HEALTH AND NUTRITION

Fleeing from home unexpectedly and in fear creates enormous physical and mental stress. This stress may continue through the various phases of displacement, and even after a permanent solution has been found. In addition, most IDPs have specific displacement-related problem caused by nutritional deficiencies or insufficient quantities of food and drinking water. The vast majority of IDPs cannot reach a doctor in time. Aside from material assistance, some form of psychosocial support may be needed to ensure that traumatised IDPs regain the ability to cope.

Health

Health status and mortality rates are the most important indicators for assessing the impact of conflict or other disasters on a population. Yet, while mortality rate studies are increasingly used to guide humanitarian action, it is not always easy, for various political and logistical reasons, to collect and publish such data.[65] Where mortality rate studies do exist, they often stretch over several years. For example, the International Rescue Committee has been conducting mortality studies in the DRC since 2000. Its latest findings were that almost 4 million people have died as a result of the conflict since it erupted in 1998, and that every month almost 38,000 deaths occur above the country's "normal" level, mostly in the eastern regions. Those deaths are mostly the result of curable diseases and are due to the lack of access to health care, which, in turn, is a result of conflict-related insecurity.[66] Mortality rates of infants and children under the age of 5 are extremely high in countries like the DRC, Ethiopia and Somalia, indicating a catastrophic health situation.

The existing – and limited – IDP-specific health data suggest that in more than half the countries affected by internal displacement, including practically all African and most Asian countries, IDPs – and in many cases the population at large – have no access to adequate health care. The main reasons are breakdown of health services in war-affected areas, lack of national financial resources, or the IDPs' remote location. Most of northern Uganda's IDPs were confined to camps with extremely limited access to health care. In several countries, including Burma, Somalia, the Palestinian Territories and Serbia (Kosovo), IDPs faced discrimination in gaining access to health care because of their ethnic origin or because of restricted freedom of movement. Lack of personal documents may also restrict access to health care; this is the case for European Roma.

Most diseases IDPs are exposed to are preventable. They include diarrhoea, acute respiratory infections, tuberculosis, malaria, cholera, measles and meningitis. Polio broke out in the Horn of Africa in 2006. The little information that is publicly available on the health status of IDPs is mostly based on anecdotal evidence, as not many health surveys specifically focus on IDPs.

While IDPs in the Balkans generally have satisfactory access to water, sanitation and health care, they are more likely than the local population to suffer from trauma-related problems.[67] Roma IDPs usually live in informal settlements with very poor sanitary conditions. IDPs in Azerbaijan and the Russian Federation access health care less easily than the local population

A displaced Lebanese child being vaccinated. (Photo: Dina Debbas, IRIN)

in some areas, due to administrative inconsistencies, lack of health care facilities and the demand for informal payments for medical treatment.

Recognising the physical expression of mental or social suffering is particularly relevant in conflict areas. Symptoms of illness, headaches or insomnia occur more often after flight or the loss of a family member. Traumatised people often suffer more profoundly from an illness than others would, and they are more resistant to treatment.[68] So even when displaced populations have the same access to health care as the local population, it is likely that they will require particular attention.

Nutrition

Nutrition and health constitute the core subsistence rights of IDPs, along with shelter and clothing (Guiding Principle 18.2). But conflict, ethnic discrimination, landmines or operational difficulties in reaching remote populations heavily undermine that right.

Caught in areas of conflict or remote parts of the country and, as a result, deprived of access to food and means of production such as arable land, IDPs often receive inadequate support from their government or the international community. Many suffer from malnutrition, often more so than the non-displaced populations who, despite suffering similar hardships, may have been able to retain resources and coping strategies. Furthermore, the mere delivery of food may not be enough to avert malnutrition. Traumatised persons suffer more frequently from eating difficulties or digestion problems. It is well-documented that a mother's trauma or depression has a direct effect on the nutritional status of her children.[69]

For most countries, very little information is available on the nutritional status of IDPs, either because there are no surveys or because the displaced were not addressed separately from the general sample population. Countries with IDP-specific nutritional information include Burma, Colombia, the CAR, Chad, Ethiopia, Liberia, Somalia, Sudan, Uganda, Timor Leste and, to a lesser degree, Angola and Nepal. All surveys indicate extremely high malnutrition rates among IDPs, with some above the critical 15 per cent emergency threshold set by the World Health Organisation.

The right to food

Providing food aid is complex and politically very sensitive. It can have an aggravating effect when parties to a conflict use food aid strategically, by diverting it from the intended beneficiaries for their own profit (as was the case with Somalia's warlords), or by deliberately restricting access to food (Burma, the DRC, Colombia, Côte d'Ivoire, Nepal, Sudan). A government's inaction can also have adverse effects, as has been the case in Colombia.

Many IDPs suffer from malnutrition and are dependent on food deliveries, often more so than non-displaced populations. (Photo: Christophe Beau, IDMC)

In other situations, it is difficult to ensure that food reaches displaced populations because they live in remote areas, while conflict-related insecurity may hinder humanitarian assistance, as has been the case in the DRC, the CAR, Ethiopia, Somalia and Uganda. In Iraq, military operations have repeatedly prevented access and delivery of humanitarian assistance.

Displaced women in Chad prepare food while camping by the roadside. (Photo: H. Caux, UNHCR)

Where food aid can be delivered, particular attention must be paid to its actual distribution to the intended beneficiaries. If existing power structures are not taken into account, marginalised and weak groups may be further disadvantaged.[70] Improved access to arable land and tools during displacement would greatly enhance IDPs' access to food and reduce their dependence on humanitarian aid. While efforts are made in Uganda and northern Somalia to provide IDPs with land, in many countries, fertile land cannot be accessed due to conflict-related insecurity (Colombia, Côte d'Ivoire, Burma, Eritrea, India and Bangladesh).

Water and sanitation

Clean water and appropriate sanitation are fundamental for a healthy environment. Access to clean water is recognised as a human right, but in at least one-third of the countries affected by internal displacement, the majority of IDPs are deprived of that right. In combination with the absence of adequate sanitation facilities, this has an extremely negative impact on their health. The spread of water-borne diseases is one consequence.

In many countries, IDPs' access to clean water and sanitation is inferior to that of the general population. These countries include Angola, Burma, the CAR, Colombia, Ethiopia, Iraq, Liberia, Mexico, Nepal, Peru, the Philippines, Somalia, Sudan and Uganda. A study carried out by Oxfam on the health of conflict-displaced populations in south Ethiopia found that many of them survived on two to three litres of water per day.[71]

Large populations in the Horn of Africa encountered similar hardship after the floods during the last quarter of 2006. The floods further contributed to the destruction of any water and sanitation infrastructure that may still have existed in this disaster-prone region. Looming conflict in Somalia seriously hampered the delivery of aid to the more than 400,000 flood-displaced.

Precarious living conditions with respect to water and sanitation are particularly evident in overcrowded camp situations – for example in the DRC, Uganda, Somalia or Sri Lanka. While camp populations can be assessed relatively easily, the majority of IDPs are dispersed in rural or urban areas, and little data exists on the hardships they experience as a result of poor water and sanitation facilities.

Mental health of IDPs

Many IDPs experience high levels of fear and humiliation. In chronic conflict areas, large segments of the population experience trauma, and children are often particularly affected.

The international humanitarian community increasingly recognises the importance of providing psycho-social help to conflict-affected populations, as indicated by an increase in comprehensive psycho-social studies. For example a 2006 IOM psycho-social needs assessment in former conflict districts of Indonesia's Aceh Province showed extremely high levels of traumatic symptoms.[72] In Colombia, NRC's legal aid to IDPs now includes the possibility of psychosocial support. The reasoning behind this service is that a traumatised person may feel too disempowered to demand his or her rights as an IDP. Those rights are, in theory, substantial in Colombia, but are often not exercised. The ability to claim their rights helps IDPs perceive themselves as actors rather than mere victims of circumstance. This work of regaining personal dignity and the strength to actively shape their lives is of particular significance to IDPs.

For the most part, psycho-social help is still provided as an adjunct to traditional humanitarian aid, although there is a growing understanding of the need to integrate it into more traditional aid work. A recent publication by the Swiss Agency for Development and Cooperation describes the various levels on which trauma influences a person's physical and mental well-being.[73]

In most countries, some sort of psycho-social aid for IDPs is currently provided, although it almost never covers the entire displaced population. The southeastern European countries affected by internal displacement come closest to providing such support to the majority of their IDPs.

The Rehabilitation and Research Centre for Torture Victims, has partnerships in several displacement-affected countries, including Bangladesh, Sri Lanka and the Philippines. In Iraq's Kurdish areas, the German-Iraqi NGO WADI supports displaced and local women in distress.[74] In Sri Lanka and Nepal, there are NGOs that are assisting IDP women and children with mental problems. In Uganda, a psychosocial resource book for teachers was developed and distributed in the north. In Russia, Médecins sans Frontières' mental health counsellors visit collective centres and conduct educational sessions on how to recognise and cope with various psychological problems. One obstacle to the success of this and other psycho-social assistance programmes is that there is a fierce stigma attached to seeking psychological help, especially for men. Generally, the support provided by local or international organisations remains limited and, at times, not well coordinated.

An inter-agency Task Force on Mental Health and Psychosocial Support was formed in June 2005 with the dual goal of integrating mental health issues into all relevant aspects of humanitarian work and of developing guidelines on mental health for organisations working in the field.

HIV/AIDS and displaced people

It has been widely recognized that HIV/AIDS has a disruptive effect on families and entire communities. Malnutrition is typically higher among populations with a high prevalence of HIV/AIDS, because the body of HIV-positive people cannot absorb nutrients as efficiently, and because there are fewer adults earning an income, which increases food insecurity. Stigmatisation further contributes to the precarious situation of people affected by HIV/AIDS.[75]

Other studies also point out that IDPs and populations living in conflict areas are at greater risk of contracting the virus than others, because of their unstable living conditions and vulnerabilities. But while it is often presumed that IDPs have higher HIV infection rates than the general population, this was not borne out in a January 2006 study of eight IDP-hosting countries. The study found that insufficient data exists to confirm a consistent higher prevalence of HIV/AIDS among displaced people and calls for more research into this issue.[76]

Even in situations where conflicts have ended, the nutrition and health status of IDPs can remain at emergency levels for a long time, due to poor access to water and sanitation, and because appropriate preventive and curative health services remain scarce. In post-conflict situations, the degree to which IDPs' nutritional and health conditions can improve is dependent on their capacity to recover from trauma and loss of assets. But in addition, governments and international donors must be willing to invest in the recovery and compensation programmes necessary to set a country on the path toward equitable development.