War, Health & Refugees in Iraq

STAKEHOLDER MEETING REPORT

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Photo: Matthew Schweitzer

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Mac Skelton joined IRIS as a Research Fellow in May 2016. Skelton's research in Iraq, funded through fellowships from the Social Science Research Council as well as the American Research Institute in Iraq, focuses on Iraqis' experiences of cancer care under conditions of war post-2003. Skelton has published scholarly articles in the Lancet and the Journal of Global Oncology and is a contributor to Brown University's Costs of War project. He is currently completing a PhD in Anthropology at Johns Hopkins University. Prior to doctoral study, he was Senior Fellow at the Business Council for International Understanding. He holds an MA in Anthropology from the American University of Beirut and a BA in Religion from Davidson College.

Sherri Kraham Talabany is the President and Executive Director of the Kurdistan -based SEED Foundation and U.S.-based SEED for Change, charitable organizations that promotes economic development, as well as social, educational, and economic development in Kurdistan.

Sherri was a senior official in the United States Government in Washington, D.C. for almost fifteen years, from 1998 – 2012, working on foreign policy, foreign assistance programming, and international development. She worked for the U.S. State Department from 1998 – 2003, starting her career working on Iraq and then in a variety of positions overseeing policies and programs worldwide. She then served as the Managing Director and later Deputy Vice President for Policy at the Millennium Challenge Corporation from 2004 – 2012, working with the poorest countries in the world to improve their policy environment to reduce poverty through economic growth.

Sherri is a lawyer who earned her degree in 1999 from George Mason University, in Virginia and currently resides in Erbil, Iraqi Kurdistan. She has been involved in volunteer activities throughout her life, serving on non-profit boards and advocating on behalf of the poor and underserved, including vulnerable minorities and displaced people. She was recognized by multiple awards from several Secretaries of State and was awarded as DevEx's 'Top 40 Under 40' Leaders in International Development in 2010.

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EXECUTIVE SUMMARY

On April 27, 2017, 35 stakeholders convened at the American University of Iraq, Sulaimani's (AUIS) Institute of Regional and International Studies (IRIS) to discuss the dynamics of healthcare for internally displaced persons (IDPs) and refugees, particularly those residing in the provinces administered by the Kurdistan Regional Government (KRG) (Dohuk, Erbil and Sulaimani). The meeting revolved around two themes: (1) mobility and Health security/access; and (2) budget cuts and pharmaceutical shortages.

Mobility & health security and access

Since 2014, patient mobility has been particularly difficult between provinces affected by intense fighting and provinces where high-level referral hospitals are located (i.e., emergency referrals). Checkpoint restrictions often inhibit the movement of patients from one province to another, especially Sunni Arab IDPs. During the battle for eastern Mosul, referral for even emergency cases (from Mosul to the first referral hospital in Erbil) took three to four hours. Patients with chronic diseases such as cancer also suffer from checkpoint delays. These patients must adhere to a regular treatment schedule and, if not, the stage of the disease can easily progress from curable to incurable.

Budget cuts & pharmaceutical shortages

Many public hospitals located in the Kurdistan Region of Iraq (KRI) are struggling to provide pharmaceuticals and services to an increased number of patients. In 2014, the Government of Iraq (GOI) instituted a government-wide cut of the entire budget to the KRG, including funds for the KRG Ministry of Health and its hospitals. Pharmaceutical allocations to the KRG continued, but more recently Baghdad reduced these amounts significantly. The KRG is currently receiving 33% of its regular allocation for pharmaceuticals despite the presence of over 1 million IDPs from the GOI provinces.

RECOMMENDATIONS

1. **Mobility**: Stakeholders stressed the importance of protecting the rights of all patients, including IDPs, to cross GOI and KRG provincial checkpoints to access hospitals.Stakeholders proposed the formation of a coordinating mechanism between the KRG Ministry of Interior officials and the Ministry of Health to enable NGOs, hospitals, and individuals to advocate on behalf of stalled cases.
2. **Budget**: The GOI Ministry of Health and KRG Ministry of Health should mutually commit to addressing funding shortages, particularly for chronic conditions. The KRG healthcare system urgently needs both pharmaceuticals and financial support from the GOI Ministry of Health given the large numbers of residents from Mosul, Salahaddin, and Anbar within its tertiary hospitals.
3. **Education**: Stakeholders affirmed the importance of working with medical education institutions in both the KRI and Iraq. For instance, the formation of conflict medicine curriculum at the Medical School at Sulaimani University would help prepare the next generation of public specialists.

IRIS looks forward to continuing efforts to move these issues forward. Please contact mac.skelton@auis.edu.krd for more information on this project.

INTRODUCTION

Since the summer of 2014, roughly 1.8 million Syrians and Iraqis have been displaced from their homes to the areas under the control of the Kurdistan Regional Government (KRG). Hospitals in the KRG provinces of Erbil, Dohuk and Sulaimani see thousands of displaced patients per week for both war-related injuries and chronic illness. On any given day, one might find a war-wounded patient from Salahaddin at Sulaimani's Emergency Hospital and a cancer patient from Anbar at Erbil's Nanakali Cancer Hospital. Given the severely weakened status of healthcare in the areas most affected by the *Daesh* conflict (Anbar, Mosul, and Salahaddin), it is inevitable that both hospitals and NGOs throughout Iraq and the Kurdistan Region of Iraq (KRI) will be administering care to a significant displaced population for years to come.

The negative impact of the war against *Daesh* on the Iraqi healthcare system is by no means exceptional: Iraq's once robust national healthcare system underwent a 25 year process of deterioration due to the impacts of UN sanctions (1990 – 2003) and two wars based largely in urban areas (1991 and 2003 – 2011), [1] which is where the main state medical institutions are located. Yet, the current dynamics of the *Daesh* conflict do present unique long-term challenges, particularly for the KRI's medical institutions. This is not only a function of the KRI's geographical proximity to areas of intense fighting but also the rising strength and reputation of the KRG's hospitals. With the maturation of KRG healthcare institutions comes the reality of sharing the burden with Baghdad in the long-term effort to administer the healthcare needs of the war-affected populations of Mosul, Salahaddin, Anbar, etc.[2]

Photo: Matthew Schweitzer

On April 27, 2017, 35 stakeholders convened at the American University of Iraq, Sulaimani's (AUIS) Institute of Regional and International Studies (IRIS) to discuss the dynamics of healthcare for internally displaced persons (IDPs) and refugees, particularly those residing in the KRG provinces (Dohuk, Erbil and Sulaimani). The meeting revolved around two themes: (1) mobility and Health security/access; and (2) budget cuts and pharmaceutical shortages. The meeting brought together directors of public hospitals, humanitarian officials, and government actors to discuss the long-term realities of healthcare for the displaced and refugee populations. The importance of pairing public hospitals and humanitarian organizations arises from the fact that the vast majority of IDPs in the KRG reside outside of refugee camps administered by NGOs and thus rely on local hospitals for healthcare needs. The meeting was by no means conclusive or final; however, several policy solutions to specific obstacles were discussed. The healthcare needs of people in conditions of conflict are highly complex,[3] and thus we recognize that an ongoing conversation among the relevant actors is necessary.

Stakeholders present

Akeel Abbas (AUIS); Nian Abdulla (Hiwa Foundation); Bakhtyar Ahmad (Civil Development Organization); Hsan Al-Allaf (Vice Governor, Ninewa province); Mohamed Ali Elshazly (UNHCR); Hero Anwar Barzo (Reach); Alexey Dudarev (UNHCR); Kadham Farooq Namiq (Hiwa Cancer Hospital); Basma Habib (University of Sulaimani); Aws Hameed Elias (ICRC); Sheelan Hassan Tayib (Ali Kamal Clinical Consultation Center); Zuleikha Kareem (U.S. Consulate in Erbil); Darya Kawa (STEP-Iraq); Rubar Khalid (Civil Development Organization); Mitzi Mak (STEP-Iraq); Carolina Mateos (UNHCR); Layth Mula Hussein (Kurdistan Society for Medical Specialties); Karzan Murad (Zhianawa Cancer Center); Akhtar Najmaden Shamsaldin (Kurdistan Society for Cancer Patient Support); Angela Ramirez (MSF-Holland); Mohammed Saleem (Azadi Hospital, Kirkuk Cancer Center); Mac Skelton (IRIS, AUIS); Sherri Kraham Talabany (SEED Foundation); Adam Tibe (UNICEF); Simon Tyler (MSF-Holland).

DISCUSSION

The meeting revolved around two themes: (1) mobility and Health security/access; and (2) budget cuts and pharmaceutical shortages.

Mobility & health security and access

Iraq's 18 provinces have widely disparate levels of healthcare. Thus, movement across provincial borders has and always will be a fundamental means of accessing care both in times of conflict and relative stability. Only a handful of provinces in proximity to the current conflict provide high-level facilities for complex conditions (e.g., Erbil, Sulaimani, Baghdad). Since 2014, patient mobility has been particularly difficult between provinces affected by intense fighting and provinces where high-level referral hospitals are located (i.e., emergency referrals). Checkpoint restrictions often inhibit the movement of patients from one province to another, especially Sunni Arab IDPs. In this context, the stakeholders discussed the problem of cross-border patient referrals. What role can hospitals, NGOs, and security officials play in ensuring patients' ability to move across provincial borders?

Stakeholders described the conditions on the ground over the past three years. Since the 2014 takeover of Mosul by *Daesh*, the ability of IDP patients to move across provincial borders in order to access hospitals has been highly unpredictable. Inequalities in the speed of passage across borders and access to ambulances and hospitals depend not only on sectarian affiliation but also on civilian/non-

civilian status. Particularly in the midst of high intensity fighting, military actors tend to have the quickest access to ambulances. Yet, the injuries of combatants and civilians are usually indistinguishable in terms of severity, raising questions about the preferential treatment given to military personnel.

During the battle for eastern Mosul, referral for even emergency cases (from Mosul to the first referral hospital in Erbil) took three to four hours. Ambulance drivers, whether employees of the Iraqi Ministry of Health or the World Health Organization (WHO), were instructed first to go to the camp, obtain a signature from the security officer, and then the camp manager. All of these constituted delays. Even with the correct documentation in place, the checkpoint officers could turn down a given case. Because the road is bumpy and drivers were forced to make several trips between Mosul and Erbil each day, WHO and Iraqi Ministry of Health ambulances broke down frequently. Lack of maintenance teams and parts slowed their return to the referral pathway. ICRC and other organizations have engaged with security forces to speed up the referral pathway, but implementation has been a challenge with shifting security personnel and changing conflict conditions.

Physical access to hospitals presents different kinds of challenges depending on the nature of the injury or illness. War-related blast, burn, and trauma injuries require immediate attention. Any delay in the referral pathways from the battlefield to the first referral hospital can have catastrophic implications for the health of the patient. The main challenge on the East side of Mosul (and many other areas where fighting has subsided) has become access to hospitals for chronic conditions. Patients residing in camps often lack the documentation needed to gain a referral approval. Or, with a scarcity of ambulances, they lack the funds for taxis.

Patients with chronic diseases such as cancer must adhere to a regular treatment schedule and, if not, the stage of the disease can easily progress from curable to incurable. Due to inequalities in the capacities of public cancer hospitals between one province and another, inter-provincial referrals are a crucial aspect of access to chemotherapy, radiotherapy, etc. For instance, hospitals in Kirkuk, Salahaddin, and Diyala routinely transfer both IDPs and permanent residents to neighboring Sulaimani or Erbil. But many patients, particularly IDPs, are turned away at entry checkpoints. Checkpoint officers do not follow standardized pro-


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cedures. The rates of refusal are highest for patients with non-visible wounds and illnesses (e.g., cancer, psychiatric conditions); however, even emergency injuries are often stalled or refused on security grounds.

Budget cuts & pharmaceutical shortages

Hospitals throughout Iraq, including in the KRI, are facing increasing challenges with funding shortages. With the rise of the IDP and refugee populations coinciding with an economic crisis and state budget cuts, many public hospitals located in the KRI are struggling to provide pharmaceuticals and services to an increased number of patients. In 2014, the federal Government of Iraq (GOI) instituted a government-wide cut of the entire budget to the KRG, including funds for the KRG Ministry of Health and its hospitals. Pharmaceutical allocations to the KRG continued, but more recently Baghdad reduced these amounts significantly. The KRG is currently receiving 33% of its regular allocation for pharmaceuticals despite the presence of over 1 million IDPs from the GOI provinces. Some KRG public hospitals have continued a policy of universal care, while others have instituted triage policies whereby local patients receive full care and most non-local patients, including IDPs, have to purchase pharmaceutical in pharmacies. During the meeting, stakeholders discussed the dynamics of budget cuts and pharmaceutical shortages, as well as the implications for IDPs. How can NGOs and hospitals work together to address budgetary shortages and the impacts on IDPs?

Stakeholders first approached this issue from the standpoint of the financial burden placed on IDPs. IDPs residing in camps do not have full access to pharmaceuticals. When they are provided, the provision often only convers a portion of what the individual needs. The United Nations High Commissioner for Refugees (UNHCR) has emergency funds to cover the medications of patients on a case-by-case basis; however, the process to acquire this assistance is arduous and the payments made do not always cover the individual for a sufficient period. SEED Foundation has also provided funds for medications on a case-by-case basis. With medications financially out of reach for IDPs, chronic cases are becoming life threatening. In recognition of this challenge, organizations such as Doctors without Borders (MSF) are increasingly moving from an exclusive focus on emergency medicine to non-communicable diseases. Chronic diseases are, in fact, emergencies when patients have been cut off from hospital access for multiple years (as is the case for many patients from Ninewa province).

Secondly, stakeholders discussed the budgetary gaps from the perspective of public hospitals administered by the KRG, which are serving not only the local population but also IDPs. Representatives of several cancer hospitals discussed the gaps in pharmaceuticals and technologies. Zhianawa Cancer Center, which is Sulaimani's public radiotherapy center, is currently servicing upwards of five provinces (Sulaimani, Diyala, Salahaddin, Kirkuk, Mosul) due to war-related displacement and inter-provincial referrals. 630 patients remain on the waiting list because the center only has one machine. Nanakali Cancer Hospital in Erbil has experienced similar difficulties, especially after the liberation of East Mosul and the influx of Mosul cancer patients into Erbil. Zhianawa, Nanakali, and many tertiary centers need urgent support. While it may seem counter-intuitive to direct more resources to provinces with high volume tertiary centers when other provinces have no tertiary capacity at all, the realities of displacement and inter-provincial referrals demand that the GOI and KRG ministries budget accordingly.

Meanwhile, due to the economic crisis, public medical salaries have dropped drastically. Fears over medical personnel burnout are high, and these hospitals have experienced great difficulty recruiting new staff. In recognition of the great risk that low pay and low morale among medical staff pose to hospitals, MSF has stepped in to provide funding to cover the salaries of 500 – 600 staff of Sulaimani's Emergency Hospital. But many other public hospitals remain underfunded. The GOI Ministry of Health has already seen an important loss of doctors since 2003, due to a combination of security conditions and deteriorated working environments.[4] Fortunately, relative stability in the KRI, from a security standpoint, has prevented similar losses of medical personnel; still, the stakeholders stressed the importance of addressing this issue quickly.

RECOMMENDATIONS

These challenges will likely remain for months and years to come, and the proposed solutions are not to be interpreted as one-time interventions, but rather as ongoing projects requiring regular advocacy and follow up. These recommendations draw on the opinions of participants in the stakeholder meeting, but ultimately they are the responsibility of the two authors.

BUDGET

The GOI Ministry of Health and KRG Ministry of Health should mutually commit to addressing funding for chronic conditions.

Now that the fighting has subsided in certain areas, the long-term reality is that of administering care for chronic conditions, including cancer. The KRG healthcare system urgently needs both pharmaceuticals and financial support from the GOI Ministry of Health given the large numbers of residents from Mosul, Salahaddin, and Anbar within its tertiary hospitals. More broadly, the GOI Ministry of Health as well as the KRG Ministry of Health should take high patient volume resulting from displacement and inter-provincial referrals into account when allocating resources. KRG provinces should receive budgetary support to ensure both local residents and IDPs from surrounding provinces receive adequate care.

MOBILITY

Stakeholders stressed the importance of protecting the rights of all patients, including IDPs, to cross GOI and KRG provincial checkpoints to access hospitals. Stakeholders also proposed the formation of a coordinating mechanism between the KRG Ministry of Interior officials and the Ministry of Health to enable NGOs, hospitals, and individuals to advocate on behalf of stalled cases.

In general, stakeholders stressed the importance of accelerating ongoing advocacy with security officers, governors, and the Ministry of Interior to promote patient movement across provincial borders.

COORDINATION ON MOSUL

In the case of Mosul, Vice Governor Hasan Al-Allaf suggested the formation of a medical coordination council to develop solutions to the challenges of both access and finance.

Such a council would help address the issue of poor coordination among officials, non-governmental actors, medical institutions, etc.

EDUCATION

Recognizing the long-term nature of these challenges, stakeholders affirmed the importance of working with medical education institutions in both the KRI and Iraq.

For instance, the formation of conflict medicine curriculum at the Medical

School at Sulaimani University, with a focus both on the ethics of equal access and the technical aspects of emergency medical situations, would help prepare the next generation of public specialists working in a region of wars.

Other recommendations and comments can be found on the podcast of the event. IRIS looks forward to continuing efforts to move these issues forward. Please contact mac.skelton@auis.edu.krd for more information on this project.

NOTES

[1] Dewachi, O., Skelton, M., Nguyen, V. K., Fouad, F. M., Sitta, G. A., Maasri, Z., & Giacaman, R. (2014). Changing therapeutic geographies of the Iraqi and Syrian wars. *The Lancet*, *383*(9915), 449-457.

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[3] Spiegel, P. B., Checchi, F., Colombo, S., & Paik, E. (2010). Health-care needs of people affected by conflict: future trends and changing frameworks. *The Lancet*, *375*(9711), 341-345.

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