

Inter-University Forced Migration Conference
at The Fletcher School
Health and Nutrition Panel
February 12, 2005

Moderator (M): Astier Almedom

Speakers: Agostino Paganini (AG)
Meriwether Beatty (MB)
Suraya Dali (SD)
Victoria Libov (VL)

In the case where a PowerPoint presentation was given, the text provides any additional comments made but not the actual text of the presentation.

M: Good Afternoon. Welcome to the Health and Nutrition Session.

(Introduces speakers by name and clarifies the question procedure)

AP: Thank you. I am happy to take get some fresh air from the den of corruption that is the current trend of the UN. This is academia, I am free.

UNICEF has taken a human rights approach. My thesis is that there exists a huge gap between what we say and what we do. The world has been moving to the right in an unthinkable way.

(Introduces concept): For every right, there is a right holder and a right bearer.

All resources should be placed within the authority of the proper bearer so as to allow him or her to fulfill the necessary job. Today's situation is such that it is obvious who the right holders are, but it is not clear who are the bearers. Examples of right bearers include the family, state, local community, and international community. By definition, the ability of those is compromised.

We have a responsibility. Are we doing it? I doubt it, since I see what the response has been. For example, 170, 000 million were pledged for the Tsunami relief, but only 300 million were given.

When going into a situation, there are different considerations, making one think about more than a simple legal obligation.

In Afghanistan, during the Taliban period, security was high in almost every city. The invasion occurred, and there was silence in the cities. NGOs poured in without

consideration, each entity selecting its own need, specialty, and brand name. The thing is, the local needs of the population evolve, there are phases. In the beginning, there is no need for psychological counsel, but chlorine to clean the water, for example, or 40 000 will die. Did die.

We have evidence of what kills people but the knowledge has not fully influenced what we do.

In the Democratic Republic of the Congo, in 2001, we looked at what happened globally. Mortality was estimated at 1.8 million people, of which, 200 000 deaths were due to violence, the rest to disease. Our search revealed that a year ago, 100 million dollars were spent on the DRC by the international community, but the money has gone to small projects, in a small geographic area, and were done according to what was thought to be good. This is a facility based approach. The DRC did not have an existing state, thus aid required a self-financing mechanism. People's coping mechanism had collapsed and internally provided economic support for reform and aid was not possible. Polio eradication in the world has almost reached its goal. In the DRC, 80% of the budget was used to fight polio, which has not had any impact on the mortality rate.

Not all studies have been negative. UNICEF has tried to increase transparency. A system that is more responsive to the improvement of basic rights is needed.

We need to look differently. Taking the Security Council model, the council defines the term, human resources, and budget of the mission. This coordinated approach is used for security decisions and needs to be applied to humanitarian crises. The present model does not fit and needs to change.

M: Thank you for a stimulating start. Let us move from rhetoric to reality now.

MB: Forced migration has a negative impact on the reproductive health of women. There is an increasingly diminished capacity to respond. Reproductive health needs to be prioritized with other humanitarian crises.

(Gives own background biographical information, introduces the Consortium for which works)

What does reproductive health mean?

(Audience responses) Family planning; prenatal care; maternal health.

(Gives own definition of reproductive health, as presented in PowerPoint). This is a consensus definition. It is important to point out the politics wrapped within the term. For example, many think of abortion when considering reproductive health. There is an inherent element of sex, which can make people nervous. All of this can prove to be problematic.

Reproductive health is a right. Women are disproportionately affected. Maternity health problems are the leading cause of death among women of reproductive age.

The key components of reproductive health are:

Safe motherhood- Every minute, one woman dies. Half a million die each year. Most of these deaths are preventable. These problems are worst in places experiencing an active stage of conflict. For Afghani women in Pakistan, maternity deaths are greater than all other causes of death combined.

(In the slide with numerical representations, the scale used is maternal deaths per 100 000 births)

What is the maternal death rate in the US? It is 8-16 percent depending on data.

Access to emergency obstetric care is key for preventing maternal deaths. First, it needs to be in place. Second, the barrier preventing women from getting there needs to be removed.

Family planning is a basic right. There is conflicting data concerning fertility in conflict settings. Some claim a decrease, others an increase due to the need to replenish deaths. It is hard to generalize.

Risk factors for STIs include population shifts between high and low prevalence areas; with money gone, women use sex for survival; the presence of military is a risk factor.

Program responses are harder to implement in real life, although fairly straightforward on paper. Donor priorities determine where funding is distributed.

Sexual violence includes rape, domestic violence, and harmful traditional practices. The media portrays the use of rape as a weapon of war. When women are in IDP camps, the risk of sexual violence committed against them increases. Camps need to

be designed so as to address or prevent these occurrences. For example, women walking to latrines alone can be at risk.

What needs to be done right away?

The Minimal Initial Service Package; above all, coordination is of primary importance.

Reproductive health concerns all. Response needs to be coordinated. It is not a luxury or a second place option.

SD: Thank you. Good Afternoon. I am honored to be here. Thank you.

(Gives an overview of the PowerPoint presentation)

I will provide a country profile for Afghanistan. The country is located in South Asia. It has endured 23 years of fighting. Afghanistan has low socioeconomic status and low GDP. Its society is conservative and patriarchal. It is the worst in the world for maternal mortality. Every 30 seconds, one woman dies. One in every four children dies before the age of 5.

There have been 6 million refugees since 1978. Most of these have been educated people leaving the country to Pakistan, Iran, North America, Europe, and Australia.

There are 1.1 million official IDPs, and the number is higher in actuality. Some have returned to Afghanistan. 200 000 are currently in Afghanistan.

(Conflict and ethnic violence slide for IDP causes)

From 1992 to 1996, 300 rockets a day fell on the city of Kabul. (A picture on the next slide shows the destruction in Kabul; it is from 1993 and the depicted site is a 20 minute walk from where she lived and is in the center of the city; she moved from Kabul with her family and expected to be removed from the city for 3 months, although it was 10 years in actuality) Droughts in 1999-2000 primarily affected the provincial population.

When refugees return, they move around the country until they can establish a good place to set roots once again. Because there has been much movement in the last 20 years, trying to demonstrate patterns of refugee movement on a map would be difficult. Families tend to move several times and this results in complex patterns.

My family moved from Kabul to North Afghanistan, where we stayed for 6 years. We then moved to the south, crossed the front, and finally arrived in Pakistan.

The decision to move is quick, it is a matter of survival. Those who have money, are able to leave; costs during fighting are high.

(Healthcare for IDPs)

Who is responsible? The International Community, and in some part it is also the responsibility of the government, but governments often cannot effectively handle it. NGOs deliver services on the ground and funds for such operations come internationally and locally. Often times, the healthcare provided for IDPs is better than the care they previously received at their place of origin, especially when the international media attracts attention to the crisis and stimulates funding and donations.

Coordination between international aid agencies is difficult. Each agency has its own mandate and interests.

Security is a big issue especially when female staff is concerned.

Overall, the sustainability of services depends on donors. In the area of return, healthcare is a problem, since IDPs do not want to return, and complexities arise.

(Slide of mortality rates) There is not much information on Pakistan and Iran, in terms of studies. Nonetheless, Pakistan has a population of 140 million when the population of refugee camps is 1.5 million. This puts the mortality rate in perspective.

(Lessons learned) 3.5 million refugees from Iran and Pakistan have returned but the system in place is not ready to meet their needs. The current short term development program in Afghanistan needs to shift to long term development- this is the big challenge.

M: Victoria Libov is from Ukraine and is herself a former refugee.

VL: I have two tasks today, to present nutrition and mental health issues.

I want to put the question mark back into our conference title. As a refugee, I would like a period. As a social services provider, I would like a question mark, so we can analyze, think, create change.

It is symbolic to be the last speaker, so I want to bring the discussion back to the US and build on what was said before.

There is a general lack of nutrition statistics, but the numbers are in the two digit percentages, and this is for the adult population alone, no even children.

With time, less supplies reach area because the international community is not capable to provide everywhere for there are so many people with needs.

Nutrition risk factors naturally increase for IDPs and refugees. People outside this room do not know the names of the nutrition-related diseases commonly found in refugee camps. Poor nutrition affects children's ability to learn. When they arrive in the United States, they are already damaged by malnutrition.

It is ironic for me as a local service provider to talk about nutrition, because in my search I only found weak programs. There was a lack of information.

What disease is most prevalent in the refugee population? The answer is diabetes and heart disease. The Asian refugees of Laos and Cambodia have been here for 30 years and we have only just now began to receive research data on the impact of their migration.

What did the US do to them? Do we help them in "the land of food"? No one educates the incoming refugee population. For example, the Russians in Oregon continue to fish in contaminated rivers. The Bantus are a new population of refugees. They reported "stomach flu" problems in hospitals. Who knows what will happen?

(Mental Health)

I will examine the service provided before and after migration.

Forced migration has destroyed the entire psycho-social system of these people. (She clarifies that the statistics provided for Asian children are for children born here, that the effect is still present after generations).

We should be proud of the system available to refugees when they first come to the United States. But this lasts for 8 months, after which the contract has expired and they are on their own. I would attach mental health disorders to the strategies suggested to help refugees adjust in the United States.

Can those people be self-sufficient? We need a professional health organization in the middle to organize the process. I would call this community engagement not community outreach. For example, many Bosnians are still depressed.

I have a daughter who is a junior in high school. Her school is fundraising money to send to Nigeria as a donation, but she came to me discouraged with the program. I want to help now, she said to me. How do I know the money will get to Nigeria? I told her to go to the apartment complex down the street where Nigerian refugees live. Help there, I told her, if you want to help today.

Question and Answer Period

Question directed by Moderator to SD: I want to address the element of community... What experience do you have of people in local communities being resourceful?

SD: The mental, psycho-social services for IDPs have not been incorporated into programs since services such as immunizations are a priority on the ground.

Generally, Afghanistan is a traditional society. We have large families that provide support for people, especially since they have lost government support. The family fibers are strong. People have extended families that all travel together, not just immediate family members.

We are behind in offering programs when it comes to mental health. It is still not a priority. A Ministry of Health colleague said, "mental health does not kill people." In his words, disease kills and donors think this. We are donor driven and donors like to see concrete numbers.

M: We are happy to see the possibility of numbers and ideas in Afghanistan. Afghanis say the UN needs to update the facilities in the country since they have put them there.

Question directed by audience member to AG: There is a divide between the UN and governments. The international community is divided. The peacekeeping model depends on the number of states that take initiative. Will there be a coherent response if the lead were left to the Security Council?

AG: The present system has no comparison, equivalent to the peacekeeping model. When your house is on fire, you dial 911. When there is a large humanitarian problem, anyone can come deal with the situation rather than have a specifically designated and trained group of people.

The peacekeeping model is not really a possibility. The Security Council represents the international community. How can MONUC be sent to the DRC and not have it assess funds?

The local governments are unable to respond, the international community has not designated one person or group to form a strategy... this is a system for us, not them.

Question directed by audience member to MB: What is the role of men, the place of men, especially in reproductive health?

MB: That is a really good question. More and more attention is needed as it concerns this topic. It is harder to put into practice. If women have the problems, they're an easier target. Some groups initially started working with male community health workers, who then encouraged women to participate. How we go about doing it is important and essential.

M: We cannot assume men are on the wrong side of an issue or alienate them.

VL: I can speak to mental health issues here. Newly arrived refugees have a hard time accessing services, and these services are not necessarily culturally sensitive. When they come to the United States they do not trust the services. In male dominated societies, it is harder for men to admit they have a mental health problem since they think of themselves, and female family members view them, as the provider, the ones that hold the family together. We need to pay more attention to their needs and find creative ways.

MB: Reproductive health had focused on women. The shift from a concentration on emergency services to long term care will increase the attention given to the participation of men.

Question directed to panel by audience member: The issue of the Rwandan prisoners... What is being done to address the psychological effects of living next to your family's killer, when you are told to reconcile with them, to move to peace?

VL: I do not know much about your case but I have an example from Bosnia. Bosnians, Serbs, and Croats live in one camp. There was a small project with conflict resolution and all sat together in one room; some progress was made. After that, more educational services were provided to the Bosnian community on mental health. It is not necessary to heal first and then meet together. Sometimes it is better to approach the issue in opposite order.

Question directed to panel by audience member: How do you prioritize actions?

SD: My experience is with Afghanistan. In a post-conflict country, what we do at the district or provincial level is develop a basic package, which took one year. Its implementation began eight months ago. At the district level, we must provide child care, maternity health and family planning.

Question directed to panel by audience member: What is being done in terms of continued care for those here and abroad?

VL: There exists a huge gap between what we do here for the same people and what was being done for them abroad. Here, they are given a cultural orientation, which does not help them much. Oregon has a Health Plan under which refugees are provided with 12 months of health insurance. The problem is that even native speakers cannot navigate the healthcare system, and refugees do not receive information or even abbreviated information. The idea of appointments often does not make sense to them.

Here, refugees are more disconnected, they are provided with less services than in camps since services in camps are concentrated in one location.

Question directed to panel by audience member: This question concerns family planning and possible social constraints. How is that issue treated and approached? How do you choose what is best under certain cultural and religious constraints? (Gives example of Iran and IUDs)

MB: The importance is of a range of methods and choices. It is important to combine family planning with cultural issues. There has been an attempt to try to reintroduce IUDs to some countries, but their use is not really a cultural issue. Condoms are also effective, so the use of dual protection is good.

Continuation or Comment to previous question by same audience member: But it is sometimes hard to get the cooperation of men when it comes to condom use in countries like Iran.

MB: It depends on women's priorities. It takes a long time to work on the issue and the continued availability of condoms is important. It is different to have women get men to use them.

Question directed to panel by audience member: Funding?

The current administration has cut funding.

Closing Remarks

I want to thank our moderators for doing such an effective job of keeping us within our time constraints. I will be brief and try to project.

I am Anna Mecagni and am a second year student, and one of the organizers of this event.

From flight to freedom, we have traced the path. What is freedom? Who gets it? Who makes it a reality?

We have tried to pull different voices, themes, organizations and perspectives together- those of NGOs, academics, refugees, and government agencies.

Human Rights and Identity have become recurring themes of this conference. Human rights are inherent in each issue. These rights include education, security, health and nutrition, and livelihood.

How do we move forward?

Everyone in this room wants to help. It is interesting to take what we have explored here and apply it to work; to break down and start anew, as we were asked to do; to understand humility; to keep trying.

We have tried to change the world by bringing people together to talk, make connections, ask questions, work across fields, disciplines, and perspectives.

Practically speaking, the work will continue. We will continue to post information on the website.

Thank you- to “our intelligent and provocative panelists,” “timely moderators,” “insightful and thoughtful participants.”