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Forced Migration: Refugee Populations

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Abstract

Undocumented migration is a global phenomenon that manifests in various contexts. This article describes the impact of the movement of large numbers of people in several African countries, producing a unique type of migrant—the refugee. We describe issues that refugee movements create on fragile health care systems, situations that precipitate refugee movements, certain human rights violations that are of particular concern such as gender based violence (GBV) and child soldiers, and lastly, implications for nursing practice and policy. We use examples from several countries in Sub-Saharan Africa, including the Democratic Republic of the Congo, Rwanda, Liberia, Sierra Leone, and Mozambique. Drawing on key documents from the United Nations High Commissioner for Refugees, current literature, as well as the international experience of the authors, this article presents an overview of forced migration and discusses opportunities for nurses to impact research, practice and policy related to refugee health.

Keywords

migration; refugee; forced migration; Sub-Saharan Africa; refugee health; human rights

This article is a part of a symposium issue about undocumented migration; the other articles focus primarily on the situation in the U.S. At the present time, the U.S. is struggling to deal with approximately 12-13 million undocumented persons. Immigration reform has been very controversial. However, undocumented migration is a global phenomenon and is manifest in different ways in various contexts. We believe it is important that the readers of *Nursing Outlook* understand aspects of the global context of undocumented migration. Thus, this article describes how issues of undocumented migration play out in one specific global context—Africa, particularly Sub-Saharan Africa. The first author has considerable experience in working and conducting research in Sub-Saharan Africa, especially Liberia, Ghana and Zambia. The second author has experience in numerous international contexts and has worked and conducted research in countries during conflict situations. The major purpose of this paper is to present a broad overview of forced migration and refugee

movements in Sub-Saharan Africa and to examine some of the major issues that have arisen as a result of the forced migration of large numbers of people. Last of all, we will discuss how nurses can take informed action in research, practice and policies related to refugee health care.

Background

The record of human migration began in pre-history and continues uninterrupted today. Politically, socially, economically and culturally—migration takes place everywhere on earth. Ongoing migratory patterns are broadcast into our living rooms, ipads and cell phones through sophisticated and creative communication networks. Migration can be a divisive issue and we frequently fail to grasp its full effects. Decolonization or the break-up of African states established and controlled by European powers led to numerous military clashes in many of the new African countries. Sixty or more years of political upheavals, wars, starvation, gross human rights violations—even genocide—have had a tremendous impact on the African people and in the way the world views and responds to refugee movements.

Refugees are often confused with other migrants. Generally, migrants decide to leave of their own volition, but legally they are still protected by their home country; whereas refugees are forced from their country of origin out of a fear of persecution (UNHCR, 2005). Persecution within their home country, often from reasons beyond the control of migrants, is most frequently the reason for fleeing. Persecution can include imprisonment, torture, harassment, civil war, human rights abuses or threats of harm. The persecutor can be a rebel group or a person or persons connected with the governing authorities (UNHCR, 2005). Persecutors can also be military forces from a neighboring country or ethnic or religious groups in opposition to one another. For example, the current violence in The Central African Republic is caused by the religious persecution of Muslims by Christians.

According to statistics from the United Nations High Commission for Refugees (UNHCR, 2013) there were 45.2 million forcibly displaced persons worldwide, including 15.4 million refugees at the end of 2012. Twenty three thousand persons per day were forced to leave their homes for internal displacement camps or camps outside their home country during the same year due to conflict or persecution. In 2013, over 7 million people were newly displaced to foreign soil including 1.1 million new refugees, the highest number since 1999; an additional 6.5 million people were newly displaced within their home country (UNHCR, 2013).

Protecting refugees and providing for their welfare requires a coordinated, global effort. Four years after it was created in 1945, the United Nations formed the UNHCR to provide humanitarian aid and international protection to refugees (UNHCR, 2005). Over the years, this mandate has expanded to include *persons of concern*, a broad term used to describe all persons of interest to UNHCR, including but not limited to: refugees, asylum seekers, internally displaced persons, and stateless persons (see Table 1).

Refugee Health

The numbers of refugees in Africa alone are staggering; sub-Saharan Africa is now home to more than 26% of the world's refugees. Close to one-third of all *persons of concern* to the UNHCR reside in Africa, consuming 1.89 billion dollars of UNHCR's 2014 budget (UNHCR, 2013b). Civil wars and violent conflict have forced millions from their homes into neighboring countries, often ill prepared to provide protection.

Developing countries frequently become a safe haven for refugees. By far these countries bear the greatest burden, hosting 80% of the world's refugees. Over 2 million refugees are living in the 49 least developed countries (UNHCR, 2013), straining already fragile health systems. This presents a challenging situation for relief communities. In a study reported by *Medecin Sans Frontieres*, workers from five internal displacement camps in the Democratic Republic of the Congo (DRC), found the main causes of death to be malnutrition, suspected malaria, infections, and diarrheal diseases (Van Herp et al., 2003). They also noted 45.3% of refugees were unvaccinated for TB and 68.5% were unvaccinated for measles. The ability to provide healthcare services within these camps was minimal. When refugees fell ill in the camps, the majority did not seek care from the local health care system due to the cost of consultation and the cost of medicine (Van Herp et al., 2003) but rather remained untreated.

Refugee camps often do not have the capacity to collect vital statistics. In a study of 12,000 internally displaced persons in the DRC, Ahoua et al. (2006) found extremely poor sanitary conditions and high population density with war related violence or murder the most frequently reported cause of death for those over 5 years old. Fifty-three percent of families reported at least one violent event involving a family member within 100 prior days prior to the survey. Because of the inability to issue a death certificate, families were left without legal confirmation of a family member's death (Ahoua, et al., 2006).

The trauma of fleeing one's country under fear of persecution cannot be overemphasized. There are numerous physical and psychological dangers of flight. The journey itself may be through treacherous territory. Those fleeing may encounter many dangers including lack of clean drinking water, lack of food, and the danger of being captured by enemies. Sometimes family members are left behind or become separated from loved ones during flight. Among a sample of 417 Mali refugees in Burkina Faso, 60% of the sample met criteria for post-traumatic stress disorder (PTSD), 83% of participants had a family member killed during the rebellion in Northern Mali, and over 90% reported problems with obtaining adequate food and shelter within the camp (Carta et al., 2013). Most had only limited access to information about the fate of family members from which they had been separated during the process of fleeing from Northern Mali to Burkina Faso.

Providing mental health services to displaced populations is often times overwhelming. The information on this topic is grossly inadequate and has mainly been reported from industrialized countries, which account for less than 20% of displaced persons (Mels et al., 2010). In a qualitative study conducted with Congolese refugee women living in a Rwandan refugee camp, participants reported chronic sadness about the past and the daily struggle to survive (Pavlish, 2005). Thomas & Thomas (2004) were some of the first investigators to

report on the impact of violence and the act of fleeing on the psychological well-being of populations displaced by war. In a comparison study of 819 adolescents from the DRC currently living in internally displaced camps, returnees from refugee camps, and non-displaced persons, Mels et al. (2010) found internally displaced persons (IDPs) reported the most psychological stress with a high exposure to violence when compared to the returnees and non-displaced persons. Additionally, IDPs reported more separation from family members, kidnapping by armed groups, war injuries and sexual abuse (Mels et al., 2010).

Receiving quality health care is a challenge for refugee populations as they are often living in crowded, unsanitary conditions. In a study conducted at refugee camps with 816 participants from three countries, Uganda, DRC, and Yemen, Whelan and Blogg (2007) found a major concern of the refugees was the treatment they received from local hospital personnel. Participants felt discriminated against by staff and believed the care they received was sub-standard. In a systematic review of the literature, Joshi et al. (2013) reported on the complex health needs exhibited by displaced persons. The services required are considerable - ranging from mental health services to transportation to receiving quality, affordable health care.

Historical Overview of International Refugee Policies

In July 1951 the General Assembly of the United Nations met in Geneva to draft and sign the 1951 Convention Relating to the Status of Refugees. The impetus for this document was the large number of refugees and displaced persons following the aftermath of World War II (Goodwin-Gill, 2008). The 1951 Convention remains today as the central reference document when examining refugee protection. It defines a refugee as someone 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 his nationality, and is unable to, or owing to such fear, is unwilling to avail himself of the protection of that country” (UNHCR, 2011, pg. 1). At the time of the drafting of the 1951 Convention, it was limited in scope to those who became refugees as a result of events prior to 1951 in Europe (UNHCR, 2005). Of course, the profound problems associated with the movement of refugees did not end with the after effects of World War II. In Africa as well as the Middle East, millions of refugees are currently of great concern and the situation changes becoming more dire almost daily.

Sub-Saharan Africa Post-Decolonization

The movement of millions of people across borders, owing to the decolonization of African countries, caused a huge challenge to the international community during the 1960's and identified a need to broaden the scope of the 1951 Convention. Many African countries faced a disintegration of political, economic, and social structures in their struggle for independence from European colonial rule. Turmoil across the continent increased, causing a shift in focus from refugees in Europe to those in Africa as African refugees were not covered under the 1951 Convention. In response, the international community developed and adopted the 1967 Protocol to the 1951 Convention. The 1967 Protocol removed the time and geographic limitations imposed by the 1951 Convention (UNHCR, 2011). Equally important, the 1967 Protocol paved the way for the African Union (then known as the

Organization of African Unity (OAU) to develop and adopt its own refugee convention known as the 1969 OAU Convention Governing the Specific Aspects of Refugee Problems in Africa. This regional treaty provides a broader definition of refugee and an obligation by member states to receive refugees and issue travel documents to those persons entering their territories (Secretary General of the OAU, 1969). Today, these three international legal documents provide the guiding framework used by the United Nations for determining refugee status. These documents spell out the protection of refugees on the African continent as well as the rights and responsibilities of both refugees and host countries. While we chose to focus on African countries, other areas of the world where there are large numbers of refugees, such as the Middle East, also fall under the UN conventions.

Undocumented Refugees: Legal and Political Implications

In Sub-Saharan African countries, civil wars and the accompanying devastation has forced millions of persons from their homes and countries. Some refugees have stayed in internal displacement camps or they have fled to camps outside of their home country. Fleeing their home country to another requires documentation as a refugee and this “documenting process” provides an identity document for an undocumented individual. Establishing one’s identity is of utmost importance in determining refugee status. In almost all countries, identity as well as lawful presence within the country must be documented for a person to establish themselves as a refugee (UNHCR, 1984). Without proper documentation, persons may be subject to detention or expulsion from the country. Because refugees of today flee for complex humanitarian reasons prompted by armed conflict, oppression, natural disasters, and violence, they often arrive in another country without the proper identifying documents. Article 27 of the 1951 Convention states; “contracting States shall issue identity papers to any refugee in their territory who does not possess a valid travel document” (UNHCR, 2010, pg. 28). This process is meant to provide a means of identity to refugees. Identity papers are only required to contain the current address, name, date and place of birth of the refugee (UNHCR, 1984). For international protection, proof of refugee status is imperative; these official identity papers readily identify a person as a refugee, affording him or her protection and services under the 1951 Convention. It is the responsibility of the accepting country to determine whether a person meets the definition of refugee. It is also the obligation of the accepting state to issue identification papers as soon as possible. Often this poses an incredible hardship on countries when asylum seekers arrive en mass. Refugees are usually fleeing violence, famine or environmental disasters so they often arrive rapidly in the host country and usually in very large numbers and with very few of their belongings. Large groups of individuals may be granted temporary protection until determination on individual status can be evaluated and assigned.

States also have the right under international refugee law to control the entry, residency, and eviction of any non-national in their country (UNHCR, 2005). Managing large numbers of refugees often strains already fragile governments with few financial resources for their own population. The treatment received and the rapidity with which refugees are able to secure travel documents or identity papers will differ from country to country. As with asylum seekers worldwide, procedures vary in each country. All states are encouraged to register asylum seekers and to quickly issue appropriate documentation that will remain valid until a

final decision is made on each individual's asylum application (UNHCR, 2002). African states frequently rely on help from international aid organizations to carry out this process.

Upon arrival in a country of asylum, refugees require assistance with securing basic necessities for everyday living such as food, clothing, shelter, and access to health care. Freedom of movement is often constrained during the initial time in a new country. While detention is not desirable, it is one way states have of controlling large numbers of people while processing claims for asylum. Registration is the process by which personal details are collected from each asylum-seeker. It is the first step in ensuring legal protection and facilitates the distribution of assistance that is needed (UNHCR, 2005). The process of collecting data on individuals raises several sensitive issues. While registration is a tool used for protection, personal data must be kept confidential (UNHCR, 2001) imposing still another challenge for accepting countries. Language is frequently an issue. Interpreters are required if asylum seekers do not speak the language of the country in which they are seeking protection.

Human Rights and UNHCR Protection Policies

In general, countries are not obligated to admit foreigners; refugees are an exception to this rule (UNHCR, 2005). *Non-refoulement* or the right to not be forcibly returned to a country where a person's safety or survival is threatened is a key principle of international protection. All countries are legally bound to not return refugees to any country where their lives or freedoms may be threatened because of political opinion, nationality, religion, race, or membership in a particular social group. The one exception to this mandate is when the refugee is a threat to national security in the state of asylum, has been convicted of a serious crime, or is considered a danger to the community (UNHCR, 2005). Even if one of these exceptions pertains, an individual cannot be returned to their country of origin if the risk of torture or cruel/inhuman treatment exists.

States cannot use national legislation to reduce their obligations to refugees although they may take different and unique approaches in drafting their own legislation (UNHCR, 2005). Ensuring humane and adequate standards of treatment is central to the role of countries accepting refugees. The Universal Declaration of Human Rights (1948) gives guidance to the international community in its efforts to promote universal respect, dignity, and fundamental freedoms to citizens of the world. Although the Declaration is not legally binding, it has huge significance as a political expression of individual human rights (UNHCR, 2005). The United Nations High Commission for Refugees oversees that the key documents governing the care of refugees are followed.

Refugees are often dependent on the host country and nongovernmental organizations (NGOs) to provide for their everyday needs as frequently the infrastructure of the host country is inadequate. While self-reliance is encouraged, there are many barriers to refugees looking for work or engaging in income generating activities. Some countries are able to issue temporary work permits to asylum-seekers or refugees that permits the refugees to farm unused plots of land (UNHCR, 2005). Freedom of movement is much greater once a refugee possesses identification papers or travel documents. The 1951 Convention describes what should be contained in travel documents. In some countries these are issued quite

readily once refugee status has been granted; but other countries only provide travel documents when specifically requested by the refugee (UNHRC, 2005).

Returnees: Issues and Concerns

Every refugee has the right to return to his/her home country. Returnees are those persons who return voluntarily to their country of origin. This may happen spontaneously –initiated by the individual – or in an organized fashion, coordinated by governments. Responsibility for improving the living conditions of a country and allowing for repatriation of its citizens lies in the country of origin, primarily with the government through the support of the international community (UNHCR, 2005). This can only be accomplished when safety and peace have been restored in a country. In post-conflict situations it may take years to rebuild infrastructure, establish peace and stability, provide job opportunities, and ensure those returning are free from human rights abuses.

UNHCR (2005) considers the central components of repatriation to be the ability of refugees to return to their home country under safe conditions and with dignity. Security in the country must be certain and refugees must be free from discrimination or punishment on the sole grounds that they left their country. There must be access to basic services such as food, water, education, and health care (UNHCR, 2005). A sudden influx of returnees can strain a country in the midst of rebuilding and has the potential to trigger additional problems for an already traumatized population.

In some cases, returning to their country of origin is not an option for refugees. When this occurs, resettlement to a permanent camp can occur. This can be within the original country of refuge or a third country. For example, refugees from Southern Sudan were displaced in neighboring African countries such as Ethiopia, Kenya, Uganda and Egypt prior to receiving refugee status in the United States (Boyle & Baird, 2012).

Impact and Implications of Refugee Movements on Vulnerable Groups

Women and children are especially vulnerable at times of forced migration. Nearly half, (46%) of all refugees are under 18 years old while women and girls account for 48% of the refugee population in the world (UNHCR, 2013). This presents unique challenges around the issues of safety and security for displaced populations.

Women and girls often flee their homes unaccompanied and travel under dire circumstances. They are at risk of abuse by those they are fleeing as well as those in the country of refuge. A number of studies have documented the prevalence of gender based violence (GBV) among refugee populations (Asgary, Emery & Wong, 2013; Whelan & Blogg, 2007; Zrally, Rubin-Smith & Betancourt, 2011). All investigators conclude that GBV is a significant and tragic problem worldwide.

In 1993 the United Nations Declaration on the Elimination of Violence Against Women defined violence as “any act of gender-based violence that results in, or is likely to result in, physical, sexual or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or private life”

(United Nations Declaration on the Elimination of Violence Against Women, 1993, p. 1). Gender-based violence has always existed, but only recently has it been recognized as a human rights problem and brought to the world's attention in international forums.

The prevalence of GBV is difficult to determine, but is believed to affect at least one-third of women at some time in their life (Tavara, 2006). In war torn countries this number is potentially much higher, yet it is rarely included in programmatic approaches targeting reproductive health care for women. In a UNICEF (2005) report on the impact of conflict, 733 randomly selected women were interviewed following the armed conflict in Sierra Leone. Of these, 20% were girls age 6-17 years. Over half (n=183; 52%) reported they had been subjected to sexual violence while three hundred and forty five (47%) had been raped and 192 (26%) reported having been gang raped.

Two studies (Omanyando, 2004; Swiss, et al. 1998) on war related violence in Liberia found 100% and 49% of childbearing women respectively reported experiencing physical or sexual violence during the recent civil war. Women reported experiencing multiple violent acts during the conflict including but not limited to rape, being beaten, threatened with a weapon, deprived of food and water, stripped of their clothing, and detained against their will. Victims reported suffering from psychological (i.e., humiliation, sense of powerlessness, depression, insomnia) as well as physical disturbances (i.e., lower abdominal pain, vaginal burning and discharge, dyspareunia, epigastric and generalized pain) affecting their daily lives and relationships with family and community. In refugee camps for Liberians in Sierra Leone, 74% of women and girls interviewed reported having experienced at least one incident of sexual violence before being displaced and 66% reported at least one incident during displacement either in or outside the camps (Watchlist, 2004).

Women in two studies from Mozambique following three decades of war reported 'injury to the spirit' manifest by loss of vitality, the will to sustain life, preoccupation with individual violation and suicidal ideation (Sideris, 2003). Women also reported sleep disturbances, unstable relationships with family, and spirit possession (gamba) that affected their capacity to conceive and raise children, thereby contributing to a marginalization of their social position (Igreja, Kleijn & Richters, 2006). Both studies looked at the long term effects of gender-based violence on the lives of women long after the end of war and found long lasting consequences such as deteriorating marital relationships, family instability, fertility problems, and continued physical violence within the community.

The long term consequences and impact on reproductive health for victims of GBV are profound. Yet in a systematic review of the literature on prevention and management strategies for consequences of GBV in refugee settings, Asgary et al. (2013) did not find a single article evaluating the prevention or treatment of GBV nor the resulting health sequelae. This review attempted to evaluate strategies and approaches for refugee or displaced populations that could prevent and/or manage GBV and its subsequent impact on health. Because of the dearth of evidence on this topic, the authors called for an increased awareness of this issue among healthcare providers and research institutes. Preliminary work is underway to develop and validate an evidence-based screening tool that would identify

female and male survivors of sexual and GBV in humanitarian settings and assist in appropriate referrals (Wirtz, Glass, Pham, Abera, Rubenstein, Singh & Vu, 2013).

Another particular kind of refugee or undocumented person that is common to Sub-Saharan Africa is the child soldier or child combatant. Thousands of children serve as armed soldiers in conflicts around the globe; often abducted or recruited by force (Human Rights Watch, 2014). Recruiting children to participate in armed conflict is a clear violation of the Convention on the Rights of the Child in multiple ways (United Nations Children Fund [UNICEF], 1989). The widespread use of child soldiers has been one of the core features of the violent conflict in the DRC for years; however children have been enlisted in different roles in armed forces in areas of conflict around the world (Coalition, 2008; Klasen, Schrage, Post, & Adam, 2011). Beah (2007) suggests that in as many as 50 countries around the world, there may be as many as 300,000 child soldiers, often taking copious amounts of drugs and wielding AK-47's. Children can take a direct role in hostilities using modern weapons, or they can be used in support roles such as porters, spies, lookouts, or messengers. They can be used for political advantage either as human shields or for propaganda purposes. Girls are often raped and forced to serve as sex slaves within makeshift militias (Minot, 2014). The Ugandan warlord, Joseph Kony, head of the Lord's Resistance Army is notorious for his use of child soldiers, both girls and boys (Human Rights Watch, 2012).

We do have some knowledge about child soldiers as various small studies have been conducted, often by persons working with organizations that are attempting to reintegrate the children back into their families and community. These studies have been conducted in various African counties and generally speaking, only small samples of former child soldiers have been interviewed. Some child soldiers have been released from armed groups in the DRC and other countries through advocacy and work performed by governments or, more often, local NGOs. Blattman & Annan (2008) worked with former child combatants in northern Uganda and reported that under most circumstances about half of former child soldiers were identified by the formal disarmament, demobilization and reintegration processes and brought to an interim care center. While they are at this interim center, the staff attempts to find their families or relatives so that the child soldier can be returned to his or her home village. Johannessen & Holgersen (2014) noted in interviews with eleven liberated child soldiers from the Congo that most of them reported they had escaped on their own and eventually made their way back to their home country and/or village.

Bayer, Klasen and Adam's (2007) reported that 92% of the 169 former child soldiers they interviewed had witnessed shootings, 54% had killed someone, and 27% had been forced to participate in sexual activities against their will. It is certainly not surprising that most studies with former child soldiers indicate a high prevalence of psychopathology.

In their study of child combatants in Uganda, Blattman & Annan (2010) have emphasized that, in addition to the psychopathology, the loss of human capital is a main consequence of children's participation in armed groups. The impact of lost years of schooling and employment seriously hampers the child's remaining years and the negative effects of the experiences last throughout adulthood and make reintegration into their families and

communities very difficult. Social rejection is another major concern in the reintegration of former child soldiers studied by Chelphi-den Hamer (2010) in *Cote d'Ivoire*. He reported that reasons for rejection by the family and village have included family poverty and fear of the former child soldier's behavior. Former child soldiers in Sierra Leone have been stigmatized when they returned to their home villages (Denov, 2010). Stigmatization is especially severe for girls as they have often been victims of sexual violence and are perceived as "used products" or "soldiers" wives (Mazurana, McKay, Carlson & Kasper, 2002. Tonheim (2012) interviewed girls who had served as former child combatants in the eastern part of the Congo. He agrees that girl combatants have a very difficult time trying to reintegrate back into their homes and communities because the stigmatization of girl combatants is quite severe throughout most African countries that have experienced recent war and violence. Drug and alcohol abuse has also been identified as a major problem in the social reintegration of former child soldiers as most of them used drugs extensively during combat situations (Beah, 2007; Lundqvist, 2005). The overarching and consistent message of all studies and official reports is that former African child soldiers require considerable help to be transformed into civilians who participate proactively in their society (Johannessen & Holgersen, 2014.)

Ishmael Beah tells a gripping story as his life as a child soldier in his memoir *A Long Way Gone: Memoirs of a Boy Soldier*. Beah fled advancing violence from rebel forces during the civil war in Sierra Leone. At the age of 13, he was forced to become a child soldier by government forces that were fighting the advancing rebel armies. Beah says he does not remember how many people he killed, but he does remember that the soldiers smoked marijuana, sniffed amphetamines and "brown-brown" a mixture of cocaine and gunpowder. Rescued by a coalition of UNICEF and NGO's, Beah says that returning to civilized society was more difficult than the act of becoming a child soldier, as he asserts that dehumanizing children is a relatively easy task. Despite the high level of international attention on the issue of child soldiers, the impact of that attention is yet to be felt by many children who are at risk of becoming child soldiers (Child Soldiers Global Report, 2008).

Research, Practice and Policy Implications for Nursing

At risk asylum-seekers such as unaccompanied children or victims of torture or sexual violence require special assistance and consideration. If possible, it is recommended that female interviewers and interpreters who are sensitive and trained in issues related to sexual violence be available to help those women seeking refugee status with the registration process and transition into new surroundings. Unaccompanied children must have a guardian appointed to assist and help care for their well-being. In some circumstances one family member may be denied asylum, in which case all others in the family should be given the chance to demonstrate their own individual entitlement (UNHCR, 2005).

During the residential stay of the refugees in the accepting country, life events continue in the camps and must be recorded. Key vital statistics such as the recording of births, deaths, and marriages are essential protection measures for individuals as well as for host countries (Mutuli, 2010). Children born in a refugee situation – where their parents are refugees – are frequently not issued a birth certificate by the host country because of logistical challenges.

Failure or inability to register a child at birth means the child has no way of proving their nationality (UNHCR, 2005) often causing long standing problems for the child.

Social infrastructure such as sanitation, adequate housing, law enforcement and legal recourse often do not exist in refugee camps. Violence may erupt putting those seeking protection under additional stress. Safety of refugees is of utmost importance. The standard for camps is to maintain adequate lighting and sanitary facilities, but that is often not the case. In conflict situations, refugee camps may need to be placed a far distance from borders to protect residents from potential threats from rebel groups. Guns and other weapons should be kept out of camps for the protection of residents but in reality, weapons of all kinds may be found or made in refugee camps. Providing a safe and clean environment for refugees takes coordination, money, and cooperation among local and international aid organizations.

Nurses must call for compassionate, humanitarian treatment of all displaced persons. Women and children must be given adequate support and protection against all forms of human rights abuses. As a profession, we must ensure refugees have access to culturally and linguistically appropriate health care. They must receive adequate protection from violence and be afforded both physical and mental health services. Children must be protected from armed conflict and conscription into rebel armies. We must advocate to government officials and policy makers to carry out recommendations put forth by the United Nations committee of experts to improve protection of children during armed conflict (Human Watch, 2013).

A model of health care for displaced persons must consist of integration of services between government and non-government entities within a country (Joshi et al., 2013). Case management, cultural and language interpreters, and specialized refugee health nurses could greatly improve the quality of care provided (Joshi et al., 2013). Nurses can avail themselves to specialized training in international humanitarian emergency response through programs such as the Minimum Initial Service Package for Reproductive Health in Crisis Situations (RHRC, 2012). Additionally, they can familiarize themselves with WHO documents guiding the care of refugees (WHO, 1996; WHO 2009).

The evidence base on refugee health must be strengthened. Better data collection and health surveillance is needed to impact the health and safety concerns of refugees, as this data is often underreported and of poor quality (Heise, Pitanguy & Germain, 1994). Improved quantity and quality of research on GBV prevention and management approaches is needed to improved delivery of health services and inform policy strategies (Asgary, Emory & Wong, 2013). Nurses, often frontline workers in refugee situations, are well positioned to lead these efforts.

Conclusion

Refugees and other *persons of concern* are becoming a burgeoning force on the African continent and elsewhere. Large populations cross borders and are internally displaced for a variety of reasons including: violence, armed conflict, oppression, and natural disasters – often fleeing without any identification. Governments in developing countries shoulder the

greatest burden of global migration, stressing the few resources these countries have for their own populations.

Global migration is fast becoming one of the biggest challenges to the international community. Instability of governments and destructive forces – both natural and those created by humans – has caused millions of people to flee their home countries for a better life elsewhere. Women and children are particularly vulnerable in these situations. Numerous guidelines from humanitarian organizations such as UNHCR and WHO exist related to the prevention and management of GBV, but to date little recognition and treatment has been given to this issue. Preventing exploitation of children and providing services for reintegration/rehabilitation back into communities is paramount.

Host countries and NGO's should make every effort to register refugees as quickly as possible and to provide a safe environment within the refugee camps. Providing basic necessities (food, safety, shelter) as well as the necessary health care to refugees will require ever more resources as global migration increases.

Finally, as a profession, nursing must contribute to the public discourse on the human rights of refugees. We must advocate for mobilization of appropriate resources when large numbers of people are forced from their country of origin due to civil war or human rights abuses. A coordinated, global effort is required to provide for the health and safety of this unique group of migrants.

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Table 1**Definition of Terms**

Refugees	Any person outside his or her country of origin who is unable or unwilling to return there due to a well-founded fear of persecution for one of the reasons set out in the 1951 Convention. Additionally, if a person has received serious and indiscriminate threats to his or her life, physical integrity, or freedom resulting from generalized violence or events seriously disturbing public order.
Asylum Seekers	Persons who have sought international protection for refugee status but their claims have not yet been determined. Not every asylum seeker will ultimately be recognized as a refugee. Every refugee is initially an asylum seeker.
Internally Displaced Persons	Those individuals who have been forced to leave their homes as a result of, or in order to avoid the effects of armed conflict, situations of generalized violence, violations of human rights, or natural or manmade disasters, and who have not crossed an international border.
Stateless Persons	Individuals who are not considered as nationals by any State under the operation of its law. They do not possess the nationality of any State. It may also include persons with undetermined nationality, such as those persons born in a refugee camp.
Returnees	Former refugees or internally displaced persons who return to their country of origin either spontaneously or in an organized manner.

Adapted from the United Nations High Commission for Refugees (UNHCR, 2005, 2013)