Health and internal displacement

Virtual workshop

4 and 11 February 2021

The Academy of Medical Sciences

IDRP REFUGEE LAW INITIATIVE | SCHOOL OF ADVANCED STUDY UNIVERSITY OF LONDON

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The Internal Displacement Research Programme is a specialised independent research programme hosted at the Refugee Law Initiative of the School of Advanced Study, University of London. It works to: raise the profile of research on internal displacement in academic and practitioner circles; support, disseminate and share current and ongoing work by researchers in this field; connect research in this field with that in cognate areas; bring new researchers to the field and develop new cross- and inter-disciplinary work; and promote and support research capacity in countries affected by internal displacement.

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Opinions expressed in this report do not necessarily represent the views of all participants at the event, the Internal Displacement Research Programme, the Academy of Medical Sciences, or its Fellows.

All web references were accessed in April 2021

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Preface

In 2020, more than 45 million people were displaced because of conflict and violence but still living in their home country. Such internally displaced persons (IDPs) face multiple physical and mental health challenges. Yet medical and health research on IDPs is limited in comparison with that carried out on refugees.

In February 2021, the UK Academy of Medical Sciences (AMS) and the Internal Displacement Research Programme (IDRP) at the School of Advanced Study, University of London, jointly organised an international interdisciplinary workshop to discuss the key health issues facing IDPs, gaps in knowledge, policy implications and the potential to establish a new global network focusing on the health of IDPs. One specific aim was to discuss the key messages to communicate to the High-Level Panel on Internal Displacement established by the United Nations (UN) Secretary General in 2019 in response to the identified global crisis in internal displacement. This High-Level Panel will consider the findings and policy brief generated by the workshop in formulating its report to the UN Secretary General by mid-2021.

During two half-day sessions, participants discussed a briefing paper developed by the meeting organisers, **Dr Jina Swartz FMedSci, Professor David Cantor**, Internal Displacement Research Programme (IDRP), and **Professor Bayard Roberts**, London School of Hygiene and Tropical Medicine. This report provides a summary of discussions at the workshop. It does not necessarily represent the views of all participants, the organisers, the AMS or IDRP.

Executive summary

By the end of 2019, the numbers of people displaced because of conflict and violence but still living within their home countries exceeded 45 million, almost double the number of border-crossing refugees (26 million). The numbers of such internally displaced persons (IDPs) have increased significantly since 2010. The overwhelming majority of IDPs are found in low- and middle-income countries.

While the office of the United Nations High Commissioner for Refugees (UNHCR) provides a global focal point with responsibility for refugees, no equivalent body exists for IDPs. Globally, responses to humanitarian crises involving internal displacement are led by an Emergency Relief Coordinator, who leads an Inter-Agency Standing Committee. Specific elements of the crisis response are delegated to individual agencies, which coordinate the work of a multitude of partners in 'clusters'. The World Health Organization (WHO) acts as the lead agency for the IDP health cluster.

The UN Guiding Principles on Internal Displacement, published in 1998, provide a set of global principles and a policy framework to shape national and international responses. At a regional level, African states have adopted two legal treaties, including the 2009 Kampala Convention, which provide some legal protections to IDP populations. Several countries have also enshrined the rights of IDPs in national law.

IDPs are typically from disadvantaged backgrounds and face further challenges following displacement, with significant implications for their health. They experience worse health outcomes than resident populations and non-displaced groups across a range of mental and physical health conditions. However, compared with refugees, comparatively little research has been carried out on the health of IDPs.

The workshop organised by the Academy of Medical Sciences and the Internal Displacement Research Programme (IDRP) at the School of Advanced Study, University of London, sought to identify key policy and research issues related to the health of IDP populations. Its primary aim was to inform the development of a briefing note on IDP health for the High-Level Panel on Internal Displacement established by the UN Secretary General in 2019.

Among the key issues raised by participants were:

- The need to consider the **diversity of IDPs** and the variety of contexts in which they live, including camp versus non-camp settings, vulnerable points in life such as childhood, adolescence, pregnancy and older age, the duration of displacement, and single versus multiple displacements.
- The need to consider the full range of **determinants of health** rather than just specific health outcomes, given that the circumstances in which IDPs live are likely to predispose to multiple health conditions.
- The importance of assessing **access to services**, as IDPs may face significant barriers to routine healthcare and referral to specialist services.
- The importance of **community dynamics and social structures**, which may both negatively impact health and wellbeing but also contribute to social support and resilience to adversity.
- The value of considering **IDP and host population interactions**, including how they affect health-seeking behaviours and health outcomes, and their implications for population interventions.

In terms of implications for policy and research, participants again raised a range of key issues:

- The political and practical challenges of gaining **access to IDPs**, particularly in settings where sovereign state activities have precipitated displacement, and the potential necessity of dealing with non-state actors.
- The value of **integrating health into wider discussions** of humanitarian relief efforts and sustainable development and engaging with global financing structures to mobilise resources.
- The potential to involve **NGOs and humanitarian agencies in research** as well as emergency responses.
- The importance of identifying findings from **refugee studies** that can be applied to IDPs, to avoid duplication of efforts.
- The need to consider **other triggers for displacement**, including environmental disasters and climate change.

Introduction

Globally, the numbers of internally displaced persons (IDPs) exceed those of refugees. In 2019, for example, an estimated 8.5 million people were newly displaced internally because of conflict and violence,[1] compared to 2.4 million new refugees.[2] By the end of 2019, the total number of IDPs displaced by conflict and violence was almost double that of refugees (45.7 million versus 26 million).[2] Conflict-driven IDPs can be found in almost all regions, but the overwhelming majority live in low- or middle-income countries (LMICs).[1]

IDPs typically have fewer legal protections than refugees. In contrast to refugees, IDPs lack a defined international legal status and can often be more difficult for international agencies and other governments to access and assist.[3] At the global level, no single institution has a dedicated responsibility for IDPs, unlike the office of the United Nations High Commissioner for Refugees (UNHCR), which has a specific mandate for refugees. UN Guiding Principles on Internal Displacement, published in 1998, provide a set of global principles and a policy framework to shape national and international responses, and include principles related to health and provision of healthcare services.[4] However, they are not mandatory.

Who or what is an IDP?

The UN Guiding Principles[4] define IDPs as follows: "internally displaced persons are persons or groups of persons who have been forced or obliged to flee or to leave their homes or places of habitual residence, in particular as a result of or in order to avoid the effects of armed conflict, situations of generalized violence, violations of human rights or natural or human-made disasters, and who have not crossed an internationally recognized State border."

At a regional level, some regions have taken steps to protect the rights of IDPs. In Africa, for example, the 2009 Kampala Convention established a new treaty law framework for IDP protection and assistance on the continent, which can be ratified by any African Union State.[5] At the national level, some countries in Europe, Latin America, Asia and Africa have passed laws specifically relating to IDP protection and assistance.[6]

At the global level, the UN humanitarian system has adopted a 'cluster' approach to coordinate and manage humanitarian responses to IDP situations, overseen by an Emergency Relief Coordinator (ERC), who heads up the Inter-Agency Standing Committee (IASC). Lead agencies take on specific aspects of responses. UNHCR, for example, is the lead agency for the global clusters of 'protection', 'shelter' and 'camp management', while WHO is the lead agency for the health cluster.

In 2019, the UN Secretary General established the High-Level Panel to address the global crisis of internal displacement. To ensure that the High-Level Panel receives input on the health implications of internal displacement, in February 2021 the Academy of Medical Sciences and the Internal Displacement Research Programme (IDRP) at the School of Advanced Study, University of London, jointly organised an international interdisciplinary workshop to discuss the key health issues facing IDPs.

1. Internal Displacement Monitoring Centre (2020). *Global Report on Internal Displacement 2019*. https://www.internal-displacement.org/global-report/grid2019/
2. United Nations High Commissioner for Refugees (2020). *Global Trends 2019*. https://www.unhcr.org/globaltrends2019/
3. Owoaje ET, *et al.* (2016). *A review of the health problems of the internally displaced persons in Africa*. Niger Postgrad Med J. **23(4)**, 161-171.
4. United Nations Commission on Human Rights (1998). *Guiding Principles on Internal Displacement, Report of the Representative of the Secretary-General on Internally Displaced Persons*. https://undocs.org/E/CN.4/1998/53/Add.2
5. African Union (2009). *African Union Convention for the Protection and Assistance of Internally Displaced Persons in Africa (Kampala Convention)*. https://au.int/en/treaties/african-union-convention-protection-and-assistance-internally-displaced-persons-africa
6. Global Protection Cluster. *Global Database on IDP Laws and Policies*. https://www.globalprotectioncluster.org/global-database-on-idp-laws-and-policies

Health challenges

A review of what is currently known about IDP health outcomes can be found in the briefing paper developed in advance by the workshop organisers, which provided an overview of the current state of research on the health of IDP populations and formed the basis for workshop discussions.[7]

IDPs are disproportionately from disadvantaged communities and face further adversity once displaced, typically experiencing greater poverty and worse labour market outcomes than other internal migrants.[8] These factors translate into significantly worse health outcomes across a range of measures of physical and mental health compared with local residents or comparable non-displaced populations. For example, IDPs typically experience higher mortality than both refugees and host populations and are at particular risk of infectious disease outbreaks.[9,10] IDPs also experience worse mental health outcomes.[11]

The lack of a global focal point and policy framework, as well as practical access challenges, appear to have contributed to limited amounts of research on IDPs, particularly as regards to their health.[12] Reporting of infectious disease outbreaks, for example, is less common among IDPs than refugees.[13] Moreover, much less public health information is typically available for IDPs than for refugees in neighbouring countries.[13] For non-communicable diseases, most research has focused on mental health with very few studies examining impacts on, for example, cardiometabolic and other chronic diseases or cancer.

In addition, research that is carried out tends to focus on IDP camps, even though less than 1% of IDPs live in managed camps and another 11% live in self-settled camps, mainly in sub-Saharan Africa.[14] Despite the paucity of research on the health of IDPs, even less research has been carried out on IDPs outside of health, such as the social, economic and political context and consequences of internal displacement.

7. Cantor DJ, Swartz JE & Roberts B. Health and Internal Displacement: A Review, Discussion Paper, Expert Workshop, Academy of Medical Sciences-Internal Displacement Research Programme, Feb. 2021
8. Cantor DJ & Ochieng Apollo J. (2020). *Internal Displacement, Internal Migration and Refugee Flows: Connecting the Dots*. Refugee Surv Quart **39(4)**, 647–664.
9. Heudtlass P, Speybroeck N & Guha-Sapir D (2016). *Excess mortality in refugees, internally displaced persons and resident populations in complex humanitarian emergencies (1998-2012) - insights from operational data*. Confl Health **10**, 15.
10. Lam E, McCarthy A & Brennan M (2015). *Vaccine-preventable diseases in humanitarian emergencies among refugee and internally-displaced populations*. Hum Vaccin Immunother **11(11)**, 2627-36.
11. Porter M & Haslam N (2005). *Predisplacement and Postdisplacement Factors Associated With Mental Health of Refugees and Internally Displaced Persons. A meta-analysis*. JAMA **294(5)**, 602–612.
12. Blanchet K, *et al*. (2017). *Evidence on public health interventions in humanitarian crises*. Lancet **390(10109)**, 2287-2296.
13. Desai AN *et al*. (2020). *Infectious disease outbreaks among forcibly displaced persons: an analysis of ProMED reports 1996-2016*. Confl Health **14**,49.
14. World Bank (2017). *Forcibly Displaced: Towards a development approach supporting refugees, the internally displaced and their hosts*. https://openknowledge.worldbank.org/handle/10986/25016

Key policy and research themes

Workshop participants identified a number of key issues related to IDP health.

Heterogeneity: It was noted that IDP populations are highly heterogeneous, and this heterogeneity will have important implications for the health challenges they face and health-related outcomes. For example, challenges will vary by age, setting and duration of displacement. Health impacts may be very different for those living in camps compared to those settling in surrounding communities.

The consequences of displacement will vary markedly across different population groups, including children, adolescents, women and older people. It may also have significant implications for those managing long-term conditions such as diabetes, respiratory conditions such as chronic obstructive pulmonary disease, and cardiovascular conditions. There is some evidence that older people, who are at increased risk of multimorbidity, may be particularly vulnerable to poor health outcomes following displacement.[15]

The length of time for which people are displaced will also have significant implications for health, as will multiple displacements.[8] Long-term displacement and displacement at key stages of life such as early life and in pregnancy have the potential to exert intergenerational effects, with health and wellbeing impacts on future generations.

Disease burdens: Limited information is available on disease burdens in IDP populations. Most studies have tended to focus on infectious disease outbreaks and some, but not all, aspects of mental health, although less is known about sub-clinical impacts on mental health that may nevertheless have important consequences for wellbeing. Other non-communicable diseases are particularly understudied. Many IDPs are also likely to be at increased risk of neglected tropical diseases.

For some conditions, particularly dementia and other neuropsychiatric conditions, disease burdens may be hard to estimate. IDPs may not see conditions as medical in nature and may therefore not seek medical help or the potential stigma attached to a disorder may prevent symptom reporting or engagement with health practitioners. In any case, few medical services may be available for complex conditions, which may therefore go unreported.

Determinants of health: Participants noted the importance of considering the wider determinants of health rather than just specific health outcomes. IDPs are likely to face hardships and living circumstances that are risk factors for multiple health conditions, and many are likely to be experiencing a range of morbidities. To fully understand the consequences of displacement, it is considered important to understand the context in which IDP populations were originally living as well as their new circumstances.

One specific issue raised is the importance of understanding **social structures** within IDP populations and how these might contribute to resilience or inform the development of interventions. In new settings, existing social connections and structures might be disrupted or new ones emerge, with the potential to have either detrimental or protective effects on health and wellbeing. Women and adolescents may be at particular risk of harm in insecure new settings.

Nutrition: The risk of nutritional deficiencies was highlighted as an important point to consider, particularly for those displaced in rural areas. Poor nutrition, which populations may be experiencing even before displacement, can contribute to multiple health problems. At particularly vulnerable stages of life, inadequate nutrition has the potential to have long-lasting and intergenerational effects on health and economic productivity.

15. Karunakara U & Stevenson F. (2012). *Ending neglect of older people in the response to humanitarian emergencies.* PLoS Med **9(12)**, e1001357.

Access to services: Limited access to health services was felt to be a potentially significant factor affecting IDP health. Health systems may already be stretched before the influx of IDPs and may struggle to manage extra demands. IDPs may also be disadvantaged by lack of agreed packages of care and inadequate integration into referral systems for more specialist care.

More positively, it was noted that innovative **digital tools** are beginning to provide new options for the remote delivery of services and connection to specialists. Opportunities exist for research studies to explore how these new tools could be used to meet the needs of IDP populations.

Displaced populations are likely to be at risk of infectious disease outbreaks, and routine surveillance activities may be disrupted in settings affected by conflict. Digital tools may facilitate **community-based surveillance**, particularly for infectious disease outbreak detection, to ensure more rapid responses and disease control.[16]

Host populations: Participants suggested that the interplay between displaced and host populations also needs to be considered. Although host populations can sometimes absorb newcomers, conflict is not uncommon. There is the potential for resentment among host populations, particularly if they are seen to receive favourable treatment, and for stigmatisation of incomers, for example if they are thought to be a source of infectious disease.

Health seeking: Multiple factors, including lack of knowledge, unfamiliarity with service provision and lack of trust, may lead IDPs to not seek help for medical conditions. Culturally, mental health difficulties may not be considered issues that fall within the medical domain. The cost of health services is often a key barrier to access in many settings.

Impacts of internal displacement on health-seeking behaviour need to be understood in order to gain a true picture of health impacts and to inform the design of interventions to encourage greater engagement with health services (where they are available).

Vaccination is often a critical component of emergency responses and important for reducing the risk of epidemics of vaccine-preventable diseases. However, lack of trust in authorities can exacerbate challenges related to **vaccine hesitancy**. How best to build health literacy, health-seeking behaviours and confidence in vaccination in IDP populations is an important evidence gap.

Interventions: How to deliver healthcare in camp settings is relatively well understood, and an area where findings from refugee populations are likely to be relevant to IDPs. However, only about one in ten IDPs live in camps and, in regions such as South America, IDP camps are very uncommon. How best to deliver services in non-camp settings is less clear. Key issues to consider include the integration of services and combined delivery of services to IDPs and host populations.

Many affordable and effective health interventions could be delivered in IDP settings. Participants suggested that there is a need for implementation research to ensure they are adapted and implemented in efficient and culturally appropriate ways.

16. Ratnayake R, *et al.* (2020). *People-centred surveillance: a narrative review of community-based surveillance among crisis-affected populations.* Lancet Planet Health. **4(10)**, e483-e495.

Box 1 provides an overview of some of the key research gaps discusses at the workshop.

Box 1: Evidence gaps/areas for further research

- Key disease burdens, such as:
  - Maternal and paediatric disease burden
  - Non-communicable disease burden (cancer, cardiovascular, diabetes/metabolic, neurodegenerative/neuropsychiatric disorders)
  - Neglected tropical diseases disease burden
  - Neglected areas of mental health, including alcohol and substance abuse
- Differential impacts, e.g. on children, adolescents and older IDPs, and intersectional impacts
- Long-term health effects, for example through longitudinal studies
- Factors underlying worse health outcomes in IDPs (contributory factors, causal pathways)
- COVID-19 control and access to COVID-19 vaccinations
- Intervention strategies in internal displacement contexts
- Sub-threshold conditions and preventive mental health interventions
- Community engagement and health education
- Impact of specific government policies on IDPs (e.g. camp closures) on health
- Comparisons with pre-displacement ecosystems to understand impact of displacement better
- 'Coping' strategies and links to wider social determinants (including safety, livelihoods etc.)
- IDP health in the context of natural or man-made disasters, including those linked to climate change
- Changing dynamics and adaptation of IDP populations
- Impact of multiple displacement and intergenerational effects

Implications for policy

There were some calls for strengthening of the policy framework to provide additional protection for IDPs. However, there is a growing body of international and national law and policy that provides specifically for IDP protection and access to healthcare. Particular challenges in implementation of these policies arise in conflict settings, when the actions of sovereign states may have precipitated displacement or parts of the country may not be under the control of a sovereign state.

In terms of raising global awareness of the health of IDP populations, it was agreed that the High-Level Panel is a vital channel of communication. The potential for engagement with inter-agency structures was also highlighted, particularly the WHO-led health cluster. In addition, the World Health Assembly was also identified as a forum in which key health issues related to IDPs could be raised, for example through side events.

Participants also noted the importance of considering health and health research within a wider humanitarian response and development context. The importance of health and health research could be highlighted among the international assistance and development communities, and global and regional finance communities (e.g. World Economic Forum, World Bank, African Development Bank, Islamic Development Bank), providing the opportunity to mobilise funding through existing mechanisms.

It was also suggested that COVID-19 vaccination provided an opportunity to test the extent to which countries are prioritising IDP populations. Most countries are developing vaccination strategies and plans, and it is not yet clear the extent to which these include specific measures to reach IDP populations.

Opportunities and challenges for research

Learning from parallel fields of study: It was noted that some findings from research carried out on refugee and other conflict-affected populations would be applicable to IDPs, and it would be important not to duplicate research unnecessarily. Research priorities should focus on those issues that most specifically relate to IDP populations rather than displaced or conflict-affected populations in general.

Access: One of the biggest challenges facing researchers is gaining access to displaced populations, particularly the majority that are not living in camps. IDPs may be dispersed among host populations, and they may maintain a low visibility if they have security fears. In addition, communication networks established by community-based groups and NGOs may also be disrupted by displacement.

National politics may also impede access to IDPs. Contact with IDP populations may be unwelcomed by some national administrations, particularly when the actions of sovereign states have been the catalyst for displacement. In other settings affected by conflict, national governments may not be in control of large swathes of a country and access is necessarily via non-state actors. In these kinds of contexts, negotiating safe access to IDPs can be extremely challenging.

An interdisciplinary approach is likely to be essential, underpinned by strong community engagement. Where possible, this could extend to research embedded within affected communities.

Security: Security challenges may make it extremely difficult to carry out research safely. Areas may not be under the control of national law enforcement bodies or sites of active conflict. Access to populations may have to be negotiated with non-state actors, and outsiders may be viewed with suspicion. An intimate knowledge of local cultures and power structures may be essential to provide a foundation for safe operations.

Definitions: The diverse nature of IDPs also poses problems for research. IDPs may have been immediately displaced or resident for extended periods, and they may have been displaced multiple times. A lack of standardisation of assessment measures also makes it difficult to compare findings in different populations. Although standardisation is critical, there is also a need to ensure that research instruments are culturally sensitive for particular settings.

Humanitarian responses: In emergency settings, meeting immediate needs typically takes priority over research, which absorbs time and resources. NGOs and humanitarian relief organisations may not necessarily see the need for research or have experience of integrating research into their activities. This can lead to lost opportunities to gather data that could inform ongoing and future humanitarian responses.

Thinking beyond conflict: Although armed conflict is an important driver of forced migration, it is not the only one. Natural disasters and environmental disruption, likely to be significantly affected by climate change, are leading to increasing levels of temporary and permanent displacement in many areas of the world. For climate- or environment-related displacement, it can be difficult to determine the precise triggers for migration, which may reflect the accumulation of multiple stressors that eventually render current living situations unsustainable.

Nevertheless, although displacement may have features in common whatever the cause, conflict-driven displacement is likely to have unique aspects. It is likely to be linked to exposure to violence and high levels of trauma, and emergency displacement. Less acute triggers may provide opportunities for greater planning before migration.

Dissemination activities and developing a community

Participants agreed that a range of different outputs are required to support advocacy activities and communication with different target audiences. A short policy brief capturing key messages was felt to be essential for policy audiences such as the High-Level Panel and other important global and national stakeholder constituencies.

A **review paper** summarising the current knowledge base on the health of conflict-affected IDPs was also felt to be a valuable contribution to stimulate interest in the research community and to provide an overview of important gaps in evidence.

In terms of research funding, the Research for Health in Humanitarian Crises (R2HC) initiative (www.elrha.org/programme/research-for-health-in-humanitarian-crises/) was identified as a possible source of funds. The scheme, which organises an annual call for proposals, is run by Elrha on behalf of UK Aid, the National Institute for Health Research (NIHR) and the Wellcome Trust.

Participants were supportive of the idea of maintaining contact and developing a network open to all those with an interest in the health of IDPs. It was felt that this could best be established as an **informal network of individuals**, with one or two centres providing some level of support to facilitate interactions.

Immediate activities for the network could include working on manuscripts synthesising current evidence on the health of IDPs. **Virtual seminars** could also be arranged to encourage discussion, networking and sharing of experience. Links could also be established with networks with related interests, including the Lancet Commission on Migration and Health.[17]

17. Abubakar I, et al. (2018). *The UCL-Lancet Commission on Migration and Health: the health of a world on the move.* Lancet. **392(10164)**, 2606-2654.

Conclusions

IDPs represent a large, diverse, disadvantaged and relatively neglected group. They experience multiple hardships, being disproportionately from low-income backgrounds, often losing housing, possessions and livelihoods, and typically being subject to disadvantage in their new settings. Despite their large numbers, there is limited understanding of the burden of disease, causes of disease and most effective interventions in IDP populations, particularly those living outside camps..

As outlined by the UN's Guiding Principles, national governments have a duty of care to IDPs. With their numbers rising year on year, there is an ever-greater need to raise awareness of the health and other consequences of internal displacement, and to encourage governments (and non-state actors when appropriate) to meet their obligations to IDPs.

To ensure that responses are appropriately delivered, there is also a need to gain a deeper understanding of the health status of IDP populations and their health needs, to identify and address the key factors driving the excess mortality and morbidity that they experience, and to ensure their equitable access to health services.

Annex 1: Workshop advisory group

- **Professor David Cantor,** Refugee Law Initiative and the Internal Displacement Research Programme, University of London
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