Mini review paper

IMPACT OF REFUGEES AND INTERNALLY DISPLACED PERSONS ON INTERNATIONAL HEALTH

ABSTRACT

The 21st century has been marked with highest distribution of wars and conflicts at local, national, regional, and international levels in world history. This has increased greatly in the last decade with a growing number of internally displaced people (IDP), refugees, and those seeking asylum. This study discussed the growing impact of refugees and IDP's on global health. Relevant data was extracted from official sites and publications of international aid agencies through electronic search. Electronic search was conducted between January 2015 and March 2016. The sources of information were MEDLINE, PUBMED, and Google search Information was sorted based on merit of relevance to the topic based on selected criteria using identified search words individually and stringed with additional search words where necessary.. The trend and dynamics of refugees migration is predominantly from the underdeveloped to the developed nations of the world while that for IDPs is largely from the politically and economically unstable regions to the more economically and politically viable ones. Study showed increasing trend of displacement of people and migration across borders at the national and international level.

Keywords: Refugees, Population, Surveillance, Migration, Diseases, International health, Internally Displaced Persons

1. INTRODUCTION

There is an estimated 6·6 million IDPs in Syria, 4·3 million refugees who have migrated across borders to other countries and 13·5 million in dare need of humanitarian aid, and more than 50% of this population is children. About 90% of these refugees are in the Middle East while 10% have migrated to Europe. Nigeria has an estimated 2·2 million IDP's predominantly in her northeast region while Afghanistan has 847, 872, and counting**.** The United Nations High Commission for Refugees (UNHCR) has put the global refugee burden at 59·5 million people with developing countries contributing 86% of this population while 38·2 million people are IDP's. A total of 5·1 million Palestinian refugees registered with the United Nations Relief and Work Agency (UNRWA), the democratic republic of Congo had 2·8 internally displaced persons in 2013, while southern Sudan had 1·5 million IDPs at the same period with the most vulnerable being women and children. This study brings to the fore, the growing impact of refugees and IDP's on global health [1, 21, 27].

2. METHODS

Electronic search was conducted between January 2015 and March 2016. The sources of information were MEDLINE, PUBMED, and Google search. Searches were additionally conducted authoritative texts, and references of retrieved articles. The themes of the title were turned into words used as search terms while ensuring that the search terms used were reorganized by the computer database vocabulary. The search terms used were refugee, internally displaced persons, international

health, policy, population, surveillance, migration, and diseases. These words were used individually, in strings of two words and above, and in some cases with additional words and medical subject headings where necessary. Care was taken to moderate the selection criteria in order not to eliminate important articles through very narrow exclusion criteria, nor inclusion of irrelevant articles by using very wide inclusion criteria [2-7]. The flow chart of the articles selection process is shown in Figure 1.

Inclusion criteria

- Articles relevant to the topic
- Articles written in English Language
- Articles with comprehensible information
- Officially published documents
- Articles with defined selection criteria

Exclusion criteria

- Articles with evidence of bias
- Articles published in non official sites
- Articles without clearly defined methods

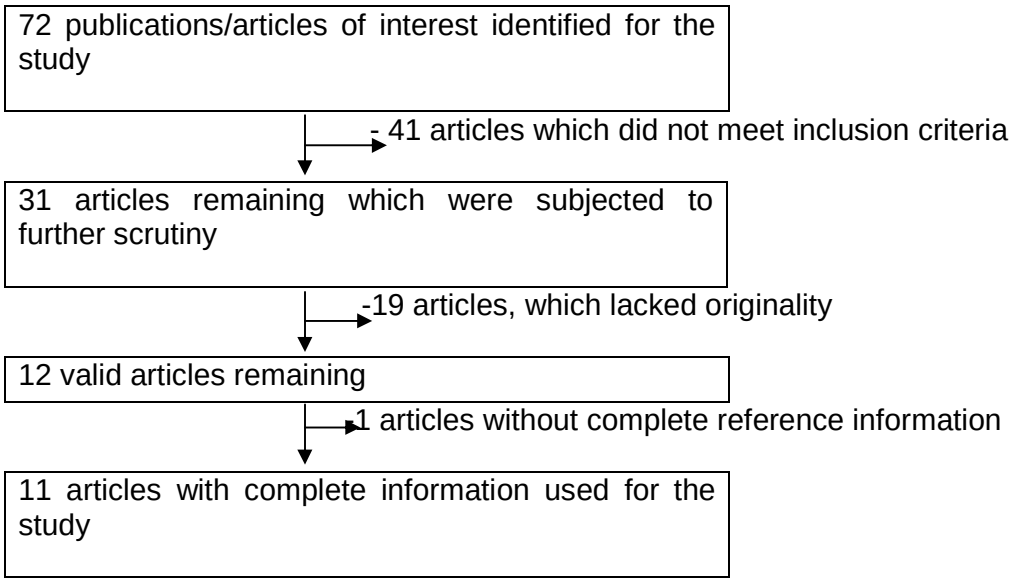

Fig. 1: Flow chart of how the articles selection process and use in the study

3. DISCUSSION

3.1 Global crises and international health

Nigeria recorded a whooping 981, 416 IDPs in the first quarter of 2015 in addition to millions of refugees who fled to neighboring countries within the sub-region due to Boko Haram insurgency in the north eastern part of the country. In North Africa, people cross to European countries on daily basis through illegal land and sea

borders. The trend has been alarming within the past two years. The advent of global health indicates that diseases do not respect boundaries but cross freely when they are not properly checked. They pose threat to people beyond the boundaries. Refugees settle in camps for proper documentation and monitor. However, most of them evade all necessary measures to escape into their host countries illegally while some take advantage of porous borders. The migratory pattern could be unpredictable since refugees and IDPS can access any route of less resistance. They settle in unhygienic camps, which are usually overcrowded and sure exposed to very harsh conditions, climates, mosquitoes, hunger, and poor sanitary conditions. Improper waste disposal and untreated drinking water are usually obtainable in cases of massive population influx, predisposing them to diseases. Women and their children constitute 80% of refugees and 75% of internally displaced persons globally [8- 11].

3.2 IDP's, refugees, epidemics and communicable diseases

Outbreaks of epidemics are very common among women and children who are usually in the majority further complicates the effect of ailments which ordinarily should not be life threatening. Sexually transmitted diseases and unwanted pregnancies are very rampant, majority of who diffuse into the main population on regular bases through sharp practices to end up as commercial sex workers. Disease vectors at different levels of their life cycle both in man and on the surfaces of their goods like baggages and clothing cross the borders alongside the IDPs and refugees. Most countries pay more attention to airports and seaports where they generate revenues than they do to the porous illegal borders, which serve as routes of entry for illegal immigrants and refugees and have become breeding grounds for diseases and epidemics unknown to the local authorities. The increasing surge of the dynamic population of refugees and IDP's equilibrate with population of surrounding towns and nations since most of the IDPs end up as refugees in surrounding countries. This is in addition to some countries without any form of outbreak preparedness, disease sensitization, or rapid response capacity. WHO refer to some diseases e.g. Ebola and Lassa fever as epidemic when only one person is affected. Going by this specification, we can comfortably say that the world has looming potential epidemic of varying diseases due to massive movement of IDPs and refugees across our porous borders**.** Communicable diseases like tuberculosis, hepatitis B, syphilis, and Human Immunodeficiency Virus (HIV/AIDS) are common in refugee camps and pose threats to surrounding and distant populations [12-15]. Cancer, diabetes mellitus, hypertension, mental health, and obesity are non-communicable diseases very common them [16- 20].

3.3 Emergency preparedness, disease surveillance and impact on international health

This underscores the need for rapid disease surveillance, sensitization and response preparedness at the national, state, local and district levels. WHO indicated that 164 suspected and 54 confirmed cases of Lassa fever in 19 states of Nigeria with 80 suspected and confirmed deaths between August 2015 and January 2016. In February 2016, the United Nations International Children's Fund (UNICEF) announced an estimated 1·6 million IDP's in northeast Nigeria with a projected 300 000 deaths among children before the end of 2016. Adults and children are in most deplorable states in the IDP camps with acute shortage of portable drinking water, food shortage, very poor hygienic condition, overcrowding, and poor shelter. The

situation is occasioned by the activities of suicide bombers, which make the camps increasingly unsafe. These conditions predispose them to plagues, diseases, and epidemics. Intestinal parasites, cholera, tuberculosis, malnutrition, malaria, and other diseases associated with deplorable poverty are common among refugees. IDP's and refugees on transit are poorly immunized, and women and children are the most vulnerable. Complex emergencies affect social determinants of health and impact negatively on public health status with its attendant health inequities, which is almost assuming a global dimension [21-26].

In 2015 and first quarter of 2016, refugees from Syria and surrounding countries in the eastern bloc migrated to Europe in hundreds of thousands with the attendant humanitarian needs. Diseases do not respect boundaries but cross borders along with refugees. Refugee camps serve as transit points for disease causing organisms that subsequently could affect the distant parts of the affected country. In the last five years, 1·1 million refugees from Syria migrated to Lebanon, 630 000 settled in Jordan which mounted more pressure on her already deplorable socioeconomic status with consequent negative impact on her already depleted health indices. The populations of refugees have grown astronomically in the past one decade with catastrophic consequences on the health indices of nations. United Nations estimated that 4·7 million refugees would be generated from Syria by the end of 2016. With the growing trends of IDP's and refugees in our sub-regions and globally, displacement in one region ripples across surrounding and distant regions and borders especially to areas of less political resistance and economic stability [25, 26]. The health structure of most nations are still not resilient enough to accommodate extra burden and shock usually introduced by refugee influx and further weakens the already weak structure [27].

3.4 Epidemics: incidence and prevalence of diseases associated with refugees

Highly contagious diseases have been reported in refugee camps and among immigrant refugees during routine screening shortly after arrival to their countries of destination. In 2008 to 2013, a global refugee report shows that 0.2% of refugees from Iraq who arrived US had class B1 tuberculosis [28]. Infectious hepatitis had been reported after screening of refugees. Out of 2957 refugees who arrived San Diego 0.7% had hepatitis B [29, 30]. HIV and Syphilis were reported among 91000 refugees traveling to US from Baghdad between 2008 and 2013 [31, 32]. Tuberculosis incidence was found to be greater among people born to foreigners than among US born persons.

3.5 Recommendations

There is increasing need for proper funding of refugee commissions and immigrations. Strict documentation and characterization of refugee's data especially considering health status should be upheld. The concept of health resilience and emergency preparedness should be strictly promoted internationally. Immigration and refugee commissions need to uphold the culture of proactive and integrated surveillance, monitoring, evaluation, training and retraining of their staff. There is urgent need for proactive planning, and support for research and development by committee of nations and funding agencies in the areas of refugee and IDP's impacts, outcomes and dynamics.

4. CONCLUSION

Care should be taken ensure comprehensive disease control, surveillance and notification because some refugees access porous borders undetected while others disperse into the general population without being detected for reasonable period. Nations should closely monitor diseases under international surveillance like yellow fever, plague, cholera, typhus, and louse-borne relapsing fever. International agencies should pay greater attention to diseases under quarantine laws especially plague, yellow fever, and cholera. United Nations should expedite actions in maintaining international peace, law and order, and development of machineries for solving economic and humanitarian problems among member countries. It will be invaluable for other specialized United Nation Agencies to assist poorer nations through technical assistance, human and natural resources development, grants and loans. Nations should uphold isolation of suspected cases, vaccination, revaccination of refugees and medical surveillance. These are the active roles that government of nations should play towards cushioning the effects and impact of refugee influx across our borders to minimize and contain disease outbreak while maintaining optimum public health status of their nations.

Conflict of interest: There is non-to declare.

Funding: There was no funding from any source

REFERENCES

1. Internal Displacement Monitoring Centre (IDMC) report data for May 2015. (Accessed on 2 March 2016 at: www.internal- displacement.org.).
2. Crombie IK. The pocket guide to critical appraisal. London: BMJ Publishing Group; 1999. p. 23–29, 56–62.
3. Gehlbach SH. Interpreting the medical literature. NY: McGraw-Hill, Inc.; 1993. p. 243–251.
4. Portney LG, Watkins MP. Foundations of clinical research: applications to practice. Ed. Upper Saddle River, NJ: Prentice Hall, Inc; 2000. p. 127–133.
5. Oxman AD, Guyatt GH. Guidelines for reading literature reviews. *CMAJ* 1988; 138:697–703.
6. DePoy E, Gitlin LN. Introduction to research: multiple strategies for health and human services. St. Louis: Mosby-Year Book, Inc; 1993. p. 61–76.
7. Polgar S, Thomas SA. Introduction to research in the health sciences, 3rd ed. Melbourne: Churchill Livingstone; 1995. p. 343–55.
8. Toole MJ, Waldman RJ. The health consequences of sudden population displacement: the plight of refugees in the modern world. *Encyclopedia Britannica, Medical and Health Annual*; 1991.
9. MJ, Waldman RJ. An analysis of mortality trends among refugee populations in Somalia, Sudan, and Thailand. *Bulletin of the World Health Organization*. 1988; 66(2):237-247.
10. Desenclos JC. Epidemiological patterns of scurvy among Ethiopian refugees. Bulletin of the World Health Organization. 1989; 67(3):309-316.
11. Constable P. Somalia suffers in solitude–diplomacy turns back on thousands afflicted by starvation, strife. Boston Globe. January 14, 1992.
12. USAID/OFDA bulletin on Lake Chad Basin Complex Emergency, Fact sheet No 4, Fiscal (FY) 2016. (Accessed on March 2, 2016 at: www.usaid.gov/what-we-do/working-crises-and-conflict/responding-times-crisis/where-we-work).

13. World Health Organization/UNICEF/Johns Hopkins University. The Health Status of the Iraqi Population in Jordan: 2009.
14. Ramos M, *et al. Health of Resettled Iraqi Refugees--San Diego County, California, October 2007-September 2009.Morbidity and Mortality Weekly Report*, 2010; Vol. 59, pp. 1614-1618.
15. World Health Organization. Tuberculosis Profile: Iraq. *World Health Organization. (A*ccessed on 29 January 2016 at: www.who.int/tb/data.).
16. Darwish-Yassine M, Wing D. Cancer epidemiology in Arab Americans and Arabs outside the Middle East. *Ethn Dis*. 2005; 15 (1):1, S1-5–S1-8.
17. Michigan Department of Community Health. Color me healthy: a profile of Michigan's racial/ethnic populations, May 2008. (Accessed on 22 January 2011 at: at http: //www.michigan.gov/documents/mdch/ColorMeHealthyProfileMay2008_2362457.pdf.).
18. Shah SM, *et al.* Arab American Immigrants in New York: health care and cancer knowledge, attitudes, and beliefs. *J Immigr Minor Health.* 2008; 10:429–36.
19. Yanni E, *et al.* The Health Profile and Chronic Diseases Co morbidities of US-Bound Iraqi Refugees Screened by the International Organization for Migration in Jordan: 2007–2009. *Journal of Immigrant and Minority Health;* DOI 10.1007/s10903-012-9578-6.
20. U.S. Department of Health and Human Services Centers for Disease Control and Prevention National Center for Emerging and Zoonotic Infectious Diseases Division of Global Migration and Quarantine. *Iraqi refugee health profile.* December 16, 2014.
21. United Nations Office for the Coordination of Humanitarian Affairs. Nigeria: northeast crisis situation report (2015). (Accessed on 2 December, 2015 at: www.humanitarianresponse.info/system/files/documents/files/OCHA%20 Nigeria%20SitRep_January%202015.pdf).
22. Operation; Returning Nigerians from Cameroon Dashboard Feb 2016; Report Date: 29/02/ 2016, UNHCR Regional Update. (Accessed on 12 March 2016 at: www.*data.unhcr.org/SahelSituation/country.php?id=502*).
23. Arnow PM, Hierholzer JC, *et al.* Acute hemorrhagic conjunctivitis: A mixed virus outbreak among Vietnamese refugees on Guam. *Am J Epidemiol*, 1977, 105(1): 68-74.
24. Toole MJ, Waldman RJ. The Public Health Aspects of Complex Emergencies and Refugee Situations. *Annual Review of Public Health*.1997; (18):283-312.
25. Friel S, Marmot MG. Action on the Social Determinants of Health and Health Inequities Goes Global. *Annual Review of Public Health*. 2011; *32* (2011): 225 -236.
26. UNHCR-Emergencies. Winter Operations Cell Daily Report 02 March 2016. Refugee/migrate crisis in Europe situation analysis - 1 March 2016. The fourth situation analysis on the refugee/migrant crisis in Europe published by ACAPS and MapAction and funded by the Start Network. (Accessed on 3 March 2016 at: *data.unhcr.org/Mediterranean/documents.php?page=1&view=grid*).
27. Katharine W, Darrin D, Nicole L. What Is Health Resilience and How Can We Build It. *Annual Review of Public Health*. 2015; *36*: 361 -374.

28. World Health Organization/UNICEF/Johns Hopkins University. The Health Status of the Iraqi Population in Jordan: 2009
29. United Nations High Commissioner for Refugees; United Nations Children's Development Fund; World Food Program. *Assessment on the Situation of Iraqi Refugees in Syria.* 2006.
30. Women's Refugee Commission. *Baseline Study: Documenting Knowledge, Attitudes and Practices of Iraqi Refugees and the Status of Family Planning Services in UNHCR's Operations in Amman, Jordan.* 2011.
31. Ramos M, *et al.* Health of Resettled Iraqi Refugees--San Diego County, California, October 2007-September 2009. *Morbidity and Mortality Weekly Report.* 2010; Vol. 59, pp. 1614-1618.
32. World Health Organization. Tuberculosis Profile: Iraq. *World Health Organization. Accessed on* March 3, 2016. Available at: www.who.int/tb/data.
33.