Mark: We are very pleased to have assembled the remarkable lineup of topic specialists who will speak during the course of the day. Our first panel features several highly distinguished leaders in their fields, and this includes the moderator, Dr. Elizabeth Ferris, Senior Fellow at the Brookings Institution. As the Co-Director of Brookings’ London School of Economics project on internal displacement, Beth Ferris focuses on the international community’s response to humanitarian crises with a particular emphasis on the human rights of internally displaced persons. Her most recent book is *The Politics of Protection: The Limits of Humanitarian Action.* Beth comes to us today in her service in this conference fresh from two and half weeks in Lebanon and Turkey, mostly on the Turkish-Syrian border, looking at the intersections between humanitarian assistance and politics. We were delighted when she accepted the invitation to moderate this panel, and having her just back since the beginning of this week from her own field research will surely bring a great added dimension to the discussion with her two panelists who are based in the region and two from here in the US. And so with that, I’d like to hand off to our moderator, Beth Ferris, who will introduce the rest of the panel. Incidentally, as you may have divined, one of our panelists, or you heard Wendy refer to it, one of our panelists, Dr. El Oakley, the minister from Libya, will be joining us by Skype. So, Beth, off to you.

Elizabeth Ferris: Thank you very much, Mark, and hats off to the Middle East Institute for putting together this wonderful program on a very important and often-overlooked topic. The panel this morning is going to be looking specifically at the health needs of populations displaced by conflict and political upheaval, and certainly there are many such populations in the Middle East. As Mark mentioned, we’re going to begin with the Minister of Health from Libya, Reida El Oakley, who has been Minister of Health since 2011. He’s a cardiologist, a professor at Ben Ghazi University, and the University of Singapore, has worked on health issues with the World Health Organization, and certainly is very knowledgeable about the issues facing Libya and the great region.

He’ll be joining us by Skype, which is always a little bit iffy. We’re hoping that the connection is flawless and that you’re able to hear and see him clearly. If for any reason we lose the connection, we’re not going to spend a lot of time trying to recall. Sometimes this works well and sometimes it’s not. But we’re going to keep our fingers crossed and hope all goes smoothly. He’ll be followed by Andrew Harper. Andrew is a UNHCR representative in Aman. Very knowledgeable on Middle East issues. I think we met a decade ago working on Iraqi displacement, and since then he’s acquired a tremendous experience on the ground in Aman and indeed throughout the region. He’ll be followed by Zaher Sahloul, who is president of the Syrian-American Medical Society, one of the leading medical relief organizations working in the field. Really has pioneered work inside Syria providing medical care, probably in some of the most difficult conditions in the world, as well as to refugees...
in neighboring countries. Finally, we'll hear from Len Rubenstein, who is director of the program in Human Rights, Health, and Conflict at the Center for Human Rights and Public Health at Johns Hopkins Bloomberg School of Public Health. Has a great overview of the situation throughout the region, has previous served as Executive Director of Physicians for Human Rights, and has managed to bring together Human Rights and health issues throughout the region and indeed more generally. Okay, I just received a little note saying that we don’t yet have a connection with Skype, so in our flexible tradition, we’re going to begin with Andrew, and Andrew, I invite you to speak for eight to ten minutes and hopefully at that point we’ll be able to go back to the Minister of Health. And if not, we’ll be creative. Thank you, Andrew.

Andrew Harper: It’s always good to be thrown into the den. I think Her Excellency has covered a great deal of the issues, which I think many of us are aware of: what the Middle East is facing, what North Africa is facing, is something which is unparalleled. We’re marking this event, and thanks go to the Middle East Institute and to IMC and the others for supporting this. We’re holding this event at the same time as World Refugee Day. The figures which came out underlined how disastrous the world is at the moment in relation to dealing with the underlying causes of displacement. But also, the collective failure in providing the most basic support to those people fleeing their homes. And if you look at the figures, they start losing all relevance. Because no one can really grasp what we’re talking about. We’re saying sixty million people have been forced from their homes.

We’re talking about 42,000 people being forced from their homes every day. Inside Syria you’ve got approaching eight million people forced from their homes. At least another 4 million who have fled across the borders. These are individuals. And unless you actually see an individual who has come across the border in search of hope, in search of medical support, you cannot really grasp it. In some aspects the refugees who cross the border and can be supported by the host states, whether it be Jordan or Lebanon or Turkey or elsewhere, they’re the lucky ones. I’d be very much interested to hear, in relation to the situation of providing medical support to the millions of people who are beyond reach inside Syria, but also not only in Syria now: we’re also talking about Iraq, we’re also talking Libya, we’re also talking Yemen, and I don’t like necessarily getting caught up in numbers because numbers, I don’t necessarily can be grasped, but what we are looking at is a trend, a trend which is becoming a bottomless pit of inhumanity. And I don’t know what the international community is going to be able to do about it, frankly.

Jordan, as everyone is aware, has been incredibly hospitable and generous to not only Syrians but also Iraqis and Palestinians before that. But many of the countries who are hosts to refugees have also had chronic underdevelopment because they don’t have the resources to deal with it. They have not been allowed to invest in the
infrastructure, whether it be on the medical facilities or in the schooling or other elements which would be required to provide support to a population of this size.

So, everyone is struggling. What we are calling for is obviously increased international support, international burden-sharing to those countries which are hosting refugees. But at some point, it’s got to be more than that. Because at some point, we cannot just continue to go out to donors and say “We need another 20 million dollars for this month. We need another 20 million dollars for the next month.” Because it’s not feasible. It’s a bankrupt system. We have to be doing more to try and address the underlying causes of the displacement and trying to find out how we can get people to be returning to the homes. It was also mentioned by Excellency the situation of the destruction of the infrastructure inside the countries. We’re seeing at the moment the bombing of hospitals, of health centers, of basic infrastructure.

And you can describe it in many other ways, but this will then mean that the refugees have got nothing to go back to. Even if there was peace tomorrow, if you look at the pictures of many parts of Damascus, if you look at the pictures of Derroz, or Aleppo, or Homs, Hama, any place where there’s been conflict, one of the targets of the conflict has been the infrastructure which provides the necessary support to refugees. So, when I talk to the Jordanians about increasing access to protection, increasing access to assistance, they say, this is great, but at what point are they going to be able to go home? And I can’t tell them that they’re going to be going home tomorrow, next month, next year, or in the foreseeable future. So, it’s particularly important for the refugee agencies such as UNHCR to look at providing the necessary support for the refugees but also for the host communities. Because at the moment, the host communities around the Middle East are feeling that they have been neglected, despite a degree of generosity, and that they will be left with a population of millions to accommodate and to provide assistance for years to come.

Just to give you some brief figures: just in the last five months, we’ve had to decide on, just to try and bring it home to you, we’ve had to decide on 111 cancer cases for children. We don’t have the resources, so we could only provide support to 65 of them. So, imagine being put in this position. I’ve got another 10 cases waiting for me when I get back. We have to make decisions in regard to the likelihood of survival, how much it’s going to cost, and what we’re seeing is we’re seeing more people coming across the border from Syria desperate because medical supplies have run out in Syria, coming to Jordan. Jordan doesn’t have the money to deal with additional cancer cases because they’re also struggling. And the lack of hope, the lack of future, is epitomized by a child who’s coming across the international frontier, across the desert, reaches sanctuary such as Jordan, and we cannot do whatever should be done for that person. So, it’s something which is a challenge.
In addition, we’ve got 8% of the total refugee population in Jordan has suffered a critical injury of one sort or another. Usually due to a battle, I don’t know what you call it, conflict-related injuries. And these put, again, enormous strains on the health facilities.

I know I’ve only got the eight or ten minutes to talk about, but I think one of the other elements that I think we need to take into account is that if you neglect a country in conflict, whether it be Syria or Yemen or Libya or Iraq, then the consequences, the negative impact of that, will transcend boundaries. And it’s not just radicalization and extremism. It’s also diseases. And Her Excellency mentioned the issue of measles and polio crossing borders. You can put up as many border guards you want to try and protect the border, but there are real health threats which will transcend the border guards. And so my absolute utmost appreciation for everyone who’s on the front line, who are providing the medical support: SAMS, IMC, the Red Crescent and others. Because they are doing a fantastic job in an almost impossible situation, but a situation that is likely to continue to deteriorate before it gets better. So I would like to, obviously, have a much more positive spin on things, but it’s challenging. And I think this is one of the reasons why we’re here. We need to try and raise the profile, rather than just treating it as a budgetary response, we need to be looking at it as more of a policy response, ensuring that what we’re addressing in Syria and these other countries, the medical element, the public health estimate, is taken into account. So, thank you.

Elizabeth Ferris: Thank you very much, Andrew, for that somewhat sobering introduction to the situation in Jordan. We’ll turn now to Zaher Sahloul from the Syrian-American Medical Society. Please, Zaher.

Zaher Sahloul: Good morning. I’m really honored to be here and to talk about a very painful issue to me and to many of us: the issue of the healthcare crisis in Syria. I was educated in Damascus University and finished my medical school from there and came to have my training at University of Illinois in Chicago. And I’m a practicing physician in Chicago. And as Ambassador Patterson has mentioned, Syria was a model country in terms of healthcare indicators before the crisis. We had equal indicators to other middle-income countries, in terms of many aspects of healthcare. The Syrian physicians who represent about 1% of the Syrian-American physicians are a product of that model country. So, 1% of our physicians here in the United States are of Syrian ancestry. The Syrian healthcare system before the crisis had very strong central planning. We had a good infrastructure in terms of hospitals, physicians, nurses, technology. It was a hybrid system between private and government-run system. All of these successes were eroded because of the crisis.

Before the crisis also there were some successes related to vaccinations. So, polio became extinct in Syria in 1999 because of the strong vaccination rate throughout
Syria, which was about 95% in different areas in Syria. The measure of morbidity, as Ambassador Patterson was saying, lately in Syria, before the crisis, was related to chronic diseases, like us here. So many Syrians had morbidities and mortalities related to diabetes, cardiac diseases, obesity, COPD, and cancer.

What is important to know about Syria since the beginning of the crisis, that Syria is the worst-case scenario. If you have to put a scenario where everything can get wrong, it is Syria. And we can talk about the aspects of the Syrian crisis from that perspective.

So, let’s start with the scale, and I know that Andrew has mentioned several numbers, but the scale of the Syrian crisis is huge. *The Economist* just a week ago ran an article about the worst humanitarian crisis in our lifetime, and probably the lifetime of our grandfathers since the first World War. And they have mentioned that Syria is the first country in terms of humanitarian impact on the population more than half of the population have been impacted by the crisis which is higher than any other country in the last 100 years in terms of crises. So this is huge in a country that is still developing. A huge impact. More than 250,000 people have been killed, as you know, and probably this is an underestimate. The United Nations has stopped counting, actually, the people who were killed. More than 1.5 million people are injured. They have either amputations or lost a limb or an eye or have shrapnel – and we’re not talking about the mental health impact of the crisis, of course, on the population. The average Syrian has lost 20 years of their life expectancy in the last four years. Twenty years. So life expectancy in Syria before the crisis was about 76 years. So not bad. And right now, the life expectancy is about 56 years. So in four years, we lost 20 years of life expectancy in Syria. Four out of five Syrians are below the poverty line. And I can go over and over about these numbers which can give you an idea about the scale of the crisis.

Now, in response to the scale of the crisis, NGOs like SANS and others like IMC and IRC and other, are trying to adapt to the situation. And I can give you an example about SAMS: Syrian-American Medical Society. Which we have not done medical relief before the crisis. This is an organization that represents Syrian-American healthcare professionals. We used to have educational seminars and some charitable work in Syria before the crisis. We had no experience with medical relief. Because of the scale of the crisis, we had to adapt to the situation. So, we increased our capacity from one full-time staffer to 75 full-time persons who work in five different countries right now, including Syria, Turkey, Lebanon, and Jordan and the United States. We had a budget of $70,000 before the crisis. Right now we have a budget of $26 million. Just four years after the crisis. Last year, the number of people who benefitted from the work of SAMS are 1.4 million patients inside Syria and in the neighboring countries. So that can give you an idea about how can we focus on NGOs in these areas of conflict that can probably replace governments.
The role of the NGOs in Syria in particular and probably in other areas like Iraq and Libya and Yemen is very important and they have replaced the government because the government has stopped providing healthcare to many people in their territories.

In terms of the title of this conference that populations who are displaced and cut off from healthcare, the types of cutting off population in Syria also you have several types. So we have areas that are under complete siege by the government or the warring parties. SAMS has produced, just a couple of months ago, a report called *Slow Death: Life and Death in Communities in Syria Under Siege*. And we have estimated that there’s 640,000 people in Syria under complete siege. That means you cannot access these populations even if you tried to do cross-border. These are not populations that you can reach from the border. They are under complete siege by mostly the government, especially around Damascus and northern Hamas, or some of the warring parties like ISIS in Derrezor and northern Aleppo. And the only way to access these populations is by smuggling medications and medical supplies though tunnels sometimes, bribing warring parties and check points, and some very unconventional ways. Eastern Al-Ghouta, which is the same area that received the largest chemical weapon attack in 2013 is under complete siege for the past three years. So there is no electricity in East Al-Ghouta for three years. So imagine running hospitals and clinics without electricity. So some of the things that we are doing in SAMS is providing also money to buy diesel fuel to operate generators to run some of these hospitals. We are also partnering with some of the organizations to provide unconventional solutions to this issue of energy by converting animal waste to methane gas in East Al-Ghouta in order to provide energy to the generators. So this is one particular population that is under complete siege.

The other part of the population under complete siege are populations under the control of the rebels or the opposition. The only way you can reach them is across the border from different countries, whether it’s Turkey or Lebanon or Jordan. So the only way to reach these populations is through cross-border relief and with very limited sometimes cross-line relief. SAMS has been doing that since the beginning of the crisis and in coordination with the United Nations.

The third type of populations who are cut off from the outside are of course the displaced population in different countries, or the refugees. So we have refugees in different neighboring countries and every country has their own way in providing healthcare to these populations. Turkey has been a model country in terms of proving healthcare. We have a variation of services by other countries, Jordan and Lebanon. But if you want to have a model country where you can provide healthcare to refugees, I would say Turkey was the model because they provide free primary and secondary healthcare to all Syrian refugees without compensation. And they give cards for every refugees and even sometimes tertiary care is provided by the government.
We have seen in the last four years a surge of communicable and infectious
diseases in Syria including polio which was extinct in 1999. So we have an epidemic
of polio in 2013 and also we have use of unconventional weapons like chemical
weapons which also strain the system in Syria. Imagine yourself a physician in Syria
that is dealing with trauma related to conventional weapons and communicable
diseases and non-communicable diseases like diabetes and heart disease and then
you have to deal with issues related to victims of chemical weapons. I can stop here
maybe and we can talk in more details about the other aspects of the crisis during
the Q and A session.

Elizabeth Ferris: Thank you very much for another sobering view of the situation,
particularly given the situation inside Syria, I think, is something we don’t hear
enough about. I understand that we now have the Minister of Health on the line. We
can’t see him, but I assume he is there. Yes. Welcome very much Mr. Minister
Oakley. We are glad to have you with us. Can you hear us okay?

Reida El Oakley: Yes I do, thank you.

Elizabeth Ferris: Thank you very much. You now have the floor for eight to ten
minutes.

Reida El Oakley: Sure. Thank you very much indeed for inviting me and I apologize
for not being able to join you this morning in Washington for some logistic reasons. A
general talk I’d like to say, or presentation, which is really healthcare during and after
crises, is often a simple sudden rise in the number of cases who need emergency
medical services. That’s often with the background of limited or no medical supplies.
For example, drugstores maybe, like happened in Ben Ghazi, were burned down.
Limited administrative support. Fewer healthcare workers; most of them have
departed Ben Ghazi. With limited or no financial support. And that often affects
health services provision to especially vulnerable people such as women, children,
patients with chronic disease, cancer, psychiatric disorders, and HIV in a very
negative way.

This problem lasts longer than the crisis itself, and it can only be helped if adequate
funds and logistic support were immediately available. What can immediately
available funds do to crises? As soon as we assume the responsibilities as Minister
of Health late last year, we fortunately had about $30 million US dollars available at
the WHO, which is Libyan money, frozen assets, being released back in 2012 that
allowed us to buy trauma kits. Trauma kits are boxes pre-prepared to treat injured,
often a box, for example, of trauma A and B and C would treat 100 people. Easy to
assemble, easy to deliver. We were able to buy kits for about 30,000 injured. We
were able to buy obstetric kids for delivery for labor, and also both medical supply
and the other dialysis for patients with kidney failure. Because the main, the other central hospital in Ben Ghazi was shut down, also in the south in (inaudible 25:07) and the southern part of Libya, the hospitals were in the conflict zone, they were closed, they were hit by a mortar bomb and then they were closed. So, we suddenly have to create new dialysis unit, otherwise these patients cannot wait for days. They have to be dialyzed every other day. Also we were able to buy some vaccines and other medication. This happened (inaudible 25:34) and the government as end of September and early October.

I was able to buy some medicine by some would call the deferred payment, and this often requires a voluntary body or company which is willing to give you medicine and you pay later, and especially if you insist on having to buy that medicine at the prices purchased back in 2011 like we did.

In addition, we had problems with children with heart disease. We had hundreds of them. And for that we were able to invite Professor William Novik from America, from Tennessee. He had a charity and we are grateful to him because we were able to operate on more than 70 cases, 70 patients, since January this year by volunteers mainly. But also you have to buy the tickets and make sure that you accommodate them well, and this is something we are grateful to.

Also we have Emergency, which is another, an Italian NGO, or charity, which have actually been dealing with the adults who have heart disease, patients who need open heart operations, for example, which you cannot do in Libya where they would be taken to a hospital, a Salaam hospital which is run by Emergency.

So we had difficulty of course to grant or guarantee medicine for patients with cancer and patients with heart disease and patients whose injury cannot be treated locally. These patients were flown to neighboring countries and were treated, again, on deferred basis, and the details for that is not available immediately, but I’m sure that will remain as debts on Libya for many years to come. We have millions, hundreds of millions of dollars accumulated in debts in various countries including Tunisia, Jordan, and Turkey, as well as Egypt of course.

We were able to acquire some donations through ICRC, MSF, and UNFBA for that, I need to acknowledge their contribution and thank them sincerely for that. The difficulty is if you didn’t have that money immediately available at the WHO, you have to wait to call for an appeal and the appeal would take minimum weeks, maybe months. And that often is not really good enough for people who need dialysis today. For that issue, I think timing, availability of donation is as crucial as the availability of money itself. Especially in countries like Libya where its oil-based economy was badly hit immediately after the start of the liberation war. However, production went back to pre-war levels in 2012 and 2013, but unfortunately with ISIS coming back
into Libya, the production went back to .5 million barrels per day instead of 175 million barrels a day.

The options we had to allow to buy medication for these people, especially cancer and heart disease medications, were either to borrow from a bank, which managed to go from local bank, but even then we didn’t have access to hard currency. We could not buy this medicine from foreign companies where most of our medication was being purchased. Deferred payments, some people will unfortunately abuse the situation, and we had silly offers like a tablet which would cost us in 2011 90 pence was being offered to us for 20 pounds. Another which costs 12 pounds in 2011, was being offered at the rate of 60. I’m looking at real figures here in front of me. Others from 6 pounds to 39 and so on.

The other option which is probably the most reasonable one is to consider using the frozen Libyan assets abroad, but that unfortunately would require a longer procedure with definite need for UN approval and also the approval of the government which is hosting the frozen asset.

The good news is that there are good people who are willing to spend their money and time to help those in need during crises, but the bad news is the lack of adequate and immediately available funds is and will remain a major problem facing affected countries.

I think if you allow me just two more minutes which will give you an idea how the world spent its 10 trillion US dollars on health every year, 10 trillion, roughly, every year. Which is, unfortunately, is being spent in a social, if you can rule out healthcare financing, is an important point I’d like to discuss, you find that countries like France and America spend about $7,000 per head per year in healthcare. As opposed to Singapore that spends only $800 per head per year for health services. Yet, America is ranked number 57 when it comes to the WHO ranking of health system. Singapore ranks number 6 in the world. And the secret to that is something called health saving accounts. Whenever an individual has an account dedicated purely for health services, where 10% of his salary is taken and put into that account, and the government with donate, that amount of money can only be used for health service. You cannot use it to buy a car or something, only for health services for him and his immediate family. And if you need to know more about that, I suggest you read Professor William Hazeltine’s book, he’s a Harvard professor who wrote a book called Affordable Excellence referring to Singapore healthcare system and funding mechanism which to me is a key to successful healthcare service anywhere in the world.

So, to improve health crises, we have two options. Either to request donations as we do and launch appeals and wait for many weeks, maybe longer, to get money. By
that time, many lives will have been lost. Or, request to increase the assets, the assessed contribution, from individual countries to the United Nations and many countries will resist that. In fact, they will refuse it. I know this for a fact, because every attempt to increase assessed contribution to the United Nations, even to the WHO, have been resisted and I think the assessed contribution to the WHO have probably never changed for the last 10 or 15 years because of countries resisting to donate more or give more to the United Nations.

The other option which is worth considering is to establish a healthcare in crisis saving account for individual countries. Similar to what we discussed about Singapore funding mechanism for its national healthcare service.

In conclusion, we need to consider translating the success of Singapore’s funding mechanism to guarantee adequate and immediately available funds for healthcare during crises for individual countries. And this can be as little as one US dollar per person per year according to the number of the population and the wealth of the country. Thank you very much indeed.

Elizabeth Ferris: Thank you very much, Mr. Minister. We are glad that you are able to participate by Skype and share some of your thoughts, particularly on the relationship between financing of healthcare and the delivery of services. We’ll go back now to Len Rubenstein who can give us an overview of some of the broader health issues in the region.

Leonard Rubenstein: Thank you very much. It’s a privilege to be here, and I’d like to pick up on a subject that Ambassador Patterson mentioned and my colleagues on the panel mentioned, which that healthcare itself has become an object of attack. And what is remarkable is not only how pervasive that is, but how neglected the problem has been on the international agenda...

Elizabeth Ferris: Sorry, Len. Would you mind moving the mic just a little closer?

Leonard Rubenstein: Only very recently has any attention been paid to this problem and what could be done about it. So I’d like to provide some context both in the Middle East and then what we can do about it.

As we know, Syria is the worst case, and I think it’s worth sharing some data about Syria. 630-plus medical personnel have been killed since the conflict began. According to Physicians for Human Rights, there have been 271 illegal attacks, and that’s probably under-reported, on 202 separate medical facilities throughout the country. Of those, almost 20% have been carried out with barrel bombs and almost all have been by the Assad regime. I had a chance to interview doctors and nurses who were working in these circumstances trying to provide healthcare, and you get
some remarkable illustrations of courage, but at the same time, equally remarkable quandaries that the medical personnel have to confront.

For example, even though healthcare needs are so enormous because of the huge numbers of injuries, people do not come, in some areas, to healthcare facilities, even field hospitals that are supposed to be hidden, because they feel it’s too dangerous to come to a healthcare facility. Imagine! It’s too dangerous to go to a hospital. Decisions about ambulance transport present a conflict like this. You can’t go during the day because you’ll be targeted by rockets, so people go at night. So you have to make a choice to keep your lights off and drive on dangerous roads without being able to see, or put your lights on and become a target for a rocket.

Now, Syria is just the tip of the iceberg, a very large iceberg, throughout the Middle East, in Yemen, in Gaza, in Iraq, in Libya, there have been concerted attacks on healthcare. And even in countries that aren’t at war, like Bahrain, Turkey, and Egypt, healthcare personnel have been subject to attack and criminalization of their activities during periods of political volatility.

The impacts of these attacks are really stunning, not only in their immediate effects, but their downstream effects. And beyond that, as these attacks continue and the violence continues, the area becomes insecure and people can’t access healthcare at all, even if there aren’t direct attacks. MSF did an important study in Afghanistan showing that one out of every five patients had a family member or close friend who had died within the last year due to a lack of access to healthcare on account of insecurity.

So, what are we going to do about that? Even in this era when global health security has become a buzz word, and security of healthcare is a major topic of international discussion, there’s very little attention to the issue. We don’t even have good evidence of the extent of attacks, who is conducting the attacks, why, what the effect is, what the downstream effects are, how contact varies, how it affects child mortality years later, none of this is really studied, remarkably.

We saw one impact, this obviously is not the Middle East, but we saw this in Libya where there was civil war that ended years ago, and after the civil war, there was a major, major global international effort to rebuild the health system, but after six or seven years of rebuilding it still wasn’t at a stage where it could cope initially with the Ebola outbreak.

So, there is some good news. Humanitarian groups are dealing with how to improve their own security, the international community, the Red Cross, is starting a campaign to develop pragmatic measure to protect hospitals, ambulance, and offer advice to militaries and even armed groups about their conduct. And those are all
positive developments. But we won’t really achieve what we need to unless there is a global response. There are four steps, I think, that are essential.

First is evidence. All of global health policy is founded on evidence. It’s driven by evidence. But we have very little evidence. The coalition I chair, the Safeguarding Health and Conflict Coalition, issued a report last month on attacks in healthcare in 20 countries. And we had to rely on media reports, on anecdotal reports, on episodic reports by human rights or health groups. That’s not a way to do global health. What we need is a systematic approach. And humanitarian organizations often collect data, but for a lot of important reasons, they don’t share it. And the ICRC itself has done global reports on the attacks on healthcare, but they don’t disaggregate or even reveal the countries that they are collecting evidence or data from, so it’s not terribly useful. In 2012, the World Health Assembly passed a resolution requiring the World Health Organization to provide leadership in collection and dissemination of attacks on healthcare, but now it’s three years later and very little progress has been made. And we need really to ratchet up that effort, otherwise we’ll be stymied in developing a coherent response.

The second is norms. We think the norms are very strong. The Geneva Conventions have been around for a very long time. But in fact, there’s a lot of ambiguity about the norms and there are situations where the Geneva Conventions don’t apply. And in this age of counterterrorism, those norms have been significantly undermined because health has been instrumentalized, whether it’s in counter-insurgency operations or Taliban attacks on vaccinators for political reasons. Health is an instrument. Even in the United States, material support for terrorism is a crime, and the crime includes healthcare. So it’s not very surprising that Assad has determined that any healthcare to the opposition is an act of terrorism. So when he prosecuted and kills health personnel, he uses that justification. The same justification that Western countries offer for fighting terrorism. So we need to make some progress on these norms. Happily in December, at Norway’s leadership, the General Assembly passed a resolution that strengthened those norms to guarantee protection of healthcare impartiality, aiding health workers in doing their jobs and demanding that states offer protection.

Of course, those norms are important, but that raises a third point: that there has to be a demand for adherence. And that too has been lacking. We need systematic reporting and monitoring. We need this to be a diplomatic priority. We need the human rights machinery of the UN to be invoked much more frequently than it is.

And finally, we need far more accountability. We have a whole system of international justice now whether it’s the international criminal court or other regional courts. We don’t have prosecutions of these cases. We need to make it clear that these are war crimes. In some cases, they are crimes against humanity. Unless we
are willing to really pursue the protection of norms through that kind of action, they won't strengthen. So, we do have some roads to travel. The four ideas that I have outlined can all be strengthened. We can talk about them more, but we first have to recognize that it's time to make this a global health issue and not something that we simply wring our hands about. Thank you.

Elizabeth Ferris: Thank you very much, Len. I think that that really summarized some of the obstacles faced. We've heard about children with cancer, people who can't get dialysis, hundreds of thousands of people who've been injured, overstretched health systems in the various countries, the difficulties of reaching these 640,000 complete besieged people in Syria, which as several speakers have noted is the worst humanitarian crisis we face. And we'll have time now for questions, but if I could use my prerogative as chair to kick thing off, Andrew, you know, one of the characteristics of Syrian refugees throughout the region is that most are not living in camps. What have we learned about provision of healthcare to those who aren't in the somewhat controlled setting of camps? What have you learned from your experience in Jordan?

Andrew Harper: It's probably our biggest concern. I think if the refugees are in camps, we've got a good handle on what the situation is. We've got teams that can regularly go around. There's a lot of partners who work in the camps. The biggest challenge is that 85% of the refugees, for instance in Jordan, and a high percentage in Lebanon, are not in camps. And it's this anonymous population, Jordan, for a long time, was offering free medical care, primary/secondary medical care for refugees up until late last year when they required refugees to pay the equivalent of the non-insured Jordanian rate. And that's still a subsidized amount. That ranges from 35%-60% of what the cost is. So it's still being subsidized by the state. The problem is that if you've got no way to pay because you're not allowed to work then the refugees can't get medical assistance. So, since the imposition of that requirement, we've actually seen a fall in the numbers of Syrian refugees accessing the public service medical facilities. And they've either gone to a private institution, paid private pharmacies, or they've gone to NGOs seeking assistance, or they've just gone without, because this is the situation we're seeing, an increasing restriction on the ability of refugees to be able to access the necessary medical support. And this is combined with a deterioration in the ability of donors to fund the necessary medical support in these areas. So it's not a very pleasant situation. We've been monitoring the numbers of Syrians going back to Syria and one of the reasons is that they can no longer afford to remain in Jordan and one of the subsets of that is that they can no longer afford to pay for the medical costs. Again, even if it is subsidized, they just don't have the money to do that. So, it's a pretty heartbreaking situation when you're seeing 100-plus people returning back to Syria every day, when at the same time we're seeing an
unprecedented amount of barrel bombing going on in Dara. Last week, for instance was the highest number of barrel bombs in Dara since the conflict started. At the same time, we started to see an increase in numbers of people returning, and that’s not a good correlation. So we’re seeing an increased cost but also messages from agencies such as WFP that they’re going to have to cut back on food assistance which sort of narrows everything down to a pretty dismal situation.

Elizabeth Ferris: I think it really raises questions too about the sustainability of this humanitarian response as we enter the fifth year of this horrible, horrible conflict. Zaher, I wonder if you could talk a little bit about cross-border operations. To what extent are these brave operations meeting even a fraction of the healthcare needs of those inside Syria.

Zaher Sahloul: Yeah, I mean, this is one of the unique characteristics of the Syrian crisis, which the fact that you have millions of people who are, you cannot access from inside the government-controlled territories. And they are, these territories, controlled by different armed groups, and the only way to access them is through neighboring countries like Turkey and Jordan especially, and less Iraq and Lebanon. So, from the beginning of the crisis, NGOs have started to do cross-border relief because that’s the only way to reach these populations. So for example, in the city of Aleppo, which is the largest city in Syria before the crisis, it had a pre-crisis population of five million people. The only way to access Aleppo or at least the part that is controlled by the armed groups or the opposition, is through Turkey. So what SAMS and other organizations like IMC have been doing that we had a relationship with the Turkish Red Crescent and the Turkish authorities that allow us to send medical containers and medical supplies and medications to Turkey and they will deliver it across the border to the Syrian side where we have a network of warehouses and physicians and nurses who can pick it up through the different hospitals in the areas controlled by the different opposition groups.

And this is the only way to deliver, for example, life-saving medications, whether it’s morphine for patients who have amputations, anesthesia medications, antibiotics and medical supplies. Of course with that there’s a lot of limitations, for example in the city of Aleppo which is a major city, there is no functioning CT scanner right now. So imagine that you have two or three million people without a CT scan. And you have barrel bombing every day, and you have injuries every day. How can you manage this injured populations or victims of barrel bombing without a CT scanner? This is something that we take for granted here, but this is something that you cannot do in many areas in Syria. Lately the United Nations have made the cross-border relief easier, after the resolutions condoning cross-border relief, but still there is servicing only a fraction of the population that is need, and the things that you can send across the border are only limited compared to the need. With the chemical weapon attacks in Syria, this is something that we don’t speak that much about,
Syria is probably the only country in the world that we have multiple use of different chemical agents against the population. So in 2013 we have seen at least 25 or so attacks with Sarin gas, or nerve gas, against the population. The largest was August 21, 2013. And in the last two years we have seen attacks with chlorine gas that also leads to death and injuries among the population. So you have already strained public healthcare system, you have hospitals that are underground because they are targeted like Len has mentioned, and then physicians have to deal with victims of unconventional agents like chemical weapons.

Elizabeth Ferris: Thank you very much. Len, when you look at the erosion of norms globally in terms of attacks on healthcare, what can humanitarians do when the norms are being violated with impunity all the time? Is it to bear witness, or to scream, or to work with the armed parties?

Leonard Rubenstein: It certainly does take a toll on humanitarian groups. And local health providers who aren’t associated with humanitarian organizations. I think it’s not fair or right to put the burden on these groups to strengthen the norms. They assert their impartiality. They abide by norms about how they should provide healthcare. So they are doing their job. I think it’s really the burden the global health and security community as a whole to reinforce their norms, and they can do this in a number of ways. The first thing is to make sure their own behavior conforms to the norms. It’s not enough to be in, you know, people in glass houses shouldn’t throw stones. We know that the more that we can assure that countries that purport to follow these norms actually do. And then there has to be a very loud and sustained effort to bring these norms into public awareness, and most of all, impose a cost for violating these norms. There has been almost complete impunity for attacks on healthcare. So the norms really can’t survive very well when that kind of impunity exists. So we need a range of actions to bring these norms to make a demand that they be respected.

Elizabeth Ferris: Thank you very much, Len. We’ll open it up now for questions. I think there are some microphones here, and if you could identify yourself and either general questions to the panel or to specific individuals. Yes? This woman here?

Female: Thank you very much for convening and having open eyes even further. My name is Manault Harrison, and I’m with Glass Mile 4D. I’m interested in learning, because of what we do, I’m interested in learning what kind of renewable energy, mobile technology, and information communication technologies are used to reach those that you cannot reach, the besieged ones and whatnot, and also those that have left the system as such, and the refugees that are sort of, have gone underground. Are there systems in use that can support them as such? Thank you.
Elizabeth Ferris: Thank you. If it’s okay with the panelists, we’ll take several questions and then give you a chance to respond. Next question right here in front, yes?

Female: Thank you. My name is Nusuch Hizadi. Very recently I was working with UNICEF. I was physically based in Afghanistan for almost four years, Sri Lanka during the conflict, I’ve not worked in the Middle Eastern region, but having worked in war zones half of my working life, I understand the situation to a great extent. My question is, in many of these countries where I have worked, when people were internally displaced due to conflict situations and they were forced to live in shelters or camps, we have found that there were profound problems due to the ethnicities. And of course gender. Women and girls were at the bottom of the priority list. The governments always have commitment, and they say yes, the policies are there, the strategies are there, but when we were trying to execute or implement and support those policies, we found the issues arising, the problems, that because of particular, specific ethnicity, certain communities were not getting the kind of attention they were supposed to get. So my question to the panel, since there was so much work has been done and you have expertise, how do you deal with these kind of ethnicity-related issues when people are moving or they’re living in camps, and how do you address the issues of gender, because the best thing goes to a particular group of people who are usually men. Thank you very much.

Elizabeth Ferris: Thank you for the question. Is there another question before we turn to the panelists? Yes, over here?

Female: Hi, my name is Diane Paul. My question is for Andrew Harper. UNHCR is very much focused on refugees at this point, but along the border of Turkey, inside Syria, there are IDP camps that are often run by war profiteers, etc. And where access is limited. But there is some access, and my question is, why is UNHCR not doing more on the issue of IDPs? Especially since they run the cluster system within Turkey for cross-border. Thank you.

Elizabeth Ferris: Thank you. We’ll turn to our panelists now. We have a question about the role of technology and energy and reaching besieged populations, one on the particular situation of gender and ethnicity, and a specific question to Andrew about UNHCR’s role with IDPs inside Syria. Who would like to begin? Yes, Zaher.

Zaher Sahloul: So I can take the first question, which is actually very important. Before that, let me just talk a little bit about the needs of people who are displaced in the Syrian crisis. Several studied were done on the refugee population about the healthcare needs of these populations. So, 54% of Syrian refugees in Lebanon have chronic diseases. 89% of the elderly refugees said they cannot afford to buy their medications for chronic diseases. 66% of them said that their health is bad. 65% of
Syrian refugees in Lebanon have mental health problems: anxiety, depression, sleep problems, somatization, and so forth. And one of our five refugees in Jordan and Lebanon have either physical or sensory impairments related to injuries that they sustained in Syria. And we have a very high pregnancy rate among women in refugee populations in Lebanon and Jordan. So this is the population that we are dealing with. And also we have increased rise of communicable diseases. Measles, TB and hepatitis, and we’ve seen an epidemic of polio. So the healthcare needs of these populations are slightly different, or different, actually, than populations in peace situations. Regarding reaching the patients in besieged areas or hard-to-reach areas, we depend on technology. Without technology, without the current communication system, it would have been impossible to reach populations, for example, in East Al-Ghouta. So we use satellite internet to reach trapped populations in East Al-Ghouta and Aleppo and Idlib and that’s the normal way of communicating with physicians and nurses over there.

We have a system that we built with the ICUs; we call it Electronic ICU, so EICU. So where we have satellite internet and several ICU units in Syria, we have a camera that is connected to the satellite internet and we have physicians, critical-care specialists in the United States, that they can zoom on the patient, they can zoom on the monitor, they can communicate with the physician or technician on the other side through Skype or Viper. The physician on the other side can send the medical files through these technologies and that way we can deal with the patients instantly and improve the care in the ICUs. In order to protect physicians and nurses as Len has mentioned, the issue of field hospital is something that is unique in the Syrian crisis. When we talk about field hospitals, maybe what comes to mind is MASH, to some of us. But this is not the case in Syria. Field hospitals in Syria are hidden in basement of buildings or farmhouses, in factories, and lately we have been building these field hospitals underground because they are targeted frequently. I was in one of the hospitals in Aleppo that was built by SAMS and it was bombed 15 times. So the last time we built it four meters underground. So you go four meters underground and you have emergency room, you have waiting rooms and operating rooms and hospital rooms and ICU. And this is the only place that you can deliver primary healthcare to the population in the area. So these field hospitals are not only to treat trauma victims, but also patients who have common colds, GI problems, diabetes, and every other condition.

Elizabeth Ferris: Thank you. Gender, ethnicity, UNHR and IDPs?

Andrew Harper: I will sort of beg that I’m not completely aware of the situation on the northern border with Turkey, other than to say that the roles and responsibilities on IDPs are different to refugees. And we do work with WHO, IFRC, the NGOs, to ensure that what we can do is undertaken. UNHRC on the IDP front is responsible for the shelter, the camp coordination, and what’s called the core relief and
distribution. That’s not to say more should not be done to take just a responsibility for how those camps are run. Because even I’m aware in Jordan that there are sever problems with regard to access and protection of those camps bordering the Turkish border. But I’d be doing an injustice if I tried to say something about the provision of medical support to those camps when I really am not the one who’s familiar with it. So apologies to that. But maybe, how’s your understand of the camps on the border?

Zaher Sahloul: In the camps?

Andrew Harper: Yeah.

Zaher Sahloul: Well, we have the largest running clinic in Zaatari…

Andrew Harper: Well, like more on the borders with Turkey, because in regards to, you saw the comparison with SAMS when they’ve got a $26 million budget. In some aspects the NGOs are doing the heavy lifting in relation to support of the IDPs in Syria. In many aspects, they are better equipped. They are more efficient. They are more effective. And so, I would not want to be giving the impression that the UN is doing more than what it actually is there. My colleagues are doing a hell of a lot, but in the case of Syria, we are seeing the NGOs taking a lot of the workload.

Zaher Sahloul: Definitely. This is something that we focus. And because 7.5 million people in Syria are internally displaced. 7.5 million. So imagine this number which is one third of the population. Many of them have tried to go to areas that they perceive as safe. That’s why you have many refugee camps or internally displaced people in areas on the Turkish border, because people think that it’s safer to be on the Turkish border. It’s not likely that it will be attacked by the government. So you have several camps and there are several hospitals that are on the borders that are providing care to these hospitals. Most of these hospitals are supported or established by NGOs. So SAMS is running some of these border hospitals and also some of the mobile clinics that are going from camp to camp. And this is the best way to deliver healthcare we have seen in areas like Aleppo, or Aleppo and Idlib. So you have a van that has a medical team, a dentist, a primary care physician, an OB/GYN physician, nurses, are moving from village to village from camp to camp to deliver healthcare and they provide free medications and vaccinations. The hospitals that are on the borders are treating mostly injured people who are moved from other cities that are the victims on bombing, most of them. The problem with the border hospitals that is attracting physicians from the inside so you are depriving people in Aleppo and other cities, from Idlib, from these physicians who are needed because they go to areas that they are perceived that is safer. Many of these border hospitals inside Syria are paying actually higher salaries than what the physicians and nurses are getting inside Syria. So there is also negatives of providing healthcare on the
borders because you are depriving people inside Syria in more deeper areas from healthcare providers.

Elizabeth Ferris: My understanding is it’s somewhere around 90% of the refugees in the region are Sunni Muslim, that they are, is that your experience, Andrew, in Jordan? Is there a particular treatment of those coming from other ethnicities or religions?

Andrew Harper: At least in Jordan, probably 99.8% of the refugees we’ve got are Sunni Muslim. The situation in Lebanon is different. You’ve got more minorities which are going there, in relation to the flows into Turkey and Iraq. You obviously had more Kurds and Turkmen and Yazidis also moving. But the bottom line is there should be no difference in between the treatment of refugees. At least in the case of Jordan, we don’t see many refugees coming who are Shi’a Ismaili, Turkmen, or Yazidi or Christians. That being said, if for instance there is an attack on Sweida in the south, we’re prepared for movement of Druze. And our response will be exactly the same as everyone else. It will be based on vulnerability. This is something that we try and stress in the overall refugee operation, not just in regards to access to medical care, but it could be on resettlement. We cannot be insuring that there’s a prioritization between any ethnicity or religion. It’s got to be based on those people who are most vulnerable.

The situation though is that we’re probably going to be seeing an increased targeting of minorities should ISIS continue to move forward on several fronts. That includes, for instance, the minorities who are Dair Alzour, who I’m very concerned about, the Druze if they get cut off in Sweida, the Ismailis as well in certain areas. So, it’s, again, it’s silly, we cannot get involved in sort of a sectarian or religious differentiation because this is what a lot of it’s coming down to. We have to make sure that those people who are most in need of protection and assistance receive that protection and assistance. I would also say in regards to the gender side of things, like there is certainly in Jordan and Lebanon a lot of attention as far as outreach to make sure that the needs of women and children, elderly, seek our address. In Jordan, for instance, we’ve undertaking 170,000 house visits.

So we’ve actually, with our partners, we’ve actually gone out to almost every household to try and address the situation there and assess the poverty. What we’ve actually found is that sometimes there’s an over-focus on the needs of women, and that then has meant that men are more vulnerable. And we’ve seen that with some food distributions or some cash distributions where it’s focused on women, but at the same time the men are not allowed to work and survive, so we have to be very careful in our assumptions, and we have to make, again, as we said before, it’s got to be evidence-based, and that’s what we’re trying to do at least in Jordan.
Elizabeth Ferris: Great. Let's take another round of questions. Let's take this gentleman over here. The gentleman in the back will be number two.

Male: Yes, I'm Russell King. I'd like you to discuss the great powers that are involved in the Middle East such as the Russian Federation, the People’s Republic of China, and Japan. I know they have a lot of clout; some of them are permanent members of the Security Council, and while it's not all about oil, certainly the wealth of the Middle East and the great game of competition is involved here, so what would you say to the great powers, what they could do to help resolve this conflict? Thank you.

Elizabeth Ferris: Okay, that's a big question. Let's have the gentleman back here.

Male: Hi. Charles Christian, Search for Common Ground. You've all spoken about how conflict can affect healthcare, but I kind of want to reverse that correlation and talk about how provision of care can affect conflict. Mr. Harper’s talked briefly about this in his last response, but the resource of healthcare is in high demand and limited supply, and applying that to communities can create internal divisions if not applied effectively. So I’d like to hear about how you’re working conflict sensitivity into your humanitarian work. Thank you.

Elizabeth Ferris: Thank you, and we’ll have the gentleman here.

Male: My name is Glen Straight. I have a question about alternative healthcare delivery. We know in the US that there’s growing recognition that alternative healthcare modalities have significant effect. And I just would like get some idea of what sort of openness and interest there is in bringing in these alternative modalities which might be less expensive than conventional modalities?

Elizabeth Ferris: Okay, three very diverse questions. Anybody want to tackle the question about the involvement of Russia, China, Japan, great powers?

Zaher Sahloul: I mean, a few comments on this issue. The first thing that, it’s unfortunate that some of these big powers have not been forthcoming in terms of providing humanitarian assistance to Syria. China and Russia are very influential countries in the Syrian crisis. There are few countries that can influence what the Syrian government can do, and these include Russia, China, and probably Iran. Iran, definitely. But in terms of humanitarian assistance, these are the least countries that contributed humanitarian assistance to Syria. So this is something that we have to put in mind. At the same time, I think it’s important to maybe try to pressure these governments to use their influence with the Syrian government to stop some of the attacks that we are seeing on healthcare providers, on civilians also. I think the
things that we have not addressed that what is unique about the Syrian crisis that we have systematic attacks on civilians.

We’re talking about schools and markets and mosques and populated areas in major cities in Syria, by mostly the government. So, we had a recent incident where we had 25 patients who are in need for hemodialysis in East Al-Ghouta. The Syrian government was blocking the entry of dialysis kits to East Al-Ghouta. Although the Syrian Red Crescent operates freely within the Syrian territories, they were not allowed to transmit dialysis kits. And we actually had a meeting with the Russian delegation in the UN and we asked them whether they can communicate with the Syrian government to influence them to allow dialysis kits, and they promised to do so.

Two weeks after that meeting, the Syrian Red Crescent was allowed to enter to Douma in East Al-Ghouta carrying these dialysis kits. So sometimes we have to do unconventional advocacy with powers that can influence what’s happening in Syria. I think there should be a lot of diplomacy with Iran in particular to see if they can pressure the Syrian government to stop chemical weapon attacks. Iran probably would hate the use of chemical weapons because of their experience in the Iraqi-Iranian war, and also stop attacks on civilians.

In terms of the alternative healthcare, the Syrian population in general are open to the use of alternative healthcare and for those who are familiar with the Arabic culture, Arabic medicine and Islamic medicine is something that people use frequently. We have witnessed more use of traditional medicine, we call it, or historic medicine, in Syrian during the crisis among refugee population and displaced populations. But I think there is more openness to use different ways of alternative medicine. I mean, this population, and I agree with you, especially for chronic pain, for somatization, that probably 50% of the refugees have somatization related to their mental trauma, will be susceptible for these type of alternative medicine.

Elizabeth Ferris: Thank you. Andrew, and then I’d like to ask Len to respond to this question about the relationship between provision of medical supplies, relief, and the way, conflict sensitivity. Andrew?

Andrew Harper: It was just interesting in regards to, you mentioned the great powers of Russia and China, but I think we’re 2015 now, we probably have to expand what is a great power. And who has got influence on the situation in Syria and Yemen, for instance. It is now the Qatars, it is now the Turks, it is now the Saudis, it is not the Kuwaitis, the UAE, the Iranians. So, it’s a different realpolitik that we are being faced with in the Middle East that we have to adjust very much to, so the Chinese engagement is extremely limited, Russia’s donations to the UN has been very small. At least in regard to Syria’s concerned. At the same time, we have to look at where
the strategic interests of these states are, and what we've definitely seen in Turkey is they can influence events in a way which they will protect their national interest, their perception of national interests. It was a great headline when the Saudis were bombing Yemen. It was in one sentence, it was “Saudis continue bombing Sana’a, UN appeal fully covered.” Didn't even miss a beat. They thought that it was okay to bomb but also pay the UN off for the first part of their appeal. So, I think if we're looking at trying to resolve the issues in Yemen, if we're looking at trying to resolve the issues in Syria, we need to sort of say, who’s got the vested interest in trying to resolve the issues, and how do we start looking at whether it’s the nuclear peace deal, whether it looks at Yemen, whether it looks at the influence of Iran in the Gulf, even Bahrain for instance. There’s a lot of moving pieces at the moment and nothing is readily apparent to us.

Elizabeth Ferris: Len?

Leonard Rubenstein: Just on the great powers question, they may not be great powers in the 19th century sense, but I think the Syrian conflict would have been a lot different today if Russia had not exercised its veto at the Security Council. At every stage, it has obstructed, delayed, prevented, global action to protect the Syrian population. I think whatever its interests are the behavior at the Security Council of Russia has led to untold harm to people in Syria, let the conflict continue, and I think we need to recognize that and call a spade a spade here.

I didn’t quite pick up the question about internal divisions. Can we get clarification?

Elizabeth Ferris: If you think about humanitarian relief is also an economic commodity that can be used to support warring, and we’ve seen it in respect to medical supplies in Syria, that they’re not seen as neutral humanitarian, that they’re seen as a way of supporting the opposition.

Leonard Rubenstein: This question of how medical care and humanitarian aid can actually affect internal divisions and I think you mentioned ethnic groups is complicated. It’s a real issue and even the issues around protection get very tied up in local issues around how medical care is viewed. For example, in Yemen, attacks on doctors and other medical staff are not exclusively related to the conflict, but there are a lot of pre-existing tensions stemming from divisions in society and the way medical care is viewed and who has access to it and what the allegiances of doctors are. So, I think we have to return to a rigorous analysis of who is benefitting. And we talk about impartiality, we have to look at how that is implemented in the real world and what steps can be taken to ameliorate some of the tensions that inevitably arise when some get it and some don’t.
Zaher Sahloul: I can comment a few points about this issue in Syria. Because Syria, first of all, is a very diverse country. There are 27 different ethnic and religious groups in Syria. So we hear a lot about the Sunni Muslims, but there is of course Kurds who are non-Arabs, we have Turkmens, we have Alawites, we have Ismailis, we have Shi'a, we have Christians of different denominations, and the Syrian crisis has affected different populations differently. Most of the people who are displaced, as you have mentioned, are Sunni Arabs. 90% of people who are refugees in Lebanon and Jordan and Turkey are Sunni Arabs. And Turkmen, probably who went to Turkey. Kurds also who went mostly to Iraq and Turkey, but this trend may change in the future.

As the dynamics inside Syria with the battles and who is winning what is changing, you may have an influx of other minorities who are right now under the control of the government, and they are safe to some extent. And healthcare provisions in these areas are reasonable. So in areas like (inaudible 1:18:06) and the city of Damascus and Homs for example, healthcare is as normal to many populations, and there is actually medications which are very cheap and available. Surgeries can be done. But these populations who are living in these areas can be affected in the next phase of the crisis as mean people predict and then you will have an influx of populations of minorities who are right now relatively safe to Lebanon and Turkey and that will create different sets of dynamics and I’m not sure whether the system will provide the same care to these populations, because most of the NGOs that right now are providing care to Sunni Arabs, many of the Syrian and Arab NGOs for example are providing care to Sunni Arabs so people from the same ethnic and religious groups. I’m not sure whether the same services will be provided to people from different minorities although we all believe in medical neutrality and you have to provide care to people from different denominations regardless of their ethnic or religious affiliations. But people are people, and human, and some minorities in Syria are perceived as the instigator of conflict and that they ally themselves with the government. They are the ones who are supporting that tax on the majority. So these dynamics will play when you are providing healthcare to someone who is in different minorities. But, I agree that this is something that we have to study and we have to plan for, otherwise there are going to be a lot of negative consequences.

Elizabeth Ferris: Thank you very much. We can take some more questions now, and I note that the Minister of Health, Mr. El Oakley, has been listening to the discussion and we’ll bring him back on if you have particular questions directed to him. This gentleman here in the back? Yes? Anybody on this side? It’s a little bit hard to see. This woman here, yes?

Male: Hi, my name is Faraz Nasji, I am a physician from Boston. I’ve been in Jordan several times. And we talk about healthcare as if it’s a unified system of various disciplines, I include surgery, OB/GYN, and we know that’s not a unified system. My
experiences in Jordan is that we have a glorified urgent care system where people who need various medications, that they used to be taking back in Syria, would go to doctors and just take those medications without surveillance. People with chronic conditions, people with cancers, are not getting their treatments. In addition, people are dying every day from lack of surgeries as well as lack of certain procedures that we just can’t do. For instance, colon cancer screening, EGDs or colonoscopies. Upper endoscopies. Very simple procedures. People can’t get them. People are dying from appendicitis every day because they simply can’t get surgeries. Is there in the future an attempt to unify those disciplines and provide surgical services to the Syrian refugees?

Elizabeth Ferris: Thank you very much. This woman over here?

Female: (inaudible 1:21:17) Two questions. First one, we know that development agencies and international organizations are doing their best to provide medical services to displaced people. But, it’s a state of emergency, our global community has budget for that. Second stage, when these displaced people are sometimes qualified as migrant people and according to research, not so much budget and there is no opportunity to provide medical services for these people when emergency period has passed. This is the first question. And the second one, as I heard from your report, your presentation, that one of the group displaced is from Syria is a group of Turkmen people. And my question is, Republic of Turkmenistan is a rich country. It’s gas country. And if there were some intent to help displaced Turkmen people from Republic of Turkmenistan?

Elizabeth Ferris: Okay. Is there another question? Yes, this person over here?

Male: My name is Bill Steubner. In regards to the great power question, I thought it was interesting that no one mentioned the United States and relative amounts of action or inaction, but specifically for Dr. Sahloul, I would like to ask what’s been the level of support for SAMS from USAID and State Department?

Elizabeth Ferris: Okay, very concrete question there. So we have questions about the treatment of chronic diseases, regular surgeries, moving beyond immediate glorified urgent care system. I understood the first part of your question along the same lines: how to ensure that those with chronic conditions are getting the care. And then a very specific question about the role of Turkmenistan in terms of receiving Turkmen refugees from Syria. And then a specific question to you, Zaher, about the support you receive from USAID. Who would like to begin?

Andrew Harper: Yeah, I’ll do the tertiary healthcare. Even if it’s a glorified healthcare system for the Syrians in Jordan, it could even be an ambitious statement, we just don’t have the money to provide the assistance which is required. We’re dealing with
a population, we’ve got at least 630,000 Syrians registered with us. The government of Jordan says there’s a total of 1.4 million Syrians in the country. The budget that I have available to me for elective healthcare, sorry, emergency healthcare, is close to two million dollars. How do you do that? How do you try and determine that, who is in need in those situations? So, we have got a team, like an exceptional healthcare committee team which goes through each case to see who would benefit the most from intervention. And however, we have to make hard decisions. So I’m just reading here what the SOP is. In general, the committee gives preference to one-off curable interventions and emergency life, limb, or sight-saving cases which have been assessed as vulnerable rather than approving costly treatments for patients with chronic illnesses which will require ongoing costly therapy. For example, high-cost tertiary care such as renal dialysis, or (inaudible 1:25:51) and chemotherapy or radiotherapy for cancer cases, are often not affordable. Renal dialysis in out-of-camp refugees cannot be covered, but attempts will be made to refer to other actors such as the Qatari Red Crescent or Islamic Relief Worldwide.

Cancer and other high cost treatments will be referred to the exceptional care committee and reviewed on a case-by-case basis. Important considerations are prognosis and cost. Other high cost treatments cannot be covered but attempts will be made to submit for medical resettlement. If you think that attempts, well, one of our major options is medical resettlement, and there’s basically been no medical resettlement, it’s not a very optimistic environment which we’ve got. We are trying to do as much as we can in relation to the funding that we’ve got, but at the moment, like let’s not kid ourselves. We don’t have the money to deal with a refugee operation. We don’t have the money to provide the food. We don’t have the money to provide assistance to the population in the camps. And my focus has to be at the moment in regards to cases which we can address, the children’s needs. But a lot of the issues which you raised are completely correct. I don’t have the money. I cannot say that we can do it. Is this going to improve? Absolutely not. Absolutely not. Will more people die? Yes. Someone is not dying per day, but are more people dying than would normally be the case? Yes.

So it is a situation which is extreme in Jordan, but it’s even worse in Syria. So, at least we are trying to do our best. Jordan has got a fairly capable medical system but it’s been overwhelmed, not necessarily be the refugees, but by its own population needs. So, it’s a challenge that we got that the government of Jordan has said that refugees can access the medical facilities but at the non-insured rate. As I said, that’s a subsidized rate, but if you’re a refugee who’s got no money then how can you access it? So if anyone has got any great ideas on how we can enhance this, we’d look forward to it. But I would also say that the situation is far worse inside Syria, particularly in the areas which are besieged that what they are outside. And if the refugees are in the camps, then we’ve got a much better handle on what their needs are, but again, not all refugees want to remain in the camps.
Zaher Sahloul: I think one of the solutions would be in the government of Turkmenistan supported the UN the way that we would like them to support. We are open to any idea of funding from Turkmenistan and other countries. There are some countries which are very big and influential in the international arena who ignored completely the Syrian crisis. Talking about Brazil, for example, or talking about major countries in Latin American, Indonesia, Malaysia, Singapore, all of these countries have not contributed that much to help the Syrian crisis. China, of course. In terms of what's happening inside Syria, in order to have surgeries, and secondary healthcare and tertiary healthcare for an internally displaced population, you need to have first safety and protection for physicians.

You need to have technology that can be if you have an MRI machine or CT scan machine, it needs to be repaired and maintained. You need to have certain medications. All of these conditions are not met inside Syria. We have right now in Syria flight of physicians and nurses because they are killed and targeted. When Len mentioned that you have 630 healthcare professionals in Syria who were killed, according to the WHO, 50% of Syrian physicians have left Syria. They continue to flee because they are afraid for their lives and because they cannot sustain themselves and their families. Part of what we do in SAMS, that we provide salaries to physicians and nurses inside Syria, but this is really nothing compared to their needs. And we are telling them to stay in areas that we know they can be targeted and killed inside.

That creates an ethical dilemma on us. We had some discussion with Len a few days ago about some of the ethical challenges that we are dealing with. And this is one of the ethical challenges, that we are asking physicians to stay in Aleppo to provide healthcare to the population in Aleppo knowing that if they are practicing in a hospital that they can be targeted or they will be targeted or they will be bombed and they may be killed. So this is some of the issues that we have, so the first and most important thing that we ask our government, and this is the response to Bill's question, is to do something to stop the attacks on healthcare and to protect civilians, something to create safe zones or safe areas inside Syria.

Northern Syria, southern Syria, that NGOs and hospitals and physicians can provide safe places for patients in order to focus on development and treating these secondary situations. The main killer in Syria by the way is not the Assad regime, although the Assad regime has killed many people, but it's NCD. We had a study a couple of years ago which showed that 200,000 Syrians died because of non-communicable diseases. And these things can be prevented of course if you have safe areas and funding. What is lacking really is the funding and the planning, the central planning, because there are millions of populations right now who have
fragmented healthcare by NGOs and different UN agencies and there is need for financial planning.

To respond to your questions, Bill, we have good support by USAID. Some of our funding comes from USAID, and other organizations that are supported by USAID, but our government is complicated. So, we have different levels of government. So for example, recently we were harassed by our banks because we were wiring money to Jordan and Lebanon that is directed to provide humanitarian assistance inside Syria, and the bank decided to close our account. We went to the Treasury Department, and they said we cannot do anything towards the banking system. And the banking system said that we are de-risking and any accounts that have higher level of risk because you are dealing with areas that you have terrorist organizations. So this is something that we are struggling with right now.

Elizabeth Ferris: Seems like there are layers of complexity to beginning to meet some of the health needs inside Syria. We'll turn now to Minister of Health Oakley. I believe he’s online? Any comments you have with respect to the questions or discussion that we've been having?

Reida El Oakley: Yes, thank you very much indeed. I enjoyed the discussion. First of all, regarding the targeting of healthcare workers, I was in Geneva in 2012 when some of these healthcare workers were targeted in Pakistan. I saw the response of the regional office in Cairo. I think they were able to speak to the clergymen and the sheik, the people who, and the (inaudible 1:33:06) in Cairo, and I believe they had a positive response in terms of controlling or at least minimizing the attacks against healthcare workers in Pakistan, and specifically those who were trying to deliver the (inaudible 1:33:23) to distant areas. I agree. There’s more. We need to do more to be able to minimize targeting hospitals and ambulances, particularly, but I think this will need time I’m sure. The great powers, I think it’s, if I have to say something to them, I would say, if you cannot make the matter easier, please do not make it any worse. Because targeting Libya as a (inaudible 1:33:51) country, has banned all UN staff from coming to the country. Number one. It actually does not allow … with great ease … they have to … personal responsibility to … [glitches in transmission] when you have an outbreak … late last year, one of the staff who was working for the WHO had to resign from his job, give up his UN passport, to be able to come to Tobruk to help us with controlling the influenza virus, which is silly because influenza, if this virus spread, it’s going to affect the whole region, maybe the whole world.

It is very unwise for the United Nations to label a place like Tobruk which is a risk area, but not to be labeled as the highest risk, and they fail to allow to identify certain cities. I was relatively safe because I buy 600,000 (inaudible 1:34:54) imported from Dubai (inaudible) 50,000, more than the cost of the kits itself. (Inaudible) has been
labeled by the UN as high risk (inaudible 1:35:10) people in conflict zones, please do not make it any worse. The same applies to World Bank. World Bank, I'm sure, they labeled Libya and probably Syria as (inaudible). Today Libya and Syria are not middle income countries. Their revenues are down, their expenditures are high, and they should be entitled to (inaudible) and other forms of UN agencies financial or medical support. They have fantastic procurement abilities, and they are able to bring more medicine and vaccines than we do. And for the World Bank not to reclassify Libya and Syria (inaudible 1:35:54), to the real economical status, which are they are both poor countries. I think they are contributing to the misery of the Libyan and the Syrian people and other people in the same position.

I think it's obscenely unwise for the United Nations, we have called repeated on CNN, we have written to the United Nations, requesting that they allow us to have certain airports and an easier, less, level of risk to make it easier to transport patients. A patient can be transported from Tobruk to Jordan in the past for 10,000 Euros. Now we pay up to 150, 180 thousand Euros to carry a patient across. This is silly, simply because of the high risk classification imposed by the United Nations. As far as the health of the refugees, it is very important, yet it is only the tip of the iceberg, because the more severe dilemma happens in conflict zones, within Aleppo and so on, because an elderly who cannot walk will never reach the refugee camp. He will die in Aleppo. A man with a broken limb will not be able to walk unless his leg is fixed. A child who has lost his parents will … the refugee camp. Health is important, but it's also as important … health provision … conflicts in a direct way. [glitches in transmission] The question (inaudible 1:37:37) and for that I applaud the (inaudible 1:37:42) to have … a conflict zone including Afghanistan. The same … Italian … charity called Emergency … hospitals providing healthcare across the board to … conflict zone. There are … I raise the hat and I thank you very much for the chance to provide …

Elizabeth Ferris: Thank you very much Mr. Minister. You’re starting to break up a little bit, but we really appreciate your comments, and particularly, again, drawing this connection between economics and the possibility of delivering healthcare services to people in the midst of conflict. I want to thank all of our panelists. I think it’s been a very rich discussion. I can’t say it’s been an enjoyable one, but I think it’s been a very important one to look at the start realities facing those trying to provide even glorified emergency care, as we’ve seen, has been inadequate, much less to deal with the whole range of issues around chronic diseases and non-communicable diseases. It’s really shattering to think about the main killer in Syria not being the barrel bombs and the chemical weapons, but being these diseases that in other situations could be easily prevented. Thank you. Mark, do you want to make an announcement about coffee break or something?
Mark: Yes, I would like to thank our panelists, Minister El Oakley who was connected with us from London, Andrew Harper from UNHCR, Leonard Rubenstein from Johns Hopkins, Zaher Sahloul from Syrian-American Medical Society, and our moderator, Elizabeth Ferris from Brookings. I think it has been a very rich first discussion, and we’re off to a good start today, and very illuminating, but, as you say, also in parts disheartening. We’ll continue to look for solutions in our next panel and throughout the rest of the program. Thank you all very much for your participation. We will, we’re a little bit ahead…

[applause]

1:40:25 transcript ends