Health of displaced Iraqis

in Egypt, Jordan, Lebanon and the Syrian Arab Republic 2011

Summary

Introduction

Four years following the mass influx of Iraqis into neighbouring countries during 2006–2007, significant numbers of displaced Iraqis remain outside their country. The number of displaced Iraqis peaked in 2006–2007, with as many as two million Iraqis resettling in nearby countries. Jordan, Lebanon and the Syrian Arab Republic host the largest number of displaced Iraqis but are not signatories to the 1951 Refugee Convention that defines the rights of refugees and obligations of the host countries. In 2007, the Ministerial Consultation on the Health Needs of Displaced Iraqis Living in Neighbouring Countries developed a strategic framework which called for displaced Iraqis to have free and equal access to local health services, assessment and monitoring of their health, and building the capacity of host ministries of health. Despite the substantial decline in registered displaced Iraqis during the past four years, it is widely believed that those who remain in neighbouring countries will do so for many years. The majority of those who remain are generally poor and need assistance, particularly for health care. Health information on displaced Iraqis is not systematically collected and analysed. This document presents a summary of a desk review conducted between 13 January and 25 February 2011. The purpose of the review was to collect and collate the most recent information regarding the health of displaced Iraqis in the neighbouring countries of Egypt, Jordan, Lebanon and the Syrian Arab Republic.

World Health Organization
Regional Office for the Eastern Mediterranean

About displaced Iraqis

Number of displaced Iraqis

1. The estimated number of displaced Iraqis varies dramatically. The best estimates can be obtained from the host countries, Office of the United Nations High Commissioner for Refugees (UNHCR) registration numbers in the host countries, United Nations working or planning figures and data obtained from independent surveys.

2. Data provided by the host governments, at the time of writing this report indicate that the total number of displaced Iraqis is about two million. The majority of these are in the Syrian Arab Republic and Jordan, while Egypt has about 70 000 and Lebanon has about 50 000 displaced Iraqis. In Jordan and the Syrian Arab Republic, displaced Iraqis added about 7% to the existing population during the peak of the crisis in 2006–2007.

3. At the end of 2009, the UNHCR reported that there were 1 785 212 refugees originating from Iraq of whom only 295 204 were registered. By January 2011, fewer than 200 000 Iraqi refugees were registered. The rate of registration has dropped since its peak in 2007, and during the first nine months of 2010 was averaging about 2991 new registrations per month.

4. UN working or planning figures of displaced Iraqis are important as they are used in formulating assistance packages. WHO estimates of displaced Iraqis for the Consolidated Appeals Process 2009 for the Syrian Arab Republic were 800 000 to 1 million, down from 1.5 million in the Inter-Agency Health Appeal in November 2007, and 500 000 for Jordan, down from 800 000 in 2007.

Where are they from?

5. Iraqis who relocated to Egypt, Jordan, Lebanon, and the Syrian Arab Republic are mostly Arabs and are from all levels of Iraqi society. The majority were previously living in urban areas and at least three quarters are from Baghdad.

Who are they?

6. The majority of displaced Iraqis live in families with an average family size of 4–5. In the Syrian Arab Republic, 20% of families were women headed. Unlike the displaced Iraqis in other neighbouring countries where females outnumber males, there were a majority of single males in Lebanon (70%).

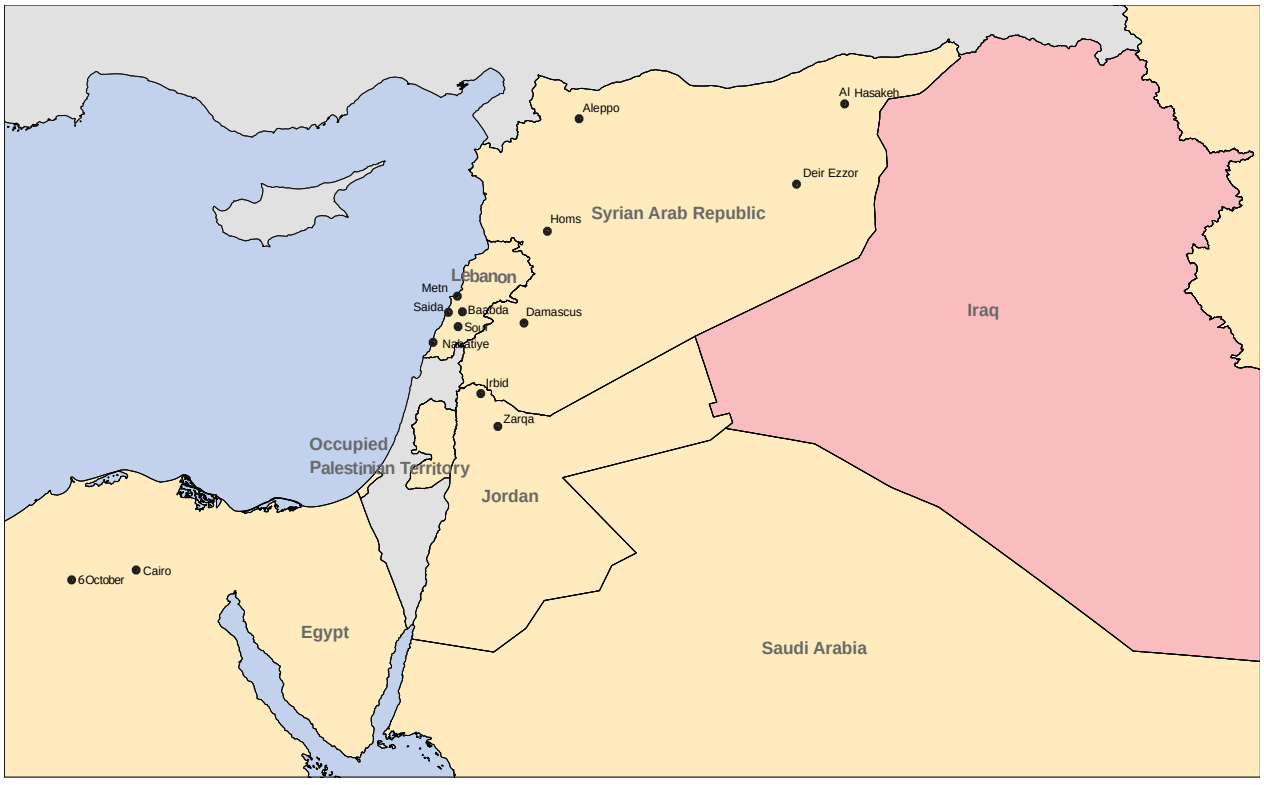
Where do they settle?

7. The majority of displaced Iraqis settled in urban areas, particularly within the capital cities of Egypt, Jordan, Lebanon and the Syrian Arab Republic.

8. In Egypt, most displaced Iraqis are living in Nasr City to the east of Cairo and also in the vicinity of 6 October City.

9. In Jordan, the capital city of Amman is home to about 85% of registered displaced Iraqis. Iraqis arriving in Jordan did not settle in camps and are still living in rented residences mainly in the major cities of Amman, Irbid and Zarqa.

10. In Lebanon, displaced Iraqis mainly occupy areas in the southern and eastern suburbs of Beirut, and the surrounding regions of Metn and Baabda. In the south of the country, most displaced Iraqis live in Nabatiye, Saida and Sour.



• Major locations of displaced Iraqis, 2006-2007

11. In the Syrian Arab Republic, the majority of refugees are concentrated in Damascus and rural Damascus, Aleppo in the north, Al Hasakeh, Homs and Deir Ezzor governorates in the east of the country.

Health of displaced Iraqis

12. There is no comprehensive health information system targeted at the health of displaced Iraqis. Information on service utilization and morbidity is available through a network of health facilities managed and supported by UN agencies, mainly WHO, UNHCR and its implementing partners.

Communicable diseases[1]

13. For displaced Iraqi children in Egypt, Jordan and the Syrian Arab Republic the most common communicable diseases are respiratory infections, followed by fever and diarrhoeal diseases.

14. Hepatitis B and C, tuberculosis and HIV/AIDS are of concern for displaced persons due to their long incubation period. There is anecdotal evidence of five cases of HIV/AIDS among Iraqis in the four countries during the past few years.

15. Within the Region, no official reports of vaccine-preventable diseases have been associated with displaced Iraqis in the past four years, despite anecdotal evidence suggesting that some countries experienced small outbreaks or sporadic cases of vaccine-preventable diseases.

16. Immunization coverage of 95%–98% was reported for displaced Iraqis in most host countries, with immunizations mostly occurring in government facilities.

[1] All the figures in the health profile come from surveys implemented during 2008 and 2009.

Chronic health conditions and noncommunicable disease

17. The prevalence of chronic health conditions among adult displaced Iraqis in Jordan was 36%. The most commonly reported conditions were hypertension, musculoskeletal problems, digestive conditions, diabetes and cardiovascular conditions.

18. Almost 34% of Iraqi households in Egypt had at least one chronic illness. In Lebanon, chronic health problems were reported by just under 10% of respondents of the Danish Refugee Council survey in November 2007. In the Syrian Arab Republic, just under 18% of displaced Iraqis had a medically-diagnosed chronic disease.

19. For displaced Iraqis in neighbouring countries, the incidence of cancer is closely following the pattern of the local population in Jordan, despite anecdotal information indicating that it is more prevalent among displaced Iraqis. There were 701 cancer cases registered by the Jordan Cancer Registry in 2008–2009. Out of the total number of displaced Iraqis with cancer in the Syrian Arab Republic 32% have breast cancer.

Disability

20. In Egypt, 8% of displaced Iraqi households reported people living with disabilities, all of whom had only one disability.

21. In Jordan, 3.4% of displaced Iraqis had disabilities. The physical disability rate was 1.7%, of which 54% were conflict-related. Males were 1.6 times more likely to be physically disabled than females.

22. In Lebanon, disabilities were reported among 2% of displaced Iraqis in the Danish Refugee Council survey. The most commonly reported disabilities were visual (22%) and lower limb disabilities (19.5%).

23. In the Syrian Arab Republic, 5.9% of displaced Iraqis live with disability (males at 7.8% and females at 4%).

Reproductive health

24. In Egypt, 81.3% of pregnant displaced Iraqi women received antenatal care and 73.1% of those received 10 or more visits. Nongovernmental organization facilities were chosen by 42.3% of pregnant women, private facilities by 38.5% and government facilities by 15.4%. Postnatal care was not received by 83.3%.

25. Nearly one third (32%) of currently or previously married displaced Iraqi women in Jordan had given birth in Jordan. Antenatal care was sought by 91% of these women and 94% of births occurred at a health facility. Contraceptive use was 40% and about 58% of current pregnancies were unplanned.

26. In Lebanon, about one third (34%) of all pregnant women had at least one antenatal care visit, 54% delivered at hospital and 2% delivered at home. In 43% of deliveries, the costs were paid by households and in 49% they were paid by nongovernmental organizations.

27. In the Syrian Arab Republic, 96.2% of displaced Iraqi mothers received prenatal care and over 95% of deliveries took place in health institutions. Around 77% of mothers used iron supplements during pregnancy.

Mental health

28. Mental problems are closely related to the conflict that the Iraqis have been through as well as to other health problems, especially noncommunicable diseases. According to WHO global evidence, the prevalence of depression increases 2.7 times with diabetes, 3.8 times with cancer, 4.4 times with HIV/AIDS and 4.6 times with tuberculosis.

29. In Egypt, the overall prevalence of depressive symptoms among displaced Iraqis was 29.2%. Females experienced a significantly higher rate of anxiety symptoms (31.8%) than males (12.8%). Depressive symptoms were observed in 16.2% of displaced Iraqis in Jordan and severe emotional distress was observed in 44.1%. Almost half of the displaced Iraqis in the Syrian Arab Republic reported some mental problems.

Health service provision

30. The two main health service provision mechanisms are through a dedicated network of UN agencies, and through building the capacity of the ministries of health for better service provision in areas hosting displaced Iraqis.

31. UNHCR has appointed dedicated health coordinators in the host countries to facilitate the provision of health services through a network of implementing partners. The main tasks of the health coordinators are to assist with managing health committees and other groups, in dealing with referrals to higher levels of care, and chairing or co-chairing regular Health Working Group meetings, which bring together UN health agencies, their implementing partners and international nongovernmental organizations.

32. In Jordan, Iraqi refugees have the choice to attend public clinics on the same basis as uninsured Jordanians or to use the services -of the nongovernmental organization-managed clinics. In Lebanon, primary health-care services are provided through the nongovernmental organization system and the Ministry of Public Health-supported network, while other health services are sought mainly in the private sector. In the Syrian Arab Republic, primary and secondary health services are provided mainly through the clinics of the Syrian Arab Red Crescent Society, while referral to tertiary level health care and services is coordinated by UNHCR implementing partners to designated public hospitals. In Egypt, the Ministry of Health has committed to ensuring the treatment of displaced Iraqis is on an equal footing with Egyptians.

Access to health care

33. In Egypt, health care services were mainly sought from private hospitals and clinics (63.3%), followed by nongovernmental organization facilities (18.1%) and government facilities (8.7%). The reasons given for not seeking health care when needed were not knowing where to get the services (50%) and high cost (21.4%).

34. The majority of Iraqi households in Jordan (64%) reported an ability to seek health care whenever it was needed. Displaced Iraqis sought health care primarily at private facilities (61%), followed by nongovernmental organization and Red Crescent facilities (23%), and government facilities (11%). Cost was the greatest barrier to accessing health care, with 59% of displaced Iraqis indicating that medical care is not affordable.

35. About one third of displaced Iraqis in Lebanon reported accessing treatment at hospitals and another third reported treatment provided at a physician's office.

36. In the Syrian Arab Republic, 32.5% of women regularly visit a public health facility to receive health care, while 55.8% of women regularly visit a doctor or private clinic.

Health expenditure

37. In Egypt, the monthly median cost of medical consultations was US$ 18.2 per household. The median cost of medications during that month was US$ 27.3 per household. For displaced Iraqi households in Jordan, the median monthly expenditure on health was 19 Jordanian dinars (about

US$ 27). Similarly, medications accounted for the majority of health-related expenses. More than half of survey respondents in Lebanon reported out-of-pocket payments for managing acute illnesses and injuries.

Funding trends

38. Between 2003 and 2007, there were no consolidated appeals for Iraq or the Region. Ministries of health in host countries had to carry the burden of displaced Iraqis into their heavily subsidized national health systems.

39. The Inter-Agency Health Appeal in September 2007 outlined the needs for 2008 and served to mobilize resources to ensure essential health care for refugees.

Summary of funds requested and received through the consolidated appeals process and regional response plans

Year	Consolidated appeals process and regional response plan funding (US$)	
	Requested	Received
2008[a]	84 852 332	–
2009[b]		
Total	355 008 503	269 089 163
Health sector	64 330 754	43 633 028
2010[c]		
Total	364 644 076	97 159 415
Health sector	76 358 687	12 539 590
2011[d]	–	–

– Data unavailable

[a] Data for 2008 obtained from the Inter-Agency Health Appeal in September 2007.

[b] Data for 2009 are for strengthening health emergency management capacity in countries.

[c] Data for 2010 from Regional Response Plan for Iraqi Refugees 2010.

[d] No funds were pledged for health at the time of preparing this review.

Achievements

Preventing major health crisis

40. No major humanitarian crises have taken place among displaced Iraqis in any of the host countries during the years following their influx in 2006–2007. There were no reports of communicable disease outbreaks or of excessive morbidity and mortality among displaced Iraqis.

Ensuring equal access to basic health services

41. Both communicable disease prevention services and access to essential life-saving treatments were provided by ministries of health to all displaced Iraqis from the beginning of the crisis. Clinic-based maternal and child health services were exempt from fees in ministry of health networks in all countries.

42. Information about available services in Jordan was provided through publishing booklets that outlined UNHCR-related services and Ministry of Health services for displaced Iraqis.

Advocating for displaced Iraqis and resource mobilization

43. Advocating for the humanitarian needs of displaced Iraqis began in April 2006 with the UNHCR Iraq operation supplementary appeal, and was followed by consolidated appeals and regional response plans in subsequent years. These appeals have been successful in obtaining substantial funding to improve the health of displaced Iraqis and build the capacity of host ministries of health to provide health services to them.

Constraints in health care provision

Dependency on aid

44. Although providing basic assistance, including health care services, was absolutely necessary at the beginning of the crisis, the continuation of this assistance over many years has resulted in dependence on assistance among some more vulnerable Iraqis.

Lack of information on displaced Iraqis

45. The importance of collecting disaggregated health status and health service utilization data for displaced Iraqis cannot be underestimated. WHO and various other agencies (including UNHCR) have advocated and supported disaggregated health information systems for displaced Iraqis for some time.

46. Ministries of health are not presented with vital information that can be used for planning and decision-making and they are not systematically receiving the UNHCR-generated information and therefore do not have the full picture of what is happening under their mandate.

47. UNHCR and other UN agencies are not regularly receiving information from the ministry of health information system, despite some information exchange occurring within the Health Coordination Groups.

48. At a time when resources and attention are declining, providing accurate and complete disaggregated information will be needed for increased advocacy activities. Without convincing evidence, health policy-makers and agencies will be unable to send clear messages to mobilize resources needed for their future work.

Transitioning from a parallel health system

49. Establishing a parallel health care provision system that was implemented by Red Crescent Societies and nongovernmental organizations, within the national system but outside the Ministry of Health system, was essential in the early stages of the crisis. However, by the start of 2009, stronger efforts should have been placed on transitioning to the local public system. This would require a shift of the coordination mechanism towards more engagement of ministries of health in the overall coordination of health care provision.

Uncoordinated capacity-building of ministries of health

50. Despite almost all agencies participating towards increasing the capacity of ministries of health, a comprehensive coordinated approach within the system managed by United Nations agencies and other partners was not apparent. Duplication of efforts and capacity-building projects by United Nations and other implementing agencies occurred in all four countries.

Inadequate mental health and psychosocial support

51. A clear distinction does not exist between mental health and psychosocial support because definitions for these terms have not been formalized. The absence of agreed definitions could impact on the coordination of a response to this important facet of health.

52. Despite some progress being made through the Inter-Agency Standing Committee guidelines for mental health and psychosocial support, the work is still in its early stages and requires more resources and collaboration before its effect on displaced Iraqis and the host population can be measured.

Insufficient coordination between health working groups

53. The attendance of ministry of health representatives at UNHCR health working groups is vital to deliver the best possible outcome for displaced Iraqis. Input from national ministries of health and also from major national nongovernmental organizations is often lacking at these meetings.

Ongoing risk of disaster in the Region

54. Displaced Iraqis will be equally affected by the various hazards from natural or other sources that each host country experiences. The risks incurred from those hazards needs to be taken into account while planning health interventions.

Planning for the future

55. As long as displaced Iraqis in neighbouring countries continue to need humanitarian health assistance, particularly when their vulnerability is increasing due to the lack of income generation and their chances for immediate repatriation or resettlement are not imminent, the international community and host countries will need to continue their support. Nonetheless, a new strategy is needed in view of the population, health and funding trends and to benefit from lessons learned so far.

56. This new strategy should ensure that:

- the humanitarian community continues advocating for the health needs of displaced Iraqis and their host community in the years to come;
- the ministers of health of the neighbouring countries renew their commitment to support access for displaced Iraqis to public services on equal footing with their own citizens;
- all actors re-orient their action and find ways to build the capacity of ministries of health in order to better meet the increasing demands on the health sector as a result of displaced populations;
- health insurance-like modalities of financing health packages for displaced Iraqis are considered;
- additional resources are available to build mid-term system capacities which would replace the parallel system currently in place;
- better coordination between various ministries of health, nongovernmental organizations and United Nations agencies with the Government of Iraq is a priority;
- there is increased involvement from both the Government of Iraq and displaced Iraqis in the planning and implementation of their assistance programmes.

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