Dialogue Summary

Reducing Preventable Preterm Deliveries among Syrian Refugees in Lebanon

K2P Policy Dialogue convenes key policymakers and stakeholders to capture contextual information, tacit knowledge, views and experiences including potential options to address high priority issues. K2P Policy Dialogues are informed by a pre-circulated K2P Policy Brief or Briefing Note to allow for focused discussion among policymakers and stakeholders.

Dialogue Summary

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K2P Dialogue Summary

Reducing Preventable Preterm Deliveries among Syrian Refugees in Lebanon

UNHCR The UN Refugee Agency
REPUBLIC OF LEBANON MINISTRY OF PUBLIC HEALTH
Knowledge to Policy Center K2P

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Dialogue
The policy dialogue about: Reducing preventable Preterm Deliveries among Syrian Refugees in Lebanon was held on April 6, 2017 at the Gefinor Rotana Hotel, Beirut, Lebanon. The policy dialogue was facilitated by Dr. Fadi El-Jardali, Director of the K2P Center.

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Preamble

The K2P Policy Dialogue, conducted on April 6, 2017, hosted 20 diverse stakeholders from multi-disciplinary backgrounds. These included representatives from

- Ministry of Public Health (MOPH)
- United Nations High Commissioner for Refugees (UNHCR)
- National Collaborative Perinatal Neonatal Network (NCPNN)
- Federation of Arab Obstetrics and Gynecology Societies
- Order of Midwives
- Order of Nurses
- Lebanese Society of Obstetrics and Gynecology
- Local and international nongovernmental organizations (NGOs) such as Makhzoumi Foundation, Amel Association, International Medical Corps, Médecins Sans Frontiers, and WHO
- Directors of hospitals, primary health care centers, physicians, researchers, and students

The policy dialogue was facilitated by Dr. Fadi El-Jardali, the Director of the K2P Center, in the presence of Dr. Walid Ammar, the Director General of the MOPH and senior health representative of UNHCR in Lebanon, Dr. Michael Woodman.

Deliberations about the problem

Dialogue participants discussed the overall framing of the problem of preterm deliveries among Syrian refugees. All participants acknowledged the existence of the problem and agreed on the need to focus on the many factors that are leading to the problem.

It was agreed that preterm birth is a significant burden on hospitals, available specialist pediatric care and places a financial burden on refugees themselves and UNHCR.

Background to the Policy Dialogue

The Policy dialogue was convened in order to support a full discussion of relevant considerations (including research evidence) about a high-priority issue in order to inform action.

Key features of the dialogue were:

1) *Addressing an issue currently being faced in Lebanon;*
2) *Focus on different underlying factors of the problem;*
3) *Focus on four elements of an approach for addressing the policy issue;*
4) *Informed by a pre-circulated K2P policy brief that synthesized both global and local research evidence about the problem, elements and key implementation considerations;*
5) *Informed by a discussion about the full range of factors that can inform how to approach the problem and possible elements of an approach for addressing it;*
6) *Brought together many parties who would be involved in or affected by future decisions related to the issue;*
7) *Ensured fair representation among policymakers, stakeholders, and researchers;*
8) *Engaged a facilitator to assist with the deliberations;*
9) *Allowed for frank, off-the-record deliberations by following the Chatham House rule: "Participants are free to use the information received during the meeting, but neither the identity nor the affiliation of the speaker(s), nor that of any other participant, may be revealed"; and*
10) *Did not aim for consensus. Participants' views and experiences and the tacit knowledge they brought to the issues at hand formed key input to the dialogue. The dialogue was designed to spark insights that can only come about when all of those who will be involved in or affected by future decisions about the issue can work through it together. The dialogue was also designed to generate action by those who participate in the dialogue and by those who review the dialogue summary.*

Although the Lebanese healthcare system is highly resilient to the refugee crisis, as many claimed, a particular concern pertained to the lack of Neonatal intensive care unit (NICU) beds for preterm babies and lack of NICU quality. Participants argued that this is creating a problem between the caregiver and the hospital administration in terms of securing places and financing the care. One participant raised the concern of the impact on the care provided to Lebanese preterm babies due to competition for limited beds.

Participants supported the problem statement and added that studies conducted in rural areas, found that Lebanese and Syrian preterm rates are similar. Nonetheless, some participants observed a higher rate of birth defects among Syrian preterm births. Also, some participants suggested that Syrian refugees are being discharged earlier than Lebanese putting them at higher risk of complications and hospital readmission.

While the dialogue focused specifically on Syrian refugees, participants pointed out the need for additional data on the preterm delivery rate among Lebanese. A particular concern pertained to providing high quality of care to Syrian refugees as well as low socioeconomic strata of the Lebanese population.

Underlying factors

Participants then proceeded to discuss the underlying factors of the problem. Most participants agreed on the multi-level factor approach to the problem at the governance, financing, delivery, medical and socio-political level.

While there was a consensus among participants on the lack of a robust referral system and opportunity to scale up or develop a package similar to Lebanese universal healthcare coverage in primary health care, there was less consensus on the neonatal intensive care percentage coverage by UNHCR. In fact, participants claimed that whilst there is 90% coverage by UNHCR a limitation is the financial ceiling or a maximum coverage of 15000 USD, and care is supported by UNHCR at 50 hospitals. This being said, one participant claimed that 50% of the 73 admissions in their hospital was covered 90% by UNHCR.

Participants emphasized that 8% of the Syrian refugee have never received antenatal care (ANC), this percentage increases if the women who attended only 1 or 2 ANC visits are added to the percentage as opposed to the 4 recommended ANC visits which add up to 53%.

Deliberations also highlighted the need to compare the population with itself before and after it got displaced, to better understand the Syrian refugee's practices, since the maternal mortality rate of Syrians in Lebanon is lower than that in Syria due to the services provided in Lebanon.

Participants agreed that some Syrian refugees are not receiving care by a skilled professional and that there is a lack of trained health care workers to address refugees' health issues. Furthermore, discussions suggested that there is a problem with implementing a Lebanese-tailored healthcare system for the Syrian population without taking into account their culture and practices. Participants suggested considering this issue while providing health care services to refugees.

Deliberations highlighted the socio-political factors contributing to preterm deliveries. There was a consensus on the higher level of gynecological infections during pregnancy, teenage pregnancies, and deliveries among refugees. Participants strongly agreed that women are getting married early to alleviate their household financial burden, and in some cases wanting more children to replace those that were lost during the war. Participants suggested that the age of the mother has a major impact on the outcome of the health of the babies in relation to their education about the health of their children. In fact, one participant explained that in a town in North Lebanon, Kernicterus (disposition of bilirubin in the brain causing severe jaundice and mental disorders in children) rates are very high because the mothers are not taking their children to the hospital until it is too late. This was claimed to be directly related to the mother's age. However, an intervention that forced mothers to follow up with physicians in the post-natal phase has decreased the rate of Kernicterus. One participant suggested training physicians on providing teenage pregnancy care.

One participant suggested that international NGOs are financing the wrong services. The main concentration is on the symptoms of a phenomenon or a disease rather than its root cause. Also, it was suggested to understand the cultural practices and treat the refugees accordingly, especially with regards to contraceptives.

Participants pointed out the need for additional data on the effect of C-section on preterm births and the percentage of C-sections leading to preterm births in Lebanon. Also, suggestions were made to separate between early and late preterm births and to define preventable preterm births.

It was strongly denoted that there is a need to develop a comprehensive system that can provide context-specific care to prevent preterm deliveries and ensure adequate care to preterm babies at birth.

Deliberations

Deliberations about Elements of an Approach for Addressing the Problem

Dialogue participants discussed the four elements that were examined in the policy brief.

Element 1› Strengthen accessibility to antenatal and postnatal care

This element tackles the necessity of strengthening accessibility to antenatal and postnatal care to increase awareness about potential danger symptoms and obstetric complications and promote early detection of serious pregnancy complications, which could have a positive impact on pregnancy outcomes. Financial incentives (i.e. conditional cash transfer, vouchers, removing user fees) and health insurance are effective strategies to improve access to health care services.

Participants acknowledged that there is an issue of access to antenatal and postnatal care, and highlighted the need to focus on the management and prevention of preterm delivery in the short-term and long-term. Also, participants agreed that there is a need to ensure sustainability through increasing the budget and investing in human resources to improve access to high-quality services.

Although there was consensus on the need to shift the cost of healthcare, there was no consensus on the means to shift such cost since in Syria the services were provided for free; while in Lebanon it is on a fee-for-services basis. Some participants suggested providing care in a bundled approach and brought up the concept of universal healthcare in order to move away from fee-for-service. As mentioned by some, this is more sustainable than conditional cash transfer, vouchers and removing user fees. One participant argued that voucher system was proven to be beneficial in their institution which was also supported by high-quality evidence. Participants agreed that although financial arrangements are important, there is a need to ensure that there are sufficient resources to maintain antenatal care.

One participant recommended having a center operated in the MOPH that spreads information on hospital's availability of NICU

beds. This way, preterm babies can be sent to hospitals with available beds. However, this would create a need for NICU ambulances to transfer babies. Another participant mentioned the lack of empty NICU beds, and nurses specialized in neonatal intensive care nurses in Lebanon. Consequently, the majority of participants acknowledged the need to invest in healthcare workforce such as physicians, midwives, and nurses.

Another issue was raised with regards to the content of the ANC provided. Participants mentioned implementing a unified and systematic card to document patients' visits and ensure that the recommended visits are implemented and the care is provided in PHCs.

Consensus was reached to implement targeted approaches for Syrian refugees through mapping, as some needs and interventions may differ among rural and urban refugees.

There was a unanimous agreement that there is a need to address the health-seeking behavior of refugees, thus creating a need to build capacity in PHC centers to raise awareness in the community about PHC services. Consequently, it was strongly agreed that there should be a robust referral system for refugees to refer the patients from the community to PHC centers to hospitals.

Element 2› Improve the quality of services delivered in health care centers by accrediting primary health care centers and integrating evidence-based guidelines

After sharing the evidence that discussed improvement in the quality of services through the implementation of healthcare accreditation and evidence-based practices (i.e. guidelines), most participants agreed on the need to implement quality improvement strategies.

It was indicated that ensuring quality in the services provided in PHC centers is essential. Participants mentioned that some ultrasounds are being done by unqualified health workers and deliveries are taking place in PHC centers, with referrals to hospitals only in case of complications. Thus, deliberations focused on the need to implement the guidelines for maternal care which have already been submitted to the MOPH, implement a set of indicators to monitor and improve quality and safety and scale up the accreditation of primary health care centers. As one participant mentioned, 92 PHC centers are undergoing accreditation, with 17 already being accredited. Yet, not all patients are

going to the PHC centers that are accredited. Moreover, participants agreed that accreditation is important but not sufficient. A system of positive and negative reinforcement should be implemented (such as pay for performance), though participants mentioned that it would be difficult to negatively reinforce primary health care centers as they are needed in the community. Nonetheless, they highlighted the need to ensure that healthcare workers in PHC centers are licensed by the MOPH, regardless of their nationality.

The importance of training and building capacity of health workers was re-iterated. A participant suggested developing a healthcare taskforce of midwives, nurses, and physicians to deal with the problem. Nonetheless, participants strongly focused on the need to increase the number of nurses and midwives. In fact, participants were concerned that there are only 39 midwives in 200 primary healthcare centers. However, one participant raised the challenge of financing the retention and training of human resources. Moreover, although the number of neonatologist in Lebanon is not high, participants agreed that some hospitals are not qualified to certify or train neonatologist.

Stakeholders acknowledged the need to look into abuse and overuse of the admission to NICU which is not being done based on guidelines. Explicit regulations by the MOPH and order of physicians such as standards for NICU admission/discharge and peer review/audits are needed to optimize the utilization of NICU beds.

Element 3› Integrate task shifting into antenatal care in primary health care centers

Task shifting increases access to care and improves the quality of care delivered while reducing preterm deliveries. Based on the evidence, nurse-led care resulted in an increase in patient satisfaction and a reduction of hospital admission and mortality.

One participant mentioned that the law acknowledges specialized nurses and that there should be an investment and joined forces in this regard, especially in relation to specialized NICU nurses. Currently, nurses in Lebanon do not actively and regularly update their knowledge and skills, so there should be a mandate for nurses to attain at least 30 hours of high quality continuing education.

Some stakeholders stated that doctors need to start believing in the role of nurses once certified.

Some strategies to strengthen the role of nurses were mentioned and agreed on; these included the need to encourage the young generation to enroll in nursing studies and to develop the scope of practice for nurses especially when task shifting is implemented, to ensure accountability among different disciplines.

A participant suggested that the problem of trust from the physicians' point of view is mainly related to the training of nursing schools which is hospital-based rather than outpatient-based. As such, there is a need to embrace Lebanon's move into PHC and include it in medical and nursing schools. Moreover, participants raised the need to define and standardize the role of physicians, as doctors in Lebanon come from different schools of medicine.

Participants raised the concern of retaining nurses in PHC centers and the perception of people in regards to task shifting. As such, participants mentioned that patient awareness sessions are essential to provide patients with an understanding of the roles of physicians, nurses, and midwives.

One organization shared their experience with task shifting. In fact, the availability of a midwife in the PHC center increased utilization and increased intrauterine device (IUD) insertion. This was implemented when physicians were not available all day. Participants agreed and mentioned that a campaign implemented by midwives leads to an increase in pap smears without resistance.

Nonetheless, some stakeholders questioned the need for task shifting in Lebanon.

Element 4› Enhance outreach community-based interventions on family planning and antenatal care

This section discussed community-based interventions (CBI) such as outreach programs and community mobilization, and their effects in significantly decreasing neonatal and perinatal mortality, stillbirths, maternal morbidity, hospital admission and C-section. The implementation of a CBI such as family planning and birth spacing may reduce pregnancy complications (i.e. preterm) and improve maternal health.

The order of nurses has finished training nurses for outreach programs such as CBHI from 220 PHCs. This was initiated by the rising need to prepare the workforce to implement CBI.

Participants agreed that there is a need to take into account the catchment area and provide CBI accordingly.

One participant mentioned that the population in Lebanon does not like to engage in health-related interventions. As such, there is a need to find the right approach to encourage engagement in CBIs. It was stated that the Lebanese and Syrian populations prefer tangible outcomes such as free laboratory tests.

One participant shared their experience with the implementation of a mother and child health initiative that offered free ANC and postnatal care (PNC). One of the lessons learned was that community outreach interventions are important in getting people into ANC.

In summary, stakeholders agreed that the problem cannot be dissociated from the comprehensive health system. They also emphasized the need to prevent preterm deliveries, to provide high-quality care in PHC centers and hospitals, and to ensure sufficient and qualified health workforce to provide such care. Moreover, there was agreement on the importance of community-based outreach to raise awareness and encourage people from the community to use PHC services.

As such participants agreed that there are short-term and long-term interventions that could be implemented to reduce preventable preterm deliveries among Syrian refugees, which include better distribution of patients across centers to alleviate the burden on some centers and strengthening the referral system.

In conclusion, there is a need for a comprehensive health care model that can be adapted to provide health care services to refugees.

Next Steps

Recommendations and Next Steps

Deliberations about the problem, underlying causes, and elements to address the problem, was successful in creating consensus among the different stakeholders The international published evidence is consistent and clear about the impact of these elements on the reduction of preventable preterm deliveries, but local data is crucial to ensure monitoring of the rates of preterm deliveries. Participants discussed and agreed on recommendations at the level of the health human resources, access to and affordability of antenatal and postnatal care, quality of care and community-based interventions.

Recommended action	Stakeholders involved
Develop neonatal and pediatric intensive care nursing certification and pilot-test it in a sample of universities in Lebanon	⇢ MoPH ⇢ Order of Nurses ⇢ Academic Institutions
Develop, in collaboration with the order of physicians, pharmacists, and MOPH, the nursing scope of practice (SOP) and empower the role of nurses through these SOP. This can be done by advocating for the nursing practice law as an initial step to enhance the scope of practice of nurses. The law will allow the education of nurses to be standardized in Lebanon. This will be followed by the development of the nursing SOPs.	⇢ MoPH ⇢ Order of Physicians ⇢ Order of Nurses ⇢ Order of Pharmacists ⇢ Deans of Nursing ⇢ Dean of Medicine ⇢ Academician and researchers ⇢ Ministry of Education ⇢ Ministry of Labor
Support PHC human resource (midwives, nurses, and physicians) to detect symptoms that could predict pregnancy complications as well as preterm births through capacity	⇢ MoPH (including department of PHC) ⇢ Order of Physicians

Recommended action	Stakeholders involved
building	⇢ Order of Nurses ⇢ Deans of Nursing ⇢ Dean of Medicine
Develop retention plan for human resources in PHC centers	⇢ MoPH department of PHC ⇢ Heads of PHC institutions ⇢ Order of Physicians ⇢ Order of Nurses
Increase the training and rotation of nurse and medical students in the primary health care sector.	⇢ Academic Institution ⇢ Deans of Nursing ⇢ Dean of Medicine ⇢ Order of Physicians ⇢ Order of Nurses
Train human resources on maternal and child health guidelines that have been already submitted to the MOPH, as well as implement and monitor the implementation of these guidelines	⇢ MoPH ⇢ Academician ⇢ Order of Physicians ⇢ Order of Nurses ⇢ Heads of PHC institutions
Improve and monitor the quality of services provided in PHC centers This can be achieved through implementation of a set of indicators to monitor and improve quality and safety and scaling up of accreditation of primary health care centers	⇢ MoPH (including department of PHC) ⇢ Heads of PHC institutions ⇢ Academicians
Develop and implement an evidence-based antenatal and postnatal package for Syrian refugees.	⇢ MoPH ⇢ United Nations agencies ⇢ Order of Physicians ⇢ Order of Nurses ⇢ Order of midwives

Recommended action	Stakeholders involved
	⇢ Academicians and researchers ⇢ Heads of PHC institutions
Improve the access to and affordability of antenatal care (ANC) through a bundled approach to care or implement universal healthcare system for Syrian refugees.	⇢ MOPH ⇢ United Nations agencies ⇢ NGOs ⇢ Donor agencies ⇢ Heads of PHC institutions ⇢ Academician and researchers
Strengthen the role of PHC in the community by strengthening referrals from community to PHC. This can be done by engaging community members so they can advocate and help attract women to these centers	⇢ UN agencies ⇢ NGOs ⇢ Heads of PHC institutions ⇢ Community members
Implement a systematic and unified card system to keep record of the care provided to the refugees	⇢ UNHCR ⇢ MOPH ⇢ Heads of PHC institutions
Monitor and evaluate data on preterm deliveries among Syrian refugees as well as Lebanese population. This can supply evidence on impact of interventions as well as help channel resources to reduce preterm deliveries in both populations	⇢ MOPH ⇢ UN agencies ⇢ NGOs ⇢ Heads of PHC institutions
Implement geographically targeted community-based interventions by mapping and prioritizing service needs among refugees in different areas This could include birth spacing techniques, recommendations for family planning/	⇢ UN agencies ⇢ NGOs ⇢ Heads of PHC institutions ⇢ Community members ⇢ Academicians and researchers

Recommended action	Stakeholders involved
contraception, community-based interventions to increase delivery in hospitals, harm reduction, C-section awareness session, nutritional/dietary advice and micronutrient supplements	

Next Steps

It was agreed that the K2P Dialogue Summary along with the revised K2P Policy Brief will be used by each stakeholder organization as a guiding policy document and that they will communicate internally and externally with relevant bodies, agencies, and department, in order to push agendas and advocate for improvements. All relevant stakeholders, experts, and organizations shall be engaged in the process. Further work is needed to create an implementation plan, with special attention to the implementation considerations that would arise from these recommendations and the subsequent policies/interventions.

Knowledge to Policy Center draws on an unparalleled breadth of synthesized evidence and context-specific knowledge to impact policy agendas and action. K2P does not restrict itself to research evidence but draws on and integrates multiple types and levels of knowledge to inform policy including grey literature, opinions and expertise of stakeholders.

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