



**Reflection on inclusive  
health services in  
northwest Syria (NWS)**

## Acknowledgement

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# Introduction

**After a decade of crisis, Syria remains one of the world's most complex humanitarian crises. Continued hostilities, new and protracted displacement, increased returns and the sustained destruction of communities have impacted Syrians' lives and futures in a devastating way. The 2021 Humanitarian Needs Overview (HNO) identified that 13.4 million people, more than half of country's pre-crisis population, need humanitarian support. Of this figure, 12.4 million require health care.**

In northwest Syria (NWS), mainly in Idlib and Aleppo Governorates, 3.4 million people are in extreme and catastrophic humanitarian need. By the end of 2021, there is a significant 29 per cent increase of people in need (PIN) compared to 2020 in Idlib and Aleppo, where the majority of those in need are internally displaced persons (IDPs), women and children. Attacks on health care facilities have decreased, while the Covid-19 pandemic, coupled with economic downturn, have pushed the healthcare system to the brink. As per UNOCHA Financial Tracking Service (October 2021), the Syria Humanitarian Response plan is 64.1 per cent underfunded and health sector also facing severe challenges with only 23.8 per cent coverage.

The most vulnerable and at-risk groups include women and girls, the elderly and people with disabilities. Women and girls are at a higher risk of facing gender-based violence (GBV) as well as domestic, physical, and emotional abuse, which hinder their access to basic human rights including health<sup>1</sup>. Recent evidence suggests that the prevalence of persons with disabilities (PWDs) living in Syria, aged 12 years and above is 25 per cent - almost twice the global average<sup>2</sup>. In Aleppo and Idlib Governorates, the internally displaced persons (IPDs) prevalence demonstrates that women and girls are more likely to experience disability than men and boys. This cohort also faces increased protection risks and infection from Covid-19 due to their interactions with and reliance on caregivers and personal assistants.

With generous financial support from the Swedish International Development Cooperation Agency (SIDA), Islamic Relief (IR) is responding to the immense health needs of vulnerable women, girls, men and boys in NWS, where we work in Idlib and Aleppo Governorates. The programme includes the provision of support to the healthcare system of NWS in order to ensure the vulnerable population of NWS has a better access to healthcare. The main focus of the programme is to uphold the core protection elements of prioritising safety and dignity and avoiding causing harm, arranging for people's meaningful access to assistance and health services, setting up comprehensive accountability measures, and supporting participation and empowerment of the affected communities. By enabling health care service delivery to a very vulnerable population in NWS, the intervention is addressing one of the major protection issues in the area - safe and equitable access to health care services.

Under the SIDA programme in 2020, IR operated inclusive car services to strengthen the referral pathways - i.e. transporting communities to and from the relevant health facilities. IR is committed to improving its approach to protection and inclusion, and with this aim in mind, conducted a learning and reflection exercise to document best practices, lessons learned and ways forward. Conclusions from this reflection paper will be used to improve future interventions on mainstreaming protection and inclusion within the health programme of Islamic Relief in Syria.

<sup>1</sup> [https://www.globalprotectioncluster.org/wp-content/uploads/Disability\\_Prevalence-and-Impact\\_FINAL-2.pdf](https://www.globalprotectioncluster.org/wp-content/uploads/Disability_Prevalence-and-Impact_FINAL-2.pdf)

<sup>2</sup> Syria -Protection Cluster November 2020

# Health services in northwest Syria :



The collapse of the healthcare system in NWS is a direct outcome of the protracted crisis. What remains of the health system in Syria today is inadequate to respond to the level of need. In NWS (Idlib and Aleppo Governorates), 82 hospitals, 178 primary health centres (PHC), 78 mobile clinics, 46 specialised care centres and 53 other facilities are functional as of June 2021<sup>3</sup>. However, even the operational facilities are far behind the global health indicators in terms of the availability of qualified staff, medicines and equipment.

The most common barriers to accessing healthcare reported by communities in NWS include the high cost of transportation to health facilities (75 per cent), lack of transport to health facilities (69 per cent), lack of medicines at health facilities (49 per cent), inability to pay for health services (47 per cent), overcrowded facilities (46 per cent), no functional health facility (30 per cent), facilities not being accessible for people with disabilities (27 per cent), lack of ambulance services (26 per cent), specialised services not

being available (15 per cent), no separate waiting space for women and girls (14 per cent)<sup>4</sup>. Furthering adding to these barriers, disrupted medication supply chains, local currency fluctuations and unilateral coercive measures on local pharmaceutical production have increased the price of medicine in Idlib and Aleppo compared to in 2019. Communities are forced to pay out of their own pockets (for general consultations, medicine, tests, treatment, etc.) and in most cases, this remains one of the main challenges to accessing healthcare services. Furthermore, the health system continues to suffer from a lack of health professionals who left Syria after the crisis began. In NWS an estimated 70 per cent of trained health professionals have left Syria.

<sup>3</sup> Health resources and service availability monitoring system -HeRAMS 2nd quarter 2021

<sup>4</sup> REACH assessment NWS-May 2020

# The link between health and protection:

The lack of access to healthcare is a major protection risk. It leads to negative health-related coping mechanisms and other protection risks. Some of the most commonly used strategies for dealing with a lack of healthcare services include visiting a pharmacy instead of a health facility (89 per cent), seeking non-professional care (31 per cent) and using non-medical items for treatment (20 per cent).<sup>5</sup> The reliance on negative coping mechanisms has worsened in the light of Covid-19 pandemic and repeated displacements which have caused serious protection issues affecting vulnerable groups including women and children of all ages and abilities. Three other major protection concerns are increasing psychosocial stress, GBV, and attacks on health facilities.

Furthermore, according to the Protection Monitoring Task Force (PMTF) reports April to June 2019, the protection cluster of NWS, costs related to transportation are one of the main obstacles to healthcare access and contribute to the accessibility gap in the area. One of the recommendations of the same report was to increase access to health services with a "focus on vulnerable groups such as boys and girls at risk, women and girls at risk, (including female-headed and child-headed households), older persons, and persons with disabilities."<sup>5</sup>

While seeking healthcare is a challenge for most community members, it is even more challenging for women, girls, people with disabilities and older people as they face additional barriers due to their gender, age and disabilities.



<sup>5</sup> Protection Monitoring Task Force (PMTF) Protection Monitoring Report April-June 2019

# Islamic Relief's health response in Syria:



IR began working in Syria in 2013 and has reached over 2.7 million people in NWS (Idlib, Aleppo, Hama, and Latakia) to date. IR operates out of two offices in Syria and also has valid registration in Turkey, which provides cross-border management through the Bab Ul Hawa border to facilitate financial, logistical, and HR technical support for the health and protection sectors. In the past eight years of operating in NWS, IR has implemented numerous high-impact health projects, benefitting over 500,000 rights-holders annually - particularly women and children. Protection projects include supporting six referral teams and providing services to 450 people each month through outreach workers. IR's well-established partnerships with donors (e.g. the United Nations Office for the Coordination of Humanitarian Affairs, United Nations Children's Fund, World Food Programme, Swedish International Development Cooperation Agency, the German Foreign Ministry, Disasters Emergency Committee, Catholic Agency for Overseas Development) have significantly catalysed project implementation across all sectors including health. IR has 108 local staff - 68 in Syria (including two dedicated protection and inclusion staff) and

40 in Turkey, who are well-versed in dynamics and culture of the communities we support. Through relationships with local councils, health directorates, communities and faith leaders, IR is able to access difficult-to-reach areas and support organisational credibility and acceptance among stakeholders that participate in project design, especially those most susceptible to GBV and inequality. All senior programme team members are trained on inclusion and protection practices and adhere to all protection guidelines and principles. This, and specific expertise on GBV case management, ensures gender mainstreaming throughout project planning and implementation. IR regularly conducts security assessments and scenario planning to ensure alternative plans are available to mitigate any potential access/safety issues. IR also participates in UN clusters and working groups, and has contributed to joint multi-sector needs assessments.

IR is currently supporting more than 70 health facilities that include two dialysis centres, one cardiology centre and four mobile health emergency units in NWS.

# Islamic Relief's inclusive car services:

Based on the learnings and findings of a SIDA-funded health programme, IR introduced inclusive car services for effective referrals. As for GBV survivors and other vulnerable groups (women, girls, people with disabilities and older people) one of the main barriers to seeking healthcare is the unavailability of safe and accessible transport to a health centre facility. The need for inclusive referral pathways was highlighted during field visits and interviews with rights-holders. In addition, supporting referral services was further suggested by health staff and during health directorate meetings in which our support of people with disabilities and other rights-holders unable to travel to the health facility was underlined. In such cases, nurses would travel to the homes of the rights-holders (mostly PWDs) and provide care. This was found to be time intensive and disruptive of other services. The preferred idea was to support referral services as suggested by all parties.

Three vehicles (ambulances with stretchers, ramps and adequate room for the comfort of the beneficiary and their companion if present) and three outreach workers (health professionals with experience of dealing with GBV cases) provided transportation and follow-up care for patients/survivors in a protective and inclusive manner.

These vehicles were based in health facilities supported by the SIDA project with stipends and running costs as well as medical items. The vehicles provided transportation to rights-holders to and from the health facilities. The support ranged from transport from a health facility of primary specialisation to a health facility of higher specialisation, transport from a health facility to a women and girls' safe space and transport from a health facility back to the patients' homes. Some of those transported had suffered GBV, and the majority were cases of PWDs in need of transport and rights-holders who had undergone a major operation and needed adapted transport to return home.

These vehicles and teams were based in: MEU3 (Al-Bardaqli), Al Hidayah PHC center (Qah) and MEU4 (Deer Hassan), all working with various medical centres and hospitals in Idlib and Aleppo Governorates.





# Methodology - Learning reflection:

The purpose of this learning reflection is to provide practical programming and operational recommendations to meet the different needs of women, men, boys and girls - especially the most vulnerable i.e. people with disabilities and older people - and to ensure we 'do no harm' and adapt services to the tight time frames, rapidly changing contexts, and insecure environments that characterise humanitarian interventions in Syria.

IR developed a structured quantitative questionnaire as a key tool for data collection from respondents mainly to understand the demographic of the people using IR's inclusive car services, their experience of the service and recommendations to improve similar interventions. Using a developed questionnaire, individual interviews were conducted with rights-holders who used the referral support vehicles in the three supported health facilities.

The questionnaire was divided into two sections: The first had general demographic information and the Washington Group Set of Disability Questions. The latter is a validated and endorsed tool developed to collect data on functional difficulties, which asks the survey participants if they have any difficulties doing certain activities. For individual interviews, participants were selected based on self-reported disabilities. The inclusion of the Washington Group questions helped to gather the perspectives of people with different disabilities and from different age and gender groups on the provided inclusive care services in order to improve access to health services. The second set of questions collected data on community feedback, the usefulness of the provided service and how this referral service could be further adapted.

A total of 130 individuals - 63 female and 67 male - with a broad age range of between 18 and 82 years engaged in this exercise. Girls and boys under 18 participated in the presence of their parents/caregivers. The interviewees were selected through random sampling method.

## Limitations:

The disaggregation of data was limited as right-holders were using the referral vehicles for many reasons including GBV. Thus, the reason for using the inclusive referral vehicle was not included in order to protect the privacy of GBV survivors who used the service.



# Findings:

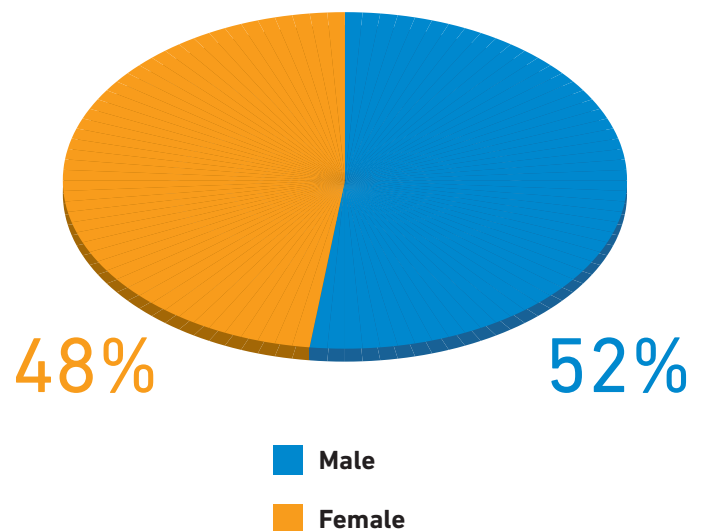


## A: Reaching diverse communities

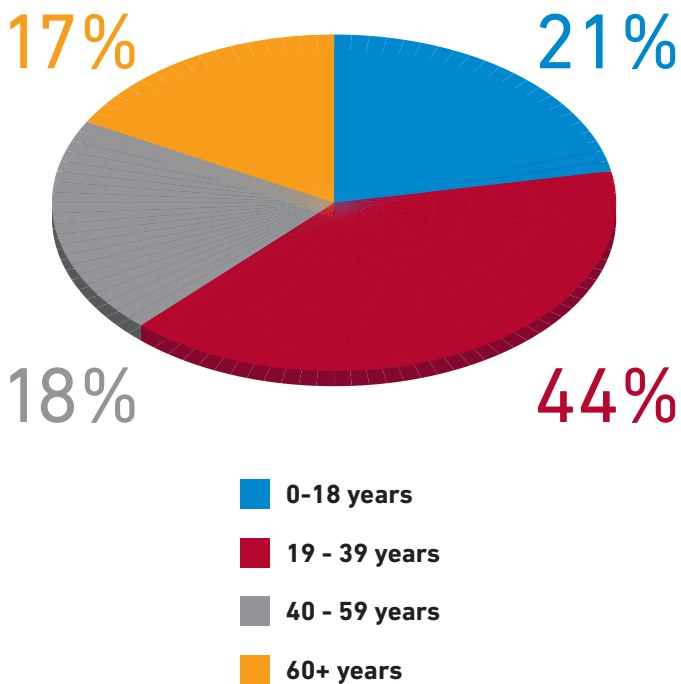
The interviews confirmed that all members of the catchment population of IDPs and host communities, including children and PWDs, were able to access health facilities through the car service.

The following pie charts show the age, sex and disability of the questionnaire respondents (main users of the inclusive car service) as percentages. As can be seen below, 48 per cent were female and 52 per cent were male. Using Washington Group questions short set, sixty-eight per cent were identified as people with disabilities with different functional limitations.

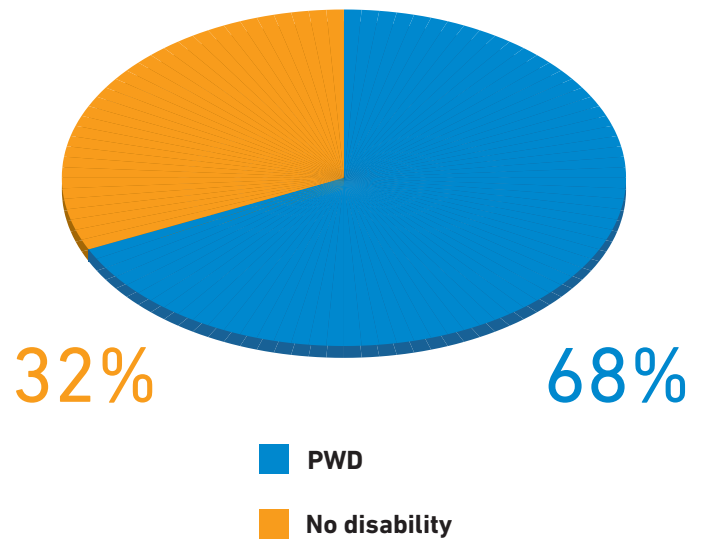
**GENDER OF RESPONDENTS**



## AGE OF RESPONDENTS



## ABILITY OF RESPONDENTS



The communities in NWS are a mix of residents, returnees and IDPs. With the escalation of hostilities, NWS (near the Turkish-Syrian border) is considered to be a safe haven and so over 70 per cent of the population in NWS is comprised of IDPs (who have been displaced within Syria, often multiple times). Syrians are facing escalating violence and deepening economic crisis exacerbated by Covid-19 and climate change. More than 90 per cent of the population live below the poverty line, with 60 per cent at risk of going hungry in 2021 — the highest amount since the Syrian crisis began. Parents are eating less so they can feed their children, and they are sending them to work instead of school. Out of the 1.7 million school-aged children (three-17 years of age) in NWS, approximately 60 percent (or more than 1 million children) are estimated to be out of school. Fourteen per cent of households in NWS live in shelter smaller than 20 square meters. Reflecting the local impact of the global climate crisis, since autumn 2020, unseasonably low levels of rainfall have contributed to water shortages and low agricultural production has fuelled inflation, particularly of staple food commodities.

Both IDPs and host communities used IR's inclusive car service. However a high percentage of the interviewees were IDPs. The IDP to host community percentage in the three areas where IR operates is as follows: Al Hidayah center (Qah) 95 per cent: five per cent, MEU (4) 93 per cent: seven per cent, MEU (3) 80 per cent: 20 per cent. This is mainly due to the fact that in these three areas there is high percentage of IDP households.

Persons with different types of disabilities were able to use the service as reflected by a wide range of respondents.

- Nine respondents mentioned they were unable to see even if they wore glasses.
- Two respondents suffered from total hearing impairment, meaning they cannot hear even if using hearing aids.
- The most reported disability among respondents was physical impairments. One of the major components in SIDA programming over the years has remained the light refurbishment of health facilities to make them accessible and inclusive. This has included providing ramps for wheelchairs, wheelchair-adapted restrooms etc. More importantly ramps are also available in the referral vehicles.
- Very few respondents had problems with concentrating or memorising information.
- A low number of interviewees reported to need a caregiver to maintain their personal hygiene/wearing clothes.

## B. Service communication (how the respondents heard about the service)

The Syrian crisis has had a strong impact on the way Syrians communicate with each other and consume media content, and has affected Syrians' social interactions in many ways. Large numbers of people have been displaced from one region to another or have had to leave the country entirely. In other cases, movement has been highly limited because of checkpoints, snipers, or indiscriminate bombing. The effects of the crisis on electricity lines, telephone lines, and internet cables has substantially transformed how Syrians can access and use media tools and devices. At the same time, globalisation and the political/security context has increased Syrians' need to access information and to be connected. The crisis has reshaped the networks of Syrians, sometimes creating separation and lack of communication, and other times encouraging new forms of interaction that have increased shared knowledge.

In NWS, in the initial years of crisis after the Government of Syria lost control of the region, the state shut down all services, including internet and landline communications. However, internet connections have now been re-established. The internet has rapidly become the most practical tool of communication for Syrians by far. In fact, Syrians in NWS today mainly rely on two means of not only connecting with each other but also receiving crucial information: one is social media platforms such as WhatsApp, Skype, Facebook and Viber, and the other is walkie talkies.

Although daily internet use is common, some barriers to access persist. For example, the costs associated with phone calls and internet communication are relatively high - on average, 3,374 SYP (US\$ 18) and 4,208 SYP (US\$ 22) is spent per month on internet and phone communication respectively. In addition to these high costs, electricity supply is a critical barrier to internet access, with batteries and internet cafes being used as the main coping measures to deal with lack of internet at home. Another cited barrier specific to the use of social media platforms is privacy protection. There are concerns related to the reliability of privacy settings for one's personal account and posts, which limits the willingness of people to use such platforms to communicate sensitive information.

Social gatherings and word of mouth (from trusted source such as local council members, camp managers, health facility staff, community leaders etc.) are widely used to share information. The absence of newspapers, television channels and radio infrastructure greatly limit their use in NWS.

IR upholds its commitment to ensuring that no one is left behind. To ensure that the targeted catchment population is aware of the inclusive car service, different methods and approaches were used. The highest percentage of respondents (55 per cent) heard about the service from medical staff working at the health centres. Twenty-nine per cent received the information from their friends/relatives, while a very small percentage - 11 per cent and five per cent - heard about the service from the internet and local councils respectively. The results show that the communication approaches were inclusive, for example by providing word of mouth information for both literate and illiterate PWDs, advertisements on the Facebook pages of the health facilities, voice messages through the WhatsApp groups of local councils and camp groups etc. Yet the use of internet/social media could be further strengthened to ensure a wider coverage for future initiatives.

## C. Perspective of inclusive car services users:

After a decade of attacks on hospitals, ambulances, and clinics, barriers to healthcare access have become a grim yet expected reality for many Syrians. Healthcare in the northwest of the country is under threat not only from military attacks on health facilities but from high-level bureaucratic decisions such as Syria cross-border resolution which now allows the use of only one border crossing. This greatly limits the timely movement of large quantities of aid – including medicine and medical disposables for health facilities - from the UN into the wide area along the Turkish-Syrian border of NWS.

The most common barriers faced by the respondents of the questionnaire when accessing health services include: no male companion capable of assisting with transportation (58 per cent), lack of transportation (20 per cent), bad road conditions (14 per cent) and long distances (eight per cent). These responses were in line with previous assessments carried out by IR. The lack of safe and secure transportation (adapted for PWDs) is also a significant barrier. Furthermore, the majority of respondents – mainly women and girls - also mentioned protection issues on the road to the health facilities as being a barrier to access as they meant the women and girls had to be accompanied by a male companion when visiting a health care facility.

Concerning the differences between male and female respondents, the following was noted:

1. The most common way of learning about the services was firstly through medical staff and secondly through friends. Ten per cent of male respondents learned about the service through friends compared to three per cent of female respondents which highlights women and girls limited access to such services.
2. Both male and female respondents suggested using social media and social gatherings to promote and increase knowledge about the services throughout the community.
3. Very high satisfaction was shown by both male and female respondents - 97 per cent, 95 per cent respectively.
4. The main difference between male and female respondents was the coping mechanisms in cases where no referral services to specialised facilities and treatment were available. Male respondents relied on paid taxis 25 per cent of the time vs 35 per cent for female respondents. Male respondents also relied on motorcycles 16 per cent of the time vs zero per cent for female respondents. Male respondents relied on friends and family 30 per cent of the time vs 43 per cent for

female respondents. These figures show that women and girls rely more heavily on other family members than men and boys. Also, motorcycles are a viable option for a minority of male respondents but not at all for female respondents.

Understanding access barriers, IR strategically included inclusive car services to reduce barriers to accessing quality health care and to help increase outreach by ensuring everyone gets the health care they deserve.

During the survey, respondents were also asked their opinions on the inclusive car service i.e. whether or not they thought it was important, relevant and effective.

Over 82 per cent of respondents felt very strongly that the car service was useful for referrals and showed a high degree of satisfaction with the service provided, including saying they will recommend it to others. The remaining 18 per cent were very satisfied and they also recommend the service. Seventy per cent of respondents said they would use another free-of-charge alternative as they cannot afford the cost of transportation. These alternatives include requesting support from relatives or neighbours (36 per cent), using public service cars such as civil defence (13 per cent), or an ambulance (13 per cent), or motorbike (eight per cent). Only 30 per cent of the respondents could afford to rent a private car.

Ninety-nine per cent of the respondents did not face any difficulty in accessing the referral car service. Only one respondent mentioned facing some difficulty accessing the service, this was mainly because there was no accompanying person to help him reach the centre.

The respondents recommended increasing the number of referral cars to expand the service provided (28 per cent), continuing the service without any interruptions because of its usefulness and relevance for the catchment population (41 per cent), including an ambulance technician to accompany patients in the car (eight per cent) and using innovative techniques and methods to spread awareness about the availability of service (six per cent). While 17 per cent thought the referral service was good enough as it is.

The analysis shows that the referral car service is extremely essential and required by the communities as it is the safest and most convenient free-of-cost service available and accessible in the targeted areas. In the future, IR can also coordinate with referral systems such as ambulances, civil defence or other such organisations providing similar support to ensure continuity of this service.

# Conclusion and recommendations:

**The following are the main conclusion and recommendations for stronger inclusive programming in IR Syria operations:**

- Build and strengthen partnerships with OPDs (Organisations of Persons with Disabilities) or groups as well as women and girls' empowerment centres/women and girls safe centres is key to further improving inclusive approaches. This would effectively help in the dissemination of information to those most in need of this service. Furthermore, such steps would enhance the reach of the service by receiving concrete feedback on how to better design the intervention by incorporating the target groups' feedback.
- Provide access to the referral car service for both IDPs and host communities on equal basis. Due to the immense health needs, all regardless of their residency status are equally in need of an inclusive referral car service. However, since the IDPs are extremely vulnerable the service should target areas where there is large proportion of IDPs.
- Accommodate the needs of people with different types of disabilities through dedicated staff at the targeted health centres. For example, train one staff member in Al-Hidaya Health Centre to guide patients with visual impairments. Similarly, liaise with sign language experts who may be contracted to assist patients who are deaf or hard of hearing.
- Use a twin track approach by strengthening referral pathways to include specialised medical centres for deaf and hard of hearing people and those with intellectual/ cognitive difficulties who may need neurological support.
- Expand the car service to include patients' pick up and drop off from their homes. This is most relevant for female patients without a male companion, and GBV survivors.
- Provide a variety of inclusive communication methods such as displaying a screen in the patient waiting room - visual explanations of important information and services provided must be exhibited for deaf and hard of hearing people.
- Coordinate with local council's/health facility's social media such as Facebook posts to reach to a large number of people.
- Inform women, PWDs and child protection support groups directly about the services provided.

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