UNRWA SYRIA: *Delivery of Health Services in the Context of the Syria Crisis*

BACKGROUND

The Syria conflict is now in its seventh year. It has precipitated a substantial humanitarian crisis, affecting millions of Syrians, as well as 527,000 Palestine refugees previously registered and living in Syria (PRS). Before the onset of the war, 80% of PRS used to live in the greater Damascus area, and the remainder in or around camps close to the major cities of Homs, Hama, Aleppo, Latakia, and Dera'a (UNRWA, 2014a). The protracted crisis has deeply affected the PRS population: 89,000 PRS have been displaced outside the country since crisis onset. Of the 438,000 PRS still residing in Syria, 254,000 have been internally displaced at least once (UNRWA, 2017a) and 43,000 are trapped in hard to reach and besieged areas such as Yarmouk, Khan Eshieh, Muzeireb and Jillin in Dera'a camps (UNRWA, 2017b).

The crisis in general, and the siege in particular, has created a war economy whereby food and non-food commodities are sold at inflated prices; this has recently also affected the price of medications. Prior to the crisis only 6% of PRS relied on UNRWA assistance, while currently 95% of PRS remaining in Syria depend on UNRWA's services and humanitarian aid for survival. Such aid includes cash, food and non-food items (among them hygiene and winter kits) (UNRWA, 2017b). Aid routinely targets the most vulnerable[1], which in the Syrian context include the besieged populations that are hardest to reach and most in need.

The forced migration of PRS – often into Lebanon and Jordan – has placed substantial pressure on receiving countries and has additionally resulted in the fragmentation of community structures and social cohesion for PRS communities remaining in Syria. Being subject to war hostilities, it is presumed that a great proportion of UNRWA staff have themselves fled in search of safety. Estimates from 2017 suggest that the war has claimed the lives of 20 Agency staff members, and left many with life-altering injuries; an additional 26 staff are presumed missing, kidnapped or detained (UNRWA, 2017b). The migration of skilled professionals in particular compromised the availability of education and health care services.

RESEARCH METHODS AND INPUT

The preliminary findings presented in this brief are based on the outcomes of 35 stakeholder interviews in Syria between February and August 2017. Stakeholders included health care and management professionals from three UNRWA primary health care facilities and country level office. The findings are also based on a group model building session with key UNRWA staff members from the Syria field in August 2017. General summary messages are presented to protect participant confidentiality and anonymity, as well as to stimulate constructive discussion and engagement with research findings. More detailed analysis linked to outputs from the group model building session will be disseminated in due course.

[1] Vulnerable PRS are at-risk groups facing one or more of the following difficulties: having security issues, being a woman or a child victimized by violence and/or abuse including GBV, living below poverty line, or facing social exclusion due to disability.

CHALLENGES AFFECTING UNRWA HEALTH CARE DELIVERY

Three principal challenges have compromised UNRWA's ability to deliver health services for PRS remaining in Syria:

1) Destruction of health care facilities and operational difficulties of accessing/operating in hard to reach areas

Prior to the onset of the Syria crisis, UNRWA operated 23 health centres across Syria, in Damascus, Dera'a, Latakia, Hama, Homs and Aleppo. Throughout the conflict, several UNRWA health centers became inoperable either temporarily or permanently, due to damage, total destruction or inaccessibility. In 2013 alone, UNRWA lost 10 health centers (UNRWA, 2014a). Currently, UNRWA operates 15 health centers, 11 health points and one mobile clinic. During the first quarter of 2013, 130,045 patient consultations were reported by the Health Department in Syria, whereas 183,451 patient consultations were recounted during the first five months of 2014. Knowing that UNRWA had more health facilities operating in 2014 compared to 2013[2] (UNRWA, 2014b) suggests that the fluctuation in the number of patient consultations could be due to the prevailing insecurity, irrespective of the number of operating health care facilities (UNRWA, 2013). Although there isn't an official supporting evidence available, however, an important observation made by health care staff point out that PRS prioritized curative over preventive treatments when hostilities were at their peak. This might also have impacted the number of patient consultations. Unfortunately, violence has impacted all Palestine refugee camps in Syria since the very beginning of the crisis. Hard to reach areas appeared as a result of interdictions to enter many of the Palestinian camps. Access to these camps and other hotspot locations is usually delivered through inter-agency convoy missions that are carried out according to strict security processes set by the Security and Safety Division at UNRWA.

2) Restricted availability of necessary human, medical and infrastructural resources/amenities needed to keep health centers operational

Health centers in Syria are operating under resource constraints. The increased rate of migration and displacement of staff, and the lack of qualified personnel in the local labor market, are the principal issues compromising staff availability at clinics. Laboratory consumables and medications are sometimes not available due to time-consuming procedures that delay the dispersal of stock at the Central Pharmacy in Damascus and/or obstruct the transportation of resources between the Central Pharmacy and clinics. Other amenities such as water and fuel oil are also scarce.

3) Changing health and community needs

The protracted conflict has resulted in a change in health needs: war-related injuries are becoming more common, resulting in long-term disabilities. Displacement (over 60% of PRS are internally displaced) and prolonged exposure to dangerous situations, has exacerbated psychological traumas and depleted the population's ability to cope with stresses. Thousands of PRS require food and non-food assistance, shelters and protection services, especially populations living in hard-to-reach or besieged areas.

As the situation in Syria remains volatile, UNRWA is expected to serve the PRS population while facing substantial challenges in the delivery of health services

[2] In 2014, UNRWA provided primary health care to approximately 37,000 PRS/ month from January- May in its 14 health facilities and 9 health points, whereas UNRWA served 43,350 PRS in its 13 health centers and 9 health points in 2013 (UNRWA, 2014b). Comparison between these two years is relevant as the Family Health Team (FHT) approach, known to affect the number of patient consultations, wasn't implemented in Syria yet.

CONTINUING SERVICE DELIVERY DURING CRISIS: THE RESILIENCE OF THE UNRWA SYSTEM

Current research suggests that a health system can be considered resilient if it is capable of responding to shocks or stressors, and their aftermath. This can be done by: a) addressing population needs with available human, financial and organizational resources (absorption), b) adjusting how the system's resources operate without changing system structure (adaptation), c) creating fundementally new services/ systems of operation that did not exist prior to the shock/stressor (transformation). We list the principal 'resilience strategies' put in place by UNRWA-Syria below.

Absorption

- **High motivation and dedication**: UNRWA staff attend clinics despite security concerns and personal issues. The deep sense of community belonging (since the majority of staff are themselves Palestinian regfugees) motivates staff to serve amid the difficulat and risky context.
- **Task shifting and multi-tasking**: At primary care level, staff cover for each other as/when needed to ensure service delivery; such behaviours assist in managing high-workloads during peak utilization.
- **Fostering coordination and collaboration activities inside and outside UNRWA clinics:** Existing UNRWA collaboration mechanisms with local and international partners were further strengthened via collaboration with the Health Cluster.

Adaptation

- **Establishing new health care delivery points to improve access to health care:** Since the beginning of the crisis, one mobile clinic and 11 health points have been opened; emergency health teams are deployed to areas of active conflict.
- **Adopting safety measures to protect UNRWA health care staff and patients:** The UNRWA Department of Health reduced clinic and staff duty hours and working days: new operating hours are aligned to times when patients are likely to access the clinic and reflect the the severity of the conflict at a certain time and the health staffs' residential closeness to his/her workplace.
- **Changing hospitalization policy:** Recognising the need for further referrals, UNRWA has expanded its referral net across Syria: new agreements were signed with 27 hospitals across the country (10 hospitals prior to the conflict). The contracted hospitals provide secondary and tertiary health care, subsidized between 75%- 95% (UNRWA, 2017b).

Transformation

- **Creating resource buffer stock in hard to reach areas**: Emergency preparedness measures relating to medication availability were insufficient prior to the crisis. Contingency medicine stocks were put in place in different areas to prevent stock rupture in case of critical situations. Clinics were also provided with fuel oil and generators in a similar manner.
- **Introducing new services / offering assistance to patients:** In response to changing health needs, new services were introduced; reimbursement for services/medical products was also altered. Mental Health and Psychosocial Support (MHPSS) services were put in place and will be integrated into primary care: the newly designed MHPSS stepped-care model is designed to enhance the mental and psychosocial well-being of refugees in UNRWA's five fields of operation. Reimbursement was expanded to include prosthetic devices needed to support patients now suffering from war-related injuries (UNRWA, 2016b).

ELEMENTS SUPPORTING RESILIENCE:

1. During the crisis, operational decisions relating to health care were principally taken at UNRWA field office level. This ensured that decisions were timely and context specific and that any changes to service delivery or programs on offer could be tailored specifically to patient and staff needs.
2. While communication in the country was compromised (e.g. due to low internet connectivity), UNRWA staff managed to communicate with each other using communication devices (such as VHF and HF radios) to ensure coordinated service delivery. UNRWA also invested in the purchase of additional armored vehicles and personal protection equipment to facilitate site visits (UNRWA, 2017b).

ONGOING CHALLENGES

1. Despite the fact that emergency interventions differ between fields, all PRS residing inside Syria and in Lebanon and Jordan receive cash assistance and hospitalization coverage for life-saving procedures from UNRWA. While UNRWA received only 35% of the Emergency Appeal in 2016, the Agency continued providing protection services and life-saving assistance to PRS. However, this shortfall meant that UNRWA efforts did not succeed in securing the budget needed for other emergency interventions and was not able to adequately meet 66% of the PRS needs in Syria, 61% in Lebanon and 64% in Jordan (UNRWA, 2016a).
2. Providing the necessary logistic elements that are needed for proper implementation of the Family Health Team (FHT) and Electronic Medical Records (E-Health) system is challenging. Elements such as proper internet service, adequate staff capacity and facility rehabilitation are still lacking.
    - Internet access: Several UNRWA health centers have either no internet access or slow internet connection. This hampers the work efficiency and increases the waiting time at clinics.
    - Staff capacity: Capacity building of health professionals and administrative staff is constantly needed at UNRWA. A training programme for physicians on "Family Medicine" can improve the quality of healthcare delivered through the FHT Approach. Moreover, training courses on Basic Computer Skills are essential as UNRWA is moving away from the labor-intensive and inaccurate paper-based system.
    - Facility Rehabilitation: the UNRWA health centers damaged or destroyed during the armed conflict still require rehabilitation to regain functionality. Repair and maintenance of UNRWA health facilities are identified as a priority in 2017 (UNRWA, 2017b).

Therefore, implementing health care reforms as per UNRWA directives across the Middle East will be difficult in Syria given lack of basic amenities.

IN SUMMARY

Throughout the conflict, UNRWA's priority was to maintain the provision of health services to PRS. The logistical flexibility to respond and adapt to changes in the armed engagement is noticeable as deployed strategies were closely aligned with the PRS population and UNRWA staff needs.

UNRWA's commitment to the improvement of the health service quality in Syria is evident. Despite the challenging environment in 2016 and the lack of resources, UNRWA-Syria attempted the implementation of two substantive health care reforms: the Family Health Team Approach (FHT) and the Electronic Medical records (E-Health) system. Out of 26 clinics, reforms were successfully implemented in 18 and 6 facilities, respectively (UNRWA, 2016b).

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