**FMO Thematic Guide: Forced Migration and Public Health**
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**1 Introduction**
A survey in eastern Democratic Republic of Congo found that most of the 1.7 million excess deaths between January 1999 and May 2000 were not from the direct effects of war, but through the destruction and disruption of access to health services, food, clean water, and sanitation, and the breakdown of disease control. In the context of such destruction and mass displacement, 'war means disease', and 'violent deaths and non-violent deaths are inseparable' (IRC 2000: http://intranet.theirc.org/docs/drc_mortality_iii_full.pdf).

Clinical medicine has long been involved with the effects of collective violence, from military surgery to the efforts of the International Committee of the Red Cross. The discipline of public health, though, began dealing with the phenomenon only in the 1970s, following

the humanitarian crisis in Biafra, Nigeria. The lessons learnt there were the basis for what has become a growing body of knowledge and medical interventions in the field of preventive health care. Public health now plays a key role in the core humanitarian relief activities of health services, health surveillance, shelter, nutrition, water, and sanitation.

This research guide provides a broad overview of some of the key themes, issues, and debates that encompass public health and forced migration, along with a number of references and Web links to sources for further study in this field.

**2 Definitions**
Public health is the art and science of preventing disease, promoting and protecting population health, and extending life through organized local and global efforts (Acheson 1998: http://www.archive.official-documents.co.uk/document/doh/ih/ih.htm). Whilst clinical medicine is part of the overall public health effort, the broad mandate of public health includes identifying underlying political, social, behavioural, and environmental determinants of health outcomes, with a particular focus on reducing social and health inequalities (Beaglehole 2003).

The World Health Organization defines health as a 'complete state of physical, mental and social well-being and not merely the absence of disease or infirmity'. Whilst criticized as too utopian and unachievable by some, (Nutbeam 1986; Sax 1990), it aptly presents the broad nature of health in its many meanings, influences, and outcomes, guiding its conception away from the purely biomedical perspective.

The International Association for the Study of Forced Migration (IASFM) describes forced migration as 'a general term that refers to the movement 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'. The main causes of involuntary displacement are wars and armed conflicts, although natural disasters and development projects are also factors. According to the United Nations High Commissioner for Refugees (UNHCR), there are some 50 million uprooted people around the world, including both refugees and internally displaced persons (IDPs), of whom around 75–80 per cent are women and children.

The legal definition of a 'refugee' is a person residing outside his or her country of nationality, who is unable or unwilling to return because of a 'well-founded fear of persecution on account of race, religion, nationality, membership in a political social group, or political opinion' (Article 1 of the 1951 United Nations Convention Relating to the Status of Refugees). The most widely used definition of IDPs is one presented in a 1992 report of the Secretary-General of the United Nations (UN), which identifies them as 'persons who have been forced to flee their homes suddenly or unexpectedly in large numbers, as a result of armed conflict, internal strife, systematic violations of human rights or natural or man-made disasters, and who are within the territory of their own country.'

**Websites:**
World Health Organization (WHO) - http://www.who.int/en/

International Association for the Study of Forced Migration (IASFM) - http://www.iasfm.org/pages/1/index.htm

United Nations High Commissioner for Refugees (UNHCR) - http://www.unhcr.org/cgi-bin/texis/vtx/basics

## 3 International legal framework

Three interrelated branches of international law, which complement and reinforce each other, relate to the health of refugees and IDPs. In each field, the body of law is primarily made up of treaties, which create binding obligations for the countries that have ratified them. International law is informed by authoritative interpretations of treaty provisions, international consensus documents, and the comments and recommendations of the bodies created by each treaty to monitor implementation. The three interrelated fields are outlined below.

### 3.1 International human rights law

International human rights law relating to health includes Article 25(1) of the Universal Declaration of Human Rights (UDHR), the 1966 International Covenant on Economic, Social, and Cultural Rights (ICESCR), and its partner covenant, the International Covenant on Civil and Political Rights (ICCPR). Of most relevance is Article 12 of the ICESCR, which recognizes 'the right of everyone to enjoy the highest attainable standard of physical and mental health'. In the refugee context, the ICESCR states that everyone has rights with regard to health, without mention of citizenship or legal residency. Article 2(2) states that these rights apply without discrimination of any kind as to 'race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status'. The United Nations Committee on Economic, Social and Cultural Rights, the treaty body composed of experts to monitor implementation of the ICESCR provisions, provided further details in 2000 on Article 12 through 'General Comment 14' (http://www.unhchr.ch/tbs/doc.nsf/(symbol)/E.C.12.2000.4.En?OpenDocument). This committee also recognized that refugees, asylum-seekers, and illegal immigrants are vulnerable and marginalized individuals protected by the treaty's non-discrimination clause.

The realization of the right to health is closely related to and dependent on the realization of other human rights, including the right to life (ICCPR Article 6); to liberty and security of person (ICCPR Article 9); to freedom from torture or cruel, inhuman, or degrading treatment or punishment (ICCPR Article 7); to enjoyment of the benefits of scientific progress (ICESCR Article 15); and to freedom of expression, including the freedom to seek, receive, and impart information (ICCPR Article 19). The Convention on the Elimination of All Forms of Discrimination Against Women (1979) and the Convention on the Rights of the Child (1989) provide further support, as do regional mechanisms such as the European Social Charter (Articles I and II); the European Convention on Human Rights and its five protocols (Article I); the African Charter on Human and Peoples' Rights (Article 16); the American Convention on Human Rights (Article 4); and the American Declaration on the Rights and Duties of Man (Article XI).

While international human rights law provides a solid legal basis for health rights, it has a number of weaknesses. Its enforcement mechanisms are notoriously weak, and in the case of ICESCR, are limited to reporting by countries to the treaty body. This shortcoming is compounded when addressing so-called 'positive rights' such as the right to health, in which states are expected to fulfil obligations, rather than respect or protect them. Treaties generally also do not create legal obligations for non-state actors such as insurgent groups, who might control territories where many refugees or IDPs find themselves. Additionally, certain human rights can be suspended in times of war or in serious national emergencies, precisely at the time when refugees and IDPs are most likely to need this protection. Furthermore, human rights conventions do not explicitly deal with internally displaced populations or forced relocations, do not provide for a right of access by humanitarian organizations, and are not binding on rebel forces. Finally, even when dealing with their own citizens, many states are

unwilling or unable to observe binding obligations included in the human rights treaties they have ratified.

**Website:**
United Nations High Commission for Human Rights (UNHCHR) - http://www.unhchr.ch

## 3.2 Refugee law
The UNHCR 1951 Refugee Convention and related Protocol of 1967 address the specific rights of refugees. The Convention requires signatory countries to treat refugees lawfully staying in their territory the same as their own nationals are treated, with respect to social security schemes including health and, specifically, maternity and sickness (Article 24). Other articles of relevance include the right to rationing (Article 20), housing (Article 21), and public relief (Article 23). For refugees who do not meet the criterion of 'lawful stay' and for non-Convention refugees, UNHCR works to guarantee that they will be treated no worse than foreigners are usually treated by that state (Article 7).

To address the shortfalls in the protection of the rights of IDPs under refugee law, non-binding legal principles on internal displacement, which draw on analogous refugee law and existing humanitarian and human rights law, have now been developed and disseminated. (Deng 1999). These principles list the important essential services that IDPs are entitled to, such as food, potable water, sanitation, shelter, and medical services. However, responsibility for the protection and provision of basic services to IDPs still rests with national governments, many of which may be unwilling to prioritize the delivery of services to IDPs, or lack the technical capacity to co-ordinate or monitor the programmes of international humanitarian organizations during emergencies.

**Website:**
UNHCR: 1951 Refugee Convention and 1967 Protocol - http://www.unhcr.org/cgi-bin/texis/vtx/basics

## 3.3 Humanitarian law
The third branch of international law of direct relevance to health and forced migration is humanitarian law. This provides an important complement to human rights and refugee law regarding the provision of health services in times of armed conflict, by partially addressing internally displaced populations, forced relocations, the right of access by humanitarian organizations, and rebel forces. It is set forth in the 1949 Geneva Conventions and their two 1977 Additional Protocols, and applies to non-combatants such as refugees and IDPs in situations of international armed conflict and in certain situations of internal armed conflict. The basic principles include the obligation for all parties to collect and care for the sick and the wounded, as well as the obligation to respect and protect hospitals, ambulances, and medical personnel. The Fourth Geneva Convention, which applies to international armed conflict where civilians are in the hands of another government or occupying power, entitles expectant women and maternity cases to special protection and assistance (Articles 6–22) and all women to special protection against rape and indecent assault (Article 27). Importantly, the occupying power is also required, if relief is inadequately supplied, to agree to relief schemes by country affiliates of the International Committee of the Red Cross, and to permit them free passage and guarantee their protection (Article 3; Article 59).

However, humanitarian law does not cover all armed conflict situations, and the difficulty in enforcing international law is often exacerbated in cases of civil war. Although IDPs are guaranteed certain basic rights under the Geneva Conventions, ensuring these rights are

secured is often the responsibility of authorities that were responsible for their displacement in the first place.

**Websites:**
International Committee of the Red Cross (ICRC) -
http://www.icrc.org/Web/Eng/siteeng0.nsf/htmlall/party_gc

UNHCR - http://www.unhcr.org

UNHCHR - http://www.unhchr.ch

**4 Impact of forced migration upon health**
Forced migration frequently occurs at times of massive disruption to food supply, sanitation, health services, and shelter. The inability of health services to cope with an influx of displaced people can rapidly lead to increased mortality and morbidity (disease) in settlement areas. An estimated 7–9 per cent of Rwandan refugees died whilst in the refugee camps of the North Kivu region of eastern Zaire in July 1994 (Goma Epidemiology Group 1995). In nearly all cases, displaced people experience a significantly higher crude mortality rate (Number of deaths over a given period per thousand persons at risk) than non-displaced populations during complex emergencies. They are particularly vulnerable due to loss of social networks and assets; lack of language, knowledge, and information on the new environment; reduced access to healthcare services; decreased food security; and often, inadequate shelter, sanitation, and access to safe water.

Among those fleeing violence, mortality rates tend to be very high when the exodus is precipitous and a large number of persons are on the move. Under these conditions, CMRs during the first days of displacement have been reported to be sixty times higher in some locations than in the country of origin. However, the varying characteristics of political violence, epidemiological conditions, settlements, levels of economic wealth, and availability and quality of health services in the war-afflicted and host countries mean that it is virtually impossible to provide a standardized picture of morbidity and mortality.

Whilst health is measured in an increasing number of ways, the most common measures amongst displaced persons at present are mortality and morbidity rates. The more complex and time-consuming nature of other studies, such as Quality Adjusted Life Years (QALY), generally precludes their use in shorter-term emergency settings. However, their broader interpretation of health would serve to highlight the effects that poverty, dependence, and lack of cohesive social support have upon the quality of physical and mental health of displaced people. Studies of refugees in the United Kingdom have found that one in six refugees has a physical health problem severe enough to affect their life and two-thirds have experienced anxiety or depression (Burnet *et al.* 2001). In a study of Iraqi asylum-seekers in London, depression was more closely linked with poor social support than with a history of torture (Gorst-Unsworth *et al.* 1998).

**Website:**
Refugee Council - http://www.refugeecouncil.org.uk

Murray C. *et al*, Armed Conflict as a Public Health Problem, The Global Burden of Disease Working Papers (01.22), 2002:
http://www.hsph.harvard.edu/burdenofdisease/publications/papers/Armed%20Conflict%20as%20a%20Public%20Health%20Problem.pdf

## 4.1 Communicable diseases

There is frequently a severe increase in the risk of communicable diseases and epidemics during and after complex emergencies involving armed conflict and mass population displacement, when safeguards of immunization, clean water and sanitation, and shelter are interrupted. Typhoid, tuberculosis, measles, cholera, bacillary and amoebic dysentery, acute respiratory infection, hepatitis, polio, schistosomiasis, various helminth infestations, common gastroenteritis, and other harmful effects related to exposure to cold weather, heat, or rain, have been common in settings of displaced persons, where crowding and poor sanitation is a common feature. Whilst meningitis is also a potential risk, mass immunization has proved to be an effective epidemic-control measure, and meningococcal morbidity and mortality rates have been relatively low.

Diarrhoeal diseases have emerged as possibly the most lethal public health threat to refugees and IDPs. More than 70 per cent of the deaths among Kurdish refugees in 1991 were associated with diarrhoea (Sharp *et al*, 1993). Cholera spread by water contaminated with *Vibrio cholerae* is estimated to have killed more than 50,000 Rwandan refugees in camps just inside Zaire during the first weeks of July 1994 (Goma Epidemiology Group 1995).

Appropriate interventions to address communicable diseases include primary, secondary, and tertiary prevention, and treatment. These include immunizations, sanitation improvements, provision of clean water, nutritional interventions including appropriate use of oral re-hydration therapy (ORT), vector control, health education, and treatment measures through laboratory services, medication, and case management. Of essential importance is the quick establishment of effective surveillance to address the susceptibility of the population; the control of pathogenic agents; effective use of treatment and resources; and monitoring and evaluation of the health intervention including vaccination coverage and effectiveness. Please also see Assessment and surveillance below for further details on surveillance techniques and methodologies.

Mass migration may lead to epidemics of communicable diseases when populations residing in areas of low disease endemicity pass through or into areas of high endemicity during the course of their migration. Alternatively, the migration of people can potentially spread the risk of communicable diseases into new areas. The association of such risk between infectious disease and migration is a historically powerful one, and drives to the heart of many wider concerns about the impact of migration on society and economy (Markel 1995).

In the United Kingdom (UK), intense public and political debate about the scale and nature of asylum and migration has led to calls for pre-entry health screening to be introduced for all long-term migrants to the UK. This has also led to calls from the press and political parties for asylum-seekers to be subject to compulsory screening on arrival and, if necessary, detained in quarantine (Conservative Party 2003). Health services have also been accused of stigmatising refugees, with a tendency to focus more on protecting the native population than benefiting the health of new arrivals (Fassil 2000). Refugee health in many areas of Britain has become the responsibility of communicable diseases departments, giving the misleading impression that refugees are vectors of infection, with the inevitable effects of increased stigmatization.

Studies in the UK and elsewhere indicate the ineffectiveness of screening and quarantine for communicable diseases such as tuberculosis, largely due to it causing individuals to evade immigration controls and medical services rather than present themselves for fear of being refused entry or deported (Coker 2003; Farmer 2003). In the case of HIV/AIDS, there exist

strong ethical and human rights concerns over the legality of refusing entry or treatment to an individual who is HIV-positive. In addition, there is no evidence to support that such a policy would effectively protect public health (UK All-Party Parliamentary Group on AIDS, July 2003: http://www.appg-aids.org.uk/publications.htm). This clearly has consequences for the global spread of tuberculosis, HIV, and other communicable diseases. Additional resources could be more effectively directed into providing better healthcare services in countries of origin, to prevent the spread of tuberculosis and HIV globally and the devastation that this can cause to the societies from which many migrants originate (Coker 2003).

**Websites:**
Medact - http://www.medact.org/tbx/pages/section.cfm?index_id=3

World Health Organization: Information and Guidelines - http://www.who.int/disasters/tg.cfm?doctypeID=25

Department of Health - http://www.dh.gov.uk/

### 4.2 HIV/AIDS

Whilst data on HIV prevalence in refugee situations is scarce, it is believed that refugees and other displaced populations are at increased risk of contracting the virus during and after displacement due to factors of poverty, disruption of family/social structures and health services, higher prevalence rates of HIV compared to their area of origin, increase in sexual violence, and increase in socio-economic vulnerability (particularly of women and children).

The association between HIV/AIDS and forced migration is particularly strong in sub-Saharan Africa, where according to UNAIDS, 70 per cent of the more than 40 million persons living with HIV/AIDS in 2002 lived, and which is a region severely affected by conflict, with a large and diverse population of displaced persons. The disruption and displacement of the Rwandan population raised awareness of the importance of HIV-prevention efforts during humanitarian emergencies. Data from post-war Rwanda showed that in 1997, HIV prevalence was 11 per cent in both rural and urban areas. This contrasts with low pre-war levels in rural areas estimated at 1 per cent, where approximately 95 per cent of the population resided, and levels of 10 per cent in urban areas. Seroprevalence among those who had lived in refugee camps in Tanzania or Zaire was 9 per cent, representing a six- to eight-fold increase over the rates in the rural areas from whence they came. Among Rwandan refugees in a camp in Tanzania, researchers were able to conclude that adolescent sexual activity might have increased since displacement, that commercial sex-work had grown in the area surrounding the camps (although not within the camp itself) and that knowledge of HIV prevention was high but condom accessibility and usage were low. Whilst Rwanda's contraceptive prevalence rate had been among the highest in sub-Saharan Africa, women and men reported that they lacked access to family planning in the camp and that they had a strong interest in continuing to use it (Schreck 2000).

Although refugees can be at increased risk and may exhibit higher prevalence rates than prior to displacement, this does not inevitably mean that they have higher prevalence rates than their surrounding host population. Indeed, HIV prevalence rates are frequently lower in refugee camps than in the surrounding populations. UNHCR and its partners measured HIV prevalence among pregnant women in more than twenty camps housing around 800,000 refugees in Kenya, Rwanda, Sudan, and Tanzania, and found that the refugee populations in three of the four countries had significantly lower HIV prevalence rates than the surrounding host communities. In the fourth, the refugees and host community had comparable rates. Possible reasons for lower prevalence include the use of agencies' HIV/AIDS programmes;

that refugees often live in camps situated in remote areas with limited freedom of movement; and that refugees often come from countries with lower HIV prevalence than the countries of asylum. Despite this, there remains a misconception that refugees spread HIV/AIDS. As a result, UNHCR felt compelled to refute this and declared that 'refugees should neither be blamed for the HIV/AIDS pandemic nor should be ignored' (Lubbers 2003 http://www.unhcr.org).

There has been a positive use of human rights law in the field of HIV/AIDS, particularly to increase access to drugs and to tackle discrimination and restriction to freedom of movement. UNHCR developed a strategy which closely follows the UNAIDS human rights-based approach, with objectives of respecting the right of refugees and asylum-seekers to live in dignity and free from discrimination, reducing HIV transmission, and improving HIV/AIDS treatment and care.

Challenges in this strategy include the limited technical and financial resources of most host countries, which struggle to meet the needs of their own populations, let alone contribute to refugee programmes. Despite recent advances in reducing prices of medication, the introduction of Prevention of Mother to Child Transmission (PMTCT) and Anti-retroviral (ARV) treatment programmes pose significant challenges due to high costs and limited resources available in the budget of health governments and refugee agencies. The situation is exacerbated by the failure of donor institutions and national HIV/AIDS programmes to specifically address the needs of refugees when developing programmes to combat the pandemic (Spiegel, 2003 http://www.unhcr.org).

A number of normative guidelines and monitoring tools on HIV/AIDS and refugees have been developed. These include:

- *Guidelines for HIV Interventions in Emergency Settings*, WHO/UNAIDS/UNHCR, 1996 - http://www.who.int/disasters/tg.cfm?doctypeID=63
- *Reproductive Health Manual*, Inter-agency Working Group, 1999 - http://www.unfpa.org/emergencies/manual/
- *Protecting the Future. HIV prevention, care and support among displaced and war-affected populations*, IRC 2003 - http://intranet.theirc.org/docs/Protecting_the_future.pdf
- *Refugee and AIDS Technical Update*, UNAIDS, 1997 http://www.unaids.org/Unaids/EN/In+focus/HIV_AIDS_security+and+humanitarian+response/HIV_AIDS+and+conflict.asp
- *Second Generation Surveillance for HIV*, WHO and UNAIDS 2000 - http://www.who.int/disasters/tg.cfm?doctypeID=63
- *HIV/AIDS and Refugees: UNHCR's Strategic Plan 2002–2004*, UNHCR - http://www.unhcr.org/
- International Federation of Red Cross and Red Crescent Societies - http://www.ifrc.org/what/health/hivaids/code/

**Websites:**
UNAIDS - http://www.unaids.org/Unaids/EN/In+focus/HIV_AIDS_security+and+humanitarian+response/HIV_AIDS+and+conflict.asp

*Refugees and AIDS: UNAIDS point of view*, Geneva, 1997 (UNAIDS Best Practice Collection) - http://www.unaids.org/en/default.asp

UNAIDS: *HIV/AIDS and Children Affected by Armed Conflict*, 2002 -
http://www.unaids.org/publications/documents/sectors/military/militarypve.pdf

Women's Commission for Refugee Women and Children: *Refugees and AIDS: What Should the Humanitarian Community Do?* - http://www.womenscommission.org/

World Health Organization: Information and Guidelines -
http://www.who.int/disasters/tg.cfm?doctypeID=25

### 4.3 Nutrition

Malnutrition and restricted production and access to food are among the most significant problems in situations of forced migration. The symbiotic relationship between malnutrition and morbidity and mortality from communicable disease further compounds poor health status, with diseases such as measles and diarrhoea inducing malnutrition, especially in young children, and malnutrition associated with high mortality rates from communicable diseases. However, it is also important to be aware of exceptions to the causal relationship between malnutrition and disease, with malaria appearing to reach higher levels after feeding programmes have been initiated (Cahill 1999).

In response to acute nutritional needs in humanitarian emergencies, the provision of free relief food and other nutrition-related programmes often takes the largest share of the international resources for humanitarian response. However, it is increasingly recognized that rather than perceiving nutrition needs in emergencies as a narrow range of interventions focused around food and physiological vulnerability, nutritional activities should include a more wide-ranging consideration of the social, political, and economic risks that affect displaced populations. This includes the capacity of individuals and households to manage such risks, particularly vulnerable groups such as women, children, the elderly, and female heads of households. The effect of not recognizing such risks was highlighted by studies amongst Kurdish refugees from Iraq in 1991, in which families headed by women were significantly more malnourished (Cahill 1999). In Rwandan refugee camps in eastern Zaire, one month after the influx of July 1994, the prevalence of acute malnutrition was 18–23 per cent. Children, particularly orphans or those in families headed by single women, were particularly vulnerable and had a significantly higher risk of malnutrition than other refugee children (Goma Epidemiology Group 1995).

**Websites:**
United Nations World Food Programme (WFP): Guidelines -
http://www.wfp.org/index.asp?section=6

World Health Organization (WHO): Information and Guidelines -
http://www.who.int/disasters/tg.cfm?doctypeID=25

### 4.4 Mental health

Over the last two decades, humanitarian agencies have paid increasing attention to the psychological and social impact of violent conflict and displacement. Approaches to care for mental health vary widely, depending on the local context, need, and agencies' interpretation of mental health and psychosocial support. A common approach has been to integrate mental health care into primary health care (see below for more details on primary health care), with specialized training for health staff such as nurses and community health workers. The justification for such an approach is that mental and physical well-being are closely connected, and that access to and delivery of these services is most effective when they are part of the basic primary health care and not restricted to specialized psychiatric institutions

that require trained doctors and expensive drugs. An alternative approach is the training of local people as counsellors, who then provide individual and group counselling to those identified as being in need of support. The training approaches and counselling techniques vary greatly, but most are based on the belief that verbalizing memories and emotions is of benefit. There exists a great diversity in the range of services offered, with some focusing more on psychological services such as counselling for individuals or groups, whilst others prefer a combination of psychological and social services through integrated 'psychosocial' programmes with the aim of preventing mental problems and social difficulties (Strange and Ager 2001).

Considerable debate exists over the notion of stress itself. Whilst most attention has focused upon post-traumatic stress disorder (PTSD) with regard to such distressing events as displacements, witnessing or participating in armed conflict, bombings, torture, rape, or attacks, some believe that PTSD is just one of many mental health problems that can arise as a consequence of trauma (Newman *et al*. 1996). Similarly, it is argued that rather than focusing on individuals, attention should also be paid to whole communities. The conceptual framework and discourse of trauma itself has also been criticized (Summerfield 1996). Firstly, it has been said that trauma is a Western concept that is not necessarily applicable to non-Western populations where people may have different understandings of distressing events and how to survive them (Richters 1998; Wessells 1999). Generalizing people as traumatized implies they have a mental disorder and are passive, vulnerable victims to events, whereas in fact, most people are able to function and survive, developing coping mechanisms appropriate to their situations (Bracken 1995; Summerfield 1999).

Aid agencies and their donors have also been criticized for perpetuating this image of passive victims in need of psychosocial care, and fostering asymmetrical power relations between the local population and outside 'experts' (Ager 1997). The result may be that the material conditions and physical health support are neglected, and the needs of the displaced population ignored. In Bosnia, agencies established psychosocial programmes specifically targeting women who had been subjected to sexual violence. However, these initiatives were not always welcomed by the women themselves, some of whom felt that their own needs and requests had been largely ignored (Richters 1998).

**Websites:**
Strang, A. B. and Ager, A., 'Building a Conceptual Framework for Psychosocial Intervention in Complex Emergencies: Reporting on the work of the Psychosocial Working Group', 2001 - www.ishhr.org/conference/articles/strang.pdf

Forced Migration Online (FMO): Thematic Guide on Psychosocial Issues - http://www.forcedmigration.org/guides/fmo004

International Trauma Research Net Conference 2002 - http://www.traumaresearch.net/con_xx.htm

Save the Children Alliance: *Promoting Psychosocial Well-being among Children Affected by Armed Conflict and Displacement: Principles and Approaches*, 1996 - http://www.savethechildren.org.uk/

International Society for Traumatic Stress Studies - http://www.istss.org

World Health Organization (WHO) - http://www.who.int/disasters/tg.cfm?doctypeID=21

World Health Report (focusing on mental health): http://www.who.int/whr2001/2001/

## 4.5 Reproductive health

Women and children make up four-fifths of the world's refugees and IDPs; and the characteristics of war and forced migration, such as the loss of security, income, home, families, social support, rape, and deliberate, forced pregnancy, increase the need for reproductive health services. This includes access to family planning, safe abortion care, prevention and treatment of sexually transmitted infections including HIV/AIDS, safe-motherhood initiatives, and tackling sexual and gender-based violence and harmful traditional practices such as female genital mutilation and early marriage.

The right to reproductive health is most clearly expressed through ICESCR's Articles 10 and 12, and further elaborated in General Comment 14 of Article 12. Further references can be found in regional human rights mechanisms, and particularly the 1979 Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) in Articles 10, 12, 14, and 16.The CEDAW Committee, which is a treaty body, issued a General Recommendation in 1999 on Article 12 of the Women's Convention, which states outright that access to health care includes reproductive health care for all women and girls, 'even if they are not legally resident in the country'. The Committee noted that special attention should be given to the health needs and rights of refugee and internally displaced women.

Despite its articulation in international law, it is really only over the last decade that sufficient attention has been focused on the particular reproductive health needs and circumstances of refugees and IDPs. This increased recognition was assisted by the Beijing Platform of Action and the 1995 Fourth World Conference on Women. Of most significance was the International Conference on Population and Development (ICPD) of 1994. With its codified Programme of Action, the ICPD developed a broader, more expansive human rights-based definition of reproductive health, and recognized that 'reproductive health care should be available in all situations and be based on the needs and expressed demands of refugees, particularly women, with full respect for the various religious and ethical values and cultural backgrounds of the refugees while also confirming with universally recognized international human rights'. The ICPD also set forth the action governments should take to promote and protect these rights. While such international consensus documents do not create binding obligations, they are agreed to by governments and thus reflect political will. They are also widely used by non-governmental organizations (NGOs) as advocacy tools and by treaty-monitoring bodies as standards for evaluating how states are meeting their treaty obligations.

Operational guidelines to facilitate the provision of reproductive health services include the 1995 Inter-agency Field Manual, which was developed by The Inter-agency Working Group for Refugee Reproductive Health (a collaboration of UN agencies and NGOs). This now serves as the most comprehensive and widely used manual for refugee reproductive health programmes. Further operational guidelines have been developed by UNHCR, WHO, the Reproductive Health Response in Conflict Consortium (RHRC), and the Women's Commission. NGO involvement has been most effectively expressed through the RHRC (previously the Reproductive Health for Refugee Consortium), which comprises a number of NGOs promoting comprehensive, quality reproductive health services for refugees. Activities include advocacy, training, research, publication of thematic guides, and monitoring and evaluation tools.

Despite the advances over the past decade, coverage remains uneven. According to a 2002 survey of eighty-one NGOs working with refugees and IDPs, only eight had specific policies or guidelines on providing reproductive health services, while only thirty-eight supplied some

of those services. Research also remains limited on the impact of forced migration upon the reproductive health of women and men, with data particularly poor on IDPs (Goodyear *et al*. 2001).

The extent and type of reproductive health interventions for refugees may also depend on prevailing religious and cultural beliefs. Interventions such as emergency contraception, condom distribution to adolescents, and access to safe abortion services (which are integral to reducing maternal mortality along with other interventions such as access to antenatal and safe obstetric care) are all particularly sensitive issues. The current US President Bush administration's opposition to reproductive rights places added pressure on the provision of such services.

**Websites:**
Division for the Advancement of Women (DAW): 1995 Fourth World Conference on Women - http://www.un.org/womenwatch/daw/

Girard, F. and Waldman, W., 'Ensuring the Reproductive Rights of Refugees and Internally Displaced Persons: Legal and Policy Issues', *International Family Planning Perspectives* 26 (4), 2000 - http://www.agi-usa.org/pubs/journals/2616700.html

Global Gag Rule (Bush administration) - http://www.globalgagrule.com

Inter-agency Working Group for Refugee Reproductive Health: 1995 Inter-agency Field Manual - http://www.unfpa.org/emergencies/manual/

International Centre for Migration and Health: *Reproductive Health in the Context of Forced Migration* - http://www.icmh.ch/WebPDF/2001%20-%20UNFPA%20-%20Reproductive%20Health%20-%20Report.pdf

Reproductive Health Response in Conflict Consortium: *Global Decade Report*, 2003 - http://www.rhrc.org/
Adolescent Refugee Reproductive Health - http://www.rhrc.org/media/rhr_basics/adol/index.html

Saving Women's Lives - http://www.savingwomenslives.org/

Sphere Project - http://www.sphereproject.org/handbook

UNHCR: *Sexual and Gender-Based Violence against Refugees, Returnees and Internally Displaced Persons: Guidelines for Prevention and Response*, 2003 - http://www.rhrc.org/pdf/gl_sgbv03.pdf

United Nations Population Fund (UNFPA) - http://www.unfpa.org
*State of World Population 2000* - http://www.unfpa.org/swp/2000/english
International Conference on Population and Development (ICPD) - http://www.unfpa.org/icpd/

Ward, J., 'If Not Now, When? Addressing Gender-Based Violence in Refugee, Internally Displaced and Post-Conflict Settings – A global overview', RHRC, 2002 - http://www.rhrc.org/resources/gbv/ifnotnow.html

WHO: Information and Guidelines - http://www.who.int/disasters/tg.cfm?doctypeID=25

*Reproductive Health During Conflict and Displacement: A Guide for Programme Managers*, 2000 - http://www.who.int/reproductive-health/publications

**5 Vulnerable groups**
**5.1 Internally displaced persons**
The number of IDPs has risen sharply in recent years, and the health status of the estimated 20–25 million IDPs is one of the key public health issues presently facing the humanitarian community. The situation is made particularly complex for two main reasons. Firstly, IDPs remain within the borders of their own country, and therefore under the jurisdiction of the same government that may have been responsible for their displacement or at least was unable to protect them in the first place. Secondly, IDPs cannot invoke the same legal protections as refugees. As a result, access by IDPs to health care is often very limited, particularly as often no specific international humanitarian agency is responsible for providing them with protection and humanitarian assistance. Although a representative of the UN Secretary-General on Internally Displaced People was appointed in 1992 and Guiding Principles on Internal Displacement were introduced in 1998, these are not legally binding.

Whilst particular difficulties lie in assessing the mortality and morbidity associated with IDPs, evidence suggests that IDPs exhibit some of the highest CMRs in humanitarian emergencies. In the early 1990s, CMRs in parts of Sudan and Somalia surpassed the emergency threshold of one death per 10,000 people per day, and reached a daily rate of about eight per 10,000 and seventeen per 10,000 respectively. IDPs in Kosovo also exhibited higher CMRs than those in refugee camps in Macedonia and Albania (Salama, Buzard, and Spiegel 2001). In Colombia, the situation is made more difficult by the fact that much displacement occurs 'silently' as people merge in with the host population, with only 22 per cent of the IDPs reporting access to medical care.

**Website:**
Pan American Health Organization (PAHO) - http://www.paho.org/

**5.2 Women**
Mortality and morbidity are often higher among women and girl refugees and IDPs. They are particularly vulnerable in situations of forced migration due to the combination of non-conflict related factors such as access to education, resources, health services, food, and ease of movement; and conflict-exacerbated factors such as social breakdown, vulnerability, sexual violence, lack of personal security, shelter, and food distribution. This is particularly so for female-headed households.

Healthcare professionals increasingly recognize the need to target the specific needs of women and girls to ensure health services are provided in a more equitable, efficient, and humane way. This includes a gendered approach to health and illness that examines differences in disease manifestations between men and women; and their perception of, and meanings given to, these events and needs. A number of agencies have expressed this approach in operational guidelines that highlight the importance of involving refugee women in planning, protection, and assistance activities. They also address issues such as physical protection; legal rights; access to health care and child health care, food, water, and fuel; the physical layout of the refugee camp setting; education and skills training; and economic opportunities.

However, many challenges remain in implementing these guidelines effectively. They include the assumption that women's health is primarily considered from the point of view of

her reproductive or maternal functions, and not in their own right. Understanding the sources of ill health for women relates to understanding how social, cultural, and economic factors interact to affect the status of women. The WHO 1995 World Health Report argues that 'a woman's health is her total well-being, not determined solely by biological factors and reproduction, but also by the effects of workloads, nutrition, stress, war and migration, amongst others'. Despite the clear risks faced by women and girls in times of forced migration, simplification of the situation and over-reliance on 'vulnerability' runs the risk of women being portrayed as passive victims, resulting in projects being imposed upon women without their participation and leadership in their design, implementation, monitoring, and evaluation (Lindsey 2001; Turner 2001).

**Website:**
WHO 1995 World Health Report -
http://www.who.int/whr2001/2001/archives/1995/index.htm

### 5.3 Children and the elderly
The experiences and circumstances of children in conflict situations and in forced migration are diverse and cannot be easily generalized. In many situations the health of children may be endangered through malnutrition, poor housing, hygiene and sanitation, and lack of access to basic health care. Adolescents in the age range 10–24 are also at most risk of HIV infection. According to UNICEF, at least 50 per cent of all new infections occur amongst this age group. The impact of conflict upon HIV/AIDS prevention programmes and access to health care, combined with increased sexual exploitation — particularly of young people — increases such risk. The high number of displaced people in areas of high HIV/AIDS prevalence further exacerbates the situation.

The notion of vulnerability also needs to be questioned for children as it potentially neglects the resilience and coping mechanisms of children, and again fosters notions of passiveness which could hinder children's inclusion and active participation in healthcare interventions intended for them. Ensuring that children's needs are appropriately addressed can perhaps be achieved through the combined application of the two dominant approaches to understanding the situation of children affected by armed conflict. The first is the child development approach, which aims to minimize risk and prevent further harm while reinforcing protecting factors that facilitate children's physical and mental well-being. The second is the rights-based approach, which focuses on the fact that children not only have needs, but also the right to have these needs met.

The Convention on the Rights of the Child, which was launched by the United Nations in 1989 and widely ratified, set international norms for the recognition and observance of children's rights. The three key principles are: (1) the best interests of the child must be observed; (2) non-discrimination must be observed to assure that all children have the right to be treated equally; and (3) children must have the right to participation (http://www.unhchr.ch/html/menu3/b/k2crc.htm).

Despite the considerable health risk faced by the elderly during times of forced migration, their needs are frequently marginalized. This was highlighted in the Balkans crisis of 1999. Whilst the CMRs among refugees displaced from Kosovo to Macedonia and Albania were relatively low, a large proportion of deaths occurred among elderly people as a result of war-related traumatic injury and chronic diseases, with elderly people more at risk for under-nutrition than young children. Yet, they were rarely considered a vulnerable group (Salama, Buzard, and Spiegel 2001).

The vulnerability of any group (women, men, children, or the elderly) differs according to its exposure to a given problem and its capacity to tackle it. The type of action necessary to respond to their needs depends on the specific circumstances and local context, and correctly identifying the specific demographic characteristics and epidemiological profiles of each displaced population. Above all is the need to involve the 'beneficiaries' in the planning, implementation, monitoring, and evaluation of healthcare interventions.

**Websites:**
The Convention on the Rights of the Child - http://www.unhchr.ch/html/menu3/b/k2crc.htm

Convention on the Rights of the Child - http://www.unicef.org/crc/crc.htm

Norwegian Refugee Council: Global IDP Project - http://www.idpproject.org/

International Committee of the Red Cross (ICRC): Women and war - http://www.icrc.org/web/eng/siteeng0.nsf/iwpList2/Focus:Women_and_war

Reproductive Health Response in Conflict Consortium (RHRC) - http://www.rhrc.org/

Saving Women's Lives - http://www.savingwomenslives.org/

World Health Organization (WHO) – http://www.who.int/disasters

UN: Women Watch: http://www.un.org/womenwatch/

UNHCR - http://www.unhcr.org

UNICEF - http://www.unicef.org/aids/index_resources.html

Women's Commission for Refugee Women and Children - http://www.womenscommission.org/

World Health Report (focusing on mental health) - http://www.who.int/whr2001/2001/

## 6 Forced migration and healthcare systems
### 6.1 Assessment and surveillance
A fundamental role of public health is to assess the current and future health needs of refugees and IDPs to help allocate resources and to design, implement, and evaluate health services and systems to meet those needs. This is based upon the collection of timely and valid quantitative and qualitative data. Of particular importance are epidemiological studies. Epidemiology is the study of the distribution, frequency, and determinants of health-related events in human populations. It is less concerned with events affecting a single individual than it is with the patterns of events in populations, and is based on the premise that adverse health outcomes do not occur randomly within a population but rather occur in somewhat predictable patterns. Such patterns may be manifested as clusters of disease, or other health outcomes in location, time, or amongst certain groups of people.

The overall objective of assessment and epidemiological surveillance is to understand the needs of displaced populations, match available resources to needs, prevent further adverse health effects, evaluate the quality and quantity of services provided, and facilitate improved performance in the planning, services, and management by individuals, organizations, and health systems. Such studies may address the following:

- Vulnerability analysis of the population at risk.
- Evaluation of the public health impact of disasters or complex emergencies.
- Analysis of risk factors for adverse health effects.
- Clinical and economic investigations of the efficacy and effectiveness of particular approaches to prevention, diagnosis and treatment of healthcare interventions.

Essential to the effective measurement of such studies is a surveillance system that integrates epidemiologic, behavioural, laboratory, demographic, vital statistical, economic, medical, anthropological, and other types of information for programme development and action. To support preparedness, WHO has established a 'Health Intelligence Network for Advanced Contingency Planning', which provides rapid access to up-to-date information on particular countries and their health indices, as well as guidance on best practices and data on disease surveillance.

However, surveillance studies are often imprecise in identifying etiologic factors associated with increased morbidity and mortality. Such studies take place in what are generally extremely difficult situations characterized by insecurity, political involvement, restricted access to areas of conflict and sources of information, public fear and mistrust, lack of infrastructure, rapid movement of large populations, and lack of trained people to carry out the survey. Many poor countries also lack reliable health registration systems, making it particularly difficult to get baseline demographic and health data and denominators to determine the proportions of deaths, diseases, and disabilities that are related to conflict and settlement in refugee and IDP settings.

Whilst progress has been made, there remain calls to further standardize and co-ordinate the protocols, procedures, and indicators for the gathering of information, and to ensure that data is available, intelligible, useful, and appropriate. A further challenge to the medical research profession lies in the fact that there remains limited protection for refugees and IDPs when participating in medical research. This is particularly important given their lack of power and control.

Data limitations can be partially overcome through 'quick and dirty' surveys which aim to ensure simplicity, speed of use, and operational feasibility. These rapid assessment and surveillance methods use data from existing/temporary medical facilities, sentinel surveillance, community questionnaires, verbal autopsies, structured and semi-structured interviews, and focus group discussions. However, one of the greatest challenges is that no matter how accurate, timely, or relevant the information for policy- and programme-making, other issues come in to play involving political and personal values. This is particularly the case in the intensified environment of the complex emergency.

A large number of health assessment tools have been developed. These include the following:

- WHO: *Rapid Health Assessment Protocols for Emergencies*, 1999 - http://www.who.int/disasters/
- UNHCR: *Operations Management Handbook*, 2003 - http://www.unhcr.org/cgi-bin/texis/vtx/publ
- The International Federation of Red Cross and Red Crescent Societies: *Disaster Preparedness Training Manual*, 1997 - http://www.ifrc.org/WHAT/disasters/dp/manual.asp
- Sphere project, *Sphere Project Handbook*, 2004 - http://www.sphereproject.org

- Johns Hopkins University School of Public Health: *Rapid Assessment Procedures (RAP): Addressing the Perceived Needs of Refugees & Internally Displaced Persons Through Participatory Learning and Action*, 2000 - http://www.jhsph.edu/refugee/images/tmb_rap_docs/rap_section1_profile.pdf
- Médecins Sans Frontières (MSF), *Refugee Health: An Approach to Emergency Situations*, 1997- http://www.msf.org/source/refbooks/msf_docs/en/Refugee_Health/RH1.pdf
- MSF - *Rapid Health Assessment of Refugee or Displaced Populations*, 1999: http://www.msf.org/source/refbooks/index.htm

**Websites:**
World Health Organization (WHO) - http://www.who.int/en/
*World Health Report 2003* - http://www.who.int/whr/
*Collective Violence*, 2002 - http://www.who.int/entity/violence_injury_prevention/violence/global_campaign/en/collectiveviolfacts.pdf

## 6.2 Relief, rehabilitation, and development
A healthcare system may be defined as the resources, organization, financing, and management that go into the delivery of health services to the population in a designated geographic entity: country, province, district, or the like. Conflict and forced migration exert direct and indirect effects on health status and health systems, and the needs of forced migrants pose significant challenges to the healthcare systems in the areas in which they arrive. The nature of these challenges varies enormously depending on the cause of displacement, the socio-economic and political conditions in the source and host countries, the capacity of local health systems, and the health needs of the displaced and host population.

In refugee settings, the government authorities of the host country delegate the responsibility for the health care of refugees either to their own representatives or to a humanitarian agency or consortium of UN and NGO agencies, depending on the government's capacity for health financing and provision. The delegation of responsibility for IDPs is more complex and problematic, with local powers often reluctant to directly provide services or allow external agencies to do so.

Those responsible for healthcare services need to decide the most effective system for their provision. Criteria which need to be addressed include, firstly, ensuring accessibility and equity of care. This includes geographic, financial, political, and sociocultural access, and must address issues of discrimination based upon gender, age, ethnicity, or political affiliation. Secondly, the quality and humanity of care, including participation by the target population in the nature and range of health services provided, must be addressed. Thirdly, co-ordination must be ensured between the types of services offered, the needs of the target population, and the various administrative and implementing bodies involved. Lastly, it is essential that the needs of the host population are fully taken into account and not marginalized in this process.

These decisions are generally based on findings from local assessments and surveillance (see above), negotiations with local authorities, agency policies, operational guidelines and specialist experience. The strong involvement of local entities in the initial assessments has also proven to be beneficial. A key difficulty faced in assessing the most effective provision of health services to refugees and IDPs is the lack of systematic data and research. Whilst the WHO and the Macfarlane Burnet Institute for Medical Research and Public Health have

begun to document studies that will build the foundation of research, no foundation of applied health research exists for complex emergencies, as it does for natural and technological disasters or for conventional cross-border wars.

In emergencies, humanitarian organizations try in the first instance to prevent loss of life and subsequently to re-establish an environment where health promotion is possible. Many relief organizations see their primary role in providing these Emergency Medical Health Interventions (EMHIs) to save lives and have an impact upon health outcomes within a couple of weeks. Their health measures are largely decided by humanitarian agencies (justified by the urgency of meeting vital needs), and are not necessarily concerned whether their activities can be replicated or sustained over the longer term.

In contrast, agencies such as UNHCR have adopted a specifically development-related, primary health care (PHC)-based perspective that attempts early on to take into account issues such as efficiency, sustainability, equity, and local involvement and ownership. PHC activities include:

- Promotion of good nutrition.
- Adequate provision of safe water and basic sanitation measures.
- Shelter and housing.
- Immunization programmes.
- Prevention and control of local endemics through communicable disease and vector control programmes.
- Reproductive health care and preventative care for mothers, infants and children.
- Treatment of common diseases and injuries.
- Provision of essential drugs.
- Health promotion and education about health problems.

EMHIs are criticized for foregoing sustainability by becoming too isolated from longer-term PHC initiatives, and for not recognizing that the needs of refugee populations are not essentially different from the everyday health needs in developing countries. However, the development/PHC approach is criticized for failing to address the unique, immediate challenge of acute morbidity and mortality. It is said that the objectives of emergency interventions must be differentiated from other forms of intervention, with specific tools developed, and a more context-specific and flexible appreciation of vulnerability (Davis 1996).

However, a synthesis of the two approaches is possible. Both use a similar strategy of aiming to ensure the widest possible access to health services and emphasising preventative measures. The varying causes of forced migration and changes over time will also effect the nature of the healthcare needs and thereby the appropriateness of different approaches. This includes shifts from casualty and acute patient care management towards provision of primary health services. Co-ordination between EMHI and PHC, including the participation of the target population in planning and implementation, would help emergency activities gain a 'developmental' dimension (Macrae *et al*. 1998).

The nature of service provision and systems development also includes debate over the establishment of parallel services for displaced persons, or a more development approach by upgrading the existing health infrastructures to provide integrated services for host and displaced persons. Whilst the former may be more able to meet the specific needs of displaced persons, it may forego sustainability and also run the risk of alienating the host population if they perceive health services for displaced people as better than their own. An

example of efforts to co-ordinate and integrate emergency health care with long-term health sector reform was led by WHO in Kosovo in 1999. This highlighted the importance of close inter-agency and cross-sectoral co-operation, and the need for a clear mandate, legitimacy, and leadership. These are clearly challenges in themselves.

Long-term planning, and ultimately legitimacy, of health services and systems also involves shifting responsibilities over time between humanitarian agencies and local or national authorities. Ensuring the extent and quality of services provided is a particular concern where doubts exist as to the capacity and/or willingness of the authorities to provide services to the displaced population. The risk is in maintenance of the socio-economic structural weaknesses that may have been a cause of the conflict or displacement itself. Rehabilitation must therefore take into account the needs of the previously under-served minority groups and ensure more equitable and appropriate access to health services.

Addressing the needs of displaced people also implies financially re-examining the conventional expectations of the national healthcare system. The potential expense and resources needed may require considerable international support, including ensuring sustainability through appropriate allocation of capital and recurrent costs (Macrae 1997). Concerns over financial sustainability have also led to debate over the use of health-user fees. Although the general consensus is that health services should be provided for free to refugees, a number of cost-recovery schemes have been introduced in long-term, protracted situations, such as in Afghanistan and the Democratic Republic of Congo, in an attempt to improve the long-term financial viability and quality of health services. Studies on the use of user fees in complex emergencies have addressed issues of equity, including people's willingness and ability to pay for health services and the impact that user fees and cost of medicines have upon purchase of other essential items and food such as food, education, and housing.

**Websites:**
London School of Hygiene and Tropical Medicine: 'Evidence-based Humanitarian Aid' - http://www.lshtm.ac.uk

International Federation of Red Cross and Red Crescent Societies: *World Disasters Report 2003* - http://www.ifrc.org/publicat/

Médecins Sans Frontières (MSF): *Refugee health: an approach to emergency situations*. London: Macmillan, 1997 - http://www.msf.org/source/refbooks/msf_docs/en/Refugee_Health/RH1.pdf

World Health Organization (WHO): *Collective Violence*. Geneva: WHO, 2002 - http://www.who.int/entity/violence_injury_prevention/violence/global_campaign/en/collectiveviolfacts.pdf

Macfarlane Burnet Institute for Medical Research and Public Health - http://www.burnet.edu.au//home

## 6.3 Health, humanitarianism, and human rights
The provision of health services to refugees and IDPs is inevitably implicated in the ongoing debate within the humanitarian field between those favouring the traditional humanitarian principles of impartiality and neutrality, and those who feel humanitarian activities should include longer-term political, developmental, and human-rights goals. Critics of the former would argue that in many cases health workers are inadvertently assisting the very

perpetrators of violence, and confer a degree of legitimacy on the perpetrators. Instead, humanitarian work should actively involve securing human rights and peace, even at the expense of neutrality and impartiality. Many agencies support this belief. Médecins Sans Frontières (MSF) was founded upon the importance of 'bearing witness' to human rights violations; and in extreme cases, services have been withdrawn from those suspected of being involved in violent activities, such as from refugee camps in Zaire in 1994. Staff of NGO have expressed their belief that humanitarian responses alone are often insufficient, and that without a commitment to human rights, humanitarian responses will only mitigate suffering, but not prevent a new generation of victims of human-rights violations (Rieff 2002). Indeed, neutrality has almost become a dirty word among many of the UK's leading aid agencies (Slim 1997).

However, the reformist approach is marked with huge practical and ethical difficulties that potentially risk the significant gains made in humanitarianism over the past half century (Fox 2001). How does one distinguish (and prioritize services between) the victims from the villains, refugees from fugitives, the deserving from the undeserving? Gerald Martone (2003) of IRC noted, 'by withdrawing life-sustaining assistance from refugees of Hutu ethnicity, humanitarian agencies abandoned the principle of impartiality. Is this not precisely the sort of prejudice and ethnic generalization that had caused the slaughter in the first place?'

Critics of the development approach also express concerns that development-oriented aid interventions may be channelled through organs of the state, so that in situations where the state is a party to conflict, humanitarian aid may lose its fundamental elements of neutrality and impartiality (White and Cliffe 2000). Making humanitarian aid political by linking it with human rights and longer-term development also runs the risk of combatants no longer recognizing or respecting the impartiality and neutrality of humanitarian agencies. As Hugo Slim noted, 'agencies cannot expect immunity or "humanitarian space" if they are leaning towards solidarity' (Slim 1997).

The humanitarian principle is further clouded by the arguments for military intervention based upon humanitarian justifications, which have been supported by a number of aid agencies. The danger is a blurring of roles as military forces get involved in the provision of humanitarian relief, with aid agencies perceived as being aligned with the those same military forces and their governments. Attacks on UN, Red Cross, and NGO staff in Afghanistan and Iraq in 2003 testify to the increasing lack of respect for humanitarian principles by belligerents.

**Website:**
ICRC: Debate on Humanitarian Action -
http://www.icrc.org/web/eng/siteeng0.nsf/iwpList2/Focus:Debate_on_humanitarian_action

**7 Regulation and ethical codes of conduct**
Unlike the situation within functioning nation-states, in the field of humanitarian assistance, health professionals and their organizations often used to be able to deliver health services without having to undergo individual or organizational accreditation in the affected country for both quality and accountability. However, since the early 1990s, indicators for the assessment, monitoring, and evaluation of health services provided by humanitarian organizations to populations affected by complex emergencies have been developed to improve the effectiveness and accountability of humanitarian response, in recognition of the potential harm that such programmes could cause. A catalyst for this was the very high mortality resulting from epidemics of cholera and dysentery among Rwandan refuges in Goma, Zaire, in 1994, with wide-scale clinical mismanagement of cholera by inexperienced

relief workers. Ongoing concerns are also expressed about the impact of poorly planned and co-ordinated donor-funded programmes in distorting needs, inflating prices and salaries, and taking local staff away from much-needed positions (Cullinan 2001). Donor agencies and host governments are also increasingly questioning the cost-effective use of their funds.

In 1994 the Red Cross movement and NGOs developed a Code of Conduct which seeks to safeguard high standards of behaviour, and to maintain the independence and effectiveness of disaster relief. In ten principles, the Code promotes the impartial character of aid, the respect of local cultures, the idea of building on local capacities, and the involvement of beneficiaries along with respect for their dignity. Furthermore, it describes the relationship that humanitarian agencies should seek with donor governments, host governments, and the UN system.

A second code of conduct was developed in the form of the Sphere project to try and improve accountability among aid agencies. Its first objective is to assist the international humanitarian community in developing a common framework for humanitarian action. Known as the 'Humanitarian Charter', the framework is based on key principles in international human rights and humanitarian law, and on the Red Cross/Red Crescent Code of Conduct. The second objective of the Sphere project is to outline minimum technical standards for humanitarian interventions. This makes explicit links to the defined levels of service delivery set out in the five core sectors of water supply and sanitation, nutrition, food aid, shelter and site planning, and health services.

Despite these developments, there is still no over-arching regulatory body with the power to enforce the attainment of standards by using the indicators outlined by Sphere and in other documents. The nearest such institutions are the Ombudsman Project and the connected Humanitarian Accountability Project, which seek to create an ombudsman of humanitarian work at field, organizational, and sector-wide level. However, they still lack enforcement mechanisms. Critical work remains in ensuring that such programmes are accountable not only to the donors and governments, but to the affected population.

It is also argued that regulatory codes need to move beyond utilitarian criteria of effectiveness, efficiency, and quantitative measurements, and should also address issues of humanity, equity, and local ownership. This is reflected in the NGO collaboration, 'The Quality Project'. It seeks a more holistic approach to quality, placing interventions in a wider political context. Others argue that the regulatory framework needs to more strongly address issues of human rights, suffering, bearing witness, and the social and political context of all humanitarian work (Robertson *et al*. 2002; Griekspoor and Collins 2001). A concern would be the impact such actions may have upon the humanitarian principles of independence, impartiality, and neutrality.

**Websites:**

Ombudsman Project - http://www.hapgeneva.org/OMBUDSMAN/ombudsman.htm

Humanitarian Accountability Project - http://www.hapinternational.org/en/

The Quality Project - http://www.projetqualite.org/pq_engl/proq_eng.htm

Sphere: Humanitarian Charter and Minimum Standards in Disaster Response - http://www.sphereproject.org

International Humanitarian Forum on War and Accountability - http://www.icrc.org/web/eng/siteeng0.nsf/iwpList2/Focus:Accountability

**8 Conclusion**
Despite the significant progress that has been made in the last thirty years in the field of public health and forced migration, significant challenges remain. These include greater access to health services by IDPs, improved co-ordination and co-operation amongst the agencies and authorities involved in public health and forced migration, and greater participation in the planning, implementation, and evaluation of health programmes by the displaced people themselves. A more informed debate also needs to take place on the association between forced migration and communicable disease. In addition, more equitable financing of humanitarian health responses which more accurately reflect levels of need is required, with a more transparent and system-wide framework for judging and responding to the relative severity of situations.

The long-term solutions to the problems that displaced people endure are clearly political in nature, and public health can play a greater role in trying to prevent conflict and displacement by identifying determinant risk factors of collective violence (http://www.who.int/disasters/bridge.cfm). These could include socio-economic inequalities, particularly between (rather than within) distinct population groups; high rates of infant mortality; rapid changes in populations structures, including large-scale refugee movements; and insufficient access to food, safe water, and health care. The challenge is whether public health can combine the mitigation of the health impact of displacement with helping to prevent displacement in the first place. Public health, as Rudolf Virchow pointed out more than a century and a half ago, is 'politics writ large' (Virchow, 1849).

**9 Other resources**
**9.1 Journals and databases**
*British Medical Journal* - http://bmj.bmjjournals.com/

*Disasters* - http://www.blackwellpublishing.com/journal.asp?ref=0361-3666&site=1

*Forced Migration Review* - http://www.fmreview.org/

*Journal of the American Medical Association* - http://jama.ama-assn.org/

*Journal of International Development* - http://www.wileyeurope.com/WileyCDA/WileyTitle/productCd-JID.html

*Journal of Refugee Studies* - http://www3.oup.co.uk/refuge/

*The Lancet* - http://www.thelancet.com

*New England Journal of Medicine* - http://content.nejm.org/

PubMed (medical and health database) - http://www.ncbi.nlm.nih.gov/PubMed/

ISI Web of Knowledge - http://wok.mimas.ac.uk/

**9.2 Academic and research institutes**
York University (Canada) Centre for Refugee Studies - http://www.yorku.ca/crs/

Columbia University Mailman School of Public Health -
http://www.mailman.hs.columbia.edu/index.html

François-Xavier Bagnoud Center for Health and Human Rights -
http://www.hsph.harvard.edu/fxbcenter/

Harvard University School of Public Health - http://www.hsph.harvard.edu/

Johns Hopkins University Bloomberg School of Public Health - http://www.jhsph.edu/

London School of Hygiene and Tropical Medicine - http://www.lshtm.ac.uk

Overseas Development Institute - http://www.odi.org.uk

Oxford University Refugee Studies Centre - http://www.rsc.ox.ac.uk

**9.3 Governmental, inter-governmental, and multilateral institutions**
Centers for Disease Control and Prevention (CDC) - http://www.cdc.gov

Department for International Development (UK) - http://www.dfid.gov.uk

European Commission Humanitarian Aid Office (ECHO) -
http://europa.eu.int/comm/echo/index_en.htm

International Committee of the Red Cross (ICRC) - http://www.icrc.org

International Federation of Red Cross and Red Crescent Societies - http://www.ifrc.org

International Organization for Migration - http://www.iom.int/

Sphere Project - http://www.sphereproject.org

United Nations Programme on HIV/AIDS (UNAIDS) - http://www.unaids.org/en/default.asp

United Nations Children's Fund (UNICEF) - http://www.unicef.org

United Nations High Commission for Refugees (UNHCR) - http://www.unhcr.org

United Nations High Commission for Human Rights (UNHCHR) - http://www.unhchr.ch

United Nations Population Fund (UNFPA) - http://www.unfpa.org

World Food Programme (WFP) - http://www.wfp.org

World Health Organization (WHO) - http://www.who.int

**9.4 Non-governmental organizations**
Action Aid - http://www.actionaid.org.uk

American Refugee Committee International - http://www.archq.org/

CARE (International) - http://www.care.org

International Centre for Migration and Health - http://www.icmh.ch/

International Rescue Committee - http://www.theirc.org/

Global IDP Project (Norwegian Refugee Council) - http://www.idpproject.org/

Medact - http://www.medact.org/tbx/pages/section.cfm?index_id=3

Merlin - http://www.merlin.org.uk/template6.asp?PageID=1

Norwegian Refugee Council - http://www.nrc.no/engindex.htm

OXFAM (International) - http://www.oxfam.org/eng/

ReliefWeb - http://www.reliefweb.int/w/rwb.nsf

Reproductive Health Response in Conflict Consortium (RHRC) - http://www.rhrc.org/

Save the Children (UK) - http://www.savethechildren.org.uk/scuk/jsp/index.jsp?flash=true

Women's Commission for Refugee Women and Children - http://www.womenscommission.org/

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