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## Anticipating the Unexpected: Urban Refugee Programming in Jordan

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Refugees have found their way to foreign cities throughout history, but the numbers residing in urban centers have grown exponentially since the early part of this decade. Often able to blend in and surrounded by the city's existing local public services and social networks, the self-sufficiency of urban refugees can be easily taken for granted. The fact they tend to be scattered widely across an urban sprawl merely adds to the perception that they are too difficult to identify and target for direct humanitarian assistance.

The flood of Iraqi refugees believed to number two million at one point who have fled war at home for shelter in Amman, Damascus, Beirut, and other Middle Eastern cities has refocused global support for humanitarian assistance programs to the urban displaced. It has also highlighted the shortcomings of internationally accepted policies and practices developed primarily to address the needs of refugees in camp settings — easily identifiable populations living in carefully delineated, well defined locations.

Not surprisingly, many of the traditionally accepted guidelines for best practices and minimum standards for assisting refugees in emergency response conditions have only limited relevance in the urban setting. In the health sector, these limitations were compounded by the fact that the health profile of the Iraqi refugees is considerably different than most refugee populations. The Iraqi population in Jordan is comparatively well educated, coming from a middle class background with a good quality, universal health care system. Non-communicable diseases, preventable only through

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significant lifestyle changes and treatable through costly and lengthy procedures, proved to be their most threatening health concerns. However, health programs for refugees in emergency settings are designed and evaluated by their ability to address acute conditions, aiming to minimize the spread of communicable disease and boost morbidity and mortality rates through maternal and child health care, nutrition programs, and promotion of basic hygiene.

### **1. A new approach**

International Medical Corps has worked with refugee and other vulnerable populations across the world for over 25 years. Since 2007 our work assisting urban refugees from Iraq has taught us several valuable lessons. Four of these we consider especially noteworthy:

- *Flexibility is a must.* International agencies that used project models cut and pasted from other refugee settings found their projects facing unexpected challenges that required flexibility and innovation to overcome. In some cases, even the core tenets of well-established programs must be questioned and reviewed for applicability and effectiveness. Failure to adapt and adjust can undermine even the best program if it is designed for the wrong conditions.

- *Local partnerships are essential.* Working together with local actors — whether they are national or municipal governments or non-government organizations indigenous to the country — provides the kind of local knowledge and cultural guidance that can strengthen programs and services for refugees in many urban settings. The process of identifying and accessing urban-based refugee populations requires a level of trust and understanding with local communities that can take months and years for an international agency to establish, a time frame not conducive to the delivery of humanitarian assistance. Moreover, the institutional memory and support of local groups, including those not traditionally engaged in humanitarian assistance, can also lead to creative approaches and be crucial for providing continuity of care.

- *Smooth relations/shared analysis and approached with UNHCR and donors.* Coordination among stakeholders is a must in any humanitarian setting. In refugee camp settings, this can be a straightforward process of ensuring appropriate coverage of basic needs with responsibilities for each sector clearly defined. In the urban context, the challenges of not only identifying the location of the vulnerable populations, but assessing and addressing their needs increases the potential for duplication, or worse, gaps in assistance. Effective coordinating mechanisms that promote transparency and regular flows of information and referral between all stakeholders are critical to

addressing protection concerns and meeting basic needs of the urban refugee.

• *Problems often hide in plain sight.* The visual image of bustling streets and crowded neighborhoods in large cities can mask a potentially crippling isolation of urban refugees. It is isolation not just from the host population, but — of far greater importance — from close friends, family and others, who may be miles away and out of reach. This is especially true for women refugees who may be even further isolated because of cultural or safety concerns. Even with the depth of our experience with refugee populations, the extent of this isolation only became evident when it began impinging on our ability to carry out the health and early childhood development programs that we had launched in Jordan for Iraqi refugees. Once we became aware of it as an issue, however, we reshaped the programs, resulting in such positive outcomes that our overall approach and strategies for assisting Iraqi refugees was revised.

### **2. How it began**

We first established emergency response programs in Iraq in 2003, and subsequently initiated refugee assistance programs in Jordan, Lebanon, and Syria. Iraqi refugees arriving in Jordan settled primarily in three major urban centers, renting apartment space according to their means, and showing no discernable settlement patterns. Most Iraqis quickly overstayed their temporary visas, after which they were recognized as “guests” by the Jordanian government in the absence of any legal provision to be recognized as refugees by the host country. Consequently, they had neither legal status nor the ability to gain lawful employment. As the United Nations and international aid community mobilized resources to respond to this forced migration, many questions typical of an urban refugee context arose, but with no accurate tracking system or reliable data on the number of, answers were scarce.

How were the most vulnerable to be identified? What measures could be taken to ensure that all in need were being reached? To what extent do the host government’s protection and assistance priorities for the newly arrived refugees differ from those of the international community and how should the distance between them be bridged? What is the impact of the refugee influx on the host population and how should humanitarian assistance target host population needs in light of that impact? These questions and many more pre-occupied the government of Jordan, the United Nations High Commissioner for Refugees (UNHCR) and non-governmental organizations (NGOs), including International Medical Corps, in designing and implementing a response that would begin to address the many challenging and unique issues.

The inherent complexities and stress of displacement, together with the scattering of Iraqi refugees

throughout a sprawling urban setting, had also fractured social ties among Iraqis in Jordan, making efforts at community mobilization particularly difficult. The lack of natural social networks hampered outreach efforts to identify vulnerable families, disseminate information and assess needs. The abrupt break in social and family networks among Iraqis caused by the displacement, coupled with anxieties about navigating through a foreign city and accessing unfamiliar public spaces, resulted in a sense of loneliness and isolation that profoundly affected the daily rhythm of Iraqi families, particularly parents.

It was against this backdrop that International Medical Corps, in partnership with three Jordan-based NGOs, initiated its health provision and health education programs, complemented by its early childhood development project.

### **3. Iraqi refugee health and access to health care in Jordan**

Health services in Jordan, provided by the Ministry of Health, the Royal Medical Service, private facilities and non-profit NGOs, are widely available in Jordan. Towards the end of 2007 the Government of Jordan granted Iraqis the right to receive health care under similar terms as non-ensured Jordanians. Yet even with this generous provision, the cost of care continued to present a substantial barrier to Iraqis. Several surveys report that 15-21% of Iraqis do not seek care when medical attention is required due to associated costs, including transportation, medications, and laboratory tests.<sup>2</sup> The required co-payment, though modest, provides an additional burden on household budgets, specifically for families with chronically ill or disabled members that require frequent visits and follow up.

When International Medical Corps began providing health care support in Jordan in 2007, there were about ten NGO-run health clinics available to Iraqis registered with UNHCR. Services in those clinics were limited to general practitioner consultations, dental care, and free drug distribution, mostly for the treatment of acute conditions. Other services outside of the general practice scope of work were referred to governmental or private facilities and required additional payments on behalf of the patient. Family planning services were very limited, and mental health and psychosocial assistance had never been an integrated part of the primary health care model in the Middle East. Referral systems between

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<sup>2</sup> *Report Survey on Health Needs and Perceptions of Patients in Jordan Red Crescent and Caritas Clinic*, IMC and JHU, 2008; *Report Survey on the Health Status of the Iraqi Population in Jordan*, UNICEF/WHO/JHU, 2009; *Report Survey on the Health Status and Needs of Care Seekers at JHAS MMU in Amman, Zarqa, and Irbid*, IMC and JHU, 2009.

NGO clinics were weak and informal, resulting in poor continuum of care, a limited ability of medical practitioners to track patient histories, and excessive transportation costs on the patient as they travelled to various service providers to properly treat their comprehensive health needs. Of those suffering from chronic conditions, few were able to receive standard care to monitor progress and prevent complications, which required specialized consultations and laboratory testing, along with the provision of expensive medications and access to healthy lifestyles education.

At the time, very little was known about the health profile and health-seeking behavior of Iraqi refugees. Between 2008 and 2009, three surveys were conducted to address this gap in knowledge and improve the type and availability of services. Through these surveys we learned that Iraqis in Jordan could be characterized as a middle-aged population with a high prevalence of non-communicable diseases. Hypertension and hyperlipidemia topped the list, followed by endocrine disorder with prevalence of diabetes and thyroid conditions, and obstructive pulmonary diseases mainly presented by asthma and obstructive bronchitis. There was a high level of education, even among the most vulnerable portions of the Iraqi population, and a correspondingly high level of sophistication of drug knowledge and diagnostic methods. The typical Iraqi household in Jordan had four to five persons, and spent an average of \$50-\$70 per month on health care expenses, which, according to one survey's assessment, corresponded to 22%-30% of the average monthly household income.

International Medical Corps also learned that among the most vulnerable Iraqi families are those with no legal status and who had minimal or no natural support networks. Vulnerable Iraqi families tended to stay at home, had limited social interaction with other Iraqis, and held strong reservations about visiting public institutions, including health clinics, community centers, and other places that may have had services catering to them. Many were cut from information about available humanitarian and governmental assistance, and were largely invisible to assistance providers. Their vulnerabilities were increasing over time, as the cumulative effects of displacement, isolation, and uncertainty about the future led to increasing psychological stressors and the aggravation of pre-existing health and mental health conditions.

Interestingly, we recognized that there were few significant differences in the profile of the Iraqi and non-Iraqi families included in the surveys. Per capita income, health needs, and health expenditures were relatively similar among vulnerable local families and displaced Iraqis, suggesting ethical reasons for an equitable distribution of care in the communities that we were targeting.

Such an operational environment was also complicated by concerns more typical of a refugee response program. Namely, it was impossible to predict how long the status quo would be maintained and for

what duration international aid for Iraqi health care would be available. No durable solutions were imminently evident. The concept of long-term integration into Jordanian society was not supported by the Government of Jordan; persistent security concerns (among other concerns) prevented large-scale returns to Iraq; and the possibility of resettlement to a third country was an option for only a small minority of Iraqis. In this context, International Medical Corps designed its strategy on developing and strengthening local capacity in Jordan's health sector, specifically targeting the niche sector of non-profit, non-governmental service providers.

#### **4. International Medical Corps' response and applied practices: The health provision and health education programs**

##### **Strengthening local capacity**

Initially International Medical Corps partnered with Jordan Red Crescent Society — a large, well-established organization with an impressive history of providing health care to needy populations. In a lesser capacity, we established a partnership with Jordan Health Aid Society (JHAS), a two-year old inchoate organization with a broad network of care providers and an impressive ability to deliver services in a fast and flexible manner, but with extremely undeveloped operational systems. JHAS managed a handful of primary health care clinics in pockets of poverty within the Kingdom, offering basic general practitioner care and subsidized medicines, financed through the sale of their own health aid card, which functioned as an affordable health insurance scheme for low-income families. We were attracted by this sustainable model of care, as it offered the most vulnerable communities in Jordan an alternative to publicly provided health care, and our partnership with JHAS subsequently grew in stages.

Despite an attractive model of care and a proven ability to scale up and respond quickly to address gaps in assistance, JHAS lacked the internal systems to manage increasingly large budgets, staff, and operational requirements. International Medical Corps worked closely with JHAS, seconding staff as necessary, to create financial and administrative systems that complied with local and international standards, promoting transparency and enhancing their capacity to meet the demands of a growing organization. Policies and procedures governing human resources, procurement, asset management, and accounting, which enforced separation of duties and provided for effective checks and balances, were established. We assisted in hiring qualified staff to fill the new positions that were required and redesigned budgets to appropriately account for overhead costs. We provided extensive and ongoing training and supervision to program managers on project design and management, quality control and monitoring and evaluation. We also offered numerous trainings to clinicians and clinic managers on

best practices, including the integration of health education, maternal and child health care, and mental health care into the primary health care package.

### **Balancing host and refugee population needs**

As the institutional capacity of JHAS developed, so too did International Medical Corps' strategy of addressing the health needs of Iraqis. An early modification to our approach involved the inclusion of non-ensured Jordanians and other nationalities in our program. This was an important adjustment, made possible by the flexibility of our donor, which allowed for up to half of the program beneficiaries to be non-Iraqis. Firstly, this change helped keep the project in compliance with a latent policy of the Government of Jordan that required at least half of all beneficiaries from internationally funded projects be citizens of the country. The adjustment was more significant, however, at the grassroots level. There was a growing resentment among local populations from the perception that the arrival of Iraqis to Jordan not only resulted in a spike in the cost of living, but that huge amounts of assistance were being provided exclusively to Iraqis and unavailable to the Jordanians and other nationalities who met many of the same vulnerability criteria. This resentment contributed to the existing rift between Iraqis and the local communities within which they lived, and helped to exacerbate the feelings of isolation and apprehension that Iraqi families were experiencing.

International Medical Corps supported JHAS clinics that were located in areas with known concentrations of Iraqis, but provided services based on need, rather than nationality. Relying on teams of outreach workers attached to each clinic, we were able to raise awareness of and create demand for our health care services in a way that benefited entire communities while maintaining the balance between Iraqis and non-Iraqis that satisfied both our donor and the Government of Jordan. Moreover, the interaction between Iraqis and non-Iraqis in the clinic waiting rooms and during health education sessions created networking opportunities and helped promote the process of social inclusion for Iraqis.

### **The “one stop shop” clinic model**

Another important program modification was the development of the “one stop shop” clinic model. In consideration of the wide array of specialized health care needs, the ineffective referral network between service providers, and the burdensome costs of transportation for the patient, International Medical Corps began expanding the number of services available in each clinic. Adding to the initial general practitioner and dental care, specialists in obstetrics and gynecology, pediatrics, endocrinology, cardiology, ophthalmology, and mental health were included on a part-time basis in the

weekly clinic schedule. Laboratory testing and the provision of medications for managing chronic conditions were also incorporated, helping to reduce the number of visits required by patients and ensuring that their comprehensive health needs were being effectively addressed.

These expanded services were covered under a sub-grant agreement between International Medical Corps and JHAS, while the basic services and JHAS operational costs continued to be covered through the sale of the health aid card, which we purchased and distributed to community members through our own outreach and needs assessments. This approach helped to promote JHAS' own cost-recovery system to ensure the long-term sustainability of its clinics even in the absence of external funding sources.

### **Mobile medical units**

In addition to the clinic-based care, we established mobile medical units that provided basic health care and health education in various locations where Iraqis were known to live. This intervention, usually reserved for reaching remote populations in rural environments, has proved to be an important way to assist urban-based Iraqi families who could not or would not access health clinics. Relying on extensive community outreach and informal neighborhood networks, the mobile clinics bring services to the immediate vicinity of vulnerable families, for whom financial, physical, or psychological barriers to accessing public or private health care facilities existed. These units also accompany International Medical Corps' home-based or case management teams on home visits when medical consultation or assistance is required.

### **Health education**

To complement these clinical and mobile services we included a health education component, a staple of International Medical Corps health programming world-wide. However, many of the common themes, including basic hygiene and sanitation, tuberculosis and HIV/AIDS awareness and prevention, and nutrition, were superfluous, with the target groups showing a high level of knowledge and already exercising good practices in these areas. While our health education continued to include traditional subject matter such as reproductive health and maternal and child health care, it increasingly emphasized self-management of chronic conditions and early detection of cancer. This eventually evolved into a healthy lifestyles campaign aimed to help families collectively address the prevalence of diabetes and hypertension among one or more family members. For such an effort to be successful requires a commitment to a change of behavior, one that must be supported by the whole family, and that even in the best of circumstances produces evident results over an extended period time. Thus it is



not necessarily conducive to the impact evaluations for short-term funding that most refugee assistance programs rely upon. Nevertheless, we have come to recognize that the long-term management of chronic conditions for this population, given the limited resources that they have and the uncertainty of continued external support, must rely less on the regular provision of expensive medications and more on prevention and disciplined self-management practices.

### **The Early Childhood Development Project**

The early childhood development project (ECD) was initiated in 2008 as a complement to International Medical Corps' health programs. The ECD project sought to target vulnerable Iraqi and Jordanian parents, young adult women intending to become mothers, and older women recognized as matriarchs of their families. The overarching aim was to promote healthy child development from birth to eight years. A more specific goal was to teach positive behavior modification techniques in order to improve parenting practices and parenting confidence.

### **Overcoming barriers**

We recruited vulnerable Jordanian and Iraqi women for the ECD project through the Jordan River Foundation's Queen Rania Center. Training sessions were conducted at the center, located in East Amman in an area with high concentrations of Iraqi refugees. Although mothers confirmed their interest in the program curriculum, attendance among Iraqis in particular was sporadic. Through informal conversations, and later through focus group discussions, we learned why. Jordanian mothers felt comfortable attending courses at the Queen Rania Center, but their Iraqi counterparts were hesitant. They expressed feelings of insecurity and a general discomfort about travelling outside of their immediate home environment. Although the Jordanian government assured the safety of their Iraqi guests, Iraqis frequently felt vulnerable to harassment and discrimination. Moreover, unlike the commonly perceived refugee camp setting, where both refugees and services are generally within close proximity, the urban setting tends to be a sprawl that requires multiple methods of transportation to reach services. In addition to being time consuming and exhausting, it can create an economic barrier that further hinders access to support.

During the first ECD program, we did ultimately reach our targeted number of Iraqi mothers. Still, it was clear that safety and security concerns, as well as the strong cultural imperative to protect female members of the community, were contributing to a lack of focus and erratic attendance. Even our decision to pay generous transportation allowances to Iraqi participants had little impact. It quickly became clear that changes would be needed in order to reach a broader cross-section of the Iraqi

female population in the continuation phase of the project.

### **Finding solutions**

We re-evaluated and then replaced the original, centralized program design that required travel to the Jordan River Foundation center and instead initiated a pilot home and community-based approach. Home and community-based programming reaches out to and meets beneficiaries within their own environments. It is an inherently intimate approach that gives the service provider immediate and unfiltered insight into a family's circumstances and the community environment. In the West, service providers are increasingly called upon to meet clients in home and community settings.

While home and community-based intervention is not a new concept, it was not commonly used in Jordan. Seeking solutions, International Medical Corps and the Jordan River Foundation decided to try it, using Iraqi women as trainers of trainers (ToT). Our thinking was simple: such an approach would boost accessibility and participation rates by easing the logistic and security constraints that had kept the refugee women away. We also anticipated that training Iraqi women for a ToT role would carry its own benefits. It would be a cost effective way of reaching more mothers, build leadership capacity and ensure a greater level of trust and investment in the program among the beneficiary population.

### **Turning assumption into reality**

After a comprehensive selection process, 20 Iraqi women were trained during a two-week ToT course on ECD. Each trainer was then expected to invite 8-10 neighboring women into her home to participate in five-days ECD training, which would be repeated for new groups throughout the project period. With just limited outreach efforts, demand for these home-based trainings quickly grew within the communities, and each trainer soon found herself hosting no less than 20 women — twice the expected number — in modestly-sized apartments. Attendance rates consistently topped 90%. This overwhelmingly positive response held throughout the subsequent training sessions, helping us reach 2,100 mothers in the course of eight months — well in excess of the targeted number.

Although these outcomes confirmed our initial assumptions, the more compelling issue for us came with the recognition of just how strong the sense of isolation was among many Iraqis in Jordan. For these isolated refugee women, the simple opportunity to meet socially through the training was clearly of equal or even greater value than the training itself. The sudden break in social and family networks that had accompanied their chaotic departure from Iraq, coupled with the anxieties of travelling through a foreign city to unfamiliar public spaces, generated an acute sense of loneliness and isolation

among Iraqis that the intimate, home-based peer trainings helped ease. Participants quickly took advantage of the training sessions to share stories and develop bonds of friendship that outlasted the training period and effectively helped expand their natural support networks.

### **Measuring results**

To measure the impact of the ECD program, we used a mix of quantitative and qualitative methods. Qualitatively we conducted focus groups, in-depth interviews and visual observation. The quantitative survey tools included: an ECD knowledge questionnaire; an evaluation of trainer and training questionnaire; a value, applicability, learning and skills (VALS) questionnaire; plus a focus group questionnaire. We also coded parent child interactions. The sampling strategy relied on random sampling, conducted over time with three time points. Data was collected at baseline as well as at two follow-up time points — the end of a five-day ECD program period and one month after the conclusion of the ECD training. Comparisons were drawn between these three periods.

Results showed the project was highly effective in transferring knowledge on early childhood development theories and practices. For example, the VALS questionnaire, designed to measure uptake in knowledge, improvement of parent/child relationships, participant perceptions of the program, and its overall benefit, found 99% of participants exhibited at least a 60% increase in knowledge of ECD principles.

But it was the program's impact on refugee isolation and loneliness — essentially a side effect only partially measured by the VALS questionnaire — that was extraordinary. Qualitative assessments conducted through focus group discussions with participants and debriefs with trainers showed improvements in the mental health and psychosocial well-being of all of the women involved in the program. Participants and mother educators (ToTs) reported significant increases in self-esteem and self-confidence and a decrease in depressive feelings. The sense of isolation that many experienced was mitigated through the regular social interaction with peers in a controlled, safe environment.

Equally notable was the positive impact of mixing Jordanian and Iraqi mothers together in the program. Many reported that training sessions broke down pre-existing barriers and stereotypes between the two groups. Some participants even reported developing friendships with members of different groups for the first time in their lives. Through the one-month delayed post-assessment, we were able to confirm that the social groups and friendships developed in the course of the trainings remained an important part of the participants' lives, providing them with increased levels of comfort in their immediate neighborhoods and an expanded social network on which to rely.

The extent of positive change brought by the program even altered the community's perception of humanitarian groups working to help them — in this case the Jordan River Foundation and International Medical Corps. Participants interpreted program adjustments that brought training sessions into their neighborhoods and their homes as an indicator that these organizations were truly committed to addressing their needs. Many seemed surprised that such a community-based approach was even possible. For us, the change offered both greater contextual insight and a more holistic understanding of the needs of urban refugees in Jordan than any health clinic data or home-based surveys could provide.

### **Conclusions/recommendations**

The process of coordinating and implementing refugee assistance programs is difficult in any context. The international response to the needs of the Iraqi population in Jordan proved to be no exception, and in many ways faced unique challenges that further complicated efforts. Jordan has a history of refugee politics as old as the country itself and is already a major recipient of international development aid. Iraqis arrived gradually, rather than in waves, from the early 1990s to the present day. By the time the international community came to recognize the significance of their numbers and needs, the population was already largely settled in urban centers. The most vulnerable amongst them had overstayed their temporary visas, living off diminishing savings and shying away from public view. The Government of Jordan was determined not to create a parallel system of assistance for Iraqis as existed for Palestinians in Jordan and did not prioritize support for Iraqis above that for their own citizens, many of whom had comparable needs. Consequently the government required that all internationally funded programs target an equal number of vulnerable Jordanians. As a result, the principal donors adopted a two-pronged approach, with a substantial portion of aid directed at building the capacity of the Jordanian infrastructure to accommodate the growing demands on services, and the rest targeting immediate assistance to Iraqis.

International Medical Corps took a similar approach, albeit on a smaller scale. We work through well-established local organizations like Jordan River Foundation, and help build the capacity of smaller, grassroots organizations like Jordan Health Aid Society, to provide improved health and social services for underserved populations living in urban poverty pockets, providing equitable care for all. At the same time, we directly operate the outreach and information dissemination efforts required to locate, assess, and support the Iraqi populations in those same neighborhoods to ensure a balanced effort. This approach proved acceptable to both the Government of Jordan as well as donor agencies, but also had the added value of easing tensions between the two populations and actually promoting an

increase in cross-cultural interaction and understanding.

Our programs have evolved considerably since their inception in 2007. The changes were necessary adaptations to an operational environment that required new ways of programming in order to have the desired impact on the refugee community we were serving. These changes also required continuous dialogue with donor agencies and partners to ensure that new program approaches were still in line with the basic goals and objectives of providing immediate support and assistance to the targeted populations. The lessons we have learned in the process have spawned a number of important points that we recommend to concerned stakeholders. These include the following:

- Outreach efforts must complement organized activities. Information dissemination among urban refugees is exponentially more difficult than among camp-based refugees. For Iraqis in Jordan, who are characterized as having weak social bonds, no discernable settlement patterns, and a strong tendency to avoid public exposure, the process of identification and creating demand for health and other services through community-based outreach efforts, must be a specifically designed and budgeted for component of all programming.
- Programming must strike a careful balance between host and refugee populations in order to avoid creating or exacerbating tensions that may exist between the two groups. Even in contexts where integration of the refugee community is not considered a durable solution, the process of including both groups in assistance-related activities can produce notable and immediate improvements in the mental health and well-being of the refugee population. It also helps encourage participation in services, which is critical for health care providers in our efforts to promote preventative care as well as regular follow-up care for chronic health care conditions.
- A common language for defining and addressing comprehensive needs of urban refugees should be developed. Standardized guidelines for emergency assistance to refugees are largely inapplicable in such an urban context. This issue has created challenges among the international community in Jordan, particularly in our efforts to define and prioritize the most urgent needs. This issue is highly relevant to health care, where considerations of treatment for the high prevalence of chronic conditions and cancer care compete with those for more basic primary health care services. However it is equally relevant to other areas, including protection and psychosocial support services.
- Given the challenges facing the refugee community to identify, access, and maneuver between service providers in the urban setting, it is important that services are integrated to the extent possible, and that effective referral mechanisms, with proper tracking procedures, are in place when integration is not possible. This requires strong coordination efforts to map activities,

and must be inclusive of national institutions and organizations that provide complementary services.

- Promoting social networks is an important means of addressing isolation and loneliness, which we have come to recognize as a major concern among urban refugees. It also encourages access to existing social services and facilitates the delivery of important messages related to health care and protection, among others. Home and neighborhood based programming provides the type of intimate settings necessary to create strong and lasting ties between families and community-based organizations.

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