Resettlement and Environmental Health

Panel contribution to the Population-Environment Research Network Cyberseminar, "Preparing for Population Displacement and Resettlement Associated with Climate Change and Large Climate Mitigation and Adaptation Projects" (November 2011), http://www.populationenvironmentresearch.org/seminars.jsp

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Abstract: *There is a near vacuum on the subject of long-term human health consequences of resettlements. The subject is in pressing need of attention. Partial lessons are available from colonization projects in the Brazilian Amazon, the Indonesian Transmigration experience and, in the setting of development forced displacement and resettlement (DFDR), from the Nam Theun 2 Hydroelectric Project in Laos PDR. Despite the increasing proliferation of health impact assessments (HIAs) for corporate development projects, this form of baseline projection of potential health consequences is no substitute for ongoing monitoring, surveillance, and adaptive mitigation of health issues in resettlement communities. Perhaps the area in most need of attention is mental health, where considerable anecdotal and very limited survey evidence indicates that there is, indeed, a primary problem associated with resettlements of all stripes. I briefly raise a number of questions about human health and resettlement that I hope will stimulate further discussion.*

Although the primary focus of this cyberseminar is climate-induced resettlement, I think it would be counter-productive and quite limiting to over-emphasize this particular driving factor of resettlement. When it comes to health outcomes associated with resettlements of many stripes, this is a vastly under-studied topic. Even within the context of DFDR, it is only in the last few years, under the auspices of the IFC, that health impact assessments (HIAs) for development projects have gained currency as part of the process of corporations securing loans from development banks that have signed onto the Equator Principles. The growing proliferation of HIAs in the corporate project context, where resettlements have been a fact of life for decades, is, at best, a start at understanding the consequences of this phenomenon. HIAs are essentially prediction exercises. They are based on pre-settlement baseline health data, to the extent that it is available, and expert judgement about likely health futures at the localities of resettlement. This, in turn leads to public health action plans for resettled communities. However, to understand consequences, there is no substitute for long-term periodic monitoring and surveillance of the health status of resettled communities, a process that is exceedingly rare not only in the context of DFDR, but among resettlements generally. It is only such follow-up that can provide the basis for adaptive tuning of interventions and mitigation strategies to sustain high levels of health and prevent outbreaks of disease and the onset of disabilities of diverse types.

One of the very few success stories in the context of DFDR, at least to-date, is the HIA, public health action plan, and its implementation with ongoing monitoring, surveillance, and adaptive tuning of a community health program for the resettled communities proximal to the Nam Theun 2 (NT2) Hydroelectric Project in Laos. This program was recently featured in Science (1). It is useful to consider a virtually unique feature of the NT2 project that ensured long-term follow-up

on community health, as well as mitigation of environmental, social, and even human rights problems. The factor to consider is that ongoing health promotion and disease prevention were written into the concession agreement (CA) between the Nam Theun Power Company and the government of Laos PDR. In addition, the CA contained the provision for a panel of experts (POE) who would conduct twice yearly inspections of the communities impacted by the NT2 dam and put forth explicit recommendations for adjustments and improvements that needed to be made to ensure that initial environmental and social agreements were upheld over time. Eighteen reports of the POE, running over the past nine years, are in the public domain at the following website: http://www.namtheun2.com/. (They can be accessed by clicking on the 'Documents' link at the top of the home page.)

In addition, the follow-up health surveillance and program implementation from 2005 - 2008 is described in the 'Health Checks Report', available under 'Health Report' on the 'Documents' link. While it is too early to say what the long-term consequences of the NT2 dam will be for the resettled communities, the activities to-date are worth studying for lessons that may improve the chances for avoiding the impoverishment that has been so much a part of resettlements in the past. Regarding DFDR and human health, we feel that a major step forward would be achieved if community health, with accompanying monitoring, surveillance, and mitigation (as needed) was incorporated in CAs for corporate projects. The challenge here is to get grass-roots, community-based activists behind the relevant governments to ensure that CAs contain critical long-term health components.

An important general feature of human health connected to resettlement is that mental health problems are among the most prominent and enduring negative features. The severe lack of rigorous documentation for this claim is admittedly problematic. However, a close reading of the descriptions of resettlements over time leaves little doubt – still usually only anecdotal – that this topic, at the very least, needs serious attention. The demise – or even major transformation – of a culture, often consequential to past resettlements, is a definite promoter of mental illness for many people. This topic deserves particular attention even in the context of HIAs for corporate development programs, as they almost universally give short shrift to mental illness while giving heavy attention to environmental toxins, infectious diseases, and, more generally, acute problems that may not show the long-term negative effects of mental illness. Far removed from the corporate development context is the study of psychological impacts of resettlement in the form of community relocation among the elderly. This area is worth examining, as it might seem, on the surface, that relocation among a general population of the elderly would not be likely to yield measurable psychological effects.

For one of many points of entry into this topic, it is useful to examine results from the Wisconsin Community Relocation Study (2). For an interesting example of the absence of consideration of mental health problems in the context of resettlement where an important infectious disease, onchocerciasis, was a driving force behind population mobility, it is useful to review analyses of the West African Onchocerciasis Control Program (OCP) (3). This program was clearly one of the most successful large scale infectious disease control efforts ever undertaken. Nevertheless, the focus on onchocerciasis shifted attention away from the many other health problems that may have impacted the resettled populations. We mention this here to emphasize that there are opportunities arising now, and that will arise in the future, where just cognizance of the potential

for mental health problems in resettlements can lead to building on a research and intervention component to programs that currently ignore this phenomenon.

Shifting to climate-change-induced resettlement, it would seem that much attention should be given to communities in the Arctic. Here resettlements consequential to warming trends and the emerging year-around sea lanes in the Arctic are already occurring. The experiences of these early efforts are certainly worth studying carefully when thinking about future easily documentable climate - induced migrations and resettlement. Robin Bronen's paper, circulated to this cyberseminar and focused on climate-induced community resettlement in Alaska, is a particularly good starting point for further discussion. Bronen's paper does not get into health issues *per se*, but it provides a nice introduction to important human health developments that are being put in place by the Alaska state government in connection with issuing of permits for corporate development programs, most notably in the oil and gas and mining sectors. The focus here has heavily been on HIAs, as would be expected at the initiation stage of programs. However, the need to establish infrastructure to ensure long-term follow-up and mitigation (as issues arise) is pressing, and much in need of sustained support from the public health community, which has largely ignored corporate programs and their profound influence.

References

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