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The State of the World's Refugees
Adapting Health Responses to Urban Environments

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THE FORCED DISPLACEMENT OF POPULATIONS, ACROSS borders and within their own countries, is one of the most visible and enduring manifestations of persecution and conflict. At the end of 2011, more than 42 million people had been forcibly displaced from their homes by conflict, including 15 million refugees and 26 million internally displaced people (IDPs).[1] In 2011, more than 4.3 million people were newly uprooted, with some 800 000 fleeing to neighboring countries in humanitarian crises stretching from Côte d'Ivoire, Libya, Syria, the border between Sudan and South Sudan, to the Horn of Africa[1] and more recently due to conflict in Mali.[2]

These new emergencies unfolded alongside unresolved crises that have resulted in millions of people living in situations of protracted displacement, often for decades. Millions of refugees and IDPs from countries such as Somalia, Afghanistan, Eritrea, Colombia, the Democratic Republic of Congo, and Iraq remain unable to return to their homes after extended periods in exile. The vast majority of refugees—approximately 80%—are hosted in the developing world, primarily in neighboring countries.

The challenges of responding to forced displacement have been shaped over the past decade by the phenomenon of urbanization. More than half of the world's population now lives in cities, and issues related to sustainable and equitable urbanization are high on the global agenda. Africa and Asia are projected to lead urban population growth in the next 4 decades. Since 1999, when the United Nations High Commissioner for Refugees (UNHCR) first began to disaggregate the number of refugees recorded as living in camps and rural and urban areas, the proportion of refugees residing in urban settings has been gradually increasing.[3] For example, the cities of Damascus and Amman received more than 1 million refugees from Iraq, and other cities such as Nairobi, Cairo, Khartoum, Kabul, Abidjan, and Bogotá have absorbed millions of refugees and IDPs.

However, capturing accurate data on displaced persons in urban areas is difficult. Many live in informal settlements and slums alongside rural-urban migrants and other poor and marginalized groups, beyond the radar of municipal authorities and aid agencies. Available data for refugees in 2011 show that the proportion of refugees 18 years and older is higher in urban settings (58%) than rural settings (46%) (UNHCR unpublished data).

The profile of countries affected by conflict and displacement is gradually shifting toward a complex mix of developing countries and those with higher baseline incomes and life expectancies. For example, during the last 10 years, large-scale new displacements occurred in the Middle East, North Africa, and Latin America, alongside major refugee outflows and protracted crises in sub-Saharan Africa and Afghanistan.

The urban displacement phenomenon has important consequences for international aid and protection agencies. In the health domain, 2 of the most important are management of noncommunicable diseases (NCDs) and health systems. The increasing global importance of NCDs was demonstrated with the 2011 UN General Assembly resolution on the prevention and control of noncommunicable diseases, which identified the socioeconomic scale of the problem and included an action-oriented declaration.[4] However, the declaration does not address the importance and challenges of NCDs in conflict and forced displacement settings.

During the past few years, UNHCR and its partners have modified their health information systems to include NCDs. For example, in 2010, of the 27 166 medical visits by 7642 Iraqi refugees in Jordan, chronic diseases were common, including hypertension (22%), visual disturbances (12%), joint disorders (11%), and type 2 diabetes mellitus (11%).[5]

The archetypal image of rows of tents stretching into the distance in refugee camps no longer captures (if indeed it ever did) the daily reality for many refugees, a substantial proportion of whom live in urban settings and have a demographic profile similar to those who live in middle-income countries. These older populations have disease profiles that are dominated by NCDs such as cardiovascular disorders, diabetes, and cancer rather than

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communicable diseases such as malaria and diarrhea exacerbated by acute malnutrition.[6]

The provision of health care within existing health care systems was previously insufficiently addressed when parallel services for displaced persons in camps were being provided, but a coordinated system of care is becoming increasingly important in noncamp situations, such as in urban settings. Issues requiring attention include health financing in protracted settings, access barriers due to user fees, and integration of services within formal health systems.[3]

UNHCR's recent experiences in advocating for, and in some cases providing, preventive and curative health services for refugees in middle-income countries in urban settings began with Iraqi refugees in Syria and Jordan.[6] The importance of integrating refugees into existing health systems, applying clear standard operating procedures, ensuring health equity among refugees and host populations, and considering different methods of health care financing led UNHCR to develop important strategies and guidance documents and to define principles that were not previously in place. These included referral health care for refugees,[7] a call for public health equity in refugee situations,[8] and guidance on health insurance schemes for refugees.[9]

Recently, UNHCR has begun to advocate and negotiate for refugees to have access to health insurance, particularly in middle-income countries where such systems exist for host populations. Benefits in providing health insurance to refugees include improved access to health services and financial protection. Indirect benefits may include the provision of official documentation via a health insurance card that may protect refugees from harassment by authorities and provide a sense of security. Furthermore, this process can facilitate the gathering of more data about refugees, enabling more objective decisions as to who is vulnerable and better analysis of who uses which services where and for what reason.[9]

For example, in Iran, health insurance for Afghan refugees was introduced in 2011. By June 2012, 347 000 refugees had enrolled in the scheme, representing 40% of registered refugees (UNHCR unpublished data). These refugees now have the opportunity to access secondary and tertiary health care for treatment of NCDs, and they have a second form of official documentation. By introducing this insurance scheme, the Iranian government has reduced the risk of having to pay for the hospitalization of refugees, and UNHCR and its partners now have more detailed data to improve their programs in other sectors beyond health. The refugee health insurance scheme works in Iran because the program is state approved, and a similar system is in place for host populations; refugees have access to employment that allows many of them to afford to pay the premiums and co-payments, and UNHCR pays for vulnerable persons that cannot do so. Examples of other health insurance schemes for smaller groups of refugees exist in Cambodia, Costa Rica, Georgia, and in some countries in West Africa, with varying levels of success. Given the positive experience in Iran, UNHCR has begun to explore the possibility of implementing such health insurance schemes in other countries, particularly in middle-income countries where refugees are generally settled in urban settings.

The last 5 years have been challenging for the humanitarian community. New emergencies have unfolded as older conflicts have persisted and became more complex. International aid agencies must continue to adapt to the changing demographic profiles of refugees and IDPs as well as to the effects of global urbanization. For the health sector, this includes a focus on NCDs and health systems with sustainable programs that support access to preventive and curative services. However, health cannot be seen in isolation from other sectors. Innovations in access to care will have a meaningful effect only if they form part of a comprehensive protection-based approach addressing the needs of refugees and IDPs across a range of sectors, including livelihoods, education, nutrition, water and sanitation, and the environment. Only by addressing these in an integrated manner, within a framework that promotes self-reliance and durable solutions, will reductions in morbidity and mortality be achieved, along with a real improvement in the quality of life for the world's 40 million refugees and displaced persons—until they can return home.

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REFERENCES

1. UNHCR global trends 2011: a year of crises. United Nations High Commissioner for Refugees. http://www.unhcr.org/4fd6f87f9.html. Accessed July 25, 2012.

2. Mali displacement expands, UNHCR appeals for $35.6 million. United Nations High Commissioner for Refugees. http://www.unhcr.org/4f4771b69.html. Accessed July 25, 2012.

3. Spiegel PB, Checchi F, Colombo S, Paik E. Health-care needs of people affected by conflict: future trends and changing frameworks. *Lancet*. 2010;375(9711):341-345.

4. Political declaration of the high-level meeting of the General Assembly on the prevention and control of non-communicable diseases. United Nations General Assembly. http://www.who.int/nmh/events/un_ncd_summit2011/political_declaration_en.pdf. Accessed July 25, 2012.

5. Mateen FJ, Carone M, Al-Saedy H, et al. Medical conditions among Iraqi refugees in Jordan: data from the United Nations Refugee Assistance Information System. *Bull World Health Organ*. 2012;90(6):444-451.

6. Mowafi H, Spiegel P. The Iraqi refugee crisis: familiar problems and new challenges. *JAMA*. 2008;299(14):1713-1715.

7. UNHCR's principles and guidance for referral health care for refugees and other persons of concern. United Nations High Commissioner for Refugees. http://www.unhcr.org/refworld/pdfid/4c1726e82.pdf. Accessed July 25, 2012.

8. Leaning J, Spiegel P, Crisp J. Public health equity in refugee situations. *Confl Health*. 2011;5:6.

9. A guidance note on health insurance schemes for refugees and other persons of concern to UNHCR. United Nations High Commissioner for Refugees. http://www.unhcr.org/4f7d4cb1342.pdf. Accessed July 25, 2012.