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(Dis)connectivities in wartime: The therapeutic geographies of Iraqi healthcare–seeking in Lebanon

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ABSTRACT

The proliferation of conflicts across borders of Middle Eastern States has transformed the landscapes of health and healthcare across the region. In the case of Iraq, state healthcare has collapsed under the strain of protracted conflicts. Meanwhile, Lebanon's post-war healthcare system is booming, and becoming more privatised. In this paper, we build on an ethnographic study on the movements and experiences of Iraqi patients in Lebanon to show how one of the consequences of war is the rise of alternative forms of healthcare–seeking practices and survival strategies – a therapeutic geography that is embedded in regional economies and geopolitical relations and reconfigurations. We argue for the need to reimagine the disconnectivity and connectivity of healthcare systems under war and conflict as grounded in the empirical realities and experiences of mobility in the Middle East.

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Connectivity; mobility; Iraq; war; therapeutic geography

Introduction

The corridors, wards, and outpatient clinics of the American University of Beirut Medical Center (AUBMC) in Lebanon bustle with Iraqi patients. Many have travelled as frequently as once a month to receive chemotherapy, radiotherapy, or undergo essential medical and surgical procedures for different kinds of afflictions, including war-related traumas. Both cancer therapy and reconstructive surgery have been the leading causes of medical travel to this 400-bed teaching hospital. According to admission records, Iraqis have become the second largest national group (after Lebanese) to seek care at this tertiary care centre since 2007.[1] Patients do not travel alone and are often accompanied by one or two family members, and sometimes a close friend. Avoiding an expensive, and long-term stay at the hospital, patients and their escorts usually stay in Beirut's numerous motels or furnished apartments. Alongside the decline in tourists in Lebanon due to political instability and the spill-over of the crisis in neighbouring Syria, an uninterrupted flow of patients from Iraq have been charting therapeutic connections across the war-torn region.

Scholarship on patients' mobility has often focused on medical travel from the Global North to medical tourism hubs in Global South countries (Connell, 2006; Runnels & Carrera, 2012; Solomon, 2011) and how profit-driven healthcare models shape local healthcare systems in destination countries (Whittaker, 2008). The journeys of Iraqi patients fall in the realm of the far more frequent South-to-South medical travel, which remains understudied with few exceptions (Connell, 2013; Kangas, 2002; Ormond & Sulianti, 2014). In such settings, scholars have used the concept of *therapeutic itineraries* to describe such movement. This work has shown how globalisation has played an

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increasing role in redefining human and technological connectivity across different states and shaping healthcare–seeking trajectories of patients within and between countries (Kangas, 2002). Moreover, *therapeutic itineraries* has come to refer to patients' alternative healthcare treatment options in the context of state recession (Brotherton, 2012). Building on this, we propose that such alternative pathways of healthcare–seeking are further complicated by broader geopolitical and socio-economic processes resulting from war (Lubkemann, 2010). We use the term *therapeutic geographies* to better capture the reorganisation of healthcare within and across borders as a result of long-term conflicts and the dismantlement of national healthcare systems, and to map the concurrent trajectories of patients across regional healthcare hubs (Dewachi et al., 2014). In anchoring our analysis in regional geographical connections and disconnections, we aim to show how therapeutic trajectories involve less of a notion of choice and preference in seeking treatment than that of 'itineraries'. Furthermore the notion of 'geographies', which are 'mapped, shaped, and defined by social, cultural, economic, and political processes' (Dewachi et al., 2014, p. 454), aims to frame the analysis within local histories of different healthcare settings.

This paper aims to go beyond stories of displacements and breakdown of national healthcare systems that often mark global health and public health discourses in the context of war.[2] We aim to show how, in the context of infrastructure breakdown, patient mobility and survival strategies map new regional connections as a response to the inability of the state to provide for its citizens. We show how, in the face of the war-induced 'recession' of state medicine in Iraq (a result of long-term war and neglect), 'alternative' configurations for healthcare have become a response not only for Iraqi civilians, but also for their government. Unable to provide quality care within its borders or reconstruct the country's devastated healthcare infrastructure, the Iraqi government has 'instrumentalised' therapeutic geographies to respond to its own failures to provide for its war-afflicted populations. In this way, this paper shows how war is not merely a destructive event resulting in disconnections, but also a constellation of generative processes that involves the reconfiguration of institutional and communal modes of survival through the formations of new connections within and beyond zones of conflict (Crane, 2013; Lubkemann, 2010; Nordstrom, 1997; Singer, 2010). Furthermore, our use of the term 'wartime' aims to highlight the continuities, and blurred demarcations, between conflict and post-conflict.

This work is based on a multi-sited ethnography that traces the social and medical fallout of invasion of Iraq, with a focus on the displacement and healthcare travels of Iraqi patients to Lebanon and the broader Middle East. Since 2008, Dewachi, a medical anthropologist living and working in Lebanon, has conducted extended interviews and participant observation with more than 70 Iraqi patients who have travelled back and forth between Iraq and Lebanon. Patients, both young and old, came from different socio-economic and religious backgrounds. The majority of patients had come to the AUBMC and other Lebanese hospitals for a variety of medical and surgical treatments. Patients and their families were interviewed both inside and outside the hospital, and some patients were followed throughout their treatment process across a number visits. Patients were referred to Dewachi through physicians working in the hospital or encountered daily in the different hotels frequented by the ethnographer during his fieldwork. He has also interviewed dozens of doctors, hospital administrators and other key informants involved in providing care to Iraqi patients in Beirut. This ethnographic approach mirrors the fragmentary nature of post-war healthcare reorganisation in the context of dismantlement of formal state healthcare systems. It also allows for situating healthcare–seeking practices and mobility in patients' experiences, showing how individuals and communities negotiate the realities of conflicts and their aftermath.

In what follows, we first give an historical overview of the 'unmaking' of Iraq's healthcare as a consequence of the 1990s Gulf War, sanctions, and occupation. We show how recent Western interventions in Iraq have been instrumental in the isolation and disconnection of Iraq's healthcare system, the rise of different modes of affliction, and the decentring of the hospital as the site of care. In the second section, we show how one consequence of the failures of state-building in post-2003 Iraq is the rise of therapeutic mobilities that cut across borders, reconnecting regional healthcare systems

through the involvement of various public and private entities and institutions. In the last section, we show how such reconfigurations of geographies of care are further refracted in the experiences of one Iraqi family and their quest to seek healthcare across the region.

Disconnections: war and the 'unmaking' of Iraqi healthcare

Iraq was once celebrated as a success story in healthcare and development (see, e.g. Garfield, Dresden, & Boyle, 2003). Such legacies have often been attributed to the country's long-standing connection with British medical institutions (Isaacs, 1976) and the influence of the succeeding Iraqi socialist regimes. During the early years of the British Mandate (1920–1932), the British centred healthcare in their state-building project, and oversaw the expansion of Iraq's healthcare and its connection to medical infrastructures and training networks in the metropole. Over the decades that followed, succeeding Iraqi governments similarly invested in health programmes and campaigns to extend their reach to rural populations and the marginalised countryside (Dewachi, 2017).

During the Iran–Iraq War (1980–1988), the Iraqi government used medicine and public health as an instrument to respond to the fallout of war and to maintain social order (Dewachi, 2017). Despite the suffering and the setback in the country's economy, the state continued to invest in low-cost primary care interventions that focused on improving the survival of children and mothers (Sayegh, 1992). With the technical help of international organisations, such as UNICEF, the government adopted pro-natal strategies and provided a more comprehensive infrastructure for maternal and child health in both urban and rural settings.

After the 1991 Gulf War, many of Iraq's health achievements were reversed and connections to both the West and the region were severed. During the 40-day war, Iraqi civilian cities were aerially bombarded with cruise missiles as a response to Iraq's invasion of Kuwait (Weir, 2016). The U.S. coalition targeted the country's vital infrastructures (Garfield, 1999), and for the following 12 years, Iraq endured one of the harshest sanctions regimes ever imposed on a country by the UN Security Council (Gordon, 2009, 2010). The sanctions, which disconnected Iraq politically and economically from the outside world, made the restoration of broken down health facilities and the upkeep of existing ones impossible (Arya & Zurbrigg, 2003; Webster, 2009). Contemporaneous public health reports noted that Iraq embarked on a path of 'de-development', marked by one of the worst and one of the most rapid retrogressions of health indicators witnessed by a country in modern history (Ali & Shah, 2000; Ascherio et al., 1992; Barnouti, 1996; Hall & Olafimihan, 1998). Almost a decade after the imposition of the sanctions, the annual healthcare budget had been reduced from $450 million to only $22 million (Marks, 1999) and the number of primary health centres nearly halved (Halliday, 1999). Thousands of Iraqi doctors escaped the country in secret in search of better economic and career prospects (Dewachi, 2017).

The sanctions contributed to the undercutting of state medicine and healthcare delivery. At the country's public hospitals, the numbers of doctors and staff dwindled yearly. Hospitals lacked all kinds of supplies, including chemicals and instruments for lab tests, essential medications (such as antibiotics and chemotherapy drugs), IV fluids, cannulas, surgical sutures, and antiseptic detergents, and proper beddings (Akunjee & Ali, 2002; Ali & Shah, 2000; Arya & Zurbrigg, 2003; Barnouti, 1996). One of the consequences of the sanctions was the outsourcing of various aspects of hospital care to patients' families and relatives (Dewachi, 2017). Patients admitted to the hospital were responsible for their own bedding and food. Doctors depended on patients' relatives to source unavailable drugs and medical supplies from the black-market. At the time, many were unable to seek care outside Iraq due to government restrictions on travel abroad and the deterioration of the economic situation under the sanctions regime.

The undermining of the country's healthcare infrastructure and authority which began during the years of sanctions continued in the post-2003 occupation. Under the occupation, Iraq's healthcare became both a target and an instrument of spiralling political violence, and hospitals became dangerous for both patients and doctors (Dewachi, 2015a). Many were looted, medical facilities were

damaged, and health personnel and patients were frequently targeted and kidnapped by militia forces controlling the hospitals and the Ministry of Health (Medact, 2008; Paley, 2006). As a result of the increasing violence and the failures to improve the working conditions and security in hospitals, more than half of the country's 34,000 doctors reportedly fled and hundreds more were killed (Al-Kindi, 2014).

Unlike the recession of many healthcare systems due to structural adjustment reforms during the 1990s, complex processes and modes of war have shaped Iraq's healthcare trajectories. While Iraq's healthcare was strengthened by wartime mobilisation and connections to international organisations during the 1980s, the effects of the 1990s war First Gulf War and the sanctions have been detrimental and irreversible. These effects were further compounded by the 2003 invasion and the spread of violence and corruption which shaped the further deterioration of the country's healthcare (Alkhuzai et al., 2008; Lancet, 2008; Webster, 2009; World Health Organization Eastern Mediterranean Regional Office [WHO EMRO], 2008). Still, after over a decade of isolation under the siege of the sanctions, the 2003 invasion made the mobilisation of the Iraqi population possible. Millions of Iraqis have become displaced, since 2003, and many of those who remained were on a quest to seek healthcare across regional borders.

This has defined a new era of reconfigured healthcare–seeking in Iraq and has given rise to alternative therapeutic geographies shaping new modes of connections between regional healthcare systems.

Connections: therapeutic geographies across Lebanon and Iraq

After the 2003 invasion, the Iraqi Ministry of Health created *Barnamej Al-'ilaj Fi El-Kharig* (the Treatment Abroad Programme). The programme was launched as a response to the inability of the Iraqi Ministry to provide healthcare in its under-resourced hospitals, and the increasing demands and discontent of a local population that continues to be affected by rising rates of afflictions and the spectre of violence in the country. The programme allowed a select few Iraqi citizens who were unable to receive medical treatment inside Iraq to apply for treatment abroad at the expense of the welfare state. This was in sharp contrast to the pre-existing and historical pattern of healthcare being a central tenet of citizenship in Iraq.[3] For the past decade, the Ministry has negotiated healthcare provision with hospitals in India, Iran, Turkey, Jordan, and Lebanon. This state-sponsored medical travel is sanctioned through a long and tedious bureaucratic process of selecting and grouping patients through medical committees and petitioning regional hospitals to bid on treatment costs.[4]

For the Iraqi government, Lebanon became a 'natural' site for outsourcing medical care in the region, due to both the reputation of the country's medical institutions and the shared common language – a problem many Iraqis were facing in non-Arabic-speaking countries. The Lebanese government had already begun capitalising on medical tourism since the end of the Lebanese Civil War (1975–1990).[5] In recent years, revenue from medical travel and tourism gained prominence given the fall in leisure tourism to several pieces of bad press: the assassination of the Lebanese Prime Minister Rafik Hariri in 2005, the Israeli military assault on Lebanon in 2006, and the issuing of yearly travel warnings by many Gulf States. These events had a dramatic effect on the country's tourism sector, reportedly costing the country around 3.5 billion dollars annually since 2005 ('Lebanon's tourism sector shows signs of blooming', 2008).

While the decreasing flow of leisure tourists from the Gulf States undermined the Lebanese economy, the fallouts of regional conflicts became opportune; the increasing numbers of Iraqis seeking healthcare in Lebanon defined new potentials for the Lebanese public and private health sectors to revive a deteriorating tourist economy. In 2007, after negotiating new bilateral agreements with the Iraqi state, the Lebanese government relaxed visa regulations for Iraqis, and both countries inaugurated frequent daily flights between Beirut and different Iraqi cities. Since then, Iraqi citizens have been able to obtain visas at Beirut's airport by showing a hotel reservation and $2000 in cash at the

port of entry. In 2010, as the influx of Iraqi patients into the country was at its peak, 'medical tourism' was declared as a national strategy in an attempt to offset the country's indebted treasury (Farghali, 2012). On several occasions, the Minister of Tourism and high-profile doctors visited Dubai (UAE), Erbil (Iraqi Kurdistan), and other regional cities to promote medical tourism in Lebanon for both millionaires as well as ordinary people (Farghali, 2012; 'Lebanon: Cosmetic medicine', 2013).

But the outsourcing of healthcare by the Iraqi government to Lebanon has not been a fair and transparent process. Applicants to the Treatment Abroad Programme often explained how the programme is shaped by favouritism and political or social patronage. Patients treated in Lebanon and elsewhere frequently reported partial care due to funding cuts and government representatives negotiating commissions at the expense of their healthcare (Zaiter, 2015). These have been further tainted by reports of corruption, overbilling, and bilateral disagreements. For example, at the Rafik Hariri Public Teaching Hospital, a whole ward had been dedicated to Iraqi patients since 2008 as part of a bilateral agreement.[6] This contract was rescinded in 2011, by which point more than 1000 Iraqi patients had visited this public hospital at the expense of the Iraqi Ministry of Health. While the Lebanese state cited internal crises (such as doctor's strikes and others) as the main reason for this cancellation, interviewed Iraqi officials complained of extremely high prices and irregularities in billings. Disenchanted with the irregularities in the Lebanese public sector, the Iraqi Ministry of Health signed another agreement in 2014 with AUBMC – a private teaching hospital – to treat patients. Over the next year, AUBMC was reported to have treated up to 850 Iraqi patients, averaging a 1 million dollar monthly expense (Zaiter, 2015).

These precarious connections between the Lebanese and the Iraqi healthcare systems speaks volumes about the complexities of 'post-war' reconstruction. They show how such therapeutic geographies are often shaped by volatile and conditional connections, and the absence of long-term planning or guarantees. They also show how patients' itineraries and mobility across the region are defined by geopolitical circumstances and local histories, rather than personal preference. In desperate attempts to respond to political, social, medical, and economic fallouts, both states have in fact instrumentalised such connections – often at the expense of more equitable healthcare. For the Iraqi state, the investment in the Treatment Abroad Programme as a 'quick fix' has diverted much of the public funds away from rebuilding the country's local health infrastructure. It has also raised accusations of corruption and favouritism that seems to haunt the country's post-war reconstruction efforts. Unable to maintain a steady flow of medical tourists, Lebanon, on the other hand, has capitalised on regional crises to offer alternatives. The future influence of such regional connections on the Lebanese healthcare system is yet to materialise, especially as an increasing number of local hospitals are opting to decrease their intake of Lebanese patients covered by national health insurance programmes in favour of cash paying medical travellers from the region.

These regional transformations in healthcare organisation are often reflected by the experiences of Iraqi patients who seek treatment in Beirut. In the following section, we explore such experiences through focusing on one Iraqi family and its quest to procure treatment across Iraq's national borders. We attempt to show how whole families continue to navigate a landscape of connections and misconnections through their everyday struggle with health seeking.

Misconnections

Hamra is one of Beirut's busiest commercial districts and a hub of private hospitals and medical laboratories. Despite the increasingly volatile situation in Lebanon, Hamra's hotels and furnished apartments continue to be occupied. The *White House* is just one of the scores of small hotels, inns, and furnished apartment buildings spread across Hamra. Its proximity to the AUBMC had made it a convenient destination for those who frequent the hospital for critical medical procedures and follow-ups. At the lobby of the hotel, Iraqi patients and their escorts sit down to sip tea, chain smoke, and exchange news, stories, and updates. Hailing from different Iraqi cities and backgrounds, all complain about the state of healthcare in Iraq and the cost of treatment in Lebanon.

Many have mobilised resources from their immediate social networks to respond to the high cost of care in Lebanon and deal with the disruptions to everyday life back home. Abu Adnan,[7] for example, has travelled from Najaf to receive his third session of chemotherapy. A 35-year-old journalist in a local newspaper, his well-off brother has volunteered to pay for his treatment in Beirut. He has paid an average of $10,000 during each visit. Abu Ghada is in Beirut with his wife who has been recently diagnosed with lymphoma. They have both left their three kids back home with his wife's mother in Baghdad and have been receiving funding from a religious charitable organisation in Iraq – one of a handful Shi'a organisations filling the gap of the financially challenged state. Without the help of the extended family to look after their children, their medical travel would not have been possible. Mahmoud is staying in the hotel with his cousin Abbas who is in Beirut for check-ups after different doctors in Iraq failed to give him a convincing diagnosis for his recurrent spells of back pain. Both in their 40s, they have taken the opportunity of being in Beirut to do some site-seeing with one of the numerous local companies that organise tours in Lebanon. With a sense of nostalgia and defeat, Abbas explains: '*Dinnyeh dawara* [the world is like a wheel]. We used to come to Lebanon for tourism, today we travel here for treatment'. Abbas's statement is reflective of a general disposition among many patients interviewed and captures the sentiment of many Iraqis about the deteriorating conditions in Iraq and the loss of their healthcare system. For many, sightseeing in Beirut is a way to mitigate the anxieties of dealing with chronic illnesses and the limitations to mobility back home due to rising insecurities and daily threats of suicide bombings.

In one of the hotel rooms, I (Dewachi) sit down with Abu Zainab – an engineer working in a government-owned factory in Hillah City – 100 km south of Baghdad. Abu Zainab is in Beirut with his wife and his seven-year-old son Laith, who has undergone reconstructive surgery to his face at AUBMC. 'The rooms here are spacious and comfortable' explained Abu Zainab as we left the lobby. Abu Zainab, his wife, and his son had all been victims of one of the frequent suicide bombing attacks that hit Hillah City during the height of political violence in 2007. He explains to me the circumstances of their collective injury:

> It happened around sunset when we were out shopping at the main market. It was a double suicide bombing; one detonated at one end of the street and the second at the other, as people fled in the opposite direction. We were 4 meters away from the second explosion. My wife was injured in her thigh … Shrapnel burnt Laith's face and arm, and I was injured in the face and leg.

After their preliminary recovery in the local hospital of Hillah, Abu Zainab began a quest to heal the family's wounds. While his wife's thigh injury was relatively superficial, the blast had burnt both of his eyelids and perforated his left eardrum and had left severe scarring on his son's right hand and face – both required long-term follow-ups and management. Twenty-one days after the injury, Abu Zainab took his son to the local teaching hospital in Hillah to undergo his first reconstructive surgery to the hand. Unfortunately, the graft failed and Laith developed an ulcer in his left eye. Abu Zainab decided to take his son to Iran for treatment:

> After three months from the event, we travelled to Iran to see a doctor for his eye ulcer and my burnt eyelids. At the time, we couldn't reach Baghdad … you know all the killings that were happening on the road to the capital … Iran was the only open possibility for us. We had heard from others that they have a good reputation for eye surgery.

For many Iraqis during the height of the sectarian violence, seeking care in neighbouring Jordan or Iran was a safer bet than attempts to venture into the capital Baghdad. Similar to Lebanon, healthcare hubs in Jordan and Iran have become main destinations for Iraqis over the past decade. Such hubs are constituents of the broader regional network that makes up therapeutic geographies for Iraqis.

Both Abu Zainab and Laith stayed in Tehran for a whole month, where they followed up regularly with doctors. Abu Zainab explained that doctors in Iran were much better, though the language barrier was a problem. According to Abu Zainab, many Iraqi patients prefer going to the city of Qom – where a larger community of Iraqis, who have lived in Iran for decades, work as translators for Iraqi medical travellers. After their return from Iran, Abu Zainab faced difficulties finding the

medications prescribed for his son due to their sporadic availability in Iraq and the spread of counterfeit medications due to lax regulations in post-invasion Iraq. He was paying close to $50 a month to transport these medications from Amman, Jordan.

For close to a year, Abu Zainab consulted doctors in Iraq and travelled to India and Iran, once again, in quest for treatment for his perforated ear and his son's scarred face, which has been affecting the closure of his lips. All the operations failed, and had cost him close to $20,000. Running out of funds, Abu Zainab applied to receive government payments for his son's injury. His salary barely covered the extra healthcare expenses and, like many victims of suicide bombings in Iraq, he travelled to Baghdad with his four-year-old son to apply for compensation from the Ministry of Health. Risking the road to the capital, the family were offered 1000 dollars only from the 'Terrorism Victims Compensation Committee'. Still, they were rejected for the Treatment Abroad Programme. The committee decided that Laith's treatment was available in Iraq and there was 'no need for treatment abroad'. As mentioned before, this echoed with many stories of Iraqi patients who levied accusations of corruption and political patronage in the Treatment Abroad Programme.

The decision of the Committee did not deter Abu Zainab's quest to seek help abroad. During the following years, he mobilised any connection he came across to share his son's medical reports. He managed to send the reports to Belgium and China for insights on the possibilities of further treatment for his son. Abu Zainab eventually managed to get the attention of a local religious organisation that offered to pay for future medical expense. Also, he drew from a fund created by workers at the factory to help employees and their families with unanticipated consequences of illness and injury.

By word-of-mouth, Abu Zainab heard about the potential of reconstructive surgery in Beirut. He was told that the AUBMC surgeons have successfully treated many injuries similar to his son's. He booked an appointment and sent his son's accumulating medical dossier to the hospital via email. He eventually travelled to Beirut with his son and wife and met with the surgeon who promised that the operation should not present any complications. The skin graft was compatible this time. After the operation, Abu Zainab and Um Zainab (his wife) were ecstatic. After five years of seeking treatment, they had high hopes that things were looking up. Finally, Abu Zainab could return back to his home in Hillah and to his work at the factory.

Still, for Abu Zainab, the fear and anticipation of the failure of the operation preoccupied his thoughts before departing Beirut. He had travelled across the region in search of proper healthcare for his son. There was a transient moment of satisfaction, but returning to Iraq meant an uncertain future. In one of his comments, he echoed many other Iraqis in their perspectives on Iraq's dismantled healthcare and the mismanaged government compensation programmes:

> It is neglect and the lack of accountability. As for the government, you know how the situation is … we don't want compensation committees … we want care. We have a broken down system, and our doctors have lost their humanity. Both inside and outside Iraq, medicine has become a business … Still … I do believe that there is some good left in this world … .

Abu Zainab's story is not an exception. Thousands of Iraqis over the past decades have been victims of injuries and suicide bombings. Like Abu Zainab's family, these injuries are, at many times, collective – affecting the entire family. It is in such a context that families become entangled with care providers across the region in a quest for healthcare. For many Iraqis, the quest for healing is rife with failed treatments, travel, bureaucracy, and out-of-pocket spending – the many misconnections that characterise their therapeutic geography.

Conclusion

The emerging therapeutic geographies between Iraq and Lebanon tell a complex story of connections, disconnections and misconnections of war and global health. It speaks to an increasing process of regionalisation of healthcare–seeking and the scramble of both the Iraqi and Lebanese states to respond to the fallout of legacies of war in the region. These anecdotes also show how such

therapeutic geographies are formed as a result of collective endeavours, traced by common experiences, knowledge sharing, and mobilising of formal and informal resources.

In the context of protracted conflicts, such processes of healthcare regionalisation, decentralisation, and privatisation have not only been motivated by neoliberal logics of state reform (see, e.g. Fitzgerald, 2009). Rather, they are a product of histories of political instability, breakdown of infrastructure, and rising mistrust in the war-afflicted healthcare systems. Such modes of disconnection have given rise to alternative modes of healthcare–seeking practices – a testimony to the myriad processes emerging under war. Meanwhile, Iraqis' alternative healthcare–seeking practices in Lebanon is a survival strategy in the face of a national healthcare system wounded by decades of war and neglect. Such strategies have been further appropriated by the state to compensate for its inability to provide for its afflicted population. At the same time, the Lebanese healthcare system, unable to maintain a steady flow of medical tourists, has capitalised on the regional crises to offer costly alternatives. Still, the political fervour of the Lebanese governments to promote medical travel to Beirut, and that of the Iraqi government to manage it, have not been matched by concrete movements towards true and meaningful reforms of their respective healthcare systems.

Iraqi patients have paved new, and often costly, paths of healthcare–seeking. Abu Zainab's struggle to seek proper care for his family captures how such wounds embedded in, and metabolise through, social relations (Dewachi, 2015b). As both a victim of violence and a caregiver, Abu Zeinab's persistent negotiation of local and regional resources – whether through government bureaucracies, regional hospitals, or religious charitable organisations – points to the experiences of everyday connections and misconnections that shape these fragmented therapeutic geographies. This fragmentation continues to drive mobility for healthcare in a region that is increasingly experiencing a breakdown of infrastructure and absence of local care. This is further emphasised by the development of healthcare hubs in recent decades, such as in Lebanon, geared towards responding to regional physical, psychological, and social wounds, bodily incarnations of war and conflict. In a region where once robust healthcare systems have been systematically dismantled and targeted, focusing on such emerging therapeutic geographies offers a productive analytic to capture the long-term consequences of war and the way war-afflicted populations define their prospects of survival. Such an approach can be useful in addressing other regional therapeutic care seeking as in the current Syrian refugee context (Parkinson & Behrouzan, 2015). Understanding the connections and disconnections that make up therapeutic geographies further shows the need for post-war reconstruction efforts that focus on rebuilding accessible and equitable national healthcare systems, that respond to the needs of populations devistated by decades of war.

Notes

1. Authors' own data (unpublished).
2. Health literature has predominantly highlighted the profound direct and indirect consequences of war, conflict and violence and the destruction of healthcare systems on health (Hindin, Brugge, & Panikkar, 2005; Levy & Sidel, 2007, 2013).
3. On the relationship between the nexus of state building, governance, and citizenship-making in Iraq, see: Dewachi (2017).
4. Costs and expenses for a delegation of patients is negotiated. This may sometimes include a flat rate for each patient as well as the provision of transport to and from the airport, hospice and meals for the patient and one companion, in addition to the travel expense and the hospital bill itself (Iraqi Ministry of Health [Iraqi MoH], n.d.).
5. For more on the post-civil war reconstruction and the fragmentation of the Lebanese healthcare system see: Kronfol (2006); Van Lerberghe, Ammar, El Rashidi, Sales, and Mechbal (1997); Van Lerberghe, Ammar, El Rashidi, Awar, et al. (1997).
6. The hospital had hired a special liaison to coordinate the arrival and departure of the patients and follow up with their needs. Meanwhile, the Iraqi Embassy had created the new position of medical attaché to facilitate its coordination with other hospitals in Lebanon.
7. All names used here are pseudonyms.

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