

Chapter Six

SOMALI REFUGEES IN ETHIOPIA

Why Are the Refugees There?

Nearly one million Somalis sought refuge in neighboring countries when famine and civil war ravaged Somalia between 1988 and 1991. At the height of the crisis, Ethiopia hosted some 600,000 Somali refugees.¹ Outbreaks of violence in Hargeisa in 1994 scuttled plans to repatriate the refugees; indeed, thousands more took flight from Somalia. The presence of an interim government in Hargeisa has now rendered northwestern Somalia significantly more stable than the area around Mogadishu. But incidents of renewed fighting in other areas, such as Burao in north-central Somalia, have resulted in large numbers of internally displaced persons.

During the late 1980s and early 1990s, more than 200,000 people were housed at Hartisheik camp in eastern Ethiopia, the largest refugee camp in the country. Spontaneous and voluntary repatriation to northwestern Somalia has reduced the numbers of refugees resident in Hartisheik to approximately 60,000 today. Another 170,000 Somali refugees live in seven other camps strung along the border with Somalia.²

Which Agencies Are Assisting the Refugees?

UNHCR funds and works with the Ethiopian government's Administration for Refugee and Returnee Affairs (ARRA) to ensure that refugees have access to the appropriate range of services. ARRA has been the primary agency responsible for providing health services to the refugee population.

General Camp Conditions

The camp at Kebri Beyah and Hartisheik A and B camps are about 50 km from the Somali border. Though they are only an hour's drive apart, the differences between the camps are striking. The market of Hartisheik, which offers everything from table football to medicines, has developed around Hartisheik A and B camps. On the other hand, Kebri Beyah is a quieter camp with little in the way of amenities.

In Hartisheik camps A and B, women and children live in *tukuls*, spherical-shaped huts whose wood frames are covered with woven grass, hides, UNHCR

^{1,2} U.S. Committee for Refugees, 1997.

blue plastic sheeting, or wattle. The women collect rations and tend to domestic chores, while most men live in town, work in the commercial sector and return to the camps as desired. Many men earn their livelihood as traders, regularly plying routes between Jijiga, Hargeisa and beyond. Tensions that exist between local and refugee populations in other settings are absent from these areas since both refugee and local populations are members of the same clan. However, the region remains politically volatile and roads are only intermittently secure.

Grade 3, when they are between ten and twelve years old and approaching puberty. There are no vocational training activities in the camps, so adolescents are often idle instead of gaining valuable skills for their return to Somalia.

General Health Conditions and Services

Health services in the camps are often more comprehensive than those offered in neighboring rural health facilities, and so they are also made available

to local populations. Under an agreement with ARRA, medicines are given free of charge to refugees, but patients from outside the camps must pay for the drugs. However, medical facilities vary widely from camp to camp. The facilities at Hartisheik are reasonably comprehensive with separate male, female, MCH and pediatric wards. The ARRA medical doctor is supported by two Somali nurses as well as community health agents and TBAs, all of whom attended an MOH train-

ing course. Ambulance services are available at the camp, though they are inadequate to meet the demands of the population.

In contrast, medical services in Kebri Beyah camp had, until recently, been provided out of a *tukul* after the MOH withdrew permission to use its facilities. Though there is now a permanent structure to house the health post, there is no physician, no laboratory, no sanitarian, no in-patient facilities, and no radio for emergency calls. It is awkward for the male head

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Somali women waiting to see a health worker outside of a clinic at Hartisheik Camp in Ethiopia.

Little was done at the outset to address educational needs at the camps, since it was originally thought that the Somalis' stay in Ethiopia would be brief. Two of the camps have no school at all, and there are neither secondary schools nor any provisions for refugee children to attend local schools in any of the camps. As a result, only 4.8 percent of all school-age refugee children attend classes, according to ARRA. Of those children who attend school, only 10 percent are girls. Somali girls rarely attend school beyond

nurse to counsel Somali women about family planning; and a dearth of female translators stymies efforts to expand services.

Reproductive Health Conditions and Services

Safe Motherhood/Emergency Obstetrics

Prenatal care is linked to an integrated MCH feeding program which includes mandatory vaccinations for infants and supplementary feeding for women and infants. Eighty-five percent of women have made two or more visits to camps' prenatal clinics. But late referrals to the regional hospital at Jijiga, at least an hour's drive away, indicate that refugee women are unaware of risk signs during pregnancy and delivery. Doctor Nasreddin of Karamara Hospital is concerned that, because refugees are not given prenatal record cards, hospitals outside the camps have no case history to refer to when women are transferred.

Ambulance services for the camps are not controlled by the medical staff but by the camp administration. They are not available 24 hours a day, and sometimes there is no transport for obstetric emergencies which require hospitalization.

According to Somali custom, a woman's husband or a member of his family must give his consent before any surgery can be performed. If a woman develops an obstetric emergency during her husband's absence, she may end up waiting long hours before her husband or one of his relatives can be contacted. While this delay does not often result in death, it can increase residual morbidity.

According to camp health personnel, most women give birth at home rather than at the camps' health

centers. TBAs are given essential equipment that is sterilized after each delivery. If women are referred to the hospital with complications, hospital staff also offer family planning and birth spacing advice. But since there are no printed materials for distribution, and husbands and families are not included in the informal talks about family planning, the effectiveness of this advice is unclear.

Postnatal care in the refugee camps is poor. According to Somali custom, delivery is followed by a 40-day seclusion period when the mother is not allowed to leave the *tukul*; hence she cannot seek postnatal care in a health centre. The supplementary feeding program for lactating mothers, run by the World Food Programme, continues for four months and encourages the use of postnatal facilities. But services are under-utilized and follow-up is negligible.

Family Planning

Oral contraceptives and condoms are available at Kebri Beyah and Hartisheik A and B camp clinics, while Depo-Provera, IUDs and tubal ligation are available at Karamara Hospital in Jijiga. Contraceptives are free of charge at the camps and at the district hospital, and they are usually in stock both at the camps and at the hospital. However, contraceptive stocks at Karamara Hospital periodically run out. During those times, clients have been given prescriptions so they can purchase contraceptives at a pharmacy.

Although condoms and pills are widely available free of charge, both knowledge and use of contraceptives among Somali refugees is low. A 1996 UNFPA study found that only 17 percent of 576 females questioned and 29 percent of 280 males questioned had knowledge of family planning methods—usually natural family planning and breast feeding.³ Dr. Nasreddin

³ UNFPA's *Report of Reproductive Health Needs Assessment of Somali Refugees*, August-September 1996.

has said that there is a belief among Somalis that family planning is against Islam. He believes that one way to begin convincing the population otherwise is by first persuading religious leaders of the benefits of family planning and spacing pregnancies. He also believes that there is a high unmet need for family planning. The head nurse at Kebra Beyah camp clinic acknowledged that many women want family planning, but he said their husbands will not sanction use. He feels that male involvement is essential for a successful family planning program. Other health workers agree that lack of understanding and communication between men and women is a substantial barrier to accessing family planning services. Staff at Karamara Hospital have recommended family planning to women who have had difficult deliveries or complications post-delivery. But many of these women return to the hospital one year later with another complicated delivery because they have not been able to convince the husband's family of the need to practice contraception.

One approach to family planning may be via the lactational amenorrhea method (LAM). Many Somali men and women are familiar with this family planning method which is also cited in the Koran. However, the refugees appear to be misinformed about the duration of effectiveness of LAM as a family planning method. Therefore, health workers should provide accurate information about this method.

Post-abortion Care /Abortion Services

Spontaneous abortion is not uncommon in the refugee camps, although the medical providers only see women if there are complications. Induced abortion does occur in the camps, although it is often referred to as spontaneous abortion or miscarriage in order to obtain recrimination-free post-abortion care.

The incidence of induced abortion is higher in Hartisheik camp than in Kebri Beyah, largely because of Hartisheik camp's urban setting, although induced abortions do occur in Kebri Beyah. Camp doctors had heard of one incidence of unsafe abortion in the three month period prior to the RHR Consortium team's visit. A woman five months pregnant had received abdominal massage from a TBA at the camp. When she arrived at the clinic, the foetus was dead and the woman subsequently died of septic shock.

Many women, both local and Somali, make their way to towns three or four hours away to obtain abortion services. According to records at Karamara Hospital, the top five reasons for admission to the hospital are:

| <u>Reason for Admission</u> | <u>%</u> |
|----------------------------------|----------|
| Tuberculosis | 19% |
| Respiratory infection | 14% |
| Treatment of incomplete abortion | 14% |
| Malaria | 13% |
| Diarrhea | 13% |

STDs

Lack of laboratory testing and the strong stigma attached to STDs make it very difficult to estimate the magnitude of the problem. Medical officers at Hartisheik A and Dawanagi camps note that the residence patterns in this refugee setting made it difficult to contain the spread of STDs. In the Hartisheik area, the Somali refugees and local Ethiopians originate from a single tribal root, hence socialization between the two populations is considered normal. Somalis and Ethiopians frequent the same local commercial sex workers who work out of bars at the camp cross-

A STEP IN THE RIGHT DIRECTION

In 1996 UNHCR and ARRA asked Save the Children Fund (UK) to set up a two-year pilot program in reproductive health for the refugees living in camps in eastern Ethiopia. By November 1997, SCF UK had hired a female RH officer to work with an ARRA counterpart in the Hartisheik A and B, Kebri Beyah and Dewanaji camps. The goals of the project include integrating RH services into all clinics, fostering cooperation among all service providers in the camps, encouraging community participation, raising awareness of RH issues through media and educational programs, and strengthening institutional capacity and capability. The projected purchase of two ambulances will go a long way toward improving emergency obstetric care at the camps. Says Dr. Peter Poore, Senior Health Advisor, of SCF UK: "This project gives us the opportunity to address a number of reproductive health issues, to improve the current situation and identify further needs."

roads or in Jijiga. Since men in both cultures rarely use condoms, risk of infection is high, as is risk of transmission to an uninfected partner during unprotected sex. Somalis also practice polygamy, so it is not unusual for a Somali man to live in Jijiga town with one wife while maintaining another wife in the refugee camp. A cycle of cross-infection among partners in a polygamous household is difficult to break unless all infected partners are treated.

Health workers say that patients commonly complain of a urinary tract infection (UTI) when the problem is actually an STD. Camp clinic laboratories do not have the capabilities for STD testing, so diagnoses are made clinically or through patient interviews and histories. Patients fear the community may learn that they have been diagnosed with an STD—even if an attending translator is the same sex. According to health workers at the camps, most STDs are both

treated and classified as UTIs. In two camps visited recently, urinary tract infections were ranked third as a cause of morbidity in persons over five during 1996 (upper and lower respiratory infections ranked first and second, respectively). UTIs/STDs are treated with a broad spectrum antibiotic. Though gonorrhea is sensitive to penicillin, there is concern that resistant strains may be emerging. Health workers at the camps say that medicines are often mis-used and treatment courses are not completed. Tracing contacts and notifying partners is also extremely difficult.

Testing for HIV infection is not available in any of the camps, although it is available at Karamara Hospital in

Jijiga. According to Karamara Hospital's 1996 Annual Report, its lab conducted 262 tests for HIV, 44 of which were sero-positive. It is impossible to identify which of those persons tested were refugees, but close contact between refugees and the local population means HIV transmission into the refugee community could become a serious problem. Condoms are available, but not widely used. They are often associated with promiscuity, which is frowned upon in Somali culture.

Sexual and Gender Violence

According to camp administrators and medical officers, and according to the refugees, themselves, violent crime against women does occur, though infrequently, in the camps and in the surrounding area. The infrequency of violent incidents against women can be attributed to the fact that the Somali and

REPRODUCTIVE HEALTH IN AFMADOU, SOMALIA

Susan Purdin first traveled to Afmadou, in Lower Jubaland, Somalia, in 1993. The civil war and on-going factional power struggles had driven out the local population—only to be replaced by UN peacekeeping forces. Purdin had come on a six-month assignment for the American Refugee Committee (ARC) to establish a district-wide program for TBAs. The project, funded by UNHCR as part of a program to prepare the region for the repatriation of 150,000 refugees expected to return from camps in Kenya, included training ten TBAs (one from each village) and setting up a system to support and supervise them.

“The community was so excited to have a training program,” Purdin recalls. “People’s biggest motivation was to learn.” Their first priority was to acquire specific skills to assist women experiencing prolonged labor. Throughout Purdin’s assignment, discussions with the TBAs touched on many issues related to women’s lives: nutritional needs, self-care during pregnancy and sexual violence. Together, Purdin and the TBAs started an MCH clinic offering prenatal care, immunizations, child growth monitoring, and condoms. At their graduation ceremony, the TBAs shared their newly-acquired knowledge with the community by singing songs whose lyrics celebrated nutrition, family planning, and the need for immunizations for women and children.

Three years later, Purdin returned to Afmadou as ARC’s Reproductive Health Coordinator. The MCH clinic was still open, and the TBAs were still providing services to their communities. An entirely local staff was performing and monitoring clinical and community work according to established protocols. In lively, mixed group meetings, Purdin talked with male and female community leaders about the RH issues that women had raised during her earlier visit. Opinions were strong. Though the community’s male power structure had decided that family planning was only acceptable when a doctor insists on it for medical reasons, several women advocated strongly the need for access to family planning. Community leaders also rejected the practice of female genital mutilation (FGM). In fact, the Mullah was the first person to address the issue, declaring that the practice went against the teachings of Islam. But others explained that as long as people believe an uncircumcised woman will be promiscuous, and as long as older women who encourage the practice continue to earn income and prestige by performing the procedure, it will be difficult to eradicate FGM completely.

Widespread flooding in Lower Jubaland during the last months of 1997 forced the community to move to dry ground; RH services, of course, were disrupted. But Purdin expects that the determined health workers of Afmadou will restore MCH services as soon as they can. Purdin is convinced these women will resolutely continue the struggle for a better future for themselves and their daughters. “Like any social change, it takes time to assimilate these concepts into the community,” says Purdin. “But when they’re ready, they’ll take the next step. And they will. They’re just amazing.”

Ethiopian communities are from the same clan. Also, women are not put at risk while they try to provide for their families. Since water and firewood are delivered to the camps, women don't have to walk miles in unprotected areas to gather those basic provisions.

The Western definition of domestic violence is not readily transferable to Somali society. Although a husband may beat his wife or force her to have sex or physically threaten her, he may be acting within his rights according to Somali culture. While a woman may not condone her husband's behavior, she may also feel that she does not have a right to contest it. Many Somali women blame the use of *khat* for their husbands' violent actions. After using the drug, some men become quarrelsome and demand sex without any regard for their wives' feelings.

Female genital mutilation (FGM), ranging from clitoridectomy to excision and infibulation, is nearly universal within Somali culture. Prior to the outbreak of civil war in Somalia, the government had publicly denounced the practice of FGM and, through donor-assisted education programs, made considerable progress toward eliminating some of the more extreme forms of the procedure.

The local branch of the National Committee on Traditional Practices in Ethiopia (NCTPE) began a pilot project in Hartisheik camp in January 1993 to determine the incidence of harmful traditional practices among the Somali refugees and develop education campaigns aimed at eradicating those practices.

When the Country Support Team of UNFPA/Ethiopia, in collaboration with UNHCR, evaluated the project four years later, they found a slight increase in awareness of the harmful effects of FGM but continued

widespread practice.⁴ In addition to providing valuable statistics and recommendations, the evaluation demonstrated how UN agencies are working together to improve the reproductive health of refugee populations.

The Next Step

Northwest Somalia is stable now—there has been no fighting in the region since late 1994—and people have begun to return. By the end of 1997, UNHCR had helped repatriate some 21,000 refugees from Ethiopia; by the end of 1998 some 60,000 more are expected to return to Somalia. As UNHCR helps rebuild the infrastructure in Somalia, it also hopes to start phasing out some of the refugee camps in Ethiopia.

Meanwhile, Dr. Bekele, Medical Officer at Hartisheik A camp, offers an insider's advice on how to improve services at the camp's health center. "A well-organized, responsible body is required [to oversee RH services]. The health center must be equipped well; essential drugs and contraceptive methods must be available," he says. "Community leaders, religious leaders, elders, women's and men's committees must be approached systematically to involve all men and women of reproductive age. A well-planned health education program by experienced people is essential to bring about behavioral changes and a successful outcome."

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⁴ UNFPA/UNHCR, End of Project Evaluation Report on Female Genital Mutilation Pilot Project in Hartisheik Refugee Camps, Somali Region, 1997

