Refugees in and out North Africa: a study of the Choucha refugee camp in Tunisia

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In recent years, North African (NA) countries ceased to be emigration-only countries and are now on the verge of becoming immigration as well as transit countries for economic migrants and refugees. Contextual as well as structural long-term factors are driving these changes. The ongoing crises in Africa and the Middle East are prompting strong outflows of refugees, which are likely to induce NA countries to share some common public policy and public health concerns with European countries in a near future. This article highlights some aspects of these changes, from the study of the consequences of the 2011 Libyan crisis in Tunisia. It addresses individual trajectories and health concerns of refugees in and out North Africa from a study of the Choucha camp in Tunisia.

The number of Iraqi refugees greatly increased from the mid-2000s. In 2011–12, the Libyan civil war resulted in one million refugees moving to Tunisian and Egyptian camps. The ongoing Syrian civil war sequences of political crisis and interethnic violence in the Horn of Africa, but also from other regions, such as Ivory Coast or Nigeria. In 2011–12, the Libyan civil war resulted in one million refugees moving to Tunisian and Egyptian camps. The ongoing Syrian civil war.

Methods

The Choucha study comprised a monographic and qualitative approach. The former was based on grey literature, statistical surveys, interviews of the main stakeholders and visits to the camp facilities and the Ben Gardane Hospital. United Nations High Commissioner for Refugees (UNHCR) reports provide general information on the situation in Tunisia regarding refugees as well as an overview of the Choucha camp organization. We made use of the special bulletins issued by the Tunisian Health Ministry jointly with the WHO and on the Ministry of health and WHO 2011 report. We also had access to the Ben Gardane hospital statistical boards and reports on hospital activities relative to refugees. In the camp, we interviewed officials and employees of UNHCR, Tunisian armed forces medical staff, Tunisian medical doctors and psychologists, and the non-governmental organizations (NGOs) operating in the camp at that time, such as IMC and The Danish Council for refugees. We interviewed the refugees’ representatives for their community from Sudan, Darfur, Eritrea, Ivory Coast and Nigeria. In Choucha region, we interviewed the Ben Gardane director and staff and UNHCR officials.

The qualitative approach consisted in a three-fold survey. It was conducted in Choucha and around throughout May 2012. The central objective was to better understand refugees’ patterns of migration, health concerns and needs. By ‘patterns of migration’ we mean purposes of migration, individual background, itinerary and
personal experience of migration. We conducted three series of interviews:

- With the representatives of the main refugee communities that were present in the camp at that time;
- With the professionals from the NGOs and public facilities that were operating in the camp;
- With the refugees themselves.

How the Libyan crisis raised common issues for North Africa and Europe

Following the so-called ‘Jasmine revolution’, Tunisia has become a transit country for legal and all forms of illegal migration to Europe. The political turmoil that occurred in Tunisia in December 2010 ended up with a new situation in terms of security and emigration control and a strong uncontrolled outflow to Europe. A total of 56 000 persons reached Europe through the sole Lampedusa island in 2011, among which 28 000 were Tunisians.

The civil war that broke out in February 2011 in neighbouring Libya then triggered an influx of almost one million people to Tunisia, including >660 000 Libyans citizens. Although having hardly recovered from its own ‘revolution’, Tunisia responded to the Libyan crisis by opening its borders to refugees, regardless of their nationalities and organized a relief effort encouraged and supported by UNHCR and other partners, such as NGOs, donors from the private sector and local population. In June 2011, UNHCR signed a Memorandum of Understanding with the Tunisian government, enabling UNCHR to intervene in refugee camps in southern Tunisia. This agreement also initiated an action program implying other Tunisian institutions, such as the Department of Defense, the Department of national Security, of Social Affairs, Justice and various NGOs involved in the issue. The UNHCR operation in Tunisia focused on three main populations: Libyans living in host families in southern Tunisia, asylum seekers and refugees of other nationalities accommodated in transit camps on the southeast border awaiting perennial solutions, as well as asylum seekers and refugees accommodated in Tunisian urban areas.

The evolution of these three categories varied according to the circumstances of the war in Libya and with the camps capacities. Refugees from Asia, mostly Bangladesh and China, were rapidly airlifted back to their homeland country with the support of their government. Egyptian refugees made their way to Egypt, and most refugees from Libya crossed the frontier back when the situation improved, although an unknown number settled in Tunisia. The remaining had no option but to stay, especially sub-Saharan Africans who had come to Libya as migrants. While southeastern villages in Tunisia hosted Libyans and Iraqi families, formal structures bore the bulk of the refugee flow. The vast majority of refugees had been taken over by their governments by the first quarter of 2012. Others obtained a refugee status and found shelter in countries such as the USA, Norway, Sweden, Australia and the Netherlands, but not in European Mediterranean countries.

The humanitarian response

In the first days of the crisis, many refugees were accommodated in empty hangars or makeshift shelters at the frontier. Spontaneous refugee facilities opened in Zarzis, Medenine, Djerba, Ben Gardane and Gabes before the Tunisian state and international responses. A transit centre was set up at Djerba airport till March 11 that would evacuate most refugees from Asia, essentially Bangladeshi. Formal help form the Tunisian state, the UNHCR and NGOs, as well as informal help from Tunisian households and firms, would start during the following days. Seven camps were installed on the southeast Tunisian border around Choucha.

- Transit camp—border Ras Jdir 23 February 2011
- Camp Choucha 24 February 2011
- Emirati camp—Ras Jdir 13 March 2011
- IFRC camp (camp then named El Hayet) 6 April 2011
- UNHCR camp—Remada 10 April 2011
- Emirati camp—Dhiba 13 April 2011
- Qatari camp—Tataouine 23 May 2011

Choucha was by far the largest camp and remained the only camp still open by mid-2012. A total of 60 nationalities were at a time present in the facilities. Some migrants were hosted directly by inhabitants of Ben Gardane and surrounding villages, such as Iraqis. This exceptional situation ended up in outbursts of ethnic violence, culminating with the death of six refugees in May 2012, before the camp was separated into districts according to the country of origin (cf. figure 1 below). Besides, the camp’s authorities decided to deal with camp organization questions and to communicate through community representatives. Representatives for health issues were also chosen who would work with the camp authorities on sanitary issues and prevention campaigns, and who would also communicate the refugees’ demands.

Advanced medical units were set up at the Ras Jdir and Dhibat frontier outposts. They were then reoriented to the Tunisian or Moroccan field hospitals (Algeria also provided a medical unit), or to other regional hospitals, mostly in Ben Gardane or even Sfax. Outpatient health consultations were provided in the camp by Tunisian physicians and health professionals as well as by NGOs (Médecins sans Frontières, Médecins du Monde intervened in 2011; International Medical Corps was still there in 2012 and in charge of the camp’s medical facility).

A Sanitary Alert system was set up to prevent epidemics, with day-to-day reports during the peak of arrivals. A coordination cell headed by UNHCR held daily meetings with the Tunisian public health ministry, EU representatives, the WHO, MSF, International
Relief Development, Tunisian Red crescent, UNICEF, Islamic relief and the International Medical Corps.

Within the camp, health actions mainly concentrated on hygiene, prevention, mental health and maternal/perinatal care. Hygiene programmes first focused on waste collection and water supply: ‘with no access to water and no sewer or waste disposal and collection hence very poor sanitary situation: ‘(…') there exist only two sanitation blocks for 10'000 persons, no shower and only a very few water points. The soil is covered with wastes of all kind’.

Two organizations concentrated on hygiene education and maternal education on hygiene through campaigns with the help of the communities' representatives.

Psychological care was organized from 3 March at the frontier posts, and from 6 March in Choucha. It was being delivered through group sessions as well as individual consultations by psychiatrists and psychologists from Tunisian and Moroccan hospitals as well as from NGOs such as MSF and Médecins du Monde and also the United Nations Population Fund.

External outpatient consultations were also supplied at the camp medical unit, reaching up to 900 consultations per day. From the health professionals we interviewed, health consumption in the camp was high not only because of the consequences of the war on refugees' health but also, and especially, because immigrants in Libya did not have a good, not to say any, access to health care in Libya.

The general assessment within UNHCR is that the camp facilities far exceed the expected standards and those of other camps, such as the camps in Kenya. Interviews of the country representatives for health tend to confirm that basic needs of refugees were met. They pointed out perinatal health, and the facilities for children and adolescents that were also set up by NGOs, such as the Danish Refugees Council which provided schooling, sport and cultural sessions, and psychological support.

The Tunisian civil society would also provide a significant contribution. Individuals would donate drugs, and private companies would also donate or even provide facilities for the refugees. At the time we visited the camp facilities most Iraqi refugees were housed by the local population.

Refugees' health records were completed and were made accessible from the health facilities. UNHCR ensures that these records have been directed to the hosting countries of the refugees; for those who were not granted a refugee status and went back to their country of origin, it is likely that no such follow-up was completed.

What was the impact on the Tunisian health system? By mid-2011, there was fear of medical shortage for the Tunisian health system itself, i.e. for Tunisians too, as the Medenine Governorate population had gained 20% from the massive flow of migrants. To our knowledge, no such study of the consequences of the refugee crisis on the Tunisian health-care system has been completed. From the information we collected, it appears the above anticipated shortages never occurred.

**Migrants testimonies**

The Choucha study comprised a monographic and a qualitative approach. The former was based on grey literature, statistical series from the main stakeholders and visits to the camp facilities. The latter consisted in a 3-fold survey. It was conducted in Choucha and around throughout May 2012. The central objective was to better understand refugees' patterns of migration and health concerns. By ‘pattern of migration’ we mean purposes of migration, individual background and itinerary and personal experience of migration. We conducted three series of interviews:

- With the representatives of the main refugees communities that were present in the camp at that time;
- With the professionals from the NGO and public facilities that were operating in the camp;
- With the refugees themselves.

Interviews with refugees were conducted in Arabic, French, English and, in some cases, native dialects, which necessitated a translator. The interviewed were first suggested by community representatives, then other respondents would be reached from this first entry point, and again. A total of 24 interviews were conducted from which a broad typology of migrants clearly surfaced. Profiles of refugees would vary according to two groups of characteristics: on one hand gender and on the other hand socio-economic status. The latter would oppose two main categories. A first category regroups low- to very low-educated individuals, with associated characteristics of economic poverty and deprivation. As of May 2012, they represented the vast majority of current refugees. They originated mainly from Sahel and sub-Saharan countries such as Eritrea, Chad and Sudan (other nationalities from West Africa were also present but in low numbers, such as Nigerians, Ivoirians Coast). A second category regroups migrants with higher education, who often graduated from colleges, such as medical doctors, engineers or teachers, mostly from countries such as Sudan or Iraq. The six cases we present below, three women and three men, have been chosen so as to be illustrative of these categories.

**Women's stories and histories**

Yodit is a 26-year-old Ethiopian who grew up in the suburbs of Addis Ababa, where she lived as a single woman with her family and relatives. She graduated from Addis Ababa, where she lived as a single woman with her family and relatives. She graduated from high school but stopped before university. She left Ethiopia with the aim of finding a job in Libya and, according to opportunities, eventually moving to Europe. She considered Italy as a hypothetical perspective, whereas Libya was a tangible objective. She would have been fully satisfied with a decent position in Libya.

She travelled within a group of young women, with whom she planned her migration project. They journeyed through Sudan, Darfur and then Libya, mostly walking or hitch-hiking. The group had to cross desert regions under such appalling conditions that some could not make it. Yodit witnessed a few deceases en route and evokes situations when the group would abandon a fellow traveller who could not carry on. Others gave up for health reasons and headed back to Ethiopia, especially those who already had health conditions. Although she did not provide straightforward answers, it is likely that Yodit and her friends underwent sexual violence, such as rapes and prostitution, along the journey.

Yodit eventually found her way to Tripoli. The journey had cost her around €1,500. Upon arrival, she and her friends were incarcerated for a period of one year. She was then hired as a home employee in a Libyan household, where she endured hard working conditions and exploitation, but managed to save some money so she could think about moving again. When war broke...
out, she entered Tunisia on the 26 March 2011, and had remained there since with the same group of young women she undertook the journey with, all of whom having had experienced similar adversities in Libya. She recalls the first days in the camp with dismay, pointing out a state of absolute insecurity. Today, she acknowledges that the situation has improved drastically. She hoped to obtain a refugee status and then settle in Canada or the USA. She was granted a refugee status by UNHCR but is now to be hosted by Spain. She thinks that racism is less acute in North America: ‘In European countries, there are many more racist persons than in North America’.

Amina is 40 years old. She came from Chad with her husband 15 years ago. He had already been working in Libya for a while, had returned to Chad to marry, then took her with him back to Libya. She has two children with him, aged 12 and 15 years. Her husband has stayed in Libya. She has had no news from him ever since, and hence fears for his life while the Red Cross and other NGOs are investigating in Libya. She was happy with her life in Libya and never thought of moving to Europe or North America. She does not consider health or health-care issues a problem in Libya. Now that she has been granted with a refugee status, she has been given the possibility to settle in Canada. She considers it an opportunity to raise her children in good conditions.

Fatima was born in Mali, where she graduated from high school. She migrated soon after to Libya with other members of her extended family. She then had various employments in Libya, mostly as a house employee. She considers her situation in Libya as ‘acceptable’, notwithstanding racism and discrimination from native Libyans. She does not consider migration to Europe a central objective but would take the opportunity, should it be not hazardous. Thanks to her fair French, she was hired by the medical unit in the camp. She came to be appreciated by the two psychologists working there, from whom she perceives a real will to help her as ‘a young woman who deserves to be helped’.

Men’s words

Suleiman originated from Darfur, Sudan. He is a college graduate and worked as a chartered accountant until interethnic violence broke out in Darfur in 1991. He arrived in Libya in 1992 as a refugee and then settled there, working in various places. Suleiman went back to Sudan in 2005 when a peace treaty that was signed between the Sudanese government and the southern Sudan rebellion rose hopes of return to peace and security after 22 years of violence. He married there, but soon ethnic violence broke again and he had to leave once more, returning to Libya as a refugee and undertaking the very same journey he had carried on two decades earlier. He explains that because his wife was to stay in Sudan, he had to divorce ‘in order to give her back freedom’. When living in Libya, he never had the idea to move north to Europe because he held good positions in Libya. Moreover, he did not want to break the law and become an illegal migrant. Besides, he is afraid of the sea. But he heard of fellow Sudanese who died trying to reach Europe from Libya.

Although Suleiman does not assess any chronic illness, his health is fragile. He was wounded in a car accident when fleeing Libya and endures steady pain since. He did not receive any treatment then, so his leg got gangrene. On arrival at the Tunisian border, he was taken to the Tunisian field hospital where he received treatment. Although he seems to be confident to recover his leg, the camp health professionals we met with believe they will probably have to proceed to amputation.

Suleiman has been granted a refugee status by UNHCR. He hoped to head to Sweden or Canada but instead got a clearance to the USA.

Mohamed is a 20-year-old Nigerian. He explains he went to Libya to find an employment there and, should he come across a safe opportunity, will cross to Europe or head to America. Like others, he fled interethnic violence and undertook a 4500 km journey through northern Nigeria, Niger, and through Libya to Tripoli. From Niger, they mostly travelled through Sahel desert zones. They often wandered along with camel herders. They made a few stops en route, hired in salt fields. Although he describes harsh living and travelling conditions, he does not point out health issues. Mohamed refuses to come back to his country of birth because of communitarian violence. Contrarily to many other fellow countrymen in the camp, he got the vaticum to a better life, a refugee status from the UNHCR. He says, he is accepted by the USA but still waits for the definitive decision.

Jean Pierre is a 25-year-old Ivory Coast national. As other Choucha refugees who have been denied such a status by UNHCR, he is somewhat mistrusting and not keen on explaining the reasons and eventual purpose of his journey. He fled Ivory Coast because of interethnic violence that erupted in Ivory Coast during the last decade, probably between 2008 and 2010. He travelled to Libya with a group of fellow countrymen. In Libya, he would work on various jobs, mostly construction. Jean Pierre arrived in the camp one year ago. He assesses many health problems among which are mental health troubles, such as migraines, that he considers to be linked with his current situation and the stress he is enduring. He is disappointed with the camp authorities and the services provided, such as tent housing, food and health services that he considers as insufficient. He argues with bitterness that his claims and those from the other Ivory Coast refugees have neither been answered nor taken into account. As many other residents still living in the camp by mid-2012, Jean Pierre has the feeling that he has reached a dead end. UNCHR has denied most West Africa refugees any status on the basis of the current embittering situation in the home country. He is in an acrimonious relationship with the UNCHR authorities who, he says, put pressure on him and others to leave by having issued a deadline after which no camp services will be provided anymore. Jean Pierre does not want to go back. He sees coming back like this as a personal failure and a humiliation in front of his relatives. Although he would not admit it in a plain voice, boating to Europe may represent an option for him and his friends.

Discussion

The above-presented monographic and qualitative studies shed light on specific patterns of migration and health issues. What we studied in the Choucha camp was unique for three main reasons.

(1) The proximity with the Libyan border: although according to UNHCR standards, refugees’ camps should be installed at least 60 km from the frontier line, the Choucha facilities were set up only 6 km from the Libyan border. This rendered security issues even more precarious and health-care supply organization more problematic.

(2) The camp hosted refugees from up to 60 nationalities. This unique feature necessitated adjustments from the camp authorities to deal with this globalized cultural and ethnical patchwork, and incidentally led to outbursts of interethnic violence in the camp.

(3) As a correlate, migrants’ profiles were very specific to the Libyan crisis. Most of the African refugees that were hosted in the camp had attained Libya fleeing violence in their country of birth. This in itself was a traumatizing experience. Some of the victims presented bullet wounds scars. Most had to leave their family with only scarce probabilities to return one day. These types of traumatisms have been largely documented in refugees’ studies. But for the Choucha inhabitants we interviewed, that had just been the beginning. As we learnt from the refugees’ interviews, the journey to Libya had been extremely demanding and sometimes violent, and then settling in Libya itself had been difficult.
Most African migrants faced months of imprisonment there, and all attested that they suffered ill treatments. Libya nevertheless appeared to be a land of opportunity for most. Though they had to face discrimination and exploitation in Libya, the refugees we met had managed to make a living. Civil war then took them by surprise, forcing them to start another migration cycle, again. For most of the refugees we interviewed, Europe and the West had never been a primary objective they would have focused on from the beginning. It rather appeared as a mere opportunity to escape the cycles of violence.

Conclusion

The UNHC estimates that one million flew from Libya to Tunisia between February and June 2011. They mainly stopped in Tunisia (530,000) and Egypt (340,000). An estimate of 18,000 eventually reached Europe. By July 2012, UNHCR had completed the transfer of its services and activities for people of concern from the Choucha transit camp to nearby urban areas. By late June, >600 refugees were living in the southern Tunisian towns of Ben Gardane and Medenine. Around 300 refugees had declined assistance in urban areas. The population at Choucha has been declining in size since 2011, allowing UNHCR to shift its operations to urban areas. The closure of the camp has the support of the Tunisian authorities, who have expressed readiness to offer temporary residence to some 250 refugees who will not be resettled to other countries.

The camp officially ceased to operate in June 2013. Nevertheless, as of mid-2014 some facilities have been reopened in Choucha to deal with African migrants who were denied a refugee status and its correlate viaticum to the West, but decided to stay.

The study’s main limitation comes from the fact that we visited the camp one year after the crisis momentum, when <4000 remained. Its originality stems from the use of both quantitative and qualitative sources. Moreover, the qualitative survey scope ranged beyond the UNHCR definition of a refugee. We collected testimonies from the official refugees and also from those who had been denied such status.

By combining monographic and qualitative approaches, we aimed at shedding new light on what is taking place under the radar of conventional information systems, and the study of Choucha permits us (i) to address new issues regarding migration and health related to changes in the social and political situation in North Africa, (ii) to deepen studies of migration patterns and how they can affect physical and mental health, access to health services in countries of arrival and (iii) to propose insights into the discussion of public policy issues for NA as for Europe, which we believe will share some common concerns regarding refugees in a close future, therefore drawing lessons on the consequences of the Arab Spring as well as of the crises that are currently occurring in the Middle East and Africa on immigration in and out NA.

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Key points

- NA countries have now become emigration as well as immigration and transit countries
- The Libyan crisis triggered the inflow of about one million refugees in Tunisia. Most of those who were requesting a refugee status were hosted in Choucha area facilities.
- The Choucha camp facilities hosted refugees from >60 countries, reflecting increasing complexity of migration routes in Africa.
- No impact was assessed on the local health system.
- The situation of those who are denied a refugee status has become an issue in itself.

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