Rebuilding a health workforce in crisis: Syrian healthcare workers

Key messages

1. No comprehensive data exist on the number and specialties of Syrian healthcare workers (HCWs) in countries neighbouring Syria, but it is clear that the impact of the conflict on workforce supply has been catastrophic with drastic implications for the ability of health systems in these countries to meet the needs of displaced populations now and in the future.

2. Syrian HCWs represent a vital workforce asset providing life-sustaining interventions now, but will also be crucial to health service provision post-conflict Syria. Nevertheless, within humanitarian response planning for the Syria crisis there remains limited recognition of the need to invest consistently in replenishment and development of the Syrian health workforce through education, continuing professional development and other means.

3. Macro-level policy change and initiatives drawing on examples of good practice for HCWs to address this shortfall are imperative, including targeted registration to practice, task-shifting and support for return to practice, international partnerships for training and mentoring, and support for existing medical training, licensing and accreditation initiatives.

4. A successful policy mix will need to take a system-wide approach and account for heterogenerity among Syrian HCWs in terms of levels of training, specialty focus, place of current residence, and outlook on future career and place of residence.

5. Research addressing the number, distribution and specialities of the displaced Syrian health workforce is essential, as is documenting the institutions and funding sources for supporting HCW education and training currently. Estimating the added economic value presented by integration of Syrian HCWs into host country labour markets could help make the case for relaxing restrictions on freedom to practice.

6. A coordinating mechanism or platform which provides leadership and allows for better workforce planning would be beneficial its shape and potential remit remain unclear.

Purpose 1. This document summarises findings from a one-day workshop hosted by the Department for International Development (DfID) and the Syria Public Health Network (SPHN) examining the Syrian informal health workforce in countries neighbouring Syria with a particular focus on urban environments in Lebanon. It draws on findings from an ongoing research project being carried out by SPHN with support from the Urban Crises Learning Fund at the International Institute for Environment and Development (IIED).

2. The paper is a *discussion* rather than a *position* paper. The findings and conclusions reported are those of the authors and event participants only and are intended to generate broader discussion around informal health workforce support needs in the context of the Syria crisis.[1]

The Syrian health workforce: a situation analysis 3. The impact of 6 years of conflict on the health workforce inside Syria has been catastrophic. Estimates of health worker flight from Syria since 2011 vary wildly, from 15,000 to up to 27,000 of as many as 42,000 doctors who lived in the country at the start of the conflict.[2] Direct and repeated targeting of health workers, health facilities, and ambulances mean that it is also now one of the most dangerous countries in which to practice worldwide.[3]

[1] Discussions were held under Chatham House rules. [2] Ismail SA, Coutts AP, Abbara A et al. Mapping Syrian health workforce numbers and labour market access in Jordan, Lebanon and Turkey. Unpublished discussion paper. 2017. [3] Fouad FM, Sparrow A, Tarakji A et al. Health workers and the weaponisation of health care in Syria: a preliminary inquiry for The Lancet–American University of Beirut Commission on Syria. The Lancet. 2017.

Prospects for an imminent end to the conflict – and with it the potential to invest in health system reconstruction at scale inside Syria – presently appear slim.

4. There is consistent evidence that host country health systems – including in Lebanon – are unable to keep up with the level of demand arising from unprecedented population movements since the beginning of the conflict.[4] The crisis has exposed the fragility of the public health systems in Lebanon and Jordan highlighting in particular (1) limited access to good quality healthcare (a problem even before the crisis), and (2) the dominance particularly in Lebanon of the private sector. Over half the Lebanese population is uninsured[5]. The gap between escalating demand for both primary and specialist care and supply has increasingly been taken up by local and international NGOs[6].

5. There are also significant, ongoing challenges to effective mapping of HCW numbers across neighbouring countries, given issues with registration of displaced populations and pronounced legal and administrative barriers to practice. This means that it is presently impossible to say with certainty how many Syrian HCWs are living and/or working in Jordan and Lebanon and in what capacity; most estimates of numbers, specialties and geographical distributions are *ad hoc* and vary by reporting agency or organisation.

6. Despite legal and administrative barriers to practice, some Syrian HCWs (at various stages of training) are working informally in neighbouring countries often under minimal supervision – a situation that presents risks both to quality of care, and to protection of the health workers themselves. Others are working in non-medical roles particularly in the NGO sector, for example as project managers, or as shop-keepers. Workshop participants anecdotally noted that in Lebanon, Syrian HCWs have been forced to register under different professional groups (e.g. concierges) in order to gain work permits.

7. Future workforce supply has been seriously undermined by the shortage of officially approved training pathways for Syrians both within Syria and those displaced beyond its borders. There are particularly pressing needs concerning interruptions to training for undergraduate and post-graduate students with very limited opportunities to resume training within formal institutional settings. This exacerbates the developing generational gap in workforce supply, and urgent policy action is required to address it.

The goals of regional and international support for Syrian HCWs 8. Fundamental questions were raised by participants regarding the framing of initiatives to support displaced Syrian

HCWs in Lebanon and elsewhere.

9. First, there was uncertainty regarding the correct balance between (1) near-term support for HCW integration into host country health systems, and (2) supporting the ability of HCWs to return to Syria when the security situation permits, with training and accreditation to facilitate immediate return to practice (or some combination of the above), and a consensus that both were important, to enable HCWs to meet immediate population health needs in the near-term, and to avoid a generational gap in HCW training - but a difference in opinion pertaining to the likelihood of HCW returning to Syria in the future.

10. Second, policymakers need to consider how to direct support most beneficially. Specifically, what balance should regional and international actors strike between (1) supporting micro-level initiatives and interventions, and (2) addressing macro-level barriers to health workforce development?

11. Assumptions regarding the answers to these questions have been implicit in the narrative concerning displaced Syrian HCWs, which has focused narrowly on training or livelihoods, but rarely on the need to support healthcare workers in the interests of building sustainable health services. Participants acknowledged that Syrian civil society groups have driven support for displaced HCWs, often without effective institutional and financial support from the World Health Organization and donor organisations.

[4] See for example:
http://www.emro.who.int/lbn/lebanon-news/improving-health-care-services-in-lebanon-in-the-context-of-the-syrian-crisis.html [5]

Coutts AP. *A multi sector needs analysis of the humanitarian response in Lebanon: Health sector*. A report prepared for the Norwegian refugee council and UNHCR (Beirut). 2014. Full MSNA situation analysis available at:
https://data.unhcr.org/syrianrefugees/download.php?id=6241; Syria Public Health Network. Rebuilding health workforces in crisis:

The case of the informal Syrian healthcare workforce [paper in preparation]. [6] For example, Medecins sans Frontieres has opened

a paediatric specialist hospital in Lebanon to meet growing health need among displaced Syrians.

Emerging evidence of good practice in supporting Syrian HCWs in Lebanon and elsewhere

Legal status, registration and professional accreditation 12. Case studies of good practice with respect to registration in Jordan and Turkey exist, but significant constraints to

practice remain.

13. In Jordan, personal connections (*wasta*) have permitted some Syrian doctors to treat Syrian patients due to a public sector strained by rising demand and limited funding. However, recent expansions to the labor market continue to exclude Syrian medical professionals and healthcare workers.

14. The Turkish government has implemented a targeted registration scheme for Syrian HCWs offering the ability to practice in Migrant Health Centres (MHCs), building on changes to work permit eligibility that allow Syrians to claim citizenship within 3 years of their arrival in the country. The WHO has been supporting this through training for doctors, nurses and midwives. For doctors, this includes (re)training in primary healthcare (identified as the key need for refugees). However, Syrian HCWs trained to specialist level cannot practice legally within the mainstream Turkish health system – meaning that a parallel refugee health system now exists. Further limits are imposed by variable access to residency

permits.

15. While pre-war accreditation systems for Syrian HCWs continue in government-controlled areas (GCAs) and a new system is emerging in non-government controlled areas (NGCAs) – overseen by the Syrian Board of Medical Specialities (SBOMS) – participants highlighted barriers to accreditation for HCWs in NGCAs and those externally displaced (e.g. absence of a formal system open to Syrians in Lebanon).

Training and continuous professional development 16. Conventional models of health worker training (in particular, the six year duration of undergraduate medical training) may no longer be fit-for-purpose given the scale of health needs both inside Syria and neighbouring countries, and low HCW supply. Task-shifting, changes to training pathways and a renewed emphasis on comprehensive primary care are vital – while maintaining quality and standards of care. mhGAP training in mental health was cited as one evidence-based, task-shifting initiative successfully deployed in Syria; the American University in Beirut have piloted short courses for field health officers to enhance community breast cancer detection.

17. University links offer opportunities to strengthen training and continuous professional development (CPD) support for displaced Syrian HCWs. There are already established links between selected NGOs working with Syrian HCWs and Gaziantep University in southern Turkey, and the potential exists to set up similar partnership arrangements with universities in Europe – including the UK.

18. Ongoing work by selected Royal Colleges in the UK – particularly the Royal College of Surgeons in Edinburgh – was identified as a model for supporting CPD for Syrian HCWs in Lebanon and other neighbouring countries. Programmes focus predominantly on e-learning and peer-to-peer mentoring.

Ongoing research needs 19. **Measuring the scale and scope of population health needs** to which displaced Syrian HCWs would need to respond was identified as a priority by attendees. While snapshot impressions of need among displaced Syrian refugees do exist[7], comprehensive real-time analysis is not yet available.

20. It was accepted that **improved data collection to understand the numbers, geographic locations and specialties of displaced Syrian HCWs** is an essential pre-requisite to improved workforce planning. SPHN are currently conducting a research project to generate primary data on HCW numbers in Jordan and Lebanon – information that could potentially form the basis of future workforce supply projections.

21. The need to **comprehensively map institutions and funding sources supporting HCW education and training in MENA** was identified as a priority by participants.

[7] Successive UNHCR health needs assessment surveys among refugees in Lebanon and Jordan, for example, offer a detailed picture of the burden of non-communicable disease among these populations, and of existing access to healthcare services. These surveys do not, however, capture health need or healthcare access among the unregistered Syrian population in neighbouring countries, which we know to be substantial.

22. The **absence of information on approaches to supporting displaced HCWs in the region historically** was noted. Future work should build the evidence base on what interventions have been attempted previously, and their effectiveness (or otherwise).

23. **Estimating the added economic value presented by integration of Syrian HCWs into host country labour markets** could generate important evidence for advocacy purposes.

24. Whatever research agenda is ultimately agreed should **emphasise regional leadership**, in which local actors take a leading position within the research projects.

Emerging policy proposals 25. This section outlines potential policy options discussed by participants in no particular order; individual proposals do not necessarily represent the settled view of all attendees at the event.

26. Various approaches to encouraging macro-level changes in policy on displaced Syrian HCWs in Lebanon were discussed. These included using **evidence from existing practice as "wedge" issues to press for legalisation** of Syrian HCW status in neighbouring countries (drawing for example on the fact that Iraqi doctors displaced to Jordan have been practising legally for some years). Donor pressure through **use of aid conditionality** is one mechanism for driving change in the status of Syrian HCWs in Lebanon.

27. There was broad acceptance of the **need for educational initiatives for host communities in Lebanon and elsewhere to challenge negative perceptions of displaced persons**. The nature and scope of these initiatives requires further development.

28. While examples of good practice already exist, there is a pressing need to **expand the scale and scope of financial assistance for training of future HCWs** – through scholarships and programme-level support to address the generational gap in workforce training. Existing initiatives are small-scale, fragmented and cannot meet the level of health need in host countries currently, or likely future health need in a reconstructed Syria. Equally, **innovation in duration, content and delivery of training will be required** to meet rising need in the context of limited HCW supply. One proposal was to put in place two, broad models of training – one for already accredited individuals who may have higher or specialist training needs, and one for individuals qualified to bachelors or baccalaureate level who could be trained rapidly as allied health professionals.

29. There was unanimous agreement on the need to **strengthen systems for training and revalidation of qualified HCWs**. Harmonisation of accreditation systems for Syrian HCWs is a key area of need, and should include formal international recognition of nascent accreditation systems being developed to support HCWs inside Syria (e.g. SBOMS) to ensure their ability to practice long-term. Other initiatives could include university pairing arrangements and advocacy work with Royal Colleges in the UK to support mentorship and peer-to-peer learning – for which cases of good practice already exist.

30. The **absence of a coordinating mechanism** to provide leadership for Syrian health workforce development, and exchange of best practice in HCW support on a regional level, was noted.

Next steps 31. To address the need for clearer estimates of numbers, specialties and training needs of displaced Syrian HCWs, SPHN will be embarking on a mapping project with Medecins du Monde in late 2017.

32. A virtual working group will be convened, featuring attendees at the event and other relevant stakeholders, to develop ideas in this briefing and generate an agenda for action. This will include efforts to prioritise areas for intervention, given the breadth of Syrian HCW training and support needs.

33. Further scoping work will identify a funding stream to develop and maintain a platform (in Arabic and English) which connects displaced Syrian HCWs; provides updates about training and learning opportunities (including e-learning sources), changes to registration requirements; showcases examples of good practice; identifies and addresses gaps; and supports research in this area.