conditions such as measles, diarrhoeal disease, malnutrition, pneumonia, and malaria, especially among women and young children. In the industrialised countries of Eastern Europe, the combination of conflict and economic collapse has led to the elderly being prone to food scarcity, people with chronic diseases going untreated, and preventive services such as antenatal care and child immunisation collapsing. Tuberculosis has been inadequately diagnosed and treated resulting in widespread multidrug resistance. The impact of extensive sexual violence documented in the former Yugoslavia, Somalia, Sierra Leone, and Rwanda has been compounded by the rapid spread of HIV and AIDS.

On the move: The Rwandan-Tanzanian border

Meanwhile, more than three million Palestinians remain stateless in the Middle East, 50 years after the events that forced them to flee their homeland.[2] Because peace remains elusive, they are neither able to return home nor permanently resettle in neighbouring countries. More than 100 000 Tibetan refugees have remained in India for more than 40 years and half a million people have been displaced by lengthy internal conflicts in Burma. These people are powerless pawns in chronic political disputes. When the Soviet Union collapsed, millions were displaced as people returned to their ethnic homelands—sometimes centuries after their ancestors were forcibly removed.

Refugees who flee their countries through fear of persecution are part of a much larger body of migrants searching for better work and education possibilities. In 2000, an estimated 150 million people were living outside the country of their birth; of these, only about 10% were refugees.[3] Prosperous industrialised nations have tightened their controls on people seeking entry, including the interdiction of boats carrying, for example, Albanians into Italy, Haitians and Chinese into the USA, and Iraqis and Afghans into Australia. These restrictions inevitably affect the chances of genuine asylum seekers to gain refuge. The trend towards reducing social services in western countries has also meant that the particular health needs of asylum seekers, many of them survivors of torture and other human rights abuses, are not addressed by public-health systems.

Since 1998, there have been humanitarian crises in Central and West Africa, the Horn of Africa, Sri Lanka, Kosovo, East Timor, and a number of Indonesian provinces. The response to these emergencies has depended on the perceived self-interests of western nations. Given the changed nature of conflicts, the post World War II focus on refugees is no longer adequate; for example, in 2000, of the 22·3 million people "of concern" to UNHCR, only 52% were refugees.[1] And with a plethora of actors now involved—UN agencies, governments, military forces, and a diverse array of non-governmental aid and advocacy organisations, the need for a consistent and well-coordinated international approach to protecting refugees and IDPs is greater than ever.

In every corner of the world, individuals, families, and entire communities seeking refuge for various reasons find that barriers to their movement are more intimidating than ever. The root causes remain lack of basic freedoms, poverty, inequality, armed conflict, and rapid environmental degradation. Old definitions of refugees are no longer sufficient and leave millions of people vulnerable and unprotected. The international response to the issue of forced migration must address root causes, be more consistent, less reactive, and take proactive prevention more seriously.

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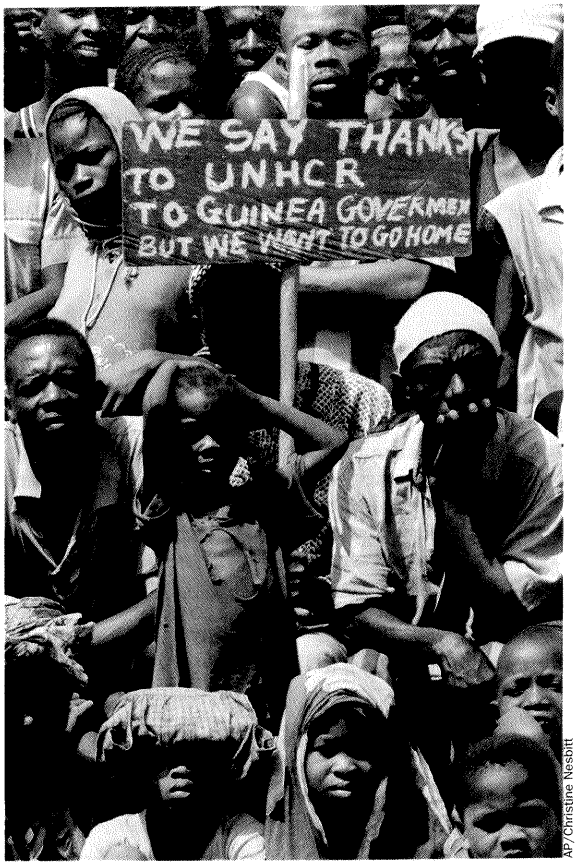
Prioritising health care in complex emergencies

Ronald J Waldman

Acute refugee crises such as those that have occurred recently in Goma, Bosnia, Somalia, Kosovo, East Timor, Angola, Sierra Leone, the Democratic Republic of Congo, to name but a few, are the emergency rooms of international public health. As with clinical emergency medicine, the primary objective of emergency relief is to stabilise the health of the refugee or internally displaced population, not to address the underlying causes. In fact, limiting the damage is often the most that can be achieved. To lower the daily crude mortality rate to one death per 10 000, the most commonly cited public-health objective in complex emergencies, would leave the affected population still dying at two to three times its baseline rate. So, when the emergency is over, things are at best better than they might have been. They are never good.

Accordingly, the public-health approach to managing complex emergencies is one of triage. Over the years, there have been many, too many, opportunities to develop a consistent approach to the organisation and delivery of health services in complex emergencies. In the first days and weeks, interventions should limit mortality. The

basics—food, water, sanitation, and shelter—usually need to be provided, after which (or preferably at the same time, if resources are available) specific health programmes are quickly put into place.[1] Measles, diarrhoea, pneumonia, malaria, malnutrition, and a limited number of other diseases with epidemic potential, such as cholera and meningitis, have recurrently been prominent causes of morbidity and mortality. The most recent of the few textbooks devoted to health care for refugees identifies the "ten top priorities" for intervention in the emergency phase and clearly distinguishes them from activities that should wait until after mortality has fallen to "acceptable" levels.[2]



AP/Christine Nesbitt

Implementing these early priorities has always been problematic. For example, whereas epidemiological data have usually directed emergency health interventions toward children and women, many societies have cultural norms that would preferentially protect other groups—the elderly, for example. Also, delivering adequate food to civilians, knowing that a large share might be diverted to support armed forces and potentially prolong conflict, has been a devilish conundrum for the relief community. At times, tensions have arisen between humanitarian groups, who need cooperation from local authorities, and human rights groups, who challenge the same authorities over alleged, and usually real, violations of human rights and international humanitarian law. Issues like these have been debated in the humanitarian literature. Underlying them, however, has been the presumption that what needs to be done is clear.

Recently, there seems to be increasing confusion on the issue of priorities. Perhaps this is because some emergencies, such as those in Kosovo and East Timor, have not been characterised by mortality in excess of the daily threshold of one death per 10 000 population. Or perhaps this is because global priorities are being accorded an urgency that competes with those of the local situation, or because much needed advocacy for previously neglected issues has been so successful. In any event, there are indications that the few lessons identified from past experiences have not been adequately learned and are not being consistently applied.

Several examples illustrate this point. Mass measles vaccination as early as possible in an emergency has become a priority for relief organisations since measles was shown to be responsible for half the deaths that occurred during a series of African emergencies 20 years ago. But at a recent WHO meeting, reports indicated that efforts to control the recent Ebola virus outbreak in Uganda were hampered by the occurrence of a measles epidemic in refugee camps in which international non-governmental organisations were providing a variety of other needed services.

The Médecins Sans Frontières textbook[2] lists measles vaccination as the second most urgent priority in emergency health interventions. However, the world's current emphasis for vaccination is the eradication of poliomyelitis and there has been increasing pressure to carry out polio vaccination campaigns during complex emergencies. It is unquestionably true that global polio eradication cannot be achieved unless all countries participate in the effort, and polio vaccination campaigns have even helped to bring about temporary cease-fires in some conflict areas. But poliomyelitis has never been an important cause of morbidity or mortality in complex emergencies, at least not when compared with measles and other health concerns. And when resources are scarce and time is short, any diversion from urgent priorities can interfere with the ability of the public-health sector to achieve its already limited objectives. Difficult as the dilemma may be, it seems fair to ask, in situations where mortality rates are unconscionably high and where lives are threatened by lack of even the most basic necessities, which priorities should be most respected: global or local?

Fortunately, women's reproductive health issues have received increased attention in recent emergencies. The appalling situation of women during times of societal upheaval had frequently been neglected in programmes addressing refugee health needs. Effective advocacy has gone a long way towards correcting this wrong, and a minimum initial service package for reproductive health has been widely adopted. Although this package of urgent interventions should be implemented along with other health services, all too often it has not been adequately integrated. Recent data from eastern Sierra Leone (International Rescue Committee, 2001, unpublished data), for example, estimate that the infant mortality rate in parts of the country is in excess of 300 deaths per 1000 livebirths per year. And yet in this setting, many important interventions were not being implemented, whereas reproductive health services were. When situations like this arise, the source of the problem is not always easy to define. Funding from donors sometimes supports only some programmes, but not the complete package of emergency services; at other times, an organsiation may focus its efforts only in one problematic area without ensuring that other organisations are complementing its efforts. In any case, populations caught up in complex emergencies will always benefit most from unrestricted access to a comprehensive package of essential

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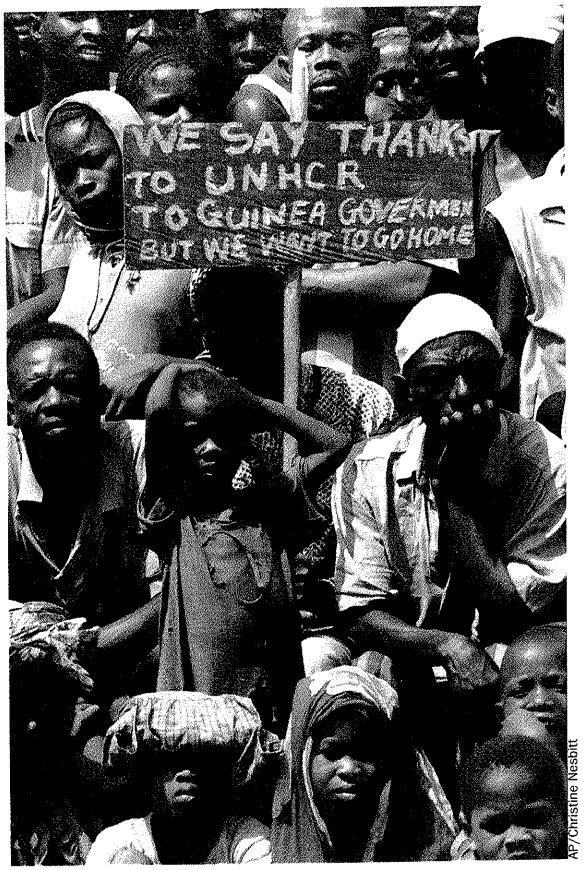

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interventions, one that addresses all major causes of mortality to which it is exposed. When essential programmes are pitted against each other for whatever reason, forcing choices that should never have to be made, it is obvious that the system is not working.

But the fact remains that in complex emergencies, in which resources are commonly limited and in which logistical and security constraints place severe limitations on what can be achieved, difficult choices will always have to be made. In practising public-health triage, even when everything is important, some things must be accorded more importance than others. Only after the essentials have been taken care of should the next wave of priorities be addressed, then the next, until the emergency is over. In emergencies, lives will always be lost that could have been saved, and diseases that could be addressed under better circumstances will go untreated. Without a systematic approach, and without a clear sense of priorities, the situation would be even worse.

Yet how can we be sure that we are doing the right things in such situations? Do lessons learned from the past truly apply to the kinds of situations we are likely to encounter in today's and tomorrow's worlds? What are the priorities in complex emergencies that are characterised by low mortality, where psychosocial and reproductive health concerns outweigh those posed by the incidence, if not the threat, of acute communicable diseases, and where chronic diseases, currently ignored by the relief community, are of greater importance even in the emergency setting? Even if we can identify those priorities, do we know how to intervene safely and effectively? The only way to answer these questions is to carry out carefully targeted, appropriately designed, applied research in complex emergencies. Important areas of essential research include the comparison of different treatment regimens for severe malnutrition in children (and adults) how and when to provide HIV/AIDS testing, counselling, and treatment services and how to assess and treat severe depression in different cultures. Although doing research in emergencies is fraught with ethical issues, real progress in addressing the health needs of refugees cannot be made until questions, which currently have no answers, are addressed. In fact, the argument has been made that it would be unethical not to do research to improve the delivery of health care to those caught up in complex emergencies—the most vulnerable and the most compromised populations in the world.

The next few years will be crucial for emergency relief. Increasingly, humanitarian assistance is being provided not in camp settings, but to entire countries whose populations are affected by societal collapse. The long-term solutions to the seemingly hopeless problems that refugees endure are fundamentally political in nature. Emergency public-health interventions provide temporary solutions at best, but unless these interventions are carefully chosen and correctly implemented, even these attempts at palliation will be inadequate. It is simply not enough for the relief community to do the right thing—it must also do it right.

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Documenting violence against refugees

Wars today are characterised by increased violence against the civilian population. As a result, refugees and internally displaced persons (IDPs) often form unprotected groups which are difficult to access. Once the international aid does reach them, however, the collection of surveillance and survey data is essential to document past abuses, notably those perpetrated during the migration. Collecting testimonies is vital; the validity of which is reinforced by the methods used to attain them and by the quality of the information obtained.

After the civil war restarted in Congo-Brazzaville in December, 1998, a third of the population of Brazzaville fled into the forests of the neighbouring Pool region, where some 250 000 displaced people remained trapped for several months with limited access to international aid. From May, 1999, targeted surveys, and the collection of surveillance and screening data among returnees in Brazzaville enabled the documentation of the health consequences of war on this population. A retrospective mortality survey registered a mortality rate during the migration of more than five times the alert threshold. Lack of food was a major problem for the displaced, as shown by the proportion of deaths due to malnutrition (50%), and by the prevalence of severe malnutrition among children younger than 5 years returning to Brazzaville (20%). Further, the 1600 cases of rape reported between May and December, 1999, from the hospitals of Brazzaville highlight the high prevalence of sexual violence directed against women and girls during migration.

In July, 1997, surveys were carried out in Ndjoundou camp in Congo-Brazzaville to document the 1500 km flight of Rwandan refugees through Zaïre during the previous 9 months. Researchers found that 82·5% of the initial group disappeared or died during the migration, and that peaks of mortality matched the attacks of the AFDL forces along their journey. These findings support the argument that there was major violence directed against this civilian population. Similar results were found in Rosaye, Montenegro, in 1999, where surveys have shown that a third of families who fled Kosovo to avoid the exactions reported being separated from at least one close family member—either "left behind" in Kosovo (28%), or "missing" (5%). The programme of attacks launched by Serbian forces was reconstructed through the documention of details from refugees on their villages of origin and the dates that they were forced to flee. These surveys enabled detailed accounts of the events to which Kosovan refugees were subjected before they left their country, and will contribute to the process of recognition by the international community of the abuses directed against this group.

Most complex emergencies are chaotic. Intervention teams are overwhelmed with work and resources and qualified personnel are limited. Carrying out such surveys can put the refugee populations and the surveyors in danger. In such situations, collection of quality epidemiological data for monitoring or advocacy purposes becomes a challenge. Nevertheless, the work done so far indicates that these surveys are practical and worthwhile in order to quantify violence targeted at civilians. Collecting testimonies is a moral obligation; in some cases it should be a priority, whatever the consequences on the official authorisations, to provide further medical and humanitarian assistance. Although documenting violence will not do much to help victims of violence in past wars, we are convinced that the documentation of these events will have an impact on the prevention of abuses against vulnerable populations, notably refugees, in the future.

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