Lesson X.X: XXXXX

MPW Course 6: Refugee and migration challenges

General Objectives

The course focuses on people who travel to escape difficult and dangerous circumstances, however they are defined – as refugees, asylum seekers, internally displaced persons or forced migrants. They are a vulnerable group whose health needs special consideration.

Health professionals must work to ensure that they suffer no discrimination in accessing services, and receive the best care possible. Health professionals can also act as educators and advocates, increasing understanding of the factors that force people to make difficult and dangerous journeys in search of a better life.

By the end of this course you will be able to:

• describe the needs of refugees and migrants related to their health and wellbeing
• understand the psychosocial impacts of the violent conflicts they may have escaped and the difficulties they are likely to have experienced during their journey into exile
• acquire skills in culturally sensitive health care provision and be able to analyse ethical dilemmas in relation to health and refugee work.
Health professionals need to understand the legal and social implications of the different terms used for people who migrate, and the consequences for people in their care. They need to be aware of the difficult and stressful journeys people have made and the possible implications for their health – whether they have spent time in a refugee camp or shanty town, or have been held in a detention facility on the borders of Europe. Understanding the stress and possibly violence that people have experienced, as well as their previous health profile, will help communication and treatment, and enable health workers to be more effective advocates and educators.

Forced migrants who seek refuge in Europe face particular challenges. Immigration laws are increasingly restrictive and health care in detention facilities can be discriminatory and inadequate. The attitude of the public is generally suspicious and mistrustful, although some feel sympathetic and some try to help. This is driven by an alarmist media and politicians seeking to gain political advantage. Health professionals have a key role to play both in protecting their patients in these circumstances, and in using their position in society to educate and advocate for a more accurate and sympathetic understanding.

Finally health professionals must be clear about their ethical obligations and duty of care, while at the same time taking care of themselves. This work can be stressful and emotional; they need to be clear and confident about their role, and know how to recognise their own symptoms of stress and what to do about them. Only then will they be able to do their best for the vulnerable people in their care.
Course 6: Refugee and migration challenges

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Chapter 1: Asylum and migration

Intermediate objectives
By the end of this chapter you will be able to:

- define key refugee and migrant terminology and describe the international law relevant to refugees and migrants
- describe the stages of the migrant’s journey and understand contemporary migration trends
- outline some of the factors that cause people to migrate and the health implications of their journeys
- explain some solutions to the problems faced by migrants that have been proposed by the international community
- debate the difference between forced and voluntary migration.
Lesson 1.1: Definitions

Authors: Maria Kett and Moyra Rushby; updated by Marion Birch

The language of migration can be confusing – and politicians and others may deliberately confuse terms for their own ends. For example, people talk of illegal immigrants when they mean asylum seekers; ‘refugee’ is frequently used to refer to any migrant. Describing people as ‘illegal’ though they have committed no crime is unfair and misleading, suggesting something criminal and unpleasant, or someone who stands apart from those of us who are ‘legal’. It should immediately be evident that debates about terminology in this area are more than theoretical. Naming a person a refugee or a migrant also has different implications under international humanitarian law.

Definitions are important

Some 150 of the world’s 200 or so states are signatories to the 1951 UN Convention Relating to the Status of Refugees and/or its 1967 protocol. Let us familiarize ourselves with some of the language used in those documents.

A refugee is...

A refugee is ‘a person who, owing to well founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion, is outside the country of his nationality and is unable or, owing to such fear, is unwilling to avail himself of the protection of that country’ – Article 1: 1951 UN Convention Relating to the Status of Refugees (UNHCR 2007).

The ‘well-founded fear of being persecuted’ has to result from one or more of the five grounds listed in the definition, namely race, religion, nationality, membership of a particular social group, and political opinion. Those recognized as refugees have a clear legal status and are afforded the protection of the Office of the UN High Commissioner for Refugees (UNHCR) (see Box 1). Refugees cannot be forced to return to a country deemed as unsafe for them on any of the grounds listed above – the principle of ‘non-refoulement’. Many
organizations assume responsibility for the care and protection of refugees, but UNHCR takes the lead. It estimated that the total number of refugees under its mandate exceeded 10 million by 2008, an increase from 8.4 million (the lowest since 1980) in 2005. The Middle East and South West Asia hosted 43%, almost half of the world’s refugees. (UNHCR 2008:1).

**Box 1: UNHCR**

UNHCR was established on 14 December 1950 by the United Nations General Assembly. It is mandated by its Statute, and guided by the 1951 convention and its 1967 protocol. International refugee law provides an essential framework for UNHCR’s humanitarian activities. Its core function is protection of the displaced people under its mandate, and ensuring that states uphold their obligations under the conventions and international humanitarian law.

For more information about UNHCR see http://unhcr.org.ua/main.php?part_id=2

The 1951 Refugee Convention is the principal legal document defining who refugees are and their rights. It also sets out the legal obligations of signatory states. The convention’s main aim was to protect the refugee population of Europe after the Second World War. The 1967 protocol to the convention expanded its remit to the protection of refugees regardless of when they were displaced. To date 145 states have signed either or both the convention and the protocol (UNHCR 2010). Those states that have not signed the convention are not bound by it, but they do remain bound by other international humanitarian law (see below).

**Asylum seekers are...**

Asylum seekers are people who have moved across international borders in search of protection under the 1951 convention, but whose claim for refugee status has not yet been settled. Annual asylum claims in Western Europe, Australia, Canada and the USA combined rose from some 90 400 in 1983 to 323 050 in 1988 and peaked at 828 645 during the Balkan crisis in 1992. Applications fell sharply in the mid-1990s but began to rise again steadily towards the end of the decade. During 2008 there were at least 839 000 asylum seekers across the world in 154 countries. The four countries in which most asylum claims were made during 2008 were South Africa, the US, France and Sudan; the number had quadrupled in South Africa since 2007 and remained stable in the US. Asylum seekers came from Afghanistan, Eritrea, Somalia and Zimbabwe in particular (UNHCR 2008:2). Not surprisingly many asylum seekers come from states enduring civil war, significant poverty, and a high incidence of human rights abuse.
The increasing scepticism about the credibility of the claims of many asylum seekers raised by politicians and the media, particularly in Western countries, has resulted in the terminology of migration being deliberately confused. Asylum seekers are frequently wrongly labelled ‘economic refugees’ or ‘bogus asylum seekers’. In the e-learning case you will hear Erika Fellar of UNHCR discuss the importance of language and the consequences of blurring meanings.

There has been debate in recent years regarding the relevance of refugee law to the current geopolitical situation, in which most conflicts are no longer between states but involve civil war or inter-ethnic violence, resulting in people being displaced within states (Chatham House 2005). Note that the convention and protocols also do not provide protection to people who choose to migrate for economic reasons.

**Internally displaced persons are...**

The *Guiding Principles on International Displacement* describe internally displaced persons (IDPs) as ‘persons or groups of persons who have been forced or obliged to flee or to leave their homes or places of habitual residence, in particular as a result of or in order to avoid the effects of armed conflict, situations of generalized violence, violations of human rights or natural or human-made disasters, and who have not crossed an internationally recognized state border (OCHA 2001).

When statistics where first gathered in 1982 it was estimated that there were 1.2 million IDPs in 11 countries. The number of people internally displaced by conflict was recently estimated to be 26 million spread across 52 countries (Internal Displacement Monitoring Centre 2008). Africa is the most affected continent with 11.6 million IDPs in 19 countries, including 1.4 million in the Democratic Republic of Congo and 4.9 million people in Sudan. However, the problem is not just an African one – for example, it is estimated that there are 2.7–4.3 million IDPs in the South American country of Colombia.

IDPs are not afforded any protection under the refugee conventions as they have not crossed international borders and therefore remain citizens of their own countries. They do, however, enjoy the protection of human rights instruments and customary law. Furthermore, in armed conflict they enjoy the same rights to the protection provided by international humanitarian law as any other civilian, as long as they take no active part in combat.

IDPs are particularly vulnerable to political change, having both insecure political status and a lack of international protection. Women and children usually make up the majority (around 75–80%), and are particularly vulnerable. There are mechanisms in place to protect IDPs, including the UN Guiding Principles. You can find more information about these principles (IDMC 2007). Though they are not legally binding, they have been incorporated in policy in a number of countries, including Angola, Burundi, Colombia, Georgia and Uganda. The extent to which these policies are actually enacted is debatable, however.
Responsibility for the wellbeing of IDPs primarily rests with national governments. Yet all too often it is the government or other state actors who have at least partly caused the conflict or ethnic tensions responsible for displacement. Opposing factions may also use IDPs as political pawns to highlight causes, which may result in their situation being worsened and prolonged.

The willingness of the UN and donor countries to intervene on behalf of IDPs and others in need of assistance and protection in their home countries has increased significantly over the last 20 years, partly because classic notions of sovereignty, which formerly precluded such intervention, are changing.

International humanitarian law...
International humanitarian law (IHL) governs the protection of the victims of armed conflict. It comprises the four Geneva Conventions of 1949, the two additional protocols of 1977, and that of 2005. In addition to the Geneva Conventions (IHL), a further set of rules governs the conduct of hostilities. These are called the Hague Rules and include the 1907 Hague Conventions, the Ottawa Landmine Convention, the Environmental Modification Convention, the Cluster Munitions Convention and, although not in any binding form, prohibition of the use of nuclear weapons.

International human rights law...
International human rights law, applicable in both conflict and peacetime, imposes standards on governments regarding how they treat individuals. Examples include the Universal Declaration of Human Rights, the Convention on the Rights of the Child, the 1951 refugee convention and the International Covenant on Economic, Social and Cultural Rights.
Lesson 1.1: Definitions

Customary international law...

Customary international law is an important part of international law. It is unwritten law and is binding on all states with or without their consent. It includes fundamental principles of international relations, such as the prohibition of slavery, piracy and torture, and most recently – through a 2005 ICRC study – enhanced protection of victims of armed conflict.

A migrant is...

A migrant is ‘any person who lives temporarily or permanently in a country where he or she was not born, and has acquired some significant social ties to this country’ (UNESCO undated). A migrant worker is a person who is to be engaged, is engaged or has been engaged in a remunerated activity in a state of which he or she is not a national (Article 2, UNGA 1990). Globally almost 50% of migrants are women (UNDESA 2008).

Conclusions

As we noted at the beginning of this chapter, these technical definitions are important because they have implications for the people concerned under national and international laws. Yet the terminology is often used in a misleading way, and the data can be confusing. For example, though the number of refugees has fallen over the last few decades, the numbers of IDPs have increased. This has implications for planning, programmes and policies, as well as for the people living in those situations.

Many people seeking asylum come from failed or failing states, and may have endured years of war, human rights abuse and, not surprisingly, significant poverty. The number of people who seek asylum in Western states comprises only a small fraction of the total number displaced around the world, however.

In the next lessons we will explore some of the reasons why people feel compelled to leave their country, and the mechanisms in place to assist with or prevent the process of migration.

References


Lesson 1.1: Definitions


UN General Assembly (1990), *The international convention on the protection of the rights of all migrant workers and members of their families*. General Assembly resolution 451158. 18 December.

UNDESA (2008), *Trends in International Migrant Stock: the 2008 revision*. UN Department of Economic and Social Affairs Population Division.


Lesson 1.2: The migrant’s journey

Authors: Maria Kett and Moyra Rushby; updated by Marion Birch

In this lesson we will look in detail at the forced migrant’s journey. You should keep in mind that each journey is personal, and in many cases the journey itself is either more or less complex than that shown in the lesson. People sometimes manage only one or two of the stages mentioned. For some the process takes a few weeks; others may remain mid-journey for generations. We will look at the health impact of this journey in general terms, setting out some concepts and ideas to be developed in the rest of this MPW course.

Learning objectives

By the end of this lesson you will be able to:

• describe the stages of the migrant’s journey
• explain the health implications
• outline the solutions proposed by the international community to the problems faced by forced migrants.

Phases of the ‘refugee experience’

The refugee experience has five phases: pre-flight, flight, reception, settlement and resettlement.

1 Pre-flight

This phase precedes the actual flight. This period involves great instability, economic hardship, violence (both personal and communal), loss of property, social disruption and maybe even famine. Some or all of these will occur on such a scale that the individual or community makes the decision to leave and seek safety, in another area of the same country or in a second country.

Modelling techniques have been developed that, with varying success, try to predict when flight will occur and what its determinants are. This is a complex topic; if you want to learn more look at the paper on predicting forced migration in the reference list (Rubin 2006).
2 Flight
The process of fleeing can be as simple as moving to stay with family in another city, or as complex as moving across the globe. It can involve the flight of just one person, or the mass movement of 10 000 people in a few days. Both pre-flight and flight conditions will have a substantial impact on the physical and mental health of forced migrants, who are at their most vulnerable in this period.

3 Reception
Migrants flee to find security and safety, but the way they are received will depend on many factors. These include ethnicity, as in the case of Afghan migrants in Pakistan. They share the same language, religion and cultural norms as the host population, and as a result their reception by the Pakistani host population was mostly welcoming.

This period allows people to gather resources and review their situation. If the flight involves large numbers of people, reception may well include provision of emergency humanitarian support, including health care.

4 Settlement
During this period people begin to integrate with the local community. They begin to see their immediate if not long-term future as being in the area of settlement. The move towards integration, both physical and psychological, will depend on the circumstances of settlement. Those who are marginalized and lack support in the early stages of settlement may become increasingly isolated and demoralized, leading to feelings of alienation. This is seen all too often when asylum is sought in Europe.

5 Resettlement
Resettlement (often of large groups of people) most often takes place within the migrant’s country of origin. It may be part of a planned programme, for example, as part of a government-sponsored development project like the Three Gorges Dam project in China, which submerged the homes of over 844 000 people and necessitated the relocation of 1.13 million. It may also result from legal or illegal commercial enterprises, such as logging activities in the Amazon region of Brazil. Resettlement can be contentious, involving movement of people from one type of land to another (for example, from fertile flood plains to desert). It may cause friction with the host population, as well as difficulties with resources, land and housing.

Migrants may also be drawn from mobile populations. For example, national
borders may have little relevance to cattle-herding pastoralists, who may move across them to escape conflict or environmental damage. Groups moving along traditional migratory pathways may not view themselves as having fled or as crossing borders, and may settle, temporarily or otherwise, without consideration of national borders.

We will return to the issue of resettlement below.

**What makes people return home?**

After the upheaval of displacement, resolving the dilemma whether to return home, resettle or even migrate to another country is a complex process, filtered through a number of ‘push and pull’ factors. This push-pull process is not merely two-way, but complex and multidirectional.

Pull factors that might influence the decision to return home include:

- improvements in health care
- the availability of housing
- de-mining programmes
- access to food and water
- financial assistance with return
- family commitments
- inducements by humanitarian agencies, including food and household goods.

Push factors that might influence the decision to return home include:

- withdrawal of humanitarian aid
- feelings of not belonging
- linguistic or cultural difficulties.

**The ‘myth of return’**

What does returning ‘home’ actually mean? After the Kosovo war in 1999, many ethnic Serbians who had lived in Kosovo for generations found themselves forced to ‘return home’ to Serbia – a country many had never lived in.

Return may act as a catalyst for further conflict, those who did not flee may resent the returnees, and the return itself may not realize their hopes. Nevertheless some communities have existed in diasporas for generations while still holding on to an expectation of return. Bhutanese refugees, for example, have lived in eastern Nepal for almost 20 years but still hope to return to their homes (COHRE 2008).
A further settlement of people may well have occurred during the period of exile and there may now be a competing claim for the same territory. It also raises the difficult issue of who actually represents the indigenous community.

‘Solutions’ – the three Rs

Part of UNHCR’s duty of protection is the realization of durable solutions to displacement to other countries. In an ideal world solutions would be found that ensured that refugees did not spend generations in refugee camps or as unwelcome visitors in their host nations.

UNHCR seeks three ‘durable solutions’ for refugees.

**Repatriation:** This is perhaps the ideal solution. Most refugees (at least in the early stages of exile) simply want to return home to their previous community and way of life. Southern Sudan provides an example. After the signing of the Comprehensive Peace Agreement in 2005, an estimated two million people had returned by the end of 2009, after spending over 20 years as refugees in neighbouring countries like Kenya and Uganda. However, another two million remain displaced. Ongoing insecurity and poor infrastructure continue to act as obstacles to return for many.

**Reintegration:** Refugees are frequently unable to return home, and the longer they remain in exile the more difficult it becomes. The next best solution is for them to integrate into the host community. An important factor here is that the largest numbers of refugees are hosted by some of the world’s poorest countries.

**Resettlement:** This is a powerful tool of protection, a means to secure other rights, a durable solution for those who cannot go home or integrate in the country of first asylum, and a means by which states can share the responsibility for refugees with overburdened host countries.

Resettlement can function as a broader support for refugee protection by assuring countries of first asylum that other countries are willing to share responsibility for refugees. It can act as a safety valve when the presence of a particular group in a refugee population is causing tensions with local people or creating security concerns. In a few cases, countries of first asylum have demanded resettlement as the price for keeping their borders open to refugees, for example, Macedonia during the Kosovo war in 1999, and south-east Asian nations facing an influx of refugees from war-torn Vietnam in the late 1970s and early 1980s.

For refugees who may be unable to return safely or to integrate locally, resettlement in a third country may be the only solution. It is the only option when the host country is unwilling to offer a permanent home to those whom repatriation would endanger. For some refugees, the country of first asylum may not be safe. Refugees escaping persecution may find that the agents of their persecutors –
government of the home country, or a rebel group – operate with impunity across the border, or that there are groups with similar agendas in their place of exile. (We will look at this in more detail in Chapter 2).

Few countries in the West provide resettlement services in large enough numbers. The European Union is currently investigating the feasibility of an EU-wide resettlement plan. Much of the legislation relating to refugee and asylum law is currently undertaken at a European level, as we will see in Chapter 3. Some individual countries, such as the UK, are considering the establishment of national resettlement programmes.

The voluntary decision to return ‘home’ officially marks the end of IDP or refugee status, but even when people have returned, they may still need some kind of reassurance, security and protection.

Pre-empting migration

International and national state policy inevitably influences migration patterns; for example, the largest groups of people claiming asylum in industrialized countries during the first half of 2009 were from Iraq, Afghanistan and Somalia (UNHCR 2009). Instead of developing policies to restrict or control migration to Europe, the EU could better direct its energies to addressing the immediate causes and mitigating factors such as early warning systems, peace-building and temporary protection, as well as developing longer-term policies to address such problems as the root causes of conflicts and failure of development (Castles, Crawley and Loughna 2003).

Resolution

The most important point in this discussion is that any solution must be durable. Many factors influence the resolution of displacement. These include:

- the will of the international community or the host government
- the political influence of the displaced group
- funding
- the strategic importance of the region
- the level of media interest
- the state of the economy in the host and home regions
- the attitude of the domicile population to incomers.
Health impacts of migration and displacement

Forced migrants are perhaps the global group most at risk of having poor health outcomes. They face an onslaught from all sides: their poor socioeconomic conditions include bad housing, poor nutrition and physical violence. The psychosocial and mental health impact of migration takes its toll with increased rates of psychiatric illness. All this may be compounded by a sense of isolation and difficulty in accessing appropriate health care.

The process of forced migration will have a profound effect on the wellbeing of all involved.

The variables that affect the health status of forced migrants include:

- their pre-existing health status
- the circumstances that caused their flight
- their conditions of passage
- the physical and psychological impact of migration.

We will study all these factors in more detail later.

For now, you should recognize that there are a number of key health issues to be addressed at all stages of the migration process (note that health priorities may vary in the emergency phase). These include:

- basic needs – food, nutrition and shelter
- environmental needs – water, sanitation and control of disease vectors
- needs of women and children
- psychosocial and mental health needs
- sexual and reproductive needs
- control of communicable diseases
- development of health care services.

Migrants are too often seen as a danger to the health of the host community, with talk of health threats and of the migrant harbouring infection (Ibrahim 2005). This outdated view comes into play most often when the host community is physically remote from the source country, for example in Western Europe and the US. Migrants actually often face much greater health risks than the host populations: the health of those seeking asylum actually deteriorates during their first year in the UK (British Medical Association 2002).

You must remember the human consequences of forced migration: disrupted lives and loss of family, friends, jobs, social networks, stress and ill health, as well as opportunities, for all concerned.
References


Lesson 1.3: Why people become migrants

Authors: Maria Kett and Moyra Rushby; updated by Marion Birch

In Lessons 1.1 and 1.2 we looked at the status of migrants, legal and otherwise, and at the stages of migration. Here we will look at some of the factors that influence decisions – both voluntary and involuntary – to migrate. Most migration tends to be within regions, with migrants often remaining within the same continent.

Migration patterns

Traditionally, more than half of all international migrants have moved from one developing country to another. In recent years, however, migration from poorer to richer countries has increased significantly (Martin 2001). Long-standing destination countries – the United States, Canada and Australia – still see large-scale movements as a result of labour recruitment, but Europe, the oil-rich Gulf states and the ‘economic tigers’ of east and south-east Asia have also become major destinations.

A number of factors have helped shift migration patterns across the world. Developed countries with low fertility rates and ageing populations have needed to admit migrants of working age. As the migrant population becomes a larger proportion of the total population, there is often a backlash against the newcomers – particularly where they are of a different race, ethnicity or religion than the majority of the host population. At the same time, flows of people between wealthy developed nations are seen as a normal part of globalization and viewed as a sign of economic success.

How much of this migration is ‘voluntary’ and how much ‘forced’?

Well-developed networks that link the supply of labour with the demand for highly skilled and unskilled workers sustain voluntary migration for economic reasons. Voluntary migrants may feel compelled to seek a new life or opportunities because of pressing problems at home. They may find that situations change in their home countries, preventing their repatriation and turning them into forced migrants.
Forced migration is fuelled by conflicts, human rights abuses and political repression that displace people from their home communities. They may choose a particular refuge because of family and community ties or economic opportunities, and may later bring family members to join them. These migrants are often stigmatized and treated inhumanely.

This interplay of social and economic factors makes the distinctions between ‘forced’ and ‘voluntary’ migration increasingly blurred. If people have no means of feeding their families or providing an education for their children within their own borders and have to move across the globe to secure their basic needs, it can be argued that their migration has been forced on them.

The underlying factors for migration have traditionally been distilled into ‘push’ and ‘pull’ categories – factors that push people away from their homes and families, and those that pull them toward new opportunities.

**Push factors** include:
- conflict
- human rights violations
- poverty
- loss of infrastructure
- family necessity.

**Pull factors** include:
- security / protection
- opportunities for employment
- ‘a better life’
- welfare
- family reunion.

Recent research on the complexity of migration decisions has led to the use of the more nuanced concept of ‘networks’. Networks are influenced by a number of connections and decision-making factors, especially knowledge and information about the host region; availability of resources in that region; and contacts in the host area (Bauer, Epstein and Gang 2005). You should also note that migration affects a much wider number of people than those who actually migrate, particularly the families that stay behind.

Levels of unauthorized migration from poorer to wealthier countries have increased: the very nature of such migration means that reliable data are not available. An estimated 50 million people are living and working abroad with irregular status – 25% cent of the world’s international migrants (UNDP 2009).
Many policies are adopted to manage this unauthorized migration, including mandatory visa requirements; sanctions against carriers transporting improperly documented migrants; pre-inspection clearance programmes; interdiction of vessels; diversion of arrivals to transit countries (for example, safe third countries); exclusion from future admission; and detention. The process is often ‘exclusionist’, favouring migrants from some countries while excluding others. Lowering barriers to movement and improving the treatment of movers would be a significant contribution to human development (UNDP 2009).

**Labour migration**

Several distinct categories of workers migrate, differentiated by their skills, the permanence of their residence in the host country and their legal status. Many work at the lower end of the skill spectrum, for instance picking fruits and vegetables, manufacturing garments and working in nursing homes. They provide these types of service in a wide range of receiving countries in almost all parts of the globe. At the higher end of the skill spectrum, migrants provide research and development expertise to industry and academia, practise as health professionals, and design, build and programme computers, to name just a few activities. Again, they can be found undertaking such assignments throughout the world.

This mobile world of workers has led to the phenomenon of transnationalism. Migrants are able to live effectively in two or more countries at any one time, aided by technological innovation in information and communications technology and dramatic declines in the cost of transport. This has had an impact on both migration and money flows.

The flow of remittances from migrant workers to their home country doubled in the six years from 2000–2006, from US$ 132 billion (€93 bn) to an estimated US$ 268 bn (€188 bn), according to the International Monetary Fund. Of this, migrants from developing countries sent home US$ 199 bn (€140 bn) (IMF 2006). The World Bank estimated this had risen to US$ 338 bn in 2008, but projected that it would fall to US$ 317 bn in 2009.

India, China and Mexico are still the largest receivers of remittances among developing countries, but when considered as a percentage of gross national product (GNP) remittances are far more significant for smaller economies such as Tajikistan, Tonga and Moldova (World Bank 2009). In some countries, remittances exceed any other form of trade, investment or foreign aid. For example, in 2006 Somalia received an estimated US$ 825 million (€578 m) from remittances (hawala), which outweighed its aid and export income.
Forced migration

The term ‘refers to the movements of refugees and internally displaced people (those displaced by conflicts) as well as people displaced by natural or environmental disasters, chemical or nuclear disasters, famine, or development projects’ (Forced Migration Online 2010). Its causes include violent conflict and human rights abuses, natural and human-made disasters, state-sponsored development projects, and human trafficking and smuggling. We shall now look at these more closely.

Violent conflict and human rights abuses: People may flee from armed conflict, generalized violence or the fear that state authorities are unable or unwilling to protect them from persecution on the grounds of nationality, race, religion, political opinion or social group.

Since the end of the Cold War there has been an increase in the number of internal conflicts based on national, ethnic or religious separatist struggles, and a concurrent increase in the number of refugees and IDPs. Deliberate forced displacement has increasingly become a tactic in situations of violent conflict.

Refugees and IDPs can become a cause of conflict as well as a consequence (Newman 2004).

Natural and human-made disasters: Natural disasters include earthquakes, floods, landslides, some types of famine and other environmental changes. Human-made disasters include industrial accidents, release of radiation and deforestation. These categories overlap (for instance, the impact of floods and landslides can be greatly exacerbated by deforestation and agricultural activities), and the effects of both are magnified by poverty. For example, the 2003 earthquake in Bam, Iran killed five times as many people as the earthquake of the same magnitude in Kobe, Japan in 1995, owing to the absence of warning systems and inadequate resources, emergency services and building regulations.

State-sponsored development projects: These are often controversial, as they usually entail large-scale infrastructure projects such as hydroelectric dams, roads, ports, airports, urban clearance initiatives, mining and deforestation, and the introduction of conservation parks/reserves and biosphere projects. An estimated 90–100 million people around the world were displaced during the 1990s as a result of infrastructural development projects. On average, 10 million people a year are displaced by dam projects alone (Conisbee and Simms 2003).

People displaced by these projects usually remain within their home country. International donors like the World Bank that sponsor these projects produce guidelines on resettlement of affected populations, but very few of the displaced are adequately compensated. They remain the responsibility of the host government, so this type of displacement often takes place with little recognition, support or assistance from outside the affected population. It affects indigenous and ethnic minorities and the urban and rural poor disproportionately.
**Human trafficking and smuggling:** Smuggled people are those moved illegally for profit. They face exploitation and great danger, as their personal safety and wellbeing, both on their journey and after arrival, are not a priority for the smugglers. They include people who have been forcibly displaced and those who leave home in search of better economic and social opportunities. Migrants of all kinds are increasingly using the services of smugglers as the borders to favoured destination countries are strengthened against asylum seekers.

People who think they are being smuggled may run the risk of being trafficked. Trafficked people are those moved by deception or coercion for the purposes of exploitation. Profit comes from the sale of their sexual services or labour in the country of destination. The trafficked person may be physically prevented from leaving, or be bound by debt or threat of violence to themselves or their family in their country of origin. This is a secret activity and data are extremely difficult to obtain.

**Refugees – a security discourse?**

Refugees and forced migrants have increasingly become part of the global discussion about security. Refugee movements are often seen as a cause of instability, and refugees are seen as a potential threat rather than as people in need of protection – as threats to security, services, financial stability and even identity. The discourse on migration and security is often racist (Ibrahim 2005). The events of 11 September 2001 led to further shifts in attitudes toward migrants, and emphasised the links with security discourses. Yet migration is an essential part of globalization in an increasingly transnational world, and can bring many benefits and opportunities.

**References**


UNDESA (2008), Trends in International Migrant Stock: the 2008 revision. UN Department of Economic and Social Affairs Population Division.


World Bank (2009), *Migration and Development Brief 11*. Migration and Remittances Team; Development Prospects Group; World Bank.
Intermediate objectives

By the end of this chapter you will be able to:

• understand the variety and complexity of the health needs of displaced people and communities, including in camps and urban areas

• describe principles and examples of best practice that should be adopted to meet these health needs.
Lesson 2.1: Health in refugee camps

Author: Moyra Rushby; updated by Marion Birch

Introduction

The majority of refugees are found in the poorest nations of the world – countries already plagued by disease, low life expectancy and poor health infrastructure. They may stay with people they know, and while poor communities are often very hospitable a shortage of resources can eventually put a strain on their hosts. Increasingly they may settle in already cramped and often insanitary shanty towns on the edges of large cities. Many will be in refugee camps, however, which present their own particular health challenges and are the subject of this lesson. Camps are often created or form spontaneously after displacement due to a disaster or conflict. During the initial emergency phase the response needs to be rapid, well organized, and use the well developed and tested protocols and standards for establishing camps. No matter how extreme the situation or the crisis, the normal ethical and legal obligations of health professionals are still applicable.

Initial or emergency response

The simple and overriding aim in the initial stages of any humanitarian crisis is to save lives, reduce morbidity and establish a situation in which people are in control of their own lives and living in reasonable and sustainable conditions.

Learning objectives

By the end of this lesson you will be able to:

• explain the health and social needs of people and communities in camps for refugees and internally displaced persons
• outline the preparations needed to cope with large numbers of forced migrants.
Morbidity and mortality in refugee camps

It is important to be aware that the types of illness that affect people in refugee camps are not abnormal. It is the incidence of disease and heightened mortality rates that make this situation different – dealing with normal people in very abnormal situations.

The health status of people arriving in refugee camps will reflect their previous nutritional, health and vaccination status as well as the length of time they have lived in an unstable and difficult situation. It will also be profoundly affected by the process of flight itself: people may have travelled for long periods without shelter, food or water, and have been subject to violence and intimidation and suffered extreme psychological trauma.

During an emergency response, when mortality rates are frequently elevated or could soon become so, priority humanitarian interventions must focus on urgent survival needs, including basic health care (Sphere Project 2004). Once survival needs have been met, and mortality rates have declined to near baseline levels, a more comprehensive range of health services should be developed. Throughout all phases of the response, a health systems approach to the design, implementation, monitoring and evaluation of services will contribute to ensuring that the most important needs are met, that coverage is appropriate, that access is optimized, and that quality is promoted.

Defining an emergency

Many people become refugees because of a humanitarian emergency. A humanitarian emergency is said to exist when:

- the crude mortality rate (CMR) exceeds one death per 10,000 people per day
- the daily mortality rate of children under five (U5MR) exceeds twice the CMR.

These threshold mortality rates have been agreed by all the main humanitarian actors. A more detailed description can be found in the Sphere handbook (Sphere Project 2004). It is beyond the scope of this lesson to debate the indicators used to define emergencies, but you should remember that the CMR...
and U5MR, although crude measures, are the best that can feasibly be collected at this stage. It is also important to be aware that the way data are collected and presented can profoundly influence how the agencies respond (for more detail see Checchi and Roberts 2005).

The CMR is the baseline against which the progress of an individual emergency may be measured, and it also allows for a measure of comparison between emergencies. The aim in the emergency phase is to reduce the CMR to below 1 per 10 000 per day and the U5MR to below 2 per 10 000 per day. Even these levels are at least twice the ‘normal’ ones and are no cause for complacency (Table 1). After the initial emergency phase both morbidity and mortality should generally decrease rapidly and quite markedly.

### Table 1: Comparison of mortality rates in emergency and non-emergency situations (UNHCR 2001)

<table>
<thead>
<tr>
<th></th>
<th>Average CMR in most developing countries:</th>
<th>0.5 deaths per 10 000 per day</th>
</tr>
</thead>
<tbody>
<tr>
<td>Relief programme under control:</td>
<td>&lt; 1 death per 10 000 per day</td>
<td></td>
</tr>
<tr>
<td>Relief programme in very serious situation:</td>
<td>&gt; 1 death per 10 000 per day</td>
<td></td>
</tr>
<tr>
<td>Emergency out of control:</td>
<td>&gt; 2 deaths per 10 000 per day</td>
<td></td>
</tr>
</tbody>
</table>

In the aftermath of the Rwanda genocide in 1994, during the first month after the influx of refugees to eastern Zaire (CDC 1996), the average daily CMR was 20–35 per 10 000 per day, or 40–60 times the normal rate in Rwanda – the highest rates ever recorded. In most emergencies mortality rates are highest among the under-fives and other vulnerable groups, but the mortality in this case was equally distributed throughout the community, probably partly due to the fact that cholera and bacillary dysentery were the main causes of mortality (Toole 1994). It was also unusual that Rwandan refugees in Burundi had a much lower CMR of 10.6 per 10 000 per day during the same period.

*Take a moment to think what might have caused these differences in the CMR. Write down your suggestions before reading on.*
The US Centers for Disease Control and Prevention attributed the CMR rate to the following differences:

- the daily number of camp arrivals;
- the total camp size; and
- the magnitude and speed of spread of the outbreaks of cholera.

In Burundi, 60,000 refugees arrived during the first wave in April and 170,000 arrived during July; in comparison, around a million refugees arrived in Zaire during a five-day period. These rapid influxes of large numbers of people facilitated transmission of infectious diseases and hindered establishment of emergency health care services in both areas.

The surveillance systems in Burundi and Zaire assisted in the identification of outbreaks, implementation and assessment of interventions (for example, control of diarrhoeal diseases through the provision of clean water and sanitation systems, distribution of soap, and training of clinical staff in aggressive rehydration therapy), and recognition of the need for increased health care services. The experiences in both countries underscore the need for simplicity and for targeting surveillance efforts during the emergency phase in refugee camps (CDC 1996).

**Morbidity**

The main health threats in the initial emergency phase are communicable diseases, malnutrition and, in places where it is endemic, malaria. It is important to collect and monitor health information for the presence of any diseases with the potential to create epidemics (for example, measles, cholera and shigellosis). Levels of disease can best be assessed by using local health workers and host country health services, with a clear and simple health registration procedure using local or national case definitions.

Communicable disease is not an inevitable result of refugee emergencies. The factors most commonly associated with refugee emergencies, however, are also those most commonly implicated in the spread of communicable disease. These are:

- poor sanitation
- overcrowding
- scarce supplies of clean water
- poor access to health care
- malnutrition
- stress
- fatigue.
In an emergency communicable disease transmission is often attributable to the lack of a sufficient quantity of water, as much as its quality. It is better to have a sufficient quantity (15 litres per person per day) of water of intermediate quality than smaller quantities of cleaner water (Sphere Project 2004).

Measles vaccination is perhaps the most important and cost effective public health measure in refugee emergencies and should be a priority. Coverage should be no less than 95% of those aged between 6 months and fifteen years.

Other critical public health interventions including the provision of adequate food, shelter and sanitation are more important in reducing mortality and morbidity than almost any purely medical response.

The next section is on assessment and surveillance. We have already considered one indicator – the Crude Mortality Rate. But is collecting more information a priority when there are lives to be saved?

Take a moment to think about why collecting more information might be important. As you read on, see if your own views match with what you read next.

Assessment and surveillance
The key to reducing morbidity and mortality in refugee camps is to maintain an ongoing process of needs assessment and surveillance that allows for planning for the changing health needs of the migrant population.

Information is the essential component of all public health activity, and data collection should be an integral part of all health planning and emergency responses. The data collected will be used to:

- plan public health interventions
- implement public health programmes
- evaluate the impact of public interventions against baseline data.

An initial rapid assessment should be made to collect baseline data and allow for reassessment as a crisis unfolds. The purpose of the initial rapid assessment is to:

- confirm the emergency;
- describe the type, impact and possible evolution of the emergency;
- measure its present and potential health impact;
- assess the adequacy of existing response capacity and immediate additional needs; and
- recommend priority action for an immediate response.
Collecting data takes time and uses valuable resources, so only essential data should be gathered that can be used, will be acted on and is not available from other sources. Complex data collection forms or requests for non-essential information will only reduce compliance.

**Health care models**

Emergency medical assistance (EMA) is a very different strategy from the more commonly understood primary health care (PHC) model (Van Damme W et al. 2002) (see Table 2). In the initial phase of any major emergency involving large flows of people, the key concerns are to reduce mortality and prevent increased morbidity.

<table>
<thead>
<tr>
<th><strong>Primary health care</strong></th>
<th><strong>Emergency medical assistance</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Triple objective:</strong> Cure, care and autonomy</td>
<td>Cure is dominant over care and autonomy</td>
</tr>
<tr>
<td><strong>Search for best balance between being effective, integrated, continuous and holistic</strong></td>
<td>Effectiveness takes precedence over other characteristics</td>
</tr>
<tr>
<td><strong>Care provided is a compromise between need and demand</strong></td>
<td>Need takes precedence over demand</td>
</tr>
</tbody>
</table>

**Table 2: Characteristics of care in PHC and EMA**

**Who funds and provides health care for displaced people?**

The first step in providing health care services and emergency health care to displaced populations is to agree who will provide care and what type of provision will be put in place.

The host national government is responsible for the provision of health care to displaced populations. It is they who will in principle decide how health care provision is set up and who will receive it. However, the reality is that most emergencies take place in countries that already struggle to provide health care, so their governments turn to the international humanitarian community for help.

There are three models of health care provision available in such situations, defined by who is funding and who is providing them. The models are:

- a health system funded by donors and provided by nongovernmental organizations (NGOs);
- a donor-funded and government-provided system; and
- a health system funded and provided by the host country.
Model 1: Donor-funded and NGO-provided
This is the most commonly used model in the emergency phase and often continues well into the non-emergency phase. Local, national and international NGOs can often respond quickly and have expertise in working in emergencies. Donors also feel comfortable providing funds to organizations with recognised accounting practices and experience that will enable them to set up effective systems with minimum constraints. These systems run in parallel to national systems, but if set up imaginatively they can support them. This model is often a necessity in the emergency phase but is widely regarded as unsustainable as a long-term option, as we will discuss below.

Model 2: Donor-funded and government-provided
The second solution is perhaps the best as it supports cash-strapped health systems with extra donor money, while governments keep some control over the provision of health services. However, many host countries have poorly developed and under-resourced services, so infrastructure and personnel may simply not be available; in other words, extra money may not be easily absorbed by the system. Furthermore, the government itself may be a party in the conflict.

Model 3: Host country funded and provided
This option only exists in countries with well-developed health systems. It presumes the host government is not hostile to the presence of displaced people within its borders. It provides the best and most sustainable solution to the problem of health care provision for refugees.

Parallel services
The first option mentioned – donor-funded and NGO-provided services – may result in the development of parallel services: in other words, a second system (in addition to the country’s own health system) is established to provide care for the refugee population. This may seem the ideal solution as it has the potential to provide a responsive health care system with experienced staff, and ensures minimum call on local resources.

Before reading on, think about what the long-term implications of developing parallel care systems in protracted refugee situations might be. Make a few notes. See if you have anticipated some of what you will read next.
• The most obvious long-term implication is that funding and resources will disappear along with the camp. The resources will be ‘owned’ by the NGO and donor providers, and may well move on to the next emergency.

• There is an obligation on the part of international donors and humanitarian organizations to offer a standard of care compatible with international standards. This may mean that services for people in camps are better than for those outside, which may result in resentment and even violence.

• When people remain displaced for a long period, provision of higher standards of health care and education in camps can be a deterrent to returning home. This is a particular issue in countries in post-conflict situations where infrastructure and services may be almost non-existent.

• Health workers from national services are often attracted to work with humanitarian agencies where they are better paid and their perceived status may be higher. Staff working for international agencies may continue to work for those agencies after the emergency is over, and may even leave the country.

• Little donor funding will be used to develop local services in a sustainable manner; nor, in many cases, will local health workers’ expertise be developed.

• Finally, building up parallel systems perpetuates the myth that communities are unable to provide for themselves.

Take some more time to consider this complex issue by following the discussion about parallel health systems in the e-learning case.

Another way of deepening your knowledge about these issues is to read the article by Ron Waldman (2005) (see reference list for web link) before moving on.
References


Lesson 2.2: Refugee health in urban settings

Author: Marion Birch

Introduction

This lesson looks at the health of refugees and internally displaced people (IDPs) in urban areas. The principles of good practice, as covered in the previous Chapter, also apply here and need to be remembered. Here we will consider the particular challenges and possible solutions in urban settings.

Since the 1950s increasing numbers of IDPs and refugees have moved to urban areas. People and communities often have to survive in the shanty towns that have grown up around many large cities (also called slums, barrios and periurban areas). More than half of the refugees UNHCR now serves live in urban areas, and in future even more refugees will try to survive in cities and towns, as will former refugees who return to their homelands and those displaced inside their own countries.

The types of illness that affect people living in crowded urban areas are not specific to shanty towns, and reflect the general disease profile of the population. However, crowded conditions, poverty and overstretched infrastructure can lead to an increased incidence of disease, higher mortality, a greater risk of epidemics and aggravated mental health problems.

In an urban area with a recent influx of displaced people, the objective of any health programme is the same as in the camps: save lives, reduce morbidity and try to establish a situation in which people are in control of their own lives and living in a reasonable and sustainable condition. No matter how extreme the situation, health professionals must strive to uphold the ethical and legal standards they respect in less challenging situations.
Arriving in the city

People may travel to cities for security, in the hope of finding work, or as a first step on their way to somewhere else. They may travel long distances to get there, in danger of their lives, and may have lacked adequate shelter, food or water for long periods. They may have been able to bring possessions with them, or fled with very little; they may have had little to bring in the first place. Crucially they may or may not have money, or items that people in the city need. It can be very traumatic for those who have left rural areas, and are used to growing their own food in an economy in which goods can be exchanged, to find themselves in an urban setting where there is no chance of cultivation and money is the only means of exchange.

The previous nutritional, health and vaccination status of people displaced into urban areas will also reflect the length and difficulty of their journey. Even if moving into the city removes people from the conflict area, it brings many challenges and much stress.

The health of refugees and IDPs in urban areas

In shanty towns water often has to be bought, and sanitation may mean defecating into a plastic bag which is then thrown on a rubbish dump. Even the plastic bag may not be free. Diarrhoeal disease and outbreaks of diseases such as cholera will be a major risk for those living in these conditions, along with the overcrowding, which will also increase the risk of transmitting respiratory diseases and skin conditions such as scabies.

Food may be present in quantity and variety at close quarters but it may not be affordable. On the other hand, local services and civil society organizations that provide food, particularly for children, may be more numerous and more accessible in terms of distance. Access to a balanced diet may be harder than in rural areas, where at least there is a possibility of maintaining a small market garden, although people show great ingenuity in urban areas growing what they can in small yards and old tins. All this means malnutrition may be a problem.

Life is likely to be very stressful. In a camp people often live with others they know – whole communities having moved and settled together.

Take a few minutes to think about the likely health problems of people displaced into urban areas, and make a few notes.
In an urban area people face different challenges:

- They may move in with people they know. Host populations are usually very hospitable and try to help, but unless they are well off, additional people in cramped conditions and on a tight budget can create considerable strains.

- They may be able to move to a part of the city where there are others from their home region, but they will face the same constraints in assisting them, however hospitable they want to be.

- They may just have to settle where there is space, and may not know the community or their neighbours.

Any of these scenarios can bring high levels of stress, particularly for those who have fled conflict and possibly abuse, and particularly need a sense of security. Until shelter is found street life brings its own risks. Materials may be costly and suitable space difficult to find when people have to construct their own shelters.

Cities have their own, sometimes complex informal economies. Different social expectations and cultures often come together and many of the displaced may have to learn new survival strategies. It is likely that the displaced will have to take up risky employment, perhaps in unregulated work sectors with insufficient health and safety measures where they feel they cannot complain because of their displaced status. They may also be open to sexual harassment and some may resort to commercial sex work (Buscher and Heller 2010). This type of employment puts their health at risk from occupational hazards.

Finally, those who came to the city with the aim of planning to continue their journey to seek asylum in another country may have additional reasons for feeling insecure. The process of planning their journey will present particular challenges and risks, and they may be at the mercy of people traffickers. They are also in a limbo, unable to concentrate on making the best of their present situation.

**Assessing the challenges for responding to urban health needs**

We know from the previous lesson the importance of working with both the community and local services. We have already noted that people may not be living with others they know, and may be trying to make their way in a fast-moving money-based economy. These issues have health implications. Community participation in the provision of services may be difficult, as people living in the same geographic area may have fragmented community structures. Finding social structures and respected leaders in a particular geographical area may be difficult; without people with this influence to work with as partners, health activities can be challenging.

Particular issues will of course be specific to particular situations. Let us consider an example that illustrates the importance of good assessment.
Exercise 1: The importance of good assessment

South Africa was in an unusual position after the end of apartheid after 1994. It suddenly became a destination for migrants from across sub-Saharan Africa, most of whom settled in urban areas. A study of the experiences of refugees in Johannesburg and their influence on the city showed that many came from countries in conflict such as the Democratic Republic of the Congo or Somalia (Landau and Jacobson 2004). They were younger than the host population, with 5% over 40 compared to 22% of South Africans. Most were male and did not have children.

These findings have implications for health care. Now take a few minutes to think what they might be, and write them down.

Your answers should include the following:

- Particular efforts may be needed to integrate the migrants into the host population, who may perceive them as a threat – this would reduce the potential for disputes and possible violence.

- The ability to work will be very important for both income, assimilation and self-respect; it will also prevent them having to make a living in illegal ways which could lead to violence and possible imprisonment.

- In particular, younger men without families will need health promotion and education on sexually transmitted diseases and HIV/AIDS.

- The police and other law enforcement officers need to be aware of refugees’ rights and treat them like anyone else while ensuring law and order.

Understanding particular health needs in urban settings where the regular health information system is either overstretched or not functioning well may need specific surveys. However, whenever possible it is important to involve national health workers and give longer-term support to the national health information system.

Other challenges

In some situations there may be a massive, rapid influx of displaced people or refugees into an urban setting; this may create a need for an emergency response. For example, the population of Luanda, the capital city of Angola, rose during
the war that ended in 2002 from approximately 400 000 in 1974 to over 4 million, 85% of whom lived in shanty towns around the central ‘concrete city’. Emergency response as well as system strengthening was necessary when there were outbreaks of cholera in the mid-1990s and 2000s.

Door to door distribution of sodium hypochlorite or chlorine powder was part of this emergency response, with a massive health promotion programme using outreach workers to ensure the solution was made up and used correctly. Outreach programmes in urban settings can be effective and have the added benefit of providing employment and potentially strengthening community ties.

Supporting, reinforcing and assisting local health and social services to cope with the additional load must be a priority in all interventions. This is important for sustainability, ownership and the best use of resources.

Remember the issues related to providing parallel services discussed in the previous lesson. Urban settings can also be particularly competitive environments, for resources, jobs and services. If refugees or displaced people are perceived as getting anything better than that available to the general population, there is potential for divisions and conflict.

While we can expect certain patterns, remember that an assessment of the refugee or displaced population is essential. Let us look at another example and the response that it needed.

**Kabul: an example of assessment and response**

The population of Kabul, the capital of Afghanistan increased from an estimated 500 000 in 2001 to over 3 million by 2007 – increasing six times in as many years. As well as natural growth, this was caused by people coming to Kabul from all over the country for economic and security reasons, and an estimated 1 million refugees returning from Pakistan and Iran, many with their families. The head of the Malalai Maternity Hospital estimated they were seeing 600 patients a day in a hospital built for 150; maternity care was one of many acute needs (IRIN 2006).

What was the response? Reproductive health programmes in many rural areas of Afghanistan concentrated on training community workers, but in Kabul the emphasis of some programmes was on building up existing hospital services, with a strong emphasis on staff support and training. This included addressing
the health care needs of the health workers themselves, reducing absenteeism due to illness, preventing disease transmission at the hospital and collecting information that would help expand the programme to other Afghan health care workers (Kitt et al. 2006).

Getting stuck on the way

Refugees are increasingly getting stuck in countries which are not their final intended destination, where they enter into a sort of limbo – prevented from going on, desperate not to be sent back, and often in difficult and stressful circumstances. This is increasingly happening on the borders of rich EU countries. We will consider the health needs of people in two such places in Europe: Lampedusa, Italy and Sangatte, France.

Take a look at the photo in Figure 1 of people arriving in Lampedusa. The health risks of drowning, dehydration and sunstroke are obvious. Over 13,000 people are estimated to have lost their lives trying to get there in 1999–2009, but people continue to take the risk and pay €1500–3000 for the trip. Look at the map in Figure 2 and you will see why: Lampedusa is one of the gateways to Europe.

Most migrants who arrive in Lampedusa are detained in a facility designed to house 800 people, which in 2009 housed approximately 1800, some of whom had to sleep under plastic sheeting. The island is visited by many tourists, many of whom are sympathetic to the migrants, but whose wealth and lifestyle contrast sharply with these living conditions and the risks people are prepared to take for a better life. Most of those in the detention facility are young men desperate to get work, and tensions are bound to build up in these stressful circumstances. In February 2009 a group of migrants set fire to a building in an attempt to escape; 60 people were injured.

This type of situation does not only take place on the fringes of Europe. Sangatte refugee camp was originally set up by the Red Cross and others concerned about the living conditions of migrants in Calais, France. It was set up to hold about 900 refugees but sometimes held as many as 2000. Most of the refugees wanted to travel to the UK, which led to some friction between France and the UK and the camp was officially closed in 2002. Since then the migrants have been camping in difficult conditions, although French groups have continued to provide some basic assistance.
Underlying inequalities – the main driver

These two examples illustrate the risks – including to their health and survival – that people are prepared to take to try to get to Europe, and the consequences of developed countries’ immigration policies for the health of the migrants they are attempting to keep out. They are also a symptom of the gross underlying inequalities that drive people to leave their home countries in the first place.

In this lesson we have looked at the particular problems of refugees and IDPs who move into urban areas, either as their final destination or as part of a longer journey. An increasing number of people find themselves displaced in urban areas, and health professionals need to be ready to address both the health consequences and the underlying causes.

References


Lesson 2.3: Violence in refugee camps

Author: Moyra Rushby

Refugees and internally displaced persons (IDPs) frequently end up living in camps after fleeing violent conflict. The expectation is that the camps will provide a refuge. In reality and unsurprisingly, refugee camps sometimes prove to be violent and unsafe. This lesson will discuss the issue of violence in refugee camps – especially violence resulting from intercommunal friction.

Introduction

Refugee camps are not communities or villages or small towns. While they may in some cases have existed for 20 or 30 years, most people who live in them are waiting to return home. Refugee camps allow people very limited control over their lives and rarely provide an opportunity for independence. The very fact they are meant to be temporary places of shelter means that people live in the expectation that their predicament will be resolved.

Much of the violence in refugee camps is also gender-based and hidden, and members of their own family or community are often violent to women, an issue discussed in more depth in the next lesson, Lesson 2.4.

Responsibility for the security of refugees lies with the host government. UN agencies also assume some responsibility through their mandates; what they can do in practice is influenced by the willingness and capacity of the host government.

Take a moment to think about what we have said so far on life in a refugee camp. Make a list of the possible causes of violence that might occur. Then read on.
Causes of violence in refugee camps

Many factors underlie the rates of violence in different societies (WHO 2002):

• cultural norms that support violence as an acceptable means to resolve conflicts;

• cultural norms that give priority to parental rights over child welfare;

• norms that entrench male dominance over women and children;

• norms that support the excessive use of force by police against citizens;

• norms that support political conflict;

• health, educational, economic and social policies that maintain high levels of social and economic inequalities between groups.

These factors are likely to be present to some degree in all communities, and their incidence will be affected by the dynamics of forced mass migration. The breakdown in established social structures and the new stresses that forced migration causes may result in increased violence in refugee camps. Yet not all camps are violent, nor is communal violence present in all refugee settings. We need to ask what other factors might act as the tipping point that makes some camps much more violent than others.

The most commonly held view is that violence in refugee camps is intrinsic to their social structure, and worsened by a range of socioeconomic factors. Camps leave people vulnerable, possibly resentful and more open to supporting military and criminal activity. Nongovernmental organizations (NGOs) and UN agencies have long held that the provision of humanitarian support and income-generating activity would go some way to prevent this.

Camps may also be filled with large numbers of young men who, with little to occupy them, may turn to violence. As they are more likely to be involved in aggressive behaviour than other groups, some believe that they need to be involved in some form of constructive activity to prevent them slipping into a life of crime and violence.
Size of refugee camps

Camps of more than 50,000 people have long been considered too large to manage. It is generally more difficult to maintain law and order in camps that are large and densely populated. ‘Such camps are more likely to be perceived as – and to become – a threat to local communities’ (Crisp and Jacobsen 1998).

If violence resulted purely from these and other socioeconomic factors it would be relatively easy to manage, and the humanitarian community would be in a strong position to do so. Yet the experience of refugee camps in Afghanistan, Kenya and the African Great Lakes region around Rwanda, Burundi and the Democratic Republic of Congo suggests that these factors do not offer sufficient explanation.

Table 1 presents the most common threats of violence faced by people living in refugee camps (Jacobsen 1999).

<table>
<thead>
<tr>
<th>Nature of threat</th>
<th>Likely causes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Direct military attack or bombardment</td>
<td>• Presence of combatants among refugees</td>
</tr>
<tr>
<td></td>
<td>• To force repatriation or break up (militarized) camps</td>
</tr>
<tr>
<td>Caught in cross-fire or armed conflict</td>
<td>• Sites too close to border or located in zone of conflict or civil war in host country</td>
</tr>
<tr>
<td>Armed raids by rebel groups or enemy forces</td>
<td>• To obtain resources or hostages</td>
</tr>
<tr>
<td></td>
<td>• To force or prevent repatriation</td>
</tr>
<tr>
<td></td>
<td>• Forced conscription</td>
</tr>
<tr>
<td></td>
<td>• Recrimination</td>
</tr>
<tr>
<td>Ethnic or political (factional) conflict between refugees or between refugees and locals</td>
<td>• Poor organization or management of camps</td>
</tr>
<tr>
<td></td>
<td>• Ineffective policing by host authorities</td>
</tr>
<tr>
<td></td>
<td>• Refugees and/or locals dissatisfied or resentful about camp conditions</td>
</tr>
<tr>
<td>Violent crime inside or outside settlement area</td>
<td>• Absence of law and order or ineffective policing of settlement area</td>
</tr>
<tr>
<td>Abuse or intimidation by camp authorities or refugee leaders</td>
<td>• To prevent or encourage repatriation</td>
</tr>
<tr>
<td></td>
<td>• Absence of law and order or ineffective policing of settlement area</td>
</tr>
</tbody>
</table>
Jacobsen includes the socioeconomic factors mentioned at the start of this lesson, but also points to other factors that seem to suggest an armed conflict may simply follow the refugee community. The camp, rather than being a place of safety, can become a further battleground on which the original conflict continues. Given the scale and violence of conflicts that result in people fleeing their homes, this is not surprising. The factors Jacobsen highlights present an even greater challenge to the host government and the humanitarian community than those mentioned earlier.

The militarization of refugee camps poses a threat to the host country as it can allow violent conflict to spread into the local community, and can be seen as a potential threat to the stability of the country or an incentive to overthrow the government. Palestinian refugees, for example, have twice suffered brutal repression by host country governments in Jordan and Lebanon, who perceived the Palestinian government-in-exile and the presence of large, militarized refugee camps as a direct threat.

In 2007, Ethiopian troops entered Somalia in support of the interim government that faced a threat from Islamic militias. People fleeing the fighting tried to cross into Kenya but were turned back by Kenyan soldiers. Kenya was finding it very difficult to distinguish between militias on the run and civilian refugees from the war. The women and children seeking asylum could also be the families of Islamist fighters who planned to follow them. ‘For security reasons, we are not allowing anyone over the border,’ said the police officer responsible for border security in Liboi (Kolterman 2007).

Refugee camps can also be seen as a source of essential supplies like food, medical supplies, vehicles and labour. Humanitarian agencies are seen as vulnerable because of their reluctance to involve security services in the protection of these resources. In the short case study on post-genocide Rwanda you will read at the end of this lesson, militarization poses profound dilemmas for the humanitarian community, and raises important questions about long-held beliefs regarding their impartiality and independence. Consider these examples:

**Negotiation with armed groups:** What if militias demand a share of camp food in exchange for remaining outside the camp or desisting from attacking camp residents? Should aid agencies comply?

**Security:** If the threat to safety is severe, is it acceptable for humanitarian organizations to use military guards to protect camps and supplies?

**Militarization of camps:** Can the humanitarian community threaten to withdraw if camps come under the control of armed combatants?

**Forced return:** Should people be actively encouraged to return home if the government of the country where they are staying threatens their safety?
These situations pose real dilemmas, and some think the humanitarian community has recognized these risks too late because it has concentrated far too much on addressing socioeconomic issues. Jacobsen suggests that security should be the first priority in forced migration, above even humanitarian aid.

You saw in Table 1 the impact of militarization forced on communities, from which they may be partly protected by good planning and camp management. However, it may be the origin of a crisis that predicts levels of violence in camps – violence may be much more likely where political persecution is the main reason for flight (Lischer 2005).

Unlike Jacobsen and others who suggest that political involvement is frequently coercive, the suggestion here is that the political and military dimensions of a refugee crisis ensure that those involved are often willing supporters and even instigators of violence. Lischer suggests that given this premise, humanitarian agencies may exacerbate the conflict if they fail to engage with this aspect of refugee crises.

**Exercise: Post-genocide Rwanda**

By looking at this case study of the militarization of the Rwandan refugee camps in Goma, Zaire (now the Democratic Republic of Congo) in 1994, you will get a clear idea of the dilemmas faced by those on the ground.

*Figure 2: Rwandan refugees making camp in Kimbumba, Eastern Zaire, 1994. Source: Wikimedia Commons. Credit: www.cdc.gov/nceh/ierh/Gallery/Zaire%201Lg.jpg*
Lesson 2.3: Violence in refugee camps

Case study: humanitarian dilemmas

Background

Following the 1994 Rwandan government genocide against the Tutsi minority group (and some politically moderate Hutu), the Rwandan Patriotic Front (RPF), the Tutsi-led liberation army which had been based in Uganda, invaded Rwanda and quickly gained territory. The Hutu population was forced to flee westwards, where a French military intervention had created a safe haven. Many Hutu refugees crossed the border into neighbouring Zaire and settled in camps set up around the town of Goma; the refugee population in this area peaked at about one million people.

When the situation inside Rwanda began to stabilize, many of the humanitarian agencies present started to raise concerns about the increasing presence of armed refugees around the camps in Zaire. Soldiers of the former Armed Forces of Rwanda and the Interahamwe militia created armed outposts on the outskirts of the camps. Many camps also began to fall under the control of ex-army or government leaders. Aid agency staff became increasingly alarmed as it was apparent that the camps had in fact become the base within which the military overthrow of the new Rwandan government was being planned. Food and other humanitarian aid was being hijacked by military groups and it was suggested that they controlled food distribution.

Humanitarian groups that UNHCR traditionally engaged to run refugee camps, such as Médecins sans Frontières, Care and Save the Children, felt unable to carry on working in such conditions. They withdrew from the camps, hoping this would draw attention to what was happening and encourage the international community to disarm the armed groups. Instead UNHCR began to rely on smaller, less experienced groups to undertake the work, with a resulting drop in its efficiency and quality.

Dilemmas of the humanitarian actors

United Nations: The UN had consulted some 60 countries about the possibility of supplying peace-keeping soldiers to protect the refugee camps in Goma. Only four responded and only one was French-speaking. Noting that it had traditionally been the responsibility of the host country to provide security in refugee camps, the UN concluded that none of the options to enhance security in the camps through a peacekeeping operation appeared viable (UN Chronicle 1995).

UNHCR: When asked why UNHCR had failed to withdraw from the camps, the then High Commissioner Sadako Ogata said there were also innocent refugees in the camps – more than half were women and children. ‘Should we have said: you are related to murderers, so you are guilty, too? My mandate – unlike those of private aid agencies – obliges me to help’ (Wilkinson 1997).

Médecins sans Frontières: Medical relief agency MSF, one of the agencies established in the camps, tried at one point to encourage repatriation of refugees. As a result of threats from Hutu leaders in the camps, and because of massacres conducted by the Armed Forces of Rwanda as they surged through Rwanda, the refugees were unwilling to go home.

A cholera epidemic broke out and the international community poured large amounts of aid into the camps, but they were controlled by people who had just perpetrated a genocide. MSF faced the dilemma that many innocent people needed help, but providing aid to the camps would strengthen and finance those who had committed genocide and were waiting for a chance to continue their ethnic cleansing (Newell 2005). The Dutch and Belgian sections of MSF decided to continue to provide aid, but the French section was exiled after voicing its moral objections to providing aid and sanctuaries for the exiled military regime.
This case study is perhaps the best-known and most extreme instance of the dilemmas of humanitarian intervention, but it is not unique. We can see from this example that there are no easy responses.

Before continuing with the next lesson, you might like to read the following discussions of similar problems (for more on the genesis of the Rwandan crisis, see Course 4, Chapter 3),

For further discussion


References


UN Chronicle (1995), Situation in refugee camp called dangerous. UN Chronicle, June. New York, United Nations Department of Public Information.


Lesson 2.4: Gender-based violence in refugee camps

Author: Moyra Rushby

Women, young children, adolescents, people with disabilities and elderly people are the most vulnerable groups living in refugee camps. In 2005 there were 12.7 million women under the responsibility of United Nations High Commissioner for Refugees (UNHCR) and the United Nations Relief and Works Agency for Palestinian Refugees (UNRWA). An estimated 65% of people displaced by conflict are female (WHO 2005). Most gender-based violence (GBV) that occurs in conflict situations is committed by armed groups and outside refugee camps.

Overview of gender-based violence

The focus of this lesson, like all the lessons in Chapter 2, is on camps for both refugees and internally displaced persons (IDP) and the term ‘refugee camp’ will be used to describe both. The term ‘displaced people’ will be used to describe all types of forced migrant.

Learning objectives

By the end of this lesson you will be able to:

- define gender-based violence
- outline the causes of gender-based violence in camps for refugees and internally displaced persons
- describe strategies for reducing gender-based violence in camps for refugees and internally displaced persons.

Figure 1: Kakuma camp, Kenya. Credit: Refugee International
Some definitions

Gender refers to attributes and roles differentially ascribed to males and females (Ward 2002:8). These attributes and roles are socially constructed, context-based and learned through socialization. Although mutable, they are rooted in longstanding assumptions societies hold about women, men, boys and girls. They inform relationships between males and females.

The roots of GBV lie in power inequities based on gender roles, which are marked by the domination of men and the subordination of women (RHRC Consortium 2007). Violence may be physical, sexual, psychological, economic or sociocultural, perpetrated in private or in public settings. It can occur throughout a woman’s lifecycle, starting with infanticide, early childhood marriage and genital mutilation, and evolving into sexual abuse, domestic violence, legal discrimination and exploitation of widows.

The UN Declaration on the Elimination of Violence against Women offered the first official definition of GBV (UN General Assembly 1993) (see Box 1).

Box 1: UN Declaration on the Elimination of Violence against Women 1993

Article 1

For the purposes of this Declaration, the term ‘violence against women’ means any act of gender-based violence that results in, or is likely to result in, physical, sexual or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life.

Article 2

Violence against women shall be understood to encompass, but not be limited to, the following:

A | physical, sexual and psychological violence occurring in the family, including battering, sexual abuse of female children in the household, dowry-related violence, marital rape, female genital mutilation and other traditional practices harmful to women, non-spousal violence and violence related to exploitation;

B | physical, sexual and psychological violence occurring within the general community, including rape, sexual abuse, sexual harassment and intimidation at work, in educational institutions and elsewhere, trafficking in women and forced prostitution;

C | physical, sexual and psychological violence perpetrated or condoned by the State, wherever it occurs.
GBV is said to be the most widespread and socially tolerated of all human rights violations. It is not restricted to violent acts targeted at women and girls where men are the perpetrators, but this is the most common form and is therefore the focus of this lesson. Unlike most other forms of violence, most cases of GBV go unreported, and even the few cases that are reported often end with no punishment of the perpetrator, while the victim is left stigmatized and in some cases criminalized. This further discourages reporting and reinforces the perpetrators’ sense of impunity.

**GBV in refugee camps**

GBV is present in some form in all communities and cultures, but as discussed in the previous lessons, many factors come together around forced migration and conflict that predispose communities to violence, and in particular female refugees to GBV.

Some of the factors that affect the vulnerability of female refugees are general ones that threaten all people living in camps, including:

- breakdown of law and order and judicial systems
- increased militarization
- breakdown of community structures and support systems
- generally increased levels of violence associated with armed conflict.

Factors that enhance the vulnerability of women and girls include:

- the breakdown of family and community structures that leave women isolated from their normal social support and protection;
- women are less likely to have an income than men, and are thus more vulnerable to being forced to exchange sex for basic needs;
- women often need to travel outside camps to collect water and wood, making them vulnerable to outside militia, combatants and aggressors among the host population;
- lack of autonomy;
- mental health problems, including the stress of the migration process;
- poorly planned camps.
Migration of any kind affects not only the individual but also the household, changing relationships between partners, resulting in overcrowding and insecurity and leading to increased violence. This has been described as both a cause and consequence of violence and insecurity (Moser and Rodgers 2005).

In situations of movement and change, ways of dealing with domestic violence also change. For example, Burmese refugee women living in Thailand report that violence against women has been traditionally managed at the household level. This prevented stigmatization of the women and family. However, as many of the perpetrators of violence against them are from the Thai military or border patrols, traditional face-saving methods are not available, and recourse to the Thai legal system may result in forced return for the women and their families (Ward 2002).

Female refugees and identity

Refugee women and girls should be presented neither as victims nor as powerless observers. The very act of migration causes a profound shift in identity, and if a person’s dominant identity becomes ‘refugee’ a sense of passivity is engendered that fails to recognize each woman’s other more positive identities. We all have a multitude of identities, and female refugees are no exception. They are also partners, mothers, daughters, combatants, politicians, peacemakers, health care providers and community leaders.

Identity is complex and important.

Take a few minutes now to think about how you would feel if you were introduced to a stranger by your ...

- profession
- religion
- gender
- nationality
- marital status
- affiliation to a particular football club.

Each one is an identity, but each will elicit a different reaction from the person to whom you are introduced.

It is important to acknowledge the strength that has enabled female refugees to survive, and recognize their ability to act as agents of change in their community. It is often women themselves who begin the long process of addressing GBV in their communities.
While all women are subject to some form of oppression, refugee women may experience what has been described as an ‘intersectionality’ of oppression (Bartolomei et al. 2003). Intersectionality refers to multiple discriminations that are woven together, making it difficult to address any one in isolation. It might, for example, involve discrimination on grounds of ethnicity, religion or economic status as well as gender. This suggests that GBV in refugee communities can only be viewed as part of a more complex pattern of oppression and discrimination.

**Take a moment to think about how you might go about preventing GBV. Write down your ideas and see if they come up below.**

**Prevention of GBV**

Since the 1990s GBV has had a much higher profile. The 1994 International Conference on Population and Development introduced the precedent of minimum health standards for forced migrants, and called for ‘all necessary measures [to] be taken to ensure the physical protection of refugees – in particular, that of refugee women and refugee children – especially against exploitation, abuse and all forms of violence (ICPD 1994: paragraph 10.24).

GBV impacts on communities and families as well as individuals, and all members of the community should be involved in measures to reduce it in all its forms.

UNHCR adopted a multisectoral approach to GBV in 2001, an approach widely accepted to be the current best practice model for addressing GBV for forced migrants. It involves:

- empowering women in their communities and involving both women and communities in addressing and resolving issues of violence;
- ensuring that planning of refugee camps includes such measures as lights on pathways used by women and children, and safe areas for lone women and unaccompanied children;
- ensuring that women are included in all levels of camp and community decision-making;
- agreeing safe times when women can go to collect wood or water and providing an escort;
- reducing wood use by providing other forms of fuel;
- making reporting of rape and domestic violence easier;
- ensuring that health workers and other camp staff are aware of and looking for signs of domestic violence and rape (Figure 2 shows how theatre can be used to raise awareness);
- ensuring the availability of female protection and health workers.
This approach has some drawbacks, not least the problem that developing systems to protect and empower female refugees may also result in undermining traditional male roles. Men’s resulting frustration and perceived loss of identity has been shown to increase levels of domestic violence (Human Rights Watch 2000).

**Figure 2: Sange village, South Kivu, Democratic Republic of the Congo. A scene from an ICRC play, performed to raise awareness of the consequences of rape: here, soldiers surround and kick the victim. Credit: ©ICRC/J. Powell/CD-E-00332**

### Health workers and GBV

A coordinated response to GBV has been advocated by the Inter Agency Standing Committee (IASC), the primary mechanism for interagency coordination of humanitarian assistance. It recommends that health care providers, police and other security personnel, legal justice actors and the local community are regularly brought together to address the issue (Egeland 2007).

Health workers in refugee camps should be constantly aware of the possibility of GBV. They should recognize that many women find it difficult to report GBV or discuss it with others because of fear and social stigma, along with the tendency of almost all cultures to blame the victim for such crimes.

Some staff should have expert skills to treat GBV-related injuries and give women information on preventing pregnancy, sexually transmitted diseases and HIV transmission. Emergency contraception will help reduce the trauma of rape victims.

It is important that not only the physical symptoms are addressed. Support can involve counselling and culturally appropriate psychosocial support. Women can be trained to support the women of their own community, which allows them to develop mechanisms for dealing with their own trauma and encourages them to address together the wider problem of GBV in their community.
Health workers should also ensure that the concept of confidentiality is explained, and that women understand that they will be treated in a confidential and respectful way, encouraging more to come forward and report GBV. By using some form of documentation or medical certification, health workers can transform the incident from a diagnosis of personal harm into a recognition that a criminal act has taken place (Médecins sans Frontières 1997).

**Before you complete this lesson, take a few minutes to read** Responding to sexual and gender-based violence in the Democratic Republic of Congo (WHO 2005). Available at: www.who.int/hac/crises/cod/2pager.pdf

**References**

- **WHO (2005).** Health in Emergencies. 2.20 January.
Chapter 3: Adapting to a new landscape

Intermediate objectives
By the end of this chapter you will be able to:

- explain the specific health needs of migrants arriving or resettling in Europe
- outline minimum reception standards and current European best practice.
Lesson 3.1: Reception in Europe – expectation and reality

Author: Lucy Kralj; updated by Marion Birch

This chapter focuses on the treatment of refugees and asylum seekers by the 25 European Union member states. It will also consider the health impacts of current EU asylum and immigration policies. Note that the terms asylum seeker and refugee are not interchangeable. You should have a clear understanding of the concepts before commencing this chapter – if necessary go back to the definitions in Lesson 1.1.

Introduction

Patterns of migration have clearly been shown to mirror global events, including patterns of violent conflict. As explained in Chapter 2, most of the world’s refugees live in countries close to the source of the armed conflict that necessitated their exile.

These are generally low-income countries – comparatively few refugees arrive in Europe. In 2009 developing countries hosted 8.3 million refugees, or 80% of the world’s refugee population. A third of all refugees were residing in the Asia and Pacific region, and 75% were Afghans. Sub-Saharan Africa was host to one fifth of all refugees, predominantly from the Democratic Republic of the Congo, Somalia and Sudan. The Middle East and North Africa hosted 19%, mostly from Iraq. Only 16% of the world’s refugees sought refuge in Europe (UNHCR 2010a).

The definition of a refugee is contained in the 1951 UN Convention relating to the Status of Refugees: ‘[any person who] owing to well-founded fear of persecution for reasons of race, religion, nationality, membership of a particular social group or political opinion is outside the country of his or her nationality and is unable, or owing to such fear, is unwilling to avail himself of the protection of that country, or

Learning objectives

By the end of this lesson you will be able to:

• identify where and how to get information about national legislation regarding the care of refugees
• demonstrate an understanding of the health impact of national asylum processes and provisions and their changing nature
• explain how public opinion, media messages and policy decisions interact and affect migrants.
who, not having a nationality and being outside the country of his former habitual residence ... is unable or, owing to such fear, is unwilling to return to it.’ An asylum seeker is an individual seeking international protection and seeking recognition under the 1951 convention. The principle of non-refoulement is an integral and essential part of the 1951 convention, declaring that no refugee shall be returned ‘in any manner whatsoever to the frontiers of territories where his life or freedom would be threatened on account of his race, religion, nationality, membership of a particular social group or political opinion’.

**Figure 1: Protester outside a UK detention centre. [www.noborders.org](http://www.noborders.org)**

### European Union policy

Many Europeans claim a proud history of offering sanctuary to those in need of international protection. For example, most Westerners would be repelled by the thought of refusing victims of the largest genocide in recent history, the Nazi holocaust. Similarly, most Europeans look back on the more recent genocides in Bosnia and Rwanda with regret, sorrow and outrage. This section will examine the European Union response to those seeking sanctuary from situations of similar danger and atrocity.

Since the 1990s the EU has undergone marked expansion and legislative changes. There has been a coordinated effort to harmonize European asylum policy, and the commitment of member states to a joint European asylum policy was reaffirmed in the European Pact on Immigration and Asylum in 2008. The aim was to establish, by the end of 2010, a common asylum procedure and an agreed uniform asylum status valid throughout Europe. The overall aims of recent directives have been to establish firmer border controls and increased security within member states.

Concomitant with the introduction of new policies, Western Europe has seen a significant decline in numbers of asylum seekers, with some countries experiencing a 30% decline between 2003 and 2004. Punitive policies, complex visa requirements and airline sanctions all contributed to this decline and also resulted in protests and campaigns (Figure 1).
More recently the number of asylum seekers has stabilised in the 15 ‘old’ EU member states (UNHCR 2010b), although Antonio Guterres, UN High Commissioner for Refugees, still felt the need to dispel popular perceptions by saying, ‘The notion that there is a flood of asylum seekers into richer countries is a myth’ (Reuters 2010).

The largest groups receiving asylum in the EU in 2008 came from Iraq, Somalia, Russia, Afghanistan and Eritrea (Eurostat 2009). These are countries with poor human rights records and ongoing conflict, but they are not – apart from Afghanistan – necessarily among the world’s least developed countries.

**Relevant EU directives and legislation**

These can be viewed in more detail at [www.unhcr.org](http://www.unhcr.org) and [www.ecre.org](http://www.ecre.org)

**Dublin (I) Convention 1990:** Asylum applications must be processed by the government of the first EU country entered by the applicant.

[http://www.ena.lu/](http://www.ena.lu/)

**Treaty of Amsterdam 1997:** Promoted freedom of movement within member states and increased external border control. EU governments were to be bound by principles of asylum management. Minimum standards were to be reached by 2004 including standards of reception conditions, temporary protection, and responsibility for examination of claims including family reunification and a list of safe third countries.


**Tampere 1999:** Upheld the principles of the 1951 Convention, promoted partnerships with refugees’ countries of origin on human rights and development issues, and placed an emphasis on integration of refugees into countries of exile.


**Dublin (II), Council Regulation (EC) No 343/2003:** This regulation replaces the provisions of the 1990 Dublin Convention with European Community legislation. Its objective is to identify as quickly as possible the member state responsible for examining an asylum application, to establish reasonable time limits for each of the phases of determining the member state responsible, and to prevent abuse of asylum procedures in the form of multiple applications.

Hague 2004: Agreed a joint EU approach to country of origin information, a single procedure for determination of claims, and common standards for removal procedures. 
ec.europa.eu/

Qualification Directive, Council Directive 2004/83/EC: Sets out minimum standards for the qualification and status of third country nationals or stateless persons as refugees or as persons who otherwise need international protection and the content of the protection granted. 

http://eur-lex.europa.eu/

EURODAC: An EU-wide database of fingerprints of all asylum applicants, which aims to reduce multiple applications. 

Concerns have been raised about various aspects of recent EU legislation. UNHCR supports the need for harmonization and recommends that all EU asylum applicants are immediately ‘processed’ in specifically designated centres, unless they are unaccompanied children or ill.

However, it is also acknowledged that as ‘Fortress Europe’ further strengthens its border controls, a greater burden of responsibility for dealing with asylum seekers falls on countries on its periphery, which are generally less economically stable than the core EU countries with enhanced immigration controls. In its effort to strengthen border controls and to deter asylum applicants, the EU may be prematurely declaring countries ‘safe’ to return to (Roth and Hall 2004).

Health concerns

Think back to earlier lessons on what types of threats to their health asylum seekers and refugees face. Make a quick list as a way of revising them before reading the summary update below.

When assessing the health care needs of asylum seekers and refugees in Europe, you will find it helpful to consider three categories of health threat they face during their journey.

Conditions in country of origin: this may include experiences of torture, war, imprisonment, sexual abuse and slavery; experiences of multiple bereavements and grotesque deaths, other forms of human rights violations, communicable diseases and problems specific to the region of origin, as well ethnicity-specific conditions.
**Conditions during flight:** consider the nature of the journey itself and its possible health consequences: it may have involved trafficking of people, enforced prostitution and other forms of exploitation; malnutrition and communicable diseases, and enduring states of protracted fear with uncertainty about the final destination.

**Conditions in country of exile:** these might include long term health consequences of torture and other human rights violations, social isolation and exclusion. The impact that social circumstances have on the health of forced migrants should not be underestimated. Lack of access to an acceptable level of housing and health care, alongside long-standing insecurity and social exclusion, result in continued poor health outcomes.

Many people fleeing violence, horror and destruction in their home countries arrive in the EU with a spark of hope that has been essential to their survival so far. Europe is perceived as a place of sanctuary and democracy where a future free of violence and despair may be achieved. The realization that this may not be so, and that life is actually far from secure, can profoundly affect asylum seekers’ already overstretched coping mechanisms.

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**Take some time to remember what may drive you to leave all that you have – family, home, job and culture – and run to a place of uncertainty with no plans and no contacts.**

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**International legal obligations**

All human beings, whichever country they are in, have guarantees to certain inalienable rights. These include those enshrined in the following human rights instruments.

- **Article 25.1 of the Universal Declaration of Human Rights (UDHR):**
  This affirms that ‘everyone has the right to a standard of living adequate for the health of himself and of his family, including food, clothing, housing and medical care and necessary social services’.  

- **Article 12 of the International Covenant on Economic, Social and Cultural Rights 1976 (CESCR):** This enjoins the States Parties to recognise ‘the right of everyone to the enjoyment of the highest attainable standard of physical and mental health’.  
Further elaboration of the CESCR in subsequent ‘general comments’ has outlined a number of core obligations. It is incumbent on States Parties to:

A | ensure the right of access to health facilities, goods and services on a non-discriminatory basis, especially for vulnerable or marginalized groups;
B | ensure access to the minimum essential food which is nutritionally adequate and safe, to ensure freedom from hunger to everyone;
C | ensure access to basic shelter, housing and sanitation, and an adequate supply of safe and potable water;
D | provide essential drugs, as from time to time defined under the WHO Action Programme on Essential Drugs; and
E | ensure equitable distribution of all health facilities, goods and services.

Access to health services

Many asylum seekers and refugees experience difficulties accessing health services. This is partly due to health being low on a list of often more pressing priorities such as finding shelter, securing income and gaining protection. Many people also struggle to access appropriate services in a strange environment and health system, and are often impeded by language difficulties.

Health services in the industrialized world are generally not equipped in terms of experience and knowledge to deal with the often complex health needs of survivors of gross human rights violations. Despite recent international events and armed conflicts involving Western states, torture is not thought in the West of as part of daily life. Health workers may feel ill equipped to cope with the enormity of the problems that survivors of gross human rights violations face. These problems frequently span a range of health and social difficulties.

Survivors, who are often refugees and asylum seekers, often feel ashamed to talk about what has happened to them. Equally, disclosure can in itself be experienced as retraumatizing. Furthermore, before arrival many people are coached by unscrupulous agents not to disclose their truths. Sadly, failure to disclose a history of human rights violations and the associated health problems may have serious implications for an individual’s right to legal protection and their likelihood of being granted refugee status.

Health workers should take health problems seriously and ensure thorough and accurate documentation of complaints, diagnoses, subsequent treatments and any signs such as scarring that could be the result of torture or extreme violence. Preparing medico-legal reports is a specialised process and some training will be required. The Istanbul Protocol sets out the principles for the effective documentation of torture and other cruel, inhuman or degrading treatment or punishment and can be viewed online (Action for Torture Survivors et al. 1999).
Health complaints are frequently compounded by social isolation and social exclusion. Asylum seekers are prohibited from paid employment in the EU. Lack of stable accommodation, poor socioeconomic status (including unemployment), and geographical proximity to armed conflict all exert a profoundly negative effect on mental health, according to studies of pre- and post-migration factors and mental health of displaced people. Women, rural people, and well-educated people with higher socioeconomic status before displacement are likely to have poorer mental health (Porter 2005). It is important, however, not to medicalize what might be many people’s normal emotional responses to such extreme situations. What is most needed to reduce emotional distress may be a return to a secure and relatively stress-free ‘normality’.

**Reception – rejection**

Throughout the EU large numbers of asylum seekers are detained for unlimited periods, both directly on arrival and before removal. The UK literature pertaining to the health impact of immigration detention is scant, but more robust evidence is emerging from Australia, where the traumatic effects are becoming evident and better documented. Hunger strikes and suicide attempts are common, and the effects on children have been shown to be extremely damaging as well as contravening the UN Convention on the Rights of the Child (Steel et al. 2006).

**The impact of individual health on decision-making**

Torture is often designed to leave no visible signs. The immigration/asylum interviewing officer may thus not be alerted to a person’s history of torture and human rights violations. However, non-disclosure can seriously affect a claim for asylum. The same is true of late disclosures, inconsistencies and omissions from claimants’ accounts. Trauma is widely documented as having a negative impact on memory (Herlihy et al. 2002). Furthermore, many survivors of gross human rights violations have sustained significant head injuries and may be left with neurological damage.

EU policy aims to deter asylum applications rather than focus on the EU states’ responsibility to protect. There has been increased media coverage of Muslim fundamentalism since the events of 11 September 2001, and the EU has also felt increasingly threatened by terrorist activities since the bombings in Madrid and London. Terrorism is being linked with the Islamic faith and migration from Islamic states, and the word Islamophobia has evolved to describe adverse reactions to followers of Islam. The knock-on effect is hostility to immigrants arriving in the EU who are now perceived to be a threat.
References


Lesson 3.2: Holistic care and cultural competence

Author: Lucy Kralj

The ‘Other ‘and ‘Othering’
The ‘Other’ is something apart from the self. It may be an individual but is often a group, ‘them’ as opposed to ‘us’. It has been argued that who and what ‘others’ are is intimately related to ‘our’ notion of who and what ‘we’ are. ‘We’ use ‘Other’ to define ourselves. We understand ourselves in relation to what we are not’ (Kitzinger and Wilkinson 1996:8).

There are many examples of the ‘Other’ in modern society, as throughout history: people who are mentally ill, prisoners, criminals, women, the poor, people with learning disabilities, foreigners and migrants. The concept of Othering is based on opposing relationships founded on polarities and dualities (for example, poor/rich, white/black, sick/well, victim/perpetrator). It is a frequent topic of literary and philosophical debate.

- The novelist Albert Camus, himself an ‘outsider’ as a French national in Algeria during French colonial rule, wrote extensively about the Other. The Outsider (L’Etranger), Exile and the Kingdom (L’exile et le Royaume) and The Plague (La Peste) all have the concept of the Other as a central theme.

- Simone de Beauvoir wrote extensively about women’s position in society as the Other. The Other is not defined by him-/her-/them-selves but rather by those in power, who make a divide in an attempt to maintain their separation and superiority through the creation and perpetuation of an underclass.

Those most likely to reinforce negative stereotypes may be those most dissatisfied with their own circumstances (Finney and Peach 2004). There is a long history of associating refugees and asylum seekers with personal insecurity, war, famine and multiple losses (Gibney 2002), associations that engender anxiety and fear in others who may then be forced to confront their own vulnerabilities. Table 1 shows more evidence of the proliferation of Othering.

Learning objectives
By the end of this lesson you will be able to:

- outline the impact of ‘otherness’ on individual and public health care;
- suggest how holistic, integrated care can be promoted for people from marginalized groups.
### Table 1: Examples of Othering and its consequences

<table>
<thead>
<tr>
<th>Powerful Group</th>
<th>Oppressed Group / the Other</th>
<th>Consequences</th>
</tr>
</thead>
</table>
| **White colonial rulers** | Non-white people in colonized countries | • Slave trade  
• Violent conflicts  
• Decades of disturbance  
• Post-colonial struggles  
• Ongoing segregation and racial tensions |
| **Nazi Party** | Jewish people and other minority groups | • Genocide  
• Nuremberg trials |
| **Hutu** | Tutsi | • Genocide  
• Decades of unsettlement and tribal conflicts  
• Trials for war crimes |
| **Apartheid regime** | Blacks / Coloureds | • Oppression  
• Generations of violence and persecution  
• Truth and Reconciliation Commission |

Table 1 also demonstrates the ongoing effects of Othering. Evidence is now emerging of the ongoing health effects of the Holocaust, three generations after the event. The same is true of the other examples. The rest of this lesson will focus on Othering in relation to health care in modern times, with the Other being a forced migrant (refugee/asylum seeker). The situation in the UK will be used as an example.

**Health care and Othering**

In health care institutions the patient is frequently regarded as the Other, with health professionals wielding the power and the control. This is particularly true of in-patient services but primary care services are not exempt. Mental health services often provide the most pertinent examples. Goffman described the mental health hospital patient as the ‘inmate’ and drew stark parallels between the life of the patient and that of the convict, both dominated by oppressive regimes in the ‘total institution’ (Goffman 1961).
Immigration policies and legislation

We will now consider how the ever more stringent European legislation and controls over borders and immigration further undermine the position of asylum seekers, and then review their treatment in health care institutions.

First take a moment to think about the effects of tighter legislation on the health of asylum seekers and their ability to access health care and social support. Write down your suggestions and tick them off as you read the rest of the lesson.

The asylum process

The asylum process comprises a series of bureaucratic hurdles to be negotiated by people arriving in a foreign system and alien culture. Interviews with government officials blur into interrogations where the burden of proof rests on the individual to demonstrate the veracity of his or her claim.

In the UK in recent years, significant media attention has been paid to the treatment of rape survivors by the judicial system, which has sometimes been deemed unsympathetic. In this context, it is now widely seen as inappropriate to pressurise people into disclosing personal and private information, particularly in relation to traumatic pasts. Yet asylum-seeking survivors of all forms of torture, including rape, are expected to disclose their entire painful and intimate histories to strangers: immigration officials who will make decisions about their future safety based on whether they find an account of ill-treatment in a foreign land credible. Failure to disclose immediately on arrival and any subsequent late disclosure can seriously damage an asylum claim.

Inadequate financial support

In the UK, the level of ‘income support’ allowance is calculated as the minimum level of financial support a person needs to live on. Asylum seekers are not allowed to work (‘employment prohibited’ is written on their mandatory identity cards) and receive only 75% of this amount throughout the duration of an active claim. Section nine of the UK Asylum and Immigration Act allows for this support to be terminated on failure of an asylum claim – possibly leading to destitution.

Right to family life

There are provisions relating to domestic violence in both criminal and civil UK law. UK women experiencing domestic violence are entitled to public funds to help them seek refuge. Asylum-seeking women experiencing domestic violence are also protected by UK law, but may remain in an abusive situation as they are
not entitled to public funds and may not feel confident to assert their rights for many other reasons. Social services departments make great efforts to keep British families together, but asylum-seeking families whose appeal rights have been exhausted run the risk of having all support discontinued. Parents may become destitute and their children may be removed and placed in state care. This may mean that children who may already have lost many family members are separated indefinitely from their only consistent caregivers.

**Criminalization**

It is now a criminal offence to arrive in the UK without valid documents. This offence is punishable with a prison sentence. Yet citizens in many countries are not routinely issued with a passport, and it is unsafe to approach persecutory regimes to request travel documents. Many people trying to escape from terrifying situations thus put themselves at the mercy of unscrupulous agents who can provide the forged documentation they need.

Asylum seekers are often physically and metaphorically segregated from mainstream British society, and increased use of detention facilities further ostracizes them. In Australia, boatloads of asylum seekers have been prevented from docking in Australian harbours and people have been detained off shore or in detention centres in the desert. African asylum seekers cross treacherous seas to arrive on European shores, only to be held in coastline detention centres and forcibly deported at the first opportunity. Media images of these events reinforce the categorization of asylum seekers as the Other.

**The role of the media in Othering**

The media in the UK and elsewhere are a powerful influence and often our only source of information about subjects of which we do not have first-hand experience. The media have been responsible for portrayals of refugees as ‘good’ or ‘bad’: the ‘good’ refugees were typically political dissidents escaping from former Soviet-bloc countries during the Cold War, while ‘bad’ refugees are usually today’s ‘bogus asylum seekers’ or ‘illegal immigrants’. The language used by the media can often serve to dehumanize this group of people.

**Islamophobia**

We have seen a rise in anxieties about terrorism throughout Western and other predominantly non-Islamic cultures. The events of 11 September 2001 set in motion the so-called ‘war on terror’ between ‘us’ and ‘them’ – the Other, the Terrorist, the Islamic Fundamentalist, the Muslim.
In the UK there has been detention without trial of Muslims suspected of involvement in terrorism, and an exponential increase in the number of Muslims stopped and searched by police. Discrimination against Muslims has badly affected some groups of immigrants who are assumed – rightly or wrongly – to be Muslims, further influencing how they are perceived and treated.

Othering and culturally sensitive health care

Health workers in major cities in the developed world are bound to encounter people of different cultural backgrounds with different types of immigration status. It can be difficult to deliver holistic care to people from diverse social and economic backgrounds who find themselves in the position of the Other negotiating an alien environment, as shown in Scenario 1.

Scenario 1

You are a general medical practitioner treating a 16-year-old girl from the Democratic Republic of Congo. She is alone in the UK and speaks no English. She has told you the immigration officials say that she is 20, and she is worried that they will send her to Scotland where she knows no one. She has found a friend at a local African church who is a great support to her.

All her family were killed in the DRC and she first came to see you because she was being sick and could not sleep. She told you she has very bad nightmares but she has not revealed their content. Her last menstrual period was 16 weeks ago (a month before she arrived in the UK). You conducted a pregnancy test that was positive but you have not yet told her, and you suspect she may have been raped. She is very tearful and distressed and appears to dissociate regularly when talking to you (dissociation means the ‘partial or complete disruption of the normal integration of a person’s conscious or psychological functioning’).

She is thin, tired, complains of severe headaches and sometimes ‘falls down.’ On questioning she reveals she was severely beaten by police in DRC and knocked unconscious more times than she can remember. She is receiving no money.

As the scenario makes clear, clinicians often deal with vast and complex needs that can feel overwhelming. Numerous problems are presented, all of which need urgent attention. Some are related to the country of origin, others to country of exile, others to the journey into exile. The internal and external worlds of the asylum seeker are frequently traumatic and cause significant distress. Some problems may fall outside the usual remit of the clinician, who may feel powerless to effect change. They may be forced to think outside conventional boxes and to work in previously uncharted ways.
First and foremost, however, health workers need to bear witness to people whose reality is consistently denied (a particular set of activities that includes collecting and providing evidence, with a sense of moral support). They are able to be alongside a person in his/her distress, and in so doing, join the Other. In a climate of hostility and disbelief the power of bearing witness cannot be understated.

Clinicians must take care not to offer false hope and reassurances, or indulge fantasies of rescuing the client. They should know their own limits and seek advice in situations of uncertainty, for example from specialist organizations. A client who has trusted a clinician with deeply personal information may have invested a huge amount in the relationship.

In the clinical session the client needs support to be heard and to be believed. Beyond the session she is likely to require advocacy to secure the sanctuary being sought in the country of exile. Health evidence may be a key part of the asylum claim, and health professionals should be aware of their responsibility to protect, in line with professional ethical codes.

Work with clients from different cultures is further complicated by different health beliefs and taboos. Consider the following examples.

**Rape**

In many cultures women and girls are held responsible for rape. Many do not disclose information to their doctor or nurse for fear of bringing shame on the family, being cast out or subject to honour reprisals. Health workers should not use family or community members as interpreters as this could inhibit disclosure. Furthermore, overt attacks on perceived misogyny may also be unhelpful and further alienate a woman: any criticism of cultural norms may be perceived as cultural imperialism, particularly if the woman herself feels guilt and shame. Studies from many cultures show that rape is a profound violation and is experienced as extremely traumatic. Survivors have unanimously expressed the need for holistic care (Christofides et al. 2006).

Male survivors of rape are even less likely to disclose, and the level of physical and mental trauma is severe and associated with high levels of psychopathology (Kaufman et al. 1980). There are few studies of male rape but it appears that male responses are similar to those expressed by women, but often with greater expressed shame, guilt and humiliation (Rentoul and Appleboom 1997).

**Epilepsy**

An estimated 50 million people worldwide suffer from epilepsy. In developing countries 75% of people with epilepsy may not receive the treatment they need – 9 out of 10 people with epilepsy in Africa go untreated. Either no treatment is
available, or epilepsy is not recognized as a biomedical disorder needing medical treatment. Various interpretations of epilepsy include ‘sacred disease’, ‘moonstruck’ and lunacy. Some cultures see it as a divine blessing, others as possession by demons. WHO campaigns to dispel ignorance of epilepsy (WHO 2010a).

**Mental health**

Hundreds of millions of people worldwide have mental disorders. WHO estimated in 2002 that 154 million people suffered from depression and 25 million people from schizophrenia. Around 24 million people suffer from Alzheimer’s disease and other dementias (WHO 2010b). In most cultures, mental health problems bring stigma to the individual and/or the family. The cultural appropriateness of the treatment provided may be particularly relevant when working with survivors of torture and human rights violations. WHO’s mental health global action programme aims to raise awareness and secure appropriate treatment.

*Take a look at the photo essay on mental health at the WHO website: www.who.int/features/2005/mental_health/en/index.html

Now read the following two scenarios. They show the complexities of dealing with cultural differences.*

**Scenario 2**

Philippine is a devout Catholic from Angola. She had a curse put on her by a traditional healer. Since then her family members all died in suspicious circumstances or became ‘crazy’. She was pregnant at the time of being cursed, and fears that the curse has been transmitted to her baby. She was put on anti-psychotic medication after explaining her history to her family doctor, who referred her to a psychiatrist.

Her symptoms did not improve with medication. After some months she was able to disclose her fears to a priest, who conducted a religious ceremony to bless her and remove the curse. She has since been significantly less fearful, and brighter in mood.
These two scenarios show the importance of recognizing cultural differences and not imposing Western health models and treatment regimes in the absence of culturally sensitive and appropriate care. Other examples of appropriate care may include dance and movement therapy, community support groups and art therapy. Traditional Western ‘talking therapies’ may be difficult: crying may be culturally unacceptable, and disclosure may be too painful.

The idea of integration is a key concept when working across cultures. Meaning ‘to make whole’, it is a process that can take place on several levels: integration of past with present and with future (‘the me before, during and after’); integration with the wider society and culture without losing a sense of one’s own background; and integration of a person’s internal and external worlds and the conflicts in both.

This does not mean ignoring cultural differences – quite the reverse. Diverse experiences need to be acknowledged. The Western approach is not always the best one to take. People need to feel that they have a valid opinion and voice to contribute to their care, and cultures and values need to be explored. A fundamental part of Othering is the denial of the voice of the Other. Health workers have a responsibility to listen and truly hear what is being said, to listen beneath the words. The Other can then have a voice.
References


Lesson 3.3: Examples of good practice in Europe

Author: Moyra Rushby

This lesson will focus on some examples of the best work being undertaken by health professionals with forced migrants. The examples represent a selection of clinical, advocacy and information/knowledge-based projects. They are mainly, though not exclusively, drawn from experience in the United Kingdom. The projects here could easily be replicated. Even more importantly, they may act as encouragement to you to seek out and support local projects of a similar nature closer to your home. Where possible we have given a website or other reference that will help you find further information and make contact with those involved.

Learning objectives

By the end of this lesson you will be able to:

• describe examples of good practice in responding to the health needs of refugees and asylum seekers;
• know where to find more information on best practice.

1 Clinical projects

Hand-held records (UK)

Hand-held records (health records that are kept by the patient) are used in the initial health assessments of asylum seekers at induction centres in the UK before dispersal outside London, as well as in health centres in dispersal areas. The Department of Health, England has produced a hand-held record for use on arrival, and several primary care providers working with asylum seekers have produced their own. The records are an example of good practice as they assist health, social care and housing providers, benefit clients who are more mobile and improve access to care and the quality of care.
The records are divided into several sections and include the following types of information:

- clinical data (e.g. blood pressure, urine analysis, weight)
- past medical history
- family history
- immunization records
- test results
- gynaecological and obstetric history (including genital mutilation)
- TB screening
- history of torture and assault, including rape
- mental health problems, especially symptoms of post-traumatic stress disorder
- dental assessment and treatment
- optical assessment and treatment
- care plans
- appointments.

Primary care providers gain extra income through meeting government targets (for example, on cytology and immunizations), so the records also assist this by recording this data. They incorporate a ‘new patient’ check that can provide baseline data when a patient first registers at a general practice.

Several sections recognise the specific needs of asylum seekers. Information from the forms can be used training and development, as well as help to identify unmet needs.

Hand-held records can also incorporate specific information for asylum seekers themselves, such as:

- how to access health care
- rights to health care
- lifestyle assessment to help identify health promotion needs
- details about where to obtain emergency care
- information about appointments
- information about key workers and how they can be contacted.
The hand-held record can thus:

- improve access to health care
- help to provide continuity of care
- set a standard of care
- help services to avoid duplication
- prevent retraumatization by helping patients avoid repeating their history
- be cost-effective
- raise awareness of issues relevant to the health of asylum seekers
- be used for planning purposes
- highlight training needs of providers
- be used for audit purposes
- highlight good practice.

More information is available at: www.dh.gov.uk/en/Policyandguidance/International/AsylumseekersAndrefugees/DH_4080751

**Multilingual appointment card (UK)**

The on-line Health for asylum seekers and refugees portal (HARP) provides social inclusion research and health information for health professionals and voluntary agencies working with minority communities. The multilingual appointment card allows the health worker to type the details in English and then choose a language to suit the client from the 28 available. The card can then be printed out and given to the client.

More information is available at: http://www.better-health.org.uk/resources and at www.communicate-health.org.uk/card/

**2 Advocacy projects**

Health advocates have been defined as people who ‘mediate between patients and professionals to make sure that clients are offered an informed choice of health care’ (Parsons and Day 1992). They work in a variety of settings and play an important part in helping people who have difficulty accessing health care. Advocates are not interpreters: they act on behalf of their clients and are willing to attend meetings, speak on their behalf and ensure that their needs are met as the clients request. They can be of particular importance to people using mental health services.

For a more detailed discussion on health advocates (and language needs) look at www2.warwick.ac.uk/fac/med/research/csri/ethnicityhealth/aspects_diversity/models/
**Project London – Médecins du Monde (UK)**

This is an advocacy project that aims to provide practical assistance, information and advice to anyone in London who is unable to access health care. Its clinic will provide interim health care while trying to help the patient access mainstream services.

It is staffed by volunteer primary health care workers and support staff. Each works a four-hour shift every two weeks. A typical team includes nine doctors, 12 nurses and 15 support workers. The age of volunteers has ranged from 23 to 76, with an average of 34. The target groups are failed asylum seekers, undocumented migrants, sex workers and the homeless, but anyone will be seen if they need help.

The functions of the specially trained support workers are to:

- inform people about how to access and use mainstream services
- provide information in the service user’s own language if necessary
- help people to register with a general practitioner
- help people to access specialist services, such as dentistry or counselling
- advocate on behalf of service users if they struggle to make phone calls or organize interpreting services
- accompany people to appointments.

The functions of the doctors and nurses are to:

- discuss health concerns with service users
- provide short-term care before they are helped to register with a GP
- treat infections and acute conditions.

The information gathered from the project is used to support advocacy work, and inform those who plan London health services about the specific needs of these vulnerable groups. The report of Project London’s first year of operation highlights interesting findings about the health needs of migrant communities (Médecins du Monde 2007).

For more information see: www.medecinsdumonde.org.uk/projectlondon/default.asp

**Face to Face mentoring project (UK)**

This project was established by the Migrant and Refugees Communities Forum to provide mentoring for forced migrants using mental health services. The mentors are recruited among refugee doctors in the UK who are currently unable to practise medicine. They have an average waiting time of 18 months before receiving a first employment contract, and the project allows them to develop skills, learn about health care provision and above all support other members of their community.
The service aims to provide people from refugee and migrant communities using mental health services with a mentor who can:

- provide emotional support
- help with social and practical needs
- help reduce social isolation
- support access to community and voluntary sector services
- provide language and interpreting support
- help develop the confidence to function in a new community.

For more information go to: Migrant and Refugee Communities Forum (MRCF) www.mrcf.org.uk/

Also see the Face to Face project at www.spn.org.uk/fileadmin/SPN_uploads/Documents/MRCF_Mentoring_Leaflet_A5.pdf

Manor Gardens Advocacy Project (UK)
The Manor Gardens Advocacy Project, established in London in 2004, aims to:

- improve the employability of refugees through providing a robust training and vocational development programme in community interpreting and bilingual health advocacy;

- facilitate access to primary health care for newly arrived asylum-seeking and refugee communities, by providing an interpreting and advocacy service to patients accessing primary care services in the London boroughs of Islington and Camden.

This is done by health advocates trained by the project. It provides experience for, and builds confidence in, newly arrived migrants, many of whom are health workers looking to return to their previous profession. The target groups are migrants from the Horn of Africa, francophone Africa, the Middle East and Eastern Europe.

For more information see: www.manorgardenscentre.org/projects/p_health.html

3 Information and knowledge bases

Pharos National Knowledge Centre (the Netherlands)
The Pharos (‘lighthouse’) centre in Utrecht focuses on developing, studying and conveying practically applicable knowledge in the field of health and health care for refugees. It works to develop knowledge and expertise and thus support health professionals and others to meet the health needs of refugees and
asylum seekers. The staff work closely with members of both refugee and health communities to look at areas of need. They develop projects and test and pilot new methods. The focus is on providing knowledge useful to practice.

The project’s outputs include training sessions, manuals and other educational tools. Its wide network ensures that information and resources are widely shared with partners and contacts.

For more information see: www.pharos.nl/supernavigatie/english or www.pharos.nl/index.html

**Medact Refugee Health Network (UK)**

This is primarily an e-mail network for health workers who work with refugees and asylum seekers to share information, resources and expertise. It was conceived following training sessions held by Medact in 1999–2001, whose evaluations recorded that some of the most important aspects were the ability to meet and share information with fellow health workers from across the UK. The network enabled them to continue this process and allowed many other health workers to join.

The network has 275 members, mostly health professionals working with asylum seekers and refugees. Others include academics and students. It is open to anyone who works with refugees and asylum seekers and has an interest in health issues.

The network has been most successful in:

- creating a sense of community among members
- supporting isolated health workers and those new to this field
- developing links between members
- highlighting areas of concern
- ensuring members have the latest information, research and news
- providing a network through which government bodies can request information or expertise.

For more information see: www.refugeehealthnetwork.org

**Platform for International Cooperation on Undocumented Migrants (PICUM) (Europe)**

The aim of this project is to improve access to health care for undocumented migrants, a specific group of socially excluded migrants. This goal will be reached by developing and promoting a system of reporting on the situation of access to health care for undocumented migrants in 11 EU member states, within the framework of the Social Inclusion and Social Protection Process (PICUM website).
The project aims to:

- conduct research to identify the legal and practical barriers to caring for undocumented migrants;
- develop and promote a method for data collection and a system of reporting on the situation of undocumented migrants in EU member states;
- increase knowledge among local bodies about European policy initiatives to combat poverty and social exclusion at European and national levels;
- build networks and promote local partnerships to address the problems of undocumented migrants;
- make recommendations that help national and European policy-makers to better address problems arising from a lack of or insufficient access to health care for undocumented migrants in the EU.

For more information see www.picum.org/

References


Chapter 4: Ethics and self-care for health workers

Intermediate objectives

By the end of this chapter you will be able to:

- outline some of the key professional and legal obligations of health workers working with migrants;
- describe some of the personal impacts of working with traumatized clients and know some basic self-help skills.
Lesson 4.1: Duty of care, confidentiality and dual loyalty

This lesson will focus on the specific issues related to duty of care that may arise in relation to forced migrants. We will consider the dual loyalties of the health worker when caring for forced migrants, and the lack of guidelines to help them. We will then consider examples where the health professional may have to make complex decisions. A wider and more detailed review of problematic cases can be found in the references at the end. These questions will also be addressed in other professional contexts in Courses 2 and 5.

The duty of care

The relationship between health professionals and those they try to help is always important; the relationship is even more important when the patient is in a particularly vulnerable position (see Figure 1) – as is the case with many asylum seekers and forced migrants. A duty of care is an obligation on one party to take care to prevent harm being suffered by another (Ethox Centre undated) and is particularly relevant in this relationship.

A duty of care exists if the relationship between health professional and patient is a professional one, even if it is not formalized – for example as part of a health care system. Where it exists the duty of care may be legal, is always ethical, and is often both.

Learning objectives

By the end of this lesson you will be able to:

- understand the concept of the professional ‘duty to care’;
- understand how the concept applies to the care of refugees;
- demonstrate an understanding of the responsibilities inherent in situations of ‘dual loyalty’.

Figure 1: Asylum detention centre. Credit: Indy media UK www.indymedia.org.uk/images/2003/11/282121.jpg
Health professionals have stringent obligations to serve the best interests of their patients (known in medical ethics as beneficence). They have obligations to a specified group of people (their patients) as well as a duty of care to the general public because of their professional competence. The term ‘duty of care’ refers to these obligations that are specific to their profession (Sokel 2006).

To summarize, health professionals have an ethical duty of care for patients and the general public within the scope of their competence, well established in professional ethics. This poses the challenge of operating in two distinct and separate spheres, the professional and the personal. Each sphere has separate obligations and duties. Under normal conditions the two spheres will not come into conflict, but guidance is not readily available when this does happen. For example, at what point in a contagious epidemic would the duty of care to the patient be superseded by the duty of care to family members and the individual professional?

### Dual loyalty

Dual loyalty relates to the duty of care. It is unavoidable in some circumstances when the rights of individuals clash with familial and social considerations. It occurs in situations such as that mentioned above, which can raise difficult issues about whom to care for, for example in an epidemic. Decisions about the duty of care can be formalized when the public health benefits are clear: for example, health professionals report the notifiable diseases of individuals to the government and work within agreed prescribing guidelines when treating them.

The particular dual loyalty we will consider here is when a third party puts pressure on a health worker to compromise their obligations to act only in the best interests of their patient, with the potential of violating the human rights of that individual. Health workers in the UK and many other countries also have to be careful not to violate the human rights of individuals incorporated into UK law.

This aspect of dual loyalty is an issue of great concern for health professionals when the state or the military use their influence to try to force them to participate in breaches of professional codes of conduct, international human rights obligations or domestic law. Specifically, those working with forced migrants are likely to find a tension arising between themselves and the state. There is a lack of guidelines for those working in this area (Harding-Pink 2004),

*Take a moment to think what specific issues related to dual loyalty might arise when health professionals are caring for asylum seekers or forced migrants. Write these down and tick them off as you read on.*
Individual professionals may feel particularly vulnerable when:

- working in detention centres, where health care provision may be limited and confidentiality may be difficult or contested;
- being asked to help facilitate forced removal;
- providing medico-legal reports for immigration hearings, in particular in cases where torture may be involved;
- complying with legislation limiting access to health care for certain groups, for instance, those who have had asylum claims rejected.

According to the World Medical Association, ‘physicians cannot be compelled to participate in any punitive or judicial action involving refugees or to administer any non-medically justified diagnostic measure or treatment, such as the use of sedatives, to facilitate easy deportation from the country’ (WMA 1998). However, as Harding-Pink says, it is not always clear when a line has been crossed. Nevertheless it is important that all concerned make themselves aware of their own obligations and the rights of others, and we will try to give some guidance below.

A common source of conflict in Europe today is when the state limits affordable access to health care provision for certain groups, for purposes of political expediency or to deter migration. Article 12 of the International Covenant on Economic, Social and Cultural Rights forbids discrimination in access to health care and underlying determinants of health, as well as to means and entitlements for their procurement, on the grounds of race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth, physical or mental disability, health status (including HIV/AIDS), sexual orientation and civil, political, social or other status, which has the intention or effect of nullifying or impairing the equal enjoyment or exercise of the right to health (UNESC 2000).

Yet there is little practical guidance on how people can implement this. It is often left to professional organizations and migrants’ rights groups to address the issue by campaigning for a change in legislation (see Lesson 4.3 for further information).

We will now turn to offering practical guidance on complex situations in which health workers might find themselves when dealing with forced migrants.

**Detention**

Many of the human rights and ethical codes pertaining to detained migrants are similar to those for prisoners – although forced migrants have normally committed no crime. The detention of people who have been tortured, children, pregnant women and those with particular health needs such as HIV can never be acceptable.
Confidentiality

Many forced migrants decided to flee their country of origin because the state failed to maintain normal social institutions, and law and order had broken down. In these situations the various arms of state, including health services, may work in tandem with security and other services. As a result, many people learned from experience to have little or no trust in official bodies.

When working with these clients it is therefore important to explain immediately the principle of confidentiality, and that information and discussion held in a professional arena will not be shared with others without their consent. However, it must also be explained that information will sometimes need to be shared with others. The client should be informed of this possibility and told when such a situation arises, for example when:

- the client is unable to make their own informed decisions
- the client consents
- the law demands it
- the client poses a risk to themselves and others
- the client is diagnosed with a notifiable disease.

Specific concerns regarding confidentiality may arise in relation to interpreters and advocacy.

- **Interpreters:** Care should be taken when choosing an interpreter for a client. Interpreters and others may understand duties of confidentiality but may not take this obligation as seriously as health professionals and it may need to be explained clearly to them. The client may expect that what is said might be shared in their often close and small community even if this is not actually so, and withhold information. In the case of suspected rape, domestic violence or HIV testing it is best to seek interpreters outside the local community, perhaps even foreign-born speakers of the client’s language.

- **Advocacy:** It may be appropriate to use data collected to advocate on behalf of certain client groups, for example, people in detention or those facing destitution or difficulties accessing health care. Information may be used that is correctly anonymized, but safeguards should be put in place to ensure that no connection can be made between the client and the information.

The professional should remember that refugees, asylum seekers and forced migrants are entitled to the same standard of confidentiality as all other clients.
**Medico-legal reporting**

Health workers may be asked to prepare medico-legal reports in support of a client’s asylum claim. Most doctors and some nurses will be able to do this, but they should be confident of their professional ability to do so before agreeing. It could prove detrimental to the client if errors are made or the competence of the health professional is questioned by the legal system.

The role of the expert witness, as defined by the court, is to give objective and impartial advice based on clinical and professional experience. No matter who requests or finances the report, it is the health professional’s duty to ensure the report is fair, accurate and provides the information requested to allow the courts to make an accurate and fair decision (PHR 2005).


**Hunger strikes**

Here we will look at the special situation of forced migrants on hunger strike.

Hunger strikes are most common when people who have been detained face removal to their country of origin. In such cases they have few options and little access to other means of making their plight public. Refusing to eat may be the one aspect of their life over which they still have some control. Guidance on the medical supervision of people on hunger strike is laid out in the Tokyo and Malta Declarations (for further information, see WMA 1991 and Reyes 1998).

When faced with someone choosing to refuse all nourishment as part of a protest, the immediate duties of the doctor are laid down in article six of the Tokyo Declaration: ‘Where a prisoner refuses nourishment and is considered by the physician as capable of forming an unimpaired and rational judgment concerning the consequences of such a voluntary refusal of nourishment, he or she shall not be fed artificially. The decision as to the capacity of the prisoner to form such a judgment should be confirmed by at least one other independent physician. The consequences of the refusal of nourishment shall be explained by the physician to the prisoner’ (WMA 1975).

In the case of forced migrants, this advice may be complicated by difficulties in communication and cultural understanding and, perhaps most important, by the individual’s past experience of torture. It is made more complex by the stress of migration and the possibility of forced return to the country of origin. In some studies 77% of hunger strikers are clinically depressed at the time of admission to hospital (Kalk et al. 1993),
Starvation itself severely affects the person’s competence and mental state, so directives issued previously in the early stages of the hunger strike will be important to how the hunger strike is allowed to proceed. In the case of forced migrants, it is important that the directives are made and understood by the health care providers, that the implications of these decisions are made clear to the person, and that they and any interpreter have fully understood what has been said.

It is good practice that a doctor with the full confidence of all those involved but acting on behalf of the striker should be invited to act as a witness and oversee the client’s advance directive (Silove et al. 1996). It is not suitable for a physician employed by the immigration or detention services to undertake this role.

There will almost certainly be tensions between the parties involved, clients, immigration officials and health care providers. The duty of the health care provider acting for the client is to follow professional guidelines and advance directive to ensure the correct procedure is followed.

If any doubt exists at any stage an ethics committee should be informed and their advice sought.

**Force-feeding**

It is generally considered unacceptable to feed a person by force if there is agreement that their decision to refuse food has been made rationally and with full awareness of the consequences. Force-feeding can be and is regarded in these circumstances as cruel, inhuman or degrading treatment. As a result, Article 2 of the Tokyo Declaration makes clear that doctors ‘shall not provide any premises, instruments, substances or knowledge to facilitate the practice of torture or other forms of cruel, inhuman or degrading treatment or to diminish the ability of the victim to resist such treatment’ (WMA 1975).

**Conclusion**

Working with forced migrants is complex but little guidance is available to health workers. Ethical dilemmas arise most often relating to the duty to the individual. Forced migrants come in search of protection and are extremely vulnerable. The duty of care applies as much to this group as to all other patients. Individual practitioners need to seek professional guidance from a reliable source such as a professional association.
References


Lesson 4.2: Caring for the carer

Author: Jack Piachaud and Judith Daniels

Those who listen closely to the harrowing experiences of others may themselves need to be cared for. The purpose of this lesson is to examine the concerns and concepts behind this idea. Carers may need to learn specific skills in order to practise in this field, and organizations might have to develop policies and strategies to help them. Those in clinical practice, even young professionals early in their careers, need to know how to manage people who recount dreadful things from their past, who have experienced great social injustice and who may express powerful emotions.

Introduction

Interest is growing in the negative effects that therapy may have on therapists. A phenomenon called secondary traumatization, which can arise while working with traumatized clients, is of special interest. It comprises a set of typical trauma-related symptoms that appear in trauma survivors with post-traumatic stress disorder (PTSD), including hyperarousal (sleep disturbances, edginess and concentration problems), avoidance (avoiding reminders of the trauma as well as intense emotions), and intrusions (overwhelming recollections of the traumatic incident in the form of intrusive memories or nightmares).

The construct of secondary traumatization (also named vicarious traumatization and compassion fatigue) has gained increasing empirical support. Recent studies have investigated symptoms of PTSD in populations as diverse as counsellors, nurses, social workers and trauma therapists working with victims and criminal offenders.

Learning objectives

By the end of this lesson you will be able to:

- discuss the concept of secondary trauma
- outline how health workers can care for themselves
- list protective mechanisms that individuals and organizations can foster.
Box 1: Definitions

Secondary trauma is a psychological state of significant distress that arises from being exposed to personal accounts of distress and injustice experienced by others. Secondary traumatization is characterized by a rapid onset of symptoms that usually decrease slowly over the next few weeks.

Self-care is a set of skills and activities that enable practitioners to contain the emotional experience of hearing about and seeing the results of torture and other forms of gross social injustice, while maintaining positive therapeutic relationships.

Carers and the caring professions

In the context of this lesson, ‘carer’ means a member of a caring profession – one that, like the health professions, concerns itself with the suffering of others. Exposure to the sadness and difficulties experienced by clients and patients can have a significant impact on these workers. This lesson explores how health professionals cope when they care for those who have experienced severe psychological trauma.

What is trauma?

The experiences of refugees and asylum seekers can be very harrowing. They may have witnessed dreadful events, and they may have lost loved ones. They may have been tortured and feared for their own lives. They have all had to flee their homes and embark on uncertain and, for some, treacherous journeys. Their experiences in Europe, where they were hoping to find safety and security, may instead be marked by hostility, poverty and rejection. These events have complex psychological effects for which the term trauma is often used, in a way that echoes the idea of physical trauma. There are important differences between physical and psychological events and there is debate on how such issues should be termed and described. This lesson will use the word ‘trauma’ to denote the psychological impact of destabilizing social events.

A traumatic incident is defined as an event in which both the following factors were present:

- the person experienced, witnessed, or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others; and
- the person’s response involved intense fear, helplessness, or horror. In children, this may be expressed by disorganized or agitated behaviour.
In primary trauma victims, a traumatic incident can lead to the development of PTSD and other mental health impairments like depression and substance abuse. The three key symptoms of PTSD are summarized in Table 1.

<table>
<thead>
<tr>
<th>Symptoms</th>
<th>Description</th>
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<tbody>
<tr>
<td><strong>Re-experiencing</strong></td>
<td>• Intrusive memories of the trauma, often associated with powerful emotions</td>
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<tr>
<td></td>
<td>• Recurrent depressing dreams</td>
</tr>
<tr>
<td></td>
<td>• Feelings that the trauma is reoccurring</td>
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<tr>
<td><strong>Avoidance</strong></td>
<td>• Trying not to think of connected issues</td>
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<tr>
<td></td>
<td>• Avoiding things which might trigger memories</td>
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<tr>
<td></td>
<td>• Emotional numbing and detachment</td>
</tr>
<tr>
<td></td>
<td>• Difficulty recalling events</td>
</tr>
<tr>
<td><strong>Hyper-arousal</strong></td>
<td>• Difficulties sleeping</td>
</tr>
<tr>
<td></td>
<td>• Exaggerated startle</td>
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<tr>
<td></td>
<td>• Irritability and anger</td>
</tr>
<tr>
<td></td>
<td>• Concentration difficulties</td>
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<td></td>
<td>• Sleep disruptions</td>
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**Dissociation**

Although many people experience traumatic events, only a subset subsequently develops PTSD or other impairments. Comparing trauma-exposed individuals with and without PTSD, dissociation during the traumatic incident has been identified as the best predictor of the ensuing psychopathology.

This dissociative state involves detachment from the overwhelming emotional content of the experience during and in the immediate aftermath of trauma. Dissociation involves disruptions in memory, body awareness, and perception of the self and the environment. It typically consists of specific changes in the perception of the self and the surroundings, like feeling unreal or as though you are in a film, feeling emotionally numb, losing a sense of time, and not feeling pain.

Dissociation is widely viewed as a survival mechanism triggered in life-threatening situations. But it carries a big risk: dissociation leads to alterations in memory encoding and storage, which in turn cause intrusive memories. This involuntary memory retrieval tends to be repetitive, uncontrollable, and highly distressing.
Working with traumatized people

Human beings are social and emotional creatures who respond to the emotions and feelings of others. If people around us laugh and feel happy or if they are sad and subdued, then we experience these feelings. A good film or play will evoke feelings in us. We can empathize when a friend or relative suffers: the loss of someone important is something most of us will experience. The closer we are to the experience, the more we feel it. Health professionals are no different from other people and are open to the full range of human emotions.

Working with asylum seekers and refugees means that we must listen to their disturbing stories, read medical reports with graphic details, become familiar with the injustice they have experienced, and observe their emotions. The impact on us will depend on our role and relationship to them. We all have an important capacity to switch off and ignore the plight of others temporarily. This may be an important resource for our job as carers, but sometimes we will not be able to keep up this emotional distance.

The impact on us can be triggered by the view of tell-tale injuries, short descriptions in legal documents, or emotions expressed by the traumatized client. If we are supporting the person in a way that consumes more time (helping them find housing, for example, or negotiate the welfare system), or if the health issue is complicated, it is important to hear their story and to understand something of their experiences. We may not need to explore the actual trauma too deeply. If the person begins to reveal more than we feel comfortable with, we may protect ourselves from overexposure by ‘calling time’, and explaining to them that the practical things are more important to deal with at the moment.

When preparing a report to support an application for asylum or more state-provided benefits, we may have to explore and record in detail the account of what happened, the trauma and the loss, and examine them for mental symptoms such as depression, sleeplessness and nightmares, and physical symptoms such as scars.
Here it is not possible to avoid the extent of what has happened to that person, but it may be possible to avoid feeling responsible for them. The task of report writing can be made into a technical activity, a purely descriptive process.

In all these settings, however, it is very common for the caring professional to be concerned for the general wellbeing of the person and to respond to their story – the injustice and the distress – even though that may not be the primary purpose of the contact. For some, there may be a difficulty in managing boundaries when presented with such distress. The wish to help with problems beyond the initial purpose of contact sometimes becomes too great; it is easy to get sucked into the distress of others.

If the purpose of the contact is to help with the emotional wellbeing of the asylum seeker or refugee, there is a need to delve more deeply into their experiences. Whatever model of psychological intervention is used, there is a need to understand and define what is causing the distress. In this context, capacity for empathy and compassion are critical therapeutic elements and are part of the makeup of most caring professionals in this field. Thus, empathy is what makes us most effective, but at the same time it makes us vulnerable to secondary traumatization.

**Empathy and compassion**

Empathy is the ability to put yourself in others’ shoes and experience their suffering. The empathetic approach needed in the therapeutic context is different from what is needed in physical health care, where the boundaries are clearer and empathy is focused on the symptoms and the disease rather than the personal experience of suffering. Compassion is the step beyond empathy – the desire to alleviate suffering. Compassion can therefore leave us with tasks that are great burdens, maybe even impossible ones, as some suffering is beyond our capacity to change.

When the empathic connection is working, it would seem that some degree of secondary trauma is inevitable. Everyone working in this field probably has experience of secondary trauma, but it is usually mild, passing quickly as the psychological defences reorganize. Whether the experience becomes a ‘disorder’ is related to how people care for themselves and how organizations support their staff.

**Counter transference**

There are times when empathy fails and it is too difficult to put ourselves in others’ shoes. Sometimes we disbelieve the stories of asylum seekers and refugees because we find their experiences too painful, or we do not wish to believe that other people could behave so badly.
Counter transference refers to the emotions evoked in the therapist by the patient. It is considered a psychological defence mechanism. At times, it can mean that we feel angry with the victim for having exposed us to such gruesome stories – the classic reaction of punishing the bearer of bad news. When even these defences are overwhelmed, we may involuntarily and automatically retreat to the last escape, which is dissociation.

**Dissociation in the helper**

In this case, we retreat to a similar protective state to that described earlier as dissociation in primary traumatized persons. This is not a conscious decision, but an automatic process. We might find it difficult to experience our emotions consciously, or feel numb and somewhat unreal. The external surroundings might feel like scene from a film. This state is protective in the moment of the exposure to graphic details, but it might carry a similar risk for us as it does for primary trauma victims. Although we might not consciously experience emotions in this state, our brain will still encode what we hear, see, and would feel. These memories might later distress us in the form of recurring, intrusive memories.

Dissociation presents an important risk factor for the development of secondary traumatization in carers. It might be helpful to keep the following questions in mind.

While I listen to my client:

- does my perception of time change, so that I experience situations as longer or shorter?
- do I lose contact with my emotions?
- do I stop making active decisions, do I feel like being on auto-pilot?
- do I experience emotions and memories from my past?
- do I feel emotionally numb?
- does the situation feel unreal or like in a film?

**Secondary traumatic stress and related conditions**

Secondary traumatic stress exists when the carer experiences similar symptoms to their patient.

This re-experiencing may be triggered by words, sounds or locations. The carer may have dreams that involve the patient. We might relive the patient’s story, but this time imagine that our own family is involved. We may avoid triggers at work that bring back these feelings, have difficulties recalling issues and make errors of judgement. We may feel numb and detached and have difficulties sleeping and concentrating. We may be irritable.
The condition can be quite debilitating. If unrecognized and untreated it can progress to more severe depressive states marked by feelings of despair, hopelessness, guilt and suicidal ideas. Therefore it is imperative to assess our own symptom levels from time to time – preferably with the help of a structured instrument like the questionnaire in Box 2. You are welcome to pass on this questionnaire as long as you mention the source:


Please think about this phase of distress. Please state how you experienced the last week by specifying for every one of the following reactions how often you experienced it:

Table 1: Questionnaire for secondary traumatization (FST)©

Never | Rarely | Sometimes | Often | Very often
---|---|---|---|---
1 | I thought about what happened to the client a lot. | | | | |
2 | I found myself thinking about what happened to the client when trying to concentrate on something else. | | | | |
3 | I had intrusive images or sensations that are connected to what I was told | | | | |
4 | I felt as if I was reliving my clients’ experience | | | | |
5 | I was afraid something bad could happen to me. | | | | |
6 | I had disturbing dreams that were connected to what I was told | | | | |
7 | I witnessed in my dream what happened to my client. | | | | |
8 | I dreamt what happened to my client as if it were happening to me. | | | | |
9 | When I was reminded of my clients’ experience I felt distressed. | | | | |
10 | When I was reminded of my clients’ experience I reacted with physiological arousal and stress. | | | | |
11 | I tried not to think about my clients’ experience. | | | | |
12 | I avoided objects, places or activities that reminded me of my clients’ experience. | | | | |
<table>
<thead>
<tr>
<th>Question</th>
<th>Response Options</th>
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<tbody>
<tr>
<td>I felt alienated from other people.</td>
<td></td>
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<tr>
<td>I withdrew from other people or was less active than normally.</td>
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<tr>
<td>My emotions were less intense than normally.</td>
<td></td>
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<tr>
<td>I was less interested in activities that I normally enjoy a lot.</td>
<td></td>
</tr>
<tr>
<td>I focused more on my personal safety.</td>
<td></td>
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<tr>
<td>I took additional precautions for my personal safety.</td>
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<tr>
<td>I felt threatened or followed.</td>
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<tr>
<td>I had trouble falling asleep or woke up more often than usually.</td>
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<tr>
<td>I was jumpy.</td>
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</tr>
<tr>
<td>I had trouble concentrating.</td>
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<tr>
<td>I was on edge.</td>
<td></td>
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<tr>
<td>We had conflicts and arguments in my team.</td>
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<tr>
<td>I was less interested in sex or enjoyed it less.</td>
<td></td>
</tr>
<tr>
<td>Due to my job stress I drank more alcohol or took more drugs.</td>
<td></td>
</tr>
<tr>
<td>I was afflicted by thoughts or visual imaginations of assaults against me or people I love.</td>
<td></td>
</tr>
<tr>
<td>My health was impaired, i.e. by headaches, nausea, infections.</td>
<td></td>
</tr>
<tr>
<td>I recalled or dreamt of my own traumahistory more often than normally.</td>
<td></td>
</tr>
<tr>
<td>I experienced myself as being depressed.</td>
<td></td>
</tr>
<tr>
<td>I thought about suicide.</td>
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</tbody>
</table>

### How long have you already been showing these reactions?

- I don’t show any of the aforementioned reactions.
- I have been showing these reactions for less than four weeks.
- I have been showing these reactions for between four and twelve weeks.
- I have been showing these reactions for between three and six months.
- I have been showing these reactions for more than six months.
**Scoring instructions for the FST®**

Please score as follows:

**NEVER = 1, RARELY = 2, SOMETIMES = 3, OFTEN = 4, VERY OFTEN = 5**

Sum up scores of all 31 items

**0–64 points ➔ not secondarily traumatised**

Please keep monitoring your stress level and allow yourself to get support when you feel you need it.

**65–82 points ➔ moderately secondarily traumatised**

If you have been showing these reactions for only a short time, please keep monitoring your stress level and fill out this questionnaire again in two weeks. Allow yourself to get support when you feel you need it.

If you have been showing these reactions for more than 12 weeks, please seek professional support now.

If you have been thinking about suicide “often” or “very often”, please seek professional support immediately.

**> 64 points ➔ seriously secondarily traumatised**

The amount of reactions you are showing makes it likely that these reactions might become chronic. Please seek professional help immediately.

**Protective mechanisms**

All of us in the caring professions have chosen to work on behalf of others, but there are many different ways to do it. For some, dealing with life and death as in surgical or emergency departments is too difficult; for others it is opening up to emotional distress that is too stressful. Selection of the right staff and proper training are the first protective steps organizations can take to help the health care team.
When assessing someone’s suitability to work with those who have experienced trauma, it will be necessary to probe the protective mechanisms (psychological defences) they have in place. For example:

- how has a person managed personal loss and trauma? (those who have not worked through their own trauma may be more at risk);
- what is their concept of hardiness? (flexibility is better than ‘hard but brittle’);
- do they have a good sense of emotional control?
- do they possess the ability to cope with change?
- do they have a commitment to the issues?
- do they possess a willingness to seek help for themselves?
- do they have realistic expectations?

The organization must also possess some important attributes:

- it must be aware of risk;
- it should be able to identify those who are becoming stressed;
- it should establish supervision mechanisms such as regular meetings that allow for exploration of feelings;
- it should implement repeated screening for secondary trauma (for example using the questionnaire in Box 2);
- it should have support systems that are not stigmatizing;
- it should facilitate proper management of workload;
- it should promote a good working environment.

**Self-care**

People can help themselves by identifying their own susceptibility to stress. A set of basic guidelines for self-care might be as follows:

- don’t take on too much
- keep taking breaks and getting enough rest
- be realistic
- don’t blame yourself for others’ problems
- stay connected to people you feel close to
- seek supervision, especially when you feel distressed
- seek mutually supportive friends
- seek training
- keep a sense of humour.
**In the work setting:**
- apply techniques that alleviate distress (like structured record-keeping, imaging details in abstract forms, planning sessions according to your needs);
- foster a culture of inter-vision and mutual support with your co-workers;
- be accepting of different coping styles in your team;
- try actively to leave work things at work.

**Outside work, people can:**
- exercise and maintain a good diet
- seek out spiritual and meditative activities
- keep up with friends and have other interests
- read something new.

**When you notice that you are distressed:**
- if possible, limit your exposure to similar trauma descriptions
- seek support
- share your emotions and experiences
- exercise regularly
- actively engage in positive imagined images such as a secure and happy place
- consciously seek out situations you used to enjoy (even if you feel blue)
- confront your own personal history and possible traumatic events.

**Reference**
Lesson 4.3: Health workers as advocates

Introduction

The role of the health professional as an advocate or campaigner is contentious. Some believe the role of campaigner or advocate should be left to others with more specific skills who work in the world of campaigning. If, however, we accept the influence of economic and social factors on individual health it seems logical that, if at all possible, health workers should try to influence these factors to benefit health. This lesson will look at some of the possible ways that health professionals can advocate on behalf of forced migrant populations and individuals.

Advocacy entails pleading in support, supporting or speaking in favour of (someone, a cause or policy), The International Committee of the Red Cross (Figure 1) uses this definition, and it will be used in this lesson because it best defines what we will discuss. While some draw distinctions between ‘campaigning’ and ‘advocacy’, here we often use them interchangeably.

Horton suggests a further definition for doctors (Horton 2002). He argues that ‘advocacy only means taking the problems that one faces day to day and pursuing their resolution outside the usual place of presentation’.

Learning objectives

By the end of this lesson you will be able to:

• make a case for why health workers should act as advocates
• list examples of different types of advocacy activities they can undertake
• describe the dilemmas involved in different types of advocacy activities.

Figure 1: Sudan, North Darfur, Abata, 60km from Zalingei. Explaining the ICRC’s role. ©ICRC/V. Miranda/SD-E-00396
This can simply mean speaking on behalf of clients, writing letters that can help promote their access to better housing, or occasionally writing to a newspaper about the closure of a local hospital. Each in its own way advocates for health, even though the person involved may not choose to see it as such.

Health professionals working with forced migrants need to be advocates at all levels, in daily client contact and at national and even global level to ensure that these people for whom they are responsible receive basic health care.

Doctors and nurses are still held in high esteem in Europe and considered to be both honest and ethical, despite many changes in the way society views them. So when they choose to speak out people are usually willing to listen, including politicians. They may speak out as individuals, as a part of a professional body or trade union, or as a member of a campaigning organization.

**Attempt to focus world attention**

Speaking out on the situation in the Democratic Republic of Congo (DRC) is an example of humanitarian agencies’ efforts to focus world attention on an issue they believe is neglected by the international community. This has taken many forms: for example, Oxfam published a report to focus attention on the forgotten conflict (Oxfam 2001). It continues to complain that the crisis remains forgotten and frequently calls on wealthy countries to provide financial support.

A ground-breaking report by the International Rescue Committee brought to the world’s attention the scale of the catastrophe in DRC (Coghlan et al. 2006). Other NGOs campaigned with varying success against the use of child soldiers, and for a ban on the mineral exports which help to finance the conflict.

A British journalist once said that news is something new happening now. People dying in Africa is happening now but it is not new. This may seem harsh but it is the reality of what is deemed to be ‘news’; and if issues are not in the news they often fail to obtain political support to facilitate international intervention. DRC remains a forgotten crisis despite a death total of more than 3.9 million (Coghlan et al. 2006). In February 2007 the UN and humanitarian agencies launched an appeal to governments for US$ 687 million (€481 million) of badly needed funding; but three months later it had received just 13% of the requested funds (Relief Web 2007). Advocacy becomes very important in such situations.
Public advocacy – speaking out

Médecins sans Frontières (MSF) is an example of an agency that undertakes advocacy activities at the global level. It describes one of its key functions as ‘seeking to raise awareness of crisis situations; MSF acts as a witness and speaks out, either in private or in public about the plight of populations in danger for whom MSF works. In doing so, MSF sets out to alleviate human suffering, to protect life and health and to restore and ensure respect for the human beings and their fundamental human rights’ (MSF 2005).

By standing apart from any government, MSF ensures that its advocacy cannot be seen as political or used by governments for their own ends.

Speaking out has costs. MSF found in Zaire that it had to leave the people it had been working for in the refugee camps when it discovered that those same camps were harbouring perpetrators of the Rwandan genocide. Governments may also ask organizations to leave if they take offence at what they say. Agencies may then leave behind vulnerable groups who had previously depended on them for food and security. In addition, most humanitarian organizations work not only with expatriates but also with local staff, who may be placed at risk if the organization withdraws or offends the host government.

In short, a careful evaluation of risk will need to be made but sometimes the need to speak out will still be compelling. You can read a good discussion of some of these difficult issues (Spencer 1997).

Silent advocacy

The International Committee of the Red Cross (ICRC) often undertakes a very different form of advocacy that the organisation itself describes as ‘silent advocacy’. In these cases the ICRC approaches governments or political groups directly by meeting or writing to them. Concerns are expressed and resolution is sought, but the detail of meetings – or even that meetings have taken place – is not disclosed. This allows the ICRC to maintain its doctrine of neutrality, and helps to ensure it continues to have access to otherwise restricted groups such as political prisoners and hostages.

This level of advocacy has many benefits – not least, it ensures that there is no public embarrassment or humiliation for parties involved in conflict, allowing them to make concessions on issues without it being seen as a sign of weakness.

The ICRC operates what it describes as a policy of ‘realistic idealism’. An example of this is that while the ICRC believes war to be fundamentally wrong, it has nevertheless accepted its existence, and formulated the Geneva Conventions that aim to reduce the impacts of armed conflict on both combatants and civilians.
The problem with this method is much the same as its benefits, however – that it is unseen. As a result ICRC may sometimes appear unresponsive if it fails to make a public condemnation of obvious human rights abuses. The lack of visibility also makes it difficult to claim the success that could be important for gaining political and financial support for future activities. Silent advocacy means that there is little public scrutiny of ICRC decisions: it is not clear who decided which compromises should be made or what can be deemed an acceptable solution in a particular context. The secrecy may also allow those involved to retain public credibility as no blame can be apportioned. The ICRC position has been much debated within and outside the organisation (ICRC 1997).

**National campaigns by health workers**

The most obvious way we as health professionals take part in advocacy at national level is through professional organizations, trade unions and campaigning groups. The aim is to influence policy and legislation through organized campaigning that makes use of professional expertise and status. The need for this form of representation, and the importance of the involvement of health professionals, is clearly shown below. Financial and moral support is invaluable, even from those unable to become actively involved. An organization representing 5000 people has much more credibility when speaking on behalf of its members than one representing 400.

There are many examples of this form of advocacy: we offer a few examples here. Take a moment to think of more examples in your own country.

**Physicians for Human Rights**
http://physiciansforhumanrights.org/asylum/

PHR (USA) has been advocating on behalf of refugees and asylum seekers for some years. Part of this work has been speaking out on government policy that negatively affects the health of refugees and asylum seekers. Representation is made at an organizational level or by encouraging members to write directly to decision-makers about their concerns. It has campaigned against detaining asylum seekers in prison and determining their age by using X-rays.
British Medical Association  

The BMA report on meeting the health care needs of asylum seekers is an example of its advocacy work (BMA 2002). The report showed that the health of those seeking asylum in the UK deteriorated in the first year after arrival. Its impact was threefold:

• it started a debate on why this was happening and how matters might be improved;
• it raised awareness among doctors who had previously been unaware of the difficulties faced by asylum seekers;
• it provided authoritative evidence for other advocacy groups to use in their work.

The Medical Foundation for the Care of Victims of Torture  
http://www.torturecare.org.uk/

Since it was founded in 1985, the Foundation has received 50,000 requests for help; 95% of its clients are refugees and asylum seekers. It provides expert medico-legal reports for torture victims that can be used to support asylum claims and other legal processes related to torture. It also offers psychological support, counselling, mentoring and other assistance. Much of the medical support is provided by volunteers. The client base allows it to speak out on torture and related issues and exert influence as a respected organization with a great deal of experience.

The Rehabilitation and Research Centre for Torture Victims  
www.rct.dk

The Rehabilitation and Research Centre for Torture Victims in Copenhagen, Denmark, is an independent organization that aims to:

• expose and document torture on a health professional basis;
• develop clinical diagnoses and treatment methods for torture survivors using systematic clinical examination, and carry out research into torture and organized violence;
• use its experience in education and advocacy to contribute to the global effort to abolish torture.

It runs a centre that treats and rehabilitates torture victims, undertakes clinical research and develops best practice. It carries out education and advocacy to raise awareness of the causes of torture, related conventions and laws, and methods of treatment and prevention, and works in partnership with southern organizations with the same aims.
Individual advocacy

Advocacy is perhaps most rewarding at an individual level. Forced migrants often lack the confidence to speak out or have an understandable reluctance to confront authority, especially as language issues may put them at a disadvantage when talking to professionals.

Forced migrants may, for instance, present to the primary care provider with an illness but actually need a letter that supports a request for housing. Your initial response may be that the person is wasting important professional time, but they would have dealt with the issue directly if they could; in their present circumstances they are obliged to use any of the resources available to them to improve their situation.

If it is possible and appropriate to do so, the health worker should consider helping them deal with social issues and meet basic needs. This can be as important for maintaining health as the provision of clinical care.

Given that forced migrants face hostility and disbelief, have limited access to health care and face imprisonment in detention centres even if they have committed no crime, taking some form of action on their behalf of this vulnerable group is compelling. Actions you might consider include:

- writing a letter to a newspaper or journal
- meeting politicians to express concern
- working with a community group to help advocate for vulnerable people.

It is important to act always according to the ethical code of your profession. Advocacy is not separate from your other professional activities although it may take place outside your normal workplace.

Know your facts – information must be evidence-based and not emotive. While discussion of ethics and human rights can be important, do not allow your own feelings to dominate. You should not speak for others or use information obtained professionally without obtaining the client’s prior and informed consent in writing. Take care even then to make sure that none of the information you use can identify a client unless they wish to be identified. Remember that someone may give their consent simply because they feel obliged to you or grateful for your help. You need to ensure they are really confident about the implications of their decision.

Finally, whilst advocacy can sometimes seem an overwhelming task, it is worth reflecting on the African proverb: ‘If you think you are too small to make a difference, try sleeping in a room with a mosquito’.
References


Glossary Course 6

**Armed conflict:**
Similar to violent conflict, but denoting conflicts where parties on both sides resort to the use of physical violence and weapons.

**Civil society:**
The United Nations defines civil society as “associations of citizens (outside their families, friends and businesses) entered into voluntarily to advance their interests, ideas and ideologies. The term does not include profit-making activity (the private sector) or governing (the public sector).”
Civil society might therefore include labour unions, faith-based groups, business and professional associations, academic and research institutions, human rights networks, consumer rights coalitions, social movements, social and sports clubs, philanthropic foundations, and other forms of ‘associational life’.

**Codes of conduct:**
The moral principles that are implicit or explicit in (inter-) national codes and which reflect good clinical practice.

**Communicable disease:**
A communicable disease is an infectious disease which is transmittable between humans or species through a variety of pathways. Examples include cholera or tuberculosis.

**Conflict:**
Perception of incompatible goals in a goal-seeking system. Conflict is not necessarily violent. In fact, parties who have incompatible goals may deal with them in productive and non-violent ways.

**Convention relating to the Status of Refugees:**
The UN Convention on refugees was adopted by the UN General Assembly in 1950 and entered into force in 1954. It sets out the protection afforded to refugees under international human rights law.

**Democracy:**
Form of government characterised by elections, majority rule, representation in parliamentary bodies, the rule of law.

**Development:**
Alan Thomas says that the term development is commonly used in three ways: as a vision of how we would like the world to be; to describe a process of historical change; and to mean the actual interventions of governments, international agencies and others make to bring development about.
Ethnicity:
The Office of National Statistics in the UK describes ethnicity as “a multi-faceted concept covering many different aspects of identity, including racial group, skin colour, country of birth and parental country of birth, language spoken at home, religion and nationality”. However a person’s ethnicity can be often defined (by themselves and others) differently, and (subjective and objective) definitions change over time. It is a complex concept that is difficult to measure.

Forced migration:
According to the International Association for the Study of Forced Migration the term forced migration ‘refers to the movements of refugees and internally displaced people (those displaced by conflicts) as well as people displaced by natural or environmental disasters, chemical or nuclear disasters, famine, or development projects’.

Gender:
Gender refers to the socially constructed roles, behaviours, activities, and attributes that a given society considers appropriate for men and women (World Health Organisation).

Gender-based violence:
Gender-based violence is violence involving men and women, in which the female is usually the victim; and which is derived from unequal power relationships between men and women. (UNFPA).

Geneva Conventions:
The Geneva Conventions were established by governments under the auspices of the International Committee of the Red Cross to regulate the conduct of war. The first Convention (1864) focused on the rights of the armed sick and wounded as well as medical personnel. The second (1906) included those fighting at sea. The third (1929) set up rules for the treatment of prisoners of war and the fourth (1949) protected civilian populations. Two additional protocols were formulated in 1977 to protect victims of international and non-international conflicts.

Health:
The World Health Organisation defines health as “a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity”.

Health system:
The World Health Organisation defines a health system as “all the activities whose primary purpose is to promote, restore or maintain health”. The functions of a health system has been defined in a more detailed way by Maureen Mackintosh and Meri Koivusalo. At the core are health services, but these are complemented by public health functions (surveillance, prevention, cross-sectoral action and emergency preparedness); systems for training the people needed to staff the system (medical and nursing schools etc); and policy, ethical and regulatory decision-making bodies which direct the health systems and the people in them.

Humanitarian aid:
Aid which is concerned with or seeking to promote human welfare.
**Humanitarian emergency:**
A humanitarian emergency is said to exist if the crude mortality rate (CMR) exceeds one death per 10,000 people per day; and the daily under-5 mortality rate (U5MR) exceeds twice the CMR.

**Impartial:**
In the context of humanitarian aid, this refers to assistance that is ‘guided solely’ by the needs of individuals.

**Independence:**
In the context of humanitarian aid this has been defined by Joanna Macrae as the ‘endeavour not to act as instruments of government foreign policy’.

**International Committee of the Red Cross:**
An organisation set up in 1863 by five Swiss citizens from Geneva: Henry Dunant was the leading figure. It strives to regulate the conduct of war firstly, by taking care of the sick and wounded and secondly, by establishing rules for the conduct of violent conflict.

**International Human Rights Law:**
International Human Rights Law lays down obligations which states are bound to respect. The Universal Declaration of Human Rights, the International Covenant on Civil and Political Rights and the International Covenant on Economic, Social and Cultural Rights (plus their optional protocols) form the so-called International Bill of Human Rights. These core instruments are supplemented by a battery of other treaties adopted to guarantee human rights (such as the Covenant on the Elimination of all forms of Discrimination Against Women).

**International Humanitarian Law:**
See the Geneva Conventions

**Landmine:**
Landmines are conventional weapons used in wars to stop military opponents from encroaching into territory. There are between 600 and 700 different types of landmines that are produced in 60 countries. Examples include blast mines and fragmentation mines.

In terms of their effects two types of landmines can be distinguished. Anti-personnel mines are directed against persons and are activated by contact, proximity or presence of a victim. Anti-vehicle-mines, on the other hand, are directed against any kind of vehicle.

**Life expectancy:**
Life expectancy is a measure of length of survival. Often expressed as an average of populations or population sub-groups, it can be calculated at birth or at any age up from birth (for example, life expectancy at age 30) to show average length of life remaining.

**Migrant:**
A migrant is ‘any person who lives temporarily or permanently in a country where he or she was not born, and has acquired some significant social ties to this country’ (UNESCO).
**Morbidity:**
Morbidity means illness or disease. Measures of morbidity such as the prevalence of chronic diseases can be used, among other measures, to help understand the health of a population.

**Mortality:**
Mortality means death. Measures of rates of mortality such as life expectancy and infant mortality can be used, among other measures, to help understand the health of a population.

**Nuclear weapons:**
A weapon whose explosive power results from a nuclear reaction. This reaction results in the release of an immense amount of energy in the form of an explosion, many times greater than that of conventional explosives.

**Peace:**
Not merely the absence of violence, but a state of mutual beneficial relationships, fair structures, and a culture of peace. Peace is also a capacity to handle conflicts with empathy, creativity and by non-violent means (J. Galtung).

**Poverty:**
Poverty has many dimensions. It can include lack of income and material goods, as well as lack of the things that we all have reason to value, such as the ability to lead a healthy life, be educated, to have political or spiritual liberty. The World Bank has set an international poverty line at about US$1 per day. The 1.2 billion people who live below this line are said to be in a state of “absolute poverty”, in other words “a condition of life so characterised by malnutrition, illiteracy and disease as to be beneath any reasonable definition of human decency” (World Bank). But poverty is also a relative concept: all societies – at different levels of economic and social development – have different standards for what constitutes living in poverty.

**Protection:**
In the context of humanitarian aid this refers to the protection efforts of humanitarian agencies in conflict areas (but not including physical armed protection).

For humanitarian agencies, protection refers to ‘all activities aimed at obtaining full respect for the rights of the individual in accordance with the letter and the spirit of the relevant bodies of law (i.e. human rights law, international humanitarian law and refugee law)’ (Inter-agency Standing Committee 1999).

**Psychosocial:**
A programme or way of thinking that puts the psychological development of individuals in the context of their social environment.

**Reconciliation:**
Repair of broken relationships and the restoration of peaceful relationships.
Refugee:
A person who, owing to well founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion, is outside the country of his nationality and is unable or, owing to such fear, is unwilling to avail himself of the protection of that country.

Right to health:
The right to health or – more precisely – the right to the highest attainable standard of physical and mental health is established in Article 12 of the International Covenant on Economic, Social and Cultural Rights. Measures states should take to fulfill the right are laid down in Article 12 and have been further elaborated in General Comments by the treaty’s monitoring committee. The right to health is subject to the principle of progressive realisation outlined in the Covenant.

Second world war:
Armed conflict beginning in September 1939 with the invasion of Poland by Nazi Germany (although Japan had invaded China in 1937). It became a ‘world war’ in a truer sense in 1941 after the bombardment of Pearl Harbour by the Japanese and the consequent declaration of war by the US on Japan and Germany. Although in terms of the percentage of soldiers killed it was a less bloody war than the first world war, the total sum of the dead – approximately 40 million – was devastating. For the first time in history in a major war the civilian dead outnumbered those within the fighting forces. The war is also infamous for Nazi Germany’s medical experiments on human beings, and its sterilisation and so-called ‘euthanasia’ programmes.

Sex:
Sex refers to the biological and physiological characteristics that define men and women. (World Health Organisation).

United Nations General Assembly:
From the UN website: established in 1945 under the Charter of the United Nations, the General Assembly occupies a central position as the chief deliberative, policy-making and representative organ of the United Nations. Comprising all 192 Members of the United Nations, it provides a forum for multilateral discussion of the full spectrum of international issues covered by the Charter. It also plays a significant role in the process of standard-setting and the codification of international law. The Assembly meets in regular session intensively from September to December each year, and thereafter as required.

United Nations High Commissioner for Refugees (UNHCR):
The UNHCR is mandated by UN member states to lead and co-ordinate international action to protect refugees worldwide.

Violence:
Unnecessary insult of basic human needs (J. Galtung).
Violent conflict:
The use of physical and psychological force or power to ‘solve’ a conflict.

War:
Extreme form of violence. Used as a means to solve conflicts between nation states, or between groups within a nation state (civil war).

World Bank:
From the World Bank website: “The World Bank is a vital source of financial and technical assistance to developing countries around the world. [...] We are not a bank in the common sense; we are made up of two unique development institutions owned by 187 member countries: the International Bank for Reconstruction and Development (IBRD) and the International Development Association (IDA). [...] The IBRD aims to reduce poverty in middle-income and creditworthy poorer countries, while IDA focuses on the world’s poorest countries. [...] Together, we provide low-interest loans, interest-free credit and grants to developing countries for a wide array of purposes that include investments in education, health, public administration, infrastructure, financial and private sector development, agriculture and environmental and natural resource management.”