Health and human rights

Forgotten refugees and other displaced populations

The wars in Afghanistan in 2002 and Iraq in 2003 have focused the world’s attention and siphoned much funding away from other humanitarian crises (table).1–6 Emergencies such as those in Colombia, the Democratic Republic of Congo (DRC), Guinea, Ivory Coast, Liberia, Sierra Leone, and southern Sudan are equally or more serious in respect of human suffering and lives lost. Governments’ provision of aid to Afghanistan and Iraq, irrespective of the motives underlying it, is laudable and indicates that with sufficient political will there are enough resources to assist in refugee situations. However, in 2002, many refugee programmes, especially in Africa, were forced to cut up to a third of their budgets, with serious consequences in their capacity to provide basic life-saving services.7,8 Further cuts are likely for 2003. These tragedies are on a second tier in terms of political or media attention and funding.

However, a third tier of protracted refugee and internally displaced person (IDP) situations receives even less attention. Consequently, such situations are chronically underfunded and often have little hope of resolution in the near future. It is difficult to quantify the health, human rights, and economic consequences for these forgotten refugees. In this report, we consider a few of these populations and call on the international community to address them properly and equitably.

**Bhutanese refugees in Nepal**

The 1991 influx of Bhutanese refugees into Nepal reportedly began because of strict enforcement of citizenship by authorities to preserve Bhutan’s Buddhist character; many Nepali-speaking Hindu Bhutanese were forced to leave. About 103 000 Bhutanese refugees now live in seven camps in eastern Nepal where they are prohibited from working and are almost entirely dependent on external aid. Nepal’s volatile security situation has provoked the authorities to take a strict approach with asylum seekers and necessitated increased security measures by the UN High Commissioner for Refugees (UNHCR) and its partners to ensure the safety of refugees and aid workers. After almost a decade of bilateral negotiations, the governments of Nepal and Bhutan announced in June, 2003, that only a small proportion of the Bhutanese refugees will be allowed to return to Bhutan with full rights of citizenship. This declaration has heightened tension and frustration among the population and could render tens of thousands of people stateless.10

Specific diseases due to the refugees living in camps for a protracted period of time remain a concern. Micronutrient diseases such as anaemia, beriberi, and scurvy exist, and psychological illnesses are common (panel).11

**Saharawi refugees in Algeria**

Morocco’s occupation of western Sahara after Spain’s 1975 withdrawal led to long-term armed conflict between Morocco and the Polisario, an

Figure 1: Dakhla refugee camp in Tindouf, Algeria

![Dakhla refugee camp in Tindouf, Algeria](https://example.com/dakhla-refugee-camp.jpg)
independence movement based in the Tindouf region of southwest Algeria. As a result, thousands fled western Sahara in 1975 and around 165 000 Saharawi refugees remain in four camps in Tindouf. Algeria does not claim any of the territory for itself, but insists that a popular referendum be held on self-determination. Despite efforts at mediation by the former US Secretary of State James Baker, and calls for aid by the Secretary General of the UN, the political process and consequently efforts to reach a durable solution remain at a standstill.

The camps exist in a harsh desert environment characterised by high temperatures and low rainfall (figure 1). Inadequate funding has led to serious intermittent shortages of food, water, and other services, provision of which often falls below minimum standards agreed for disaster response.13 Health information systems are unable to provide accurate mortality and morbidity data, but in an anthropometric and micronutrient nutrition survey in September, 2002, 11% (95% CI 8–14) of 6–59-month-old children had acute global malnutrition and 35% (27–44) had anaemia (haemoglobin <110·0 g/L)—none had severe anaemia (<70·0 g/L). In non-pregnant women, the rate of anaemia (<12·0 g/L) was 48% (39–57) and of severe anaemia 4% (1–8). 7% (4–11) of adolescents had visible goitre.12

Urban refugees in South Africa14

In South Africa, 76 000 people of concern to UNHCR are situated in five major urban centres; 23 600 are recognised refugees and 52 400 are asylum seekers, mainly from Angola, Burundi, Congo-Brazzaville, DRC, Ethiopia, Rwanda, Somalia, and Sudan. The introduction of South Africa’s democratic constitution in 1994 provided rights and access to services for refugees and asylum seekers. There is no government sponsored assistance programme for these people, but they have the same right to basic health care, primary education (age 6–12 years), and work—from 6 months after applying for asylum—as South African nationals. However, 99% of refugees in Johannesburg and Pretoria do not possess proper identity cards, despite a guarantee of provision in the 1998 Refugee Act.15 The cards enable access to services such as health care and education as well as employment. In the survey, 17% of refugees reported serious difficulties with access to emergency health care and 30% of primary-school-aged children did not attend school. Furthermore, 39% of refugees obtain only one meal a day, and those with a chronic illness, such as AIDS, need additional assistance in finding adequate shelter. Xenophobic attitudes in much of South African society further hinder urban refugees from attaining basic human rights established by the Humanitarian Charter of the Sphere Project.16

Refugees and IDPs in Serbia and Montenegro17

Most displaced people in Europe live in Serbia and Montenegro. More than 350 000 are refugees (mainly from Bosnia and Herzegovina and Croatia; some from the Former Yugoslav Republic of Macedonia, and Slovenia) and over 225 000 are IDPs (largely from Kosovo province). Most of these people are integrated into local populations, but 21 000 refugees and 11 000 IDPs are accommodated in collective centres (figure 2). The plight of these unfortunate people has largely been ignored by the outside world.

Although Serbia and Montenegro is heading towards stability, the high social cost of economic transition, and donors’ decisions to reduce funding progressively for humanitarian assistance, has made the refugee and IDP situation more precarious. Long-term solutions include voluntary repatriation, local integration, and resettlement for a few vulnerable refugees for whom no other solution is feasible. However, Serbia and Montenegro needs first to create a national asylum system and the surrounding countries to implement property repossession procedures, which requires funds, personnel, and political will. Meanwhile, high unemployment and poor state health and education services in some regions combined with documenta-

Conclusions

Insufficient political will by leaders and governments and the indifference of influential regional and world powers allow these chronic situations to smoulder. The consequent lack of media attention and donor funding combined with bureaucratic barriers and xenophobia cause millions of forgotten refugees and IDPs, only some of whom are mentioned in this report, to face hopelessness and despair. Their basic human rights are often differentially recognised or denied.18 At the very least, aid for all displaced person situations should follow the Humanitarian Charter and meet the minimum standards in disaster response,19 whenever feasible. Extrapolating from recommendations by the report on the Commission of Macroeconomics and Health to displaced populations,17 significantly more investment by governments and donor communities in health-related services for this disadvantaged community is needed. Research is required to study how much funding is necessary and who should provide it; the diverse nature of the various situations and sustainability must be considered.

Perceptions of the transitional nature of these emergencies have been problematic in visualising refugees’ needs holistically as well as in long-term programme planning. However, the protracted nature of many refugee situations is gradually changing this narrow view, underscoring the need to identify and improve linkages between relief and development work through a local integration plan in which refugees’ needs are incorporated into the national development strategy of the host country. In addition, the international community needs to improve their political and monetary support towards durable solutions, such as repatriation, local integration, and resettlement in the countries of origin.

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Consequences of armed conflict for an ethnic Karen population

A long-running conflict between central Burma authorities and armed Karen opposition groups has driven some 100,000 refugees across the border to Thailand. An unknown number are displaced within Burma. From March, 2002, Nu Po camp (Tak Province, Thailand), one of seven Thai sites hosting Karen refugees (map), received an unexpected influx of refugees from the neighbouring Dooplaya District of Burma, a region containing about 60 villages of around 150–200 people each, grouped into four townships. Consistent accounts of violence and high death rates among these new arrivals, including allegations of direct attacks on civilians, prompted us to do an exhaustive mortality survey in refugees who had arrived in Nu Po camp since March, 2002.

The survey was approved by camp authorities, and all participants gave oral informed consent. Between Oct 11 and Oct 13, 2002, we used a pretested questionnaire to measure mortality and other population changes retrospectively during a recall period of 271 days from Jan 14 (Karen New Year) to survey date. Family heads were interviewed about differences in the composition of their households between the beginning and the end of this period, and about events accounting for these differences (births, deaths, separations, disappearances, etc). We defined families as groups living together in Nu Po camp. Causes of death were self-reported. An open, systematic question was also asked about the main family's reason for leaving Burma; responses were coded into categories predefined on the basis of information gathered from stakeholders in the camp.

We interviewed 244 families, all of whom came from Dooplaya District. A majority (184 [75%]) came from Kya In township; 46 (19%) families originated from Kawkareik township, and the remaining 14 from other townships.

within Dooplaya District. 1349 individuals had been living in these families in their home villages at the beginning of the recall period; of these, 238 stayed behind in the village, 105 left the family, 40 disappeared, and 31 died; 45 were born and 48 joined. Of the 1028 people who made it to Nu Po, 798 (78%) arrived between April and June; 74% reported travelling for 2 weeks or less and 8% took more than 1 month to reach the camp. The 31 deaths are equivalent to a crude mortality rate of 1.0 per 10 000/day (average population 1182). Five of the 45 babies born during the recall period died. Violence caused 15 of the 31 deaths. Nine were due to gunshot, five to explosion, and one to beating. Three of those killed were women and seven were children younger than 15 years. All violence-related deaths occurred inside Burma. Medical causes accounted for the remaining deaths. 90 (37%) families mentioned “war or insecurity” (attacks on their village or neighbouring villages, fear of persecution) as their main reason for leaving Burma; 83 (34%) mentioned “forced labour” (both sexes and children seemed equally susceptible to this practice); and 53 (22%) “forced relocation” by troops to various displacement sites. 36 (15%) families spontaneously reported that their house had been set on fire, and eight villages were named as having been burnt down. 163 (67%) families stated that they had been interviewed for registration; however, only two (1%) could show a refugee card.

Our findings show high mortality due to violence in a population of Karen refugees who fled Burma, mainly because of military actions. The mortality rate (about twice the normal rate in less-developed countries) is probably underestimated, since deaths of people who stayed behind, left the families, or disappeared are not reported. Our findings also raise great concern about the living and security conditions of the people remaining in the villages, displacement sites, or in flight within Dooplaya District.