



PRIMARY HEALTH CARE PROJECT

ASSESSMENT REPORT

Health and Social Needs Among Internally Displaced Persons (IDPs) in Iraq

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ACRONYMS

GoI	Government of Iraq
IDPs	Internally Displaced Persons
IOM	International Organization for Migration
MoDM	Ministry of Displacement and Migration
PHC	Primary Health Clinics
PHCPI	Primary Health Care Project in Iraq, USAID
UNHCR	United Nations High Commissioner for Refugees
USAID	U.S. Agency for International Development

SUMMARY

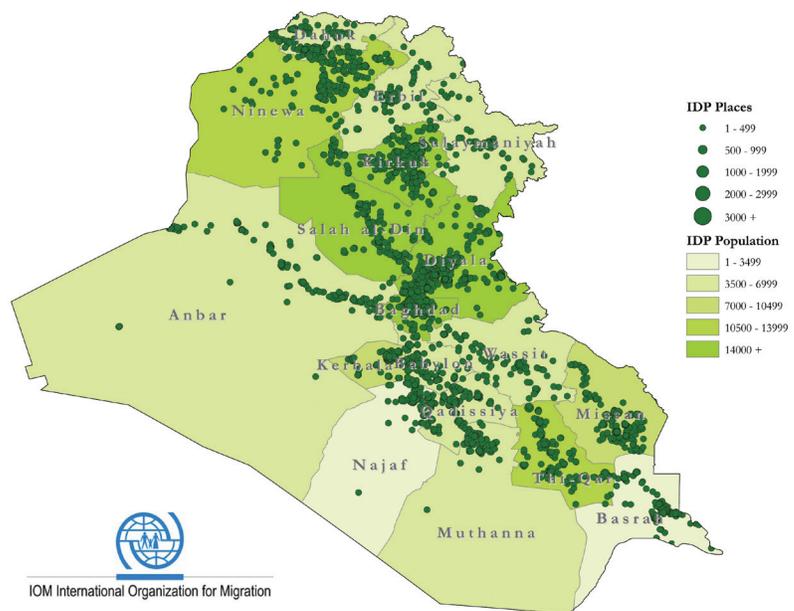
More than two and a half million Iraqis are considered Internally Displaced Persons (IDPs) by the Ministry of Displacement and Migration (MoDM), highlighting the extent of forced or coercive movement of Iraqis from their homes as a result of ongoing sectarian strife, terrorism, and insurgency. Especially over the last ten years, Iraq has experienced a severe pattern of population displacement and emigration. Despite persistent efforts made by national authorities, these populations continue to face critical health challenges related to limited or intermittent access to health and sanitation services, poor nutrition, and injuries or disabilities resulting from their movement in conflict zones.

Although USAID/Primary Health Care Project in Iraq (PHCPI) has been designed to strengthen health sector capacity to provide essential primary health care services and expand the availability of these services throughout the country to benefit the population as a whole, increasing coverage and service uptake for key vulnerable populations such as children under five, pregnant women and IDPs is a key consideration.

INTRODUCTION

While Iraq's refugee crisis has garnered much international attention, the situation of IDPs has gone largely unnoticed. At its peak in 2007–2008, the estimated number of IDPs in Iraq was 2.8 million.¹ Current estimates put the number of IDPs at 1.9 million at the end of 2011 by the International Organization of Migration (IOM)² and 1.1 million by the UN High Commission on Refugees (UNHCR) in January 2012. The recent influx of Iraqis returning from Syria may now produce an increase in the total number of IDPs in 2012.³ The major internal displacement of Iraqis occurred in 2006, corresponding with the peak of refugee flight. Many families have since integrated into local communities, found employment and represent a stable and “completed” migration. But others are stranded in temporary settlements around the country.

Figure 1. Distribution of IDP Families, February 2011



1 Morton MJ, Burnham G. Iraq's internally displaced persons: a hidden crisis. *JAMA*, 2008; 300:727-9.

2 IOM. <http://www.iom.int/jahia/Jahia/iraq> accessed 19 Sept 2012.

3 UNHCR, 2012 Country Operations Profile. <http://www.unhcr.org/pages/49e486426.html> accessed 19 September 2012.

While there had been extensive discussion about numbers and the development of programs to facilitate return and integration, the identification of needs and provision of services has sometimes been indifferent. Part of the difficulty is in identifying this population. According to an IDP report issued in February 2011, most IDPs live in rented facilities, 9.6% live in collective settlements, and 19.3% reside in temporary shelters of mud and scavenged materials.⁴ Evictions of those living on public lands are an increasing problem. In some places, assistance has been provided to IDPs through the MoDM, the Iraqi Red Crescent Society, UNHCR, and the IOM. However, the general pattern is initial assistance to newly displaced populations and then less attention as time passes, even though needs may not have changed or be increased. Additionally, many IDPs do not receive formal or regular assistance from any source. In a number of places in Iraq a number of non-governmental organizations or civil society groups have been helping IDPs. At some sites community health workers have been working, but the presence and outcomes from these services have not been assessed. This study was designed to assess the needs of IDPs for health and other social services in IDP settlements in a variety of locations within Iraq as such as children under five, pregnant women and IDPs is a key consideration.

ASSESSMENT OBJECTIVES

The goal of this study was to assess the health and social needs among internally displaced populations in seven locations in Iraq during July 2012. The objectives were to:

1. Identify the health priorities of the IDPs and services available to them.
2. Establish baseline measures to monitor and evaluate programs of the key stakeholders working with these populations.
3. Provide background information to inform the content of training for community health workers in selected IDP settlements.

4 IOM. Review of displacement and return in Iraq, February 2011. <http://www.iauiraq.org/documents/1308/librar.pdf> accessed 28 Sept, 2012.

METHODS

The overall study design was developed in early 2012 in conjunction with the Ministry of Health (MOH) and the MoDM. The intent was to sample from the largest IDP settlements in the various regions of Iraq to attempt a general overview of common needs and services. Resources were inadequate for sample sizes which could compare findings in one settlement area against another. The proper sample size estimated for the study was 799 families.

Information was collected from households using a questionnaire consisting of standard questions for displaced populations as well questions designed or adapted specifically for the IDPs in Iraq which would address health seeking behavior and access to health services. The questionnaire is appended.

In addition to household interviews, in-depth interviews were conducted with health workers in the PHC clinics nearest to the IDP settlements. Health workers were selected who were likely to have some understanding of the health needs and living circumstances of the IDPs. An interview guide was developed for health workers with the intent of triangulating responses from the IDPs as well as providing information about the health facility closest to the IDP location.

Site selection. In each of areas (dividing Iraqi into regions), the largest IDP settlement was selected from each region to ensure a population of at least 115 households per site (Except for Sulaymania) where the total number in the camp were 102. In Baghdad, sites were selected in both Rusafa and Karkh areas. Sometimes more than one camp is included to ensure getting the requested sampling number. Sites were selected to include locations where local NGOs or civil society groups had been reportedly working to improve services. These locations are found in Table 1.

Table 1. Sample site locations

Governorate	No. HHs
Basrah	150 (16.4%)
Sulaymania	102 (11.2%)
Babil	119 (13.0%)
Baghdad, (2)	305 (33.4%)
Karbala	122 (13.3%)
Kirkuk	116 (12.7%)
TOTAL	914

Survey teams. These were constituted from seven geographic areas of Iraq. The teams consisted of members affiliated with the MOH and its tributaries joined by workers from National Civil Societies; the teams were given 5 days training in Baghdad. This included pilot testing of the forms in IDP communities, the development of questionnaire and time needed to cover questionnaire selected topics including non-communicable diseases, importance of antenatal care, schedule of immunizations, and health messages. In the communities, surveyors worked in teams with supervisors. Many sites were relatively small, and households were selected purposively to include distributions of dwelling types from more established with concrete block construction to the poorest temporary shelter within these settlements. Permission was obtained from the MODM and the MOH, which also participated in the survey planning. Surveys were coordinated with local civil authorities. No personal identifiers were collected. Data forms were kept secure while transported and during computer entry and analysis. Data were analyzed as a group without separating out responses from various locations.

RESULTS

Household surveys

The survey was conducted in July and August 2012. In total, data was collected from 914 displaced households representing 4,936 persons in the seven IDP settlement areas. Usually the respondent was the head of household but sometimes the spouse. If no responsible adult was present in the household, the team moved on to the next selected structure. The refusal rate was less than 1%.

Household characteristics

The average household size contained 5.4 persons. In the households there were on average 1.4 children under age five, and 1.4 women between the age of 15 and 49 years old. In 46 households there had been a death of a child under age five since they had migrated to the current location. *The households have been in their current location since 2006.* There were 19 households (2.1%) which reported a maternal death since migration to the current location.

Among the IDP households 516 (55.6%) lived in dwellings of concrete block construction, 357 (39.1%) in dwellings made of mud, and 41 (4.5%) in tents or caravans (trailers). The household economic status was queried, using as reference the living standards of others in Iraq. These were self-defined categories. There were 713 (78%) heads of household who said the household lived in poverty, 179 (19.6%) said their economic status average for Iraq, and 22 (2.4%) said their economic condition well.

The majority of households (73.5%) said they had migrated to the settlements because of security concerns. When asked about intention to return to the area of their original residence, only 33 (3.6%) said they would consider returning to the location of their previous

residence. The two main reasons for not returning given by the others were security (568, 62.1%) and economic reasons (333, 36.4%).

Access to health services and health needs

Households were asked about the distance to the nearest PHC services. There were 223 (24.4%) households that indicated a clinic was present inside the settlement area; 39.9% said within 1km, and 75.3% were within two km of a PHC. Only 6.2% of households were five km or further from a PHC. Households were also asked the perceptions of distance to the nearest PHC facility. Half of households said PHC services were “far” from their households and 247 (27.0%) considered PHCs as inaccessible. In spite of the perceived inaccessibility of health facilities, 783 households (85.7%) said they had visited health facilities when needed. However, the level of satisfaction with PHC services received was low, with only 417 (45.6%) saying those services were good or acceptable.

This population clearly has many health needs, and access to health information through health promotion campaigns would an important way

When asked an open ended question about what were their most pressing public health needs, access to health facilities, sewage disposal, access to water supplies and rodent control were the most common responses.

to reach them, in the absence of accessible clinics. However, only 98 households (10.7%) were aware of any health promotion campaigns, including health and social campaigns.

When households were asked about illness in the last four weeks, 216 (23.6%) indicated diarrhea have been present in a family member, 48 (5.3%) indicated a respiratory tract infection had occurred, and 20.8% said a respiratory infection in combination with another condition had occurred. Households were also asked if one of their members had been diagnosed with a non-communicable disease. There were 175 (19.1%) with a household member with diabetes, 275 (30.1%) with hypertension, and 40 (4.4%) with asthma. Of persons with diabetes, 80 (8.8%) also had hypertension.

Access to other services

Only 279 (40.9%) said schools were near to the settlement, with the balance saying they were far away or inaccessible (134, 14.7%). Access to sports facilities was another concern with only 4.2% saying that sports or other social facilities were readily accessible. Households were asked about availability to municipal services such as solid waste disposal, and 9.5% responded that these were present. As NGOs and other groups were widely reportedly as providing assistance in these communities, we asked households if they were aware of civil society organizational activities on-going in their settlement. Only 113 households or 12.4% could recall the presence or activities of such organizations.

There were 318 (34.5%) of houses with piped water and 402 (44%) which had electricity. Only 51 (5.6%) of houses were connected to sewers.

Key informant interviews

Eight health workers were interviewed in the seven most proximate PHC facilities about use of their health facilities by IDPs.

DISCUSSION

The attention to refugees from Iraq has ignored the plight of the country's IDPs. At the peak in 2007-2008, there were 2.8 million IDPs in Iraq.⁵ Numbers were estimated to be 1.1 million at the beginning of 2012, with expectations of little change in these numbers during the year. With on-going events in Syria, returning refugees may now become IDPs, something that needs to be monitored closely, as their needs may differ from those of the long-term IDPs in Iraq. While the vast majority of IDPs are living in rented dwelling, and less visible. Those living in IDP settlements could be assumed represent the more vulnerable within this population, and be in need of additional monitoring and assistance. Perhaps the most vulnerable would be those living in temporary shelters of scavenged materials and not part of *de facto* settlements. This latter group was only minimally included in the survey. This suggests a population that cannot return to its place of origin for security and economic reasons and is now trapped in poverty. The willingness to return is now at about the lowest level since IOM began asking in 2006.

Reviewing the current data from IDPs in settlements, the household's perceived poverty, and lack of access to many services is striking. From the public health perspective, there are concerns about the lack of access to water and sanitation, and problems with rodents. While over half live in more permanent concrete block structures, information is lacking on the quality of these structures and the interior space available to household members. Most households indicate

5 Morton MJ, Burnham G. Iraq's internally displaced persons: a hidden crisis. JAMA, 2008; 300:727-9

6 Burnham G, Hoe C, Hung YW, Ferati A, Dyer A, Hilfi TA, Aboud R, Hasoon T. Perceptions and utilization of primary health care services in Iraq: findings from a national household survey. BMC Intl. Health Hum Rights. 2011 Dec 16; 11:15..

that Primary Health Care clinics are accessible when the distances are reported, and well inside WHO standards. Although the household perceptions are that these PHC facilities are too far away, in fact they seemed to be commonly utilized when needed. However, when PHC services are utilized, in less than half of instances did the household respondent indicate satisfaction with the outcomes. This is much less than seen in a previous national PHC survey, and should be investigated further.⁶

Of concern is both the prevalence of communicable disease and non-communicable disease in the IDP population. Although the prevalence of non-communicable diseases reported is similar to the general population in Iraq, the frequency of diarrhea reported is a concern, and consistent with the poor access to water and sanitation present in these settlements. It is not clear what health services those with non-communicable diseases are receiving, or if the PHCs are meeting these needs.

Although this is a population that has been known to exist in Iraq for 10 years, it is still a concern that the civil society assistance organization are largely unknown in this community and that health promotion campaigns largely miss this population. This seems consistent with the other findings that these settlements have generally not be integrated into municipal services or access to schools facilitated.

RECOMMENDATIONS AND CONCLUSION

Based on the survey results, next steps should include encouraging the Government of Iraq (GOI), as well as the individual ministries and organizations that work with IDP populations, *to strive to improve the health and environmental services provided to IDPs* so that they are on par with the services provided to and expected by other Iraqis. IDPs remain highly disadvantaged groups and targeted interventions are required to address their specific challenges and meet their specific needs. Based on the assessment findings, such health-related interventions could include:

- Health workers in facilities close to IDP settlements need to be provided with training on interacting with and responding to the needs of IDP patients.
- Community health workers should be trained and utilized to support services to IDPs.
- Health promotion campaigns need to be developed that specifically target IDP populations and encourage their participation in and ownership of their own health care.

The overall goal would be that IDPs and their host communities are able to routinely access high quality health services in the country. There are already a number of activities underway to develop systems and capacities to manage the needs of IDPs for security, emergency relief, health, and movement/ repatriation. With an emphasis on community stabilization, initiatives have been put forward to encourage grassroots economic development. Ensuring that these efforts are also connected to ongoing work to build community health structures is critical for the development of primary health care systems able to provide quality services to vulnerable populations.

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