

Humanitarian and medical challenges of assisting new refugees in Lebanon and Iraq

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The massive and continuing flows of Syrian and Palestinian refugees to Syria's neighbours have shown the limitations of humanitarian practice and present new challenges for medical and humanitarian interventions.

As the crisis in Syria continues, humanitarian needs inside and outside the country are escalating rapidly. Since the crisis began in March 2011, the ability of international organisations to provide aid inside Syria has been severely restricted. Most international agencies have therefore focused attention on the situation of those refugees who have crossed the border into Turkey, Lebanon, Jordan and Iraq. UNHCR estimates the total number of refugees – including further afield in Egypt and elsewhere – at two million people as of late August 2013.¹

The substantial impact that these two years of mass influx has had on neighbouring countries has not been addressed appropriately by the international community. Most of the present priorities and practices for health-care provision in conflict settings are still, unfortunately, based on those decades where conflict was usually synonymous with overcrowded refugee camps sheltering young populations from developing countries. Most contemporary wars, however, are taking place in higher income settings with better baseline health indicators and they are of protracted duration. These facts are profoundly changing the demography and disease profile of conflict-affected populations.

Northern Iraq

During 2012, many Syrian Kurds fled to neighbouring Iraq, to the region in the north governed by the Kurdish Regional Government (KRG). Doomiz Camp, near the Iraqi city of Dohuk, was opened in April 2012 while the central government in Baghdad opened two other camps in the southwestern part of Iraq. Eighteen

months later the assistance provided in Doomiz camp is far from acceptable. The investment in water and sanitation has never been enough, the different phases of the camp were not properly planned, very few international actors are present and there is a dramatic lack of mid- to long-term vision in anticipation of new arrivals in the camp. While the Kurdish authorities initially had a welcoming policy towards refugees, the lack of support from the international community eventually pushed them to restrict assistance in various ways, including, for example, closing the border in May 2013. The KRG has permitted refugees to access public services free of charge but these services are beginning to come under strain.

More recent clashes in eastern Syria caused the KRG authorities to reopen the border on 15 August 2013. More than 30,000 people poured into Iraqi Kurdistan over a few days, filling the newly-opened camp at Kawargost in Erbil to capacity. Two other camps are due to be opened in the area but they will only have the capacity to absorb the new influx, offering nothing to the overwhelming majority of refugees scattered in urban areas.

Lebanon

The influx of refugees to Lebanon has been in several phases. While in May 2012 there were 20,000 Syrian refugees mainly in the northern part of Lebanon, by early August 2013 there were 570,000 according to UNHCR – and around 1.3 million according to the government. In addition to the 425,000 Palestine refugees registered in Lebanon before the war, UNRWA estimates that 50,000 more have arrived from Palestinian refugee camps in Syria since the beginning

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of the war. With a total Lebanese population of an estimated 4.2 million, refugees in Lebanon now represent almost 25% of the total population. The Lebanese government, following an official policy of 'dissociation' from the Syrian conflict, has left its borders open and has refused to open camps to host refugees. Therefore, people are scattered all over the country, mainly in impoverished areas where services are already under severe strain. The response to their needs has been massively underfunded.

Health systems

Although its hospitals have been destroyed and its pharmaceutical industry damaged, Syria used to have one of the best health systems in the region before the crisis. The epidemiological profile of the population and its needs therefore differ substantially from the refugee settings which may be more familiar to humanitarian actors.

Iraq's health system was severely depleted by years of embargo followed by the US-led occupation and civil war. The Lebanese health system is based on private practice and is therefore difficult to access for the most vulnerable people. For example, a survey conducted by MSF found that almost 15% of the refugees interviewed could not access hospitals because they were unable to pay the fees (up to 25% of the costs, the rest being covered by UNHCR). Nine out of ten interviewees said that the price of prescribed drugs was the main barrier to their accessing medical care.² The continuing influx of refugees has put both health systems under severe strain. Health structures are overstretched and cannot cope with more patients. These difficulties also raise tensions between the host communities and the refugee populations and therefore need to be tackled urgently and effectively.

Middle-income 'disease burden'

Refugees from middle-income countries present a different demographic profile and disease burden than the classical refugee profile that humanitarians across the world are used to working with. In

the past in mass influx situations there was a high mortality rate during the acute phase of emergencies, mainly fuelled by epidemics, the exacerbation of endemic infectious diseases and acute malnutrition. In this situation today, however, much of the excess morbidity and mortality result from the exacerbation of existing chronic diseases (such as cardio-vascular, hypertension, diabetes, tuberculosis and HIV). In these cases, treatment continuation becomes essential. The complexity and long-term duration of chronic diseases call for different thinking and new strategies.

Most of the primary health-care consultations done by MSF in Lebanon and Iraq since early 2012 can be attributed to chronic diseases. Continuation of treatment – not just access to it – becomes essential. But when interviewing Syrian refugees in the Bekaa Valley and Saida in Lebanon, more than half of the respondents (52%) said that they could not afford treatment for chronic diseases, and nearly one-third (30%) had to suspend treatment because it was too expensive to continue. In Iraq, access to treatment is supposedly free but in reality, due to frequent breakdowns in supply, refugees have to buy their medicines in private pharmacies.

Outbreak-prone diseases too are still a threat to conflict-affected populations in middle-income countries. Iraq has experienced a measles outbreak that had to be controlled by mass vaccination in the refugee camp. Lebanon too suffers from outbreaks that, even though of lesser magnitude, are much more difficult to control due to the widespread distribution of the refugee population. The incidence of infectious diseases – even though lower than in other settings – is still considerable. In view of these realities, preventive and curative responses involving not only primary but also secondary and tertiary level health care with free service provision need to evolve substantially.

Health challenges in open settings and camps

One of the main issues is the link between the registration of people and access

to services, including health services.³ 41% of interviewees said they were not registered, mainly because they lacked information on how and where to register, because registration points were too far away, because of delays at registration facilities or because they were worried about not having the proper legal papers and therefore being sent back to Syria.

In Lebanon, and specifically in the Bekaa Valley, refugees are so scattered that access to hospitals is extremely difficult. Moreover, even though UNHCR is covering some of the hospital costs for refugees, they are not covering them all. Most of the refugees will ultimately have to pay to access secondary or tertiary health care.

The fact that the largest proportion of Syrian refugees is currently residing in urban environments rather than in camps poses major challenges for health interventions. According to UNHCR, 65% of refugees in the region are living outside camps. While Syrian refugees in Lebanon are scattered over 1,000 municipalities, mostly in impoverished urban areas, in Iraq they live both in camps and cities. This diversity of settings is a challenge for medical and health interventions.

In a camp a comprehensive and centralised system can be designed to ensure access to health, and a simple surveillance system for major outbreak-prone diseases might be enough. Unfortunately outbreaks are occurring among the refugees scattered in Lebanon and the surveillance system in place is incapable of predicting them early enough. Refugees in urban settings anyway face intermittent access to health services due to overstretched public systems in the hosting countries, which are unable to cope even with the demands of their own population. Urban refugees often live informally alongside residents. The fact that both have similar needs and vulnerabilities and that they share the same under-resourced health system will inevitably have an impact on local residents' attitude towards refugees, which will in

turn ultimately generate exclusion and inequities in the provision of services.

In Iraq, the majority of refugees are residing in urban settings. Access to primary and secondary health care seems to be free but the system appears to be facing an influx of consultations that is overwhelming their capacity. In Lebanon, as in Iraq, the unpredictable distribution of aid to Syrian refugees is leading to increased competition for scarce resources. The economic disparity created by this unequal distribution is generating resentment and ambivalence towards Syrian refugees. The living conditions of refugees in open settings remain inappropriate; the payment of rent represents an additional burden on their budget, and most of them live in inappropriate shelters such as schools, mosques and dilapidated buildings. Overall, assistance to Syrian refugees still falls short of their needs.

Conclusions

Health policies and interventions have not kept up with the profound global changes in conflict settings, and the Syrian conflict has been no exception. Humanitarian actors need to adapt their strategies to the reality of refugees today and their specific disease burdens. As the disease burden has shifted to chronic diseases, there is also a need for more complex interventions that take into consideration the continuation of care. Nevertheless, outbreak-prone diseases are still present, and this demands good surveillance systems that can anticipate and take action.

Barriers to access to secondary and tertiary health care – such as the cost of services, short opening hours and long distances – have to be taken into account when assisting Syrian refugees. There is a need for a systematic integration of affordable non-communicable diseases treatment in the health-care system. Moreover, all vulnerable refugees suffering from acute medical conditions should gain full and fast access to hospital care.

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Urban refugees scattered all over Iraqi Kurdistan and Lebanon face huge difficulties in accessing aid. This again raises the issue of how to best address the needs of people displaced in open settings.

In August 2013 UN High Commissioner for Refugees António Guterres talked of the urgent need to adopt a more generous and consistent approach to Syrians seeking shelter and asylum in Europe. Germany and Sweden have accepted nearly two-thirds of Syrians seeking protection in the EU; more countries need to help Syria's neighbours shoulder the burden by offering asylum or resettlement. The Syrian crisis has shown a huge gap between the need for assistance and actual response. This type of long-term crisis also needs long-term planning and commitment from donors, states and agencies. Syria's neighbours have most of the time welcomed, hosted and assisted refugees; without proper support for local authorities and structures, however, mass influxes will eventually only provoke rejection when local capacities falter and fail.

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1. <http://data.unhcr.org/syrianrefugees/regional.php>

2. MSF survey conducted in Lebanon in December 2012
www.doctorswithoutborders.org/publications/article.cfm?id=6627

3. Randomised surveys on households in Saïda, Ein Al Helweh camp, the Bekaa Valley and Tripoli, conducted by MSF in May 2012, December 2012 and June 2013.

“What is the most important thing you brought from home?”



Ahmed holds his cane without which, he says, he could not have made the two-hour crossing on foot to the Iraqi border. (Domiz refugee camp in the Kurdistan Region of Iraq)



Tamara brought her diploma so that she can continue her education. (Adiyaman refugee camp, Turkey)



Abdul holds the keys to his home in Damascus. “God willing, I will see you this time next year in Damascus,” he told the photographer. (Bekaa Valley, Lebanon)