# American Bar Association Section of International Law and Practice Report to the House of Delegates

## Refugee Health Needs*

### RECOMMENDATION

**BE IT RESOLVED,** That the American Bar Association urges the United Nations (a) to provide international protection for refugee health needs; (b) to review the adequacy of current international agreements to address the health and related humanitarian needs of refugees and other displaced persons; (c) to strengthen the protection of refugee health under the existing international agreements; and (d) to develop international agreements, or other mechanisms, to protect the health needs of all other displaced persons.

### REPORT

### I. Introduction and Background

This resolution urges an examination by the United Nations of international agreements covering health protection for refugees and other displaced persons. The examination should focus: (1) on finding a way to strengthen the protection of refugee health under the existing refugee conventions; and (2) on preparing international agreements, and practical solutions to meet health needs of displaced persons, other than those who qualify as refugees under the applicable convention.

War, natural disaster, civil strife, and persecution have resulted in an estimated 15 million refugees and more than 15 million other displaced persons worldwide.[1]

*This Recommendation and Report was adopted by the House of Delegates in August 1991. The Recommendation and Report was developed by the Committee on International Health Law of the Section, chaired by Lane Porter.

1. Toole, M.J., and Waldman, R.J., Prevention of Excess Mortality in Refugee and Displaced Populations in Developing Countries, Journal of the American Medical Association, June 27, 1990, pp. 3296–3302, footnote 1, citing *World Refugee Survey—1988 in Review,* Washington, D.C.: US Committee for Refugees; 1989.

The number of refugees worldwide is reported[2] to have doubled between 1980 and 1990. In 1985 the worldwide number of refugees was 10.1 million and in 1989 there were an estimated 15.1 million refugees, worldwide.[3]

Refugees are accorded assistance and protection by the United Nations High Commissioner for Refugees (UNHCR) under the 1951 Convention relating to the Status of Refugees and the 1967 Protocol to that Convention (1951 Convention).[4] The 1951 Convention defines the term "refugee" as any person who: owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion, is outside the country of nationality and is unable or, owing to such fear, is unwilling to avail himself of the protection of that country.

Moreover, there are an estimated between 15 and 20 million other displaced persons who do not qualify as refugees and therefore are not covered under the 1951 Convention. These persons do not qualify as refugees because they—did not cross international borders; crossed international borders for reasons other than a well founded fear of persecution; otherwise did not meet refugee qualifying status.[5]

Recent events—including the Gulf war; fundamental political and economic reforms in Europe and elsewhere; as well as internal civil strife in other locations—place new burdens on the response of the international community to aid refugees and other displaced persons.

Furthermore, the health needs of the existing more than 30 million refugees and other displaced persons are frequently inadequately served.

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2. "Refugees in U.S. Foreign Policy," CRS Issue Brief (90-419F), by Louis McHugh, Foreign Affairs and National Defense Division, Congressional Research Service, The Library of Congress, August 22, 1990.

3. Testimony of Roger P. Winter, Director, U.S. Committee For Refugees, on the International Refugee Funding Crises, before the U.S. Senate Committee on Appropriations, Subcommittee on Foreign Operations, May 7, 1990.

4. See also the Statute of the Office of the United Nations High Commissioner For Refugees, General Assembly Resolution 428(V) of 14 December 1950. For texts of these documents, see UNHCR, Collection of International Documents Concerning Refugees 3, 10, 40 (1988).

5. "More than 15 million refugees are in need of assistance and protection. An even larger number of people are in refugee-like situations, displaced (within or outside of their countries because of wars, civil strife and repressive policies) but not given legal status as refugees." Martin, et al., *Issues in Refugee and Displaced Women and Children,* Refugee Policy Group, Center for Policy Analysis and Research on Refugee Issues, Washington, D.C., prepared for Expert Group Meeting on Refugee and Displaced Women and Children, Vienna, 2–6 July 1990, at 1. See also Cohen, R., *Introducing Refugee Issues into the United Nations Human Rights Agenda,* Refugee Policy Group, January 1990, at 25. "Millions of people displaced within the borders of their own countries often are beyond the reach of refugee and humanitarian organizations. Although 15–20 million have been compelled to leave their homes for the same reasons as refugees—well-founded fear of persecution, gross violations of human rights, and internal conflict—they do not qualify as refugees because they did not cross an international border. Yet their numbers are reported to exceed those of refugees and most need protection and assistance urgently. Humanitarian organizations have little or no access in many cases because governments deny them entry or refuse to accept or abide by the Geneva Convention."

There is an opportunity for the American Bar Association to participate with other organizations in an examination of the sufficiency of international agreements to enable effective international community responses to the current health and related needs of all displaced persons. Appropriate modifications or additions to international agreements can be proposed for adoption.

## II. Adverse Health Circumstances of Displaced Persons

### A. Persons Internally Displaced by Gulf War

In March, 1991, at the close of the Gulf war, controversy developed between allied forces and international relief agencies concerning division of responsibilities for health and humanitarian protection of internally displaced persons located in areas of Iraq occupied by U.S. and other allied forces.[6] The need to clarify the respective roles of the international relief community and the allied forces apparently delayed the provision of health and other humanitarian services to displaced persons in need.

6. See "Border Town Becomes Wasteland of Refugees, Iraqis in U.S.-Held Zone Plead for Food," by Nora Boustany, *Washington Post*, March 20, 1991. "This U.S.—held Iraqi border town, which in peaceful times flourished on trade with travelers between Kuwait City and the southern port of Basra, has now become a wasteland for its residents and thousands of refugees stranded with little food and nowhere to go. [W]hen relief officials announced a tentative agreement for the U.S. military to provide food and water—5,000 Iraqis fleeing their government's bloody repression of a Shiite Muslim uprising had crowded into Safwan, fully overwhelming this once self-sufficient farming town. . . . For days, relief organizations and the U.S. military disagreed on who was responsible for helping the refugees, but Walter Stocker, the chief International Committee of the Red Cross delegate in Kuwait, said . . . that under a tentative agreement, U.S. forces will begin distributing food and water. Still unresolved, according to Stocker, is who should meet the broader humanitarian needs of the growing number of refugees here and who is responsible for their security. Even if immediate relief needs were met, he warned, 'not only the United States but also Iraq' would have to decide on their future."

Also, see "Flood of Refugees Burdens U.S. Forces," by R.J. Smith, *The Washington Post*, March 28, 1991. ". . . U.S. military personnel in southern Iraq and Kuwait find their daily routine increasingly dominated by the task of providing food, water and medicine for a surging population of refugees, with no clear end in sight, according to defense and military officials. . . . U.S. forces so far have provided 27,000 military . . . 'meals ready to eat' and 20,000 liters of water to refugees in Safwan. More than 1,100 Iraqi civilians have also received U.S. supervised medical care in Safwan and at military field hospitals in the area. . . . General Colin L. Powell, Chairman of the Joint Chiefs of Staff, said . . . that 7,000 refugees had reached Safwan over several days, and other officials said . . . that the influx is of increasing concern to U.S. military commanders. 'It's clearly more than they expected, because they didn't expect to have to be dealing with it at all,' said a U.S. defense official."

See "Iraqi Refugees Tell U.S. Soldiers of Extreme Brutality in the South," by John Kifner, *New York Times*, March 28, 1991. "The United States Army had for days refused to take formal responsibility for the growing number of refugees in the area, apparently fearing that it would become bogged down. Nevertheless, troops have been handing out boxes of their rations and bottled water along the road."

The Geneva Convention Relative to the Protection of Civilian Persons in Time of War[7] states obligations of the occupying power for the provision of food and medical supplies for the population;[8] and for hygiene and public health.[9]

An analysis of provisions of the Geneva Conventions, and other international agreements, seems warranted and necessary to clarify and determine the appropriate responsibilities for health protection by occupying military forces, local governments, and international relief agencies.

### B. Persons Displaced from Iraq to Iran

The Director General of the World Health Organization went to Iran in March, 1991, to visit persons who, after cessation of hostilities in the Gulf war, had evacuated southern Iraq and settled into one of three camps located in Iran. On March 17, 1991 it was reported there were 30,000 evacuees from Iraq then located in Iran, mainly in Khuzestan Province. Of identified immediate concern was the provision of safe water and sanitation facilities.[10]

### C. For Persons in Kuwait and in Iraq—Immediate Humanitarian Needs; Rehabilitation of Public Health Infrastructures

A joint WHO/UNICEF mission visited Iraq in February 1991 to assess immediate health needs. WHO concluded[11] that the top health priorities in both

7. Geneva Convention Relative to the Protection of Civilian Persons in Time of War, August 12, 1949. 6 U.S.T. 3516; T.I.A.S. No. 3365; 75 U.N.T.S. 85.

8. Article 55 provides, in part: "To the fullest extent of the means available to it, the Occupying Power has the duty of ensuring the food and medical supplies of the population; it should, in particular, bring in the necessary foodstuffs, medical stores and other articles if the resources of the occupied territory are inadequate."

9. Article 56 provides, in part: "To the fullest of the means available to it, the Occupying Power has the duty of ensuring and maintaining, with the cooperation of national and local authorities, the medical and hospital establishments and services, public health and hygiene in the occupied territory, with particular reference to the adoption and application of the prophylactic and preventive measures necessary to combat the spread of contagious diseases and epidemics."

10. See "Evacuees From Iraq Pouring Into the Islamic Republic of Iran—WHO Director-General Promises Immediate Support—," *WHO Press*, World Health Organization, Press Release WHO/21, 19 March 1991. "Although the city Khorramshahr was entirely destroyed during the Iran-Iraq war and has no infrastructure for receiving such an influx of refugees, the Government [of Iran] has made every possible effort to set up a camp and to arrange for water supply and primary health care, particularly mother and child health care. Of immediate concern is providing the refugees with safe water and sanitation facilities. . . . Despite the fairly good nutritional condition of the refugees, a relatively high number of children had diarrhea. . . . If the situation continues more displaced persons will flee from Iraq to this part of the Islamic Republic of Iran. This is an area where most of the border towns were completely demolished during the Iran-Iraq war, resulting in a lack of hospital and other health care facilities . . . ."

11. WHO/UNICEF Special Mission to Iraq, February 1991. The World Health Organization Rushes Help to The Gulf, Press Release WHO/18, 14 March 1991, at 2. The press release account of the mission's report: "the single most urgent health threat, to Baghdad and the country is that of waterborne epidemics." Another finding of the mission was that the nutritional situation of women and children could deteriorate rapidly without immediate action. The supply of vaccines and essential

Kuwait and Iraq were: rehabilitation of the wounded, disease control, environmental protection, and the provision of safe water and sanitation.

Moreover, WHO urged the reconstruction of health care systems which were damaged extensively in the war, including the development of human resources, as well as health care facilities in both countries.

### D. Regional Health Consequences of Extensive Environmental Damage

The burning of Kuwaiti oil fields, and the destruction of sanitation, waste water and treatment facilities created several environmental health hazards and damage to the ecosystem of the Gulf region, and to the health of individuals: immediate danger from air and water pollution; impact of solid and chemical waste disposal into the sea and rivers; problem of guaranteeing sanitation and safe drinking-water.

During the March 1991 visit to Iran, the Director General of the World Health Organization emphasized[12] that the war's impact on the environment of the Gulf has unknown long term health consequences. The Director General noted an urgent comprehensive survey was needed in order to assess the situation and find ways and means of mitigating the effects of the war on health and the environment. Both the government of Kuwait and Iran requested assessment teams be dispatched to the region for this purpose. The Director General appealed to the international community for collaboration in finding the necessary resources to carry out this activity.

## III. Protection of Refugee Health Under the 1951 Convention and 1967 Protocol Relating to the Status of Refugees

The Statute of the Office of the United Nations High Commissioner for Refugees (Annex, General Assembly Resolution 428(V) of 14 December 1950) provides that the High Commissioner will provide international protection to refugees and seek permanent solutions for the problem of refugees by assisting governments.

As noted previously, the 1951 Convention defines[13] the term "refugee" as applicable to any person who owing to a well-founded fear of persecution for

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drugs was also recommended as well as preparation for possible epidemics of cholera a meningococcal meningitis in particular. Immediate actions were needed to ensure a supply of safe water, including the supply of chemicals for water treatment and spare parts and diesel fuel for generators.

12. "Environmental Health Hazards in the Gulf Area," World Health Organization, Press Release WHO/20, 19 March 1991. See also, "The World Health Organization Rushes Help to the Gulf," Id.

13. Supra, note 4. The 1951 Convention relating to the Status of Refugees, Article 1, Definition of the Term "Refugee."

reasons of race, religion, nationality, membership of a particular social group or political opinion, is outside the country of his nationality and is unable or, owing to such fear, is unwilling to avail himself of the protection of that country.

The 1951 Convention provides further[14] that the contracting state shall accord to refugees lawfully staying in their territory the same treatment as is accorded to nationals in respect of "social security," i.e., legal provisions in respect of employment injury, occupational diseases, maternity, sickness, disability, old age, death, unemployment, family responsibilities and any other contingency which, according to national laws or regulations, is covered by a social security scheme, subject to enumerated limitations.

Commentary on the 1951 Convention characterizes it as a point of departure in considering the appropriate standard of treatment of refugees, with its principal objective always the regulation of issues of legal status and treatment, while not setting out comprehensive solutions.[15]

Examination of the provisions of the 1951 Convention may reveal opportunities for modifications to strengthen its provisions by enabling the delivery of additional or more appropriate health and related services.

## IV. Refugee Health

### A. Early

Mortality rates of refugees and other displaced persons in developing countries are reported extremely high during the early emergency phase of displacement. In certain countries the mortality rates for internally displaced persons have been estimated up to 60 times the expected rate.[16]

The reported major causes of death among refugees and displaced persons during the early emergency phase are: (1) measles; (2) diarrheal diseases; and (3) acute respiratory tract infections (e.g., pneumonia).[17] In this regard, officials at the U.S. Centers for Disease Control recommend six specific remedial steps

14. Id., Article 24 (Labor Legislation and Social Security).

15. Goodwin-Gill, Guy S. *The Refugee in International Law,* Clarendon Press, Oxford, 1983, at 149.

16. Toole, M. and Waldman, R., supra, note 1, at 3296.

17. Id., at 3299. The authors are senior staff members of the international health program offices at the Centers for Disease Control, U.S. Department of Health and Human Services. They report (at 3298) that measles, diarrheal diseases, and acute respiratory tract infections accounted for 50% to 95% of all recorded refugee deaths during the emergency phases in Thailand, Somalia, Sudan, and Malawi.

Moreover, they further report (at pp. 3300–3301) their view that survival for refugees during the emergency phase of displacement requires five accomplishments: (1) providing food rations that contain adequate calories, protein, and essential micronutrients; (2) providing clean water in sufficient quality; (3) implementing appropriate interventions for the prevention of specific communicable diseases; (4) instituting appropriate curative programs with adequate population coverage; and (5) establishing a health information system.

that should be accomplished during the early emergency phase: (a) strengthening host country capacity to provide technically sound assistance; (b) strengthening the technical resources of the UNHCR; (c) involving displaced communities in relief programs; (d) insuring that the relief supplies of donor governments that are channelled through host governments and the UNHCR reflect the real needs of refugees; (e) alternatives to closed refugee camps should be promoted; and (f) refugee relief programs should be systematically evaluated.

### B. Long Term

The major reported[18] long term causes of death for refugees in camps are diarrheal diseases and acute respiratory tract infections. Other diseases (e.g., malaria) specific to the region can be major contributors to mortality.

Moreover, serious long term mental health problems have been identified among refugee and displaced persons in border camps and other concentrations.[19]

### C. Improving Health Status of Refugees and Displaced Persons

Consensus statements and recommendations for improving health status of refugees and other displaced persons have been made by groups expert in refugee public health issues. An assessment of international agreements concerning refugee health could usefully begin within these materials.

Suggestions concern better coordination and program development after the early emergency phase, as well as training and personnel issues.[20]

Other recommendations have been advanced concerning developing a different, more comprehensive, approach to the health problems of refugees. One identified deficiency in the international response is failure to establish refugee health programs that are sustainable over the long term. The emphasis on alternative approaches to those currently delivered would: focus on the basic health needs of the refugee community (e.g., food, water, shelter, sanitation, immunization for measles); emphasize primary care, health promotion, and disease prevention; and attend to the long term mental health as well as physical health needs of individual refugees and their communities.[21]

18. Id., at 3299

19. Mollica, R., and Jalbert, R., Community of Confinement: The Mental Health Crisis in Site Two (Displaced Persons Camps on the Thai-Kampuchean Border), Committee on Refugees and Migrants, *The World Federation For Mental Health*, February 1989.

20. The Georgetown Declaration on Health Care For Displaced Persons and Refugees, Health Care For Displaced Persons and Refugees: An International Symposium, December 4–7, 1988.

21. *Ensuring the Health of Refugees: Taking a Broader Vision*, Refugee Policy Group, Washington, D.C. 1990, at 1–3.

## V. Lack of International Agreements Covering Displaced Persons Not Qualifying as Refugees

There are no international agreements for the health protection of displaced persons who do not qualify as refugees under the 1951 Convention.

### A. Displaced Persons Not Qualifying as Refugees

Some displaced persons include those who cross no international border and thus do not qualify as refugees but experience adverse health and other consequences due to war, internal strife, natural disasters, persecution, or other causes.

Other displaced persons include those who cross international borders, and who are displaced by events such as war, internal civil strife, natural disasters, but whose flight is not based on a well-founded fear of persecution and therefore do not qualify as refugees.

### B. Humanitarian Response in Practice

Expert commentary by Guy S. Goodwin-Gill, a former member of the UNHCR legal advisor's office, states that apart from a 1969 Organization of African Unity Convention expanding the refugee definition, no international instrument has formally expanded the basic definition of the term "refugee" as found in the 1951 Convention.[22]

However, Mr. Goodwin-Gill notes[23] that State and international organization practice, however, "now also acknowledges, at least for certain purposes, the inclusion of a broader class . . . . who may be described . . . . as 'refugees and displaced persons of concern to the international community,' [which] comprises others who, having left their country of origin, are without or unable to avail themselves of the protection of the government of that country. Relevant factors in classifying 'displaced persons' will be 'external aggression, occupation, foreign domination or events seriously disturbing public order' in all or part of the country of origin."[24]

An examination of international agreements should seek a clearer understanding of obligations which states undertake when accepting entry of displaced persons into humanitarian programs which include health services.[25] Suggestions

22. Goodwin-Gill, Guy S., supra, note 15, at 216.

23. Id.

24. Organization of African Unity: 1969 Convention on Refugee Problems in Africa, Addis Ababa, September 10, 1969, UNHCR, Collection, supra, note 4, at 193.

25. Mr. Goodwin-Gill notes: "None of the UN General Assembly's resolutions approving UNHCR action on behalf of those outside the Statute sufficiently and clearly declares that the Office's mandate is being extended, or that new or greater obligations are being imposed on states. Given the status of such resolutions as recommendations only, their terms require analysis in the context of voting on adoption and, in particular, the actual behavior of states." Id., at 216.

for development of guidelines and standards to implement these obligations may be warranted.

Moreover, the examination should consider also the question of the obligations that states should undertake in determining and then protecting the immediate and long-term health needs of other displaced persons.[26]

## Conclusion

By means of this recommendation the American Bar Association can support and participate in a coordinated international review of the adequacy of current international agreements to address the health and related humanitarian needs of refugees and other displaced persons.

An examination of international agreements designed to enable effective international community responses can reveal impediments as well as facilitating mechanisms to adequate health and other humanitarian responses. Recommendations to strengthen provisions of the 1951 Convention, other international agreements, and practices may be warranted to respond to current and anticipated health needs of all displaced persons.

Furthermore, the examination may result in recommendations for new international agreements, or other mechanisms, to protect effectively the health and other humanitarian needs of all displaced persons.

Respectfully submitted,
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26. Mr. Goodwin-Gill: "State practice in admission and treatment also tends not to distinguish between refugees and displaced persons, at least in respect to initial reception. Standards of treatment after entry may vary, however, as may the choice of lasting solutions." Id., at 217.