

HEALTH CONSEQUENCES OF WAR AND HEALTH RELIEF: CHALLENGES OF ASSESSMENT

Jok Madut Jok

Accurate assessment of health care for populations displaced by oppression, civil wars or resulting famine is vital to the design of health relief programs and the evaluation of health intervention. As Godfrey and Kalache (1989) observe, this need has recently received considerable attention from inter-governmental organizations such as United Nations High Commission for Refugees (UNCHR), non-governmental organizations such as OXFAM, CARE, Save the Children (OXFAM, 1983) and from academic units as evident in the works of Jellife and Jellife (1981).

As Dick and Simmonds (1983) point out, health problems associated with displacements are 'similar but different' to those of stable communities in the developing world. Moreover, it is often not possible for people displaced by war to return to their homes or to resettle in another country of asylum. Thus, Simmonds recommends that "health relief needs to be planned and implemented within the context of development with adjustments for the emergency phase and rapidly changing circumstances" (1984:730).

One main thing is associated with emergency period following displacement. This is likely to be scarcity of resources. In response to this fact, community leaders and relief workers are presented with a dilemma. They have to make a choice between distributing the scarce resources equally among the entire population, or directing help to those in dire need. The idea of targeting scarce resources for those most in need is a principle of triage which is a well established and accepted principle in medical practice. It was first developed for ranking surgical cases in times of war since World War II (Godfrey and Kalache, 1989). This practice has been adopted in relief, especially in nutritional care (Aal, 1970). Although this practice is a logical one, it leaves the needs of certain groups in refugee populations unattended.

This essay will discuss research techniques used to help increase understanding of the health of populations displaced by war and associated famines. I will draw on examples from several war-torn countries in Africa, Middle East, and Latin America to show scarcity of accurate information on certain groups among populations displaced by oppression, civil wars or famine, and which lead to their neglect in health and nutritional relief. Drawing on analyses of social scientists, I will attempt to identify the best ways of targeting the most vulnerable

groups for priority in health relief. The usefulness of health and nutritional relief depends on the accuracy of the data that is fed into analysis. Faulty data and rough estimates may lead to results that would seriously mislead relief planners. Under conditions of conflict and poor facilities, appropriate and accurate information for assessment of displaced people's health and planning of relief can be difficult to acquire.

As Godfrey and Kalache argue, "targeting health care is only successful when the individuals or groups most in need can be easily identified and contacted" (1989:707). Health relief or health care in general provided by international health organizations has always carried out primary care and mother-child care activities, thus, the groups that UNICEF and other organizations have supported have been children under 5 years of age, those who are ill, and pregnant and lactating women.¹ For example, UNICEF has adopted the GOBI-FFF strategy which gives priority to seven activities which are thought to be effective, low-cost control measures for the most important health problems of children, namely growth monitoring, oral rehydration therapy, breastfeeding and immunization, food supplementation, family spacing and female literacy. Given the state of health conditions in the entire refugee population, appropriateness and effectiveness of such a targeted approach has come under fire in general, but to a lesser degree in health relief. In health relief, especially during the emergency phase, there is a particular concern that health problems of other age/sex groups require equal priority, and that some important dimensions in target groups' health are usually not well documented.

Information on the health and nutritional needs of women, and the elderly populations displaced by war and famine tends to be relatively scarce. Most of what is available is usually derived from studies involving entire populations or focusing on a specific disease in a situation of a particular health problem (Ityavyar and Ogba, 1989). However, in general, in many Third World countries several problems associated with wars, such as physical destruction of social infrastructures, health care facilities, and problems of refugees which create constant mobility of displaced persons by political violence exacerbate already existent long term health constraints, hunger, and malnutrition.

To give some examples, in Nicaragua, according to Garfield (1989), each of the warring parties (the Sandinista government and Contra rebels) in mid 1980s targeted civilian population accused of collaboration with the enemy. The rebels targeted farm cooperatives and rural health centers in order to destabilize the Sandinista government as a means to win victory. Contra rebels attacks, lack of supplies and war-

related economic instability forced about 250,000 civilians from their homes. Of all these displaced persons, less than half settled in new agricultural communities established by the government in areas adjacent to their original habitats, but most of the rest fled to major cities. This migration was a severe strain on the social and health infrastructure of the country.

Likewise, international health organizations have been struggling since 1983 to deliver health and nutrition relief to the people of Southern Sudan cut off from health and nutritional services by violent conflict between the government and the South-based Sudan Peoples Liberation Army. Thousands of civilians have been caused to flee to big cities in the North and to the neighboring countries of Ethiopia, Kenya, Uganda, Zaire and Central African Republic (Dodge, 1990; Duku, 1988; Twose and Pogrund, 1988 and Dodge and Ibrahim, 1988). As Sabo and Kibirige (1989) report, similar conditions existed in Eritrea. Ethiopian occupation of Eritrea in 1952 led rapidly to the deterioration of health care and since then, Ethiopian health care in Eritrea has progressively deteriorated over the years, with the Ethiopian government's misuse of food as a weapon to force Eritrean militants to the negotiation table. Food has also been used to entice Eritrean and Tigrean peasants into urban areas where they can be controlled and resettled (mostly without their families) to Southeast Ethiopia. This caused displacement of thousands of Eritreans to Sudan.

Also, studies of the conditions of children under political violence have alarmed people about the stress children face in reaction to events of political violence, such as conditions of endemic war situations in Lebanon, Cambodia and the Philippines (Armenian, 1989). Effects of political violence on health are also very eminent in Israeli occupied Gaza Strip and West Bank (Annon, 1990). In Mozambique, where the South Africa-backed rebel group, RENAMO (Mozambique National Resistance), has been waging an economic war aimed at destroying social infrastructures like hospitals, peasants' homes and farms, thousands of civilians have been forced to leave their homes for neighboring countries or to the big cities. Health care of these people has deteriorated in the migrant lands as economies of host countries are ravaged by famine resulting from drought, and Mozambique is now the country with the lowest quality of life measurement (Rutherford and Mahajane, 1985).

What characterizes refugee populations in most of these countries is that they are composed mainly of women, children and the elderly (Melrille, 1992). In most cases, young adult men are involved in fighting. Therefore, refugee health care analysts must seek additional sources of information for estimating efficiency of expatriate health care.

One of the contributions which social scientists can make to relief policy and evaluation is to supplement health care specialists by gathering data on how displaced populations actually perceive help, how refugees can participate in distribution of relief, and how they acquire coping mechanisms and information on where to settle. This type of research can provide relief workers and host governments with more accurate information on the social organization of displaced persons and help them design more effective policies to relieve aid projects of cultural practices which sometimes function, if not well understood, as constraints on health care delivery.

What and how can we learn from this situations?

Examining the information on health relief targeting, it seems obvious that there is need for aiming studies to determine the demographic characteristics of displaced populations in order to identify the different groups for further design of accurate targeting of relief services. The population may be composed of healthy children, children with malnutrition, children with disabilities, pregnant women, lactating women, and the elderly². All these groups have different and varying degrees of health needs. Thus the second step after documentation of demographic characteristics is to identify functional disabilities in children and the elderly, and assessment of socio-economic support mechanisms which are available to, and are being used by each group. This approach, as Gibson (1989), Sabo and Kibirige (1989), Ityavyar and Ogba (1989), Shears (1987), and Zwi (1989) have found out in different parts of the world where health has suffered from political violence, attempts to provide a picture of the extent to which morbidity events and migration affect the life-style of certain groups such as older adults and ultimately their degree of autonomy. This agenda frees health relief workers from concentrating on disease finding activities, and may be complemented by semi-structured interviews with community and agency officials. This activity helps assess the extent to which each group can be considered in health policies, plans and activities. From this picture thus, the risk of death, illness and disability in each group and their specific health and related needs with implication for targeting practices in health relief may be portrayed.

In an attempt to assess conditions of each represented group, researchers in this field (Dodge, 1990; Godfrey and Kalache, 1989 and Rutherford and Mahajane, 1985) designed two kinds of questionnaire. The first one is a questionnaire which reports self-reported disability,

illness or death of family members leading to lots of social support. These are ranked according to the degree of difficulty experienced with a number of functional activities. In the case of older refugees, these activities may include pain, walking, seeing, personal hygiene, and chewing/swallowing. But in the case of the rest of the population, of consideration is the health status, access to resources and ability to support the family. Gardner *et al.* (1972) and Cobey *et al.* (1983) say that this approach is based on activities of daily living, and has been used extensively in epidemiological studies of ageing and functional disability of other age groups. The difficulty experienced with each of the functional activities is classified according to the level of assistance required, ranging from total independence to complete dependence. Other questions are used to assess the social support mechanisms and economic resources which are available to, and are being used by the group subject of focus. The problem with this kind of questionnaire is the sampling techniques which have to differ as the research moves from one camp to another, and which present researchers and health workers with difficulty of dividing the camps into villages and organizing the shelters into well-defined rows to allow a stratified sample to be drawn. After which a number of households can be randomly selected using random number tables.

The second questionnaire is aimed at households rather than individuals in order to determine the demographic characteristics of the entire population. Given the urgent nature of relief services, this questionnaire, like the one above, needs to be carried out by several teams of interviewers in order to complete the survey in a short time. Increasing the number of interviewers and separating the questionnaires can simplify the training of the survey team and reduce the amount of time needed to complete the survey. This questionnaire usually will record the age, gender, occupation, migration history and current location for each family member. Respondents may be limited to the head, or the acting head, of the household. However, like any research tool, this approach has its shortfalls. Because it relies on self-reporting, it must take into account potential biases in the results. The results may be distorted by the subjective nature of the information, lapses in memory or purposeful distortions in hopes of aid or as a cover for political activities. It is possible that such biases may increase the type and severity of disability, illness or resources reported by household heads in the hope of receiving assistance. Given the political nature of their displacement, family members in household survey may under-report on their relatives who they fear may fall in the hands of the government.

Who are in Need the Most?

Although health care for populations displaced by war and famine has entered the forefront of international attention with particular concern for children and women and with recognition that the health problems associated with these displacements are similar but different, as mentioned above, to those of stable communities of the developing world, it is yet observable in the literature that there are discrepancies in targeting for health relief. This is related, aside from war and displacement, to cultural practices that do not necessarily change once a population is displaced, and which do not lend themselves automatically to availability of health or nutritional care. For instance, despite the claim that women have been given enough attention, rates of maternal mortality, inadequate women's diet during pregnancy, high energy expenditure associated with physical activity in production, violence against women (including forcible extra-marital sex), high fertility levels which have sparked ever greater concern among health professionals over the increasing reproductive health problems and susceptibility of Third World women to a multitude of reproduction-related health problems have not been addressed in health relief efforts.

Let us examine the above conditions in detail, to show why women may be more vulnerable to a multitude of problems. According to recent data, unsuccessful pregnancy and its unhealthy outcomes are associated, among many issues, with the effect of energy expenditure (note that women, under conditions of civil conflict become the primary food producers), poor diet and subsequent weight loss (Huffman, 1988). In Southern Sudan for example, of many causes of female reproductive health problems reported over the last decade or so, the major one is anemia mainly due to poor nutrition and frequent pregnancies (Aziz, 1980). Other problems include unacceptability of child spacing among some ethnic groups, existence (paradoxically) of infertility that may be explained by prevalence of untreated pelvic infections, fibroid and fistulas (Naisho, 1982). The problem of maternal health in many Third World countries assumes proportions of even greater magnitude when we take into account the wide spread desire for children, preference for male children, women's productive activities and poor health care, inadequate child-bearing age, multiparity, and most critical, cultural constraints, most of which are exacerbated by conditions of civil war and displacement of which I gave examples above.

Another problem that put women (who constitute over 75% of refugee population) top on the research agenda is sexual violence. Repeated brutally forced sexual contact is a common aspect of the displaced female experience, either during the escape, at border crossings or during their life in camps. Although there are reports on rape from war-torn countries, these data are likely to underestimate the problem given the reluctance of women and other family members to report incidents of rape. The perceived honor prevents them from reporting rape. Some societies continue to attach a stigma to the woman who has been sexually violated. Many displaced women who have been raped or violated in any other sexual way are regarded by their community to have no more value, and they are sometimes isolated. As traumatic as it sounds, it becomes hard to assess these women's psychological problems that may result. It is thus a task of researchers to highlight this trauma in order to design a support system for these women.

Therefore, it should be of consideration, when designing research for health relief, to account for a number of macro and micro level conditions. Women are not only reproducers, as it appears in health relief targeting, but are also producers of food and health for their families, and should be looked at from all these angles, and for that matter, are the most in need. So attempts should be made to collect demographic and social cultural information for planning, monitoring or evaluating health status or health services.

Another group of refugees that is easy to forget are the elderly. As Godfrey and Kalache (1989) note, the health of older refugees deserves equal attention because older adults have difficulty with refugee life which involves walking and depending on oneself. Usually, older adults have problems of pain and sight and tend to depend on family members. Their needs are very basic: food, water, shelter and clothing, and do not differ from those of the entire population. Although older adults may function independently, they may sometimes do poorly so that they are vulnerable under difficult circumstances or their conditions may deteriorate, particularly for those who have difficulties with a wide range of activities. Studies of refugees in Sudan, Eritrea, Ethiopia, Mozambique and Lebanon mentioned above, suggest that older adults, particularly the elderly, are always indeed vulnerable to illness, disability, and death.

NOTES

¹This, of course, varies from one country to another. In several war and famine-ravaged countries, very little attention has been given to pregnant women.

²I have excluded other age groups because, unless they are ill, they don't usually present relief workers with severe problems.

BIBLIOGRAPHY

- Aall, C. "Relief, Nutrition and Health Problems in the Nigerian/Biafran War," *Journal of Tropical Pediatrics*, 16, 1970, 70-90.
- Annon. "The Conditions of Health Services in the Gaza Strip," *Medicine and Law*, 6(2), 1990, 140-51.
- Armenian, H. K. "Perceptions from Epidemiologic Research in Endemic War," *Soc. Sci. Med.*, 28 (2), 1989, 643-7.
- Armenian, H. K. and A. Acra. "From the Missionaries to the Endemic War: Public Health and Research at the American University of Beirut," *Journal of Public Health Policy*, 9 (2), 1988, 261-72.
- Bohanan, Paul. *Law and Warfare: Studies in the Anthropology of Conflict*. Austin: University of Texas Press, 1977.
- Cobey, J. H. et al. "Health Needs Assessment at the Refugee Processing Center, Bataan," *Migr. News*, 1, 1983, 121-122.
- Dick, B. and S. Simmonds. "Refugee Health Care—Similar but Different?" *Disasters*, 7, 1983, 291-303.
- Dodge, Cole P. "Health Implications of War in Sudan and Uganda," *Soc. Sci. Med.*, 22 (7), 1990, 713-21.
- Dodge, Cole and Sadiq A. Ibrahim. "The Civilians Suffer Most," *War Wounds: Sudanese Reporting on Their War*. London: Panos Institute, 1988.
- Duffield, Mark. "Absolute Distress: Structural Causes of Hunger in Sudan," *Middle East Report*, Sept.-Oct. 1990.
- Duku, Oliver M. "Cut off from Health Care," *War Wounds: Sudanese Reporting on their War*. London: Panos Institute, 1988.

-
- Ferguson, Brian. *Warfare, Culture and Environment*. Orlando, Florida: Academic Press, 1984.
- Florey, C. D. "Weak Associations in Epidemiologic Research: Some Examples and their Interpretation," *International Journal of Epidemiology*, 17 (4), 1988, 950-4.
- Gardner, P. *et al.* "Health Priorities Among Bangladesh Refugees," *Lancet*, 1, 1972, 834-36.
- Garfield, R. "War-Related Changes in Health and Health Services in Nicaragua," *Soc. Sci. Med.*, 28 (7), 1989, 669-76.
- Garfield, R. and A. Neught. "Epidemiologic Analysis of Warfare: A Historical Review," *JAMA*, 26 (5), 1991, 688-92.
- Gibson, Kerry. "Children in Political Violence," *Soc. Sci. Med.*, 28 (7), 1989, 659-67.
- Ginzberg, E. "Everything I Know about Health Care I Learned in the Pentagon in World War II," *Academic Medicine*, 66 (8), 1991, 349-52.(check original)
- Godfrey, N. and Alexander Kalache. "Health Needs of Older Adults Displaced to Sudan by War and Famine: Questioning Current Targeting Practices in Health Relief," *Soc. Sci. Med.*, 28 (7), 1989, 707-13.
- Hondius, A. J. and L. H. Van Willigen. "Baseline Health Care for Refugees in the Netherlands," *Soc. Sci. Med.*, 28 (7), 1989, 729-33.
- Ityavyar, D. and Leo Ogba. "Violence, Conflict and Health in Africa," *Soc. Sci. Med.*, 28 (7), 1989, 649-57.
- Jelliffe, D. B. and E. F. P. Jelliffe. "Refugee Medicine: the Need for New Approaches," *Science*, 21, 1981, 14-15; 18-19.
- Kardiner, Abram. *The Traumatic Neuroses of War*. New York: P. B. Hoeber, Inc., 1941.
- Kroll, Jerome *et al.* "Depression and Post Traumatic Stress Disorders in South East Asian Refugees," *American Journal of Psychiatry*, 146 (12), 1989, 15992 (check original)

Melville, M. B. and M. B. Lykes. "Guatemalan Indian Children and the Sociocultural Effects of Government Sponsored Terrorism," *Soc. Sci. Med.*, 34 (5), 1992, 537-48.

Oxfam Medical Unit. *Oxfam's Practical Guide to Refugee Health Care*. Oxfam: Oxford, 1983.

Rutherford, G. W. and A. E. Mahajane. "Morbidity and Mortality in the Mozabican Famine of 1983: Prevalence of Death and Illness Among Dislocated Persons in Gaza and Inhambane Provinces," *Jou. Trop. Pediatr.*, 31, 1985, 143-149.

Shears, P. *et al.* "Epidemiological Assessment of the Health and Nutrition of Ethiopian Refugees in Emergency Camps in Sudan, 1985," *Br. Med. Jou.*, 295, 1987, 314-318.

Simmonds, S. P. "Refugees, Health and Development," *Trans R. Soc. Trop. Med. Hyg.*, 78, 1984, 726-733.

Simmonds, S. P. and H. Brown. "Angola: Meeting Health and Health-Related Needs with Refugees," *Disasters*, 3, 1979, 403-411.

Spocher, Alexander. *Saipan, the Ethnology of a War-Devastated Island*. Chicago Natural History Museum, 1954.

Twose, Nigel and Benjamin Pogrud (eds.). *War Wounds: Development Costs of Conflict in Southern Sudan*. London: Panos Institute, 1988.

Zwi, A and A. Ugala. "Towards an Epidemiology of Political Violence in the Third World," *Soc. Sci. Med.*, 28 (7), 1989, 633-40.