Chapter 3

Health on the move: the impact of forced displacement on health

Good health depends on resources in the environment, control of disease threats and coordination of preventive and curative provision. Forced displacement represents a challenge to each of these elements that can last for years.

After sudden-onset disasters, immediate health-issues typically concern food, water, sanitation and shelter. The March 2011 Japanese tsunami, the floods and landslides in the Philippines following Tropical Storm Washi in December 2011, and tornadoes in the US state of Kentucky in March 2012 all resulted in acute health challenges.

Problematic as these disruptions are, they are most threatening when combined with a population's prevailing vulnerabilities. For example, the acute challenges presented by the Haiti earthquake, including a high number of crush injuries, were exacerbated by the chronic weakness of the health system. The crisis in Somalia reflects the interaction of acute health challenges related to shortages of food and water and chronic undernutrition, weak governance and political violence.

This combination of acute and chronic threats to health can lead to extraordinarily high mortality rates in refugee and displaced populations. By convention, a health emergency is defined by a mortality rate of more than three deaths per 1,000 of population per month – a rate exceeded in the 1990s among displaced populations in, for example, Angola, Bhutan, Bosnia, Burundi, Iraq, Mozambique, Rwanda, Somalia and Sudan.

For many forced migrants, displacement often leads to a life in organized refugee or internally displaced persons (IDP) camps. These facilitate monitoring of mortality and morbidity, surveillance, and rapid response to outbreaks of communicable disease. Such measures lead to as much as a 75 per cent decrease in deaths in six months.

However, camp conditions also present significant public health concerns. Crowded conditions enable rapid transmission of diseases such as cholera and hepatitis E, linked to limited access to water and sanitation.

Conflict and disaster in general contribute to an erosion of structures regarding sexual behaviour, and unsafe and transactional sex in such environments present health threats. Camp conditions further disrupt cultural norms, social conventions and community governance.

Management of risk for HIV and AIDS and other sexually transmitted diseases is a focus of concern in camps. But sexual and gender-based violence (GBV) also emerges, notably in terms of exposure to rape or other sexual abuse by armed groups.

Evidence of high levels of GBV is growing within camps. A study in IDP camps in northern Uganda found women facing up to ten times the risk of violent assault by their husband than by a stranger. The reason for this is unclear, but the loss of traditional male roles and authority has been frequently noted.

In camps or integrated settlements for IDPs or refugees, the health consequences of displacement are due less to the specific risks associated with migration than to the weaknesses of health systems. Other than in the immediate aftermath of a major disaster when there are specific health threats, most displaced populations face the same health problems as non-displaced populations, only in greater numbers. Even with conflict, mortality reflects inflated risk of existing patterns of disease more than deaths due to military action.

With forced migration, public health systems are chronically weak, and are weakened further by disruptions to logistics and drug supplies and loss of staff. Forced migrants are especially vulnerable to these disruptions and those affecting public health infrastructure and coordination. Maternal and reproductive health services are particularly vulnerable to disruption.

Continuity is another major challenge presented by the disruption of access to health systems for forced migrants. In the case of tuberculosis, for example, displacement can result in failure to complete the six months of DOTS or 'directly-observed treatment short-course'. Similar challenges face IDPs who are receiving anti-retroviral therapy for HIV infection.

Another area where continuity of care among displaced populations is crucial is in relation to people with severe and enduring mental health problems.

These issues are of major significance after acute emergencies and major population displacement. But they continue to affect displaced populations in more protracted situations, including countries of asylum or resettlement. Here the concern is less disease risk or weakness in health systems, but more access to the health system as a result of legal, economic or cultural barriers.

These issues play out differently in the context of protracted displacement and permanent resettlement.

In the former case, for Iraqis in Jordan the UN refugee agency (UNHCR) is responsible for ensuring refugees' access to health facilities through specialist clinics or supporting host government provision. Access is often severely restricted, however, with a minority of refugees receiving such support. In such contexts the work of the IFRC and National Societies may be crucial. In Jordan, the IFRC and the Jordanian Red Crescent have facilitated access to health care for unregistered refugees with a cash-transfer scheme engaging local health service providers.

By contrast, in countries of resettlement, barriers to health care for refugees may be more subtle. In the US, only refugees whose resettlement stems from a successful claim in a country of temporary settlement can register with a health-care provider within 60 days of arrival. Despite eligibility for Medicaid, refugees underutilize health provision, with major barriers to accessing health care often related to language and communication.

Health care in disasters and complex emergencies has advanced significantly in recent years. Surveillance and epidemiology have played a key role, documenting the risk of disease to displaced populations, the factors associated with this, and effective means of control. Measles, once a major threat to refugees, is well controlled now that children aged over six months are routinely immunized on arrival in a camp. The management of health for displaced populations is codified in the *Sphere Handbook.*

Professionalization requires not just evaluation and codification of effective interventions, but also harmonization of standards and principles, and it is also marked by improved coordination. The humanitarian field has witnessed significant investment in this area over the last decade. The cluster system has brought benefits to the health sector, with the global health cluster providing technical guidance, training and coordination. Practice on the ground appears varied, however, with recognition that the response to the 2010 Haiti earthquake was inadequate.

Camps may serve political and pragmatic ends, but much of camp life is toxic from a health perspective.

The mainstreaming of forced migrants' health needs in national plans should apply not only to countries of temporary or protracted settlement but also to those of permanent settlement. There are frequently many barriers to effective service access in countries of resettlement, some rooted in socio-cultural practices.

This mainstreaming of health services is a crucial task for governments, but civil society plays an essential role. Access to health care is a key indicator of migrants' integration into their countries of resettlement, and the role of civil society in advocating for and facilitating access to health care for displaced populations can be crucial. Perceived equity in health-care provision underpins stable governance.

Red Cross Red Crescent National Societies ensure the engagement of civil society with displaced populations. Kenya Red Cross youth volunteers have, for example, played a key role in work with displaced populations, including mediation with youth engaged in the post-election violence of 2010.

Consideration of migrants' needs is an issue of equity, even though, as noted, they are often neglected in national exercises to prioritize health. Interventions are often made but are not accessible to all, such as reproductive, maternal and child health-services.

Maternal and child health services are a particular priority due to huge differentials in maternal and infant mortality between and within countries.

While communicable diseases remain a challenge, they centre more on logistics and political will than technical issues, but there is growing awareness of the incidences of non-communicable diseases in the lives of displaced communities.

Mental health and psychosocial support have become a major area of humanitarian programming. Although some criticize the prioritization of this area of work, the adoption of the Inter-Agency Standing Committee's *Guidelines on Mental Health and Psychosocial Support in Emergency Settings* has put psychosocial interventions on a more rigorous footing.

BOX Persecution and forced migration in relation to sexual orientation and gender identity

Lesbian, gay, bisexual, transgender and intersex (LGBTI) issues currently represent the frontier of human rights work, giving rise to a new divide in global politics.

In western Europe and North America, there have been important gains in LGBTI rights and recognition of the 'pink' dollar and vote, and the corresponding need to cater for this constituency in the domestic political arena. In sub-Saharan Africa, by contrast, persecution of sexual and gender minorities have, with support from religious and cultural conservatives, become an essential part of populist politics.

Sexual-orientation and gender-identity issues connect weaknesses in domestic political systems with tensions in international relations, as exemplified in recent threats by western governments like Sweden's threat to make aid conditional on respect for LGBTI rights. These interconnections and the state-sponsored homophobia they produce generate new activism and asylum seekers.

Internalized homophobia, fear of disclosure and lack of vocabulary with which to explain themselves cause many sexual and gender minority asylum-seekers to disclose either late or not at all.

Many asylum and immigration regimes are themselves homophobic. For example, in the UK 76 per cent of all asylum seekers were rejected on first hearing, a figure that rose to 98.5 per cent for LGBTI individuals. Asylum seekers who are 'outed' often face intense stigmatization from their own refugee and host communities, with exceptionally high levels of vulnerability with regard to access to health care, housing, employment and education.

Perhaps the most important published tools on asylum seekers and refugees at the UN level are UNHCR's *Guidance Note on Refugee Claims Relating to Sexual Orientation and Gender Identity* and *Working With Lesbian, Gay, Bisexual, Transgender and Intersex Persons in Forced Displacement.* More broadly, the 2006 Yogyakarta Principles are an important source. Given that most humanitarian staff in a given context are socialized into the same homophobic religious and cultural norms which enable persecution of LGBTI persons, extensive training is necessary.

Health care should be a priority for humanitarian actors seeking to support LGBTI persons in disaster situations, and an important entry point to identify sexual and gender minorities is through refugee sex-workers.

Support for LGBTI persons must be an integral component to human rights and work on GBV. Organizations that are selective about the rights they support and the forms of violence they seek to address should be challenged.

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