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United Nations interagency health-needs-assessment mission

Southern Turkey, 4–5 December 2012

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Joint Mission of WHO, UNFPA, UNHCR, UNICEF and IOM

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Abstract

On 4–5 December 2012, a United Nations interagency health-needs-assessment mission was conducted in four of the 14 camps for Syrians under temporary protection of the Turkish Government in southern Turkey: two in the Gaziantep province (İslahiye and Nizip camps), and one each in the provinces of Kahramanmaraş (Central camp) and Osmaniye (Cevdetiye camp). The mission, which was organized jointly with the World Health Organization (WHO), the Ministry of Health of Turkey and the Disaster and Emergency Management Presidency of the Prime Ministry of Turkey (AFAD), the United Nations Populations Fund (UNFPA), the United Nations Children's Fund (UNICEF), the Office of the United Nations High Commissioner for refugees (UNHCR) and comprised representatives of the International Organization for Migration (IOM). It was coordinated by WHO.

The primary goals of the mission were: to gain a better understanding of the capacities existing in the camps, including the health services provided, and the functioning of the referral system; and, on the basis of the findings, identify how the United Nations agencies could contribute to supporting activities related to safeguarding the health of the more than 138 000 Syrian citizens living in Turkey at the time of the mission.

The mission team found that the high-level Turkish health-care services were accessible to and free of charge for all Syrians under temporary protection, independent of whether they were living in or outside the camps. Possible areas of United Nations' support were related to: meeting the health and protection needs of the refugees; strengthening preventive public health efforts; setting up an integrated disease early-warning system (EWARN); improving health-information management; facilitating data-sharing; expanding the community-based mental-health and psychosocial support services; and running health-promotion and advocacy campaigns.

Keywords
Delivery of health care
Emergency medical services
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Health priorities
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Executive summary

Fig. 1. Entrance to Nizip camp

Source: WHO.

On 4–5 December 2012, a United Nations interagency health-needs-assessment mission was carried out in four of the 14 camps for Syrians under temporary protection in southern Turkey: two in Gaziantep province (Nizip (Fig. 1) and İslahiye), and one in each of the provinces of Kahramanmaraş (Central camp) and Osmaniye (Cevdetiye camp). The mission, which was organized jointly with the World Health Organization (WHO), the Ministry of Health of Turkey and the Disaster and Emergency Management Presidency of the Prime Ministry of Turkey (AFAD) and coordinated by WHO, the United Nations Populations Fund (UNFPA), the United Nations Children's Fund (UNICEF), the Office of the United Nations High Commissioner for refugees (UNHCR) and comprised representatives of the International Organization for Migration (IOM).

At the time of the mission, more than 138 000[1] Syrian citizens seeking temporary refuge in Turkey were accommodated in 14 camps along the Turkish—Syrian border.

The aim of the mission was to assess the potential public health needs of the Syrians under temporary protection in Turkey and the services provided by the Turkish health authorities.

[1] The figures included in the report are those, which were available or provided to the team at the time of the mission (4—5 December 2012).

During the mission, the team was accompanied by representatives of the local and national health authorities (Annex 1). Before visiting the camps, the team was briefed by the health authorities on the organization of the camps, the number of people accommodated and the provision of health care (Fig. 2). The team also met with the Governor of the Osmaniye province (Fig. 3).

Fig. 2. Briefing by local authorities on camp organization

Fig. 3. Meeting between mission team and Governor of Osmaniye province

Source: WHO.

The level of health-care services in Turkey is high. According to the Ministry of Health, in accordance with AFAD circular no. 374 of 18 February 2013, all health-care services are provided free of charge to Syrian refugees registered in the camp sites whether they reside inside or outside them. This means that those living in the camps, and many of the estimated 80 000 living with host families or privately, have access to primary, secondary and tertiary health services and health entitlements on a par with Turkish citizens. According to health officials at the Gaziantep Sehit Kamil Hospital, free access to health services had also been granted to Syrian citizens not registered in camps.

Health issues were fully addressed by the emergency and curative services provided 24/7 in the health centres run by the Ministry of Health in the camps. These health centres were complemented by field hospitals linked to a hospital-referral system at the district, provincial and regional levels. In addition, the Ministry of Health had developed public health programmes. At the time of the mission, preparations for winter were well underway in the camps.

The Turkish Government was planning to establish several new camp sites as more Syrians were expected to seek shelter and protection in Turkey because of the continuing conflict in the Syrian Arab Republic.

The findings of the mission will be used in further consultation with the Turkish Ministry of Health, AFAD, the Ministry of Foreign Affairs of Turkey and the local authorities to determine how the United Nations agencies in general, and WHO in particular, could:

- provide technical support and guidance to address potentially evolving public health needs and gaps;
- strengthen the sustainability and preparedness of the health-care services and the health system at large;
- develop, with support from the donor community, strategic approaches and targeted projects aimed at mobilizing resources to assist Turkey in ensuring the continuity of health services for the Syrian population under temporary protection on Turkish territory.

The mission team highly appreciated and acknowledged the enormous efforts of the Government of Turkey to provide comprehensive health services to the Syrian refugees. However, emergency and curative health services are costly and the number of people to be catered for in the near future was likely to increase further. Therefore, the findings of the mission should translate into concrete proposals to help the Government of Turkey to sustain health services for the Syrian refugees, further develop disease-surveillance and early-warning systems and psychosocial-support services, and maintain the high level of health services provided without compromising services for the host population.

The mission team concluded that the main health needs had been addressed by the primary-care (emergency and curative) services provided directly in the camps through health centres and field hospitals, and fully integrated into the system of referral to secondary- and tertiary-care hospitals. As mentioned above, all Syrian citizens in the camps, as well as those living with families or privately outside the camps, had free access to all health services and essential curative treatment.

As regards public health aspects, the mission members consulted with the Ministry of Health on potential technical areas of collaboration in which United Nations agencies could support the Ministry's efforts and strengthen its public health programmes. Particular emphasis was placed on the importance of advocating for the harmonization and alignment of public health programmes with internationally recommended health-response standards (e.g. those of the Minimum Initial Service Package (MISP) for Reproductive Health in Crisis Situations developed by the Interagency Working Group for Reproductive Health and WHO).

The mission team very much appreciated the organizational arrangements made by the Turkish Government for this mission and the continued assistance and quality of health-care services provided to the Syrian population under temporary protection on Turkish territory.

Background

In June 2011, in the aftermath of the Arab Spring, a political crisis evolved in the Syrian Arab Republic, which resulted in an estimated 1.2 million people fleeing their homes and more than 500 000 people seeking shelter in neighbouring countries. An estimated 260 000 Syrians fled to Turkey. The majority were accommodated in camps along the Turkish—Syrian border; others found shelter with relatives or friends, or in rented apartments. Over 50 000 Syrians have opted to return voluntarily to the Syrian Arab Republic at various intervals since the onset of the crisis. Syrians in Turkey fall under the temporary protection regime declared by the Government of Turkey, which guarantees an open-border policy and allows the admission of Syrians seeking protection, including protection against forcible return (non-refoulement), and the provision of protection without individual refugee-status determination.

By early December 2012, 14 camps in seven provinces (Adiyaman, Gaziantep, Hatay, Kahramanmaras, Kilis, Osmaniye and Sanliurfa) were hosting more than 138 000 Syrians, more than five times the number registered in early June 2011.[2] An estimated 80 000 Syrians were accommodated outside the camps.

In addition to this influx of Syrian citizens, Turkey had experienced an unprecedented increase in the number of asylum applications over the previous 20 months, mainly from Iraqi and Somali nationals. In December 2012, the number of non-Syrian asylum seekers and refugees exceeded 40 000, putting an additional strain on the country's protection environment, which UNHCR continues to support in terms of reception, registration, refugee-status determination and assistance. These population groups were not assessed during the interagency mission.

Since the onset of the Syrian population influx in summer 2011, the Turkish authorities' emergency-response system has mobilized substantial internal resources to provide a consistently high standard of services. Newly arriving Syrians are swiftly accommodated in camps set up with the support of the Turkish Red Crescent Society. Camp populations have thus been provided with food, shelter, non-food items and medical assistance without interruption. Yet, while in 2011, the Government of Turkey indicated that it had sufficient capacity to deal with the influx alone, by April 2012, a significant increase in numbers prompted it to accept support from international organizations in the form of core-relief items for Syrian refugees. In connection with the June 2012 revision of the Regional Response Plan for Syrian Refugees (RRP), the Government made a formal request to the international community for further support. Therefore, the international agencies updated their financial requirements in the revised RRP to this end.

[2] By 6 February 2013, 176 962 Syrians were accommodated in 15 camps.

Aim and expected results of the mission

The aim of the mission was to obtain an overview of the health situation, the environmental challenges and the living conditions of the Syrians under temporary protection in Turkey to enable better targeting of future United Nations' and donor support to the Government of Turkey in the area of health. The mission would also try to assess the additional resources required to accommodate a potentially increasing number of Syrians under temporary protection and, at the same time, maintain the high standard of health services provided to the Syrians under temporary protection and the Turkish host population.

WHO is fully committed to further exploring and developing technical-support projects to facilitate the strengthening of public health services. The work, which would be carried out jointly with the Ministry of Health of Turkey and United Nations partners, would support the broader agenda of conflict resolution and build on experiences connected with the "health-as-a-bridge-for-peace" framework[3] and the protection of human rights.

The expected results of the mission were: identification of the short-, medium- and long-term priorities regarding technical support to the Government of Turkey in strengthening public health services; development of joint projects to mobilize donor support, ensuring continued high-quality health services for all Syrians under temporary protection without compromising the health services for the host population; and documentation of the substantial efforts made by the Turkish Government to provide high-quality health services to the Syrian population under temporary protection.

Mission details: participants and itinerary

Eighteen representatives of and technical experts from four United Nations agencies (UNFPA, UNHCR, UNICEF and WHO) and IOM comprised the mission team; they were accompanied by six representatives of the Turkish Ministry of Health (Annex 1). WHO, as the leading United Nations health agency, took responsibility for coordinating the mission.

On 4 December 2012, the mission commenced with a visit to the Provincial Health Directorate of Gaziantep where Dr Abdülkadir Özbek, Head of Department for Disaster and Emergency Management, Ministry of Health, and Professor Dr Metin Karakök, Provincial Health Director,

Provincial Health Directorate, Ministry of Health, briefed the team. The team was given an overview of the situation in Gaziantep province at the time, including details of the health services provided to the

[3] Information available: http://www.who.int/hac/techguidance/hbp/about/en/ (accessed 1 April 2013).

Syrian population residing temporarily in camps on Turkish territory. Up to the time of the mission (4—5 December 2012), the Government of Turkey had been providing comprehensive services, including a broad range of preventive and curative health services, to the approximately 200 000 population estimated to be living in Turkey. However, the situation had developed and the Government had requested international support to be able to continue and sustain these services until it was safe for the population to return to the Syrian Arab Republic.

During the first day, the mission team visited two camps in Gaziantep province, Nizip camp and İslahiye camp. In each camp, the team met with the camp coordinators and representatives of the local health authorities (Annex 2).

On 5 December 2013, the team paid a visit to Kahramanmaraş province (Central camp) and Osmaniye province (Cevdetiye camp). Briefings were given by representative of the local health authorities; visits to the camp facilities followed.

Mission findings

5.1 General information

The findings of the mission are based on facts presented by local officials and people living in the camps. They are structured according to a pre-agreed questionnaire and detailed separately for each camp site visited. A general summary of the findings is presented at the end of each chapter.

The Government of Turkey had mobilized 24 new ambulances to complement the 68 provided by the General Directorate of Emergency Health Services of the Ministry of Health, bringing the total to 92. The ambulances were primarily used for medical transfers from the border to the camps or from the camps to referral hospitals. These additional medical resources were fully integrated into the routine referral system to avoid establishing a parallel system. Thirty to forty physicians had been deployed as surge capacity to support the southern provinces hosting Syrian population.

Syrians seeking health care in Turkey could be grouped as follows:

- people who had fled to Turkey and were living in camps;
- people (registered or unregistered) who were benefiting from temporary protection in Turkey and receiving free health care in accordance with Article 14 of letter no. B-10-0-TGH-0-09-00-04/38845 of the General Directorate of Primary Health Care Services of 21 September 2011 concerning derogation from general practice, and AFAD circular no. 374 of 18 January 2013;
- people who had come to Turkey for medical treatment with or without referrals from Syrian hospitals;
- people who were wounded.

Initially, only Syrian patients with camp registration cards (in some camps magnetic registration cards are provided), or who had been referred by Syrian hospitals, were entitled to medical treatment and pharmaceuticals free of charge. However, as of 5 December 2012, Syrians residing outside camps became eligible to free health services in hospitals in the border region.

The primary-health-care (PHC) services were linked to the public-hospital network in municipalities close to the camp sites. There was a well-established network of referral institutions, including tertiary-care hospitals, with no apparent capacity gaps. Hospital referrals appeared to be well coordinated through a centralized dispatch system within the network of facilities, and capable of effectively managing increased loads of patients (Syrian and Turkish). Hospitalization, including surgical treatment and non-emergency interventions, was provided to Syrians free of charge, including those living in urban settings.

Each of the camps visited had sufficient PHC capacity to provide on-site curative and emergency care and to address the basic acute and chronic health needs of the Syrians. Each camp had one health centre, or a medical facility in tents and prefabricated or permanent buildings, providing health services with the capacity to manage an average of 60 patients per physician per day. Maternal-and-child-health services, including antenatal and postnatal care and immunization services (expanded programme on immunization (EPI)), were integrated. The system was built on the Turkish PHC set-up and was, thus, fully integrated into the national system. Additional staffing requirements were covered by the Ministry of Health with an allocation of 30—40 physicians (general practitioners and specialists), nurses and auxiliary staff from its public-hospital network. Interpreters (Syrians under temporary protection) were available in all camps to work with the health professionals in the polyclinics and facilitate service delivery.

There was a routine health-screening protocol for newly arriving Syrians under temporary protection.

5.1.1. Epidemiological profile

The main acute morbidities recorded among the camp population were:

- acute respiratory infections;
- gastroenteritis/ diarrhoea;
- hepatitis A and B;
- skin infections.

Regarding communicable diseases with epidemic potential, an episode of a higher-than-usual case-load of hepatitis A patients was reported, triggering an alert. The Ministry of Health initiated consecutive response measures, including preventive measures and vaccination campaigns in the affected areas.

The main chronic conditions recorded were:

- hypertension;
- ischemic heart disease;
- diabetes;
- chronic obstructive lung disease.

In some of the camps visited, the preventive services, including hygiene promotion, health education with active community participation, and psychosocial support, seemed not yet to be fully established and would benefit from enhanced attention. While a routine disease-surveillance system captures syndromes, such as acute gastroenteritis/diarrhoeal disease, jaundice, rashes, acute respiratory illness and specific diseases, such as measles, malaria, leishmaniasis and tuberculosis.

The early-warning system in Turkey was mostly event-based and case-based. In this regard, all of the information collected was duly assessed, together with relevant data collected from the refugee camps, related provinces and other national and international sources. Relevant units of the Ministry of Health were involved in providing comprehensive and coordinated response to all public health issues detected.

Laboratory services were readily available in the camps' polyclinics; more sophisticated samples were sent to the referral hospitals. A regular system of reporting health data collected at the provincial level to the central level was in place.

EPI and antenatal services were well established. Screening for malnutrition and nutrition deficiencies was primarily clinically based, rather than community based.

The reported prevalence of tuberculosis (TB) in the Syrian Arab Republic was 23 per 100 000 population in 2011 (WHO estimate), including cases of multi-drug-resistant TB (MDR-TB). In Jordan, 16 cases of TB were diagnosed among a Syrian population of 40 634 screened, equalling a prevalence of 39/100 000 population.[4] Active screening for TB in the Turkish camps had been initiated not long before the mission took place and 3250 male and 3050 female Syrians had been screened in Gaziantep province. Five were classified as suspicious cases, one of which was eventually diagnosed with TB. In Adıyaman, no TB cases had been detected among 6750 people screened. TB screening was ongoing in Kahramanmaraş. Two active TBC cases had been detected through screenings conducted up to the time of the mission; it was reported that treatment of these cases and chemoprophylaxis for eight family members had been started.

Malaria screening was carried out in Osmaniye province during the summer of 2012; no cases had been identified.

Essential medications for acute and chronic conditions were provided free of charge. Sufficient stocks of pharmaceuticals and medical supplies were available and hospitals had sufficient routine stocks to cover a six-month period.

Translators were available and working with health professionals in all camp polyclinics to facilitate services.

5.1.2 Maternal and child health

Health services for mothers and newborns were integrated, in the context of reproductive health, into PHC activities within the well-established routine health-services delivery structure. In their contact with health-care workers, the mission team promoted and advocated for the use of MISP, including: the prevention and management of sexual and gender-based violence; the reduction of HIV transmission; the decline of maternal and neonatal mortality and morbidity; and planning for comprehensive reproductive-health services, including a basic, functioning information system.

Family-planning activities had started in the camps but physicians and nurses seemed not to be completely familiar with the specific family-planning needs in the refugee context, particularly in relation to the post-abortion and post-partum services, which are essential in camp situations. Community-based counselling was only partly available and special training on reproductive health was limited. The recording system for antenatal and postnatal care required considerable revision. The information system also needed fine-tuning to better capture the age distribution of pregnant women and new mothers. Pregnant women were only registered and monitored if they sought health services in polyclinics, one of the reasons for the overall lower-than-expected numbers of registered pregnant women usually seen in camp settings. Vitamin A was provided to pregnant women and they were seen by a doctor at least twice during their pregnancies if they are registered at polyclinics. All deliveries were conducted in hospitals. Data on pregnancies, births and miscarriages were available. Premature births had not been recorded at the same rate as, for instance, was the case in Lebanon, although there were commonalities.

According to the Ministry of Health, there had been no reports about gender-based violence from within the camps. The authorities took care to group families and ethnicities together to minimize possible

[4] Source: Reliefweb [web site]. IOM regional response to the Syria crisis, December 2012. Geneva, United Nations Office for the Coordination of Humanitarian Affairs, 2012.

violence. Midwives and social workers visited the tents daily and reported any suspected domestic violence. According to the Ministry of Health, no problems relating to substance abuse had been recorded.

Counselling services for young people were limited and there was a gap in youth-friendly services. The health needs of adolescents were only partly addressed.

5.1.3 Psychosocial support

The Ministry of Health informed the team about the psychosocial support services that were available in all camps, regardless of possible language problems. In Hatay, the local population knows Arabic and, should a language barrier arise, AFAD would arrange for interpretation. However, these services had just commenced at the time of the mission and there was a lack of Arabic-speaking psychologists and psychiatrists. The social workers were not sufficiently trained to carry out psychosocial support. These psychosocial services could be enhanced and extended by establishing community-based psychosocial support services and involving the Ministry of Family and Social Policies more in the provision of counselling services in the camps.

5.1.4 Nutrition

Detailed data on malnutrition or nutritional deficiencies were not yet being collected systematically. Clinically, micronutrient deficiencies and anaemia had been observed among children and pregnant and lactating women. The extent to which acute and/or chronic malnutrition (stunting) posed a significant public health issue was difficult to assess. The Turkish health authorities were promoting breast-feeding through the midwives and other health professionals in their PHC and baby-friendly hospital facilities, including those in the camps. However, the use of breast-milk substitutes among Syrian mothers was traditionally high. Infant formula was widely available, but there were plans to increase the price of it in an effort to discourage mothers from using it. In addition, leaflets in Arabic promoting breastfeeding were to be distributed and consulting services set up to this end. The mission team proposed supporting the Turkish Government in these efforts by issuing a joint statement on infant and young-child feeding practices.

In the four camps visited, the Syrians under temporary protection were receiving pre-cooked meals three times a day. There were no communal or household cooking options. The World Food Programme (WFP) was providing food vouchers (in addition to the rations provided by AFAD) in specific locations and was in the process of expanding this programme. Food safety was being monitored by the Ministry of Health.

5.1.5 Immunization

The Turkish authorities had initially tried to accommodate the Syrian vaccination schedule (for children whose vaccination status was known). However, at the time of the mission, the Turkish vaccination schedule was being used (Annex 4) and vaccination of the Syrian children was being integrated into it (Fig. 4). As part of the measles- and polio-elimination programmes, a catch-up vaccination campaign for children below five years of age was implemented between 26 October and 10 December 2012. Children below 15 years of age who were admitted to camps were administered an MMR: Measles, Mumps, Rubella vaccine and an oral polio vaccine (OPV). In some areas of the Syrian Arab Republic, the vaccination coverage is estimated to be as low as 60%. Special measles-vaccination and catch-up campaigns, as well as routine vaccinations, had been carried out in camps earlier in 2012. Chickenpox was added to the childhood immunization schedule for Turkey not long before the mission took place and it was the intention to incorporate it into the schedule for camp populations because of the increasing numbers of cases being reported.

Fig. 4. Turkish immunization card for Syrian children

Source: WHO.

5.1.6 Environmental health

The environmental health services covered the regular testing of the quality of drinking-water and the removal of waste. All four camps visited had sufficient supplies of potable water. According to officials from the Ministry of Health, the quality of the water in camps was regularly tested several times a day and waste removal took place on a daily (in some places, weekly) basis. Camps situated next to a city were connected to the municipal public water and sewage systems and water was channelled to several distribution points in the camps. However, there were concerns about particulate matter in the drinking-water in one camp and constant problems with the showers. Sanitation facilities (showers and toilets) in camps were available either in prefabricated containers or in more durable infrastructures (Fig. 5). AFAD was aware of the wear and tear issues, and ongoing efforts were being made to replace run-down and broken latrines, showers and piping.

There was no community involvement in aspects related to water, sanitation and hygiene. Waste management, as well as cleaning and maintenance of the facilities were outsourced to private contractors. This may prevent the development of a sense of ownership among the residents and promote improper usage.

5.1.7 United Nations' involvement

At the time of the mission, UNHCR was working in 13 of the 14 camps and the Turkish Red Crescent, the Ministry of Health and AFAD were operating in all of them.

UNHCR involvement was related to: the provision of non-food items to camps, including tents, blankets and kitchen sets; monitoring the camps through daily visits; protection, registration and repatriation activities; and the provision of technical advice on camp management and related issues.

Fig. 5. Washing, toilet and bathroom facilities in a camp

Source: WHO.

WFP was involved in providing food cards to Syrians under temporary protection in Kilis and in four of the camps in Hatay; these could be used to buy food in supermarkets in Kilis and in contracted shops and supermarkets in Hatay. Not all camps had cooking facilities in the tents; most were supplied with three hot meals per day.

IOM was providing non-food items to five camps based on a list shared with the Government.

The Turkish Red Crescent was providing food and non-food items to all camp populations.

There was a misperception among the Syrians under temporary protection in camps that the Government of Turkey had received substantial financial resources from the donor community for providing camp services, which is not the case.

5.2 Gaziantep – Nizip camp

5.2.1 General information and population figures

Nizip camp , which is located some 60 km from the Syrian border, was opened on 3 October 2012 and health services started on 4 October 2012. There is no town or market near the camp, which is situated in a valley beneath a large dam.

At the time of the mission, the most recent figures (from November 2012) showed that 9063 people had been registered, of whom 498 had returned voluntarily to the Syrian Arab Republic. Table 1, relating to an earlier period, shows the breakdown of the camp population at the time.

Fig. 6. Laundry facilities at Nizip camp

Source: AFAD.

An additional 3000 people, including children, who had not been allowed to enter the camp, were awaiting transfer to other camps in a holding area adjacent to the camp.

Table 1. Population figures Nizip camp

Population	Figures
Men	2.551
Women	2.073
Boys (0-18 years)	2.174
Girls (0-18 years)	2.178
Total	8.976

Source: Ministry of Health of Turkey.

5.2.2 Health services, personnel and supplies

The camp had its own, onsite, dedicated polyclinic where physicians and health professionals communicated through interpreters. The health services provided included the monitoring and treatment of communicable and noncommunicable diseases, pregnancy monitoring, ad hoc vaccination of children, and the administration of vaccinations according to the routine schedule. Vaccination against hepatitis A had been carried out. In daytime, three family doctors and three nurses were available. On a regular basis, though not daily, a gynaecologist, a paediatrician and specialists in internal medicine visited the camp to provide specialist consultations. Acute respiratory infections were the most frequent causes of illness in children but none of the cases observed were severe. There were a few cases of neurological disorders, mainly epilepsy and convulsions. Drugs, of which there was no shortage, were prescribed free of charge. Referral patients were transferred to the district hospital in Gaziantep. One doctor and one nurse were on duty after hours to ensure 24/7 coverage. Daily access to the referral hospital was provided through a minibus shuttle. An ambulance was available 24/7 to transfer severe cases. Social workers visited the tents and provided support for those requiring psychosocial care. Medical screening took place during registration and medical check-ups were carried out during tent visits.

5.2.3 Nutritional status, food security and food safety

Cooked meals were provided three times a day; no cooking facilities were available for the Syrians under temporary protection.

5.2.4 Reproductive health and family planning

A detailed assessment of the reproductive-health and family-planning services, based on the MISP checklist, was not feasible. General observations made about the reproductive-health service are included in section 5.1.2.

Fig. 7. Laboratory facilities in the polyclinic at Nizip camp

Source: WHO.

Table 2. Status of routine vaccination of children (0–11 months), Nizip camp

Vaccination type	No. of children vaccinated
Bacille Calmette Guerin (BCG)	151
5-in-1 combination vaccine (1 dose)	243
5-in-1 combination vaccine (2 doses)	139
5-in-1 combination vaccine (3 doses)	98
Hepatitis B (1st dose)	178
Hepatitis B (2nd dose)	204
Hepatitis B (3rd dose)	118
Pneumococcal conjugate vaccine (PCV) (1st dose)	243
PCV (2nd dose)	31
PCV (3rd dose)	2
OPV	171
CCHF	202

Source: Ministry of Health of Turkey.

5.2.5 Epidemiological information and vaccination status

The epidemical profile was similar to that described in section 5.1.1. Fig. 7 depicts the laboratory facilities in the camp polyclinic. Table 2 shows the routine vaccination status provided by the Ministry of Health.

5.2.6 Environmental health

Hot water was available in the showers; washing machines and dryers were provided for the camp population. Drinking-water was tested twice weekly. Bottled water was provided to families with children up to 4 years of age. The general water source was a large dam situated above the camp. Waste was removed regularly.

5.3 Gaziantep – İslahiye camp

Fig. 8. Prefabricated health facility

Source: AFAD.

5.3.1 General information and population figures

The camp, which is situated close to İslahiye town, was opened on 20 March 2012 and the provision of health services started six days later. The camp comprised 1743 tents, of which 855 were donated by the Turkish Red Crescent and 815 by UNHCR.

All tents were of the type intended for summer use but efforts to equip them for winter (mainly through insulated floor linings) were well underway; all tents had been improved with an extra covering of insulating plastic. The mission arrived after a whole day of heavy rain. Blankets and insulated tent floors for the winter had been distributed from a warehouse. Electric heaters provided earlier had to be removed due to power-supply problems.

Syrians with registration cards were able to move freely in and out of the camp site.

Table 3 gives a breakdown of the population figures.

Table 3. Population figures, İslahiye camp

Population	Figures
Camp capacity	8000
Male	2159
Female	1993
Boys (0 – 18 years)	2282
Girls (0 – 18 years)	2090
Total	8524

Source: Ministry of Health of Turkey.

There were 1743 tents in the camp provided by the Turkish Red Crescent Society (funded by AFAD) and UNHCR; 1355 children were enrolled in the school and 21 vocational courses were ongoing.

Up to the time of the mission, 50 319 medical interventions had been carried out in the camp polyclinic and referral hospital. The camp population was served three hot meals a day by the Turkish Red Crescent Society. United Nations' activities in this camp included UNHCR staff presence 2—3 times a week to provide support on protection-related issues and observe interviews regarding voluntary repatriation. No other United Nations agency was working there as yet.

5.3.2 Health services, personnel and supplies

A tent polyclinic had been established by the Ministry of Health and, at the time of the mission, it was staffed by five family doctors, who were providing primary care services on a daily basis.

They were complemented by a specialist in internal medicine, a paediatrician and a gynaecologist, who visited the camp several times a week to provide specialist consultations. The polyclinic was an extension of the provincial referral hospital to which it was connected through a computer system by means of which patient data could be transferred and shared. A similar computer system was in place for laboratory testing. Camp officials had so far reported 120 emergency patients, 90 paediatric patients and 40 internal-medicine patients. It was possible to perform small surgical interventions in the polyclinic. X-ray and ultrasound devices were available. Translators were working with the health-care staff to facilitate the services. The referral hospital was located 5 km from the camp and patients were transferred there by ambulance.

Health campaigns, such as vaccination campaigns, were verbally announced to the camp population via loud speakers. Cases of hepatitis A and chickenpox had been recorded in the camp; quarantine tents were available.

Counselling (for women and children only) was provided by a psychologist and a psychiatrist who came to the polyclinic. There was no active case-finding so that the counselling service was not yet fully effective. The Ministry of Family and Social Policies was making arrangements to activate psychosocial services in this camp.

5.3.3 Nutritional status, food security and food safety

Hot meals were provided three times a day.

5.3.4 Reproductive health and family planning

Activities carried out in this area were as described in section 5.1.2. Psychosocial support and rehabilitation programmes were run by visiting specialists, in collaboration with hospital consultants. The Ministry of Family and Social Policies was in charge of monitoring the programmes.

5.3.5 Epidemiological information and vaccination status

The epidemiological profile corresponded to that outlined in section 5.1.1. The Ministry of Health gave the mission team the following information on the current vaccination status of the children living in the camp (Table 4).

Table 4. Status of routine vaccination of children (0–11 months), İslahiye camp

Vaccination type	No. of children vaccinated
Bacille Calmette Guerin (BCG)	314
5-in-1 combination vaccine (1 dose)	617
5-in-1 combination vaccine (2 doses)	666
5-in-1 combination vaccine (3 doses)	530
Hepatitis B (1st dose)	895
Hepatitis B (2nd dose)	1034
Hepatitis B (3rd dose)	217
Pneumococcal conjugate vaccine (PCV) (1st dose)	409
PCV (2nd dose)	61
PCV (3rd dose)	4
OPV	681
CCHF	277

Source: Ministry of Health of Turkey.

According to briefing received, preventive health screening had been carried out in the camp: 2168 children aged 0—18 months had been screened and vaccinated with seven antigens in accordance with the Turkish vaccination schedule. Children with valid Syrian vaccination cards continue to be vaccinated according to the Syrian vaccination schedule.

The main diseases prevalent were respiratory diseases, urinary tract infections, diarrheal diseases and skin infections. Chickenpox and hepatitis A had been recorded with a rise in numbers of cases in autumn 2012. On average, 120—130 children were seen by the doctors daily.

The polyclinic was operating a biochemical laboratory, with blood and urine testing. They were taking between 45 and 50 samples a day, on average three tests per patient. It was also possible to send blood samples to the reference hospital for further analysis, the results being made available to the polyclinic via computer system.

5.3.6 Environmental health

From a personal-hygiene viewpoint, there were 100 washing machines and 100 dryers available (200 families/machine) operated by camp staff. Some maintenance and improvement of the laundry facilities were needed. Drinking-water was monitored by the Ministry of Health and chlorination levels were controlled on a daily basis. Hand-washing with soap was promoted in the school; adults, however, were not being targeted. Therefore, hand-washing and showering, including the use of soap, needed to be advocated for through health-promotion activities and hygiene training.

5.3.7 General information about Gaziantep province

UNHCR had (since April 2012) had 10 field staff in Gaziantep province to provide assistance and advice on protection-related issues and monitor interviews regarding voluntary repatriation. UNHCR had also provided core-relief items (tents, blankets, kitchen sets, plastic sheeting bed mats, etc.) to the Government of Turkey through the Turkish Red Crescent Society.

Between 20 March 2012, when the first of the three camps (İslahiye, Karkamış and Nizip) in the province was opened, and end October 2012, a total of 29 672 patients received treatment in the polyclinics of these camps administered by 215 camp-based health-care workers (Tables 5 and 6). In addition to these health-care workers, specialist health services were provided mainly through specialists working in the hospitals belonging to the local referral system. An additional 309 Syrian patients were treated in private hospitals.

Table 5. Distribution of health services provided to Syrians in İslahiye, Karkamış and Nizip camps, Gaziantep province, March—October 2012

Month	No. of visits of Syrians to polyclinics	No. of Syrians hospitalized	No. of surgical interventions performed on Syrians	No. of hospital births	No. of hospital deaths
March	563	6	1	2	1
April	491	69	13	15	0
May	747	44	18	16	1
June	1 759	74	40	8	1
July	4 708	112	60	14	7
August	6 579	243	167	21	14
September	6 453	303	219	15	16
October	8 372	355	124	63	23
Totals	29 672	1 206	642	154	63

Source: Ministry of Health of Turkey.

Table 6. Type and numbers of health personnel available in İslahiye, Karkamış and Nizip camps, Gaziantep province, March—October 2012

Type of health personnel	No. available
Specialists	9
General practitioners	9
Nurses	50
Midwives	21
Health officers	91
Health technicians	15
Laboratory technicians	1
Unit heads	1
Drivers	7
Cleaners	11
Total	215

Source: Ministry of Health of Turkey.

During the same period, the camp population in the province included 1063 infants and 313 pregnant women; 2752 children aged 0—5 years were vaccinated and 142 drinking-water samples from sources in the camps were tested (including microbiological testing).

The state hospital in Gaziantep was providing tertiary care for refugees in all camps in the province and specialized services in the İslahiye, Karkamış and Nizip camps. It had a normal bed capacity of 330 but was operating with an extended capacity of nearly 500 beds; 130 medical specialists were employed. There were 11 operating theatres and several incubators; a paediatric intensive-care unit (ICU) was expected to be operational in the near future. At the time of the mission, 17 Syrians were hospitalized.

Patient registration took place at the camps, where an epicrisis form was completed and a request filed specifying the treatment and referral services required. If hospital admission was needed, relevant information specifying the hospital to which the patient should be transferred for further, specialized treatment was sent via the emergency call number, 112.

The hospital also provided various specialized surgical services, including neurosurgery, plastic-orthopaedic surgery and trauma surgery. Pregnant women were first examined at the PHC level and only then referred to the secondary or tertiary levels. They were also provided with health information. The hospital had a special room for obstetrics surgery.

At the time of the mission, the obstetrics and gynaecology ward was currently being renovated to enhance its functionality and capacity. The health-care workers were responsive to the reproductive-health needs of patients. Pregnancy termination and family planning were available, as well as appropriate counselling services.

Syrians under temporary protection generally had the same entitlements as the locals and were treated on an equal par with Turkish citizens. Even highly specialized services, such as haemodialysis, were provided, and oncological patients were treated free of charge.

5.4 Kahramanmaraş – Central camp

5.4.1 General information and population figures

The camp was opened on 9 August 2012 and, at the time of the mission, 15 525 people were accommodated there. The camp featured a social tent with gender division, as requested by the camp residents, and a children's tent. Everything appeared to be extremely well organized and clean. There were 12 979 people living inside the camp area and, because of limited space, the approximately 3000 awaiting registration in the camp's database were accommodated temporarily in a communal tent. These 3000 people were also provided with basic services, such as food and medical assistance.

Adults had the possibility of participating in Turkish-language classes, as well as in sewing sessions. All tents were being prepared for winter: insulated floor coverings were being installed and heaters distributed. Three blankets per person and carpets were also to be distributed. The camp had two children's playgrounds. The nearby municipality and local businessmen were in the process of collecting winter clothes and boots and distributing them to the Syrians under temporary protection.

Table 7 shows a breakdown of the population figures.

Table 7. Population figures: Kahramanmaraş Central camp

Population	Figures
Men	6 468
Women	6 372
Boys (under 18 years)	3 458
Girls (under 18 years)	3 338
Total	12 840

Source: UNHCR.

5.4.2 Health services, personnel and supplies

The camp polyclinic is an extension of the state hospital in the city of Kahramanmaraş (capital of Kahramanmaraş province). It was providing services related to internal medicine, gynaecology and paediatrics on a daily basis, and was staffed by three family doctors and four nurses and midwives. Of the 548 hospitalizations recorded, 155 were for surgical interventions, 144 were for deliveries and 7 were people who died. Two ambulances were available 24/7.

Since the establishment of the camp, some 6000 people had been screened for malaria but no cases had been detected. TB screening was ongoing and, at the time of the mission, two active TBC cases had been detected. It was reported that treatment of these cases and chemoprophylaxis for eight family members had started. Infants were provided with iron and vitamin D.

Measles, mumps, rubella (MMR) vaccinations had been administered to children aged 2—5 years. Two cases of leishmaniasis had been detected and treated. The following diseases and conditions were being observed (numbers diagnosed by the time of the mission shown in brackets): heart conditions (52); leukaemia (2); cancer (number not specified); orthopaedic problems (39), prostate problems (2), disabilities (10), epilepsy (3); and diabetes (137). In addition, 7 cases of partial paralysis had been diagnosed and there had been 21 deaths. A preliminary check-up showed that at least 36 people had mental health problems. There were no official data on rape, incest or domestic violence. All hospital patients were screened for hepatitis A and HIV. It was planned to employ an infectious diseases specialist in the camp. A special diet was provided for diabetes patients.

The polyclinic was distributing leaflets in Arabic promoting hygiene. It was also conducting insect-control measures (including mosquitoes), providing support to disabled persons and promoting breast-feeding. Wheelchairs and hearing aids were available. Five psychologists and one psychiatrist were covering the psychological/psychiatric services and needs.

5.4.3 Nutritional status, food security and food safety

Three hot meals a day were provided, and food safety was monitored accordingly.

5.4.4 Reproductive health and family planning

Oral contraception and condoms were available but no complementary awareness campaigns or training and counselling activities were being undertaken. In recognition of the systematic antenatal, postnatal, infant-health monitoring services existing in Kahramanmaraş province, the Ministry of Health had awarded it the status of "baby-friendly province".

There were plans to produce and disseminate a brochure in Arabic to promote breast-feeding and discourage the use of baby formula.

5.4.5 Epidemiological information and vaccination status

The Ministry of Health provided the following data regarding the vaccination status of the children in Central camp (Table 8):

5.4.6 Environmental health

Two assessment reports on the environmental health conditions in the camp had been produced by the Ministry of Health and presented to AFAD.

The water and sewage pipes were connected to the respective municipality systems; 11 samples were taken daily to measure levels of chlorine in the drinking-water and biological and chemical analyses were carried out weekly. The resulting data were submitted to the Ministry of Health.

Table 8. Vaccination status (children 0–11 months), Kahramanmaraş Central camp

Vaccination type	No. of children vaccinated
Bacille Calmette Guerin (BCG)	73
5-in-1 combination vaccine (1 dose)	262
5-in-1 combination vaccine (2 doses)	130
5-in-1 combination vaccine (3 doses)	85
Hepatitis B (1st dose)	75
Hepatitis B (2nd dose)	238
Hepatitis B (3rd dose)	57
Pneumococcal conjugate vaccine (PCV) (1st dose)	262
PCV (2nd dose)	130
PCV (3rd dose)	84
OPV	160
CCHF	137

Source: Ministry of Health of Turkey.

5.5 Osmaniye – Cevdetiye camp

5.5.1 General information and population figures

According to the UNHCR, the total population in the camp was 7795, comprising 3595 males (46%) and 4200 females (54%).

Table 9. Population figures, Cevdetiye camp, Osmaniye

Population	Figures
Men	3595
Women	4200
Boys (under 18 years)	1627
Girls (under 18 years)	1615
Total	7795

Source: UNHCR.

5.5.2 Information about health services, personnel and supplies

The polyclinic in the camp featured departments and specialist services for general medicine, paediatrics and gynaecology. Blood samples were analysed in the laboratory of the hospital in Osmaniye and the results made accessible to the camp physicians online. Dental services were also available. The polyclinic was providing services for 24 152 patients, of which 4406 were hospitalized. The main disease profiles registered related to infectious diseases (2495), gastrointestinal conditions (817), urinary conditions (373), hypertension (346) and chronic heart disease (168).

5.5.3 Nutritional status, food security and food safety

Three hot meals were provided daily and food safety was monitored.

5.5.4 Reproductive health and family planning

Reproductive-health services, such as family planning and antenatal/postnatal care were provided by PHC

staff, which also monitored hospital referrals for deliveries. All patients were registered by location and tent and followed up in accordance with the PHC recording system. Monitoring of infant growth and pregnant women was also taking place.

The Ministry of Health provided the following data, which were current at the time of the mission:

- number of infants (0–11 months): 186
- number of babies (12–60 months: 860
- number of pregnant women: 43
- number of deliveries: 12.

Fig. 10. The mission team visiting the polyclinic in Cevdetiye camp, Osmaniye.

Source: WHO.

5.5.5 Epidemiological information and vaccination status

The mission team (Fig. 10) was presented with data on the vaccination status in Cevdetiye camp (Table 10).

5.5.6 Environmental health

Samples of drinking-water were collected daily and the level of chlorine controlled. Regular biological and chemical analyses were carried out.

The camp is located in an area where vector-control measures are carried out during the summer months.

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Table 10. Vaccination status (children 0–11 months), Cevdetiye camp, Osmaniye

Vaccination type	No. of children vaccinated
Bacille Calmette Guerin (BCG)	59
5-in-1 combination vaccine (1 dose)	91
5-in-1 combination vaccine (2 doses)	65
5-in-1 combination vaccine (3 doses)	40
Hepatitis B (1st dose)	36
Hepatitis B (2nd dose)	118
Hepatitis B (3rd dose)	39
Pneumococcal conjugate vaccine (PCV) (1st dose)	90
PCV (2nd dose)	64
PCV (3rd dose)	35
OPV	45
CCHF	890

Source: Ministry of Health of Turkey.

5.6 Issues related to protection and displacement, and additional observations

5.6.1 General information

The continuous influx of people fleeing from the Syrian Arab Republic to Turkey commenced in June 2011 and increased substantially in March 2012. Buses and ambulances were used to transport people from the border crossings to camp sites, including those in Gaziantep province.

At the time of the mission, Gaziantep province was hosting a total of 23 838 Syrians under temporary protection from the Syrian Arab Republic, including 1591 ethnic Turkmen, distributed in three camps: Nizip (8976); İslahiye (8524); and Karkamış (6338). All three camps were tent camps. Preparations for winter were ongoing; in particular, reinforcement of the tent floors with insulated plastic covering and carpets. In addition, electrical heating devices had been distributed to each tent. Each inhabitant was entitled to three blankets, the distribution of which was almost complete at the time of the mission. Drinking-water, latrines, sewage disposal, heating, electricity and hot water for showers and washing were available 24/7.

The majority of the camps set up by the Turkish Government for Syrians under temporary protections — Şanlıurfa (Ceylanpınar and Akçakale), Kilis (Öncüpınar), Gaziantep (Karkamış), Hatay (Altınozu 1, Altınozu 2, Yayladağı 1 and Yayladağı 2) — were situated close to the Syrian border; several were located at a distance of 60—100 km north of the border.

General information on the camps, provided by AFAD, can be found in Annex 3.

5.6.2 Registration of refugees

The registration system varied from camp to camp. Syrians wishing to seek refuge in Turkey are initially registered at the border and assigned by the authorities to a particular camp where a more comprehensive registration process, including security checks, takes place. Family reunification is facilitated where relevant.

The Turkish authorities were using information-technology (IT) systems with identification software, including photos and personal information. While initially some Syrians under temporary protection were reluctant to be registered, it became more clearly understood that registration was an important means of accessing services and entitlements, and helpful in reuniting families. Electronic registration software, which was only

available at the Kahramanmaraş central camp at the time of the mission, also allowed for the inclusion of details about chronic diseases and medications. No routine health screening is carried out upon arrival at the camp. The Syrians under temporary protection receive plastic magnetic identity (ID) cards, allowing them to enter the camp and access medical services.

Trauma cases received at the border points are transported by ambulance to the nearest referral hospital. Pregnant women are monitored in the polyclinics at the primary care level and referred to secondary or tertiary services only if this is necessary. Syrians under temporary protection in urban locations can seek medical treatment in hospitals in the respective regions. For those formally registered in camps, the costs of such treatment are covered by AFAD. Hospital care has been free of charge for all registered camp refugees since June 2011. The postings and signs in the polyclinics are all written in Arabic, which helps those seeking clinical services.

According to Ministry of Health officials, only Syrians were registered in the camps but refugees of other nationalities who had been living in the Syrian Arab Republic prior to arrival in Turkey would be subject to the same entitlements as Syrians.

Job opportunities for the Syrian camp population were limited. Syrians under temporary protection are not covered by insurance and are, therefore, not allowed to work. However, some Syrians under temporary protection were working (and being paid) as teachers and interpreters, or engaged informally, for example, in agricultural work on nearby farms, in handicrafts, such as sewing, and in gardening activities. All cleaning and cooking services for camps are contracted out to external companies, leaving no possibility to employ Syrians under temporary protection to do this work. In Nizip camp, Syrians were assisting in food distribution for a nominal sum. The active engagement of camp residents in community services can help to develop a sense of ownership and should, therefore, be expanded and strengthened in all camp sites towards the maintenance of psychosocial well-being.

In Nizip and Osmaniye camps, persons involved in communicating the day-to-day needs of the residents to camp management had been elected to represent subunits of 20 or 30 tents.

A food market had been established in the Osmaniye camp.

Conclusions and proposed priority activities

6.1 Conclusions

The mission observed that the main health issues were fully addressed by the primary emergency and curative services provided directly in the camps through health centres and field hospitals. This includes the provision of specialized curative services through the referral system in public hospitals.

All Syrian citizens in the camps, as well as those accommodated in family homes or privately outside the camps, had full access to all health services and treatment free of charge.

The mission team discussed some specific public health issues with the Ministry of Health to determine the technical priorities for cooperation with a view to further consolidating and supporting the efforts being made through public health programmes developed by the Ministry of Health. In the light of a potential increase in health and protection needs, the health system would need to focus strongly on preventive public health care.

While routine disease surveillance was in place, it needs to be adapted to meet the particular surveillance needs of camp environments, to facilitate the quick identification of potential epidemics and the early initiation of response action.

It would be beneficial to develop a more systematic, regular approach to information exchange between the central and other levels, as well as across departments. Standardization of the registration system would contribute to enhancing the quality of the services provided.

6.1.1 Health-care indicators

The following indicators should be measured to allow monitoring of health-care services in the camps:

number of Syrians under temporary protection in Turkey covered by health monitoring and public health programmes;

- number of Syrians under temporary protection under temporary protection in Turkey benefiting from health services;
- number of local health providers with specific needs for training and technical support.
- MISP indicators.

6.1.2 Target

The target is 100% health-care coverage of the affected populations under temporary protection in Turkey.

6.2 Proposed priority activities

Based on consultations with the Turkish authorities, it is proposed that United Nations' support focus on the following action.

- To support the Turkish health authorities in: monitoring health trends; identifying emerging and evolving public health needs through regular joint assessments of camp populations; and facilitating mobilization of resources to support health-service needs. (WHO)
- To assist the Turkish health authorities in developing and strengthening public health programmes and health-promotion activities in camp settings by providing relevant training for local health providers to work in emergency situations and support for the affected populations. (UNFPA, UNICEF, WHO)
- To assist the Turkish health authorities in enhancing disease surveillance and strengthening the early-warning system to facilitate the early detection of and timely response to outbreaks of infectious diseases. (WHO)
- To support the Turkish health and social authorities in strengthening and expanding community mental-health and psychosocial support services through the training of local health and social providers in assisting the affected populations. (WHO)
- To implement awareness-raising campaigns on the importance of mental-health and psychosocial support, and of safeguarding the well-being of the refugees. (WHO, UNICEF, IOM)
- To work with the Turkish health authorities on setting up joint advocacy campaigns, for example, to promote breastfeeding, water and sanitation hygiene, etc. (UNFPA, UNICEF, WHO)
- To procure interagency emergency health kits, trauma- and other WHO medical kits, and TB diagnostic and laboratory reagents. (WHO)
- To establish a temporary United Nations office in southern Turkey to support the authorities in coordinating the work of the health partners and sharing information among them, and to ensure the integration of the necessary public health capacity and expertise. (UNFPA, UNICEF, WHO)
- To help standardize the existing registration systems and harmonize the monitoring systems, and to ensure the inclusion of evaluation and information-sharing components. (WHO, UNFPA, UNHCR, UNICEF, IOM)
- To conduct further in-depth assessments of particular aspects of the health services with the aim of ensuring that the international humanitarian health response standards, such as MISP within the context of the Sphere Project[5], are being adhered to, for example, with respect to meeting the health needs of mothers and newborn and to preventing gender-based violence. (UNFPA, UNICEF, WHO)
- To share the newly developed WHO minimum package of cross-border TB control and care with the Turkish authorities, and to conduct a technical workshop on its use. (WHO)
- To strengthen community participation and the engagement of camp residents in camp community-service activities with the aim of building a sense of ownership. (WHO, UNHCR, UNICEF, IOM)

6.2.1 Additional data requirements

Regarding the registration and monitoring of data related to reproductive health and gender-based violence in camps, information on the following should be collected on a regular basis.

1. Number of women aged 15—49.
2. Number of pregnancies and deliveries (including age distribution).
3. Number of abortions and stillbirths (including age distribution).
4. Number of couples using modern contraceptives.
5. Mixed method data for family planning services.
6. Data on distributed family-planning commodities.
7. Number of cases of sexually transmitted infections.
8. Number of antenatal/postpartum care visits.

[5] Information available: http://www.sphereproject.org/about/, accessed 9 April 20123.

9. Number of maternal deaths.
10. Number of cases of gender-based violence, subdivided under:
    a. early marriages
    b. polygamy
    c. physical violence
    d. sexual abuse/violence.

6.2.2 Proposed campaigns to be conducted in collaboration with the Government of Turkey

Breast-feeding campaign

Cases of acute malnutrition have been detected by health professionals and camp management in children and mothers arriving from the Syrian Arab Republic. The use of infant formula is common among Syrian mothers and it has not been possible to promote breastfeeding sufficiently. This should be encouraged proactively through effective awareness-raising campaigns.

Hygiene-promotion campaign

Protracted overcrowding leads to the wear and tear of sanitation facilities. The promotion of hand-washing with soap needs stronger encouragement among both children and adults. Soap and hygiene kits should be made available and hygiene campaigns should be enhanced.

Catch-up immunization campaign

Immunization services have been discontinued in some areas of the Syrian Arab Republic since the onset of the crisis. Some of the children arrive at the Turkish border were without vaccination cards, which results in broken vaccination routines. Conducting further targeted immunization campaigns should be considered.

Psychosocial support services

At the time of the mission, the provision of psychosocial support services was not systemized, and problems in this area could exacerbate. Therefore, prevention, identification and referral services in this area should be established in a systematic manner.

Annex 1
Members of the United Nations interagency health needs assessment mission and accompanying Turkish officals

United Nations interagency health needs assessment mission

WHO Regional Office for Europe

Dr Mehmet Ali Biliker
National Professional Officer, WHO Country Office, Turkey, Early Warning and Response System

Dr Ute Enderlein
WHO, Technical Officer, Country Emergency Preparedness and Response

Dr Toker Ergüder
National Professional Officer, WHO Country Office, Turkey

Ms Mevlüde Gül Keleş
Translator in WHO Country Office, Turkey

Dr Maria Cristina Profili
WHO Representative/ Head of Country Office, Turkey

Dr Gerald Rockenschaub
Programme Manager, Country Emergency Preparedness and Response

Mr Emanuele Tacconi,
Administrative Officer, WHO Country Office, Turkey

UNFPA

Mr Meltem Ağduk
Gender Programme Coordinator

Dr İlyas Derman Boztok
National Consultant for the Syrian Crisis

Dr Gökhan Yıldırımkaya
Reproductive Health Programme Coordinator

UNHCR

Ms Fatin Al-Lamii
Field Assistant/Interpreter

Mr Yiğit Anıl Gürer
Field Assistant

Mr Heiko Hering
Senior Regional Public Health and HIV Officer

Mr Baran Nedimoğlu
Senior Programme Assistant

Mr John Solecki
Senior Operations Officer

UNICEF

Ms Hande Dilaver
Programme Assistant

Mr Jan Sigismund
Emergency Coordinator

IOM

Dr Kaisa Kontunen
Migration Health Emergency Preparedness and Response Officer

Mr Mazen Aboul Hosn
IOM, Emergency/Psychosocial Officer

Non-IOM staff

Mr Murat Alpaslan
Driver (private company)

Ms Eda Güldürmez
Translator

Mr Ercan Özcan
Driver (private company)

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Accompanying Turkish officials

Ministry of Health, Ankara

General Directorate for Emergency Health Services

Professor Dr Ali Coskun
General Director

Dr Muzaffer Akkoca
Specialist, Head of Department

Dr Abdülkadir Özbek
Head of Department

Dr Murat Şimşek
Unit for Coordination with National and International Institutions

Mr Şentürk Çayır
Expert

Dr Burcu Doğan
Expert

Annex 2
Institutions and camps visited and persons interviewed

Public Hospitals Administration

Dr Hüseyin Murat Merci Mahmutoğlu
Specialist, Head of Department

Public Health Institution

Dr Özgür Erdem
Specialist, Public Health Department

Ali Göktepe
Communicable Disease Department

AFAD

Mr Fatih Özer
Head of Department

Gaziantep province

Prof Dr Metin Karakök
Provincial Health Director

Dr Selim Bülent Cansunar
Chief Physician
Sehit Kamil State Hospital

Dr Ömer Yahut
Hospital Coordinator for Syrian Crises

Dr Derya Sayar
Deputy Director of Provincial Health Directorate

Mr Hasan Tiryakioğlu
Deputy Director of Provincial Health Directorate

Nizip camp

Mr Enes Cihan Duman
Health Officer

Dr Ahmet Cinibel
Specialist Doctor, Internal Medicine

Mrs Kısmet Çelik
Midwife

Dr Gökçehan Kara
General Practitioner, Nizip Community Health Centre

Mrs Ümmühan Mutlu
Midwife, responsible for vaccination

Mrs Meral Türkmen
Midwife, responsible for vaccination

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Mr Mehmet Güven
Director of Nizip camp

İslahiye camp

Dr Ömer Faruk Güney,
Chief Doctor
Field Hospital of İslahiye camp

Dr Şeref Etcibagşi
Specialist, Family Medicine

Mr Kenan Yılmaz
Data processing officer

Mrs Hediye Güneş
Nurse

Mrs Canan İpekoğlu
Nurse

Mr Tanju Er
Laboratory technician

Dr Metin Ay
Specialist

Mrs Gülay Kaya
Interpreter

Mrs Selvin Türk
Data Processing Officer

Mr Akın Özdemir
Camp Manager, İslahiye camp

Kahramanmaraş province

Dr Mehmet İlker Çitil
Provincial Health Director

Dr Ahmet Yener
Provincial Public Health Director

Dr Kamil Türkmen
Public Hospitals Director

Mr Sadi Uzun
Deputy Provincial Director

Dr Mehmet Özdemir
Deputy Provincial Director

Mr Akif Merci
Provincial Public Health Directorate

Dr Meltem Arpasatar
Provincial Public Health Directorate

Dr Murat Coşkun
Deputy Provincial Health Directorate

Mr Ahmet Yılmaz
Provincial Health Directorate

Mr Şahin Yelek
Provincial Health Directorate

Mr Abid Başarıcı
Deputy, Provincial Health Directorate

Mrs Gürhan Çıkım
Provincial Health Directorate

Mr Ümit Gül
Provincial Health Directorate

Mrs Fadime Batur
Provincial Health Directorate

Mr Yasin Mortaş
Photographer

Kahramanmaraş camp

Mr Tuncay Akkoyun
Camp Manager and Governor of Türkoğlu District

Dr Mustafa Sakallı
Specialist

Mrs Asuman Demirören
Responsible officer for vaccination

Mrs Nurcan Taysa
Responsible officer for vaccination

Mrs Fatma Tüylü
Responsible officer for vaccination

Mrs Hatice Öztürk
Responsible officer for vaccination

Osmaniye province

Mr Celalettin Cerrah
Governor

Back

Dr Mehmet Cingöz
Provincial Health Director

Dr Alper Latif Boz
Provincial Public Health Director

Dr Cem Uraldı
Public Hospitals Director

Osmaniye camp

Dr Bilgin Akoğul
Deputy, Provincial Health Director

Mr Ali Çağlar
Deputy Governor, Camp Manager

Annex 3

Information on camps for Syrians under temporary protection in Turkey (provided by AFAD, Ankara, on 15 November 2012)

There are 14 accommodation centers in seven provinces (Adıyaman, Gaziantep, Hatay, Kahramanmaraş, Kilis, Osmaniye and Şanlıurfa). Of these, 13 are tent camps while Öncüpınar in Kilis is a container camp.

There are five tent camps in Hatay of which one is a temporary reception center. The total population in the Hatay camps is 12 437 persons (Table 1).

Table 1. Camps for Syrians under temporary protection in Hatay province

Name of camp	Population in camp	Camp established
Altınözü 1	1 194	09.06.2011
Altınözü 2	1 979	10.06.2011
Yayladağı 1	2 710	30.04.2011
Yayladağı 2	3 288	12.07.2011
Apaydın (temporary reception)	3 266	09.10.2011

There are three tent camps in the province of Gaziantep with a total population of 22 472 persons (Table 2).

Table 2. Camps for Syrians under temporary protection in Gaziantep province

Name of camp	Population in camp	Camp established
İslahiye	8 409	17.03.2012
Karkamış	6 233	28.08.2012
Nizip	7 830	03.10.2012

There are two tent camps in the province of Şanlıurfa with a total population of 40 801 persons (Table 3).

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Table 3. Camps for Syrians under temporary protection in Şanlıurfa province

Name of camp	Population in camp	Camp established
Ceylanpınar	23 774	01.03.2012
Akçakale	17 027	06.07.2012

There is one camp in each of the provinces of Adıyaman (Central), Kahramanmaraş (Central), Kilis (Öncüpınar) and Osmaniye (Cevdetiye) (Table 4).

Table 4. Camps for Syrians under temporary protection in Adıyaman (Central), Kahramanmaraş (Central), Kilis (Öncüpınar) and Osmaniye (Cevdetiye) provinces (one in each)

Name of province	Population in camp	Camp established
Adıyaman (Central)	6 084	22.09.2012
Kahramanmaraş (Central)	15 248	01.09.2012
Kilis (Öncüpınar)	13 243	17.03.2012
Osmaniye (Cevdetiye)	8 224	09.09.2012

AFAD reports that accommodation centers provide for all humanitarian needs, such as sanitation, nutrition, health, warm clothing, education, worshipping, banking and social activities.

About 22 000 children and youths have access to education services (including preschool services for 2000 children). In addition, vocational training courses in sewing, hairdressing and similar activities are offered.

Accommodation centers also offer TV rooms, internet and laundry services.

Security is ensured through police, gendarmerie and private security, as well as security cameras.

Mobile clinics, health professionals/specialists doctors, as well as ambulances, are available.

Overall, the camps accommodate a total of 118 509 persons in 26 279 shelters (24 226 tents and 2053 containers, on average 4.5 persons per shelter; the average in the Kilis Öncüpınar container camp is 6.5 persons per shelter).

In addition to those in camps, there are 703 people accommodated in hospitals (patients and accompanying persons).

Annex 4

Turkish vaccination schedule

Vaccination type	Birth	Months							Primary	
		1	2	4	6	12	18	24	1st grade	8th grade
Hep. B	I	II	-	-	III	-	-	-	-	-
BCG	-	-	I	-	-	-	-	-	-	-
DaPT—IPA—-Hib	-	-	I	II	III	-	R	-	-	-
CPV	-	-	I	II	III	R	-	-	-	-
MMR	-	-	-	-	-	I	-	-	R	-
DaPT—IPA	-	-	-	-	-	-	-	-	R	-
OPV	-	-	-	-	I	-	II	-	-	-
Td	-	-	-	-	-	-	-	-	-	R
Hep. A[a]	-	-	-	-	-	-	I	II	-	-
Chickenpox	-	-	-	-	-	I	-	-	-	-

Notes: [a]As of October 2012.

DaPT-IPA-Hib = diphtheria, acellular pertussis, tetanus, inactive polio, hemophilus influenza type B vaccine (5-in-1 combination vaccine).
MMR = measles, mumps, rubella vaccine.
OPV = oral polio vaccine.
Td = adult diphtheria—tetanus vaccine.
R = repeat dose (booster).
All vaccines in the schedule are free of charge.

The WHO Regional Office for Europe

The World Health Organization (WHO) is a specialized agency of the United Nations created in 1948 with the primary responsibility for international health matters and public health. The WHO Regional Office for Europe is one of six regional offices throughout the world, each with its own programme geared to the particular health conditions of the countries it serves.

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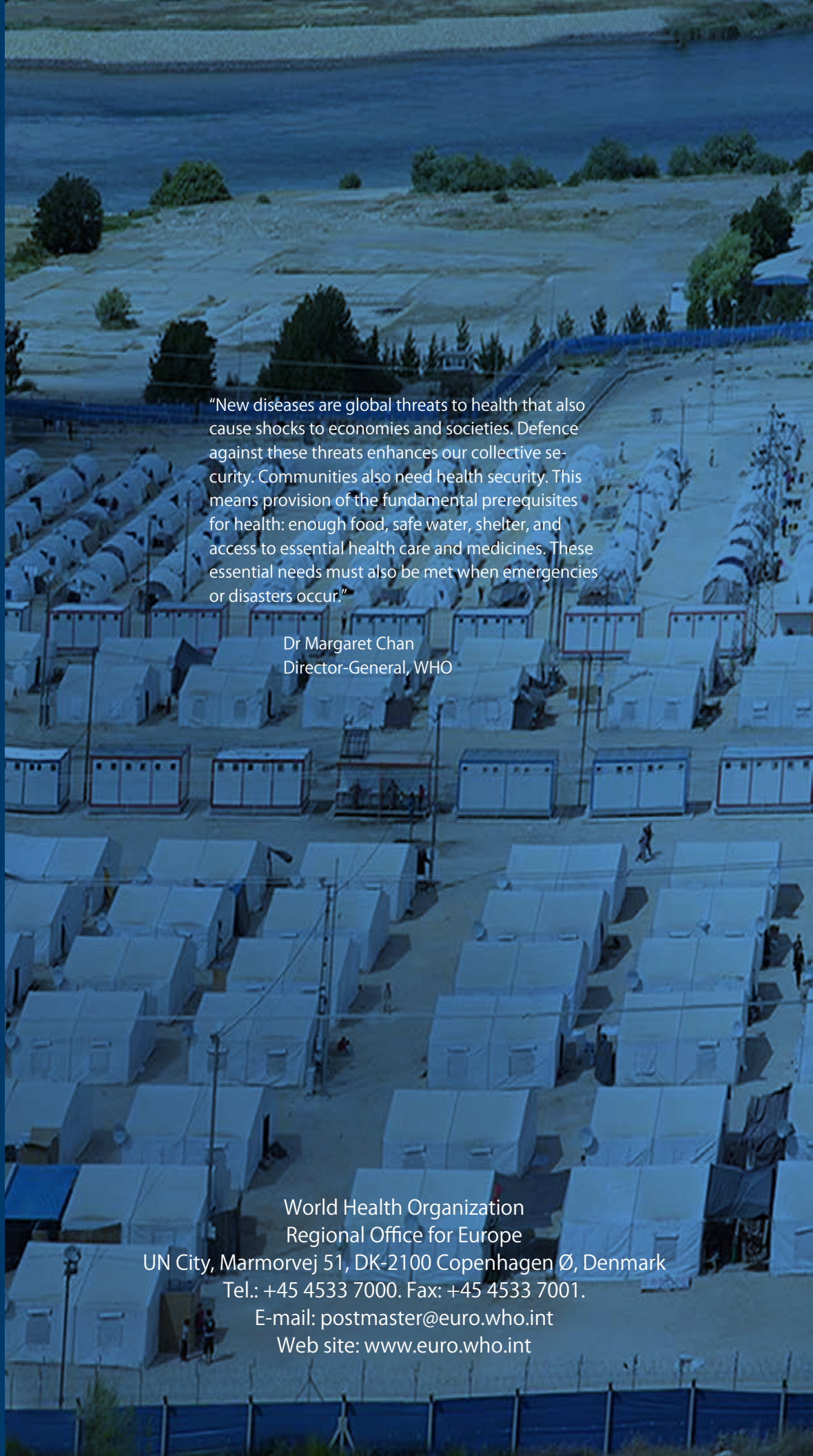

"New diseases are global threats to health that also cause shocks to economies and societies. Defence against these threats enhances our collective security. Communities also need health security. This means provision of the fundamental prerequisites for health: enough food, safe water, shelter, and access to essential health care and medicines. These essential needs must also be met when emergencies or disasters occur."

Dr Margaret Chan
Director-General, WHO

World Health Organization
Regional Office for Europe
UN City, Marmorvej 51, DK-2100 Copenhagen Ø, Denmark
Tel.: +45 4533 7000. Fax: +45 4533 7001.
E-mail: postmaster@euro.who.int
Web site: www.euro.who.int