

THE BROOKINGS INSTITUTION  
**MONITORING HEALTH SERVICES AMONG  
IRAQI REFUGEES AND INTERNALLY DISPLACED PERSONS**

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## P R O C E E D I N G S

MS. FERRIS: Okay, good afternoon, everyone, and welcome to this event on Monitoring Health Services among Iraqi Refugees and Internally Displaced Persons. My name is Elizabeth Ferris. I'm a senior fellow here at Brookings and co-director of the Brookings-Bern Project on Internal Displacement.

Health is a key factor, a key issue, in all stages of displacement. Certainly, it's one reason people leave their communities when they can't obtain health services for themselves or their families. For people in exile -- refugees -- the quality of health care can say a lot about the extent to which people feel comfortable and able to maintain their residence or their refuge outside their country of origin.

And more and more we're realizing that establishments of health services is key to questions of return in Iraq. At a recent meeting we had in Doha, Qatar, looking at durable solutions for Iraqi refugees and internally displaced persons, or IDPs, over and over again we heard, yes, security is important, but equally as important are questions of livelihoods and jobs and access to public services. And so we're delighted today to present three speakers talking about different aspects of health as they relate to displacement and, perhaps, as they relate to the future of the country as a whole.

We'll begin with Gil Burnham, who is co-director of the Center for Refugee and Disaster Response at Johns Hopkins Bloomberg School of Public Health. He's done a lot of research in the region and, indeed, throughout the world. He'll be speaking about the changes in health care, particularly at a major university or tertiary hospitals in Iraq -- inside Iraq.

So, in a seamless transition, we'll start with an overview of health services in Iraq and then we'll move to Agron Ferati, who will talk from the International Medical

Corps, who will talk specifically about health among internally displaced populations inside Iraq. He's lived and worked in Iraq for over five years. He has a lot of experience in different situation -- emergency situations around the world.

Then we'll turn to Shannon Doocy, who is the co-director of the Health in Crisis MPH Concentration, also at John Hopkins Bloomberg School of Health. And she will be talking particularly about research carried out in neighboring countries among Iraqi refugees.

Each of the speakers will speak for about 15 minutes. As they have a PowerPoint, we're going to allow them to see the Power Points of others. And so we'll invite them to come up one at a time to speak and then we'll sit up here and take all of your questions.

Now, it was pointed out to me by the first speaker that when you have three speakers in a row, there's a tendency to ask most questions of the most recent one. So be warned. Get out your pencils, write down questions you may have for the first two speakers, because we certainly don't want them to feel neglected. Thank you very much.

Gilbert?

MR. BURNHAM: Thank you very much, Beth. It's a pleasure to be here and it's a pleasure to talk about some of the work we've done looking at the function of the health system in Iraq, and doing this both from externally and internally, as well. So we're going to look at two studies that we've carried out over the last couple of years. And we're going to start off looking at questions of migration of doctors.

Now, there is a fairly extensive literature about doctors who migrate, but almost all of this literature is about migration for economic reasons -- the kind of economic stimulus. And so a lot has been written on Brain Drains and so forth. There's very little written on what happens to medical personnel after or in conflict situation. Now, this is

especially apropos in countries where doctors are trained in their medical school, and they're textbooks and so forth are in English. It gives them an international marketable skill and they're joining this large international labor pool that's moving around the world, working in various parts of the world.

Looking at specific issues related to conflict, I could find only a few references here. One of them was way back after the Cuban revolution. About half of the doctors left Cuba at the time and probably 98 percent of those settled in Miami, but large numbers moved. After Zimbabwe started deteriorating so badly, it was determined that about 840 out of the 1,200 doctors that were trained in Zimbabwe during the '90s left. And Zimbabwe, if anybody knows, had a fairly sophisticated system, and some of us in our earlier life were involved in various ways with medical education in Zimbabwe, a very well-established situation.

And in Iran it was estimated that someplace between 2,000 and 8,000 doctors left after, well, two events: the revolution there as well as the Iran-Iraq war. Now all of these numbers are suspect because nobody really kept close tabs on the actual numbers. So, when we turn to Iraq, the data is even more fuzzy. Some estimates have said -- and if we look for the reference for these, these are mostly in popular newspapers -- some references have said that half of the doctors have left the country. Other references say 2,000 or 3,000 of them have been killed. And most of this is just what reporters are surmising talking to various groups.

However, there are multiple reports of changing in the capacity of the health system and changes in the quality of services. So I'm going to talk today about two studies we carried out. The first one looks at 12 tertiary hospitals. These are the top end of health services in Iraq. Six of these were in Baghdad and six were outside. And we divided the tertiary hospitals between university hospitals and general hospitals, so those more part of

the training program at the university and those that were freestanding which would have trainees in them, but would not be specifically responsible to the Ministry of Higher Education and to the training system. And we looked at the changes in staffing between the years 2004 and 2007.

Then a second study we did were interviews with 401 Iraqi doctors in Jordan. And we collected information about their experiences in the various health facilities they worked in during the time they were in Iraq. And this ran between 2003 and 2007.

So, prior to 2003, it was estimated -- again, no solid data -- that Baghdad probably had half of Iraqi doctors, even though it accounted for probably less than a quarter of the population of Iraq. And so, in the study, we looked at the total number of specialists and we found that in the 12 hospitals, the total number of specialists decreased from 1,243 to 1,166. So that's not a major drop. But then if we looked at what happened among the various hospitals in the country, we saw a drop in the specialists in Baghdad to 78 percent of what they were in January of 2004. And yet, the rest of the country increased in the number of specialists at the top end -- these tertiary hospitals -- which might, in some way, not be that bad a situation because looking at the absolute numbers, hospitals outside of Baghdad were clearly understaffed with specialists compared to what Baghdad looked like.

And this looks at departures per year from 2004 onwards. So this kind of thin gray line represents the country as a whole. This looks at non-Baghdad hospitals -- departures from hospitals -- and this looks at Baghdad hospitals. And so, in 2006, at the height of the violence, Baghdad lost 29 percent of its specialists during that year. And up until 2005, there was adequate replacement. So, in spite of the large number of departures, that there were new doctors, new trainees coming on-line that could fill those positions. But after 2005, the replacements were considerably less every year than the departures.

And we looked at this by specialties. This is a bit busy, but it basically

shows that all the specialties, whether you're a surgical specialist, a nonsurgical specialist, or a medical specialist in Baghdad, all of these dropped off. And it didn't seem to be any specific pattern. There was departure in all areas.

Outside of Baghdad, as I said, the numbers actually increased and this was because many people left Baghdad to move to other hospitals. And it was interesting that people left Baghdad even to move to places like Basra, which were undergoing a fair amount of violence during some of these times. The anecdotal reports were that this was where people were from; they felt more comfortable in this environment. They were safer in areas that they were familiar with.

So, why people left? In some cases we couldn't find this information. Some of the registers and the people in the hospitals didn't have the full information. Seventy-four percent of the people who left transferred to other hospitals. And, in some cases, they left suddenly with no warning. And then a month or two months or three months later, a message would come from Urbal or someplace else, saying now I'm in Urbal; please arrange for the transfer of my records and data to this particular hospital. And many of these departures were in the face of various threats. People suddenly left.

Twelve percent of people retired. This was a bit difficult because there wasn't a full retirement scheme available for all doctors. Thirteen percent were known to have left because of various threats. So that's 111 tertiary specialists in all that left either because of threats or kidnapping or some violent event that happened to them personally, not necessarily family. And 1 percent died for other reasons.

So the overall -- during this period of time we looked at, the overall risk of violent events was 30 violent events per 1,000 doctors. So that gives a level at the tertiary hospitals. And the tertiary hospitals we'll talk about in a minute were somewhat different than other hospitals in the area.

Then we carried out a study of 401 Iraqi doctors who were in Jordan. And we used something called "respondent-driven sampling," and we started off with a certain number of seeds -- a certain number of start points, which represented a variety of different characteristics: male, female, specialist, old, young, and so forth. And so that way we could get a more diverse picture of what was actually going on. And this is a method that's commonly used for populations that are out of sight, that you can't reach easily. And they, in turn, refer colleagues, et cetera.

And we asked them about what were their experiences in Iraq before they left? What was their experiences while they were in Jordan? What were their thoughts about the future and what were they presently doing? And we'll talk a little bit about some of those in a minute.

Forty-three percent of these had arrived in 2006. So if we looked at when people arrived, 2006 by far was the busiest year; 2007, the flow dropped off substantially. This very much mirrors the migration pattern of refugees in both Syria and Jordan, and it very much mirrors the situation of violence in Iraq. And 61 percent of these 401 doctors left because of violent events that had happened to them personally, so this is not just violent events in the family. Seventy-five percent of their families had had violent events, so this was very much violent event-driven.

So we can say already that there's some potential bias that could creep in this area. We're looking at a population that is clearly affected by violence. But, on the other hand, whenever you look at data like this, you acknowledge the biases, but you say, okay, what else is there available? And so nothing actually is available.

So, what we found was basically the older doctors, the males, the specialists, and so forth, were more likely to have experienced violent events than younger doctors and females and the non-specialists. And so this looks at what happened in their

facilities. So here's a situation where we could get both numerator and denominator. So we can say how many doctors were in your facility where you were working in the year 2003? And during that period of time, what violent events occurred?

We could go to 2004, 2005, so we can build up this pattern. So this was the rate of violent events among doctors. This is per 1,000 per year. And so if this were violent deaths -- so we're up to 45 per 1,000 in 2006, a much higher rate than we saw among the specialists. Kidnappings a bit less, dropping off in 2007. And violent injuries, survival from violent events, a bit higher in the beginning, dropped off again in 2007. So this is kind of the pattern we saw of violence going on with individual facilities and doctors in those facilities. We didn't measure nurses and other people, as well.

So what about the function of the health system? What did people say was actually happening in their system? So first off we asked about unfilled positions. How many vacant positions that normally would be staffed, but now are not being staffed?

So, in 2003, a quarter of people said, well, at least 80 percent of the staff positions were filled and the next quarter said 90, and so forth. So, for 2003, we could see that over 90 percent of the positions were filled. And you can see, as time went along, this is the 50 percent line, so 50 percent of doctors would say, by 2004, well, it was about 85 percent. Fifty percent of doctors said that in 2005 it was 60 percent. And by 2006, half of doctors were saying only 30 percent of the positions were filled in my institution during that period of time.

And then we asked about equipment. Did the equipment work? Did it work all the time or at least most of the time? And so, in the beginning, half of the doctors would say, yes, at least 80 percent of the time things were functioning. And this drops off substantially by 2006. And by 2007, things started improving a bit. Our numbers were a bit smaller in 2007, so it's hard to put a lot of credence for some of these numbers.



We ask the same question about drugs. In the beginning, drugs were quite readily available. Those dropped off and then again rose in 2007, suggesting that in 2007, even though the numbers were small, things had improved a bit.

And then we looked at what proportion of the admissions were due to violence. And in 2003, half of the doctors said, well, less than 40 percent were due to violent events. And that rose to 2006, where half of the doctors said at least 50 percent -- at least 80 percent of admissions were due to violent causes. And then, as the next year went on and the violence diminished, this mirrors that.

And then we ask about, were complex procedures -- complicated procedures being carried out by underqualified people? This is something, if you work in a hospital, you worry about this all the time. Are you really qualified to do this particular surgery or this particular procedure? So, in the beginning, half of the doctors said, well, you know, less than 20 percent of procedures are carried out by unqualified people. But by 2006, it was up to 60 percent. Again, mirroring the migration of doctors and also the use of junior doctors into some of these more complex situations.

So, then we asked, finally, about future plans. What are you planning to do for the future? And remember these are doctors principally trained mostly in English, so their internationally marketable skill throughout the Middle East and elsewhere, as well. So, the majority of doctors outside of Iraq did not plan to return at the end of the conflict. And nobody planned to return while any kind of conflict was going on, or just a few percent. So everybody's got to wait and see. If things settle down then, you know, somewhere under half said, yes, they would go back.

Fifty-two percent wanted to settle in another country and 18 percent wanted to stay in Jordan. Those living outside of Iraq more than two years were much less likely to return. They've already shown that they can survive quite well and if they were involved in

any kind of violent events and so forth, they were certainly less likely to want to go back to Iraq. Older doctors, specialists, and so forth were clearly less likely to say that they wanted to return.

So that's kind of the general pattern of those things. So our conclusion was that clearly the conflict has caused a major loss of human capital. And the reason we chose tertiary hospitals to look at, this was the major investment. This was the largest single investment of the health system and educational system in building human capacity, so it's caused a major loss of this capacity.

It's going to be difficult to rebuild; not impossible, but it's going to be difficult. It seems to be clear from multiple indicators; quality of health service has been dropping off. I didn't show this, but we've heard about how utilities are not widely available despite reconstruction efforts, but in hospitals, utilities tend to be there. People had water and electricity most of the time. Not all of the time, but most of the time.

Bed occupancy has remained high throughout the time, but the more elective procedures and other procedures have been replaced largely by dealing with injuries related to violence.

And finally, replacing the capital and redirecting the hospital system away from a very heavily hospital-oriented tertiary care to more primary care, to more general practice, and so forth. It's clearly a need, but this is going to take a lot of effort to do this and it's going to take a lot of political will to pull this off.

Okay. So, remember one or two questions and then we'll turn things over to Agron to talk about IDP issues and so forth in the country, and then finally Shannon will talk a bit about the refugee in neighboring countries.

MR. FERATI: Refugees and IDPs. Usually what triggers the displacement is intimidation, fear, and security. Those who choose to remain within the boundaries of the

country or those who choose to cross the boundaries of the country.

Mostly, by political leadership, both refugees and IDPs at the onset of the emergency, when it's a manmade created emergency, are politically misused. Whenever there is an intervention -- an international intervention, whether it be Kosovo or -- other country would see IDPs and refugees on TV. So politicians would use this group of population just to trigger intervention. However, they are mostly forgotten once political gain has been made in the country. So they are left aside, and the example is Iraq.

So suddenly they are not even a second priority. They are somewhere down the line. So not necessarily the most people are appointed to handle the situation. And not to mention the shift in demographics, which affects the elections -- political gains in certain geographic locations.

My name is Agron Ferati. I'm with International Medical Corps. Thank you. It is my pleasure to be here today and we really appreciate Brookings' forum because I'm a practitioner, so it serves a lot when you are out there in the field to read the guidelines from the big perspective, and then narrow down to the small perspective, what that means on an individual level.

So the International Medical Corps is a global humanitarian and not-for-profit organization. As many other organizations, IMC is dedicated to saving lives and relieving suffering through different levels or layers of health care interventions, but also a relief and development sort of intervention that helps society move forward.

In emergencies we deploy in a matter of hours to aid victims wherever they are and whatever conditions are, mainly in the natural disaster or manmade disasters. We also bring tools and knowledge to communities to help them organize and define their own priorities; help them articulate those priorities and advocate for those priorities to a main social service provider, whether it be a government or the private sector. And we work with

them to bridge that service delivery gap at any short period and then transition.

There's no difference between IMC and any other not-for-profit organization. We are all out there. It's just the risk that we are taking that other great organizations, such as Mercy Corps and others. They are out there in Iraq, doing a great job. So there is no difference between IMC, so enough of promoting IMC.

A bit of a big picture, and this is what we've been the most focusing since 2003, talking about Iraq: 29 million people. And the second slide shows Iraq in comparison to the East part of United States, and some geopolitical comparison in terms of water, geology, population, and major cities. So that kind of -- because it's probably not for this audience, but for others that perhaps are not aware of where Iraq is and what is actually happening out there except what they hear on CNN and other media outlets.

Iraq has read the Brookings, also; says that Iraq has a long history of displacement. So, when we talk Iraq specific, there is nothing new to Iraqis to just pick their bags and leave. They've been doing that since the '80s because of the economic reasons, because of their tribal structure, because where the main sort of hub of the tribe is and the families are scattered around the major cities. So, however, our focus is post-2003, so we have several categories of IDPs.

One, those who were displaced prior to 2003, mainly in Iran, Kirkuk, and other areas in which we are all promoting that they should return. But they've been displaced for 20 or 30 years. Once they return, will they really find the society that they left 20 years ago, and so on and so forth?

And then we have 2003 and 2006 wars. Horrible wars like in Fallujah, Tal Afar, Al-Qa'im, Haditha, Arawah, Baghdad, Najaf, Basra, Al-Sadr City, and so on and so forth -- Al-Sadr was later -- where Iraq has witnessed more of a temporary displacement where people would leave due to the military interventions and then, within a month or, you

know, during the short period of time, they would return and start rebuilding their own -- you know, rebuild what they have lost.

And then we have -- 2006, actually where, in February, some (inaudible) happened when more permanent displacement happened where people were forced to leave. The Baghdad demographics have shifted totally. The once mixed area, now it's either one -- driven by one sect or another sect. And then we have a period of 2008 and today with sporadic and, in some instances, even organized return is happening.

However, what is happening right now, that the families have become neighbors. So, people living in the same house, they become neighbors. Neighbors have become strangers. So how do they integrate back into the society once they belonged and now they are strangers there? We'll go -- what actually, since '80s, wars have had impact on Iraq.

I would focus on only three issues. There are millions of IDPS and refugees, and we all know that. We have a really good understanding of the big picture and the numbers, all the numbers. Everybody uses 4 or 5 million, but who verified that? Who has the accurate data? Because we don't question UNHCR data and then we go along with that because we all feel comfortable. That's the number out there on the website. Google will give us great, you know, statistics. So we go, we plot that number, write in our report, and we go along with that.

What war has created in Iraq is it has undermined technical and technological advancement. Iraq is operating today how they operated in '80s. The equipment, technology, even today we have the Leener Accelerator arriving in a tertiary level hospital, everybody's afraid to press the start button because they don't know. It's radiation. What's going to happen?

Political and social relationships were undermined. Families becoming

neighbors, neighbors becoming strangers. And then we have collapsed private sector. Iraq is the government-run sort of social -- the main social service provider, and so on and so forth, and the major employer. But where is the private sector? This is the sector that should absorb most of the skilled, and even unskilled, laborers out there that are on the market.

Displacement. We all know millions have been forced to leave their homes. Intimidation, threatening, security. There are others who have left because of economic reasons. Why should I remain in Baghdad as a surgeon, when I can go in Dubai and earn \$5,000 salary, while in Baghdad I risk my own life, my family's lives, for \$600 or \$700? So they are also this group of individuals that left because of the economics.

Once they left, within the country we had a tremendous pressure on the host families and the social sort of network that has absorbed the internally displaced people. Because it was not the government or the NGOs that have actually extended a hand and provided the needed assistance. I list cousins and neighbors who have opened their door and accepted internally displaced persons to stay with them and provided them a shelter. Children have suffered a lot.

We often -- if somebody witnessed a domestic violence in the developed world, within their family while they were children, they remember that throughout their life period, and even if they visit psychiatrist who talk about this issue. Imagine these children, 90 percent of them witnessed the violence, seen their father being beaten, mother being raped, how this will reflect on the future generations of Iraq.

And often overlooked minorities, we forget -- because of the conflict of two sides, we forget that others also exist in Iraq and that the population of others, including Christians, have dropped by 50 percent because they have left. And we forget the conflict in Mosul and Baghdad, and so on and so forth -- Yazidi, Turkmen, and others. So they should

also be on our radar screen and discussing about them.

2008, although -- fragile, but yet real return is happening. Organized, sporadic, individuals are returning back home to find either their property being occupied by another family or they don't have any property because they sold their house. They went to Syria, now they're paying rent in Syria, which is \$400 or \$500 a month, but they have to pay rent in Baghdad, too. So where do they stay? They choose to stay in Syria because they have no job. They have to repay rent in Baghdad, and so on and so forth.

It's easy always to say security, security, security, but who makes the security? The communities themselves, if they are organized, they create a safe environment. It's not the government or the U.S. Forces that will come and secure the environment.

The fear is that if the social network is not ready to absorb the communities -- main social service providers are not ready to provide the needed services -- communities will go, if I may use the word, relapse. They will again go back into a violent area. Public sector is overcrowded, private sector suffers from investment, there are no policies in place to protect the investment, and so on and so forth. So they are not able to absorb enough of the skilled laborers.

Second, Gilbert talked about a lot of doctors being outside. Another side is, does really Ministry and the current government want these people to return? Can't they function without them? It's been six years that they have functioned without them and now these doctors that are outside should question how they are going to return? Will they have the same society present in position when they return? No. Somebody else is already in that position. Will they make these exceptions now and fire people that are all in these positions in order to accommodate just their returning? Absolutely not. I have served as a senior advisor to the Ministry of Health, the Ministry of Displacement and Migration, Ministry

of Labor and Social Affairs, and Ministry of Education -- four very controversial ministries -- at the same time. Looking at the displacement as a broader social service provision issue rather than one ministry.

They don't want. They have no place to accommodate. They want top surgeons, top academics, but they don't want a lab technician because they already have lab technicians available and providing these services.

So, about 43 percent of the Iraq population is under age of 15, so that's another threat. That within the next several years we will have the growing youth population, which, with the education sector barely functioning, with the private sector not able to absorb this, where the youth will go? Who will employ them? Is it another sort of threatening factor to the Iraq future?

Hospitals and clinics, we all know how many are there and how they function. So 86 percent of the government revenues are coming from their own wealth and resources. Once I was in Diyala and Baqubah, a tribe leader said I wish I could wake up in the morning and be told by the government that there is no oil anymore in Iraq. Because at that time I would know that I will ask my sons to start looking for alternative jobs rather than going in front of the government office every day and asking them to pay my bills and give me charity. At that time I would take the different steps because this is how the society has gone. We're rich, don't worry about it. The government will provide for you.

Recently, in 2007 and '08, we have conducted a national survey led by the Minister of Displacement and Migration, where IMC serves as an international agency to develop their management and fiscal capacity within the government, and the branch offices. And in partnership with UNHCR, IM, the Ministry of the Kossit, and IMC has been an implementing agency on the ground with the Ministry of Displacement and Migration.

The chart says that over 81 percent of displaced individuals coming from



Baghdad, Diyala, and Mosul. So, really, displacement is not an Iraq issue. It's a specific issue. It has to do with Baghdad; it has to be dealt with Diyala, Mosul, Al Ambar to some small extent, Basra to a minor extent. So, we're all talking about Iraq and the IDP problem rather than going down where the root of the problem is, in Baghdad, and breaking it down to 52 different sort of cities, and municipalities, and addressing the issue at the small local level, rather than talking at the big picture. And nobody really dares to really address the issues at the community level. So, it's about 81 percent are from Baghdad, Diyala, and Mosul.

It's a major urban displacement. I believe it is the major in the world. So when it's urban displacement, every individual has free access to health services, to education, to water and sanitation, to electricity, as the host families have. So this one, perhaps, will give us a different picture than those that we are sort of acquainted more in Africa setting, where people have no access to primary health care. And this gives us an evidence of -- this is the survey of 10,000 or 11,000 families across 220,000 population sample.

The 93 percent of IDPs have free access to some sort of health service. And why is so? Because Iraq constitution says that every single individual Iraqi has free access -- and it's a government guarantee in the constitution -- guaranteed access to free services. It's not like in the U.S. You have insurance; you can go to the services. So everybody has a free access, so they can walk into the clinic, they can walk into the secondary level, tertiary level, and get the services.

Now the question is about the quality. Here we have a quantity and the remaining -- say because of transportation, the rest are -- those who are living in more rural areas where PATs are about 5, 10, 15 miles far from where they live. So they seek more of an alternative to the official primary health care services.

An important chart here is that this is the Australian government funded National Emergency Medical Program. We have done the injury incidents survey throughout Baghdad, they surveyed about 1,200 families. And as you can see, only 6 percent injuries are due to explosions. Iraq is slowly returning to a normal, where we have, fall -- 51. Poisoning because of the food and the electricity, 13 percent. We have hit by another object, and so on and so forth, for 19 percent. Which brings us to the point that the system is broken since the '80s. PRCs are unable to meet the demand and that's why a secondary and tertiary level is receiving so many patients because they are not going to the secondary level.

Lack of properly trained staff. Incentives to promote professional development, and a really not a clear division between the public and private partnership, or health sector. Most of the physicians have are private practice. This is where they make money. And there are a few sort of recommendations that come out of the six years working with the Ministry of Health, in the partnership between IMC and Ministry of Health is that increased assistance aimed at strengthening service delivery capacities through establishing centers of excellence. And in engaging Iraqis not through the training process where a few PowerPoint presentations here. We have great professors talking about health system, but actually on the job mentoring process.

Then we have the increased assistance to promote policy and system strengthening, where Ministry of Health can more and more serve as a purchaser of health services, rather than direct provider. And increased assistance that promotes sort of professionalism within the Ministry of Health in higher education where they can identify what are the demands for the skilled health workers, so they can start supplying this demand in the next years.

Interventions in the national community were always focusing -- if H1N1 is

media-driven something, is lots of it on TV, double (inaudible) three or four reports, so USAID goes in and invests \$10 million on HIV to train some Ministry of Health workers so they can issue some media campaign, but, rather, focusing on the interventions or the pressure points, which are at every single sector -- primary, secondary, tertiary -- whether to create or trigger the broader intervention. HIV, H1N1 is part of the primary health care, so it's a communicable disease. So it can be handled by the other type of intervention.

And a few recommendations -- just one more minute. On the humanitarian issues, displacement and vulnerability -- here increased assistance aiming at creating conditions necessary for safe, voluntary, and sustainable return, or integration, reintegration of IDPS. If they have been IDP for seven or eight years, they have created a new family there, a new business, they don't want to return because they don't have property or worth to return.

Second, developing a unified legal and administrative framework, which Brookings already discussed, I think, last week. This needs to happen. And we need to move more from looking at the Ministry of Displacement and Migration as a critical element, and moving to other ministries who are actually providing social services. Ministry of Labor and Social Affairs, Ministry of Health, who are the service providers because MoDM will not set up the clinics, will not set up the Woman Empowerment Centers, and so on and so forth.

And at the community level, the solutions need to be fully integrated within the society. So it will be that those who have returned to not be discriminated. Those who have returned to be integrated fully within the society. Those who have returned to have participatory and equal voice in deciding what the future will be.

Basically, I would wish just to capable and responsive government from anti-prospect -- I mean, the needs -- it's the government that meets all it's citizen's needs. And in Iraq it is -- it will be the only driving force on the long run for sustainability and

prosperity Iraq. They are the main social service provider. And Iraq displacement is not only the humanitarian sort of issue, but it has to be looked from the security, stability, and future prosperity of Iraq.

Thank you.

MS. FERRIS: (inaudible)

MS. DOOCY: All right. Well, I'm going to finish up talking about the Iraqi population that's displaced in Jordan and Syria.

To give you guys a little bit of an overview of the work that we've done, we've done two surveys. And the general aim was to kind of provide a description of the population and their unmet needs.

First of all, in Jordan, the aim was to work with WHO and UNICEF to form the consolidated appeal. And then in Syria, we did a follow-up survey with ICMC. So, in Jordan you can see there are about 1,200 households in the survey. In Syria, it was a little smaller with 800.

And we aimed to get a representative sample of the Iraqis in both countries, but you can imagine with limited data that was available, we had a pretty tough time. So, we ended up doing what's kind of a standard method, a cluster survey where once we identified the cluster locations, we would find the nearest Iraqi household and then they would refer us to other Iraqi households that were in that neighborhood. You could imagine there's some potential limitations to this, but it was kind of the only feasible solution that we really could come up with.

So, to give you a little bit of background, our findings in Jordan and Syria pretty much aligned with some of the ones that you've seen earlier. Where migration peaked in 2006, which coincides with the increasing levels of violence in Iraq, and the majority of Iraqis in both Jordan and Syria are displaced from Baghdad. So, about two-thirds

in Jordan -- or, I'm sorry, three-quarters in Jordan and two-thirds in Syria. And most of the arrivals were post-2006, though they tended to be a majority arriving later, I would say, in Syria a bit than in Jordan.

Some information that we had only from the survey in Syria was that almost 90 percent of households that experienced one or more violent events in Iraq. So, again, violence is very associated with migration.

To give you a brief overview of the demographics. You can see they're relatively similar between Jordan and Syria, so an average household size of four and a half in both countries. One in four to one in five households were headed by women. And a population that is a little older than the population that we just saw in Iraq. So, around 30 percent -- or 36 percent were children. And then, the older adults about 5 percent and 8 percent, respectively. So, compared to the age distribution of the Iraq population, the refugee populations in Jordan and Syria are older and especially children under 10 years of age are relatively underrepresented.

In terms of living conditions, again, it's a very urban displacement. So, about three-quarters of the population in both Jordan and Syria were residing in either Amman or Damascus. As Agron said, this means pretty much very good access to water and sanitation and electricity.

In the refugee context, access to health and education was a little more problematic than in the context of internal displacement.

In general, we found that the population in Syria was less affluent than those in Jordan, but the cost of living in Syria is also less. So, potentially that's not a huge problem.

In both countries, though, it was very clear that the populations were reporting that over time, their financial status was deteriorating, which is not to be

unexpected. So, they were also very dependent on remittances. And to those -- the extent that savings were still available, there was a lot of spending down of savings.

So, a brief overview of household economy. About 40 percent of households in both countries had somebody that was employed. This could be, I would say, in most cases, unofficial employment. But we were also a little uncertain about how forthcoming people were about the information on employment.

The median monthly income in Jordan is going to be significantly higher than in Syria. And you can see in Jordan if we compare these to international poverty thresholds, only 3 percent were living at under \$1 per person per day and 17 percent were under \$2 per person per day. In comparison in Syria, 14 percent were under \$1 per person per day and 41 percent were under \$2 per person per day. So, that's very significant.

The median monthly expenditures, you can see are a little higher than the incomes. We actually had a hard time getting some people to answer our questions on income, and we felt like the populations that were maybe doing better were less likely to answer.

But, again, with people receiving humanitarian assistance and spending down their savings, it's not totally unexpected that we might see expenditures that are higher than incomes. So, we recognize there are definitely some questions that remain with this data.

One of the things that we were interested in was food security and coping mechanism use. And this is kind of, as you'll see, a pretty standard battery of questions that are used in a lot of conflict and emergency settings.

The average number of meals consumed per day was around two and a half. We found that about 40 percent of households -- 40 to 45 percent in each country were consuming 2 or fewer meals per day.

When you look at kind of some of the basic coping mechanisms that were used, you'll see that especially in Syria, a high number are selling things to purchase food, which is concerning, especially if you're selling productive assets. And they're also eating kind of less expensive, lower quality foods and then feeling hungry and going entire days without eating, which are pretty big indications of distress.

The one main thing that I want to bring to your attention was there was a very big and important difference in the way the survey was structured. So, for Jordan we asked have you done any of these things while you've been in Jordan? Whereas in Syria we asked in the month proceeding the survey. So you can see all of these rates in Syria are pretty much higher and they're for a shorter time period, which might suggest that the food security situation is more problematic in Syria.

When you get to health care seeking, these populations are going to have similar access to health care, where vast majority said they were able to seek care right when they needed it, but the locations where they're getting their health care are very different. So, you can see in Jordan the private sector is the primary provider of health services, where in Syria it's going to be the Syrian Arab Red Crescent. And use of government facilities in Syria, two-thirds said they had used a government health facility at some point whereas in Jordan there is a much bigger reluctance to use government facilities. It's only about a third.

And I would say in general, this seems to be true in Jordan, that there's a stronger private sector. And even among Jordanians, the more affluent Jordanians are going to tend to prefer to use the private sector. Whereas in Syria, the private sector isn't quite as well developed.

When we asked about perceived access to medical care, the top graph is from Jordan. So you can see that really, maybe a third feel that they can always afford

medical care, but nearly two-thirds say they can get the care whenever they need it. In comparison, in Syria, it's also relatively similar with affordability of care and general access to care. But you could see that cost really does seem to be a big barrier for accessing care.

To give you an overview of disabilities, we found that disability rate in Syria was almost double that of Jordan. And we're really not sure why. One reason may be that the migration to Syria was a little bit later than the migration to Jordan, so people were more exposed to violence. And you can see in Syria, about two-thirds of disability was related -- or, I'm sorry, three-quarters of disability was related to conflict as compared to Jordan, where it was only about two-thirds.

Chronic medical conditions of this population is a huge concern, as I'm sure you guys are all aware of. So, we found a prevalence of about 52 percent among adults in Syria and a little lower prevalence rate in Jordan. But really if you look at the list of the top chronic conditions, they're very similar. So, hypertension, musculoskeletal disorders, cardiovascular, digestive, sort of the usual suspects.

When you look at spending on health, this was a very interesting difference. So, in Jordan, your mean and median spending on health are about \$70 and \$27, respectively. In Syria, it's \$91 and \$46. Yet we know that the Syrian -- Iraqis in Syria have lower incomes and, in general, theoretically, a lower cost of living overall.

In Syria, half the expenses are going to be on medication and half are on service provision. Whereas in Jordan, nearly all the spending is on medication and they're able to access services for a lot less in terms of what they actually pay to the facility.

And then again, about 40 percent in Jordan said they could afford medical care, less so in Syria. So the cost of care in Syria seems to be a big concern, though it's also a barrier in Jordan as well.

So, some key challenges in health. Obviously, chronic diseases are



expensive, and the humanitarian assistance community isn't very, I would say, experienced in dealing with them. We're sort of used to acute infections and basic primary care in less developed settings. So this is, I think, an area that's going to provide a lot of challenges.

And I think working with the -- or Syrian and Jordanian health systems is something that's going to have to be done just to avoid creating parallel systems. But funding of all of this is a huge concern.

And I think what really needs to happen is going to be better access to just a basic essential service package that's universal. Whether that can happen is a whole other question.

Some of the ideas that have been suggested for improving access to health services are either targeted assistance just to poor families, either via cash grants or subsidies, and also universal access to a standardized package of care that includes perhaps all levels of care. But that would also imply that there needs to be kind of some establishment of better referral systems.

When you look at humanitarian assistance, we spent a little bit of time on this in our questionnaire. Because we were most interested in it, but it was also a little bit sensitive. So we couldn't get as much information as we'd really wanted.

We found in Jordan that 77 percent were registered with UNHCR, 92 percent in Syria. This was a little higher than we expected. In Jordan, 10 percent of households were receiving some form of cash assistance, and a quarter were in Syria.

The main discrepancy here is in food aid. So 18 percent in Jordan received food aid compared to 90 percent in Syria. But when you recall the household food security data, the food situation in Syria seems a lot worse. So if 90 percent are receiving food aid, what's going on with that food aid? And why isn't food security looking any better?

If you look at kind of quality of diet, you can see that the quality of diet in

Jordan is a lot better than the quality of diet in Syria. And if you look at the proportion that's reporting a decrease in their food status, more than half of the population in Syria reports that their food security status is decreased whereas the -- only 30 to 40 percent do so in Jordan.

We weren't able to ask anything more than this on the food aid, and we're hoping to do some follow-up survey work in the next couple of months. But we would definitely welcome any insights and comments you have on this because I've kind of been left scratching my head as to what's going on with the food situation.

We did a little bit of analysis on who receives humanitarian assistance, looking at food aid and cash in both Jordan and Syria. So, for food aid in Jordan, you can see that it's targeted pretty much by your socioeconomic status, so you're much more likely to receive food aid if you're in a lower income quartile. Also, if you're registered with UNHCR and if you have children in your household.

In comparison, in Syria, the targeting strategy seems very different. But also, remember, 90 percent of the population is receiving food aid. So, you're much more likely to receive food aid if you're registered by UNHCR. If you have children and also very interestingly the more educated your household members are, the more likely you are to receive food aid, which is something that is seen, I would say, in other refugee settings as well. But probably not something that the humanitarian assistance community is very happy with.

Lastly, those that lived in Damascus were twice as likely to get food aid as those that lived outside of Damascus. And if you were recently displaced in Syria versus displaced a lot earlier, you were also more likely to receive aid, which is a good thing.

When we move on to cash assistance, you can see that the targeting pattern in Jordan is really pretty similar. So, obviously if you're lower income, you're more

likely to receive cash. A good thing. And then, the same thing if you're registered with UNHCR, more likely to receive cash. So not unexpected.

When you get to Syria, you can see in Syria they're targeting female head of households. So, female-headed households were six to seven times more likely to receive cash than households headed by men, which in the context of Syria, where it's very difficult to be engaged in the formal labor market regardless of your sex, and then if you're a single-headed household, culturally even more difficult to work, this is probably a very good strategy.

What I was wondering is, why isn't same thing happening in Jordan? And so that's another thing that's unknown.

The other thing I wanted to just mention was, in Syria again, if you lived in the capital city, you're again more likely to receive cash. So, perhaps moving aid outside of Damascus would be an appropriate targeting strategy.

So, some food aid observations. The receipt of food aid in Syria is much more widespread than in Jordan. And food security between the two countries was similar if not worse in Syria, which is perplexing.

Syria, we also look at mid-upper arm circumference in young children, which is a measure of acute malnutrition. It's not the ideal measure, but it was all that we could do. And we found that malnutrition was about 4.6 in Syria compared to less than 2 percent in Jordan, so almost double.

The other thing that was reported that we're very interested in is 78 percent of households in Syria reported selling their food aid. And anecdotally, this has come up in other settings and other sources. And some of the reasons are that maybe they don't like what's distributed. Other ideas are that perhaps the World Food Program is giving out lots of aid because they can't give out cash. And so, the idea is maybe the households can

keep some food, sell some of it to meet their other basic needs. But this is, again, something that we're interested in exploring more and don't really have great answers to.

One of the suggestions that has come up kind of in the face of decreasing funding availability is, why not cash-based programs or voucher programs? Where they're logistically much easier to implement, you kind of have a higher return at the beneficiary level per dollar invested. So, I think that's one area where the discussions in the future might be going is voucher programs or target aid cash assistance.

And lastly I think better targeting of both food and cash in both Jordan and Syria is going to be very important. Some agencies have suggested doing a comprehensive vulnerability assessment of every potential beneficiary household. And then providing aid based on that. That's a great idea in theory, although I'm not sure how that would actually be implemented given the resources that are available to the international community and the time that it would take to go through that. But that's one of the ideas that's been proposed.

And then the other thing is, are there more sustainable ways where we could kind of go about promoting humanitarian assistance programs, encouraging the national governments to provide support? Because I think it's very clear that the vast majority of Iraqis are not planning to return any time in the near future. And funding cuts are definitely eminent.

So, thank you, that's it for me.

MS. FERRIS: Okay, thank you all very much for three illuminating presentations. And we have time now for questions and questions can be directed at any or all of the three.

Yes, please. And if you could identify yourself. There will be a microphone coming.

MS. COOLEY: Microphone secured. First of all, let me thank the panelists for an incredible presentation.

My name is Jenae Cooley . I'm the program officer for Iraqi refugees, specifically Jordan, at the Bureau of Population Refugees and Migration at the U.S. State Department. So, I find this incredibly illuminating because my responsibility is to try to manage our funding assistance to our partners in the field, of which IMC is a very good one. So, thank you all for these presentations. And I had a -- just one comment and two questions, actually, if I may.

With regards to the question of parallel systems, we struggle with this on a daily basis and I'd welcome your comments. We came across -- we continually deal with your challenge that you had with regards to how to access folks and get information. Dr. Doocy, you mentioned having to do this kind of cluster approach where one neighbor would introduce you to the next neighbor because of the limitations we have with the host government on getting data of who is being accessed -- who is accessing government facilities in Jordan.

It's very challenging, and with regards to how we report to the Hill and OMB and other various institutions who are extremely interested in understanding how our funding is benefiting the Iraqi refugees in Jordan. So, we struggle with -- you know, we can build a parallel system, as you mentioned, by funding direct partners like NGOs to provide health services, because then we can get that data back. But when we give data in other ways through the governments -- or give assistance in other ways through the government, it's challenging to sometimes get substantial data, as you ran across, to be able to determine what kind of services these beneficiaries are receiving. So, something that we are trying to address as well and would love to speak to you more on that.

The specific question that I had was, when you mentioned that -- and I

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believe Dr. Burnham, you mentioned this, too -- the 42 percent in Jordan and the 39 percent in Syria of the households who reportedly had somebody employed. If you had any anecdotal information about where they were employed. And the question, Dr. Burnham, relative to that, for you would be if you heard any anecdotal information about Iraqi doctors in Jordan trying to find a way through the myriad of bureaucracy to get a work permit to practice medicine in Jordan.

Thank you.

MR. BURNHAM: I think those are very good questions. And I think maybe I'll turn it over to Shannon to talk about the employment, because we did ask specifically about that.

MS. DOOCY: So, I can say for the two broader surveys in Jordan and Syria, we weren't able to ask much of anything on where people were employed in the household survey in Jordan. In Syria, we did have a pretty good opportunity to sort of delve into some of the details.

And most people were employed, I would say, in below their kind of education or skill level, in informal kind of situations. There were a lot that were working construction, I think also in kind of the service and restaurant industry.

And mostly men. And then there were -- I think it was about 31 percent of households said that they had somebody that was interested in being employed, but that were not able to find work. And I can kind of get you both of those reports so you can read up on those sections if you'd like.

And then for the Iraqi doctors, it seemed like among the younger doctors, a lot of them were kind of volunteering, working with -- for no fee just to gain experience and hopefully get a position. But the university hospitals in Jordan were employing some of the older, more senior doctors.

MR. BURNHAM: Yes. I think that some of the -- as many of you know, there's been some movement back and forth between Iraq and Jordan in the medical system for quite some time. So some of the senior doctors were registered, were semi-established, and so they could function fairly well in Jordan.

There were also a number that were working under other people's licenses. So, they weren't ostensibly registered in the system, but they were kind of in a temporary position. And I think these are many of the people who were looking for moving out to some other location.

And just as a little anecdote to that, we had four -- six Iraqi doctors who were our interviewers for this, for the Iraqi doctor study. And these were really smart kids and most of them were fairly recent graduates. I think all of them are now in the U.S. enriching our own health system. And I think the same pattern we're going to see in other situations as well.

SPEAKER: And could I clarify, when you spoke about -- sorry. When you spoke about these Iraqi doctors, we're referring uniquely to refugees? Those who've registered with UNHCR? Or Iraqis who've left Iraq and may not necessarily be registered yet with the UN as refugees?

MS. DOOCY: I think almost all of them were registered.

SPEAKER: They're all registered, thank you.

MR. BURNHAM: And I think the reason for that is you're registered because that's what you have to do to get onto the next phase of your life.

SPEAKER: Thank you.

MR. FERATI: If I can add to that, in Jordan, Syria, and Lebanon, in 2007 and 2008, after the return started, we have one way of perhaps -- a different way of conducting a survey. We have done a survey with the Ministry of Foreign Affairs, Ministry of

Displacement and Migration from the Iraq embassies. So each day, the Iraqis will go to the embassy to seek any assistance from their own embassy, we will survey them. So, that really does not affect the host government and they are able to talk.

So, we have surveyed, I think, thousands of individuals in that setting. So they are willing to share information because they feel comfortable. And embassies are pretty much open. Tell me that --

MR. BURNHAM: Yeah, go ahead. One final point. With IMC, we also in Jordan and with Caritas, did a survey of clinic users, and finding out what people were missing and what people wanted and so forth. Actually, it was, I thought, a very good study. Again, focused just on that population. And the one service that everybody wanted -- almost everybody -- that was not available, were mental health services in some way.

MR. FERATI: And thanks to PRM, the mental health services are being funded in Jordan and Syria and Lebanon. And just a question, they're not -- as a practitioner, I can clearly say from IMC and from other organization that they're never setting up the parallel system, either in Jordan or Syria or Lebanon.

I think donors that doesn't allow that and the clinic is not to create the competition.

MS. FERRIS: Okay. Next questions. Yes, right here and then there.

Yes?

MS. MARCADO: Hi. I'm Robin Marcado from International Relief and Development. My question is for Dr. Burnham. I remembered it just because you were first.

MR. BURNHAM: Okay, go ahead.

MS. MARCADO: But I'll throw it out there for everybody. But I specifically wanted to ask about the ability of Iraq to produce its own doctors, which, you know, many of the universities are operating, but they're not operating at 100 percent. Many of them were



looted after 2003, and they were already working off decades-old textbooks and, you know, ancient material, broken machines, that kind of thing. And they simply don't have the ability to train the doctors they need for the next generation. And in your presentation, I wondered -- well, I was wondering of that aspect of it if that came into the numbers that you were telling us.

And on just as a side note, one of my friends is actually an Iraqi doctor who is one of those people that fled in 2004. And he was the dean of neurosurgery at Baghdad University. And he went back to Jordan the next year to have a dinner with some of his Iraqi colleagues that had also fled, and it was like the top specialists from all over the country, and he thought that the tragedy not only was that these are doctors that had left the country, but they were also professors and that they weren't training the next generation. And so, you don't have cancer specialists who are training people to -- you know, the next group of people coming up.

And I also wondered if you could comment about, you know, in terms of the United States. We've poured billions into Iraq and we've been very generous towards rebuilding the infrastructure. But we haven't necessarily been generous towards higher education. And I was wondering if you could speak to that as well.

MR. BURNHAM: Well, I think that's a very complex issue there. But I think you raised a number of important points.

And we've heard the same thing. We had a conference, we patched in the dean from the school of medicine in Baghdad and he said, you know, I've closed my ear, nose, and throat now. I no longer have any specialists and my psychiatry department's going to get closed next week. And so forth.

So, loss of those tertiary specialists who are in the educational system has been a big problem. Now, that's going to take a while to rebuild. And, in fact, the whole

medical education system is going to take a while to rebuild. And like -- you know, every other time that Humpty Dumpty crashes, you want to rebuild it in a different way than it was initially. And the system has been very hospital-oriented, very specialist-oriented in the past. Now this needs to have, as Agron mentioned, a focus on primary health care.

And there is a program starting to look at developing family doctors and so forth and IMC has been involved very much in that. There's quite a bit of work that's gone on in refresher courses. But there's only so much refresher courses that you can do.

There is a basic need to rebuild faculty and rebuild faculties along a different way than in the past. And in a situation like Iraq, it's very classic, and we see this in many other places. You tend to be isolated from the rest of the world, you tend to focus very much on the pattern that you followed for the last 20 or 30 years. And this needs -- the whole curriculum needs to be changed.

Nursing, for instance. We haven't talked about that. There's a major need for high-level nursing care education in the country. The schools -- the country does not have a school of public health. A lot has been discussion about that, there's some community medicine departments. Not the same thing. This is a major need for construction as well.

So, right across the board, we need to look at reconstruction of things. And at the same time, the schools of medicine and nursing are fed from secondary education schools. Many of these have taken a hammering as well. Many people don't have the preparation in the basic sciences and so forth that one needs. That also needs to be rebuilt.

So this needs to start right at the bottom level. And this is going to be a long term situation. But this is the time that these decisions and these focus -- these reorientations need to be remade.

MR. FERATI: Just to add to that. There is a lot of enthusiasm in Iraq to

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rebuild the Ministry of Higher Education capacity. First priority is doing a very fine job in Iraq, so you guys are also involved in certain aspects, perhaps at the lower level, not necessarily at curriculum development. But Ministry recognizes this need.

But also, we should perhaps focus on John Hopkins in saying, why you don't want to twin with the local universities and the risk-taking of universities, like from the U.S., who want to open their door to a twinning process, that mentoring process, to change the curriculum at the global level, to conduct what is the Iraq health care or other specialty needs 10, 15 years down the line? So, start addressing these.

Today as we speak, there is a national first conference on research and development. Dr. Alan Dyer is there. At a national level, about 40, 50 Iraqis physicians from Jordan return back to sort of look at the research and development. And we're hoping that some positive changes are taking place. But also, Iraq, they don't want to open that much. Because they feel that they can do it themselves. And it might take 10, 15 years, but, until then, the U.S. and other countries will progress 15 more years.

So, it's about twinning, it's about looking at the demand and what they can supply. Not tomorrow. They want to fix the problem tomorrow. But 5, 10 years down the line, how they are going to meet the needs.

MR. BURNHAM: Yeah. And I just might add to that. Sorry. From the university standpoint, this is the kind of thing we like to do all the time, but we need to have a matchmaker.

MR. FERATI: Yeah.

MR. BURNHAM: We need to have some kind of fixer to say, okay, you know, we're going to facilitate this. Not just for one refresher course. And that's what we see a lot in Iraq right now is short-term refresher courses.

How do we look at a long-term relationship in this and how do we build that

kind of thing? How do we build that trust which we have to have first? How do we look at what those needs are, not just coming in with some kind of package that worked well in Uganda and worked well in East Timor? And, you know, now try to adapt it for here.

MR. FERATI: And a cost.

MR. BURNHAM: Yeah.

MR. FERATI: There is cost. Harvard, for example, we work with are very expensive. So, who is going to pay?

MR. BURNHAM: Yeah.

MS. FERRIS: Ah, yes. I have Jesse here. And then in the back?

MR. BERNSTEIN: Hi, Jesse Bernstein from Human Rights First. I have two questions for the speaker from IMC.

You talked about the fact that the Ministry of Health and other line ministries have to step up and it's not really MODM. I wonder if you could further elaborate on how you see that could actually happen and what type of advocacy is needed to ensure that the line ministries actually fulfill their responsibilities. And what is the role of the MODM within that?

My second question is, you also mentioned the legal and administrative framework, and I wonder if you could elaborate on that. Is that framework impeding access to rights? Are there certain parts of the framework that are good and useful?

And my final question is for the first speaker. You mentioned minorities and return of minorities? I wonder if you could elaborate on that. And are there specific minority -- health needs of minorities that need to be taken into account.

MR. FERATI: So, first question was what?

MS. FERRIS: Line ministries and MODM?

MR. FERATI: Iraq constitution says that every Iraqi, no matter whether you

are IDP or the host, you have the government guarantee free access to services. So if you are from Baghdad to Urbal, you have a right to access every services.

If we looked at the constitution and why Ministry of Displacement Migration has been established and what is their main role, that's the first starting point. And we often overlook that. Ministry is there to collect the data, process and report on information and serve as an ombudsman of the Iraqi displaced people and refugees. They are not there to provide services. Often other organizations, like IMC, IRD, and Mercy Corps, we go to the Ministry and say, hey guys, why don't you come and help us so we can do this cool intervention together? Some ministries get more of a media attention.

So, we should look at the constitution and what's the ministry role, and support them to build their capacity within that role. Ministry of Health, Ministry of Labor and Social Affairs, Education -- these are the prime social service provider. So, they have to step up their efforts, because the distribution of medication, for example, it's done according to the formula, which was developed in '70s, according to at that time distribution of population.

So, now we suddenly have 10,000 host citizens living in certain neighborhoods -- in Al-Dora, for example. And then we have about 12 -- 20 more thousands Sunnis coming in Al-Dora.

But the PHC in Al-Dora, Primary Health Care centers, receive the same share of medication that they used to receive, while the Al-Dora had 7,000 people. School's capacity is not about -- UNICEF has the grade status and reports, and they come up that we need more schools. It's not about schools, it's about the quality of education.

Iraq right now wants to invest billions of dollars of building more and more hospitals, which Dr. Gilbert addressed. You don't have a gatekeeper, which is the Primary Health Care centers to process this. Once they end up to the tertiary level, oh then we are

dealing with a brain surgery, we are dealing with cancer and so on and so forth. Do they need million inpatient bed hospital? No, they don't.

Second question was --

MR. BERNSTEIN: About the legal and administrative framework.

MR. FERATI: A legal framework is basically setting up stage how the community structure and the services should be developed to absorb the IDPs. Looking at the counselor situation, UNHCR after the war came up with six years' cascade plan how counselors will start interning from Albania and so on and so forth.

What has happened, that our refugees has returned within a week. So, that plan did not really work. So what is really what has to happen in Iraq is to look at the neighborhood level, involved organization or the government entity such as PRM to facilitate sort of the dialogue; Brookings Institute and others to bring the practitioners from the neighborhood level to really set the stage.

And that legal framework is to give other ministries an increase in budget so they can actually start delivering the services.

Third one is minority. I have addressed MSU and I talk about this.

MR. BURNHAM: I think that's what we found, anecdotally. Because the sensitivity, we really didn't include many questions about religion, ethnic groups, and so forth in that. But the anecdotal situation was that if you're a minority group, and you're faced with a lot of violence, you're more likely to move to within Iraq or move outside Iraq.

And in Syria, we've had a general feeling -- and maybe Shannon can correct me on this -- that there was a larger Christian population going to Syria than Jordan. And one of the reasons, also, I think was that the Syrian government was very open to religious organizations providing assistance much more, perhaps, than in Jordan.

But, again, we don't have any serious data on that.

MR. FERATI: To add to that, I work with IMCs here in Jordan and Lebanon, including Gaza. So why the church is stronger in Syria. Caritas and CRS, they are working through the church and our first intervention in Syria as IMC, we were able to access the Christian minorities population, who -- they were more open to sharing information and opening their -- in Iraq is the major concern and issue.

The shifting demographics is an issue. It's an issue that people are not willing to return to Baghdad, but rather than moving more into the Mosul, northern concentrated area where they concentrate along the church lines, along -- they are opening their own schools, so we're going to -- from human rights issues, which I don't want to enter that area. It's not of what IMC does. But it's a major concern. They've been overlooked -- Hasidis , Hawazis -- I mean, these are the lot of other groups because they are not the main -- the actor into the violence and war. That's why it's being overlooked.

MS. FERRIS: Thank you. The gentleman in the back?

MR. ADAMS: Hi, yes. Jesus. Ian Adams, Islamist Supreme Council of Iraq. Like to first off thank you all for coming out and talking today.

The question I have is one that's very broad. And for that I apologize, and you may have already touched upon it today. But I may have been lost in the deluge of information that was given in the past hour.

The question that I do have is, what do you find is the largest gap in the public policy and the government policy that is preventing the augmentation or the improvement of the Iraqi health services?

MS. FERRIS: Who'd like to take the first --

MR. FERATI: Yeah, I can --

MR. BURNHAM: Yeah, Agron, probably.

MR. FERATI: The -- basically the -- at times here, we have sort of -- we are

helping the Ministry of Health develop the national strategy and channel that funded by PRM Ministry and by the U.S. Embassy, U.S. aid and Australian government and some others. So, what we are unable is to create that strategic long-term vision and cascade plan, and to look at the pressure point interventions, but rather than being scattered in addressing every single aspect of the health care sector, which does not bring the results.

So there is no clear vision, there is no clear strategy, there is a wrong strategy investing in the tertiary and secondary level. Building the hospital why? Because the government wants a lot of publicity, and publicity can be created only by showing the 500 inpatient bed hospitals, and so on and so forth.

Other interventions seen by Basra Children Hospital, where it's a 95-bed hospital and so on and so forth. And IMC staffs to open this hospital. How are we going to open it? There are no cancer specialists. How are you going to open when there is no radiation oncology specialists?

So, what we have to do at that time, improvise by partnering with the American University of Beirut and start sending people to certify them at the competency base certification program. Working with atomic energy -- but this is nothing that can be addressed within the month. And the results that even donor ones from us, it's a short term, tangible, give me the numbers. And what should happen is the pressure point long-term programs cascaded approach. That's the only way forward.

MR. BURNHAM: And I might add to that also that all -- virtually all doctors in Iraq are employed in the public sector. But in order to survive, you have to have a private clinic as well. And when we see this situation, we see an overdevelopment of specialists. And that's the way you rise in the system, that's the way you improve your income generating activities in your private clinic, and so forth. And so, that -- somehow, we've got to figure a way to break that kind of cycle, and that's not a short-term kind of situation.



And so that kind of feeds this overspecialization, these big hospitals. Nobody wants to do primary health care because, you know, the -- or the primary specialties because the income from that, both public and private, is not nearly as great.

And then, again, as Agron says, governments want to visibility -- this is the way they build their legitimacy. So, you want to see big structures, and so forth. And so we see this over and over again where you see overspecialization, overdependence on hospitals.

And then at the same time, there needs to be a serious look at medical education. And we could say that same thing about the U.S. So, it's not unique for Iraq. But Iraq's had an inheritance from a medical education system that goes back to British days. And in many ways, it's very appropriate, you know. I've got a degree from British university and it's very fine. But things have moved on. And we have to look at things in a different way than we did in the '70s, when many of the -- much of the framework for the medical education was put into place.

MS. FERRIS: Yes, I think there was one more here. And then perhaps we should wrap it up.

MS. MORALES: Yeah, my name is Maria Morales . I'm from International Relief and Development as well. And the question is actually -- was directed to this issue of the private sector. And I wish you could clarify a little bit more of where does that private sector sit currently within the actual legal administrative framework. Or what's the plan?

I know you mentioned that financing of services rather than provision of services was one of the recommendations. Could you elaborate that on that a little bit more?

MS. FERRIS: Maybe before you -- I'm sorry. If you could repeat your question, then let's take this woman down here. We'll take them two together, if that's okay.

MS. MORALES: Yeah, the question was --

MR. FERATI: Can you repeat the -- private sector?

Ms. MORALES: Yeah, to clarify the role of the private sector currently.

And what was the recommendation of the -- a little bit more.

MR. FERATI: Okay.

Ms. FERRIS: Okay, and then this question right here we'll put together.

MS. SCHNELLER: Hi, I'm Rachel Schneller . I'm at the Council on Foreign Relations also doing research into Iraq and its refugee issues, but kind of from a different angle. But I was wondering about the -- you were -- it -- the information about the food aid and the cash assistance and those numbers, it made me wonder what the mechanism is in place for refugees to gain access for that.

And the reason I'm asking is because a number of the Iraqi refugees I've asked have described in detail going through the whole process of registering at UNHCR, but have said that at no point were they ever offered or made aware of any assistance. And so I was wondering if their perception is that you have to have connections to get this. I'm not sure if that's just a perception or what the deal is.

But how -- do refugees, when they apply or register at the UNHCR, are they automatically given access for information? Or how is this whole process set up?

MS. FERRIS: Okay. We've got a question then about the private sector and health care in Iraq, and then about access to systems in other countries.

MR. FERATI: A private sector key developing any nation is the private sector. If governments start rebuilding roads, building the bridges, and so on and so forth, that will take decades, as we are seeing in Iraq. And working for IRD, if you go to your president in your program, you are basically relying on the private sector to build the parks and so on and so forth. And it's nonexistent at this point of time. They have no capacity.

There is a legal framework. There is a policy in place to sort of encourage the foreign investment, but there is no protection of -- that protects the foreign investors from investing in Iraq. So, they don't have that guarantee. So basically until the private sector really stand up to its full potential in Iraq and start employing people, then until then we'll see the difficulties that Iraq is facing.

Second on the health private sector is basically -- these are the issues that the gentleman addressed in the back. If Ministry of Health starts being a service purchaser rather than service provider, what that means is that in many countries you set up the performance standards. The basic service packages by saying Agron Ferati is a physician, and these are your targets. So you look more at the quality and you are compensated for that, including the decentralized process where the budgets are more managed at the local level rather than central level. Because central level managing the budget, they are not close to the service provider.

Minister is not close to the hospital. He goes there for political or individual or professional reasons, but he's not on daily basis. So, people who are managing the hospital should have more influence on a pedamiological data collection, and so on and so forth.

MR. BURNHAM: And just to add at that. We're not here to talk about Afghanistan, but we're doing a huge amount of work in Afghanistan. And there, post-conflict -- well, I don't know if it's post conflict, but post-disappearance -- initial disappearance of the Taliban, that was exactly the plan, where you purchase services. There were performance-based agreements. And our job at Johns Hopkins was to do national monitoring of the quality of services to actually verify what these kinds of services are.

When you have a situation like you have in Iraq now, where you are employed by the public sector, but you have this private sector in order to make a living, this

becomes a very iniquitous system because it allows the public sector to underpay people, thinking of the private sector is now going to make up for it. And this has lots of implications for how treatment is done, and the failure to develop really a robust private sector.

We've got a lot of clinics, no big private hospitals to speak of. And there's a lot of issues that down the way we're just purchasing huge amounts of problems.

Shannon.

MS. DOOCY: Okay. So, I would say with respect to humanitarian assistance, I mean, first of all, in Syria almost everybody was receiving food aid. So it seemed to be that when you registered at UNHCR, kind of the entire community was aware that food assistance was a benefit that almost went with UNHCR registration.

So, virtually everybody was able to access food and almost all the food aid was from the UN. In Jordan, a very small minority were able to access food aid, and a lot of the food was from NGOs, and also from churches, mosques, and community groups. So, it was difficult, I would say, to generalize in terms of if people are aware of how to access it because these organizations didn't necessarily have a coordinated approach to distributing food.

So, no, I think the -- I think your kind of perception is exactly right. We had the same feeling that, especially in Jordan for food, there was the kind of feeling that you got it because you were lucky or you were connected. But there was no kind of consistent process within the UN system to access food or cash if you were particularly needy.

In Jordan, I would say that both food and cash tended to be targeted towards lower income individuals. In Syria, the cash assistance was largely for female-headed households. But I don't know among those female-headed households what kind of criteria was used. And it was something that we really tried to explore a little bit more via key informant interviews, but it was, you know, I would say difficult to kind of get very clear

answers, so.

MR. FERATI: I would just add to that the quotient, because the very -- the small proportion or the percentage of Iraqi refugees or the guests in Syria and Jordan are actually reduced than with UNHCR. So if we are looking at the -- they are progressing the numbers. But if you look at the estimate how many are there and how many are adjusted, it's a small percentage.

MS. DOOCY: Right. But a lot of people might argue about the actual estimate (inaudible).

MR. BURNHAM: Yeah.

MR. FERATI: So --

Ms. FERRIS: The questions of numbers are always quite political.

MR. BURNHAM: Yeah, exactly. And when we got into -- when Shannon got into the issue of Jordan, she's the one that faced this. Jordan government specifically said, you know, you're not going to talk about those numbers, so.

MS. DOOCY: Right.

MS. FERRIS: Thank you all for coming, and please join me in thanking our panelists here.

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