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Committee Secretary
Joint Standing Committee on Migration
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Dear Committee Secretariat

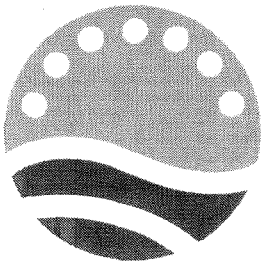
Following is a submission from the Multicultural Development Association Inc. (MDA) to the Committee's current inquiry into the migration treatment of disability.

MDA is a specialist settlement, advocacy and community development organisation with highly respected credentials in offering a variety of services to refugees and migrants. We are currently the largest service provider in Queensland assisting in the settlement of refugees when they first arrive in Australia. MDA provides this settlement support as part of a consortium with 4 Walls, a community housing provider, and Queensland Program of Assistance to Survivors of Torture and Trauma (QPASST).

MDA would be happy to provide further evidence or details if that would be of assistance to the Committee.

Yours sincerely

Karen Lee
Executive Manager
Government and Community Advocacy Team
MDA



MDA
Multicultural Development Association

Submission to the Joint Standing Committee on Migration's Inquiry into immigration treatment of disability

Multicultural Development Association inc. (MDA)

27 October 2009

Introduction

The Multicultural Development Association (MDA) welcomes this much needed inquiry into a process which has been a major stumbling block for many refugees in gaining permanent residence in Australia. As Queensland's largest settlement agency, MDA settles approximately 1,100 newly arrived refugees annually and currently works with 3,500 migrants and refugees in total.

We are uniquely placed to respond to the settlement needs of our clients who present with any number of settlement issues at any one time. A large percentage of our clients are humanitarian entrants and many attempt to sponsor their family members as soon as they are able to. Some are prevented from doing so because of a failure to satisfy health requirements and assessments.

It is important to distinguish between refugees who arrive via the humanitarian program as opposed to visa entrants who arrive via the general migration program because of the inherent protection obligations that are recognised and granted. The definition of a refugee is[1]:

> A person who "owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group, or political opinion, is outside the country of his nationality, and is unable to or, owing to such fear, is unwilling to avail himself of the protection of that country..."

Accordingly, MDA acknowledges the Australian government's continued commitment to the humanitarian program.

As part of the migration process, all potential migrants are required to undergo a rigorous health assessment in order to determine their eligibility for residency in Australia. MDA believe that this aspect of the migration process can be particularly unfair and discriminatory for vulnerable groups like refugees who are already disadvantaged. Refugees should be either exempt from this requirement or should be given special consideration because of their circumstances.

In addition, the assessment process does not take into consideration potential contributions the applicants or their families can and do make to the Australia community as a whole. We congratulate the Committee for having the insight to broaden out the scope of the current process to begin discussions on these important issues.

Effect of the health assessment on vulnerable groups – Refugees

While the health assessment is an important necessary element of the migration process, there needs to be consideration given to refugees who are amongst the most disadvantaged and vulnerable groups. This is all the more pertinent for refugees who

[1] The 1951 United Nations Convention relating to the Status of Refugees

as a result of conflict and war become casualties and suffer disabilities as a consequence.

A report by the Women's Commission for Refugee Women and Children states:

> ...persons with disabilities remain among the most hidden, neglected and socially excluded of all displaced people today. People with disabilities are often literally and programmatically "invisible" in refugee and internally displaced persons (IDP) assistance programs.
>
> They are not identified or counted in refugee registration and data collection exercises; they are excluded from or unable to access mainstream assistance programs as a result of attitudinal, physical and social barriers; they are forgotten in the establishment of specialized and targeted services; and they are ignored in the appointment of camp leadership and community management structures[2].

Therefore, MDA believes that refugees should not be further disadvantaged from being able to seek protection in Australia because of the stringent health requirements. For refugees living in camps, and also those who have sought asylum onshore through dangerous and often perilous journeys, there should be special consideration for these groups of people as well as families in the determination of their applications.

Most visa assessments are not undertaken at refugee camps but in the closest metropolitan city, and the journeys that are required are often long. For those that have been found with medical conditions like tuberculosis, clients are required to be treated for a lengthy period of time until their conditions improve and are able to be given a clean bill of health to travel.

For many it means having to stay for an indeterminate period outside camps until their results have been delivered. What this means is that people are hiding in cities where they may be further discriminated against, or at risk of injury or death because of their ethnicity or disability. Further because they are refugees they are not counted in any riots or incursions that may break out because they have no status and are invisible. This is especially dangerous for single women, children, the elderly or those with disability or heath conditions that are vulnerable targets and unable to avail themselves of places of safe refuge.

Exemption of the Migration Act from the Disability Discrimination Act

Another issue of concern is the fact that the provisions of the *Migration Act 1958* (The Migration Act) and its Regulations are mostly exempt from the *Disability Discrimination Act 1992* (The DDA).

As The DDA is compatible with the intent of the *United Nations Conventions on the Rights of Persons with Disabilities* (Convention on Disability) in enshrining the rights of people with disability, we believe that this exemption from the Migration Act

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[2] Women's commission for Refugee Women and Children, *Disabilities among Refugees and Conflict-Affected Populations*, June 2008, pg 2.

enables the process applied to health assessments to breach the Convention on Disability

MDA asserts that this exemption places refugees at a further disadvantage and in effect bars their ability to seek protection in Australia which again breaches other United Nations Conventions in international law which we are a signatory to. A 2004 Productivity Commission Review of The DDA also supports this view in finding that "some criteria [of the health test] may indirectly discriminate against some people with disabilities".[3] Legal advice from the Director of the Centre for International Law at the University of Sydney also finds that our migration laws are not fully compliant with Australia's obligations under the UN Declaration on the Rights of Persons with Disabilities.[4]

MDA are of the strong view that our laws should not further add to any direct or indirect discrimination of people with a disability and to further disadvantaged and vulnerable groups.

The following 2 case studies are examples of where an application has been denied and also instances where the health requirements are discriminatory. Neither of these are isolated incidents nor are they unique to our clients but demonstrate why the health requirements should be amended:

Case study 1 – characterisation of specific refugee groups

There are specific large groups of refugees that can be characterised by the ways in which civil war has permanently affected them. This is often the case for Sierra Leonean and Liberian refugees, who have been the victims of mass amputations by rebel militia. MDA has settled approximately 32 families from Sierra Leone and 72 families from Liberia over the last five years, none of which have been amputees. Anecdotally in the community, we are aware that there have been a handful that have been accepted and granted visas but these are few and far in between.

Questions have to be asked as to why we are only receiving refugees from this sector of the region that are physically whole and intact. Applications lodged here by refugees in attempts to sponsor family members who are amputees have been rejected, with little detail on the major reasons for this decision. Discrimination is difficult to quantify because of this lack of information or data.

Case study 2 – individual case

Two young Rwandan female clients of mixed Hutu and Tutsi ethnicity fled war and genocide in their country, leaving family behind and arrived in Australia in 2003. Both sisters had endured significant trauma as a result of genocide which resulted in displacement and family separation, suffered discrimination as a minority group because of their mixed ethnicity and targeted because of their gender by ever present groups of soldiers who utilised rape as a weapon of war.

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[3] Productivity Commission, *Review of the Disability Discrimination Act 1992*, April 2004

[4] See advice in Submission 1 to this inquiry from the National Ethnic Disability Alliance

In 2004 an application was lodged for their mother to join them in Brisbane. The application took approximately four months and was subsequently rejected because she had failed to meet the health requirements according to the legislation. The health issues were a result of serious gunshot wounds to both her legs in a civilian attack which resulted in disfigurement and permanent disability.

Subsequently, the sisters applied for a further visitor's visa which was also rejected.

Both these case studies demonstrate that the health requirements in its prioritisation of the cost to Australia, does not take into consideration the ways in which families are prepared to care for each other and to support each other financially and emotionally.

The human toll that this process takes is a heavy one to bear for all parties. The months of uncertainty awaiting a decision, coupled with an eventual rejection is extremely stressful. It is divisive of family relationships, places hardship on those left behind due to their quality of life as well as places great distress for those who are here and unable to be reunited with their loved ones. This stress affects settlement for many refugees and their families.

Importance of family ties in the process of settlement

The presence of family links and ties are especially important for many refugees in the settlement process. As such the refugee experience is one that often involves lengthy and traumatic separation from family members without any surety of whether they are still alive or dead. For many of our clients who are newly arrived in Australia, a large majority seek out avenues to build family connections in their first 6 months of arrival.

The importance of family reunification for resettled refugees is clearly advocated by bodies like the Refugee Council of Australia (RCOA) and has been acknowledge and indeed emphasised repeatedly at the first international conference on refugee settlement, the International Conference on the Reception and Integration of Resettled Refugees that was held in Sweden in April 2001.

Research has found that resettled refugees who are separated from family members are prevented from fully turning their attention to the settlement process. Depending on their circumstances, many will be:

- preoccupied with locating lost family members, desperately trying to find out whether they are dead or alive;
- deeply concerned for the well-being of relatives who are in precarious situations in the country of origin or the country of first asylum;
- devoting a large part of their income to supporting family members overseas;
- unable to make any long-term plans, believing they must not do so until the family can make them together.

> On the other hand, intact families are more likely to be able to devote their full energies to rebuilding their lives and the host country will, in turn, benefit from the economic and social contributions the family can make to their new country[5].

MDA case coordinators have confirmed anecdotal evidence that a percentage of their clients have returned to their countries of origin after numerous attempts to sponsor their families to Australia. Many such people have been unable to fully settle after a number of years due to lack of family ties and connections in the community. The health assessment criteria maybe one of a number of factors that prevents this reunification.

Positive contributions of immigration

It is a well established fact that the majority of refugees who settle in Australia take up Australian citizenship as soon as they can. Many are without countries and the want to belong and be part of to a thriving positive nation is a major incentive for those who want to build new lives and afford opportunities to their children.

The economic contributions that immigration brings to Australia are indeed significant as a whole. MDA contend that besides their contribution to the economy, migrants contribute in many other non-economic ways. They add diversity to the nation and give us a better understanding of different cultures by living side by side with Australians from other cultural and ethnic backgrounds. The cultural diversity that immigration brings adds to the rich tapestry of Australia's culture.

The health requirements under the Migration Act leads to unjust and unfair decisions that do not properly take into account the valuable contributions the family or applicant will make to Australia as a whole, while concentrating only on the potential cost burden for the applicant who has been rejected.

Disabled persons' potential to contribute and participate is seldom recognised: they are more often seen as a problem than a resource. And more often ignored than assisted[6].

A high profile case in point which generated media headlines was that of German citizen Dr Bernard Moeller who moved with his family to rural Victoria in 2006 to help fill a doctor shortage. In October 2008, his son Lukas Moeller became the public face of how the Health Requirement under the *Migration Act 1958 (Cth)*, compulsory for all visa applicants coming to Australia, can lead to clearly unjust decisions. 13 year old Lukas has Down Syndrome and the Moeller family were denied permanent residency on the basis that Lukas's disability would place an undue burden on the Australian taxpayer. The assessment was that Lukas would cost the taxpayer over $450 000.

Calculating the future costs associated with disability over a person's life time is a tremendously difficult process; a process that is sometimes ad-hoc with significant

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[5] Refugee Council of Australia (RCOA), Discussion paper on, "*Family unity and family reunification obligations to family unity*", August 2001, p2

[6] Women's commission for Refugee Women and Children, ibid

margins for subjective interpretation. Further, the health assessment does not take into account whether or not services will actually be utilised or whether individuals are able to self fund the costs associated with their illness or disability. More importantly, it does not take into consideration the contribution that the family make as a whole to Australia or to their communities as in the case of Dr Moeller who was filling a skill shortage in rural Victoria.

In addition to this, the requirements make no allowance for the ways in which people like Lukas Moeller may contribute in the future.

The contributions that refugees have made to Australia to fill skill shortages are numerous. However, there have been few studies conducted into the economic benefits specifically of refugees as opposed to migrants more generally, and where such studies have been conducted they often focus on a very specific locality or refugee population. A 2003 study of 'The Economic Impact of Afghan Refugees in Young, NSW' found that the regional economy benefited significantly by the presence of Afghan refugees living and working in the town[7].

The evidence of how diverse Australia has become is evident in the cultural exchange between communities and also with mainstream culture. MDA celebrated World Refugee Day this year with over 9,500 people in attendance which showcased a wealth of talent and diversity by refugee communities living in Brisbane which also sought to promote understanding, cross cultural interaction and community spirit. Another signature event hosted by MDA is our annual Candlelight Walk with approximately 1,300 local people, Parliamentarians, celebrities and newly arrived refugees joining together to walk for a commitment to a world that was safe for all people to live without fear. These successful events and many others highlight the tremendous and growing support that Australians have given to refugees and migrant communities over the years.

In terms of specific contributions by refugees with disability, there are success stories such as that of Mr Abebe Fekadu a paraplegic from Ethiopia who became one of the world's top ten for power lifting and went on to represent Australia at the Beijing Paralympics in 2008. However, Mr Fekadu was only granted permanent residence and eventual Australian citizenship residence after triggering section 417 of the Migration Act to allow for his case to be considered through ministerial intervention.

MDA would like to acknowledge the exceptions like Mr Fekadu's case that have been granted a visa to Australia under Ministerial intervention. However, it is an extremely lengthy and expensive process by which applications have to exhaust every level of appeal before they are allowed to make a request under s417. This is an unnecessarily bureaucratic process which places tremendous strain on the Minister of Immigration's office as well as causes years of hardship for applicants and should be amended.

This submission does not propose to delve further into the intricacies of Ministerial intervention and will leave it to the legal bodies and organisations that are more qualified to do so.

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[7] F Stillwell, *The Economic Impact of Afghan Refugees in Young, NSW*, Online text, January 2003, p. 3.

Conclusion

MDA believes that refugees and their families should not be penalised by the health requirements of the Migration because of their exceptional circumstances and the fact that they can be classified as a vulnerable group. The prevention of family reunification is an extremely important one for successful settlement and should be one that is prioritised in the assessment of applications.

In assessing the instances of those who present with disabilities or with health conditions, full consideration should be given to the contributions of the individual or the family as a whole to society, as opposed to just a cost to the tax payer.

Recommendations

Recommendation 1

That the health requirement should be waived for specifically vulnerable groups like refugees and their families that are sponsored via the humanitarian visa category or family reunion category.

Recommendation 2

Should recommendations 1 fail to be adopted, that there be a separate category for refugees and their families to be given special consideration at the level of primary decision making and not have to wait for lengthy periods and be rejected at all levels of appeal before they are allowed to proceed to the state of Ministerial intervention.

We believe that the process of getting to the stage of Ministerial intervention is a very long and arduous process which can take years and this is particularly difficult for those who are waiting in countries that are unsafe or involved in conflict. This is a particular issue for a further vulnerable sub group that are made up of women, children and the elderly.