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Healthcare Services for the Displaced: A Comparative Study between  
Internally and Externally Displaced Populations in the Duhok  
Governorate of Iraq

An honor's thesis presented to the  
Department of Public Policy and Administration  
University at Albany, State University of New York  
in partial fulfillment of the requirements  
for graduation with Honors in Public Policy and Management  
and  
graduation from The Honors College

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**Abstract:**

Although forced displacement is not a new problem, the topic has gained increasing attention due to the Syrian refugee crisis. This paper serves to explore the legal, contextual and practical differences between internally and externally displaced populations. The correlation between legal displacement status and access to healthcare is explored. Information was gathered from surveys of displaced individuals residing in urban areas of the Duhok region of Iraq, as well as comparing the amount of services provided to displacement camps in the region. It is found that there is a statistically significant difference in health services accessed by internally displaced and externally displaced individuals in the Duhok Governorate of Iraq.

## **Acknowledgements:**

I would first like to thank my thesis advisor, Dr. Kamiar Alaei, Director of the Global Institute for Health and Human Rights at the University at Albany, for helping to inspire this project. Thank you for your help to establish and conceptualize this research.

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## **Legal Background:**

### Introduction:

Displacement is arguably the biggest humanitarian crisis of recent time. The United Nations (UN) estimates that a record 65.6 million individuals were forcibly displaced from their homes in 2016 (UNHCR Figures at a Glance 2017). Externally displaced Syrian refugees are the focus of much media attention. However, millions more suffer outside of the public spotlight. The Internal Displacement Monitoring Center estimates that 2016 produced 31.1 million new internal displacements due to conflict and violence (Global Report 2017). Syria and Iraq each carry heavy burdens, with roughly 842,000 and 659,000 internally displaced, respectively (Global Report 2017).

The legal status of the internally displaced, in crisis yet still the responsibilities of their struggling countries, leave many in want of basic needs. Furthermore, they are vulnerable because their respective countries already struggle with the crises which created the displacement originally. This paper strives to explore the services provided to different subgroups of displaced populations: externally displaced Syrians in Iraq and internally displaced Iraqis. Through this comparison, the importance of displacement status as it relates to the services provided to displaced populations will be evaluated.

### A Changing Definition for the Displaced:

As a logical side effect to war, displacement has been a humanitarian problem for centuries. However, Gilbert Jaeger, former Director of Protection for the United Nations High Commission on Refugees (UNHCR), argues in his 2001 *On the history of the international protection of refugees*, that "...the history of international protections starts with the League of Nations," (Jaeger 2001, 727). The League of Nations set the framework which laid an

institutional foundation for displacement that the UN developed. For example, according to Sir John Hope Simpson of Oxford University Press, the "...Council [was invited] to appoint a High Commissioner to define the status of refugees, to secure their repatriation or their employment outside Russia, and to co- ordinate measures for their assistance," (Simpson 1938, 199). This was the basis for the UN appointing a High Commissioner for Refugees in 1951.

The UN established their working definition of a refugee in their *1951 Convention on the Rights of the Refugee*. A 1998 UN *Human Rights Study Series* manual summarizes this definition as any person who has a:

well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion, is outside of his nationality and is unable, or owing to such fear, is unwilling to avail himself of the protection of that country; or who, not having a nationality and being outside the country of his former habitual residence as a result of such events, is unable or, owing to such fear, is unwilling to return to it, (Deng 1998, 24)

The key wording in this case being *outside of his nationality*. In fact, Article 1 Section C of the Convention and Protocol Relating to the Status of the Refugee specifically outlines many cases in which a person is stripped of their status if they re-avails or continues residence in their original country (United Nations General Assembly 1951). This disqualifies IDPs from the Convention and Protocol Relating to the Status of the Refugee. Because of this, a new framework is needed.

Although the general definition remains relatively constant, differing international bodies have characterized internally displaced populations, and their relationship to externally displaced persons, differently. However, the most universal definition of the internally displaced comes from the UN. The first clear definition of the IDP was by Francis Zheng, Representative on

Internally Displaced Persons in 1992 (Mooney 2005, 10). This definition, however, was too narrow in some respects and too broad in others, excluding some populations who could be qualified as IDPs, and making it difficult to precisely identify the populations (Mooney 2005, 11). The United Nations deliberated, and decided in 1998 to change their definition to:

Persons or groups of persons who have been forced or obliged to flee or to leave their homes or places of habitual residence, in particular as a result of or in order to avoid the effects of armed conflict, situations of generalized violence, violations of human rights or natural or human-made disasters, and who have not crossed an internationally recognized State border (United Nations Commission on Human Rights 1998, 5).

The definition was changed from its 1992 iteration to allow for displacement due to natural disaster, and for border changes and state developments (United Nations Commission on Human Rights 1998, 5). Regardless, the definition is almost indistinguishable from that of the externally displaced, besides the geographical location of the population. Functionally, an IDP would be considered a refugee if they merely crossed an international border.

By definition, the differences between externally and internally displaced populations are negligible. However, the difference in practice is more severe. The UN has commented that

...their [IDPs] presence within national territory means that their own Government bears primary responsibility for meeting their protection and assistance needs. However, because Governments frequently cause or tolerate internal displacement and/or are unwilling or unable to guarantee the basic rights and meet the needs of their internally displaced citizens, intergovernmental organizations have, at times, assumed these roles on an ad hoc basis (Deng 1998, 10).

The responsibility of the host country to care for their IDP is a major weight which accounts for the discrepancy between services to the two populations. It is also primary obstacle which intergovernmental bodies have to contend with as they evaluate delivering services to these populations. Many questions arise from this dilemma of jurisdiction. What happens when the



responsible party denies care to a needy population? How can the international community care for needy populations while still respecting national sovereignty? Is it more responsible to provide aid during a humanitarian crisis, or to respect a nation's responsibility to care for its own people?

Legal Considerations:

National sovereignty is the key legal consideration barring international bodies and states from assisting in IDP relief. National sovereignty is commonly viewed as the authority of a state to govern its own people. Its role is to enforce the internal order of the country while also protecting the nationals of that country from external threats (Agnew 2005, 437). Tom Lavers argues in his 2016 article *Agricultural Investment in Ethiopia: Undermining National Sovereignty or a Tool for State Building* that "...state sovereignty derives from the interaction of the political authority of the state with respect to society and the state's capacity for autonomous decision making with respect to external actors," (Lavers 2016, 1080). This understanding is complicated by states in crisis. During period of internal civil violence, the authority of the established state can be called into question.

The UN Office of Humanitarian Affairs (UNOCHA) reports in its *Principles of Humanitarian Action* that two key factors of humanitarian relief work must be neutrality and impartiality (UN Office of Humanitarian Affairs 2012, 1). Neutrality is respected when humanitarian actors do "...not take sides in hostilities or engage in controversies of a political, racial, religious, or ideological nature," (UN Office of Humanitarian Affairs 2012, 1). Similarly, impartiality is defined through humanitarian action being taken through need alone, without giving distinctions based on "...nationality, race, gender, religious belief, class or political opinions," (UN Office of Humanitarian Affairs 2012, 1). These two considerations are most

important when considering national sovereignty. International actors should not become involved with the internal matters of a country. They act in a grey area when IDPs are involved, should the state be engaged in hostilities which cause a humanitarian crisis.

The realities of war and violence add further legal murkiness to the humanitarian aid for IDPs. Stakeholders caring for the internally and externally displaced need to abide by the complex web of international law. Human rights need to be considered in the micro- and the macro-level historical, cultural, and political context. Special emphasis must be placed on international humanitarian law, which governs public and private action during wartime. According Elizabeth Umlas at Oxford University, the fundamental premise of international humanitarian law is that “...even in times of armed conflict human dignity must be respected and protected, and means and methods of warfare regulated,” (Umlas 2015, 9). Sometimes however, the very instrument which is meant to safeguard human liberties spells their destruction.

The misinterpretation of clauses which relate to liability in warfare can create barriers for international humanitarian actors. Umlas states that “Civilians who directly participate in hostilities lose their protection from attack for the time they are carrying out those activities,” (Umlas 2015, 17). This further expands to businesses, where “...if business property is used for military purposes, it becomes a military object and risks being legitimately attacked by parties to the conflict,” (Umlas 2015, 17) This is problematic, because in times of violence perpetrated by the government, humanitarian aid response can be interpreted as assisting the opposing side. The case of the Syrian civil war shows this. Allen-Ebrahimian writes that “In addition to military campaigns against rebel groups, Syrian President Bashar al-Assad’s forces have deliberately targeted medical facilities, schools, and infrastructure throughout opposition-held regions,” (Allen-Ebrahimian 2017). Although many view these actions as war crimes, the Assad regime is

probably using a liberal interpretation of warfare liability to perpetuate and justify its violence. Since the humanitarian aid is supporting opposition lead population in caring for them, he is eliminating it. Humanitarian aid, therefore, must strategize so as to not further instigate violence, or appear to abet hostile activity. No matter the legal validity of a claim to assisting opposition, humanitarian actors do not want to further escalate violence onto civilian populations. International humanitarian actors work in increasingly complicated environments to assure their aid, especially in the case of assisting IDPs.

United Nations Response:

The 1951 Convention on the Status of Refugees did not include a mention of the internally displaced (UN General Assembly 1951). The first UN identification of the internally displaced occurred in a 1972 Economic and Social Council resolution, which calls the High Commissioner to aid with refugees in Sudan as well as "...persons displaced within the country," (Dessalegne 1994, 51). This begun the common UN practice of serving IDPs on an *ad hoc*, or case by case, basis. However, even the UN acknowledges that in its beginning stages, "UNHCR's response [to IDPs] attracted some criticism for its selectivity," (UNHCR Informal Consultative Meeting 2007, 1). Cases assisting IDPs during this time were largely connected to refugee cases already in action, and even then they analyzed it on a case by case basis (Dessalegne 1994, 53). The UN continued until 1992, when they formally explored the field of IDPs. Even so, much of their previous strategy for aiding the IDP remained.

The UN is hesitant in official policy regarding IDPs. When considering IDPs, they make sure to respect national sovereignty at each situation. With their power coming from the agreement of each state, it is logical that this is their first inclination. For instance, in their 2007 *The Protection of Internally Displaced Persons and the Role of the UNHCR*, they explain that

“The work of the UNHCR and other international organizations rallying to a humanitarian crisis of internal displacement in these instances will thus be complementary to sovereign responsibilities which evidently must be discharged,” (UNHCR Informal Consultative Meeting 2007, 11). This marks a breaking from the role the UNHCR envisions itself for the treatment of refugees. Whereas with refugees the UNHCR takes more of an active and jurisdictional role, with IDPs, it views itself as supplementary.

They further report that UN General Assembly Resolution 53/125, paragraph 16 is a strong framework which guides UNHCR intervention regarding IDPs (UNHCR Informal Consultative Meeting 2007, 14). This resolution states that the humanitarian assistance and protection of IDPs must be taken by the UNHCR “...on the basis of specific requests from the Secretary-General or the competent organs of the United Nations and with the consent of the State concerned, taking into account the complementarities of the mandates and expertise of other relevant organizations,” (UNHCR Informal Consultative Meeting 2007, 14) It goes on to note that “activities on behalf of internally displaced persons must not undermine the institution of asylum,” (UNHCR Informal Consultative Meeting 2007, 14). With this initial framework, the UNHCR respects both the institutions of sovereignty and asylum, while also placing emphasis on humanitarian action. It highlights the UNHCR as a collaboration between the commission and the state. It also specifies that the UNHCR cannot act alone in deciding to provide aid in situations of internal displacement. Before action is taken, both the Secretary-General and the State must consent to the action.

UN action towards IDPs can be generally summarized into two categories: situations which are related to the existing work of the UNHCR, and situations where the UNHCR is invited to help manage intervention with the State and other international actors. Because each

situation is different, analysis is given on an ad hoc basis about the involvement of the UNHCR.

The UN notes in their *Study Series on Internal Displacement* that:

Situations in which UNHCR has worked with internally displaced persons include its returnee programmes, special operations often undertaken at the request of the United Nations General Assembly or the United Nations Secretary-General, and the providing of humanitarian and development assistance to refugees and internally displaced persons in a particular region (Deng 1998, 26).

The two categories of UNHCR assistance for IDPs are logical. When the UNHCR is already involved in aid, such as in returnee programs, it is time and resource effective to use to the same agency to address similar problems. Such as in the original 1972 Sudanese returnee program, it just makes sense for the UNHCR to handle every returnee regardless of if they are returning from the next county or the next country (Dessalegne 1994, 4).

The first category of UNHCR involvement becomes more complicated when special consideration is given to the context of internal displacement. In their *Internally Displaced Persons Compilation and Analysis of Legal Norms*, they note that in some cases, "...the same causes have produced both displacement and refugee flows or there is a significant risk of cross-border movement of some or all of the internally displaced," (Deng 1998, 9). The UNHCR applies to these cases for a multitude of reasons. They are oftentimes already working with the population that is externally displaced due to the conflict, which applies to their first consideration. Next, there is serious threat for the internally displaced to become external refugees, which the UNHCR would like to safeguard against. To ameliorate this issue, they report that "In these situations, UNHCR will favourably consider assuming primary responsibility for the internally displaced, assessing in each case the benefits of its involvement in terms of protection and solutions as well as the need for assistance and protection," (Deng 1998, 9). This marks a drastic change in established UNHCR functions. Normally, the UNHCR

remains a supplemental assistance in instances of IDPs. However, in instances where the same factors cause both external and internal displacement, and there is a risk for the internally displaced to become externally displaced, the UNHCR consider becoming a primary aid. This is the key reason why this paper makes a distinction between the IDP in Syria and in Iraq. In Syria, this condition applies, because the reason why the IDP are displaced is the same as the cause of the external refugee crisis.

### **Healthcare Needs of Displaced Populations**

Displaced populations are vulnerable to many health complications due to their displaced status. The United Nations has reported that "...a mass influx of refugees always creates the immediate danger of major loss of life" (United Nations Executive Committee 1995). This is due to potential violence that could occur against, or between, the displaced individuals, as well as health risks which come with having crowds of people in close quarters. The major causes for mortality in refugee populations are cause specific and include measles, diarrheal diseases, acute respiratory infections, malaria and malnutrition (United Nations Executive Committee 1995). Together these factors account to between 60 and 80% of all reported causes of death among refugee populations (United Nations Executive Committee 1995). Many of these cases could be ameliorated given proper healthcare services in camps for the displaced, with adequate shelter and WASH facilities. The UN points to a multi-sectoral strategy of prevention to help target these key factors of mortality, with each sector working together to achieve these goals. Key strategies which camp management look to is to address overcrowding, nutritional status of food, quantity and quality of water, environmental sanitation and shelter (United Nations Executive Committee 1995).

Although the World Health Organization (WHO) reports that displaced populations' susceptibility to chronic disease is similar to the country's regular population, other problems pose risks in long term scenarios. "The most frequent health problems of newly arrived refugees and migrants include accidental injuries, hypothermia, burns, gastrointestinal injuries, cardiovascular events, pregnancy –and delivery related complications – diabetes and hypertension," (Migration and Health). Many of these issues, like those discussed with the UN, occur due to the environmental factors of the road to displacement as well as the camps where the displaced reside.

Special attention is given to the health status of women and children in displaced situations. Reproductive healthcare, especially when other resources are scant, is not always available to women who are displaced. HIV infection and viral hepatitis, as well as other sexually transmitted infections, are common among individuals in the camps (Migration and Health). Women face exploitative work conditions as well as sexual violence in displacement camps. Women can also be vulnerable due to "poverty, separation from a spouse, social and cultural norms, language barriers, substandard living conditions and exploitative working conditions, including sexual violence," (Migration and Health). These cultural conditions lead to decreased psychological and physical wellbeing. The UN has noted that it is important to provide adequate support to women, as they play a key role in assuring the health of families in camps as the usually sole care providers in families. Thus, the health of children and families will be negatively impacted if the health of their mother deteriorates. Children, like children in the more general population, are also vulnerable. They have increased sensitivity to problems related to nutrition, dehydration and communicable diseases. Increased attention to children is always a major strategy in the safeguarding of displaced populations.

The mental health of displaced populations has also been a subject of wide study. Displaced populations experience tremendous levels of violence which could contribute to negative mental health factors. In addition to this, they also may deal with the loss and death of loved ones, abuse, and the grievances for the loss of their home. The trauma of flight in and of itself is also a risk factor for serious mental illness (United Nations Executive Committee 1995). Examples of negative effects include depression, post traumatic stress disorder, anxiety, and severe grief. The most studied mental health implications for displaced populations, however, are post-traumatic stress disorder (PTSD) and depression (Thomas 2004, 121). The World Bank also marks generalized anxiety, panic attacks, adjustment disorder and somatization as key mental health problems faced by displaced populations (Marquez 2016, 7). They also note that prevalence rates for children and adolescents are much higher than the more general population. For children and adolescents, rates of PTSD are 50-90% as compared to 10-40% in adults, and rates of major depression are 6-40% for children and adolescents and 5-15% for adults (Marquez 2016, 7). Mental health side effects may also contribute to negative health, because it acts to “...deplete the physical and emotional reserves of the population, and natural resistance to disease is thus lost,” (United Nations Executive Committee 1995) This means that treatment for mental health can also serve to prevent the escalation of other health concerns.

Studies have indicated that IDPs may be more at risk to negative health and mental health factors (Thomas 2004, 121). For instance, Salama and colleagues found that in Kosovo, IDPs suffered more traumatic events for longer periods of events than comparable refugees, and thus displayed higher psychological morbidity prevalence (Salama 2001, 1431). Salama reports that “...some of the highest crude mortality rates (CMRs) in humanitarian emergencies have been among IDPs in the past decade (Salama 2001, 1431). He cites biological, environmental and



organizational factors to contribute to this, such as inaccessibility of vaccinations and also food distributions in IDP camps, as well as the oftentimes turbulent environments surrounding IDPs and their camps (Salama 2001, 1431).

## **Country Contexts:**

### **Iraqi Displacement:**

The UN Office for Coordination of Humanitarian Affairs (OCHA) reports that as of September 2017, 3,200,000 individuals were internally displaced in Iraq (Iraq OCHA). The subject of the Iraq War and subsequent occupation and violence is contentious and often emotionally charged. However, in order to understand the contextual background of those internally displaced in Iraq, a basic background on the subject is necessary.

The United States' Iraq War provides some contextual background to contemporary internal displacement in Iraq. The first phase of the United States military operation in Iraq occurred from March through April 2003, and was a brief and conventionally fought war against the Iraqi military and paramilitary forces (Iraq War 2011). The United States President, George Bush, argued that a mission in Iraq was needed to hold the Iraqi government responsible for their support of terrorist activity, possession and manufacturing of weapons of mass destruction, and Iraqi government crimes against civilian populations (Iraq War 2011). On May 23, 2003, the Iraqi military disbanded (The Iraq War: Timeline). The American lead forces then began an occupation of the country to help restore order (Iraq War Britannica). During this time, guerilla combatants began to attack American and government forces (Iraq War 2011). United States and Iraqi government forces worked trying to restore security to the area until the eventual American pull out in 2011 (Iraq Profile 2017). During this time, there were periods of violence created by guerilla groups and dissent among ethnic and religious groups. It was during this time that the

Islamic State of Iraq and the Levant (ISIL) was created. ISIL can trace its roots to al-Qaeda in Iraq, the Mujahedeen Shura Council in Iraq and the Jund al-Sahhaba (Gulmohamad 2014, 2). Each of these groups were formed by militant Sunni combatants angered at US occupation and the Shia-Muslim run government of Iraq, and became a leading force of the insurgency during this time (Islamic State and the Crisis 2018).

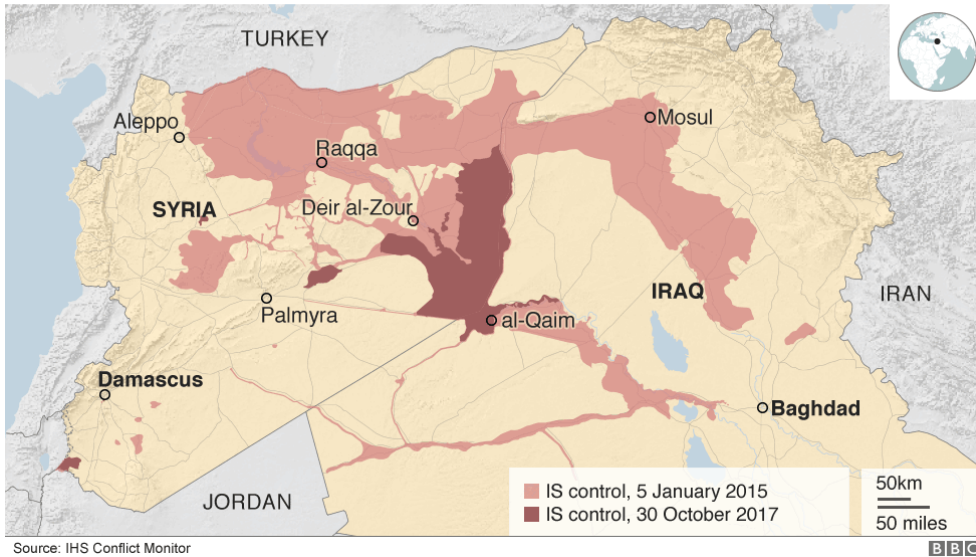
The conflict with ISIL is the or much internal displacement in Iraq. ISIL is known for its terrorist activity, extremism and strict regime where it gains control. ISIL is fighting for an autonomous Islamic run State in the region, and resorts to violence and terrorist tactics to do so. For instance, according to the British Broadcasting Corporation, at least 6,878 civilians were killed in violence related to ISIL in 2016, with more than 2,700 deaths occurring in September alone (Islamic State and the Crisis 2018). Since 2014, the estimated civilian deaths by the Iraq government is more than 66,345 (Islamic State and the Crisis 2018). The group has been accused of committing many war crimes and crimes against humanity, such as the ethnic cleansing of minority groups and mass murder of civilians (Iraq: ISIS Abducting). Groups targeted by ISIL include Christians, Turkmen, Shabaks, Yazidis, Kurds, Shia Muslims and political dissenters (Iraq Crisis 2014).

In 2013, ISIL began taking control of part of Syria (Islamic State and the Crisis 2018). In 2014, ISIL began pushing into northern and Western Iraq. When they advanced into areas controlled by the Kurdish minority and killed or enslaved members of the Yazidi religious group, it prompted U.S. led coalition to begin airstrikes on areas under ISIL control in April 2014 (Islamic State and the Crisis 2018). The fall of Mosul to ISIL control from Iraqi forces from Iraqi marked a significant fortification of the ISIL enthusiasm and strength, as the leader of ISIL, Abu Bakr al-Baghdadi, declared a global caliphate from Mosul upon taking control of it (Al-Salhy

2014). ISIL continued to expand in the years follow, controlling the Iraqi cities of Mosul and al-Qaim, as well as Syrian cities of Raqqa and Deir al Zour (Islamic State and the Crisis 2018).

According to the Associated Press, “ISIL fighters overran nearly a third of Iraqi territory, including Mosul, the country’s largest city, in summer 2014,” (Associated Press 2017).

**How much territory IS has lost since January 2015**



*Figure 1 ISIL Control of Iraq and Syria by year (Islamic State and the Crisis)*

During those years, United States backed coalitions of regional and Western groups fought to regain control of the region. Allied forces against ISIL in the region include: Saudi Arabia, United Arab Emirates, Turkey, Jordan, Egypt,

Qatar, Bahrain, United Kingdom, Australia, France, Germany, Canada, and The Netherlands (Fantz 2014). Iraqi fighters allied with the coalition include: “Iraqi army forces, Kurdish peshmerga fighters and Shia militias (Torpey 2017). The Battle for Mosul was an important advancement win for the allied forces. With Iraqi forces supported by U.S. backed airstrikes, the allied forces were able to regain control of Mosul after a 37-week offensive in July 2017 (Torpey 2017). Although the city was liberated from ISIL control, 800,000 civilians fled as a direct result of the fighting and the UN reported that half of all casualties was from civilians – with 2,463 estimated civilian deaths and 1,661 civilian injuries in the region (How the Battle for Mosul 2017) U.S. backed Iraqi forces continued to fight to regain territory until, on December 9, 2017,

Iraq's Prime-Minister, Haider al-Abadi, announced that Iraqi forces were in full control of the country (Associated Press 2017). However, it is reported that ISIL maintains the capability to carry out insurgent attacks and cause further destruction in the area even with limited territorial capability (Associated Press 2017).

During this conflict, civilians were faced with violence from each side, be it intentionally or unintentionally. A common strategy in this conflict by the US and its allied Iraq forces was through air strikes, which lead to the death of many civilians. The US military confirmed that at least 603 civilians were unintentionally killed in since they have engaged ISIL in 2014 (Cahill 2017). Thus, staying in cities where the violence was occurring was dangerous for civilians. However, fleeing was also a threat to the civilian population. The UN Human Rights Office reported that ISIL had been known to use civilians as shields as well as killing any resident who tried to flee (Cahill 2017).

#### Syrian Displacement:

The Syrian Civil War, ongoing since 2011, has shocked the world due to its atrocities and the amount of individuals it has forcibly displaced. The UNHCR has reported that there are 13,100,000 individuals in need in Syria, with 6,100,000 internally displaced and 5,400,000 refugees as of December 2017 (Syria Emergency 2017). In Iraq, there are 246,974 Syrian refugees, with most of the population settling down in the Kurdistan region (Syrian Regional Refugee Response 2017). The displacement from the Syrian Civil War is due to two factors: government and opposition force clashes and ISIL expansion.

Pro-democracy protests in the Syrian capital of Damascus in 2011 ignited the Syrian conflict. Similar to other Arab Spring movements concerned with removing longstanding, anti-democratic leaders from power, the peaceful demonstrations largely centered on President Bashar al-Assad and his family's 40-year reign over the government (Sinjab 2013).

Following violent crackdowns against the demonstrators by Assad's security forces, the protests transformed into an armed conflict, which spread to cities throughout Syria (Sinjab 2013).

As the conflict progressed, foreign actors became more involved. The United States, Saudi Arabia, Qatar, and Turkey began providing economic and military support to opposition fighters in an attempt to dislodge the Assad government (Humud 2018, 1). In the hopes of maintaining a strong regional ally, Iran began providing the Assad government with weapons and money, and by proxy through Hezbollah militias from Lebanon (Hubbard 2018). Kurdish groups in northwest Syria, with the support of Iraqi Kurdistan, joined the opposition and operated with increasing independence and authority (Hiltermann 2018). Their goals aligned with other Syrian opposition groups, but they were also influenced by motivations of Kurdish independence (Hiltermann 2018).

International inaction and a split between Russian support for Assad and US insistence that Assad leave power has thus far added further intransigence to the conflict. Reports of grave breaches of international humanitarian law, such as torture and chemical weapons attacks, and the presence of millions of Syrian refugees in neighboring states resulted in international pushes for peace. The Russians also have been conducting their own air strikes in Syria since October 2015 (Syria Crisis 2017). The official goal of which is to eradicate terrorism from Syria, however Russia's clear policy in Syria has been to bolster the Assad regime and eliminate all armed opposition groups (Syria Crisis 2017). Russian support of the Assad regime has fortified the regime's political standing and has blocked much international action on the conflict.

The activity of Al-Qaeda and Islamic State factions in the Syrian opposition complicated and further bloodied the conflict. Al-Qaeda has supported various Islamist opposition groups with weapons and fighters (Lister 2017). The Assad regime has branded all opposition groups as terrorist extremists and punished them accordingly, no matter their affiliation (Lister 2017). This is a key strategy of the Assad regime to justify their violence toward the Syrian opposition groups, shown by their release of Sunni men with ties to terrorist groups in 2011 (Lister 2017). The Islamic State has also capitalized on the chaos, gaining territory and influence in many areas of Syria during the conflict, especially in 2014 (Syria: The Story of the Conflict 2016). The rise of these groups leaves Syrian civilians stranded between violence perpetrated by both the Assad regime and the Islamic State, and many have suffered from atrocities and forced displacement caused by both sides.

Violations of international humanitarian law has fueled the crisis of forced displacement in Syria. This is partially based on the strategy of the Assad regime and its allies. Attacks, using heavy weapons like barrel bombs, chlorine gas, and cluster munitions, have targeted civilians populated areas, hospitals and schools (Idris 2017, 2). There have been civilian casualties at the hands of almost all the actors fighting in Syria, including the regime and its allies, armed Syrian opposition groups, the Islamic State, Kurdish groups and the international coalition (Idris 2017, 2). There has also been reports of individuals being captured, tortured and killed on the ground in Syria (Syria: Events 2016). What more, the Syrian regime has unlawfully restricted humanitarian assistance to the area. This is because the regime forces humanitarian actors to obtain regime permits to act in certain areas (Syria: Events 2016). The few humanitarian actors who were allowed in were subject to scrutiny and obstruction, with 80,000 medical treatment items being detained from humanitarian actors in

February 2016 alone (Syria: Events 2016). The Syrian civilian population had to face these atrocities from all sides, forcing many out of their homes.

*Duhok Governorate:*

The population of Syrian refugees and Iraqi IDPs explored in this study resides in the Duhok Governorate of Iraq. Duhok is one of the three northern Iraqi regions, along with Erbil and



Sulaymaniyah, which create the Iraqi Kurdistan Region (Eklund 2012, 50). This means that Duhok is governed by the Governorate of Duhok, the Iraq Kurdistan Regional Government, and the federal government Iraq. The Duhok Governorate itself is divided into four districts of Duhok, Amedi, Sumel and Zakho (Duhok Governorate 2015, 1).

*Figure 2: Duhok Governorate Location (Location 2011)*

The Iraqi Kurdistan Region is semi-autonomous, and has been holding independent elections since 1992 (Eklund 2012, 50). However, it has also experience decades of conflict, both with the government of Iraq and individually, between the Kurdistan Democratic Party (KDP) and the Patriotic Union of Kurdistan (PUK) (Contemporary History). The KDP and PUK fought a civil war for control of the Iraqi Kurdistan region from 1994 to 1998 after power-sharing arrangements failed, but were resolved with the signing of the Washington Agreement in 1998 (Contemporary History). In the Iraqi constitution of 2005, the Kurdistan Regional Government and the Kurdish Parliament were formally acknowledged and confirmed (Bali 2017, 222). In 2006, the KDP and PUK were formally consolidated to form one governing body of the Iraqi Kurdistan Region, and the area is governed through a Parliament and Kurdish Prime minister (Contemporary History).

The Kurdistan region is rich in oil, and the Iraq federal government is reliant on revenue brought in from Kurdish oil production (Bali 2017, 222). Because of this, the 2005 Iraqi constitution committed to spending 17% of its budget in the Kurdistan region, transforming the region from being viewed as an opposition group to it being seen as “...one of Iraq’s core political components,” (Bali 2017, 222). However, in recent years, this payment has been a cause of conflict. The KRG started to export its oil independently of the Iraq federal government, and in return, they stopped allocating their budgetary revenue to the region in 2015 (Bali 2017, 222). This caused economic unbalance in the area, the KRG had previously relied on this budgetary support (Bali 2017, 2222). This economic context in the Kurdistan region at this time is important to consider as it was during this time that the populations studied were displaced to the region.

The Duhok Governorate hosts a majority of the displaced population in the Kurdistan region, which in turn hosts the majority of the displaced population in Iraq. In 2016, the population of Duhok was 1.47 million and the population of displaced individuals, including refugees and IDPs, was 718,000 (Displacement as a Challenge 2016, 5). Duhok hosts 38% of the total Syrian refugee population hosted in Iraq, with 92,831 individuals, and 19% of Iraq’s IDPs, with 625,169 individuals, as of 2016 (Displacement as a Challenge 2016, 11). The displaced populations are concentrated in twenty-two camps in Governorate, four for Syrian refugees and eighteen for IDPs (IDPs and Refugees in Duhok 2016, 9). 37% of IDPs reside in camps and 63% in urban areas, whereas 56% of refugees reside in camps, with 44% residing out of camps (IDPs and Refugees in Duhok 2016, 10). Duhok is the location of settlement for so many displaced because of its relatively stable political atmosphere, as well as economic support (Eklund 2012, 48). The location of the Duhok Governorate may also be attractive to migrants, as it shares its



border with Turkey. Individuals who have plans to cross into Turkey may find themselves settled in Duhok beforehand.

The health system in the Duhok Governorate reflects the federal system governing the region. Health policy and implementation is directed primarily through the Duhok General Directorate of Health and the Ministry of Health of the Kurdistan Region (Directorate General of Health Duhok). The region hosts eight hospitals and 148 primary and secondary health centers serving over 600,000 and over 1.5 million patients, respectively, each year (Duhok Health Statistics). Humanitarian activity is also accounted for the health support that the Duhok Governorate receives. The Board of Relief and Humanitarian Affairs (BRHA) was established in 2015, and operates within the governmental structure of the Duhok Governorate to help in the administration and implementation of humanitarian services for refugees, IDPs and vulnerable host communities in the region (IDPs and Refugees in Duhok 2016, 2). This humanitarian infrastructure, with the relationship between the BRHA, Duhok Governorate and multilateral humanitarian actors who provide services in the area, provide the framework for the implementation of health services to the displaced populations residing in the region.

### **Data Methods:**

The data analyzed was found through two separate reports published by the UNHCR and the Governorate of Duhok. The first dataset is a profiling study of displaced individuals living in urban environments in the Duhok Governorate, compiled for a report entitled “Displacement as a Challenge and Opportunity: Urban Profile – refugees, internally displaced persons and host community, Duhok Governorate, Kurdistan Region of Iraq.” This report used a sample from the dataset to make its claims. The profiling study was a collaboration between the UNHCR, Duhok

Statistics Office, the Board of Relief and Humanitarian Affairs, and The Joint IDP Profiling Service (Iraq- Duhok Urban Profiling 2016). The study covers 7,063 interviews with individuals, with 1,605 Syrian refugees and 2,431 IDPs included (Iraq- Duhok Urban Profiling 2016) This sample size allows for “...an extrapolation of statistically representative results with a 5% margin of error in each stratum,” and are statistically representative for each group (Iraq- Duhok Urban Profiling 2016). Individuals were questioned in May and June of 2016. The questions ranged from subjects like education, work history, health accessibility and general biographical information, in order to understand the realities of the individuals living in urban areas of Duhok at the time. For the purposes of this inquiry, only the questions on health were considered.

The second group of data was collected originally by the Duhok Governorate’s Board of Relief and Humanitarian Affairs for their report entitled “IDPs and Refugees in the Duhok Governorate: Profile and General Information.” This was a profiling study from February 2016 which analyzed the living conditions of the displaced populations in the Duhok Governorate of Iraq (IDPs and Refugees in Duhok 2016). The purpose of this study was to provide information to humanitarian actors in the region. It reports on the facilities and services supplied in each of the displacement camps (IDPs and Refugees in Duhok 2016). This study provides an excellent counterbalance to the first study, which was largely qualitative. For the purpose of this analysis, the amount of healthcare services provided in both the IDP camps and the refugee camps in the Duhok Governorate were compared.

## **Results:**

To find the number of individuals who classified their access to healthcare in each category, the data from the first source was coded in Microsoft Excel. First, the respondents were sorted by displacement status, then their responses were coded by category so that the responses

could be compared. In order to be compared using the same metrics, each of the responses were converted into proportions.

**Table 1: Health Accessibility Responses for Refugees and IDPs** (Iraq- Duhok Urban Profiling 2016)<sup>1</sup>

Health Access Response	Number Refugees	Number IDPs
Very good	128	301
Good	848	1372
Satisfactory	414	316
Insufficient	144	334
Not accessible	71	108
<b>Total</b>	<b>1605</b>	<b>2431</b>

**Table 2: Health Accessibility Response Proportions for Refugees and IDPs** (Iraq- Duhok Urban Profiling 2016)

Health Access Response	Proportion Refugees	Proportion IDPs	Total Proportion
Very good	8%	12%	11%
Good	53%	56%	55%
Satisfactory	26%	13%	18%
Insufficient	9%	14%	12%
Not accessible	4%	4%	4%

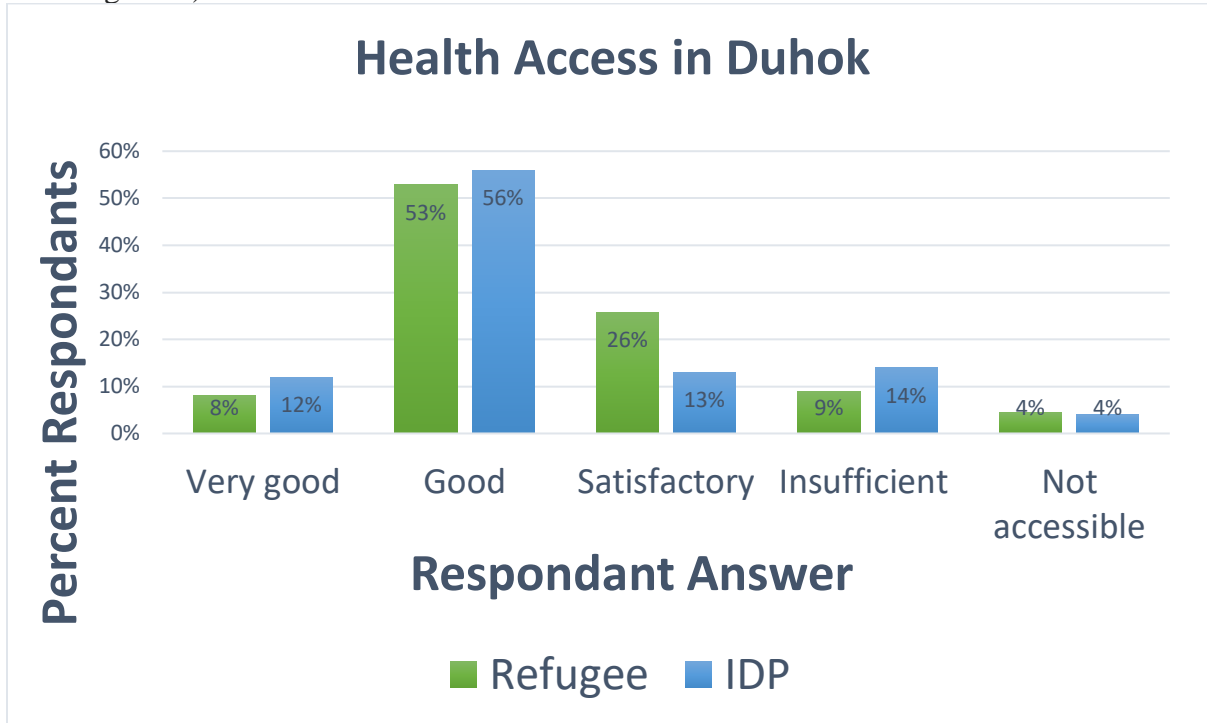
The resulting graphs are skewed right, with the majority of the respondents answering that they have “Good” access to healthcare, living in urban areas of the Duhok governorate. This is the same for both the refugee population and the IDP population. However, the curve for the refugee population appears to be more normally distributed, with more answering satisfactory than insufficient. For the IDP population, there are more who answered insufficient than satisfactory. These are also the two categories with the most difference between the refugees and

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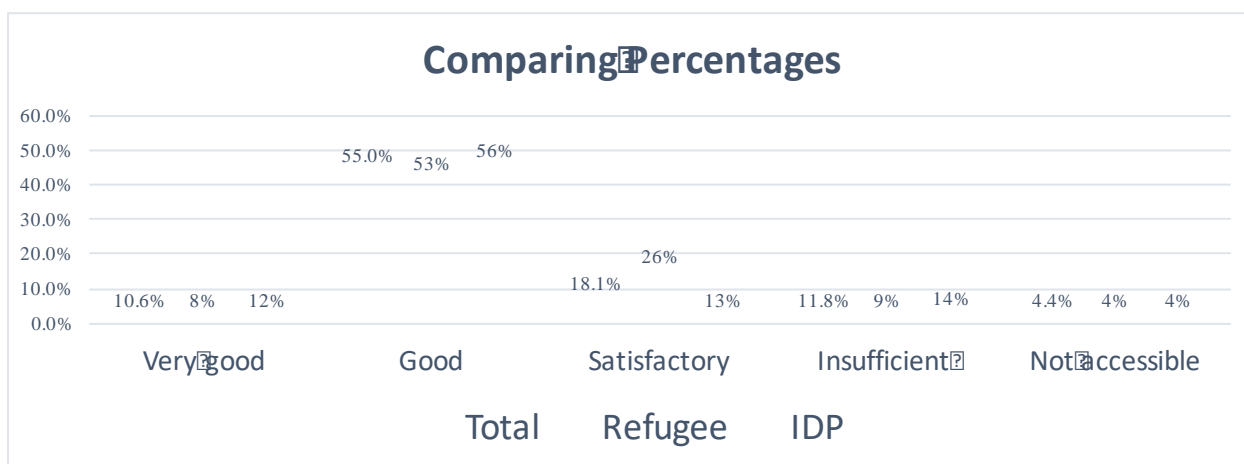
<sup>1</sup> The raw data for each table and graph were found in the Iraq- Duhok Urban Profiling and IDPs and Refugees reports, however the data was coded, organized and presented by Shannon Moquin.

IDPs tested. 13% more refugees than IDPs answered that they had satisfactory access to healthcare, and 5% more IDPs than refugees answered that they had insufficient access to healthcare.

**Figure 3: Comparing questionnaire responses by response** (Iraq- Duhok Urban Profiling 2016)



**Figure 4: Comparing responses with total responses** (Iraq- Duhok Urban Profiling 2016)



**Table 3: Z-Test for Two Proportions**

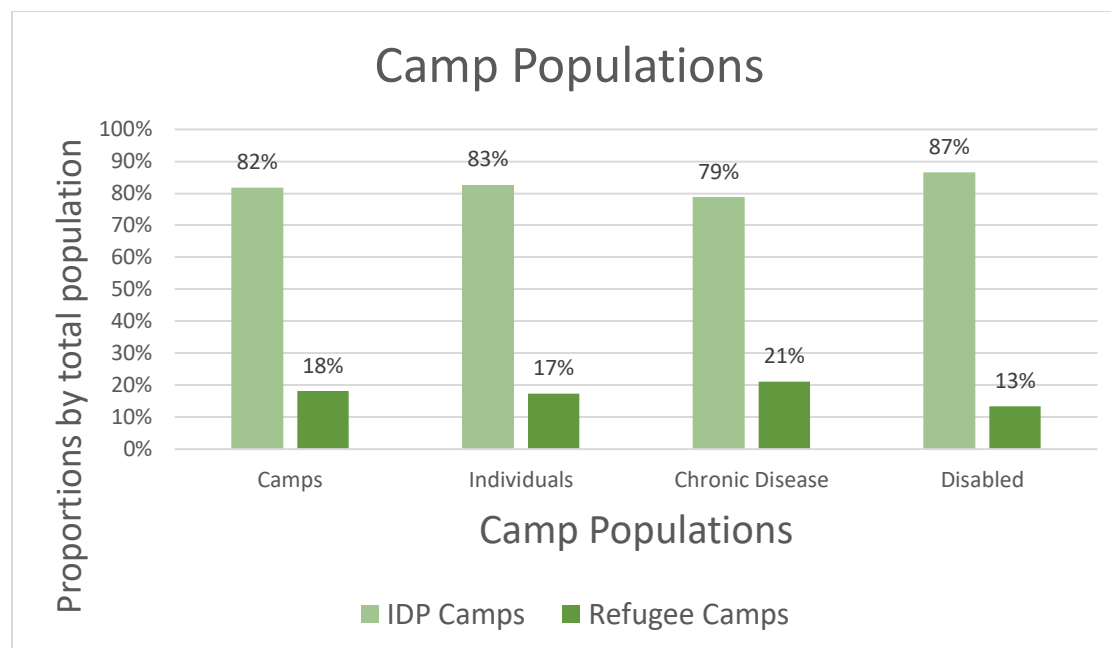
	Proportions	N	P-Hat 1	P-Hat 2	P-Bar	Q-Bar	Z-Value
Refugee V Good	0.080	1605	0.12	0.08	0.11	0.89	4.45
IDP V Good	0.124	2431					
Refugee Good	0.528	1605	0.56	0.53	0.55	0.45	2.25
IDP Good	0.564	2431					
Refugee Sat	0.258	1605	0.26	0.13	0.18	0.82	10.34
IDP Sat	0.130	2431					
Refugee Insuff	0.090	1605	0.14	0.09	0.12	0.88	4.59
IDP Insuff	0.137	2431					
Refugee NA	0.044	1605	0.04	0.04	0.04	0.96	0.03
IDP NA	0.044	2431					

In order to test for statistical significance between the refugee and IDP responses, a Z-test for two proportions was conducted for each category. The Z-test for two proportions was chosen because the goal is to test to see if the proportions for the two groups, the IDPs and the refugees, were statistically significant. For this study the null hypothesis would be that the proportions would be the same, and the alternative hypothesis would be that they would differ. This makes it a two tailed z-test for two proportions. A z-test is appropriate for this sample because the sample size is large enough.

The results of the z-tests for two proportions were significant. For each category besides the “No Access” to healthcare, there was a statistically significant result at the 95% confidence level, which is allowed by the dataset. This is because each of the Z-values were greater than 1.96, the Z-value allowed for 95% confidence. This means that for each of the categories besides “No Access,” there was a significant difference between refugees and IDPs’ access to healthcare. For the “Good” Category, the z-value is .02445, meaning that there is only a 2.445% chance that this result is random. For each other category besides not accessible, the p-values are less than .00007, meaning that their results are even more statistically significant. For each of these categories, “Very Good,” “Good,” “Satisfactory” and “Insufficient,” there is sufficient evidence

to reject the null hypothesis that the proportions are the same, to accept the alternate hypothesis that the proportions are not the same for the access to healthcare for IDPs and refugees in urban areas of the Duhok Governorate.

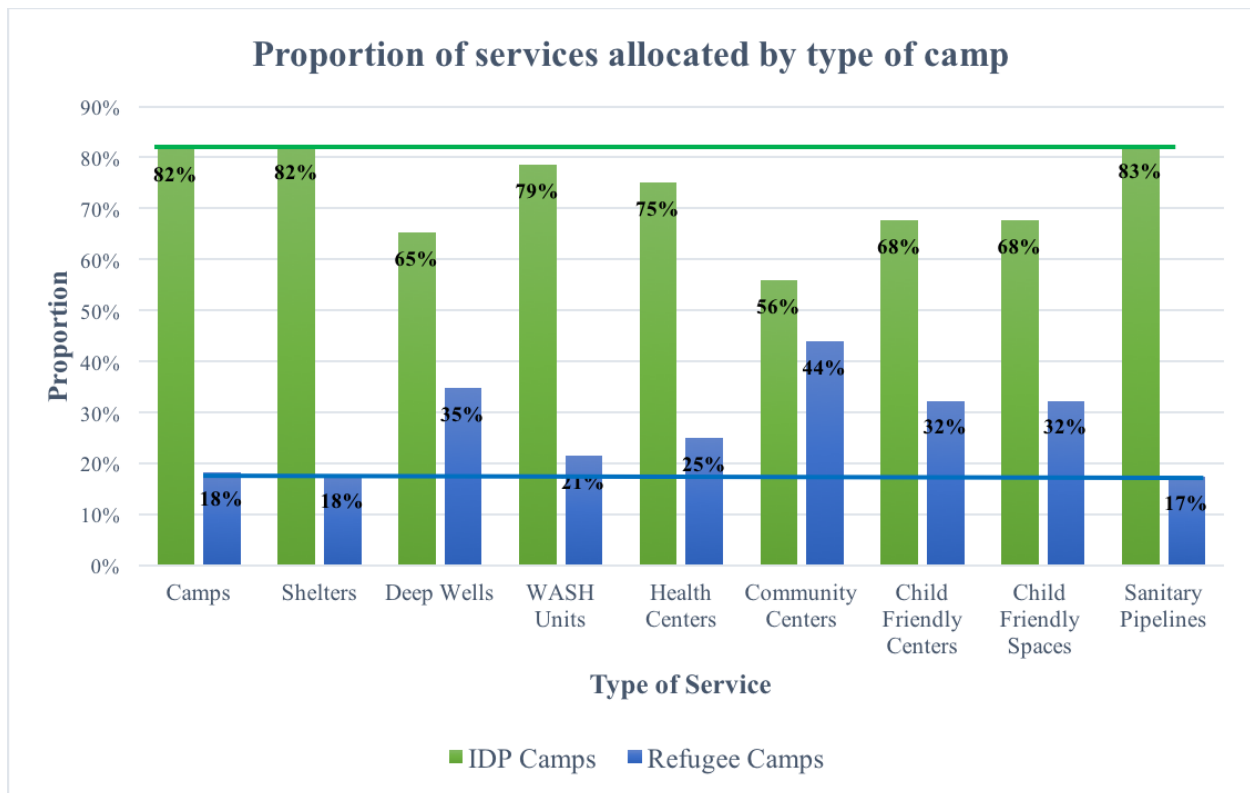
**Figure 6: Camp Population Proportions (IDPs and Refugees in Duhok 2016)**



The Duhok Governorate has twenty-two camps dedicated for displaced individuals, and has published a report describing the populations and services in each of those camps. Eighteen of the camps are for IDPs, to serve the population of 189,321 IDPs in camps in 2016, and four of them are for refugees, to serve the population of 39,735 refugees in 2016. This means that out of the total displaced population residing in camps, 83% is IDPs and 17% is refugees. The number of camps which house these individuals reflects this proportion, with 82% of the camps being dedicated to IDPs and 18% to refugees. As the population parameters get more specific, these proportions do not fluctuate much. For the population of displaced individuals living in camps, 79% are IDPs and 21% are refugees. This means that refugees represent more than their

population proportion in the population of displaced individuals living with chronic diseases in camps in the Duhok governorate. IDPs have an increased proportion of the disabled population among the displaced population living in camps, with 87% of the disabled being IDPs and 13% being refugees. All in all, Figure 6 shows that the proportion of IDPs as compared to refugees in camps in Duhok are stable. There is not much fluctuation between the proportions, which is to be expected, as one would assume that the proportions of different segments of a population should roughly mirror the proportions of the populations themselves.

**Figure 7: Proportion of services allocated by type of camp (IDPs and Refugees in Duhok 2016)**



The proportion of services in IDP and refugee camps do not reflect the expected proportions for the distribution of camps. The general trend seen in Figure 7 is that IDP camps

have less services per their proportion of the general camp population than do refugees. For instance, 83% of camps are IDP camps, yet only 75% of the health centers accessed by displaced populations in Duhok are for IDPs. This is an 8% difference in proportion. Similarly, the proportion of community centers dropped to 56% for IDP camps, the proportion for child friendly centers and spaces both reached 68%, and the proportion for deep wells were 65%. The only areas with insignificant fluctuations were for the shelters in the camps, Water Sanitation and Hygiene (WASH) Units, and sanitary pipelines, which each stayed within 3% of the proportion for the population. These results are interesting, as the services accessible divided by the total amount of services for all displaced individuals changed. This may provide support to the previous conclusion that healthcare services accessed by refugees and IDP differ.

### **Analysis:**

The purpose of this inquiry was to assess whether there was a statistical significant difference in healthcare accessibility for internally and externally displaced individuals in the Duhok Governorate of Iraq. An analysis of the individual responses by displaced individuals in the region and a closer look into the healthcare services which were provided in the camps for the displaced show that there is a statistically significant difference between the two groups. What more, this difference is oftentimes attributed to refugees having higher access to healthcare services.

There is 95% confidence that refugees had a higher degree of “Satisfactory” access to healthcare and that IDPs had a higher degree of “Insufficient” access to healthcare. Other categories, such as “Very Good” and “Good,” also experienced significant differences. However, there is even more of a difference between the answers for “Satisfactory” and “Insufficient,” which both saw major discrepancies. Although these answers were a result of a qualitative study



and the answers are self reported, there is a large enough sample size to assume that the results are normative. The results are also representative for the urban displaced population in Duhok. Furthermore, the qualitative markers “Satisfactory” and “Insufficient,” have more clearly understood differences than the differences between “Good” and “Very Good.” This makes the qualitative answer more understandable. Therefore, it can be clearly stated that there is a significant difference of healthcare accessibility between internally displaced and externally displaced populations in urban areas of the Duhok Governorate. It can also be observed that this difference can be attributed to the refugees in this population experiencing a higher quality of healthcare than that of the IDPs.

The observations from the displacement camps in the Duhok Governorate support the conclusion that healthcare access differs for the differing populations. This is because the proportion of services provided in the camps did not remain constant to the proportion of IDP to refugee camps, or to the proportion of needy individuals in those camps. This supports an assumption that another factor is responsible for this discrepancy instead of need. It also provides more of a holistic context into the experiences the displaced individuals in the Duhok Governorate, as many of them reside in these displacement camps.

## **Conclusion:**

The legal differences between internally and externally displacement depends on what type of border a population crosses. However, when it comes to the type of healthcare a population has access to, this seemingly minute detail may be more significant. IDPs and refugees in the Duhok Governorate of Iraq experience significantly unequal access to healthcare. This is the case even when the healthcare needs of displaced populations are very similar, and

that the populations in need for each subcategory are comparable. However, the greater resources available to refugee populations that are not afforded to IDPs may be one of the reasons why refugees have a greater access to these services. IDPs are a valuable resource to countries hoping to rebuild after conflict and violence. In addition to safeguarding the right to health for IDPs, it is in the best interest of the international community to see these populations supported.

In the future, more research needs to be done to understand the relationship between displacement status and access to services. This way, state and non-state actors may be better mobilized to work together to ameliorate the discrepancy in the services which are provided. For instance, similar studies should look into other sectors of humanitarian response, such as the access to education or meal provisions. In order to support humanitarian actors in the delivery of such services, more research needs to be done regarding the legal implications of closing the gap in the delivery of services. In other words – what can be done, legally, to ensure that every individual has access to life-saving services, regardless of which borders they had to cross when they fled violence.

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