

Camp to clinic: a refugee journey

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The dark storm clouds on the horizon at dusk are typical of the wet season in Sudan. On this particular day, the wind that normally heralds the daily drenching of our compound had abated. It almost seemed it was in reverence to Tik, an 8-year-old Dinka girl, walking home leaning on her father and using a stick to compensate for her stiff-legged gait. A simple leg wound for Tik had translated into 3 weeks of painful muscle spasms as a result of tetanus. After successful treatment with diazepam, antibiotics and nutritional support, she was going home to her tent in the refugee camp. Another tent in the camp sheltered severely malnourished children receiving food and medicine from a non-government organisation in this remote area of war-torn Sudan.



Tik returning home after treatment for tetanus (pictured with Katherine Hale)

Children like Tik are not alone. At the start of 2005, there were 19.2 million people “of concern” to the United Nations High Commissioner for Refugees (UNHCR).¹ This included refugees, civilians who have returned home but still need help, people displaced internally within their own countries, asylum seekers and stateless people. Most refugees are fleeing war, famine or insecurity. Large numbers have recently returned home to Afghanistan, but refugee displacements have actually grown in Darfur, western Sudan. There are almost 7 million and 5 million people of concern in Asia and Africa, respectively.¹ Afghanistan, Sudan, Burundi and the Democratic Republic of the Congo (DRC) are the top four countries in terms of numbers.¹ Australia resettled about 13 000 refugees in the 2004–05 financial year.² At least 1500 of these came from large refugee camps in Sudan, Guinea and Tanzania.³ Understanding the conditions in the refugee camps and the medical facilities available before arrival in Australia will help health care providers meet the needs of these new arrivals.

Camp conditions and medical services

Refugee camps are often set up in countries neighbouring the conflict (Box). They can be assembled with little forward planning and virtually no infrastructure. There may be geographical difficulties — the area may have minimal food, water and shelter.⁶ Health care in refugee camps is provided by local authorities, and may be supplemented by international non-government organisations (NGOs) such as Oxfam or Médecins sans Frontières. Basic clinics provide primary health care and medicine for common acute conditions such as malaria, respiratory infections and gastroenteritis. Diagnosis is primarily clinical, with fundamental laboratory services such as malaria films and tuberculosis smears a luxury. Clinics are run by nurses, clinical assistants (with 2–3 years’ training in medical diagnosis and treatment) or doctors. There may be expatriate staff. Conditions can be very basic and a clinic may consist of wooden support poles and plastic sheeting. Local staff are adept at diagnosing and

An example from Meheba, Zambia

Meheba is a refugee settlement in north-western Zambia. It was set up in response to an influx of refugees from Angola fleeing civil war in 1971. In 2001, the population was about 47 000, most of whom originated from Angola, mixed with smaller groups of Congolese, Burundians and Somalians.⁴



Imelda and Jane (pictured with their mother in the clinic at Meheba, Zambia) are 2-month-old twins. They were born in the camp to Mary, who had recently fled unrest in Angola. Mary’s husband had disappeared in the war. Their birthweights were 1.6 kg and 1.7 kg, respectively. Their gestation was unknown, but they were presumed premature. It was Mary’s third pregnancy and she had no antenatal care. Mary received nutritional supplements and the babies were fed expressed breast milk through a nasogastric tube for 6 weeks until they were able to suck adequately. They received close attention to their temperature control, prompt treatment of a respiratory tract infection, and vitamin supplementation. They weighed 2.8 kg and 2.9 kg and were well when discharged.

With the death of one of the rebel leaders in Angola, in 2002, peace after three decades of civil war enabled repatriation of large numbers of refugees from Meheba, and its population fell to 13 000 in 2005.⁵ ♦

treating common acute conditions, but have more difficulty with chronic diseases such as diabetes and asthma. For example, in a malaria-endemic area, there will rightly be a low threshold for diagnosing and treating malaria in a febrile child. Limited vaccinations are available in these countries (commonly BCG, oral polio, measles and tetanus toxoid, with others less so). Medications also vary in availability, quantity and quality. However, access to essential medicines provided by the NGOs is life-saving, and advances are being made in the ambulatory treatment of acute severe malnutrition with high-energy protein paste based on peanuts.⁶

Health screening of entrants into Australia

Refugees apply for refugee status at the local UNHCR office. If it is approved, their settlement in western countries, including Australia, is negotiated by UNHCR. Predeparture medical and character checks are mandatory prerequisites for the granting of permanent resettlement visas. A medical examination and the following medical tests are currently performed:

- Chest x-ray for tuberculosis screening (if over 11 years);
- HIV serological testing (if ≥ 15 years);
- Syphilis serological testing (if ≥ 15 years and from a camp); and
- Urinalysis may or may not be performed.⁷

The health checks are carried out by panels of doctors and specialists nominated by the Australian Government Department of Immigration and Multicultural Affairs (DIMA) in the country of departure. If the results of these checks are deemed satisfactory, a residency visa is granted and travel arrangements awaited. If a medical problem is discovered, then these entrants are subject to health undertakings, in which specified medical treatment on arrival in Australia is an obligation.

Further predeparture medical screening 72 hours before departure for Australia was introduced in mid 2005 for refugees and some sponsored humanitarian entrants departing from eastern and western Africa, Egypt, Sudan and Thailand. It consists of a rapid malaria test and treatment, intestinal parasite treatment and measles–mumps–rubella vaccine if aged < 30 years. This is recorded on an electronic health manifest, which is made available to the local settlement service provider through DIMA.⁷

The success of this predeparture screening had not yet been fully evaluated. There continue to be anecdotal reports of major medical problems that have been missed (including malaria, HIV, tuberculosis and sickle cell anaemia), and communication to final health care providers (refugee health clinics and general practitioners) of what had been done is inconsistent. The timing and quality of the health checks are also variable.

Entrants who have been sponsored by family or friends do not always benefit from the above screening. These entrants are not routinely enrolled into settlement services on arrival and thus provision of health care in Australia may be delayed.

Conclusion

Here, we have described life in refugee camps and highlighted differences in health care quality between developed and developing countries in terms of conditions, resources, diagnosis, treatment, patient expectations, and sophistication. Predeparture screening can potentially detect important medical problems. Medical providers for refugees in Australia need an awareness of these complex issues.

Competing interests

None identified.

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