

Refugees and Health Problems in East and Central Africa

*M. J. Mbonile**

Abstract

It is well documented that local communities and families which receive refugees provide food and other related services may face food insecurity and price inflation within a very short period of arrival of refugees. Besides refugee influxes have devastating effects on both traditional and improved water supplies. They may also lead to a diversion of local peoples' health and other services and also put the local community at a high risk of acquiring communicable diseases such as HIV/AIDS, STDs, and malaria.

Introduction

People fleeing from a country where there is persecution usually migrate to any nearby states be they those which have similar environmental conditions as those of the refugee's country of origin or otherwise. For example, refugees fleeing from Somalia to Northern Kenya or Southern Ethiopia or refugees fleeing from Burundi and Rwanda to Kigoma and Ngara in north-western Tanzania may face little change in terms of environment. However, even where this may be the case, the social environment may be different. The said refugees may have come from areas with high levels of illiteracy, morbidity and malnutrition. The areas where the refugees are forced to settle may lack better infrastructure with respect to water supply and sanitation. Even worse the problems the refugees have to face may be magnified by the mere fact that the areas where refugees are forced to settle are remote, inhabited and have poor communication and social services. Indeed the sudden arrival of refugees creates an immediate demand for the said social services to be installed (Mazur, 1987:443).

In general the presence of refugees in large numbers becomes a big challenge to host countries, international agencies and Non-governmental Organizations and so the influx of refugees may push host governments to the edge of their tolerance limits as well as disturb the host population from carrying out normal

* Associate Professor, Department of Geography/Demographic Training Unit, University of Dar es Salaam

activities. This may sometimes lead to total chaos in the areas where the refugees pass and settle for the first time. At the initial stage of the settlement of refugees this uncontrolled move may expose the refugees and local communities to higher risks of epidemic diseases such as cholera, mental stress and insecurity. Moreover, in such risky situations it is the vulnerable groups such as women, children and the aged who suffer most from all types of social and health deterioration (URT, 1995).

Water and Sanitation Services

As indicated earlier the sudden influx of refugees in an area may have devastating impact on both traditional and improved water sources in terms of quality and quantity of water supply as well as mechanical performance. In fact the sheer increase in water demand while the supply remained constant may create competition for water between the local community and refugees. This situation more often leads to the loss of time which could have been spent on other economic activities and sometimes it leads to major social conflicts (URT, 1995:24). For instance in 1994 just within 24 hours, more than 1 million Rwandese refugees crossed to Zaire and Tanzania in an effort to escape the genocide in Rwanda. Benaco, which suddenly had to be host to 250,000 refugees, was almost turned into a town within a short time (UNHCR, 1996:22). This automatically implies that there were higher demands for water to meet their demands. Taking into account that the UNHCR average water requirement of an individual being put at 20 litres every day, Benaco alone demanded 250,000 x 20 litres every day. Indeed, this requirement had to be met because of good quality water is very important if someone is to avoid the rapid spread of water borne diseases.

At the same time any demand for water for consumption requires a proper method of disposing it so that it does not harm the health of the people. These liquid and solid waste disposal become an issue which has to be resolved parallel to the issue of the supply of water within a short time of the arrival of refugees. In fact if the issue of water is neglected or delayed it may result into higher morbidity and mortality rates among refugees. A typical example in the Great Lakes region was observed in 1995 in the Kivu region in the Republic of Congo where one of the areas occupied by the refugees had no water and haphazard littering of wastes led to an outbreak of cholera which claimed the lives of many refugees before international organizations intervened. Almost the same conditions had been observed in Eastern Ethiopia where large numbers of refugees from Somalia settled leading to UNHCR having to ferry large quantities of water to the camps. Nonetheless, since the sources of water were very far the supply per head was reduced 5 litres per day which was quite far below the average requirements of 20 litres. In addition, this exercise was very expensive as it cost about US \$ 2.5 million every year just to ferry water (UNHCR, 1996:22).

Refugees and Health Problems in East and Central Africa

In some cases refugees out-number the local population and so overstretch local infrastructure like water and sanitation services because it has to sustain both the natives and the new arrivals. This leads to the breakdown of the services as what happened in Ngara District which during the peak of the refugee influx in 1995 it had a refugee population of about 500,000 while the local population was estimated to be about 200,000. This big increase in refugees within a short period almost paralyzed the infrastructure that was not planned for a population of about 700,000 people. As such due to severe competition several installations such as hand pumps are destroyed during the scramble for water and in the long run there was overpumping of water which exhausted and lowered the water table which in turn lead to critical water shortages. Above all the destruction of natural resources such as forests in the catchment area led to a permanent reduction in water supply. This situation has had disastrous effects on the health of both local residents and the refugees (URT, 1995:24).

Food Security

Availability of food is an important element in a refugee camp for refugees do not carry with them any significant amount of food as they move. More often they carry supplies, which lasts for a few days. Therefore, it is the families and local communities in the areas where refugees are welcomed who provide food and related services to the refugees before governments and aid agencies come to rescue the situation. Indeed the sharing of food in a subsistence economy may occasion the onset of a famine in the relevant area. This problem becomes more critical when donor communities coming to rescue the situation but concentrate their attention on the refugees and leave the local communities to feed themselves (URT, 1995:24). In the case of the Great Lakes region, the host communities provided items such as maize, sorghum, beans, cassava, cooking oil, salt, sugar and other goods amounting to several tones.

The other effect of the big influx of refugees is that they raise the prices of staple foods and as such increase food insecurity. The food insecurity is also increased by refugees who prefer local staple foods. Apart from food supplied by host communities, refugees get their food rations from the UNHCR. Furthermore, food distribution in the camps is the main source of life in the camps and so the type, quantity and quality of food are very important elements in refugees' area. Equally important is the method of distribution of food. This is so because food as a means of survival can be used as a political weapon and so some people just to meet their own food demands without any concern for the refugees. In fact even in the camps, there is food disappearance that lead some refugees to get more while others very little or nothing at all (Pottier, 1996:410).

In general some of the tricks used by refugees to get more food rations in the camps include double registration, new arrivals claims and other claims such as losing ration cards. These practices were very common in Ngara refugee camps where in some cases camps were so congested that it was very difficult to distribute food efficiently. Indeed Benaco Camp became so congested in such a way that it was considered necessary to create Lumasi Camp to ease the situation. Since at Benaco Camp it was very difficult to distribute food refugees were snatching food from one another and the flow of information on food arrivals or shortages was a big problem (Pottier, 1996: 411).

Furthermore, food availability depends a lot on the responses of the recipient government and the donor community. These are supposed to meet their pledges and distribute the food available at the right time. Nonetheless, the rations distributed to refugees are primarily cereals, oil and dried milk which more often lacks vitamin C, iron and other nutrients which make a healthy diet (Berry, 1989:108). If this problem is not scientifically addressed it may lead to diseases like scurvy and anemia. Even worse is the fact that the food deficit is normally encountered by lactating mothers, children and expectant mothers. Above all insufficient amounts of food per head and poor nutritional status leads to lower immunity and leads to the higher risks of incidence of diseases in the camps (Dualeh, 1995:5; Nkosi, 1996:23).

Food insecurity becomes more critical when refugees market some of the food distributed to them with the aim of getting other requirements. The marketing of donor food by refugees is not liked neither by the donor community nor the distributing authorities in the camps. However, the main reason for selling food rations by refugees is the cultural preferences of these refugees which in this case include staple foods such as bananas, wheat, sorghum, fresh or dried foods in case of the Great Lakes (UNHCR, 1996:16). This preference for staple foods by refugees in an area with their various feeding practices may stimulate acute food shortages to both local and refugee populations. A good example are refugees from Rwanda in Ngara who use bananas as their staple food as the local community. The arrival of refugees created a big scarcity of bananas and the price went up quickly from about Tshs 500 to about Tshs 1,600. Also where there are no good plans and control of food diversions it can lead to the decline of national reserves in staple foods (Zelter, 1995:161). This is because refugees in their camps do not have a democratic power structure and so those among them who engage in staple food distribution become very powerful (Berry, 1989:107).

Diseases and Health Services

The concept of health implies a situation of total well being physically, mentally and socially; it does not merely mean absence of diseases. Therefore, from this

Refugees and Health Problems in East and Central Africa

definition health is a significant variable in the proper management of refugees who have been uprooted completely from the environment with which they are more familiar (Lobo, 1993:11). Usually risks are very high at the beginning of massive influx of refugees as host governments and the donor agencies are ill prepared to handle the extra population. For instance, the movement to Goma by refugees from Rwanda was so fast that it was not possible for donor agencies and the then Zairean Government to help them much. Practically there were no water and sanitation services, no health facilities and housing facilities. As a result about 50,000 refugees lost their lives mainly due to the cholera outbreak. In this case it was difficult even to bury those who died on arrival (UNHCR, 1996:18). Moreover, the influx of refugees necessitates the reorientation of medical services, supplies and other related health programmes. The health impact of refugees in the area of destination is more often reflected in the following critical areas:

- (a) Out break of new disease patterns
- (b) Poor sanitary conditions
- (c) Overstretched medical personnel
- (d) Inadequacy of medical supplies
- (e) Destruction and over use of medical facilities

As it has been observed by URT (1995) the influx of refugees which was accompanied by overcrowding in temporary camps with poor sanitation conditions, inadequate food and water supply resulted in new disease patterns that spread like bush fire. The main diseases that accounted for 60-80% of deaths in the camps included tuberculosis, measles, diarrhoea, acute respiratory infections, malaria, meningitis, malnutrition and mental health problems (stress). These were largely due to overcrowding in the camps and its related effects like inadequate shelter, poor sanitation, lack of clean water and poor nutrition. Hence this tended to lower the immunity levels among the refugee population and frustrate the efforts to control the situation. For example, it was discovered that refugees from Somalia residing in camps in Ethiopia had up to about 20% of children with high malnutrition and so frustrated campaigns like immunization or environmental health programmes.

When people are forced to move out of their place of residence it may create obstacles for them to get access to good health. This is because:

- (a) it may be very far from home/settlement.
- (b) there may be no services at the centres.
- (c) the factions may use health facilities for their own interest, limiting access to the general population.
- (d) sometimes the relevant government regimes may want the personnel in the health sector to torture the people (e.g. sterilization without consent (Muecke, 1992:517).

- (e) may be the people trapped in the middle of fighting groups.
- (f) the security of the health personnel hinders delivery of health services to the people.
- (g) it is difficult to know the most therapy for the ailments of some of the people due to the complications from, for examples torture or fever which causes stress.
- (h) loss of relatives resources to attend for the family needs including provision of health services and the encounter by the refugee new diseases, a new system of health care and new food stuffs create additional health problems to the refugees.

If the aim is to put a total emphasis on the importance of health issues in refugee settlements are essential it is important to note it is a mistake to concentrate medical care and other social services to refugees alone. In fact food, water, sanitation, housing and others are equally important to host communities and provision of these services to the two communities protect the health of the area more effectively (Dualeh, 1995:5). In order to handle the influx of refugees, there is a need for immediate for immediate public attention and planning for hazard management (Yahmed, 1994:26). In fact the experience with respect to the outbreak of cholera in Goma-Zaire mentioned earlier has taught a good lesson that proper hazard management is very important both in the country of origin and the country of refugee destination. The loss of about 50,000 people within a very short period of time in Goma would not have happened if there had been a proper hazard management. This requires intensive preventive measures in tackling the underlying factors that contribute to the spread of diseases.

These preventive measures include the control of communicable disease, running nutritional programmes, training of community health workers and raising awareness what needs to be done should disasters occur both locally and at global level (Ogata, 1995:3). In contrast to what happened within the Goma case reports on the establishment of camps in new areas such as Benaco, Msuhura and Lumasi in Kagera Region show how proper management of refugees led to better control of sexually transmitted diseases (STDS) as indicated by Table 1.

The research conducted by the Medical Research Foundation in Ngara District revealed a prevalence of STDs among women attending ante-natal clinics but the level of STDs declined significantly after medical treatment in the camps and this occurred largely because there was a thorough screening of syphilis among pregnant women. It was also found that more male out-patients had contact with commercial sex workers (CSW) and had high rates of STDs and the discovery was an important step in counselling refugees to avoid unsafe sex which leads to getting STDS and HIV/AIDS.

Refugees and Health Problems in East and Central Africa

Table 1: Sexual Behaviour and Past STDs Data in Refugee Camps in Kagera Region

Characteristics	Ante-natal	OPD Benaco	OPD Msuhura	OPD Lumasi	Com-munity Benaco	Com-munity Msuhura	Com-munity Lumasi
No seen	150	100	103	106	157	38	106
<i>Partner last year</i>							
None	0	29	22	36	29	24	17
More than one	7.3	17	20	9	25	21	26
<i>Partner last 3 months</i>							
None	0	36	27	46	41	47	26
More than one	0	6	12	2	8	8	11
Sexual contact with CSW	-	43	31	11	10	3	9
Ever used condoms	1.3	18	14	14	13	10	12
<i>Past-genital discharge syndrome</i>							
Ever	4.3	19	17	10	10	10	9
Last 3 months	-	3	6	2	2	5	2
<i>Past-Genital Ulcer Syndrome</i>							
Ever	5	7	16	7	16	18	16
Last 3 months	-	4	7	3	6	10	9

Source: African Medical Research Foundation- Mwanza 1996

Nonetheless, among the community members close to the camps it was found that the population had experienced a genital ulcer syndrome during the past three months and there were more signs of STDS and cases of scabies, lice, genital warts and genital discharge which required an extensive medical care to cover even the surrounding communities.

Another big achievement of having proper management of refugee camps is in the prevention of stress that has received less attention in the past. The control and prevention of stress is important because it is a direct result of torture or war that affects the refugees psychologically. Generally, bandit attacks, shelling, loss of close relatives or family members, sexual abuse or denial of basic human rights can lead to mental stress. This approach, however, deviated from past experiences where most of the refugee health programmes tended to concentrate on the other aspects of health. Hence it is essential to know that any medical care to refugees is more than controlling epidemic diseases and bullet injuries. It includes among others giving enough protection, food and combating stress (Muecke, 1992:512).

Reproductive Health

Due to the nature and environment under which hazards creating refugees occur, refugees have tended to be young and the overall young age has resulted

in high fertility rates and perhaps made even higher by the high mortality rates experienced in their home countries. Also due to high mortality rates of children they are prompted to have high replacement rates of babies in the countries of asylum. Besides this even if the fertility rates were to drop drastically a large generation of youngsters and their parents would need additional health and other services during the coming decades (Mbago, 1988).

Moreover, the reproductive health needs of refugee women are high as they are confronted by special risks in the refugee community. Some of them are expectant mothers and they need regular medical check-up while the lactating ones need to attend clinics at more regular intervals. Therefore, lack of reproductive health facilities contributes to high levels of maternal and infant mortality (Mbago, 1994). Due to lack of these facilities some mothers are attended by untrained Traditional Birth Attendants (TBS) who have little knowledge of reproductive health and or may fail to attend complicated maternal cases. As stated earlier these reproductive health problems are more intensified by the environment in which these mothers live such as remote areas and so are forced to travel long distances and face rapes, attacks, stress and poor nutritional status. All these problems may encourage a lot of complicated labour cases. In some areas refugees still practice dangerous traditional birth and sexual controls such as genital mutilation. These leads to more maternal birth problems (UNHCR, 1996:20).

The demand for family planning and MCH services in the camps is usually very high. This is because besides having chances for family reunification some mothers who have lost children in the course of moving and others due to epidemics and malnutrition or those who have lost family members after reaching the camp may wish to build new families. On the other hand they may decide to develop the old ones, which leads to higher birth rates. Hence new social relations which are developed in the camps contribute to high birth rates (Djedaah, 1995:10). Above all refugee women in their reproductive ages faces a lot of risks. The rampant rapes as observed with respect to the Rwandase refugees cause widespread infections of STDS, HIV/AIDS, unwanted pregnancies, unsafe abortions, post traumatic stress syndrome (PTSS) and social obstruction. Victims of rapes sometimes end up committing suicide and so these victims need a lot of counselling, medical check ups, contraceptives and frequent visits by medical personnel. When all these are not available a lot of refugee in the reproductive age bracket are exposed to a lot of health risks (Djeddah, 1995).

Mortality

According to Mbago (1994:452) there are many socio-economic factors that may account for a higher risk of death by refugees than by the local populations.

Refugees and Health Problems in East and Central Africa

These include low income, inadequate housing, low levels of maternal education, environmental stress and language problems. Just to cite a few examples of these socio-economic problems it has been observed that mobile refugees have a higher risk of dying when compared to the local community. For instance if we take a look at famous Rwandese refugee exodus in 1995 it involved over 1 million people with only 200 aid agencies serving them. Ever since the number of refugees was too big the demands for clean water, food, sanitation, medical service were beyond attainable levels of the agencies in the field. This resulted in many people dying in Goma and Ngara areas leave alone those who were dying from the fighting which was going on in Rwanda. It took two months for the UNHCR and Aid agencies to contain the situation. To contain it people were compelled to work very hard to bury the dead ones, to set up water pipes, to distribute food, medicines, tents for shelter and to create a sanitation system. Most of the deaths were a result of diseases mainly epidemics and malnutrition. Later on there were those who were dying due to lack of health services, bullet wounds and shell injuries.

Above all the risk of dying among women, children and the aged was even greater than among men. Women may for example fail to get MCH services because of the following reasons:-

- (a) lack of a female examiner
- (b) long distances to the health centres
- (c) absence of care for female specific problems
- (d) disregard to traditional health care system

All these may cause complications in pregnancy and child bearing processes and so lead to high maternal mortality rates (Dualeh, 1995:5; Symke, 1995:95).

Conclusion

Generally, it has been observed that the influx of refugees in an area implies higher demands for water which may disrupt both traditional and improved water supplies which serve both refugees and local communities. Due to this abrupt destruction of water systems, the host government and donor agencies may be forced to use a lot of money to supply water to several refugee camps which sometimes are logistically located far apart from each other. Besides this refugees generate a lot of waste material whose collection and disposal requires operations similar to those which apply with respect in urban areas.

The influx of refugees increases food insecurity both to refugees and local communities leading to rampant malnutrition. In addition, due to overcrowding epidemics like malaria, STDS/HIV/AIDS, tuberculosis, meningitis may spread at alarming rates.

M.J. Mbonile

In terms of reproductive health the pre-dominance of young age groups among refugees may lead to an increase in fertility in the refugee camps or areas of destination. Also due to replacement syndrome among refugees who would have experienced family or household disruptions the fertility behaviour of refugees may witness sudden change.

Changes in the socio-economic and natural environment of refugees coupled with severe stress may lead to high mortality among the refugees when compared to the local communities. Furthermore, refugees experience high mortality simply because they have to start life from scratch and so their housing conditions and nutritional status are extremely poor.

If we regard the process of refugee generation as a disaster caused by natural and/or human factors it is proper to institute better methods of disaster management. This will save the life of many people who can perish within a short period just as was witnessed in the case mentioned earlier. Proper management of refugee camps gives ample opportunity to solve other problems both in the host and country of origin of refugees.

References

- Berry, A., 1989 *Refugee Women Case Study Somalia; Working with Refugee Women, A Practical Guide*, pp 107-108.
- Djeddah, C., 1995: Refugee Families: *World Health 48th year* (6), pp. 10-11.
- Dualeh, M.W., 1995: Let us join forces: *World Health 48th year* No. 6, pp 4-5.
- Fair, D., 1996: "Refugee in Sub-Saharan Africa from Cause to Solution", *Africa Insight*, Vol. 26 No. 1, pp 36-47.
- Lobo, M., 1993: The plight of Refugees., *World Health 46th year* No. 6, pp 11-13.
- Mbago, M.C.Y., 1994: "Some correlates of Child Mortality in Refugee Populated Regions", *Journal of Biosocial Science*, Vol. 26, 1554, pp 451-467.
- Mazur, R., 1987: "Linking popular initiative and aid agencies: The Case of Refugees, *Development and Change*", Vol. 18 pp, 437-461.
- Muecke, M.A., 1992: "New Paradigms for Refugee health problems", *Social Science and medicine*, Vol. 35 No. 4, pp 515-523.

Refugees and Health Problems in East and Central Africa

- Nkosi, J., 1996: Saturday in Kibondo; *Refugees II* 1996, pp. 22-23.
- Ogata, S., 1995: Refugees, a challenge to humanity, *World Health* 48th year No. 6 pp.3.
- Pottier, J., 1996: "Relief and Repatriation; Views by Rwandan Refugees; Lessons for Humanitarian Aid Workers", *African Affairs*, Vol. 95 pp. 403-429.
- Smyke, P., 1995: Refugee Women, *The Courier*, No. 150, pp. 55.
- UNHCR, 1996: Life in a Refugee Camp, *Refugees III*, pp. 16-23.
- United Republic of Tanzania, 1995: *Donors Conference on Reconstruction and Development of Kigoma Region*. Dar es Salaam: Prime Ministers Office.
- Yahmed, S.B., 1994: "Population growth and disasters": *World Health* 47th year No. 3. pp. 26-27.
- Zelter, R., 1995: Incorporation and Exclusion; The life cycle of Malawi's Refugee Assistance Programmes *World Development*, Vol. 23 No. 10 pp. 1653-1667.