

International Conference on Refugees and Diabetes

Dead Sea, Jordan

10-12 April 2017

Dead Sea Declaration and Call to Action on Refugees and Diabetes

Under the patronage of HRH Princess Muna al-Hussein, the International Conference on Refugees and Diabetes, involving more than 75 representatives of the Ministries of Health from Jordan, Lebanon, Palestine and Sudan; bilateral agencies; civil society organizations; academia; the private sector; and United Nations organizations, held at the Dead Sea in Jordan between 10 and 12 of April 2017, highlighted the challenge posed by diabetes in the refugee population – a source of suffering for individuals and their families, a great strain on health care systems and economies, and an impediment to the achievement of the Sustainable Development Goals and the pledge to leave no one behind.

The participants adopted the following declaration and urgent call to action.

I. We express grave concern about the growing crisis of diabetes in refugees:

The world is facing a humanitarian crisis¹. 65.3 million people have been forced out of their homes, and 26.5 million are considered refugees, including 5.2 million Palestine refugees registered with the United Nations Relief and Works Agency for Palestine Refugees in the Near East (UNRWA). They have been forced to leave their countries, living in fragile, insecure environments with uncertain access not only to health care, but also to livelihoods.

The countries in the Eastern Mediterranean Region of the World Health Organization (WHO) are the epicentre of this crisis. Refugees from Palestine and Syria alone now constitute 10.1 million people. Jordan, Palestine and Lebanon currently host 6.1 million refugees in total. Achieving the Sustainable Development Goals – not only SDG 3.8, universal health coverage for all by 2030, but the entire set of goals – will require a specific focus on the millions of vulnerable refugees worldwide.

According to WHO, the number of people with diabetes has risen from 108 million in 1980 to 422 million in 2014. WHO projects that diabetes will be the seventh leading cause of death by 2030 and notes that diabetes prevalence has been rising more rapidly in middle- and low-income countries.

The global prevalence of diabetes among adults over 18 years of age was 8.5 per cent in 2014. Among refugees, diabetes prevalence is estimated to be at least 50 per cent higher. People with diabetes need access to medicines and care, healthy food, and safe environments for physical activity. They also need information and guidance about how to manage their disease in order to prevent the development of complications.

Refugees and people displaced as a result of conflict have limited access to all of the above, in addition to psychosocial stress; this combination of factors causes suffering, exacerbates the health issues of refugees with diabetes, and precipitates the onset of diabetes in predisposed and at-risk refugees.

Undiagnosed and poorly controlled diabetes may precipitate acute, life-threatening, and late-stage complications such as blindness, amputation, kidney failure, cardiovascular events and early death, inflicting suffering on individuals and their families and straining already-stretched health care resources. Yet diabetes care is not always fully integrated in humanitarian response plans, despite the serious burden it places on refugees and the health systems that serve them, including the host nations.

¹ UNHCR, 2015.

Whereas the rights of refugees are protected under a series of international frameworks²;

And whereas

- The UN Sustainable Development Goals and
- The Political Declaration of the High-Level Meeting of the General Assembly on the Prevention and Control of Non-Communicable Diseases (NCD) specifically address the growing threat posed by NCDs, including diabetes

II. We appreciate that:

National health systems in the Eastern Mediterranean Region and elsewhere worldwide, as well as donor organizations, civil society and the private sector, are providing essential health care and making laudable efforts on behalf of vulnerable refugees every day.

III. We affirm that:

1. Protection from harm and entitlement for service is a prerequisite for effective humanitarian assistance;
2. The inclusion of the health needs of refugees living with diabetes and/or other non-communicable diseases in humanitarian preparedness and responses strategies and plans should be considered;
3. Delivery of structured, uninterrupted access to quality diabetes care with financial protection, to prevent life-threatening and debilitating complications, should be an integral component of public policies and programmes directing health services for refugees and displaced populations, without discrimination on the basis of gender, age, religion, nationality, race, or health or legal status;
4. Investment in the prevention of diabetes, its comorbidities and complications by providing structured care may reduce disability, improve quality of life and is cost-effective;
5. Although evidence-based best practices in diabetes care for refugees exist, more research is needed, and should be used as a platform for improving prevention, treatment and care for refugees worldwide;
6. Inter-sectoral, inter-country and inter-agency coordination and collaboration mechanisms working towards improving the health of refugees with diabetes and other related comorbidities should be pursued;

²Main international frameworks in this regard:

- The UN Convention Relating to the Status of Refugees developed in 1951, also known as the 1951 Refugee Convention;
- The 1967 Protocol Relating to the Status of Refugees;
- The 1974 United Nations Declaration on the Protection of Women and Children in Emergency and Armed Conflict;
- The New York Declaration for Refugees and Migrants adapted by the UN General Assembly at its seventieth session, on 19 September 2016;
- The World Health Assembly resolution (WHA61.17) on the health of migrants;
- The Outcome document of the High-level Meeting on Refugee and Migrant Health, Rome, Italy, November 2015.

7. Social, economic and environmental factors that are amplifying the numbers of refugees affected by diabetes, related comorbidities and late complications need to be addressed urgently;
8. Focusing on diabetes is likely to improve health system capacity to manage other related NCDs and comorbidities, as chronic disease management and care has many commonalities across disease areas; and
9. Sustainable financing to fulfill these obligations should be secured.

IV. We commit ourselves to addressing the prevention and care of diabetes in refugee populations by working to:

1. Strengthen health systems to provide universal access to essential health services, including diabetes care to refugees and displaced populations in need;
2. Ensure that diabetes care is part of health system response plans for emergencies and refugee situations, with the mechanisms required to deliver diagnostics, medicines, and referral services to refugees, including for uninterrupted diabetes care;
3. Promote refugee and migrant-sensitive health services that are culturally, linguistically, age, gender and context appropriate;
4. Continue advocating for adequate and sustainable financing mechanisms for providing health care to refugees, including effective diabetes care delivery;
5. Emphasize and promote partnerships and inter-sectoral/multisectoral coordination mechanisms among governmental and non-governmental agencies to deliver health care to refugees, including diabetes care;
6. Establish and implement standards, guidelines and procedures as well as proper task-based training for available health care providers to deliver effective diabetes care to refugees;
7. Ensure proper mechanisms for data collection, to document, monitor, evaluate and continuously improve care for refugees with diabetes while respecting patient privacy; and
8. Conduct operational research to improve prevention and diabetes care for refugees, including cost-effectiveness studies, and share better practices.

V. We call upon our partners and other stakeholders to:

1. Include diabetes care in all humanitarian responses, both during the acute phase and protracted phase of an emergency;
2. Establish supporting mechanisms including an essential package for diabetes and other common non-communicable diseases in emergency kits; and
3. Strengthen health systems to provide care for common non-communicable diseases at the primary care level.

Through this declaration, we hope to inspire ourselves and our partners to live up to the responsibility and capacity of each organization to address the crisis of diabetes in refugee populations worldwide.