DURABLE SOLUTIONS PLATFORM

MPI
MIGRATION POLICY INSTITUTE

A BRIDGE TO FIRMER GROUND:

LEARNING FROM INTERNATIONAL EXPERIENCES TO SUPPORT PATHWAYS TO SOLUTIONS IN THE SYRIAN REFUGEE CONTEXT

CHAPTER 5

HEALTHCARE

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Photo By: Ahmad Al-Jarery

1. INTRODUCTION

Among the numerous challenges displaced Syrians face, access to quality healthcare remains one of the most salient. The urgency of this need has only intensified in the context of the COVID-19 pandemic. Refugees often suffer from health complications due to injuries and trauma sustained during the conflict they are fleeing, while on their journey to the host country, or as a result of endemic conditions exacerbated by poverty. Analyses of the health needs of Syrian refugees have pointed to issues such as skin, digestive, and respiratory ailments;[1] chronic illnesses such cardiovascular disease, diabetes, and hypertension;[2] outbreaks of previously eradicated diseases and increases in the spread of drug-resistant tuberculosis;[3] and significant mental health challenges.[4]

Box 1. About this Project

This chapter is part of a research project by the Durable Solutions Platform (DSP) and the Migration Policy Institute (MPI), titled "A Bridge To Firmer Ground: Learning from International Experiences to Support Pathways to Solutions in the Syrian Refugee Context". As the protracted Syrian refugee crisis continues and refugee communities, host governments, and international donors and implementers attempt to move toward durable solutions, this project analyzes projects, policies, and approaches from around the world and draws lessons learned for the Syrian context. This report provides recommendations for host-country policymakers, regional and international bodies, and nongovernmental actors.

The other chapters of this research report are available here.

The four countries that host the majority of Syrian refugees have, to varying extents, included refugees living outside of camps in their national healthcare systems (see Box 2). However, many of these systems struggle with the pressure placed on health infrastructure and personnel, including insufficient numbers of doctors and specialists.[5] Additionally, efforts to make healthcare accessible to refugees focus largely on primary care, and it often remains difficult to access secondary and tertiary care. The pressures placed on health systems by the arrival of large number of refugees can also cause resentment within host communities, as other locals face many of the same challenges to accessing healthcare.

Box 2. Syrian Refugees' Access to Healthcare

Jordan: Syrians living outside of camps initially received free primary healthcare at public facilities, but since 2014, they have had to pay the same rate as uninsured Jordanians. Rate requirements have subsequently fluctuated.[6] Syrians in camps can access healthcare provided by humanitarian organizations there.

Lebanon: Syrian refugees use the same healthcare facilities as Lebanese nationals, which is highly fragmented and privatized. For primary care, international donors support different schemes implemented by nongovernmental organizations (NGOs). The UN High Commissioner for Refugees (UNHCR) also covers some of registered refugees' healthcare costs for secondary healthcare.[7]

Turkey: Syrians registered with the government are entitled to the same health services as Turkish citizens in their province of registration. Primary healthcare was free until December 2019, when co-payment requirements were introduced.

Kurdistan Region of Iraq (KRI): Syrians have access to free primary healthcare through camp-based centers or public health facilities in host communities.[8] In 2018, the World Health Organization (WHO) restarted a comprehensive health support program in the region, benefitting both refugee and host-community members through improved access to primary, secondary, and tertiary healthcare facilities.[9]

Significant gaps also exist in addressing the specific needs of refugees, in particular women who are at increased risk of sexual and gender-based violence.[10] Syrians face limited access to gynecologists and staff with reproductive healthcare training as well as family planning services. Maternal care is often also an issue, and many refugee women have limited access to care during their pregnancy and can face more complications during delivery as a result.[11] Other healthcare gaps include mental health services[12] and psychosocial support, treatment for chronic diseases,[13] and services for persons with disabilities.[14]

The COVID-19 pandemic has exacerbated these needs, and refugees in the region (and around the world) face barriers to accessing social safety nets and often live in locations where healthcare systems were already under strain before the pandemic hit. In Jordan, a COVID-19 assessment (among Syrians, Jordanians, and other residents) found that nearly 70 percent of respondents faced challenges accessing basic healthcare.[15] Similarly, in Iraq, a survey to gauge the impacts of the pandemic found that one-third of refugees were concerned about accessing healthcare facilities, and that one-third of elderly individuals and those with certain needs or serious medical conditions have not received the care they need.[16] COVID-19 testing and treating has become the top priority for healthcare providers, limiting the resources available to provide treatment for other conditions. In addition, the economic impacts of the pandemic have deepened the economic barriers many refugees already faced to accessing care and the pressures health systems were already under to provide for their needs and those of other residents.

Efforts have been made in recent years to improve refugees' access to healthcare, and while the pandemic has been disruptive, it has also demonstrated how critical this work is. Driven by UNHCR and the WHO, global policy towards refugee health focuses on providing access to healthcare and specialized support (including reproductive and mental healthcare) and addressing socioeconomic determinants of health outcomes, such as nutrition and hygiene.[17] Policies have also increasingly recognized the importance of including refugees in national health systems and providing long-term support, improving the capacity of these systems to serve both refugees and host communities, and mainstreaming refugee health issues into national health strategies.[18] There is also an increased emphasis on the need to improve data collection and information dissemination to combat knowledge gaps.[19]

This chapter presents lessons learned about improving refugees' access to healthcare from case studies across three areas: (2) designing inclusive health policies; (3) improving the overall resilience of health systems in refugee-hosting communities; and (4) supporting specialized care for refugees, with a particular focus on refugee women in this specific case.

2. HEALTH POLICIES AND MEASURES INCLUSIVE OF REFUGEES

In the Middle East, many Syrian refugees continue to have limited access to completely free or subsidized public healthcare. Where they have access to health services delivered by international organizations and NGOs, these are often part of a parallel system. The model adopted in Costa Rica to incorporate vulnerable refugees and asylum seekers into the national healthcare system offers potentially useful lessons for the Syrian refugee context. While Costa Rica hosts a smaller refugee population than the major host countries for Syrian refugees, this case study illustrates well how inclusive policies can be developed and implemented.

ACCESS TO PUBLIC HEALTHCARE IN COSTA RICA

Country	Costa Rica
Year active	Originally, January through December 2020. It has been extended until March 2021 because of the availability of funds already contemplated for the implementation of the agreement.
Key objective	Agreement between UNHCR and the Costa Rican Social Security Fund (CCSS) to provide vulnerable refugees and asylum seekers with free access to the national healthcare system.[20]
Target population	6,000 vulnerable refugees and asylum seekers, with priority given to people with serious and chronic conditions, those deemed the most socioeconomically vulnerable, and households with people over age 60, health workers, and those who face the greatest risk of COVID-19 infection (refugees and asylum seekers who are health workers by profession and who are not working in the formal sector but have been caring for people in their networks since the beginning of the pandemic)[21]
Budget	USD 1.8 million, provided by UNHCR,[22] plus additional financial support provided by the government of Costa Rica

CONTEXT AND DESIGN OF THE UNHCR–CCSS AGREEMENT

In December 2019, UNHCR and the Costa Rican Social Security Fund (CCSS) signed an agreement to expand asylum seekers' and refugees' access to the national healthcare system, motivated by the sharp increase in the number of asylum seekers entering the country. In 2019, Costa Rica was among the top ten countries worldwide receiving the most new asylum claims,[23] with more than 86,000 Nicaraguans arriving that year, driven by political unrest, violence, and a social crisis in their country.[24] This resulted in increased waiting periods for basic services and forced many newcomers to rely heavily on savings, increasing their vulnerabilities[25] and testing the country's capacity to protect and integrate them.

Assessments conducted by UNHCR have consistently identified access to healthcare as a critical need among vulnerable refugees and asylum seekers in the country.[26] Indeed, many reach Costa Rica with serious injuries incurred during their travels or due to violence experienced in their countries of origin.[27] In response, UNHCR and Costa Rican authorities have made additional efforts to address this issue, as well as made a commitment during the 72nd World Health Assembly in May 2019 to promote the health of refugees and migrants by securing their access to universal healthcare coverage.[28]

Box 3. What Is the UNHCR-CCSS Agreement?

The UNHCR–Costa Rican Social Security Fund agreement aimed to provide access to healthcare for 6,000 asylum seekers and refugees in 2020.[29] Beneficiaries received free health insurance allowing them to access the national healthcare system for the duration of the agreement (initially, January-December 2020, but later extended to March 2021), or until they found a job—in which case the employer would cover their health insurance premiums.[30] The initiative excluded minors (children under age 18), pregnant and nursing women, and other individuals already eligible for medical coverage. Beneficiaries were given an insurance card with their photograph on it and the insurance number assigned to them by the CCSS.[31]

Designing and implementing this agreement relied on strong buy-in from, and coordination between, the Costa Rican government and UNHCR. UNHCR Costa Rica was in charge of creating and delivering a recommended list of beneficiaries to CCSS and providing documentation to individuals who did not already hold a refugee ID. CCSS determined the final list of beneficiaries after ensuring that UNHCR's proposed candidates were actually eligible—that is, that they were not already eligible to enroll in or benefiting from other social schemes.[32]

UNHCR and the Costa Rican government split the costs of the program. The USD 1.8 million provided by UNHCR covered the estimated cost of the monthly insurance premiums per person over the year-long program.[33] Meanwhile, the government funded the majority of the expenses as it was responsible for paying the medical bills (i.e., covering any difference between the fixed insurance rate paid by UNHCR per beneficiary and the actual cost of medical care provided).[34]

Between June and July 2020, the list of beneficiaries was finalized, with 5,982 refugees and asylum seekers enrolled in the Costa Rican healthcare system under the agreement. In June 2020, more than 69 percent of refugees and asylum seekers benefiting from the agreement were Nicaraguans, 12 percent Cubans, more than 10 percent Venezuelans, and around 5 percent Salvadorans, and almost 55 percent of all beneficiaries were female (this distribution may have shifted somewhat as some beneficiaries found jobs and exited the program and others joined). Around 700 households benefitting from the agreement had members age 60 and above.[35]

Although no evaluation of the initiative is yet available, beneficiaries reported that it allowed them to undergo surgeries and interventions that they could not have otherwise afforded or accessed.[36] The negative impact of COVID-19 on the Costa Rican economy jeopardizes, however, the long-term plans set out in the agreement, even as need remains high as many refugees are facing increased difficulties in finding a job, especially one that would allow them to enter an employer-sponsored health insurance program (in comparison, all nationals have full access to healthcare). The agreement, initially valid for a year, was extended until March 2021 using funds that had already been set aside for program implementation and that were still available.[37] In addition, UNHCR Costa Rica has indicated they are in the process of negotiating a new agreement that allows them to maintain medical insurance coverage for the original number of beneficiaries under the program (6,000) and extend it to 4,000 new beneficiaries for nine more months (April-December 2021).[38]

LESSONS LEARNED AND APPLICABILITY FOR THE SYRIAN REFUGEE CONTEXT

1

ENSURE EFFICIENT AND EFFECTIVE BENEFICIARY SELECTION

- Selection criteria should be clearly defined and communicated to refugees from the inception of a program.
- Program design should take into account the amount of time that will be needed to lay the groundwork for its implementation and to organize the selection process.

Setting clear criteria for healthcare access and communicating them to potential beneficiaries is important to ensure the selection process is quick, transparent, and that people understand it and do not feel discriminated against if they are not selected.[39] For example, under the Costa Rican agreement, pregnant women were not enrolled because they were already eligible for maternity assistance; this had to be clearly communicated to ensure they knew from whom they could receive support.[40] In order to disseminate information about the program, a call center refugees and asylum seekers could reach out to was set up, and online news as well as refugee networks played an important role in reaching potential beneficiaries.[41]

Given the sensitivities around selection and the importance of raising awareness among potential beneficiaries, it is important that program design allots sufficient time for these foundational steps. In Costa Rica, the initial selection process took more than four months to complete. UNHCR had to ensure that beneficiaries met the selection criteria, after which the CCSS crosschecked them against social welfare databases to confirm whether they were already benefiting from or eligible for healthcare under other programs.[42] While this initially delayed refugees' access to essential services and reduced the number of months refugees would benefit from the agreement, in the end, the extensions signed by UNHCR with the CCSS to guarantee access to insurance until March 2021 addressed this issue.

In hindsight, UNHCR acknowledged it would have been better to negotiate a 12-month insurance period that would start from the moment a beneficiary was enrolled instead of following the calendar year.[43] In the Syrian refugee context, the swift implementation of similar agreements could be complicated in some countries by the lack of formal registration of refugees as well as by the lack of rigorous assessments of their socioeconomic and health conditions. These gaps would make it more difficult to accurately target the eligible populations and even register them in the national healthcare system. Still, existing vulnerability assessments and targeting mechanisms used for social assistance could be a good source of information for similar health programs in the region until more systematic assessment systems can be put in place.

2

INCREASE AWARENESS ON REFUGEES' ACCESS TO HEALTHCARE

- Communicating with the staff at health centers about the conditions of healthcare agreement as well as how to identify beneficiaries can help ensure refugees can access services open to them.
- Designing measures to counter anti-refugee sentiment can help reduce tensions between host communities and refugees that might arise from the latter's inclusion in healthcare systems.
- Raising awareness among refugees of their rights and opportunities to access healthcare can improve program uptake.

When new populations and categories of people are granted access to healthcare, workers throughout the health system need to be informed of these changes to ensure smooth rollout and implementation of coverage. Shortly after the UNHCR-CCSS agreement was signed, the CCSS (supported by UNHCR) started issuing guidelines and launched a mass communication campaign to educate its staff and support their capacity to (1) recognize the new documentation issued for refugee and asylum seeker beneficiaries of the initiative, (2) acknowledge refugees' rights and their benefits under the agreement, and (3) understand how the agreement works in practice and the steps to follow.[44] By raising awareness among its staff, CCSS aimed to prevent refugees from being inappropriately rejected at CCSS's health centers or being asked to pay for services that should be free. In the Syrian refugee context, especially given the various shifts in refugee assistance that have taken place over the duration of the crisis, it is imperative that those involved in distributing program benefits, such as staff at primary healthcare centers, are informed of the most recent developments and that potential tensions between care providers and beneficiaries are carefully managed.

Refugees and other migrants in countries around the world often encounter xenophobia, which can hinder their access to programs and services for which they qualify. Recognizing that this could keep some Nicaraguans in Costa Rica from seeking or effectively accessing healthcare services, the CCSS and UNHCR decided to add a public communication component to the program.[45] This took the form of leaflets distributed at health centers explaining the agreement to help beneficiaries understand how it works and locals understand the scope of the project (this is, that there was a limited number of beneficiaries, and, most importantly, that it was being supported by UNHCR).[46] The agreement also benefited from the existing #TodaslasVocesCuentan campaign led by UNHCR to humanize refugees in Costa Rica, which shared stories of beneficiaries to promote solidarity. The education of CCSS staff, through the release of guidelines, proved effective as it reduced the chances of program beneficiaries being rejected at health centers, whether due to staff ignorance of the new agreement (and some beneficiaries lacking UNHCR-issued health credentials as a result of the pandemic) or, in some cases, as a result of negative attitudes towards refugees and migrants.[47]

Countries hosting large numbers of Syrian refugees and considering implementing similar health policies could learn from these efforts to counter anti-refugee attitudes and tensions between refugees and nationals.[48] In Lebanon, for example, there were tension at the beginning of the crisis, when the international community started providing and subsidizing access to healthcare for Syrian refugees, while vulnerable Lebanese communities living in the same geographical area were also in need of healthcare assistance.[49] In Jordan, anti-refugee sentiment has been triggered, at least in part, by reports that Jordanians awaiting elective surgery were turned away so that hospitals could treat the war injuries and other urgent medical conditions of refugees.[50] Training for healthcare center staff and outreach to local communities could help ease such tensions and improve refugees' access to care.

3

ENSURE LONG-TERM IMPACT AND SUSTAINABILITY WITH A CLEAR EXIT STRATEGY

- This transition requires sustained support and funding from international partners to increase refugees' access to employment and, as a result, their enrolment in an employer-based insurance system, and/or to grant the most vulnerable refugees who are not able to find a job by the end of the program continued access to healthcare.

By providing refugees and asylum seekers with access to healthcare through the national system, the UNHCR-CCSS agreement not only helped them address their most pressing needs (particularly given its coincidence with the COVID-19 pandemic) but also laid the groundwork for the initiative to have a more durable impact on beneficiaries' lives by helping refugees stay enrolled in the healthcare system.[51] As beneficiaries have already been integrated in the CCSS (and have provided the required documentation to do so, facilitated by UNHCR),[52] the expectation is that it should be easier for them to continue to benefit from national healthcare, as compared to other newcomers who are missing documentation or face barriers to enrollment due to a lack of information or misinformation.[53]

Building continuity and sustainability into the design of healthcare programs can take on two forms. First, donors, the government, and international partners can support livelihoods projects to enhance refugee employment and, once they are employed, help them enroll in the employer-based insurance system, as UNHCR did in Costa Rica.[54] Implementing this exit strategy requires working closely with employers and the government to provide beneficiaries with better access to jobs in the formal sector in order to ensure they can stay in the health insurance system after the program's end through the co-payment system.[55] This might be challenging to implement in countries hosting large numbers of Syrian refugees, where many refugees face substantial barriers to accessing job opportunities that would enable them to keep up their enrolment in health insurance. For example, in Jordan, despite employers being required to enroll their employees in social security irrespective of their nationality,[56] a 2018 study found that only 20 percent of Syrian workers holding work permits were covered by social security.[57] In the same vein, another study found that some Syrian refugee

respondents in Turkey lacked sufficient understanding of social assistance system procedures to feel comfortable trying to upgrade their residency cards so that they could access healthcare.[58]

The second approach to creating long-term impact is to integrate those refugees who had not found a job before the end of the program into the host country's unemployment insurance scheme (where there is one) or to use donor-provided funds to at least cover their monthly insurance premiums. Such long-term support could help increase the pool of financial resources that go into the national healthcare system and support capacity-building within the system, thereby benefiting host communities as well as refugees. Where the finances of the host country's government are already stretched thin, this type of ongoing support will likely only be possible with continued support from international donors, as in Costa Rica and Lebanon (see below).

Recommendations

National governments:

- Work towards providing comprehensive access to healthcare for refugees, potentially through integrating them into national insurance schemes to ensure their access to primary, secondary, and tertiary care, where financially and politically viable.
- Prepare a budget plan that accounts for the additional costs resulting from service delivery for refugees.
- Issue guidelines to staff of health centers and hospitals to ensure they are familiar with the terms under which refugees can access health services (e.g., which forms of documentation are required).
- Conduct awareness-raising campaigns about the rights of refugees and host communities to access healthcare, to both diffuse potential tensions and increase use of services.

Implementing partners:

- Collect and regularly analyze data on refugees' health and socioeconomic conditions.
- Set clear selection criteria to help refugees understand whether a program is open to them, and start the selection process as soon as possible and with a clear timeline for when service access will begin.
- Help raise awareness among refugees about their rights and the conditions under which they can access health services.

Donors:

- Provide long-term support to host countries in their efforts to fund healthcare for the most vulnerable refugees and members of host communities.

3. INVESTING IN THE RESILIENCE OF HEALTH SYSTEMS IN HOST SOCIETIES

Syrian refugees who live outside of camps in KRI,[59] Jordan,[60] Turkey[61] and Lebanon receive their healthcare through the same primary healthcare centers (PHCC) and hospitals as members of their host communities. In Lebanon, international actors, including the European Union and the World Bank, have supported several initiatives that aim to benefit refugees' health by strengthening the capacity of national systems and subsidizing care for refugees and low-income Lebanese. The outcomes of and challenges faced by these programs, leading to the Lebanese government's development of the Immediate Response Model (IRM) following the August 2020 explosion in Beirut that killed hundreds and injured thousands more as well as the creation of a long-term primary healthcare subsidization protocol, provide important lessons for implementing similar approaches throughout the region.

INVESTING IN LEBANON'S PRIMARY HEALTHCARE SYSTEM

Country	Lebanon	
Donor/Lender	European Union	World Bank
Years active	Reducing Economic Barriers to Accessing Health Services (REBAHS) I: 2018–20 REBAHS II: Since 2020	Emergency Primary Healthcare Restoration Project (EPHRP): 2015–19 Lebanon Health Resilience Project (LHRP): Since 2017
Key objectives	Increase access to quality primary healthcare, mental healthcare and psychosocial support, and support for persons with disabilities	Increase access to quality health services, particularly at primary healthcare centers and public hospitals
Target population	REBAHS I: More than 635,000 Syrian refugees and vulnerable Lebanese REBAHS II: 860,000 Syrian refugees and vulnerable Lebanese[62]	EPHRP: 150,000 vulnerable Lebanese LHRP: 250,000 vulnerable Lebanese (eligible for subsidized packages) and 250,000 Syrian refugees (indirect beneficiaries)[63]
Budget	REBAHS I: EUR 31,852,672 REBAHS II: EUR 42 million[64]	EPHRP: USD 15 million from the Lebanon Syrian Crisis Trust Fund (grant) LHRP: USD 120 million financing credit from the World Bank (including USD 24.2 million in concessional loans from the Global Concessional Financing Facility), USD 30 million from the Islamic Development Bank)[65]

CONTEXT AND DESIGN OF THE PROJECTS

Ensuring that refugees have access to health services is a critical component of both emergency responses to forced displacement crises and of pathways towards durable solutions. While UNHCR and other humanitarian actors usually provide immediate healthcare to refugees in low- and middle-income countries,[66] refugees' inclusion in national health systems generally leads to more sustainable outcomes. Therefore, UNHCR and other humanitarian and development actors have repeatedly advocated for the strengthening of national health systems in refugee-hosting countries, an objective also promoted by the Global Compact on Refugees.[67]

Since the beginning of the Syria crisis, Syrian refugees in Lebanon have relied on the Lebanese healthcare system and used the same PHCCs and public hospitals as Lebanese citizens.[68] This has come, however, with increasing pressure on health providers,[69] all within a system that already largely failed to keep up with local needs. Lebanon's healthcare system has historically been a fragmented mix of public and private providers, with many Lebanese not enrolled in insurance schemes and unable to afford care in private institutions.[70] The system's lack of regulation has led to wide variations in quality of care, and the fee-for-service model often increases the costs for patients.[71] As a result, those who cannot afford quality care tend to delay treatment, exacerbating their health issues. The high costs of care affect Lebanese as well as Syrians, who have in certain cases returned to Syria for free non-life-threatening secondary care.[72]

In 2013, Lebanon announced it was moving to a universal healthcare system that would cover all citizens, with a specific emphasis on poor and vulnerable Lebanese.[73] In order to build towards this goal, the Ministry of Public Health (MoPH) launched the pilot project Emergency Primary Healthcare Restoration Project (EPHRP) in 2015, funded by a USD 15-million grant by the World Bank. The project aimed to subsidize preventive care[74] for 150,000 vulnerable Lebanese and to strengthen the capacity of 75 PHCCs frequented by vulnerable Lebanese and Syrian refugees.[75] In 2018, the European Union, through the EU Trust Fund for Syria, supported the Reducing Economic Barriers to Accessing Health Services (REBAHS I) project.[76] REBAHS I introduced a holistic subsidization model under which patients, both Lebanese and non-Lebanese, could receive consultations, tests, and medications for LBP 3,000, with the remaining LBP 7,000 covered by the project (at the time, roughly USD 2 and USD 4.6, respectively) at supported PHCCs, some of which were also supported under EPHRP.[77] REBAHS I also provided financial, in-kind, and capacity-building support for targeted PHCCs and helped improve the MoPH's health information system. Shortly after the project's inception, REBAHS I introduced a complementarity component to allow Lebanese patients who had finished the preventative package under EPHRP to take advantage of REBAHS support and its additional curative package.[78]

Lessons learned from these projects were incorporated into their successors: the European Union's REBAHS II and the World Bank's Lebanon Health Resilience Project (LHRP). REBAHS II has been designed to build out the components of REBAHS I, including an increased focus on strengthening the Lebanese health system, capacity-building, and assisting PHCCs in attaining certificates of quality standards, as well as integrating mental health, psychosocial support, and care for persons with disabilities into services at PHCCs.[79] The project, which has been fully operational from since March 2020, continues to subsidize care for vulnerable Lebanese and refugees, supporting 70,000 primary healthcare consultations in December 2020 alone.[80] The LHRP, learning from the fact that many of its vulnerable Lebanese beneficiaries wanted curative rather than preventative care, expanded on the number and types of packages offered under EPHRP[81] and aimed to monitor the specific impact of the capacity-building aspects of the program on Syrian refugees as part of its results framework.[82] The implementation of the project has, however, been significantly delayed due to contractual, operational, and political issues,[83] and it was restructured in March 2020 to strengthen the MoPH's capacity to respond to the needs that emerged with the onset of the COVID-19 pandemic, including by providing for medical equipment and goods, testing and coverage of coronavirus-related service fees.[84] In January 2021, funds were reallocated under the LHRP to support the procurement and deployment of COVID-19 vaccines.[85]

Box 4. Building a Uniform Model

Following the August 4, 2020, Beirut explosion, the Primary Healthcare Department of the MoPH introduced an Immediate Response Model (IRM) to subsidize and streamline the provision of primary healthcare in the 21 PHCCs treating patients directly affected by the explosion.[86] The model, which is based on experiences from REBAHS and EPHRP, is a simplified version of the holistic subsidization model: it subsidizes all provider consultations, with no limit as to how many consultations a beneficiary can receive, as well as specified diagnostic tests.[87] While some of the PHCCs were already part of REBAHS and thus had experience with this model, the IRM is new for others and represents a shift in how care is funded. Different international NGOs support each PHCC, with funding coming from international donors.[88] The MoPH coordinates these actors through a common portal and health information system.[89]

Building on this model, the MoPH is in the process of designing a long-term primary healthcare subsidization protocol, which is intended to serve as a uniform model for the entire MoPH network. A task force, comprising the actors involved in the IRM and the MoPH, is working to revisit the subsidization packages developed for the EPHRP, LHRP, and REBAHS interventions, as well as payment mechanisms and costing strategies. Already, packages such as wellness and neonatal care have been finalized, a results framework has been identified, and conversations are ongoing about the inclusion of support services for mental health and persons with disabilities.[90]

The EU- and World Bank-supported interventions have succeeded to differing degrees in expanding access to primary healthcare. REBAHS I reached more than 635,000 beneficiaries (59 percent Syrian and 40 percent Lebanese), provided more than 190,000 diagnostic tests, nearly 190,000 vaccination visits, nearly 112,000 antenatal care consultations, and postnatal care to more than 8,500 women.[91] Uptake of REBAHS support by vulnerable Lebanese has increased over time, a product both of the worsening economic situation in Lebanon as well as community outreach efforts built into the project.[92] While the latest data available show EPHRP nearing its 150,000-beneficiary target, lessons learned include the need to move beyond a model focused solely on preventative care and the inadequacy of the system used for targeting beneficiaries. And given the shift in LHRP's focus to COVID-19 response, it remains to be seen whether the World Bank will play a significant role in supporting primary healthcare under the current funding model.

LESSONS LEARNED AND APPLICABILITY FOR THE SYRIAN REFUGEE CONTEXT

1

BUILD INCLUSIVE HEALTHCARE SYSTEMS FOR HOST COMMUNITIES AND REFUGEES

- Ensuring equity of care between refugees and host communities can help defuse social tensions.
- Subsidized care brings health and economic benefits to host communities and refugees, building resilience for both..

The Lebanese experience indicates that including refugees in national health systems can be critical to promoting social cohesion in host regions, but it requires emphasizing equity of care for all populations.[93] In the first years of the Syrian refugee crisis, tensions rose between host communities and Syrians because while international actors covered primary healthcare for Syrians, vulnerable Lebanese had to pay for care under the expensive fee-for-service model.[94] The EPHRP began to address these tensions by subsidizing preventive care for those identified by the Lebanon's vulnerability targeting system as most in need of care. Meanwhile, the REBAHS model took a broader approach by subsidizing primary care for all who sought it at the targeted PHCCs, including both Lebanese and non-Lebanese patients.[95] Over time, the REBAHS model's broader targeting proved effective at ensuring equity of care and popular amongst beneficiaries, and the Beirut blast provided the incentive for the MoPH to use this strategy for the IRM and as the basis for the long-

term uniform model. Importantly, subsidizing care for both vulnerable Lebanese and Syrian refugees set a precedent,[96] and by implementing a model based on equity, it would be difficult to later shift course and exclude previously supported populations. At the same time, this will require long-term support from donors to ensure that the Lebanese healthcare system can maintain this inclusive approach.

By guaranteeing equity of care for both refugees and vulnerable members of host communities, these interventions ensure that their economic and health benefits are enjoyed by all. Subsidized care allows patients to use the money they would spend on healthcare for other purposes, helping reduce household debt and negative coping mechanisms.[97] And by providing access to both preventative and curative healthcare, these interventions improve patient health, which reduces the need for more expensive care down the road. While other countries hosting large numbers of Syrian refugees do not have healthcare systems with the same complexity as Lebanon, ensuring that vulnerable members of host and refugee communities have access to the same subsidized care can help defuse social tensions, improve health and economic outcomes, and foster continued trust in the primary healthcare system.

2

IMPROVE OPERATIONS FROM THE TOP DOWN AND THE BOTTOM UP

- Capacity-building interventions need to address both systemic issues facing primary healthcare as well as the ability of individual PHCCs to provide care.
- Improving the capacity of individual PHCCs builds the community's trust in the quality of care they will receive there, which can lead patients to continue to access care at the centers even after donor interventions cease.

The capacity-building initiatives built into the various interventions in Lebanon have addressed both the primary healthcare system and the care provided at individual PHCCs. At the systems level, investments by NGOs and the MoPH in improving Lebanon's health information service have been particularly useful as the service helps coordinate the care administered throughout the MoPH network and ensures that efforts are not being duplicated. At the PHCC level, NGOs are working with individual PHCCs to strengthen the quality of care provided, integrate mental health services and services for persons with disabilities, and engage in community outreach—efforts that promise to build trust between PHCCs and their communities. If the community sees that the PHCCs can be relied upon for quality care, and if PHCCs commit to ensuring that the cost of care is transparent, their relationship with the community may continue even if support from international donors is withdrawn.[98] Additionally, building the capacity of PHCC management will have a longer-lasting impact for improving future management decisions.[99] Across the Syrian refugee context, capacity-building efforts for healthcare systems can similarly take these two approaches. By effectively partnering with local actors and national systems, implementers can more effectively work towards sustainability.

3

ENHANCE COOPERATION BETWEEN KEY PARTNERS

- Actors and their interventions should complement rather than duplicate each other's efforts, a goal that can be facilitated by improving coordination.

Throughout the Syrian refugee crisis, a plethora of international actors have implemented interventions in Lebanon's healthcare system. These programs have often overlapped in terms of their targeted populations, the healthcare centers involved, and services provided. This has sometimes led to tensions between partners as they compete to include different interventions within their remit or are compared to each other.[100] In contrast, the complementarity model added to REBAHS, following discussions and coordination between implementing partners and with the MoPH, helped ensure that EPHRP beneficiaries (who were all Lebanese) received continuity of care.[101] The ongoing implementation of the IRM and the development of the long-term uniform model shows that with sufficient coordination from the relevant government bodies and effective information-sharing technology, multiple actors can come together to support a uniform healthcare strategy even in a highly fragmented system. These collaboration and coordination mechanisms could be used in other sectors and in other countries hosting Syrian refugees to ensure that efforts complement each other and are guided by an overarching government strategy.

Recommendations

National governments:

- Strengthen local health facilities to improve quality of care for both host-country nationals and Syrian refugees, for instance by investing in capital improvements, integrating mental health services and support for persons with disabilities into primary healthcare, and improving management and monitoring tools such as information-sharing systems.
- Ensure equity of care by providing subsidized healthcare to refugees and members of host communities on the basis of common vulnerability criteria.
- Coordinate the actions of implementing partners to ensure complementarity, for example through the development of a coordination platform. This also promotes government ownership of the collective efforts, which can help improve and sustain the government's commitment to the process.

Implementing partners:

- Build the operational and management capacity of local healthcare centers to ensure quality care, for instance by prioritizing effective service delivery.
- Align humanitarian interventions in the health sector with the host-country government's national health strategy and with development interventions.
- Conduct effective outreach to ensure potential beneficiaries (host communities and refugees) are aware of the health services available to them and to build trust in the quality and affordability of that care.

Donors:

- Secure long-term funding for healthcare interventions in host countries and ensure that refugees are included as beneficiaries alongside host communities.
- Work with host governments to coordinate funding and project implementation so they develop greater ownership over the delivery of health services for all populations on the basis of their needs.

4. SUPPORT FOR SPECIALIZED CARE FOR REFUGEES (MATERNAL AND NEONATAL CARE)

Providing specialized healthcare poses specific challenges in refugee contexts, especially maternal and neonatal care. In the Middle East, Syrian refugees often have limited access to care before, during, and after a child's birth, as well as limited knowledge about essential newborn care.[102] UNHCR's Saving Newborn and Maternal Lives in Refugee Situations programs, which have been implemented in various countries hosting large numbers of refugees, provide several lessons learned that can help inform this type of intervention in the Syrian refugee context.

UNHCR'S SAVING NEWBORN AND MATERNAL LIVES IN REFUGEE SITUATIONS PROGRAMS

Countries	Phase 1: South Sudan, Kenya, Jordan Phase 2: Extension to Chad, Cameroon, Niger
Years active	Phase 1: 2016–18 Phase 2: 2018–20
Key objectives	Improve newborn and maternal care in refugee situations; enhance access to infrastructure and services for women and newborns; counsel women during and after pregnancy; improve health facilities and staff capacity through the provision of equipment and training
Target population	Mothers and newborns in refugee situations, with host communities benefitting from investments in referral district hospitals
Budget	Phase 1: USD 1,003,704 Phase 2: USD 2,979,135 The two interventions are funded through grants by the Bill and Melinda Gates Foundation.[103]

CONTEXT AND NATURE OF THE PROGRAMS

In countries affected by crisis or conflict, maternal and neonatal (newborn) health outcomes are often poor. In such countries, an estimated 1 in 54 women die during pregnancy or childbirth, compared to 1 in 5,400 in high-income countries.[104] Similarly, more than half of the countries with the highest neonatal mortality rates (≥30 per 1,000 live births) are affected by conflict and displacement.[105] The leading causes of these deaths are the lack of capacity to provide emergency obstetric care[106] and restricted access to essential services before, during, and after pregnancy.[107]

UNHCR, through funding from the Bill and Melinda Gates Foundation, has allocated nearly USD 4 million since 2016 to address these challenges in refugee settings across six countries in Africa and the Middle East. In 2016, UNHCR launched the first phase of the Saving Newborn and Maternal Lives in Refugee Situations program[108] in South Sudan, Kenya, and Jordan. These countries were chosen mainly due to the large number of refugees living in camps.[109] Following an initial assessment, UNHCR developed tailored action plans and clinical training packages aimed at improving health workers' knowledge of and skills in providing essential newborn and maternal healthcare.[110]

In the second phase, launched in 2018, UNHCR expanded the program to Chad, Cameroon, and Niger (for two years, until 2020) and sought to apply and consolidate lessons learned from the initial pilot phase. While the objectives remained largely the same, the second phase placed greater emphasis on maternal care and family planning.[111] UNHCR selected these three countries because of their poor reproductive health outcomes and weak health systems, which had come under greater strain following large arrival of refugee populations (with the three countries collectively hosting more than 1 million refugees and asylum seekers).[112]

Box 5. Saving Newborn and Maternal Lives in Refugee Situations Programs

The first phase of the Saving Newborn and Maternal Lives in Refugee Situations program was structured around three main components in the three chosen countries:

1. Strengthening community-based interventions, with a network of local health workers receiving training on how to provide health advice;
2. Enhancing care for low-birthweight newborns, including through methods that can be easily applied in refugee settings;[113] and
3. Improving essential infrastructure for the care of sick or small newborns, for example through the construction of a newborn care unit in South Sudan.[114]

In its second phase in three newly selected countries,[115] UNHCR focused on the following elements:

1. Providing equipment to health centers in refugee sites and referral district hospitals to improve, for example, routine childbirth and emergency obstetric and neonatal care as well as care for sick or small newborns;
2. Developing clinical guidelines and implementing training for health workers (e.g., on family planning, skin-to-skin methods, home visits, and women-centered and respectful maternity services), mainly through the training of "master trainers" in each health facility who would then pass on knowledge to their peers; and
3. Monitoring and data collection on, for example, neonatal mortality and stillbirth rates among refugee mothers and newborns to better address factors contributing to negative outcomes.[116]

A 2019 evaluation[117] of the first phase of the program showed that, prior to the intervention, many good practices in newborn and maternal care were known in theory by staff in health facilities in refugee camps, but that they were not rigorously applied, either due to a lack of training or medical supplies. The evaluation reported that health workers' skills and knowledge improved in areas such as newborn resuscitation and essential newborn care following the intervention.[118] The second phase has not yet been evaluated, but a handful of related studies have reviewed some of the program's outputs.[119] Overall, the initiative had significant coverage, delivering training and medical supplies to 29 health facilities, 21 health centers in refugee sites, and eight referral district hospitals across Chad, Cameroon, and Niger.[120] According to a 2020 study, the on-site training delivered to health workers was deemed particularly successful in the second phase of the program.[121] However, the overall limited funding available to build adequate health infrastructure in humanitarian settings remains a key barrier to providing even basic medical supplies and quality healthcare.[122] For this reason, UNHCR mainly focused on interventions adapted to local constraints to address newborn and maternal health.[123]

LESSONS LEARNED AND APPLICABILITY TO THE SYRIAN REFUGEE CONTEXT

1

DESIGN AND ADAPT PROGRAMS TO RESPOND TO LOCAL NEEDS

- Newborn and maternal health interventions are not "one-size-fits-all" programs; they need to be adjusted to the local context in low-income or middle-income countries.
- Taking stock of the equipment available and assessing healthcare techniques used across different country contexts are critical steps to designing an intervention tailored to the level of resources, technical know-how, and customs in a target location.

The Saving Newborn and Maternal Lives program was implemented in six low- and middle-income countries during two separate phases. To ensure that the intervention could effectively address local needs in these different contexts, UNHCR first assessed existing gaps and priorities in each country. This included taking stock of the equipment available at local health facilities and asking maternity staff to demonstrate certain healthcare techniques, such as neonatal resuscitation.[124] The evidence gathered helped program designers better understand the local healthcare systems and adapt training packages and the provision of equipment according to the level of existing resources, technical know-how, and cultural practices.[125] As a result of the assessments, resource constraints in countries such as Chad and Niger led UNHCR to focus on promoting practices (e.g., skin-to-skin care and breastfeeding) that do not require high and sustained resource investments. By contrast, in middle-income countries, such as Jordan, UNHCR identified a preference among the refugee population for higher-tech interventions (e.g., placing a newborn in an incubator). However, this preference is not always the most appropriate approach for healthcare initiatives in a displacement context. Studies show that various low-cost health interventions, such as maternal kangaroo care, can be at least as safe and effective.[126] Such low-tech approaches can also often be more widely applied in displacement situations and can dramatically reduce the cost of care, pointing to the need to raise awareness among program beneficiaries of the benefits of low-cost health interventions.[127]

This is relevant throughout the Syrian refugee context. For example, in Turkey, caesarean sections are often performed without a medical reason, as per WHO clinical guidelines, despite their increased risk to the health of mother and child compared to vaginal births.[128] Caesarean section rates are currently 30 percent above the global average in Turkey, with higher rates reported in metropolitan areas where most refugees in the country settle.[129] Increased training of health practitioners on routine childbirth care might therefore be particularly useful in this context, with studies showing that midwife care can reduce uses of unnecessary caesarean sections.[130]

2

USE LOCAL RESOURCES TO IMPROVE NEWBORN AND MATERNAL HEALTH IN REFUGEE CONTEXTS

- Involving national and local NGOs and health practitioners with a presence on the ground can limit the need for international consultants and trainers to travel to program locations, which is particularly useful in remote refugee settings.
- Linking district hospitals to health facilities in refugee camps helps integrate these health systems and ensure refugees' access to ongoing or specialized care, provided long-term donor support can be secured at both the local and district levels.

Early on in the program, UNHCR faced challenges delivering essential medical supplies and services to targeted health facilities located in refugee camps in remote regions.[131] In Niger, for example, the agency was at times unable to deploy staff to the field given the security and travel restrictions in the country.[132] As a result, UNHCR shifted its approach and sought to draw more on local resources to mitigate the need for travel and also to help facilitate linkages between refugee interventions and local health systems. This meant involving national NGOs with a local presence as implementing organizations as well as investing heavily in the training of local doctors and midwifes rather than international consultants.

Although this approach required significant upfront investment in training equipment in local health facilities and put some pressure on midwives and doctors to effectively balance their clinical duties with their training commitments, it also helped to facilitate more regular practice as the necessary equipment and expertise were all readily available within the target communities.[133] In addition, it also led the program to work closely with national health ministries to better link primary health centers in refugee camps with district hospitals in the surrounding region (e.g., through referrals). However, as investments in medical equipment and the training of health workers mainly took place in local health facilities, district hospitals benefited less from these measures. In order to reach the growing number of refugees settling outside camps, as well as to support the broader communities in which they live, similar interventions could be scaled up at the district level.[134]

In the Syrian displacement context, refugees often settle outside camps in urban settings, which means they tend access public health facilities. Still, in Lebanon studies have found that distance to health centers can pose a challenge for accessing maternal and neonatal healthcare.[135] To increase coverage, it is important to strengthen local health facilities and advocate for care close to home, such as via postnatal home visits to reach mothers, as promoted under the Saving Newborn and Maternal Lives program.[136] It is also important to train local health staff in regions where higher level of insecurity and measures to combat the spread of COVID-19 might restrict travel and threaten refugees' access to primary healthcare.[137] Finally, effectively linking new health interventions to public health services, for example through referrals to district hospitals, depends on the functioning of these health systems. The room to do so may be limited in countries such as Lebanon, where overall access to specialized services such as emergency obstetric care is limited.[138]

3

ADOPT A COMMUNITY-LED AND COMPETENCE-BUILDING APPROACH

- Training "master trainers" who can pass on their knowledge to others is a low-cost, high-impact approach to increasing knowledge about newborn and maternal health.
- Using online communications channels, such as WhatsApp, with trainers can facilitate improved guidance, peer support, and knowledge exchange.

A large part of the UNHCR program centers around developing innovative competence-building approaches to train community health workers. Specifically, UNHCR has trained refugees who are familiar with local languages and customs as community health workers.[139] Among other topics, the trainings covered how to conduct home visits, call an ambulance, and offer basic services when professional health staff are not available.[140] The program also trained so-called "master trainers," usually doctors or midwives from the host community who are already working in local health facilities, and who then share their knowledge with other health practitioners. This was done through a low-dose, high-frequency approach, which includes on-site short teaching lessons (low dose) followed by longer practice sessions (high frequency).[141]

Despite some challenges in the selection and training of master trainers, including limited proficiency in the instruction language and a lack of motivation among some participants, this approach presented a low-cost option for improving newborn and maternal health competencies in the targeted facilities. In the first phase of the program, a total of 45 master trainers were trained, who then trained a number of health workers in their own facilities in Chad (309), Cameroon (425), and

Niger (100).[142] In addition, the use of WhatsApp groups to maintain ongoing communication and support for master trainers enabled the program to provide further guidance and facilitated peer-support between master trainers.[143]

While countries such as Jordan and Turkey have implemented community-led health training in the past,[144] such approaches could still be scaled up to ensure a more widespread understanding of good maternal and neonatal healthcare practices. A 2015 survey by UNHCR, for example, found that only 23 percent of Syrian women in Jordanian refugee camps were aware of the reproductive health services available to them.[145] The Saving Newborn and Maternal Lives program provides a blueprint for implementing trainings and fostering a community of peers to address these needs, both in low- and middle-income countries.

Recommendations

National government:

- Increase cooperation with UNHCR and implementing partners and link health facilities in refugee camps to district hospitals to help integrate these health systems.

Implementing partners:

- Conduct thorough needs assessments to inform intervention design and adjust for the level of resources, technical knowledge, and cultural practices in the target community.
- Work with national NGOs that have a local presence and with health practitioners on the ground to limit the need for external actors to travel to target locations.
- Use the cascading "master trainer" model to disseminate knowledge and leverage online communications channels, such as WhatsApp, to enable better and ongoing guidance and to facilitate peer support and knowledge exchanges between participants.

By: DRC

5. CONCLUSIONS

Across the globe, refugees face significant barriers to accessing healthcare, whether as a result of not being included in national insurance schemes, an inability to afford primary as well as specialized care, a lack of capacity in local health systems to care for refugees (and at times, other residents as well), or a dearth of data on refugee health needs. While the major countries hosting Syrian refugees have all attempted to provide healthcare to refugees, the protracted crisis has led to reductions in support in some countries while others have been able to maintain relatively robust inclusion of refugees in health systems.

The approaches, policies, and programs analyzed in this chapter provide a number of lessons that should be applied in the Syrian context. First, inclusive healthcare policies require comprehensive, holistic considerations, including how to ensure the policy is implemented smoothly; planning for refugees' long-term access to healthcare, such as through a national or employer-based system; and improving services for host communities as well as refugees to ensure adequate care for all. Second, capacity-building measures, for both general and specialized care, should target local actors and be rooted in an understanding of the local context. Local actors are often best suited as partners in providing healthcare and understanding the local health context in which they operate, assets that will improve the efficacy of an intervention.

As the COVID-19 pandemic puts immense pressure on each country's healthcare system, it also presents an opportunity to better understand systemic issues and address them head on to improve care now and in a post-pandemic world. When rebuilding health systems, refugees' needs must be taken fully into consideration and included as a key objective.

Main Recommendations

National governments:

- Work toward integrating refugees into national insurance schemes to ensure they have access to primary, secondary, and tertiary healthcare.
- Carefully consider how to ensure long-term, sustainable refugee inclusion in and access to healthcare during the planning phase of programs to ensure a smooth, predictable transition once program activities end.
- Invest in local health facilities to improve the quality of care for both host-country nationals and Syrian refugees.
- When possible, link health facilities in refugee camps to district hospitals to support the integration of these health systems.

Implementing partners:

- Conduct thorough baseline assessments to inform the design of interventions and adjust for the level of resources, technical knowledge, and cultural practices in the target community.
- Work with national NGOs that have a local presence and with health practitioners on the ground to limit the need for external actors to travel to program sites. This includes working closely with refugee communities to ensure needs are reflected in program design and operation.

Donors:

- Ensure that funding for public health projects is designed with refugees as a key beneficiary in mind, and that serving them is as part of the results framework.
- Support host-country efforts to fund access to healthcare for the most vulnerable refugees, while also providing support for improvements in the overall healthcare system in host countries, by making health services more effective and inclusive of all residents.

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41 Interview with María Jose Barth and Irving Pérez, UNHCR Costa Rica.

42 Interview with María Jose Barth and Irving Pérez, UNHCR Costa Rica.

43 The decision to include asylum seekers and not only refugees in the agreement was made due to the long waiting periods in the asylum process. Since the situation in Nicaragua worsened, asylum claims in Costa Rica have steadily increased, putting serious strains on the national system. According to UNHCR, individuals must wait around six months to lodge an asylum claim, which increases their dependence on savings and limits their access to services, both outcomes that increase their vulnerability and especially for those who arrive in Costa Rica with serious injuries or other medical needs after fleeing their country of origin. See UNHCR, "Health Insurance Scheme: Project Details."

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89 Author interview with Dr. Randa Hamadeh, Head, Social Health Service and Primary Healthcare Department, Ministry of Public Health, January 20, 2021.

90 Author interview with Adam Jacovou, Project Coordinator, Eduard Tschan, Country Director, Anil Kangal, Deputy Country Director, and Iman Khalil, Health Coordinator, International Medical Corps, January 20, 2021.

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93 Author interview with Dr. Randa Hamadeh, Head, Social Health Service and Primary Healthcare Department, Ministry of Public Health, January 20, 2021.

94 Author interview with Dr. Randa Hamadeh, Head, Social Health Service and Primary Healthcare Department, Ministry of Public Health, January 20, 2021.

95 Because of the variation in quality throughout Lebanon's healthcare system, those who can afford to seek care elsewhere do not use the Ministry of Public Health's PHCC network. As such, all patients seeking care at REBAHS-supported PHCCs are more vulnerable members of society.

96 Author interview with Dr. Randa Hamadeh, Head, Social Health Service and Primary Healthcare Department, Ministry of Public Health, January 20, 2021.

97 Author interview with Adam Jacovou, Project Coordinator, Eduard Tschan, Country Director, Anil Kangal, Deputy Country Director, and Iman Khalil, Health Coordinator, International Medical Corps, January 20, 2021.

98 Author interview with Adam Jacovou, Project Coordinator, Eduard Tschan, Country Director, Anil Kangal, Deputy Country Director, and Iman Khalil, Health Coordinator, International Medical Corps, January 20, 2021.

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108 The first phase of the program is called Saving Newborn Lives in Refugee Situations, whereas the second phase of the program is called Saving Newborn and Maternal Lives in Refugee Situations. For the remainder of this case study, the latter name will be used to describe the overall program, but a distinction will be made between the first and second phases.

109 UNHCR, "Saving Newborn Lives in Refugee Situations" (terms of reference, November 30, 2015).

110 UNHCR, "Saving Newborn Lives in Refugee Settings: Evaluation Summary" (assessment brief, 2019).

111 In part, this was a formality, since the interlinkages between newborn and maternal health had been recognized in the first phase but not always captured formally on paper. See UNHCR, "Saving Newborn Lives in Refugee Settings: Evaluation Summary."

112 UNHCR, "Saving Maternal and Newborn Lives in Refugee Settings: Summary of Project Extension Baseline Assessment" (assessment brief, n.d.); Amsalu et al., "Lessons Learned From Helping Babies Survive."

113 This mainly refers to so-called kangaroo mother care, which involves the infant being carried, usually by the mother, with skin-to-skin contact in order to promote the health and well-being of infants born preterm. See WHO, Kangaroo mother care: a practical guide (Geneva: WHO, 2003).

114 UNHCR, "Saving Newborn Lives in Refugee Settings: Evaluation Summary".

115 UNHCR, "Saving Maternal and Newborn Lives in Refugee Settings: Summary of Project Extension Baseline Assessment."

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118 UNHCR, "Saving Newborn Lives in Refugee Settings: Evaluation Summary."

119 Amsalu et al., "Lessons Learned From Helping Babies Survive"; Stephanie Gee, Josep Vargas, and Angel M. Foster, "'We need good nutrition but we have no money to buy food': sociocultural context, care experiences, and newborn health in two UNHCR-supported camps in South Sudan," BioMed Central International Health and Human Rights 18 (November 2018).

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126 O.E. Ibe et al., "A comparison of kangaroo mother care and conventional incubator care for thermal regulation of infants < 2000 g in Nigeria using continuous ambulatory temperature monitoring," Annals of Tropical Paediatrics 24, no. 3 (2013): 245–51; Pan American Health Oorganization, "Kangaroo Mother Care: Kangaroo mother care — A safe and effective solution," accessed January 25, 2021.

127 For example, in refugee camps such as Zaatari, strong efforts and close coordination on the part of camp management, UNHCR, and the UN Children's Fund (UNICEF) were needed to implement breastfeeding policies, considering the refugee population had become accustomed to using infant formula. This is in part because of general customs but also because previous donors had distributed infant formula in the camp's health facilities. To counter the widespread use of infant formula, new policies were designed that require mothers to get a prescription following a needs assessment by a midwife to obtain formula. See UNHCR and Save the Children, Infant and Young Child Feeding in Refugee Situations: A Multi-Sectoral Framework for Action (Geneva: UNHCR and Save the Children, 2018); Edgar Luce, "Evolution of WFP's food assistance programme for Syrian refugees in Jordan," accessed January 25, 2021; Government of Saudi Arabia, "Saudi clinics distribute infant formula to Syrian refugees" (press release, April 2, 2016).

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131 Amsalu et al., "Lessons Learned From Helping Babies Survive."

132 Amsalu et al., "Lessons Learned From Helping Babies Survive."

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140 UNHCR, "Saving Newborn Lives in Refugee Settings: Evaluation Summary."

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142 Amsalu et al., "Lessons Learned From Helping Babies Survive."

143 The WhatsApp group included trainers, local UNHCR public health officers, and a UNHCR reproductive health officer in Geneva. See Amsalu et al., "Lessons Learned From Helping Babies Survive."

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145 UNHCR, "Health Sector Humanitarian Response Strategy: Jordan 2014-2015" (manual and guideline, UNHCR, June 2015).

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