

## Syria Public Health Network (SPHN)

### Syria's health: an overview of current knowledge and policy priorities

#### Headlines

- The complexity, magnitude and duration of the conflict has had far reaching effects on health and healthcare services in Syria and in neighbouring countries. This has led to unprecedented increases in both communicable and non-communicable diseases with re-emergence of previously controlled infections.
- The capacity of health systems inside Syria and in neighbouring countries to respond has been undermined by damage to facilities and governance fragmentation (inside Syria), health worker flight, shortages of essential medicines and critical financing shortfalls. Inside Syria, there are now three to four parallel health systems in operation, such that a previously functioning health sector is fragmented and uncoordinated with increasing militarization and politicization of healthcare institutions.
- The humanitarian response has been hampered by weaknesses in the health systems of neighbouring countries with curtailment of access for Syrian refugees and restrictions at a policy level on employment of healthcare workers, financing shortfalls, weak coordination, a lack of sharing in data collected by humanitarian agencies, and in particular an inability to identify what interventions have worked for whom and when in terms of health.
- Priorities for action include improving access to healthcare – especially in neighbouring countries where mechanisms including aid conditionality could be used to strengthen public health service providers and the development of Universal Health Care coverage for host communities and refugees; expanding the pool of funding available for health by re-allocating funding for development; removing restrictions on licences to practice for displaced Syrian health professionals who are well placed to support the response and strengthening health surveillance and monitoring systems in Syria and the region

#### Background

1. In March 2015, a group of Syrian medical professionals, humanitarian aid workers, public health specialists and academic researchers met in London to review current knowledge about the health situation in Syria and surrounding countries, and highlight gaps. The SPHN was established to drive forward elements of the agenda identified at the March meeting and galvanise support for ongoing research and collaborative work.
2. This briefing draws together key findings from three workshops convened by the Network that have addressed various aspects of the crisis in Syria and surrounding countries, including health system functionality and mental health and psychosocial support (MHPSS) needs. The briefing is intended for policymakers in the UK and elsewhere, medical and public health professionals working on Syria, and academic researchers participating in the “Supporting Syria and the Region” conference in London.

#### Putting the humanitarian situation in Syria in regional context

3. The humanitarian crisis afflicting Syria and neighbouring countries is now one of the gravest worldwide. Some 13.5m people inside Syria (around 74% of the total population) are estimated by the UN's Office for Coordination of Humanitarian Affairs (OCHA) to be in humanitarian need as of January 2016. Furthermore, Syria ranks top across the Middle East and North Africa in terms of the proportion of the population in need of access to basic health services (63%) and protection (74%). Two million children are now out of school.<sup>1</sup>
4. The scale of displacement caused by the conflict in Syria is unprecedented in recent times. Rates of internal displacement are difficult to estimate accurately but it is thought that 9-10 million Syrians have been forced to move, many on multiple occasions. Current estimates are of over 4,087,000 refugees. Most refugees have moved to Turkey, but there are large numbers in Lebanon, Jordan, Iraq and Egypt. Around 51% are under the age of 18.

<sup>1</sup> OCHA (2016). Middle East and North Africa: crises in focus – an overview of humanitarian needs in the region. Online at: [https://gallery.mailchimp.com/8cf3bdfdba0a875ff6dd19093/files/MENA\\_HNO\\_Overview\\_ENGLISH\\_01.pdf](https://gallery.mailchimp.com/8cf3bdfdba0a875ff6dd19093/files/MENA_HNO_Overview_ENGLISH_01.pdf) [accessed 28/1/16].

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### The changing burden of disease among Syrians

5. Prior to the beginning of the conflict in March 2011, Syria was a middle-income country with a well-educated, urban population and good health indicator performance. Data to 2010 show comprehensive vaccine coverage, good infant and maternal mortality figures and demonstrate that Syria was on track to meet MDG targets. There was, however, a rising burden of non-communicable disease (NCD).<sup>2</sup>
6. The impact of the conflict on health outcomes has been wide ranging. There has been a fall in vaccination coverage from 90% to 52% with cases of measles and polio reported.<sup>3</sup>

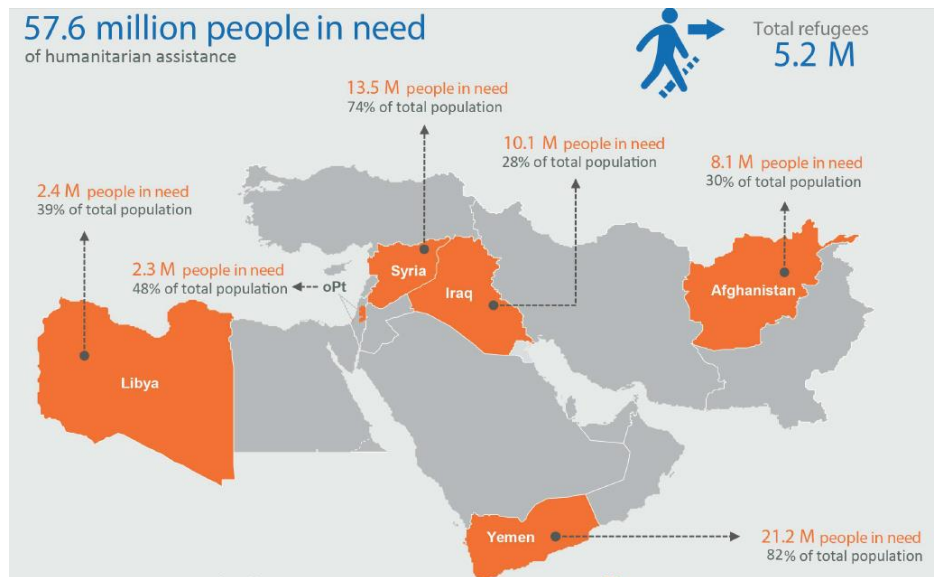


Figure 1: overview of humanitarian needs across the Middle East and North Africa at the beginning of 2016 (source: OCHA<sup>1</sup>)

Disruption to waste management and clear water supplies has led to an increase in communicable diseases, particularly those which are water-borne including typhoid, diarrhoeal disease and hepatitis A. NCD burden is rising, in part because the humanitarian health response in Syria and surrounding countries has been fragmented, uncoordinated and has been shaped around a short-term crisis response with little focus on long-term conditions, the disabled, the elderly, mental health or preventative healthcare. This has been compounded by a lack of access to secondary or tertiary healthcare as well as the destruction of health centres inside Syria with estimates suggesting that up to 70% of health facilities are not functioning.

7. From a mental health perspective, many Syrians have experienced prolonged exposure to high levels of psychological stress as a result of displacement, unemployment, hostile reactions from locals in accepting countries, torture, sexual violence and – among children – forced labour and exploitation. Clinic-reported prevalence rates for mental disorder should be treated with caution but indicate high levels of psychosocial distress (42%)<sup>4</sup>, anxiety and depression among refugees in Turkey and Lebanon. PTSD is comparatively rare although some refugee camp-based studies have reported rates of up to 33%<sup>5</sup>. There is evidence of a recent rise in severe mental disorder. However, data on mental health problems among displaced Syrians outside refugee camp settings is in short supply. This is problematic given that 70-75% of Syrian refugees in Jordan, for example, live outside camps.

### The capacity of health systems in Syria and surrounding countries to meet the challenge

8. The destruction of the healthcare sector and services inside Syria has led to fragmented **governance structures** with at least three systems now running in parallel including government, opposition (Nusra, Free Syrian Army), so-called Islamic State (IS or Daesh) and semi-autonomous Kurdish areas. The Whole of

<sup>2</sup> Taleb ZB, Bahelah R, Fouad FM, Coutts A, Wilcox M, Maziak W. Syria: health in a country undergoing tragic transition. *International journal of public health*. 2015 Jan;60(1):63-72.

<sup>3</sup> Abbara A, K Blanchet, Z Sahloul, F Fouad, A Coutts, W Maziak. The Effect of the Conflict on Syria's Health System and Human Resources for Health. *World Health & Population* 2015; 16(1): 84–92.

<sup>4</sup> Jefe-Bahloul H, Moustafa MK, Shebl FM, Barkil-Oteo A. Pilot assessment and survey of syrian refugees' psychological stress and openness to referral for telepsychiatry (PASSPORT Study). *Telemed J E Health*. 2014 Oct;20(10):977-9. doi: 10.1089/tmj.2013.0373.

<sup>5</sup> Alpak G, Unal A, Bulbul F et al. Post-traumatic stress disorder among Syrian refugees in Turkey: a cross-sectional study. *Int J Psychiatry Clin Pract*. 2015 Mar;19(1):45-50. doi: 10.3109/13651501.2014.961930.

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Syria approach, though well-intentioned has not been effective due to difficulties co-ordinating the response across these areas.

9. **Weak service coordination** is a major challenge in the context of MHPSS. Innovative MHPSS service delivery models are emerging in neighbouring countries, including those led by Medecins du Monde (Mdm) in Lebanon. Mdm use a case management approach with input from psychotherapists, social workers, and oversight from a technical advisor. Their success may partly be attributable to wider political commitment to mental health in Lebanon exemplified by the National Mental Health Strategy. Services operate most effectively when closely integrated with existing primary and secondary health care provision. Inside Syria, the WHO is working with 10-12 primary health care clinics to improve access to MHPSS in government controlled areas.
10. **Access to health services** is a major problem both within Syria and surrounding countries. Health outcomes in neighbouring countries are impacted negatively by legal restrictions (relating to access to registration of refugees, access to employment opportunities in neighbouring countries) which impact on health as well as the dominance of the private providers in countries such as Lebanon which has driven up the financial costs of the response. In Lebanon 85% of the health services are privately owned. It is estimated that 45% of those living outside of the camps in Jordan are unable to register and are therefore not granted access to health services. In Lebanon, registration of Syrian refugees ceased in early 2015 with increased border restrictions.
11. Inside Syria, health service delivery has been undermined both by direct damage to facilities (half of the country's public hospitals have been damaged or destroyed, and 27% of primary health facilities are now out of service) and damage to critical infrastructure – including electricity and water supplies – on which health services depend. However, there are important variations in health service delivery across the country with significant differences between government and non-government controlled areas.
12. There are critical shortages of **essential medicines** inside Syria, prices of many of which have risen to a level beyond the means of most Syrians. Particular note is made of besieged and difficult to reach areas inside Syria where an estimated 640,200 civilians reside without access to medical or humanitarian aid; in these areas, many of those requiring urgent treatment die due to a lack of basic healthcare, equipment or medicine. Other than a lack of essential medicines, equipment, expertise or humanitarian aid, restricted access to these areas directly impacts healthcare provision.
13. From a **workforce** perspective, at least half of healthcare workers (HCWs) have left Syria. Of the remaining, more than half are nurses and few experienced physicians or surgeons remain. For HCWs in Jordan, Lebanon and Turkey, there are limited opportunities for on-going training and restrictions with strict penalties for those found to be working or providing healthcare, even to fellow Syrian refugees. There are particular workforce challenges in mental health: prior to the conflict there were less than 100 psychiatrists across Syria and no psychiatric nurses. There are just 71 psychiatrists in Lebanon today, mostly working in Beirut. Provision in rural and poorer urban areas in Lebanon is fragmented. Some organisations are providing inappropriate care using poorly trained workers – with potentially harmful consequences.
14. Strengthening **health information systems (HIS)** and provision of timely, relevant, high-quality data is a priority to ensure the correct identification of current and future health priorities. There have been a number of surveys conducted on refugees' health profiles and use of services with limited evidence on the quality of services provided, access to services, appropriateness of referrals and affordability of care across public and private providers. HISs relevant to NCDs was highlighted as a particular priority. This will impact on quality of healthcare provision and the monitoring and evaluation of interventions. A lack of information from particular areas inside Syria (eg Daesh controlled areas) is highlighted as a particular concern. Use of community-centred healthcare delivery models in order to collect data and participatory feedback loops to address continuity of care and accountability to donor populations is also important.

#### The response to date and gaps identified

15. There has been a lack of **funding commitment for health** in response plans. The focus is now on livelihoods and education yet health and access to health care are fundamental components that will affect

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the success of these policies and interventions. Practical interventions must be explored in lieu of traditional intervention models – for instance, unemployment is a main source of chronic distress for Syrian refugees, thus there may be good reason to believe that investing in livelihoods programming may improve mental health outcomes at scale more significantly than traditional therapies.

16. Gaps include major **shortfalls in routine monitoring and evaluation** systems for health programmes and interventions targeting Syrians inside Syria and in neighbouring countries. There are examples of funded projects and interventions which lack an impact evaluation component or a real-time monitoring system. This makes it very difficult to determine whether programmes are having impact, and undermines the effectiveness of the response.
17. In addition, there is a **need for validated interventions** for Syrian populations. In mental health, for example, some interventions that have been validated elsewhere (e.g. Teaching Recovery Techniques, an intervention designed to give children affected by war better coping strategies for psychological stress) show promise, but it is unclear what other service models might be appropriate and implementation research is in short supply. Similarly, tried and tested interventions for broader NCD management in conflict-affected settings are in short supply – implementation research on this topic should be a priority.
18. Primary epidemiological work on prevalence of disease is difficult to deliver given the complexity of the situation on the ground, but remains desirable to better inform health needs assessments – although there is good evidence from other conflict and post-conflict situations to offer guidance. However, the **lack of timely, reliable data from functioning HISs** is highlighted as a priority on which to base current and future health needs, assess quality of healthcare provision and humanitarian relief.

#### Recommendations

- R1. Commitment to establishing what works, for whom and when:** all those involved in the response should commit to strengthen routine monitoring and impact evaluation of programmes as a matter of course, and ideally to building long-term evaluations into the way that interventions are designed.
- R2. Improving access to healthcare** for Syrians is an urgent priority. In practical terms this remains enormously challenging inside Syria where disregard by the warring parties for medical facilities and the safety of HCWs has been a persistent problem during the conflict. There are various mechanisms by which improved access could be achieved in neighbouring countries, including application of clearer conditionality on aid to neighbouring countries for development and humanitarian needs relating to the crisis. The drive for Universal Health Coverage (UHC) offers an opportunity to remove legal and financial barriers to access to care, with population-wide benefits.
- R3. Funding for health** remains a significant problem in the response more generally. The Network believes that a case can be made for re-allocating funding for development to the emergency response given the gravity of the humanitarian situation in Syria and neighbouring countries.
- R4. Support for healthcare workers' rights to train and work in neighbouring countries** (even on a restricted basis) is essential at policy level, both to provide for Syrian refugees but also to train and maintain the skills of the healthcare workers who would form the future of Syria's health service. Failure to capitalise on the availability of skilled Syrian health professionals to date constitutes a major lost opportunity in the response and one that requires rectification.
- R5. Revisiting the wider objectives of the response:** the Network recommends a process of 'humanitarian transformation' with a consultation on how fit the global humanitarian response systems and the major international players have been in leading the regional response. This should be based on a thorough and independent review of the current response. In this protracted and complicated conflict which is marked by increasing ethnic and religious tensions and increasing civilian casualties, there needs to be a more long-term vision to bridge humanitarian and development policies with nation-building through health potentially used as a negotiating tool.

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#### **About the Syria Public Health Network**

The Syria Public Health Network was established in early 2015 in response to calls for an independent and critical assessment of the humanitarian and health response to the crisis, from colleagues working in Syria and the wider region. It aims to create an independent and neutral space for discussion, analysis and to generate policy proposals for the types of health interventions and research that might help to address current and future health needs in Syria and the region. A key function of the network is to improve understanding of the types of research and interventions that are taking place within the health response, and their political and social determinants. Workshops organised by the network incorporate key people working for UN agencies, donors, iNGOs, NGOs as well as academic researchers, journalists and those working on the ground in Syria and neighbouring countries.

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