World Health Organization

Regional Office for the Eastern Mediterranean

REFUGEES AND INTERNALLY DISPLACED PERSONS IN THE EASTERN MEDITERRANEAN REGION: A HEALTH PERSPECTIVE

November 2015

Overview

As host to some of the world's biggest emergencies and protracted crises, the Eastern Mediterranean Region (EMR) carries the largest burden of displaced populations globally.

Out of a total of 50 million refugees and IDPs worldwide, more than 29 million (58%) came from the Region (see figure 1) by October 2015. This includes more than 9 million refugees and 20 million internally displaced persons (IDPs).

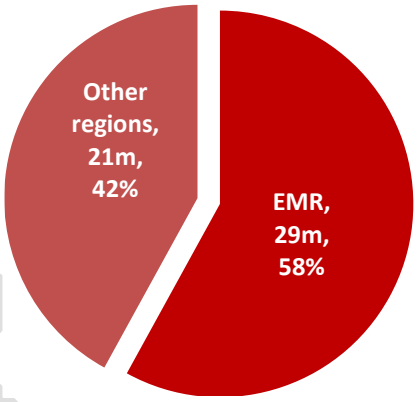

Figure 1 Proportion of refugees and IDPs originating from EMR compared to other regions

Syria is currently the world's biggest producer of refugees and IDPs, with more than 40% of the population now displaced both inside the country and in neighbouring states. Afghanistan and Somalia face two of the longest-spanning refugee situations, with Afghanis constituting the second-largest refugee group in the world, and Somalia facing one of the world's most complex refugee situations.

Over the past two years, the region saw massive internal displacement in Iraq, with more than 3 million people fleeing their homes since June 2014, and in Yemen, where more than 2.3 million people were internally displaced since March 2015.

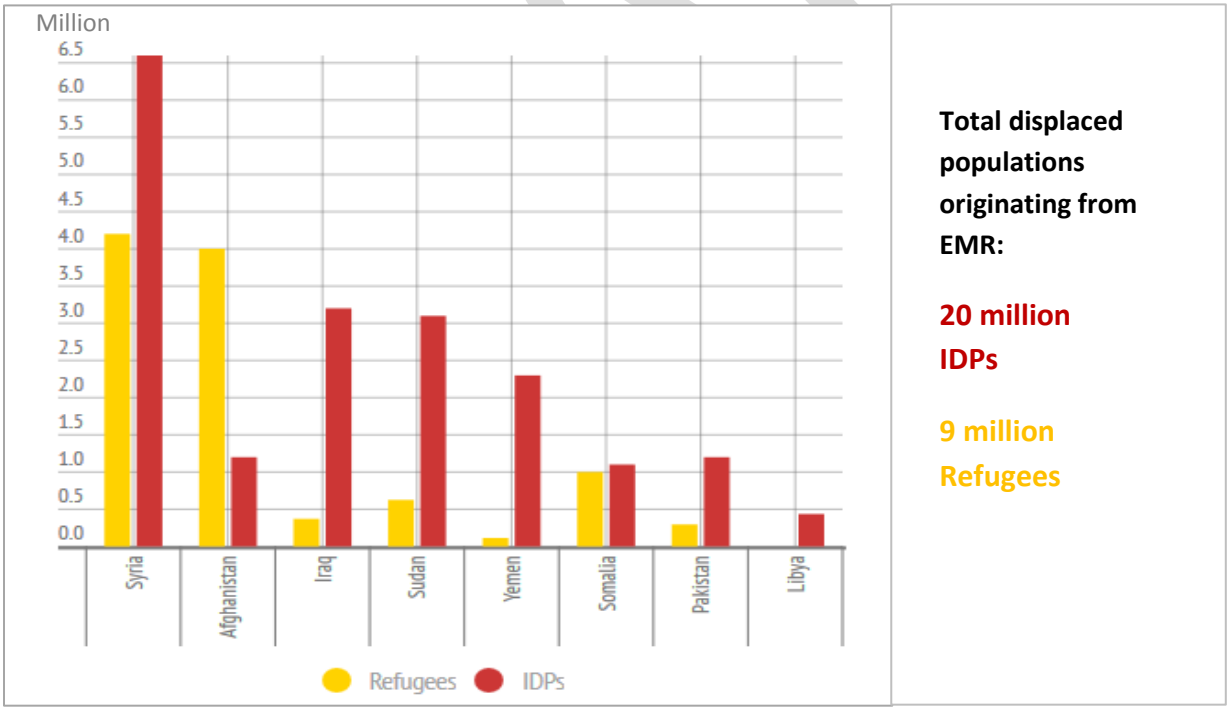

Figure 2 Top refugees and IDP-generating countries in EMR
Source: http://reliefweb.int/sites/reliefweb.int/files/resources/geo%20%281%29_3.pdf)

Host communities

Four countries in EMR host more than half of the world's refugees (see figure 3). Across the region, a large majority of refugees are being hosted by local populations, with only a small proportion living in camps. Although the response of the local communities is based on the principle of solidarity, all bear the brunt of the current crisis.

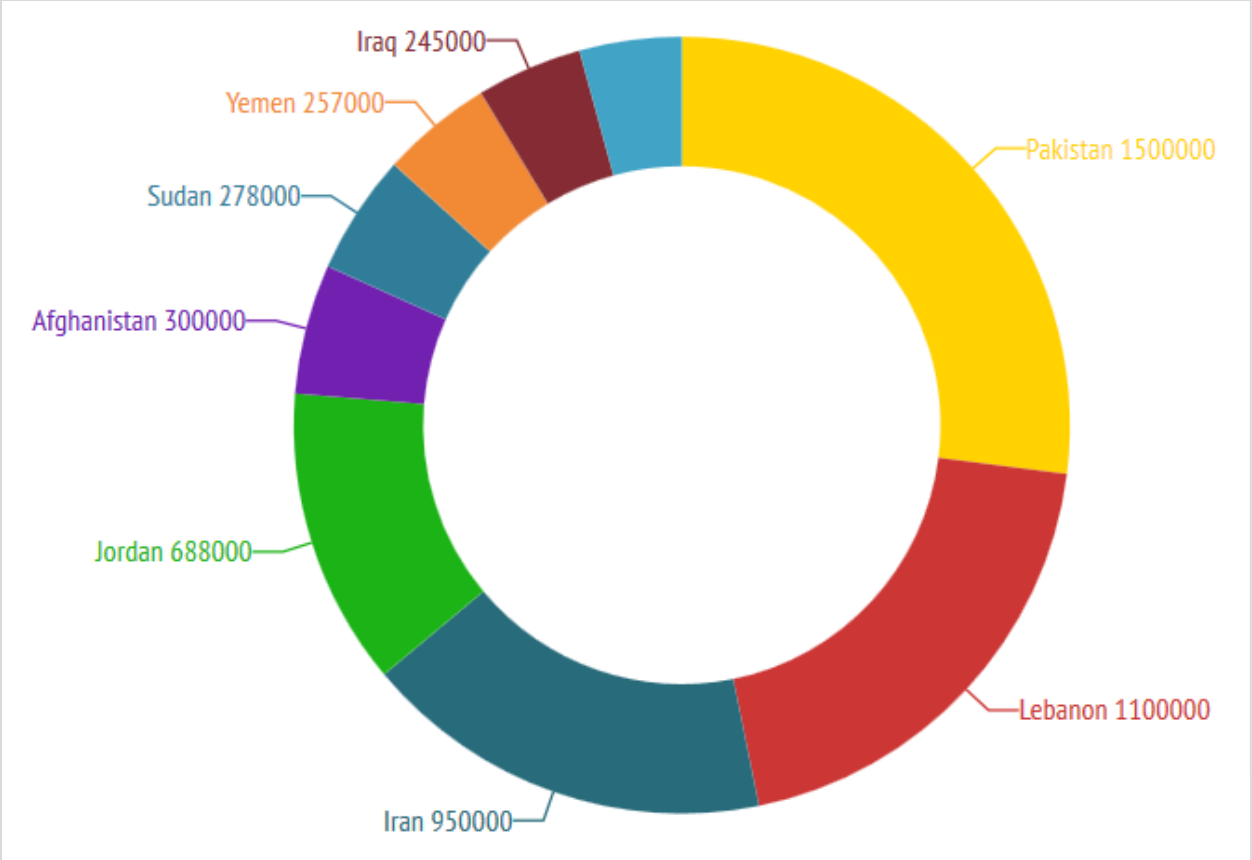

Figure 3 Top refugee-hosting countries in EMR (millions)

Out of the 4.2 million Syrian refugees, more than half are hosted by four countries in EMR, directly or indirectly impacting total of more than 12 million people in the host communities (see figure 4).

Despite facing significant socio-economic challenges, Jordan and Lebanon maintained an open-door policy towards Syrian refugees since the beginning of the crisis, only implementing border control measures in 2015. Having crossed the borders, Syrians find themselves in a safer environment, but still struggle to live normal lives. For example, access to income-generating activities in order to become self-sufficient is limited. During a high level meeting on

3RP Beneficiaries: Syrian Refugees and Members of Local Communities			
Country	Refugees	Local Communities	
		Direct	Indirect
Egypt	120,000	34,550	5,734,324
Iraq	250,000	47,941	2,397,033
Jordan	700,000	138,150	2,632,994
Lebanon	1,500,000	336,000	1,422,000
Turkey	1,700,000*	500,000	8,216,534
Total	4,270,000	1,056,641	20,402,885

Figure 4 Projected numbers of Syrian refugees and host populations in neighboring countries directly and indirectly affected by the crisis

resilience held at the Dead Sea, neighboring countries seemed to be inclined to address this issue and to ease access to work permits.

Lebanon, a country of four million people, has demonstrated unfaltering solidarity towards displaced populations. Even with its recent history of political conflict, and stress on its infrastructure, Lebanon is now the highest per capita host of refugees in the world.[1] Additionally, the Government of Lebanon estimates that almost 1.5 million vulnerable Lebanese nationals are directly or indirectly affected by the refugee crisis and in need of humanitarian assistance. Syrians live among host communities and are, for the most part, sheltered in the poorest areas, sharing scarce resources with many Lebanese who live below the poverty line. It is estimated that around 25% of the Lebanese people are living in poverty and that some additional 170,000 Lebanese are driven into poverty due to the impact of the Syrian crisis.

More than 80% of registered Syrian refugees (around 518,000) in Jordan live in **non-camp settings** in urban and rural areas. Informal settlements, such as makeshift or unfinished buildings, are usually overcrowded with limited access to safe water and adequate sanitation, and refugees are creating additional challenges for national health systems, particularly in the urban areas of Amman and the Northern governorates of Jordan.

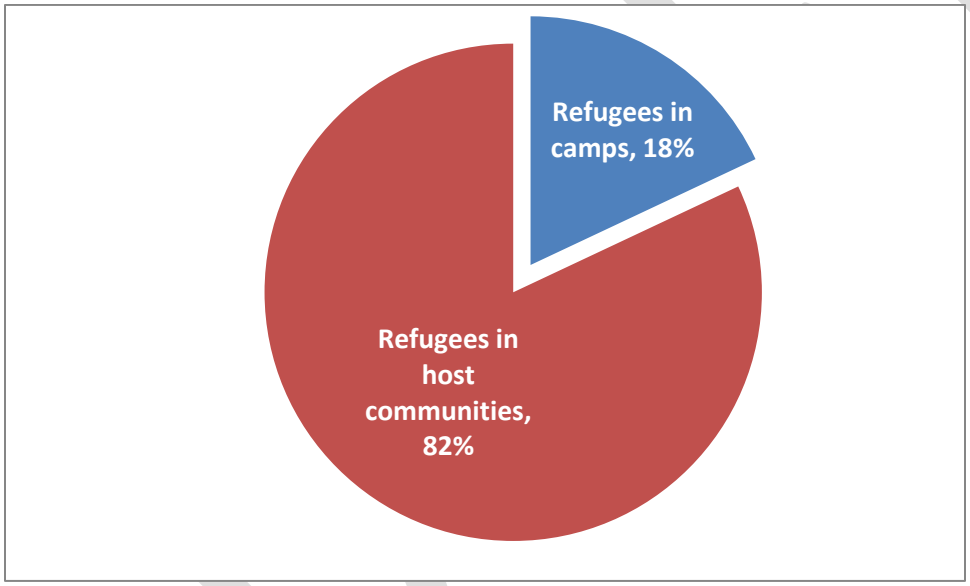

Figure 5 Living arrangements of Syrian refugees in Jordan

In other parts of the region, refugees and IDPs also live primarily among host communities. Humanitarian efforts must be stepped up to ensure that refugees, IDPs and the host communities themselves are able to meet their basic needs and access life-saving health services.

Public Health Impact

The cumulative public health consequences of emergencies in the region on displaced populations are profound and enduring, affecting not only the displaced populations themselves, but also host communities, and playing a key role in determining the health security of the entire region.

[1] http://www.3rpsyriacrisis.org/wp-content/uploads/2015/01/3RP-Report-Overview.pdf

Mental health

Violence and displacement also increases the need for mental health services, especially for women and children, and this situation is further exacerbated by the lack of mental health professionals in crisis countries. Since the beginning of the conflict in Syria, a severe increase in psychological distress has been observed among the population. Over 50% of the population is estimated to be in need of psychosocial support. Out of the three psychiatric facilities in the country, the Aleppo psychiatric hospital has been destroyed. Psychotropic and epilepsy medications are often removed from shipments of interagency convoys.[2] Further efforts are particularly needed regarding psychological counseling in Syria, Iraq and Yemen. In Lebanon, mental health conditions constitute around 2% of all cases seen at the PHC facilities as per UNHCR data. The most frequent mental health conditions presented at PHC centres are severe emotional distress (35%), epilepsy (20%), and intellectual disabilities (10%).

Reproductive, maternal and child health

The main challenges facing reproductive, maternal and child health among refugee and displaced populations include: low use of antenatal care and high rates of caesarean sections, child diarrhea due to limited access to safe water, acute respiratory disease, acute malnutrition and micronutrient deficiency such as iron deficiency and inappropriate infant and young child feeding.

Noncommunicable diseases

The management of noncommunicable diseases (NCDs) is a key challenge. NCDs constitute a major health threat for displaced populations, and refugees who have found themselves at increasing risk of deteriorating health status. A significant number of refugees suffer from chronic diseases such as hypertension, cardiovascular diseases, diabetes and cancer, all requiring costly and long-term treatment.

Data on utilization of the PHC services by the Syrian refugees/displaced indicates that around 8% of patients have NCD-related complaints. Nearly 30% of refugees in Jordan suffer from NCDs such as hypertension or diabetes, and 78% of households in Egypt have reported a family member suffering from a chronic disease.[3] The most frequently observed NCDs are asthma/chronic obstructive pulmonary disease (COPD), diabetes, hypertension and cardiovascular diseases.

Communicable diseases

Growing mass population movement, **vaccine shortages and low vaccine rates have increased the risk of communicable disease outbreaks** and threatened the health security of the entire region. The expansion of vaccination activities into hard-to-reach areas is essential to achieve broader population coverage. This is of critical importance if transmission of vaccine-preventable diseases such as polio, measles and tuberculosis, is to be halted, particularly in the present context of high population mobility and overcrowded living conditions.

In 2013, a polio outbreak in Syria led to the re-introduction of the disease in the Middle East, prompting a 12-month emergency immunization response by WHO and partners and the vaccination of more than

[2] http://www.emro.who.int/images/stories/syria/SituationReport_20140615.pdf
[3] http://www.3rpsyriacrisis.org/wp-content/uploads/2015/01/3RP-Report-Overview.pdf

25 million children in 8 countries. Measles remains a threat, as cases continue to increase in Syria[4]. In Lebanon, the threat of outbreaks of acute watery diarrhea, hepatitis A, cholera, tuberculosis, measles, mumps, and other diseases are of concern, given the poor living conditions and frequent population movements between informal dwellings which have limited access to health care services. There is a need to protect more than one million refugees and members of host communities against viral hepatitis A through public health measures, including hygiene and access to safe water.

Large refugee numbers add pressure on existing **water and sanitation services** in the hosting countries and increase environmental health risks. Even before the crisis in Syria, Jordan was the fourth most water scarce country in the world. In Iraq, the pressure on services in impacted communities is also acute because of the overlapping refugee and IDP crises. With the majority of refugees living outside camps, public WASH services are under stress, and local authorities require support to improve and run public water, sewage, wastewater treatment, and municipal solid waste collection and disposal systems. As of the end of 2014, all of the refugees living in camps in Iraq and Jordan were in need of WASH support. There are competing demands for safe drinking water and wastewater services from both local communities and the refugees living in impacted areas.[5]

Cholera remains a major public health risk in the Eastern Mediterranean Region. The cholera outbreak in Iraq, September 2015, continues to pose a threat inside the country as well as among its neighbouring countries. Exacerbated by the fact that much of the country's water and sanitation infrastructure has almost collapsed, the outbreak also increased as a result of excessive rainfall that triggered flooding in the capital and surrounding governorates.

In Yemen, where more than two million people have been internally displaced since March 2015, the collapse of the health system and shortages of safe drinking-water have resulted in increased risk of diarrhea, malaria, and dengue fever. Lack of access due to insecurity, a breakdown in health services and communication systems, has created challenges in the timely monitoring and detection of cases, and has impeded a response to an outbreak of dengue fever.

In Afghanistan and Pakistan, polio is still an issue. Eradication efforts are challenged by insecurity and very low vaccination coverage of the refugee population. Although major outbreaks have not been seen, they continue to be a major concern for both the refugee population and hosting communities.

Casualties and injuries

With injuries remaining a considerable burden among refugees, some types of war wounds require costly surgical treatment and lengthy rehabilitation. Training health care professionals in war surgery and the treatment of burns remains a challenge especially in countries such as Yemen, where more than 27,000 people have been injured since the beginning of the crisis in March. In Syria, more than 25,000 people are injured in relation to the conflict every month, placing an additional burden on the WHO to support trauma and surgical care of patients inside Syria and injured refugees fleeing to neighbouring countries. In Jordan, 8% per cent of refugees are reported to have a significant injury,[6] of which 90% are conflict-related, and 25% have a physical, sensory or intellectual impairment. These health problems

[4] http://www.emro.who.int/images/stories/syria/SituationReport_20140615.pdf
[5] http://www.3rpsyriacrisis.org/wp-content/uploads/2015/01/3RP-Report-Overview.pdf
[6] Handicap International/HelpAge International. Hidden victims of the Syria crisis: Disabled, Injured and Older Refugees, 2014.

require long-term assistance and specialized services that are already overstretched, including convalescent care, nursing, and functional rehabilitation.

Information management

In counties experiencing political conflict, and where insecurity impedes access to all affected areas, the humanitarian response to the civil war in Syria and the plight of IDPs in particular is marred by a lack of information on the scope and nature of their needs. A well-functioning health information system is needed to ensure production, analysis, dissemination and use of reliable and timely information on health determinants, health systems performance and health status (disaggregated by refugee status).

Challenges in meeting health needs

The operating environment for humanitarian actors in many countries of the Region remains volatile, with fragile security, limited access, threats to health care workers, and increased social and economic challenges affecting humanitarian operations.

Access to affected populations

With the number of countries experiencing political conflict in the region, one of the biggest issues impeding the ability of health partners to reach all affected populations is limited access for health partners. This is seen on a daily basis in Yemen, Iraq and Syria. In Syria, out of a total of 12.2 million in need of health care, 4.8 million live in hard to reach or besieged areas.[7] In Iraq, out of a total of 8.6 million in need of health care services, 2.5 million are at high risk in extremely difficult to reach areas.[8] In Yemen, where more than 15 million people require health services, restricted access into the country via all ports has delayed a timely response. It is estimated that out of those requiring health services, almost 5 million people are in inaccessible areas.[9] Inside the country, lack of access to health care for timely diagnosis and treatment has increased the risk of diseases such as malaria and dengue fever, and immunization campaigns have been postponed due to violence and insecurity.

There is a need to strengthen cross-line and cross-border operations to allow health partners to reach greater number of people with life-saving emergency health assistance. This includes strengthening cross-line coordination in collaboration with neighbouring countries and across sectors.

Safety of health care workers

Insecurity and violence in countries hosting internally displaced persons affect patients' access to health facilities and threaten the safety of health workers, patients and health facilities. The neutrality of healthcare workers and health facilities is not always respected in a number of countries experiencing conflicts in the Region. Health care workers have been killed, kidnapped, and assaulted, health facilities have been taken over for non-medical purposes, and ambulances have been looted, stolen, shot at and

[7] Syrian Arab Republic Strategic response plan 2015. OCHA 2015. http://reliefweb.int/sites/reliefweb.int/files/resources/2015_SRP_Syria_EN_AdvanceCopy_171214.pdf
[8] Iraq Humanitarian Response Plan 2015. OCHA 2015. https://docs.unocha.org/sites/dms/Documents/2015%20Iraq%20Humanitarian%20Response%20Plan.pdf
[9] OCHA Yemen Humanitarian Catastrophe Situation Report No. 13

denied travel through checkpoints. In the past 12 months, WHO has publically condemned such attacks in Afghanistan, Iraq, the occupied Palestinian territories, Sudan, Syria and Yemen.[10]

As a result, the health workforce has also been significantly reduced as many health professionals flee the violence, resulting in shortages in surgeons, anesthesiologists, laboratory professionals, female reproductive health professionals, and mental health experts, among others. Those who remain often encounter difficulties in accessing their place of work as a result of blocked roads, checkpoints and insecurity.

The functionality of the health system and provision of health care services is further impeded as a result of damages of health infrastructure. As a result of the conflict, 58% of all hospitals in Syria are either partially or non-functioning[11], and almost 23% of health facilities in Yemen are non-functioning.[12] Additionally, provision of medical supplies and equipment continues to be hampered by the continuing deterioration of the security situation and constraints imposed on humanitarian operations.

Overburdened health systems

Displaced populations have overstretched health systems of host countries to capacity, both in terms of finances and staff resources. The increased demands on services like health, education, water and sanitation are overwhelming, exposing countries to serious health risks and resulting in loss of health gains achieved with years of hard work.

The health sector in Jordan continues to face increasing needs and vulnerabilities with continued demand for services from refugees, a changing population demographic, changing epidemiology of disease and increasing rates of determinants of poor health. Rising healthcare costs, of both services and supplies, also raise issues of sustainable financing mechanisms for this increased demand. Free access to health services for Syrian refugees was withdrawn in November 2014. More than half of Syrian households having severe or high health vulnerability, but current humanitarian funding levels mean that less than half of refugees in the urban setting are supported to access essential health services in primary and secondary care.

Lebanon's health sector capacity has been burdened and under-resourced and needs stronger international support. Due to the influx of Syrian refugees, which now constitute 30% 0f the population, the country's economic growth, fiscal health, and ability to provide basic services have all been affected, threatening to undermine the country's development progress.

Health institutions and service providers in Lebanon are stretched to the limits in terms of human resources and infrastructure. The workload in most health care units has increased significantly, which is overstretching the human resource capacity at the central and peripheral level within the Ministry of Public Health. The health system is also characterized by a surplus of medical doctors and a severe shortage in nurses and paramedical staff. With the current level of capacity, the health system will become increasingly unable to meet the needs of both Lebanese nationals and refugees.

Socio-economic vulnerability

[10] http://www.emro.who.int/media/news/who-regional-director-urges-respect-for-the.html
[11] http://www.emro.who.int/images/stories/syria/documents/HeRAMS_Snapshots_PublicHospitals_Sep2015.pdf
[12] http://www.who.int/bulletin/volumes/93/10/15-021015.pdf?ua=1

Populations fleeing violence and conflict often arrive to neighboring countries that are themselves facing insecurity, political turmoil, economic hardships, limited employment opportunities, and scarce resources. As a result, in many cases, refugees compete with host communities for jobs, health care and other services.

In countries hosting Syrian refugees, especially Jordan and Lebanon, there is evidence that social tensions are increasingly becoming an issue in the neighbouring countries. An increase in competition for scarce resources, housing, and employment opportunities and a decline in the standard of living have resulted in limited interactions between communities and increased protection and security risks.

A needs-assessment review carried out in Jordan in October 2014 confirmed that 74% of refugees are extremely or very vulnerable, with needs being highest in northern and central governorates. Refugee families, particularly those living in non-camp settings, report increased debt and dependency on humanitarian assistance or reliance upon negative coping strategies.

In Lebanon, the refugee influx has been accompanied by a decline in overall socio-economic indicators. GDP growth decreased from 10% in 2010 to 1% in 2014, while unemployment has doubled. These factors have tested the economic, political and social resilience of the country, and have strained public spending.

The international community has acknowledged the issue and recently called for a high level meeting on resilience in Jordan. Increasing the income generating opportunities and a diversification in livelihoods have been identified as future challenges that need to be addressed to reduce the dependence on aid by the affected populations.

Inadequate funding

Addressing the health challenges of refugees in all these countries needs substantial funding. As winter approaches, the health consequences will be even higher compared to the current already crucial situation. While needs are increasing, 3RP progress report June 2015 indicates that the health sector is only 17% funded.

Working with partners

In all countries in the region hosting refugees and IDPs, WHO has a key role in health sector coordination, working together with national health authorities and with local and international partners on the ground to ensure a coordinated and effective health response.

In line with its Inter Agency Standing Committee (IASC) mandate, WHO has the formal lead role for coordination where 'health cluster' coordination mechanisms have been established **(Afghanistan, Iraq, OPT, Pakistan, Somalia, Sudan and Yemen)**. In other countries, where clusters have not been formally established (including **Syria, Lebanon and Jordan**), the WHO nonetheless assumes responsibility for leading 'health sector' coordination.

In Amman, the health cluster lead is co-shared between WHO and the International Rescue Committee. In Gaziantep, where there is a Humanitarian Liaison Group and a health cluster, in an innovative

approach, responsibility for leading the health cluster is shared between WHO, Save-the-Children and a Syrian NGO - Syrian American Medical Society.

The Jordan Response Platform for the Syria Crisis (JRPSC), led by the Ministry of Planning and International Cooperation (MOPIC), is the strategic partnership mechanism for a comprehensive refugee, resilience-strengthening and development response to the impact of the Syria crisis on Jordan. In early 2014, a Strategic Advisory Group was created to provide technical and strategic support to and increase ownership and joint accountability within the Health Sector. Currently, the Health Sector is comprised of a main working group (11 members) and two sub-working groups (Nutrition and Reproductive Health); a third sub-working group, Mental Health and Psycho-Social Support, falls under both the Protection and Health Sectors.

In December 2014, the Government of Lebanon established the Lebanon Crisis Response Plan (LCRP). The LCRP describes how the Government of Lebanon and its partners will work together to reinforce stability through this crisis while also protecting Lebanon's most vulnerable inhabitants, including de facto refugees. In the health sector, the WHO and UNHCR co-chair the health coordination working group (28 partners) and with the IMC the mental health and psycho-social support coordination. The Health Steering Committee was launched in March 2015 as a Ministry of Public Health (MoPH) initiative. It is led by the Director General of the MoPH with members from the MoPH, Ministry of Social Affairs (MoSA), WHO, UNHCR, UNICEF, UNDP, United Nations Resident Coordinator Office, ECHO and the World Bank. This committee focuses on strategic planning and decision-making related to the health sector.

In Iraq, where WHO has the formal health cluster lead (activated in February 2014), there are a total 48 health partners participating in health coordination.

In Yemen, 58 international and national partners had an active operational presence in all 20 governorates affected by conflict. Specifically for the health sector, the Humanitarian Response Plan 2015 has a total of 17 implementing partners (UN agencies, INGOs and NGOs).

WHO response

Leadership and coordination: WHO assumes the role of lead / co-lead of the health sector and cluster working groups in the five countries affected by the Syria crisis.

Information: WHO supports conducting health assessments (20 assessments conducted to date in 5 countries), as well as generates and disseminates health information through situation reports, health bulletins, donor snapshots and health impact analysis. WHO also gathers relevant data through numerous sentinel sites and thereby is able to collect quality data on surveillance. Quality data analysis is paramount to shape operational decision-making.

Technical expertise: Technical support is provided to MoHs and other partners on strategy/policy for priority public health issues, and technical guidelines are shared on key public health topics in emergencies. To scale up national capacity, WHO trains partners, front line health workers and surveillance officers on detection and rapid response to outbreaks and public health threats. WHO also supports the scaling up of urgently needed mental health programmes. In camps, WHO monitors water quality and supports vector control in camps and communities. WHO strengthens communicable disease and Early Warning Alert and response systems (EWARS). Immunization campaigns against polio and measles are conducted, covering the refugee population and host populations. In 2015, a Middle East

polio campaign concluded following the immunization of 27 million children in 8 countries across the Region.

Core services: Health facilities are provided with medicines and medical equipment for refugees and host communities, including support for referral services and patients with disabilities. Improved access to quality preventive and curative health services are provided through the recruitment of health professionals and provision of mobile clinics. Medical supplies and care have been accelerated by establishing hubs/sub-offices in the affected communities.

Way forward

Supporting IDPs and refugees is a shared responsibility and health care must be available to everyone who needs it. While advocacy for the safety of health care workers and health facilities is on-going and needs to be increased, additional attention needs to be given to the safety of displaced populations, and their basic human right to health. Greater advocacy is required to ensure access to populations affected by conflict, and protect healthcare workers and patients. This involves ensuring that health is recognised as neutral by all parties involved in conflict, and that populations should have unrestricted access to health services regardless of political affiliation or geographical location.

Four years into the Syria crisis, the humanitarian and health situation continues to deteriorate, and continuous assessment is required to identify urgent public health needs, and mobilize the required resources.

Greater inter-regional collaboration and coordination is required to ensure a holistic approach to ensuring the health needs of affected populations, and emphasis should also be placed multi-sectorial involvement at government and humanitarian levels on forging greater partnerships.

More emphasis also needs to be placed on community engagement and social mobilization, recognizing that host communities, community leaders and community workers are the primary responders, especially in areas that are hard-to-reach or inaccessible to international agencies.

Recent experience has shown that response capacities of humanitarian actors need to be enhanced, in addition to strengthening of coordination modalities through joint planning, information management and monitoring. Greater recognition should also be given to national leadership and centrality of national plans, and greater support provided to governments in the region to meet current needs and ensure a sustainable longer term response. Strengthening of national and local institutions and systems' capacities to cope with increased demands and continue providing quality services is also a priority.