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The neglected health needs of older Syrian refugees in Jordan

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Older refugees are often a neglected population, particularly when it comes to health. In Jordan, the specific health needs of older Syrian refugees tend to be overlooked, due in part to a lack of data, institutional biases and the nature of the humanitarian response.

Despite increasing international recognition of their specific needs and the challenges that older people face during times of crisis, this age group remains one of the most neglected within the humanitarian and development response, in particular when it comes to health. Older Syrian refugees in Jordan are no exception. According to HelpAge International,¹ an estimated 77% of all refugees over the age of 60 have specific needs related to mobility, nutrition and health care, and more than half of them report suffering from forms of psychological distress. However, according to UNHCR statistics, 57% of refugees with chronic conditions in Jordan say they cannot afford the care they need.²

Despite several mentions of the health needs of older Syrian refugees in the Jordan Response Plan for the Syrian Crisis 2017-2019 (a document outlining the Jordanian government's short-term development objectives), interviews with policymakers and humanitarian responders have consistently shown gaps between policy and implementation. Some of the reasons which have emerged include a lack of data on the needs and vulnerabilities of older refugees, the nature of the humanitarian response, and a narrowing of institutional mandates.

A lack of data

HelpAge International has documented both the widespread neglect of older Syrian refugees in Jordan and the contributions that older refugees make within their families and communities. While many older refugees have been left behind in Jordan to fend for themselves while family members leave to search for better opportunities, other older refugees have

taken over caring responsibilities for sick relatives and orphaned grandchildren.

However, when asked about health programmes catering for the needs of older Syrian refugees, most humanitarian responders pointed to the lack of data regarding the number of older refugees in Jordan, their particular health-care needs and what would be required to improve their health. "There is a perception that older people are being taken care of by their families, and there is a lack of data," a health adviser from a donor organisation said when asked whether older refugees are integrated into any of the organisation's refugee programmes. "And what would we do in particular?" she added.

In many cases interviewees reported that, despite guidelines indicating the need for data disaggregated by age, organisations often fail to collect data about older refugees.³ Even when the data are collected, older people are often categorised as a single group of those aged over 60, despite the varying health status and needs within this heterogeneous population. There is also a dearth of research on the vulnerabilities which can arise from the intersecting dimensions of age, gender and disability. "There is an enormous evidence gap that relates to domestic abuse perpetrated against older women," said one interviewee working with refugees in Jordan. "We know it exists but because we haven't evidenced it, it is hard to start a discussion."

Part of the reason for the neglect of older people's health needs during a crisis is tied to the overwhelming focus on women and children's health both in terms of data collection and the overall medical response. The lack of data and research on the specific health needs of older refugees

appears to contribute to a cycle of neglect in which older refugees consistently fall through the cracks. With little data on this age group, international donors prefer to focus on populations whose health needs are well documented and to invest in organisations that have well-established technical procedures and mechanisms in place to assess and respond to these needs.

Institutional mandates

In addition to a lack of attention to chronic diseases, the increasing specialisation of humanitarian and development agencies has also contributed to the overall neglect of the needs of older refugees. Individual organisational mandates often prioritise categories considered vulnerable such as women, children and persons with disabilities, resulting in a lack of expertise on cross-sectoral issues such as ageing. And while specialisation can bring about positive developments for some of the most vulnerable populations, for older people it means they have few advocates for their cause. As one policy advisor said, “the idea that we might add older men and women to the discussion is not even on the table because we are so focused on women and girls.”

The refugee health response

With Syrian refugees now having resided in Jordan for almost seven years, many humanitarian responders say that an overwhelming focus on an emergency situation and life-saving treatment is no longer adequate for a protracted crisis. In fact, the refugee response – and more specifically the medical response – is based on decades of experience responding to emergencies in sub-Saharan Africa: providing basic primary care and emergency care, preventing the spread of communicable diseases, and vaccinating children. Though these are valuable public health interventions, the demographic make-up of the Syrian refugee population, from a former middle-income country, presents an older population with more complex health needs which often require costlier and longer-term interventions.

More than half of all Syrian refugee households have at least one member suffering from a non-communicable disease such as hypertension, arthritis or diabetes.⁴ Non-communicable diseases are in fact one of the most common causes of mortality and morbidity across Jordan and account for more than 70% of deaths;⁵ as time wears on, the needs of refugees with non-communicable diseases – which disproportionately affect older age groups – become increasingly more acute and costly to treat.

One interviewee, who works at a non-governmental organisation (NGO) providing health care to refugees in Jordan, expressed her frustration with the lack of a model for managing the health-care needs of populations affected by a protracted crisis. “...all the handbooks like the Sphere Standards are for a rapid onset crisis. It doesn’t deal with what you do if it lasts seven years like the Syria crisis.”

In recent years, national policies appear to have started taking these factors into account. The Jordan Response Plan for 2017-2019 focuses heavily on the need to strengthen national health-care systems for secondary and tertiary care in order to prevent and treat chronic diseases. Implementation, however, has been slow. The task force on non-communicable diseases within the UN’s Health Sector Working Group is no longer active, and most agencies and international NGOs tend to focus exclusively on primary care and maternal and neonatal health. According to many interviewees working within the sector, focusing on chronic diseases is expensive, entails large amounts of coordination with the existing national health-care system, and would require a longer-term outlook.



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65-year-old Syrian refugee living in Jordan with his wife; both have disabilities.

The way forward

With many Syrian refugees in Jordan now approaching their eighth year in exile, the health needs of this population are aggravated by their lack of legal status. Refugees are by definition a vulnerable population with restricted access to health care, livelihoods and, arguably, a sustainable future. This precariousness is further exacerbated by the fact that Jordan is not a signatory to the 1951 Convention Relating to the Status of Refugees and its generosity towards refugees is being tested to the limit. In 2014, the government rescinded its free health-care services for Syrian refugees, who now pay the same rate as uninsured Jordanians. With extremely limited employment opportunities, many refugee households are now sliding further into poverty. For older refugees, health care is often unaffordable and bills can place a heavy burden on entire families.

While no one argues for diverting attention and resources from women and girls, advocates in the field as well as some humanitarian responders are calling for greater inclusiveness in the humanitarian and development response. Data collection and analysis could be more representative of the needs and voices of older refugees. Concerted efforts to include older people's feedback – especially at the level of

programme monitoring and evaluation – would ensure that this demographic is more visible within overall response efforts.

Other ways to integrate the needs of older people can be relatively inexpensive. Experts on ageing say that small changes such as using larger print for signs and leaflets would help older people and people with visual impairments access the services they need. Another simple intervention would be to offer meals and food assistance packages which also cater for the nutritional needs of older adults as well as any adults who have particular dietary requirements due to chronic conditions such as diabetes or hypertension. Cataract surgery is another cheap and easy intervention which could greatly improve the lives of older refugees.

In addition to ensuring that older refugees receive the care they need, enhanced awareness and greater integration into the overall humanitarian and development response would allow older people to actively participate in their communities. More importantly, this would allow older people to gain recognition for their contributions as caregivers, as experienced and respected community members, and as potential volunteers.

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1. An organisation which advocates for the rights of older people in humanitarian crises.
2. UNHCR (2015) *Health access and utilization survey among non-camp Syrian refugees in Jordan* <http://bit.ly/UNHCR-health-Jordan-2015>
3. See Sphere Project's *Handbook on Minimum Standards in Humanitarian Response*, Core Standard 3 injunction to "Disaggregate population data by, at the very least, sex and age". Accompanying guidance note 4 states: "At the earliest opportunity, further disaggregate by sex and age for children 0–5 male/female, 6–12 male/female and 13–17 male/female, and then in 10-year age brackets, e.g. 50–59, male/female; 60–69, male/female; 70–79, male/female; 80+, male/female." www.spherehandbook.org/en/core-standard-3-assessment/
4. Doocy S et al (2015) 'Prevalence and care-seeking for chronic diseases among Syrian refugees in Jordan', *BMC Public Health* <http://bit.ly/BMC-2015-Doocy>
5. According to the Jordan Noncommunicable Disease Alliance <https://ncdalliance.org>