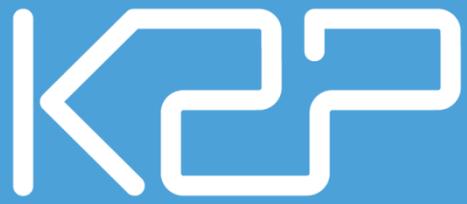


# Briefing Note

Promoting Access to  
Essential Health Care  
Services for Syrian  
Refugees in Lebanon

K2P Briefing Notes quickly and effectively advise policymakers and stakeholders about a pressing public issue by bringing together global research evidence and local evidence. K2P Briefing Notes are prepared to aid policymakers and other stakeholders in managing urgent public health issues. K2P Briefing Notes describe priority issues, synthesize context-specific evidence, and offer recommendations for action.



# Briefing Note

+ Included



Description of a  
priority issue



Synthesis of  
contextualized  
evidence



Recommendations  
for addressing  
the issue

× Not  
Included



Does not conduct a  
**comprehensive review of the  
literature** but relies on a quick  
assessment of databases



**Faculty of Health Sciences**  
Knowledge to Policy | K2P | Center

## K2P Briefing Note

# Promoting Access to Essential Health Care Services for Syrian Refugees in Lebanon

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# Executive Summary

# Executive Summary

## **Purpose**

The purpose of this Briefing Note is to shed light on the current situation of Syrian refugees in Lebanon in terms of their access to quality health services, including the stakeholders that are involved, the services they cover and existing gaps.

## **Issue**

The constant and large influx of Syrian refugees in Lebanon due to the escalating Syrian conflict has put a great pressure and burden on the Lebanese healthcare system and economy (Refaat & Mohanna, 2013). While there are many local and international NGOs, humanitarian organizations and governmental agencies involved in providing humanitarian assistance and health care services to Syrian refugees, the existing arrangements within the system are limiting access of refugees to essential health care services. This has led to a rise in communicable diseases, increased the risk of epidemics, suboptimal control of chronic diseases, in addition to other health related matters such as maternal and child health problems and mental health disorders. How can stakeholder organizations secure better access to essential and urgent healthcare needs of Syrian refugees?

## **Context**

Since the start of the Syrian conflict in 2011, Lebanon has been host to incoming refugees. According to UNHCR estimates, there are 1,050,877 Syrians in Lebanon (UNHCR, 2014), comprising 25% of the Lebanese population. Most refugees are concentrated in the North and Bekaa regions, particularly in host communities that the most poor, underserved and vulnerable like Akkar and Ersal (WB&UN, 2013).

## Current Situation

### Communicable Diseases

There has been a rise in communicable diseases (measles) and increased risk of epidemics like Tuberculosis, Polio, Waterborne disease (WB&UN, 2013).

### Chronic Diseases

Based on local data, in Beirut and its suburbs, 54% of Syrian refugees had chronic diseases most commonly cardiovascular disease (14.77%) and diabetes (12.5%), and 47% suffered from skin diseases, 27% from digestive system diseases, 19% from respiratory diseases, and 13% with mental illness (Refaat & Mohanna, 2013; Amel, 2013).

### Maternal Health

Local information reveals that the pregnancy rate among Syrian refugees was found to be 9% with many returning to Syria to give birth in order to avoid the high healthcare costs in Lebanon (Amel, 2013)

### Mental Health

A systematic review on the mental health of Syrian refugees in Lebanon found that refugees suffer from anxiety, depression, lethargy, eating and sleeping problems, anger and fatigue (Quosh, Eloul, & Ajlani, 2013). Strengthening the delivery of MH services at the primary care level is essential to the MH strategy for Syrian refugees (UNHCR, 2013-f).

### Older Persons

A local study conducted by CLMC on the health situation of older Syrian refugees found that 66% of older persons described their health as bad and 87% could not afford their medication (Chahada et al. 2013 (Helpage & HI, 2014). 77 % of older people were found to have specific needs (Helpage & HI, 2014).

### Impairment and Injuries

According to a study on Syrian refugees in Lebanon and Jordan (Helpage & HI, 2014), one in five refugees is affected by physical, sensory or intellectual impairment.

## **Health Situation of Syrian Refugees in Lebanon**

### **Access of Syrian Refugees to Healthcare**

- Local data indicates that only 48% of Syrian refugees attended medical consultations and among these, 51.14% indicated going to private clinics while 29% attended public hospitals (Amel, 2013).
- High healthcare expenditure is the most influential barrier to accessing healthcare for Syrian refugees (Amel, 2013; Chahada et al. 2013, UN, 2013).

### **Providers and Agencies Involved**

- Many organizations are involved in providing financial, humanitarian, food and healthcare aid to Syrian refugees (Figure 1); however, there is poor coordination between them resulting in duplication of activities, and inequitable distribution of aid to refugees that is not based on the needs of refugees (Christophersen & Thorleifsson, 2013).
- Regarding health response, UNHCR co-leads the health sector with WHO and the MOPH (UN, 2013) which is an adapted version of the sectoral model to suit the Lebanese context. To date, there has been no clear policy or plan by the government regarding refugee health response. UNHCR draws up its strategic plan for health at a national level in consultation with the ministry of public health.
- Foreign aid is far less than the amount needed to effectively respond to the health needs of the Syrian refugees (Refaat & Mohanna, 2013). Recently following the Paris meetings, the World Bank has agreed to set up a multi-donor trust fund to support Lebanon (WB, 2014). Almost all agencies involved in the relief of Syrian refugees suffer from lack of funding (UNHCR, 2013-b; UNICEF, 2013-b).
- Table 3 in the annex details the roles and responsibilities of each of these stakeholders.

### **Problem Areas in Health Response to Syrian Refugees**

- Shortage in funding
- Current supply of medicine.
- Shortage of Trained health professionals
- Poor responsiveness
- Unmet needs of primary and preventive care:
- Lack of information
- Nature of the Lebanese Healthcare system
- Inefficiencies in Coordination

## What the Evidence Says

### Delivery

Some of the most important considerations in the delivery aspect of the Refugees Health Response are:

- Role of Non-State Sector (NGOs, international agencies, donors)
- Rapid Health and Needs Assessment
- Refugee Health Information Systems
- Basic Package for Health Services (BPHS)

(Refer to full Briefing Note for more Details)

### Financing

Several financing options have been explored in the literature

Financing Method	Description
<b>General budgetary support</b>	General Budget support involves a large number of donors working in a coordinated manner providing financial assistance to countries. The support is given to governments and focuses on poverty reduction. Funds are transferred to the government to be spent using their own financial management, procurement and accountability systems.
Sector-wide Approaches (SWAs)	SWAp is a method donors use to achieve common objectives with the government and to unify priorities of both sides (Newbrander, 2007). Recipient governments and donors draw up a national health sector plan together and only activities within this plan are funded (Hutton & Tanner, 2004). SWAp mandates that the ministry of health take the lead role (Sundewall & Sahlin-Andersson, 2006).
Contracting:	Contracting NGOs is being used as a mechanism to provide health services to large populations in a number of fragile states. The contracts are usually funded by a donor in response to the need to expand services rapidly and the lack of functioning government infrastructure and workforce to deliver these services.
Performance-based financing (PBF)	PBF, which links payments to the achievement of measurable results
Global health partnerships (GHPs):	GHPs can aid fragile states in filling gaps, such as restarting a national tuberculosis (TB) program with a grant from the Global Fund to Fight AIDS, Tuberculosis and Malaria)

### Governance

Donor coordination mechanisms and tracking systems are necessary to support efforts aiming at strengthening health systems and expanding access and provide coherence to the task of strengthening the capacity of the health system (WHO 2007 & WHO 2013). One method to coordinate humanitarian aid is the clustering approach. This approach divides humanitarian aid into clusters, with every cluster having a lead which then coordinates with the relevant NGOs (Morris, 2006).

## **Recommendations**

1. Develop an essential package of healthcare services for Syrian refugees and Lebanese people
2. Develop a mechanism at the level of the government to raise funds to finance the delivery of the essential package
3. Explore mixed approaches of financing and resource allocation that are context specific and better respond to needs
4. Expand the number of primary healthcare centers, and hospitals that are within the humanitarian sector and explore options to reduce the co-payments for hospitalization costs
5. Developing refugee health information system through:
  - Identifying priority data needs and requirements
  - Defining the purpose and rationale for required data
  - Developing guidelines for data collection, data quality, data use, and dissemination
  - Establishing a mechanism for data monitoring, data sharing between all stakeholders including the private sector
  - Establishing data hub (or one stop shop) for data and information on refugees health
6. Invest in building capacities of local infrastructure (financial and delivery mechanisms) and local government (municipalities) to handle crisis situations.
7. Explore mechanisms to increase transparency in the work including resource allocation of NGOs and other agencies in delivering health interventions
8. Invest in decentralizing decision making capacity at the level of the government departments to match interventions and aid to the needs of the local community
9. Identify research priorities on refugee health, shape research agendas and support studies to produce knowledge that can fill existing gaps, to help develop and implement evidence-based interventions and to provide policy guidance to improve coverage and access
10. Strengthen the stewardship function of governmental departments and having a lead organization that is capable to play a major role by coordinating and establishing effective partnerships with local and international agencies, donors, and academic institutions and conducting monitoring and evaluation
11. Conduct a series of targeted policy dialogues meetings to operationalize key recommendations that were agreed upon by stakeholders in the first K2P Policy Dialogue meeting on June 4<sup>th</sup>, 2014. Those meetings will help develop the action plans and timelines for the implementation of recommendations.

# Content

# K2P Briefing Note

## Purpose

The purpose of this Briefing Note is to shed light on the current situation of Syrian refugees in Lebanon in terms of their access to quality health services,<sup>1</sup> including the stakeholders that are involved, the services they cover and existing gaps. This K2P Briefing Note clarifies current issues by laying out the facts without conducting a critical analysis and offers a recommendation.

## Issue

The constant and large influx of Syrian refugees in Lebanon due to the escalating Syrian conflict has put a great pressure and burden on the Lebanese healthcare system and economy (Refaat & Mohanna, 2013). The limited resources and overstretched hosting capacities have transformed the Syrian crisis into a Lebanese-Syrian crisis (Refaat & Mohanna, 2013). While there are many local and international NGOs, humanitarian organizations and governmental agencies involved in providing humanitarian assistance and health care services to Syrian refugees, the existing arrangements within the system are limiting access of refugees to essential health care services. This has led to a rise in communicable diseases, increased the risk of epidemics, suboptimal control of chronic diseases, in addition to other health related matters such as maternal and child health problems and mental health disorders. How can stakeholder organizations secure better access to essential and urgent healthcare needs of Syrian refugees?

## Context

Since the start of the Syrian conflict in 2011, Lebanon has been host to incoming refugees. According to UNHCR estimates, there are 1,050,877 Syrians in Lebanon (UNHCR, 2014), comprising 25% of the Lebanese population. However, the Lebanese government estimates an even higher number of Syrian refugees of 1.5 million refugees and some estimate up to 2 million, in addition to an estimated at 52,000 Palestinian refugees from Syria (UNRWA, 2014). Most refugees are concentrated in the North and Bekaa regions, particularly in host communities that the most poor, underserved and vulnerable like Akkar and Ersal (WB&UN, 2013). They must share scarce resources with Lebanese who live below the poverty line (WHO,

## Background to Briefing Note

*A K2P Briefing Note quickly and effectively advises policymakers and stakeholders about a pressing public issue by bringing together global research evidence and local evidence.*

*A K2P Briefing Note is prepared to aid policymakers and other stakeholders in managing urgent public health issues.*

*A K2P Briefing Note describes priority issues, synthesizes context-specific evidence, and offers recommendations for action.*

### The preparation of the briefing note involved six steps:

- 1) *Identifying and selecting a relevant topic according to K2P criteria*
- 2) *Appraising and synthesizing relevant research evidence*
- 3) *Drafting the Briefing Note in such a way as to present concisely and in accessible language the global and local research evidence;*
- 4) *Undergoing merit review*
- 5) *Finalizing the Briefing Note based on the input of merit reviewers.*
- 6) *Submitting finalized Briefing Note for translation into Arabic, validating translation and disseminating through policy dialogues and other mechanisms.*

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<sup>1</sup> A basic package of healthcare services includes both public health measures and individual clinical services which are highly cost effective and help resolve major health problems which match the epidemiological profile of the country

2014). In fact, most of the Syrian refugees are living in locations where over half of the host population (67%) and living below the poverty line (WHO, 2014). This makes the impact of the crisis even harder on the already suffering hosting community and the refugees themselves as there is a poor public health infrastructure in these communities. There are estimations of 2.4 million vulnerable Lebanese and Syrian refugees (Kousi, 2013). Moreover, 35% of total Syrian refugees are considered vulnerable, half of whom are women (49%), with 22% women in childbearing age, 40% children, and 2.6% older adults (UN, 2013; WB&UN, 2013).

## Current Situation

### Communicable Diseases

There has been a rise in communicable diseases (measles) and increased risk of epidemics like Tuberculosis, Polio, Waterborne disease (WB&UN, 2013). Local assessments showed that in Beirut and its suburbs, 65% of Syrian refugee patients had acute illness with the most common ailments being dental problems (48%) and influenza (20.45%). The refugee crisis has also marked the emergence of previously non-existing communicable disease in Lebanon like cutaneous leishmaniasis (420 cases by July 2013) (WB&UN, 2013).

### Chronic Diseases

Based on local data, in Beirut and its suburbs, 54% of Syrian refugees had chronic diseases most commonly cardiovascular disease (14.77%) and diabetes (12.5%), and 47% suffered from skin diseases, 27% from digestive system diseases, 19% from respiratory diseases, and 13% with mental illness (Refaat & Mohanna, 2013; Amel, 2013). Referrals for secondary and tertiary care included gastrointestinal infections (8.5%), trauma (7%), non-communicable diseases (6.5%) and respiratory infections (6.6%) (UNHCR, 2013-c). Among the elderly Syrian refugees, all had a chronic disease, 60% had hypertension, 47% had diabetes, and 30% had cardiovascular disease (Chahada et al. 2013). Moreover, there is an additional 1,500 cancer patients in Lebanon.

### Maternal Health

Local information reveals that the pregnancy rate among Syrian refugees was found to be 9% with many returning to Syria to give birth in order to avoid the high healthcare costs in Lebanon (Amel, 2013). Most referrals in secondary and tertiary care were for obstetrics (36.5%) of which 30.5% were for Caesarean sections (UNHCR, 2013-c).

### Mental Health

A systematic review on the mental health of Syrian refugees in Lebanon found that refugees suffer from anxiety, depression, lethargy, eating and sleeping problems, anger and fatigue (Quosh, Eloul, & Ajlani, 2013). Different assessment found feeling of frustration and humiliation due to unmet needs and dependency on aid (Quosh, Eloul, & Ajlani, 2013). PTSD was found at rates between 36 and 63% for adults with higher rates for children (Quosh, Eloul, & Ajlani, 2013). There is lack of coordination on the provision of mental health services (UNHCR, 2013-f). Strengthening the delivery of MH services at the primary care level is essential to the MH strategy for Syrian refugees (UNHCR, 2013-f).

### Older Persons

Though older persons comprise a thin slice of the Syrian refugee population in Lebanon (2.6%), they are particularly at a vulnerable state due to specific needs and constraints (Chahada et al. 2013). A local study conducted by CLMC on the health situation of older Syrian refugees found that 66% of older persons described their health as bad and 87% could not afford their medication (Chahada et al. 2013). Mental health was also found to be an issue with 66% of older persons feeling anxious (Chahada et al. 2013). Another study found that 54 per cent of older surveyed refugees have a chronic disease (Helpage & HI, 2014). 77% of older people were found to have specific needs (Helpage & HI, 2014).

### Impairment and Injuries

According to a study on Syrian refugees in Lebanon and Jordan (Helpage & HI, 2014) one in five refugees is affected by physical, sensory or intellectual impairment. In fact, 5.7 % of surveyed Syrian refugees in Jordan and Lebanon have a significant injury. 80 % of injuries were sustained as a direct consequence of war in Syria.

## **Health Situation of Syrian Refugees in Lebanon**

### **Access of Syrian Refugees to Healthcare**

- Local data indicates that only 48% of Syrian refugees attended medical consultations and among these, 51.14% indicated going to private clinics while 29% attended public hospitals (Amel, 2013).
- Syrian refugees in the Bekaa Valley reportedly had less perceived access to healthcare than refugees in other regions in Lebanon (Gulland, 2013).
- Secondary health-care services are available to Syrians but they continue to face large out-of-pocket payments in a system dominated by the private sector
- High healthcare expenditure is the most influential barrier to accessing healthcare for Syrian refugees (Amel, 2013; Chahada et al. 2013, UN, 2013). The majority of Syrian refugees lacked the ability to cover healthcare costs (Amel, 2013; Chahada et al. 2013; Gulland, 2013) which in turn may have prevented them from seeing a physician (Chahada et al. 2013) or led them to suspend their treatment (Gulland, 2013). The fiscal barriers could be forcing increasing numbers of refugees to return to Syria in order to access secondary care services, take on debt to seek private care or to not seek care at all (Coutts and Fouad 2013; Medicine du Monde 2013; Amnesty International, 2014). When refugees don't get treatment for health problems it results in further complication and severely negative health consequences on the long term for individuals and their families; far worse than initial health issue (Amnesty International, 2014).
- Much of these fiscal barriers are related to high unemployment rates among Syrian refugees (1/3 for men and 2/3 for women looking for employment), and earning much less than the minimum wage (between 40 to 60 % less than minimum wage) (Amnesty International, 2014; International Labor Organization, 2014).
- Other barriers preventing Syrian refugees from accessing healthcare include distance, short working hours of clinics and health centers, and availability of trained personnel (UNHCR, 2013-b).

### **Providers and Agencies Involved**

- Many organizations are involved in providing financial, humanitarian, food and healthcare aid to Syrian refugees (Figure 1); however, there is poor coordination between them resulting in duplication of activities, and inequitable distribution of aid to refugees that is not based on the needs of refugees (Christophersen & Thorleifsson, 2013).
- UNHCR is the lead mandated agency responsible for refugees protection with the support of humanitarian country team (HCT) and it co-leads with MOSA the interagency coordination (UN, 2013). Regarding health response, UNHCR co-leads the health sector with WHO and the MOPH (UN, 2013) which is an adapted

version of the sectoral model to suit the Lebanese context. To date, there has been no clear policy or plan by the government regarding refugee health response. UN agencies provides technical support and in kind contribution to the ministries and not fiscal (monetary support). UNHCR draws up its strategic plan for health at a national level in consultation with the ministry of public health.

- Currently there is a health working group that is supposed to coordinate between UNHCR, WHO, and other agencies, but it has been described as used for information sharing rather than an effective decision making forum (World Vision, 2013).
- Foreign aid is far less than the amount needed to effectively respond to the health needs of the Syrian refugees (Refaat & Mohanna, 2013). Lebanon has received less than 50% of funding requirements, and funding pledges are not being kept. In 2013 donor health pledges reached 154 million dollars, less than the required for impact on refugees and host community (WB&UN, 2013). World Bank estimates costs of refugee health to be between 216-366 million dollars in 2014 (WB&UN, 2013). WB also estimates that it would take 1.4-1.6 billion dollars to stabilize and restore the access and quality of care in Lebanon to pre-conflict levels (UN, 2013-d). The latest GoL response plan estimates the cost of healthcare for Syrians and host community at 368 million USD (WB&UN, 2013). In 2014 UN appeal was about 4.2 billion dollars for Syrian refugees, but at the time only 17% of funding requirements were met (Amnesty International, 2014). The Lebanese ministry of health most recently estimated the cost of refugee health response at 400 million dollars.
- Recently following the Paris meetings, the World Bank has agreed to set up a multi-donor trust fund to support Lebanon (WB, 2014). Almost all agencies involved in the relief of Syrian refugees suffer from lack of funding (UNHCR, 2013-b; UNICEF, 2013-b).
- Recently UNHCR embarked on a two year project to support the primary healthcare network to better absorb the Syrian refugees through providing equipment, staff and extending operational hours.
- Table 3 in the annex details the roles and responsibilities of each of these stakeholders.

### **Health Impact on the Host Community**

The Syrian crisis has impacted the economic and social conditions of the Lebanese population where instability in Lebanon has decreased tourism earnings and service industry. Unemployment rate has risen due to increased competition from Syrians who offer cheaper labor. Hostility and frustration from refugees is on the rise especially that most host communities are already poor and vulnerable. Moreover, most refugees are concentrated in the North and Bekaa regions, particularly in host communities that are the most poor, underserved and vulnerable like Akkar and Ersal (WB&UN, 2013). This makes the impact of the crisis even

harder on the host communities and the refugees themselves as there is a poor public health infrastructure. Regarding impact on healthcare:

The Ministry of Social Affairs and health report an average of a 40% increase in the use of their services which ranges between 20 to 60% across the country (WB, 2013).

- Reduced access of Lebanese Population to primary healthcare setting and public hospitals due to overcrowding, increased waiting time, and perceived decreased quality of care (WB& UN, 2013)
- Medication shortages for Lebanese population and increased cost of medicine (WB& UN, 2013)
- Financial pressure on public hospitals leading to impoverishment and possible closing down (WB& UN, 2013).
- Increased exposure to communicable diseases (lice, measles, polio, tuberculosis, waterborne diseases) (WB& UN, 2013)
- Emergence of new diseases previously non-existing in Lebanon (leishmania)(WB& UN, 2013)
- Increased unpaid commitments of MOPH to private hospitals (WB& UN, 2013)

#### **Problem Areas in Health Response to Syrian Refugees**

- **Shortage in funding** and resources to meet increased demand of healthcare services by Syrian refugees at primary care and hospital level (drugs, healthcare professionals, financial commitments to private hospitals). This has reduced access of refugees to care particularly at the secondary care level. Backlog of payment to hospitals by GLOBEMED has led to turning away refugees despite having available beds (Amnesty International, 2014).
- **Current supply of medicine** for chronic and acute disease is insufficient to meet rising demands.
- **Shortage of Trained health professionals** and primary and secondary health settings (WB& UN, 2013)
- **Poor responsiveness** to rapidly changing situations, and sometimes relief is delivered too late
- **Unmet needs of primary and preventive care:** The current delivery and financial arrangement of primary healthcare network is not able to meet the needs of all Syrian refugees and refugees have inequitable access to it (WB& UN, 2013), (Table 4 in the annex). Gap in the coverage of secondary and tertiary care of the Syrian Refugees and lack of efficient referral system at the primary care level (UN, 2013; Yamout et al, 2013).
- **Lack of information** on the distribution and the needs of Syrian refugees which is essential for designing healthcare interventions. This is compromising the decision making process and hindering needs based interventions. Though rapid assessments have been conducted it is unclear how reliable,

representative or systematic they were (small samples, representing specific populations...). There is also a lack of information in the point of view of refugees who don't understand eligibility requirements for healthcare and find them confusing (Amnesty International, 2014). One report mentioned not being able to get a response when calling the GLOBEMED hotline (Amnesty International, 2014).

- **Nature of the Lebanese Healthcare system:** Unlike other countries (Jordan and Turkey) with public healthcare systems that can quickly and effectively absorb refugees, the Lebanese health care system is fragmented, privatized and not coordinated. The Lebanese government is still struggling on how to provide access to health care for their population with no essential health care package. When the health system is already weak providing health services to refugees becomes challenging.
- **Inefficiencies in Coordination:** The current relief efforts has problems in coordination between local and international agencies and governmental bodies causing duplication of activities, decreased efficiency of relief work (high number of coordinators and personnel) and increased tension between refugees and hosting communities (Shibli, 2013; Yamout et al, 2013). It is unclear how much the work of NGOs has been based on local needs rather than external agendas and priorities of international NGOs.

### **What the Evidence Says**

- A scoping review of global evidence revealed limited information on tackling the health needs of refugees, but the available evidence revealed three levels of interventions.
- **Public Health interventions:** Vaccination, vitamin A supplementation, family planning, health education, disease early warning system, comprehensive epidemiological surveillance system, mental health intervention, soap distribution
- **Medical interventions:** mental health intervention (drug treatment, cognitive behavioral therapy, narrative exposure therapy) Is there any evidence regarding other medical interventions like chronic diseases, tertiary treatment and so on?
- **Health system interventions:** integrating new mental health services into primary care (1), training of personnel (1), integrated PHC (1 in Canada), Rapid needs assessment, essential services package

Evidence regarding health system interventions for refugees was sparse. As such, the briefing note made use of evidence regarding emergency, disaster and post conflict health interventions.

- Evidence suggests specific priority actions to help respond to immediate needs (Newbrander, 2007):

1. Address urgent health needs of refugees;
  2. Gather information;
  3. Create a package of basic health services to refugees;
  4. Develop policies, strategies and plans;
  5. Build up human resources for health;
  6. Ensure that there is a regular supply of essential drugs;
  7. Finance services adequately;
  8. Redevelop and reform the health sector;
  9. Rehabilitate or reconstruct health facilities; and
  10. Coordinate donors
- Global evidence indicates that strengthening health systems to respond to mass casualty events, such as the large influx of refugees, requires a system level plan of multi-sectorial action; including the following health system components: Delivery, Financing and Governance.

## **Delivery**

### **Role of Non-State Sector (NGOs, international agencies, donors)**

- The engagement of NGOs, relief agencies and donors in expanding access to health services is crucial in fragile states where the government lacks the capacity to respond to essential health needs.
- The type of humanitarian assistance ranges from mass immunization campaigns to specialized field hospitals preventive medicine, reproductive health services, emergency surgical interventions, mental health, and HIV prevention (Betsi et al., 2006; Pavignani & Colombo, 2005).
- Some of these interventions have proven effective. For example, under-five mortality rates in refugee camps where humanitarian agencies intervened tend to be lower than in non-displaced populations remaining in the area (Singh, Karunakara, Burnham, & Hill, 2005).
- The work of NGOs should be needs based and respond to local and emerging needs.

### **Rapid Health and Needs Assessment**

- Rapid health assessment, using registries and brief questionnaires of a representative sample with an emphasis on vulnerable populations, can help stakeholders and policymakers gain insight into the health requirements of an affected population in order to develop and prioritize health interventions or formulate a basic health services package (Korteweg et al, 2010).

## Refugee Health Information Systems

A well-functioning health information system is one of the essential components of an effective health system (WHO, 2007).

### Basic Package for Health Services (BPHS)

- A basic package of healthcare services includes both public health measures and individual clinical services which are highly cost effective and help resolve major health problems (Bobadilla et al, 1994). As epidemiological profiles of countries differ national packages should be tailored to the country's circumstances (Bobadilla et al, 1994). As such, it's designed to deal with principal health problems in descending order of importance (Bobadilla et al, 1994).
- In poor circumstances a concentrated package of healthcare services makes it easier to estimate the need for external assistance and better use of donor resources (Bobadilla et al, 1994). A number of countries including Afghanistan, the Democratic Republic of Congo (DRC), Liberia, southern Sudan and Uganda developed a Basic Package for Health Services (BPHS) to guide the implementation of health services
- The Public Health–Based Decision Tool set criteria for guiding the MOPH in Afghanistan in developing the BPHS:
  - Their impact on major health problems
  - Effectiveness
  - The possibility of scale-up
  - Equity
  - Sustainability

### Financing

For more detailed information on financing, governance and coordination please refer to the policy brief summary. There are several options for donors to finance health services as demonstrated by Table 1.

Table 1 **Financing mechanisms** for Donors and Governments

Financing Method	Advantages	Disadvantages
<b>General budgetary support</b> earmarked for the health sector General Budget support involves a large number of donors working in coordinated manner providing financial	Allows control of resources to be in the hand of the government who can deliver their own agendas and develop their own policies and programs. Creates ownership of the process and favors accountability within the government.	donors retain the right to stop funds at any time if they suspect mis-use of their financial assistance Political systems may not be ready due to problems with governance and corruption There are problems with accountability as although control is

<b>Financing Method</b>	<b>Advantages</b>	<b>Disadvantages</b>
<p>assistance to countries. The support is given to governments and focuses on poverty reduction. Funds are transferred to the government to be spent using their own financial management procurement and accountability systems. The support could be for general budget or earmarked for health sector.</p>	<p>Minimizing transaction costs Provides a platform for policy dialogues with recipient countries Supports the development of democratic and liberal systems Flexible and efficient system</p>	<p>with the host community the donor country still wants to know how the money was spent and how effective it was The host country might not have the administrative capacity to effectively manage financial allocations There is no actual proof that it will deliver benefits to the poorest and most marginalized people and communities</p>
<p><b>Sector-wide Approaches (SWAp)</b> constitute a mechanism for harmonizing donors while pursuing alignment with government priorities. Recipient governments and donors only fund activities in the national health sector plan SWAp gives attention to planning, HIS, financial planning. It strengthens district level management capacity within decentralized policies. SWAp pools donor funds and earmarks it for high priority activities like an essential health package It mandates that the ministry of health take the lead It has been applied in countries like Zambia, Mozembeqe, Tanzania, Rwanda</p>	<p>Facilitate strong government ownership and leadership of the health sector by transferring decision-making to the developing country. Better coordination and information sharing Strengthened countrywide management and delivery systems Reduced duplication, lower transaction costs Increased equity and sustainability Improved aid effectiveness and health sector efficiency</p>	<p>Weakness of the government in managing such coordination, poor interministerial relationships, change in governments and senior personnel Needs strong leadership capacity of the ministry of health Evidence of effectiveness and health impact is mixed The starting conditions and the evolutionary path of SWAp have been very inconsistent in different contexts that it is impossible to say what health impacts should be expected and when, particularly in view of fluctuations in health indicators.</p>
<p><b>Contracting:</b> Contracting NGOs is being used as a mechanism to provide</p>	<p>Could increase access to services and is appropriate is scale up services in post-conflict and fragile states</p>	<p>May bypass government mechanisms if donors provide contracts or grants directly to NGOs</p>

Financing Method	Advantages	Disadvantages
<p>health services to large populations in a number of fragile states. The contracts are usually funded by a donor in response to the need to expand services rapidly and the lack of functioning government infrastructure and workforce to deliver these services. As a result, perhaps paradoxically, the weaker the country's government capacity, the more likely it is that contracting is adopted. The most prominent example of this is Afghanistan.</p>	<p>Allows a greater focus on measurable results            Increases managerial autonomy            Draws on private sector expertise            Increases effectiveness and efficiency through competition.            Allows governments to focus on other roles such as planning, standard setting, financing, and regulation            Allows for rapid expansion of health service</p>	<p>Evidence not strong enough            Success depends greatly on design and context of implementation            Competition may not exist, especially in low income countries where there may be no alternative providers            Contracts may be difficult to specify and monitor            Management costs may wipe out efficiency gains            Contracting may fragment the health system            Governments with weak capacity to deliver services may also be weak in a stewardship role            The long term effects of a competitive process in acting as a spur to efficient service delivery also cannot yet be assessed</p>
<p><b>Performance-based financing (PBF):</b> PBF, which links payments to the achievement of measurable results</p>	<p>Enhanced Quality of Care            Improved Clinical Effectiveness            Cost Effectiveness            More equitable access to quality care</p>	<p>No strong evidence to prove effectiveness            needs strong political and management support and health information and reporting system            Cost of implementation: costs of monitoring performance and gaming the system            Bureaucratization: administrative costs associated with monitoring performance and managing disbursement of the financial incentives            Corruption: Financial incentives may be stolen or misused if not adequately managed            Dependency on financial incentives: Provider may stop on improving performance when the incentives end            Cherry-picking: selecting healthier cases to achieve better outcomes            Distortions: stimulation of efforts on the measures of performance included in the P4P scheme            Gaming the system: improving on reporting rather than improving</p>

Financing Method	Advantages	Disadvantages
<p><b>Global health partnerships (GHPs):</b> GHPs can aid fragile states in filling gaps, such as restarting a national tuberculosis (TB) program with a grant from the Global Fund to Fight AIDS, Tuberculosis and Malaria)</p>	<p>Avoiding duplication of investments and activities producing economies of scale pooling resources, sharing knowledge to improve the effectiveness of activities building a common ‘brand’ that gains legitimacy and support. Raises the profile of the disease Mobilizing commitment and funding Accelerating progress Innovation Cost effectiveness Tackles neglected diseases Well targeted towards burden of disease in the countries that are in need of socio-economic assistance</p>	<p>performance</p> <p>May not be integrated into basic health services may not be sustainable, may not provide support for health system development as they do not have whole systems view of the system they are operating in Risk that weak human resource and systems capacity at central and local levels may be overwhelmed by the proliferation of multiple GHPs (and other HIV/AIDS initiatives), each with its separate demands. To date, resources to finance assistance have been limited, as has a structured approach to defining needs and building and coordinating demand and supply. Instead technical assistance has been ad hoc and driven by urgent and immediate needs at country level. Though the GHPs have equity objectives, they tend to lack explicit pro-poor or gender-sensitive operational approaches, or robust measures to provide evidence of benefit to the very poorest people. There is a risk that country spending patterns will be dictated by the GHPs, and the need to sustain the activities and services provided by them, rather than by national priorities May increase fragmentation of the global health landscape, poor coordination and duplication among GHPs there is the risk that the proliferation of multiple GHPs - alongside other initiatives, particularly on HIV/AIDS - may overwhelm countries’ central capacity and weaker health systems.</p>

(Newbrander et al. 2011; Eldridge & Palmer, 2009; Frantz, 2004, Hutton & Tanner, 2004; Lagarde & Palmer, 2009; Liu et al, 2008; Unwin , 2004; Palmer at al, 2006; Canes et al, 2004).

## Governance

- Donor coordination mechanisms and tracking systems are necessary to support efforts aiming at strengthening health systems and expanding access and provide coherence to the task of strengthening the capacity of the health system (WHO 2007 & WHO 2013).
- The BPHS is a helpful tool to harmonize activities between across agencies (Newbrander et al. 2011).
- One method to coordinate humanitarian aid is the clustering approach.

Table 2 **Advantages and Disadvantages** of Cluster Approach

Cluster Approach	Advantages	Disadvantages
<p>This approach <b>divides humanitarian aid into clusters</b>, with every cluster having a lead which then coordinates with the relevant NGOs (Morris, 2006). This method has been applied in six countries (Chad, Democratic Republic of the Congo (DRC), Haiti, Myanmar, the occupied Palestinian territory (oPt) and Uganda) and evaluated (Steets et al, 2010).</p>	<ul style="list-style-type: none"> <li>- Improved coverage of humanitarian aid</li> <li>- Gaps in humanitarian assistance are better identified and duplications are reduced. As a result, humanitarian actors can better target their assistance and resources are used more efficiently</li> <li>- The ability of humanitarian actors to learn is increased through peer review mechanisms and enhanced technical and sometimes normative discussions (Knowledge sharing)</li> <li>- Efficient use of resources</li> <li>- There is greater clarity concerning leadership roles and more, better trained staff is dedicated to coordination thus creating a clearer point of contact (Steets et al, 2010).</li> <li>- Strong partnership between UN agencies and other international humanitarian actors which improves information sharing, advocacy power, coherence,</li> <li>- Improved humanitarian identity for cluster members</li> </ul>	<ul style="list-style-type: none"> <li>- problems with transition activities</li> <li>- Weakened national ownership (Steets et al, 2010).</li> <li>- Exclusion of national actors and failure to link/build on/ support existing coordination and response mechanisms</li> <li>- Most response clusters don't promote participatory approach</li> <li>- May threaten humanitarian principles when cluster members have close relationships with actors involved in conflict and other stakeholders</li> <li>- Poor cluster management and facilitation prevents clusters from reaching full potential (Lack of training, time dedicated for coordination)</li> <li>- Ineffectiveness of inter-cluster coordination and poor integration of cross-cutting issues</li> </ul>

## Examples from Countries

Table 3 **Country Healthcare responses** to emergency situations in Low and Middle Income countries

Country	Emergency Situation	Healthcare Response
Jordan	Syrian Refugees	<ul style="list-style-type: none"> <li>- Jordan has a public healthcare system and was able through the support (fiscal and technical) of the international community to absorb the influx of refugees.</li> <li>- All levels of the GoJ are engaged in the response, from the Office of the Prime Minister, the Ministry of Foreign Affairs, the Ministry of Interior (MoI) and MoPIC, to the line ministries working with each of the sectors, and the governorates and municipalities in refugee-affected areas (UN, 2013-d). MOH took the lead in relief effort. The Jordanian MOH provides full access to health services for the Syrians outside camps along with the local Jordanian population.</li> <li>- A joint rapid health assessment led by the Jordanian MOH and WHO is underway to better determine facility capacity and service utilization patterns in the most affected governorates (Murshidi et al. 2013).</li> </ul>
Turkey	Syrian Refugees	<ul style="list-style-type: none"> <li>- The Turkish government provides free access to national healthcare services (UN, 2013-c). Provision of health-care services for Syrian refugees through primary health care centers, medical emergency stations, mobile clinics, and tent hospitals (Döner et al. 2013).</li> <li>- The Turkish government has taken the lead role in determining and implementing assistance to the Syrian refugees through the Prime Ministry Disaster and Emergency Management Presidency (AFAD) (UNHCR, 2013-e, UNHCR, 2013-f).</li> <li>- The government passed legislation to regulate the rights of Syrian refugees and has established a directorate general for migration management with which UNHCR will coordinate for protection of refugees (UN, 2013-c).</li> <li>- One of the factors of success of the health response in Turkey is the ability of physicians to work (ŞENAY,2013),</li> <li>- Donors in Turkey expressed interest in supporting activities for health coordination, information management, integration of Syrian health professionals in Turkey and quantification of burden on health care facilities in Turkey (UNHCR, 2013-f).</li> </ul>
Afghanistan	Military Conflict	<ul style="list-style-type: none"> <li>- The MOH played a major role by coordinating and establishing effective partnerships with UN agencies, donors, and academic institutions, developing a basic essential package of primary health services, allocating major donors to key underserved rural areas, using major NGOs for service delivery of the package, as well as performing monitoring and evaluation (Salama et al. 2004).</li> </ul>

Country	Emergency Situation	Healthcare Response
Syria	Iraqi Refugees	<ul style="list-style-type: none"> <li>- Iraqi refugees prior to the Syrian crisis, had access to public health services, but only for emergency and primary health care.</li> <li>- Most poor Iraqis relied on Syrian Red Crescent clinics supported by UNHCR, which existed in areas of high concentration of Iraqis (Al-Khalidi et al. 2007).</li> </ul>

# Limitations

Due to the changing nature the Syrian refugee crisis it's important to acknowledge the following limitations to this Briefing Note. First, most of the local evidence comes from grey literature including reports from NGOs and rapid situation assessments not from peer reviewed journal articles. Second, the numbers reported in this briefing note regarding size of the refugees, their distribution and health profile may only be valid for a short period as the situation is highly unstable and the number of Syrian refugees in Lebanon is constantly on the rise. Third, the global evidence referenced was not based on a comprehensive review of the literature but on a scoping review.

# Recommendations

# Recommendations

This K2P Briefing Note was used to inform the K2P Policy Dialogue that was held in June 4<sup>th</sup>, 2014. The recommendations below were discussed and agreed on by the diverse stakeholders that participated in the dialogue meeting. Please refer to the K2P Dialogue Summary report for details on the stakeholder's deliberations and recommendations.

1. Develop an essential package of healthcare services for Syrian refugees and Lebanese people
2. Develop a mechanism at the level of the government to raise funds to finance the delivery of the essential package
3. Explore mixed approaches of financing and resource allocation that are context specific and better respond to needs
4. Expand the number of primary healthcare centers, and hospitals that are within the humanitarian sector and explore options to reduce the co-payments for hospitalization costs
5. Developing refugee health information system through:
  - Identifying priority data needs and requirements
  - Defining the purpose and rationale for required data
  - Developing guidelines for data collection, data quality, data use, and dissemination
  - Establishing a mechanism for data monitoring, data sharing between all stakeholders including the private sector
  - Establishing data hub (or one stop shop) for data and information on refugees health
6. Invest in building capacities of local infrastructure (financial and delivery mechanisms) and local government (municipalities) to handle crisis situations.
7. Explore mechanisms to increase transparency in the work including resource allocation of NGOs and other agencies in delivering health interventions
8. Invest in decentralizing decision making capacity at the level of the government departments to match interventions and aid to the needs of the local community
9. Identify research priorities on refugee health, shape research agendas and support studies to produce knowledge that can fill existing gaps, to help develop and implement evidence-based interventions and to provide policy guidance to improve coverage and access
10. Strengthen the stewardship function of governmental departments and having a lead organization that is capable to play a major role by coordinating and establishing effective partnerships with local and international agencies, donors, and academic institutions and conducting monitoring and evaluation

11. Conduct a series of targeted policy dialogues meetings to operationalize key recommendations that were agreed upon by stakeholders in the first K2P Policy Dialogue meeting on June 4<sup>th</sup>, 2014. Those meetings will help develop the action plans and timelines for the implementation of recommendations.

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# Annexes

# Annex

Table 4 **Roles and Responsibilities of Providers and Agencies** involved in Health Related Relief of Refugees

<b>Provider/ Agency</b>	<b>Roles and Responsibilities</b>
<i>Ministry of Public Health (MOPH)</i>	<ul style="list-style-type: none"> <li>→ The MoPH provides primary health care services to displaced Syrians through its national primary health care network.</li> <li>→ To meet the increased demand driven by influx of displaced Syrians, the MoPH has increased the capacity of primary healthcare centers.</li> <li>→ The MoPH also has 16 mobile clinics purchased by UNICEF that go to tented settlements, to provide medical consultations, vaccination, health education , treatment of lice and scabies and to distribute drugs ( 120,000) .</li> <li>→ Recently the MoPH launched an immunization campaign that reached 162,000 children mostly Syrians, and vaccinated 730,000 children against Polio 40% of which are Syrians. MoPH has also collaborated with UNHCR to set up vaccination points in four UNHCR centers and collaborated with the General Security Forces to set up vaccination centers at the borders to vaccinate Syrian children moving between Syria and Lebanon.</li> <li>→ MoPH also covers emergency care for displaced Syrians at public hospitals which is leading to their impoverishment.</li> <li>→ Conduction of 3 training workshops by the MoPH PHC team on prevention and treatment of lice and scabies addressed to 150 healthcare providers supported by UNICEF and in collaboration with the MoE and MoSA.</li> <li>→ Conduction of 4 training workshops by the MoPH PHC team and with the collaboration of UNFPA on (MISP) Minimum Intitial Service Package on Reproductive and Sexual Health in Crisis addressed to approximately 100 healthcare providers in UNRWA and MoSA.</li> <li>→ Establishment of Nutrition Emergency Committee in collaboration with IOCC, and representatives from UNHCR, UNICEF, AUB, IMC, Save the Children, to prevent and manage malnutrition in response to Syrian crisis.</li> </ul>
<i>UNHCR</i>	<ul style="list-style-type: none"> <li>- The main agency involved in provision of health services to Syrian refugees.</li> <li>- Implementing partners in Lebanon: International Medical Corps (IMC); Caritas Lebanon Migrant Center (CLMC); Makhzoumi Foundation; Première Urgence - Aide Médicale Internationale (PU-AMI); International Orthodox Christian Charities (IOCC); Amel Association – Lebanese Popular Association for Popular Action (AMEL) Restart Center; Association Justice and Misericorde (AJEM) (UNHCR, 2013-b).</li> </ul> <p><b>Primary Healthcare:</b></p> <ul style="list-style-type: none"> <li>- UNHCR supports a network of primary health care centers serving as the entry point for refugees needing medical care (UNHCR, 2013-b).</li> <li>- UNHCR partners have mobile health service clinics for populations in informal and tented settlements.</li> <li>- UNHCR plans on expanding the existing network of mobile medical units to ensure free-of-charge access to the most vulnerable refugees and those living in remote locations (UNHCR, 2013-b).</li> </ul>

<b>Provider/ Agency</b>	<b>Roles and Responsibilities</b>
	<ul style="list-style-type: none"> <li>- Syrian refugees are charged the same as Lebanese Nationals a nominal fee between 3000 and 5000 LL. UNHCR covers 85% of diagnostic costs and 100% of costs of medicine for special groups like children&lt;5, seniors&gt;60 and pregnant women.</li> </ul> <p><b>Secondary and Tertiary healthcare:</b></p> <ul style="list-style-type: none"> <li>- UNHCR has a network of referral hospitals across Lebanon. A community health workforce has been initiated to better support refugees upon hospital admission and proper follow-up after discharge for certain medical conditions (UNHCR, 2013-b).</li> <li>- Coverage of secondary and tertiary healthcare depends on the cost.</li> <li>- <b>If the estimated costs &lt;USD 1500:</b> UNHCR does not have to pre-approve this service. UNHCR covers 75% of costs and the refugees cover the remaining 25%. For the extremely vulnerable, UNHCR will cover 90% of costs. For survivors of gender-based violence and torture, UNHCR covers 100% of the costs (UNHCR, 2013-c).</li> <li>- <b>If the estimated cost ≥USD 1500:</b> These require review by UNHCR or referral to an exceptional care committee (ECC). Some cases that are below the financial limit are referred to UNHCR if deemed exceptional, for example cases that have presented outside the pre-approved hospital network (UNHCR, 2013-c). Emergency UNHCR approval is strictly for immediate life-saving or limb-saving cases (UNHCR, 2013-c). ECC approval is needed for non-emergency cases in need of life-prolonging expensive tertiary health care (UNHCR, 2013-c).</li> <li>- <b>GLOBEMED:</b> reviews the cases of persons seeking hospitalizations and decides whether to approve for subsidization based on criteria from WHO international Classification of Diseases and UNHCR standard Operating Procedures (Amnesty International, 2014),</li> </ul>
<i>UNICEF</i>	<ul style="list-style-type: none"> <li>- UNICEF collaborates with UNHCR and other partners in the WASH program, which is an interagency initiative (UNHCR, UNICEF, Acted, OXFAM, Caritas Lebanon Migrant Center (CLMC), Relief International, JEN and Mercy Corps, and Makhzoumi Foundation) that distributes hygiene kits, baby kits, water tanks, filters and latrines (UNHCR, 2013-d).</li> <li>- UNICEF supports 16 mobile medical teams that provide direct healthcare interventions in tented settlements across Lebanon (UNICEF, 2013-a).</li> <li>- UNICEF is active in the field of vaccination and has recently collaborated with the Ministry of Public Health (MOPH) to vaccinate children&lt;5 in informal tented settlements, as well as providing mandatory polio immunization to children at the three border crossings from Syria to Lebanon (UNICEF, 2013-b).</li> </ul>
<i>UNFPA</i>	<ul style="list-style-type: none"> <li>- UNFPA is active in the field of mental health, reproductive health, psycho-social support, and clinical management of rape.</li> <li>- UNFPA purchased reproductive health related pharmaceuticals to be provided at MOPH primary healthcare centers.</li> <li>- They also launched family planning counseling training of nurses, mid-wives, physicians and community health professionals (UNFPA, 2013).</li> </ul>
<i>MOSA</i>	<ul style="list-style-type: none"> <li>- Social Development centers, primary healthcare, medication, rapid testing</li> </ul>
<i>Medicins Sans Frontiers (MSF)</i>	<ul style="list-style-type: none"> <li>- MSF offers primary healthcare services for chronic and acute illness, pre- and post-natal care and mental health, while also providing medication free of charge in primary healthcare clinics (Williams, 2013).</li> <li>- MSF has clinics in Tripoli, the Bekaa Valley, Sidon and the outskirts of Beirut.</li> <li>- So far, the clinics have treated 3,400 patients, but doctors report that more patients are in need and foreign funding is low (Williams, 2013).</li> </ul>
<i>MdM Lebanon</i>	<ul style="list-style-type: none"> <li>- MdM supports three primary healthcare centers near the Syrian border in Bekaa valley and provide free primary healthcare, reproductive health, and health education (MdM, 2013)</li> </ul>

<b>Provider/ Agency</b>	<b>Roles and Responsibilities</b>
<i>Handicap International (HI)</i>	- This NGO is active in the Bekaa and North Lebanon and provides secondary care to vulnerable and disabled groups in the form of physical rehabilitation, physiotherapy, prosthesis, orthosis, at the hospital and community level (HI, 2013)
<i>Amel</i>	- Vaccination and primary healthcare
<i>CLMC</i>	- Vaccination and primary healthcare
<i>IOM</i>	- Vaccination
<i>SCI</i>	- Vaccination and primary healthcare
<i>WHO</i>	- Training, procurement of vaccination drugs
<i>CVT</i>	- Mental Health services
<i>IMC</i>	- Primary healthcare, medications
<i>IOCC</i>	- Primary healthcare, prenatal postnatal care, community support
<i>Islamic Relief</i>	- Medication, diagnostic procedures, health education
<i>Makassed</i>	- Primary healthcare, Medication, diagnostic procedures, consultation
<i>PU-AMI</i>	- Health Awareness, Chronic medication, diagnostic procedures, consultation
<i>Restart</i>	- Mental health
<i>UNRWA</i>	- Primary healthcare to Palestinian refugees coming from Syria
<i>Makhzoumi</i>	- Psychosocial support and community activities

Table 5. **Distribution of Syrian refugees and primary healthcare centers** within the MOPH primary healthcare network by governate(s)

<b>Distribution by governate(s)</b>	<b>Syrian refugees (%)</b>	<b>Primary healthcare centers (%)</b>
Bekaa	30	17
North	25	20
Beirut and Mount Lebanon	20	33
South and Nabatiyeh	12	29

(UNHCR, 2013-a; MOPH, 2013)

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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