GETTING READY TO GO:

SPECIAL NEEDS OF REFUGEE WOMEN AND CHILDREN

THE HEALTH PERSPECTIVE

Introduction

During the next 12 months, it is likely that approximately 6 million refugees will begin to make their way home: from Thailand to Cambodia; from Iran and Pakistan to Afghanistan; and from Sudan to Eritrea and to the Ethiopian province of Tigray. It is also possible that a further 600,000 Liberian refugees will return home from Guinea and Cote d'Ivoire, and another 300,000 refugees in eastern Ethiopia might return to northern Somalia. The future of other large refugee populations, such as the Palestinians in the Middle East, Mozambicans in Malawi, southern Somalis in Kenya, and Burmese in Bangladesh remains highly uncertain due to the continued failure to peacefully resolve the problems that generated these latter mass population movements. What I would like to do during this presentation, is to examine the major implications of repatriation on the health of these refugee communities, many of whom have been confined to camps and largely dependent upon international assistance for more than ten years.

During 1991, we witnessed the worst kind of repatriation: the sudden (and forced) return from western Ethiopia of approximately 300,000 southern Sudanese refugees, many of them unaccompanied minors who required continued assistance and physical protection from the international community. Their sudden flight created another acute emergency in southern Sudan, requiring a heroic response from the global community in a geographic region where the logistics of aid are near impossible, and where the cooperation of the national government is absent. Only last week, this saga continued when 30,000 of these unaccompanied minors fled Sudan for Kenya. Given its abrupt and unpredictable nature, there was little that we could have done to prepare for such a massive repatriation, but I mention it as an example of what we must strive to avoid--a repatriation emergency on the scope of the original refugee emergency. In many cases where repatriation is currently being seriously discussed and encouraged, the security situation in the refugees' country of origin is still highly unstable (e.g., Cambodia, Afghanistan, and north-west Somalia). The greatest threat to the health of these refugees remains the physical threat of renewed violence in their homelands, and--perhaps the greatest threat--each of these countries contains vast regions where land-mines and other anti-personnel weapons have been deployed for many years. The innocence and curiosity of young children place them at high risk of life-threatening injuries caused by these weapons. The first thing to do in getting refugees ready to go home, is to ensure their safety once they do return.

Major potential health problems in children

Between 15-20% of refugee communities comprise children less than five years of age; this is the group most vulnerable to diseases that cause high death rates. The diseases that affect this age group are the same diseases that cause high death rates in non-refugee children throughout the developing world--malnutrition, measles and other vaccine-preventable diseases, diarrhea and dehydration, respiratory infections, and malaria. At the time when these refugees first fled their homelands, they often suffered high death rates in the camps; however, after years with relatively adequate food supplies, high vaccination coverage rates, relatively safe water supplies, and good basic health services, their general health status has improved to a level higher than that of children still living in their countries of origin. Afghanistan, Ethiopia, Cambodia, Somalia, and Mozambique are among the ten countries with the highest infant and child mortality rates in the world. Approximately one-quarter of all children born in these countries die before the age of five years. The infant mortality rate among Afghan refugees in Pakistan is now approximately one-third that in Afghanistan itself; the infant death rate among Cambodian refugees is less than a quarter that in Cambodia. The greatest threat to the health of these refugee children when they return home (apart from the physical injuries I mentioned earlier) will be an environment where access to adequate food, clean water, and basic health services may be difficult. For example, only about 4% of rural Cambodian families currently have access to safe water supplies. The next panel will address the issues related to reconstruction back home; I will merely emphasize how critical it will be to ensure that, in the regions to which refugees return, considerable efforts are made to provide access to food and clean water and to strengthen local health services.

Back to getting ready to go! Given the likelihood that health services in the regions to which refugees are repatriated will not be running at full steam immediately, it will be essential to ensure that all children under five are fully vaccinated against measles, diphtheria, whooping cough, tetanus, and polio before their return. To demonstrate the vulnerability of a population to a diseases such as measles, in the absence of a functioning vaccination program, I offer the following example:

In a returning population of 100,000, approximately 20,000 would be children under five years of age. If 80% of children 9 months to 5 years were vaccinated against measles at the time of repatriation, that leaves approximately 3-4,000 children at risk of measles. Within only 9 months after returning to an area without a vaccination program, this number would increase to approximately 8,000 (or approximately 40% of all under fives), more than enough to allow a measles epidemic to explode. In such an event, without any intervention, almost all unvaccinated children would get measles and approximately 10% of them would probably die. Thus, 1 in every 25 of these repatriated children could die from measles due to the lack of functioning health services. To avoid this, we must ensure that firstly, all children leaving a camp to return home are fully vaccinated; secondly, that a vaccination program is functioning in the region to which they return.

Development assistance efforts in countries like Cambodia and Afghanistan, therefore, need to be accelerated.

Malnutrition rates in refugee children in Thailand, Malawi, and Sudan are currently relatively low. There is evidence, however, that malnutrition rates among Afghans in Pakistan have risen recently; this increase may be associated with recent ration cuts. Refugee communities must not be sent home with high malnutrition rates; malnutrition will lead to children being more susceptible to illness and death from communicable diseases. It is, therefore, critical that donors do not decrease their contributions to refugee feeding programs in this phase prior to repatriation. The danger of donor fatigue in these situations is very real.

After measles and malnutrition, the most important threat to child health is diarrheal disease. The most effective method of preventing diarrhea will be to ensure safe water and adequate sanitation facilities in all villages to which refugees return. Large transit camps need to be avoided, given the danger of epidemics of diarrheal diseases, especially cholera which is endemic in most of the countries to which refugees are returning. In addition, the probability of **death** from diarrhea and dehydration may be reduced by ensuring that an oral rehydration program is in place. Prior to returning home, moreover, we must ensure that an adequate number of community health workers are trained in the use of oral rehydration fluid to treat dehydration. In addition, all mothers should know how to manage their children in the event of diarrhea, by giving them appropriate, locally-available fluids and by continuing to provide adequate nutrition. These mothers should also have been exposed to relevant health education messages related to breast-feeding, weaning foods, hygiene, and other measures important for the prevention of diarrhea.

This leads me to broader strategies for preparing mothers and children for the trip home. In every community that returns to their home village or town, there should be at least one community health worker trained in the prevention and primary treatment of the basic health problems that commonly affect women and children. Several studies in Thai camps for Cambodian refugees have demonstrated that women perform most effectively in the role of community health worker. These studies have shown that women tend to be more accepted and trusted by the community, and tend to perform their role in a more consistent and reliable manner than men. Women, therefore, should comprise the majority of these community health workers.

Women's health

Women's share of the household workload often increased while they were in refugee camps, particularly in Africa. The shortage of water and cooking fuel in many camps in the Horn of Africa meant many hours walking long distances and carrying heavy loads. In addition, total reliance on food rations that often lacked essential nutrients led to women suffering from various nutritional deficiencies disproportionately compared with

men. Incidence rates of scurvy (in Ethiopian and Sudanese camps), pellagra (in Malawi), and anemia (almost everywhere) have been much higher in women. The high prevalence of anemia has placed many refugee women at grave risk of the severe complications of childbirth, especially hemorrhage. Women repatriating to Cambodia, Ethiopia, and Afghanistan are returning to countries where the maternal mortality rate is between 600 and 1000 per 100,000 births. If the average woman gives birth to eight children, then her chance of dying in the course of one of those births will be between 5% and 8% in these countries. The most common causes of maternal deaths are hemorrhage, infection, and--at least in the case of Ethiopia--septic abortion.

Two interventions will greatly decrease this death toll: access to family planning services and delivery of infants in the presence of a trained health worker. While continued access to family planning services will depend on the quality and availability of health services back home, much can be done beforehand at least in educating women and raising their awareness about various methods of contraception. Regarding birth attendants, it is essential that every returning community has at least one trained, traditional midwife--trained, that is, to maintain a hygienic environment during delivery and to manage excessive bleeding. These midwives will also have an impact on neonatal tetanus, a potential major cause of infant deaths. For these village midwives to continue to provide useful services to women back home, they will also need support and supervision from a functioning primary health care service. In the case of Afghan refugees in Pakistan, many women have been exposed to the benefits of modern primary health care for the first time while in refugee camps or villages. Many traditional birth attendants and female health workers have been trained and given a prominent role in the health care system. It would be a tragedy if these women returned home and lost that role because of the lack of basic health services back in Afghanistan.

I need to mention here another critical health problem that threatens to overwhelm many communities in developing countries; that is AIDS. Many of the refugee communities discussed here are either coming from, or going to, countries where the prevalence of infection with the human immunodeficiency virus is extremely high. Ethiopian refugees are returning to a country where the prevalence rate is as high as 60% among high-risk groups in the population. Mozambican refugees have been living in Malawi, a country where up to 30% of all pregnant women are HIV +ve; likewise, Cambodians have been living in a country currently in the midst of an HIV epidemic. While there is no reason to believe that refugees are at any higher risk for HIV transmission than non-refugees, they should at least have access to the same level of education and preventive measures available to others through national AIDS control programs, inadequate that these may be. The problem of AIDS and other sexually transmitted diseases needs to be addressed honestly in refugee camps: men, women, and adolescents need to be exposed to education on how to protect themselves from acquiring the AIDS virus. HIV prevention needs to be made a higher priority than it currently is in refugee camps.

In conclusion, the two critical elements of preparation for going home are the training of community health workers, especially women, who might continue to provide adequate primary health care to their communities upon return, and secondly, support to basic health services back home. Most important, however, is to ensure that refugees are returning to a safe and secure environment. The refugees that we are considering today fled the horrors of war and persecution; many of them witnessed and directly suffered atrocities, particularly in Cambodia, Mozambique, and Somalia. It is understandable that they return with considerable trepidation. As I said earlier, we should not precipitate new disasters by proceeding with repatriation in undue haste, be it motivated by a wish to absolve ourselves of responsibility for the care of refugees or by misguided optimism about the situation back home. While the disastrous repatriation of Sudanese last year might not have been preventable, similar disasters in Afghanistan, Cambodia, and Ethiopia are preventable through careful planning and implementation. Mass repatriation is an exciting prospect for the 1990s; let us ensure that it not become a new form of international public health emergency.

Michael J. Toole, MD
Centers for Disease Control
Atlanta, GA

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