
TAKING
THE
LEAD
IN
CRISIS

A child awaits his family's asylum hearing at the at the El Chaparral border station in San Ysidro, California.

Photograph: Sandy Huffaker

Columbia Mailman School has long worked to help communities faced with humanitarian crises. Today, with wars raging across the planet and millions of people displaced by economic upheaval and climate crisis, the School is rising to new challenges for global public health. By Jim Morrison

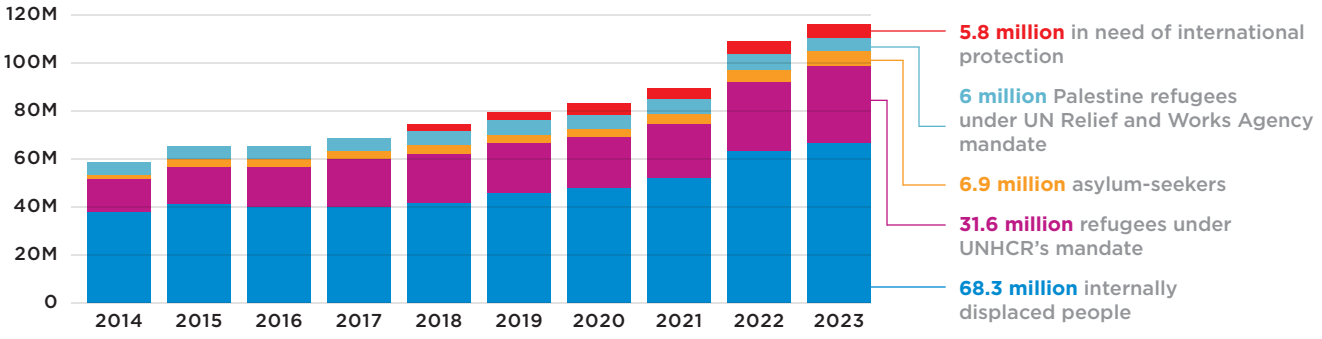
FOR CLAIRE GREENE, PhD, MPH, THE MEMORY OF THE GROUP OF VENEZUELAN PEOPLE THAT SHE MET IN A MIGRANT SHELTER IN COLOMBIA LAST SPRING LINGERED LONG AFTER SHE RETURNED TO COLUMBIA MAILMAN SCHOOL, where she is an assistant professor in the Heilbrunn Department of Population and Family Health. Eleven adults traveling with children had journeyed hundreds of miles from Venezuela to Peru, mostly on foot. They arrived with only a few bags of belongings. In Peru, one member fell ill but could not get care. So, like so many migrants today, they kept moving, backtracking to Colombia, which they had left a year earlier. They expected to gain access to emergency care there, because migrants had access to it, but they lacked legal status and getting it takes time and has barriers. "The devastation and the frustration," Greene recalls. "They were making huge decisions about where their family was living, uprooting again only to find they were basically back where they started and not sure where to go next. It left me feeling really sad."

Greene, who teaches in the School's Program on Forced Migration and Health, has examined how to bring mental healthcare to those fleeing upheaval since 2010. Her work has been complicated in recent years by a change: Migrants today are constantly in transit—often for years—while awaiting asylum, which has heightened the effect on their mental health. An estimated 22 percent of people in conflict-affected communities have a mental health problem, triple the usual rate. "It's a population that has unique risks for mental health problems, but is also underserved despite the fact that they're in greater need of supports," she says.

As the School's Program on Forced Migration and Health celebrates its 25th anniversary, the challenges for those forced to flee are increasing in number and complexity. Migration has more than doubled since 1990. The climate crisis is driving migration as populations depart from places that are too hot, too dry, or too wet. Or conflict may cause migrants to move, and drought, flooding, cyclones, or heat exacerbate their plight. In Kenya and Bangladesh, where

A DECADE OF FORCIBLE DISPLACEMENT WORLDWIDE

The number of people displaced by persecution, conflict, violence, human rights violations, or events seriously disturbing public order almost doubled.



SOURCE: UNHCR Global Trends 2023

the government says 1 in 7 will be displaced, migrants are pushed into areas already endangered by climate change. "It's a double whammy for populations that have been displaced primarily, in the first instance, by conflict, but are now being housed in places that are at the edge of climate insecurity," says Monette Zard, former director of the Program on Forced Migration and Health and now a professor in the program. Researchers like Greene are stretching to find fresh solutions in hot spots like Central America, Eastern Europe, Africa, and the Middle East.

Conflicts, too, have multiplied. In 2024, there were 56 conflicts worldwide, the most since World War II, according to the Global Peace Index. In 2022 alone, the United Nations documented 3,931 verified instances of denial of humanitarian access to children living in conflict zones, with the highest figures verified in the Occupied Palestinian Territory, Yemen, Afghanistan, and Mali.

Providing health support to migrants was a driving mission when the Program on Forced Migration and Health was founded during a humanitarian crisis coming out of the Rwandan genocide. Three Columbia Mailman School leaders were pioneers in creating the field of humanitarian health: James McCarthy, PhD, then-director of the Heilbrunn Center for Population and Family Health; Allan Rosenfield, MD, then-dean of the School; and Ron Waldman, MD, MPH, the program's founding director.

"At the time that the idea for this program was being developed in the late 1990s, the humanitarian sector, and particularly the health sector within it, had really neared its lowest point," recalls Waldman. A civil war in Somalia created nearly half a million refugees in the 1990s. The violence in Rwanda in 1994 led to half a million people fleeing to camps in the Democratic Republic of Congo, where cholera killed 45,000 people in weeks. "It was the disaster following the disaster," Waldman says. "The [need for] humanitarian intervention was as bad as it could get."

One of the School's first initiatives was to participate in an evaluation of the Sphere standards, an effort started in 1997 to craft and maintain minimum guidelines for humanitarian response. The standards spelled out the need to provide water, showers, communal places, sleeping areas, an infirmary, and dedicated space for counseling. In 2006, the School also pioneered the Reproductive Health Access, Information, and Services in Emergencies (RAISE) initiative at Columbia Mailman School. RAISE and its partners catalyzed changes in how sexual and reproductive health was addressed in humanitarian settings and were among the first to focus on improving access to contraception and abortion.

Sara Casey, DrPH '16, now the director of RAISE, began working with the program as a student two decades ago. "When we started, family planning methods were not available in many of the places in which we worked, especially sub-Saharan Africa," she says. "People had outdated training. They didn't have supplies. Postabortion care, if a woman had an unsafe abortion, was very difficult to get." Casey says the focus, now that larger organizations have programs in place, is to expand into smaller, women-led local groups. "They're there before the crisis happens, during, and after," she says. "We've been trying to find better ways to amplify their voices and help them get into the rooms where the humanitarian community makes decisions."

Over the years, researchers like Greene have come to use health systems as a delivery path for services through a "whole of person" approach that looks at not only mental and physical health, but also at their circumstances and opportunities for things like employment. "What goes into making someone healthy is multifaceted," says Zard. "It's about water. It's about education. The social determinants of health are critical to whether someone can live a healthy life. Health is an entry point to talking about a wide variety of things that we know are critical to well-being."

With the number of displaced people growing and the length of displacement increasingly measured in decades, integrating services to help rebuild lives is an evolving challenge. Greene says a minimum of 1 in 5 people affected by a humanitarian emergency will need mental health services.

But many stay only a few days in a shelter, not enough time to get care from a psychologist or other provider. "There's almost nothing there for those who are in transit," she says. "Many of the migrants we interview say this is the first time that they've even talked about this with anyone."

Getting them care means exploring new intervention ideas, coordinating with providers, and collecting more data. One new approach has been to give migrants a fanny pack with basic mental health information including a card with contact information so they can tap into services along their route. The self-care kits include a cellphone bag, basic hygiene products, and stress management cards with tips.

Greene has begun a project based in Mexico at the United States and Guatemalan borders to recruit up to 300 migrants to follow over 18 months to understand how their health and health needs evolve, particularly where mental disorders are concerned. Notes Zard, "We need to figure out how we change service delivery so that we are meeting their needs—both the fact that they're moving, but also that particular needs may arise out of that movement."

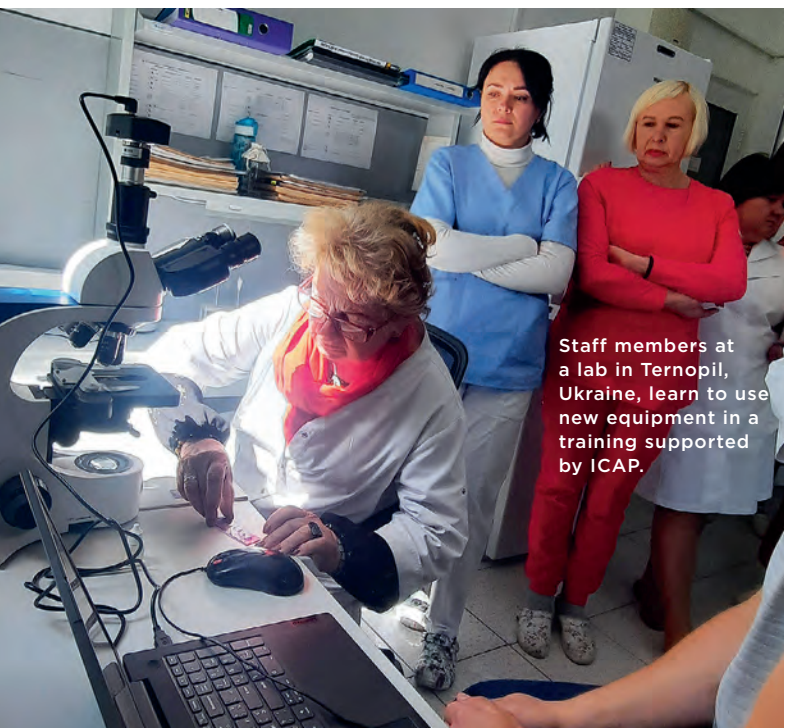
The Program on Forced Migration and Health is not the only team at Columbia Mailman School focused on global crises. As global conflicts rise, so do complex health crises. In Ukraine, ICAP at Columbia University is working with the Ukrainian Center for Public Health in a program funded by the Centers for Disease Control and Prevention. ICAP, as a global health leader that combines innovative research with collaborative technical assistance, is ideally positioned to help implement an antimicrobial resistance (AMR) project to combat infections that no longer respond to available antibiotics. In conflict settings, AMR rates increase, especially among wounded military patients. They suffer traumatic wounds and surgeries under conditions that give rise to infection. Then they are evacuated to several healthcare settings over weeks, providing opportunities for antimicrobial-resistant organisms to spread.

AMR causes more deaths globally than HIV or malaria, according to the World Health Organization, which calls it a top ten public health threat. In Ukraine, one of the most concerning AMR infections is *Klebsiella pneumoniae*. Rapid identification of resistant infections such as this one is key to getting ahead of an outbreak. "A big focus of our work has been improving diagnostic capacity," says Andrea Howard, MD, director of ICAP's Clinical and Laboratory Unit.

The hospitals may receive more than 50 wounded people at a time, and identifying infections as soon as possible is a challenge. ICAP began working with healthcare facilities in the Ternopil, Khmelnytskyi, and Vinnytsia regions to procure laboratory equipment and supplies, and to train local workers in how to make the best use of equipment that identifies pathogens within minutes. ICAP has also helped to establish multidisciplinary teams at the hospitals, including a laboratorian, a clinician, an infection prevention and control specialist, an epidemiologist, and a clinical pharmacist.

Sarah Legare, MPH, CPHQ, ICAP's regional AMR advisor, and Oksana Dereviankina, MD, MBA, ICAP country representative in Ukraine, visited hospitals in the program in January to examine how they're using new equipment, adjusting their workflows, and isolating patients who may be carrying resistant organisms. There has been progress. The hospitals have developed infection prevention and control committees, standardized lab procedures, and increased collaboration. For Legare, walking the wards is a window into the human reality of her work. "To see these men with their injuries in wheelchairs and on crutches and understand a little bit of what they've been through has been personally meaningful to me. We hope it will be impactful, not only for Ukraine, but for Europe, and even globally, to understand and mitigate the risks that AMR is posing right now."

Zard says the conditions worldwide today are reminiscent of the circumstances that led to the founding of the Program on Forced Migration and Health. "We are in an era that is really troubling as a humanitarian," she says. "What we thought was the minimum that was required of humanity—that we should not starve populations, that we should not bomb health facilities, that healthcare workers and patients should be protected—all seems to be in play right now. And that, for me, is a profound challenge to everything we hold dear about humanitarian work." ●



Photograph: Courtesy ICAP

Staff members at a lab in Ternopil, Ukraine, learn to use new equipment in a training supported by ICAP.

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