

# Sudanese refugees: sufferings and suggested management

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**E**gypt and the Sudan have historically provided a continuum of social and cultural exchange. With the Nile valley providing the only route between the Mediterranean and sub-Saharan Africa, Egypt became the natural host for Sudanese refugees.

It is important to point out that the Sudanese refugee population is not a homogeneous group. Immigrants from Sudan have had different reasons for their move. In the south of Sudan over the past two decades, large numbers of people have sought to escape the drought as well as civil war. This is unlike the situation in western Sudan, where mass murder and the burning of villages have characterised ethnic and religious conflict. Further, Egypt's Sudanese immigrants include some who did not flee war or hunger but who sought better socio-economic standards. These include professionals employed in their host country.

## Historical background

Genocide and conflict in the south of Sudan started more than 20 years ago. It is between two ethnic/religious groupings: the southern, mostly Christian ethnic group and the northern Arab-Muslim rulers. The hostility between the two is deeply rooted but flared up after the discovery of oil in the south of Sudan in the 1970s (Lesch, 1998; Johnson, 2003).

The reality of what is happening in Darfur, in the western part of Sudan, has been well documented. Many people have fled after attacks on their villages by Arab Janjaweed militias, who have burned hundreds of villages and murdered thousands of civilians. This conflict began in February 2003, with the emergence of two anti-government groups: the Sudan Liberation Army and the Justice and Equity Movement. These two groups began fighting the pro-government Janjaweed militia and units of the regular Sudanese army. The conflict resulted in the displacement of up to 200 000 Sudanese.

## Magnitude and effects of the refugee problem

The problem of refugees is of alarming proportion. One out of 275 persons globally is of concern to the United Nations High Commissioner for Refugees (UNHCR, 2002). A further 21 million people are displaced within their own countries. Some 80% of refugees are women and children (Forbes, 1992). Families face the added effects of high infant mortality rates (Eisenbruch, 1998).

Many studies have shown that refugees have a wide range of psychological problems, such as psychosis, post-traumatic

stress disorder and depression (Mollica *et al*, 1993; Van Ommeren *et al*, 2001; De Jong, 2002). Adolescent refugees were found to have high levels of emotional distress related to their experience of violence. Longitudinal studies have shown that resettled adolescent refugees have significantly high levels of psychological distress, school failure, post-traumatic stress disorder and depression. Furthermore, children are less likely than adults to receive psychological care. This may be attributed to cultural differences in the expression of symptoms.

It has been estimated that about 2 million Sudanese people have died in the conflicts in the south of Sudan and that 4 million have been displaced. In addition, an unknown number of women and children have been captured and sent to the north to be sold into slavery – sexual and otherwise.

Surveys conducted in western Darfur by the World Health Organization (WHO) showed that 6000–10 000 people were dying each month from disease and the effect of malnutrition (WHO, 2004). This humanitarian crisis has political causes and the failure to recognise and address these is catastrophic.

Refugees, especially children, are exposed to malnutrition. Women are being repeatedly raped and terrorised. Refugees are also at high risk of communicable diseases, notably acute respiratory infections, diarrhoea and malaria. Outbreaks of disease are more likely to occur in refugee camps because there are limited amounts of potable water, low standards of environmental hygiene and sanitation, malnutrition and low vaccination coverage.

Women in many cases have been raped in front of their husbands, children and the entire community; unfortunately, rape is used as a weapon in this war. Girls as young as 8 years old are being raped and used as sex slaves in Darfur. Rape has a devastating impact on the health of women and girls, including medical complications and injuries, sexually transmitted diseases and HIV. Women may also become pregnant, which can have its own complications, as may delivery. Raped women may also suffer a lifetime of stigma and marginalisation from their families and communities.

## The effects of violence

The experiences reported by Sudanese children include watching their villages being attacked by militia, fleeing with family and friends from the villages during attacks, watching family members being killed or mutilated, watching the death of other children, facing wild animals, getting lost during escape, being drowned in rivers and facing diseases of all kinds.

Paardekooper *et al* (1999) showed that Sudanese children, compared with Ugandan children, reported significantly more

Table 1 Comparison of the proportions of Sudanese and Ugandan children experiencing traumatising events<sup>1</sup>

Item (Did the child ever experience...)	Sudanese (%) (n = 345)	Ugandan (%) (n = 82)
Loss of property	93.6	1.3***
Lack of food	91.3	58.2***
Loss of family member	80.0	34.6***
Witnessing death of family member	63.0	61.3
Lack of water	62.1	10.5***
Ill health, no medical care	62.1	36.4***
Near death	51.2	42.1
Torture	28.0	0.0***
Being lost or kidnapped	25.5	1.3***
Witnessing injury of family member	19.9	6.4**
Witnessing murder of family member	19.2	3.9**
Isolation from family members	17.3	5.3**
Sexual abuse	9.0	0.0***
Imprisonment	62.0	0.0
Injury	7.0	0.0

\*\* $P < 0.01$ ; \*\*\* $P < 0.001$ .

1. From Paardekooper *et al* (1999), with permission.

traumatic events, more daily stressors and less satisfying social support; they also had more psychological complaints, including symptoms of post-traumatic stress disorder such as trouble with sleep, nervousness, traumatic memories, depressive symptoms and psychosomatic complaints (Tables 1 and 2).

## Current situation of refugees in Egypt

As a result of the war in the south of Sudan, up to 30 000 southern Sudanese refugees fled to Egypt; most are now living in Cairo. As the war is ongoing in their home country, the odds of their returning home soon are very slim.

Egypt is a low- to middle-income country with limited resources, and it is still struggling to provide sufficient services for its own population; thus, the migration of Sudanese refugees to Egypt is becoming a burden on the economy.

The refugees have different habits, skin colour, beliefs and religion, customs and language; these confirm their status as 'outsiders'. Many refugees are unable to work legally, to find housing, to obtain education for their children or even to access medical services. Thousands of Sudanese refugee families struggle to survive.

Sudanese refugees in Egypt face challenges adapting to their new situation and experience social, physical and mental problems. The collapse of their systems of social support, combined with socio-economic marginalisation, similarly lead to poor physical health, malnutrition and psychological disorder (Jablensky *et al*, 1992).

## How can we help?

Many Sudanese refugees find themselves trapped in camps as refugees, without any immediate hope of moving. Meanwhile they are treated in ways that lead them to feel that they have no rights. Development programmes for refugees, to be effective, must be able to achieve the refugees' objectives, and so should help them to scrape a living and to live

Table 2 Comparison of the proportions of Sudanese and Ugandan children experiencing recent stressors<sup>1</sup>

Item (Did the child this last week experience...)	Sudanese (%) (n = 345)	Ugandan (%) (n = 82)
Lack of clothing	88.0	47.5***
Poor sanitation	79.6	18.5***
Hunger	69.4	35.8***
Worry about family members	69.2	22.2***
Having no school fees	58.4	46.0**
Having to take care of siblings	56.3	42.0
Illness, no medical care	55.1	4.9***
Too much workload in the house	48.2	27.2***
Nightmares	45.1	30.0
Lack of parental attention	35.9	26.8
Isolation from family members	32.1	10.0***
Loneliness	31.3	26.0
Feeling insecure	28.7	14.8

\*\* $P < 0.01$ ; \*\*\* $P < 0.001$ .

1. From Paardekooper *et al* (1999), with permission.

in dignity; programmes should also educate children and protect families, and prepare refugees eventually to return to their home country. Programmes should protect refugees' rights and protect the refugees themselves, and should respect their cultural beliefs and customs; they should also ensure access to healthcare, including mental healthcare.

Refugees will benefit most from programmes that preserve their cultural identity (Eisenbruch, 1990; Berry, 1991). The role of traditional healers is well recognised in helping people to recover from the trauma of war and being a refugee, even in cases where HIV/AIDS emerges, such as in Uganda and Cambodia (Green, 2000).

The idea that culture plays a crucial role in the process of recovery from traumatic events arose because such events are directed by local historical experiences and are mediated by local cultural factors. Understanding local idioms of distress will unlock the local clinical symptom profile of psychological and social disorders (Eisenbruch, 1992). Combinations of local resources such as traditional healers, healthcare workers and relief workers can ameliorate the psychosocial problems of large groups, not just individuals (De Jong, 2002).

Development programmes for refugees have many obstacles to overcome, notably ongoing conflicts, but also the refugees' lack of freedom of movement, insecurity, lack of rights, poor socio-economic status and exclusion from participating in the political decision-making process.

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## THEMATIC PAPER – THE MENTAL HEALTH OF REFUGEES

# Post-traumatic stress disorder among Afghan refugees following war

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There was a large influx of Afghan refugees into Pakistan during the 1980s and in particular after the US invasion of Afghanistan in 2001. That refugees have high rates of mental health problems has been well established (e.g. De Jong *et al*, 2000) – causes include migration, often with painful transit experiences, difficult camp life and the experience of major trauma, including multiple losses of family members as well as the loss of property and traditional lifestyle. However, the Afghan refugees in Pakistan have been poorly studied. Although the mental health problems of Afghan refugees have been studied in the West, the numbers of participants in such research have been relatively small.

The burden of healthcare for Afghan refugees lies mainly with the Pakistani government and non-governmental organisations. The refugees place a further burden on the already poorly financed healthcare system in Pakistan. It is encouraging to note that the host population has shown great courage and patience in support of Afghan refugees.

Many studies in the West have found high rates of psychiatric disorder among refugees (Summerfield, 2001). Wide variations in the rates of these disorders can be attributed to differing cultures and experiences in the groups sampled. Although the concept of post-traumatic stress disorder (PTSD) has been questioned and it has been suggested that rates may have been exaggerated (Watters, 2001), the rates of PTSD have been estimated to be as high as 90% in psychiatric clinic populations (Silove, 1999).

In a community study of Afghan refugees in The Netherlands, the prevalence of PTSD was found to be 35% (Gernaat *et al*, 2002). Similarly, a US study examined the psychological

effects of the war in Afghanistan on two groups of young Afghan refugees currently residing in the USA. The investigators found the rates of mental health problems to be higher among the Pashto-speaking population than among the Tajik population (Mghir & Raskin, 1999). In another US study (Mghir *et al*, 1995), 38 refugees aged between 12 and 24 years were interviewed with the Structured Clinical Interview for DSM–III–R. Five of the participants met the criteria for PTSD and 11 met the criteria for major depression (13 had either PTSD or major depression or both).

Afghans living in the Western world represent a small proportion of that country's refugees. Pakistan provides a better opportunity for the study of the mental health problems of the larger Afghan refugee population. We undertook a study to measure the prevalence of psychiatric morbidity among Afghan refugees.

## Method

This was a cross-sectional study. Information was collected from Afghan refugees attending a psychiatric service in Peshawar between December 2003 and March 2004. All the refugees attending who fulfilled our inclusion criteria were approached, and all those who consented were included in our study. The inclusion criteria were: being an Afghan refugee, between the ages of 15 and 65 years, attending the psychiatric service and having a diagnosis of a functional psychiatric illness. Those with a diagnosis of learning disability, dementia or organic brain disorder were excluded from the study.