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In refugee settings, alcohol and other psychoactive substances can potentiate many underlying problems and contribute to the erosion of social relations and community structure. Interventions to minimise harmful use of alcohol and other psychoactive substances can lead to positive changes, but must be customised to the specific needs of each setting. Rapid assessments with appropriate tools, understanding the situation, partnership with workers and refugees, as well as inclusive approaches are all essential. Based on field experience in two refugee camps, these elements are discussed and recommendations are proposed for integrated interventions for alcohol and psychoactive substances.

Keywords: alcohol, camps, community interventions, Guinea, Kenya, psychoactive substances, refugees

Introduction

Refugees residing in camps often face a multitude of interrelated problems. Situations such as lack of space, reduced livelihood opportunities, breakdown in community social support, dependence on aid and erosion of cultural values may all contribute to the emergence or increase of social problems. Within this web of interrelated factors, alcohol and other psychoactive substances can be both an additional stressor and a consequence of stressors. Contrary to popular belief, most alcohol and drug related harm is the result of hazardous and harmful use, and not simply the consequence of dependence (Rehm et al., 2003; Gururaj et al., 2006). In refugee camp settings it is essential to acknowledge the existence of substance related problems. Pragmatic interventions targeting the entire community (not only users) could make a positive difference, while also being linked to ongoing programmes. These interventions and programme are discussed below, based on experience collected during field missions in Guinea and Kenya.

Alcohol and substance use in refugee camps in Kenya and Guinea

This article describes the findings of two assessments in refugee camps in Kenya and Guinea in late 2009. As in other camps, drinking of alcohol (home-made and branded) as well as smoking of cannabis and chewing of *khat* are widely observed phenomena in these settings.[1]

Camps: situation and context

In Guinea (N'Zerekore) three camps (Kankouan I, II and Laine) host French speaking refugees originating mainly from the Ivory Coast. English speaking refugees come mainly from Liberia. French speaking refugees usually have an efficient family support and immediate, but sometimes erratic, access to care, are involved in a dynamic process of integration, with the majority of children enrolled in the educational system.

The English speaking refugees however, often have major resentments towards integration and are often hostile to external interventions. This influences their access to public health care, education and other services.

In northeastern Kenya the Dadaab refugee camps were established in 1992, with the vast majority of the 277 509 refugees being Somali. The refugee population in Dadaab has increased by more than 20% since early 2009. Children represent 50% of the camp population. The camp hosts a mixed population of refugees that have lived there for many years and recent new arrivals.

The information obtained is the result of two field visits by the first author to the campsites (four weeks in Guinea and two weeks in Kenya). In Guinea (Conakry and N'Zerekore), the findings have been collated based on participatory observations, direct observations, non structured interviews with the refugees' committees, discussions with field workers (medical doctors, nurses, community based workers and psychosocial workers) and a two-day reflective workshop including field workers, refugees, members of the Guinean Red Cross and implementing partners. In Kenya (Nairobi and Dadaab), findings are based on direct observations, participatory observation, feedback from a coordination meeting with implementing partners involved in substance use prevention and management, discussions with field workers (community based workers, (medical) doctors, psychologist and nurses) and interviews with refugees. In Guinea, all information was collected directly in French and English. In Kenya, parts of the findings were collected with the assistance of a translator.

Alcohol

Alcohol is the most widely used substance in refugee camps visited in Guinea. In general, branded alcohol is being used, but some members of the communities tend to prefer home brewed substances using local ingredients. Brewed alcohols range from cane juice liquor, to palm wine, fermented millet or sorghum. They are regularly consumed in the communities, and are relatively cheap (e.g. approximately 500 ml of homemade fermented cereals cost 0.25 US dollars in Kenya). For some women, alcohol preparation is the main source of income. There is no up-to-date systematic inventory of homemade alcoholic beverages available in refugee camps with related consequences, but their presence is confirmed in various refugee settings (e.g. *blanco* in Guinea). According to refugees, alcohol is brewed for sale in the camp, while in the country of origin; alcohol was mostly brewed for community events and celebrations.

Khat

Among the Somali community in the refugee camps in Kenya *khat* is the drug of choice. *Khat* is imported from outside the camps on a regular basis, and made available at numerous selling points, both inside and outside of the camps. The quality and price of *khat* varies dramatically from one selling point to another. It is fairly expensive compared to alcoholic brews; a bundle of *khat* (used for a day) costs between 6 and 12 US dollars. Amongst users, *khat* is not considered a drug and is chewed openly within and outside the camps. The trade is usually organised by women, and it is a major source of income for families. Interviews revealed that refugees experienced reduced libido, cognitive side effects (such as memory problems and poor concentration), anxiety, and even hallucinations. While elders usually use *khat* regularly, but with no other substances, the younger

generations of refugees tend to use *khat* in combination with other substances (such as benzodiazepines and/or alcohol) with repeated episodes of intoxication.

Cannabis

Cannabis has been reported in both refugee sites amongst teenagers and young adults. According to refugees, cannabis use tends also to be present in the countries of origin and in the older generations as well. Even with unverified references of cannabis growing near the refugee camps, assessments indicate that it is usually brought from outside the camps and resold to the members of the communities. The exact impact of cannabis use in the refugee camps remains undetermined, and some individuals' beliefs on the effects of cannabis indicate confusion. It seems that cannabis has always been part of the community practice; however, refugees indicate that cannabis intoxication episodes (described as sudden burst of violence) were rarely observed in the past.

Other products and polysubstance use

Next to alcohol, cannabis and *khat*, there are a large variety of other drugs reportedly used. These substances range from benzodiazepines (often in combination with *khat*), promethazine, glue, petrol and other substance that can be inhaled. There are also occasional references to unusual products such as gunpowder or local plants used for either their psychoactive effects, or other reasons (e.g. capacity to increase male potency). In terms of multiple usage, some users combine *khat* with alcohol and/or benzodiazepines. There are no indications for the existence of injecting drug use.

Alcohol and psychoactive substance are known to be associated with direct and indirect consequences. Table 1 gives a summary of potential consequences of the use of alcohol and psychoactive substances, as perceived by refugees and field workers (medical doctors, nurses, community workers and psychosocial workers).

When asked, some refugees clearly connect alcohol and drugs use with potential consequences. Others are more reluctant to consider alcohol and drug use as a problem in their community. While refugees stated that the conditions under which alcohol is brewed have changed, many mentioned that there is also no significant increase in use, compared to the country of origin. However, some refugees did mention that that some individuals may resort to excessive alcohol or drug use, and therefore present problems of uncontrollable violence and '*inexplicable*' mental disorders.

Excessive alcohol and substance use are linked to a wide range of causes, such as psychological trauma, limited capacity to cope with stressful events, insecure situations, frustration and anger and lack of future perspectives. Among young adolescents recently arrived in Dadaab, poor expectations for the future were especially mentioned and, according to the refugee communities, this group shows changing drinking patterns or use of substances other than those they previously used. During discussions with a group of newly arrived young refugees, they explained that when they discovered the camp living conditions and spoke with people who have been there for decades, they feel literally trapped between the dramatic situation in their country of origin and an almost absolute lack of future perspectives. This is not only specific to Dadaab. The negative influence of the refugee situation on wellbeing and mental health status is well documented (Laban et al., 2008; Horn, 2009; Mels et al., 2010).

Table 1. Direct and indirect alcohol and psychoactive substances consequences

Area of burden	Commonly described consequences
Medical	Physical problems related to intoxication and regular excessive consumption, such as accidental injuries and liver cirrhosis. Unplanned pregnancy risks. Individuals with chronic disease, who also are heavy drinkers, frequently forget to take their medicines or are otherwise not consistent in taking it. Physical injuries caused to others by intoxicated persons.
Psychological	Incapacity to reason properly, with some developing mental health conditions. Exacerbation of underlying mental health problems. Suicides attempts in those engaged in heavy alcohol use.
Socio-economical	Undermining of community values, loss of culture, dignity and respect. Financial problems commonly result from indebtedness and trading family rations for alcohol. Household impoverishment. Personal and security issues (such as theft). Incapacity to get involved in any physically demanding labour.
Behavioural	Sexual and gender based violence, including wife and child abuse, sexual harassment, rape. Other violent sexual behaviour that constitutes a high risk for unprotected sex and the transmission of HIV and sexually transmitted infections. Public disturbance, interpersonal violence and other criminal (e.g. theft) and antisocial behaviours. Slipping drugs (e.g. benzodiazepine) into drinks of unsuspecting women leading to rape. Risk-taking behaviours, including unsafe sex and commercial sex near bars.

Assessment and development of plan of action on alcohol and substance use: lessons from the field

1) *Do not assume that all alcohol and substance use disorders are related to the situation in the refugee camp* The two assessments show that in refugee settings, alcohol and substance use are common. Interviews revealed that use of alcohol and psychoactive substances could be the result of many combinations of problems, not all related to the refugee situation. Individuals can arrive in the camps with a pre-existing problem, develop problems immediately after arrival, or develop problems from time to time (e.g. binge drinking), while others never develop alcohol nor substance use problems. Discussions also revealed that newly arrived refugees may show some changing patterns of alcohol and substance use habits, but this will need to be reviewed carefully. Nevertheless, refugee camps are merely a specific environment that can, in some individuals, be part of a constellation of elements leading to the development of harmful use.
2) *Promote understanding to facilitate interventions* It is essential to spend time in discussion with all participants, including

field workers, refugees and heads of programmes, to ensure they understand that interventions about alcohol and substance use are not isolated, but multi-sectoral by nature, and should be implemented within existing programmes. The purpose is not to create new activities, but to offer a different vision of the existing situation and stimulate creativity; to better consider alcohol and substance use and the way it affects the camp's life. During the assessments in the camps in Kenya and Guinea refugees and staff raised some questions. They reveal both their resistance and concerns:

- *Are you here to forbid the use of alcohol?*
- *Are you going to expel me from the camp if I am a user?*
- *Do you also consider the use of alcohol by staff as a problem?*
- *Are you going to develop a new programme? If yes, who is going to be in charge of it? How much will it cost? Will it increase my workload?*
- *Is there really something we can do about it? Is that going to help us in our job, or in our lives?*
- *Do you think it is a problem in the refugee camp? It cannot be a priority at the moment. There is already a programme for alcohol prevention.*

All of these potential questions and associated resistances need to be addressed in order to facilitate the sustainability of alcohol and substance use interventions.

3) *The entire community is affected by alcohol and substance use, not only the users* Alcohol and psychoactive substance related problems might not be present in the large majority of refugees, but the consequences on the community are significant, and not only limited to users. Therefore, interventions targeting only those with alcohol and drug use disorders must be complemented by preventive interventions and interventions to support families and carers of people with alcohol and drug use disorders. Furthermore, preventive educational awareness campaigns can be developed with communities to address possible changing patterns in the community.

4) *Involve refugees in coordinated initiatives* The consequences of alcohol and drug use are complex, and may affect the programmes' efficiency and the community dynamic. Therefore, workers and refugees must be involved together in a coordinated approach that will use the best of both worlds. Starting from coordination meetings, to information collection and circulation, efforts should be merged. Training only the staff, or individuals providing single sessions with information for the community, are not enough.

5) *Collect information using specific methods and instruments* Having an advanced knowledge of the refugee situation is useful, but not sufficient on it own. Considering the situation in refugee camps is associated with the need to act quickly, one of the most pragmatic tools is the *'rapid assessment of alcohol and other substance use in conflict affected and displaced populations'* (UNHCR/WHO, 2008). This tool can be effectively combined with the questionnaire available in the ASSIST package (WHO, 2003). The use of the ASSIST questionnaire can generate additional information regarding the use and consequences of alcohol and/or psychoactive substances in individuals, while giving an indication of the intensity of potential problems.

The brief intervention model usually associated with the ASSIST questionnaire might also be of interest in refugees' camps even though some adjustments might be considered in respect of the context.

6) *Develop a horizontal, rather than a vertical, approach to alcohol and substance use* Field workers are already overwhelmed by their daily programmes. Community based interventions, gender based violence management, public health and HIV programmes and many other activities already take place in every camp. Proposing a new vertical programme to prevent and address alcohol and psychoactive substance related problems would create an additional burden and resistance. Alcohol and drug problem management should therefore, preferably, be integrated within existing programmes. It is important to emphasise to the workers that this is not meant to add a new element to their portfolio, but will strengthen the efficiency of already existing programmes. In Guinea, for example, refugees proposed to organise visits to the psychiatric hospital where members of their community were hospitalised for alcohol related problems. Their objective was to give support to the affected families, and facilitate the social reinsertion of patients after their discharge. They also proposed to organise informal discussions with children where they explained how they manage to cope with the camp situation, without being involved in violent or negative behaviours. These activities do not specifically target alcohol nor substance use, but have an impact on the entire community and positive consequences on already existing programmes, without creating an additional burden for the implementing partners.

Conclusion

Interventions to reduce the impact of alcohol and psychoactive substances on refugees should not focus only on users. Limiting interventions to only those who are problematic users, while ignoring the associated context and consequences, will have a modest impact. Concentrating the efforts on dependent users would only give partial results, minimise the problem, stigmatise the condition, and marginalise affected individuals (Benegal et al., 2009). Having a limited conception of *dependence* as the main reason for alcohol/drug related harm in the community may lead to restrictive public health strategies. While focusing on individuals with dependency issues has led to the development of specialised treatment facilities and rehabilitation centres. However, field experience indicates that such specialised interventions, when available, are often not very accessible nor affordable, especially in rural areas (Parry, 2005; Perngparn et al., 2008). Furthermore, the overall efficacy of structures for treatment of dependence is often very low (Ray, 2004).

Interventions should focus on the entire community and not only on harmful, hazardous or dependant users. The authors propose that the following interrelated elements should be considered when developing an integrated community based approach to reduction of alcohol and substance use problems:

1. Vertical approaches should be avoided, and creative ways to strengthen already existing programmes should be explored. Alcohol and psychoactive substance interventions should be integrated within existing services and interventions.

2. Epidemiological data must be collected systematically using specific instruments in order to evaluate and properly understand the role and impact of alcohol and substance use on each targeted community.
3. Refugees possess important knowledge and understanding of the context of the situation. Therefore, they should be part of coordinated actions and at the centre of any type of intervention. This means that partnership, community based approaches and coordinated actions are the cornerstones of efficient interventions.

A challenge to effective programming is the resistance to accept that alcohol and psychoactive substance problems are, as in any other situation, also present in refugee camps, and can undermine the stability of the community. A second challenge is to convince the authorities and partners that effective interventions can be established without creating an additional burden for the field workers, or disturbing the dynamic of the community.

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