

Briefing

Urban, Policy and planning

Keywords:
Urban Crises Learning Fund, Syria,
health, informal sector



Syria Public
Health Network



URBAN
CRISES

Issue date
March 2018

Policy pointers

Lebanese policymakers should view displaced Syrian healthcare workers as a vital resource to help meet rising health demands and as essential stakeholders in early recovery plans for Syria, and consider introducing limited registration.

Alongside local educational and professional bodies, donors should radically expand education and training (to help close the generational gap in the Syrian health workforce); and researchers should gather evidence on successful education and training for refugee healthcare workers (to adapt to the Lebanese context).

The livelihoods element of the humanitarian response to the Syrian conflict should include policy measures and interventions to assist displaced healthcare workers.

Data collection and data management systems to monitor the numbers of displaced Syrian healthcare workers in Lebanon, their locations and what their capacities are, should be robustly improved.

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Syrian health workers in Lebanon: supporting an informal workforce in crisis

Syria's health professionals have been displaced to neighbouring countries including Jordan and Lebanon since the devastating civil war began in 2011. Our mixed-methods research focused on Lebanon, exploring the emerging phenomenon of qualified Syrians carrying out informal healthcare work to meet local needs. We found a diverse workforce practising in the informal sector, predominantly in primary care settings and as volunteers. But interviewees reported living in fear of exposure and experience wage discrimination in comparison with locals. We recommend that the Lebanese government consider limited registration for Syrian healthcare workers — enabling them to deliver services formally to Syrian refugees — and that donors radically expand the scale and scope of their support for education and training initiatives in the region to prevent the generational gap in the Syrian health workforce from growing.

Syria's health system has been crippled by a conflict in which the targeting of health professionals has contributed to an exodus of qualified healthcare professionals. Those now residing in neighbouring countries face practical, legal and political barriers to working as doctors;¹ registration is possible for a minority but is costly and bureaucratic. Flagship initiatives such as the Jordan Compact² offer valuable employment opportunities for Syrian refugees, but focus on low-skilled sectors. While the humanitarian response has continually emphasised economic livelihoods and education for displaced Syrians,³ it has overlooked necessary links between these domains and health and healthcare, and in particular, the need to invest consistently along the continuum from health worker training through continuous professional development to workforce replenishment.

This briefing summarises findings from an in-depth exploration⁴ of the position of qualified Syrian

healthcare workers (HCWs), now working either formally or informally, displaced to Lebanon (see Box 1), and offers a series of policy and research recommendations for different stakeholder groups involved in the humanitarian response.

Syrian refugees: distribution and needs

Over the last six years, Lebanon has experienced an unprecedented refugee migration from neighbouring Syria, with 1 million refugees registered as of January 2018.⁵ While UN agencies conventionally view this as an urban refugee phenomenon, displaced Syrians are in fact living across urban and peri-urban areas and often some distance from the major centres (such as Beirut, Tripoli and Saida). Many live in informal makeshift dwellings. Three northern governorates⁶ now host almost 60% of the entire refugee population in Lebanon;⁷ many reside in areas

The need to invest consistently along the continuum from health worker training to workforce replenishment has been overlooked

where a majority of the host population were already living below the poverty line. Health needs among Syrian refugee populations are significant: among those in Lebanon, chronic conditions such

as cardiovascular disease, hypertension and type II diabetes have been predominant since 2012.^{8,9} These conditions often require long-term management by healthcare professionals with regular clinic visits and medication.

The resulting strain on Lebanese public services is reportedly severe,^{10,11} even without the added pressure, many of these areas have struggled historically to attract qualified health professionals to meet local community demand. Syrian refugees often find it very difficult to afford the care they need in Lebanon's highly privatised healthcare system and may need to travel long distances to access specialist services. As a result, the primary public healthcare system has become key in responding to refugee health needs, supported by the Lebanese Ministry of Public Health as well as NGO partners and UN agencies.¹² But there remains a large healthcare gap for Syrian refugees, including those without documentation and those who need affordable healthcare.¹³ This is where the informal market comes into play.

Findings: the Syrian informal healthcare workforce in Lebanon

Note on methodology. To overcome some of the challenges to obtaining information on informal

employment in marginalised communities, we triangulated evidence from multiple data sources:

1. A desk-based literature review
2. A series of key informant interviews with Syrian HCWs
3. A quantitative survey of Syrian HCWs in informal employment
4. A policy stakeholder workshop that explored barriers to and facilitators of informal practice for Syrian HCWs in Lebanon, and ways in which the status and professional prospects of Syrian health workers might be improved.

Workforce make-up. Our survey presents a snapshot of the displaced Syrian health workforce. 40 informal healthcare workers (IHCWs) participated: 57% were male and 43% female; the mean age was 32 years; 80% were working in peri-urban areas. Around 70% were formally registered as refugees; the remainder were either not formally registered or documented as temporary residents in Lebanon.

The sample represented diverse professional groups, but the majority were medical doctors (33%) and nurses (22%), followed by physiotherapists (10%). Other IHCWs — including dentists, pharmacists, psychologists and radiographers — were represented in smaller numbers. All survey participants were actively working and had been doing so for an average of just under three years. All had practiced in their area of specialisation or training, but 25% had also practiced outside this. More than half worked on a voluntary basis. Overwhelmingly, Syrian IHCWs saw patients in primary healthcare settings (77% of respondents); other practice settings included HCWs' or patients homes and private clinics, and in some instances private hospitals. Work in secondary care settings was not reported. Although participants most commonly saw Syrian patients, 60% of the sample also saw patients from Lebanon and other countries.

Experience of life and work. Working in these environments presents varied and severe challenges for many Syrian IHCWs (see Table 1). Legal and administrative factors (including work permits and accreditation) were universally identified as key barriers to formal practice, exacerbated by: persistent fear and distress (including threat of deportation), ethical challenges, discrimination and inability to make a living.

Recommendations for change

Policy recommendations. It is clear that if nothing changes for Syrian HCWs in Lebanon, the situation will likely have a negative effect on the future supply of labour. This outcome would undermine both early recovery efforts when the

Box 1. Who are the 'informal healthcare workers'?

Within this research, 'informal healthcare workers' (IHCWs) are operating in urban and rural contexts, and include:

- Unregistered or non-graduates providing healthcare services in their host communities
- Alternative health providers
- Community health workers (CHWs).

For consistency with existing international frameworks, terminology and ongoing work by the International Labour Organization¹⁴ and the World Health Organization, 'informal economy' and 'informal employment' refer to:

- All economic activities by workers that are (in law or in practice) not covered or insufficiently covered by formal arrangements
- Employment in informal and unregistered establishments and households
- Informal employment (employment without any social benefits and entitlements) in formal (registered) establishments.

The definition does not cover illicit activities.

Table 1. Issues facing informal Syrian healthcare workers in Lebanon

Theme	Sub-theme	Detail
Routes into formal and informal employment	Word of mouth	Local networks are key; approaching Lebanese and informal Syrian employers with CVs not successful
	Process of finding work	Usually takes three to six months to find work, typically initially on a voluntary basis
Facilitators for informal employment	Responding to demand for care among Syrian refugees	Refugees' need for financially and geographically accessible care creates demand for informal provision. For many health workers, the simple fact of responding to unmet health needs among Syrian refugees was a strong motivator for practice. Others felt that trust and cultural affiliation were stronger with Syrian patients
	Livelihoods	Informal work supplements income rather than enabling IHCWs to make a full living
	Skills maintenance	Informal employment is an essential way to maintain clinical skills
	Novel employment opportunities	The informal care system provides opportunities to gain clinical skills in new areas (such as the training of female outreach workers to improve breast cancer awareness among refugees)
	Tacit support from Lebanese organisations and individuals — and a 'blind eye' from authorities	Lebanese organisations and individuals have supplied important backing to Syrian health professionals. This — combined with permissiveness from local authorities in some areas — has provided Syrian HCWs with informal spaces in which to work
Barriers to employment (informal and formal)	Work permits, licensing and accreditation	Most HCWs would like to work in the formal sector but the cost and bureaucracy of legal and administrative permissions were universally cited as major barriers to practice
	Regulatory issues and risks for healthcare workers	Risk occurs at organisational level (fear of closure) and individual level (fear of discovery; challenges of operating without legal or regulatory protection)
	Personal ethics	Some Syrian HCWs were reticent about formal labour market integration as they perceive professional practices in the mainstream Lebanese health system as unethical or even corrupt
	Fear and ongoing distress	Almost all participants highlighted the toll that living in constant fear of being discovered (and threatened with deportation) had on them and their families
	Discrimination	This usually takes the form of much lower wages for Syrian HCWs than Lebanese counterparts; hostility from Lebanese health professionals who saw them as job market rivals was a lesser factor

conflict in Syria ends and the pursuit of Universal Health Coverage (UHC) in Lebanon and the region. At a policy level, legal barriers to registration for Syrian HCWs must be urgently addressed — possibly through limited registration, as enacted in Turkey. Recommendations for the government must recognise the immense challenges to labour market integration of a Syrian refugee population that now accounts for over 25% of all residents. There are, however, key roles for donors in expanding financial support for training and development programmes for Syrian HCWs, and for educational institutions in developing and implementing the necessary materials. See Box 2 (overleaf) for full policy recommendations.

Research recommendations. Key research needs include:

- Further mapping work on HCW numbers, specialties and geographical distribution to support workforce planning
- Information gathering and analysis on current and potential educational initiatives to support

training and development for Syrian HCWs (drawing on evidence from other contexts)

- A reliable and robust figure for the numbers of Syrian HCWs displaced from Syria since 2011.

There is also a pressing need:

- For robust research addressing the current and future burden of health needs among displaced populations, and health workforce requirements to meet them
- To understand the range of educational initiatives that could support training and development for refugee HCWs (based on findings from other contexts) and the potential to replicate these in Lebanon.

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Box 2. Policy recommendations

The Lebanese government:

- Should consider building on experiences in Turkey where limited registration allows Syrian doctors to treat displaced compatriots. This approach was strongly advocated by our interviewees and has support from major international agencies.¹⁵
- Should collaborate with local academic institutions, such as the American University of Beirut, to support completion of training for those whose healthcare studies have been interrupted (also reducing potential risk of malpractice).
- Has a central role in reshaping the prevailing narrative around refugee workers, by (1) emphasising that incorporating Syrian HCWs into the workforce (providing health services to Syrian refugees exclusively) will alleviate pressure on the Lebanese health system; and (2) recognising that assisting and investing in Syrian HCWs is a key human capital development policy that can help movement towards more UHC goals.

Donor organisations:

- May consider placing conditions on financial contributions to drive improvements in working conditions for Syrian IHCWs.
- Should urgently expand financial support for training initiatives for displaced Syrian HCWs, including support to ensure skills maintenance and to help reduce the size of the emerging generational gap in Syrian health workers.
- Could work with the WHO to lobby the Lebanese government to recognise Syrian IHCWs as a human capital investment that can help them move toward UHC. This is a WHO policy priority and could help address the health needs of refugees and deprived Lebanese communities who cannot afford large 'out-of-pocket' healthcare expenditures.

International NGOs:

- Should continue to lobby decision makers and ministries in Lebanon, emphasising that employing Syrian HCWs in the humanitarian response is a win-win option: helping meet immediate health needs **and** supporting economic livelihoods for a large and increasingly impoverished section of the population.

Educational and professional bodies:

- In Lebanon, should set up training programmes to support Syrian HCW skills maintenance (with donor and/or government support) and forge links with institutions in other countries that are either (1) currently providing opportunities to Syrian health workers or students, or (2) providing training in highly specialised areas where demand for skilled practitioners is significant.
- Should consider developing new curricula to support task-shifting initiatives to either retrain existing Syrian HCWs or support the development of wholly new workforce occupations that address the mismatch between health needs and existing workforce supply in Lebanon.

Notes

¹ Fouad, FM, Alameddine, M and Coutts, A (2016) Human resources in protracted crises: Syrian medical workers. *The Lancet* 387(10028), p.1613. /

² The Jordan Compact is an international aid experiment under which Jordan has been offered concessional loans and preferential trade terms in return for opening its labour market to some of the estimated 650,000 refugees who fled there during the war in Syria (see: www.odi.org/publications/11045-jordan-compact-lessons-learned-and-implications-future-refugee-compacts; last accessed on 20/02/2018). / ³ UN/ Government of Lebanon (2017) Lebanon Crisis Response Plan, 2017-20. www.3rpsyriacrisis.org/wp-content/uploads/2017/01/Lebanon-Crisis-Response-Plan-2017-2020.pdf (last accessed on 20/02/2018). / ⁴ Ismail SA, Coutts AP, Rayes D, Roborgh S, Abbara A, Orcutt M, Fouad FM, Honein G, El Arnaout N, Noubani A and Rutherford S (forthcoming) Refugees, healthcare and crises: informal Syrian health workers in Lebanon. IIED, London. <http://pubs.iied.org/10856IIED> / ⁵ As of December 2017. UNHCR/UNICEF/WFP (2017) Vulnerability Assessment of Syrian Refugees in Lebanon 2016. <https://reliefweb.int/sites/reliefweb.int/files/resources/VASyR2016.pdf> (last accessed 20/12/2017). / ⁶ Lebanon is divided into eight governorates, all except Beirut and Akkar are divided further into districts. / ⁷ UNOCHA (2017) 2018 humanitarian needs overview: Syrian Arab Republic. <http://bit.ly/2shN1RP> / ⁸ Coutts, A, Fouad, F and Akik, C (2015) Understanding the Use of Segregation Measures in Primary Healthcare Settings in Lebanon. Unpublished paper prepared for the European Union, Instrument for Stability project. Lebanon. / ⁹ Doocy, S, Lyles, E, Hanquart, B and Woodman, M (2016) Prevalence, care-seeking, and health service utilization for non-communicable diseases among Syrian refugees and host communities in Lebanon. *Conflict and health* 10(1), p.21. / ¹⁰ Hobballah, A. 'Lebanese health care system: challenge and solutions'. Presentation at MedHealth Beirut 2013. / ¹¹ World Bank (2013) Economic and social impact assessment of the Syrian conflict. Report No. 81098-LB. / ¹² DfID (2016) Seeking Sustainability for Refugee Health Care in Lebanon: Review and Recommendations. DfID, London. / ¹³ UNHCR (2015) Multi sector needs analysis. Health chapter prepared by Dr A P Coutts. <https://data.unhcr.org/syrianrefugees/download.php?id=5397> / ¹⁴ ILO (2015) Resolution concerning efforts to facilitate the transition from the informal to the formal economy (ILC, 104th session). / ¹⁵ As evidenced in the Jobs Make a Difference report. UNDP/ILO/WFP (2017) Jobs Make a Difference: Expanding Economic Opportunities for Syrian Refugees and Host Communities. www.arabstates.undp.org/content/dam/rbas/doc/SyriaResponse/Exec-Summary-Jobs%20Make%20the%20Difference.pdf (last accessed 20/12/2017).



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This paper is funded by the UK Department for International Development (DFID) through the Urban Crises Learning Fund. The fund is part of DFID's Urban Crises Programme on the urban aspects of humanitarian action, which involves IIED and the International Rescue Committee (IRC).

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ISBN 978-1-78431-566-5

This research was funded by UK aid from the UK Government, however the views expressed do not necessarily reflect the views of the UK Government.

