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The mental health of refugees and asylum seekers on Manus Island

Handout/Reuters Pictures

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On Oct 31, 2017, the Governments of Australia and Papua New Guinea ended support for the Manus Island Regional Processing Centre, an Australian immigration detention facility on Manus Island, Papua New Guinea. Instead, currently incomplete and substandard facilities without adequate service provision have been hastily constructed to accommodate people.[1] 379 refugees and asylum seekers refused to leave the centre stating fears for their security.[2,3] They managed to survive for several weeks with no provision of food and water or electricity and in poor hygienic circumstances. However, on Nov 23–24, 2017, the Papua New Guinea police went into the centre moving people out on buses to these incomplete facilities.[1] The physical and mental health of these people is precarious.[4]

Since 2013, an estimated 3000 refugees and asylum seekers have been forcibly transferred by Australia to so-called offshore facilities in Papua New Guinea and Nauru where asylum claims of people who entered Australian territories by boat are processed.[5] Around 1200 refugees and asylum seekers remain in Nauru and 900 in Papua New Guinea.[6] The office of the United Nations High Commissioner for Refugees (UNHCR) has repeatedly spoken out against this practice that does not provide international protection to those who need it but is driven by the desire to deter future asylum seekers and deny any possibility of settlement in Australia.[7]

At the former detention facilities people had been placed for indefinite periods without external freedom of movement and no prospects for resettlement in Australia or family reunification.[8] Such an environment is wholly inappropriate for the housing of refugees and asylum seekers, violates their basic rights, and has associated social and health costs.[9,10] The punitive conditions and absence of realistic long-term solutions cause harm to asylum seekers, particularly related to their mental health.[11,12] During a monitoring visit by UNHCR to Manus Island in 2016, one of us (SS) with other medical colleagues held individual interviews with 181 of the detainees in the Manus Island Regional Processing Centre. Most (90%) of the detainees met criteria for severe mental health conditions such as major depression, severe anxiety disorder, and probable post-traumatic stress disorder.[7] Diagnoses could not be confirmed against Diagnostic and Statistical Manual of Mental Disorders, 4th Edition (DSM-IV) or International Classification of Diseases, Tenth Revision (ICD-10) criteria and therefore cannot be seen as evidence of the presence of a true mental disorder but indicate high rates of psychological distress. Most interviewees (71%) had experienced torture or traumatic events before seeking asylum and most reported not having symptoms of mental disorders before detention.[7] The UNHCR team concluded that the lengthy, arbitrary, and indefinite nature of immigration detention on Manus Island, together with hopelessness in the absence of durable settlement options, had corroded the resilience of the detainees, and made them vulnerable to mental illness.[7]

In April, 2016, the Supreme Court of Papua New Guinea ruled that the Manus Island Regional Processing Centre was unconstitutional.[13] UNHCR has unequivocally advised the Governments of Australia and Papua New Guinea that comprehensive support services for refugees and asylum seekers are a fundamental precondition to the proper closure of the Manus Island Regional Processing Centre.[7] The authorities of Papua New Guinea, one of the poorest countries in the region with a Human Development Index ranking of 154 out of 188,[14] do not have the means and infrastructure to implement such guidance without support. In these circumstances, Australia's abrupt withdrawal from Manus Island Regional Processing Centre leaves a vulnerable population abandoned.[15] Most refugees and asylum seekers in the centre did not want to go to the offered alternative accommodation on the island due to well founded fears that they would not be welcomed by the local population.[16] Papua New Guinean nationals stormed the centre in February, 2014, killing one asylum seeker and severely injuring others.[17] In April, 2017, Papua New Guinea Government soldiers fired repeatedly

into the centre after an altercation with refugees.[18,19] The people of Manus Island have had insufficient information about the presence of refugees within their community and there has been a notable absence of planning for this transition. Despite these problems, many within the local community have attempted to render assistance.

In October, 2017, all previous services were withdrawn and skeleton services introduced to the nearby transit centres on the island, including security personnel and a business hours primary care clinic. People were given a month's supply of medication. All psychological services were abruptly withdrawn. A new smaller mental health team without torture and trauma counselling is being constituted. Refugees and asylum seekers were told to access the nearby Lorengau General Hospital for all other health services but have no access to interpreters. The hospital currently has no surgeon or anaesthetist and was given no extra resources to help care for the refugees and asylum seekers. Mental health services in this health facility are rudimentary and unable to cater for the mental health needs of refugees and asylum seekers with diverse cultural backgrounds and specific experiences of torture and adversity.[20]

On Oct 31, 2017, the authorities shut off water and power and stopped food supplies to the centre.[3] Stress and despair among the remaining asylum seekers and refugees increased as the authorities of Papua New Guinea started to dismantle the centre.[21,22] The forcible removal of refugees and asylum seekers from the defunct Manus Island Regional Processing Centre will mitigate the risk of waterborne disease outbreaks. However, their frustrations and disempowerment could have tragic outcomes and might lead some to desperate and destructive actions, including self-harm, suicide, or violence. These are regrettable but foreseeable and preventable outcomes of the cumulative circumstances refugees and asylum seekers have been placed in. The detrimental effects of prolonged detention on the mental health of people seeking international protection are well documented[23] and the adverse experiences during detention could have long-lasting negative effects on the mental health of refugees.[24-26] In the absence of realistic alternatives, the refugees and asylum seekers on Manus Island face ongoing uncertainty and fear. If they are moved from Papua New Guinea to a safe and supportive environment, refugees could be expected to largely recover from the psychological stress and adversities they have experienced at the offshore immigration detention facility and go on to rebuild their lives. It remains the Australian Government's responsibility to seek durable solutions for the people who seek protection in their land.

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A new vision for global health leadership

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The complexity of global health problems demands leadership that represents the pluralism in society. The absence of gender parity in the leadership of key global health institutions in academic, governmental, and non-governmental organisations is evidence that this aspiration for diverse and inclusive leadership is not yet a reality.[1,2] Women continue to represent most of the health workforce worldwide yet remain the minority in global health leadership.[3] For example, only 31% of the world's ministers of health are women, and among the chief executives of the 27 health-care companies in the 2017 global *Fortune 500,* only one is female.[4]

For the **Women Leaders in Global Health** conference see https://www.wlghconference.org/

To address this gap the inaugural 2017 Women Leaders in Global Health Conference (WLGH) at Stanford University, CA, USA, brought together more than 400 leaders, mostly women, from 68 countries, representing more than 250 organisations and institutions. The attendees reflected on current gaps and barriers to the advancement of women in global health and the steps needed to achieve gender equity in leadership. A number of key themes emerged.

First, the need to diversify leadership is not only an aspiration for inclusivity but is also supported by evidence for better outcomes. Gender diversity in decision making and participation in the workforce results in stronger economies, more productive institutions, and more stable governance.[5,6] In global health, women bring insight and ingenuity to complex problems, leveraging their service on the front lines as caregivers for their families and communities and often improving outcomes.[2]

Second, the barriers that impede gender parity in leadership are often deeply embedded in cultural norms, historical events, and stereotyping. Young emerging leaders in fields such as law, engineering, and health face stereotypes based on gender, culture, and discipline even as they tackle critical global health issues. For countries recovering from periods of struggle or hardship, the challenges women face in reaching leadership positions can reflect the reaction of leaders who were oppressed and are now reluctant to share their power having finally experienced freedom. Gender equity in leadership may come as these nations heal from conflict and women's roles in the struggle are acknowledged.

Third, creating capacity for gender parity in leadership will require engaging all genders and generations. This principle requires the strengthening of civic education and reinforcing the values of diversity and pluralism for all young people. The next generation of women need to be equipped with leadership skills. Another step is support for conferences, such as this inaugural WLGH event, where young women can access the guidance, inspiration, and wisdom of peers and senior leaders in global health. Welcoming men to such conferences is important to ensure they develop a better understanding of the barriers women face. The next WLGH meeting is planned for Nov 9, 2018, at the London School of Hygiene & Tropical Medicine in the UK, with Rwanda, Peru, and India being considered as future venues.

Fourth, transformation of institutions is crucial to ensure that structural barriers do not block women