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Humanitarian intervention in a changing world: need for a new model of care

Ran van der Wal

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- 1 While the humanitarian crisis in the Middle East is one of the most devastating of our era according to Antonio Guterres, UN High Commissioner for Refugees (UNHCR), humanitarian aid approaches its limits¹. This paper will look into one of those limits: the challenges of addressing non-communicable diseases (NCDs)² in humanitarian interventions. First, the development of humanitarian health interventions, and the changing nature and contexts of emergencies are described. Second, the specific context and consequences of the Syria-crisis are addressed. Finally, this paper mentions some of the new avenues to be explored, as suggested by experts. Even though humanitarian interventions concern both natural and man-made disasters, this paper specifically focuses on the latter.

Changing humanitarian contexts

- 2 During the past decades, profound global changes in humanitarian contexts have been observed. In the 1970s and 1980s, the predominant form of humanitarian assistance was service provision in crowded camps to large refugee populations in low-income countries. Refugees, displaced people outside their country of nationality because of fear of persecution, were relatively young and mortality was mainly due to epidemics, exacerbations of endemic infectious diseases and malnutrition. Effective health interventions emphasized straightforward primary health care (vaccinations, antibiotic treatments and nutritional supplements), were relatively inexpensive, and offered as services parallel to national health systems of host countries. Threshold rates to indicate different emergency phases and epidemics, as well as clinical and nutritional guidelines

were developed, culminating into models of best practice laid down in the SPHERE handbook (1997) that sets minimum standards for humanitarian interventions³.

- 3 The conflict in former Yugoslavia (1990s), however, affected developed middle-income countries with much lower baseline mortality rates, better environmental conditions, and relatively healthy populations. In the “*developed country model*” people fleeing conflict were better off, older, and more knowledgeable about health and hygiene⁴. Contrary to standards based on developing country models, where a crude mortality rate (CMR) of 1/10,000 deaths per day indicates an acute emergency and especially children <5 are affected, war in the Balkans demonstrated that refugees from Kosovo, Macedonia and Albania never suffered CMRs this high and children were rarely malnourished. Instead, mortality was highest in adults who died from war-related injuries (64%) and chronic diseases (20%), the second leading cause of death during the Kosovo conflict. The doubling of the pre-conflict baseline mortality rate has therefore been proposed as a more appropriate indicator of acute emergencies in developed countries⁵.
- 4 Subsequent conflicts in the Middle East confirm that the traditional humanitarian intervention model based on developing countries is inappropriate for (lower) middle-income countries. In the Arab world between 1990 and 2010, the combination of increased overall income and life expectancy with high levels of smoking, physical inactivity and unhealthy diets led to a shift in the disease burden: from communicable diseases and reproduction-related causes to deaths caused by NCDs. Smoking rates among men in Syria, Jordan, and Lebanon were around 40-50%, and obesity rates were around 25% for men and 30-40% for women⁶. A retrospective study found that more than 50% of Iraqi refugees that resettled in the US between 2007-2010 were obese and found a high prevalence in NCDs: 51.1% of the Iraqi refugees suffered from at least 1 NCD and 9.5% from 3 or more⁷.
- 5 Not only have demographics and disease burdens changed, conflicts themselves have become increasingly complex and protracted, with displaced populations dispersed in urban areas and throughout the region, instead of settled in neatly managed camps.

Context and consequences of the Syria conflict

- 6 The Syria conflict clearly illustrates the limits of humanitarian intervention. There are twice as many internally displaced persons (IDPs) in Syria (7.6 million) as there are Syrian refugees (3.8 million), and the latter are dispersed over several countries (notably in Turkey: 1.6 million, Lebanon: 1.2 million, and Jordan: 622,000)⁸. Most displaced people live hidden among host populations, often illegally, in poor urban areas, which makes it challenging for humanitarian organizations to identify and access them.
- 7 Taleb et al (2015)⁹ describe the changing health care needs of Syrians as a result of the conflict. Syria, a lower-middle-income country with roughly 22 million inhabitants in epidemiological transition, suffers the double burden of disease. In 2012, around 20% of Syrian children were overweight and obese, which co-existed with an average of 40% of under-five children suffering from anemia and 10-30% being malnourished. Two out of five Syrians were hypertensive, or obese, and, between 1996 and 2006, the overall mortality rate due to coronary heart disease rose by 64%. These pre-existing conditions contributed to the population’s vulnerability when internal conflict broke out in March

2011, increasing stress levels and decreasing adequate nutrition, physical activity and psychological well-being.

- 8 Treatment interruptions and other consequences of internal conflict exacerbated the NCD burden Syrians faced. Destruction of health facilities (60% of hospitals and 38% of primary care facilities), ambulances (78%), and the lack of safe roads and transportation made access to health care a serious challenge. Most health personnel fled the country leaving very few doctors behind. With the systematic targeting of both health care personnel and patients, as government forces suspected patients to be rebels and medical staff their accomplices, patients feared seeking health care; or, in rebel-held territories, civilians struggled to access treatment as combatants were being given priority. Access is further compounded by severe shortages of drugs when many pharmaceutical facilities, previously responsible for 90% of Syria's drugs production, closed because of insecurity, high fuel costs and a scarcity of raw materials.
- 9 The results were that, by the end of 2012, an estimated 70,000 cancer patients and 5,000 dialysis patients in Syria were not receiving the required treatment and an estimated 300,000 Syrians died from NCDs since the start of the conflict. Moreover, infectious diseases and polio are re-emerging¹⁰.
- 10 Neighboring countries, stretched to near bankruptcy because of the mass influx of Syrian refugees, appealed to the international community for assistance. In 2013, Jordan's minister of health reported that preventive and curative health services to refugees were provided by Jordan, representing USD 53 million in the period between January and April 2013, to which the international community contributed USD 5 million only¹¹. Health care costs are a combination of the number of refugees and the disease burden they bring with them: whereas 134 Syrians in Jordan had received cancer treatment in 2011, the number was expected to rise above 600 for 2013. Not surprisingly, Jordan repealed free health care to refugees by the end of 2014, obliging them to pay a nominal fee similar to uninsured Jordanians. In Lebanon, where Syrian refugees make up for more than 25% of its population, health care is privatized. Medical treatment, notably for chronic diseases, is simply unaffordable for most refugees. Many therefore choose to travel back to Syria to seek treatment, risking entry into an insecure Syria, and suffering the uncertainty of being granted re-entry to their country of refuge.

Challenges in humanitarian response

- 11 Meanwhile, humanitarian actors struggle to deliver services facing similar problems. Only a handful of international actors received permission to work in Syria, mainly deployed from Damascus, and channeled through the Red Crescent and Syrian government-appointed local organizations that are overburdened and restricted to limited geographical areas. Rebel-held territories receive unofficial cross-border aid, which is dangerous and lacks transparency. In neighboring countries, the dispersion of refugees challenges access by humanitarian actors, as there are no official refugee camps in Lebanon and in Jordan only 30% of the refugees reside in camps¹⁰. Instead of service provision parallel to national governments, humanitarian actors now need to look into supporting national health systems and collaborating with, or being coordinated by national governments. Surveillance activities and data collection are hampered as national governments don't necessarily collect data on refugees, which leads to a lack of evidence on which to base interventions¹². Health facilities and medical staff in host

countries are overstretched, and unable to cope with the increased workload, but when refugee doctors treat their fellow refugees they risk arrest and deportation¹³.

Need for out-of-the-box reflection

- 12 The protracted nature of the crisis forces to focus on delivering services beyond relief and emergency care and to include addressing secondary and tertiary care, required for an effective response to NCDs. This means, however, that funds of an entirely different magnitude are required than for similar humanitarian interventions in poor countries. Besides from being unavailable, this has raised ethical concerns regarding the inequity of assistance and service delivery in 'rich' countries compared to poor¹⁴. Yet, out of the 7 major armed conflicts (>1000 deaths) in 2013, four occurred in (lower-) middle-income countries (Syria, Iraq, Pakistan, and Nigeria) of which the conflict in Syria was the most violent¹⁵. Moreover, the epidemiological transition increasingly affects low-income countries as well, so one way or another, in order to effectively respond to the medical needs of its beneficiaries, humanitarian actors will need to address NCDs.
- 13 This is easier said than done. Spiegel et al. (2014)¹⁶ point out that financially, besides the need for more funds, funding needs to be more sustainable given the chronic nature of NCDs. If donors would consider multi-year funding instead of the 1-year funding that is usual for humanitarian emergencies, humanitarian medical actors could more effectively plan and manage the long-term health care needs of people suffering from NCDs. Authors suggest involving development actors and funds, such as funding from the World Bank, to strengthen host countries' capacity to deal with the added burden of refugees and to avoid disparities between refugees and host populations. As prevention and early detection of NCDs are more cost-effective than managing NCDs at later stages of the disease, it is suggested to include preventive screening, diagnosis and active detection and treatment of NCDs in primary care. Mobile technology could be used to inform displaced populations where to seek health care and to provide health education. To support continuum of care and improve data collection, web-based electronic medical records across national boundaries, such as regional cancer registries, could be developed.
- 14 These are mere suggestions, and evidence for best practices will need to be documented. Excellent coordination of actors and activities will be key, especially when reaching out to non-traditional partners, such as development actors, and concerted efforts and political goodwill are essential. But evident is that, to effectively and equitably respond to NCDs in today's complex humanitarian crises, a longer-term public health perspective is required and new avenues need to be explored.
- 15 To conclude, it is clear that the world is changing with increased urbanization, ageing populations, changing disease burdens, and changing conflicts. To effectively respond to humanitarian crises, demographic and epidemiological profiles need to be taken into account, which, as recent conflicts in the Middle East have demonstrated, require out-of-the-box reflection in order to develop a new model of care that takes these new realities into account.

NOTES

1.

Guterres A. *Think the aid system can cope? It can't*, 2015 [18 Jan 2015]. Available from: <https://agenda.weforum.org>

2. NCDs are non-infectious, generally progress slowly and have long-term health consequences. The 4 common types of NCDs are cardiovascular disease, cancer, diabetes, and chronic lung disease. They share common risk factors (tobacco use, harmful alcohol use, unhealthy diets, and physical inactivity) and could mostly be prevented if risk factors would be reduced. The WHO reports that NCDs represent 63% of all annual deaths globally, of which 80% occur in low- and middle-income countries. *WHO. Global Status Report on noncommunicable diseases 2010*. World Health Organization. 2011.

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Mots-clés: action humanitaire, enjeux humanitaires, organisation non gouvernementale (ONG), population vulnérable, prise en charge médicale

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