Dialogue Summary

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

K2P Policy Dialogue convene 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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Knowledge to Policy Center K2P

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The authors wish to thank the K2P core team including Diana Jamal and Lamya El Bawab.

Dialogue
The policy dialogue about Promoting Access to Basic Health Care Services for Syrian Refugees in Lebanon was held on 4 June 2014 at the Gefinor Rotana Hotel, Beirut, Lebanon. The policy dialogue was facilitated by Dr. Fadi El-Jardali, the director of the K2P Center.

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Contents

Content

Preamble

The K2P Policy Dialogue was attended by diverse stakeholders: policy and decision makers, representatives from relevant ministries (ministry of public health (MOPH) and ministry of social affairs (MOSA)), UN agencies representatives(World Health Organization – WHO, United Nations Refugee Agency UNHCR), international (International Red Cross Committee - ICRC, Medcine du Monde - MDM, (IMC-International Medical Corps) and local non-governmental organization representatives (Amel, Caritas Lebanon Migrants Center - CLMC , etc.), primary care directors and Kaza doctors, as well as researchers and public health scholars. The policy dialogue hosted 28 people and was facilitated by Dr. Fadi El-Jardali, Director of K2P with the presence of Dr. Walid Ammar, the Director General of the Ministry of Public Health and Dr. Hassan El Bushra, the WHO Representative in Lebanon.

Deliberations about the problem

Access to healthcare services

Dialogue participants discussed the overall framing of the issue of access of Syrian refugees to basic healthcare services. Few participants pointed out the need to expand from caring only about basic services to offering secondary and tertiary care given the long term nature of the crisis and the increasing expectations of refugees. Participants highlighted the need to be more specific concerning the number of Syrians that lacked basic care and what was meant by basic care and asked about the evidence behind the statement in the briefing note "hundreds of thousands of Syrian refugees deprived from basic health care services". It was mentioned that access to care means different things to different people and it was all about how you define it. Some issues of access are common to Lebanese and Syrians alike such as access to cancer treatment. Participants agreed to replace the term "Basic

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 three 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.

healthcare services" with "essential healthcare services" to be inclusive. Some participants stressed the need to differentiate between the two concepts of access and utilization where in some cases, access might be available and beneficiaries might choose not to utilize it, such as in vaccination. It was mentioned that some Syrians choose to go to the private sector or back to Syria rather than use the PHC network. However, all participants agreed that there were gaps in coverage of healthcare for Syrian refugees without clear quantification of these gaps. The word "coverage" was found controversial as it could mean many things (financial coverage or access) and access was considered a better term.

Participants mentioned that the type of available evidence was limited to NGO reports and grey literature and of low quality and particular evidence on coverage and access was weak and that this was declared in the "limitations" section in the briefing note. It was also mentioned that the lack of high quality evidence should not mean that nothing should be done about the problem and that we should work with the information and evidence that is currently available. Other participants pointed out the gaps in the literature pertaining to these issues and felt that research agendas should be steered towards filling this gap. Participants mentioned the presence of other sources of data such as the number of people immunized, PHC reports, and reports from the district departments of the MOPH which paint a different picture concerning coverage of care and particularly for vaccination.

Other participants assured that there are a high number of humanitarian actors who support the primary healthcare (PHC) network in Lebanon and that the issue of access was less related to the number of centers and more to issues of affordability, financial coverage, distance and competition over limited resources. Participants agreed that there were system level issues hindering access of refugees to healthcare.

Some participants mentioned that the data used in this briefing note needs to be complemented by additional high quality evidence. The high prevalence of chronic diseases is a problem in both the Syrian refugee and Lebanese host population and care should be integrated and harmonized for both. Dialogue participants also stressed the idea of harmonizing care between the two populations through having a comprehensive approach that focused on empowerment and development. Participants affirmed the need to give attention to the

elderly and disabled when choosing target groups and not only women and children.

It was pointed out that one of the difficulties faced when providing care to Syrian refugees was that Syrians were constantly on the move and transitioning from camp sites which was negatively affecting the delivery of healthcare interventions.

Other participants mentioned that Syrian refugees have good access to primary care with the admittedly limited scope of services provided and that it took a while to get there and this experience can be used to derive lessons on how to restore this level of quality care and access. Few participants also assured that things are a lot better now in terms of access to care than they were before. Other participants mentioned that hospital services should be included in the package delivered to the Syrians and that the main problem in that was shortage of funding.

Accordingly, participants agreed on the following reframing of the issue or problem statement:

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.

Health System arrangements include: Delivery, financial and Governance Arrangements.

Dialogue deliberations addressed each of these issues.

Delivery & Financial arrangements

Few participants felt that it was imperative to be practical as to what can be achieved by humanitarian actors and the MOPH. Other participants assured the need to take into account the host community and healthcare system in Lebanon when considering access of Syrian refugees to healthcare. It was mentioned that the Syrian crisis could give Lebanon an opportunity to reform and improve the healthcare system.

Some participants considered that the inability for Lebanon to respond effectively to the healthcare needs of the Syrians is a fact that is beyond the capacity of Lebanon and more of an international obligation. That being said, it was mentioned that there is no discrimination against Syrians at the level of primary care and efforts are being made to safeguard against that. At the level of hospitals, participants mentioned that some private hospitals are equally denying admission for Syrian refugees as well as Lebanese citizens due to financial constraints. It was also noted that the MOPH has only full authority over public hospitals that do not deny admission. According to participants, this led to Syrian refugees heavily accessing public hospitals which contributed to their financial crisis and shortage in medications. It was mentioned that the major problems are at the level of hospital care.

Other participants stressed the need to take into consideration the context of the healthcare system including physician practice patterns, overprescribing, and limited resources. It was stressed that there are inefficiencies in how money is being spent and that injecting more money into the system would not be a solution for that. Other participants mentioned that the multiplicity of actors could be viewed as a good or bad thing and that the lack of funding should be given more focus. Another participant argued that the high number of actors was due to the diversity in locations of refugees (1700 locations). Participants mentioned that there was a gap in the literature on financing and accountability mechanisms when dealing with large scale humanitarian crisis such as Syrian Refugees. Another participant argued that there are enough primary healthcare centers in the system and that instead of opening up new ones, the existing centers should be supported and infrastructure strengthened. It was mentioned that the initial capacity of the system should be taken into account as refugees settled into peripheral areas where the health centers were not used to this high demand on services. Capacity was noted as a major barrier in the ability to provide care to refugees in addition to funding and distance. Other participants agreed that capacity was a major issue and those constraints in term of resources, space, time and human resources were hindering the ability to provide care. It was also argued that despite the good relationship between UNHCR, WHO and MOPH, the system and particularly the feedback procedures should be improved in order to overcome capacity limitations perhaps through providing

nurses and doctors. The approach currently followed was described by some of the participants as highly vertical and that for example, it was unclear to refugees and health workers which cases qualified as vulnerable or life threatening and earned hospital assistance from UNHCR. Participants mentioned that the MOPH assistance to the PHC network through providing non-fiscal support (medications) was insufficient, and more support was needed especially from the international community. Other participants argued that UNHCR supports existing clinics but there are other areas requiring establishment of more clinics.

As for the health information system, it was mentioned that there is existing data on the utilization of healthcare system but not on the needs of refugees and those not being able to access or utilize it. Despite the limited information available at the MOPH it was agreed that we should leverage more on this type of data and more commitment was needed in terms of using and analysing the data and developing performance indicators. In addition, centralizing the data was found to be a problem. Another issue that came up was access to data in that some information and key documents are not publicly accessible without MOPH approval like WHO related documents. Participants mentioned that this creates major challenges and proposed that the data related to the health of Syrian refugees should be better governed and disseminated. Other sources of data included secondary healthcare reports released by UNHCR.

Another issue that was mentioned was the inability for Syrian medical professionals such as doctors to practice in Lebanon. It was felt by some participants that allowing them to work would reduce the gap in human resources for health and benefit the overall health response. It was mentioned that data was currently being collected on this and that a possible solution could be issuing temporary permits or zone restricted permits to practice. Another participant countered that medical professions in Lebanon were governed by orders that had specific criteria for professionals to practice and that if bridging programs were not set up to satisfy these criteria these persons would not be able to practice. It was also mentioned that despite these Syrians physicians not being given a license to practice, MOPH is not taking any measures against them. Another participant mentioned that in Turkey they are thinking about using the Syrian human resources for health to respond to the crisis and are viewing refugees not as a burden but rather as a

resource that can be utilized. It was also mentioned that in Turkey they have camps and are establishing parallel healthcare system to provide healthcare to refugees and that the context differs greatly from the Lebanese one where we are integrating the refugees into our current system.

The issue of communication was also brought up, where institutions were encouraged to improve their communication with the MOPH and the polio panic/scare was brought up as an example of poor communication.

It was also mentioned that groups like Palestinians from Syria, Lebanese returning from Syria, should also be taken into account not just Syrian refugees.

It was mentioned that conducting a comprehensive needs assessment would help planning and distribution of roles in a way that would reduce duplication. Another participant argued that a needs assessment would cost a lot of time (with a rapidly changing situation) and money that could be used elsewhere. Other participants mentioned that the current setup is unclear and that it changed from emergency to developmental and that there is no clear understanding of what the situation will be like in the future which is a major limitation. It was mentioned that a comprehensive predictive situation analysis was needed which takes into account different scenarios (best and worst cases) and plans accordingly. Some participants considered that in one scenario, the system would stop being able to absorb the refugee influx and this would require major change in the health system arrangement.

Some participants pointed out the need to look away from just curative care and focus on the social determinants of health like shelter, water and sanitation which are greatly affecting the health of the refugees and their subsequent health needs.

Governance Arrangements

Participants discussed the governance arrangement as below.

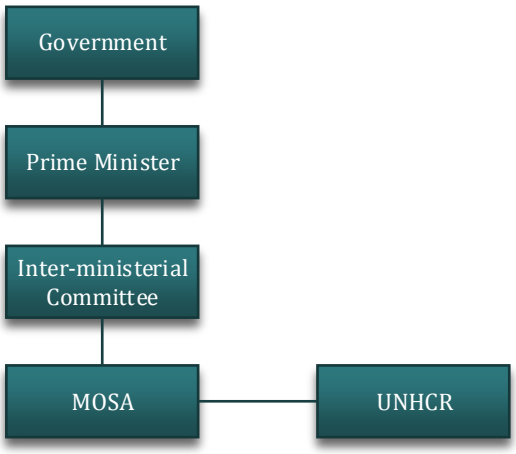

Figure 1 **Governance of Overall Refugee Response**

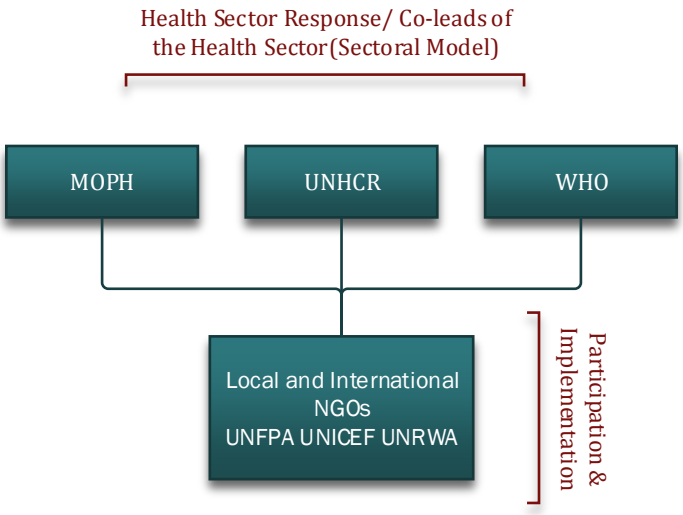

Figure 2 **Governance of Health Sector Response**

As for coordination and governance, some participants mentioned that usually there would be one lead umbrella organization and it was unclear in this case which organization it was. The role of the inter-ministerial committee at the level of the prime minister was found doubtful and ineffective. Some participants considered that there is no single entity leading the coordination. Other participants considered that the MOPH was leading the response in the health sector with WHO and UNHCR as co-leads. It was mentioned that all stakeholders were being represented through technical and steering committees at MOPH and the European Union (EU) fund was discussed and planned through using the existing system led by the MOPH. It was pointed out that the ministry of social affairs (MOSA) was not represented at this committee and that their representation was limited to the PHC level not the policy level in the health sector.

When discussing the capacity of the MOPH to take the lead on refugee health response, few participants compared the context of Lebanon to Jordan and argued that the ability of the Jordanian MOH to take charge stemmed from the presence of a strong central government, public health sector, smaller numbers of refugees, and presence of camps. This participant pointed out the difference such as in Lebanon we have a weak government, multiplicity of partners, large size of refugees and lack of encampment, lack of command and control system by the MOPH (more like negotiations), and too many powerful players. It was noted by few participants that we can learn from other countries and customize some of their interventions. MOPH was considered to be steering the system not managing it through command and control mechanisms. For instance, MOPH does not have authority to use command and control mechanisms with UNHCR and WHO which operate by their own set of rules. Few participants mentioned that due to preconceived notions of corruptions and bureaucracy within the government, some agencies came to work with governmental departments considerably late into the start of the crisis. Other participants considered that UN agencies were there to support the government. It was also mentioned that it took a long time to establish a good working relationship with the different actors possibly due to the hope that the crisis would soon come to an end but now all partners have recognized the significance of this problem and are collaborating. It was acknowledged that the relationship between MOPH and UNHCR has improved immensely and that the MOPH major intervention through providing free vaccinations and integrating the refugees into the system in some areas.

As for information sharing, some participants admitted that information does not flow well and there was ambiguity on who takes the lead. Participants mentioned that having the MOPH present at meetings has made a great difference and helped in the inter-agency coordination through increased participation and engagement. Another participant felt that the MOPH was in fact decentralized through its district Kaza doctors which coordinate work and that it took a long time for the international actors to harmonize and communicate with them which decreases duplication of efforts. Another participant mentioned that the MOPH had weak capacity and shortage of staff which required them to work closely with NGOs as they are needed to fill this gap. It was mentioned that despite all efforts to achieve maximum engagement with

NGOs, it was not possible to attend all meetings and still get work done at the MOPH due to shortage in staff. Another participant mentioned the need to leverage on the existing resources. Other participants pointed out the need for one focal point at the MOPH to coordinate with as to reduce information loss. Another participant argued that the capacity issue at the MOPH should be addressed by the EU fund and it was mentioned that people are currently being recruited but even then, there is no space for them.

Participants concluded that agencies and NGOs and other stakeholder organizations involved in the health assistance require more guidance (including reporting requirements) from leading organizations such as MOPH that has knowledge about local context. This will help improve coordination, alignment and standardize processes.

Deliberations

Deliberations about Policy Options for Addressing the Problem

Dialogue participants discussed several options of a policy approach that had been examined in the briefing note.

Option 1: Budget Support; Donors combine their funds and give them support to the government's budget. The funds are spent and used through the government's own financial, governance and delivery systems.

- Participants agreed that this option would not be suitable for Lebanon and that money would be better spent in the hands of UN agencies that with the government and the ministry of finance.
- It was noted that if money was to be given to government's budget, a treaty had to be ratified and that this decision would be taken at a much higher level. Other participants argued that for the government to receive donations, they had to be the ones providing care (public provision of healthcare services) while in Lebanon there is predominance of the private sector.
- The briefing note reported on some implementation barriers for this option including poor governance and administrative capacity and accountability mechanisms of recipient governments to manage large sums of financial assistance (Unwin, 2004; Lawson, 2005).

Option 2: Sector-Wide Approach (SWAp) - Recipient governments and donors draw up a national health sector plan together and only activities within this plan are funded. The ministry of health takes the lead role through a participatory process with NGOs and ministries

- Some participants considered that this approach is partially being applied in Lebanon. Participants also considered that currently there is a plan developed with

performance indicators and tasks are being implemented through UNHCR, WHO and NGOs.

- Participants felt that service delivery to Syrians should be more comprehensive and that to reduce fragmentation, the SWAp should be used.
- It was considered that UN agencies are not under the command of the MOPH and function according to the conditions of funding.
- Other participants stated that some donors are not ready to move to the SWAp model.
- Some of the success factors required for this option include leadership capacity of the MOPH, the systematic development of a structured plan, decentralized decision making and delivery systems, the use of a participatory model, and getting all stakeholders (MOPH, ministry of finance MOSA, all UN agencies, NGOs, PHCS and hospitals) on board.
- Most participants agreed that this option is the most acceptable for the context of Lebanon and that it needs to be reinforced.

Option 3: Cluster Approach: This approach divides humanitarian aid into clusters, with every cluster having a lead which then coordinates with the relevant NGOs. Usually UN agencies take the lead on clusters and are responsible for coordination meetings at the country and global level and are providers of last resort.

- Some participants considered that the cluster system is used for the internally displaced persons (IDPs) and that doesn't necessarily mean that the government should be dismantled.
- Some participants remarked on the success of the cluster system in the 2006 relief efforts in coordination with the MOPH and that we can learn from it.
- Other participants considered that the cluster system was not relevant here as it was applied for a crisis that only lasted few months, refugees soon returned to their home

and the flag of the UN was used to get things accomplished. Accordingly this made the cluster not suitable for the Syrian refugee crisis. It was noted by participants that the success of the Cluster approach then was built on the trust with NGOs.

- Few participants considered that the current working group model that is being applied for the health response is similar to the cluster approach.
- Some of the implementation considerations for this approach include knowledge and analysis of local structures, and communication channels with partners.

Option 4: Contracting - 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.

- Some participants considered that the contractual mechanism is already being implemented in some cases and is complement the SWAp approach. An example was given on the system for providing secondary care to Syrian refugees such that hospitals are contracted to deliver services and NGOs come in to fill the gaps.
- Some participants felt that contracting as a mechanism does not work and does not fit well with SWAp approach.
- There was lack of clarity among participants as to whether contracting can deliver better access to quality healthcare services. It was mentioned that even if contracting is used, the government should still be involved.
- Other participants emphasized the need to link contracting to performance. The accreditation program for the PHC network was mentioned as a proper gateway to establishing performance based indicators and providing fiscal support accordingly.

Additional Deliberations on Policy Options

Participants agreed that given the current situation, and the different mechanisms that are being employed, it was important to

understand what mixed strategy would best address the problem and fit the context of Lebanon. There was lack of clarity among the participants on who can take such decisions or choose which option to apply: government or UN agencies.

Few participants felt that the Syrian Refugee crisis and the health related problems could be an opportunity to build capacity in the government for establishing long term planning processes.

Some participants mentioned that in the latest series of government meetings there seemed to be an understanding that UN agencies are only present to help the Syrians and not to support Lebanon. Few highlighted a problem with defining the role of UN agencies. It was mentioned that such decisions on approaches can only be made at higher levels.

Deliberations about Recommendations and Next Steps

Participants discussed initial recommendations and next steps from the K2P Briefing Note:

- Participants considered that the health information system at the level of the PHC network was already in place and should be enhanced in order not to create parallel systems but the quality and completion of reporting should be enhanced.
- Other participants remarked on the capacity of the centers to collect data and report which highlights the role of humanitarian actors.
- Other participants pointed out that the purpose of the data should be defined along with what data is required including guidelines and protocols.
- Some participants mentioned that the private sector has a lot of data but there is no leverage on them.
- It was also highlighted that an entity should synthesize this information and all NGOs should share these reports.
- It was suggested that K2P take the lead role in collecting, analyzing, and disseminating data and information related to Syrian refugees in Lebanon
- Participants agreed to merge these two recommendations.
- It was noted by participants that services should be expanded from curative to preventive as well.
- Participants agreed that a mechanism for “raising funds” should be developed not “receiving funds”.
- Participants agreed that a basic package should include both refugees and Lebanese where some Lebanese are even worse off than the Syrians.
- Participants considered that it was not the UNHCR network but the humanitarian sector.

- Some participants also stated that currently 66 hospitals are contracted to deliver secondary care to Syrians based on the MOPH flat rate which is a high number and asked when the line should be drawn in terms of expanding the hospital network.
- Some participants argued that even with UNHCR covering 75% of lifesaving hospitalization, the remaining 25% was very high and refugees could not afford it. To that, participants responded by saying that there will never be enough funding and that Lebanon is a very expensive hospital care setting. It was also mentioned that primary healthcare should be given more attention. Some participants suggested having a more efficient system through developing criteria for the admission to a basket of services can lead to efficiencies (i.e. savings) which can be used to reduce the 25% co-payment for hospital services
- Some participants mentioned that funding assessments were already being conducted at the level of the regional response plans where everything is being costed.
- Participants agreed to the importance of collaboration and participation and reaching a mixed hybrid solution and felt that a series of focused policy dialogue meetings could be an excellent venue for collaborative problem solving.
- Participants agreed on the need to increase transparency which could be tackled through a specific policy dialogue focusing on that.

Next Steps

Recommendations and Next Steps

Participants agreed on the following revised recommendations:

1. Develop an essential package of healthcare services for Syrian refugees and Lebanese people.
2. Reinforce and fully implement the Sector-Wide Approach (SWAp) option that is outlined in the K2P Briefing Note and discussed above in the Dialogue Summary.
3. Develop a mechanism at the level of the government to raise funds to finance the delivery of the essential package.
4. Explore mixed approaches of financing and resource allocation that are context specific and better respond to needs.
5. 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.
6. 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
7. Invest in building capacities of local infrastructure (financial and delivery mechanisms) and local government (municipalities) to handle crisis situations.

8. Explore mechanisms to increase transparency in the work including resource allocation of NGOs and other agencies in delivering health interventions.
9. 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.
10. 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.
11. Strengthen the stewardship function of governmental departments and having a lead organization that is capable of playing a major role by coordinating and establishing effective partnerships with local and international agencies, donors, and academic institutions and conducting monitoring and evaluation.
12. 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 4th 2014. Those meetings will help develop the action plans and timelines for the implementation of recommendations.

Next Steps

It was agreed that the K2P dialogue summary report along with the revised K2P briefing note will be used by each stakeholder organization as guiding reports and that they will communicate internally and externally with relevant committees, etc. in order to push agendas and advocate for improvements in current organizations and systems and to disseminate these documents to relevant committees. Also, they discussed the need to operationalize key recommendations that came out from the dialogue meeting and put them into action.

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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