Urban refugee health: meeting the challenges

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Many of the accepted health strategies, policies and interventions for refugees are based on past experiences where refugees are in camp settings and in poor countries. Rethinking of these to take account of the many urban and middle-income refugees is underway.

More than half of the world's refugees now reside in non-camp settings, including urban areas, and a larger proportion of them than before are now fleeing from middle-income countries where the demographic and disease epidemiologic profiles are those of an older population with chronic diseases. Furthermore, refugees in urban areas often face numerous disadvantages compared with low-income city dwellers – disadvantages such as lack of community support systems, 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 user fees and other health-care costs). Stigma and discrimination may also reduce access to already overstretched government health services.

In response to the publication in 2009 of UNHCR's Policy on Refugee Protection and Solutions in Urban Areas, UNHCR's Public Health and HIV Section has adopted a three-pronged strategy – focusing on advocacy, support of existing capacities and monitoring of delivery – to work with its partners to increase access to affordable and good quality health services for urban refugees and other persons of concern.[1]

Advocacy

UNHCR will advocate with the authorities on behalf of refugees to ensure that public services such as health care, nutrition programmes and water and sanitation services are made available to these populations at a limited or no cost.

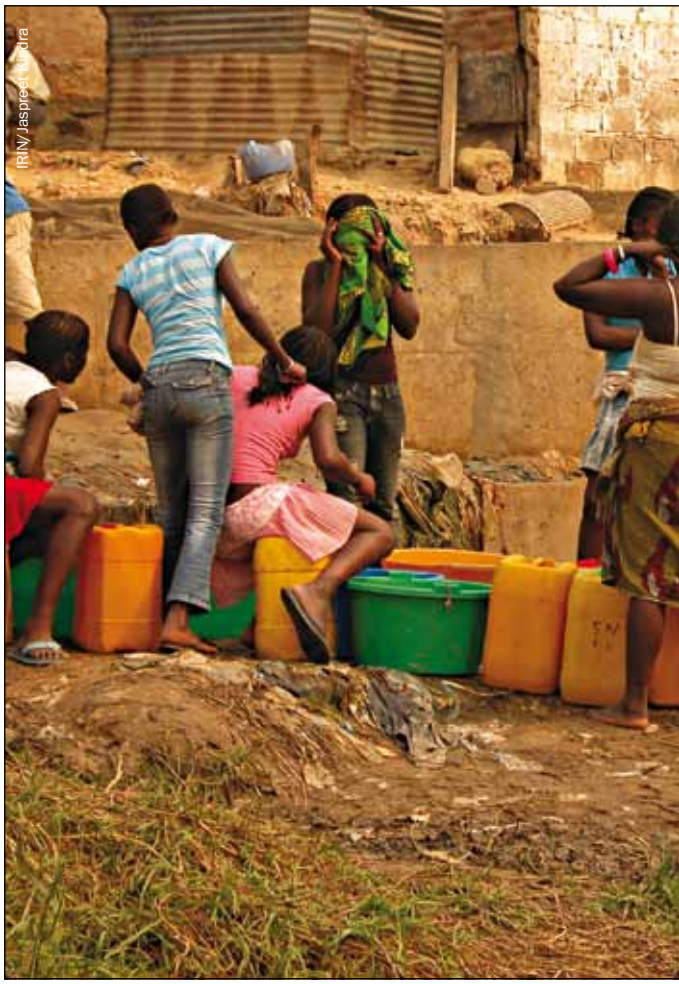
Ethical issues of equity of access and quality of care, both between refugees and host populations as well as between refugees living in the same and different countries, have been an important and controversial topic for many years – and are particularly relevant in urban refugee situations.[2] In most situations, policies and treatments should follow the host country's health ministry's guidelines and protocols. However, if these are incorrect or inappropriate, UNHCR and its partners will prefer to use internationally recognised guidelines, and in the meantime work with the national authorities to improve the guidelines and protocols.

Given the need to prioritise efforts and allocation of resources, and while priorities will vary from one situation to another, they will usually include safeguarding the well-being of pregnant and lactating women, children under five years of age, unaccompanied and separated children, orphans, older people and those who are seriously ill, including those with HIV and tuberculosis. Other priorities include providing care and counselling to people with specific needs, especially people with disabilities, those who are traumatised or mentally ill, victims of torture and sexual and gender-based violence, and those with complex diseases requiring specialised care.

Support

Integration of refugees into such health systems in urban environments is a more efficient use of limited resources than setting up separate facilities. So it makes sense to integrate health-care treatment into existing public services and to augment the capacity of these systems, directly when funding is available and indirectly by encouraging the engagement of various donors and other actors.

Initially, UNHCR and partners (such as WHO, UNICEF and medical or health NGOs) will assess whether existing services need help to expand their capacity, and how to manage any such expansion. This approach has the added benefit of encouraging the authorities and the local population to recognise the fact that refugees can bring additional resources to the towns and cities where they have settled. These benefits may have the indirect effect of improving the protection space for refugees and others.



Residents of the Boa Vista informal settlement queue for water, Luanda, Angola.

As a general rule, when working in urban areas, UNHCR will avoid setting up 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. If refugees cannot afford user fees for health services, agencies may need to cover certain costs for the more vulnerable refugees to ensure that all have access to good quality health services.

Community health outreach programmes that reach out to refugees as well as the host community are essential to ensure communication of the rules and regulations of whatever services there are, improve access to all levels of care, provide health education and help ensure effective delivery of preventive services. Outreach workers may even deliver home-based health-care services when appropriate.

Given that poverty and food security are often present among refugees in urban areas, if refugees cannot be integrated into existing government food and nutrition programmes for local populations, as is desirable, new programmes may indeed need to be created.

Similarly important parts of the strategy include a) advocacy for refugees to be included in any local (government) social safety nets, b) support to local water and sanitation authorities to improve the existing infrastructure to cope with the additional burden placed on existing systems by the arrival of displaced populations and c) outreach through existing hygiene promotion activities.

Minimising the number of partners and facilities/institutions while trying to ensure sufficient access to services has many advantages – in terms of establishing agreements, securing protection and confidentiality, monitoring the quality of care and rationalising and monitoring the costs.

Monitoring

Monitoring the public health and nutritional status of urban refugees is important for ensuring that these do not fall below acceptable standards and to provide sufficient information to advocate effectively and support health services for urban refugees. The challenges, however, are increased by the populations being dispersed, often in wide and multiple geographic areas, and in some cases not wishing to be registered.[3] 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 a particular group of refugees. Furthermore, many health information systems do not function well anyway and may not provide sufficient data to allow for prioritisation of activities or to allow for proper monitoring and evaluation.

Besides the difficulty in profiling urban refugee populations, urban health information systems are more complicated than camp-based systems because of the number of facilities at different levels (i.e. community-based, primary health care, secondary care and tertiary care facilities) and different providers (e.g. public, private, NGO) involved in such a system. The health information system must also take into account or be linked to budget monitoring to allow for the evaluation of the costs of a programme and relate the costs to services rendered.

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 sentinel sites or prospective, community-based surveillance may be more useful approaches in many situations but are rarely used, perhaps reflecting a failure of imagination and funding rather than insurmountable technical problems.

In promoting access to affordable health services for urban refugees, UNHCR will follow its Public Health and HIV Guiding Principles.[4] 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.

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1. For the remainder of this article the term 'refugees' should be understood to refer to other categories of persons of concern to UNHCR, such as asylum seekers, internally displaced persons, stateless persons and returnees.
2. UNHCR. 'Public health equity in refugee settings.' Geneva, 2009.
3. See Davies and Jacobsen article pp13-15.
4. http://www.unhcr.org/488600152.html