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).

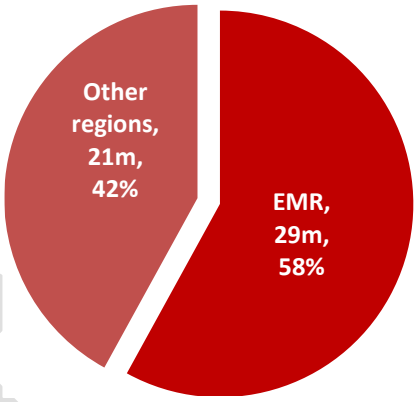

Figure 1 Proportion of refugees and IDPs originating from EMR compared to other regions

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.

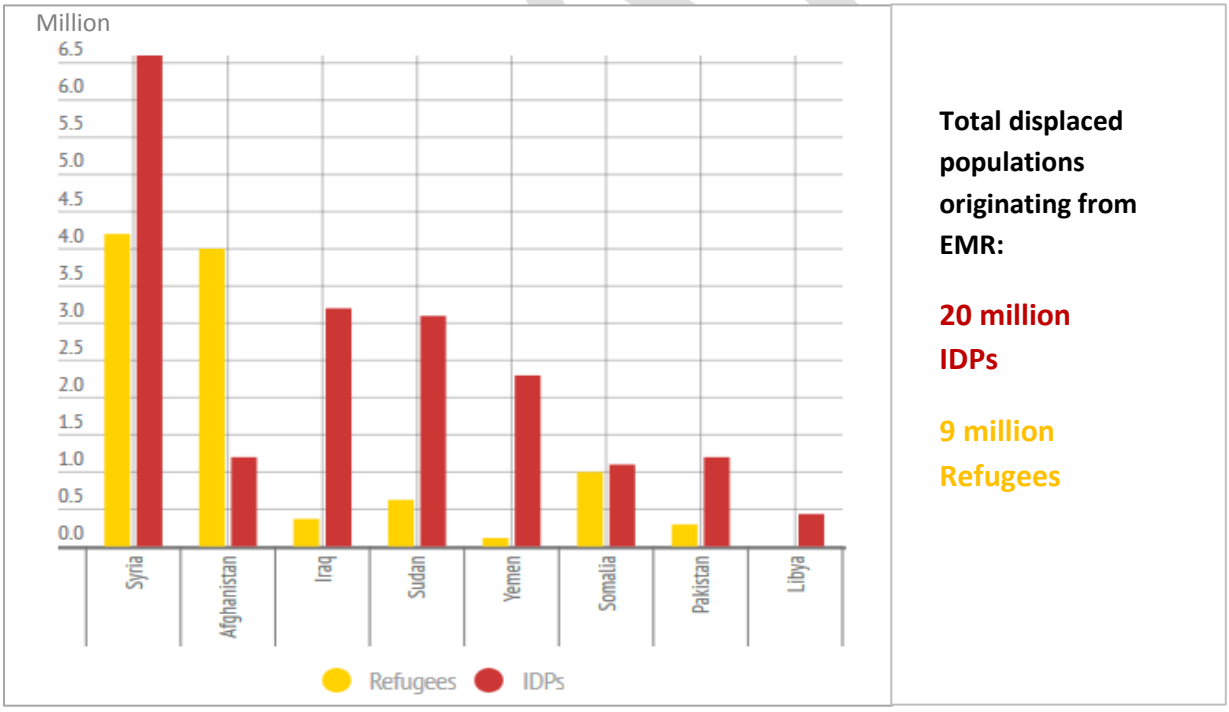

Figure 2 Top refugees and IDP-generating countries in EMR
Source: http://reliefweb.int/sites/reliefweb.int/files/resources/geo%20%281%29_3.pdf)

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.

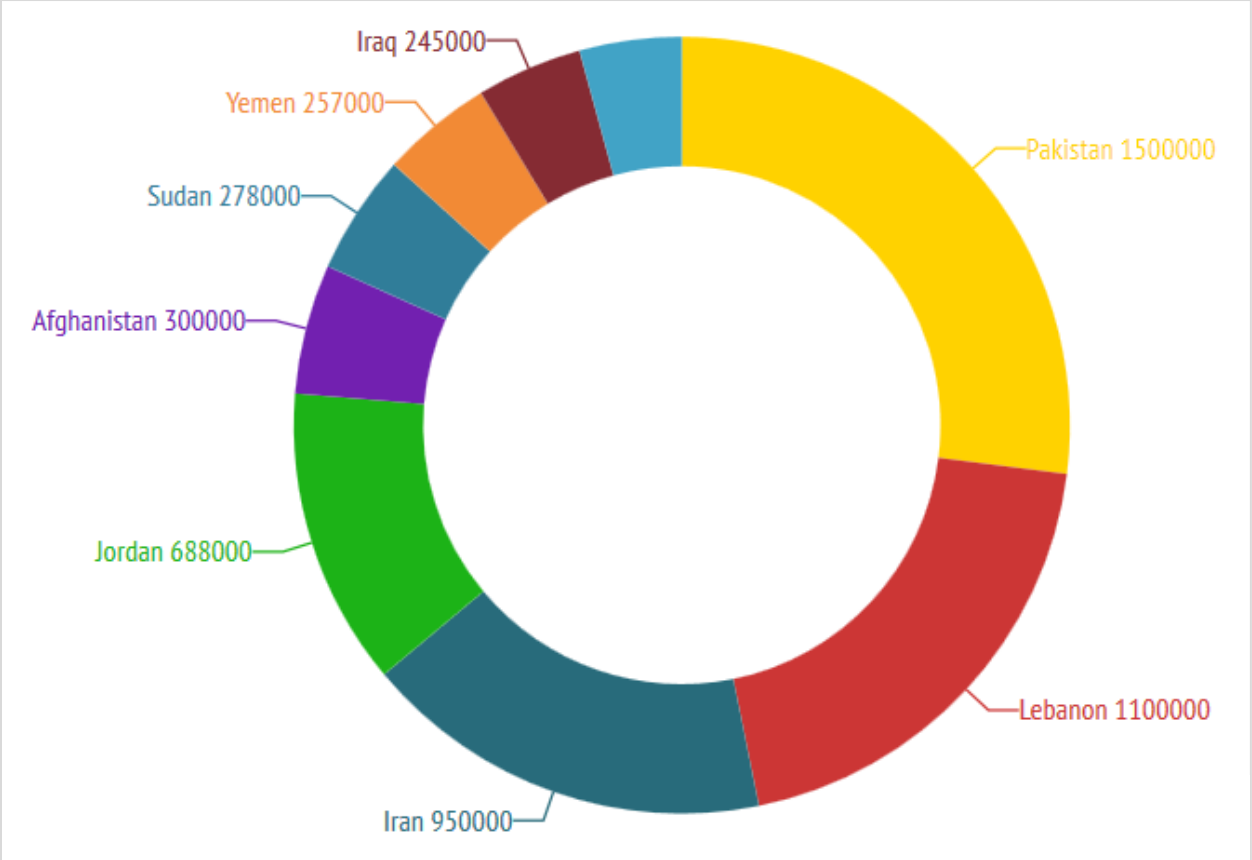

Figure 3 Top refugee-hosting countries in EMR (millions)

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.

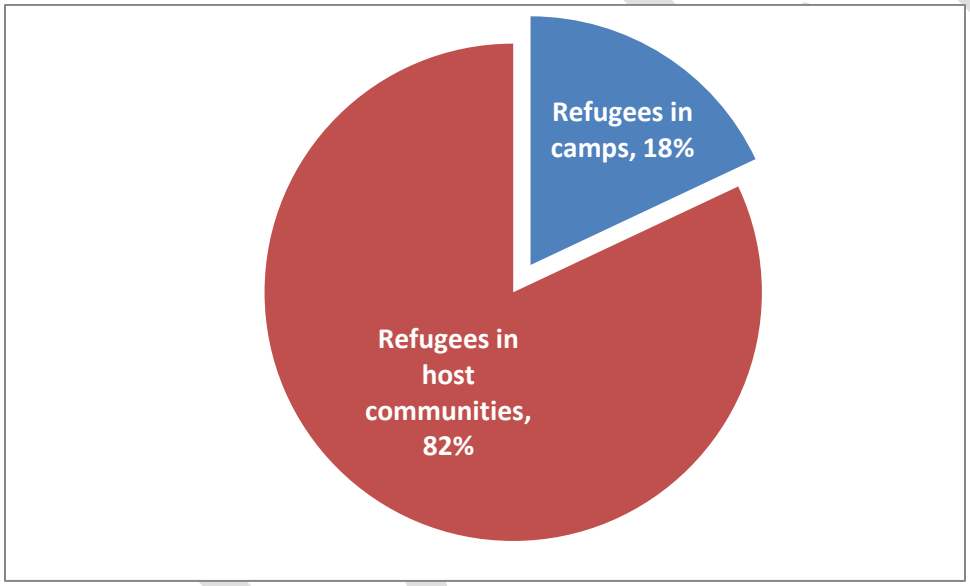

Figure 5 Living arrangements of Syrian refugees in Jordan

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