EUROPEAN COMMISSION

ECHO

HUMANITARIAN AID OFFICE

EVALUATION OF THE ECHO ACTIONS
IN FAVOUR OF THE BURMESE REFUGEES IN THAILAND
CONTRACT n° ECHO/EVA/210/2001/01018

FINAL REPORT

1 HEALTH SECTOR

Dates of the Evaluation: 21 February to 19 March 2002
(Field visits)

Name of the Evaluator: Dr Pascal Crépin

This report has been produced at the request of the European Commission, and financed by it. The comments contained herein reflect the opinion of the consultant only.

PROLOG CONSULT – Belgium May 2002

ACKNOWLEDGEMENTS

The members of the evaluation team would like to express their thanks to the following individuals and organisations for their help and co-operation during this mission –

Mr. Richard Lewartowski, the ECHO Evaluation and ECHO 3 staff, Brussels.

Mr. Bernard Delpuech and staff of ECHO, Bangkok.

Mr. Andreas List, E.U., Bangkok.

The Heads of BBC, MHD, AMI, UNHCR, KRC, SMRU, and other NGO's working in the field.

Table of contents

ANNEXES

1) Terms of Reference (TOR)
2) BBC refugees sites population figures.
3) Mae Ra Ma Luang camp layout
4) Mae Kong Ka camp layout.
5) Umpien Mai camp layout.
6) Nupo camp layout.
7) Schedule of visits.
8) Schedule of appointments.
9) Tables of (i) data per camp & ratio, and (ii) cost-efficiency & Human Resources
10) Job description AMI & MHD.
11) Organisation Chart MHD
12) Organisation Chart ARC
13) KRC monthly report.
14) Examples of medical record documents.

EXECUTIVE SUMMARY

INTRODUCTION

Country of Operation: Thailand-Burmese border area
Name of partners: AMI (Aide Medicale Internationale, France), ICCO (Interchuch Organisation for Development Co-operation, the Netherlands), and MHD (Malteser Hilfsdienst, Germany)
Decisions covered:
ECHO/THAI/210/2001/01001.
ECHO/THAI/210/2001/01002
ECHO/THAI/210/2001/01003
Total amount: EURO 4,500,000.
Date and duration of the mission: 21 February to 19 March 2002 (field visits)
Sector concerned and description:
General humanitarian aid relief operation in favour of Thai-Burmese border refugees. ICCO was financed by ECHO to implement a food supply assistance operation, which was not covered by the present evaluation. However, ICCO also contributed to set up the BBC (Burmese Border Consortium) local organisation, which was itself directly involved in the camps management.
The NGOs AMI and MHD were entrusted by ECHO with the implementation of the Health humanitarian assistance to approximately 51.468 Karen refugees located in four camps sites along the Thai-Burmese border.

CONCLUSIONS

RELEVANCE

Objectives of the Operation
The objective of the ECHO-financed part of AMI and MHD operations is to provide basic health care to mainly Karen refugees located in camps sites along the Thai-Burmese border. The implementation approach is going some way to reduce aid-dependency, and at the same time is helping to preserve the refugees' own culture and life-style, making eventual return to their own homes less problematic.

Identification of Needs
The current level of support is fully relevant to the needs of the target population, for the following reasons:

- no legal status is given to the refugees/displaced people by the Thai authorities.
- The refugee communities in the camps are not given the possibility to generate income up to the self-sufficiency level.
- No important agricultural activities are permitted.
- No funds in the refugee communities are available to take care of basic medical care.
- Predictability of the future situation including the influx of new caseloads is very low and emergency measures have to be taken.
- The ever-present severe security situation for the refugees is improved by the presence of international NGOs and their staff in the camps (passive protection measures).

The above justifications comply with the basic mandate of humanitarian organisations, as the objective is to save and preserve life in emergency and post-emergency situations. Since new arrivals and future developments are unpredictable, the presence of ECHO-funded NGOs in the camps is useful to prevent further suffering of people.

Targeting Criteria

The ECHO-financed operations in Thailand focus on the ethnic populations, which fled Burma and are living in the refugee camps along the Thai-Burmese border. This situation is seen as temporary only by the Thai authorities. As a consequence, the refugees are not given the possibility to generate income up to self-sufficiency level. As a result, the entire refugee population needs to be targeted by health assistance.

EFFECTIVENESS

The ECHO funding in the health sector remains effective in overall terms. With the passing of time, the assistance programme has gradually shifted from pure emergency to something approaching recovery and transition to development, though as stated above, sustainability conditions are absent.
In the emergency situation phase, the priority was to provide health care. Had there been no intervention, the refugee population would have suffered and succumbed to sickness and death due to the high prevalence of tropical diseases in this area.
The refugees have currently access to health services, medical treatment and have the possibility to be referred in Thai hospital at all times. As with any such situation however, changes occur, populations increase, hardware deteriorates, and environmental conditions are being modified, which makes the need for continued input as vital now as it was in the emergency phase.

EFFICIENCY

Were things done in the best possible way ? Considering history and political constraints, this specific refugee population has generally received an appropriate level of humanitarian assistance.
If, as an indicator of efficiency for example, one was to look at all the camps funded by ECHO and ask "do you have access to medical facilities at all times", the answer would be **yes**.
"Are the systems being run in an efficient way" is perhaps more difficult to define. The NGOs operating the systems have funds with which to work, and generally speaking, provide value for money. Some exceptions can be found in the lack of co-ordination, and also in the overlapping of medical activities or of geographical area of responsibilities between NGOs and camps.

IMPACT

The impact of ECHO funding in the health sector has over the years developed into a long-term, positive action. The building in both theoretical and physical terms of a sound infrastructure is plain to see. It has lessened human suffering, and had a direct effect on the health of the community. This can clearly be assessed in the low rates of diseases, throughout the camps.
There has furthermore been an unplanned impact in the benefit gained by local villagers, who use the health centres in the camps.

RECOMMENDATIONS

It is recommended that a programme of rationalisation of the health sector should be considered as a priority, based on:

- the organisation capacity, management performance, and cost-efficiency of the NGOs;
- the actual geographical area of responsibility of those NGOs (AMI, MHD), and
- the geographical location of the camps all along the Thai-Burmese border.

It should be recommended, for the two camps located in the North:

- to suggest to AMI to hand over to MHD, the responsibility of Mae Ra Ma Luang camp.
- MHD should continue to keep the responsibility of Mae Kong Ka camp.

It is also recommended, for the two camps located in the South:

- to suggest to AMI to hand over curative health services of Umpien Mai and Nupo camps to ARC, which is already responsible of preventative health services.

It is recommended that further training be given to the medics (local health assistants) in the camps:

- in diagnostic procedures, and in consensus building. The model used by MHD for referral would appear to contain these elements and could be used as a model.
- To give access to the new local generations who want to work for their community as medics.

It is highly recommended that the AIDCO-funded and AMI-implemented Thai Village project must have a workable management, operation and co-ordination structure in place, if the project wants to have any reasonable chance of success.

LESSONS LEARNT

In the expert's opinion, the present ECHO funding in health sector is well justified; there is clearly a need to provide both curative and preventative medical facilities.

However, at the present time, several medical agencies are simultaneously present in most of the camps, even the small ones, which raises a number of key questions:
Is there a need for more than one medical agency to be present in the same camp?
Is it cost-effective?
Does it benefit the patient?
Based on the findings of the evaluation, the answer would appear to be negative. Rationalisation of the health sector should therefore be considered a priority.

MAIN REPORT

1. SUMMARY OF FINDINGS

In February 2002, ECHO has commissioned an independent evaluation to assess its funded activities in Health sector, carried out during six years in favour of the Burmese refugee population in the Thai border area. The evaluation focused its work on four camps, i.e. (1) Mae Ra Ma Luang, (2) Mae Kong Ka, (3) Umpien Mai, and (4) Nupo.
The **key findings** in the Health sector were as follows:

- The NGOs funded by ECHO are active in each camp and implement activities according to objectives and budget lines.
- In the four camps visited, the evaluator found health structures of OPD (out patient department) and IPD (in patient department).
- The majority of medical staff in the camps covered by the evaluation were initially trained between 1992 and 1994.
- The medical staff were found to be complying with the Burmese Border Guide Lines (BBGL), which are updated on a regular basis.
- The medical staff was observed to be on duty at all times, when visits by the evaluation team took place.
- Pharmacies (stock & detail) are well organize with stocks of unexpired drugs.
- The main diseases affecting the refugees were treated in an adequate manner according to the BBGL medical standard.
- For serious medical or surgical cases, referral systems have been organised by NGOs, using medical and surgical facilities of Umphang, Maessariang, Maesot, and Chang Mai Thai hospitals.
- However, it was also observed that, due to the protracted situation, there was a growing tendency to develop new pathologies, such as chronic diseases and those related to elderly patients (*a fact noticed during the evaluation but not included in the statistical report, which focused on the main diseases only*). The Karen medical staff -who followed 1,5 year of training 10 years ago- seem to be increasingly less comfortable in the management of such cases.
- The Karen medical staff was in need of backup. This assistance can be achieved in a number of ways, either through local structures such as the one used by MHD, or through the services of well trained expatriate staff. This need is not only strictly medical, but is also a main instrument to the local staff in terms of motivation and recognition.
- As outlined below in the report, there appeared to be a lack of co-ordination in health care services between the various actors. Examples of this can be seen in the TB (tuberculosis) and AIDS treatments. TB follows Thai national protocol, but the level of NGO involvement depends on the expertise of the expatriate staff. From the prevention by cotrimoxazole to OI (opportunistic infection) and ARV(anti-retroviral) treatment, the management of AIDS cases depends on the different budgets and resources of the actors involved.
- Some medical equipment was observed to be of poor quality, and in some cases outdated cool boxes could be found.
- An area of concern in the Nupo camp was the poor condition of the IPD and OPD buildings, which are in urgent need of rehabilitation.
- In Umpien Mai, the general impression of the management in the health sector gave some reasons for concerns: shortages of drugs, de-motivation of staff, etc. There appeared to be no overlapping in the rotation cycles of short-term expatriate staff.

- It was also observed that some duplications of medical services were taking place in Umpien and Nupo, leading to poor management of resources, and cost ineffectiveness.
- It therefore appeared to the evaluation that, due to the geographical location of the actors in the medical sector, a rationalisation is needed to ensure the best use of human resources and the limited finances (see recommendations).
- Finally, the Thai Village Health project financed by AIDCO is also an area of concern. This project should strength Thai Health services in remote minority area of the Thai Burmese border. During discussions with the staff involved, serious doubts were raised over the general management and co-ordination of this project, which is now at mid-term. The project co-ordinator was not able to provide a logical frame work of activities for the past 18 months, nor projected activities for the 18 months to come. Budget spending since the beginning of the project was not to be found either. This is a long-term project and as such will require a well structured framework so that sustainability can be achieved. The Thai Health Authorities are actively involved in the project, further making the need for planning and co-ordination a necessity.

2. METHODOLOGY OF THE EVALUATION

The Health sector evaluation was carried out by Dr Pascal Crépin, an expert from PROLOG Consult - Belgium, experienced in humanitarian aid operations.

From 21 February to 19 March 2002, the expert carried out a field mission in Thailand. During the evaluation, meetings with the ECHO representative and the EU delegation in Bangkok took place, followed by further in-depth discussions, desk meetings and field missions to the ECHO-funded refugee camps. The field mission was preceded and followed by briefing/desk study and debriefing periods at ECHO in Brussels.

More specifically, the expert took the following steps to evaluate the activities of the partners in Thailand:

- Inception meetings with the Director of BBC Bangkok, the project managers of Malteser, Germany and AMI (Thailand), and other operators active on the Thai-Burmese-Border.

- In addition to the camps supported by MHD & AMI, interviews were held with other agencies working in the health sector. Also, visits were made to Mae La camp (MSF), and local Thai villages, in order to gather information to facilitate comparisons in terms of well being and organisation, of the respective populations.

- Interviews with the representatives of the refugee communities such as the Karen Refugee Committee (KRC) at their headquarters in Mae Sot, the UNHCR representative in Mae Sot, the head of the Malaria Research Unit (SMRU), and representatives from the American Rescue Committee (ARC), and Médecins Sans Frontières (MSF).

- On-site inspections of health facilities in camps funded by ECHO (and by some other donors for comparison purposes), together with visits to adjacent Thai villages.

3. BACKGROUND

The Burmese military junta, the SPDC, has ruled the country by force and repression since 1998, with no form of democracy and total disregard for human rights. Ethnic minorities are the most vulnerable and, particularly in the border areas, the Burmese junta sees them as a major problem. The junta considers them to be supporters of the rebel movements, giving shelter or backing to elements of resistance. They are therefore maltreated and suffer violent repression at the hands of the military. Local populations in these areas live in fear of their leaders.

Refugees arriving at the Thai border belong to these Burmese ethnic minorities (Karen, Karenni and Mon) and say that they have fled to escape oppression, forced labour, and financial extortion. They have had their homes destroyed, their crops burnt and other goods confiscated. Hunger and fear force them to flee to the Thai border.

New candidates to obtain refugee status cross the border in small groups in order not to attract the attention of the Thai authorities. Many of them do not obtain this status because they do not comply with the strict requirements imposed by the authorities and are, therefore, forced to live clandestinely around the camps to obtain aid from the humanitarian organisations. Officially refugees receive no aid from the Thai authorities. They are forbidden to work and only authorised NGOs may run humanitarian programmes to support them. Refugees are not permitted to leave the camps and if they are caught breaking the rules they risk being imprisoned. They have no economic independence, they cannot return to their place of origin and are therefore increasingly dependent on humanitarian aid for their survival.

The present evaluation includes the assessment of the performance of those ECHO partners active in Thailand and included in the assistance network set up by ECHO. As a result of the evaluation, recommendations are given stating the future needs and regions for intervention and the introduction of possible measures and adaptation to increase the efficiency of the operation.

The evaluator was asked to assess four humanitarian operations in Thailand funded by the European Community Humanitarian Office, implemented by the partner NGOs AMI (Aide Medicale Internationale, France), ICCO (Interchuch Organisation for Development Co-operation, the Netherlands), and MHD (Malteser Hilfsdienst, Germany). ICCO, in charge of food aid, further contributed to set up the BBC (Burmese Border Consortium) local organisation, which was itself directly involved in the camps management. The present report will therefore mostly use the acronym BBC to designate the activities evaluated.

As stated above, ICCO was entrusted by ECHO with the implementation of a humanitarian assistance operation for food supply, which is not covered by the TOR of the evaluation. ECHO funding includes 100% of the rice, yellow beans, cooking oil, and cooking fuel needs of Mae La and Umpien Mai camps, for approximately 57.261 Karen refugees. The NGOs AMI and MHD were funded by ECHO to carry out humanitarian assistance operations in the Health and Water & Sanitation sectors, for approximately 51.468 Karen refugees located in four camps sites along the Thai-Burmese border. The total value of the operational contracts amount to Euro 4,500,000 for the provision, purchase and distribution of food and relief items from 1 January to 31 December 2001. Whilst BBC is not specifically targeted by this evaluation study, it was noted at site inspections and meetings with camp leaders, that the agency was stable, professionally managed and run in an effective and efficient manner.

4. HEALTH SITUATION WITHIN THE CAMPS

The evaluation focused on the Health sector. Comparisons were made with organisations working in the same sectors, though these were not funded by ECHO.
See tables in Annex 9 (Data per camp & ratio, and cost-efficiency & RH)

4.1 Mae RA Ma Luang camp, Mae Hong Song province. Population: 9.830

4.1.1 Background

This camp has been established since 1995. During that period, the camp has grown from what was an emergency situation to what is now resembling a typical Thai-Karen village. At the present time, all essential services needed for normal living conditions have been well established. This development has been nurtured, and enhanced by the vital intervention of the NGO and financing institutions.

4.1.2 Actors

A number of external actors are currently involved in continuation of essential services to maintain the well being of the refugee population. The main health activities are undertaken by AMI and MHD.
AMI have been operational in the camp since 1995. During that period, the NGO has introduced primary health care services and referral system for severe medical cases as well as surgical cases.
MHD has, in recent times, also been involved in medical activities in a limited area of the same camp.
BBC currently maintains the security and supply of food items to the whole of the camp. In addition, there are minor organisations contributing to educational and other social services.
.

4.1.3 Present situation / Health

The present situation has evolved, both by the intervention of NGOs as described above and by integration and assimilation of the refugees themselves. After initial training and periodic refresher courses, the camp has become self-reliant in terms of day-to-day medical organisation and operations in a number of other areas. The character of the Karen people has brought together a well-structured society within the camps. This has had the effect of producing, with the initial help of the actors concerned, a mainly self-sufficient society in terms of management and daily activities.
There is one IPD in the section 4 of the camp (see layout in Annexes), one IPD in section 7A, and three OPDs in sections 4, 5A, 7A. these are run by AMI. For its part, MHD operates an IPD/OPD in section 7B.

As a result, sections 1, 2, 3, 4, 5, 6, 7A (90% of the camp population) are under AMI management, and section 7B (10% of camp population) is under MHD management (see map in Annexes).

Respective ratios are as follows: one medic per 588 refugees (AMI), and one medic per 500 refugees (MHD). In this camp, we found the highest rate of consultation and hospitalisation per year and per refugees (7,35) and (0,28). Number of reference /year, OPD=82, and IPD=89. {see statistics tables}
One reference /57 refugees/ year, total number of patients referred =171.

Excepted for vitamin B1 deficiency (beri-beri), the incidence of the main diseases is nearly identical to the other camps. Regarding vitamin B deficiency there was a peak among adult population in May, June, and July 2001. Consumption of factory-polished rice could be one of the reasons, though un-

precise case definition could over-report some cases. In Umpien Mai camp, AMI organised a refresher course focusing on vitamin B1 deficiency.

The TB incidence in Mae Ra Mae Luang is 0,722%, and the EPI programme follows the Thai MOH (Ministry of Health) protocol. AMI and MHD both report a 96% immunisation coverage for under 1 year age old population, and 95% immunisation coverage for the 1 to 5 year old population. The average mortality rate is 25/10.000, and child mortality rate is 0,25 % (AMI source). Crude mortality rate is 34/10000, and child mortality rate 0,60 % (MHD source).

4.1.4 Comments

Since the initial training and refresher courses provided as described above, the local medical staff are working within the camp in an efficient and effective way.
Medical conditions such as low respiratory tract infection, diarrhoea, malaria, vitamin B1 deficiency, and tuberculosis -which at the present time form the major medical prevalent conditions in the camp- are treated by the local medical staff in an efficient and effective manner. Furthermore, beyond the local medical input, AMI continues to provide medical expatriate aid. During this evaluation, AMI had three medical practitioners involved in the health and welfare of the camp population. However, the inputs of such practitioners were short-term, and as a result have limited value. Inexperienced expatriate human resources, lack of guidance from the AMI co-ordinator, and absence of organigramme, have all a negative impact on cost-efficiency and on the actual experience of Karen medical staff.

The above, together with a similar input from MHD to a restricted part of the camp, leads to clear duplication of medical input in a small compact camp.

It should finally be noted that a standardisation of medical indicators recorded by the NGOs working on the Thai-Burmese border will be soon achieved and available (Burmese Border Data Base), and that seven hours are needed to reach this camp by car during rainy season.

4.1.5 Conclusions

In view of the above comments and given the complexity of the geographical situation and the ability of the current actors, it is concluded that to be effective both medically and financially, and above all not forgetting the welfare of the refugees themselves, the current situation of having two actors simultaneously involved in similar medical activities in what is a small and efficiently running camp should be rationalised. Based on the performance of the medical evidence of the two actors involved in the camp, it is also concluded that MHD is the most appropriate actor to take the overall responsibility of the camp.

4.1.6 Recommendations

In view of the above conclusions, it is recommended that a *rationalisation* of the expatriate medical organisations be considered. From the information gathered (better management capacities, operational performance and cost-efficiency) and from interviews carried out with AMI and MHD (expatriate and local staff) as well as with the beneficiary camp population, it is recommended that MHD should be invited to consider taking over the complete health responsibility for this camp.

4.2 Mae Kong Ka, Mae Hong Song province. Population: 15.385

4.2.1 Background

This camp follows the natural line of the river, and was established in 1994. The geographical location divides the site into two logical areas, sectors 1 – 5 being approached from the South, and

sectors 6 – 12 from the North. Some parts (section 5) are accessible on foot, others (section 6) by vehicle.

4.2.2 Actors

Overall control comes under the remit of MHD. There are 6 office-based staff, and at the camp level 14 medics, 23 nurses, 9 midwifes, 16 health workers, plus 14 lab-technicians.
Day to day activities are carried out by the medical team working mainly in autonomy.
Continuous training takes place in all areas, resulting in an efficient and well co-ordinated team.

4.2.3 Present situation / Health

The main diseases recorded in the camp at the time of the evaluation were: low respiratory tract infection, diarrhoea, malaria, and vitamin B1 deficiency. The number of new tuberculosis cases is the lowest per camp population. The medical staff was observed to be competent in the diagnosis and recording of the health status of the patients. It was also observed that the treatments prescribed were in compliance with the medical BBGL standards. The first line of treatment is the basic use of simple drugs. This when necessary is followed up by second line treatment. In severe cases and after consultation of either Liaison Health Co-ordinator, Health Co-ordinator or Clinical Co-ordinator, patients can be referred to either Mae Sariang Thai hospital or ultimately to Chang Mai hospital.

There is one IPD in section 12, one IPD in section 2, and four OPDs in sections 12, 7, 6, and 2. All the camp is under MHD management (see layout in Annexes).
The local ratio is one medic per 1283 refugees. In this camp the rates of consultation and hospitalisation per year and per refugees are respectively (5,89) and (0,18). 1 reference per 52 refugees per year is recorded (total number of patient referred =295). Incidence of the main diseases are nearly identical to the other camps, excepted incidence of diarrhoea. To investigate and reduce the number of diarrhoea, MHD did in June 2001 a survey of *Knowledge and Practice on diarrhoea of mother of children under 5y*.
TB incidence in Mae Kong Ka camp is 0,124% (the lowest rate among the 5 camps visited. The EPI programme follows the Thai MOH protocol. MHD reports 96% immunisation coverage for under 1 year age old population, and 95% immunisation coverage for the 1 to 5 year old population.

Crude mortality rate is 34/10000, and child mortality rate is 0,60 % (MHD source). Neonatal mortality rate is at 14,7 /1000 live birth, and the infant mortality rate is at 36,8/ 1000 live birth. The crude birth rate is 27,5 /1000.

4.2.4 Comments

Observations and interviews of both office and field staff in this medical sector have shown a well trained and motivated work force. The current method of continuous training has been shown to have paid dividends. The use of the laboratory in helping the medical staff to accurately diagnose the cases greatly assists in the well being of the patients, and produces greater efficiency in both the consumption and cost of prescribed drugs.

4.2.5 Conclusions and Recommendations

Discussion and interviews with the medical staff have indicated the possibility of shortages in all categories of field medical staff. To emphasise this comment it must be noted that, with 1 medic for 1283 refugees, Mae Kong Ka ranks second just after Mae La camp (1 medic for 1761 refugees)
In term of general management, HR at office level and efficiency, MHD should be used as a model. (See organisation chart in Annex).
During the time spent in the camp to interview and observe the medical staff carrying out their normal duties, an overall impression of dedication and professional concern was observed. It is recommended that the present system of training be continued and encouraged. It is further

recommended that the requested increase in medical staff be considered in the light of the continuing increase in the population of the camp.

4.3 Umpiem Mai camp, Tak Province. Population: 16.758

4.3.1 Background

Umpiem Mai was established in 1999, and currently has a population of approximately 16,800. Refugees were moved from two old camps, namely Huay kalok, and Morger, located nearer to the border. These camps were closed for security reasons.
Health services in the camp were handed over in 2001 from MSF to AMI, funded by ECHO, and to ARC (American Refugee Council) international, funded by other donors.
ARC international is responsible for Reproductive & Child Health (RCH), and for Community Health Education (CHE) within the camp.
AMI is responsible at the present time for curative medicine (IPD, OPD).

4.3.2 Present situation / Health

The main diseases recorded at the time of the evaluation were: low respiratory tract infection, diarrhoea, malaria, and tuberculosis. One case of rabies was found in the camp, and since this event vaccine and immunisation are provided by AMI. The medical staff was observed to be competent in the diagnosis and the recording of the health status of the patient. It was also observed that the treatments prescribed were in compliance with the medical BBGL. The first line of treatment is the basic use of simple drugs, this when necessary being followed up by second line treatment.
In severe cases and ideally after consultation with AMI's expatriate doctor, patients can be referred to Umphang and Mae Sot Thai hospital or ultimately to Chang Mai hospital. In the present management structure this situation is cumbersome, requiring the presence of an expatriate medical doctor who is not necessarily available at the critical time.
As described in the paragraph below, both AMI and ARC international are involved in health services of the camp. During the evaluation, it became obvious that a number of instances of overlapping and duplication took place, leading to cost inefficiency.

There is one IPD/OPD in section A of the camp. AMI is in charge of OPD management, but shares the building with ARC, which is responsible for uncomplicated deliveries. AMI is in charge of IPD where curative health services and treatment of complicated deliveries are available.

ARC manages RCH and CHE with 148 local staff (60 community health workers, 5 supervisors, 43 TBA, 18 midwifes, 14 assistants, 8 nurses within a camp). ARC main buildings are located in zone A (OPD) and on the top of section B where they run RCH & CHE activities.
ARC is well organised and provides RCH, CHE and water & sanitation in three camps (Umpien Mai, Nupo, and Sangklabury). In addition, they are also in charge of curative health services in Sangklabury.

The camp ratio is one medic per 1197 refugees. In Umpien Mai, the rates of consultation and hospitalisation per year and per refugees are (2,55) and (0,11). There is, on average, 1 reference / 54 refugees / year (total number of patient referred =310). Incidence of the main diseases are nearly identical to the other camps, excepted incidence of vitamin B1 deficiency among adult population (109/1000) (over reported due to poor cases definition) .
The TB incidence in Umpien Mai camp is rated at 0,835%. The EPI programme follows the Thai MOH protocol. Average mortality rate is 80/10000, and child mortality rate is 0,37 % (AMI source).

4.3.3 Comments

In Umpien Mai camp, after the withdrawal of MSF, curative and preventive health services have been shared between two NGOs. At the time of the evaluation, we found two delivery rooms in the same medical compound, managed by two different NGOs, both with their own staff, their own rules, etc.! What is worse is the poor level of confidence of ARC expatriate staff regarding the delivery services provided by AMI.
As in Mae Ra Ma Luang camp, the overall concept of referral and the relevant staffing needs to be addressed using Mae Kong Ka camp as an example. It has been seen that the decision process can be managed within the confines of the camp and by the local staff. This means that specialised training must also be carried out in order to provide the staff with the expertise they require, and more importantly the back up of **suitable staff based at the office level**. This does not mean, however, that the staff have to be necessarily expatriate. Again referring to Mae Kong Ka, a successful system of referral has been designed, using Thai or Thai-Karen staff and a well-defined decision process.

During interviews with the medical staff in the camp, some concern was expressed by the medics regarding the changes that have taken place within the international NGOs involved in health care.
An example to illustrate the point is that, when a medic in the camp requests orders for drugs –duly specifying type and quantity-, this order is then sent to Maesot and further to Bangkok for processing by the relevant NGO staff. The length of time required for clearing this process is excessive, and often when the order is finally sent to the camp, items and quantities bear no relationship to the initial request. Strong complaints were made by Umpien's medic about the unavailability of rabies vaccine. There could be a number of reasons for this, one being the possibility of poor management (job description and tasks sharing are not well defined at AMI office level) and another being the lack of cash. Whatever the reason, this practically results in delays in treatments, in lack of confidence of the medical staff, and in time consuming paper work to resolve the situation.

4.3.4 Recommendations

- There should be only one NGO in charge of Health services in Umpien Mai camp.
- In order to alleviate what is seen as a worsening situation in terms of health management for the camp, a solution has to be found. Indications based on interviews, discussions and observations, all point to the fact that short-term medical interventions are not necessarily the most efficient way of solving what is a complex and local problem.
-The key issue is to ensure that at the office level, there are people who are adequately trained to make a relevant and rapid decision when dealing with a case of referral or other important medical matters, based on the information provided by the field staff.
- The NGO in charge of the camp should secure the access of IPD / OPD (stairways).
- The opening of a new OPD located in section B should facilitate access to health services in this part of the camp, spreading on a mountainside.

4.3.5 Conclusions

This camp is well established, having settled on this particular site for a number of years.

The fact that ARC and AMI are both currently working within the health sector in the camp is definitely not seen as ideal. As outlined above, the supply of drugs, the referral of patients and the overlapping of services require further discussions at headquarters level to establish the most efficient way of managing an already stretched service. An observation was also made during the field visit regarding the personal safety of people negotiating the very steep slopes of the camp when attending medical centres. It is highly advisable in certain areas to provide hand railing or to fix ropes to assist pregnant women and sick people to circulate in dangerous areas.
Some medical equipment in the camp was obviously nearing the end of its useful life. Additionally, some equipment such as stethoscopes, although new, were of poor quality and were easily broken.

Training is seen as an important element within the health sector, not only to update skills but also to provide motivation for all levels of staff. It is an recommended approach for people wishing to be involved in the health sector, and at the same time wishing to achieve a worthwhile goal.

4.4 Nupo camp, Tak Province. Population: 9.744

4.4.1 Background

Nupo was established in 1997, and unlike the other camps visited during the evaluation, it lies on flat ground. Being close to the border, security at the camp is both visible and strict. The camp as in Umpiem Mai is assisted by two main NGOs: AMI is responsible for curative care, and ARC is responsible for preventative care.
Until 1997, AMI had the responsibility for all health activities within the camp; it was only in 2001 that ARC undertook the preventative responsibility.

4.4.2 Present situation / Health

The operation of the camp in terms of health care is similar to that of Umpiem Mai.
Low respiratory tract infection, diarrhoea, malaria, tuberculosis are all prevalent in the camp to a greater or lesser degree *(*see table Data camp & ratio in Annex 9). Diarrhoea incidence (among adult population) is around 300/1000 in Nupo, Mae La, and Mae Ra Ma Luang.
Fifty percent of the patients attending OPD are from up to 16 surrounding villages, as well as 36% of those people hospitalised in IPD. As the result of this influx, general waiting times for treatment can be long.
At the present time, there is a potential issue for the refugees with acute medical problems occurring during the weekend. No NGO transport is available and no communication can be established with the Umpang offices.
In Nupo, we found the highest tuberculosis incidence among the five camps visited. The Thai Ministry of Health currently administers treatment which is paid for by AMI. The evaluation was told by the medics in charge that on occasions, necessary drugs were in short supply, making health care problematic.

There is one IPD/OPD, managed by AMI. The staff comprises 16 medics, 21 nurses, 9 lab technicians, and 4 home visitors.
ARC manages RCH (Reproductive & child Health) and CHE (Community Health Education), and utilises the following staff:

local RCH staff: 23	local CHE staff: 43
2 supervisors	2 supervisors
2 assistants supervisor	1 assistant supervisor
1 TBA	15 team leader
10 midwifes	25 community health worker
1 assistant	
6 nurses EPI	
1 translator	

Synthesis table of Karen HR in Nupo (camp leader source)

AMI	59
COEER	10
HI	10
Herbal	12
ARC	104

The ratio is consequently of one medic per 600 refugees.
In this camp, the rates of consultation and hospitalisation per year and per refugees are (5,93) and (0,23), and the average is 1 reference per 16 refugees/ year (total number of patient referred =599).

The incidence of the main diseases is nearly identical to the other camps. TB incidence in Nupo camp is 1,332%. The EPI programme also follows the Thai MOH protocol. AMI report a 96% immunisation coverage for under 1 year age old population, and 95% immunisation coverage for the 1 to 5 year old population.
Average mortality rate is 34/10000, and child mortality rate is 0,11 % (AMI source).

4.4.3 Comments

-The previous comments made about Umpien Mai camp are still relevant to Nupo. The intervention of two NGOs in a small community is not necessarily appropriate, either for the organisations themselves or for the people they are treating. The overlapping of services such as delivery raises problems from a management perspective.
-It was noted that in Nupo camp, both buildings and equipment were in need of renovation or renewal.
-A combination of staff change, lack of drugs and poor equipment leads to de-motivation and to the cycle of further staff turnover, which maintains a vicious circle of events.
-In an interview with the camp leader, it was indicated that once yearly, at the time of the King's birthday, 70 people from the camp donate blood to the Umpang Thai hospital as a token of appreciation of the help given by the Health Authorities.
-The fact that this camp is very close to the border means that the military presence is more apparent than in the other camps visited by the evaluation. There are reports regarding the maltreatment of the refugees by the military. These matters have been reported to the KRC (Karen Refugee Committee) and discussed. However, the outcomes are not clear.

4.4.4 Conclusions and Recommendations

- We recommend to designate only one NGO in charge of Health services in Nupo camp.
- Given the comments made by the medical staff within the camp regarding shortage of drugs etc., the proposal to stock more drugs in the camp is a sensible solution, and should be implemented.
- As in Umpien Mai camp, a streamlining of the management structure at the office level of AMI appears to be a constraint to the efficient running of the medical sector and should be addressed as a matter of urgency to resolve the situation.
- Existing refresher /training courses for nurses currently being carried out should continue and be expanded.

4.5 Mea La camp, Tak Province. Population: 35 to 40.000

4.5.1 Background

Mae La camp is the largest of the refugee camps on the Thai Burmese Border. It is run by MSF and funded mainly through private donations, not by ECHO.
As part of the ECHO evaluation, it was nevertheless considered important that an overall comparative view be taken of the situation in ECHO-funded camps, and in some others as well.
Mae La is seen as a focal point for many of the visiting donors, politicians, aid groups, etc. as it is within easy reach by road from Mae Sot. The camp follows the line of the road, and can be either driven through or walked through, which makes short visits possible.

As with many of the camps along the border, Mae La has grown in size and population over an extended number of years. As a result, the camp has two IPD and two OPD units run by MSF. In addition, SMRU (Shoklo Malaria Research Unit) provides delivery services. As in the other camps visited by the evaluation, SMRU carries out continuous programme of malaria research and translates them into effective treatment of the disease.

4.5.2 Present situation / Health

The local medical staff amounts to 11 medics, 21 nurses, 1 midwife, and 17 lab-technicians. In terms of diseases, the camp follows a similar pattern to that of the other camps visited.
There is an average of one medic per 1761 refugees. The rates of consultation and hospitalisation per year and per refugees are respectively (3,56) and (0,04)., and there is one reference per 21 refugees per year (total number of patient referred Y2001 =1953).

Low respiratory tract infection is the major problem, especially among the under 5 years old population (1314/1000), followed by diarrhoea (878/1000) and malaria.
Tuberculosis incidence is 0,501%
Immunisation coverage for the BCG is established at 99,6%, and immunisation coverage for the Measles at 97,9%. Crude mortality rateis 47/10000, and child mortality rate is 0,88 % (MSF source).

It was noted that last year an outbreak of dengue fever (100 cases) occurred within the camp. The situation was brought under control, with the result that no child or adult deaths happened. Equipment was purchased and is located in the camp to fumigate the inside of the dwellings and to spray the outsides as a method of control, should further outbreaks occur.
In addition to the preparation for dengue fever, a separate cholera camp has also been established in readiness, should an outbreak of this disease occur.
As mentioned in the previous paragraph, both MSF and SMRU are involved in delivery services. This can be seen sometimes as an overlapping of resources, though the services provided by SMRU seem to be of a higher standard than that of MSF. This is partly due to the fact that the former is specialised in malaria research treatment, particularly amongst pregnant women.
The ever present problem of referrals is again an issue to be addressed. The local medical staff, when left to there own devices, tend to refer many of the cases that present themselves –and which are perhaps outside there expertise- to the local Thai hospital. In this situation, the need for expatriate medical staff to be either in the camp or on call is paramount. It is MSF's choice to adopt this method of dealing with this issue, and it would appear that the system is adequate in this particular environment.
Despite the turnover of expatriate medical staff, the system would appear to function well, as adequate time allowances are made to ensure smooth operation of the system when change over occur.
The local medical staff appeared to be motivated and satisfied with the duties, and receive continuous one-to-one training on a regular basis.

4.5.3 Comments

The camp, having been established over a long period of time, has adapted to the various situations that arise from a large population in terms of health care, both preventative and curative activities.
Generally speaking, the system of health services in the camp would appear to be working well. Co-ordination in matters of training is particularly important, requiring regular dialogue to take place between the parties involved, to avoid unnecessary time and efforts.

4.5.4 Recommendations

The activities of MSF in all aspects of the camp provide a sound basis on which to build firm, sustainable foundations for running what is now essentially a small town, with all its associated problems. Useful insights can be found in the methods of management and control within the

medical sector, and could serve as an example to other agencies working in similar fields in other locations. The next step in what is a continuous process of learning and adapting to an ever evolving series of events, may be the establishing of a further level of training to bridge the gap between health care and health management.

4.5.5 Conclusions

The visit to the camp was both worthwhile and informative. Many lessons could be learned by agencies working in a similar field, and much time could be gained in the process. The dissemination of information should be encouraged and facilitated for the benefit not only of the NGOs, but of the refugees themselves.

5. COMPARATIVE EFFICIENCY AND COST-EFFICIENCY OF NGOs

The AMI and MHD approaches to their respective tasks in the camps vary significantly. Both NGOs have been active in the border region over a significant period of time, and have gained credibility both within the international and local NGO framework.
There have however been significant changes, both in geographical and operational inputs of the actors. This in turn has had an effect on the overall efficiency in the health sector.

MHD, which has full responsibility for health at the Mae Kong Ka camp, and partial responsibility at Mae La Ra Luang, has developed a well designed management structure, both at the office and at the camp levels. The staff is generally working on a long-term basis, is able to speak the local language, and is well trained and motivated. MHD operates only one office in Maesariang.

AMI currently manages the majority of Mae La Ra Luang in terms of health, and is responsible for specific health inputs in Umpiem Mae and Nu Po camps. At the office level, the staff is generally short-term, and as such it is not always able to offer the level of guidance and motivation to the local staff, which is generally required in the ongoing situation.
AMI runs an office in Bangkok as well as three other bases near to the camps: (i) in Maesot for Umpien camp, (ii) in Umpahang for Nupo camp, and (iii) in Maesariang for Mae Ra Ma Luang.

The need for health sector co-ordination and standardisation, within camps and between NGOs, does not appear to draw a strong commitment despite the fact that forums exist for such exchanges.

In three of the four camps visited, we found two medical NGOs involved in health activities:

- Mae Ra Ma Luang (AMI & MHD)
- Umpien Mai (AMI & ARC)
- Nupo (AMI & ARC)

In two camps, we also found overlapping of medical activities:

- Umpien Mai (AMI & ARC) delivery services
- Nupo (AMI & ARC) delivery services

The issue of medical referrals has been raised a number of times in the evaluation documents, and presents a dichotomy. On the one hand, there is a promotion of the philosophy of self-management of the camps, and on the other hand the intervention of expatriate staff is still crucial.

To illustrate the issue, several ways to organise a referral system were found:

- MHD had clear organisation charts, precise job description, and well trained staff.

- AMI's organigrammes were not available, and expatriate job description were different from what could be assessed in the field. AMI decided to have a Thai-Karen nurse in Mae Ra Ma Luang, Umpien and Nupo, though one of the position is still vacant (in Umpien). During the interviews, the two Thai-Karen nurses gave diverging descriptions of their tasks.

The figures below can further provide some elements of comparative cost-efficiency between MHD and AMI. The conclusion is that the cost efficiency of AMI should be improved (see also tables in Annex 9).

Expatriate budget line :	MHD=87.750 Euro	AMI=312.600 Euro
Transport budget line :	MHD=49.500 Euro	AMI=77.500 Euro

To the opinion of the evaluator, the differences in terms of population under the responsibility of each NGO (MHD: 16.268 refugees, and AMI: 35.200 refugees) could not alone explain that the expatriate budget line of AMI is 3,5 times the size of MHD's.
The scattering of AMI actions in favour of the Burmese refugees in Thailand, the lack of guidance and coordination from AMI co-ordination team in Bangkok, all seem to be linked to the lack of inexperience of the expatriate staff *(*see table of Human Resource profiles, Annex 9). These factors would need to be significantly modified to improve AMI cost-efficiency.

6. CO-ORDINATION STRUCTURE

As described above, the current responsibilities of AMI and MHD are complex. MHD has full control of health in Mae Kong Ka camp; AMI has 90% responsibility at Mae La Ra Luang camp, the remaining 10% being under the control of MHD. At Umpiem and Nu Po camps, AMI has responsibility for curative health, whereas the preventative are provided by ARC International (not ECHO-funded).
In this framework, co-ordination is essential.

In theory, the key structure for the co-ordination of the NGOs activities and the exchange of information with the local authorities in Thailand should be the monthly CCSDPT meeting (Committee for Co-ordination of Services to Displaced Persons in Thailand), which is held in Bangkok.
However, the actual co-ordination approach differs from the theoretical framework. In the case of health, there would appear to be widespread discrepancies in the activities carried out and, in some instances, in their overall management.

The CCSDPT is usually divided into a general co-ordination meeting and specific workshops, since the NGOs have a package of implementation procedures, covering *i.a.* medical aid. Major guidelines of the NGOs activities are as follows:

- Maintenance of similar levels of support in each camp for medical and food assistance.
- Co-ordination of all activities and regular exchange of information
- Supplementary activities between the medical aid operators and the food operators.

Furthermore, in each camp one NGO has the leadership and management responsibility for all activities in the camp, in order to prevent overlapping of donations and competition situations amongst the implementing agencies.

7. VILLAGE HEALTH PROJECT

To better respond to section 2.3, dot 4, of the evaluation TOR (to study the LRRD possibilities – if any), the expert undertook a brief review of the current health situation prevailing in a few villages located around the camps, since numerous villagers were using the refugees facilities and the management of the Thai Village Health project financed by AIDCO did raise some concern with the evaluation team, as already stated in the Chapter 1 above.

One of them was the village of Pawoohta, in the province of Mae Sariang. The visit helped to illustrate the general situation and also provided an insight to the proposals put forward to AIDCO by some of the NGOs already working for ECHO in the area.

The village of Pawoohta consisted of 240 people, 30 of them children (10 under the age of 5), and 5 pregnant women. The principal method of agriculture is slash and burn, a technique practised by the village over many generations. Recent tightening of controls by the Thai Forestry Department, however, are aiming to put an end to this form of land cultivation.
A health centre was located in the centre of the village, and gave the appearance of being unused. When questioning about health care, the evaluation was informed that Thai government health workers visited the village once a month. Asked about immunisation of children etc.. , despite various searches the village headman was unable to produce any documentation supporting such a programme. One item that was produced was documentation for (women) family planning, though the medication had not been followed up in the appropriate time scale.

The villagers lived what can only be described as a hand-to-mouth existence, possibly at a lower level than that of the refugees. Interestingly, although the basic infrastructure in terms of material components, such as a health centre, etc. were in place, training of local people to run the system did not appear to have taken place, leaving the village very poorly off.

8. CONCLUSIONS

The current ECHO funded projects are justified in terms of humanitarian mandate and needs of the target population. It is recommended that this support continue at the current level until the situation of the refugees changes, and a dignified return to their hometowns becomes possible.

It must be remembered that the refugees in the camps are trapped in a situation that allows little or no contact with the outside world, in terms of social interaction and development. The international agencies therefore play a major part in attempting to bridge the gap.

On-going training plays an important role in the efficient management of the camps, and in developing confidence, motivation, and recognition of those refugees involved in operational duties within the camps. The proposed seminars outlined in the recommendations provide a tool from which to develop such issues.

It is incumbent on the international agencies therefore to make all efforts to transfer knowledge and experience. Any lack of leadership, skills, or motivation present, or perceived to be present in the international agencies, impacts directly on the refugees with whom they work, and is assimilated by them.

Such a condition can lead to frustration, lack of direction, and at worst, unrest. The above recommendations go some way to ensuring that the refugees interests and needs are served in a constructive and efficient manner.

It needs also to be stressed that the prolonged use of insecticides in the camps is a cause for health concern, and should be further investigated as a matter of urgency. These insecticides, some of them highly toxic such as DDT, are currently being provided and disseminated by the Thai authorities.

9. RECOMMENDATIONS

It is recommended that a programme of rationalisation of the health sector should be considered as a priority, on the basis of the assessed efficiency:

- according to actual geographical area of responsibility of NGOs (AMI, MHD).
- According to geographical location of the camps all along the Thai-Burmese border.
- Based on organisation, performance, and cost efficiency of NGOs under ECHO contract.

It is recommended, for the two camps located in the North:

- to suggest to AMI to hand over to MHD, the responsibility of Mae Ra Ma Luang camp.
- MHD should continue to keep the responsibility of Mae Kong Ka camp.

It is recommended, for the two camps located in the South:

- to suggest to AMI to hand over curative health services of Umpien Mai camp to ARC, which is already responsible for preventative health services.
- To similarly suggest to AMI to hand over curative health services of Nupo camp to ARC, which is already responsible for preventative health services.

Rationalisation of the health sector of NGO funded by ECHO should address issues such as overlapping, cost-effectiveness, and efficient use of both management and physical resources.

It is recommended that further training be given to the medics in the camps:

- in diagnostic procedures, and in consensus building. The model used by MHD for referral appears to contain all necessary elements and could be used as a model.
- To give access to the new local generations who want to work for their community as medics.

It is finally recommended regarding the AMI Thai Village project to made clear that management, operation, and co-ordinated structure must be in place and must be seen to be working within the AMI overall management, in order for the project to have a reasonable chance of success.