Changing Health Needs in Complex Emergencies

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Refugees and Internally Displaced People, end-2014

UNHCR, June 2015
Major Refugee Source and Host Countries

**Major refugee-hosting countries | end-2014**

- Turkey
- Pakistan
- Lebanon
- Islamic Rep. of Iran
- Ethiopia
- Jordan
- Kenya
- Chad
- Uganda
- China

(in millions)

**Number of refugees per 1,000 inhabitants | 2014**

- Lebanon: 232
- Jordan: 87
- Nauru: 39
- Chad: 34
- Djibouti: 23
- South Sudan: 21
- Turkey: 21
- Mauritania: 19
- Sweden: 15
- Malta: 14

UNHCR, June 2015
21st century refugee health challenges

- **Chronicity**: displacement lasting for years and decades
- **Diverse displaced populations**: from middle income as well as low income countries
- **Urbanization**: majority of displaced people not in refugee camps

Expanding health needs
Chronicity
Chronicity: Protracted Refugee Situations

• A situation in which refugees have been in exile “for five or more years ... without immediate prospects for implementation of durable solutions” (UNHCR 2009)

• 75% of refugees are currently living in protracted refugee situations

• UNHCR estimates that the average length of major protracted refugee situations has increased from 9 years in 1993 to 17 years at the end of 2003

• “...refugees find themselves in a long-lasting and intractable state of limbo. Their lives may not be at risk, but their basic rights and essential economic, social, and psychological needs remain unfulfilled after years in exile.” (UNHCR 2004)
39 Protracted Refugee Situations in early 2014
Not including Syrians displaced by civil war starting in 2011

European University Institute Migration Policy Centre
(UNHCR & UNRWA data)
Chronicity: Implications of Protracted Displacement

• Needs often shift from emergency humanitarian response to longer-term development
  – Health issues encompass both acute and chronic conditions
  – May require engagement of a broader range of stakeholders, including civil society and private sector
  – Need for displaced people to play an important role over time in their own livelihoods (jobs, education, governance, etc.)

• Important questions arise with regards to effect of refugee health needs on host country health systems
  – Parallel health systems vs. integration?
  – Where will the resources come from?
Diverse Displaced Populations
Refugees: Changing Socioeconomic Status
Number of Refugees by Human Development Index category of country of origin 1993-2008

Percent of Total Deaths caused by Non-Communicable Diseases in the Largest Source Countries of Refugees in 2014
(Source: WHO NCD Country Profiles, 2014)

Countries in Order of Number of Refugees

<table>
<thead>
<tr>
<th>Country</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Syrian Arab Republic</td>
<td>46%</td>
</tr>
<tr>
<td>Afghanistan</td>
<td>37%</td>
</tr>
<tr>
<td>Somalia</td>
<td>34%</td>
</tr>
<tr>
<td>Sudan</td>
<td>34%</td>
</tr>
<tr>
<td>South Sudan</td>
<td>23%</td>
</tr>
<tr>
<td>Dem Rep Congo</td>
<td>59%</td>
</tr>
<tr>
<td>Myanmar</td>
<td>62%</td>
</tr>
<tr>
<td>Central African Rep</td>
<td>20%</td>
</tr>
<tr>
<td>Iraq</td>
<td>37%</td>
</tr>
<tr>
<td>Eritrea</td>
<td>37%</td>
</tr>
</tbody>
</table>

No NCD mortality data available.
Diverse Displaced Populations

• Increasingly, refugees are coming from middle-income countries, where chronic and non-communicable diseases are prevalent
  – For example, the leading cause of death in Syria before the war was cardiovascular disease

• As displacement and exile lengthen, the need to address non-communicable diseases (NCDs) grows
  – Risk factors for NCDs e.g. smoking, overweight/obesity
  – Diabetes, cardiovascular disease, mental health
  – In addition to traditional needs such as shelter, sanitation, safe water, food/nutrition, maternal/child care, prevention and management of communicable diseases etc.
# CVD Risk Factors Among Somali Immigrants in the US

<table>
<thead>
<tr>
<th>Risk Factor</th>
<th>Unadjusted OR (95% CI)</th>
<th>Adjusted(^a) OR (95% CI)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diabetes</td>
<td>2.49 (1.78–3.48)</td>
<td>2.78 (1.76–4.40)</td>
</tr>
<tr>
<td>Pre-diabetes</td>
<td>1.30 (1.04–1.63)</td>
<td>1.57 (1.16–2.13)</td>
</tr>
<tr>
<td>Diabetes or pre-diabetes</td>
<td>1.65 (1.36–2.02)</td>
<td>2.29 (1.70–3.10)</td>
</tr>
<tr>
<td>Hypertension</td>
<td>0.90 (0.71–1.14)</td>
<td>1.14 (0.78–1.65)</td>
</tr>
<tr>
<td>Uncontrolled hypertension</td>
<td>1.25 (0.85–1.84)</td>
<td>1.56 (0.94–2.60)</td>
</tr>
<tr>
<td>Dyslipidemia</td>
<td>0.80 (0.64–0.998)</td>
<td>0.65 (0.47–0.91)</td>
</tr>
<tr>
<td>Overweight and obesity (BMI ≥ 25)</td>
<td>1.26 (1.05–1.51)</td>
<td>1.17 (0.92–1.49)(^b)</td>
</tr>
</tbody>
</table>

Urbanization
Urbanization

• Only 1/3 of the world’s 10.5 million refugees now live in camps
• Approximately 89% of Syrian refugees in the Middle East and Turkey live in local host communities
• This vastly complicates the provision of health services
Urbanization

Number of refugees living in camps, urban and rural/dispersed settings 1996-2008

Reality: Growing Need for Continuity Prevention and Care

- Displacement for many years
- New health needs
- Multiple urgent and competing priorities
- Accessing health service in contexts where care for chronic illness may be limited

Prevention priorities
- New models of care
- New coalitions
- New skills
- New policy frameworks
ICAP and PFMH

• ICAP at Columbia University
  – Founded in 2004 to confront major global health threats by strengthening health systems around the world
  – Now works with MOHs and other partners to support health programs, education, training, and research in 21 countries
  – Extensive experience designing, implementing and evaluating programs to address both infectious and chronic diseases

• MSPH Program on Forced Migration and Health
  – Founded in 1998 with support from the Mellon Foundation
  – A leading center on humanitarian research and teaching
  – Has helped build a knowledge base that is improving humanitarian action and health during global disasters and conflicts
  – More than 400 graduates working in 70+ countries
Confronting NCDs in the Middle East and Turkey

Project initiated in 2013 to explore NCDs in the Middle East and Turkey

• Leading cause of death and disability
• Potential to learn from HIV scale-up and the public health approach
• Important regional successes

ICAP partnered with the CU Institute of Human Nutrition and the CU Global Centers in Amman and Istanbul on a project
Confronting NCDs in the Middle East and Turkey

- Istanbul consultations 2013
- Amman workshop 2014
- Faculty visits (EPIC 2014)
- Student exchange
- Istanbul panel 2015
Responding to Changing Health Needs in Complex Emergencies: A Policy Imperative

Project exploring policy challenges relevant to the changing health needs of refugees

Primary focus on:

• Syrian refugees in Turkey, Lebanon and Jordan
• Changing health needs, including chronic conditions and non-communicable diseases

A partnership between ICAP, Program on Forced Migration and Health, the CU Global Centers in Amman and Istanbul, the American University of Beirut, and others
Priority Questions

• How can health systems adapt to the changing needs of refugees?
  – Chronic displacement
  – Urbanization
  – New health needs

• What are the training needs to achieve the skills needed to meet new the needs?

• What are the policy implications for host countries, international agencies and relief organizations?

• What types of coalitions of stakeholders are needed to address this critical humanitarian imperative?
Thank you
Teşekkür ederim

Photograph: SWNS.com