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Iraq's Internally Displaced Persons A Hidden Crisis

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INTERNAL DISPLACEMENT AND REFUGEE FLIGHT DUE TO VIOLENCE and instability have forced approximately 1 in 6 Iraqis from their homes.¹ The plight of persons displaced within Iraq by pervasive violence has received less attention than has the flood of Iraqi refugees into neighboring countries. Internally displaced persons (IDPs) within Iraq now number 2.8 million² and are far less accessible to aid organizations than Iraqi refugees.³ While the protection and care of refugees are covered in an international mandate, IDPs, fleeing for the same reasons as refugees, are covered by the weaker Guiding Principles on Internal Displacement.⁴ Political issues over sovereignty are at the root of this disparity.

Internal displacement is not a new problem for Iraq. During the Saddam Hussein era, nearly 1 million fled repressions, the draining of the marshlands, and widespread human rights abuse. With the US-led 2003 invasion of Iraq, internal displacement began again. From 2003-2005 an additional 402 000 persons were displaced.⁵ The 2006 bombing of the Askirya shrine in Samarra, and the widespread sectarian violence that followed, displaced another 1.6 million within Iraq.² During late 2007 and early 2008, continuing displacement has ebbed. This present stabilization may have resulted from communities that are now more ethnically homogeneous, from a reduction in overall violence, or because a lack of financial resources has left stranded many who would otherwise flee.

Prior to 2006, most of Iraq's IDPs fled from central and southern regions to the country's northern governorates and selected areas in the south. After the widespread violence of 2006, the flight shifted to Baghdad and Diyala provinces. By 2008, approximately 560 000 IDPs were living in Baghdad.⁶ For Iraq as a whole, 60% of IDPs are located in the 6 central governorates, 27% in the southern region, and 15% in the north.⁵ Of those displaced, 82% are women and children, making Iraq's IDPs a particularly vulnerable population.⁷ According to the International Organization for Migration, more than 60% of Iraq's displaced are Shia Arab; 27% are Sunni Arab, 3% are Christian Assyrian, and the remainder are Kurds, Turkmen, and other ethno-religious minorities.⁷ There are also an estimated 15 000 Palestinians in Iraq who have been abused by various sectarian elements and unwelcome as refugees in neigh-

boring countries. In addition to the displaced persons, the fragile living environment and the decline in many public services have left a further 6 million Iraqis in need of immediate emergency assistance.⁸

In a recent survey of more than 177 000 Iraqi families conducted by the International Organization for Migration and the Iraqi Ministry of Displacement and Migration, the reasons most commonly given by IDPs for displacement are direct threats to life (61%), presence of generalized violence (47%), and fear (40%).⁹ An estimated 1 million of Iraq's displaced persons are without adequate access to shelter and food, and an estimated 300 000 are without access to clean water.⁶ The majority (59%) of those displaced live in rented housing. Another 22% live in collective settlements, public buildings, or makeshift shelters; 18% live with family members or a host family; and 1% live in tents or camps.⁵ Among the 177 000 internally displaced families surveyed by the International Organization for Migration, 70% of IDPs identified their top priorities as shelter, food, and access to work; 20% indicated access to water and legal assistance; 12% indicated health care; and 6% each reported sanitation and education.⁶

Little information exists about the health status of IDPs in Iraq. However, this massive displacement has occurred in a country with a maternal mortality rate of 84 per 100 000 births, an infant mortality of 37 per 1000, and a younger than 5 years mortality of 46 per 1000 (2006).^{10,11} Among IDPs, health surveillance has reported outbreaks of gastrointestinal tract and dermatological diseases, especially among children, as well as persisting malnutrition.⁶ Those IDPs without consistent access to safe water sources exhibit an increased incidence of diarrheal and gastrointestinal tract illnesses.⁵ However, attention to water and sanitation needs improved after the October 2007 outbreak of cholera in northern Iraq.

Female IDPs are particularly vulnerable, and the International Organization for Migration reports an increase in spontaneous abortions, as well as a lack of prenatal, maternity, and postnatal care.⁵ In addition, international organizations report the absence of maternity services, mental health services, and care for chronic diseases as particular needs. More-

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over, the economic plight of IDPs is underscored by reports of female IDPs resorting to prostitution to support themselves and their families.⁴ Female IDPs are also subject to an increased incidence of rape as well as heightened vulnerability to religious persecution in areas of resettlement.^{5,12}

Donor assistance to Iraq has concentrated heavily on reconstruction, with relatively small amounts of funding for humanitarian assistance.⁸ International humanitarian organizations, which normally would provide direct assistance to IDPs, have mostly left Iraq, partly because of the intensity of the violence and partly because of the restricted humanitarian space (ie, access and freedom to provide aid independent of political and military constraints). The few international organizations supporting health services in Iraq generally prefer to maintain a low profile, assisting the Iraqi Red Crescent and Iraqi nongovernmental organizations rather than maintaining an independent infrastructure in the country. Some Iraqi government services are available specifically for IDPs, such as the Ministry of Displacement and Migration, which works with nongovernmental organizations to provide resources for displaced persons. The International Organization for Migration also has played a major role in providing assistance and building awareness of the needs of IDPs in Iraq.

For health care, IDPs must rely to a large extent on existing health facilities, which are plagued by shortages of health professionals, medical supplies, and essential medicines as well as by decades of neglect under the previous regime.⁷ Although detailed health data are lacking for specific conditions, the prevalence of mental illness, particularly among children, is believed to be high among IDPs, perhaps due to the pervasive exposure to violence that often initiates displacement. Many displaced persons who have chronic health conditions, such as hypertension and diabetes, have lost their medication cards, hindering their access to needed medications.⁷ Those IDPs who have reported difficulty in accessing health care cite financial constraints, the lack of facilities, and distance to care as the major factors impeding care.¹³ A significant proportion of health expenditures in Iraq are out of pocket. Although Iraqi public sector and Iraqi Red Crescent facilities provide free care, limited access and shortages of personnel and supplies are some of the factors that may cause many Iraqis to rely on private services.¹³ The 50% unemployment rate for Iraq, which is even higher among IDPs, makes costs an even greater barrier to health care.¹⁴ The International Organization for Migration's June 2008 survey¹³ found that 14% of Iraq's IDPs stated that they had no access to health care, and nearly one-third reported that they cannot access needed medications.¹³

A major challenge for all Iraqis has been access to quality health care and services. Wars, sanctions, and, more recently, the flight of medical professionals have left the health system severely strapped for capacity, especially in Baghdad. With ongoing violence, the health system is heavily focused on curative and trauma care, leaving primary care and public health programs undersupported.^{3,15} The continuing needs for

trauma services led Iraq's Minister of Health, Saleh Al-Hasnawi, to recently state that "emergency medicine is the first priority" for health care in Iraq.¹¹ The Ministry of Health is actively seeking development of emergency medical services, blood transfusion capabilities, and medical supplies for emergency departments.¹¹ However, primary health services are also in need of reconstruction and basic supplies. Currently there is only 1 primary health clinic per 15 500 Iraqis; of these clinics, only 65% are staffed by physicians.¹¹ For some areas, because of access limited by violence or the critical shortage of physicians, informal private clinics staffed by nurses or paraprofessionals have been created.

A serious commitment by donor countries is needed to support organizations that can provide services to displaced persons in the current circumstances of violence and disorder. A shift in donor focus toward immediate humanitarian assistance, not concentrating solely on longer-term rehabilitation projects, is also needed. The United Nations requested \$261 million in January 2008 for Iraqi refugees and displaced persons but has thus far received only one-third of this amount.² This contrasts with the more than \$20 billion donated for development aid by members of the Organization for Economic Co-operation and Development between 2003 and 2005 alone.⁸ Fulfilling humanitarian aid commitments is an essential element of a strategy to develop health in Iraq. Mechanisms for the rapid disbursement of such funds for urgent needs must also be established.

However, increased funding is only part of the solution. Currently, only 60% of Iraqis dependent on food assistance have access to Public Distribution System rations,⁸ stemming largely from a lack of access due to violence and security concerns, as well as inefficiencies in operations, rather than from a lack of supply.⁵ Also problematic is the issuance of Public Distribution System ration cards, which are difficult to obtain or to transfer from their place of origin.³ Reforms in aid delivery to accommodate security and logistical challenges are required to meet these urgent humanitarian needs of IDPs. Local governmental authorities can assume a larger role in the collaborative management and delivery of aid. Increasing the subsistence payment for households headed by widows is another strategy to provide assistance to the neediest displaced populations and is well within the budgetary capacity of the Iraqi government.⁸ Enhancing the capabilities of Iraq's own institutions to manage the displacement crisis is another facet of an overall strategy to assist IDPs. Although external assistance is certainly needed in the near term, the United Nations High Commissioner for Refugees and the International Organization for Migration are working to promote self-sufficiency in the Ministry of Displacement and Migration through technical assistance in the development of a national policy for management of migration.

When the violence in Iraq eventually ends, many IDPs likely will wish to return to their original homes, and efforts must be planned to ease and facilitate that process. From past experience, however, many will permanently settle in

their new locations, especially if the violence is protracted.³ The end result can be scattered populations that are permanently disadvantaged and that have physical and mental health needs. A fundamental reorientation of health and social services will be needed to provide mental health care to those traumatized by violence as well as an increased focus on primary health care and preventive health measures, both for those who return home as well as those who stay in their new locations.

The plight of IDPs in Iraq is but another example of unmet and underrecognized health and protection needs in countries in conflict. Protecting human rights, providing human security for basic needs, and ultimately facilitating return or resettlement with dignity remain even greater challenges in the first decade of the 21st century.

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Cyclone Nargis and the Politics of Relief and Reconstruction Aid in Burma (Myanmar)

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IN EARLY MAY 2008, CYCLONE NARGIS TORE ACROSS SOUTHERN coastal areas of Burma (Myanmar), pushing a tidal surge through villages and rice paddies. The 12-foot wall of water killed tens of thousands of people and left hundreds of thousands homeless and vulnerable to injury and disease. Even in the commercial capital of Rangoon, where structures are more sturdily constructed, winds up to 120 mph sheared off roofs and uprooted trees and electrical poles. The UN Food and Agriculture Organization estimates that the tropical storm rendered 500 000 or more acres of the 3.2 million acres of paddy land in the Irrawaddy Delta, the hardest hit region, unavailable for the monsoon planting season that began in June.¹ After the storm, Burma's commander-in-chief, Senior General Than Shwe, declared that Burma was capable of handling the relief effort but would allow limited international assistance so long as "no strings were attached."²

Typically, the public health model for disasters highlights a cycle of preparedness, mitigation, response, and recovery. When a natural disaster strikes, national and, if needed, international relief workers rush to the scene in an effort to save lives by providing 5 essential types of aid: search/rescue/protection, health, food, water, and shelter.³ At the same time, public health professionals conduct rapid assessments using cluster sampling methods to document mortality and morbidity, emerging epidemics, property destruction, homelessness and displacement, damage to water and sanitation networks, loss of electrical power and livestock, disruption of health care services, and food shortages. They also apply immediate public health measures—removing corpses, managing solid waste, immunizing survivors, disinfecting drinking water, educating displaced survivors about

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