Displacement and health

Samantha L Thomas* and **Stuart DM Thomas†**

**Department of War Studies, King's College London, London, UK and †Department of Forensic Mental Health Science, Institute of Psychiatry, London, UK*

The health needs of displaced populations vary widely. The question as to the demands displaced populations place on health care resources and health care providers in their destination countries or regions remains the subject of great debate and contention. Internationally, health care workers are faced with complex challenges in providing care to displaced populations. This paper highlights some of the key health issues for displaced populations around the globe. Whilst 'Band Aid' solutions to existing health problems are useful in the short term, the paper describes the need for long-term public health prevention and educational strategies to enable displaced communities full access to and participation in their new 'home' communities.

Introduction

"Sometimes they flee across national frontiers. Sometimes not. To them it makes little difference. They may not even know which country they are in, when they first arrive in a place of refuge. Those who are still in their own country are in just as desperate need of protection and relief as those who are not. And those who have crossed a border sometimes find themselves better off than the "host" population which gives them refuge, but which does not benefit from the same assistance programmes."

Kofi Anan, 2000[1].

The question as to the demands displaced populations place on health care resources in their destination countries or regions remains the subject of great debate and contention. Displacement may occur within an individual's own country (internal displacement), or lead to flight across national borders to neighbouring or other countries (as asylum seekers). The process of displacement will inevitably lead to an added health and social burden on the receiving state, region or country. Quantification of the health care needs of these groups is therefore required so that the sometimes scarce resources can best be targeted to meet the challenging needs of these diverse groups.

Sometimes needs will be longstanding and established before any displacement activity, whereas others may result from the displacement journey or integration and settlement in their determined destination. As

Correspondence to: Dr Samantha L Thomas, Ph.D., Medical Sociologist, Department of War Studies, King's College London, Strand, London WC2R 2LS. E-mail: SamThomas1973@aol.com

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the number of refugees and internally displaced people (IDPs) increase, global communities face the challenge of providing social, welfare and healthcare services, which respect both the uniqueness of their situation and the individual differences of cultural identity and health beliefs. Added to these challenges is the need to provide meaningful opportunities for refugees and IDPs to fully participate in their new communities.

Davey Smith argues that the relationship between ethnicity, socio-economic position, and health is complex, changes over time, and may differ extensively between countries of origin and host countries[2]. As such, we must consider a range of factors when investigating the health of migrating or displaced groups. Furthermore, we must be aware that health status may change over time—particularly between different generational groups.

Migration and health

Migration and health has interested social scientists and epidemiologists for many years. It is worth briefly mentioning the relationship between migration and health, in order to socially and culturally locate our future discussion on the relationship between displacement and health.

During migration, a number of factors may impact on health. Perhaps the most interesting debate has surrounded the fact that first generation migrant populations (mostly from developing nations to the West) may often initially have a lower crude mortality rate than the host population. This has often been termed the *healthy migrant bias* as it is the healthiest individuals who are selected by others, or self selected for migration[3,4]. It has been argued that this bias is only temporary. Whilst mortality from communicable diseases, which are common in the country of origin, quickly declines on arrival in host countries, there is an inevitable time lag in the accumulation of relevant risk factors for diseases such as ischaemic heart disease[5], cancer[6], diabetes[7], stroke[8] and asthma[9]. Furthermore, the *salmon bias* which hypothesizes that many migrants may return "home" when they are elderly or critically ill, may also distort mortality rates of migrants in a host country. It is difficult to test whether this is in fact correct given the methodological complications of tracing the health of migrants returning home over time. *Genetic predisposition* to disease may also impact on post-migration health. It is important to note that heterogeneity in genetic and biological factors will mean that the health outcomes of migrant groups will not be uniform. Predisposition or fragility of some migrant groups to certain health problems (such as sickle cell anaemia) will also inevitably mean that some groups will do better than others. Finally, all of the above factors

will be compounded by *socio-economic* and *cultural* differences in diet, nutrition, health habits, housing, help seeking behaviour and psychological orientations.

Who are displaced people?

The forced migration literature is full of conflicting definitions about different groups of displaced people around the globe. No one definition completely encompasses the different groups of displaced people. Broadly speaking, the main groups of interest in this debate are refugees and asylum seekers (who are displaced outside of their national borders) and IDPs (who are displaced within their own nation states). As such, our definitions draw on criteria defined by the United Nations, enshrined in international law, as a standard by which to compare groups.

Refugees and asylum seekers

The United Nations defines a refugee as someone 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 such 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 as a result of such events, is unable or, owing to such fear, is unwilling to return to it"[10].

However, most of the world's refugees do not have formal determinations of their status under the United Nations Refugee Convention. As such, groups such as asylum seekers—those who are awaiting status determinations as refugees—are also encompassed in the United Nations definition.

IDPs

The United Nations High Commission for Refugees (UNHCR) defines IDPs as:

> "people [who] are also forced to flee . . . but they either cannot or do not wish to cross an international border"[11].

Thus, an IDP may have been forced to flee their home for the same reasons as a refugee, but the difference is that they have not crossed an

internationally recognized border. Whilst many IDPs are in similar situations to refugees and face the same kinds of problems, international refugee law does not protect them. Because of this, IDPs remain subject to the sovereignty of their own government and consequently may not have access to international aid and services that can be made available for refugees.

How many and where?

Globally, the reported number of refugees has fluctuated significantly in the last 10 years. This fluctuation is caused by the number of conflicts in the globe, the places in which these conflicts occur, and how this conflict is viewed by external countries. In 2002, there were an estimated 13 million refugees across the globe[12], but the numbers identified vary greatly both between and within continents. For example, in 2002, there were approximately 3 million refugees from Africa, 850,000 from Europe, 750,000 from the Americas and the Caribbean, 900,000 from East Asia and the Pacific, 5 million from the Middle East, and 2 million from South and Central Asia[12]. One of the main difficulties is that different countries may define refugees in different ways, according to their own national standards. Furthermore, different countries may have different criteria for the entry and repatriation of refugees. They may also collect data about refugees in different ways. As such, the interpretation of official statistics must be viewed with some caution, and as estimates.

Accurate estimates of the number of IDPs are even more difficult to determine. This is mainly because non-governmental organizations, particularly human rights and humanitarian aid agencies, are most heavily relied upon for the determination and collection of data on this group of people. Because of this, estimates vary widely. However, as an indication of the sheer scale of the problem, in 2002 the Global IDP Survey estimated the number of conflict-driven IDPs to be 25 million people[13]. Countries with the highest estimated number of IDPs in this 2002 survey included Burma, Indonesia and Turkey. Each of these countries had a reported 600,000 and 1 million IDPs[12].

What causes displacement?

Moore and Shellman (2002) propose a simple cost-benefit model and argue that people will stay in their homes when the expected benefits of staying exceed the costs of staying, and they will leave when the costs of staying exceed the benefits of staying (where cost would be associated with physical, emotional, social and environmental factors in addition to any

monetary cost *per se*)[14]. Generally speaking an individual will flee when the integrity of their person is threatened and they will tend to flee toward countries/areas where they expect conditions to be better[15]. However, for many displaced people, movement merely means a shift from one poor and vulnerable situation into similar further vulnerable circumstances. Additionally the question as to the perceived longevity of the displacement requires consideration and whether this 'move' will be temporary (for example until the conflict ceases) or permanent.

Clearly not every experience of forced flight matches legal requirements defined by international law. Indeed patterns of flight may be voluntary or forced. Whilst socio-economic factors, such as poverty and under-development, may not directly cause forced migration they certainly play a central role in the development of conflict.

It is generally accepted that refugees and IDPs flee from similar root causes, and have similar occurrences, circumstances and experiences before fleeing from their homes. Some such common causes may include persecution, violence, armed conflict and war—all generally recognized precursors that can lead to flight/migration.

Additional consideration needs to be given to the circumstances of 'environmental refugees'[16,17] displaced by natural events (such as earthquakes[18], or droughts[19]) and other more iatrogenic factors such as deforestation and pollution[20], and the needs of these distinct populations.

What are the pre-flight, flight and post-flight phases of displacement?

A variety of events and factors can make individuals and populations susceptible to health risks. In focusing on displaced populations, aspects of vulnerability can be categorized and associated with specific stages or phases of the process of displacement; namely pre-flight, during flight and post-flight.

Pre-flight

Many populations will have pre-existing vulnerable groups that are more susceptible to the effects of conflict or an otherwise adverse event and therefore more likely to become displaced internally or internationally. This vulnerability may be the result of poverty, poor housing, violence, ethnicity, religion, or limited access to health services or preventive health measures associated with, for example, infectious diseases. The presence of such groups can be an important predictor of the potential

impact and subsequent health burden on health care services associated with the displacement process.

Flight

The actual process of moving and displacement can lead to health related difficulties, particularly for vulnerable groups such as children, women and the elderly or otherwise infirm. The risks associated with flight cover health-related problems including a lack of basic survival necessities required to sustain 'good' basic health such as food, shelter and water. Added to this would be the lack of access to emergency health care in times of need, and the commonly poor sanitary conditions that have to be endured during this transitory period.

Post-flight

People adversely affected by the displacement process, and those with existing conditions will be the principal groups most vulnerable to health difficulties immediately upon arrival in their destination place. Initial needs that require addressing for the entire displaced population will relate to basic housing, food, water and sanitation. The degree to which these general needs, let alone the more specific needs of certain groups in the population, can be provided at an appropriate level will be largely determined by the nature and capacity of the receiving state/province/country. It should also be noted here that the places that refugees and IDPs flee to may not be 'developed' in a traditionally westernized sense and therefore may not be ready or prepared to deal with a sudden influx of people. Therefore, in these circumstances, additional complications arise, as discussed below. This is particularly problematic for IDPs as they would not routinely have access to aid and support services that may be available in other countries for (international) refugees.

What are the health difficulties of displaced populations?

The United Nations 'Guiding Principles on Internal Displacement' are a series of 30 principles relating to the protection from displacement; protection during displacement; humanitarian assistance; and the return, resettlement and reintegration of IDPs[21]. Principle 19 specifically addresses the provision of appropriate heath care, stating:

1 All wounded and sick internally displaced persons as well as those with disabilities shall receive to the fullest extent practicable and with the least possible

delay, the medical care and attention they require, without distinction on any grounds other than medical ones. When necessary, internally displaced persons shall have access to psychological and social services.

2 Special attention should be paid to the health needs of women, including access to female health care providers and services, such as reproductive health care, as well as appropriate counselling for victims of sexual and other abuses.

3 Special attention should also be given to the prevention of contagious and infectious diseases, including AIDS, among internally displaced persons.

There are several key health issues of importance here, which are now considered and summarized in turn:

Mental health

Previous research on the mental health of refugees has most commonly focused on two areas—post-traumatic stress disorder (PTSD) and depression. A number of studies have indicated that refugees suffer significantly more mental health impairment than other groups[22,23]. Four of the most common psychological reactions found in refugee and displaced people groups have included—PTSD (as a reaction to violence and/or torture), depression (for example as a reaction to loss), somatization, and existential dilemmas (where belief patterns have been challenged)[24,25]. As discussed, perceived psychiatric or psychological distress may be the result of experiences before flight, during flight from their homes, and on arrival in their new homeland.

Whilst studies about the mental health of asylum seekers (those without formal refugee status) are still in their infancy, there is evidence that post-migration stress may add to the effect of previous trauma, creating additional mental health risk[26]. Perhaps one of the most concerning findings is about the impact of detention (*i.e.* imprisonment or containment whilst decisions about refugee status are being processed). A recent study in the United States found that the mental health of asylum seekers in detention was extremely poor, including high levels of anxiety, depression and post-traumatic stress symptoms, which became worse the longer individuals were in detention[27]. In Australia, detained asylum seekers reported exposure to an average of 12.4 (of a possible 16) major trauma categories, compared with 4.8 for asylum-seeker compatriots residing in the community[28]. However, the question remains about how asylum seekers will adapt to community life if/when they are released from detention.

Not all refugees and IDPs will present with symptoms of psychiatric distress on arrival in their new home. Psychiatric distress may present days, weeks, months or even years after the initial flight phase. For

example, a study estimating the prevalence of mental illness and poor mental health among Guatemalan refugee communities located in Mexico 20 years after conflict showed that 12% fulfilled the criteria for PTSD, over half (54%) had anxiety symptoms, and more than a third (39%) had symptoms of depression. Factors associated with PTSD were witnessing the disappearance of family members, being close to death, or living with many other people in one house. Elevated anxiety symptoms were associated with witnessing a massacre, being wounded and experiencing a number of traumatic events[29]. Other studies have shown that refugees have a marked tendency to present somatic rather than emotional conditions when seeking help for underlying mental health difficulties[30]. IDPs may be additionally vulnerable to mental health difficulties. A study in Kosovo reported that IDPs suffered more traumatic events for a longer period of time than refugees and had higher associated levels of psychological morbidity[31]. In a group of Vietnamese refugees in Australia, trauma-related mental illness appeared to decrease steadily over time. However, a subgroup of people with a high degree of exposure to trauma had long-term psychiatric morbidity[32].

These issues have clear implications for the establishment and continuation of community-based outreach services for both refugees and IDPs to monitor the longer term mental health difficulties associated with individual difficulties relating to adjustment and adaptive coping mechanisms.

Health of women and children

It is estimated that nearly 80% of refugees and IDPs are women and children. They are particularly vulnerable to physical and mental health difficulties, and have unique health care needs. In recent years, increasing attention has been paid to quantifying the number of refugee and IDP women and children who have experienced sexual violence during conflict situations. Some studies indicate that upwards of 60% of refugee and IDP women in some settings have been the victims of rape and sexual abuse[33]. Alongside this, many women and young girls may have had abortions, therefore particular sensitivity should be paid by clinicians and related health care workers. Reproductive and sexual health programmes (including cervical screening, AIDS awareness, and mother-baby health) need to be a particular focus for health interventions in the longer term.

Studies examining the health and well-being of refugee and immigrant children show high levels of exposure to violence, and experiences of multiple stressors[34–38]. In a recent retrospective study of former UNITA members and their families displaced within Angola, excess levels of global

and child mortality were reported[39] both before and after their resettlement in camps after the ceasefire of 4 April 2002. Young people who arrive unaccompanied are additionally vulnerable and multiagency working is particularly necessary to provide multifaceted care. All young refugees and IDPs may be at risk of further exploitation. For example, recent research shows that many refugee children in the UK have been bullied at school. Food insecurity and child hunger may also continue once families arrive in the place of arrival[40]. Many children may also arrive without a record of appropriate vaccinations, which could have important public health ramifications. Whilst many young people show resilience in the face of these adversities and in adjusting to their new home environment, it is important that child friendly services which address a combination of social and psychological needs be made available.

Physical health and infectious diseases

Phases of a humanitarian emergency can usefully be defined in terms of crude mortality rates (CMRs). These relate to the number of deaths in a specified population over a specified period of time. (*Note that it is valid to make comparisons within specified populations at different time frames but not between different populations, as there is no account for their different underlying characteristics that may affect the overall rate of disease occurrence and/or mortality.*) There is some evidence that displacement increases these CMRs to at least double normal baseline rates in the population before any displacement activity. The most critical phase, an 'emergency phase', is defined when the CMR is greater than one death per 10,000 people in a single day[41].

However, it should be noted that as these displaced populations generally remain in their new 'homes' for sustained periods of time the CMR will level out as health patterns stabilize over time (a post-emergency phase) and healthcare needs are identified and met. During this time there is need for continued surveillance and health monitoring to ascertain any changes in the health status of these populations over time.

The public health implications of infectious diseases in refugees and IDPs are still difficult to address both in developed and developing nations. Infectious diseases can be particularly prevalent in displaced populations owing to both the actual physical conditions displaced people find themselves in as a result of the conflict/adverse events, as well as a lack of basic health knowledge, education and/or promotion within the population itself. Measles, a lack of sanitation, malaria, diarrhoea and acute respiratory infections all contribute to an excess CMR amongst displaced populations, especially in under-developed countries[42]. For example a study of 25,000 Kurds in refugee camps in north-western Iran

had a CMR nine times higher than the CMR of Iraq[43]. Sustained conflict and forced migration have also led to an increase in chronic diseases such as diabetes[44]. These largely preventable (and highly treatable) disease states are also often exacerbated by malnutrition.

Screening of newly arrived refugees to developed nations has highlighted that healthcare providers should be aware of the often acute needs of these populations. Whilst refugee populations have been seen as having increased risk for acute tuberculosis and related infection, Hepatitis B and intestinal parasite infection[45] it is important to remember that refugees from different parts of the globe will present with different types of health difficulties. Many countries still lack the appropriate resources to address these health needs, alongside the language barriers, cultural differences and economic difficulties inherent in refugee populations. Meeting these needs in culturally acceptable and financially feasible ways is challenging for many healthcare systems[46].

How may health needs be assessed?

Historically one of the main problems associated with being able to help and treat these displaced persons is the time delay between becoming aware of a newly displaced group and being able to pool and mobilize the resources necessary to assess, filter and treat the diverse health care needs that are presented. But arguably there are relatively clear indicators of an impending large-scale population displacement. Furthermore, from previous experience with conflicts, it is possible to predict the main health-related problems that services will be faced with, at least in the short term. As such the mobilization of health care interventions and resources could become more proactive as opposed to reactive by having a standard set of contingency plans in place internationally. Such forward planning would improve health outcomes for the displaced individuals and provide more equivalent levels of care and treatment to that available to others in the country/region.

How should health care be provided?

It is recommended that health care should be provided in a tiered fashion with appropriate screening phases to reduce the health burden on what will inevitably be scarce resources. Community-based outreach services have been highlighted as an effective initial screening device so as to reduce the number of inappropriate self-referrals.

A common standard of healthcare should be agreed and adhered to according to a standardized treatment schedule. It is also recommended

that where confirmed diagnoses are not readily available, treatment should be applied on a symptomatic relief basis. The need for clear verbal and written information about any healthcare interventions is also a necessity in a dialect familiar to the individual concerned.

Issues of health promotion and health education are vital. It has been recommended that locally respected professionals (such as traditional healers, midwives and elders) are used to provide initial training which will lead to a more effective communication of the basic principles and practices of health and therefore improved compliance with intervention strategies.

Individual responsibility should be encouraged and health care services should operate alongside local infrastructure with local involvement, all the time encouraging the advancement of local skills and knowledge[33]. It is also essential that health workers have implicit understanding of local health beliefs and concepts of health and disease as well as information on how these displaced populations access healthcare services. This can be especially relevant in terms of ascertaining the prevalence of disease states and any hidden morbidity or mortality associated with alternate health beliefs.

It should also be noted that the conflict that led to initial displacement may also have caused damage to the local infrastructure and the health services. In these cases, it is essential that a phase of rebuilding must run parallel to any programmes set up to provide the early stages of emergency health interventions.

As already noted above, health-related disorders can manifest themselves at various stages of the pre- and post-flight phases of displacement. Therefore the longer term health needs of these displaced populations will need to be monitored *via* community outreach services over sustained periods of time.

Conclusion

The health needs of displaced populations vary widely. Whilst the root causes for flight may be similar, experiences are heterogeneous and multifaceted. It is the recognition of these individual differences in experience that underpins the assessment of, access to and delivery of targeted healthcare interventions with displaced people. However, many nations are restricted in their ability to provide such services as a result of financial or resource restraints. As such, multi-agency working is essential to pool resources in the most effective, efficient, culturally appropriate and financially feasible way. Existing international guidelines and standards provide a basic starting point for the provision of care to these groups. However, it is also important to recognize that the quality of life of refugees and IDPs does not automatically improve once they have arrived in their new 'home'. 'Band Aid' solutions to existing health problems will not

lead to full participation in new communities. Rather, thoughtful prevention and education strategies are also needed to challenge popular misconceptions about displacement and displaced populations, and to allow these groups to realise their full potential within civil society.

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