

# Health among Iraqi Urban Refugees

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**UNHCR**  
The UN  
Refugee Agency

# Urban Refugees in Middle Income Countries

- Current strategies, policies and interventions based on older paradigms of persons of concern (PoCs)\* in low income countries in camp settings
  - Parallel services
  - Dependent and confined populations (pop)
- Most current conflicts are not camp settings
  - Urban settings or rural scattered settings
- More conflicts in middle income countries
  - Demographic and epidemiological shifts

\* PoCs include all conflict-affected populations including refugees, internally displaced persons, asylum seekers, stateless persons, returnees, non-displaced persons, and surrounding host communities



# Three-pronged Strategy to Address Urban Health\*

## 1. Advocacy

- To ensure authorities make public health, nutrition, WatSan services available to these populations at low or no cost

## 2. Support

- Support PoCs by integrating them into existing public services when possible and by augmenting capacity of these systems



# Iraqi Refugee Patient Facility Usage and Cost, Syria - Jan-Sep 2009

Facility	No. of Patients treated	Est. Cost (USD)	Cost/Pers on (USD)
Syrian Arab Red Crescent (Primary and secondary care)	206,000	2,800,000	14
Damascus Hospital	8,500	160,000	19
OBGYN Hospital	245	23,000	94
Pediatric Hospital	30	18,600	620
Al Assad Hospitals	492	73,700	150
Al Bayroni Oncology Hospital	1,675	103,000	61
AL Basel Cardiac Hospital	255	273,328	1,072
Ibn Rushed Cardiac Hospital	44	30,000	682
Total	217,241	3,481,628	16

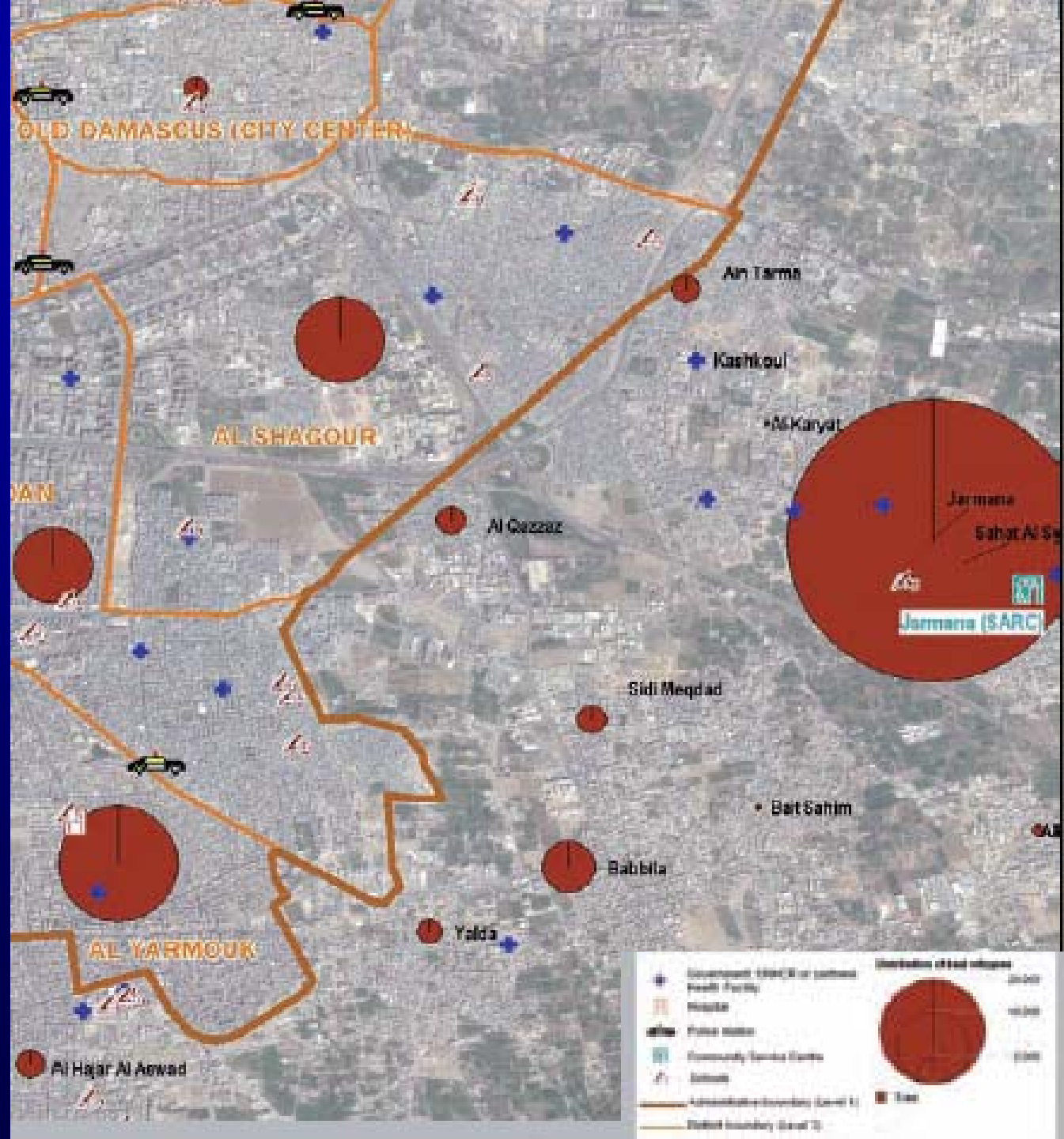
# Three-pronged Strategy to address urban health (cont)

3. Assess, monitor and evaluate (M&E) and use data to *ensure adequate and equitable provision of health services*
  - *Challenging because PoCs dispersed and may not register (e.g. protection issues)*



# Distribution of registered Iraqi refugees and services in Damascus, Syria. UNHCR

Oct 2007



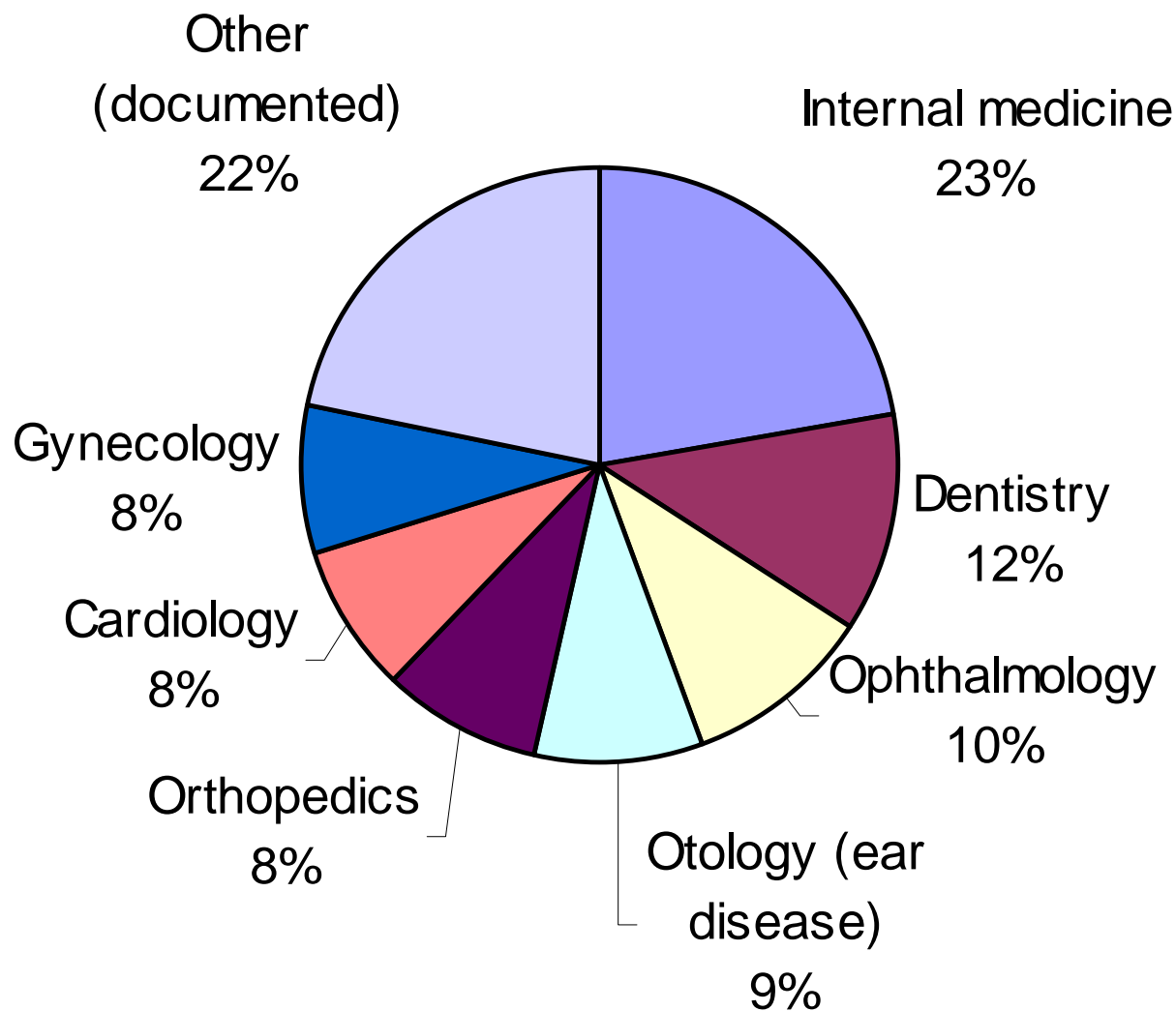
# Assess, M&E (cont)

Estimating disease incidence rates and PoC usage of services is difficult

- Accurate pop denominator often unavailable and PoCs may use >1 health facility/provider
- Thus, proportional morbidity rates by facility is norm
  - Provides important but limited data to prioritise decision-making and to effectively M&E programmes



# SARC Clinics' Data, Dec 2009



# Tertiary Care for Iraqi Refugees in Syria in 2009

HCR spent ~USD 4 million (69% on 4 main categories)

Type	Number	Total Cost	Av. Cost/Case
Cardiac surgeries	300	\$0.755 m	\$2,517
Cancer	455	\$1.4 m	\$3,077
Renal dialysis	32	\$0.120 m	\$3,750
Other renal cases	30	\$0.250 m	\$8,333
Orthopedic surgeries	60	\$0.250 m	\$4,167
<b>TOTAL</b>	<b>877</b>	<b>\$2.775 m</b>	<b>\$3,164</b>

# Cancers among Iraqi Refugees in Syria in 2009

- Of 455 documented cancer cases in 2009, 52.0% were breast, blood disorders and thyroid cancers
- Only 4.8% were among persons <20 yrs with 31.0% among those  $\geq 60$  yrs

Type	Number	Percent
Breast	144	31.6
Leukemia	42	9.2
Thyroid	31	6.8
Lymphoma	20	4.4
Misc	218	47.9
<b>TOTAL</b>	<b>455</b>	

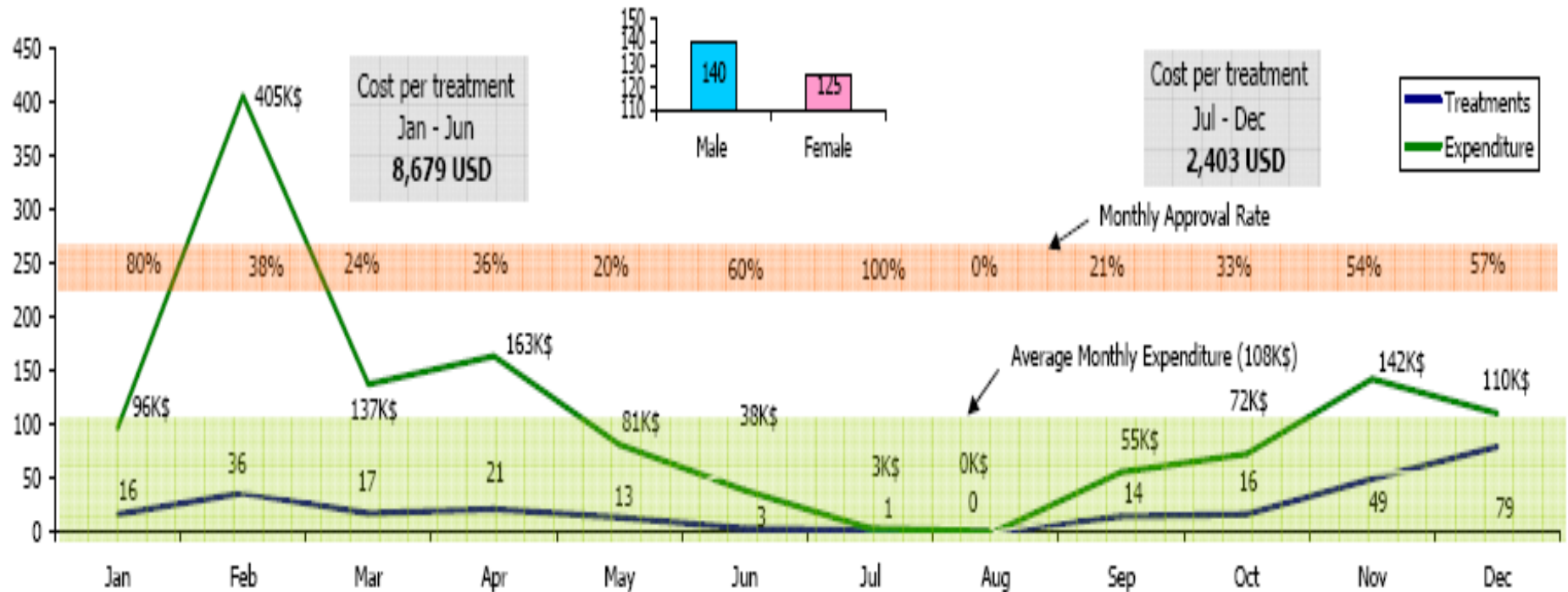


# Tertiary Care Cases in Jordan Iraqi Refugees 2009

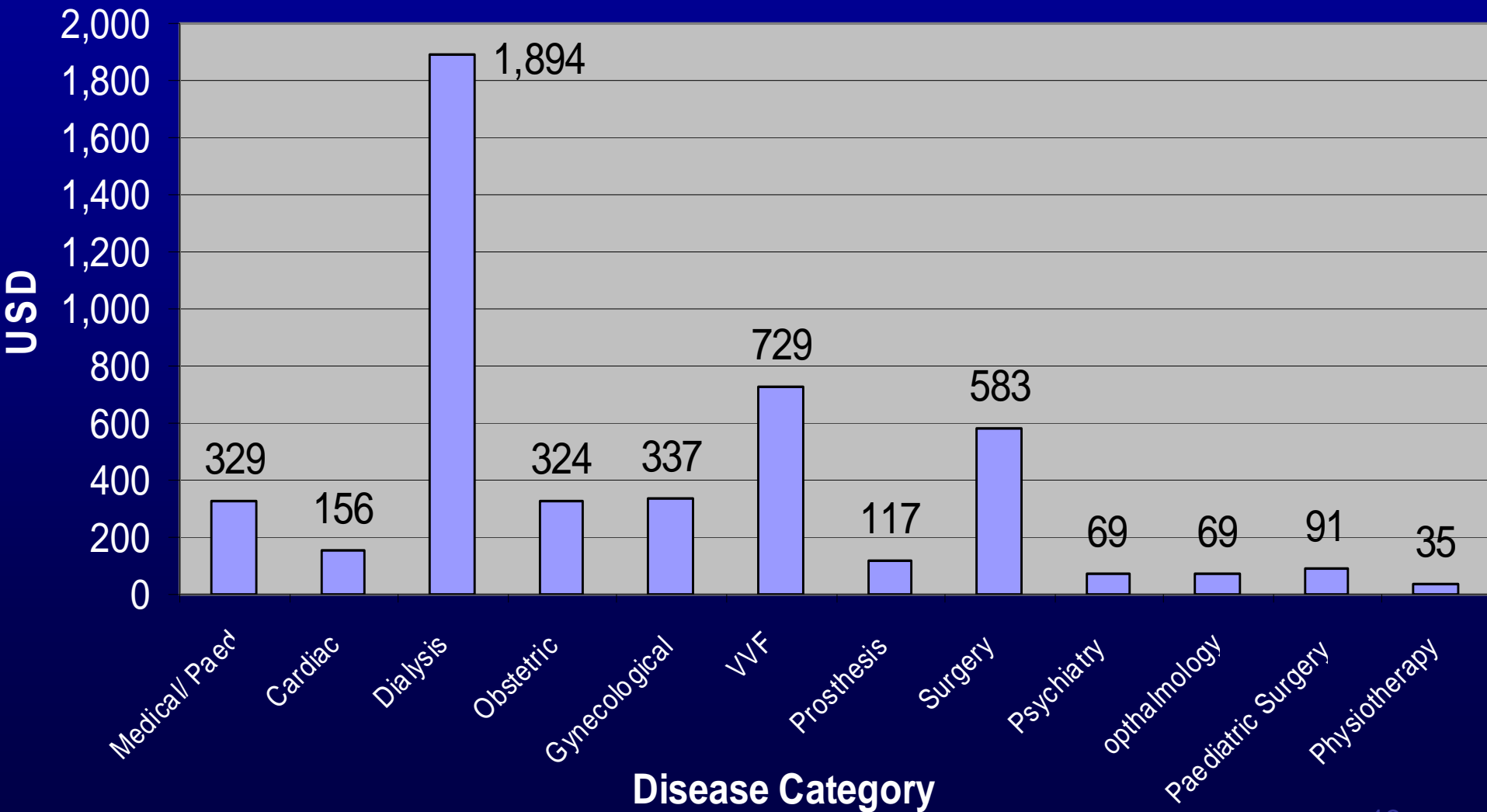
Disease	#Cases	%	USD	Cost/ Case	Highest cost
Cardiac	63	25.3%	430,859	6,839.03	11,000
Cancer	42	16.9%	415,610	9,895.48	24,000
Surgery	37	14.9%	96,408	2,605.63	18,500
Cataract	23	9.2%	23,870	1,037.83	2,500
Renal failure	16	6.4%	98,722	6,170.11	7,650
Pregnancy compl./neonatal	14	5.6%	47,599	3,399.92	7,000
Pneumonia/lung	12	4.8%	46,376	3,864.64	6,000
ENT	7	2.8%	3,658	522.60	-
Thalassemia/ Haemophilia	5	2.0%	39,831	7,966.10	7,500
Other	30	12.0%	98,884	3,296.14	16,000
<b>Total</b>	<b>249</b>	<b>100.0%</b>	<b>1,301,816</b>	<b>5,228.18</b>	<b>24,000</b>

# Emergency and Tertiary Care for Iraqi Refugees, Jordan 2009

265 Tertiary or Emergency Health Care Cases Approved in 2009



# Average Cost of Referral by Disease Category, Nairobi Kenya Oct 2008-Sep 2009



# Lessons Learned

1. Similar level of care and access to health services to that of host population should be provided to refugees
2. Camp-based models for delivering health care to refugees in developing countries are inappropriate for urban refugees in middle income countries
3. Whenever possible, care to refugees should be integrated into existing services.



# Lessons Learned (cont)

4. Emergency and primary health care (PHC) must remain main focus of health service provision, followed by secondary care
5. Tertiary care is important component of overall health care but is very expensive, helps very limited number of people, is time consuming and complex to manage, and may act as a pull factor for persons still residing in Iraq
6. Chronic diseases among persons >18 years represent majority of cases seen in PHC centers with hypertension, high cholesterol and hypertension most predominant



# Lessons Learned (cont)

7. Treatment for cancer and cardiovascular operations are most common causes of expensive tertiary care
8. Exceptional Care Committee should be developed with standard operating procedures to ensure equity and transparency for tertiary care
9. Negotiated contracts with limited number of org. and hospitals for minimum prices similar to that of local pop. allows for easier monitoring and quality control
10. Strong communication strategy in appropriate languages and forms that involves refugees and health care workers needs to be quickly adopted

