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***“Population Displacement Health Challenges in Today's World”***

Master of Ceremonies, Deputy Administrator, distinguished guests, ladies and gentlemen. Let me start by thanking Gordon Gregory and the organisers of this 8<sup>th</sup> National Rural Health Conference for their kind invitation for me to provide a keynote presentation today.

After some 32 years of working in some of the world's most desperate corners, I hope in the next 20 minutes or so to share with you some reflections on the global situation with regard to people who suffer more than most – the displaced, and on the health challenges they both face and pose.

After the end of the 2<sup>nd</sup> World War, the United Nations was created to promote international peace and security. In 1951, the situation of millions of individuals displaced by persecution during that war led to the creation of the United Nations High Commissioner for Refugees, with its mandate to provide international protection and assistance for refugees when they are unable to avail themselves of the protection of their own State, often because their own State persecutes them.

Today, UNHCR assists about 17 million people who have been forced to live away from their homes as a result of conflict and persecution around the world (around 75% of them are women and children.) UNHCR remains the guardian of international law under the 1951 Convention regarding the Status of Refugees. UNHCR is also the guardian of the 1954 and 1961 international conventions on statelessness.

A major benchmark in the past half century took place in the late 1980s and early 1990s, since which time conflicts between States have largely ceased, but internal conflicts have continued. Although these largely take place within the borders of a country, these create tensions not only in neighbouring countries, but in testing the international community's political will in balancing respect for sovereign integrity against protecting individual human rights.

In what circumstances should the international community “intervene” in the affairs of a sovereign state? Some say “when there is widespread and indiscriminate abuse of human rights” – but who defines how widespread or how indiscriminate? There has been no international agreement on this issue to date between the permanent members of the United Nations Security Council, and perhaps there cannot be such agreement, for or against, until the long-debated UN Reform process takes place.

As a result, UNHCR has increasingly been called upon to assist other people in ‘refugee-like’ situations, such as people who have been internally displaced within their own country (IDPs).

Those who have fled their homes, and have lost their land, their possessions, and often their security and dignity, are amongst the world’s most vulnerable individuals. They not only have a right to protection and assistance, they often cannot survive without it.

So is the world a better place today than it was 50 years ago? It is hard to be optimistic, based on my experience.

On the plus side, the numbers of people seeking asylum in another country, and the overall numbers of refugees have been going down in the past few years. Last year, the number of asylum seekers was at its lowest recorded level since 1987, and the number of registered refugees in the world was down to 9.7 million. The number of persons of concern to UNHCR, which includes recent returnees and IDPs, was down to 17 million.

There are, however, always some “hot spots” where new displacement can be expected. Many of these are in West Africa.

Relieving the suffering of these huge numbers of people demands particular attention in the health sector, which is recognised under many international laws, including *inter alia* the 1948 Universal Declaration of Human Rights, the 1949 Geneva Conventions, the Convention on the Rights of the Child, and the UN Guiding Principles on Internal Displacement.

On the negative side, man’s inhumanity to its own kind, and mother nature’s anger, have periodically continued to swell the tide of displacement. Some of the worst examples of this occur when the international community fails – such as in Rwanda in 1994, when an estimated 800,000 people were slaughtered in a highly predictable genocide, and over a million fled into surrounding countries in a “river of people”; and in Srebrenica in 1995, when 8,000 people were massacred, whose bodies have since been recovered and provide evidence for the International Criminal Tribunal for Former Yugoslavia. Some already argue that the more recent and ongoing situation in Sudan’s western region of Darfur is another example. Over 200,000 have already fled across the border into neighbouring Chad.

It always saddens me when the political will and resources required to turn good intentions into reality fail to be forthcoming. Whether it be poverty reduction, reducing environmental degradation, or fighting to prevent the spread of HIV/AIDS, how many times must we be silent witnesses to preventable human suffering?

The tsunami which struck 12 countries on 26 December last year may not have been preventable, but it took over 250,000 lives, and led to the internal displacement of millions more. On that occasion, for once, the response of the international community in

addressing the immediate needs of the survivors was a ‘tsunami’ in its own right. It certainly gave me hope to see such a huge outpouring of generosity. The “Aussie Spirit” was one of many examples. On this occasion, the focus of the CNN lens might have been temporary, as usual, but for once the resources were then when they were needed. This is seldom the case in my line of work.

On a less optimistic note, in Indonesia and in Sri Lanka, the tsunami response has once again been affected by the delicate balance between state sovereignty and individual human rights, due to the internal political instability as the governments counter the BAM and LTTE insurgents.

What are the health concerns I mentioned earlier? In the time allowed I can give only a brief sketch of the range of health issues that face refugees and other displaced people in today’s world, whether they still be in their country of origin, or are in a country of asylum, or are being resettled in another country such as Australia.

As people flee from war and persecution, they are at great risk of injury, or of contracting potentially fatal diseases. The main ‘killers’ in refugees situations are measles, diarrhoeal diseases (including cholera), acute respiratory infections (pneumonia), malnutrition and malaria (and around 70% of the people who are of concern to UNHCR are in malaria endemic areas.) Other health problems include tuberculosis, meningitis, vector-borne diseases, HIV/AIDS and other sexually transmitted diseases, pregnancy and obstetric complications as well as vaccine-preventable childhood diseases. In times of displacement emergencies, the sudden increase in such relatively easy-to-prevent conditions is due to a drastic deterioration in people’s living conditions. Furthermore, many displaced persons find themselves living in volatile situations, with over-crowding and lack of basic privacy commonplace, thus placing them at greater risk of sexual violence, resulting in accelerated spread of sexually transmitted diseases and unwanted pregnancies.

Let me paint a bit of a picture of what health challenges displaced people face, in the immediate aftermath of their flight, as they seek asylum. At first, they often lack recognition as refugees, and have to “live rough”, as this photo of a refugee family’s house in the Malaysian jungle, just outside Kuala Lumpur, shows. Such asylum seekers often live in constant fear of deportation. Xenophobia that has spread around the world since the 9-11 attacks, and is partly a cause of countries tightening security measures preventing the movement of terrorists and migrants. There is a worrying recent phenomenon of mixed displacement flows – some are genuine asylum seekers, and some not, such as migrants being smuggled into countries, or even worse, vulnerable women and children being trafficked for prostitution. Boat people, such as those from Vietnam in the early 1980s, from Haiti in the 1990s, or fleeing Afghanistan and Iraq earlier this century, some of whom arrived in Australia after the Tampa incident, are increasingly being detained until their true status is determined, as can be seen in this photo of the Baxter Detention Centre.

The mental health dangers caused by detention of asylum-seekers, including the impact of detention on children, have been well canvassed in the media, and there have been detailed studies by Australian health professionals, some of whom may be here at this conference, so some of you may be much closer to the issue than I am.

UNHCR's position on the detention of asylum-seekers is that it is inherently undesirable. The situation of asylum-seekers differs fundamentally from that of other migrants, given that as a result of their flight from persecution, they may not be in a position to comply with the standard legal formalities for entry. While UNHCR recognizes that it is necessary to carry out some health and security checks, but detention should be for the shortest possible time, and in the absence of any alternatives. And as we said in our submission to the Human Right Commissioner's Inquiry into Children in Detention, if children must be detained at airports or immigration holding-centres, they should not be held in prison-like conditions. In UNHCR's view, barbed wire fences surrounding detention centres, strict security arrangements, and curtailment of freedom of movement, are akin to prison-like conditions.

The displaced are thus re-exposed to insecurity and physical violence; there is often a lack of adequate shelter and sanitation facilities; these people are packed into overcrowded camps or makeshift settlements in most asylum countries, where there is nearly always insufficient access to good food, clean water and basic supplies for personal hygiene; they have no immunity to the local diseases of their new environment; and they suffer considerable emotional stress as a result of their traumatic experiences and the uncertainty of their situation (about 35% of the world's refugees have been exposed to some form of physical or psychological torture).

Once the initial displacement is over, UNHCR, in close cooperation with its partners and host governments, offers a wide range of health services – in acute emergency situations, in long-term refugee situations and in areas of refugee return.

In these programs, many of which take place in huge refugee camps, such as those around Goma in (then) Eastern Zaire in 1994, UNHCR follows a set of guiding principles which include giving priority to primary health care with attention to preventive measures and basic curative services, such as promoting proper nutrition, adequate water supply, basic sanitation, reproductive and child care, treatment of common diseases, immunisation and health education; involving refugees in developing and providing the health services for themselves; taking into account the particular needs of children under five, women and other vulnerable people; ensuring services available to refugees are equivalent to those available to country nationals; and ensuring health programs are sustainable and comply with internationally accepted health standards

A nutrition study carried out among the refugees in Chad last June found very high incidence of malnutrition among the refugee population as well as the local Chad population. The study found that almost 40% of children in both populations suffered from global acute malnutrition while another 6% suffered acute malnutrition. There were

also very high levels of diarrhoea, insufficient availability of water and an overall lack of public health infrastructure.

Given the conditions, UNHCR provides supplementary feeding programmes for all children under five and all pregnant and lactating women. The program is supported by other measures such as advice to breastfeeding mothers, and on how to efficiently use the food received, increasing food hygiene to prevent diarrhoea and other illnesses, vaccinations against measles and polio and improvements to water supply.

The solutions for displacement range from returning home, to integration into society in displacement, to resettlement in a third country when no other option exists. The vast majority do, however, eventually return to their own country when conditions there improve sufficiently. During such return, or “voluntary repatriation”, health concerns once again demand attention, for similar reasons, as you can see in this photo of return to Afghanistan, showing a transit centre near Peshawar.

In Afghanistan, for example, more than 3.6 million refugees have returned from neighbouring countries like Pakistan and Iran since UNHCR’s voluntary repatriation programme began in 2002 after the fall of the Taliban in 2001 and the Bonn Agreement set Afghanistan on the long and bumpy road to political stability and socio-economic development.

UNHCR has a number of programmes to help the returning refugees rebuild their lives. Returnees receive a grant to cover basic needs, as well as access to medical facilities, immunisations and landmine awareness training. Under UNHCR’s housing programmes, we supply tool kits and materials for families to build new homes where old ones have been destroyed. We also support the rehabilitation of public buildings and restoration of water supply (essential to restore good conditions for good health).

One of the most daunting health concerns is dealing with trauma. UNHCR staff often find themselves dealing with traumatized people, such as in this photo I took recently of a man (standing with his arms crossed) in a meeting with the UNHCR Assistant High Commissioner on the east coast of Sri Lanka this January. He had just lost his wife and two of his children, when they were torn from his arms by the tsunami waves.

Another distressing, albeit common, challenge during and after conflicts is dealing with landmine victims. Afghanistan has more than a million people living with disabilities, according to the Afghan Ministry of Martyrs and Disabled (MOMD), and a quarter of them - at least 250,000 - are victims of landmines and unexploded ordnance (UXOs).

Having briefly spoken about the emergency situations faced by asylum seekers, and about those who languish in refugee camps in asylum countries, let me turn to those who are resettled in a 3<sup>rd</sup> country.

Of the nearly ten million or so refugees that UNHCR is currently assisting worldwide, opportunities exist for around 1% of them (some 100,000 refugees) to be referred for resettlement to countries such as America, Canada, New Zealand and Australia.

These places are reserved for those refugees who have no prospect of returning home and for whom local integration into their countries of asylum is not a possibility. UNHCR also considers the need for family reunification and vulnerability (woman at risk, victims of torture) when assessing a refugee's need for resettlement.

Australia has a long and proud tradition of accepting refugees under its humanitarian resettlement programme, and provides very good services to help them start a new life, as this photo of young Liberian girls arriving in Australia in January from Laine camp in Guinea shows. They were among a group of over 300 people who arrived under the Women at Risk programme - aimed at women who do not have the protection of a male relative and are in danger of victimisation and serious abuse because of their gender.

Even during their resettlement, refugees face a range of health challenges: they have to adapt to different language, different cultural practices, different health and education systems, and different workplace arrangements. To meet these challenges good physical and mental health is crucial.

Taking mental health as one example; this includes post traumatic stress syndrome, depression, anxiety, grief, guilt, somatic disorders. Up to 35% of the world's refugees have been subject to some form of severe physical and/or psychological torture. Happily, Australia offers counselling for trauma and torture victims for the first 12 months of their resettlement. This is an initiative that has gained worldwide recognition and support.

On the other hand, Australia carries out rigorous health checks on refugees who come here under its humanitarian program. The Government advises that this is in order to satisfy public interest criteria, and is intended to protect the interests of Australians. The medical examinations include a chest x-ray for those 11 years and over to check for tuberculosis. (Tuberculosis is the only condition under Australian law that automatically precludes the granting of a visa. Applicants with active or untreated TB must undergo a course of treatment in the asylum country, followed by further tests to confirm that the disease has been adequately treated. More worryingly, concerns about costs of resettled refugee health support on the Australian health system do, in effect, exclude other worthy entrants, including people with HIV/AIDS. Testing for HIV/AIDS is mandatory for all refugees referrals aged 15 or over, or even under 15 if they are being adopted or have a history of blood transfusions or other clinical indications. The existing Government guidelines say that applicants who test positive may still satisfy the health requirement provided the estimated potential cost is not considered undue, but in many cases, the effect of this policy is to exclude many refugees with HIV. The less demanding health screening standards in other resettlement countries such as America and Canada also undermine international coherence.

The case of a Pakistani refugee who set himself alight outside Parliament House in Canberra recently, who subsequently died of his injuries, drew stark attention to the issue of medical testing and family reunion. As the Refugee Council of Australia documented in relation to this case, for many years this man had been trying to bring his wife and children to Australia, and on each occasion, the application was rejected because one of his children was mentally impaired. His act demonstrated the depth of the anguish many refugees feel when separated from their families.

In Australia, asylum-seekers fall into two distinct groups: those who entered Australia with 'authorization' (e.g. with a visitors or student visa) are allowed to remain in the community while their applications are processed; and those who entered Australia without authorization (e.g. on a boat or a plane) and are detained until they are granted refugee status, a temporary protection visa, or they leave the country. Since 1999, asylum-seekers who arrive in an unauthorized way, and are found to be genuine refugees, are given a temporary protection visa (or TPV). TPV holders do get access to Medicare benefits and trauma counseling, but do not get the same access to services as permanent protection visa (PPV) holders, nor do they have any right to family reunification or travel documents allowing them to move in and out of Australia. These restrictions and the ongoing 'temporariness' of their situations can compound existing health issues.

I will conclude then by asking you to spare a thought from time to time during this conference on rural health in Australia for the health concerns faced by the world's displaced, that I have briefly highlighted here.

As you look at the symbol of UNHCR shown on this final slide, I hope my presentation will have helped you to understand better why I, many colleagues in the UN and in UNHCR in particular, and our many partners around the world, feel it is so important to reach out and metaphorically or physically 'cup our hands' around vulnerable people, in an effort to provide them with protection from abuse of their rights, and with relief from suffering. I believe that this closing image is appropriate both to UNHCR's work around the world, and to your own important work in Australia's health system.

Thank you for your attention.

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