Introduction

Imagine: You are 13 years old and the oldest of seven children; following months of political strife, war breaks out in your country. After a short time, watching bombs drop from the sky and listening to gunfire throughout the night become the norm. One evening, after going to the nearby store, you return to screaming and chaos. Your aunt, uncle, and cousins' home next door to your own is a pile of rubble on one end; you can see straight into the living room from the street. After this incident, your father tells you that you, your siblings, and mother must leave the country, as it is too dangerous—he will join you all in month after he has gathered more money. Several weeks after living in a tent in a border country refugee camp, you quickly realize that you have not really escaped danger. Your little brother was so traumatized by the bombing that he will not leave your mother's side to go to school. Your youngest siblings are suffering from diarrhea and dehydration likely due to unclean water tanks—the only source of water in the camp. Your mother has accepted a marriage proposal for your 12-year-old sister as a means of protecting her daughter and greater security for the family. As for you, you work at an auto shop 6 days a week to help attain enough food in order for your family to survive.

Despite the many international aid efforts for displaced refugees around the world, the story above is reality for far too many families. Often, international resources are insufficient or too slow to arrive, leaving millions of refugees fighting for their lives.[1] Child refugees are especially vulnerable, as malnourished children are highly susceptible to disease. Also, children may suffer from PTSD or other mental health issues without receiving adequate health care or therapy.[1] Using existing literature, this paper will first present background information on the challenges faced by child refugees as a result of displacement as well as camp-life. Second, this paper will review evidence for the main health implications faced by child refugees: psychological problems, malnutrition, and communicable diseases. Third, this paper will analyze policies and international aid efforts to relieve child suffering.

Background

There are currently more than 45.2 million forcibly displaced people in the world, constituting the most serious refugee crisis for the last 20 years, and children below 18 years make up about 46 percent of the world's refugees.[1] Many of these children spend their entire childhood far from home and may have experienced war and violence resulting in detrimental psychological consequences. Children are especially susceptible in times of war as a result of their dependency on others and their difficulty understanding many situations that they may confront.[2] For example, often families become broken, leading children to be cared for by only one parent or without either parent.[3] As a result, sometimes the oldest child must act as head of the family and take care of younger siblings, leaving their childhood behind to take on adult responsibilities at a very young age.[3] Even when both parents are present, children may lose role models to guide their development as a result of the abnormal camp conditions.[3] For instance, to obtain food for their family, parents may be dependent on handouts from strangers or may have to stand in queues, undermining their roles as breadwinners and authority figures.[3] Furthermore, families and children living in refugee camps face unique challenges, as camps are artificial environments where freedom of movement is restricted.[3] As a result of this restriction, camps are often overcrowded and underserved leading to malnutrition, accumulation of waste, contaminated water, and communicable diseases.

Mental Health

War induced trauma, displacement, immigration, and chronic poverty are a few factors that place refugee children at heightened risk for psychological problems. Refugee children may witness family members or other people being physically assaulted, sexually assaulted, or killed.[2] Furthermore, in war torn countries children may see gruesome injuries or deaths due to bombings. For example, in one Swedish study examining 55 Chilean newly immigrated children, of the children whose parents had been tortured or persecuted, 75 percent had sleep disturbances, 69 percent anxiety, 42 percent depression and concentration failures, and 39 percent aggressiveness.[4] In contrast, children whose families had escaped persecution were found to have significantly lower symptom levels.[4] It is important to note that according to a different study, most children generally show minimal distress in the face of armed conflicts; however, when the chain of violent events reaches the child's nuclear family, psychological effects are often serious.[4] Therefore, when parents of refugee children are killed or adversely affected, children are especially at risk for mental health issues.

Children are not only impacted by what they see and hear; they are also profoundly affected by their own personal experiences. For instance, pre-migration, children may be regularly exposed to bombings, and in many refugee camps, children face an increased risk of sexual abuse and violence.[2] Thus, it is likely that refugee children lack a sense of safety and security in their camp environment, leading to negative psychological implications. For example, one review of psychosocial studies conducted in Canada, the United States, and Sweden found that between 30 percent and 75 percent of refugee children and adolescents demonstrated symptoms and signs of posttraumatic stress disorder (PTSD).[5] There are a number of factors that may contribute to this high level of PTSD in refugee children; however, two primary factors are likely violence experienced by close family members and observed by children or violence experienced by children themselves.

Malnutrition

In addition to negative mental health consequences from living in camps, refugee children also suffer from malnutrition. Food rations provided to families in refugee camps tend to be too small to meet a healthy caloric intake, leading children to become malnourished and more susceptible to disease.[5] Prevalence rates of acute malnutrition among children less than 5 years of age in various refugee populations have been as high as 50 percent among Ethiopian child refugees in eastern Sudan (1985), 45 percent among Sudanese child refugees arriving in Ethiopia during 1990, and 48 percent among Mozambicans in Zimbabwe (1992).[5] Such high percentages demonstrate the widespread suffering by children as well as the severe extent to which refugee camps are under-resourced. Furthermore, even though a child may enter a camp adequately nourished and in good health, he or she may develop acute malnutrition due to inadequate food rations or severe epidemics of diarrheal disease.

In addition, for both Tigrayan refugees in Eastern Sudan (1979-1980) and Cambodian refugees in Thailand (1984-1985) age-specific mortality rates were highest in children under the age of 5, which was four times higher than the mortality rates in the 15-44 year age group; notably, among children identified as severely undernourished, the mortality rate was particularly high.[6] This association demonstrates that malnutrition and mortality are closely linked, and this finding highlights the urgent need for greater international support to provide adequate food rations for child refugees. Additionally, children in

families without an adult male are especially in need, as these children have a significantly higher risk of malnutrition than children in male-headed households.[5] Furthermore, malnutrition not only causes children to suffer from hunger, as preventable conditions such as diarrheal disease, measles, and acute respiratory infections are often exacerbated by malnutrition.[7]

Poor Sanitation & Communicable Diseases

The most common reported causes of death among refugees during the early influx phase have been diarrheal diseases, measles, acute respiratory infections, malaria, and other infectious diseases.[7] Intestinal parasites linked to diarrheal diseases are strongly associated with crowding, sources of drinking water, and poor sewage networks.[8] These poor conditions are experienced by Palestinian refugees in Nuseirat camp of Gaza Strip who live in overcrowded conditions with sewage and wastewater flowing in open channels along roads and through agricultural land, posing serious environmental health hazards.[8] It is common for children to play in and around disposal sites, putting children at a high health risk, as contamination of children's hands is significantly correlated with the incidence of diarrhea.[8] Palestinian children becoming infected with parasites and suffering from diarrhea is a serious issue, as the highest prevalence of intestinal parasites has been found in children younger than 5 years.[8] Furthermore, children with diarrhea are likely to experience other negative health outcomes such as dehydration, which can quickly become fatal when paired with malnourishment.

Poor sewage networks are only one source of harmful bacteria; refugee children may obtain other bacteria that cause cholera from dirty water storage containers and contaminated drinking water. Cholera is an infection of the small intestine, which causes diarrhea and vomiting, and it has occurred in refugee camps in Bangladesh, Iraq, Malawi, Nepal, Turkey, Swaziland, Zimbabwe, and Kenya.[7] Furthermore, infections leading to severe diarrheal disease have reached epidemic levels in some cases, and this magnitude of diarrheal disease has become increasingly common since 1990.[7] Therefore, it is evident that, historically, international efforts to improve water supply and sanitation in refugee camps have been limited or unsuccessful, as numerous refugee children continue to die due to bacterial infections.[8]

Policy Implications

Providing support to refugee children and their families is a multi-faceted initiative, as refugees need shelter, protection, food, water, safety, health services, as well as educational resources for children. Currently, there are a number of United Nations (UN) and non-UN organizations that work toward providing resources for refugees.[9] For example, the World Food Program and the World and Agriculture Organization of the UN deliver food to locations where it is most needed, and for shelter, refugee camps and facilities are set up and maintained by the UN High Commissioner for Refugees (UNHCR) and the International Organization for Migration.[9] Also, the World Health Organization works to provide medical services and protection from infectious diseases, and the UN Children's Fund with the help of international Save the Children Alliance provide educational opportunities for refugee children.[9] To coordinate these assistance efforts, the Inter-Agency Standing Committee (IASC) brings together all major humanitarian agencies, both within and outside the UN system.[9] Chaired by the UN Emergency Relief Coordinator, the IASC develops policies and divides responsibilities among humanitarian agencies.[9]

Although there are a number of organizations working toward providing relief for

refugees, in many cases resources are not sufficient for refugees to maintain a healthy lifestyle within their respective refugee camps.[10] This discrepancy may be a result of having no international law or regulation declaring the minimum that refugee camps need or how long refugee camps should be provided aid. Therefore, in an effort to standardize humanitarian initiatives, UNHCR launched The Sphere Project in 1997; the outcome was "The Humanitarian Charter and Minimum Standards on Disaster Response" guidebook.[11] Although this guidebook has been developed, children still face precarious situations while living in refugee camps; for instance, displaced Syrian children currently suffer from malnutrition and psychological problems.[12]

Thus, in order to improve the lives of refugee children, international laws should be developed to insure that the minimum standards recommended by the UNHCR guidebook are met. Furthermore, international policies should outline the duration of time that camps receive aid, as efforts may be prematurely re-directed if a new crisis occurs. Furthermore, in order to provide sufficient aid for refugees living in camps for long periods of time, an international humanitarian relief entity or sector of IASC should be developed to keep track of the needs of established refugee camps for which immediate re-settlement is not possible.

Related Sources of Interest

Mental Health of Refugees:
http://www.unhcr.org/3bc6eac74.pdf
Youth and Mental Health:
http://refugeehealthta.org/physical-mental-health/mental-health/youth-and-mental-health/
Refugee Children: Guidelines on Protection and Care:
http://www.refworld.org/docid/3ae6b3470.html
The UN Refugee Agency :
http://www.unhcr.org/pages/49c3646c1e8.html

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