operational partner of UNHCR. Concerns about the ineffectiveness of vaccination activities before 1988 were expressed by UNHCR when the Centres for Disease Control found that at most 55% of young children had been vaccinated with BCG against tuberculosis in 1987. In 1988, UNHCR contributed 596 000 US$ for an intensified programme, 190 000 of which was for the procurement of vaccines. UNHCR also sought support from other specialised agencies of the UN which were concerned with immunization coverage. Unicef contributed 785 000 US$ for the vaccines, related supplies and equipment as well as the services of a consultant for one week before embarking on the new programme. WHO also provided the services of a consultant in the planning stages who advised UNHCR and the Government on strategies for carrying out surveys of coverage, delivering vaccination, organising the cold chain and deciding upon a policy for injection equipment. Many charitable agencies also made a contribution by employing staff to carry out vaccination activities[12].

13.1.4.2 Management of the malaria control programme

Simultaneously, efforts were made to assess and enhance the effectiveness of other disease control activities. Like the Italian Cooperation for Development which had

assumed responsibility for advising, monitoring and supporting the tuberculosis control programme in the North West Frontier in 1984 and John Snow Incorporated which took responsibility for the programme for immunizations in 1988, Medecins Sans Frontieres Belgium was given responsibility for strengthening the management of malaria control in 1988. Although all three organizations worked with Pakistani officials of the refugee health programme, technical standards and organizational and administrative protocols which were subsequently set by these agencies were usually adopted for nation-wide use in the refugee health programme. Thus, responsibility for programme management was heavily influenced, even assumed, by these agencies in practice although they were ostensibly in an advisory role to the Government.

The most notable exception was the tuberculosis control programme in Baluchistan which continued to be funded and monitored on an annual basis by the Regional Office of WHO for the Eastern Mediterranean in Alexandria, Egypt. Management and implementation of this tuberculosis control programme remained the responsibility of the Refugee Health Directorate in Baluchistan. Nevertheless, policies and plans were formulated in collaboration with WHO and the programme was monitored nationally by the Senior Health Coordinator of UNHCR. Thus, in general the management of disease control programmes increasingly became the responsibility of foreign aid agencies under the direction of UNHCR.

13.1.4.3 Moving beyond concerns for effective care to considerations of efficiency

In addition to strengthening management, control programmes for malaria and tuberculosis were streamlined by re-assigning similar tasks to only one member of the basic health units in the North West Frontier and Punjab. In Baluchistan, posts for Health Prevention Outreach Workers were created in the basic health units in 1986. These outreach workers similarly assumed responsibility for all preventive services, including sanitation measures, malaria and tuberculosis control and immunizations[13]. This reassignment of responsibilities indicates that the degree to which interventions were provided efficiently was an issue of concern for the first time. Concerns for

effective control of communicable diseases and common illnesses had dominated the work of those responsible for managing and implementing care during the initial influx of Afghans to Pakistan. Now, concerns for inefficient use of resources were expressed and acted on, primarily by those who were financing the refugee health programme - UNHCR and WHO.

13.1.4.4 Initiating and carrying out a sanitation programme

Even though the provision of adequate supplies of water was organised for the Afghans when they first began to arrive in large numbers in 1980, it was not until 1985 that the settlement of nearly three million Afghans in over 300 villages made systems to dispose of wastes a high priority. Although sanitation projects had been undertaken by at least two charitable agencies, the Austrian Relief Committee and Les Enfants du Monde, and Unicef since 1980, the needs in 1985 far exceeded existing efforts. This led the Senior Health Coordinator to establish a new programme to provide basic latrines and health education regarding the importance of their use.

Subsequently, these activities became his responsibility within UNHCR and at least eight organizations were asked to initiate and manage such services. In the North West Frontier, the Austrian Relief Committee, International Rescue Committee, Pakistan Red Crescent Society and Unicef set up projects in 1985. In 1986, Catholic Relief Services, Action Internationale Contra la Faim and Medecins Sans Frontieres France set up similar programmes in Baluchistan, and Catholic Relief Services established a project in Punjab. Simultaneously, the Danish Committee for Aid to Afghan Refugees began to organise schemes for improved water supplies in the North West Frontier. Some of these agencies built upon existing efforts, such as the Austrian Relief Committee and Unicef. Others undertook this work as new projects in addition to their other health programmes.

Similar to other disease control programmes, these environmental health programmes were managed and implemented within the refugee health programme under the overall direction of UNHCR in collaboration with Unicef and charitable agencies. It

was not until November of 1989 that a position for a Deputy Director of sanitation programmes within the Refugee Health Directorate in the North West Frontier was created - some three to four years after the programme had begun. This post within the Government was created because sanitation activities had not been fully integrated within the Government's refugee health programme and because coordination was poor between the Field Supervisory Medical Officers in the districts and tribal agencies and the charitable agencies which were implementing projects. Clearly, this programme had been set up and run in the camps by foreign aid agencies relatively independently from refugee health services provided by the Government.

13.1.5 Foreign aid agencies as managers of community-based health programmes in collaboration with UNHCR and Unicef

The community health worker programme was extended in 1985 to two other districts and tribal agencies in the North West Frontier and training of traditional birth attendants, 'dais', was begun in one district. By the end of 1985, 21 camps had undergone the initial motivation of the community and 39 community health supervisors had been trained. These community health supervisors had trained 567 community health workers. In addition, two community dais were trained who in turn had trained 18 family dais[14]. These achievements were not accomplished without many difficulties. First was the inability of community dais to train family dais on their own. Second was the issue of payment of the community health workers which were working as volunteers and later, salaries of community health supervisors. Lastly was a perceived lack of support from the Government for the programme.

Save the Children staff felt that, unlike the community health supervisors, the community dais could not adequately train family dais on their own which meant that the Save the Children team had to be more actively involved in training than originally intended. Subsequently, two additional lady health visitors joined the Save the Children team in March 1986. In addition to their responsibilities for training, this team was also to provide supervision, follow-up and resupply of equipment to the dais since lady health visitors in the basic health units were unable to take on these tasks.

In order to increase the accountability of community health workers to the health services and to ensure continued participation, Save the Children staff proposed payment of Pakistan rupees 300 per month, initially by the Refugee Health Directorate and later by the communities[15]. However, since there were no problems with volunteering in practice during 1985, 1986 and 1987, community health workers continued to work as volunteers. Unlike community health workers, community health supervisors were given a salary of rupees 800 per month from the beginning. Although the receipt of a salary made them similar to other staff of the basic health unit, rupees 800 per month was considerably less than other staff members with comparable responsibilities, namely malaria supervisors and vaccinators. The difference in salaries created increasing discontentment since the community health supervisors had also been given additional tasks, for example following tuberculosis cases, assisting with vaccinations, identifying handicapped refugees and assisting in maintaining the records of the basic health unit[16]. As a result, salaries were reviewed mid-1987 and subsequently increased.

Lastly, Save the Children staff perceived a lack of support from officials of the government refugee health programme[17]. Problems had been encountered with refugee health staff which were attributed by Save the Children staff to:

- traditionally, health care was the domain of professionally trained persons. The use of illiterate and semi-literate health workers was not acceptable to all existing health staff.

- most health staff had been trained in well-equipped hospitals with a curative bias. The use of community health workers was a new concept with different areas of emphasis.

- there was a consistently high turnover of staff in all of the basic health units. This prevented continuity in the development of the programme and necessitated continual training of basic health unit staff.

- difficulties had been encountered with the supply and resupply of medicines to the community health workers. Many health staff opposed the use of medicines by lay health workers.

These problems led Save the Children staff to propose the creation of a supervisory post in the refugee health directorate with funding from UNHCR. The main responsibilities of this Deputy Director would be to supervise and integrate the community health workers and dais in the refugee health programme[18]. However, this Deputy Director who was appointed in September of 1986 was on secondment to Save the Children for over one year and worked from the Save the Children office until October 1987 (Figure 13.1). Thus, the acceptance of community-based health workers and their integration in the existing refugee health services was slow. Early in 1987, Save the Children further proposed the creation of supervisory posts in the districts and tribal agencies for the community health worker and dai programmes, similar to immunizations and malaria control[19]. Furthermore, they proposed the employment of a second lady health visitor in the basic health units to supervise the dais. Both proposals were agreed to by UNHCR which provided the funds to do so. However, a second proposal was submitted in the autumn of 1987 suggesting that an agreement had not been reached with the Refugee Health Directorate[20]. In addition, it was learned that the Government had signed bilateral agreements in February 1987 with the Italian Corporation for Development and a private foundation in the Netherlands to provide mother and child health care.

Notwithstanding the lack of integration of the community health worker and dai programmes and the rumours about new mother and child health care programmes, training continued and, by 1989, 96 community health supervisors and 1920 community health workers had been trained in the North West Frontier alone. While training continued and the programme expanded to incorporate other districts, additional supervisory posts were created within the Refugee Health Directorate which enhanced the acceptability of the programme among staff of the refugee health programme. But it did not provide the means for more full integration of the

programme which remained under the management largely of the Save the Children Fund in practice.

13.2 Leadership within the refugee health programme: the Government of Pakistan, UNHCR or WHO?

Planning and implementing health relief for Afghan refugees was the concern of three specialised agencies or funds of the UN: UNHCR whose mandate covers the well-being of refugees in every sphere, WHO whose mandate gives it responsibility for all aspects of health and Unicef whose mandate provides for the well-being of children world-wide. Overlapping mandates and the need to respond quickly and coherently usually results in the designation of one agency as the leader within the UN. In Pakistan, UNHCR was designated as the lead agency for the refugee relief operation overall. Notwithstanding this delegation of authority, leadership within the refugee health programme changed hands three times over a ten year period.

Leadership of the refugee health programme was first assumed by the Government of Pakistan, through provincial health and political authorities. In extending existing services to Afghans and in planning for a separate system of health services for them, provincial authorities were first assisted in 1980 by WHO and Unicef who were advising national programmes for disease control and by UNHCR who provided the additional resources which were needed. Advice on technical and administrative matters generally was also made available by UNHCR when medical doctors and nurses were seconded from charitable agencies to their sub-offices in Peshawar and Quetta in 1980 through 1982.

The arrival of the Senior Health Coordinator in 1982 shifted managerial responsibilities. Within the UN system, the appointment of a Senior Health Coordinator as an official of WHO meant that WHO took responsibility for providing leadership for refugee health. Other agencies of the UN, together with many charitable agencies from abroad, then looked to WHO for guidance and leadership. Support for this post came primarily from the UN agencies: firstly, UNHCR which needed

technical advice on the allocation of funds and which was willing to fund such a position, and secondly, WHO whose Emergency Relief Operations Unit in Geneva was trying to develop expertise and a role in refugee health.

In keeping with WHO's preferred manner of working in an advisory capacity with member governments, provincial health authorities retained decision-making and administrative powers. But the creation of a post within the federal structures shifted responsibility for policy-making, planning and management for refugee health nationally. In addition to conferring with the Chief Commissionerate for Afghan Refugees and the States and Frontiers Regions and Kashmir Affairs Division, policies and plans were now formulated jointly with WHO and UNHCR through the Senior Health Coordinator. The technical and professional expertise of the Senior Health Coordinator, his position within the international aid agencies and his role in planning and approving financial and material resources donated through the UN meant that the balance of power was weighted in his favour. Thus, WHO provided much of the leadership of the refugee health programme in practice from 1982 - 1985.

The inevitable conflicts and stresses of working for two different agencies eventually led UNHCR to create their own post for a Senior Health Coordinator and to request the secondment of the provincial health coordinators from the Save the Children Fund rather than WHO in 1986. This shifted responsibility for refugee health within the UN system from WHO to UNHCR. Unlike WHO which worked primarily in an advisory capacity, UNHCR then took responsibility for making policy and plans as well as monitoring, evaluating and managing the refugee health programme generally.

UNHCR did this firstly by setting the standards of care to be used within individual programmes. One of the first activities of every Senior Health Coordinator was to write guidelines for the management of common diseases and the organization of health care. Beginning in 1982 and continuing throughout the following years, it was the Senior Health Coordinator who garnered support for standardised care and who made and approved specific proposals. Unfortunately, the turnover of medical professionals in this post meant that revisions were frequent. Thus, with the exception

of the first guidelines which were written in 1982, most proposals were rarely disseminated widely and enforced. Nevertheless, the authority to determine standards of care became the responsibility primarily of UNHCR when they made the Senior Health Coordinator and provincial Health Coordinators members of their own staff in 1986.

Secondly, UNHCR arranged for the effectiveness of existing interventions to be assessed. They asked the Centres for Disease Control of the US Government to evaluate the health and nutritional status of the refugees annually. Other agencies measured the coverage of priority interventions, such as immunizations, or their effectiveness in controlling problem diseases, such as malaria. While these evaluations provided important indicators of the successes and weaknesses of the refugee health programme, officials of the Government had relatively little say in planning or interpreting these evaluations. This was true even though many of the programmes being assessed were implemented by the Government. Furthermore, no training programmes were carried out to enable officials of the Government to use these assessments as management tools: many of the evaluations made extensive use of epidemiological techniques which were new to most government health officials. Clearly, UNHCR consolidated their leadership by gathering important information which they then used in planning and managing the refugee health services.

Thirdly, UNHCR promoted more efficient use of resources. Publication of studies which found widespread malaria and tuberculosis among the Afghans in the early 1980s had made many of the health programmes political as well as technical issues of concern to government and international officials. Urgent needs to be seen to be doing something meant that it was not until the Senior Health Coordinator was first appointed in 1982 that the inefficiencies and limited effectiveness of existing provincial programmes to control diseases were first addressed. The subsequent incorporation of these programmes within the refugee health services gave refugee health officials greater control over disease control activities and personnel. Yet improvements were still too few, and beginning in 1985, UNHCR adopted a two-fold strategy. Concerns for inefficiencies led to a reduction in the numbers of health

workers in the camps and their assignment to carry out more than one task. Interestingly, this concern was paramount to UNHCR who funded these programmes.

Concerns for ineffectiveness of disease control interventions and the lack of community health activities led UNHCR to contract other foreign aid agencies to take responsibility for advising and supporting the management of the various health programmes and services. Although these agencies were ostensibly in an advisory role to the Government, in practice they influenced decision making and administration immensely. Like the Senior Health Coordinator of UNHCR, many advisors from charitable agencies had considerable technical and professional expertise and they had responsibilities for approving donations of money and materials from abroad. Some had their own source of funds, but many relied on UNHCR. Collaborative relationships between these agencies and UNHCR meant that UNHCR supported these agencies in taking decisions and carrying them out. Thus, UNHCR consolidated their own leadership partly through collaborative relationships with other foreign aid agencies who took responsibility for managing various health programmes.

Again, these developments raise important questions about UNHCR's relatively new role in refugee health. Could the increasing involvement of UNHCR in refugee health mean less, not more, support for host governments in providing refugee health services?

13.3 The refugee health programme: in summary

Throughout the 1980s, the Provincial Refugee Health Directorates managed an independent health programme for Afghan refugees. 'Basic health services' were given priority and were provided for the refugees through basic health units distributed at a ratio of 1:15 000 refugees living in the camps. The Government took responsibility for providing care among two-thirds of the refugee population while foreign and domestic charitable agencies cared for the rest. Specialised care was made available by the Government and UNHCR through existing government facilities, such as rural health centres and hospitals. In addition, there were numerous specialty and referral

facilities exclusively for Afghans which were organised, financed and managed by charitable agencies and political parties independently.

Since health relief was first provided in 1980, basic curative care and the control of malaria, tuberculosis and vaccine preventable diseases were the priority components. All associated priority interventions were eventually provided in the camps by staff of the basic health units. Management of these programmes, however, gradually became the responsibility of foreign aid agencies in collaboration primarily with UNHCR and to a lesser extent the Government. Since 1985, other disease control programmes were initiated, for example for environmental health, which were also initiated and managed by foreign aid agencies in collaboration with UNHCR and the Government.

Efforts to provide preventive services were limited to clinics run by Pakistani lady health visitors and Afghan traditional birth attendants for women and young children in the basic health units; but even these clinics were biased towards providing curative care and disease control. This curative and facility-based focus was not been substantially altered by the adoption of a Primary Health Care approach in 1982. In practice, the adoption of a Primary Health Care approach meant the provision of community-based health workers in addition to existing services. These programmes were initiated and implemented solely by charitable agencies with support from inter-governmental organizations. Thus, community health workers and trained traditional birth attendants were not readily accepted by, and integrated in, existing refugee health services.

In addition to the refugee health programme, a host of foreign aid agencies became involved in providing health relief for those who remained in Afghanistan and those injured as a result of the armed conflict. This cross-border relief operation gave priority to basic first aid and medical care as well as medical and surgical care of those wounded in war. Many of the programmes set up by these agencies were organised and managed from a base in Pakistan. There was, however, little coordination between the two relief operations; other specialised agencies of the UN

and a host of charitable or private organizations were specifically engaged for this effort.

Similarly, there was little coordination between the refugee health programme and health services provided by the Government of Pakistan for its own people. Although the refugee health programme was built around the same interventions which were given priority in the on-going health services of the Government, separate lines of accountability for managerial and political authority, different systems of remuneration and working conditions for health personnel, the participation of a host of foreign relief aid agencies and access to vast sums of money and material goods for refugee relief through various institutions of the international community enabled the refugee health programme to function independently. Not only did these and other factors influence the development of a parallel system of health services which functioned in isolation from other systems of health care within Pakistan, they contributed to the creation of a system of health services which consistently provided a higher quality of care. Unlike on-going health programmes of the Provincial Governments which continued to be under-resourced, insufficiently staffed and poorly managed, measures were taken to overcome these obstacles and others early in the development of the refugee health programme. This meant that health services provided for the refugees ensured that basic care of a quality acceptable to the Government and international aid agencies alike was available on a regular basis.

13.4 References

1. UNHCR and CCAR/GOP (1986) Operations manual for Afghan Refugee Health Programme in Pakistan. Islamabad, Pakistan: United Nations High Commissioner for Refugees and the Chief Commissionerate for Afghan Refugees, States and Frontier Regions and Kashmir Affairs Division, Government of Pakistan, 168 pp. plus annexes

2. CCAR and UNHCR (1989) Guidelines for environmental health services for Afghan refugees in Pakistan. Islamabad, Pakistan: Pictoral Printers Ltd, for the United Nations High Commissioner for Refugees and the Chief Commissionerate for Afghan Refugees, States and Frontier Regions and Kashmir Affairs Division, Government of Pakistan, 72 pp.

3. CCAR and UNHCR (1989) Guidelines. Maternal and child health. Islamabad, Pakistan: Pictoral Printers Ltd. for the United Nations High Commissioner for Refugees and the Chief Commissionerate for Afghan Refugees, States and Frontier Regions and Kashmir Affairs Division, Government of Pakistan, 44 pp.

4. Simmonds SP (1981) Assignment report. the health of the Afghan refugees in Pakistan. Geneva, Switzerland: World Health Organization, Emergency Relief Operations Unit, 17 pp.

5. Khan AR and Elo O (1984) Annual report 1984, Afghan Refugee Health Programme. Islamabad, Pakistan: Chief Commissionerate for Afghan Refugees, Government of Pakistan / United Nations High Commissioner for Refugees, 184 pp.

   Ahtone J, Berends P and Khan AR (1985) Annual report 1985. Afghan Refugee Health Programme Pakistan. Islamabad, Pakistan: Chief Commissionerate for Afghan Refugees, Government of Pakistan / United Nations High Commissioner for Refugees, 124 pp.

6. UNHCR and CCAR/GOP (1986), #1

7. Boss L, Brink E and Dondero D (1984) Evaluation of the infant mortality and childhood nutrition status among Afghan refugees in Pakistan. Atlanta, Georgia, USA: Centres for Disease Control, US Public Health Service, 19 pp. with appendices

8. Khan AR and Nesbit R (1987) Annual report 1986. Afghan refugee health report 1986. Afghan refugee health programme Pakistan. Islamabad, Pakistan: Chief Commissionerate for Afghan Refugees/United Nations High Commissioner for Refugees, p. 12.

9. Khan AR and Nesbit R (1987), p. 12, #8

10. Pointer AE (1988) Acceleration of Expanded Programme of Immunizations to Afghan refugees in North West Frontier Province. August 4 - 23, 1988. Geneva, Switzerland and Boston, Massachusettes, USA: United Nations High Commissioner for Refugees, TSS Consultancy Report 46/88 / John Snow Incorporated, 18 pp. with appendices

11. Nesbit R (1989) Report on the Expanded Programme for Immunizations for Afghan Refugee Health Programme for 1988. Islamabad, Pakistan: United Nations High Commissioner for Refugees, 8 pp. plus tables

12. Nesbit R (1989), #11

13. Senior Health Coordinator WHO/UNHCR (1985). Draft: Health services - Baluchistan. Quetta, Baluchistan, Pakistan: United Nations High Commissioner for Refugees, 6 pp.

14. SCF (1985) Development of Primary Health Care in Afghan refugee villages. Annual report 1985 for UNHCR. Peshawar, NWFP, Pakistan: Save the Children Fund, 10 pp.

15. Field Director SCF (1985a) Minutes of the meeting held at UNICEF on 3.4. 1985. Peshawar, NWFP, Pakistan: Save the Children Fund, 2 pp.

16. Deputy PDH PHC (1987) Letter to Save the Children Fund, Peshawar, 24 March 1987

17. SCF (1985), #14

Field Director SCF (1985b) Letter to FSMO Dir District, 13 September 1985. Peshawar, NWFP, Pakistan: Save the Children Fund, 1 p.

18. UNHCR (1986) Project description: The development of Primary Health Care programme for Afghan refugees by Save the Children Fund. Peshawar, NWFP, Pakistan: United Nations High Commissioner for Refugees, 3 pp.

19. PHC Advisor SCF/UNICEF (1987) Proposal on development of PHC programme in Afghan refugee villages in NWFP. Peshawar, NWFP, Pakistan: Save the Children Fund, 8 pp.

20. PHC Advisor SCF/Unicef (1987), #19

CHAPTER FOURTEEN

Getting in on the act: understanding the multiplicity of agencies promoting the health of Afghan refugees in Pakistan

The process by which health policies were formulated and put into practice for Afghans seeking refuge in Pakistan involved numerous and seemingly disparate institutions. Yet, the evolution of health services for them, and the varied and changing roles of the many institutions involved within it, concur with the analysis of the international policies to promote the health of refugees: there is coherence and consistency to the policy process. Furthermore, key findings from both studies emphasise the highly political nature of that process, both within a national and international context. This draws attention to issues of power and reinforces an understanding of policy as the means through which power is managed within society. In this thesis, this was found to be true both for Pakistani society, as a nation-state, and for the international or global society within which the varied actors all worked. Clearly, the process by which health policies are formulated and carried out reflects relationships of power, the way it is controlled and for what ends it is used. Drawing on the main findings and conclusions of the study in Pakistan, the following discussion highlights key characteristics of, and the issues of paramount concern to, the policy process which ostensibly aims to promote the health of refugees.

14.1 The policy process: neglected dimensions of culture and discursive practices

14.1.1 Policies for refugee health: synergistic or antagonistic to self- and community- health development?

Assistance was first given to Afghan refugees by local people living near the borders with Afghanistan in the North West Frontier and Baluchistan. The choice of the Afghans to seek refuge among these people was greatly influenced by shared ethnicity,

kinship, geographical heritage and political ideology. In other words, those seeking refuge sought help from those who would be sympathetic to their needs. Surely this was just one of many strategies adopted by the Afghans to protect and promote their own well-being.

Yet in setting up health services for them, the Afghans themselves were involved only as users or as auxiliaries to Pakistani and foreign health professionals. They were excluded from the management of these health services at all levels, especially decision-making processes for policy-making, planning, administering, monitoring or evaluating care provided. This was true even though services were provided ostensibly for their benefit. Consequently, official policies which were adopted failed to take account of, and build upon, the ways in which the Afghans perceived, promoted and protected their own health and well-being.

Instead, interventions which were made available reflected the priorities of national programmes for health of the Government of Pakistan and of global programmes for health of the international aid agencies. Even community-based health activities which were part of the Primary Health Care rhetoric of stated policies of both the Government and the international aid agencies, such as the training of refugee health workers and home visiting, and health care of special groups, such as for women and children, were low priorities in the refugee health programme.

Not surprisingly, there was little evidence that health services provided for the Afghan refugees in Pakistan influenced their health and nutritional status in any significant way. Instead, commonly measured indicators of death, illness and malnutrition remained much the same as in Afghanistan prior to their relocation despite a decade of service provision in Pakistan. Similarly, health services for the Afghan refugees appeared to be organised separate from, or in parallel with, their own practices for health; there was no evidence that they had become an integral component of Afghan society even though selected interventions may have become more acceptable to them.

14.1.2 Refugee health care: a demand driven response?

The exclusion of the Afghans from decision-making processes, the lack of any notable change in their health and nutritional status and the parallel organization of official and informal systems of health care calls into question the provision of relief in response to demands based on the health of the refugees themselves. Consistent with approaches which perceive the policy process as a rational one, Cavallo[1] points out that 'the tendency to see charity (or health relief) as dependent on the conditions of the poor (including refugees), and on the structure and development of poverty undoubtedly remains prevalent'. She then goes on to point out that any 'analysis normally accords a central role to demographic or economic factors (prices, epidemics, famines, population growth, demographic crisis, immigration, etc).... Charity (or health relief) ... is interpreted essentially as a *response* to the needs of the poor (refugees).... concern for the situation of the poor (refugees) is seen as the motivating element behind charitable action'.

In highlighting this trend, Cavallo rightly points out that 'this inhibits exploration of other kinds of explanations, relatively independent of the needs of the poor, but linked rather to *the multiple meanings which charity held for benefactors*'(emphasis added)[2]. One central question arising from this analysis of health policies for refugees is the nature and source of demand which generates relief or on-going services for health since they do not appear to respond to the health needs and related strategies for care of the refugees themselves.

Instead, this pattern suggests that those institutions endowed with power to promote health are unwilling to share it with refugees. The incorporation of refugees as legitimate managers and providers of health care raises several issues which focus on power. Clearly, the power to decide which health activities would be provided, by whom, and with what resources, rested with the international agencies and, to a lesser extent, governmental health officials. The power of the purse, the perceived expertise of medical doctors and nurses, and the coverage given to the plight of the refugees in the Pakistani and international press, for example, are just some of the factors which

gave the Government of Pakistan and especially the international agencies greater control and influence over the decisions which were taken and the programmes which were implemented.

14.1.3 Cultural dimensions of health relief policy

The organization and provision of health interventions outside of existing cultural and social practices for health within Afghan society (whose culture and social structures generally differ markedly from Western, Middle Eastern and South Asian societies) points to the reality of different concepts of health and health care. Obviously there is no universal concept of health and thus health relief since each culture defines it differently. Official policies of institutions for refugee health relief thus reflect the values of a specific culture. Within the context of an international health relief operation for refugees, it is therefore possible to identify a dominant culture within which health relief is defined and dealt with in contrast with those cultures which are subjugated. Even within a national effort for health relief, one culture will dominate official policies while other cultural definitions and practices will be ignored, repressed or incorporated within the dominant cultural framework.

The dominance of allopathic medicine and epidemiology in policies of national and international institutions promoting the health of refugees suggests that institutional policies, and many individual practitioners, take for granted that there is a universal culture for health and health relief. Not only does this prevent health providers from learning from the people and from supporting individuals and communities in caring for their own health, it allows health relief to be an instrument for imposing cultural values. The cultural dimensions of policy, including the role of culture in managing power and relationships of power, need to be added in future to any analytic framework of health policies.

14.1.4 Discursive practices and health relief

The dominance of an allopathic medical and epidemiological paradigm in determining the content of health policies for refugees, both nationally and world-wide, not only reflects the cultural values of those national societies which are most influential within the international community, it is evidence that there is an official discourse which has been developed for health generally and for refugee health care specifically. This official discourse for refugee health has institutional, political, scientific and social implications for the way in which refugee health problems are defined and the ways in which they are to be solved. It also defines the roles of health providers, from medical doctors to community health workers, as well as those of the beneficiaries of health relief interventions. Discursive analyses are a specialised discipline which, like culture, need to be incorporated in any future analytic framework of health policy.

14.2 National policies for refugee health: maintaining domestic stability

14.2.1 Host governments: key or peripheral actors?

This study originally aimed to identify major policy issues in refugee health care which are faced by host governments. As the official political and legal authorities of their national society, they are commonly thought to be, or are promoted as, key actors in the provision of health care for refugees. Within the health sector more generally, governments have been advocated as the means through which health services should be provided in lower income economies.

Yet, national and local governments are only one institution of society through which health policy is formulated and practised. They may or may not be key institutions in the policy process for the health of refugees. For example, in Pakistan and Somalia national or provincial governments played a significant role in managing and providing health care for refugees. Refugees and displaced persons in Thailand and Honduras, however, have access to health services which are managed and provided by international aid agencies; the governments have only peripheral roles in more

general political, legal and administrative matters. Although goods and funds for the Guatemalan relief effort were donated by several agencies outside of Mexico, few were active in making decisions about priority problems and the means for their resolution, and even fewer took part in putting strategies adopted into practice; instead, community-based groups and institutions of civil society[13] took the lead in working with and caring for the Guatemalans.

Clearly, some of the numerous and varied groups within any host society will have an interest in taking part in caring for refugees directly while others may feel a need to be involved only indirectly or not at all. This is as true of governments and military organizations as of institutions of civil society. Moreover, the particular role undertaken in the policy process by any institution of the host society will reflect primarily the interests of the institution in question, especially its relationships of power with other groups within its own society. Any analysis of the policy process must take into account the organization of society and particularly the roles played by *both* the institutions of political[24] and civil society.

14.2.2 A significant influx of refugees: tens or hundreds of thousands?

The Federal Government of Pakistan initiated relief activities for a relatively small number of refugees: less than 5 per cent of the registered refugee population a decade later or as few as 20 000 refugees living in separate camps or villages. Relief was initiated by the Government not only in response to humanitarian needs for food and shelter, but more importantly to the effects of several thousand refugees on their somewhat precarious and strained political relationships with tribal and ethnic groups

---

1. According to Antonio Gramsci's definition, civil society 'comprises all the 'so-called' private organisations such as churches, trade unions, political parties and cultural associations which are distinct from the process of production and from the public apparatuses of the state.'

2. According to Antonio Gramsci's definition, political society includes 'the various institutions of the state - the armed forces, police, law courts and prisons together with all the administrative departments concerning taxation, finance, trade, industry, social security, etc.'.

in the North West Frontier and Baluchistan. Similarly, providing relief had political and economic implications for their political and strategic relationships with other governments, both near and far, as well as with international aid agencies. The provision of relief by the national and provincial governments was in response to the demands of their own constituencies: it was in their interest to be seen to be sympathetic and responsive.

14.2.3 Powerful symbols, but empty gestures?

Initial relief activities initiated by the Government gave priority to meeting basic needs for food and shelter through the distribution of commodities and materials. These priority needs and the methods used for meeting them were based on those used in previous disaster relief operations. They reflect an official discourse which defines relief according to immediate biological survival needs only; appropriate responses then revolve around the provision of needed goods and services as acts of charity or welfare.

Health care was one of the first services extended to the refugees by provincial governments. Similar to initial relief activities which were carried out through existing disaster relief mechanisms, health relief was provided by existing health facilities or extensions of existing services. In practice, a lack of resources and poorly developed structures for disaster relief generally meant that food and other supplies were distributed on an *ad hoc* basis. In the North West Frontier and Baluchistan, existing rural health services were inadequate or inappropriate to meet the needs of local people, let alone refugees; health relief activities were, consequently, also provided initially on an *ad hoc* basis.

14.2.4 Expanding official spheres of influence

The inadequacy of existing health services provided by the Government in rural areas, the inappropriateness of many health interventions given priority in governmental health policy and the inability of governmental structures to respond in any substantial

or consistent way to the health needs of their own people suggests that the Government was motivated less by the health needs of the refugees or local people affected by the influx than by the opportunity to consolidate and extend their influence in the health sector.

Governmental provision of health services for the Afghans brought employment to thousands of medical doctors and paramedical professionals in Pakistan. In the context of scarce and diminishing public resources for health services within Pakistan, the adoption of a providing role also brought much needed funds and drugs, supplies and equipment in sizable quantities to the Government. Thus, the Government was able to satisfy the demands not only for employment and the resources needed to practice medicine, but also for continued leadership and influence of one of the most wealthy and politically active professional groups (medical) in their society; simultaneously, they enhanced their own position as providers of health services of a better quality for a larger number of people. Shared ethnicity, kinship, religious affiliation and political orientation of the local people and the Afghans also meant that the provision of health services for the refugees satisfied many domestic demands for government sponsored health relief. Thus, the priority given to health not only appeared to meet commonly perceived needs for humanitarian relief but more importantly allowed medical practitioners in Pakistani society and the Government to consolidate and enhance their roles as the organizers and legitimate providers of health care.

14.3 National or international policies for the health of Afghans in Pakistan?

14.3.1 National and international publicity: delineating demand

Just as the Pakistani media played a key role in establishing and maintaining domestic support for the refugees and for efforts by the Government or local charitable and political organizations to assist them, publication of the Afghan's flight to Pakistan by the international media generated support among western publics for the provision of relief by international aid agencies and donor governments. Equally important, domestic and international publicity established a system of accountability, for

example of the Government of Pakistan to its own people as well as the international aid agencies and the international public at large; similarly, international aid agencies were held accountable to their own constituencies at home and abroad for their efforts, or lack of them. Clearly, the media was one means through which demand was created among the constituencies of the institutions providing health care for the Afghans.

Furthermore, domestic and international publicity influenced the definition of health problems, for example as malaria, measles and other diseases, as well as appropriate solutions, for example the provision of emergency medical care by medical professionals, Pakistani or foreign respectively. Both perspectives fail to meet the short- and long-term needs of refugees. The definition of poor health as disease fails to address other essential requirements for well-being, such as safety and security, water and other essential items, and an ability to provide for self and family. This approach narrows the causes of poor health to those acceptable in a medical, epidemiological framework. The choice of appropriate solutions is then limited, for example to the extensive use of pharmaceuticals. By adopting such a definition of health and associated responses for care, the media was one means through which the official discourse which defined health and health care for refugees was expressed, promoted and given legitimacy.

Popular media images of refugees as helpless victims among destitute hosts implies that those with resources and expertise are needed to manage and carry out relief activities. In organising and providing health care for the Afghans, responsibility for health was given to medical professionals, both within Pakistan and from abroad. Sympathies aroused by the media generated support for governmental and international agencies to provide emergency medical care rather than a range of relief and development activities for refugees and local people which were initiated and carried out by the refugees themselves and their local and national hosts. In so doing, the media transmitted and perpetuated an incorrect and paternalistic view of refugees; it was one means through which the official discourse which defined the roles of health relief providers and beneficiaries was expressed, promoted and given legitimacy.

14.3.2 Separate or integrated health services for refugees?

Domestic and international publicity of the arrival of several thousand Afghans seeking asylum in Pakistan created complex and sensitive relationships between interested groups and organizations within Pakistan and internationally. There was then great pressure on the Government, since it had adopted the lead role in organizing and managing refugee relief, not only to be seen to be doing something but to actually do it. Consequently, powerless and poorly developed existing structures for relief were quickly replaced by separate commissions (or departments) created specifically for refugee relief. Similarly, governmental policies for health relief were then formulated which authorised the creation of a separate system of governmental health services for the Afghan refugees. Within this new system of health services, separate programmes were established for different health and nutritional interventions, for example for disease control and basic curative care. This shift in policy was largely in response to the demands generated by the international community for the provision of aid immediately and exclusively for the Afghans.

International policies since World War II have characterised refugees as temporary visitors, partly by classifying them separately from other migrants or national citizens and partly by providing separate and distinct interventions for them. By definition, a temporary stay is a short one, negating the need for any thought or action for the longer-term. Efforts are made, therefore, to meet only the most immediate and pressing needs, with minimal inconvenience or disruption. The health relief effort for the Afghans was obviously no exception.

14.3.3 Expediency at the expense of efficient and sustainable services?

The creation of a separate system of health services for the Afghans clearly facilitated rapid and authoritative decision-making, together with the distribution of resources needed to implement them, because it allowed entrenched bureaucratic procedures and lengthy political processes within existing governmental structures to be bypassed. Even though this policy enabled the Government to act in a more timely, authoritative

and effective way, it ignored considerations of both the efficient use of resources within a national context of growing scarcity and the potential for services to be sustained in the longer-term.

Concern for the inefficient use of resources was only expressed by the international aid agencies paying for refugee health care many years later when they wished to scale down their involvement or withdraw altogether. Concerns that this separate system of health services be sustainable in future were never on the agenda of either the Government or the international aid agencies; only the future employment of Pakistani medical personnel and the reallocation of material resources were placed on the political agendas of medical trade unions and provincial politicians alike when plans to end the programme were first discussed in 1989.

14.3.4 Health services for refugees: just basic?

Despite existing governmental health policies which gave priority to disease control interventions and the provision of medical and surgical care by medical practitioners in hospitals or health centres, government priorities for refugee health services were to provide basic preventive and primary medical care in camps/villages. The shift away from centre-based provision of rather sophisticated care may well have reflected the concern of foreign health professionals for more equitable access to care; arguments put forward, however, suggested that their concerns were for the level of sophistication rather than the appropriateness of activities which were to be undertaken on behalf of the refugees.

There was, and still is, a preoccupation with the potential for refugee health services to be much better than those available locally. Such a concern ignores the realities of many existing health services, especially in marginalised areas: they are poorly developed, staffed and supplied or they do not exist at all. This applies as much to referral services as to basic care. Unless foreign health workers are prepared to provide similarly poor services or none at all for refugees living in such areas, such

a comparison misses the more fundamental consideration of whether the services provided are appropriate and workable.

14.3.5 Or referral too?

Current guidelines of key international aid agencies for more equitable access to health services give priority to providing basic services which address the most common problems of most refugees rather than sophisticated care which meets only the needs of a few. Such a priority was adopted in Pakistan; health services in camps/villages were limited to preventive and primary medical care in Basic Health Units and Health Posts, and seriously ill people were referred to existing government hospitals. This policy did ensure the provision of basic medical services in nearly all of the camps.

Even though funds and supplies were given by UNHCR to government hospitals in order to upgrade and improve referral services for the Afghans, it did not greatly improve care given in government hospitals since concurrent efforts to strengthen national and provincial health management were absent. Consequently, this system of basic health services did not address the needs of a population at war. In particular, needs for first aid and sophisticated surgical and medical treatments were acute among those wounded by armed conflict. The absence of efforts to strengthen the management and day-to-day running of national, provincial and district hospitals led to the creation of separate referral services which were managed and run by Afghan and Islamic political parties, sympathetic local and foreign Red Cross societies, and private or charitable agencies. Consequently, there were comparatively few benefits for the development of public referral services in Pakistan while the private provision of highly advanced and costly medical and surgical care proliferated haphazardly.

14.3.6 Humanitarian or strategic purposes?

Similar to policies for priority interventions which were largely determined by the policies and practices of international aid agencies, the roles of foreign charitable agencies in the relief effort were significantly influenced by foreign interests of allied

Islamic and donor governments. Policies which limited the involvement of foreign agencies and health personnel changed markedly when cross-border operations and care of those wounded in war became international priorities as the war escalated in the mid-1980s. Previously, limited participation of foreign agencies and personnel suited both the Pakistanis who needed to provide employment for their own medical personnel and who wanted to control the rapidly changing political relationships with various Pathan and Islamic groups in Pakistan and Afghanistan, as well as with the most influential foreign aid donors who did not want to appear to be actively engaged in armed conflict with the Soviet Union.

Foreign military, religious and strategic policies to give active support to the Mujahideen incorporated medical care of those fighting the war, either from a base in Pakistan or their home lands in Afghanistan. Pressures from interested parties in the western countries and Islamic nations to support the rebels were matched by those exerted by sympathetic religious parties or tribal groups in Pakistan. Nonetheless, policies to provide many services through private, charitable foreign agencies and the provision of needed resources for their implementation came directly from foreign allied and donor governments, their publics and, to a lesser extent, the specialised agencies of the UN. Eventually, the need for such agencies to consult and cooperate with the Government became a formality, which many foreign agencies ignored.

14.3.7 Foreign charity - a solution to, or part of, the problem?

The expanded roles adopted by private, charitable or aid agencies from abroad in both the management and direct provision of health care was justified by arguments stressing acute needs for high quality of care. Voluntary agencies were seen to be the means to implement emergency services quickly, especially since health professionals, equipment or supplies in Pakistan *or Afghanistan* were insufficient to meet the current needs of the Afghans. Not only could these agencies provide needed resources quickly, their organization allowed lengthy bureaucratic and diplomatic procedures to be bypassed.

Thus, these agencies posed a dilemma for the Government who needed some of the resources these agencies could provide and especially the sympathies of those who supported them. Moreover, wide-spread images of desperate needs for care, and beliefs that governments divert funds for their own purposes, put great pressure on the Government to accept and work with these agencies. Otherwise, they could have been accused of refusing international assistance, thereby denying the provision of essential services or jeopardising other sources of international aid. Consequently, a plethora of agencies began to work in Pakistan - with or without official approval - in all aspects of the relief operation.

Unlike Somalia where foreign charities played a key role in securing international support for host government officials to manage and provide health services for their refugees, the Afghan relief effort became an international free for all. Perhaps more than other policies, the shift from limiting the roles of foreigners within a planned service to one where each appeared to decide independently what work would be undertaken, where and with what resources points to the power of international agencies and donor governments in determining policy and enforcing its practice. This was true not only in cross-border operations or services for the war wounded but also within what began as a public, national health service for the refugees: foreign charities increasingly took over the management of specific programmes and interventions within the refugee health service as well as the provision of care directly.

14.3.8 Seeking assistance from the UN: UNHCR, Unicef or *WHO*?

Three specialised agencies or funds of the UN played key roles in promoting the health of the Afghan refugees in Pakistan: UNHCR, Unicef and WHO. Specific health programmes and projects which were supported by these three different UN agencies were generally complementary in content, with WHO supporting disease control while Unicef promoted community health interventions and UNHCR provided the additional resources which were needed, for example. Such a division of labour between WHO and Unicef, in fact, reflects more general priorities for health which have been adopted and mutually agreed for their development programmes. Yet health programmes which

were supported by the different UN agencies were usually carried out in isolation from national health or development programmes, and often from each other. The inputs of Unicef and WHO in particular, who were working in national health development, often failed to consider the refugees as anything but a temporary problem with refugee health activities planned and implemented as temporary, isolated solutions. Overlapping and poorly defined roles for refugee health of UNHCR, Unicef and WHO meant that their involvement changed over time and in content. Surely, this creates confusion for those seeking assistance from the UN; it may also lead to significant delays in planning and implementing health activities by governments.

14.3.9 Management of refugee health by, with, for or instead of, national and local institutions?

Leadership within the refugee health programme changed hands three times over a ten year period. The arrival of the Senior Health Coordinator in 1982 meant that WHO took responsibility in practice for providing national leadership for refugee health. Support for this post and the authority granted to it came primarily from UNHCR which needed technical advice on the allocation of funds and which was willing to finance such a position, and WHO which had seconded other senior health professionals to refugee programmes in Thailand (1979) and Somalia (1981). The technical and professional expertise of the Senior Health Coordinator, his position within the international aid agencies and his role in planning and approving financial and material resources donated through the UN meant that he held considerable power. Unlike the refugee health operation in Somalia where the secondment of a senior health professional to the Government allowed the Ministry of Health to take the leading role, the posting of a Senior Health Coordinator by WHO within UNHCR meant that policies and plans were then formulated jointly by WHO and UNHCR through the Senior Health Coordinator.

The power of the purse then enabled UNHCR to create their own post for a Senior Health Coordinator and to request the secondment of provincial health advisors from the Save the Children Fund rather than WHO in 1986. This shifted responsibility for

refugee health within the UN system from WHO to UNHCR; it also shifted leadership responsibilities within the national refugee health services from WHO to UNHCR.

Instead of acting in an advisory or collaborative role, UNHCR then took responsibility for making policy and plans as well as monitoring, evaluating and managing the refugee health programme generally. UNHCR did this firstly by writing guidelines for the management of common diseases and the organization of health care. Secondly, UNHCR arranged for the effectiveness or impact of existing interventions to be assessed by foreign organizations, for example the health and nutritional status of the refugees and the coverage of priority interventions. UNHCR did not, however, support training programmes in management, epidemiology or public health which would enable officials of the Government to make use of these assessments. Thus, UNHCR consolidated their leadership by gathering important information which they then used in planning and managing the refugee health services.

Thirdly, concerns that disease control interventions were ineffective and that there was a lack of community health activities similarly led UNHCR to contract other foreign aid agencies to take responsibility for advising and supporting the management of the various health programmes and services. While many agencies had staff with considerable technical and professional expertise, few had their own source of funds, relying on UNHCR. Collaborative relationships between these agencies and UNHCR meant that UNHCR supported these agencies in taking decisions and carrying them out. Thus, UNHCR consolidated their own leadership partly through collaborative relationships with other foreign aid agencies who increasingly managed individual health programmes for the refugees.

The increasing involvement of UNHCR in the management of refugee health in recent years reduced support for the Government to provide refugee health services. Instead, UNHCR itself exerted greater control over all aspects of the management process, and it increasingly chose to collaborate with other foreign aid agencies to implement refugee health activities.

14.3.10 Strengthening or undermining host capacities?

The creation of a separate system of health services for the Afghans allowed refugee health care to be the responsibility of firstly the Provincial Departments of Health, then the Commissions for the Afghan Refugees and finally the international aid agencies. Even though international agencies organise and provide health services for refugees in other countries, such as Honduras and Thailand, the value of such an approach is questionable in both the short-term, when numerous agencies arrive and establish an array of programmes according to their different priorities and abilities, and in the longer-term, when donor fatigue prevents further involvement of these agencies and the refugees and their hosts are left to fend for themselves.

There are several good reasons for local or national bodies, such as ministries of health, to take responsibility for refugee health care. Firstly, it is an opportunity to strengthen their management capabilities. Equally important is the opportunity to train and provide experience in health relief. As a result, the fragmented approach to providing health services is less likely to be compounded by a separate system of health care for the refugees within the country. Consequently, extreme differences between health services for refugees and nationals are likely to be avoided; accessibility and the quality of national health services may also be improved. In brief, the governmental or other local administrative body responsible for health would gain training and experience in managing and implementing health relief and on-going services rather than an *ad hoc* organization with a short life span or a foreign agency involved only temporarily.

The organization and management of health services for the Afghans failed to incorporate much needed 1) training of health providers in management and public health, 2) national standards for the provision and organization of care in a unified and coherent manner, 3) on-going seminars and workshops to communicate updated technical information and skills, 4) supervisory mechanisms to motivate staff who worked in routine jobs in isolated places, 5) career opportunities for growth and promotion, 6) communication systems to facilitate and enhance cooperative and

productive working relationships between the many institutions involved and 7) management structures with centralised policy-making and clear lines of authority and accountability. The failure to take these and other related issues into consideration suggests that the provision of health services for refugees was at the expense of health development.

14.4 Speculating about the future of the refugee health services in Pakistan

When this research was completed in 1989, world attention was drawn to a seemingly endless and horribly violent conflict between different political factions in Afghanistan following the withdrawal of Soviet troops. Within the international community, urgent needs for relief and rehabilitation in Afghanistan were topical: assessments of the damages of war were being undertaken, plans to reconstruct essential services were being formulated and preparations to put the plans into practice were made. Changes in the political conditions from which the Afghan refugees originally fled begged the question of the future of health services established for them in Pakistan, particularly those managed by the Government. Would they simply be discontinued? Should they be maintained? Or should they be integrated in national health programmes? Continued fighting since 1989 and an additional international war in 1990 have meant that these questions are as relevant today as they were five years ago.

14.4.1 The ideal policy option: integration

There are several good reasons why the refugee health programme in Pakistan should not simply be discontinued. Firstly, some Afghans will not return to Afghanistan but will continue to live in marginal areas where national health services are poorly developed or do not exist at all. Secondly, local people have benefited from refugee health services, especially in remote and isolated areas. The vast sums of money, huge quantities of material goods and extensive efforts used to establish and build up refugee health services need not be wasted. Lastly, vast resources have been used to improve the management of refugee health services. Significant progress has been made, not only in creating systems of supervision and support for the provision of

basic care in villages, but importantly in reorienting refugee health programmes to include community health interventions, for example the use of essential drugs and training of community-based health workers. There are at least four different ways in which refugee health services could be integrated into national health programmes[5].

1.The refugee health service structure in its entirety is redefined as a permanent unit within the Government.

With an annual budget of over six million US$ since 1983 from UNHCR alone[6], this is a costly option which would not be justified if large numbers of refugees leave the areas in which they are currently living. Nor would the costs of maintaining a duplicate system be justified easily since national funds for health are already minimal and over stretched. Although the Tibetan health care system in India suggests that quasi-separate systems may be useful and feasible among some refugee communities, many of the factors which would argue for a quasi-separate structure do not readily apply to the Afghans in Pakistan. For example, the Afghans are unlike the Tibetans in India in at least three important ways; they are culturally and ethnically similar to their hosts, they do not live in a unified society and they do not have a long history of their own system for health care delivery. This option is, therefore, unlikely to be able to meet the needs of both the Afghans or their hosts in the longer-term.

2.Specific refugee health programmes are incorporated within corresponding national, provincial or district programmes.

In this option, the policies, practices and resources of specific refugee and national programmes would need to be evaluated. Subsequent mergers would then be able to build upon past experiences and existing resources of both programmes in order to strengthen on-going services. One strategy would be to incorporate camp health services into district and tribal agency health programmes. At provincial level, refugee health programmes for disease control, training community-based health workers and public health management could be evaluated and then merged with counterpart provincial programmes. Such a strategy would also facilitate the employment of many

medical doctors, lady health visitors and other paramedical staff who currently work in the refugee services. Senior officials who have been on deputation could use their skills and experience as managers within provincial programmes. It would thus allow existing financial, material and human resources to be used in the longer-term.

3.Management units for refugee health services are maintained but given new terms of reference, for example to manage health relief preparedness and response at national and provincial levels.

This option would seek to build on the experiences and abilities of existing management structures to respond quickly, appropriately and with authority to future disasters - which inevitably will occur. This option would have been appropriate in Somalia before the current civil war broke out, where the Refugee Health Unit had gained considerable expertise in planning, preparing and managing health relief in acute emergencies[7]. The experiences of the Provincial health officials in the early 1980s suggests that district and local health workers would be unlikely to respond to a separate management structure. Moreover, the fragmented and bureaucratic nature of the refugee health management structure, the need for clear and authoritative lines of accountability in emergencies, and current inefficiencies and limited effectiveness of refugee health activities make this option an unsuitable choice in Pakistan.

4.Resources from the refugee health services are simply transferred to the government health sector.

National health workers would be reassigned within, and drugs, supplies and equipment would become the property of, the Government's health services. This option may be effective in countries where national health services are well developed. However, in Pakistan, where health services are poorly developed, such a transfer would most likely result in the loss or disuse of resources and experience from the refugee health programme.

14.4.2 The likely reality: disintegration

Regardless of the many reasons which can be given in favour of, or against, these policy options, the process of formulating and implementing policies for refugee health in Pakistan suggests that the refugee health services will disintegrate because of a lack of political will and resources, and poorly developed national health structures.

Refugee health services were established by the Government and international aid agencies as a temporary, international programme solely for the immediate benefit of refugees living in separate villages. There has been little, if any, commitment of the international agencies most directly involved in refugee health relief (UNHCR and charitable agencies) to development in Pakistan. Nor has there been any substantial commitment by the specialised agencies and funds of the UN involved in health development (Unicef and WHO) to the refugees. The few international agencies currently supporting only refugee health services will probably transfer their support to repatriation programmes for those who return to Afghanistan or discontinue their involvement completely.

This process began in 1985 when many agencies first took part in cross-border relief operations and it intensified in 1989 when Soviet troops withdrew from Afghanistan. Many of those who might have redirected their efforts to developing health services in Pakistan (those who were already doing so, in addition to, or as part of, their refugee health assistance) had to leave during the war with Iraq. Moreover, it seems unlikely that international agencies currently working in health development in Pakistan would have supported the integration of refugee health programmes, partly because of their lack of involvement to date, partly because integration would require substantial resources in addition to those currently available, and partly because evaluations may find that refugee programmes provide better services requiring changes in their own.

The governmental health sector is equally unlikely to plan and request assistance for integrating refugee and national health programmes. Not only do they lack the

resources to undertake such an integration independently, but their health service infrastructure is unable to accommodate some refugee health programmes, for example training community-based health workers. However, the problem is more than a lack of resources and a curative bias. Management support systems are poorly developed. Systems which ensure regular delivery of needed supplies and regular communication with senior health officials are functioning poorly at best. Opportunities for continued training or promotion of health staff are limited. The resulting apathy and low morale among staff is further compounded by poor personnel policies which fail to make health staff accountable to district, provincial and national bodies, instead of well-organised unions. Poor management policies and practices remained entrenched, perpetuating apathy, low morale and indifference amongst health staff. Fundamental structural changes needed to achieve integration would, therefore, be difficult and unpopular.

14.5 References

1. Cavallo S (1991) The motivations of benefactors. An overview of approaches to the study of charity. In: Barry J and Jones C Medicine and charity before the welfare state. London and New York: Routledge, pp. 46-62, p. 50

2. Cavallo S (1991), #1, p. 51

3. Simon R (1988) Gramsci's political thought. London, UK: Lawrence and Wishart. p. 69

4. Simon R (1988), #3, p. 70

5. Godfrey N and Mursal H (1990) International aid and national health policies for refugees: Lessons from Somalia. Journal of Refugee Studies 3(2):110-134

6. Khan AR and Nesbit R (1987) Annual report 1986. Afghan refugee health programme Pakistan. Islamabad, Pakistan: Chief Commissionerate for Afghan Refugees/United Nations High Commissioner for Refugees, 129 pp.

7. Godfrey N and Mursal H (1989), #5

CHAPTER FIFTEEN

Policies for the health of refugees: promoting human rights, compassion or self-interests?

Disasters generally and refugees and displaced populations specifically are an increasing challenge, mostly for the governments and peoples of poorer countries in Africa, Asia, the Middle East and Latin America. The advent of the 1990s was marked, in fact, by the urgent needs of these people in Bangladesh, Iraq, Sudan and Turkey, for example. The responses by the international community continue, however, to be called into question. These responses can be understood within the context of the evolution of policies for international health relief during three historical periods.

The development of the global health relief system can be divided into three distinct historical periods characterised by their prevailing political and economic systems. Thus, the division into three periods is not arbitrary, each being distinguished by differences in the institutions and institutional relationships through which policy is formulated and implemented, the dominant body of knowledge which dictates the content of policy, and the group of experts who provide organizational and cultural leadership which directs and legitimises policy.

Firstly, during the latter half of the 1800s when the Red Cross movement initiated medical relief for those wounded in war as a humanitarian activity of nation-states. Secondly, during the first half of this century when inter-governmental institutions were created to continue and extend the tradition of inter-nationally provided medical relief to entire populations in response to the World Wars. Lastly, during the past forty years when western charities and inter-governmental relief agencies increasingly manage and provide medical and public health activities for relief in the developing world.

Within these three periods of policy evolution, the prominent roles currently played by the specialised agencies and funds of the United Nations and private charitable agencies based in Europe and North America can be understood, especially since a historical approach places their policies and practices within the context of the cultural and political environment in which they originate. Although this research focused on these organizations, their policies and practices also highlight the important role played by donor governments and the various interest groups they represent - although in-depth consideration of their roles was beyond the scope of this thesis.

15.1 Key findings

15.1.1 A system for health relief globally

This thesis documents important legacies from the Red Cross movement of the late 1800s and subsequent relief practices during and after the first World War. Between the formation of the Red Cross in the 1860s and the creation of the League of Nations after World War I, private charitable agencies provided health relief during and after war, both nationally and internationally. As private, charitable organizations these institutions drew heavily on Christian and humanist ideologies of helping those in need. This religious and humanist framework promoted relief as a humanitarian activity worthy of popular support which in turn legitimised the provision of relief to all in need regardless of nationality or national boundaries. Nevertheless, as institutions in a political system of nation-states, these private agencies depended on national governments for political authority to act in times of war; ironically, some, such as the Red Cross, even worked directly under the auspices of the military.

Medical and surgical care of individuals wounded during armed conflict was the primary concern of these relief agencies in the late 1800s, but by the end of the first World War health relief had expanded to incorporate the needs of civilians who were affected by armed conflict for basic medical care . Thus, international health relief began as a highly specialised and technical field in which medical and surgical

sciences were applied to the casualties of war, but its mandate soon grew to care for civilians affected by war.

The engagement of governments, collectively and directly, in the provision of international health relief was then examined. All of the principal inter-governmental institutions currently involved in international health relief were originally established in response to the two World Wars. Like their predecessors, the private charities, these institutions depended on national governments for their existence and for legitimate authority to act in international relief operations. Nearly all depended on national governments to provide the vast resources needed for relief.

Unlike most private charitable agencies before them, these inter-governmental organizations were often faced with caring for entire populations, for example those under seige or those displaced by fighting or foreign occupation. Instead of setting up separate systems for health relief during the first half of the 1900s, however, most inter-governmental organizations facilitated and supported the provision of basic medical and surgical care by existing health services of local or national governments as well as those provided by private charitable agencies. Thus, health relief was not a distinct activity of the majority of inter-governmental institutions at that time, but rather of national governments primarily in Europe and private charitable agencies.

In contrast with the first one hundred years of international health relief for refugees, health care has been a significant component, if not one of the main activities, of international aid operations for refugees since the second World War. Medical doctors continue to manage international health relief operations but they are now required to have additional training in public health and epidemiology. Whether as staff of, or as consultants to, the main relief institutions, they recommend and confer legitimacy to health policies for refugees within a medical, epidemiological approach to public health. Thus, the priority in health relief for refugees now emphasises the provision of basic care for the most common health and nutrition problems; preventive measures, such as immunizations, adequate quantities of water and systems for the disposal of human wastes, are thought to be or equal, if not greater, importance than

caring for individuals wounded during armed conflict, providing emergency and basic medical care and controlling epidemics of disease.

The institutions through which they formulate and implement health policies for refugees remain the same. Three specialised agencies or funds of the United Nations and private charities play key roles in the provision of international health relief for refugees. An in-depth analysis of the policies of the United Nations High Commissioner for Refugees (UNHCR), the World Health Organization (WHO) and the United Nations International Children's Fund (Unicef) to promote the health of refugees exposes the simplicity and naivete of calls for one agency or fund within the UN system to adopt the leading or coordinating role in refugee health relief. Instead, this review illuminates important similarities in their policy-making processes, for example dependency on governments of wealthy nations in the North Atlantic region for political authority and financial resources or a very real vulnerability to the political interests of governments party to the conflict and associated relief operation.

Marked differences are also highlighted, drawing attention to obstacles and limitations to improving the ways in which they participate in international health relief efforts. For example, UNHCR plans and budgets yearly since its mandate provides for assistance in the shorter-term only. WHO's participation is hampered by excessively bureaucratic structures and procedures or by what many consider a narrow and out-dated focus on diseases and selected medical interventions. While appearing to be best placed to respond quickly and appropriately to the health needs of refugees, Unicef's selective approach to health care and its smaller size as an organization appear to constrain its interest in undertaking such an intensive, comprehensive and demanding role.

Thus, despite limited capacities to go beyond symbolic responses, the availability of considerable sums of money, the opportunity to enhance institutional prestige among the international public and a need to avoid unwanted publicity of being seen to be unsympathetic, irrelevant or ineffective in responding to the desperate needs of so

many people generates enormous pressure on these agencies to take part in health relief operations - even if only symbolically.

Private charitable organizations were also considered as conduits for the provision of health care among refugee populations, both as complementary partners with inter-governmental aid agencies and as potential alternatives. An examination of their roles in refugee health relief since the second World War reveals a close and complimentary association with domestic and foreign policy priorities of their own governments. Placing international health relief for refugees within the context of domestic and foreign policy interests of the wealthier nations helps to explain long standing preferences for technical solutions to the health needs of refugees within a welfare approach to relief aid.

Looking at the context in which these types of organizations provide health relief for refugees also brings to light their essential role in putting health policies into practice. Agencies with some affiliation to churches are found to have played a key role, especially during the years when many countries gained independence from colonial rule. More recently, a variety of charitable or private organizations have made the most of the sensational coverage given to refugees in the media to extend the scope of their work, geographically, sectorally and financially.

Thus, several charitable agencies have moved beyond the frontline to participate in the policy process as equal partners rather than as auxiliaries. This has brought them international recognition, substantial financial resources and rapid organizational growth. In turn, they now exert considerable influence in the policy making process. But, like the inter-governmental agencies, their influence is prejudiced by their dependency on wealthy, powerful governments for the legal, political and financial authority to work.

Dependency on wealthy, powerful governments characterises all of the international agencies involved in the provision of health relief for refugees, suggesting that most are motivate more by self-interest than compassion. Similarly, common myths of

political neutrality are exposed, for example, through an analysis of the mechanisms used by wealthy governments to ensure that the work of the UN does not mitigate against their own interests. Specific roles which the specialised agencies of the UN and the private charitable organizations are most likely to play in any given refugee health relief operation can, therefore, be anticipated as well as the interventions most likely to be given priority within the prevailing medical, epidemiological approach to public health.

15.1.2 Health relief for Afghans in Pakistan, 1978 - 1988

In choosing to provide relief for Afghan refugees as early as 1978, the Federal and Provincial Governments of Pakistan were greatly influenced by shared kinship, ethnic identity and opposition to the policies of the Afghan Government of their own people in Baluchistan and the North West Frontier Provinces. This, together with pressures from foreign agencies, led them to create a separate and extensive health service specifically for the Afghan refugees. In setting up a refugee health service, officials of the Government and United Nations opted to provide basic curative care and disease control through the provision firstly of mobile teams and later static facilities in the refugee villages.

Foreign health workers were restricted to advisory and administrative roles and Pakistani health workers were employed to staff and manage the services in village, district and regional offices. Financial incentives were given to Pakistani medical doctors and Lady Health Visitors to offset the difficulties of living in remote and poorly developed areas as well as the lack of opportunities for career advancement. Such organizational policies ensured that the Government took responsibility for managing and providing health relief with support from the international aid agencies. They also allowed the Government to meet domestic needs for employment within the health sector, to avoid political conflict with tribal majorities in the northwestern provinces and to promote political and religious links with parties in Afghanistan.

Domestic and international publicity put the Government under great pressure to put their health plans for the North West Frontier and Baluchistan Provinces into practice. Simultaneously, they extended services to refugees resettled in Punjab Province. While the Government consolidated its primary role in the provision of refugee health services, some foreign charitable agencies began to provide health relief in Afghanistan or sophisticated surgical and medical care in special-built hospitals in Pakistan independently; their efforts were in support of those at war. Most, however, continued to assist the Government, for example by setting up a community health component of services provided in the refugee villages.

The somewhat chaotic and uncoordinated efforts of so many health professionals, health programmes and aid agencies led the UNHCR and WHO to employ a Senior Health Coordinator for the refugee health programme at the same time. Based on the advice of this coordinator and his many efforts to strengthen and support Governmental officials in managing the programme, greater coherence was brought to the refugee health services, for example through the integration of disease control measures in rural health facilities and through the introduction of technical standards for health care nation-wide.

Between 1984 and 1988, the number of private, charitable organizations providing health care for the Afghans increased tremendously. Poor management and implementation of health services in Baluchistan before 1985 and the availability of large sums of money from the US Government since 1984 created an opening for charities to play an expanded role. Agencies with existing programmes for the refugees then extended the geographical and technical scope of their work to include the needs of those remaining in Afghanistan or those fighting the war. Many new agencies were created, by Afghan political parties, for example. Other foreign charities set up new programmes or services, both in Pakistan and Afghanistan. Some agencies even took over services previously provided by the Government. Interestingly, the arrival of these agencies coincided with the escalation of the armed conflict between the rebels and Afghan Government; the anarchic way in which they worked in

Pakistan begs the question whether they were motivated by a charitable or military cause.

Not surprisingly, a greatly expanded role for foreign charities in the provision of health care for Afghans from a base in Pakistan coincided with a shift in leadership of the refugee health programme to UNHCR. Not only did UNHCR create their own positions for health professionals to manage the programme nation-wide, they delegated management of disease control and community health programmes to other foreign aid agencies: for example, a private consulting firm from the US (immunizations), a bilateral aid agency of the Italian Government (tuberculosis) and selected western charities from the Netherlands, Austria, the US and the UK (malaria, sanitation and community health workers).

UNHCR's ability to take the leading role was largely due to their financial role, but it was also greatly facilitated by the policies and practices of influential donor governments - for both the relief programme and Pakistan's developmental programme. Greater involvement of UNHCR in refugee health relief may well mean less, not more, support for the efforts of host governments or other locally-based administrations to promote the health of refugees, their own people or both.

In analyzing the findings of the case study in Pakistan key dimensions of the policy process were found to have been neglected: culture and discursive practices. Similarly, the analysis calls into question the notion that health relief is provided in response to demands based on the health of the refugees themselves. Instead, the exclusion of the Afghans from decision-making processes, the lack of any notable change in their health status, and the parallel organization of official relief and informal systems of health care highlights the need to maintain domestic stability in setting national policies for refugees. Again, key considerations of the policy process were found to have been neglected because the complexity of national societies have not been adequately taken into account. Instead, the rhetoric of national and international goals for health relief focus exclusively and simplistically on host governments. Nevertheless, these governments represent the interests of powerful groups within their

society and this was found to be reflected in policies for refugee health adopted by them.

But policies established nationally were quickly altered to accommodate the interests of international aid agencies and the groups they represent. In questioning whether policies are determined nationally or internationally, eight key policy issues which face providers of health care for refugees were identified. The evolution of policy in Pakistan indicates that foreign groups had tremendous influence in determining what would be done, for whom, by whom, with what resources, and for how long. Sadly, in speculating about the future of existing health services for the Afghans in Pakistan, this trend in the policy process suggests that they will disintegrate, leaving few - if any - lasting benefits for either the refugees or their hosts.

15.2 Recommendations: idealistic or realistic?

Derived from this study, there are several ways in which international organizations can assist governments or other locally-based administrations who host, or who will host in future, large populations displaced forcibly from their homes:

- By improving health services in marginalised areas, especially in areas surrounding disputed international borders or areas of conflict.

- By developing disaster preparedness of national and local governments, particularly for displacements of large groups of people who will be unable to return to their homes for long or indefinite periods of time.

- By ensuring that priority is given to community development interventions, environmentally sound technologies and other measures which allow refugees and their hosts to provide for themselves and their families.

- By providing experienced health personnel for relief, especially immediately following an influx of refugees.

- By providing material and financial resources for health relief *throughout* the relief operation *and* the development of on-going services.

- By developing and conducting training programmes for national and refugee health workers, particularly in the management of public health services.

- By providing experienced foreign health advisers to work with governments directly at national and provincial levels. Their roles should be to assist the government or other local administrative body in :

    1. Establishing policies and standards for the organization and delivery of health care.
    2. Training national and refugee health workers.
    3. Developing logistical and administrative support systems.
    4. Conducting forums for on-going communication among the various agencies, such as workshops, seminars and regular meetings.
    5. Developing briefing sessions for newly arriving foreign health workers.
    6. Monitoring the implementation of health activities.
    7. Promoting understanding and good will between international organizations, host governments and local groups, and the refugees.
    8. Encouraging and supporting simultaneous support and assistance to improve management and implementation of health services for nationals living in refugee-affected areas.

Yet the process of formulating and implementing policies for refugee health suggests that many of these recommendations are idealistic and unlikely to be put into practice. Instead, themes common to all of the analyses suggest more general conclusions about the policy process.

15.3 Policies for refugee health: promoting health or self-interests?

15.3.1 The multiplicity of agencies: benevolent anarchy or a coherent system?

Within the humanist tradition established by the Red Cross, nation-states in Europe and North America evolved a separate system for providing health relief internationally during and after the two world wars. That a system exists, however, is not readily apparent. The practice of categorising relief organizations into three large, seemingly disparate, groups, namely governmental, non-governmental and inter- (or supra-) governmental enhances the perception that private, charitable agencies, the UN and many other inter-governmental organizations are separate from each other and, more importantly, from national governments who often have less noble, self-interested motives associated with them.

Moreover, such general groupings often focus attention on a few of the largest, most well-established organizations instead of the fluid process with which organizations are formed, merged with others or disbanded altogether. Many relief organizations have been transient, being created specifically for one relief operation. Others have found additional on-going purposes or have been succeeded by more permanent institutions in which relief was only one, usually low, priority. Thus, the numerous types, structures and purposes of the organizations involved in relief, the fluidity with which they are created, altered, merged or discontinued and their perceived separation from one another and from national governments (and therefore struggles for power), mask the reality of a coherent system with an image of benevolent organizational anarchy.

15.3.2 Many leaders, few followers

Multiple agencies and personnel were involved in the policy process. Each had their own objectives and methods of working, and many agencies worked partially or entirely on their own. This meant that there were many leaders and few followers. The tendency of prominent international agencies in the 1980s has, consequently, been to

focus criticism on the lack of coordination among the various organizations providing relief aid. Concern to improve health status by improved coordination suggests an underlying conflict among relief agencies not only in the way they perceive the problem and its solution but more fundamentally for power and legitimacy. Why are relief agencies, which are so well established, so well resourced and have extensive experience with refugees, unable to coordinate their work despite explicit desires to do so? Can we continue to believe that it is a technical or managerial problem? Competition and conflict were constant features of the relationships between involved agencies; this led to inefficient use of resources and it created a fragile and unstable system to manage and implement health interventions.

15.3.3 Charity or a human right?

Beginning with the Red Cross and continuing throughout its history, charitable organizations and the specialised agencies of the UN involved in relief have been promoted and perceived primarily as humanitarian institutions. Health relief in particular continues to be perceived and justified within a humanitarian framework of helping the needy; it has not become a right which ensures that people will have access to those measures and resources necessary for their survival and well-being. Instead, the scale and scope of need, as well as appropriate responses, remain open to interpretation.

15.3.4 Compassion or self-interest?

Both charitable organizations and UN agencies are dependent on national governments for authority to exist and to act. Dependency remains greatest on governments of wealthy nations who control the global political environment and who provide most resources for relief aid. In combination with the shift in institutional responsibility for health relief from national militaries (before World War I), or national health authorities (during the World Wars) to international aid agencies after World War II, governments and local organizations or poorer countries often have little, if any, control over international relief operations today.

There is a lack of trust and good faith in host governments by many international agencies and personnel, and an utter disregard for the refugees' priorities by most international agencies and governments, in the policy process for health. Interactions between these three groups revealed a marked reluctance of many international agencies to relinquish their autonomy and control over resources. Neither the Government nor the refugees were given the authority and means to participate on equal terms with international agencies. Nor were they able to become independent of international aid.

15.3.5 Power symbols, empty - even harmful - gestures

Even though most wars today are of lengthy or indefinite duration, refugee health care continues to be planned and provided as a temporary activity to meet short-term needs. Organizational responsibility for health relief is usually separated from development or on-going health services - locally, nationally and internationally. Not only are refugees defined as a temporary problem but they are considered an international responsibility. Priority is then given to the provision of emergency care by foreign professionals. Thus, the separate systems of health care which are created rarely become independent of foreign support - for their survival materially and politically.

Relief activities now focus on meeting the basic survival needs of entire populations, for example, for food, shelter, clothing and basic health care. Unlike the first 100 years of relief when emergency surgical and basic medical care were priority health relief measures, public health interventions are now one of the main priorities of relief organizations. Nevertheless, health relief practice continues to emphasise technical interventions which are organized and managed primarily by medical doctors, many of whom have additional training in public health. Yet, these interventions are usually structures to meet only immediate needs, and many are minimalistic, for example, food rations, selective feeding programmes, medical screening, vaccination campaigns and emergency medical care. At present, this approach fails to address the underlying economic, social or political vulnerabilities which contribute to poor health, poor nutrition and even the loss of life. Damages to individual and national dignity, social

and economic conditions and even health and nutritional status may be considerable even though policies ostensibly aim to promote the health of refugees.

BIBLIOGRAPHY

AACC (1983) Handbook for refugee workers. Nairobi, Kenya: All Africa Conference of Churches, Refugee Service

Aall C (1970) Relief, nutrition and health problems in the Nigerian/Biafran war. Journal of Tropical Paediatrics 16:70-90

Abel-Smith B (1988) The rise and decline of the early HMOs: Some international experiences. The Milbank Quarterly 66(4): 694-719

Acting Director, Assistance, UNHCR (1979) Project 79/AP/THA/SA/14 - Provision of health coordinator by the World Health Organization (WHO) for refugees in Thailand. Letter to Responsible Officer, Emergency Relief Operations, World Health Organization, 21 December 1979, 2 pp.

Administrator MSF (1987) Letter to Chief Sub-office UNHCR, 14 July 1987. Quetta, Baluchistan, Pakistan: Medecins Sans Frontier

Afghan Refugee Health Programme (1984) Tuberculosis control programme for Afghan refugees in Pakistan. Plan of operation. Islamabad, Pakistan: Chief Commissionerate for Afghan Refugees, Government of Pakistan/United Nations High Commissioner for Refugees, 12 pp.

Afghan Refugee Health Programme (1984) Malaria control. Plan of operations. Islamabad, Pakistan: Chief Commissionerate for Afghan Refugees, Government of Pakistan/United Nations High Commissioner for Refugees, 12 pp.

Afghan Refugee Health Programme (1984) Annual report 1983 (Strategies for 1984). Islamabad, Pakistan: the Chief Commissionerate for Afghan Refugees, States and Frontier Regions and Kashmir Affairs Division, Federal Government of Pakistan and the World Health Organization, Emergency Relief Operations, 24 pp. plus annexes

Afghan Refugee Health Programme (1984) Expanded Programme for Immunization (EPI). Plan of Operations. Islamabad, Pakistan: Chief Commissionerate for Afghan Refugees, Government of Pakistan/United Nations High Commissioner for Refugees, 11 pp.

Agency Coordinating Body for Afghan Relief (1989a) ACBAR directory of members. Islamabad, Pakistan: Pan Graphics Ltd, November, 133 pp.

Agency Coordinating Body for Afghan Relief (1989b) Directory. Draft edition for members. Peshawar, Pakistan: Agency Coordinating Body for Afghan Relief, June

Ahtone J, Berends P and Khan AR (1985) Annual report 1985. Afghan refugee health programme Pakistan. Islamabad, Pakistan: Chief Commissionerate for Afghan Refugees, Government of Pakistan/United Nations High Commissioner for Refugees, 124 pp.

Alavi H and Khusro A (1962) Pakistan: The burden of US aid. New University Thought 2(4), 16 pp.

Allen T (1990) Putting people first again: Non-governmental organizations and the 'new orthodoxy' for development. Disasters 14(1):63-68

Allegra DT et al (1980) Emergency refugee health care - a chronicle of the Khmer refugee-assistance operation. Atlanta, Georgia, USA: Centres for Disease Control, Public Health Service, Department of Health and Human Services, Government of the USA, 188 pp.

Antonov AN (1947) Children born during the seige of Leningrad in 1942. The Journal of Pediatrics 30:250-259

Armstrong P, Glyn A and Harrison J (1984) Capitalism since World War II. The making and breaking of the great boom. London, UK: Fontana Paperbacks, 482 pp.

Arrupe P (1985) The refugee crisis in Africa: Opportunity and challenge for the Church. Migration News 4:47-48

Assistant Director, International Health, CDC (1980) Letter to the Deputy High Commissioner and the Deputy Chief Programming Section, UNHCR, 10 June 1980, 2 pp.

Baitenmann H (1990) NGOs and the Afghan war: the politicisation of humanitarian aid. Third World Quarterly 12(1):62-85

Barros J (1972) The United Nations past, present and future. New York, USA: The Free Press, 266 pp.

Bennett FJ, Jelliffe DB, Jelliffe EDP and Moffat M (1968) The nutrition and disease pattern of children in a refugee settlement. East African Medical Journal 45:229-246

Berkov R (1957) The World Health Organization: A study in decentralized international administration. Paris, France: Etudes d'Histoire Economique, Politique et Sociale, 162 pp.

Black M (1986) The children and the nations. The story of Unicef. New York, USA: the United Nations Children's Fund, 496 pp.

Bizzozero OJ Jr, Johnson KG and Ciocco A (1966) Radiation-related leukaemia in Hiroshima and Nagasaki, 1946-1964. New England Journal of Medicine 274(20):1095-1101

Boss L, Brink E and Dondero D (1984) Evaluation of the infant mortality and childhood nutrition status among Afghan refugees in Pakistan. Atlanta, Georgia, USA: Centres for Disease Control, US Public Health Service, 19 pp. with appendices

BRC (1987) Afghanistan: The Human Tragedy. London, UK: British Refugee Council, 27 pp.

Brownfeld AC (1986) Just what is our policy toward Afghan rebels? Human Events, 16 August, 10:706

Boissier P (1985) From Solferino to Tsushima. History of the International Committee of the Red Cross. Geneva, Switzerland: the Henry Dunant Institute and the International Committee of the Red Cross, 384 pp.

Bolling LR and Smith C (1982) Private foreign aid. US philanthropy for relief and development. Boulder, Colorado, USA: Westview Press, 294 pp.

Brockington F (1975) World health. Edinburgh, London and New York: Churchill Livingston

Brown ER (1979) Rockefeller medicine men. Berkeley, Los Angeles, USA: University of California Press, 241 pp.

Brown MM (ed) (1984) The rise and rise of the volag. The Economist, Developmental Report, August, pp. 1-2

Burnell PJ (1991) Charity, politics and the Third World. London, UK: Harvester Wheatsheaf, 286 pp.

Cabinet Division National Disaster Plan. Islamabad, Pakistan: Disaster Preparedness and Relief Cell, Cabinet Division, Government of Pakistan, 20 pp.

Cavallo S (1991) The motivations of benefactors. An overview of approaches to the study of charity. In: Barry J and Jones C Medicine and charity before the welfare state. London and New York: Routledge, pp. 46-62

CCAR/GOP (1984) Humanitarian assistance programme for Afghan refugees in Pakistan. Islamabad, Pakistan: Chief Commissionerate for Afghan Refugees, Government of Pakistan, 28 pp.

CCAR/GOP (1989) 3.27 Million Uprooted Afghans in Pakistan. Islamabad, Pakistan: Chief Commissionerate for Afghan Refugees, States and Frontier Regions and Kashmir Affairs Division, Federal Government of Pakistan, p. 9 of 16

CCAR and UNHCR (1989) Guidelines for environmental health services for Afghan refugees in Pakistan. Islamabad, Pakistan: Pictoral Printers Ltd, for the United Nations High Commissioner for Refugees and the Chief Commissionerate for Afghan Refugees, States and Frontier Regions and Kashmir Affairs Division, Government of Pakistan, 72 pp.

Centre de Recherche sur l'Epidemiologie des Desastres and Medecins Sans Frontieres Belgique (1988) Organization d'un camp de refugies. Guide operationnel pour la phase d'urgence. Modules 1-4. Fiches techniques and annexes. Brussells, Belgium

Chambers R (1985) Memorandum to the House of Commons Foreign Affairs Committee. Sussex, UK: Institute of Development Studies, 4 pp. plus 6 pp. of notes

Cheema PI (1983) The Afghanistan crisis and Pakistan's security dilemma. Asian survey 23(3):227-243

Chief, Emergency Preparedness and Response, WHO (1989) Note for the record. UNHCR/WHO collaboration in the Islamic Republic of Iran. 9 September 1989. Geneva, Switzerland: Emergency Preparedness and Response, World Health Organization, 3 pp.

Chief, Emergency Unit UNHCR (1980) Letter to the Responsible Officer, Office of Emergency Relief Operations, World Health Organization, 21 November 1980, 1 p.

Chief, Emergency Unit, UNHCR (1980) Letter to the Responsible Officer, Office of Emergency Relief Operations, World Health Organization, 18 December 1980, 1 p.

Chief, Emergency Unit, UNHCR (1980) Note for the file. EU/39/B, 21 November 1980, 2 pp.

Chief, Emergency Unit, UNHCR (1982) Letter to the Research Fellow and Head of the Refugee Health Group, London School of Hygiene and Tropical Medicine, 22 February 1982, 1 p.

Chief, Sub-office Peshawar UNHCR (1982) Letter to Chief of Mission, UNHCR, 21 September 1982. Peshawar, NWFP, Pakistan: United Nations High Commissioner for Refugees, 1 pp.

Chief Sub-office Quetta UNHCR (1987) Letter to Project Director for Health for Afghan Refugees, Government of Baluchistan, 14 October 1987. Quetta, Baluchistan, Pakistan: United Nations High Commissioner for Refugees

Chief of Mission AICF (1987) Letter to Commissioner for Afghan Refugee in Baluchistan, 11 November 1987. Quetta, Baluchistan, Pakistan: Action International Contra la Faim

Chief of Mission UNHCR (1981) Letter to Joint Secretary, States and Frontier Regions Division, Government of Pakistan, 28 May 1987. Islamabad, Pakistan: United Nations High Commissioner for Refugees, 1 pp.

CICARWS (1981) Recent WCC statements concerning refugees. Refugees. Oikoumene. Geneva, Switzerland: Refugee Service of the Commission on Inter-Church Aid, Refugee and World Service, World Council of Churches, September, 9 pp.

Clark J (1991) Democratizing development. The role of voluntary organizations. London, UK: Earthscan, 253 pp.

Coles G (1989) Approaching the refugee problem today. In: Loescher G and Monahan L (eds) Refugees and international relations. Oxford University Press, pp. 373-410

Cuenod J (1991) Report on refugees, displaced persons and returnees. Report to the Economic and Social Council of the United Nations. Geneva, Switzerland: the Economic and Social Council, the United Nations

Cumper GE (1986) The changing role of NGOs: no longer the eunuch in the harem? Health Policy and Planning 1(4):335-344

Cutts F (1984) Training community health workers in refugee camps: a case study from Pakistan. Disasters 8(3):198-205

D'Souza F (1984) A new camp for vintage refugees? Disasters 8(1):11-12

Davis M (ed) (1976) Civil wars and the politics of international relief. Africa, South Asia and the Caribbean. Praeger International Studies in International Politics, 103 pp.

Deputy Chief, Programming Section, UNHCR (1980) Note for the file. Centres for Disease Control, USA: Possible assistance to UNHCR. Reference number 118, 22 May 1980, 2 pp.

Deputy PDH PHC (1987) Letter to Save the Children Fund, Peshawar, NWFP, Pakistan, 24 March 1987

Director-General WHO (1951) Official records of the World Health Organization 14:48, Annex 9

Director-General, WHO (1962) The role of WHO in emergencies. Official Records of the World Health Organization 124:50-53

Disasters (1979), volume 3, number 4

Disasters (1981), volume 5, number 3

Division for Higher Education and Research, Council of Europe (1982) European workshop on the educational aspects of health in disasters, 2-5 March 1982, Strasbourg, 48 pp.

Dodd R (1991) The marketing of mercy. A review of the emergency response of the League of Red Cross and Red Crescent Societies and of other agencies. Geneva, Switzerland: League of Red Cross and Red Crescent Societies, May, 45 pp.

Downs C and Solimano G (1989) Toward an evaluation of the NGO experience in Chile: Implications for social policy and future investigation. In: Downs C, Solimano G, Vergara C and Zuniga L (eds) Social policy from the grassroots. Nongovernmental organizations in Chile. Boulder, San Francisco and London: Westview Press, 212 pp.

Drug Action Programme, WHO (1990) The new emergency health kit. List of drugs and medical supplies for a population of 10 000 persons for approximately 3 months. Geneva, Switzerland: The Drug Action Programme, World Health Organization, 42 pp.

Duke S (1992) The UN financi crisis: A history and analysis. International Relations 11(2):127-150

Ericksson L-G, Melander G and Nobel P (eds) (1981) An analysing account of the Conference on the African Refugee Problem. Arusha, May 1979. Uppsala, Sweden: Scandinavian Institute of African Studies, 226 pp.

Emergency Preparedness and Response, WHO (1986) Review of the United Nations system-wide emergency situations preparedness and its coordination aspects and links to longer-term development in the light of the experience gained from the emergency operations in Africa. Background paper prepared for the joint meeting of CPC/ACC, Geneva, 1-2 July 1986

Emergency Preparedness and Response, WHO (1989) Emergency Preparedness and Response 1989 - 1991. Geneva, Switzerland: the World Health Organization, PCO/EPR/89.5, 8 pp.

Emergency Relief Operations, WHO (1989) Annual Report 1989. Geneva, Switzerland: the World Health Organization

Emergency Section, UNHCR (1987) Emergency managers update. Geneva, Switzerland: United Nations High Commissioner for Refugees

Field Director SCF (1985a) Minutes of the meeting held at UNICEF on 3.4. 1985. Peshawar, NWFP, Pakistan: Save the Children Fund, 2 pp.

Field Director SCF (1985b) Letter to FSMO Dir District, 13 September 1985. Peshawar, NWFP, Pakistan: Save the Children Fund, 1 p.

Fox DM (1986) Health policies, health politics. Princeton, New Jersey, USA: Princeton University Press, 226 pp.

Foreign Assistance Act of 1962, Public Law 87-565 (76 Stat. 225) Part 1, Chapter 6, Section 461; cited in Smith BH (1990) More than altruism. The politics of private foreign aid. Princeton, New Jersey, USA: Princeton University Press, p. 59

Foreign Assistance Act of 1966, Public Law 89-583 (80 stat. 795)ll, part 1, chapter 2, title 9, section 281; cited in Smith BH (1990) More than altruism. The politics of private foreign aid. Princeton, New Jersey, USA: Princeton University Press, p. 59

Foreign Assistance Act of 1973, Public Law 93-189 (87 stat. 714), part 1, Chapter 1, Section 123; cited in Smith BH (1990) More than altruism. The politics of private foreign aid. Princeton, New Jersey, USA: Princeton University Press, p. 68

Freeman K (1965) If any man build. The history of the Save the Children Fund. London, UK: Hodder and Stoughton, 146 pp. plus annexes

Freyermuth Encisco G and Godfrey N (1991) Guatemalan refugees in Mexico: Living in a continuous state of emergency. Chiapas, Mexico and London, UK: El Centro de Investigaciones y Estudios Superiores en Antropologia Social del Sureste and the London School of Hygiene and Tropical Medicine, 50 pp.

FSMO Zhob/Loralei Districts (1987) Letter to Project Director for Health of Afghan Refugees, Government of Baluchistan, 21 November 1987. Quetta, Baluchistan, Pakistan: Project Directorate for Health of Afghan Refugees, Government of Baluchistan

Gagnebin B and Gazay M (1963) Encounter with Henry Dunant. Geneva, Switzerland: Libraire de l'Universite, GEORG and Cie, S.A., 118 pp.

Gallagher D (1989) The evolution of the international refugee system. International Migration Review 23(3):579-598

Gardner P, Rohde JE and Majumdar MB (1972) Health priorities among Bangladesh refugees. The Lancet 1:834-836

Georgetown University Medical Centre (1988) Health care for displaced persons and refugees: An international symposium. Washington, D.C., USA: 4-7 December 1988

Gill P (1986) A year in the death of Africa. Politics, bureaucracy and the famine. London, UK: Paladin, p. 82

Gillespie S (1989) Use of dried skim milk powder in refugee programmes. SCN News 4:22. Report of the meeting on DSM, 7 April 1989, in the newsletter of the Sub-Committee on Nutrition, the Administrative Committee on Coordination, United Nations

Godfrey N (1989) Refugees and national health policies. A comparative study of the development of national health policies for refugees in Pakistan and Somalia. Report to the Overseas Development Administration of the UK Government. London, UK: London School of Hygiene and Tropical Medicine, April, 41 pp.

Godfrey N and Mursal H (1990) International aid and national health policies for refugees: Lessons from Somalia. Journal of Refugee Studies 3(2):110-134

Godfrey N and Vaughan P (1988) A modified proposal to enable an in-depth study to be carried out of the roles of inter- and non- governmental agencies and refugee organizations in the development and implementation of refugee health policies and plans. Research proposal submitted to the Pew Charitable Trust, USA. London, UK: London School of Hygiene and Tropical Medicine, 9 pp.

Goodman NM (1952) International health organizations and their work. Edinburgh and London, UK: Churchill Livingston

Goodman NM (1971) International health organizations and their work. Edinburgh and London, UK: Churchill Livingston, 2nd edition, 398 pp.

Gordenker L (1987) Refugees in international politics. London, UK and Sydney, Australia: Croom Helm, 214 pp.

Gorman RF (1984) Introduction. In: Gorman RF (ed) Private Voluntary Organizations as agents of development. Boulder, San Francisco and London: Westview Press, pp. 1-12

Green A (1987) The role of non-governmental organizations and the private sector in the provision of health care in developing countries. International Journal of Health Planning and Management 2:37-58

Griffith M (1981) Training of Afghan community health workers. Peshawar, NWFP, Pakistan: United Nations Children's Fund (UNICEF), 3 pp.

Hancock G (1989) Lords of poverty. London, UK: Mandarin Paperbacks, Octopus Publishing Group, 193 pp.

Hapgood D (ed) (1968) The role of popular participation in development. MIT Report No. 17, Cambridge, Massachusetts, USA: Center for International Studies, Massachusetts Institute of Technology

Harrell-Bond B (1986) Imposing Aid. Emergency assistance to refugees. Oxford, UK: Oxford University Press

Hata K (1975) Management survey on emergency relief operations. Geneva, Switzerland: the World Health Organization, Management Survey Report No. 137, October 1975, 28 pp.

Health Unit, UNHCR Briefing notes: UNHCR health programmes. Geneva, Switzerland: United Nations High Commissioner for Refugees, 3 pp.

Health Unit UNHCR (1987) Development plan. Health unit, Technical Support Services. Geneva, Switzerland: United Nations High Commissioner for Refugees, 4 pp.

Hellinger D (1987) NGOs and the large aid donors: changing the terms of engagement. World Development 15, Supplement

Hickman R (1971) Deteriorating health of refugee children in India. The Lancet 2:917-918

Hingson LL (1981) The role of private international assistance in response to major disasters. Disasters 5(4):407-410

Holborn LW (1975) Refugees: A problem of our time. The work of the United Nations High Commissioner for Refugees, 1951 - 1972. Metuchen, New Jersey, USA: The Scarecrow Press, Inc., 2 volumes, 1446 pp.

How is Unicef organised? Why Unicef? Geneva, Switzerland: United Nations Children's Fund, p. 5

Howarth T and Brooman J (1987) Twentieth century history. The world since 1900. London, UK and New York, USA: Longman Group, 308 pp.

ICRC (1986) Presenting the ICRC. Geneva, Switzerland: The International Committee of the Red Cross, 19 pp.

ICRC and LORCS (1983) International Red Cross Handbook. Geneva, Switzerland: the International Committee of the Red Cross, the League of Red Cross and Red Crescent Societies and the Henry Dunant Institute, 707 pp. plus annexes

ICRC and UNICEF (1981) Kampuchea. Back from the brink. Geneva, Switzerland: The International Committee of the Red Cross, 40 pp.

ICVA (1984) Assistance to African Refugees by Voluntary Agencies. Geneva, Switzerland: International Council of Voluntary Agencies, May, 113 pp.

Ifekwunigwe AE (1976) Emergency assistance. The nature and organization of disaster relief. Food and nutrition (Roma) 2:6-13

Jaeger G (1982) Participation of Non-governmental Organizations in the activities of the United Nations High Commissioner for Refugees. In: Willett P (ed) Pressure groups in the global system. London, UK: Francis Pinter, pp. 171-178

Jelliffe DB and Jelliffe EDP (1981) Refugee medicine: the need for new approaches. Sciences 21:14-15, 18-19

Karp C (1984) A five year summary. Afghan resistance and Soviet occupation. Washington DC, USA: US Department of State, Bureau of Public Affairs, December, 4 pp.

Kay DA (1972) The United Nations and decolonization. In: Barros J (ed) The United Nations: Past, present and future. New York, USA: The Free Press / London, UK: Collier-MacMillan Ltd., pp. 143-170

Kent RC (1987) The anatomy of disaster relief. The international relief network in action. London, UK: Pinter Publishers, 183 pp.

Khan AR (1988) Director Medical Services, Chief Commissionerate for Afghan Refugees, States and Frontier Regions Division, Federal Government of Pakistan. Interview 6 January 1988 Islamabad, Pakistan.

Khan AR and Elo O (1984) Annual report 1984, Afghan Refugee Health programme. Islamabad, Pakistan: Chief Commissionerate for Afghan Refugees, Government of Pakistan/United Nations High Commissioner for Refugees, 184 pp.

Khan AR and Nesbit R (1987) Annual report 1986. Afghan refugee health report 1986. Afghan refugee health programme Pakistan. Islamabad, Pakistan: Chief Commissionerate for Afghan Refugees/United Nations High Commissioner for Refugees, 129 pp.

Khan AS Health cover for Afghan refugees in NWFP. Paper of Project Director for Health Afghan refugees in NWFP. Peshawar, Pakistan: Commissionerate for Afghan Refugees NWFP, 3 pp.

Khan AS Medical cover - Afghan refugees in NWFP. Peshawar, NWFP Pakistan: Commissionerate for Afghan Refugees, Government of NWFP, 8 pp.

Khan AS (1987) former Project Director For Health for Afghan Refugees, Provincial Government of NWFP. Interviews 24 and 30 August 1987, 2, 15, 19 and 20 September 1987, Peshawar, NWFP, Pakistan.

Khan AU (1987) former Deputy Secretary, Emergency Relief Cell, Cabinet Division, Federal Government of Pakistan. Interview 26 July 1987, Rawalpindi, Pakistan

Kranzler D (1972/73) The Jewish refugee community of Shanghai, 1938-1945. Wiener Library Bulletin 26(3/4):28-37

Kuntz D, Forbes Martin S and Clark L (1990) Ensuring the health of refugees: Taking a broader vision. Washington, D.C., USA: Refugee Policy Group, 39 pp.

Lador-Lederer JJ (1963) International Non-Governmental Organizations and economic entities. AW Sythoff-Leyden, 384 pp.

League of Red Cross Societies (1959) International disaster relief manual. Geneva, Switzerland: League of Red Cross and Red Crescent Societies

League of Red Cross Societies (1970) Red Cross disaster relief handbook. Geneva, Switzerland: League of Red Cross and Red Crescent Societies

League of Red Cross Societies (1979) Red Cross and refugees. Disasters 3(4):357-358

League of Red Cross Societies The role of international organizations in disaster relief coordination. Geneva, Switzerland: International Federation of National Red Cross and Red Crescent Socities, 19 pp.

Leichter HM (1975) A comparative approach to policy analysis. Health care policy in four nations. Cambridge, London, New York, Melbourne: Cambridge University Press, 281 pp. plus appendices

Lewis DE (1991) Non Governmental Organizations (NGOs) and alternative strategies in the 1990s: Bridging the development gap between Central America and the Caribbean. Paper presented at the Conference on **Alternatives for the 1990s Caribbean** of the Institute of Commonwealth Studies and the Institute of Latin American Studies - Caribbean Studies Programme, London University, 9-11 January 1991, 26 pp.

Lewis J (1986) What price community medicine? The philosophy, practice and politics of public health since 1919. Brighton, England: Wheatsheaf Books Ltd., 164 pp.

Liaison Unit with Non-governmental Organizations (1989) Directory of Non-governmental Organizations. Geneva, Switzerland: United Nations High Commissioner for Refugees, 144 pp.

Lissner J (1976) The politics of altruism. Geneva, Switzerland: Lutheran World Federation, Department of Studies

Loescher G and Scanlan LA (1986) Calculated kindness. Refugees and America's half-open door policy, 1945 - present. New York, USA and London, UK: The Free Press, Macmillan, 272 pp.

Luard E (1966) The evolution of international organizations. London, UK: Thames and Hudson

Macalister-Smith P (1985) International humanitarian assistance. Disaster relief actions in international law and organization. Dordrecht, Germany; Boston, USA and Lancaster, UK: Martinus Nijhoff Publishers, 230 pp.

Magnus RH (1987) Humanitarian responses to an inhuman strategy. In: Farr GM and Merriam JG Afghan resistance. The politics of survival. Boulder, Colorado, USA and London, UK: Westview Press, pp. 191-212

Mahler H and Hocke JP (1987) Memorandum of understanding governing collaboration and coordination between the United Nations High Commissioner for Refugees and the World Health Organization. Geneva, Switzerland: United Nations High Commissioner for Refugees / the World Health Organization

Mamdani M and Simmonds S (1986) Evaluation of the World Health Organization's Emergency Health Kit: Standard drugs and clinic equipment for 10 000 persons for 3 months - first phase. London, UK: London School of Hygiene and Tropical Medicine, 26 pp.

Medical Advisor UNHCR (1981) Annual self-evaluation report of 'Humanitarian assistance to Afghan refugees in Pakistan, general health care, NWFP, 1 January-31 December 1981'. Peshawar, NWFP, Pakistan: United Nations High Commissioner for Refugees, 7 pp.

Medical Advisor UNHCR (1981) How to start with a Basic Health Programme. Peshawar, NWFP, Pakistan: United Nations High Commissioner for Refugees, 3 pp.

Medical Advisor UNHCR (1981) Second paper on "Basic" preventive health care for Afghan refugees. Peshawar, NWFP, Pakistan: United Nations High Commissioner for Refugees, 3 pp.

Merriam JG (1989) Arms shipments to the Afghan resistance. In: Farr GM and Merriam JG Afghan resistance. The politics of survival. Boulder, Colorado, USA and London, UK: Westview Press, pp. 71-101

Milashkin AG (1965) (Study of the effectiveness of antibiotics during World War II.) Voen-Med-Ah 11:80-82

Minear L (1984) Reflections on development policy: A view from the private voluntary sector. In: Gorman RF (ed) Private Voluntary Organizations as agents of development. Boulder, Colorado, USA and London, UK: Westview Press, chapter 2, pp. 13-40

Mingst KA (1990) The United States and the World Health Organization. In: Karns MP and Mingst KA, The United States and multilateral institutions. Patterns of changing instrumentality and influence. Boston, USA: Unwin Hyman, pp. 205-230

MSF (1988) Organization d'un camp de refugies. Guide operationnel pour la phase d'urgence. Modules 1-4, Fiches techniques and annexes. Bruxelles, Belgium: Medecins Sans Frontieres Belgique and the Centre de Recherche sur l'Epidemiologie des Desastres

Nesbit R (1989) Report on the Expanded Programme for Immunizations for Afghan Refugee Health Programme for 1988. Islamabad, Pakistan: United Nations High Commissioner for Refugees, 8 pp. plus tables

Nobel P (1983) Meeting of the OAU Secretariat and Voluntary Agencies on African Refugees. Arusha, March 1983. Uppsala, Sweden: Scandinavian Institute of African Studies, 36 pp.

The Non-governmental Organizations Group on Primary Health Care (1981) The role of non-governmental organizations in formulating strategies for health for all by the year 2000. Geneva, Switzerland: World Health Organization

Ockwell R (1986) Assisting in emergencies. A resource handbook for UNICEF field staff. Geneva, Switzerland: United Nations Children's Fund

Oxfam (1983) Oxfam's practical guide to refugee health care. Oxford, UK: Oxfam Medical Unit, Oxfam Working Paper No. 2.

Oxfam (1984) Health care to refugees. An assessment of needs and responses. in ICVA Timely solutions. Voluntary agencies and African refugees. Geneva, Switzerland: International Council of Voluntary Agencies, Working Group on Refugees and Migration, Subgroup on African Refugees, pp. 7-8

Oxfam (1989) A brief history of Oxfam. Information from Oxfam. Oxford, UK: Oxfam Information Department, September, 4 pp.

PAHO (1982) Emergency Vector Control after Natural Disaster. Washington D.C., USA: Pan American Health Organization, Scientific Publication No. 419

PAHO (1982) Environmental health management after natural disasters. Washington DC, USA: Pan American Health Organization, Scientific Publication No. 430

PAHO (1982) Epidemiologic surveillance after natural disaster. Washington DC, USA: Pan American Health Organization, Scientific Publication No. 420

PDH Baluchistan (1982) Narrative report on the implementation of health projects under the UNHCR assistance programme for the year 1982 as it stood on 31.12.82. Quetta, Baluchistan, Pakistan: Project Directorate for Health for Afghan Refugees, Government of Baluchistan, 6 pp.

PDH Baluchistan (1985) Letter to the Commissioner for Afghan Refugees in Baluchistan, 25.12.82. Quetta, Baluchistan, Pakistan: Project Directorate for Health for Afghan Refugees, Government of Baluchistan, 3 pp.

PDH Baluchistan (1986) Letter to Commissioner for Afghan Refugees, Baluchistan, 2 June 1986. Quetta, Baluchistan, Pakistan: Project Directorate for Health for Afghan Refugees, Government of Baluchistan

PDH Baluchistan (1987) Letter to Chief of Mission AICF, 22 November 1987. Quetta, Baluchistan, Pakistan: Project Directorate for Health of Afghan Refugees, Government of Baluchistan

PDH Baluchistan (1987) Report on the Afghan refugee health programme in Baluchistan for 1987. Quetta, Baluchistan, Pakistan: Project Directorate for Health for Afghan Refugees, Government of Baluchistan, 5 pp.

PHC Advisor SCF/UNICEF (1985a) Proposal to train community and family dais. Peshawar, NWFP, Pakistan: Save the Children Fund, 6 pp.

PHC Advisor SCF/UNICEF (1985b) Development of Primary Health Care in Afghan refugee villages. Interim report 1 November 1984 - 31 January 1985. Peshawar, NWFP, Pakistan: Save the Children Fund, 4 pp.

PHC Advisor SCF/UNICEF (1987) Proposal on development of PHC programme in Afghan refugee villages in NWFP. Peshawar, NWFP, Pakistan: Save the Children Fund, 8 pp.

Planning and Development Division (1986) Rural health programme of Pakistan, 1986 - 1990. Islamabad, Pakistan: Planning and Development Division, Federal Government of Pakistan, 114 pp.

Pointer AE (1988) Acceleration of Expanded Programme of Immunizations to Afghan refugees in North West Frontier Province. August 4 - 23, 1988. Geneva, Switzerland and Boston, Massachusettes, USA: United Nations High Commissioner for Refugees, TSS Consultancy Report 46/88 / John Snow Incorporated, 18 pp. with appendices

PRCS (1986) Inauguration ceremony of the Red Crescent Referral Hospital, Kalabagh, for Afghan refugees. Newsletter 1(3):4-5, Punjab Provincial Branch of the Pakistan Red Crescent Society

Programme Officer UNHCR (1981) Self-evaluation report on the health sector 1981 programme. Quetta, Baluchistan, Pakistan: United Nations High Commissioner for Refugees, 9 pp.

Programme Office UNHCR (1982) Self-evaluation report on the health sector - No.11. Extended 1981 programme. 1982 programme up to 30 June 1982. Quetta, Baluchistan, Pakistan: United Nations High Commissioner for Refugees, 18 pp.

Protocol between the Governments of the Republic of Italy and the Islamic Republic of Pakistan concerning the tuberculosis control programme among the Afghan refugees in the North West Frontier Province of Pakistan (1983) Islamabad, Pakistan: Economic Affairs Division, Government of Pakistan/Italian Embassy, Government of Italy

Provincial Chief Malaria Control Programme (1981) Malaria control activities in the Afghan refugees camps. Quetta, Baluchistan, Pakistan: Malaria Control Programme, Government of Baluchistan, 5 pp.

Provincial Chief Malaria Control Programme (1982) Working paper for 9th meeting of the provincial co-ordination committee meeting. Peshawar, NWFP, Pakistan: Malaria Control Programme, Department of Health, Government of NWFP, 4 pp.

Regional Coordination Department, ACBAR (1989) ACBAR/SWABAC database. Regional coordination for Afghanistan and Pakistan. Second Edition, November. University Town, Peshawar, Pakistan: Agency Coordinating Body for Afghan Relief, 213 pp.

Responsible Officer, Emergency Relief Operations, WHO (1977) Memorandum to the Director-General, 5 December 1977, 2 pp., Geneva, Switzerland: the World Health Organization

Responsible Officer, Emergency Relief Operations, WHO (1980) Letter to the Chief, Emergency Unit UNHCR, 3 December 1980, 2 pp.

Roberts HR (1984) The domestic environment of AID-registered PVOs: Characteristics and Impact. In: Gorman RF (ed) Private Voluntary Organizations as agents of development. Boulder, Colorado, USA and London, UK: Westview Press, 256 pp.

Rosen G (1958) A history of public health. New York, USA: MD Publications, 551 pp.

SAFRON (1981) Medical cover plan for Afghan refugees. Islamabad, Pakistan: letter to Chief of Mission, UNHCR, 22 June 1981, 6 pp.

SAFRON (1985) Letter to Chief of Mission, UNHCR, 11 November 1985, 1 p.

Salisbury H (1969) The 900 days. The seige of Leningrad. London, UK: Macmillan Publishers Ltd., 596 pp.

SCF (1985) Development of Primary Health Care in Afghan refugee villages. Annual report 1985 for UNHCR. Peshawar, NWFP, Pakistan: Save the Children Fund, 10 pp.

Seaman JA (1972) Relief work in a refugee camp for Bangladesh refugees in India. The Lancet 2:866-870

Senior Health Coordinator WHO/UNHCR (1982) Report of field visits, date 25 October 1982. Quetta, Baluchistan, Pakistan: United Nations High Commissioner for Refugees, 3 pp.

Senior Health Coordinator WHO/UNHCR (1985). Draft: Health services - Baluchistan. Quetta, Baluchistan, Pakistan: United Nations High Commissioner for Refugees, 6 pp.

Shafique A (1987) Deputy Secretary Emergency Relief Cell, Cabinet Division, Federal Government of Pakistan. Interviews 16 and 26 July 1987, Rawalpindi, Pakistan

Shawcross W (1984) The quality of mercy. Cambodia, holocaust and modern conscience. London, UK: Andre Deutsch Ltd., 433 pp.

Simon R (1988) Gramsci's political thought. London, UK: Lawrence and Wishart, 145 pp.

Simmonds SP (1980) Seminar on health and health-related needs of refugees: National Office of the Commissioner for Refugees, Somalia. Disasters 4(2):129-132

Simmonds SP (1981) Assignment report. The health of the Afghan Refugees in Pakistan. Geneva, Switzerland: the World Health Organization, Emergency Relief Operations, 17 pp.

Simmonds SP and Hussain M (1986) The health of Afghan refugees in Pakistan. Alexandria, Egypt: World Health Organization, Regional Office for the Eastern Mediterranean, 19 pp.

Simmonds S and Ryding D (1986) Refugee mental health - a bibliography. London, UK: Refugee Health Group, London School of Hygiene and Tropical Medicine

Simmonds S, Vaughan P and Godfrey N (1986) Refugees and national health policies. A comparative study of the development of refugee and national health policies by host governments. London, UK: Evaluation and Planning Centre, London School of Hygiene and Tropical Medicine, 25 pp. plus appendices

Simmonds SP, Vaughan JP and Gunn SW (eds) (1983) Refugee community health care. Oxford, UK: Oxford University Press, 250 pp.

Singer C and Underwood EA (1962) A short history of medicine. Oxford, UK: Clarendon Press, 755 pp.

Smith BH (1990) More than altruism. The politics of private foreign aid. Princeton, New Jersey, USA: Princeton University Press, 284 pp.

Smith RN (1984) An uncommon man. The triumph of Herbert Hoover. New York, USA: Simon and Schuster, 435 pp.

Sovetov SE (1965) (Protection of the health of children and adolescents during World War II.) Gig-Sanit 30(6):45-48

'State/AID response to General Accounting Office's draft to the Congress: "Need to build an international disaster relief agency"', Appendix II, Comptroller-General of the United States, Need for an International Disaster Relief Agency, Washington DC, General Accounting Office, 1976, pp. 19; cited in Kent RC (1987), p. 81

Steiner HJ (1991) Diverse partners: Non-governmental Organizations in the human rights movement. The report of a retreat of human rights activists. Cambridge, Massachusetts, USA: Harvard Law School, Human Rights Programme, and Human Rights International, 82 pp.

Stevens C and van Themaat JV (1985) Non-governmental influences on Euro-South relations. In: Stevens C and van Themaat JV (eds) Pressure groups, policies and development. The private sector and EEC-Third World Policy. London, UK: Hodder and Stoughton, chapter 1

Strong MF (1986) Relations between the OEOA and the private sector including NGOs/PVOs and private donors. New York, USA: The UN Office for Emergency Operations in Africa, Report No. OEOA/3/15, 70+ pp.

Suhrke A (1983) Global refugee movements and strategies of response. In: Kritz M (ed) US immigration and refugee policy. Lexington, Massachusetts, USA: Lexington Books, D.C. Heath and Company, pp. 157-173

Suleman M (1988) Malaria in Afghan refugees in Pakistan. Transactions of the Royal Society of Tropical Medicine and Hygiene 82(1):44-47

Tareen AR (1988) Project Director for Health of Afghan Refugees, Commissionerate for Afghan Refugees, Provincial Government of Baluchistan. Interview 4 January 1988, Quetta, Baluchistan, Pakistan.

Taylor AJP (1954) The struggle for mastery in Europe, 1848-1918. Oxford University Press, 601 pp.

Technical Support Service, UNHCR (1987) Developmental plan. Provisional document. Geneva, Switzerland: Technical Support Section, United Nations High Commissioner for Refugee, 17 pp.

Technical Support Service, UNHCR (1987) UNHCR essential drugs policies. Geneva, Switzerland: United Nations High Commissioner for Refugees, 118 pp.

Technical Support Service, UNHCR (1987) UNHCR guidelines for the use of imported food items in selective feeding programmes. Geneva, Switzerland: United Nations High Commissioner for Refugees, 151 pp.

Technical Support Service, UNHCR (1987) UNHCR operational guidelines for health and nutritional care in refugee settings. Geneva, Switzerland: United Nations High Commissioner for Refugees, 207 pp.

Technical Support Service, UNHCR (1988) AIDS. Rapport 3:3 The newsletter of the Technical Support Section of Office of the United Nations High Commissioner for Refugees in Geneva, Switzerland

Technical Support Service, UNHCR (1988) Announcement. Rapport 2:2 The newsletter of the Technical Support Section of Office of the United Nations High Commissioner for Refugees in Geneva, Switzerland

Technical Support Service, UNHCR (1988) Social services and emergency unit join TSS. Rapport 2:2. Newsletter of the Technical Support Service, United Nations High Commissioner for Refugees, Geneva, Switzerland

Technical Support Service, UNHCR (1989) Memorandum of Understanding between UNHCR and CDC. Rapport 7/8:10, Newsletter of the Technical Support Service, United Nations High Commissioner for Refugees, Geneva, Switzerland

Technical Support Service, UNHCR (1989) UNHCR staff in health and nutrition. Rapport 7/8:9-10, Newsletter of the Technical Support Service, United Nations High Commissioner for Refugees, Geneva, Switzerland

Tewson J (1991) Interview with the Director. More than a mission... Charity Projects Annual Review 90-91. London, UK: Charity Projects, pp. 14-15

Twitchett KJ (ed) (1971) The evolving United Nations: A prospect for peace? London, UK: Europa Publications, 190 pp.

Twose N (1987) European NGOs: Growth or partnership? World Development Forum 15, Supplement:7-10

UN (1946) Yearbook of the United Nations. New York, USA: United Nations, Department of Public Information

UN (1946-85) Yearbook of the United Nations. Lake Success, New York, USA: United Nations, Department of Public Information, see relevant years discussed.

UN (1950) Yearbook of the United Nations. New York, USA: United Nations, Department of Public Information

UN (1953) Yearbook of the United Nations. Lake Success, New York, USA: United Nations, Department of Public Information, pp. 461-468

UN (1963) Yearbook of the United Nations. New York, USA: United Nations, Department of Public Information

UN (1965) Yearbook of the United Nations. Lake Success, New York, USA: United Nations, Department of Public Information, pp. 419-27, 852

UN (1966) Yearbook of the United Nations. Lake Success, New York, USA: United Nations, Department of Public Information, pp. 383-92, 1121

UN (1967) Yearbook of the United Nations. Lake Success, New York, USA: United Nations, Department of Public Information, pp. 460-70, 986

UN (1969) Yearbook of the United Nations. Lake Success, New York, USA: United Nations, Department of Public Information, pp. 455-65, 1011

UNBRO (1988) Medical guidelines for the Thai-Kampuchean border. Aranyaprathet, Thailand: United Nations Border Relief Operation.

UNHCR (1980) UNHCR: The last ten years. Geneva, Switzerland: United Nations High Commissioner for Refugees, 88 pp.

UNHCR (1980) UNHCR and the Voluntary Agencies. News from the United Nations High Commissioner for Refugees 5/6, December 1979/January 1980, 14 pp.

UNHCR (1980) UNHCR Humanitarian Assistance Programme to Afghan Refugees in Pakistan. Period under review - 1980 Calendar Year. Report No. 9. Islamabad, Pakistan: Office of the Chief of Mission, United Nations High Commissioner for Refugees, 83 pp.

UNHCR (1982) Handbook for emergencies. Geneva, Switzerland: United Nations High Commissioner for Refugee, 189 pp.

UNHCR (1983) UNHCR Sub-office in Peshawar. Afghan refugees in NWFP. Peshawar, Pakistan: United Nations High Commissioner for Refugees, 5 pp.

UNHCR (1984) Project self-evaluation. Primary health Care to Afghan Refugees in NWFP. 1 July 1984 - 31 December 1984. Peshawar, NWFP, Pakistan: United Nations High Commissioner for Afghan Refugees, 3 pp.

UNHCR (1986) Project description: The development of Primary Health Care programme for Afghan refugees by Save the Children Fund. Peshawar, NWFP, Pakistan: United Nations High Commissioner for Refugees, 3 pp.

UNHCR (1987) News in brief. Pakistan: bombings. Refugees, April, p. 7

UNHCR (1987) UNHCR activities for 1986 -1987 and programme for 1987 - 1988. Report. Islamabad, Pakistan: United Nations High Commissioner for Refugees, 3 volumes

UNHCR (1989) Directory of non-governmental organizations. Geneva, Switzerland: Liaison Unit with Non-Governmental Organizations, United Nations High Commissioner for Refugees, 144 pp.

UNHCR (1989) UNHCR Essential drugs manual. Guidelines for use of drugs in refugee settings and UNHCR list of essential drugs. Geneva, Switzerland: Technical Support Section, United Nations High Commissioner for Refugees, 89 pp.

UNHCR and CCAR/GOP (1986) Operations manual for Afghan Refugee Health Programme in Pakistan. Islamabad, Pakistan: United Nations High Commissioner for Refugees and the Chief Commissionerate for Afghan Refugees, States and Frontier Regions and Kashmir Affairs Division, Government of Pakistan, 168 pp. plus annexes

Unicef (1990) Facts and figures. New York, USA: United Nations Children's Fund

Unicef (1991) Emergency operations in 1990. New York, USA: United Nations Children's Fund, Report to the Executive Board 1991 session. Document E/ICEF/1991/11, 7 February 1991, 29 pp.

Unicef (1991) Unicef action plan for complex emergency situations in Africa 1991. New York, USA: United Nations Children's Fund, Emergency Unit

Unicef (1991) Unicef Annual Report. New York, USA: United Nations Children's Fund, 60 pp.

Unicef (1991) Unicef at 40. Unicef news. New York, USA: United Nations Children's Fund, 44 pp.

Unicef (1991) Unicef role in situations involving refugees, returnees and displaced persons. New York, USA: United Nations Children's Fund, Emergency Unit working paper, 1 p.

UNRWA and ICVA (1984) Report of the second consultation between Non-governmental Organizations and the United Nations Relief and Works Agency for Palestinian Refugees in the Near East. Vienna, Austria: UNRWA, 6 pp. plus ten annexes.

US Committee for Refugees (1981) 1981 World refugee survey. New York, USA: The United States Committee for Refugees, printed by Hudson Press, 62 pp.

US Committee for Refugees (1992) World Refugee Survey. Washington DC, USA, US Committee for Refugees

van Heemst JJP (1985) European NGOs and the Third World: A background analysis. In: Stevens C and van Themaat JV (eds) Pressure groups, policies and development. The private sector and EEC-Third World Policy. London, UK: Hodder and Stoughton, chapter 2.

Volovik AB (1967) (Leningrad paediatrician during the war and blockade.) Vopr-Okhr-Materin-Det 12(9):58-61

Wada S, Yamashita Y, Miura M, Matsuura N, Yamakido M (1964) Studies on age of onset of diabetes mellitus in relation to atomic bomb exposure. Hiroshima Journal of Medical Science 13(3):265-275

Walters FP (1966) The League of Nations. In: Luard E The evolution of international organizations. London, UK: Thames and Hudson, pp. 25-41

Western KA (1971) The epidemiology of natural and man-made disasters. The present state of the art. Report submitted for the Diploma in Tropical Public Health. London, UK: London School of Hygiene and Tropical Medicine, 108 pp.

WHO (1980) Expanded programme on immunization Pakistan. Suggested plan of action for Afghan refugees. Quetta, Baluchistan, Pakistan: United Nations High Commissioner for Refugees, 10 pp.

WHO (1982) Basic Documents. Geneva, Switzerland: the World Health Organization, p. 1

WHO (1984) WHO Emergency Health Kit. Standard drugs and clinic equipment for 10 000 persons for 3 months. Geneva, Switzerland: World Health Organization, 27 pp.

WHO (1986) The second ten years of the World Health Organization. Geneva, Switzerland: World Health Organization, p. 57

WHO and LORCS (1989) Coping with natural disasters: the role of local health personnel and the community. Geneva, Switzerland: the World Health Organization and the League of Red Cross and Red Crescent Societies, 62 pp.

Williams D (1987) The Specialised Agencies and the United Nations. The system in crisis. London, UK: C. Hurst and Company, 269 pp.

Wirsing RG (1981) The Baluchis and Pathans. London, UK: Minority Rights Group, Report No. 48, 23 pp.

World Bank (1987) World Development Report 1987. Oxford, UK: Oxford University Press, 285 pp.

World Bank (1990) World Bank Development Report. New York, USA: Oxford University Press, 260 pp.

World Health Assembly, WHO (1975) Assistance to newly independent and emerging states in Africa. World Health Assembly resolution WHO28.78. Official Records of the World Health Organization 226:44

York S and Grant K (1980) Afghan refugees in Pakistan. A preliminary report 5th September 1980. London, UK: International Disaster Institute, 23 pp.

Zaman S (1987) Humanitarian assistance programme for Afghan refugees in North West Frontier Province. Peshawar, Pakistan: Afghan Refugee Commissionerate NWFP, Public Relations Unit, January, 72 pp.

Zia-ul-Haq M (1986) Afghan refugees camp. Kot Chandna. Lahore, Pakistan: personal paper of M Zia-ul-Haq, 9 pp.

Ziferstein I (1967) Psychological habituation to war: a sociopsychological case study. American Journal of Orthopsychiatry 37(3):457-468

Zollner M-I (1983) UNHCR tries to remain non-operational. Refugees 19, May