SWEET SIXTY ?

The 60th anniversary of the UN Refugee Convention: refugee crises in 2011 and challenges for the future

MEDECINS SANS FRONTIERES

Médecins Sans Frontières (MSF) is an international medical relief organisation.
MSF is an independent and neutral aid agency that serves all people regardless of race, political and religious affiliation.

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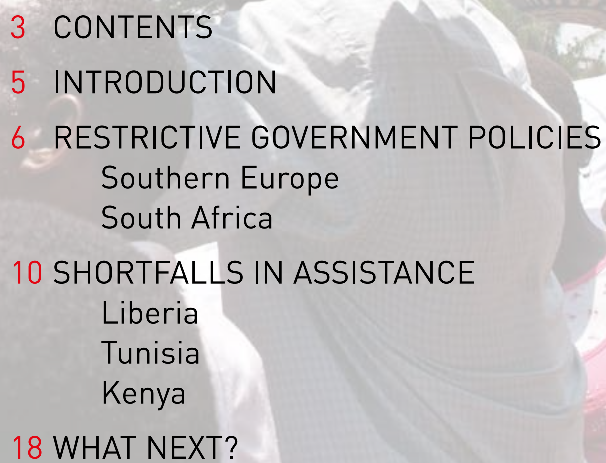

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WE HATE THE WORD REFUGEE. BEING A REFUGEE IS LIKE BEING IN A JAIL IN THE OPEN AIR."

Nadifa, 19, has lived in Dadaab, Kenya all her life

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INTRODUCTION

As the 1951 Convention relating to the Status of Refugees turns 60, millions of refugees – confined in camps, or scraping an existence in rural areas and cities – are facing a critical humanitarian situation. Refugees' health and lives are being put in danger as a result of restrictive government policies and serious shortfalls in assistance. Médecins Sans Frontières (MSF) is extremely concerned by the global trend to restrict the movements of refugees and asylum seekers and to deprive them of the protection they need and are entitled to.

There are 15.1 million recognised refugees across the world. As party to the 1951 Convention and the 1967 Protocol, states have committed to protect refugees from harm. Host governments have significant responsibilities towards those who seek asylum in their countries, while refugees have specific rights, enshrined in international, regional and national legislation, including the right to a level of healthcare similar to that of the host population.[1] However, all too often national governments circumvent, fail to uphold or simply ignore those rights. This has the dual effect of shutting the door to asylum seekers, and constraining assistance to refugees within host countries' borders – with adverse consequences on their lives and on their health.

1 "The 1951 Refugee Convention states that refugees should enjoy access to health services equivalent to that of the host population, while everyone has the right under international law to the highest standards of physical and mental health," UNHCR.

As an independent medical humanitarian organisation, MSF does not differentiate between its patients – be they refugees, asylum seekers, migrants, or simply men, women or children who are unable to get the healthcare they need. In addition to the more than 15 million recognised refugees, there are millions of other people, fleeing violence in their countries of origin or seeking a better life elsewhere, who are without legal protection and assistance. Nevertheless, on the anniversary of the Refugee Convention, there is a need to reflect on the collective struggle on the part of governments, mandated actors and civil society to provide basic welfare for refugees and asylum seekers.

This document is not an exhaustive account of the contemporary challenges faced by refugees and asylum seekers; instead it is a firsthand perspective drawn from MSF projects in 2011. It aims to illustrate – through five examples in southern Europe, South Africa, Liberia, Tunisia and Kenya –the restrictive policies of governments towards refugees and asylum seekers, and the shortfalls in assistance provided to them.

RESTRICTIVE GOVERNMENT POLICIES

States have primary responsibility for the welfare of refugees and asylum seekers, but the enactment of certain policies, and the lack of implementation of others, is leaving many people vulnerable. The trend has been towards "increasingly restrictive, control-oriented and indiscriminate migration policies, at times at the expense of core human rights protections."[2]

These policies include systematic detention, restricted access to asylum procedures, refoulement3 and diminished or denied assistance. Refugees may also face harassment from national authorities, discrimination and, in protracted cases, a lack of prospects for integration. All of these have a clear impact on the physical and psychological wellbeing of refugee and asylum seekers, as we have seen in southern Europe and South Africa.

SOUTHERN EUROPE

In 2011, the popular uprisings in North Africa pushed some 57,000 refugees, asylum seekers and migrants to flee across the Mediterranean sea to southern Europe. The vast majority landed on the Italian island of Lampedusa. Departing mainly from Tunisia and Libya, they undertook perilous journeys by boat, and perhaps as many as 2,000 perished at sea. The arrival of people fleeing North Africa was depicted as "illegal" or opportunistic migration, but the need for legal protection and assistance was real, prompting Italy to issue Tunisians permits to stay for up to six months and to consider all those fleeing Libya as asylum seekers. In Lampedusa, MSF came across many extremely vulnerable people, including the survivors of sexual violence, torture and ill-treatment, as well as victims of human trafficking.

Aiming to curb the landings on its coasts, the Italian government quickly moved to sign bilateral agreements with the new Tunisian government and the Libyan Transitional Council. First Italy announced that all Tunisians arriving after 5 April 2011 would be designated as economic migrants and repatriated. In June 2011, the Italian government revisited its Friendship Treaty with Libya, which included migration control provisions, and signed a new memorandum of understanding with the Libyan Transitional Council, in part to "combat illegal migration". These agreements amounted to pushing back potential asylum seekers from Europe's shores. As MSF teams learned through talking to patients in Italy and Malta, these agreements have had serious health consequences for many asylum seekers, including violence and ill-treatment in detention facilities back in Libya.

In addition, certain European countries, including Italy, were party to the Libyan conflict – and thus bore, as MSF publicly indicated, an even greater responsibility. Indeed, Europe Union member states' weak response to the boats arriving on their shores contradicted the claimed purpose of NATO's military intervention – which was predicated upon the protection of civilians.

MSF has worked at landing points along Italy's coastline since 1999, in both reception centres and open settings, to provide medical care and mental health support to those arriving on the country's shores. Over the past few years, MSF has also been working in Malta and Greece in similar projects. We have repeatedly called attention to the appalling living conditions in reception centres and their far-reaching impact on the inmates' physical and mental health.[4] Moreover, the quasi-systematic detention upon arrival of not only migrants but also refugees and asylum seekers is a threat to the health of people who have fled danger and hardship in their countries of origin.

Many new arrivals landed in Italy, after boat journeys fraught with danger, suffering from seasickness, dehydration, hypothermia and generalised body pain. In March of this year, 3,000 new arrivals slept on the docks in Lampedusa for several days, sharing 16 toilets and surviving on 1.5 litres of water per day.[5] In September, a fire in one of the overcrowded reception centres in Lampedusa

2 'Asylum, Migration and Refugee Protection: Realities, Myths and the Promise of Things to Come,' Erika Feller, 2006, in the International Journal of Refugee Law. Erika Feller is the Assistant High Commissioner on Protection at UNHCR. The article was written in a private capacity.

3 The principle of non-refoulement is enshrined in Art. 33 of the 1951 Refugee Convention which states that "No Contracting State shall expel or return ("refouler") a refugee in any manner whatsoever to the frontiers of territories where his [or her] life or freedom would be threatened on account of his [or her] race, religion, nationality, membership of a particular social group or political opinion."

4 See: 'Not Criminals', MSF, April 2009; 'The Impact of Detention on Migrants' health,' MSF, January 2010; and 'From North Africa to Italy: Seeking Refuge, Finding Suffering,'MSF, May 2011.

5 UNHCR emergency guidelines state that the absolute minimum allocation is seven litres per person per day and one latrine per five people, UNHCR Handbook for Emergencies, 2007.

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brought attention to the precarious conditions and stress to which migrants, asylum seekers and refugees were exposed. The Lampedusa centre has since been closed down and the island's port declared unsafe for rescue at sea operations, putting even more lives at risk.

European Union member states have yet to ensure appropriate medical and mental health support, and have yet to respect minimum standards for the reception of asylum seekers and vulnerable people, including unaccompanied minors and victims of torture, sexual violence and human trafficking. Adhering to the standards set out in the EC "Reception" Directive[6] is unlikely to create a "pull-factor" towards Europe, as is commonly stated; rather it is a humanitarian necessity.

Unlike 60 years ago, today it is developing countries which host 80 percent of the world's refugee population. Close to one million people crossed the border from Libya into Tunisia between February and September 2011,[7] in contrast with the nearly 60,000 arrivals to Europe. Europe's funding of humanitarian refugee operations worldwide should be in addition to, rather than as a substitute for, providing adequate reception conditions to those who flee conflict and persecution at home.

6 European Council Directive 2003/9/EC of 27 January 2003 sets minimum standards for the reception of asylum seekers.

7 Update on UNHCR's operations in the Middle East and North Africa, UNHCR, September 2001.

SOUTH AFRICA

On the southern tip of the African continent, South Africa's stable environment, economic success and progressive constitutional laws regarding refugees have attracted hundreds of thousands of migrants and asylum seekers from all over the continent. In recent years, the majority of those seeking refuge in South Africa have come from Zimbabwe, while others have travelled from other African nations such as Somalia where a deteriorating humanitarian situation and the collapse of the state have made life untenable. A complex mixture of economic, political and security reasons have brought people to seek refuge and subsistence in South Africa.

In 2007, MSF started providing humanitarian assistance to refugees, asylum seekers and migrants in South Africa through two projects: one in inner-city Johannesburg and the other in Musina, at the main border crossing with Zimbabwe. These projects provide primary healthcare, mental health support and referrals to hospitals including for chronic conditions such as HIV and tuberculosis (TB). Patients suffer from a wide range of pathologies including respiratory infections, diarrhoeal and gastro-intestinal conditions, sexually transmitted infections, skin conditions, physical and psychological trauma related to sexual violence, and stress-related ailments. Many of these pathologies can be directly attributed to their journey crossing into South Africa, and to the poor living conditions in Johannesburg.

For the past two years, Zimbabweans residing in South Africa had been covered by temporary protection measures which allowed them to stay and work legally in the country. However, since October 2011, the government has resumed deportations for those migrants who are without documentation. MSF is concerned that South Africa is denying entry to refugees[8] and asylum seekers at its borders: our teams have witnessed Zimbabweans without passports being barred entry at the Musina border post. MSF is also concerned that, since January 2011, people have been driven back to the border and denied the possibility of applying for asylum. This practice is tantamount to refoulement, which is a breach of South African national law and violates one of the core articles of the Refugee Convention – itself accepted as an established principle of international customary law.

Asylum seekers from Somalia and other countries, including Ethiopia and the Democratic Republic of Congo, have informed our medical teams that they were refused entry under a 'first safe country' principle, under which people are expected to apply for asylum in the first safe country in which they arrive. This does not account for the dangerous journey to the country of asylum, and has no basis in either national or international law. This harmful policy is now spreading to the whole region, with some refugees and asylum seekers being arrested and deported at the borders of Mozambique, Tanzania and Malawi.

The health consequences for refugees, asylum seekers and migrants are serious. In South Africa, the majority of our patients at the border crossing of Musina report the systematic theft of their belongings, including medication. Many have had their TB and HIV treatment interrupted, which can result in life-threatening medical complications. Furthermore, these policies encourage irregular entry into the country, which in itself is fraught with danger – from drowning in the Limpopo river to falling prey to criminal gangs. In the first six months of 2011, MSF treated 42 victims of sexual violence who had been assaulted by gangs while crossing the border. These patients reported that a further 159 victims had been exposed to similar sexual assaults but did not seek assistance.

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8 Somalis are recognised as *prima facie* refugees by South Africa.

SHORTFALLS IN ASSISTANCE

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OBTAINING REFUGEE STATUS GIVES, AT A MINIMUM, THE RIGHT TO RESIDE IN THE HOST COUNTRY."

Obtaining refugee status gives, at a minimum, the right to reside in the host country. This legal protection through documentation is often not enough to enable refugees to subsist. As MSF has observed in Liberia, Tunisia and Kenya, timely and adequate medical assistance is often unavailable, frequently because of a lack of resources or political will.

LIBERIA

Following the violence in Côte d'Ivoire in early 2011, some 188,000 refugees crossed the border into Liberia, while half a million people were displaced within the country itself. In western Côte D'Ivoire and northeastern Liberia, MSF ran mobile medical clinics on both sides of the border. Many Ivorians told our teams their experiences of suffering violence, repeated displacement, kidnapping and rape during the post-election violence in Côte d'Ivoire. In the Liberian border region of Nimba county, which already had scarce social services and generally low health indicators, the arrival of up to 93,000 refugees was perceived as a threat to ongoing stabilisation efforts by the international community. At the same time as refugees arrived, humanitarian actors were scaling down and aid efforts were turning toward development. In this vacuum, the immediate emergency response was stalled.

From the start, United Nations contingency planning foresaw a voluntary settlement of 70 percent of refugees to camps for "security and logistical reasons".[9] Yet in Nimba county, no more than 5,000 refugees moved to the identified camp and settlements, leaving the majority of refugees in host communities with no systematic provision of international aid. Host and refugee populations shared scant available resources, rendering both populations more vulnerable. In the absence of dependable assistance, MSF found that refugees regularly crossed the border back into Côte d'Ivoire, at great personal risk, to retrieve food or seeds from their abandoned homes or to search for lost relatives. At the same time, no mechanisms for international protection were established until six months after the start of the emergency.

Fortunately, MSF did not observe a major health crisis in Nimba county, but the experience highlighted the inadequacy of a coordinated response to what in many ways was a typical contemporary refugee crisis: a foreseeable and slow-onset influx of refugees across a border. The Liberia case exposes the failure to apply lessons learned in prior refugee crises, most notably to address jointly the needs of refugees and the host community. It was a conscious decision on the part of the Liberian government and the UN's refugee agency, the UNHCR, not to provide assistance in the politically sensitive border area where the majority of refugees were located. Despite a range of established best practices in such a classic situation, assistance and protection for refugees failed to materialise in a timely manner in Liberia. The experience of Ivorian refugees raises the questions if and how today's international responses to refugees will be able to adapt to the many and increasing challenges in more complex settings, in cities or in mixed migration flows.

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9 'Draft Interagency Contingency Plan, Potential Increase of Ivorian Refugees in Liberia (Nimba, Grand Gedeh, River Gee, and Maryland Counties,' UNHCR, March 2011.

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TUNISIA

The vast majority of those who fled the Libyan conflict went to the country's immediate neighbours, Egypt and Tunisia. Prior to 2011, Libya had been a transit point as well as a destination for many sub-Saharan Africans. When the fighting broke out in Libya, hundreds of thousands of people fled to Tunisia – among them nearly 700,000 Libyan nationals escaping violence, as well as 11,500 refugees and asylum seekers from Eritrea, Ethiopia, Iraq, Côte d'Ivoire, Somalia and Sudan.

MSF began providing medical assistance in March 2011, with a focus on mental health. The main project was in Shousha camp, where Tunisian authorities centralised the refugee population. From the onset, assistance at the camp was inadequate; there were security problems, a lack of access to secondary healthcare, the obstruction of medical referrals by the Tunisian military, poor waste management and water shortages. Over the following months, many refugees and asylum seekers returned to Libya – which was still at war – because of the difficult living conditions and the lack of prospects in Shousha. MSF mental health teams were also being told by patients that they preferred to cross the Mediterranean sea to Europe rather than stay indefinitely in the camp in these poor conditions.

The failure to provide assistance and protection in Shousha camp remains particularly damning given the involvement of the international community in the Libyan conflict. Refugees were given the impossible choice between staying in Shousha with few prospects, returning to war-torn Libya, or attempting the dangerous sea crossing to Europe. Several thousand mainly sub-Saharan Africans remained stranded for months, unable to return to their countries of origin.

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KENYA

Shortfalls in assistance to refugees are not confined to sudden emergencies, as the case of Somalis illustrates. In the words of UN High Commissioner for Refugees António Guterres, "there isn't any group of refugees who are as systematically undesired, stigmatised and discriminated against as the Somalis." Our teams have provided healthcare to Somalis in many countries: in Somalia, Kenya and Ethiopia, but also further afield in Libya, Yemen, South Africa and Italy. Since obtaining refugee status is often not enough, migration becomes a way for them to survive in search of a better life.

The dire humanitarian situation for refugees in Dadaab, in northern Kenya, is by now well known. The plight of the nearly half a million mostly Somalis in the Dadaab camps was broadcast across the world's media this year because of the extraordinarily high number of arrivals escaping violence and hunger in Somalia.

Yet the current refugee crisis in these settlements – characterised by what some have called a "humanitarian regime of detention"[10] – is neither new nor temporary. The Dadaab camps were built more than two decades ago, and the settlements have more in common with urban slums than with the traditional image of a refugee camp – by definition temporary accommodation. Dadaab, it is worth emphasising, is Kenya's fourth largest city, and it has now been a decade since its population surpassed the site's maximum capacity.

Despite the attention and the allocated funds, Dadaab fails to be a safe environment. Alarmingly, some health indicators for refugees worsen after their arrival in the camps. For example, in January 2011 MSF conducted a household survey in an area of Dadaab that showed rates of 3 percent severe acute malnutrition (SAM) and 12 percent global acute malnutrition (GAM) among children under five years old. A repeat assessment in the same area six months later showed rates of 6.3 percent SAM and 24.3 percent GAM. Another more recent study conducted by MSF's epidemiological branch confirmed that the refugees' precarious living conditions are indeed having profound consequences on their health.

MSF worked in Dadaab for 12 years before returning in 2009 in response to the nutritional and health

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emergencies affecting the camps' population. The humanitarian infrastructure is simply not set up to deal with people who have been living in crisis for 20 years. Refugee camps waste lives away: half of Dadaab's refugees are under 17; they have grown up in the camps and have little prospect of leaving them.

Providing assistance to Dadaab's refugees to ameliorate their daily lives remains a priority for us. Despite serious security concerns for our teams, MSF strives to provide a high level of medical care to a refugee population who have little prospect of going home. However, we do not want to be complicit in maintaining a status quo in which a permanent humanitarian emergency conceals political issues. The government of Kenya has responsibilities towards these refugees. At the very least, it should uphold its obligations under the Refugee Convention and improve reception conditions at the border.

REFUGEE CAMPS WASTE LIVES AWAY: HALF OF DADAAB REFUGEES ARE UNDER 17 AND HAVE LITTLE PROSPECTS.„

10 Refugees need to be issued a pass to exit the camps, even for medical emergencies, and this is seldom granted. Refugees without proper documentation risk arrest and detention.

The gradual increase of urban refugees – both in absolute numbers and in percentage terms – has been a challenge for humanitarian organisations. In contrast to refugee camps, it is harder to identify, register and target services to a geographically diffuse and invisible population. Refugees gravitate towards cities for socio-economic reasons, but MSF's work in various urban contexts shows that they often lack the most basic services, including healthcare. Indeed, the welfare of refugees goes beyond their legal documentation: in urban areas it requires having access to existing social services as well as the state's protection from discriminatory practices.

In South Africa, for example, the city of Johannesburg has identified 1,305 slum buildings with an estimated population of a quarter of a million, many of them Zimbabwean asylum seekers. A survey conducted by MSF documented the conditions of 82 slum buildings which were home to between 50,000 and 60,000 inhabitants. The living conditions were below the minimum standards set for refugee camps: close to 85 percent had less than the required 3.5 square metres per person; 38 percent shared a water tap with more than 200 people; and just under half shared a toilet with 100 people – far below the minimum required in an acute emergency. MSF worked with the residents in five of these slum buildings to remove waste – and called on the authorities to ensure greater integration of urban refugees, asylum seekers and migrants into existing social services.

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MENTAL HEALTH

Refugees and asylum seekers leave an unstable situation in their home countries, and often risk their lives in their quest for a safe place to stay. With so many experiencing danger in the course of their journeys, one of our key concerns is that refugees lack adequate mental health support. MSF's mental health programmes aim primarily to reduce people's symptoms and improve their ability to function. This work is done by local counsellors, with MSF psychologists and psychiatrists providing technical support and clinical supervision.

Recent mental health assessments done by MSF in Italy, Malta and Greece point to the risk of depression, anxiety and post-traumatic stress disorder amongst asylum seekers. These are aggravated by detention, both upon arrival in Europe and also in transit countries, as well as by the lack of information about their legal situation.

> *"I tried two times to come to Italy. The first one was in August 2009; our boat was already out at sea but a Libyan boat arrived and took us back to Libya. I was jailed for about one month in a prison near Tripoli airport. (...) We were 65 people in a rectangular room measuring five by eight metres. (...) We did not have water and so we had to drink from the two toilets we had for 65 people."*
>
> Somali refugee in Caltanissetta, Italy, April 2011

An April 2011, a mental health assessment was conducted among Libyans who had fled across the border to Dehiba in Tunisia. It found that the overwhelming majority of mental health patients showed symptoms of anxiety and depression which were directly related to the conflict in Libya. In Shousha camp, in Tunisia, MSF found that psychologically vulnerable people routinely faced difficulty in accessing other forms of medical care and services. From March to August 2011, MSF conducted more than 12,500 individual and group mental health consultations with victims of the Libyan conflict in Tunisia.

> *"I don't know how to plan, or what will happen tomorrow, or how we will survive today. (...) A lot of people are trying to go back to Libya and cross the Mediterranean sea to reach Lampedusa to get a better life."*
>
> Eritrean refugee in Shousha camp, Tunisia, July 2011

The mental health of refugees and asylum seekers is often affected by their journey to safety. Traumatic events can occur within the borders of the host countries. For example, 83 percent of the cases of sexual violence documented by MSF at the Zimbabwean-South African border in a three-month period in 2010 occurred within South Africa.

> *"I crossed the river with a group of four people. We were met by a gang of seven guma guma (criminal gang members) on the South African side who were armed with knives and guns. They forced me to have sex with the women in my group and I refused. Then one of the guma guma raped me. I don't actually know how many of them forced themselves on me because I was confused by the whole incident. I fainted and when I woke up they were nowhere to be found."*
>
> Zimbabwean asylum seeker in Musina, South Africa

WHAT NEXT?

For too many people, to be a refugee in 2011 is to confront the harsh realities of oppressive government policies and severe shortfalls in lifesaving assistance. Yet the examples detailed in this report do not mean that the international legal refugee framework is a failure. The Refugee Convention, its subsequent Protocol and the regional conventions remain important safeguards for refugee protection and assistance by governments, the UNHCR and civil society actors.

MSF calls on all states to recognise the physical and psychological vulnerabilities of people who have fled from their countries, and to offer them adequate medical assistance and protection. Policies and practices such as those described above make it increasingly difficult for people even to apply for asylum and have serious medical and human consequences. These policies are forcing refugees and asylum seekers to live in hiding and to perceive the state as oppressive rather than protective. While not necessarily contravening international and national laws, states are violating the spirit of the 1951 Refugee Convention and the meaning of asylum.

MSF's medical and humanitarian work has a tangible but ultimately limited impact on the welfare of refugees and asylum seekers. The challenge in the years ahead will be for states to fulfill their responsibilities and allow the UNHCR and civil society the necessary space to provide protection and assistance to refugees and asylum seekers. This would be in the spirit of the 1951 Refugee Convention, and would really provide something to celebrate.

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Médecins Sans Frontières
Dupré Street 94 - 1090 Brussels - Belgium
www.msf.org