Chronic Crisis
Humanitarians Respond to New Realities

by Tim Paul | photos by Mezar Matar
Fouad Mohamed Fouad, his wife, and their two children left their home in Aleppo, Syria, in late 2012 for a short visit in Beirut. What began as a two-week holiday has become a perpetually extended displacement, with no end in sight.

Back in 2011, the political situation in Syria was escalating from scattered protests to violent civil war. Fouad, a doctor and co-founder of the Syria Center for Tobacco Studies, watched as pro-democracy demonstrators endured brutal reprisals by the regime of President Bashar Assad. Even providing medical aid became increasingly risky. A friend of Fouad’s, a fellow physician, was arrested for treating protesters, then tortured by police; three students who transported medications to besieged areas were murdered.

By the time Fouad and his family arrived in Beirut, their homeland was in freefall. At first, the family hoped to wait out the violence. But a brief return to Aleppo by Fouad’s wife made it clear that going back home safely was no longer an option. Today, Fouad counts himself among the lucky. He has a research position at the American University of Beirut and many friends. Even so, he says, “it was painful to leave the place where we were so deeply rooted.”

Some 5 million Syrians have fled the country since 2011; another 9 million—more than half of the remaining population—are displaced internally.
And yet, worldwide, Syrian émigrés are a mere fraction of those displaced. According to the United Nations, there are more refugees than ever before. No fewer than 65 million people have been forced from their homes.

That number is only expected to grow as political instability and economic uncertainty exacerbate ethnic and religious clashes, and climate change devastates once habitable lands. Yet the humanitarian-aid system developed in response to short conflicts in the poorest countries is proving ill-suited for the new reality: protracted crises where people displaced from middle-income countries settle, not in refugee camps, but in cities, often coping with recent traumas as well as longer term health issues. To design a better system, say Mailman School scholars, the world requires better data on refugees’ needs, as well as the analytical tools to analyze that information.

Refugee Science

Since the founding of the International Red Cross in the 1860s, the humanitarian’s modus operandi has been a rapid response to emergencies—whether

Nine-year-old Cedra and her cousin Omar, 11, were smuggled with their families from their homes in Aleppo, Syria, and have lived in Istanbul for 18 months. To help contribute to their families’ finances, the children sell tissues in the upscale Cihangir neighborhood.

Syrians in Turkey are not legally permitted to hold jobs, but many, including children, eke out a living by working off the books in factories or as domestic servants—low-paying jobs that come with risks like injury and sexual abuse. For Cedra’s family, finances are particularly tight due to an injury her father suffered that has prevented him from working.
natural disasters or armed conflicts. And aid organizations have considered anything that delayed or diverted resources an obstacle. But according to Neil Boothby, EdD, a psychologist and authority on children in adversity, tackling the problems of 21st-century displaced populations demands a new, evidence-based approach.

“We’ll always need first responders to provide food, shelter, and urgent medical attention,” says Boothby, the Allan Rosenfield Professor and director of the Mailman School’s Program on Forced Migration and Health. “But today’s extended crises have pushed the old system to the breaking point. We must go beyond emergency response to engage with issues like chronic disease, human rights abuses, and economic constraints in a way that combines efficiency and scientific rigor and can be sustained over time.”

Consider gender-based violence. Defined as a war crime subject to penalties imposed by the International Criminal Court, its extent among refugees is largely unknown. In a 2009 study, Boothby and colleagues investigated Ugandan women’s experiences of violence and rape after the women had been displaced by a decades-long guerilla war. In the face of reluctance by officials to discuss the crimes, the investigators went straight to women living in four refugee camps, asking about the women’s own experiences and those of their neighbors. In relatively crowded conditions, Boothby notes, “everybody knows everybody’s business.”

The results revealed that 5 percent of the displaced women had been raped by someone outside their household, while nearly a third had been forced to have sex by a husband or intimate partner. Yet most interventions to that point had assumed the attackers were strangers. The team’s findings opened the eyes of government officials and aid workers to the reality of gender-based violence within households and helped them recalibrate their efforts, with parenting programs shown to reduce domestic violence. The innovative “neighborhood method” also demonstrated an effective technique for measuring gender-based violence by tapping into community knowledge while reducing the time and expense of a traditional survey.

**Breaking the Mold**

One of the most widely publicized images that has been captured during the Syrian crisis was that of 3-year-old Alan Kurdi, drowned as his family crossed the Mediterranean Sea en route to Canada, by way of Greece. While the American media has highlighted the stories of Syrians fleeing the Middle East for Europe, North America, and other distant lands, more than three-quarters of Syrian refugees have actually settled in just three countries: Jordan, Lebanon, and Turkey. As émigrés from a middle-income country, they carry with them a unique set of resources and health concerns.

“You’re seeing people fleeing Syria with a smartphone and some money in their pockets,” says Boothby. It’s a stark contrast to people displaced from Somalia or the Democratic Republic of Congo. “These aren’t the kind of refugees we see in Africa, dying from diarrhea or malaria,” he says. “In the Middle East, we’re seeing people come in with hypertension and diabetes.”

Chronic diseases were the leading cause of death in Syria before the war. And they remain a problem for the millions who have left the country. Surveys of Syrians in Jordan and Lebanon found that more than half of households include someone coping with a chronic condition. Yet few are receiving the care they need.

In large part, that’s because U.N. agencies and nongovernmental organizations still deliver services through refugee camps. Yet 90 percent of Syrian refugees opt for alternative housing. “The majority of these people are going to cities,” says Boothby, “because there are more opportunities there.” And with urban refugees beyond the reach of international aid agencies, the burden of providing services falls on the host countries. Consider Jordan, where in some parts of the country refugees now outnumber citizens. There, the government welcomed refugees into its public health system; in 2014, when their sheer numbers became too many, their benefits were abruptly cut off.

Lebanon, on the other hand, has a privatized health system, and while the United Nations High Commission on Refugees (UNHCR) tries to fill the void for those who can’t afford insurance, some care remains out of reach. The Syrian doctor Fouad tells the story of a middle-aged refugee who discovered a lump in her breast. Her doctor recommended a mammogram, but she was unable to afford the procedure, which isn’t covered by UNHCR. Six months later, after the cancer had spread to her lymph nodes, a doctor referred her to a hospital for treatment. While 75 percent of the costs would have been covered, the remainder exceeded her budget. She died not long after.

*Thirty-eight-year-old Ayham, a graduate of Damascus University, treats a fellow refugee at a clinic on the north side of Istanbul. Many Syrians arrive with chronic dental issues like severe tooth decay and painful gum infections. Those with proper identification can receive free medical care in public facilities, but they are overcrowded and the language barrier makes communication difficult.*
It doesn’t even take an acute crisis like a cancer diagnosis to undermine a refugee’s well-being, says Miriam Rabkin, MD ’92, MPH ’02, an associate professor of Epidemiology who works with Fouad and others to study the delivery of prevention, care, and treatment services for underserved populations in the Middle East. “If you’re not treating your diabetes or your high blood pressure for a couple of months during an emergency, you might get by,” she says. “But if you’re not treating it for years on end, you’re going to have serious problems.”

Unsettled

In 2015, Boothby made a fact-finding mission to Jordan and Turkey. In Istanbul, he met a Syrian who pulled out his smartphone to show the professor images of his life before and after the war, starting with the comfortable home where he had once lived. “In the next set of photographs,” says the professor, “everything was destroyed. Rubble.” A physician in his home country, the man lacked the credentials to practice medicine in Turkey. Says Boothby: “You could see what it was like to lose not only your home but who you are.”

The man took Boothby inside the rugged space where he and his family had settled—a former warehouse without running water or interior walls. In a sleeping area separated by hanging sheets, his wife kept a pair of suitcases. Two years after their exodus, both remained packed. “She wasn’t willing to give up on the idea of going home,” says Boothby. “The suitcases represented the hope of reclaiming who they were.”

A shortage of housing and jobs in host countries has exacerbated the mental and physical strains on displaced families—not least of all the children, who make up half of all Syrian refugees. Many skip school to support their families. In Jordan, Boothby saw children working long hours in a battery factory and employed as domestic servants. Several of the factory workers were scarred from handling the acid; one was blind. Among the girls working in local homes, a third had been sexually exploited or abused.

“Schools can be very protective environments, especially for girls,” says Lindsay Stark, MPH ’06, DrPH ’10, an associate professor of Population and Family Health and director of Columbia’s Child Protection in Crisis Learning Network. But forced to choose, parents send their boys to school and hope marriage will shield their daughters from hardship and sexual violence. “It is often the case that early marriage is already a common part of the social norms,” says Stark. “But in conflicts, the age of the girls goes even lower.”

Nearly a third of Syrian marriages registered in Jordan in early 2014 involved a girl under 18 years of age. Of those, close to half were wed to men at least 10 years older. In more conservative parts of Jordan, Syrian girls are forced to marry Jordanian men, sometimes becoming second or third wives and gaining only dubious legal standing. Should something happen to the husband, his refugee widow would be left unprotected.

In 2010, nearly all Syrian children attended school. Since the war began, that proportion has plummeted to one in four. Host country schools are often overcrowded and unwelcoming to refugees. Many Syrian youth have been out of the classroom for years, some never to return.

“We’re going to have a generation of youth who are uneducated and unemployable and extremely mixed up when it comes to political ideologies and getting along with people,” says Boothby. “It’s going to be a huge problem for the entire region and the world.”

Attention to Evidence

Even anecdotal information from a fact-finding mission like Boothby’s 2015 trip can be useful in complex emergencies. Following his travels in the Middle East, the professor presented his findings to UNHCR, UNICEF, the Turkish Ministry of Health, and the River Jordan Foundation. At the same time, Mailman School researchers are intent on collecting robust data to lead the way to effective solutions.

Shatha El Nakib, MPH ’15, a researcher for the Program on Forced Migration and Health based in Jordan, gives the example of malnutrition in Lebanon. A widely used nutrition estimate by UNICEF from 2013 that rated the situation “poor” was subse-
quently revised by the U.S. Centers for Disease Control and Prevention to be “within acceptable levels.” El Nakib is among those who remain unsure which numbers to trust. It’s not just the paucity of data, she says, but the uneven quality of the data collected that should give pause to scholars and humanitarians alike.

“It’s next to impossible to tailor an intervention without having an idea of the scale of the problem,” says El Nakib. In efforts to identify more-reliable data on the extent of malnutrition in Lebanon, she uncovered records from the International Organization of Migration that can help paint a clearer picture for aid organizations like UNICEF so they know where to direct their resources. In tandem, she, Boothby, and their colleagues developed a program to train UNICEF staff to collect and analyze data themselves.

As part of an eight-day course at Columbia University’s Global Center in Amman, Jordan, in December 2015, Mailman teachers introduced UNICEF staff to the fundamentals of epidemiology, including how to do surveys and estimate the prevalence of disease. Participants also learned how to respond in the early days of an emergency, then make interventions sustainable. “A lot of it is about teaching them to conduct a rapid assessment to

Human rights activist Oula Ramadan is founder and executive director of the Badael Foundation, a Syrian NGO headquartered in Istanbul. Named for the Arabic word for alternatives, the organization works to break the cycle of violence in Syria and prepare the way for peace and reconciliation. Ramadan, who fled Syria in 2011, has taught hundreds how to de-escalate conflict, with a focus on protecting and empowering women activists. She is also a founding member of Planet Syria, which advocates an end to barrel bombs, the promotion of a no-fly zone, and meaningful peace negotiations. In 2014, the Italy-based nonprofit No Peace Without Justice awarded Ramadan its Human Rights Award.
prioritize their programs,” says Boothby, who developed the curriculum. “The goal is to help them bridge the gap between humanitarian relief and development.”

Going forward, Boothby and El Nakib intend to develop online courses and, eventually, a university program to provide regular trainings for aid groups and national health ministries. Meanwhile, the researchers have embarked on a multi-country needs assessment. Working with collaborators at Columbia’s global centers in Istanbul and Amman and at the American University of Beirut, including the Syrian doctor Fouad, they will interview people displaced from Syria to learn what chronic-disease treatment services refugees have benefited from and what barriers to care they have encountered. The investigators’ goal: identify effective programs that could be replicated in other settings, for Syrians or other displaced populations facing similar challenges.

One promising model is UNICEF’s work in Egypt. Instead of starting new programs or duplicating existing programs to serve refugees, the agency partnered with the local ministry of health to strengthen the national health system, investing in and lending technical expertise to campaigns that serve both refugees and the host population. As part of that effort,
UNICEF hired Syrians as community health workers. “It was a good entry point into the Syrian community,” says El Nakib, “and a good way to build trust.”

Community Matters

Six years after the conclusion of World War II, most displaced people returned home. But even if the conflict in Syria were to end tomorrow, experts say, the refugee crisis would likely continue for decades. Around the world, growing numbers of refugees are fleeing countries fractured along ethnic and religious lines—and with few opportunities to return. According to UNHCR, the average span of displacement worldwide is now 20 years, up from 9 years in the 1990s.

Another factor is climate change, which a 2015 study by scientists at Columbia’s Lamont-Doherty Earth Observatory found to be a factor in the drought that preceded the conflict in Syria. “Increasingly, we’re going to see environmental reasons for why people are displaced,” says Boothby. In the coming decades, rising sea levels and extreme weather threaten to displace communities from Miami to Mumbai. “This is a whole new reason to focus on emergency preparedness and resilience.”

The most successful efforts leverage talent within the refugee community. “Syrians came with tremendous resources,” says Boothby, “not least of all the doctors, nurses, and teachers.”

Fouad tells a story of a Syrian woman who started a school in Lebanon’s Bekaa Valley. When it opened in 2013, there were 60 students; today, the student body numbers more than 1,200. Through the efforts of Syrian expats, including Fouad, the school provides health services as well as a quality education. It also serves as a social hub for refugees attending soccer matches. In effect, the school stands in for a town square. “It sends an important message,” says Fouad, “about living a healthy life and how to be useful in your community.”

Fouad still dreams of returning to Syria but acknowledges that could be a long time coming. In the meantime, he says, he resists invitations to settle in Europe or the United States because he wants to stay close to his fellow refugees. “I think I can make a bigger difference here.”

Learning from HIV

At first blush, physician Miriam Rabkin’s insight seems completely counterintuitive: Efforts to enhance care for refugees with chronic disease should be modeled after the fight against HIV in sub-Saharan Africa. Writing in Global Public Health, the associate professor of Epidemiology notes that while HIV is an infectious disease efforts to curb the epidemic have succeeded by responding to it as a chronic condition: promoting screening and providing care for those who need it for as long as necessary.

Managing any chronic condition is challenging even for non-displaced people, requiring coordinated care, a steady supply of prescriptions, clinical and laboratory monitoring, and medical records. Providers must remain in close contact with patients to boost their chances of staying on track with medications and behavioral changes. “For people on the move,” says Rabkin, “all those things are extraordinarily challenging.”

Over the last 13 years in more than 20 countries, Rabkin and her ICAP colleagues have helped orchestrate programs that help nations manage HIV for millions of people—including forced migrants. A 2014 study by a team at the London School of Hygiene & Tropical Medicine found that, in many settings, the majority of refugees with HIV were being effectively treated.

The bigger lesson from HIV is that science can do more than determine the efficacy of a given drug: It can identify successful methods for reaching patients. Over the course of 35 studies, including several randomized clinical trials, ICAP has examined questions like the value of early treatment in the prenatal setting to prevent mother-to-child HIV transmission, and how a package of interventions that includes text-message reminders and a financial incentive can improve linkage to treatment and boost people’s ability to stay on schedule with their medication. Interventions should be applied in a coordinated fashion, says ICAP Director Wafaa El-Sadr. “Research is needed every step of the way.” This kind of implementation science, she adds, can “bridge the gap between knowledge and impact.”

In complex emergencies, says Neil Boothby, EdD, director of the Program on Forced Migration and Health, program assessment must be prompt and done in a way that maintains a degree of critical distance from the situation at hand, but also closely enough so that findings can be rapidly incorporated. “When lives are at stake—whether due to Ebola, famine, or conflict—you’ve got to quickly create a learning-feedback loop,” he says. “On the playground it’s get ready, get set, go. In emergencies it’s go, get ready, get set. You’ve got to know within a couple of days what you’re going to do.”


Syrian citizen journalist MEZAR MATAR is finishing his first long documentary, “The Scattered Memory’s Ceiling.”