



Globalisation, Migration and Health

Challenges and Opportunities

Edited by: Andre M N Renzaho (University of Western Sydney, Australia)

CHAPTER 3: The social and health dimensions of refugees and complex humanitarian emergencies

http://www.worldscientific.com/doi/abs/10.1142/9781783268894_0003

This chapter PDF is prepared specially for Joseph Kamara and André M.N. Renzaho .

Copyright of the works in this Book chapter is vested with Imperial College Press. The following Book chapter is allowed for your personal use only and may not be resold, copied, further disseminated, or hosted on any other third party website or repository without the copyright holders' written permission.

For more information about the book, please visit:

<http://www.worldscientific.com/worldscibooks/10.1142/P1063>

For any queries, please contact sales@wspc.com.sg

Chapter 3

The social and health dimensions of refugees and complex humanitarian emergencies

Mr Joseph Kamara and Professor André M.N. Renzaho

Introduction

The concept of “refugee” and its definition has a complex history and dates back to the eighteenth century. The 1793 French Constitution declared that France would take in people fleeing their homelands in search for freedom (Noiriel, 1991). Similarly, the 1905 British Aliens Act emphasised that an immigrant who sought

“admission to avoid prosecution or punishment on religious or political grounds or for an offence of a political character, or persecution, involving danger of imprisonment or danger to life and limb, on account of religious belief would be protected in Britain” (Collyer, 2005, p. 289).

At the turn of the twentieth century, the League of Nations defined a refugee as a person who was unable to obtain any protection or representation from his or her own country (Glynn, 2011). This definition was

included in the 1919 League of Nations Charter, which was drafted by a handful of countries led by the USA under President Thomas Woodrow Wilson. The charter came into effect in early 1920 to reduce human suffering after the First World War (Riga, 1989). However, the process of a universally-accepted definition of what constituted a “refugee” did not gain momentum until the 1940s. The emphasis was mainly on who qualified to be protected by The International Refugee Organisation (IRO). There were disagreements among key member states led by the USA and France who favoured a geographical- and time-based definition limited to European events before 1951 due to a fear of financial commitments necessary to protect a broader range of refugees (Glynn, 2011). Britain, Belgium and Germany preferred a universal definition and were supported by other members such as Israel, China and African countries (Glynn, 2011). As Robinson (1953) notes, in order to eliminate any confusion over what constitutes a refugee and to address the lack of international agreements on how to protect post-Second World War refugees, the United Nations Economic and Social Council requested the Secretary-General of The United Nations to evaluate issues related to the protection of stateless persons and to make recommendations under Resolution 116 (VI) (D) adopted on 2 March 1948. Consequently, the Secretary-General, under Resolution 248 (IX) (B), appointed an Ad Hoc Committee on Statelessness and Related Problems which consisted of representatives from 13 governments. This committee completed its work, the outcome of which was the drafting of a consolidated Convention Relating to the Status of Refugees and a Protocol Relating to the Status of Stateless Person (the Refugee Convention). The draft of the Refugee Convention was adopted at the United Nations Conference of Plenipotentiaries that took place in Geneva from 2 to 25 July 1951, and came into force on 22 April 1954 (Robinson, 1953). The adopted consolidated Refugee Convention defined a refugee as any person who

“owing to well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion, is outside the country of his nationality and is unable or, owing to such fear, is unwilling to avail himself of the protection of that country” (UNHCR, 1951, p.14).

The Refugee Convention became the key legal document that authoritatively outlined the refugee's rights and entitlements as well as the legal obligations of states (UNHCR, 2010). However, the Refugee Convention specified geographic and temporary restrictions, thus limiting protection to European refugees only and those affected prior to 1 January 1951. These restrictions were removed in the 1967 Protocol Relating to the Status of Refugees, which subsequently strengthened the universal protection of refugees.

Refugees flee due to the loss of confidence in their own governments to protect and provide a secure environment that meets their basic needs and rights. To be recognised as a refugee, one needs to cross a border to another country. Those who experience the same problems as refugees but are unable to cross their country's border to seek protection of another country are known as internally displaced persons (IDPs). It is not the purpose of this chapter to define and discuss IDPs (for more information on IDPs, please see Chapter 2). Similarly, a person fleeing their own country to seek protection in another country but whose application for protection as a refugee is pending or denied is an asylum seeker. Issues related to asylum seekers are detailed in Chapters 5 and 6. This chapter focuses on refugees in complex humanitarian emergencies (CHEs). It starts with a historical perspective on CHEs and the description of key health consequences. It then examines the governance and political dimensions of CHEs.

CHEs: history and patterns

The concept of people fleeing injustice across borders dates back to the seventeenth century when the French protestant minorities fled to neighbouring countries and the USA. This was in response to the Catholic King Louis XIV's revoking of the edict of Nantes issued by an earlier King Henry IV in 1598 to protect the religious minorities (Barnett, 2002). The 1648 Peace Treaty of Westphalia to end a 30-year period of wars in Europe marked the birth of the modern refugee concept in Europe (Croxtton, 1999). Since then, refugees have become an integral component of the modern state as many people continue to flee their home countries in search of protection from persecution due to their ideals, beliefs, religious affiliations or race. For example, in the nineteenth century, violent European

revolutions caused many people to flee their affected home countries (Barnett, 2002). The 1917–1921 Russian Revolution left over one million Russians stateless across Europe. The 1933–1945 Jewish holocaust sparked another wave of people fleeing persecution from Nazi Germany, also known as the Third Reich. The increased refugee needs overwhelmed the IRO and led to the establishment of a stronger office of the United Nations High Commissioner for Refugees (UNHCR) in 1950 with a three-year mandate to streamline refugee affairs (Maynard, 1982). However, refugees continued to be a hallmark of a troubled world and required the extension of the UNHCR's mandate beyond the initially approved three years. This was vindicated by the new wave of refugees fleeing the defeat of the Hungarian revolution by the Union of Soviet Socialist Republics in 1956 and refugees fleeing conflicts that emerged out of the 1960s era of decolonisation of Africa. More refugee crises unfolded in Asia, Latin America in the 1970s, Africa in the 1980s, the Balkans in the 1990s and early 2000s, and more recent crises in North Africa, the Middle East, South and South East Asia.

These historic events mean that the Refugee Convention has gone through transitions. What began as a convention to protect victims of the Falangists during the Spanish Civil War and the Third Reich, as well as other Europeans displaced by the Second World War, became a rallying point for the protection of refugees across the world. The 1960s brought an end to years of Africa's colonisation which was replaced by weak comprador governments, systems and structures. Many new independent African countries descended into civil wars causing waves of IDPs and refugees who were not protected by the Refugee Convention due to the geographical limitations discussed earlier. This shortcoming led to the creation of NGOs such as Médecins Sans Frontières (MSF) in 1971 in the aftermath of the 1967–1970 humanitarian emergency response to the Biafran War in Nigeria. MSF reinvented the concept of emergency aid and has since led the humanitarian industry in shaping responses and policies on complex emergencies (Redfield, 2005). Consequently, a CHE is a non-partisan response to mitigate a major crisis of a “*multi-causal nature requiring a system-wide response including long-term combination of political solutions, conflict resolution and peacekeeping*” (Duffield, 1994, p. 4). Therefore, the United Nations Office for the Coordination of

Humanitarian Affairs (1999) has defined a CHE as

“a humanitarian crisis in a country, region, or society where there is total or considerable breakdown of authority resulting from internal or external conflict and which requires an international response that goes beyond the mandate or capacity of any single and/or ongoing UN country program” (p. 4).

A CHE has six characteristics that differentiate it from natural disasters. These characteristics are “extensive violence and loss of life”, “massive displacements of people”, “widespread damage to societies and economies”, “the need for large-scale, multi-faceted humanitarian assistance”, “the hindrance or prevention of humanitarian assistance by political and military constraints”, and “significant security risks for humanitarian relief workers in some areas” (United Nations Office for the Coordination of Human Affairs, 1999; p. 4). As such, CHEs are man-made and politically-induced disasters closely related to political mismanagement, weak government institutions and oppressive regimes that collapse when challenged by armed insurrections. Most CHEs are characterised by the disintegration of socioeconomic structures and marginalisation of specific groups, which compromises their rights and results in massive displacements. An example of typology used for CHEs is provided in Table 1.

Perhaps the conflicts that characterised decolonised countries in the 1950s and 1960s could explain the exponential increase in the number of refugees requiring humanitarian responses over the past four decades. For example, between 1970 and 2014, refugees across Africa increased from 153,700 to almost four million (Table 2). The majority of the refugees on the African continent are mainly hosted by the countries of the Central and Eastern African regions. In the 1990s, Sudan, Malawi, Ethiopia, Somalia, DR Congo, Guinea and Burundi were hotspots that hosted more refugees than any other African country. To date, Chad, Ethiopia and Kenya host the highest number of refugees in the region. Similarly, the entire Asian region hosted 2,200 and six million refugees in 1960 and 2014, respectively. However, most of the refugees are currently concentrated in Pakistan, Islamic Republic of Iran and Lebanon (Table 2). With the exception of Lebanon, the same countries have hosted most of Asia’s refugees since the

Table 1: A typology of CHEs

	War	Disease	Hunger	Displacement	Type
Afghanistan	x	x	x	x	acute
Mozambique	x	x	x	x	acute
Angola	x	x	x	x	acute
Somalia	x	x	x	x	acute
Rwanda	x	x	x	x	acute
Liberia	x	x		x	serious
Burundi	x	x		x	serious
Sri Lanka	x	x		x	serious
Sierra Leone	x	x		x	serious
Sudan	x		x	x	serious
Ethiopia		x	x	x	serious
Eritrea		x	x	x	serious
Myanmar		x	x	x	serious
Bosnia	x			x	violent
Croatia	x			x	violent
Tajikistan	x			x	violent
Colombia	x			x	violent
Azerbaijan	x			x	violent
Armenia	x			x	violent
Georgia	x			x	violent
Iraq	x			x	violent
Niger		x	x		poverty
Nigeria		x	x		poverty
Bangladesh		x	x		poverty
Laos		x	x		poverty
Central African Repub.		x	x		poverty
India	x		x		mixed

Source: Klugman, 1999.

Table 2: Refugee population by region of asylum between 1960 and 2016

Region	1960	1970	1980	1990	2000	2010	2014*
Total Africa	153,700	992,085	4,123,590	5,890,673	3,627,130	2,408,676	3,987,405
Eastern Africa	—	328,030	2,613,930	3,284,669	1,662,103	971,009	1,078,814
Middle Africa	150,000	524,650	841,110	485,559	602,800	797,406	1,174,093
Northern Africa	3,700	67,780	546,780	1,202,492	605,508	376,312	946,261
Southern Africa	—	4,565	16,770	43,467	46,567	68,898	362,355
Western Africa	—	67,060	105,000	874,486	710,152	195,051	425,882
Total Latin America and the Caribbean	548,629	624,518	675,053	1,814,522	673,064	803,990	634,445
Caribbean	—	1,000	6,770	5,954	1,602	1,099	33,847
Central America	—	3,000	95,000	1,161,394	27,656	38,361	106,885
South America	—	102,000	76,920	27,526	8,593	334,407	333,229
North America	548,629	518,518	496,363	619,648	635,213	430,123	160,484
Total Asia	2,200	152,930	2,631,990	8,163,888	5,383,418	5,715,818	5,853,790
Central Asia	—	—	—	—	99,085	10,368	436,366
Eastern Asia	—	67,000	292,380	302,691	298,851	304,096	10,899
Southern Asia	—	64,560	1,766,930	7,661,114	4,191,287	3,484,526	1,889,915
South-eastern Asia	—	20,000	437,530	159,117	294,225	181,310	292,247
Western Asia	2,200	1,370	135,150	40,966	499,970	1,735,518	3,224,363

(Continued)

Table 2: (Continued)

Region	1960	1970	1980	1990	2000	2010	2014*
Total Europe	700,835	569,397	485,329	1,295,803	2,144,635	1,441,831	1,598,669
Eastern Europe	—	—	1,000	45,123	40,628	39,111	65,307
Northern Europe	193,000	182,000	168,000	153,295	343,468	320,779	1,155,564
Southern Europe	31,000	74,330	56,371	29,418	517,369	159,865	152,223
Western Europe	476,835	313,067	259,958	1,067,967	1,243,170	922,076	225,575
Total Oceania	—	44,000	315,000	109,680	71,032	33,814	47,982
Australia and New Zealand	—	44,000	314,000	102,581	65,169	24,112	35,906
Melanesia	—	—	1,000	7,099	5,863	9,702	11,984
Micronesia	—	—	—	—	—	—	35
Polynesia	—	—	—	—	—	—	57
Uncategorised	152,000	21,000	167,650	5,284	—	—	—

* Estimates by mid-2014 and is subject to change. Note: Data for 1960–2010 cover refugees protected by UNHCR and other people in refugee-like situations. Data for 2014 cover only people recognised as refugees under the 1951 UN Convention, 1967 protocol, the 1969 OAU Convention, people granted a complementary form of protection and those with temporary protection. All data exclude resettled refugees and Palestinian Refugees under UNRWA. Data especially for industrialised regions are based on UNHCR estimates. A dash (—) denotes zero or unavailable.

Source: UNHCR (2015a), Statistical online population database. Geneva: UNHCR. Available at <http://www.unhcr.org/pages/4a013eb06.html>. Accessed on 3 April 2015.

1980s. Africa and Asia produce and host more than half of the total global refugees. Some of the hosting countries in these regions are overwhelmed by the refugee burden. For example, Lebanon, a small country of 10,452 km² with a population of 4.467 million hosts 178 refugees per 1,000 citizens (Holmes, 2014). Data by the United Nations (2014) suggest that by April 2014, Lebanon had over one million refugees, making it one of the countries with the highest per capita concentration of refugees. Similarly, Chad, one of the poorest countries in the world, hosts 34 refugees per 1,000 persons which is proportionally a significant burden on the barely functional social services. In 2013, Afghanistan, Syrian Arab Republic and Somalia produced approximately 6 million refugees and half of these were children. It is interesting to note that in forced mass displacements such as the Syrian refugees in Lebanon, the recipient country may have limited capacity to address the rapid influx, hence making CHEs a significant political, security and public health burden (Brennan and Nandy, 2001). As Brennan and Nandy (2001) note, natural disasters, which often relate to major adverse events resulting from natural processes of the environment such as drought, volcanic eruption, avalanches, earthquakes, wildfires, flooding, tsunami or health threats such as the flu pandemic or Ebola outbreak, can aggravate CHEs and vice versa. However, overall CHEs account for more mortality than all natural and technological disasters.

Refugees' health and burden of disease

Globally, refugees' health remains a key challenge in humanitarian responses. At the onset of CHEs, the most significant burden of disease is mainly infectious and communicable diseases. However, chronic non-communicable diseases (NCDs) continue to affect refugees in CHEs, especially in the Middle East, even though they attract limited or no attention. Overall, there have been improvements in the quality and delivery of humanitarian assistance over time. This has significantly contributed to the reduction of mortality among refugees in CHEs. With the exception of the 31.9 crude mortality rate (CMR) reported among Cambodian refugees in Thailand in 1979 (CDC 1992) and the 1994 Rwandese refugee crisis in DR Congo, where CMR was estimated between 20 and 35 per 1000 per day (Goma Epidemiology Group, 1995), there has been a remarkable reduction in refugee mortality across

Table 3: Estimated daily crude mortality rates (deaths per 10,000/day) in selected refugee populations 1979–2014

Reference	Period	Country of origin	Country of refugee	Name of refugee camp	CMR	U5MR	CMR (b) thresholds: emergency (baseline)	U5MR (b) thresholds: emergency (baseline)
Toole and Waldman (1990)	August 1980	Ethiopia	Somalia	Gedo & Woqooyi Galbeed	10.1 (a)	NR	0.8 (0.41)	2.1 (1.07)
	October 1979	Cambodia	Thailand	Khao-I-Dang	10.6 (a)	NR	0.4 (0.19)	0.3 (0.15)
CDC (1993)	August 1992	Mozambique	Zimbabwe	Chambuta	3.50	NR	0.8 (0.41)	2.1 (1.07)
CDC (1993)	Jan–September, 1992	Mozambique	Malawi	Lisungwe	1.0–3.6	5.0	0.8 (0.41)	2.1 (1.07)
Goma Epidemiology Group (1995)	July–August, 1994	Rwanda	Zaire	Katale	41.3	NR	0.8 (0.41)	2.1 (1.07)
				Kibumba	28.1	NR	0.8 (0.41)	2.1 (1.07)
				Mugunga	29.4	NR	0.8 (0.41)	2.1 (1.07)
				All camps	32.9	NR	0.8 (0.41)	2.1 (1.07)
Friedman and Spiegel (2000)	February 2000	East Timor	Indonesia	14 unnamed sentinel sites	0.2	NR	0.4 (0.19)	0.3 (0.15)
CDC (2001)	January–May, 2001	Liberia/Sierra Leon	Guinea	Parrots Beak	0.3–0.9	0.9	0.8 (0.41)	2.1 (1.07)
Tomczyk <i>et al.</i> (2004)	June 2004	Sudan	Chad	Iridimi/Touloum/Kounoungo	1.56	1.46	0.8 (0.41)	2.1 (1.07)

(Continued)

Chapter 10
http://www.worldscientific.com/doi/abs/10.1142/9781783268894_0003
 The social and health dimensions of refugees and complex humanitarian emergencies
 © Imperial College Press
 For personal use only.

Table 3: (Continued)

Reference	Period	Country of origin	Country of refugee	Name of refugee camp	CMR	U5MR	CMR (b) thresholds: emergency (baseline)	U5MR (b) thresholds: emergency (baseline)
UNHCR (2008a)	October 2006	Sudan	Ethiopia	Dimma	0.04 (a)	0.00 (a)	0.8 (0.41)	2.1 (1.07)
UNHCR (2008a)	October 2007	Eritrea/Somalia/ Ethiopia	Djibouti	Ali Adde	0.06 (a)	0.11 (a)	0.8 (0.41)	2.1 (1.07)
UNHCR (2008a)	June 2007	Sudan and DRC	Uganda	Adjumani	0.05 (a)	0.16 (a)	0.8 (0.41)	2.1 (1.07)
Spiegel <i>et al.</i> (2011)	July–August, 2011	Somalia	Kenya	Dabab	0.44	1.53	0.8 (0.41)	2.1 (1.07)
UNHCR (2013a)	October 2012/ September 2013	Syria	Iraq	Domiz	<0.16 (a)	<0.16 (a)	0.3 (0.16)	0.5 (0.27)
	October 2012/July 2013		Jordan	Za’atri	0.07	0.04	0.3 (0.16)	0.5 (0.27)
UNHCR (2013b)	March 2013	Somalia	Ethiopia	Hilaweyn camp	0.32	1.08	0.8 (0.41)	2.1 (1.07)
Andresen <i>et al.</i> (2014)	June–July, 2014	Sudan		Kule	1.63	5.64	0.8 (0.41)	2.1 (1.07)

(a) Converted from /1000/month to /10,000/day for ease of interpretation; (b) Sphere emergency (baseline) thresholds; NR = Not reported; CMR = Crude Mortality Rate; U5MR = under-five mortality rate.

regions (Table 3). In subsequent paragraphs, we discuss the most common communicable diseases that affect refugees.

Communicable diseases

Diarrhoeal diseases: While violence associated with conflict causes most morbidity and mortality in the early phases of CHEs, diarrhoeal diseases are among the primary causes of mortality and morbidity among refugees. Although diarrheal diseases are preventable through the provision of safe water and its storage, good sanitation, and hygiene education, they still account for more than 40% of deaths in the acute phase of an emergency (Connolly *et al.*, 2004). Of those dying from diarrheal diseases, over 80% occur in children aged younger than two years old. There have been some cases where mortality attributable to diarrhoeal diseases is higher than 40%, namely the 1994 Rwandese refugee crisis in Goma, Zaire. In this emergency, 85% of all deaths in the first month were due to diarrheal diseases especially cholera and shigella dysentery (Goma Epidemiology Group 1995). Earlier studies suggest diarrhoeal diseases accounted for 28% to 85% of deaths in refugee camps in Somalia in 1980, Ethiopia in 1982 and Malawi in 1988 (Porter *et al.*, 1990).

Acute respiration infections (ARIs): ARIs account for a high proportions of morbidity and mortality in refugee camps. The prevalence of ARIs among refugees has been reported to vary from 27.7% among adults to 34.4% among one-year-old children or younger (Bellos *et al.*, 2010). Diaz and Achi (1989) reported that 63% of morbidity in Nicaraguan refugees in Costa Rica in 1998 was due to ARIs. Of all primary health care consultations, ARIs account for the biggest share of the burden of communicable diseases, making up 62.9%, 41.2% and 30.3% of the communicable disease burden among Syrians in refugee camps in Iraq, Jordan and Lebanon, respectively (UNHCR, 2013a). The proportion of deaths attributable to ARI among refugees varies between 25% and 36% among children younger than five years and 9% and 26% across the whole refugee population, making ARIs second only to diarrhoeal diseases (Bellos *et al.*, 2010). In Kakuma refugee camp in Kenya, ARIs were identified as the leading cause of mortality and morbidity among Sudanese refugees, accounting

for 30–40% of deaths among children younger than five years (World Health Organisation, 2008).

Measles: Several studies have examined the impact of measles on children in CHEs. This highly infectious viral disease is easily transmitted through contact with bodily fluids and air droplets. Measles is often rampant in refugee populations because of concentrated exposure in high population density (Aaby *et al.*, 1984; Toole *et al.*, 1989). Well known documented risk factors include inadequate or poor measles vaccination status, vaccination campaigns, and surveillance; living conditions such as overcrowding and high density camps; frequent movement of refugees in the neighbouring community and in other camps; malnutrition and famine including vitamin A deficiency; and insecurity and inaccessibility to target zone (Aaby *et al.*, 1984; Kouadio *et al.*, 2010; Toole *et al.*, 1989). Measles severity is measured by its attack rate which is defined as the number of cases per population at risk in a specific area at a given time (Kouadio *et al.*, 2010). For example, Porter and colleagues (1990) found that, between November 1988 and January 1989, measles outbreaks occurred in 11 Mozambican refugee camps in Malawi. They reported measles attack rates as high as 10–26% among children aged 6–9 months and 3–21% among children aged less than six months. Kouadio and colleagues (2010) found other measles outbreaks with a high attack rate, including Vietnamese refugees in Hong Kong (attack rate of 25.5%) and Cambodian refugees in Thailand (attack rate of 17.4%).

They also reported lower attack rate (<5%) among Ethiopians in refugee camps in Sudan (attack rate of 3.1%). Measles case fatality rates have varied with a rate as high as 15–21% reported among less than five-year-old Mozambican children in refugee camps in Malawi (Porter *et al.*, 1990). Other high-case fatality rates have been documented among Ethiopian refugees in Wad Kowli in Sudan in 1985 (32.4%) (Shears *et al.*, 1987). Prior to the 1990s when measles immunisation in refugee camps was inadequate, measles accounted for 42–53% of deaths (Toole and Waldman, 1988). However, some studies suggest that there has been a reduction in measles mortality among the refugee population due to improved surveillance, quick mass immunisation and vitamin A supplementation in early stages of emergencies (Paquet and Hanquet, 1998). For

example, the measles case fatality rate averaged 13.1% (median = 10%) prior to 2000 compared to an average of 6.3% (median = 1.3%) after 2000 (Kouadio *et al.*, 2010).

Malaria: Malaria is common in endemic tropical and sub-tropical regions, and is life-threatening in CHEs. In 2013, there were 584,000 deaths due to malaria, of which 90% occurred in Sub Saharan Africa (SSA) (World Health Organisation, 2014a). These data suggest that malaria is a major cause of morbidity and mortality in SSA including refugee populations. Malaria outbreaks and transmission are facilitated by conducive environmental factors such as warm temperatures, plenty of stagnant water and bushes in areas where refugee camps are often located. Approximately two-thirds (63%) of CHEs occur in malaria-endemic areas, and in areas of high transmission, malaria accounted for up to 40–50% of all deaths in CHEs (World Health Organisation, 2005). There is no doubt that progress has been made in reducing the burden of malaria among refugees in CHEs due to the declining transmission rates as a result of effective support and promotion of malaria control policies and programmes in the early phase of emergencies (UNHCR, 2008b). Available evidence suggests that between 2006 and 2009 the annual incidence of malaria in children younger than five years of age decreased more than one-third in refugee sites in Kenya, Tanzania and Uganda, reflecting the pattern of the host countries (O’Meara *et al.*, 2010). This is consistent with a reduction in malaria incidence rates of 25% globally, and 31% in the WHO Africa region observed between 2000 and 2012 as a result of the scale-up of intervention strategies (World Health Organisation, 2014a). Notwithstanding this decline, malaria remains a significant burden in the post-emergency refugee sites with an overall incidence in refugee sites in Tanzania of 399 cases per 1,000 refugees and 728 cases per 1,000 in children younger than five years (Anderson *et al.*, 2011). In a retrospective mortality survey of 51 post-emergency camps in Azerbaijan, Ethiopia, Myanmar, Nepal, Tanzania, Thailand and Uganda covering the 1998–2000 period, Spiegel *et al.* (2002) reported an overall malaria incidence of 576 cases per 1,000 persons and 936 cases per 1,000 children. Among Congolese refugees in Lugufu camp in Tanzania, malaria accounted for 33.3% of all deaths (Talley *et al.*, 2001). The progress made to reduce the

burden of malaria in CHEs needs to be consolidated both within and outside post-emergency sites. The focus needs to be on managing movement of malaria across regions and international borders, which if not controlled poses a major obstacle to achieving malaria elimination (Richards *et al.*, 2009). Because of its adaptive capacity, malaria is likely to remain as one of the major causes of refugee morbidity and mortality in the tropics especially those in poor camp conditions.

HIV/AIDS: HIV/AIDS is a chronic disease with a negative toll on vulnerable populations in CHEs where conditions make it thrive. However, available evidence suggests that it is not among the leading causes of refugee mortality and morbidity. Despite the common belief that CHE conditions create more vulnerability in accelerating the HIV/AIDS epidemic, there is insufficient evidence to support mass HIV/AIDS interventions among refugees in CHEs (Spiegel, 2004). A systematic review of HIV among refugee populations in Africa by Spiegel and colleagues (2007) found that there is lower HIV prevalence among refugees compared to neighbouring non-refugee populations. They found, for example, that the prevalence for HIV in the Dadaab refugee camp in Kenya was only 0.6% in 2003 compared with 26% in 2002 in the neighbouring sentinel site in Garisa. Similarly, the HIV prevalence in 2004 was 1.0% in the Palorinya Sudanese refugee settlement in Uganda, compared with 5.9% in the neighbouring non-refugee populations. Similar trends were observed by the same study in refugee camps in Zambia, Tanzania and Rwanda. In Mae La refugee camp on the Thai–Myanmar border, the HIV prevalence between 1995 and 2003 was estimated at 0.2–0.4% among refugees compared with a prevalence of 1.8–2.4% observed among neighbouring non-refugee populations (Plewes *et al.*, 2008). Nonetheless, the impact of the disease on refugee health cannot be underestimated because HIV spreads fastest in conditions of poverty and social instability, lack of protection and weak bargaining power in transactional sex, conditions that typify refugees in CHEs (Hankins *et al.*, 2002). The HIV risk in CHEs can be aggravated by the breakdown of social structures, sexual violence, alcohol and drug abuse (Spiegel, 2004). While combating HIV in CHEs requires integrated interventions, such an approach remains too difficult to implement especially during the acute

period of the emergency. For example, mandatory HIV testing in refugee circumstances is a difficult initiative to implement. Besides, mandatory blood testing for transfusion contravenes the refugees' basic rights and hence is a contraindicated policy.

Tuberculosis: Studies on the impact of tuberculosis among refugees in CHEs are scarce but generally it is not a leading cause of mortality post-1990s and traditionally became only a critical issue after measles and diarrheal diseases were under control (CDC, 1992). A study in two refugee camps in Asia found that the disease incidence varied from 2.2% to 5.8% in refugee camps in Thailand and the Philippines (Sutter and Haefliger, 1990). A 2012 systematic review of the disease in crisis-affected populations identified 51 studies. Of these, only 23 focused on camp-based refugees. The other studies were based on populations in similar conditions as refugees (Kimbrough *et al.*, 2012). The study reported that the case fatality rate among refugees varied from 2% among Somali refugees in Kenya to 11% among Burundian and Rwandese refugees in Tanzania, which is significantly lower than the 20% case fatality rate for developing countries. Prior to the 1990s, tuberculosis was a serious issue among refugees, accounting for 26% of all deaths among refugees in Somalia 1985, 38–50% of all deaths among refugees in Eastern Sudan, and during this time tuberculosis ranked the third leading cause of death overall and the leading cause of mortality among adults (CDC, 1992). However, improvements in humanitarian aid delivery have led to the establishment of effective tuberculosis prevention and control programmes (Coninx, 2007). These interventions are often not rolled out during the acute phases of the emergencies due to competing lifesaving interventions and the multifaceted and complex nature of tuberculosis programmes. It is difficult to follow the standard treatment requirements such as the directly observed treatment as it lasts six months while a patient is under supervision of a health worker (Coninx, 2007). In these CHE contexts, ensuring patient compliance with the treatment, the required personnel to supervise treatment, the uncertain duration of stay, frequent changes of camp locations and poor camp organisation may hinder tuberculosis treatment programmes (CDC, 1992).

Non-communicable diseases

Globally, the impact of NCDs has surpassed that of communicable diseases, maternal and perinatal, nutrition-related mortality combined (World Health Organisation, 2011). According to the latest data by the World Health Organisation from 194 countries, only 15% of NCDs mortality occur in high-income countries, and a staggering 85% occur in low- and middle-income countries (World Health Organisation, 2014b), which also have high incidences of CHEs.

Despite being a significant burden of disease in CHEs, especially in the Middle East, NCDs remain a neglected health care need among refugees. A study by MSF Switzerland among refugees in Lebanon and Iraq concluded that while high mortality rate during acute phases of emergencies have traditionally been fuelled by the exacerbation of endemic infectious diseases and acute malnutrition, in the Middle East, excess morbidity and mortality are closely related to the exacerbation of existing chronic diseases such as cardio-vascular diseases, hypertension and diabetes (Abu Sa'Da and Serafini, 2013). While treatment continuation becomes essential, the study found that for Syrian refugees in Lebanon, 52% could not afford treatment for chronic diseases and a further 30% had no choice but to suspend treatment because of the exorbitant prices of drugs. Some of the challenges of addressing NCDs in refugee settings are complex and multifaceted. They include inadequate linkage between the refugee registration process and access to services, camp-based vs. non-camp-based refugees, lack of funding for the treatment of NCDs and the continuity of care and poorly equipped health care infrastructure of host countries (Abu Sa'Da and Serafini, 2013; Elliott, 2015). In the case of Syrian refugees in Lebanon, for example, 41% were not registered due to lack of information on how and where to register, the fact that the registration centres were too far away, delays at the registration centres and fear of being sent back to Syria as a result of not having proper legal documents. With 65% of Syrian refugees in Lebanon living outside camps, they are scattered over 1,000 municipalities, most of which are impoverished urban areas. In contrast, in Iraq, refugees live predominantly in camps as well as in cities (Abu Sa'Da and Serafini, 2013). These factors affect negatively the continuity of care for those with NCDs such as diabetes as non-registered refugees

need to fund their own treatment, and for those registered they may have difficulty accessing available services due to distance (if they live outside camps) or lack of information.

Diabetes and cardio-vascular diseases: Diabetes causes a significant health burden for both refugees and non-refugee populations albeit not being prioritised in humanitarian interventions (Zimmet, 2003). Various studies assert that diabetes and its complications can be exacerbated by lack of basic care and treatment in CHEs, hence negatively impacting on refugees' wellbeing and quickly progressing to mortality (Coffey *et al.*, 2002; Rubin and Peyrot, 1999). The UNHCR (2013a) has reported that the proportion of all primary health care consultations accounted for by NCDs is 7.4% among Syrian refugees in Iraq, 21.8% among Syrian refugees in Jordan and 8.3% among Syrian refugees in Lebanon. Recent data by Médecins Sans Frontières (2014) suggest that nearly 90% of Syrian refugees in Lebanon attending their health services arrive with prior diagnoses of chronic disease, mainly hypertension and diabetes. In a systematic review of NCDs among urban refugees in developing countries, Amara and Aljunid (2014) found that other than the UNHCR ordinary reports, there are limited studies on the prevalence of NCDs among refugees. The overall prevalence of NCDs among urban refugees ranged from 9% to 50% among refugees in the Middle East and 1% to 30% among refugees in Asia and Africa with the most prevalent NCDs being musculoskeletal disease and pain problems, cardio-vascular diseases, diabetes and chronic respiratory disease. However, cancer and renal disease were reported less frequently. More specifically, screening prior to resettlement in a third country estimated a prevalence of hypertension of 33% among Iraqi refugees and 18.7% among Palestinian refugees (Amara and Aljunid, 2014). In Asia, prevalence of hypertension among Cambodian refugees in Thailand was reported to be 16.5% (Culhane-Pera *et al.*, 2009) while among urban refugees in SSA it was estimated at 1% in Kenya, 3% in Togo and 28% in Congo (Amara and Aljunid, 2014). Similarly, Amara and Aljunid (2014) reported that the prevalence of cardiovascular diseases varied from 7% among Burmese urban refugees in Malaysia to 10% among Afghanistan urban refugees in Iran. The prevalence of diabetes was significantly higher among refugees

from the Middle Eastern Region, ranging from 7.6% to 9.8% among Palestinian and Iraqi refugees. In SSA, it was estimated at 8% among refugees from DR Congo, Rwanda and Angola living in urban Congo compared to 1% to 2% among other refugees in African urban centres. In Asia, the prevalence of diabetes ranged between 6% and 8% among urban refugees while that of the metabolic syndrome, a clustering of abdominal obesity, hypertension, elevated fasting plasma glucose and dyslipidaemia, was estimated at 15.3% in women and 20.8% in men among North Korean refugees in Seoul (Amara and Aljunid, 2014). However, these prevalence rates should be taken with caution because of the heterogeneity of the studies' designs, variation in sample sizes and the use of different instrumentations' diagnostic criteria.

Malnutrition: Food shortages remain very frequent in CHEs, and together with an impaired health environment, can lead to two types of nutrition problems: macronutrient and micronutrient deficiencies. The macronutrient deficiencies are universally described under the “protein-energy malnutrition” umbrella and include acute malnutrition or wasting chronic malnutrition or stunting and underweight, defined respectively as weight-for-height (WFH), height-for-age (HFA) and weight-for-age (WFA) indices below minus two standard deviations of the median reference population. While stunting and underweight are also very prevalent among refugees, only wasting is used to classify the degree of severity of CHEs (Table 4a) and for decision-making purposes (Table 4b). When anthropometrically defined, a child is classified as acutely malnourished when their WFH index is <-2 z-score and/or has bilateral oedema. The prevalence of acute malnutrition in CHEs has consistently been between the serious and critical categories. An alarming prevalence of acute malnutrition was reported among refugee children in eastern and central Africa over the past three decades. For example, monitoring data by the United Nations System Standing Committee on Nutrition in the late 1990s and early 2000s indicate that the prevalence of global acute malnutrition among refugees varied between 12.8% and 16.9% in Eritrea, 7.5% and 12% in Ethiopia, 16.8% and 34.4% in Kenya, 15.9% and 21% in Somalia, and 12.1% and 21.5% in Sudan. The Goma Epidemiological Group (1995) reported a prevalence of global acute malnutrition of 23.1% in Katale camp, 20.1% in Kibumba

Table 4: (a) WHO classification of severity of malnutrition in a community

Severity of malnutrition	Prevalence of wasting (% weight-for-height below median — 2SD)	Mean weight-for-height z-score
Acceptable	<5%>	> -0.40
Poor	5–9%	-0.40 to -0.69
Serious	10–14	-0.70 to -0.99
Critical	>15%	< -1.00

Table 4: (b) Decision-making and programming

GAM (z-score)	Other contributing factors	Classification	Intervention
<3%	<ul style="list-style-type: none"> • CMR < 0.5/10,000/d • Food: >2,100 kcal/p/d • Water: >15 litres/p/d • Adequate livelihood assets 	Generally food secure	Targeted assistance of food insecure; investment in food and economic production systems
>3% but <10%	<ul style="list-style-type: none"> • CMR: <0.5/10,000/d • U5MR: <1/10,000/d • Food: borderline (2,100/p/d) • Water: borderline (15L/p/d) 	Chronically food insecure	“Safety nets” to high-risk groups; advocacy; close monitoring; increase resilience of livelihood systems
10–15%	<ul style="list-style-type: none"> • CMR: 0.5–1/10,000/d • U5MR: 1–2/10,000/d • Food: ≤2,100kcal/d • Water: 7.5–15L/p/d 	Acute food and livelihood crisis	GFD+ targeted SFP + TFP; advocacy, address underlying structural causes
>15%	<ul style="list-style-type: none"> • CMR: 1–2/10,000/d • U5MR: >2/10,000/d • Food: <2,100kcal/p/d • Water: <7.5L/p/d 	Humanitarian emergency	GFD + blanket SFP +TFP; advocacy, address underlying structural causes
>30%	<ul style="list-style-type: none"> • CMR: >2/10,000/p/d • Disease outbreaks(pandemic) • Food: <2,100 kcal/p/d • Water: <4 L/p/d 	Humanitarian catastrophe	GFD + blanket SFP +TFP; comprehensive assistance with basic needs: sanitation, water, health, soaps etc.

Source: Adapted from Food and Agriculture Organisation (2006). CMR = crude mortality rate; U5MR = under-five mortality rate; p/d = per person per day; L/p/d = litres per person per day; kcal/p/d = kilocalories per person per day; GFD = general food distribution; SFP = supplementary feeding program; TFP = therapeutic feeding program.

camp and 17.7% in Mugunga camp among Rwandan refugee children in Zaire (now the Democratic Republic of Congo). Although the prevalence of global acute malnutrition was lower in western Africa (3.4–7.8%), central Africa (3.7–15.7%) and southern Africa (6.9–15.5%) than eastern Africa, it was still higher than what is acceptable (United Nations System Standing Committee on Nutrition, 2004). Precarious nutrition situations have also been reported among refugee children in Asia (Young and Jaspars, 2006). Among recent Syrian refugees in Jordan, the prevalence of global acute malnutrition has been estimated at 5.1% among refugees living outside camps and 5.8% among those in refugee camps (UNHCR, 2013a). Among Syrian refugees in Lebanon, the prevalence of global acute malnutrition was slightly higher, varying from 4.1% to 8.9% (United Nations Children's Fund, 2014). High-case fatality of 19–30% was reported among children treated for severe acute malnutrition prior to the 1990s (Schofield and Ashworth, 1996), but it has since plummeted due to better protocols and evidence-based guidelines and products (Salama *et al.*, 2004).

Micronutrient deficiencies: In terms of micronutrient deficiencies, the most prevalent among refugees are Vitamin A deficiency (xerophthalmia), iron deficiency and anaemia, scurvy (Vitamin C deficiency), beriberi (Thiamin deficiency), iodine deficiency and pellagra (Niacin deficiency) (Prinzo and De Benoist, 2002). Some of the best known approaches to address micronutrient deficiencies in CHEs include mass vitamin A distribution to all children younger than 5 years (and older children when required) every 4 to 5 months, and a short-term supplementation strategy for other micronutrients as required, compulsory fortification of food aid commodities, mainly oil, salt, blended foods and cereal flour, effective identification, treatment, and prevention of malaria and diarrhoeal disease, deworming, and small-scale home gardening programmes.

Prior to the 1990s, vitamin A deficiency was common among refugees in Asia and Africa and was associated with various morbidities such as measles, diarrhoeal diseases and preventable blindness (Semba, 1998). The prevalence of vitamin A deficiency among refugees varied between 20.5% and 61.7% (Seal *et al.*, 2005). However, improved standards of care and guidelines around mass measles immunisation and vitamin A distribution in CHEs have improved the vitamin A status of refugees. Mass

measles immunisation is critical because of the well-known synergistic relationship between measles and vitamin A deficiency (Toole *et al.*, 1989; Tomczyk *et al.*, 2004; Dabbagh *et al.*, 2009). Evidence suggests that adequate vitamin A intake among young children up to 6 years old through vitamin A supplementation and food fortification increases children's likelihood of surviving an infection, and reduces the risk of death from measles by 50%, from diarrhoea by about 40% and overall mortality by 23–30% (Beaton *et al.*, 1993; Glasziou and Mackerras, 1993; Fawzi *et al.*, 1993).

Anaemia is among the major causes of poor health in refugees and affects nearly half of the children in complex emergencies (Kemmer *et al.*, 2003; Ramakrishnan and Semba, 2008). Iron deficiency and anaemia attributed to inadequate intake of iron found in foods such as beef, chicken and seafood that are not often available to refugees varies by region. In Asia, the prevalence of iron deficiency and anaemia among refugees was estimated at 84% (iron deficiency) and 72% (anaemia) among Burmese refugees (Kemmer *et al.*, 2003). In the Middle Eastern region, refugee studies have documented an anaemia prevalence of 67% (Hassan *et al.*, 1997) and in SSA, the prevalence among refugee populations was reported to vary between 15% and 75% for iron deficiency and 12.8 and 90% for anaemia (Seal *et al.*, 2005; Toole, 1992; Woodruff *et al.*, 2006). Vitamin C is another important micronutrient that refugees often lack albeit being commonly available in citrus fruits. Its deficiency leads to scurvy which is rare but can be debilitating among refugee populations who are mainly dependent on food aid rations, a diet that does not include fruit and vegetables. Scurvy outbreaks have been documented in various CHEs in recent times among refugee populations in SSA (CDC, 1989; Magan *et al.*, 1983; Toole, 1992), Bhutanese refugees in Nepal (Save the Children, 1997) and people in refugee-like conditions in Afghanistan (Cheung *et al.*, 2003). The prevalence of scurvy has been estimated between 13.6% and 44% among refugees in Sudan and Somalia (Desenclos *et al.*, 1989; Magan *et al.*, 1983) and 6.3% among refugee-like population in Afghanistan (Cheung *et al.*, 2003).

Beriberi is common in south-east Asia, especially among refugee populations that primarily subsist on rice (polished) and is a result of thiamine deficiency (Hansch, 1999). Thiamine deficiency poses a significant health burden and can cause fatalities if left untreated for prolonged

periods. Prior to 2000, the prevalence of thiamine deficiency varied from 8% among Cambodian refugees (Berry-Koch *et al.*, 1990) to 57.7% among Burmese refugee women (McGready *et al.*, 2001). A study by Luxemburger *et al.* (2003) found that thiamine deficiency accounted for 40% of infant mortality among refugees in Thailand between 1987 and 1990. Since then, the disease prevalence has been on the decline due to improved surveillance and fortified food rations for refugees.

Finally, pellagra is caused by niacin and/or tryptophan deficiency and is mainly localised in refugee populations on maize-based rations with an inadequate supply of protein, especially in east and southern Africa (Hansch, 1999). Often characterised by “the three Ds” for diarrhea, dermatitis, and dementia (and a possible 4th D for death), pellagra remains a disease difficult to diagnose in the absence of the skin lesion. Pellagra outbreaks have been documented in various emergency situations and its prevalence was reported to be 6.3% during a major outbreak among refugees in Malawi (Malfait *et al.*, 1993). Other outbreaks have been reported among refugees in Angola (Table 5). Since then, humanitarian agencies have learnt to prevent further outbreaks of the disease through food fortification and supplementation (Hansch, 1999).

Mental health: Even though poor mental health remains one of the significant burdens of diseases in CHEs, it does not feature among the top emergency response priorities (Box 1) due to many factors: the controversies and disagreement over the public health value of the post-traumatic stress disorder (PTSD) a disease and concept as well as the appropriateness of non-integrated vertical trauma-focused services (Van Ommeren *et al.*, 2005). Nevertheless, in 2005, Porter and Haslam published a meta-analysis to examine the degree of compromised mental health among refugees. They found that despite the large heterogeneity in retained studies, refugees scored 0.41 standard deviations lower on mental health indices than their non-refugee counterparts. However, the effect size had overlapping confidence intervals suggesting that refugees had only moderately poorer mental health outcomes. The study also found that post-displacement conditions moderated mental health outcomes, and poor mental health outcome among forced migrants was associated with living in institutional accommodation, restricted economic opportunity, internal displacement

Table 5: Early outbreaks of micronutrient deficiencies in refugee populations

year	Location	Prevalence/incidence
Pellagra (WHO 2000)		
1988	• Zimbabwe	1.5%
1989	• Malawi (11 camps)	0.5%
1990	• Malawi (11 camps)	6.3%
1990	• Malawi (all camps)	2.0%
1991	• Malawi (Nsanje district)	0.2%
1994	• Nepal (Bhutanese refugees)	0.5/10 000/day (incidence)
1994	• Nepal (Bhutanese refugees)	0.005/10 000/day (incidence)
1995	• Mozambique	1.4%
1999	• Angola	2.6/1000/week
Vitamin A deficiency (Xerophthalmia) (CDC, 1992)		
1986–1987	• Somalia	7%
1985	• Niger	2.1%
1982	• Thailand (Kampuchean refugees)	4.3%
1984	• Mauritania	2.7%
Scurvy (CDC, 1992)		
1984	• Sudan	22%
1985	• Somalia	6.9–44.0%
1989	• Ethiopia	1.0–2.0%
Iron Deficiency (Anaemia) (CDC, 1992)		
1990	• Syria, Jordan, West Bank & Gaza	54.5–73.9% (children)
1990	• Syria, Jordan, West Bank & Gaza	12.5–62.5% (women)
1990+	• Ethiopia	10.0–13.0%
Thiamine deficiency/Beriberi (WHO, 1999)		
1995	• Thailand (Karen refugee women)	57.7% in postpartum women
1980	• Thailand (Cambodian refugees)	8% in adults only
1981	• Thailand (Cambodian refugees)	5%
1992	• Thailand (Karen refugees)	6% of breast-feeding women/cases of infantile beriberi
1995	• Nepal (Bhutanese refugees)	0.85–1.83/10,000/day

Box 1: Top priorities to address in emergencies

1. Rapid assessment of the health status of the population
2. Mass vaccination against measles
3. Water and sanitation
4. Food and nutrition
5. Shelter and site planning, and non-food items
6. Health care: curative care based on the use of standardized therapeutic protocols using essentials drugs
7. Control and prevention of communicable diseases and potential epidemics
8. Public health surveillance and alert
9. Assessment of human resources and training, and supervision of community health workers
10. Coordination of different operational partners

Source: Bigot *et al.* (1997).

and repatriation to the country they previously fled. However, the homogeneity analysis indicated a significant variability among studies with heterogeneity rather than sampling error explaining 96% of the variance in effect size points.

The review of evidence of the pre-2004 burden of mental health in complex emergencies by Mollica *et al.* (2004) found that mental health disorders are a significant burden among both adults and children. In adults, the prevalence of PTSD among refugees in Thailand varied from 4.6% among Burmese refugees to 37.2% in Cambodian refugees, and was estimated at 17.1% among Albanian refugees in Kosovo and 26% among Bosnian refugees in Croatia. The prevalence of depression was estimated at 41.8% and 67.9% among Burmese and Cambodian refugees in Thailand, respectively, and 39% among Bosnian refugees in Croatia. Similar patterns were reported among children. The prevalence of PTSD varied between 24% and 50% while that of depression varied between 11% and 68%. A number of studies have reported a high prevalence of mental health disorders among refugees in south America (Sabin *et al.*, 2003; Cardozo *et al.*, 2004), in the Middle East (United Nations Relief Works Agency 2009) and Africa (Reeler and Immerman 1994; Onyut *et al.*, 2009; Neuner *et al.*,

2004; Tang and Fox, 2001; Fox and Tang, 2000). The proportion of all primary health care consultations accounted for by mental health disorders was 0.5%, 1.3% and 1.4% among Syrian refugees in Iraq, Jordan and Lebanon respectively (UNHCR, 2013a). Given the stigma associated with mental disorders in low- and middle-income countries, this pattern of service use may reflect an underutilisation of primary health care. However, it is difficult to compare results summarised across studies as they use different scales and criteria, exacerbated by the lack of accurate population estimates and culturally validated screening instruments (Mollica *et al.*, 2004). The various instruments used to measure mental health in complex emergencies include the Harvard Trauma Questionnaire, the Hopkins Symptom Checklist-25, Diagnostic and Statistical Manual of Mental Disorders criteria, the Posttraumatic Diagnostic Scale, the Composite International Diagnostic Interview, the Impact of Event Scale and many others.

While there are emergency thresholds for communicable diseases and malnutrition, and cut-off points for establishing the effectiveness of interventions in complex emergencies as specified in the Sphere guidelines, there are no standardised thresholds for mental health disorders. However, emerging evidence suggests that early intervention could be effective in addressing mental health issues in CHEs. Wietse *et al.* (2008) evaluated the efficacy of school-based mental health intervention for children affected by political violence in Indonesia using a cluster randomised trial. The intervention included 15 sessions delivered over 5 weeks of a manualised school-based group intervention such as trauma-processing activities, cooperative play and creative expressive elements. They found that after adjusting for clustering of participants within schools, the intervention improved PTSD symptoms and retained hope in the treatment, but did not improve traumatic idioms (stress-related physical symptoms), depressive symptoms, anxiety and functioning impairment when compared to the control group. Similarly, Layne *et al.* (2001) used a school-based psychotherapeutic intervention for war-traumatised Bosnian adolescents which included a four-module, 20-session trauma and grief-focused group psychotherapy. The authors found that the intervention not only reduced levels of PTSD but also reduced depression and grief symptoms. Reduced stress was associated with psychosocial adaptation. These findings are

consistent with those reported by Gordon *et al.* (2004) but not supported by other studies. For example, Thabet *et al.* (2005) found that a short-term, seven-session group crisis intervention for children (drawing, free play, storytelling and expression of feelings) experiencing ongoing conflict in the Gaza Strip and presenting with PTSD symptoms had no significant impact on children's PTSD or depressive symptoms. Lack of intervention effect has also been reported by Dybdahl (2001) in a study of mother/child during the Bosnian war and Paardekoooper (2002) among Sudanese refugee children. These contradictory results could be explained by many factors including differences in intervention scope and implementations (e.g. involving vs. not involving parents during interventions), small sample sizes, variations in measurements in the intervention outcomes (e.g. use of different scales) and variation in study designs (quasi-experimental vs. randomised controlled trials). Notwithstanding these limitations, emerging literature advocates for standardisation of mental health care interventions in CHEs (Van Ommeren *et al.*, 2005; Thabet *et al.*, 2005; Dybdahl 2001; Paardekoooper 2002).

Refugee governance and regional mechanisms in CHEs

The refugee governance in CHEs is complex and involves various stakeholders such as the UNHCR, the host government, other UN agencies and partner Non governmental organisations (NGOs) to provide humanitarian assistance and to mitigate human suffering. The governance of refugees varies by regions. In this section we summarise some of the most relevant mechanisms. In SSA, the refugee governance is mandated by the 1951 Refugee Convention and its 1967 Protocol and the 1969 African Refugee Convention by the African Union (AU). These are enshrined in local legislations and translated into operational policies. In other regions such as south-east Asia, refugee governance is also guided by national legislations and other regional mechanisms summarised below. However, many countries in Asia and the Pacific according to the WHO's regions are not a party to the Refugee Convention. Only 11 out of the 38 countries in the WHO's Asia and the Pacific region (28.9%) have ratified the 1951 Refugee Convention and its 1967 protocols. These countries are Australia, New Zealand, Timor-Leste, Papua New Guinea, Fiji, Samoa, Solomon

Islands, China, Japan, the Philippines and Korea (UNHCR, 2015b). In the Middle Eastern region, refugee governance is more complex. In theory, it is guided by the 1951 Refugee Convention and its 1967 Protocol but in practice the refugee governance is informal and varies between contexts, countries and localities. For example, Hanafi (2010) suggests that Palestinian refugee camps across the Middle East are governed by smaller but powerful non-state actors with allegiance to political and religious groups which undermine formal agencies such as United Nations Relief Works and Agency (UNRWA). In the Americas, refugee governance during the 1980s was predominantly based on state interests. Most of the countries affected by CHEs did not have formal mechanisms and had not ratified the 1951 Refugee Convention and its 1967 protocols (Hartigan, 1992).

Africa

Africa is one of the most politically volatile regions at the forefront of human rights violations resulting in producing and hosting a continuum of large waves of refugees (Table 2). To address this shortfall, the region has created various mechanisms to address human rights issues. Since the 1960s, when most African states gained independence from the European colonial powers, the region has had a unique refugee context in that it generated and hosted large numbers of refugees including freedom fighters. The creation of new African states and the large numbers of people displaced by the various conflicts that emerged out of the collapse of colonialism necessitated an indigenous African refugee solution. In 1969, the Organisation of the African Unity (OAU) member states ratified the African Refugee Convention which became a centrepiece of refugee protection in Africa (Okoth-Obbo, 2001). The African Refugee Convention promoted the sharing of the refugee burden among member states, equipped member states with commensurate skills in refugee protection and monitored the enactment of national laws consistent with the principles of refugee protection. In 2001, the OAU transitioned into the AU which continues to influence and lead the humanitarian thinking, policies and action related to refugee protection in the region. Some of the African Refugee Convention's achievements include the establishment of various regional coordination mechanisms such as the Protocol Relating to the Establishment of Peace and

Security Council of the AU. This protocol came into effect in December 2003 to address conflicts that transformed millions of people into refugee life (African Union, 2002). This protocol also addresses capacity-building of member states and sub-regional organisations in coordination, management and resolution of conflicts and crises in tandem with management of other humanitarian and emergency affairs (United Nations, 2010; Inter-Agency Standing Committee, 2014).

In April 1999, the AU Ministerial conference held in Mauritius established the Mauritius Grand Bay Declaration and Plan of Action (Keetharuth, 2009). The Ministerial conference was held at the backdrop of escalating human rights violations including crimes against humanity and genocide that had earlier transpired in Rwanda. The Grand Bay declaration committed member states to emphasise the respect for human rights, establish social justice, uphold good governance and the rule of law. In addition, the Grand Bay declaration emphasised the independence of the judiciary and the eradication of crimes against humanity and genocide as core tenets for Africa's security and stability (African Commission on Human and Peoples' Rights, 1999). Later, in 2004, the African Commission on Human and Peoples' Rights held its 35th session which was dedicated to the protection of the rights of all displaced people including asylum seekers, refugees and IDPs. During the session, member states created the Special Rapporteur on Refugees, Asylum Seekers, Migrants and IDPs as a mechanism to research and identify, investigate and make recommendations for member states on how to improve the protection of all categories of displaced (African Commission on Human and Peoples' Rights, 2004; Sahli-Fadel, 2012). However, the creation and operationalisation of this new mechanism has not improved the protection of refugees or mitigated the emergence of new refugee situations as ongoing conflicts among member states of Burundi, Chad, Central Africa, Mali, Sudan, South Sudan and Somalia continue to uproot millions of refugees from their homelands (Mukirya Nyanduga, 2006). Despite the quest to promote and uphold human rights, Africa continues to trail other regions in refugee protection. Scholars such as Okoth-Obbo (2001) and Rutinwa (1996) noted that some member states like DR Congo, Kenya, Rwanda, Tanzania and Uganda, among others have openly undermined refugee protection mechanisms through forced repatriations, refoulement of large numbers of refugees at

gun point or closing borders to refugees fleeing violence. These practices are inconsistent with the principles of refugee protection.

Middle East

The Middle Eastern region has experienced a significant refugee burden for the past six decades and remains a politically volatile region producing and hosting vast numbers of refugees. Responding to the 1948 mass displacement of Palestinians, the UN General Assembly under resolution 302 (IV) of 8 December 1949 established the United Nations Relief and Works Agency (UNRWA) as a temporary mechanism to provide humanitarian assistance and protection to Palestinian refugees (Bartholomeusz, 2009). Since its creation, UNRWA's mandate has been renewed and broadened to include non-Palestinians displaced by conflict and in need of humanitarian assistance in the region (Bartholomeusz, 2009). However, UNRWA's mandate does not include refugees' resettlement due to political restrictions instituted during UNRWA's formation and by countries hosting Palestinian refugees as they see the refugee burden as a security and political risk (Adelman, 1982). The UNRWA reports directly to the UN Secretary-General but relies on the host governments' permission to operate within their borders. Nonetheless, the UNRWA remains the leading formal agency providing social services such as refugees' welfare and health care, education and protection in the region.

There are other complex and intricate non-state actors providing an alternative governance of the humanitarian assistance for Palestinian refugees. These non-state actors include political and religious factions and popular committees known locally as *lijan sha'biyya*. The *lijan sha'biyya* are very influential but undertake their activities with little or no coordination with the mainstream agencies (Hanafi, 2010; Hanafi and Long, 2010). Each non-state actor is independent and controls a specific camps or group of camps with private militias which undermine the role and responsibilities of formal agencies and host governments (Sayigh, 1995; Hanafi and Hassan, 2009). The absence of a unified and authoritative structure makes standardisation of humanitarian assistance across camps difficult while constraining refugees in poor living conditions. Prior to the emergence of the non-state actors, the regional governments

exercised control (parallel to the UNRWA) of Palestinian refugees by placing armed forces in the camps (Peteet, 1987; Sayigh, 1995). The militarisation of the humanitarian assistance caused resentment among refugees, the consequence of which was the formation of refugees' own coordination committees in the camps. These refugee committees were later infiltrated by various political factions such as Fatah loyalists and dissidents aligned to different power brokers in the region such as the Shi'ites, Hezbollah, Maronites and the Arab Socialist Baathists to control the camps for political reasons.

South-east Asia

The south-eastern Asia region is a refugee-prone area with large numbers of refugees concentrated in the Meakong countries. A number of countries such as Indonesia, Malaysia, Myanmar, Thailand and Vietnam, in the WHO geographical region of south-east Asia have generated or hosted most refugees since 1960 but are not signatories to the 1951 Refugee Convention and its 1967 Protocol. Out of the 11 countries in south-east Asia, only Cambodia, China, the Philippines and Timor-Leste are signatories to the 1951 Refugee Convention. However, the region's member states have put in place several mechanisms to address the refugee burden. Such mechanisms include the International Covenant on Economic, Social and Cultural Rights, the Comprehensive Plan of Action (CPA), the Bali Process on People Smuggling, Trafficking in Persons and Related Transnational Crime, and the Emergency Transit Agreement between the UNHCR and the government of the Philippines. Although all the mechanisms are not refugee-specific, they have provisions for refugees.

The CPA began in 1989 and ended in 1997. It was a refugee mechanism that replaced an earlier commitment made by 65 countries at a UN conference on Indochinese refugees in Geneva in July 1979 to respond to the burgeoning refugee crisis in south-east Asia. The crisis mainly involved boat loads of refugees fleeing from repressive regimes in Cambodia, Laos and Vietnam. In a study of the 1970s to 1980s refugee crisis in south-east Asia, Robinson (2004) noted that the Indochinese conference committed itself to resettle refugees from the first countries of asylum, halt the refoulement of boatloads of refugees and speed up refugee processing to decongest

the overcrowded camps in the region. Inadvertently, the third-country resettlement policy led to a further influx of boat loads of refugees in the region which outweighed the Indochinese conference commitments by 1998. Ten years after the Indochinese conference, the CPA was adopted by 70 countries in a follow-up conference held in Geneva to address the protracted Indochinese refugee situation in the region (Francis and Maguire, 2013). The CPA was funded by the international donor community and implemented by the UNHCR. It hinged on promoting cooperation between affected countries which included refugees' countries of origin (mainly Cambodia, Vietnam and Laos), countries of asylum or transit (predominantly Malaysia, Hong Kong, Thailand and Indonesia) and final countries of settlement (mainly in North America, Europe and Australia). The success of this cooperation was premised on the desire to reduce illegal departures and clamp down on people smugglers, to provide first asylum to all arrivals and establish their status until a durable solution is found, to apply international standards in determining the refugee status for all asylum seekers, to resettle all those meeting requirements for a refugees status in third countries and to repatriate those found to be ineligible for a refugee status (Robinson, 2004). This cooperation promoted international cooperation on resettlements and ended the turning away of refugees on boats and pushing them back to sea by the affected countries. It further prevented loss of refugee lives at sea and led to significant reductions in the number of asylum seekers. However, it also introduced the controversial regional screening and forced repatriation of those deemed ineligible.

Since the end of the CPA, new migration trends such as people smuggling which affect refugees emerged in Asia. In 2002, the UNHCR supported by Australia advanced a new regional mechanism known as the Bali Process on People Smuggling, Trafficking in Persons and Related Transnational Crime which is still ongoing (Francis and Maguire, 2013; Piper, 2005). The Bali Process was founded by a coalition of 45 Asian and Oceania countries together with UNHCR and the International Organisation for Migration (The Bali Process Regional Support Office, 2015). The main objectives of the Bali Process have been to address the causes of migration, combat people trafficking and smuggling, assist victims of human trafficking; and promote the principles of the 1951 Refugee Convention. Since inception, it has attracted more membership from Europe, South Africa

and international agencies such as the United Nations Office of Drug and Crime, European Commission and the International Committee of the Red Cross among others. Recently, Rohingya refugees fleeing Myanmar have been stuck at sea because Indonesia, Malaysia and Thailand were refusing to welcome and process them. Instead the boats are being pushed back to the sea. These events suggest that the Bali Process is not effective in addressing people smuggling and illegal movement of people in the region (Human Rights Watch, 2015).

Other important regional mechanisms in the refugee affairs include the 2009 Emergency Transit Agreement (ongoing) between the International Organisation for Migration (IOM), UNHCR and the government of the Philippines. The agreement established mechanisms for processing refugees at risk of refoulement and those awaiting processing and resettlement to third countries (International Organisation for Migration, 2009). Specific areas covered under the agreement have included transporting refugees to and from the Philippines, refugees' health care, and preparation for life in third countries. The agreement is unique in that it provides for the evacuation of refugees at high risk of refoulement to the Philippines for protection (International Organisation for Migration, 2009).

The Americas

The Americas have emerged from serious conflicts and oppressive regimes through the 1980s and 1990s which displaced large numbers of refugees especially in Guatemala, Argentina, Chile and Uruguay. The region has implemented various mechanisms addressing broad issues such as human rights which also cover refugees. The main mechanisms include the Inter-American Commission on Human Rights, the American Convention on Human Rights and the Centre for Justice and International Law (CEJIL). These play different but critical roles complementing each other in the protection of refugees.

The Inter-American Commission on Human Rights was the first regional mechanism to protect human rights and was created in 1959 during the Fifth Meeting of Consultation of Ministers of Foreign Affairs of the Organization of American States (OAS) in Santiago and became operational in 1960 (Scheman, 1965). The Commission was established to promote and

monitor human rights among member states, and handle petitions on human rights violations and recommend measures for improving human rights. Additionally, the Commission was tasked to report on its performance, document member states' human rights records and advise member states on matters of human rights. The Commission, which is still functional, operates within the framework of each member state's constitution and laws which in some instances contradict the Commissions' own constitution as validated in Haiti where the repressive regime used laws to violate citizens' rights (Goldman, 2009). Although the Commission was later on augmented by the Inter-American Human Rights Court in 1978 to investigate and prosecute human rights abuses (Buergenthal, 1982), it lacks the authority to police and enforce appropriate action for non-compliant member states. It relies on the moral sanction of naming and shaming human rights violators through its reports that it made public (Fox, 1988). The Commission performs a dual mandate as a charter body of the OAS and as a Convention agency whose activities and involvement are confined within the member states of the American Convention on Human Rights.

The American Convention on Human Rights (the Pact of San José) is an ongoing regional human rights mechanism that was adopted in 1969 after a long period of negotiations and refinement by member states (Fox, 1973). The Pact obliges member states to respect the rights and freedom of their citizens without discrimination and where necessary adopt appropriate legislation to guarantee the citizens' rights and freedoms (The Organisation of American States, 1969). The strength of the Pact lies in the assurance of guaranteeing socio-cultural as well as political and civil rights, and articulating how these rights should be protected (Goldman, 2009). The Pact also unites the efforts of American states to pursue the ideals of democracy and to promote social justice for all (Fox, 1973). The Pact is monitored by the Inter-American Commission on Human Rights and the Inter-American Court of Human Rights to ensure compliance by the member states. However, some of the criticisms of the Pact include the duplication of roles of the Inter-American Commission on Human Rights, especially the latter's jurisdictional court. Goldman (2009) observed that the Pact is one of the most ambitious regional mechanisms to guarantee maximum citizens' rights especially in member states where constitutions and domestic laws have not pronounced themselves on the subject matter.

The Center for Justice and International Law (CEJIL) is a private organisation advocating for the protection of human rights in the region. CEJIL was created in 1991 in Caracas by a group of individuals motivated by the desire to equip human rights advocates with the capacity to navigate the complex regional mechanisms to seek justice for those whose rights and freedom guaranteed by the Inter-American System were violated (Centre for Justice and International Law, 2014). CEJIL provides pro-bono services to victims of human rights abuses who would otherwise be denied the opportunity to seek justice in their own countries (Centre for Justice and International Law, 2014). CEJIL's objectives include responding to state-orchestrated human rights violations, promoting equality before the law, strengthening the region's democratisation process and promoting access to the Inter-American mechanisms (Centre for Justice and International Law, 2015). Since the end of the civil wars that plagued the Americas in the 1980s and 1990s, CEJIL has led various initiatives towards negotiating mutual settlements that have underpinned the improvement of member states' human rights records (Baluarte, 2006). Additionally, CEJIL plays a critical role in monitoring the performance of the Inter-American organisations and the implementation of the recommendations of the Inter-American Commission and its jurisdictional court to ensure justice for human rights victims. Some of the CEJIL's acclaims include the championing of the pioneer Brazilian law on violence against women (Centre for Justice and International Law, 2014) and compelling Peru to withdraw amnesty from individuals who violated human rights on a large scale during the armed conflict that raged between 1980 and 2000 (Sikkink and Walling, 2007).

Social and health policy response

One of the best known frameworks to guide the humanitarian response to refugees' needs is the SPHERE project. It specified minimum standards in humanitarian assistance based on evidence, experience and best practice. However, policy discussions on refugee health are often considered with limited understanding of the local context of health service provision. There have been some successful country policies that have improved refugee access to health service information, health care and cultural

competency. We explore some randomly selected examples of country refugee policies to reflect diversity in social response and geographic representation:

Pakistan has a national policy operationalised in July 2013 specifically to address the social and health needs of Afghan refugees, who make up the majority of refugees in its borders. The policy focuses on safety and dignity, voluntary repatriation and support to host communities (Khan, 2014). Prior to this policy, Pakistan's federal laws were silent on refugees and relied on the Foreigners Order of October 1951. The Foreigners Order was enshrined into Pakistani domestic laws and gave power to immigration and custom officers at Pakistan's borders to grant or deny entry into Pakistan. The Foreigners Order stipulated that foreigners not in possession of a passport or valid visa to Pakistan, or those who have not been exempted from passport and visa requirements can be denied entry. This mainly affected refugees who often fled their domiciles to enter Pakistan without any relevant travel documents. The Foreigners Order did not articulate the basis to grant or deny entry of asylum seekers and refugees and their protection. The Foreigners Order restricted refugee movements beyond gazetted areas and areas of residence (National Legislative Bodies/National Authorities, 1951). In July 2013, the government operationalised a new national policy specifically for Afghan refugees in anticipation of the withdrawal of NATO forces from Afghanistan in 2014. NATO's withdrawal was expected to trigger a further influx of refugees into Pakistan due to perceived increases in insecurity. In spite of the Foreigners Order and the new policy on Afghanistan refugees, Pakistan still lacks a comprehensive policy covering all aspects of refugees under its care.

Islamic Republic of Iran promotes a holistic approach to enhance prospects of permanent solutions especially for protracted refugee situations (UNHCR, 2015c). Article 155 of the Iranian Constitution recognised political refugees provided they are not traitors or criminals under the Iranian law. In 1963, Iran instituted a legal framework on refugees that was supplemented by the ratification of the Refugee Convention in 1976. In the same year, Iran commissioned a special Bureau of Aliens and the Foreign Immigrant Affairs to oversee refugee matters such as the provision of health care, education and resettlement (Alborzi, 2006).

Kenya enacted a Refugee Act in 2006 to enable the implementation of the 1951 Refugee Convention and its 1967 Protocol, together with the 1969 African Refugee Convention. The Act classified refugees into two groups, namely, the statutory refugees and prima facie refugees. Statutory refugees are those defined in paragraph 1A(1) of the 1951 Refugee Convention and refers to the categories of refugee before, during and shortly after The Second World War (Maynard, 1982). Prima facie refugees are recognised based on the obvious conditions that caused their influx (Rutinwa, 2002). In other words, it is the country's mechanism to manage admission, protection and provision of humanitarian assistance to large groups of refugees that come under its care. The Refugee Act laid out the conditions for the exclusion and withdrawal of refugee status which included those who have committed crimes either outside or within Kenya, have dual nationality and are able to seek refuge in their second country of origin or people from places where the factors that led to them seeking refuge no longer exist. The Refugee Act established a Department for Refugee Affairs (DRA) to coordinate and manage refugee-related matters including refugee health care and protection. The DRA is responsible for policy development, coordinating international assistance, receiving and processing applications for refugee status, registration, issuing identity cards and travel documents, and management of refugee camps (Government of Kenya, 2006).

Ethiopia is a signatory to the 1951 Refugee Convention and its 1967 Protocol. It is also a signatory to the 1969 African Refugee Convention. Article 55(1) of the Ethiopian Constitution provides the same level of refugee recognition and protection as the 1951 Refugee Convention (Government of Ethiopia, 2004). However, provisions for refugees' integration in the community are limited as the law maintains reservations on matters pertaining to refugees' employment. Nonetheless, the law allows refugees to live outside camps and engage in informal livelihood opportunities. It also provides for refugees' health care and education.

Turkey is one of the original signatories to the 1951 Refugee Convention but still maintains a selective preference of only refugees from Europe (Burch, 2013). Refugees from other regions are not entitled to protection in Turkey. However, its geographical location between Asia and Europe as

well as its good living conditions make it an attractive destination for refugees and a transit point to Europe. Under Turkey's refugee law, non-European refugees must apply only for "temporary asylum" to remain in Turkey while their claims are evaluated (Burch, 2013). As they wait for processing, refugees are required to live only in gazetted areas and to seek police permission to travel outside of the gazetted area. While non-European applicants found to be genuine refugees are referred to UNHCR for resettlement, European applicants found to be genuine refugees are provided the same level of health care as that are accorded to Turkish natives at no cost. Unregistered refugees and those living outside the gazetted areas are not permitted to access free health care and other essential services (World Health Organisation, 2014c). Nonetheless, the preference of European over non-European is discriminatory and leaves non-European refugees without protection while they wait for the processing of their application and resettlement. This waiting period is often characterised by harsh conditions which push many of them to attempt to enter Europe illegally, and those who are caught trying to escape are subject to refoulement (Levitan, 2009).

Lebanon does not have refugee legislation and commensurate institutions to address refugees' needs and is not a signatory to the 1951 Refugee Convention and its 1967 Protocol (Crisp *et al.*, 2009). This could be attributed to a precedent set by the 1948 mass arrival of Palestinian refugees who remained indefinitely. Ratifying the 1951 Refugee Convention or its 1967 Protocol would compel Lebanon to accept and protect more refugees from the country's politically turbulent neighbours. Refusing to ratify the 1951 Refugee Convention and institutionalise local mechanisms to protect refugees did not stop the influx of new refugees especially from Iraq and Syria. Instead, it has created a vacuum that is bridged by non-state actors, local communities as well as the private sector which provide refugee services such as health care. Similarly, the government has realised that ignoring the existence of refugees within its borders was counterproductive and has since decided to provide refugees with free access to public primary health care. However, the country's health care system is often overstretched and inefficient. The secondary health care system is privatised and too costly for refugees (Crisp *et al.*, 2009).

Conclusion

Refugees are a product of failed political systems and require political solutions. Refugees continue to be a significant strain on the host countries' social protection as host governments struggle to respond to the needs of their own constituencies while at the same time fulfilling their international obligations to refugees. As the mass movement of refugees continues, those that host them in large numbers will get overwhelmed while the refugee push factors remain unaddressed across regions. While there has been significant improvements in refugee protection as reflected in the reduced mortalities and morbidities, there is still need to research into how to improve wellbeing especially in protracted refugee conditions given that some of the refugees will never experience a durable solution in their lifetime. For example, Palestinian refugees have lived in camps across the Middle East since 1948 and Bhutanese refugees have lived in camps in eastern Nepal since the early 1990s. Therefore, the integration of humanitarian and political solutions should be paramount to any humanitarian response in CHEs because apolitical humanitarianism has only focused on reducing the suffering of refugees while failing to address causes of refugee conditions.

References

- Aaby, P. *et al.* (1984). Overcrowding and intensive exposure as determinants of measles mortality. *American Journal of Epidemiology*, 120(1), 49–63.
- Abu Sa'Da, C. & Serafini, M. (2013). Syria crisis—humanitarian and medical challenges of assisting new refugees in Lebanon and Iraq. *Forced Migration Review*, 44, 70–73.
- Adelman, H. (1982). Politics and refugees: The United Nations Relief and Works agency for Palestine refugees in the near east. *Refuge: Canada's Journal on Refugees*, 1(8), 1–4.
- African Commission on Human and Peoples' Rights (1999). *Grand Bay (Mauritius) declaration and plan of action*, 1999. ACHPR, Banjul, GAM. Available at: <http://www.achpr.org/instruments/grandbay/>. Accessed 29 May 2015.
- African Commission on Human and Peoples' Rights (2004). *Special rapporteur on refugees, asylum seekers, migrants and internally displaced persons*. ACHPR, Banjul, GAM. Available at: <http://www.achpr.org/mechanisms/refugees-and-internally-displaced-persons/>. Accessed 25 May 2015.
- African Union (2002). Protocol relating to the establishment of the peace and security council of the African Union, 9 July 2002. Available at: <http://www.refworld.org/docid/3f4b1d374.html>. Accessed 28 May 2015.

- Alborzi, M.R. (2006). *Evaluating the Effectiveness of International Refugee Law: The Protection of Iraqi Refugees*. Martinus Nijhoff Publishers, Leiden, NED.
- Amara, A. & Aljunid, S. (2014). Noncommunicable diseases among urban refugees and asylum-seekers in developing countries: A neglected health care need. *Globalization and Health*, 10, 1–14.
- Anderson, J. *et al.* (2011). The burden of malaria in post-emergency refugee sites: A retrospective study. *Conflict and Health*, 5(1), 1752–1505.
- Andresen, E. *et al.* (2014). Malnutrition and elevated mortality among refugees from South Sudan — Ethiopia, June–July 2014. Centres for Diseases Control, Atlanta, GA. Available at: <http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6332a5.htm>. Accessed 5 April 2015.
- Baluarte, D.C. (2006). Inter-American justice comes to the Dominican Republic: An island shakes as human rights and sovereignty clash. *Human Rights Brief*, 13(2), 7.
- Barnett, L. (2002). Global governance and the evolution of the international refugee regime. *International Journal of Refugee Law*, 14(2–3), 238–262.
- Bartholomeusz, L. (2009). The mandate of UNRWA at sixty. *Refugee Survey Quarterly*, 28(2–3), 452–474.
- Beaton G.H. *et al.* (1993). Effectiveness of vitamin A supplementation in the control of young child morbidity and mortality in developing countries. United Nations Administrative Committee on Coordination, Sub-committee on Nutrition State-of-the-Art Series: Nutrition Policy. Discussion Paper No. 13.
- Bellos, A. *et al.* (2010). The burden of acute respiratory infections in crisis-affected populations: A systematic review. *Conflict and Health*, 4, 1–12.
- Berry-Koch, A. *et al.* (1990). Alleviation of nutritional deficiency diseases in refugees. *Food & Nutrition Bulletin*, 12(2), 106–112.
- Bigot, A. *et al.* (1997). *Refugee Health: An Approach to Emergency Situations*. MacMillan Education Ltd, London, UK.
- Brennan, R.J. & Nandy, R. (2001). Complex humanitarian emergencies: A major global health challenge. *Emergency Medicine*, 13(2), 147–156.
- Buergenthal, T. (1982). The Inter-American court of human rights. *American Journal of International Law*, 76(2), 231–245.
- Burch, J. (2013). Turkey has new law on asylum, but sets limits for non-Europeans. Reuters, Ankara, TUR. Available at: <http://www.reuters.com/article/2013/04/12/us-turkey-refugees-idUSBRE93B0XO20130412>. Accessed 6 March 2005.
- Cardozo, B.L., *et al.* (2004). Karenni refugees living in Thai-Burmese border camps: Traumatic experiences, mental health outcomes, and social functioning. *Social Science & Medicine*, 58(12), 2637–2644.

- Centre for Justice and International Law (2014). The selection process of the Inter-American commission and court on human rights: Reflections on necessary reforms. CEJIL, Buenos Aires, ARG. Available at: https://cejil.org/sites/default/files/Position%20Paper%20No.%2010_3.pdf. Accessed 10 May 2015.
- Centre for Justice and International Law (2015). Mission, vision and principal objectives. Washington, D.C. Available at: <https://cejil.org/en/cejil/about-cejil>. Accessed 10 May 2015.
- CDC (1989). Nutritional status of Somali refugees in Eastern Ethiopia, September 1988–May 1989. *Morbidity and Mortality Weekly Report*, 38, 455–456.
- CDC (1992). Famine-affected, refugee, and displaced populations: Recommendations for public health issues. *Morbidity and Mortality Weekly Report*, 41, No. RR-13. US Epidemiology Program Office. Public Health Service; US Department of Health and Human Services.
- CDC (1993). Mortality among newly arrived Mozambican refugees–Zimbabwe and Malawi, 1992. *Morbidity and Mortality Weekly Report*, 42(24), 468. US Epidemiology Program Office. Public Health Service; US Department of Health and Human Services.
- CDC (2001). Surveillance of mortality during a refugee crisis–Guinea, January–May 2001. *Morbidity and Mortality Weekly Report*, 50(46), 1029. US Epidemiology Program Office.
- Cheung, E. *et al.* (2003). An epidemic of scurvy in Afghanistan: Assessment and response. *Food & Nutrition Bulletin*, 24(3), 247–255.
- Coffey, J.T. *et al.* (2002). Valuing health-related quality of life in diabetes. *Diabetes Care*, 25(12), 2238–2243.
- Collyer, M. (2005). Secret agents: Anarchists, Islamists and responses to politically active refugees in London. *Ethnic and Racial Studies*, 28(2), 278–303.
- Coninx, R. (2007). Tuberculosis in complex emergencies. *Bulletin of the World Health Organization*, 85(8), 637–640.
- Connolly, M.I.A. *et al.* (2004). Communicable diseases in complex emergencies: Impact and challenges. *The Lancet*, 364(9449), 1974–1983.
- Crisp, J., *et al.* (2009). Surviving in the city: A review of UNHCR's operation for Iraqi refugees in urban areas of Jordan, Lebanon and Syria. UNHCR, Geneva, SWI.
- Croxton, D. (1999). The peace of Westphalia of 1648 and the origins of sovereignty. *The International History Review*, 21(3), 569–591.
- Culhane-Pera, K.A. *et al.* (2009). Cardiovascular disease risks in Hmong refugees from Wat Tham Krabok, Thailand. *Journal of Immigrant and Minority Health*, 11(5), 372–379.
- Dabbagh, A., *et al.* (2009). Global measles mortality, 2000–2008. *Morbidity and Mortality Weekly Report*, 58(47), 1321–1326.

- Desenclos, J.-C., *et al.* (1989). Epidemiological patterns of scurvy among Ethiopian refugees. *Bulletin of the World Health Organization*, 67(3), 309.
- Diaz, T. & Achi, R. (1989). Infectious diseases in a Nicaraguan refugee camp in Costa Rica. *Tropical Doctor*, 19(1), 14–17.
- Duffield, M. (1994). *Complex emergencies and the crisis of developmentalism*. Institute of Development Studies, University of Sussex, Brighton, UK.
- Dybdahl, R. (2001). Children and mothers in war: An outcome study of a psychosocial intervention program. *Child Development*, 72(4), 1214–1230.
- Elliott, J. (2015) Survival management: Syrian refugees living with diabetes face extraordinary challenges. Médecins Sans Frontières, Canada. Available at: <http://www.msf.ca/en/article/survival-management-syrian-refugees-living-with-diabetes-face-extraordinary-challenges>. Accessed 3 June 2015.
- Fawzi, W.W. *et al.* (1993). Vitamin A supplementation and child mortality: A meta-analysis. *Journal of the American Medical Association*, 269, 898–903.
- Food and Agricultural Organisation (2006). Integrated food security and humanitarian phase classification (IPC) framework. FAO's Agriculture and Development Economics Division (ESA), Rome, ITA. Available at: ftp://ftp.fao.org/es/ESA/policybriefs/pb_03.pdf. Accessed 5 May 2015.
- Fox, D. T. (1973). Convention on human rights and prospects for United States ratification. *Human Rights*, 3(2), 243–281.
- Fox, D. T. (1988). Inter-American commission on human rights finds United States in violation. *American Journal of International Law*, 82(3), 601–603.
- Fox, S.H. & Tang, S.S. (2000). The Sierra Leonean refugee experience: Traumatic events and psychiatric sequelae. *The Journal of Nervous and Mental Disease*, 188(8), 490–495.
- Francis, A. & Maguire, R. (2013). Shifting Powers: Protection of refugees and displaced persons in the Asia pacific region. In: Francis, A. & Maguire, R. (eds.), *Protection of Refugees and Displaced Persons in the Asia Pacific Region*, Ashgate Publishing, Farnham, UK. pp. 1–11.
- Friedman, C. & Spiegel, P. (2000). West Timor mission report, January 24–March 2, 2000. United Nations High Commissioner for Refugees and Centers for Disease Control, Kupang, WTI.
- Glasziou, P.P., Mackerras, D.E. (1993). Vitamin A supplementation in infectious diseases: A meta-analysis. *British Medical Journal*, 306, 366–370.
- Glynn, I. (2011). The genesis and development of article 1 of the 1951 refugee convention. *Journal of Refugee Studies*, 25(1), 134–148.
- Goldman, R.K. (2009). History and action: The Inter-American human rights system and the role of the Inter-American commission on human rights. *Human Rights Quarterly*, 31(4), 856–887.

- Goma Epidemiology Group (1995). Public health impact of Rwandan refugee crisis: What happened in Goma, Zaire, in July, 1994? *Lancet*, 345(8946), 339–344.
- Gordon, J.S., et al. (2004). Treatment of posttraumatic stress disorder in post war Kosovo high school students using mind-body skills groups: A pilot study. *Journal of Traumatic Stress*, 17(2), 143–147.
- Government of Ethiopia (2004). Proclamation No. 409/2004 of 2004, Refugee Proclamation. Federal Negarit Gazeta, Addis Ababa, ETH.
- Government of Kenya (2006). *The refugee act*. Gazette Supplement, Nairobi, KEN.
- Hanafi, S. (2010). Governing Palestinian Refugee Camps in the Arab East. Issam Fares Institute for Public Policy and International Affairs, AUB, Beirut, LEB.
- Hanafi, S. & Hassan, I.S. (2009). Constructing and governing Nahr el-Bared camp. An 'ideal' model of exclusion. *Majallat al-Dirasat al-Falastiniyya (Journal of Palestine Studies)*. Beirut: Institute of Palestine Studies, 78, 39–52.
- Hanafi, S. & Long, T. (2010). Governance, governmentality, and the state of exception in the Palestinian refugee camps of Lebanon. *Journal of Refugee Studies*, 23(2), 134–159.
- Hankins, C.A., et al. (2002). Transmission and prevention of HIV and sexually transmitted infections in war settings: Implications for current and future armed conflicts. *Aids*, 16(17), 2245–2252.
- Hansch, S. (1999). Enhancing the nutritional quality of relief diets overview of knowledge and experience: Background paper prepared for the Workshop by the Congressional Hunger Center, April 1999. Congressional Hunger Center, Washington DC. Available at: http://pdf.usaid.gov/pdf_docs/pnadj175.pdf. Accessed 6 May 2015.
- Hartigan, K. (1992). Matching humanitarian norms with cold, hard interests: The making of refugee policies in Mexico and Honduras, 1980–1989. *International Organization*, 46(03), 709–730.
- Hassan, K., et al. (1997). Factors associated with anaemia in refugee children. *The Journal of Nutrition*, 127(11), 2194–2198.
- Holmes, D. (2014). Chronic disease care crisis for Lebanon's Syrian refugees. *Lancet Diabetes Endocrinol*, 3(2), 102.
- Human Rights Watch (2015). Southeast Asia: accounts from Rohingya boat people. HRW, New York, NY. Available at: <http://www.hrw.org/news/2015/05/27/south-east-asia-accounts-rohingya-boat-people>. Accessed 1 June 2015.
- Inter-Agency Standing Committee (2014). Inter-agency standing committee: Concise terms of reference and action procedures. IASC, Geneva, SWI. Available at: <http://www.humanitarianinfo.org/iasc/pagelocator.aspx?page=about-default>. Accessed 8 May 2015.

- International Organisation for Migration (2009). Philippine government, IOM, UNHCR Sign refugee transit agreement. IOM, Manila. Available at: <https://www.iom.int/news/philippine-government-iom-unhcr-sign-refugee-transit-agreement>. Accessed 9 May 2015.
- Kemmer, T.M., *et al.* (2003). Iron deficiency is unacceptably high in refugee children from Burma. *The Journal of Nutrition*, 133(12), 4143–4149.
- Keetharuth, S.B. (2009). Major African legal instruments. In: Bösl, A. and Diescho, J. eds. *Human Rights in Africa: Legal Perspectives on their Protection and Promotion*. Macmillan Education Namibia, Windhoek, NAM.
- Khan, A.M. (2014). Pakistan's national refugee policy. *Refugee Migration Review*, 46 (May 2014), 22.
- Kimbrough, W., *et al.* (2012). The burden of tuberculosis in crisis-affected populations: A systematic review. *The Lancet Infectious Diseases*, 12(12), 950–965.
- Klugman, J. (1999). Social and economic policies to prevent complex humanitarian emergencies: Lessons from experience. United Nations University & World Institute for Development Economics Research, Helsinki, FIN.
- Kouadio, I.K. *et al.* (2010). Measles outbreaks in displaced populations: A review of transmission, morbidity and mortality associated factors. *BMC International Health and Human Rights*, 10(1), 5.
- Layne, C.M. *et al.* (2001). Trauma/grief-focused group psychotherapy: School-based post war intervention with traumatized Bosnian adolescents. *Group Dynamics: Theory, Research, and Practice*, 5(4), 277.
- Levitan, R. (2009). Refugee protection in Turkey. *Forced Migration Review*, 32, 56–57.
- Luxemburger, C. *et al.* (2003). Beri-beri: The major cause of infant mortality in Karen refugees. *Transactions of the Royal Society of Tropical Medicine and Hygiene*, 97(2), 251–255.
- Magan, A. M. *et al.* (1983). An outbreak of scurvy in Somali refugee camps. *Disasters*, 7(2), 94–96.
- Malfait, P. *et al.* (1993). An outbreak of pellagra related to changes in dietary niacin among Mozambican refugees in Malawi. *International Journal of Epidemiology*, 22(3), 504–511.
- Maynard, P.D. (1982). The legal competence of the United Nations High Commissioner for Refugees. *International and Comparative Law Quarterly*, 31(3), 415–425.
- McGready, R. *et al.* (2001). Postpartum thiamine deficiency in a Karen displaced population. *The American Journal of Clinical Nutrition*, 74(6), 808–813.
- Médecins Sans Frontières (2014). Treating chronic diseases among Syrian refugees. Available at: <http://www.doctorswithoutborders.org/news-stories/field-news/treating-chronic-diseases-among-syrian-refugees>. Accessed 26 May 2015.

- Mollica, R.F. *et al.* (2004). Mental health in complex emergencies. *The Lancet*, 364(9450), 2058–2067.
- Mukirya Nyanduga, B.T. (2006). Special rapporteur on refugees, asylum seekers, migrants and internally displaced persons. African Commission on Human and Peoples' Rights. Banjul, GAM.
- National Legislative Bodies/National Authorities, 1951. Foreigners order, 1951. National Assembly of Pakistan. Available at: <http://www.refworld.org/docid/3ae6b4f717.html>. Accessed 5 March 2015.
- Neuner, F. *et al.* (2004). A comparison of narrative exposure therapy, supportive counseling, and psychoeducation for treating posttraumatic stress disorder in an African refugee settlement. *Journal of Consulting and Clinical Psychology*, 72(4), 579.
- Noiriel, G. (1991). *La Tyrannie du National. Le Droit d'Asile en Europe 1793–1993*. Calmann-Le'vy, Paris, FRA.
- Okoth-Obbo, G. (2001). Thirty years on: A legal review of the 1969 OAU refugee convention governing the specific aspects of refugee problems in Africa. *Refugee Survey Quarterly*, 20(1), 79.
- O'Meara, W.P. (2010). Changes in the burden of malaria in sub-Saharan Africa. *Lancet Infectious Diseases*, 10, 545–555.
- Onyut, L.P. *et al.* (2009). Trauma, poverty and mental health among Somali and Rwandese refugees living in an African refugee settlement — an epidemiological study. *Conflict and Health*, 3(6), 90–107.
- Paardekooper, B.P. (2002). *Children of the Forgotten War: A Comparison of Two Intervention Programs for Promotion of Well-being of Sudanese Refugee Children*. Vrije Universiteit Academic Proefschrift, Amsterdam, NED.
- Paquet, C. & Hanquet, G. (1998). Control of infectious diseases in refugee and displaced populations in developing countries. *Bulletin de l'Institut Pasteur*, 96(1), 3–14.
- Peteet, J. (1987). Socio-political integration and conflict resolution in the Palestinian camps in Lebanon. *Journal of Palestine Studies*, 16(2), 29–44.
- Piper, N. (2005). A problem by a different name? A review of research on trafficking in South-East Asia and Oceania. *International Migration*, 43(1–2), 203–233.
- Plewes, K. *et al.* (2008). Low seroprevalence of HIV and syphilis in pregnant women in refugee camps on the Thai–Burma border. *International Journal of STD & AIDS*, 19(12), 833–837.
- Porter, J.D. *et al.* (1990). Measles outbreaks in the Mozambican refugee camps in Malawi: The continued need for an effective vaccine. *International Journal of Epidemiology*, 19(4), 1072–1077.

- Porter, M. & Haslam, N. (2005). Predisplacement and postdisplacement factors associated with mental health of refugees and internally displaced persons: A meta-analysis. *Journal of American Medical Association*, 294(5), 602–612.
- Prinzo, Z.W. and De Benoist, B. (2002). Meeting the challenges of micronutrient deficiencies in emergency-affected populations. *Proceedings of the Nutrition Society*, 61(02), 251–257.
- Ramakrishnan, U. & Semba, R.D. (2008). Iron deficiency and anaemia. In: Semba, R. & Bloem, M. (eds.), *Nutrition and Health in Developing Countries*, 2nd edn. Humana Press, Totowa, NJ.
- Redfield, P. (2005). Doctors, borders, and life in crisis. *Cultural Anthropology*, 20(3), 328–361.
- Reeler, A.P. & Immerman, R. (1994). A preliminary investigation into psychological disorders among Mozambican refugees: Prevalence and clinical features. *The Central African Journal of Medicine*, 40(11), 309–315.
- Richards, A.K. *et al.* (2009). Cross-border malaria control for internally displaced persons: Observational results from a pilot programme in eastern Burma/Myanmar. *Tropical Medicine & International Health*, 14(5), 512–521.
- Riga, J.F. (1989). Defenses for sanctuary movement: A humanitarian plea falling upon deaf ears. *Boston College International and Comparative Law Review*, 12(1), 225–263.
- Robinson, N. (1953). *Convention Relating to the Status of Refugees: Its History, Contents and Interpretation*. Institute of Jewish Affairs, New York, NY.
- Robinson, W.C. (2004). The comprehensive plan of action for Indochinese refugees, 1989–1997: Sharing the burden and passing the buck. *Journal of Refugee Studies*, 17(3), 319–333.
- Rubin, R.R. & Peyrot, M. (1999). Quality of life and diabetes. *Diabetes/Metabolism Research and Reviews*, 15(3), 205–218.
- Rutinwa, B. (1996). The Tanzanian government's response to the Rwandan emergency. *Journal of Refugee Studies*, 9(3), 291.
- Rutinwa, B. (2002). Prima facie status and refugee protection. UNHCR, Geneva, SWI.
- Sabin, M. *et al.* (2003). Factors associated with poor mental health among Guatemalan refugees living in Mexico 20 years after civil conflict. *Journal of the American Medical Association*, 290(5), 635–642.
- Sahli-Fadel, M. (2012). Report of the mechanism of the Special Rapporteur on rights of refugees, asylum seekers and internally displaced and migrants in Africa since its creation. African Commission on Human & Peoples' Rights, Yamoussoukro, CIV.
- Salama, P. *et al.* (2004). Lessons learned from complex emergencies over past decade. *The Lancet*, 364(9447), 1801–1813.

- Save the Children UK (1997). *Household Food Assessment of Shudunabari and Bedlangi Refugee Camps, Jhapa District, South-East Nepal*. Save the Children UK, London.
- Sayigh, R. (1995). Palestinians in Lebanon: Harsh present, uncertain future. *Journal of Palestine Studies*, 25(1), 37–53.
- Scheman, L.R. (1965). The Inter-American commission on human rights. *The American Journal of International Law*, 59(2), 335–344.
- Schofield, C. & Ashworth, A. (1996). Why have mortality rates for severe malnutrition remained so high? *Bulletin of the World Health Organization*, 74(2), 223.
- Seal, A.J. *et al.* (2005). Iron and vitamin A deficiency in long-term African refugees. *The Journal of Nutrition*, 135(4), 808–813.
- Semba, R.D. (1998). The role of vitamin A and related retinoids in immune function. *Nutrition Reviews*, 56(1), S38–S48.
- Shears, P. *et al.* (1987). Epidemiological assessment of the health and nutrition of Ethiopian refugees in emergency camps in Sudan, 1985. *British Medical Journal*, 295(6593), 314–318.
- Sikkink, K. & Walling, C.B. (2007). The impact of human rights trials in Latin America. *Journal of Peace Research*, 44(4), 427–445.
- Spiegel, P., *et al.* (2002). Health programmes and policies associated with decreased mortality in displaced people in postemergency phase camps: A retrospective study. *The Lancet*, 360(9349), 1927–1934.
- Spiegel, P.B. (2004). HIV/AIDS among conflict affected and displaced populations: Dispelling myths and taking action. *Disasters*, 28(3), 322–339.
- Spiegel, P.B. *et al.* (2007). Prevalence of HIV infection in conflict-affected and displaced people in seven sub-Saharan African countries: A systematic review. *The Lancet*, 369(9580), 2187–2195.
- Spiegel, P.B. *et al.* (2011). Notes from the field: Mortality among refugees fleeing Somalia — Dadaab Refugee Camps, Kenya, July – August 2011. Centres of Disease Control, Atlanta, GA. Available at: <http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6033a4.htm>. Accessed 5 April 2015.
- Spiegel, P. *et al.* (2012). Health programmes and policies associated with decreased mortality in displaced people in post emergency phase camps: A retrospective study. *Lancet*, 360, 1927–1934.
- Sutter, R.W. & Haeffliger, E. (1990). Tuberculosis morbidity and infection in Vietnamese in Southeast Asian refugee camps 1, 2. *American Review of Respiratory Diseases*, 141, 1483–1486.
- Talley, L. *et al.* (2001). An investigation of increasing mortality among Congolese refugees in Lugufu camp, Tanzania, May–June 1999. *Journal of Refugee Studies*, 14(4), 412–427.

- Tang, S.S. & Fox, S.H. (2001). Traumatic experiences and the mental health of Senegalese refugees. *The Journal of Nervous and Mental Disease*, 189(8), 507–512.
- Thabet, A.A. *et al.* (2005). Group crisis intervention for children during ongoing war conflict. *European Child & Adolescent Psychiatry*, 14(5), 262–269.
- The Bali Process Regional Support Office (2015). The Bali process on people smuggling, trafficking in persons and related crime. RSO, Bangkok, THA. Available at: <http://www.baliprocess.net/files/RSO/RSO%20Information%20Sheet%20-%20Bali%20Process%20Conclusions.pdf>. Accessed 1 June 2015.
- The Organisation of American States (1969). American convention on human rights “Pact of San Jose, Costa Rica” (B-32). San Jose, CRA. Available at: <http://www.mindbank.info/item/1254>. Accessed 10 May 2015.
- Tomczyk, B., *et al.* (2004). Emergency nutrition and mortality surveys conducted among Sudanese refugees and Chadian villagers in North East Chad, June 2004. Centre for Disease Control, Atlanta, GA.
- Toole, M.J. & Waldman, R.J. (1988). An analysis of mortality trends among refugee populations in Somalia, Sudan, and Thailand. *Bulletin of the World Health Organization*, 66(2), 237–247.
- Toole, M. J. *et al.* (1989). Measles prevention and control in emergency settings. *Bulletin of the World Health Organization*, 67(4), 381–388.
- Toole, M.J. & Waldman, R.J. (1990). Prevention of excess mortality in refugee and displaced populations in developing countries. *Journal of American Medical Association*, 263, 3296–3302.
- Toole, M. (1992). Micronutrient deficiencies in refugees. *The Lancet*, 339(8803), 1214–1216.
- Toole, M.J. *et al.* (1989). Measles prevention and control in emergency settings. *Bulletin of the World Health Organization*, 67(4), 381.
- United Nations (2010). Peace and security cluster: Report to the 11th session of the regional coordination mechanism (RCM-Africa). NEPAD, Addis Ababa, ETH. Available at: <http://www.nepad.org/system/files/PeaceandSecurity.pdf>. Accessed 20 May 2015.
- United Nations (2014). Report of the United Nations High Commissioner for refugees covering the period 1 July 2013–June 2014. United Nations, New York, NY.
- United Nations Children’s Fund (2014). Joint Nutrition Assessment Syrian Refugees in Lebanon. UNHCR, UNICEF and WFP, Amman, JDN. Available at: <https://data.unhcr.org/syrianrefugees/download.php?id=4600>. Accessed 20 May 2015.
- UNHCR (2008a). 2008 Annual report: East and horn of Africa. United Nations High Commissioner for Refugees, Geneva, SWI.
- UNHCR (2008b). UNHCR’s strategic plan for malaria control 2008–2012. United Nations High Commissioner for Refugees, Geneva, SWI.

- UNHCR (2010). The convention and protocols relating to the status of refugees. United Nations High Commissioner for Refugees, Geneva, SWI. Available at: <http://www.unhcr.org/protect/PROTECTION/3b66c2aa10.pdf>. Accessed 21 July 2015.
- UNHCR (2013a). Inter-agency regional response for Syrian refugees in Jordan host communities and Za’Atri refugee camps. United Nations High Commissioner for Refugees, Amman, JDN. Available at: <https://data.unhcr.org/syrianrefugees/download.php?id=2744>. Accessed 20 May 2015.
- UNHCR (2013b). Joint nutrition and health surveys Dollo Addo refugee camps. United Nations High Commissioner for Refugees, ARRA, WFP, UNICEF, SC-I, ACF, IMC, GOAL, Addis Ababa, ETH.
- UNHCR (2014). War’s human cost: UNHCR global trends 2013. United Nations High Commissioner for Refugees, Geneva, SWI.
- UNHCR (2015a). Statistical online population database. United Nations High Commissioner for Refugees, Geneva, SWI. Available at: <http://www.unhcr.org/pages/4a013eb06.html>. Accessed 3 April 2015.
- UNHCR (2015b). State parties to the 1951 convention relating to the status of refugees and the 1967 protocol. United Nations High Commissioner for Refugees Available at: <http://www.unhcr.org/3b73b0d63.html>. Accessed 4 May 2015.
- UNHCR (2015c). 2015 UNHCR country operations profile — Islamic Republic of Iran. United Nations High Commissioner for Refugees, Geneva, SWI. Available at: <http://www.unhcr.org/pages/49e486f96.html>. Accessed 5 March 2015.
- UNRWA (2009). The Gaza labour market in 2008: A briefing paper. December 2009. United Nations Relief Works Agency. Available at: <http://www.unrwa.org/userfiles/201001196450.pdf>. Accessed 29 April 2015.
- United Nations Office for the Coordination of Humanitarian Affairs (1999). *Orientation Handbook on Complex Emergencies*. United Nations, New York, NY.
- United Nations System Standing Committee on Nutrition (2004). Nutrition information in crisis situations: Report No. 2 — summary. Available at: <http://apps.who.int/disasters/repo/13489.pdf>. Accessed 4 May 2015.
- Van Ommeren. *et al.* (2005). Mental and social health during and after acute emergencies: Emerging consensus? *Bulletin of the World Health Organization*, 83(1), 71–75.
- Wietse, A.T. *et al.* (2008). School-based mental health intervention for children affected by political violence in Indonesia: A cluster randomized trial. *Journal of the American Medical Association*, 300(6), 655–662.
- Woodruff, B.A. *et al.* (2006). Anaemia, iron status and vitamin A deficiency among adolescent refugees in Kenya and Nepal. *Public Health Nutrition*, 9(01), 26–34.
- World Health Organization (1999). Thiamine deficiency and its prevention and control in major emergencies. Report No: WHO/NHD/99.13. Department of Nutrition for Health and Development, WHO, Geneva, SWI.

- World Health Organization (2000). Pellagra and its prevention and control in major emergencies. WHO, Geneva, SWI.
- World Health Organisation. (2005). *Malaria Control in Complex Emergencies: An Inter-agency Field Handbook*. WHO, Geneva, SWI.
- World Health Organisation (2008). East and horn Africa 2008 annual report. WHO, Geneva, SWI. Available at: <http://www.unhcr.org/4b506cca9.html>. Accessed 4 April 2015.
- World Health Organisation. (2011). Global status report on non communicable diseases 2010. WHO, Geneva, SWI.
- World Health Organisation. (2014a). World malaria report 2014. WHO, Geneva, SWI.
- World Health Organisation. (2014b). Noncommunicable diseases country profiles 2014. WHO, Geneva, SWI.
- World Health Organisation. (2014c). WHO donor snapshot–Turkey: January–June 2014. WHO, Geneva, SWI.
- Young, H. & Jaspars, S. (2006). The meaning and measurement of acute malnutrition in emergencies: A primer for decision-makers. Overseas Development Institute (ODI). Humanitarian practice network (HPN).
- Zimmet, P. (2003). The burden of type 2 diabetes: Are we doing enough? *Diabetes & Metabolism*, 29(4), 6S9–6S18.