

Medicine for refugees



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Since the end of the Cold War in 1989, many new conflicts have happened across the world, particularly in Africa. Civilians—and infrastructure and services on which they depend—are often seen as legitimate targets. Civilians represented fewer than 10% of trauma victims in World War I and more than 40% in World War II. Nowadays, more than 90% of casualties are civilians. This targeting causes the mass population movements that have become a feature of the past two decades. In 1974, there were 2 million refugees in the world. At the start of 2003, the United Nations High Commissioner for Refugees (UNHCR) reported 20·5 million. But refugees crossing borders are only part of the picture. Millions of people are internally displaced, often stranded and unable to flee, bringing the total figure to more than 36 million. About half the world's displaced people are in the Middle East. Africa—with 12·9% of the world's population—has 41% of the world's displaced. With six wars in progress in Africa, today more than 100 million people are directly affected, and 14 million displaced are living in temporary shelters.

Whether a Kosovar shopkeeper, Afghan artisan, or a Liberian subsistence farmer, displacement ratchets up the burden of disease. Communicable diseases such as malaria, measles, tuberculosis, and diarrhoea are major causes of suffering and death for many of today's war-affected populations. In the turmoil associated with conflict and displacement, death rates attributable to these diseases generally rise sharply, through absence of access to basic prevention and protection tools and effective treatment. Cramped camps, poor sanitation, and malnutrition are common, which greatly increase vulnerability. Violence and sexual abuse are an everyday part of life for many displaced people, both in acute and long-term conflicts. Psychological trauma associated with forced displacement can be intense and longlasting.

Although the UN has a mandate to assist and protect refugees, no one has overall responsibility for people internally displaced or internally stranded, whose needs may be far greater than for refugees. Our models for the health care of displaced populations come largely from work done in developing countries of Asia and Africa in the 1980s. But nowadays we are seeing increasing numbers of conflict-affected populations in countries of middle development such as the former Yugoslavia, parts of the former Soviet Union, and Iraq. Health workers might not be prepared for the types of diseases they will encounter, nor will supplies and protocols be appropriate. From standard practice, surveillance might focus on measles in a population whose greatest risks are asthma, hypertension, and insulin-dependent diabetes.

We have been slow to learn from mistakes in the way health services are provided. Augmentation of existing services is usually essential in emergencies to reduce death rates quickly. However, the parallel services established for refugees may outlive their justification. High levels of care for refugees, while neglecting needs of hosts, add fuel to the resentments host populations generally feel towards refugees. Equally, refugees may hesitate to return home if adequate health services do not exist there. If planned carefully, emergency health interventions can support displaced and host populations and help inform and accelerate national policy development. SPHERE humanitarian charter and minimum standards in disaster response (<http://www.sphereproject.org>) have done much to strengthen the care of refugees.

Humanitarian non-governmental organisations (NGOs), alongside governments and the UN, have become the primary health-care deliverers in most emergencies. Resolution of conflicts is often protracted and NGOs increasingly stay for years. Uncertain funding, high staff turnover, poor access to displaced people, and dangerous circumstances



Camps for the internally displaced and stranded, Sierra Leone, 1995

make the work of these groups especially difficult. The effect of using for-profit contractors to provide assistance, in preference to humanitarian organisations and the UN, has yet to be fully assessed.

Meeting the health needs for war-affected populations is becoming increasingly complex. Poor security often restricts services to displaced people. The need for effective new methods designed for the operational and technical constraints of emergencies has never been greater.

Malaria—not guns—is the single largest killer of conflict-affected populations in Africa. Drug resistance has developed rapidly over the past decade as a result of poor treatment practices and mass population movement. Health-care providers need technical and political support to select the most effective treatments to save lives in these challenging circumstances. Insecticide-treated plastic sheeting has been developed to meet the temporary shelter and vector control needs of displaced people. This innovative new material kills mosquitoes and flies that rest on it and is now under fullscale assessment in emergencies with the MENTOR initiative (http://www.jhsph.edu/Refugee/Humanitarian_Assistance) and UNHCR, with support from the European Commission and the US State Department Bureau for Population and Refugee Migration to ascertain its ability to control malaria related disease in camp settings. By combining shelter and disease-control actions, insecticide-treated plastic sheeting could present substantial material and operational cost savings. It can be distributed rapidly to displaced families without need for medical teams or extensive community education to achieve effective use. Insecticide-treated blankets and lightweight shelter lining materials may also prove valuable in the future.

Diarrhoea is a common cause of death for refugee children. New technology for point-of-use water treatment can reduce this threat where safe water supplies are not available. Simplified integrated management of childhood illness for emergency situations could help to reduce deaths from common killers. Increasingly, displacement of populations is recognised as a key factor in the spread of tuberculosis and HIV. Establishing effective and sustainable control measures is a major challenge and we can do much better. The extent of mental trauma after conflict is now starting to be recognised. New simplified methods of group therapy have proved successful in Uganda.

How services are provided and access assured among the most vulnerable needs constant scrutiny. Surveillance is the backbone of the public health response to emergencies, yet data collection, analysis, and dissemination to decision makers is often problematic in chaotic circumstances. A novel where-there-is-no-epidemiologist approach for data collection using small sample sizes, indirect estimations, and remote sensing methods is needed to enable front-line health workers make the right decisions based on what data are available. Evidence-based public health has no more fertile ground for growth than in guiding health care of displaced populations.

Yet the fatal flaw remains: emergency public health for the displaced and stranded is a response to the failure and collapse of states. We neglect our responsibilities if we do not advocate for the health and rights of these vulnerable populations who are increasingly tossed about as human debris among the rivalries and aspirations of thugs and warlords.