

# Health and security

## Summary

In the previous chapters, vulnerability was approached sectorally, in terms of poverty, employment and education. Human security (as an antidote to vulnerability) can also be defined to include health status and nutrition security, community relations, access to social services and threat perception.<sup>104</sup>

This chapter analyses housing conditions, threat perceptions, and health and nutrition conditions for displaced as opposed to majority households. The displaced face a very insecure housing situation: most live in accommodations for refugees with sub-standard sanitation infrastructure. These conditions, and the fact that they often have left much behind in the places from which they fled, mean that the displaced possess fewer basic household items, such as furniture or books. Access to information and communication technologies is often inadequate as well.

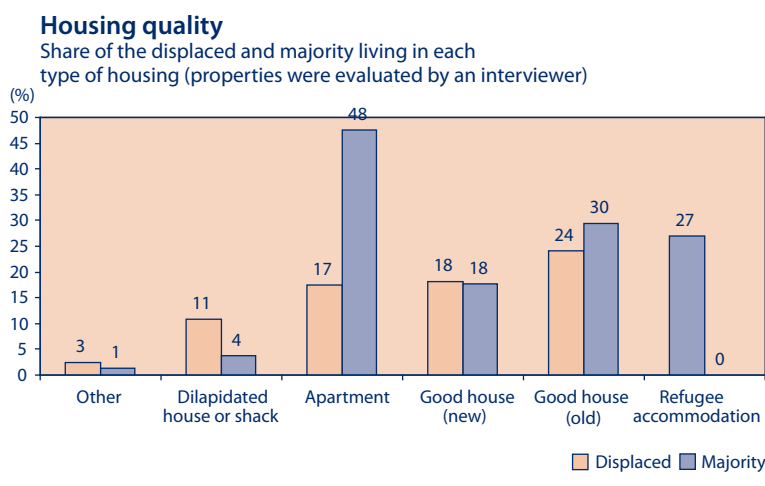
The displaced rate their health status worse compared to one year earlier. Some important gender differences exist in terms of incidence of chronic illnesses: more women are affected by chronic illnesses among both displaced and majority households. The displaced are more likely to suffer from neuroses and disorders related to the psychological trauma of displacement. Large physical distances to health facilities, low incomes, and lack of proper identity documents, are major barriers to access to health services for displaced households. Insufficient vaccination coverage (most often due to inadequate identity documents) is a major determinant of vulnerability, particularly for displaced children. Like Roma, displaced households are much more likely than majority households to go to bed hungry because they cannot afford food. Displaced children are particularly susceptible to nutrition risks.

The most common threat reported by both displaced and majority households is 'lack of sufficient incomes'. However, while large proportions of displaced households view hunger, poor sanitation and inadequate housing as the greatest threats to their households, majority respondents are more concerned with such issues as crime and corruption. When asked who would be the best placed to handle these threats, both groups responded that the family should handle problems of low incomes, hunger and inadequate housing. Poor sanitation and corruption, by contrast, were seen by both groups as requiring the intervention of the police, NGOs or local government.

## Housing status

While almost all majority households live either in apartments or houses considered to be in good condition, almost two fifths (38 per cent) of displaced households live in camps and other accommodations specifically for refugees, or in dilapidated houses and shacks (see Figure 2-29).

FIGURE 2 – 29



<sup>104</sup> The survey did not ask questions related to violence, though it is confirmed that violence, including inter-personal violence, is a major health threat that particularly affects women.

Table 2-6  
**Gender aspects of health status**

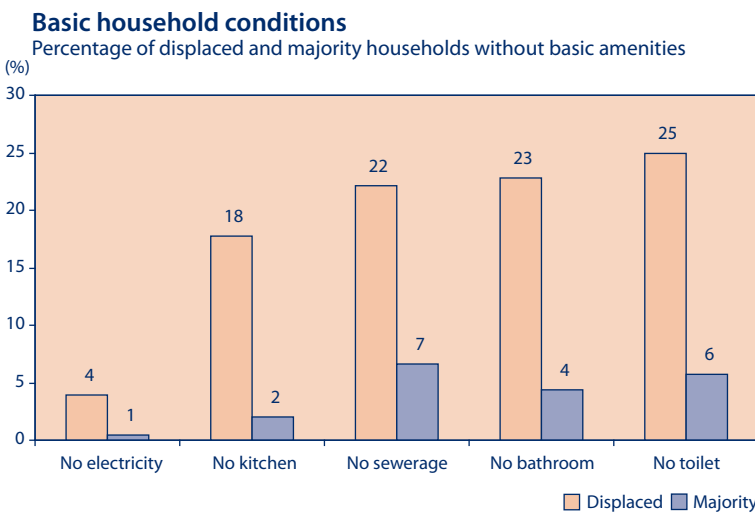
	Majority		Displaced	
	Male	Female	Male	Female
Average score on self-assessment of improvement/deterioration of health in the last year (with '5' representing 'much worse' and '1' meaning 'much better')	3.1	3.2	3.2	3.4
Incidence of chronic illnesses (percentage of those who reported having chronic illness)	16	20	19	23
Average number of days of normal activity lost as a result of illness	13.9	11.2	18.4	17.5

Differences in the housing status of majority and displaced households are also reflected in crowding. While majority households can expect to have an average of three rooms in their homes, displaced households have an average of just two. Similarly, while majority households enjoy

an average of 27 square metres per household member at home, displaced persons have just 17 square metres. Access to basic infrastructure is an additional useful proxy of household vulnerability, and displaced households are extremely vulnerable in this respect. The data show that almost a quarter of all displaced households live without access to an indoor toilet; similar proportions live without access to a bathroom or sewerage for waste disposal in their homes (see Figure 2-30).

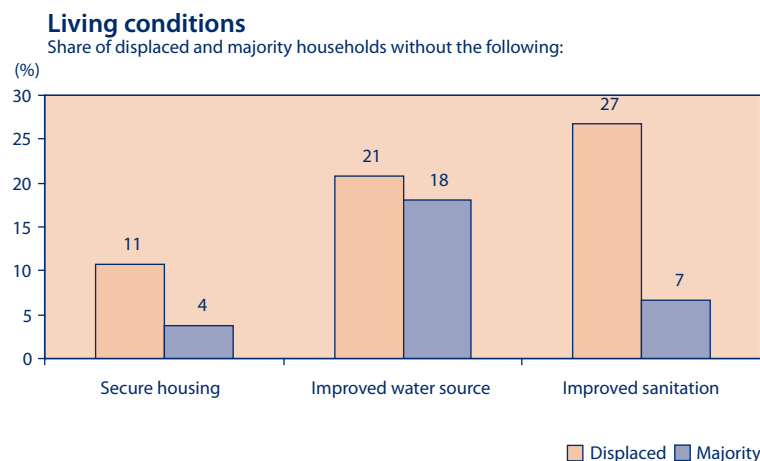
Examining the data according to MDG indicators shows that the proportions of displaced households without access to secure housing (i.e., living in dilapidated houses or shacks), improved water sources (i.e., piped water within the dwelling or garden/yard), or improved sanitation (i.e., toilet or bathroom inside the house), are far higher than the proportions of majority households, and far below MDG targets for countries in the region (see Figure 2-31).

FIGURE 2 – 30



The data show that, relative to majority households, the displaced lack access to such household items as washing machines, ovens, refrigerators, and in many cases even a bed for each member of the household (see Figure 2-32). They also show that displaced households are far more likely to use wood for either heating or cooking than majority households (Figure 2-33). The displaced are less likely to have the use of either central heating or piped gas to heat their homes, or electricity or gas to cook with.

FIGURE 2 – 31



**Health and nutrition**

Halting or reversing the spread of disease and eliminating hunger are central components of the MDGs. The data suggest that displaced households in the Western Balkans are particularly vulnerable to poor health and malnutrition, and illustrate the need for disaggregated health data to monitor their status. The data show that displaced respondents lost an average of 17 days of normal activity as a result of illness, compared to just 12 days for majority respondents. This seems to be related both to the higher incidence of illness among displaced respondents and their less satisfactory access to healthcare. As the data in Table 2-6 show, women in both groups of households report somewhat worse health during the last year than men. Differences in incidence of chronic illnesses are par-

ticularly pronounced. Despite this, women from both majority and displaced communities report fewer working days lost than men. This suggests that women are either more likely to report their illness to be ‘chronic’, are less likely to let illness affect their everyday activities, or are engaged in everyday activities that are less disrupted by illness.

Twenty-two per cent of displaced respondents (compared to 18 per cent of majority respondents) report suffering from some form of chronic illness. This may be due to the lower quality of housing: the incidence of diseases among displaced households associated with dust and other lung irritants that are attributable to poor housing conditions, such as bronchitis or emphysema, is higher than among majority households (14 per cent of the displaced compared to 8 per cent of the majority). The data also support one of the more alarming findings often reported by qualitative research – the frequency of neuroses and psychological trauma.

Just 35 per cent of displaced households have access to a family doctor, compared to 43 per cent for majority households. The data suggest that such limited access to health care for displaced households is caused by their remoteness: 35 and 36 per cent of displaced households reported living more than three kilometres from a primary medical centre or general practitioner respectively, compared to 17 and 24 per cent for majority households. (However, 39 per cent of displaced households reported living within three kilometres of traditional healers, compared to 30 per cent of majority households—see Figure 2-34). These data suggest that, in light of the scarcity of modern medical care in the vicinity of the camps in which they live, displaced households turn more to traditional – largely unregulated – forms of health care.

In addition to their physical isolation, low incomes and inadequate identity documents are also barriers to adequate health care for displaced persons. Thirty-eight per cent of displaced households reported periods during the past 12 months in which they could not afford to purchase medicines prescribed to a member of the household (compared to 20 per cent for majority households). Although throughout the former Yugoslavia displaced per-

FIGURE 2 – 32

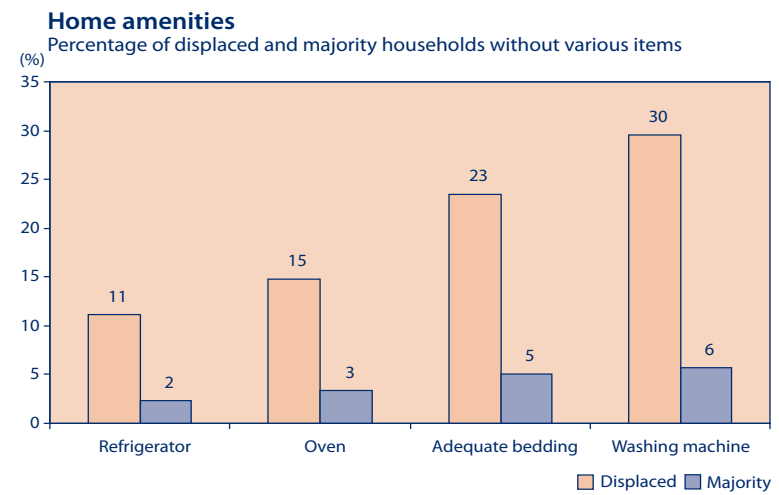


FIGURE 2 – 33

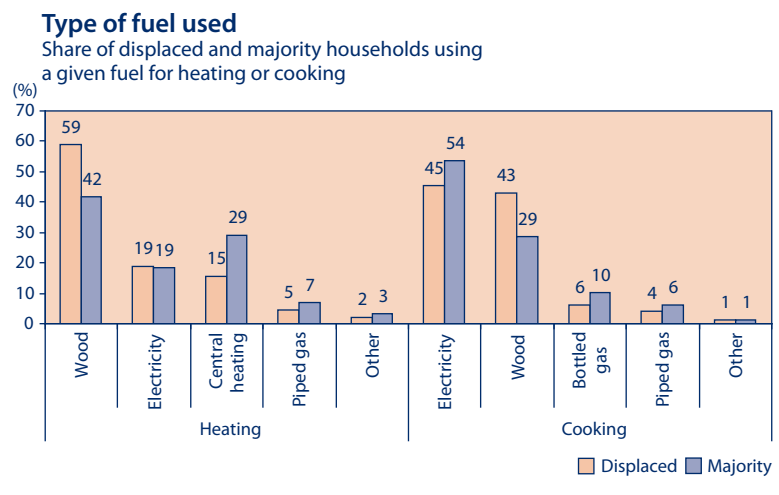
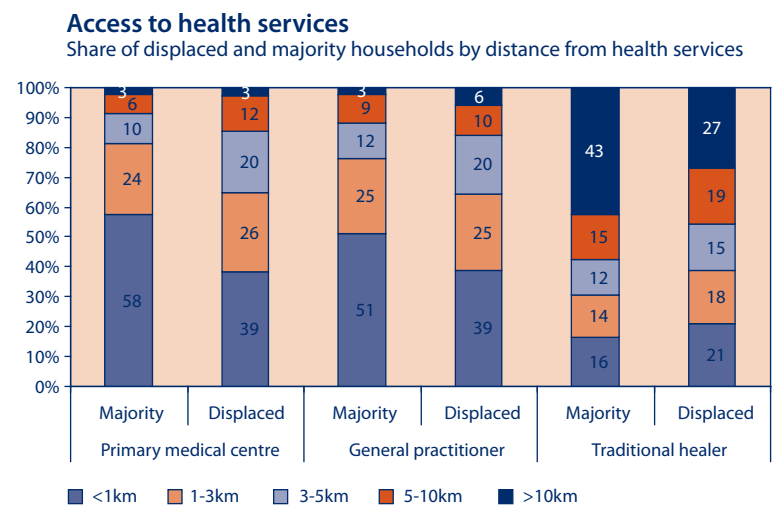


FIGURE 2 – 34



sons were officially given ID cards entitling them to health care, 9 per cent of displaced respondents reported having been denied medical service due to lack of proper docu-

**Box 18: National MDG targets, vulnerable groups and displaced households' access to improved sanitation**

Improved sanitation is often used to measure countries' progress toward reaching MDG 7. In the case of displaced persons, this indicator reflects the quality of housing and associated infrastructure in the settlements where these households reside.

In **Montenegro**, the national MDG report calls for universal access to improved sanitation by 2015, up from 98.5 per cent in 2005. At the national level, meeting this goal would require annual increases in such access of 0.15 percentage points. But for displaced households, progress at this rate would mean that the target would only be met in 2137. If the government wishes to achieve improved sanitation by 2015 for all displaced households, the pace at which access to improved sanitation is growing would need to be increased by over 12 times.

In **Serbia**, the national MDG report likewise called for achieving full access to improved sanitation by 2015, up from 88.3 per cent in 2000. At the national level, meeting this goal would require annual increases in such access of 0.78 percentage points. But for displaced households, progress at this rate would mean that the target would only be met in 2049. If the government wishes to achieve improved sanitation by 2015 for all displaced households, the pace at which access to improved sanitation is growing would need to be increased by over four times.

Because these indicators reflect living conditions in collective centres, real progress is likely to require more definitive, sustainable solutions to the problems of displacement, such as return to their homes or more complete integration into their new countries and societies.

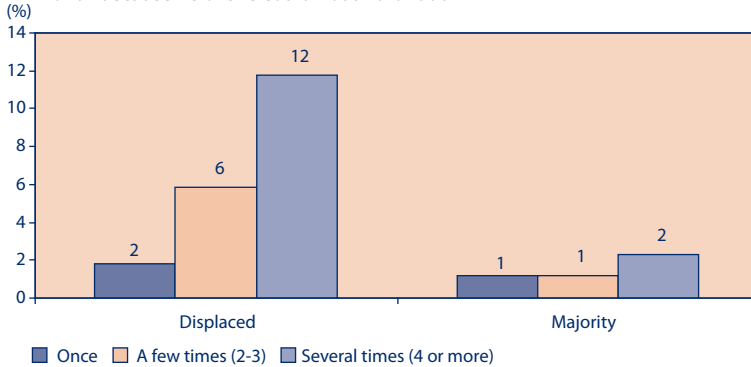
ber of children who are not vaccinated is not large, and caution should be exercised in interpreting these findings, these results point to the unresolved status of displaced persons as a major determinant of their vulnerability.

Health status is directly related to nutrition, which in turn is influenced by expenditures (i.e., poverty). The data show that although the reported differences in nutrition security for Roma households are much more pronounced than for majority and displaced households, the latter still face considerable risks. As much as 12 per cent of displaced households (versus 2 per cent of majority households) reported experiencing four or more cases within a month when they went to bed hungry because they couldn't afford food. Almost one fifth of displaced households face nutrition risk, compared with 4 per cent of majority households (Figure 2-35). For children from displaced households, this figure rises to 27 per cent, compared to just 7 per cent for children from majority households.

FIGURE 2 – 35

**Nutrition vulnerability**

Percentage of households in which a member went to bed hungry in the past month because he or she could not afford food



ments. (Only 3 per cent of majority respondents reported having had such an experience.) The survey data indicate that 6 per cent of displaced persons' children are not vaccinated against such common diseases as polio, diphtheria, tetanus, and whooping cough, with a lack of medical identity cards (ID) given most frequently (38 per cent) as the reason for this. Although 5 per cent of children under 14 years of age from majority households also do not receive vaccinations, the most common reason given for this is that vaccinations are 'not considered important'. Thus, although the total num-

**Political participation and access to information**

Political participation is essential for ensuring that the needs of the displaced are met. However, the survey data show that displaced households have much lower social or political engagement than majority households. Just 13 displaced households surveyed (1 per cent of the total sample) reported having at least one household member who is a member of the local municipal council or assembly, compared to 35 majority households (3 per cent of the total sample). Limited access to information, which is an important component of social and political participation, might be a contributing factor. The data show that the displaced are far less likely than the majority to have access to various sources of information in their homes.

**Threat perceptions**

In light of their higher rates of poverty and unemployment, their poorer housing conditions and health and nutrition status, it is not surprising that the largest threats perceived by displaced households are those of insufficient incomes, inadequate housing, crime, hunger, conflict or physical

insecurity, and sanitation-related diseases (see Figure 2-36). On the other hand, majority communities are more likely to perceive threats in terms of such governance-related issues as corruption and environmental pollution. This reflects majority communities' deeper integration into economic and political processes, as described in the *Political participation and access to information* section above.

When asked who is best placed to manage the response to threats, answers varied according to the threat in question. Across both groups, respondents who reported low incomes, hunger, or inadequate housing to be the greatest threats to their households tended to believe that their family would be best placed to manage these threats. Of those who emphasized corruption or poor sanitation as the greatest threats, the highest proportion of both groups responded that the police, NGOs, or local governments were best placed to tackle them. For those who viewed environmental pollution as the worst threat to their households, the preferred response agent varied across groups. It is indicative that the highest percentage of displaced persons and majority respondents indicated that NGOs would be best placed to respond.

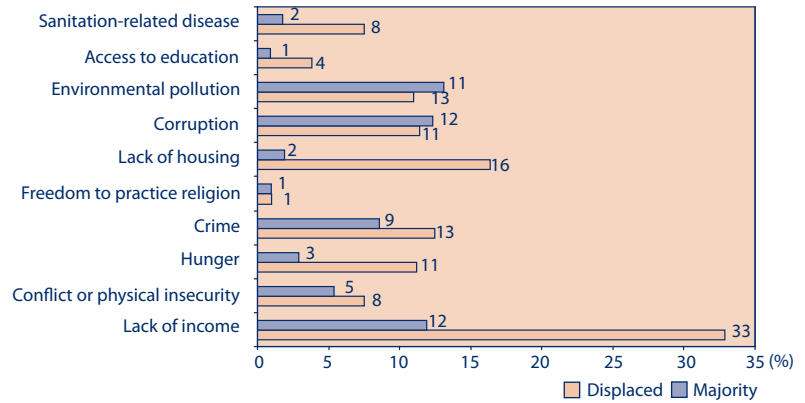
### Conclusions from Chapter 2.4

The survey data point to considerably different profiles of household vulnerability and security in the case of displaced versus majority households. While both groups complain about insufficient incomes, displaced households face additional challenges related to their unsettled status, and more frequently emphasize such issues as inadequate housing, the absence of household goods, and nutrition insecurity in their subjective threats assessment. Perhaps surprisingly, displaced persons do not frequently mention such threats as ethnic-related violence or threats to their possessions. These threats may have been associated with the conflict phase, which for most households was over by 2000. By the same token, the absence of on-going conflicts in the Balkans means that less attention is focused on the plight of the displaced and their families. This disinterest does not help attract the broad support needed to improve their situation. Indeed, the biggest threat to displaced persons at present may be the lack of imminent 'televizable' threats that can

FIGURE 2 – 36

#### Perceived threats

Percentage of the displaced and majority reporting each threat to be the most serious facing their household



#### Box 19: Displaced children in Serbia – struggling for survival, far from development

Nominally, education in all Southeast European countries is free and available to all. In reality, however, different groups face different problems in exercising their right to education.

Children of displaced families are particularly vulnerable to educational risks. In some cases, collective centres are far from schools, making it difficult for children to attend. A Norwegian Refugee Council report on internally displaced persons found that 20 per cent of displaced children in Serbia do not attend school. Those who attend often do so in classes with over 50 children per classroom.

Language can also be a barrier, particularly for Albanian- or Roma-speaking children. Chronic illnesses, lack of proper clothing, and intolerance from local children can add further difficulties. Most of the displaced Roma children from Kosovo have either never been to school or dropped out before completing the fourth year. Even when children show an interest in school, cultural attitudes to education compound the practical and psychological barriers to school attendance.

Some of the children are in orphanages, others are in foster care, others live with close or distant relatives. Twelve per cent of children in Serbian orphanages are displaced. Life for these children has been described as "only survival, no development". Nutritional risks are also present: to date, school meals have not been part of the education programmes. While such risks are present for the entire population, they can be particularly difficult for displaced children. Border communities and other strategically located municipalities can be hit by large influxes of displaced persons, putting the educational system and other public services under severe stress. For example, in certain areas of Vojvodina and Kraljevo, 42 per cent of the people are refugees and IDPs.

UNICEF plays a leading role in providing education for these children, organizing 'catch up' classes for approximately 30,000 displaced children of primary school age (some 1,000 of whom are Roma) in collective and community centres and in Serbian primary schools. Most of the assistance for children has gone to education for younger children. UNICEF reports that more than 8,000 children in Serbia have lost a parent or been orphaned during the decade of wars. Their lack of prospects makes youth understandably angry and prone to destructive behaviour. If they are left without positive role models and opportunities to constructively craft their future, displaced children are at risk of growing into angry young people who perpetuate cycles of violence and retaliation.

Box based on "Refugee and Internally Displaced Women and Children in Serbia and Montenegro". September 2001. Women's Commission for Refugee Women and Children (WCRWC). New York: WCRWC.

generate attention and precipitate decisive action. International organizations can do much in this respect.

Health status data reported by displaced respondents outline worrying trends. Displaced persons are most heavily affected by neuroses and psychological disorders that are the direct consequence of conflict and resettlement-related trauma. These findings call for special attention like psychiatric counselling, particularly for children. Lack of

appropriate medical identification is another problem detected by the survey. Registration-related barriers are a formal obstacle that can prevent access to primary health care and hospital services. Since these barriers are closely related to questions of the status of displaced households, resolving these 'status issues' should be a matter of international concerted action. Addressing discrepancies between legislation and its implementation should be particular concerns.