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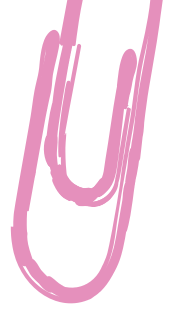

Refugees, healthcare and crises: informal Syrian health workers in Lebanon

Sharif A Ismail, Adam P Coutts, Diana Rayes, Sophie Roborgh, Aula Abbara, Miriam Orcutt, Fouad M Fouad, Gladys Honein, Nour El Arnaout, Aya Noubani, Hana Nimer and Spencer Rutherford

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In Syria, seven years of conflict has been catastrophic. Thousands of qualified doctors and health workers have left since 2011. In neighbouring countries, informal employment among displaced Syrian health workers is broadly acknowledged. But the scale, scope and nature are poorly documented. This working paper details both the scale and the challenges Syrian healthcare workers face in Lebanon. It explores strategies Syrian health workers use to help cope with barriers such as formal labour market entry, the threat of deportation, ethical challenges in practice, and discrimination.

There is an urgent need to address legal barriers to registration to practise for Syrian healthcare workers. Key further research includes mapping health worker numbers, specialties and geographical distribution to support workforce planning, and research on current and potential training and development initiatives to further support Syrian health workers.

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Acronyms

AUB	American University of Beirut
CPD	Continuing professional development
CV	Curriculum vitae
HCW	Healthcare worker
GHI	Global Health Institute
IDI	In-depth interview
IHCW	Informal healthcare worker
IIED	International Institute of Environment and Development
ILO	International Labour Organization
MAPs	Multi Aid Programs
MENA	Middle East and North Africa
NGO	Non-governmental organisation
PHC	Primary healthcare
SBOMS	Syrian Board of Medical Specialties
SPHN	Syria Public Health Network
UHC	Universal health coverage
UNHCR	United Nations High Commissioner for Refugees
WHO	World Health Organization

Summary

The impact of nearly seven years of conflict on the Syrian health system has been catastrophic. Thousands of qualified doctors and health workers have left the country since 2011, and Syria today is one of the most dangerous countries in the world in which to practise as a healthcare worker.

Although an emerging phenomenon of informal employment among displaced Syrian health workers is broadly acknowledged in some countries neighbouring Syria, the scale, scope and nature of this workforce is poorly documented. A key aim of this research was to detail both the scale of this activity and the challenges that Syrian healthcare workers (HCWs) face in Lebanon. The research also gathered data on the strategies that Syrian health workers have developed to work in the informal economy.

Findings from this work indicate the presence of a diverse, qualified workforce of Syrian health professionals currently practising informally in Lebanon, including physicians, nurses, midwives, psychologists, and health administrators. These health professionals practice overwhelmingly in primary care clinics and although Syrian refugees account for the majority of their caseloads, they do provide limited services to Lebanese citizens in addition to community members from other neighbouring countries.

In the case of Lebanon, the informal employment of Syrian healthcare workers is primarily a peri-urban phenomenon. The humanitarian crisis in Lebanon and Jordan is often referred to as an urban issue, but demand for informal health workers seems to have emerged in peri-urban areas outside the major cities where the cost of living is cheaper for both refugees and HCWs, existing healthcare coverage is more limited, and where it may be easier to operate informally in the labour market away from the scrutiny of central state authorities.

The lived reality of working in these environments for many Syrian HCWs remains extremely challenging. Besides well-recognised barriers to formal labour market entry (residency status, professional registration, accreditation), health workers interviewed for this working paper identified persistent fear and distress (including the threat of deportation), ethical challenges in practice, and discrimination both in terms of pay and attitudes from host populations among the daily challenges of practising informally in Lebanon.

There is little evidence from our research that providing informal healthcare services offers a viable and sustainable source of living for individuals engaged in the system. It is evident that Syrian HCWs deliver services either on a voluntary basis or for minimal financial remuneration.

At policy level, there is an urgent need to address legal barriers to registration to practise for Syrian HCWs – possibly through limited registration. Recommendations for the Lebanese government must, however, be tempered by recognition of the immense challenges to labour market integration for a Syrian refugee population that now accounts for over 25 per cent of all residents of Lebanon. 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 materials for these.

Key research needs include further mapping work on health worker numbers, specialties and geographical distribution to support workforce planning as well as information gathering and analysis on current and potential educational initiatives to support Syrian healthcare worker training and development (drawing on evidence from other contexts).

1 Introduction

After nearly seven years of conflict, the health of Syrians, their health system and its workforce are in crisis. Repeated targeting of healthcare workers (HCWs), health facilities and ambulances inside Syria means that it is now one of the most dangerous countries in which to practise (Fouad *et al.* 2017). Thousands of qualified doctors (to take one workforce cadre) working in Syria in 2011 have left the country (Ismail *et al.* 2017; WHO 2014).[1] In the most insecure parts of the country health worker shortages are dire: the 393,000 Syrians living in besieged Eastern Ghouta near Damascus are served by fewer than 10 surgeons (UNOCHA 2017a; Miles 2017). But health worker protection is also a fundamental issue in neighbouring countries, where many Syrian HCWs are barred from formal practice and instead work informally without regulatory oversight or social protection.

Despite the increasing need to close the gap in refugee health needs and the humanitarian response in host communities, financial, logistical and political barriers have made it difficult to integrate members of the Syrian population with possession of medical or other clinical training (Fouad *et al.* 2016). Research and empirical evidence on this issue is acutely needed in countries such as Lebanon, Jordan and Turkey, which have taken the largest share of Syrian refugees since the onset of the Syrian conflict. In addition, the humanitarian response has continually emphasised economic livelihoods and education for Syrians but has at the same time overlooked the importance of links between these domains in health and healthcare – in particular, the need to invest consistently across the continuum from health worker training, through continuous professional development to workforce replenishment.

The issue of displaced healthcare workers and how to integrate them into host community labour markets has become an important global political and financial issue which has the potential to affect the economic development of countries (Buchan *et al.* 2017). In many countries, the integration and employment of 'migrant' health workers have also become politically contentious, with attendant challenges for policymakers. Importantly, the existing literature is limited in terms of documenting the day-to-day realities of displaced professional groups such as healthcare workers and the implications these may have for local labour markets in host communities, workforce development and reconstruction. A key purpose of this working paper is to explore and describe the social, economic and political challenges faced by displaced health workers, using the case study of Syrian health professionals working informally in urban and peri-urban settings in Lebanon. The research findings outlined in this working paper provide much-needed evidence to support workforce development and improve the living standards, health and wellbeing of the health workers themselves and those they treat.

[1] Media and academics often use the figure that 50 or 70 per cent of the Syrian health workforce has left the country. This figure is unreliable and further rigorous work needs to be conducted to provide robust estimates.

2 Research aims and objectives

This research aimed to help identify and develop workable policy options for Syrian health worker training and development, with a primary focus on neighbouring countries that have experienced a significant inward displacement of Syrian refugees. While our case study here was Syria HCWs in urban and peri-urban settings in Lebanon, we aimed to draw lessons for similar or future protracted and emergency contexts, where there is a need to transition from humanitarian response to investment in local health services, providing capacity building and health system rebuilding.

Specifically, the research explored:

- What is known about the scale of Syrian HCW flight to Lebanon? How is care provided informally by Syrian HCWs in Lebanon? What are their current geographical locations and their links to the formal health system? What are their healthcare specialisations?
- What innovative policies and programmes have local and international humanitarian agencies put into place in host countries to include the Syrian health workforce in the response (eg community health worker programmes)? What is their impact? What recommendations do they have for scaling these up?
- What are the sources of funding for these initiatives, and what are the context-specific barriers and facilitators in implementing these initiatives?
- What – if any – 'task-shifting' initiatives[2] have been undertaken to support health service delivery?
- What is known about the extent of training/capacity building provided for Syrian HCWs among the refugee populations in Lebanon? To what extent are the training and development needs of Syrian HCWs being met in host countries?
- How can the information above contribute to the long-term rebuilding of the Syrian healthcare workforce with a view toward post-conflict reconstruction?

[2] Task-shifting refers to the practice of shifting selected healthcare tasks from higher-trained health workers to less highly trained health workers in order to maximise the efficient use of health workforce resources. Typically, this involves movement of healthcare tasks between medical doctors, nurses and community health workers. This strategy has been broadly advocated as a cost-effective measure in resource-constrained settings, and increasingly in high-income country health systems.

3 Informal health work in fragile and conflict-affected settings

3.1 Defining 'informal healthcare workers'

The term 'informal healthcare workers' (IHCWs) encompasses the vast range of health service providers in both urban and rural contexts. This working paper takes IHCWs to include: unregistered or non-graduates providing healthcare services in their respective host communities, alternative health providers, and community health workers. In order to maintain consistency with existing international frameworks, terminology and ongoing work by the International Labour Organization (ILO) and the World Health Organization (WHO) this working paper takes the informal economy and informal employment to refer to:

[A]ll economic activities by workers and economic units that are – in law or in practice – not covered or insufficiently covered by formal arrangements; and (b) does not cover illicit activities, in particular the provision of services or the production, sale, possession or use of goods forbidden by law, including the illicit production and trafficking of drugs, the illicit manufacturing of and trafficking in firearms, trafficking in persons, and money laundering, as defined in the relevant international treaties (ILO 2015).[3]

Within this definition, informal employment is that which:

[L]acks or has low coverage by social protection, poor or hazardous working conditions and generally low remuneration, and productivity, and a lack of organisation, voice and representation in policy-making – that is, decent work deficits. Statistically, informal employment includes employment in informal and unregistered establishments and households, and informal employment (employment without any social benefits and entitlements) in formal (registered) establishments (ILO 2017; ILO 2015).[4]

Given Syria's developed healthcare system and diversity of the health workforce before the start of the conflict – which sets it apart from low-income country experiences that form the basis of much analysis on IHCWs – the usual classification of the 'informal healthcare workforce' (IHWF) requires adjustment. Of crucial importance is the realisation that there is no dichotomy between formality and informality of this healthcare workforce, but health workers are instead positioned on a continuum between formality and informality. The health workers featured in this working paper all possess core qualifications to provide healthcare, such as a medical degree or relevant health sciences degree, obtained in Syria either prior to the conflict or in the years since it started. However, they are prohibited from engaging in formal practice in their host countries because of legal, regulatory, administrative or other barriers. We acknowledge that there are potentially many healthcare workers practising informally in Lebanon whose education was interrupted during the conflict and were unable to complete their core qualifications and training. There is currently very limited data on the size of this cohort.

Besides the qualifications and practices of health workers themselves, informal health work can also be defined according to the setting in which care is delivered. In this sense, we define the IHWF as providing care outside formalised facilities such as hospitals and private clinics recognised by a regulatory body, such as a ministry of

[3] The ILO further adopted the Transition from the Informal to the Formal Economy Recommendation 2015 (No 204).

[4] See also ILO guides on the statistical definition of informal employment.

health. It may be provided in pharmacies and informal clinics. The location of care provision varies based on context but can take place in the IHCW's home, a shop, a community centre, or in the patient's home as well (Sudhinaraset *et al.* 2013). Their work in a non-formalised capacity has several repercussions. IHCWs receive payments directly from patients and lack financial oversight. More importantly, they lack oversight when it comes to the quality of care they provide. The IHWF is engaged by beneficiaries mostly due to convenience, affordability, and social and cultural inclinations, such as respect and trust within a given community (Sudhinaraset *et al.* 2013).

This working paper will focus on an IHWF comprised of displaced Syrian healthcare workers who are either registered or unregistered with the United Nations High Commissioner for Refugees (UNHCR). This consists of doctors, dentists, psychologists, pharmacists, nurses, medical assistants and technicians who engage in informal healthcare provision that falls outside of the formal healthcare system due to lack of registration or recognition as formal providers in-country and are typically paid directly by patients, including those who provide healthcare on a voluntary basis. This definition may also include fully accredited (or formal) Syrian HCWs who provide informal care 'on the side' to supplement their income. The focus on this specific population is motivated by existing evidence suggesting the large-scale displacement of qualified health professionals to countries such as Lebanon, who have not been able to enter or integrate into the labour market in a formalised manner and therefore risk practice in inadequately regulated environments without due protection for either patients or HCWs themselves.

3.2 Case-study context: health and healthcare in crisis in Syria

The conflict in Syria has been characterised by a persistent lack of regard for the safety of civilians, healthcare workers and health facilities by all warring parties. Recent estimates indicate that over 60 per cent of hospitals and clinics inside Syria have been destroyed and approximately 700 medical staff killed, tortured or executed (Fouad *et al.* 2017). Syria's health system, which was one of the better performers in the Middle East and North Africa (MENA) region before the outbreak of the conflict, has been crippled. Detailed – and above all, reliable – evidence on the scale of HCW flight from Syria is in short supply but is likely to have been substantial since the outbreak of fighting in 2011 (Abbara *et al.* 2015). The effect on access to medical care for Syrians has been severe, not just in government and non-government-controlled areas inside Syria, but also in surrounding countries. In December 2017, approximately 11.3 million people were estimated to require healthcare assistance within Syria (UNOCHA 2017b).

The ongoing exodus of highly skilled workers from Syria – characteristic of crises in middle-income, largely urban settings – affects the ability of aid organisations and governments to deliver emergency humanitarian assistance to people in Syria and the region. This potentially threatens the long-term resilience of the Syrian population and host communities elsewhere. Available evidence on post-conflict reconstruction of health systems from similar settings indicates that rebuilding the health workforce is one of the top priorities for action to ensure strengthened healthcare provision for citizens in both the short and long term. Near-term strategies to meet changing demand in conflict and post-conflict settings – notably 'task-shifting' – may also offer important solutions for displaced populations where host community resources fall short, but must be appropriately designed and tested to fit local needs and to ensure quality of care is not compromised (Roome *et al.* 2014). There is burgeoning consensus on the need to start addressing health workforce development challenges even as conflicts continue, partly because of the level of investment involved in resource terms, but principally because of the length of time involved in developing locally appropriate programmes and training new health professionals to a safe degree of competency (Smith 2005).

For humanitarian actors responding to the Syria crisis looking for sustainable programming options, it could be considered a critical oversight not to invest in the health resources available within the refugee community. In order to support the Syrian health system, with an eye to future rebuilding, the humanitarian community has been exploring ways to leverage Syrian healthcare workers living in host countries, both for the near-term and long-term health of Syrians. This research study is designed specifically to address this concern and provide qualitative and quantitative evidence that can be used to assist in the future design of the humanitarian response.

3.3 Health needs among Syrians and health system responses before and since 2011

3.3.1 The Syrian health workforce before and after 2011

Before the crisis, the Syrian health system was one of the more developed in the region (Ben Taleb *et al.* 2015). Despite low public investment in health services[5] maternal and infant mortality and life expectancy[6] were comparable

[5] Total government expenditure on health in Syria was 2.9 per cent per gross domestic product in 2009.

[6] Life expectancy in Syria increased from 56 years in 1970 to 73.1 years in 2010.

to many southern European countries. Medical training in Syria was based on six years of post-baccalaureate and five years for pharmacy and dental programmes (Ismail *et al.* 2017). However, the density of the health workforce remained low in comparison to other developing countries, with 1.5 physicians, 1.9 nurses, and 0.8 pharmacists per 1,000 Syrians reported in 2010 (Ismail *et al.* 2017).

Similar to other countries in the region, Syria endured disparities in specialties and geographical distribution of skilled healthcare workers were apparent (Fouad 2013). The emigration of Syrian physicians seeking better financial packages and higher standards of living abroad in the USA and the UK further affected the number of skilled HCWs inside Syria. By 2010, regulated health provision experienced several challenges, including an increase in the number of private healthcare providers. These were considered formal, but were not subject to control and regulation practices involving quality assurance and accreditation. This issue remains unresolved due to a lack of a formal system for the accreditation of medical graduates by the Ministry of Higher Education (Ismail *et al.* 2017).

The erosion of the Syrian health system since 2011 – and with it, the number of qualified HCWs living inside the country – has been rapid. Remaining health workers in non-government-controlled areas have been systematically targeted since the beginning of the crisis. In 2016 alone, health facilities were targeted nearly 200 times by the Syrian government and its allies (Fouad *et al.* 2017). As a result, large numbers of specialised and experienced Syrian HCWs have migrated to surrounding countries or retired their services, leaving behind younger and less-experienced HCWs who remain to fill a growing gap in healthcare provision. Further disparities have emerged nationwide driven in part by the breakdown in systems. In non-government-controlled areas, the interim Ministry of Health has set up health directorates, such as those in Aleppo and Idlib, to cater to regulations and management of incoming humanitarian aid, financial support for hospitals and other health facilities, continuing education and overall healthcare regulation in relevant geographical areas. Meanwhile, the Syrian Ministry of Health continues to function independently in Damascus (Ismail *et al.* 2017).

3.3.2 Refugee health needs

Among the many health needs of Syrian refugees in Lebanon[7], chronic diseases, such as type II diabetes, hypertension and cardiovascular disease have been predominant since 2012 (Coutts *et al.* 2013; Doocy *et al.* 2016).[8] These conditions often require high out-of-pocket payments for regular visits and medication within Lebanese clinics, prompting refugees to look elsewhere (eg the informal sector) for more accessible healthcare services (Coutts *et al.* 2015; Parkinson and Behrouzan 2015; UNHCR 2014). Due to the predominantly privatised system in Lebanon, the primary public healthcare system has taken on the bulk of this load, supported by the Lebanese Ministry of Public Health as well as non-governmental organisation (NGO) partners and UN agencies (DFID 2016; UNHCR Lebanon 2015). Although UNHCR provides basic access for registered Syrian refugees to primary healthcare (PHC) clinics,[9] there remains the gap of unregistered refugees without documentation who face challenges in accessing healthcare services throughout the country (UNHCR Lebanon 2015).

3.3.3 Implications of the conflict for neighbouring country health systems

The conflict has not only dramatically disabled the Syrian health system but has also placed considerable strain on the health systems of surrounding countries such as Lebanon, Jordan and Turkey due to the mass migration of Syrian refugees (Fouad *et al.* 2017). Among this population are a cadre of professional Syrian HCWs who seek opportunities to practise in these host countries.

Due to circumstance, some of these health professionals include medical students or early-grade doctors, who could not graduate or specialise after the onset of the crisis. Policies toward this group differ among different host countries, with Turkey arguably making most headway in improving opportunities for continued training and practice. Conditions have often proved very difficult for such trainees, as many are not permitted to enrol in residency programmes, or are forced to repeat their medical education, at the cost of valuable time and money. Some would have been required to study in a new language (Ismail *et al.* 2017). However, even if they were to complete their training, it is not likely they will be able to practise legally due to labour market restrictions.

Since numbers regarding the percentage of Syrian HCWs living in Jordan, Turkey and Lebanon are limited, it is difficult to determine what percentage continue to practise informally (Ismail *et al.* 2017). Given rising refugee health needs and the vast legal and administrative barriers prohibiting displaced Syrian HCWs from gaining

[7] The vulnerability assessment of Syrian refugees (VaSyR) survey (2017) suggests healthcare demand for refugees living in Lebanon is at 67 per cent, with 70 per cent of households reporting similar needs for their children.

[8] A number of studies (Doocy *et al.* 2016) conducted by a collaboration of Johns Hopkins, UNHCR and AUB have highlighted the healthcare needs among refugee populations in Lebanon. In 2017, 67 per cent of adult refugees were reported needing healthcare in the past year, with a further 70 per cent of households reporting their child needing healthcare over the same period. Twenty per cent of households reported at least one hospitalisation in the past year. Common healthcare needs include chronic conditions, with 50 per cent of households reporting the presence of hypertension, cardiovascular disease, diabetes, chronic respiratory disease, or arthritis in the past year. A further 65 per cent of refugees reported an acute illness, including respiratory tract infections, and skin infections.

[9] Syrian refugees registered with UNHCR can have up to 75 per cent of their healthcare covered, leaving an unsubsidised 25 per cent for Syrians to pay out-of-pocket.

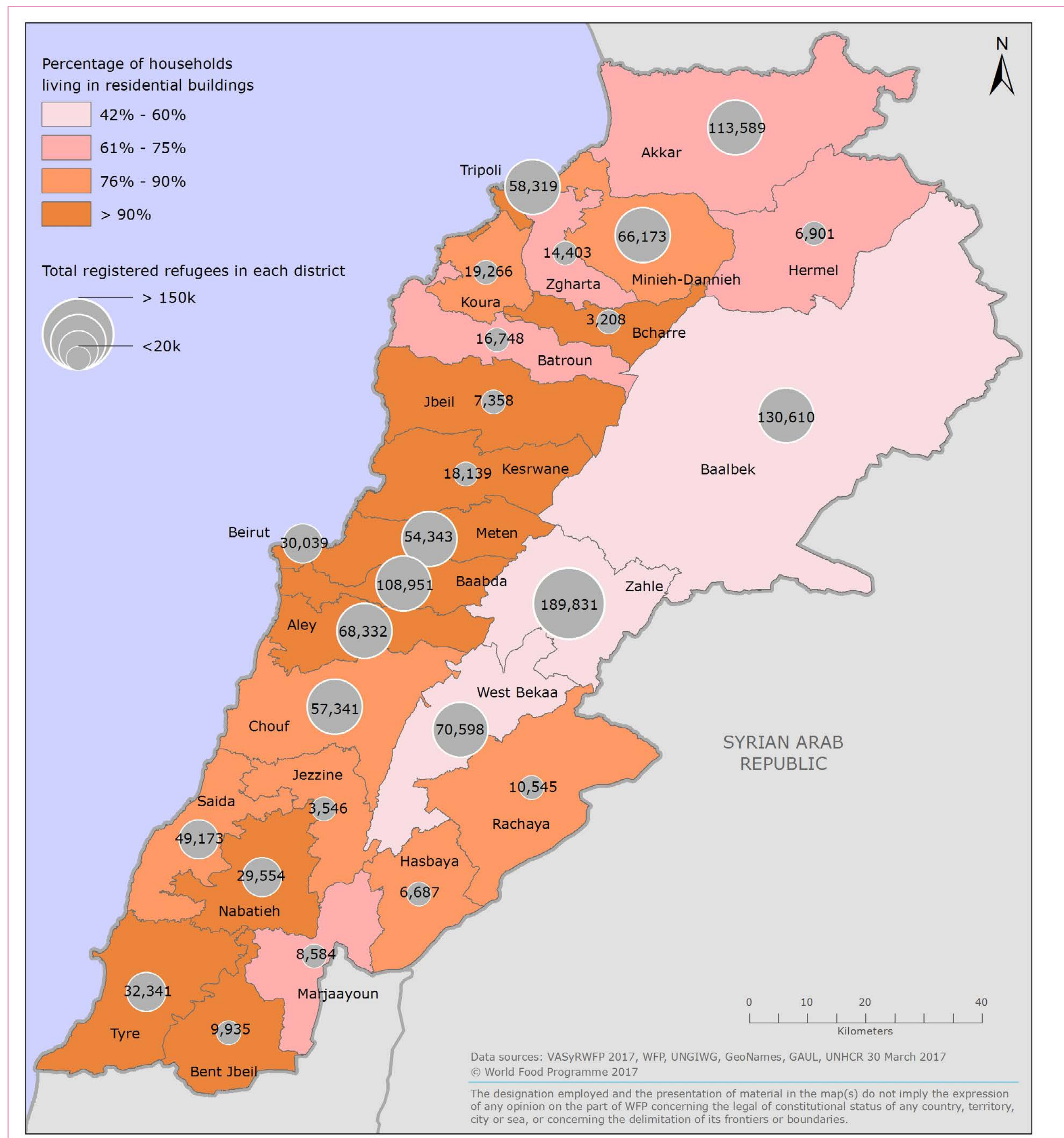
formal access to healthcare institutions, the rise of an informal health system and network could be viewed as a pragmatic humanitarian response.

3.3.4 Lebanese healthcare system and Syrian refugees: a source of tension?

Over the last six years, Lebanon has experienced an unprecedented refugee migration from neighbouring Syria, with at least 1 million refugees registered in Lebanon as of December 2017 (UNHCR 2017b). This has put a severe strain on the public services of Lebanese host communities and governmental authorities from central through to local (municipality) levels (Hobballah 2013; World Bank 2013). UN agencies conventionally view the Syrian refugee phenomenon in Lebanon as an urban one, given the absence of formal camps for this demographic. However, this overall assessment belies a complex reality in which refugees are distributed across urban and peri-urban areas of Lebanon, often some distance from the major centres (Beirut, Tripoli and Saida for example), and often living in informal makeshift dwellings (Figure 1) (UNHCR *et al.* 2017).

The regions of Akkar, Tripoli and Bekaa in particular have hosted almost 60 per cent of the entire refugee population (UNOCHA 2017b). It is estimated by the United Nations that refugees are residing in areas where 67 per cent of

Figure 1. Distribution of Syrian refugees living in Lebanon by district, and percentage of refugees in each area living in residential buildings



Source: UNHCR *et al.* (2017)

the host population was already living below the poverty line (UNHCR *et al.* 2017). This means that in many communities, refugees share the already limited public services such as health and education and compete for employment opportunities with host communities. As a result, increased utilisation of already overstretched and underfunded public health services has reportedly led to a rise in tensions between host communities and the refugee population.

The evidence relating to the actual rise in tensions is mixed. Reports have tended to originate from media outlets which have mostly portrayed Syrian refugees as a burden and dangerous to the stability of Lebanon. Another source is anecdotal evidence presented by NGO partners at UNHCR sector working groups. A large-scale survey of community tensions found that 61 per cent of the 446 surveyed host communities witnessed refugee-related incidences of tension or violence (Carnegie Middle East Centre 2014).

Overall community tensions in Lebanon and in neighbouring countries affected by the Syrian refugee crisis appear to be primarily over access to employment opportunities. Numerous studies have found Syrians are blamed for the increasing levels of unemployment among host communities as they are willing to accept work for lower wages while still benefiting from humanitarian aid (Harb and Saab 2014).

In the health sector, overstretched public health services have reportedly caused tensions, as host communities experience reduced access. There are reports of shortages of chronic disease medication and a lack of beds in public hospitals. Prior to the Syrian conflict, over 50 per cent of the Lebanese population did not have access to formal health insurance, relying on underfunded and often poor-quality health services (UNHCR 2014). Given limited universal health insurance in Lebanon, people are faced with large out-of-pocket payments in order to access care (Salti *et al.* 2010). Very often, individuals will forego medical care due to the cost barriers in such situations or will pay the medical fees, exacerbating indebtedness and deprivation often referred to as 'catastrophic' health expenditures (DFID 2016; UNHCR 2014).

In addition, there is a perception and attitude among deprived Lebanese communities that Syrian refugees receive preferential healthcare treatment, due to humanitarian assistance covering part of the consultation fees (International Alert and Integrity Research and Consultancy 2014). According to WHO, 'host communities also fear infectious disease outbreaks due to increasing numbers of refugees living in unsanitary informal settlements' (WHO 2014). This has contributed to the development of prejudice and stigmatisation of refugees among the local communities.

The most recent examination of the links between access to healthcare services and community tensions was conducted by the University of Sagesse (Lebanon) in 2014, with a follow up in 2016, on behalf of UNHCR under the European Union-funded project Support to Conflict Reduction for the Vulnerable Population of Lebanon (UNHCR and University of Sagesse unpublished). The baseline study identified the sources and causes of conflict in a sample of Lebanese communities. It found that Lebanese referred to 'competition over employment, perceived economic advantage of Syrians (due to living conditions support provided by international organisations) and healthcare access and provision' as sources of conflict. Refugees were reported to access all required healthcare services at a lower out-of-pocket cost given the support provided by various national and international organisations, while Lebanese were paying the full cost of services. This discrepancy in out-of-pocket expenses in healthcare was perceived by Lebanese as unfair.

4 Research methodology

Given the limited evidence on the existence of an informal health system and healthcare workers in Lebanon and the well-recognised challenges to obtaining information on these marginalised groups, the methodology for this project was designed to triangulate evidence from multiple data sources. In collaboration with our partners at the Global Health Institute (GHI) at the American University of Beirut (AUB) we carried out:

- A desk-based literature review,
- A series of in-depth, key informant interviews,
- A quantitative survey of Syrian HCWs, and finally
- A policy stakeholder workshop.

Our aim was to explore barriers and facilitators to informal practice for Syrian HCWs in Lebanon, and ways in which the status and professional prospects of Syrian health workers might be improved. Findings from these four strands were integrated by the research team in the latter stages of the project, using themes identified from the literature review and interviews.

4.1 Desk-based literature review

A review was conducted to provide background on the topic of a Syrian informal healthcare workforce since 2010. Academic and grey literature, and news sources regarding the Syrian healthcare workforce presence in Jordan, Lebanon and Turkey were scoped using the keywords combinations 'Syrian health workers', 'Syrian health workforce', 'informal healthcare providers'.

Due to the limited data and research studies on this topic, a 'snowballing approach' was used to identify sources regarding informal Syrian healthcare workers. A number of definition papers were included in the scoping review to identify inclusion criteria for the population of interest. Previous research studies done by the Syria Public Health Network (SPHN) team as well as resources from AUB were included, highlighting both pre-conflict as well as post-conflict circumstances for this particular population. The review focused on literature regarding this workforce in other contexts, but mainly in countries hosting Syrian refugees such as Jordan, Turkey and mainly, Lebanon.

Research regarding the effect of the Syrian healthcare workforce on the Lebanese health system was highlighted as well as the general profile and qualifications of Syrians in Lebanon since 2011. The aim of the review was to inform the design of the in-depth interviews (IDIs) and survey. A number of key themes were identified from this literature review such as right-to-work and residency issues, the peri-urban nature of the refugee crisis in Lebanon, institutional barriers in the form of the private health system in Lebanon and dominance of the Syndicate of Hospitals.[10]

4.2 Key informant interviews

Respondent-driven sampling (RDS) methods were used to recruit Syrian health professionals (including doctors, nurses, dentists, psychologists, health administrators and laboratory technicians) working informally throughout Lebanon for participation in the study. Initial participants already known to the principal investigators at the AUB GHI were contacted by telephone by members of the AUB GHI research team to introduce the study objectives and request the participation of each health professional in an in-depth interview and assistance in distributing the quantitative survey questionnaire among themselves and colleagues within service delivery centres. IDI interview schedules were available in both English and Arabic (see Appendix 1).

IDIs assessed Syrian health worker perspectives on the types of services provided in their clinics, as well as the processes and functionalities of these services using a semi-structured interview schedule. IDI questions were formulated based on the following domains:

[10] The Syndicate of Hospitals in Lebanon aims to ensure service quality and to promote Lebanon as a referral centre for tertiary healthcare in the Middle East. It represents and serves private hospitals, working in partnership with stakeholders committed to improving and protecting health. See: www.syndicateofhospitals.org.lb/about

- The process and time since the informal health practice had started in their area,
- The location at which these services are being offered,
- The types of healthcare service offered, and
- Obstacles to formal employment and provision of informal health services.

The IDI approach and interview schedule was approved by the Institutional Review Board (IRB) at the AUB. Interviews were administered by two Arabic-speaking research team members from the AUB GHI in a private, quiet room within the health centre or clinic offering health services to Syrian refugees. In addition, two interviews took place at the AUB. Oral consent was obtained at the beginning of each interview for participation and to record the interview using a mobile recording application. Interview length ranged from 15 minutes to one hour.

4.3 Quantitative survey

The quantitative survey included multiple-choice questions addressing:

- Socioeconomic background and demographics, and coping and resettlement mechanisms,
- Healthcare profession and types of healthcare services provided,
- The available funding for these health services, the modality, and time since the informal health practice has started,
- The location at which these services are being offered, and
- The level of refugee accessibility to these health services, including the benefits and challenges in providing informal health support to this demographic.

The quantitative survey sampling approach was also respondent-driven and the questionnaire was administered by two alternative routes: either interview participants were asked to fill out a structured survey questionnaire immediately after their interview, or participants were contacted directly to fill out the questionnaire.

4.4 Stakeholder workshop

The final component of the research methodology was a policy workshop held at the UK Department for International Development (DFID), London, 16 October 2017. This event brought together about 30 individuals from a range of organisations including donors, NGOs operating in the field both inside Syria and in neighbouring countries, policy analysts and academic researchers – with an emphasis on Syrian representation. The event combined research presentations with plenary discussions on addressing:

- Syrian HCW numbers in neighbouring countries,
- Major barriers to labour market integration and informal healthcare work opportunities in countries neighbouring Syria (with a focus on Lebanon), and
- Possible policy and research-based solutions to these, as identified by roundtable participants.

Findings from these discussions are given throughout this working paper.

4.5 Caveats and limitations to the analysis

There were a number of caveats in the data collection process and analysis due to the sensitivity of the topic; fear and hesitation from participants; and difficulty in accessing and engaging a significant number of the population of interest.

The ethical challenges surrounding the research topic resulted in difficulties obtaining ethical approval in a timely manner, resulting in severe delays which affected qualitative and quantitative analysis of the resulting data. Furthermore, Syrian health professionals approached to participate in the study demonstrated fear and hesitation when objectives of the study were shared with them. Some of the health professionals contacted arranged a meeting and then cancelled the meeting or dropped out of the interview without a specific reason. This obstacle was mitigated if the participant was familiar with the use of interview data in academic research studies or had a personal connection to a member of the research team.[11] Furthermore, interview participants also showed hesitation during the consent process and when answering questions, depending on the authority and connections of the participant of interest. Female participants showed greater hesitation when disclosing information than male counterparts.

General challenges included accessibility of this population, which depended mainly on word-of-mouth and interviewing participants during their working hours, in which they were often interrupted throughout the interview or could not participate due to work-related responsibilities. Other healthcare professionals approached for interviews opted to participate in the quantitative survey only or in either the interview or quantitative survey. Furthermore, participants were mainly males resulting in an underrepresentation of women among the health professionals interviewed.

[11] In these cases, familiarity between the participant and research team member facilitated trust throughout the recruitment and research process rather than peer pressure.

5

The formal position of Syrian IHCWs in Lebanon: literature findings

5.1 Syrian health worker numbers in Lebanon: what do we know?

Data regarding the number of Syrian HCWs in Lebanon and their given geographical locations are very limited. Current numbers are sourced predominantly from UNHCR registries of refugee professionals and are therefore unlikely to be representative of the whole population since a large proportion of Syrians who have moved to Lebanon since the beginning of the conflict are undocumented.[12]

To practise in Lebanon, medical doctors are generally required to obtain a licence from the Ministry of Health and register with the Lebanon Order of Physicians and Syndicate of Hospitals (see also Table 1). Board examinations are available for those with specialty training (Ismail *et al.* 2017). Doctors providing primary care do not require a licence to practise. Overseas trained clinicians – including Syrians – required formal recognition of their medical qualifications (through the Ministry of Higher Education), and also had to sit board examinations. Fees associated with this process were high (US$50,000 in order to practise in tertiary care settings after passing board examinations, for example) and were a major barrier to workforce integration for overseas-trained medical practitioners.[13] There are some exceptions to this system for overseas-affiliated institutions – notably the American University in Beirut which adheres to USA medical board examinations and licensing procedures (Ismail *et al.* 2017).

5.2 Right-to-work issues

Despite the essential skills that Syrian HCWs could use to support the overextended Lebanese health system and public health services offered to host communities, legal licensing and accreditation, work permits and labour laws continue to be the main obstacles facing Syrian HCWs in Lebanon (Ismail *et al.* 2017). Syrian HCWs are not permitted labour market access in Lebanon unless able to obtain sponsorship and a work permit. A work permit is only granted if residency status has been granted. There are specific, additional requirements for some classes of HCW: in order to practise as a doctor or pharmacist in the country, for example, Lebanese citizenship must have been acquired in the last 10 years (Arab NGO Network for Development 2016). However, significant legal impediments to labour market access for Syrians exist in Lebanon. Firstly, the country is not a signatory to the

[12] According to UNHCR, there are 57 doctors, 305 nurses, 20 associate nurses and midwives, and 68 paramedical staff among refugees living in Lebanon as of January 2017; no indication whether these are informal or formal practitioners (source: interview data compiled for this project).

[13] Research work is ongoing as part of this project to identify the processes through which other HCWs acquired the ability to practise in Lebanon.

Table 1. Summary of professional status considerations for Syrian health workers who wish to practise in Lebanon in comparison with Jordan and Turkey – the two other major recipient countries

COUNTRY	FORMAL LICENSING AND ACCREDITATION REQUIREMENTS	CONTINUING PROFESSIONAL DEVELOPMENT (CPD)	LABOUR MARKET ACCESS FOR SYRIANS
Jordan	▪ Recognition of educational qualifications ▪ Licensing through the Ministry of Health ▪ Registration with the relevant professional association ▪ Board examinations for specialist doctors	▪ No formal system	▪ Not permitted to practise
Lebanon	▪ Recognition of educational qualifications ▪ Licensing through the Ministry of Health ▪ Registration with the relevant professional association ▪ Board examinations for specialist doctors	▪ No formal system	▪ Not permitted to practise
Turkey	▪ Recognition of educational qualifications ▪ Licensing through the Ministry of Health	▪ Limited CPD activities through the Ministry of Health: certificates in family medicine, emergency medicine and others	▪ To treat Syrians only (in migrant health centres – not in the wider health system)

1951 UN Refugee Convention and its 1967 protocol, which establish the rights of refugees to engage in wage-earning employment and self-employment. There is also no explicit right for refugees to work mentioned in the labour legislation of Lebanon.

In addition, entry to the formal labour market for Syrians in general has been progressively eroded as legal barriers and stricter residency requirements have been introduced (ILO 2016). First, the system for applying for first-time and renewed permits has become extremely slow and difficult to navigate. According to interview data, in 2013, just 508 first-time work permits were given to Syrian nationals (out of a total of nearly 50,000 first-time work permits) and 725 existing permits for Syrians were renewed in the same year.[14] Syrians are frequently unable to renew their permits in time.

Second, the scope of rights available to Syrians has been progressively curtailed. In December 2014, the Lebanese Ministry of Labour implemented Decree 197 limiting possible work for Syrian nationals to the agriculture, construction and cleaning-service sectors – automatically disbarring HCWs from full labour market participation in the country. Until 2015, those Syrian refugees who were able to obtain sponsorship and a work permit had their legal status changed to that of 'migrant workers' and were able to work in those industries. Following mounting social unrest and problems with public services provision, the Lebanese government suspended this right in 2015.

An exception throughout the region is the participation of Syrian HCWs in the operation of international and local humanitarian agencies. NGOs such as the International Medical Corps continue to train Syrian staff as community health workers. Syrian health professionals from Multi Aid Programs (MAPs)[15] stated that, if qualified, Syrian HCWs such as doctors were granted work permits from the Lebanese Ministry of Labour, a number of the challenges experienced by the Lebanese health system would be alleviated (Rutherford 2016). However, capacity building at the current rate cannot keep up with the growing and pressing health needs of the population.

[14] By this stage, UNHCR had registered nearly 860,000 Syrian 'persons of concern' in Lebanon.

[15] MAPs is a Syrian grassroots organisation backed by a virtual Lebanese advisory board, which is providing care to an ever-increasing number of Syrian refugees in Bekaa and elsewhere.

6 Lived experiences of informal Syrian HCWs in Lebanon: findings

This chapter brings together findings from qualitative and quantitative field research with Syrian HCWs working informally in Lebanon.

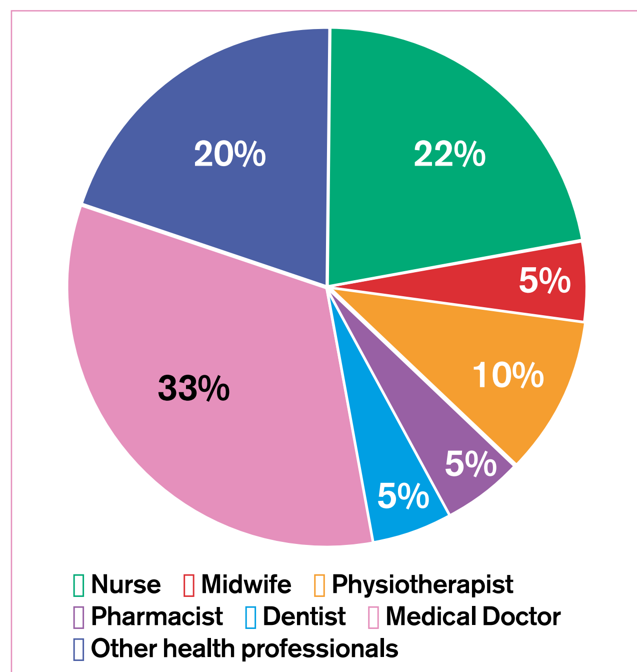
6.1 Who are the informal Syrian health workforce in Lebanon?

A total of 40 healthcare workers participated in the quantitative survey – a proportion of whom also contributed to qualitative data gathered on lived experiences (see figures 2 and 3). Because of the sampling approach used in this study, we report the results of this survey as an indicative snapshot of the characteristics of informal Syrian health workers living and working in urban and peri-urban areas of Lebanon. The hard-to-access nature of the study population, and the contentiousness of the subject matter, mean that the picture presented here necessarily cannot be comprehensive (a point to which we return in depth in the discussion).

The study sample was relatively evenly split between males (57 per cent) and females (43 per cent), and this population was generally young (mean age of 32 years) and overwhelmingly concentrated in peri-urban areas (80 per cent). Just over 70 per cent were formally registered refugees in Lebanon; the remainder were either not formally registered or documented as temporary residents in Lebanon.

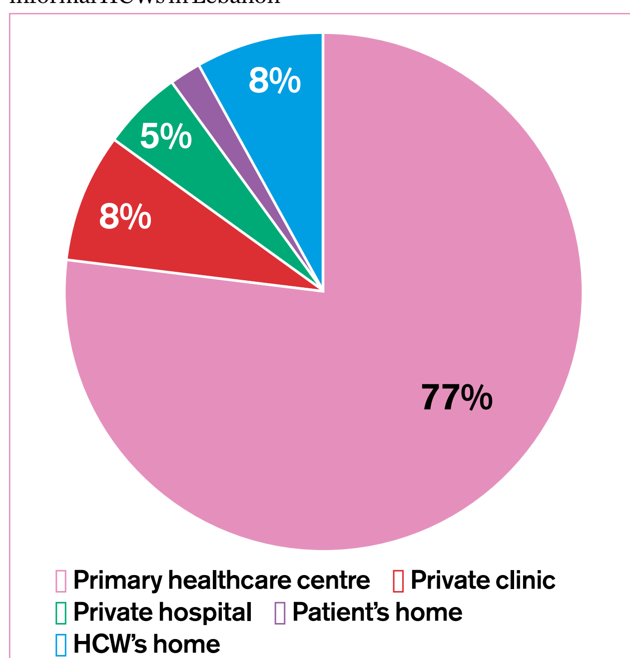
The professional groups represented in the sample were diverse, but a majority were medical doctors and nurses (Figure 2). All survey participants were actively working at the time of the study; on average, these individuals had worked in Lebanon for just under three years and none were actively involved in medical practice inside Syria since then (eg in the context of periodic return journeys across the border). During their time in Lebanon all had practised

Figure 2. Distribution of survey participants by workforce cadre[16]



[16] 'Other health professionals' here refers to groups including psychologists and radiographers.

Figure 3. Reported locations of practice for participating informal HCWs in Lebanon



in their area of specialisation or training, but 25 per cent had also practised outside their immediate area of training.

Overwhelmingly, Syrian HCWs working informally saw patients in primary healthcare settings in Lebanon (77 per cent of respondents) (Figure 3). Other practice settings included HCWs' or patients' homes and in some instances private hospitals, but work in secondary care settings was generally not reported in this group. Although participants most commonly saw Syrian patients, 60 per cent of the sample saw Lebanese, Iraqi and Palestinian patients in addition (among other nationalities). Most (55 per cent) reported working on a voluntary basis. The remainder charged fees if patients were able to pay (18 per cent) or on a fee-for-service basis (26 per cent) while 80 per cent of those surveyed received no additional contributions in kind.

The survey included a small number of questions on barriers and facilitators to practise (themes explored in far more depth in the interviews), and 60 per cent of respondents had encountered formal legal barriers to practise (including an inability to obtain practice licences, registration issues and formal challenges to their status from the authorities, among other factors). Primary motivations for practising despite these barriers included financial reasons alone (34 per cent), and a combination of financial reasons and acknowledged health needs among the communities in which they live (47 per cent).

6.2 The roles of Syrian informal health workers in Lebanon

A total of 23 key informant interviews were carried out in three waves of respondent-driven sampling between late October and early December 2017 to gather data on lived experiences. Table 2 provides an overview of respondent characteristics for the qualitative interviews.

Table 2. Breakdown of interviewees participating in the qualitative data gathering.

CHARACTERISTICS		TOTAL (N=23)	PERCENTAGE OF SAMPLE
Gender	Male	19	82
	Female	4	17
Geographical location	Urban	10	43
	Peri-urban	13	56
Occupation	Medical doctor (physician)	9	39
	Nurse	5	21
	Physiotherapist	3	13
	Pharmacist	2	8
	Dentist	1	4
	Psychologist	1	4
	Other allied health professionals	2	8
Years of professional experience in Syria	<5	15	65
	5–10	5	21
	>10	3	13
Years of experience in Lebanon	<1	4	17
	1–2	6	26
	3–4	9	39
	5 or more	4	17

Interviewees came from diverse professional backgrounds in Syria pre-conflict and varied considerably in the level of post-graduate experience they were able to offer to potential employers in Lebanon. The roles they occupied in the formal and informal sectors varied considerably with a majority in administrative and allied health professional roles rather than frontline clinical work. For those who were practising clinically, most were doing so in primary care or clinic settings as generalists. Depending on the context, opportunities for specialists to use their skills and training varied based on availability of resources for a given specialty (eg radiologists with X-rays, anaesthesiologists with anaesthetics, and surgeons with operating rooms).

Interviewees were united, however, in their approach to seeking work on arrival in Lebanon: by informal methods, principally **word of mouth**. This was partly in recognition of the challenges to formal labour market access for Syrian refugees in Lebanon (on which further detail is given below), but can also be explained by the strength of social networks that pre-dated flight from Syria and seem often to have been geographically based.

For example, a number of informants originated from Homs in Syria and had learnt of potential employment opportunities through contacts from that city, in one case even before their arrival in Lebanon. Those who reported having tried to seek work formally – approaching both Lebanese and informal Syrian employers directly by distributing their curriculum vitae (CV) for example – found this to be a frustrating experience with at least one citing a lack of *wasta* (personal connections) among Lebanese providers. Those with specialisations, such as surgeons, reportedly found it easier to find employment due to sheer need within clinics.

In any event, the process of finding work was often a lengthy one – whether conducted formally or informally. Most interviewees had to wait at least three to six months before finding work, usually initially on a voluntary basis only, working either as support workers to injured Syrians who had been evacuated to Lebanon for treatment, with NGOs, or with Lebanese health providers. Volunteer experiences helped build networks of personal connections with the potential then to identify opportunities to work as informal health providers. HCWs in the study worked either as assistants to Lebanese HCWs or in the employment of organisations majority-run by Syrians and providing informal care to Syrian refugees. None of those interviewed ran independent practices.

6.3 Factors facilitating Syrian HCW employment in the informal sector in Lebanon

6.3.1 Changing health needs and responding to demand for care among Syrian refugees

Various factors seem to have spurred the development of informal healthcare provision by Syrians in Lebanon, among the most important of which are patient factors, including the **perceived financial accessibility of informal care** for Syrian refugees. A blanket charge of US$2 was cited by some interviewees as a particular attraction for Syrian refugees in comparison with the mainstream Lebanese health system, which is seen as prohibitively expensive.

The services we are providing in terms of prices are incomparable. For example, a patient does not have to pay US$150 like elsewhere [...] We are not a for-profit organisation.

Geographical accessibility is also a factor for many Syrian patients given the concentration of refugees in the Lebanese border governorates where the concentration of specialists is relatively low.

Lebanese doctors are clustered in Beirut, so it is harder to find doctors in the rural areas. The [Lebanese] doctors are not encouraged by the government to work in rural areas. Since there are refugees in these border towns, Syrians are working in these areas.

It is also clear that emerging informal providers are **responding to specific healthcare needs** among the Syrian refugee population that are not otherwise being catered for. Besides core healthcare provision, particular gaps seem to have emerged in provision of rehabilitation services (for those refugees who have undergone surgical procedures following injury, for example, but do not receive hospital follow-up care) and social care, which qualified HCWs are helping to respond to. Taken together, these realities are reflected in the caseload for clinics providing care to refugees on an informal basis – where perhaps 90–95 per cent of all patients seen are Syrian.

About 5–10 per cent of our patients are Lebanese. The reason for this is because Syrian doctors are good at what they do. We have a very difficult vetting process to hire doctors. We have a high-quality paediatrician and an ophthalmologist. In the Bekaa Valley, the doctors are not of the same calibre. Lebanese patients here would often go to Syria or Beirut to receive healthcare services. It [Bekaa] was always weaker in terms of offering health services, which improved with the presence of Syrian doctors. Syrian doctors made a difference here. If we did not have

as many Syrian patients placing pressure on the clinics, we would have at least 25 per cent Lebanese presence.

There were mixed views on whether **trust and cultural affiliation** were drivers for the decision to seek care from Syrian informal HCWs despite alternative options within Lebanese hospitals or clinics. Some interviewees clearly felt this was central.

The Syrian refugee knows how to interact mostly with the Syrian provider. The main reasons are language and communication. The Lebanese doctor does not understand the Syrian refugee, and the refugee does not feel he explained himself well and might have missed something.

I am just like them – I am displaced, I am financially unstable [...] I am dealing with the same problems. In addition to this, our traditions and culture are the same, which helps them relax more and feel more comfortable. Our pain is one.

Syrians here, especially those in the camps, are from the rural areas in Syria, so they are a bit difficult to interact with. Some of them cannot read or write. They don't know how to come to appointments or to interact with the doctor, so when they were attending Lebanese clinics or seeing Lebanese doctors, they were exposed to maltreatment. We know how to deal with them because we used to live with them anyway.

Others, however, suggested that illness – or at least perceived illness – was the main driver for seeking care and that patients would seek that care wherever they felt they were most likely to receive it. For some patients, the very fact that care was informally provided could prove a discouragement to taking it up, because of lack of clarity around the experience and qualifications of those offering it. Cost factors and geographical accessibility would prove significant factors in these cases.

6.3.2 Livelihoods, skills-maintenance and human concerns among Syrian HCWs

For Syrian HCWs themselves, the rationales for seeking informal employment are somewhat simpler. At a basic level there is a need to generate income in the face of difficult personal circumstances and little prospect of work in the formal Lebanese health sector. Many of those interviewed were holding down at least two positions at once to help make ends meet, covering administrative and clinical functions.

Bekaa is not Beirut [in terms of price] [...] But you have to find something to help you eat, drink and live, so we asked around and they [informal network] said they were looking for a specialist in this centre.

For some – especially those with extended families in Lebanon – there were practical considerations too to ensure their ability to stay, in the hope of finding permanent employment and perhaps permanent residency status in the future. Others were not optimistic about a future in Lebanon, particularly in regard to securing a livelihood. They felt stuck until circumstances in Syria were appropriate for return.

Skills maintenance was seen by many health professionals as a central reason for seeking informal employment in the face of significant risks to personal safety. It also was closely linked to maintenance of **personal esteem**, particularly for younger/recently graduated healthcare workers who seek to develop themselves and apply their skills. For these individuals, informality provides a route out of having to accept unrelated or menial work and a means for maintaining personal dignity.

The more important thing is to continue working. It is difficult for a clinician to stop working in their profession. As a surgeon, I have not practised for a while now and it makes me unhappy. Nearly half of our specialty training within OB/GYN [obstetrician-gynaecologist] is surgery. Now, I have to focus on diagnosis and treatment. Imagine after all of this studying and training, as a doctor, to not be able to practise. We are accepting these circumstances of work, without work permits or registration or working legally, in order to continue our qualified work.

However, **a human sense of concern** seems to be an important driver of informal employment for Syrian HCWs. There was particular pride among many of those interviewed at the cost model that many informal providers in Lebanon use, emphasising accessibility for patients.

[Our lack of financial gain] is very important and should be highlighted. It is very important that we do not make a profit here. No one is making a profit, we are always in loss [financially]. This is very important.

All those interviewed – irrespective of how actively they were practising at the time of interview – emphasised the importance of responding to human need, especially if faced with medical emergencies.

6.3.3 Novel employment opportunities presented by an expanding informal care system

One of the more striking findings from the interviews was a sense that the developing informal care system in Lebanon provides new opportunities, which may make the informal sector particularly attractive as an employment option for Syrian HCWs – despite the status and remuneration constraints. One example of this is a newly trained cadre of female public health workers who are helping to deliver a breast cancer early-detection service in some areas of Lebanon through outreach work (a service developed by clinics principally serving the Syrian refugee population). Another is the perception among some HCWs interviewed that – through their informal work – they are gaining exposure to clinical and non-clinical care work that they

would not otherwise have. This applies particularly to allied health professionals who have had exposure to emergency care and injury rehabilitation work at a level that would have been unusual before the conflict.

Doctors in the clinics have gained vast experience because of the sheer amount of patients and types of pathologies they see. Syrian doctors are known for being good at what they do, but due to the conditions of the war and the injuries that have resulted, they have treated cases they have never seen before.

6.3.4 Tacit support from Lebanese organisations and individuals

An important factor underpinning the expansion of informal care in Lebanon has been the willingness of organisations and political groups to 'sponsor' activities in support of Syrian refugees. One of the principal beneficiaries of this has been MAPs. Similarly, the Syrian American Medical Society has been a long-standing sponsor for a number of the clinics operating in Lebanon. A number of clinics historically offered services for no cost until funding sources became tight.

In addition, a number of Lebanese healthcare workers have facilitated the presence of Syrian healthcare workers and their willingness to work by means of sponsorship within their private clinics, or registering themselves as directors of clinics in which Syrian healthcare workers 'volunteer'. One interviewee described the vital role their sponsor had had in ensuring their ability to stay in Lebanon when the residency visa for them and their family had run out, as evidence of the sponsor's commitment to partnership. Furthermore, independent Lebanese providers as well as private and public hospitals in surrounding areas are often informally contracted with the clinic as referral points for patients with secondary or tertiary care needs that cannot be met within the given clinic. There are naturally elements of negotiation in this process, particularly given financial constraints for many Syrian refugees, as one interviewee explained.

We tell the Lebanese doctor, we will send you a patient, but you cannot charge him the way you usually do. We will refer a number of patients to you, but you will have to give these patients a discount to benefit the patient and vice versa. If a patient does not have money, the Lebanese doctor may tell them to come to our clinic to receive services.

6.3.5 Local authority oversight and passiveness

Most participants expressed that local authorities have 'turned a blind eye' to the situation of Syrian refugees, particularly in peri-urban areas where there is a large presence of Syrian refugees and needs are reportedly too great to be met by the Lebanese health system alone. The issue at hand was identified as a political one that could not be tampered with. The general understanding was that the government was aware of these clinics and their operations but chose to ignore them.

The government is turning a blind eye to the Syrian situation. Although it is illegal [to open clinics and operate as health workers], the current health system cannot serve the needs of these refugees. Where will all the people go? The government cannot handle all of this.

A number of respondents expressed pessimism and exasperation in regards to engaging with authorities to find a short-term solution for Syrian healthcare workers, citing the source of the problem was largely political and included an agenda for the exit of Syrians from Lebanon and back to Syria. These views tended to align with the dominant media-political narrative in Lebanon that the presence of Syrians across the country creates tensions and that they should return to their own country.

6.4 Barriers to informal employment in Lebanon

6.4.1 The challenge of obtaining work permits, licensing and accreditation

Difficulties in ensuring appropriate legal permissions to work were – as the findings from the literature review suggest – among the commonly cited barriers to practise. Most individuals stated that their residency permits were legal, although they often faced difficulties when renewing their residency permits, particularly if they are identified as a doctor in their Syrian passport – or were challenged directly on their current employment status by government officials. Otherwise, Syrians are generally registered as unemployed or registered under other professions allowed by the Ministry of Labour which cover employment in the low-end service sector, such as waiters and building maintenance managers (UNDP *et al.* 2017).

Regarding work permits, almost all interviewed said they did not know any Syrian health professionals with legal work permits. Many proposed temporary permission to operate within clinics serving Syrian refugees only, in order to facilitate regulation and oversight of services, to work in a legal manner and to avoid threats or risks of deportation. This was mainly expressed as being for the sake of both Syrian health professionals and Syrian refugees – namely, for the first to provide and for the second to receive accessible health services. The situation was described by some as ironic, as healthcare workers aspire to be legal but do not have the capacity to pursue legality given government restrictions.

The main issue starts with permits – individuals do not have permits. Ninety per cent of people are willing to pay for a permit but cannot.

Everything in my life was legal up until this point. The worst is that the war has forced us to live in illegal circumstances.

None of my colleagues are working with legal status in Lebanon. I don't know any Syrians working legally in Lebanon, especially in healthcare.

I think there should be centres for Syrian refugees employed by Syrian doctors, like Palestinians [...] We are a solution. In Lebanon there is a huge problem [. . .] In Turkey, they register doctors and have them pay regular fees. In Lebanon, you are not allowed to be legal and you stay fearful. The government is losing. If they were smart, they would have us pay a certain amount a month. People will pay. But they don't want to. The reason is there is no government, really, it is political interest. They don't look out for the interest of people, just for the interest of individuals.

While many interviewees recognised the value of working alongside Lebanese colleagues to ensure they could access work opportunities in the absence of legal mechanisms for labour market entry, others viewed this as an impediment to skills development. One interviewee, for example, lamented the need to work as an assistant to Lebanese HCWs in performing procedures and tests that he would have carried out independently in Syria – limiting opportunities for skills development.

6.4.2 Regulatory issues and risks for healthcare providers

Most clinics featured in this research have not faced direct pressure from local authorities or from Lebanese authorities. However, a small number have been 'given' warnings of potential investigations into their operations and people associated with them. A number of interviewees expressed respect for Lebanese labour laws regarding healthcare workers (ie medical degrees require conversion and certification by the ministry, but at high financial costs). However, there were suggestions for a temporary permit or permission to operate only on displaced Syrians in order to serve the needs of this particular time and place.

There really is no way to get registered. I have to convert my medical training and degree and it takes a while to do so. Coming from very difficult, exploitative, and tiring circumstances, it is not the ideal situation right now. I found an opportunity to provide for my children and one looks at their priority.

We have a visit promised this week from the Ministry of Health, I had someone from the ministry tell me that we are guaranteed an investigative visit at this clinic [...] with potential for shutdown. Before, we were applying for registration for the clinic so that they can come see our services. When they saw that most staff were Syrian, whether doctors or nurses, they would refuse our registration. But for an investigation, this is the first time [...] We don't know what to expect. Maybe we will be told to shut down, most likely because of discounted services provided and potential competition with local health providers.

Another component of healthcare providers' distress is the responsibility of working without regulation or oversight from a regulatory body, such as the Ministry of Health. This was especially the case for the surgeons interviewed.

Working illegally is a large responsibility, especially in surgical operations [...] We count to ten (we are very diligent) before working with any patient so that we are not exposed to any risks. The life of the patient is within our hands and we have no [overarching] support. This is the large responsibility we carry.

6.4.3 Personal ethics

A number of interviewees cited personal ethical concerns as a rationale for stepping back from, or avoiding frontline clinical work alongside Lebanese HCWs. There was a perception among some respondents that professional practices in the mainstream Lebanese health system were unethical or even corrupt. One respondent – a medical doctor – cited examples of inflated billing of patients for minor surgical procedures as an example, highlighting the difficulties this would present to Syrian refugees in Lebanon with limited financial means to pay for care. Another – a pharmacist – spoke of encouragement in a Lebanese-run pharmacy he worked at to dispense medications at every opportunity irrespective of clinical indication, and highlighted the use of placebos for Syrian refugees with psychological complaints. Both interviewees spoke of clashes between these practices and their personal ethical beliefs, or the professional codes of ethics from their training in Syria.[17]

6.4.4 Fear and ongoing distress

In addition to the stress of working without legal work permits, almost all participants highlighted the toll that living in constant fear of being discovered by local authorities had on them and their families. Although not all interviewed health workers had experienced threats first hand, some had been reported by community members to the ministry or security forces and had been warned to stop working immediately or risk deportation. This was particularly the case for the few participants who conducted home visits, or had colleagues who provided clinical consultations within their homes and were complained about by community members to local authorities.

In a month, I have to renew my residency permit. By then, I need to make sure my movements are limited. The doctors and physiotherapists who do home visits without proper registration face these risks [due to increased movements].

We always feel distressed [...] At any point you can lose your job. If something was to change, we would feel

[17] Although it should be noted that there is no formal ethical code (and was no such code before the conflict) to which doctors trained in Syria are required to adhere to by regulatory and oversight bodies.

reassured with the confirmation we are working legally.

Checkpoints throughout peri-urban areas and border patrol at airports were also an identified source of distress for Syrian HCWs. Syrian physicians in particular expressed the fear of presenting their Syrian passport or identity card to local authorities (which indicate their profession) and potentially inviting additional questioning regarding their livelihoods. Female HCWs, by contrast, were less likely to report this as a problem for them as officials assume they are not working.

6.4.5 Discrimination and wider community attitudes toward Syrian HCWs

The question of discrimination from host communities in Lebanon was addressed by some interviewees in the context of their day-to-day fears. While discrimination was demonstrated principally through lower wage payments to Syrian HCWs in comparison with their Lebanese counterparts, there was a sense that Syrians' acceptance of those low wages bred resentment for increasing competition in the jobs market in Lebanon. There was a perception that Syrian HCWs' informal status was exploited by providers to their advantage.

Our salaries are very minimal because we are always told that we are Syrians and we don't have the right to work here in Lebanon. And that's why I have to work in more than one centre.

Attitudes in some communities were summed up as follows:

Due to our situation after the crisis in Syria, we as informal Syrian providers, are accepting the minimal wages. Therefore, in many cases we are filling more positions than the Lebanese, who won't accept the salaries we take and this has left feelings of hatred among the host community.

Quite how widespread these views might be among host communities is not possible to gauge and might usefully be the subject of onward work from this project.

7

Looking ahead: improving prospects for Syrian HCWs in Lebanon

7.1 Perspectives from Syrian HCWs themselves

Healthcare professionals who participated in the interviews recommended that the Lebanese ministries allow temporary work permits (three to six months) for doctors and other health professionals solely providing services to Syrian refugees, after passing a qualifying exam to certify their expertise as healthcare professionals. Alternatively, Syrian healthcare workers could be invited to participate in an examination to qualify them for temporary work. As one participant explained, the burden on the healthcare workforce in peri-urban areas is too great to meet the need of the Syrian refugee population in addition to the Lebanese community.

Even with the presence of Syrian healthcare workers here, if you go into any Lebanese clinic, you see ahead of you [in line] 10 or 20 patients and appointments in Bekaa were never this busy. Every day you have one third Syrians and the rest Lebanese, now the doctor has to give appointments for following weeks.

If Lebanon took all of the Syrian doctors in Lebanon and put them in a room and locked them there, would they [Lebanon] be able to handle the needs of refugees in the country? I always ask myself this, and I think it is impossible.

Most participants expressed the need for ongoing training within their healthcare specialty. Among those recommended were conferences or weekly seminars provided through NGOs or Lebanese universities that would allow these professionals to receive credits or certificates to advance their skills and development while they are displaced. A great number of healthcare workers interviewed expressed that refresher trainings and updates on available healthcare services was an important part of being a health professional who carries the responsibility of providing treatment to patients, and that since their displacement they have felt 'frozen in time' in terms of capacity building and self-investment. Many proposed that universities such as the AUB or Lebanese American University provide such trainings in Arabic or English in order to develop their CVs in case they return to Syria to rebuild the healthcare system.

7.2 Perspectives from wider policy stakeholders

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

Various approaches to **encouraging macro-level changes in policy** on displaced Syrian HCWs in

Lebanon were identified. These included using evidence from existing practice at the local level as a 'wedge' to press for legalisation that would recognise the rights of Syrian HCW status in neighbouring countries, including Lebanon. (This draws for example on the fact that Iraqi doctors displaced to Jordan have been practising legally for some years). Material presented in the preceding chapter suggests evidence of locally effective practices to integrate Syrian HCWs is available in Lebanon. Donor pressure through use of aid conditionality is one potential mechanism for driving change in the status of Syrian HCWs in Lebanon.

There was broad acceptance of the need for **educational initiatives for host communities** in Lebanon and elsewhere to challenge negative perceptions of displaced persons – and in particular the rising prospect of discrimination against Syrian HCWs. The nature and scope of these initiatives requires further development.

While examples of good practice already exist, there is a pressing need to expand the scale and scope of financial assistance for the 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 current level of health needs in host countries such as Lebanon, let alone future health needs 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 bachelor's level who could be trained rapidly as allied health professionals. All of these, however, depend on acceptance of the Syrian health workers' ability to practise formally.

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 (for example the Syrian Board of Medical Specialties or SBOMS [18]) to ensure their ability to practise long term, as well as simpler, more financially accessible accreditation systems in neighbouring countries such as Lebanon. 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. There is clearly some way to go in this regard in Lebanon, where practical access to licensing and accreditation is limited.

7.3 What key research is needed to improve the position of Syrian HCWs in Lebanon?

A series of broader research needs were also identified by policy stakeholders consulted for this project. First and foremost among these was the need to improve the availability and quality of data in view of both the shortage and unreliability of existing information on Syrian health workforce numbers. Detailed attempts to **measure the scale and scope of population health needs** to which displaced Syrian HCWs would need to respond were identified as a priority by attendees. While snapshot impressions of need among displaced Syrian refugees do exist, comprehensive real-time analysis is not yet available.

Similarly, it was accepted that **improved data collection to understand the numbers, geographic locations, and specialties of displaced Syrian HCWs** is an essential prerequisite for improved workforce planning. More detailed data on whether displaced HCWs have completed their core academic and professional qualifications in Syria is needed in order to be able to design interventions that will help this cohort achieve these core professional requirements. 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.

Secondly, the need to comprehensively map institutions and funding sources supporting HCW education and training in MENA was identified as a priority by participants. The absence of information on approaches to support displaced HCWs in the region was noted. Future work should build the evidence base on which interventions have been attempted previously, and their effectiveness (or otherwise) in Lebanon and elsewhere to help inform policymaking.

[18] SBOMS is a new accreditation body that has emerged in non-government-controlled areas inside Syria to support trainee doctors, with some technical support from medical Royal Colleges in the UK.

8 Discussion and recommendations

8.1 Summary of main findings

Pathways into **formal** employment for Syrian HCWs in the health sector in Lebanon are currently closed. In addition to the basic question of residency status, Syrian HCWs face a number of administrative, legal and professional regulatory barriers to formal practice including but not limited to difficulties obtaining legal work permits, inability to secure professional licences to practise without incurring often unmanageable costs, and other, related challenges – all of which preclude formal labour market entry.

However, it is apparent that an extensive network of **informal** healthcare provision by Syrian HCWs has emerged in Lebanon in recent years to help meet ongoing health needs among Syrian refugees primarily, but also to provide services to other displaced populations and Lebanese citizens mainly in underserved areas. The means by which this informal healthcare workforce in Lebanon has developed is particularly notable: based primarily on word-of-mouth communication of employment opportunities within communal networks made up of colleagues, former classmates, family members and patients.

According to Syrian HCWs, these trends are also a result of **informal health-seeking behaviours** among Syrian refugee patients in urban and peri-urban areas. HCWs interviewed for this working paper argued that Syrian refugee patients find informal service providers more readily available within their displaced communities, more financially accessible, and may perceive them to be higher quality than formal networks in Lebanon. Therefore, it is important to hold this as a consideration as the informal healthcare workforce is ultimately buoyed by displaced Syrians themselves.

The primarily peri-urban locations in which Syrian HCWs work may reflect a combination of historical migration patterns and pragmatic social and economic factors – large numbers of refugees live in these peri-urban areas and living costs are lower than in urban centres such as Beirut. The border towns in Lebanon also serve as marketplaces and waypoints from which people would move back and forth between Syria and Lebanon pre-crisis. It may also be argued that these areas have been receiving suboptimal attention and monitoring by authorities in Lebanon in terms of public service provision, including health. The arrival of large numbers of refugees attracted donor and international NGO funds and operations which have provided a market and employment opportunities for those with specialist skills such as healthcare workers.

Among those surveyed, medical doctors were disproportionately represented in comparison to other health workforce occupations in the sample contacted for this working paper – possibly reflecting an imbalance in the distribution of specialisms among the displaced Syrian health workforce in Lebanon. These health professionals practise overwhelmingly in primary healthcare clinics and are therefore more beneficial to local host populations. However, this does little to reduce tensions between Syrian refugees and the local Lebanese population in areas where PHCs mostly attract Syrian patients due to accessibility of these clinics in both financial and geographic terms.

The lived reality of working in these environments for many Syrian HCWs remains extremely challenging. Besides well-recognised barriers to formal labour market entry (residency status, professional registration and so on), health workers interviewed for this working paper identified persistent fear and distress (including the threat of deportation), ethical challenges in practice, and discrimination both in terms of pay and attitudes from host populations among the daily challenges of practising

informally in Lebanon. There is, in addition, little sense from the material gathered in this working paper that Syrian health workers are able to make a viable and sustainable living from their informal work at present, despite clear evidence of demand for the care they provide. For the most part, Syrian HCWs deliver services either on a voluntary basis or for minimal payment.

Turning to long-term health workforce support and reconstruction, there remains a severe gap in provision of training and continuing professional education for Syrian healthcare professionals in Lebanon. The risk of deskilling is accentuated for specialists who – for the most part – have very limited opportunities to practise outside primary care settings. Predominantly, Syrians themselves have – correctly – driven support for displaced HCWs, but often without effective institutional and financial backing from major agencies and donors. In general terms, the regional response to the Syrian health workforce crisis has been under resourced and poorly coordinated. These factors have all contributed to a widening, generational gap in the health workforce supply.

8.2 Policy recommendations

Findings from this research point to a series of recommendations for health system stakeholders in Lebanon, and for academic and policy researchers, to help improve the position of Syrian HCWs, as outlined in Table 3 below:

8.3 Research recommendations

We also identify a series of recommendations for researchers (see Table 4).

8.4 Wider perspectives on conducting research with vulnerable groups

Finally, this work highlights some broader considerations in conducting research with vulnerable groups in the context of large-scale population displacement, and in particular informal employment, for future research. The ethical dilemmas surrounding the gathering of data from refugees and vulnerable displaced persons has been little documented by academics and policy practitioners studying the Syria crisis, yet poses a real research and policy challenge.[19] Since 2012, a large body of research and data has been developed by conducting large-scale surveys and interviews with Syrian refugees in Lebanon, Jordan, Turkey and Iraq across a range of policy themes – health, education and livelihoods. Consequently, these groups now report survey fatigue and often cite that little has changed in terms of their living standards despite the volume of academic and policy research that has taken place and been published.

Table 3. Recommendations for researchers working in this area

DOMAIN	RECOMMENDATION(S)
Health needs and workforce supply	▪ There is a pressing need for robust, prospective research work addressing the current and future burden of health needs among displaced populations, and likely health workforce requirements to meet these needs. ▪ Routine data collection on Syrian HCW numbers, specialties and geographical distribution should be strengthened to help improve programming and to support training and skills development. ▪ Provide a methodologically robust and accurate figure on the numbers of Syrian healthcare workers who have left Syria since 2011.
Making the case for health worker support	▪ Develop the economic and financial models and case for supporting displaced Syrian HCWs in host communities: how can displaced healthcare workers contribute to helping countries such as Lebanon achieve universal healthcare goals?
Identifying health system barriers and facilitators to refugee health worker support	▪ Researchers should conduct further work on the political economy of the Lebanese health system to examine governance and decision-making practices. Very little research has been done in these areas and it would add a greater understanding of the challenges and opportunities facing the Lebanese health system in managing the response to refugee inflows. ▪ There is a pressing need to understand the range of educational initiatives that could support training and development for refugee health workers (based on findings from other contexts) and the potential for translation to Lebanon.

[19] See Pearlman (2015) for a full discussion. There is a vast wealth of material on the ethics of researching refugee groups in general (see http://bit.ly/2ue8Zpl). Over the last seven years of academic research on the Syrian crisis, little consideration appears to have been given to the ethical conduct of fieldwork and the impact this has on refugees.

Table 4. Policy recommendations for key stakeholders in Lebanon to support Syrian HCWs in the country

CONSTITUENCY	RECOMMENDATION(S)
Lebanese government	▪ The Lebanese government should consider building on experiences in Turkey and latterly Jordan where Syrian medical workers have been enabled through limited registration to treat displaced people with some success. A limited registration approach was strongly advocated by interviewees for this project, and has support from major international agencies as evidenced in the *Jobs make the difference* report (UNDP *et al.* 2017). ▪ The government should work in collaboration with local academic institutions to provide courses and support enrolment to assist those whose studies have been interrupted. This will help them to complete their core professional qualifications and reduce the potential risk of malpractice. The government could have a central role in reshaping the narrative in this area: by emphasising that incorporating Syrian HCWs into the overall workforce (but providing health services to Syrian refugees exclusively) should be perceived as a relieving factor vis-à-vis the burden faced by a Lebanese health system shocked by an additional increase of 25 per cent in the size of the market served; and by recognising that assisting and investing in Syrian healthcare workers is a key human capital development policy that can help the government to move toward more universal healthcare goals.
Donor organisations and WHO	▪ Recognise that allowing the situation of informality to continue among Syrian healthcare workers may have a deleterious effect on the future supply of labour, and in so doing undermine both early recovery policies and the pursuit of universal health coverage (UHC). Due to cost of living pressures many healthcare workers will seek to leave the region for Europe with little likelihood of return. ▪ There is an urgent need for expanded financial support for training initiatives for displaced Syrian HCWs to ensure skills maintenance and to help reduce the size of the emerging generational gap in Syrian health workers. Donor organisations are well placed to provide this. ▪ Donors may also consider leveraging financial contributions through the use of aid conditionality, to drive improvements in working conditions for Syrian HCWs. ▪ Recognise that the dominance of the private healthcare sector in Lebanon is a barrier to achieving health equity and universal healthcare goals. Given UHC is now a key WHO policy priority, donors could work with WHO to lobby the Lebanese government to recognise informal Syrian healthcare workers as a human capital investment that can help them move toward UHC and address the health needs of refugees and deprived Lebanese communities who cannot afford the large out-of-pocket healthcare expenditures in private-sector settings.
International NGOs	▪ There is an important role for international NGOs in continuing to lobby relevant decision makers and ministries in Lebanon with the message that utilising Syrian healthcare workers in the humanitarian response is a win-win option, helping to meet immediate health needs among the Lebanese and displaced Syrian populations; and to support economic livelihoods for a large and increasingly impoverished section of the population in Lebanon.
Educational and professional institutions	▪ Educational institutions in Lebanon have a crucial role in setting up training/continuing professional development (CPD) programmes to support Syrian HCW skills maintenance, and in forging links with institutions in other countries that are either (1) currently providing opportunities, however limited, to Syrian health workers or students, or (2) providing training in highly specialised areas where demand for skilled practitioners is significant (eg renal dialysis). ▪ Educational institutions should also consider development of new curricula to support task-shifting initiatives to either retrain existing Syrian HCWs or support the development of wholly new workforce occupations – given the scale of the mismatch between health needs and existing workforce supply. ▪ Local medical institutions should lobby decision makers and ministries on the value of fellow healthcare workers to the domestic health economy. ▪ Local medical institutions should assist in the development of training and CPD programmes for medical doctors, nurses and other professional health workforce occupations.

Our experiences in this project demonstrated the importance of establishing rapport with centres or groups of healthcare professionals before approaching for participation in study – especially where questions of informal or illegal employment are concerned. Many participants had significant concerns around confidentiality and personal safety; methods to alleviate this for future work could include arranging interviews during breaks or outside of working hours to avoid intrusions on privacy, and using written notes rather than electronic recordings to put participants at ease. Consent poses a major challenge in work of this nature; research ethics boards often require written consent but anecdotal evidence from participants in this work suggested some would have preferred to give verbal consent rather than committing signatures to paper. Some researchers studying informal health workers in other settings have found a compromise in the form of signed pseudonyms. All of these measures are designed, ultimately, to help improve response rates – but the reality in many research projects seeking access to vulnerable groups is that ensuring statistically robust sample sizes may, simply, not be feasible.

Finally, robust approval mechanisms are essential for work with vulnerable groups. Routine shortfalls in ethical approval standards for research conducted in the Middle East have been noted elsewhere (Pearlman 2015), and we would advocate securing ethical approval from a local educational institution and formal political approval from the Ministry of Health.

9 Conclusions

The scale of the population challenge facing governments in countries such as Jordan, Lebanon and Turkey that have experienced large refugee inflows since the beginning of the conflict in Syria in 2011, is unprecedented. In Lebanon alone, refugees now account for at least a quarter of the resident population. The Syrian refugee phenomenon in Lebanon is frequently portrayed as an urban phenomenon, but the reality is that displaced Syrians today live across a range of urban and peri-urban contexts, in residential and makeshift settings.

The research findings outlined in this working paper document the emergence of an informal Syrian health workforce in Lebanon responding primarily to health needs among Syrian refugees in peri-urban areas of the country where access to health professionals is more limited than in the major cities (in particular, Beirut). The lived reality of work for many of these Syrian HCWs is, as our findings show, extremely difficult. Policy measures to help improve the conditions in which they work could include limited registration to practise, and expanded support from donor organisations and educational institutions for training, continuing and completion of professional qualifications. Ultimately, however, their situation may only improve substantively when and if local political stakeholders are persuaded that integrating Syrian HCWs into the humanitarian response is a win-win policy approach that offers opportunities both to meet the health needs of refugees and host communities, and supports meaningful economic livelihoods for those struggling to make ends meet.

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Appendix 1. Topic guide for the qualitative interview

Dr…

My name is [name]. I am interested in learning more about the role of the Syrian health professionals who are displaced and their contribution to health partners in Lebanon.

Introduction: You recently indicated during an interview with one of our team that you are a healthcare professional trained in Syria and currently residing in Lebanon.

Opening question: What is your healthcare profession, for example doctor, nurse, midwife, pharmacist etc?

Further questions

- For how long did you practice in Syria?

Please briefly share some background about your professional experience:

- What is your main area of expertise?
- Who was your patient population in Syria?
- When did you arrive in Lebanon and for how long have you been working Lebanon? Describe to me your professional experience after being displaced to Lebanon.
- If you have stopped working in healthcare, what have you been doing?
- How are you keeping up with your professional knowledge?
- Are you still in contact with some of your patients?

Questions related to the types of health services currently being involved in

Refugees living in Lebanon may face challenges accessing healthcare services. Given that you are a trained health professional, you can help alleviate this burden within your local communities.

- Can you share the type of health services you are currently providing to your local community?
- What challenges have you faced doing this?

Further questions

- Are some of your patients residing in your local community?
- If yes, do they come to you seeking healthcare?
- What type of health services do you provide them with?
- Do other individuals living in your current local community know you are a trained healthcare professional?
- If yes, how do they know?
- Do they ask for your service?
- What type of health services do you provide them with?
- Do you see them in your own residence?
- Do you carry out home visits?
- Do you have access to medical equipment to assist in the provision of care?
- Do you have someone who assists you?

Questions related to informal provision of health services

- Are you concerned about the legality of practising in a country where you are not formally licensed to practise?
- Can you describe your concerns in more detail please?
- Have you encountered any problems so far?
- If yes, what was the outcome?

Questions related to the functionality of these health services

- Are the local community appreciative of your services?

Further questions

- Did they tell you their views?
- Did you note a difference in their health situation after your provision of health service?
- Did you encounter any complication as a result of your intervention?
- What about your peer professionals, do you get the chance to interact with them?
- Do you share your concerns and views about current interventions? Please describe the type of interactions you have with them.
- Do you get the sense that they support you? Deter you?

Questions related to connections to the formal health system

- Do you interact with your peers practising formally in Lebanon?
- What was the nature of these interactions?
- Were there any particularly challenges?

Further questions

- Are you in contact with those residing in your local community? Or outside your local community?
- Do they know that you are informally providing health services to your fellow Syrians?
- What is their attitude toward this informal provision?
- If they know a Syrian refugee who has experienced barriers to accessing their services, do they refer them to you for care? Describe to me one situation where you provided a service to someone referred to you from a mainstream professional.
- If you have a Syrian refugee who needs a service that you cannot provide, how do you refer them to a registered health professional to receive appropriate care?
- Do you encounter any barriers during the referral process? Tell me more about this experience.

Recommendations

- Do you have any suggestions for improving the potential role informal healthcare providers can play to alleviate the access burden to services among Syrian refugees?
- What about the role in reducing the burden on the host community healthcare system?

Finally

- Is there anything you would like to add?

In Syria, seven years of conflict has been catastrophic. Thousands of qualified doctors and health workers have left since 2011. In neighbouring countries, informal employment among displaced Syrian health workers is broadly acknowledged. But the scale, scope and nature are poorly documented. This working paper details both the scale and the challenges Syrian healthcare workers face in Lebanon. It explores strategies Syrian health workers use to help cope with barriers such as formal labour market entry, the threat of deportation, ethical challenges in practice, and discrimination.

There is an urgent need to address legal barriers to registration to practise for Syrian healthcare workers. Key further research includes mapping health worker numbers, specialties and geographical distribution to support workforce planning, and research on current and potential training and development initiatives to further support Syrian health workers.

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