

Refugee Health Care

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Background

Prior to the 20th Century, movement from one country to another was commonplace and requests for asylum were rarely challenged. When nation-states began to fix their borders they often rejected refugees or uprooted others for political, ethnic or religious reasons. International interest in protection for refugees first occurred in the 1920s. However, it was not until 1951 that the United Nations Office of the High Commissioner for Refugees (UNHCR) was founded to deal with persons, in Europe, displaced by the events of WW II. One of their first duties was to define *refugees* as,

“Any person who owing to well founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion, is outside the country of his nationality and is unable, or owing to fear is unwilling to avail himself of the protection of that country; or who, not having a nationality and being outside the country of his former habitual residence, is unable, or having such fear is unwilling to return to it.”

In 1967 the definition was amended to apply to all persons, without geographic restrictions, fleeing their nation’s border with genuine fear of persecution. To this date, the term refugee does not apply to those fleeing the consequences of natural disaster or economic strife.

Internally displaced populations (IDPs) are separated from their homes and livelihood but remain within the borders of their native countries. In the 1990s IDPs made up the vast majority of displaced populations, often languishing for years in mountain or desert terrains to escape and avoid capture, torture or death at the hands of warring factions. It is important to recognize that existing international laws and treaties protect *refugees*, and the UNHCR is mandated to ensure their health, shelter and protection. *IDPs*, however, are not covered under existing international legal protections as they remain within the borders of a ‘sovereign’ nation-state. The international humanitarian community of organizations and agencies is best able to do provide relief within a refugee camp setting (i.e., after a group crosses an international border and becomes “refugees”). However, they are less able to provide the same level of care to IDPs due to lack of internal security. Because IDPs are still within the country which is persecuting them, international agencies are often prevented from accessing the country altogether, or at best have their efforts severely hampered. In the recent Congo conflict relief workers lost contact with over one hundred thousand IDPs, as they went deeper and deeper into the jungle to escape advancing forces. Satellite surveillance attempts were made to track the course of their plight, but many died from disease before assistance was re-established.

It is critical for every health care worker responding to a complex emergency to understand the fundamental importance of the epidemiology of the event. Epidemiology includes the indicators of mortality and morbidity, malnutrition, and case fatality rates from infectious and other diseases. The rates are compared to known mortality rates of the population during times of peace. For example, mortality rates in most African countries are listed epidemiologically as an

average of 0.5 persons per 10,000 population per day. When this rate reaches 1.0 death/ 10,000 population/day, this is a serious situation, at 2.0, this is an emergency, and when it reaches 5.0 a severe disaster or famine is at hand. Whereas the mortality rates of refugees are often 7-10 times the expected baseline for that population, the mortality rates among IDPs are frequently 20-50 times higher. The refugee camps of Rwandans that escaped across the border in neighboring Zaire in 1994 were 60 times the baseline, the highest ever recorded. In a recent study by the International Rescue Committee it was found that approximately 1.7 million excess deaths occurred this past year due to fighting in the Congo. Only 11% of those deaths were due to trauma from war, the remainder of the deaths being due to complications of untreated or detected malaria, diarrheal diseases and the complications of malnutrition, all of which are preventable. Worse, *unaccompanied minors*, either separated or orphaned from their parents, suffer more because they are unable to access the healthcare system, no matter how basic it is, and further lack the basic protection and nurturing provided by adults. Until they are identified and treated by relief workers, unaccompanied minors often experience mortality rates as high as 800 times the expected baseline. Families headed by single females (i.e., when the man is either dead or separated from the family), also represent a particularly vulnerable refugee population group.

For the most part, refugees are seen in the context of events popularly called *complex emergencies*, which represent the ultimate pathway of nation-state disruption. Complex emergencies differ from other international emergencies, such as earthquakes or floods, in that the cause of the emergency as well as the assistance to the afflicted are bound by intense levels of political considerations. In the 1990s the accelerated collapse of former Cold War nations brought refugee numbers to an all time high. Recent conflicts and wars in northern Iraq, Somalia, Rwanda, Angola, the former Yugoslavia, the Province of Kosovo, the Congo, and East Timor represent complex emergencies. The complexity refers to the multifaceted responses initiated by the international community to assist the victims of these conflicts. It is anticipated that complex emergencies will remain a major issue throughout this decade, especially where increasing populations, urban decay and resource competition remain problems. Although each of the over 38 major conflicts that have occurred since the end of the Cold War is unique in its social and political causes, all share similar characteristics:

- Nation-states experience administrative, economic, and political social decay and collapse, as well as increasing competition for resources (food, water, arable land, territory) between conflicting groups.
- Conflict and war produces high levels of violence with the highest mortality and morbidity rates suffered by the civilian population, especially vulnerable populations of women, children, the elderly and the handicapped.
- Cultures, ethnic groups, and/or specific religious groups are at risk of extinction (genocide).
- These represent primarily internal wars with major violations of the Geneva Conventions and the Universal Declaration of Human Rights.
- They are long lasting, widespread and disrupt the security of a region.
- They represent catastrophic public health emergencies, caused primarily from the destruction of existing public health infrastructure.
- They lead to increased migration (as refugees or internally displaced populations).

In complex emergencies the health system is the first to be destroyed and the last to be rehabilitated, leaving many civilians without health care for many months before they actually flee. Complex emergencies are best recognized for their severe health disruptions, and for the migration of civilians as either refugees or internally displaced populations.

Currently (early 2001), there are at least 31 complex emergencies occurring in every continent of the world, involving over 310 million people. The United Nations suggests that an additional 40 countries with a total of over 1800 million people are at risk of deteriorating into state collapse. In the latter half of the 1990s a disturbing trend was recognized. The “3rd World” poor were moving more and more to urban settings, often because of increasingly insecure rural environments. As a result, large cities are suffering overpopulation, urban decay and unreasonable demands on their public health infrastructure, especially water and sanitation. Interestingly, as the economies have worsened in developing countries, dengue fever has become a sensitive indicator for urban decay. The dengue fever vector has apparently found a breeding place in the accumulated trash and stagnate water and sewage pools of large cities suffering an increasingly overburdened public health infrastructure. Thus, rates of dengue fever often represent the level of social decay a city has.

International Response System

Health care and other resources are provided by United Nations Agencies (e.g., World Food Program, UNICEF, UNHCR, WHO), the International Committee of the Red Cross (ICRC), and many non-governmental organizations (NGOs), along with coalition militaries (under a UN Security Council mandate for Peacekeeping or Peace Enforcement). All play a major role in the emergency response, recovery and rehabilitation phases of complex emergencies. The primary goal for intervention of the international community is the immediate reduction of mortality and morbidity and the cessation of abuses of human rights and international humanitarian law.

The humanitarian response system has gone through major reforms during the last several years. To ensure a level of coordination, the UN Office of the Coordinator for Humanitarian Affairs (OCHA) provides a Humanitarian Coordinator and an Interagency Working Group, representing members of the major relief organizations, to expedite coordination of assistance. If refugee populations are involved, UNHCR traditionally takes on the lead agency role and is mandated to coordinate all relief and assistance activities. Any organization or agency providing assistance must register with the lead agency office in the country or region, and receive security and other briefings to ensure some unity of effort, communication and coordination. Civil-military Operations Centers (CMOCs) meet regularly to coordinate relief convoys, assist in determining program priorities and to provide security briefings.

All the major organizations and agencies have their own logistics support systems, but may share these, and other services if necessary. Most relief programs are supported by outside donations or donors (private or governmental), and are directed toward specific requirements (e.g., food, shelter, water and sanitation equipment) identified through field assessments and monitored by surveillance systems.

NGOs provide the bulk of relief and development programs worldwide. They may be funded by UN Agencies, governmental donors (such as the US State Department Office of Foreign Disaster Assistance “OFDA”), or strictly by public donations. NGOs numbered about 28 in northern Iraq, 58 in Somalia, over 150 in Rwanda, up to 400 in the former Yugoslavia and over 700 in Haiti. They are often known by the specialty area they do best, ranging from health care provided by groups such as Medecins sans Frontiers (MSF), Merlin, International Medical Corps (IMC), International Rescue Committee (IRC) and others, to water and sanitation projects with OXFAM, CARE or the IRC, to specific vulnerable population programs such as those provided by Save the Children. NGOs are mandated to provide care in a neutral, impartial and universal manner, and in doing so they are provided certain protections, and access to victims, under international humanitarian law. This, of course, only occurs if the warring factions allow them the access and the ability to do so. Unfortunately, the past decade of complex emergencies has brought with it increasing mortality rates of Peacekeeping coalition forces, the ICRC and NGOs, all directly related to the conflict itself. Many relief workers have been specifically targeted, with the intent to remove all expatriates (and the international attention they bring) from the internal conflict.

The decade of the 1990s also identified that humanitarian relief required consistent standards of care and professionalization of the relief worker. The Sphere Project, developed through an NGO consortium, along with a consensus of research and field experience, provides both a Humanitarian Charter, and minimum standards in disaster response. These serve as guidelines for all relief organizations, and a means to monitor and evaluate the effectiveness and efficiency of the relief effort. In the early 1990s only 6 courses existed to educate and train the relief worker. Currently there are over 200 worldwide, most using the Sphere Project, and other international organization guidelines, in their curriculum.

One of the priorities of any refugee camp is the early development of a health information system (HIS). The HIS regularly collects relevant data on population, diseases, injuries, environmental conditions and health services in a standardized format, in order to detect major health problems. In addition, recommendations for health services staffing at each level are available, as are service packages for specific health problems (e.g., reproductive health, STDs, neonatal care, immunizations, etc) that translate into ‘good practice’ guidelines.

Refugee Health Issues

Refugee health care is complex. It differs greatly depending on the epidemiology of the event, as well as the locale. However, research has shown that the principal causes of mortality during most refugee emergencies are:

- Malnutrition and under nutrition
- Measles
- Diarrhea
- Pneumonia and other acute respiratory illnesses
- Other conditions (e.g., malaria) which are location-specific

This occurs because complex emergencies disrupt or destroy the public health infrastructure of a village, community, a city or an entire country. The conditions listed above are direct results of public health disruption and would, otherwise, be preventable. Refugee camps are anomalies. In effect, they are large dense groupings of people, usually at the end of a long and arduous escape, with few possessions and no provision for shelter, food, water, sanitation or fuel. In Somali refugees suffering from malnutrition, measles proved to be the leading cause of death. This occurred because malnutrition and micronutrient deficiencies can lead to an immune deficient state which allows for increased susceptibility to even minor bacteria and viruses. In an over crowded refugee environment, measles and other infectious diseases spread easily and rapidly. Measles, while benign in a healthy individual, becomes a malignant disease in the malnourished, causing complications such as pneumonia or meningo-encephalitis, in up to 70% of those infected. Both Vitamin A (a micronutrient that provides for cellular immunity protection) and measles vaccination can be life saving. In many refugee situations measles vaccination is as critical an intervention as the provision of food.

In Rwanda, trauma deaths from machete and other wounds predominated in the early stages of the debacle. Once the refugees crossed into camps in neighboring countries, the densely crowded camp conditions (over 300,000) with nonexistent public health protections, provided an environment where epidemics of dysentery and cholera could rapidly proliferate. In the former Yugoslavia, large weaponry was prevalent, so war trauma victims dominated the mortality rates. Since the elderly either were unwilling or unable to escape the war, or were often left behind, malnutrition and unattended chronic diseases became commonplace in men and women over age 65.

The priority interventions during an emergency refugee relief effort should therefore ensure:

- Adequate food rations (both quality and quantity) (defined by the Sphere Project as >2100 kcal/adult/day)
- Clean and sufficient water (defined by the Sphere Project as >20 Liters/adult/day)
- Good sanitation (defined by the Sphere Project as at least 1 latrine/20 persons)
- Appropriate shelter, blankets, clothing
- Immediate immunization of vulnerable groups against measles

Clinical skills are critical, but in refugee settings public health and preventive medicine skills are usually more important. Health care providers work hand in hand with water and sanitation experts, logisticians, planners, and engineers to solve the 'public health emergencies' that are so common in a refugee or internally displaced population. Health care programs should emphasize:

- Culturally appropriate primary health care, utilizing community health workers
- A rapid assessment followed by surveillance capacity as part of the planning and decision making process
- Public health and preventive medicine programs to control diarrhea and acute respiratory diseases
- Oral rehydration fluids and re-feeding programs for those with dehydration and malnutrition
- Standardized therapies, WHO essential drugs and equipment, and attention to Sphere guidelines

Examples of health concerns in recent complex emergencies:

Kosovo/Albania: Children made up to 63% of the displaced population; 25% were women. Most deaths were from shelling. Males between the ages of 16-18 and elderly males were most often the direct and indiscriminate targets of the opposing weaponry.

Health care providers were 60% Albanians, underscoring the importance of expatriate healthcare workers being able and willing to support, complement and train indigenous efforts to care for those in need, and to assist in rehabilitating the health care infrastructure. Relief workers, in order to seek out and care for refugees still in the mountains deployed Mobile Units. Most commonly, they dealt with diarrheal diseases, acute respiratory infections and dermatological problems.

Eastern Indonesia: Infant mortality rates were very high in this population, as was that of children under the age of five (these populations represent two especially important groups to survey and monitor when assessing the health of vulnerable children in complex emergencies). Major illnesses were food-borne diarrheal diseases, malaria, Japanese B Encephalitis and Dengue Fever. Relief workers also had to contend with bites from scorpions, spiders and snakes, and with unusual reactions to poisonous plants.

Haiti: Health problems are similar to those that were seen in the United States at the turn of the century, and are common to poor countries (such as Haiti) even in non-emergency periods. Once the emergency phase was over, relief programs emphasized prevention, mitigation and development issues, all directed to rehabilitate and recover the inadequate public health system. Preventive programs have the best opportunity to improve the long-term state of health within a country.

Domestic Refugee Health

This past decade, domestic medical and public health teams have been mobilized to deal with the influx of refugees into the United States from the conflicts in Kosovo and northern Iraq. As well, Haitians coming ashore in Florida, and into camps in Guantanamo Bay, have stressed existing public health resources. Refugees arriving in the United States are required to receive an overseas medical examination before resettlement into the United States. This examination is intended to exclude refugees with the following conditions:

- Communicable diseases of public health significance
- Current or past physical or mental disorders that have been associated with harmful behavior (including drug abuse or addiction)

Refugees may be detained and medically examined if they are suspected of having any of the following diseases:

- Cholera
- Diphtheria
- Infectious tuberculosis
- Plague
- Smallpox

- Yellow fever
- Viral hemorrhagic fevers

Most refugees will have unattended chronic diseases, such as hypertension and diabetes. Dental problems, both decay and gingivitis is severe and often complicated by chronic malnutrition and micronutrient deficiency diseases. Refugees from the Former Yugoslavia had not received dental care for over 6 years, and were rarely able to brush their teeth.

Mental health problems are common. Relief workers considered suicide to be the major public health problem in Sarajevo. Acute stress disorder, post-traumatic stress disorder, depression, psychosomatic and anxiety disorders are common diagnoses made in refugee camp populations. One must remember that these are normal people caught up in severe brutality, the plight of escape, and the grief of multiple losses. Many refugees will have experienced imprisonment, isolation, torture and rape. It is critical to recognize that traditional western approaches to assessment and intervention will be unsuccessful and possibly counterproductive. Many women who are victims of rape will not admit to it. Victims will talk easily about the war, but will hide the fact that were tortured or raped. This will not be uncovered or resolved with short-term therapies; only very sensitive, cross-culturally focused interventions that involve the family, the community, and gender-specific therapists and translators should be considered. Wellness is most often seen as a community issue of acceptance and forgiveness. A therapy directed toward healing the individual psyche is rarely understood.

Role for NDMS

In previous modules, it has been emphasized that a fundamental understanding of disaster response is crucial to being a productive member of an NDMS response team. Nowhere is this more critical than in complex emergencies. Health care providers must first understand, and work within, a complex international humanitarian response system characterized by multiple organizations and a rapidly changing and dangerous environment. As representatives of the US Government, NDMS workers will need to understand the mission and limitations of a politically charged environment. As such, it would be unlikely that NDMS personnel would work directly with NGOs and other organizations that must remain separate from military or governmental affiliation.

Flexibility, maturity and a strong knowledge base of health issues, discussed above, are minimum prerequisites. You may find yourselves supporting other agencies and organizations that have years and years of experience in these events. You will need to work in an austere environment where resources are scarce and security is crucial. This being said, potential roles for NDMS professionals in refugee care might include the following:

- Health care providers supplementing US Government/military medical assets in response to complex emergencies under an international peace enforcement scenario sanctioned by the UN. In this regard, the work would be primarily in force protection, meaning the provision of medical care to US Government and Military personnel.

- Use of NDMS specialty teams (e.g., medical, mental health, mortuary, etc) to supplement assets of the US Military and/or assets of a Government that is experiencing a refugee migration, but is otherwise not involved in the conflict itself.
- Similar teams to supplement medical/public health and other US assets seconded to a UN peacekeeping role.
- Similar teams deployed to assist an offshore base that has assumed responsibility for the shelter and care of asylum seekers (as occurred in Guantanamo Bay).
- Similar teams deployed to care and screen refugees at domestic bases that have the responsibility to temporarily house refugees during a conflict (assuming they will return to their country of origin once the conflict ceases, as was the case with Kosovo refugees sent to military bases in New England); or the care and screening of refugees taken to a protected sanctuary before eventual immigration to the US (as was the case of Kurds removed from northern Iraq to the US military base on Guam).

What NDMS workers have already learned in managing large-scale natural disasters in a permissive environment is most valuable. However, healthcare providers with the potential for service in international complex emergencies must first receive additional education on health issues in complex emergencies, international humanitarian law, and security and evacuation training, as well as attend psychological briefings, and receive critical cross-cultural awareness before deployment.

Recommended additional readings:

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