Syria Public Health Network

CHATHAM HOUSE
The Royal Institute of International Affairs

Policy brief
Syria's health: the silent burden of chronic diseases

Background: non-communicable disease among Syrians

1. Syria had undergone an epidemiological transition from communicable to non-communicable diseases (NCDs) before the conflict with a particularly high burden of cardiovascular disease (CVD) and diabetes. For example, in 2004, it was estimated that CVD was responsible for more than half of all causes of mortality in Aleppo[4], due in part to the high prevalence of risk factors for CVD, such as hypertension, obesity and smoking amongst the Syrian population[2].
2. The magnitude and duration of the conflict and the resulting mass displacement has had a profound effect on NCD care across the region, with unprecedented increases in untreated NCDs. A range of studies[1], and most recently a five-country regional situational analysis conducted by the WHO Eastern Mediterranean Regional Office (EMRO), demonstrated that before the crisis 79% of mortality was related to NCDs. In Syria, post-crisis, this is now 46% mainly due to the increase in trauma-related mortality. The most common NCDs among the Syrian population are: diabetes; hypertension; chronic respiratory conditions; cancer; mental health disorders, particularly schizophrenia, psychosis and major depressive disorder.

The situation on the ground and challenges for NCD care in Syria and neighbouring countries

1. ***Governance and health services***

a. *Health systems* in the region are diverse and a distinction needs to be made between Syria and neighbouring countries in terms of service delivery organisation and governance. NCD services are delivered by a mix of public, private, NGOs and UN agencies, often in the context of human resource limitations and a lack of funding. The lack of capacity in health systems and among local actors in Syria has limited NCD care. Improving the ability of the humanitarian sector and local health systems to respond effectively to protracted crises, including addressing long-term public health solutions, access to services and quality of care is a priority in addressing NCDs. Lesson-learning from examples of effective integration of NCD care into existing primary healthcare (PHC) services should be shared, such as UNWRA who also developed an emergency funding system and established parallel health information systems for NCD care.

b. *Referral pathways:* PHC systems and referral pathways vary by country. Given that NCD care is often complex and may require secondary and tertiary care, the plans for hospital-based care of NCDs need to be defined in each setting with clear referral pathways and management protocols as currently there is a lack of standardisation of protocols and indicators for NCDs.

c. *Access to healthcare:* Inequity in access to healthcare may be seen between host communities and Syrian refugees and this can create social tensions. Additionally the vulnerability of particular groups, both within Syria and in neighbouring countries, must be considered and specific needs assessed. As noted in our previous policy briefing, 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.

2. ***Response coordination and health workforce***

a. *The humanitarian health response* has been fragmented in Syria and surrounding countries and shaped around a short-term crisis response. Difficulties in humanitarian relief coordination within Syria has limited NCD response and the ability to collect information.

b. *Data sharing* across organisations is limited, including few platforms where countries can share experiences regarding NCD care. There is also still a lack of adaptation of HIS tools for NCD management.

c. *Health workforce:* At least half of healthcare workers (HCWs) have left Syria and of the remaining, more than half are nurses and few experienced physicians remain. This combined with the critical shortage of essential medicines has a very direct impact on provision of complex NCD care. Additionally the level of damage to healthcare facilities has had a significant impact on NCD care; according to HeRAMS data, which assessed 113 public hospitals, only 45% were fully functioning as of March 2016.

3. ***Prevention and health promotion***
NCD prevention and health promotion work remains under-developed. There are examples of community engagement approaches for health promotion that are effective. However the policy environment in each country, including broader policies at population level such as tobacco control policies, need to be strengthened. The public health impact of behaviour change in emergency settings and difficult environments such as refugee camps cannot be underestimated.

Recommendations

1. ***Promoting steps toward universal health coverage in the region:*** a policy shift towards universal healthcare which integrates refugees and host communities, has a funded national system and prioritises NCDs is necessary. A strategy of prevention adopted with the management of NCDs integrated into PHCs across the region will save time, money and improve health outcomes for NCDs, thereby reducing the burden on secondary healthcare services and UN agencies.
2. ***Protection:*** service design should encourage equal access to healthcare for both host communities and Syrian refugees. Protection and asylum policies in neighbouring countries should also be considered as integral to the health response, with clear acknowledgement of the impact of health policies and border closures on the long-term health of refugees. The health impact of the progressive curtailment of the rights of refugees since the start of the conflict has been profound, with reduced access to food, health and social assistance as a result of international funding gaps, poor access to refugees and internally displaced persons (IDPs) and a lack of livelihood opportunities.
3. ***Service delivery:*** major challenges remain for the quality of service provision for NCDs. To facilitate improvements, purchases should be made from standardised lists of essential drugs, further work should be undertaken to standardise guidelines and protocols alongside standardised training packages. Distinctions should be made taking into account the different health systems within the countries surrounding Syria and inside Syria in both government and non-government controlled areas. Strong leadership and coordination is now needed across the health response if the NCD crisis is to be effectively tackled. The WHO EMRO Emergency NCD toolkit once it is finalised and implemented across the region represents an opportunity for stronger leadership from WHO on the response on NCDs.
4. ***Building capacity:*** the Syrian population itself should be viewed as an asset in Syria and neighbouring countries i.e. Syrian health workers could be an integral and valuable part of the NCD response.
5. ***Data and health information systems (HIS):*** strengthening HIS and the provision of timely, high-quality and reliable data relating to NCDs is a priority to ensure the correct identification of current and future health priorities; this will affect the quality of healthcare provision and the monitoring and evaluation of interventions. It is important to differentiate between the types of NCDs and adjust programmes accordingly; granular information by disease area is not widely available at present. A lack of information from particular areas inside Syria (e.g. Daaesh-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, are important considerations. There is a need for individual healthcare records and for PHC indictors of quality of care to be standardised in order to facilitate comparisons.
6. ***The wider humanitarian system:*** experiences since 2011 have demonstrated conclusively the need for an increased focus on humanitarian response in the context of protracted humanitarian crises and mass displacement. The challenges posed by NCDs reinforce the need for focus on a long-term model rather than a purely emergency approach, with strong coordination and reduced duplication in services. Far greater inter-sectoral coordination and cooperation is needed to tackle health problems across the region. Improving inter-sectoral coordination also means adopting common procurement methods and networks in order to increase the effectiveness of aid delivery.
7. ***Advocacy*** for unrestricted access to the crisis- affected populations across Syria is paramount to ensure that all populations have access to healthcare. Critical health workforce and health facility shortages within Syria should also be addressed urgently in order to prevent further deterioration of health within the country.

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Research needs

1. Timely, reliable data on the incidence of NCDs from functioning health information systems (HIS) on which to base current and future health needs, to enable access to high-quality healthcare provision and humanitarian relief remains a priority. However, detailed risk factor surveys, which are expensive and time-consuming to conduct, should be avoided.
2. There is a need to better understand the social and political context in which NCD care systems operate in the region. The models of care adopted in different countries reflect the degree of integration of NCDs into the primary care system and the history of health sector reforms (financing; service delivery; various degrees of NCD readiness between countries; public-private mix and progressive privatisation; PHC provision) among many other factors. Through documenting good practice across the region, technical guidance can be produced for broader use. In particular, learning from healthcare and NCD provision within previous similar crises is important e.g. Iraq, Afghanistan, Yemen, Bosnia.
3. There is an urgent need to examine which NCD interventions and health interventions more broadly have worked in the response, why and for whom, particularly which ones have been cost effective. Currently there is little evidence of which interventions and programmes have been effective in terms of protecting and improving health and wellbeing.
4. Detailed evidence on the effectiveness of different care delivery models for NCD patients in crisis-affected populations is urgently needed and implementation research on this topic should be a priority.
5. Data-driven assessments of stratification within NCD services are needed. In particular, there is a need for cost-effectiveness analyses to help inform the choice of stratification approach and inclusion of risk assessment systems in order to identify higher-risk groups.

References

1. *Rahim, HFA, Sibai, A, Khader, Y et al. Non-communicable diseases in the Arab world. Lancet. 2014;**383**: 356–367.*
2. *Khattab, A, Javaidb, A, Iraqi, G et al. Smoking habits in the Middle East and North Africa: results of the BREATHE study. Respir Med. 2012; **106**: S16–S24.*
3. *Tageldin, MA, Nafti, S, Khan, JA et al. for the BREATHE Study Group. Distribution of COPD-related symptoms in the Middle East and North Africa: results of the BREATHE study. Respir Med. 2012; **106**:S25–S32.*
4. *Maziak, W, Rastam, S, Mzayek, F, Ward, KD, Eissenberg, T, and Keil, U. Cardiovascular health among adults in Syria: a model from developing countries. Ann Epidemiol. 2007;**17**:713–720.*

*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 and independent and neutral space for discussion and analysis, and to generate policy proposals to facilitate creation of health interventions and research to address the 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. Roundtables organised by the network incorporate key individuals working with UN agencies, donors, iNGOs, academic researcher and those working on the ground in the region. This briefing includes some of the main findings from the Chatham House & Syria Public Health Network roundtable on 3rd June 2016 "Addressing non-communicable Diseases in the Syria crisis." For further information visit our website on: http://www.syriahealthnetwork.org or email syriahealthnetwork@gmail.com*