Urban Refugee Health

1. The issue

Many of the health strategies, policies and interventions for refugees are based on past experiences where refugees are situated in camp settings and in poor countries. In such situations, existing Government health services are often insufficient to meet the needs of their nationals. Refugees are located in remote and isolated areas where the only practical alternative is parallel health services provided and implemented by non-governmental organisations (NGOs), and coordinated and monitored by UNHCR. This situation leads to a relatively confined population that is often dependent upon most services including food aid and health care. An exacerbation of existing communicable diseases often punctuated with epidemics and acute malnutrition are the most common illnesses; these are often aggravated by water and sanitation issues and poor shelter. Numerous guidelines for interventions have been developed to address this situation together with various indicators and standards.[1-4]

However, recent UNHCR studies have found that almost half of the world's refugees now reside in non-camp settings including urban areas[5]. Furthermore, a larger proportion of refugees are now fleeing from middle income countries. In the latter setting, the demographic and epidemiologic profiles are that of an older population with chronic diseases. These changes have had major consequences for UNHCR and its partners.[6] Recently, UNHCR published its Policy on Refugee Protection and Solutions in Urban Areas (2009). The Policy is based on the principle of expanding protection space beyond camp-settings: "the rights of refugees and UNHCR's mandated responsibilities towards them are not affected by their location, the means whereby they arrived in an urban area or their status (or lack thereof) in national legislation"[7]. UNHCR considers urban areas to be a legitimate place for refugees to enjoy fundamental rights.

Three-Pronged Strategy to Address Refugee Urban Health: Advocate, Support and Monitor

UNHCR must ensure that urban refugees and other persons of concern have **access to affordable health services, education and other services.** Refugees in urban areas often face numerous disadvantages compared with low-income city dwellers; these include lack of community support systems, uncertain legal status making them subject to harassment by authorities, cultural and linguistic differences, exclusion from social security systems or health insurance schemes, and insufficient disposable income (e.g. to pay for transport to access such services and for co-payments and other ancillary health care costs). Stigma and discrimination may also reduce access to already overstretched Government health services.

Access to affordable health services for urban refugees will follow **UNHCR's Public Health and HIV Guiding Principles**[8]. Among these principles, issues relating to

integration, partnership, quality of services (i.e. availability, accessibility, equity, appropriateness, acceptability, effectiveness and efficiency) and **sustainability** are of particular relevance to the urban refugee situation.

UNHCR is promoting a **three-pronged strategy** to address access to affordable and good quality health services for urban refugees and other persons of concern in conjunction with its partners[1].[7]

1. *Advocacy*

UNHCR advocates on behalf of refugees and other persons of concern to ensure that the authorities make public services such as health care, nutrition programmes, and water and sanitation services available to these populations at low or no cost.

Those who need existing health services should be able to obtain them regardless of status, gender, age, marital status, race, religion, sexual orientation or disability. Guiding Principles state that refugees and other persons of concern should have a similar level of access and quality of care similar to that of where they came from and to that of their hosts populations. Ethical issues of **equity**, both between refugees and host populations, as well as between refugees living in the same and different countries, have been an important and controversial topic for many years. Due to the recent Iraqi refugee crisis, this issue has been examined further by UNHCR and is particularly relevant in urban refugee situations. In most situations, policies and treatments follow the host countries' Ministry of Health **guidelines and protocols**. However, if these are found to be incorrect or inappropriate, UNHCR and its partners will use internationally recognised guidelines, and in the meantime work with the national authorities to improve such guidelines and protocols.[8]

During the **emergency phase**, primary health care (PHC) and emergency health services (including emergency obstetrical and neonatal care) should be free of charge. The PHC approach is based on community participation at a cost the community and the country can afford to maintain at every stage of their development. It includes prevention as well as curative services. During the **post-emergency** phase, services should be affordable and accessible to refugees and other persons of concern. Health care fees applied to these populations should be equivalent or less to fees applied to the local population or to vulnerable groups. Depending upon the context, UNHCR and its partners should advocate for refugees and other persons of concern to have access to national health insurance schemes when feasible. Access to good quality PHC and emergency health services remains UNHCR's priority.

Given the need to prioritize its efforts and allocation of resources, UNHCR will focus on the provision of services to those refugees and persons of concern **whose needs are most urgent**. While these priorities will vary, they will usually include safeguarding the well-being of pregnant and lactating women, children under five, unaccompanied and separated children, orphans, older people and those who are seriously ill, including those with HIV and Tuberculosis. Other priorities include

[1] Partners include but are not limited to Governments, UN agencies, international organisations, non-governmental organisations, faith-based organisations, bilateral and multilateral donors, foundations and the private sector.

providing care and counselling to people with specific needs, especially people with disabilities, those who are traumatized or mentally ill, victims of torture and sexual and gender-based violence as well as those with complex diseases requiring specialized care.[7]

2. Support

UNHCR supporst urban refugees and other persons of concern by integrating them into the existing public services and by augmenting the capacity of these systems. UNHCR will achieve this directly when funding is available and indirectly by encouraging the engagement of various donors and other actors.

Integration of refugees and other persons of concern into existing health system(s) is a more efficient use of limited resources. This approach has the added benefit of encouraging the authorities and the local population to recognize the additional resources that urban refugees can bring to the towns and cities where they have settled. These benefits may have an indirect effect of **improving the protection space** for refugees and other persons of concern to UNHCR.

Initially, UNHCR and partners (such as WHO and UNICEF) will **assess the capacity** of existing public (and possibly non-profit, NGO, community-based, faith-based and private) services to accommodate the refugees and other persons of concern, and will then augment this capacity.

As a general rule, when working in urban areas, UNHCR will avoid the establishment of separate and parallel services for its beneficiaries, and will instead seek to reinforce existing delivery systems, whether they are public, private, not for profit or community-based. When health services are of adequate quality and used by the national host populations, the use of these public health systems are preferred. However, in some countries these systems are not functioning adequately and citizens do not use them. In these circumstances, UNHCR may have to seek other alternatives such as non-profit, NGO, community-based, faith-based and private services.

Community health **outreach programmes** that involve refugees and other persons of concern as well as the host community are essential to ensure communication of the rules and regulations of there services, improve access to all levels of care, provide health education and aid in effective delivery of preventive services. These workers may also deliver home-based health care services when appropriate.

UNHCR recognizes that **special assistance arrangements** will be required for refugees in situations where they are excluded from national health and welfare programmes, such as access to national health insurance programmes and the provision of subsidized food. Given that poverty and food security are often present among refugees in urban areas, refugees and other persons of conern need to be integrated into existing food and nutrition programmes for local populations or new programmes may need to be created. UNHCR, in partnership with UNICEF, WFP and FAO, will seek to uphold the right to adequate food through coordination with existing programmes or through bilateral arrangements where refugees and other

persons of concern are unable to enroll in Government food assistance programmes. Furthermore, UNHCR will continue to advocate for refugees to be included into local social safety nets developed by the Government.

Similarly, UNHCR will work with partners (e.g. UNICEF, UNHabitat, World Bank) and the local **Water and Sanitation authorities** to improve the existing infrastructure due to the additional burden these displaced populations put on the existing systems. UNHCR will also implement hygiene promotion activities with our partners through outreach work and existing local programmes if they exist.

Furthermore, refugees may not be able to afford **co-payments** for health services, investigations or medications. UNHCR may need to cover certain costs for the most vulnerable refugees (e.g. orphans, single headed households, psychosocially impaired) to ensure that all persons of concern to UNHCR have access to good quality health services.

Health care **referral costs to secondary and tertiary care** facilities will be covered by UNHCR when authorized as set out in the Standard Operating Procedures. The type of referrals to be covered depends upon the situation and the available funding. Hospital fees applied to refugees should be equivalent to fees applied to the local population or to vulnerable groups.[11] Medical or surgical referrals will be preferably treated in public or private non-profit hospitals whenever possible. Minimising the number of partners and facilities/institutions while ensuring sufficient access to services for refugees and other persons of concern present many advantages to UNHCR in terms of establishing agreements, securing protection and confidentiality, monitoring the quality of care, and adapting to the various cultural and linguistic differences of these displaced populations. It also helps to negotiate, rationalise and monitor the costs.[11]

3. Assessment, monitoring and evaluation

UNHCR assesses, monitors and evaluates the health (including water, sanitation and access to health care) and nutritional status of urban refugees and other persons of concern to ensure that they do not fall below acceptable standards. This is essential to back up advocacy and support health care for urban refugees and other persons of concern.

Assessing, monitoring and evaluating the public health and nutritional status of urban refugees and other persons of concern is very **challenging** because the population is dispersed, often in wide and multiple geographic areas, and may not wish to be registered for a variety of reasons including protection issues. Therefore, estimating the actual size of this so-called 'hidden' population as well as its demographic characteristics and geographical distribution is very difficult. Consequently, establishing a **health information system** or undertaking population-based surveys (e.g. for malnutrition, water access and usage, mortality) is complicated and can be expensive.

Integrating refugees into existing health systems generally includes using existing health information systems. This can be problematic as some systems are not

sufficiently flexible to allow for **essential modifications to disaggregate data** according to nationals and refugees or to add certain disease categories that may be more predominant among or relevant to a particular group of refugees. Furthermore, many health information systems may not provide sufficient data to allow for prioritisation of activities according to limited funds or to allow for proper monitoring and evaluation.

Since an accurate population denominator is often unavailable and affected populations may use more than one health facility or provider (including public, private, NGO, etc…) to seek care, estimating disease incidence rates and the refugees' usage of services is very difficult. Thus, **proportional morbidity rates according to facility** are the norm; this provides important but limited data to prioritize decision making and to effectively monitor and evaluate programmes. In some situations, although not ideal, sentinel sites which attempt to be representative of different parts of the affected population may be used.

In non-camp settings, **population-based sample surveys** have proved difficult, politically controversial and bias-prone, and some of their methods still require validation. **Other surveillance methods** such as prospective, community-based surveillance of mortality, nutritional status and other key health events may be a more useful approach in many situations.

References

1.Médecins Sans Frontières. Refugee Health. An Approach to emergency situations, 1997.
2.Steering Committee for Humanitarian Response I. The Sphere project:humanitarian charter and minimum standards in disaster response. Geneva: Sphere Project, 2004.
3.UNHCR. Standards and indicators report. Geneva, 2005.
4.UNHCR. Handbook for Emergencies. Geneva: UNHCR, 2007.
5.UNHCR. Statistical Yearbooks (1994-2007). http://www.unhcr.org/pages/4a02afce6.html. Geneva.
6.Spiegel P, Checchi F, Colombo S, Paik E. Health care needs of persons affected by conflict: future trends and changing paradigms. *Lancet. In press* 2010.
7.UNHCR. UNHCR policy on refugee protection and solutions in urban areas. Geneva, 2009.
8.UNHCR. Public health and HIV guiding principles, 2008-2012. Geneva, 2008.
9.UNHCR. Public health equity in refugee settings. Geneva, 2009.
10. Mowafi H, Spiegel P. The Iraqi refugee crisis: familiar problems and new challenges. *Jama* 2008;299(14):1713-5.
11. UNHCR. Principles and guidance for referral health care for refugees and other persons of concern. Geneva, 2009.