

**ACTION
FOR
HUMANITY**

 **Syria
Relief**

 North West Syria

SEMI FIXED HEALTH UNITS MODALITIES, POTENTIAL AND LESSONS LEARNED

Charity Number: 1154881



List of abbreviations

CHW Community Health Workers
AFH Action For Humanity
SR Syria Relief
NWS North West Syria
IDP Internally Displaced Population
PPE Personal Protective Equipment

Written By: Ronja Baatz – Mohamad Shahin
Contributer: Ahmad Habboush

Background

For the past two years (Nov 2020 - May 2022), Syria Relief (SR) has developed a semi-fixed clinic approach which allows for the delivery of a comprehensive set of health services in the challenging setting of internal displacement camps in North West Syria (NWS). The project aims to deliver primary health services, essential reproductive healthcare, nutrition services and pharmaceuticals to the internally displaced population (IDP) in camps.

The project recognized that while camp residents have limited ability to travel to or pay for health services, it is not feasible to establish fixed health services inside of all IDP camps. A mobile strategy remains indispensable for the time being. At the same time, the intermittent nature of mobile health services is a widely recognized shortcoming.

Mobile clinics are poorly suited for monitoring chronic illness and are not always present to respond to medical emergencies. However, in humanitarian contexts, including displacement and the establishment of ad hoc camps, mobile approach is nevertheless needed. The semi-fixed clinics SR has been running try to strike a balance between providing continuous care while servicing multiple communities at a time.

This brief description covers how the mobile health strategy was conceived and implemented, and how it navigated the challenges of the COVID-19 pandemic. It also discusses the lessons we have learned in the process. It is meant to inform other healthcare providers about this approach and invite discussion.

Recommendations

We strongly recommend that service providers maintain some form of mobile service delivery as part of the health strategy in NWS.

We strongly recommend that donors consider longer term funding. This will allow:

- service providers to move away from a semi-fixed funding approach. And provide some consistency in service delivery
- service providers to build a degree of trust with affected populations and establish stronger relationships.
- Cumulative data collection, such as individual patient files

We strongly recommend that donors invest in and procure trailers as a sustainable asset for health service delivery in times of emergencies. This will:

- Improve the privacy and quality of the services, as well as the trust of the beneficiaries.
- Ensure better quality and less operational cost in the long run
- Contribute to the sustainability of the project: Owning the vehicles within the organisation means a reduced reliance on donor support which can channelled into other priorities. If funds run low in the future, the clinic can continue running at decreased capacity, and is not limited by the availability of the facilities.
- Significantly reduce the monthly running costs of the project because the alternative is renting vehicles for the whole month.



Mobile Health Clinics

The term 'mobile clinic' is used to describe both mobile teams which visit communities by car, as well as mobile medical units, or vehicles with enough space for medical examinations (Abujaber et al. 2021). The use of mobile health clinics in humanitarian emergencies is widespread, but little researched (McGowan et al. 2020).

Few commonly accepted guidelines exist, and guidelines for implementation are especially rare (Abujaber et al. 2021). For the Syrian context, the most detailed guideline is the Essential Health Service Package (EHSP), which describes the tasks and the structure of a basic mobile clinic (Ramadan et al., 2020)

Health System Service Delivery and Current Governance in North West Syria

Before the 2011 crisis, Syria was a middle-income country with relatively good health indicators. In the wake of the crisis, however, the effects of war and the targeted attacks on health providers resulted in a severe deterioration of the healthcare system. The non-government areas in NWS suffer severely from this. The effects of war are compounded by critical limitations to access to medical equipment and medications, as the borders are tightly controlled. Moreover, up to half of the health facilities have been destroyed in the war, and up to 70% of healthcare providers fled the country (Alhafar and Janos, 2021). This has further increased workload and mental pressure for the remaining staff.

In 2019, NWS experienced a new wave of displacement after a large-scale offensive caused an estimated 1 million people to be displaced. About 2.6 million of the 4.6 million people living in NWS are internally displaced, and about 1.6 million of these live in IDP camps, monitored by the Camp Coordination and Camp Management (CCCM) cluster. These camps experience significant gaps in essential services.

The governance of the health response in these camps is done mainly through the Health Cluster, located in Gaziantep, Turkey in coordination with other entities such as health directorates and community-based organisations. The health system is primarily run by humanitarian actors and funded by international donors. The role of the Health Cluster is to keep track of service distribution, issue service provision standards, communicate priorities and set emergency response plans (Alzoubi et al. 2019).





Establishing Mobile Services

Running mobile services through SR was introduced in the wake of the COVID-19 pandemic. At first, the approach was modelled as mobile teams. However, six months after the project initiation, it became clear that although the approach is needed to deliver urgent health needs for IDPs, working with mobile teams had significant shortcomings. Therefore, in a next phase of the project, Syria Relief bought two trailers, and switched to a semi-fixed approach.

In the first stage (Nov 2020 - Jul 2021), SR rented a total of four vehicles inside Syria, two per medical unit, and had them converted into mobile medical practices. The larger converted vehicle was equipped with water and electricity access inside, and the smaller van had an examination table and shelves.

Full medical examinations were not possible inside the vehicles and had to be conducted in tents. However, the vehicles could transport the medical team, medication and equipment. Especially once SR secured sufficient budget to run a basic pharmacy, the spaciousness of the larger van proved useful.

For each of the two teams, SR hired a general practitioner, a midwife, two nurses, a pharmacist, two nutrition councillors and four community health workers (CHW). The team we hired complied with the EHSP guideline, except that we added a pharmacist to the team, and did not hire a mental health worker. The recruitment took a long time because medical staff are scarce in NWS. But through our networks, we eventually managed to complete the team.

COVID-19 Protection

The clinics began operations at the height of the COVID-19 pandemic in Syria. They had to implement sound infection prevention measures from the start. Ensuring availability of Personal Protective Equipment (PPE), disinfectant and cleaning supplies, and maintaining social distance in the waiting areas and queues were all crucial components of the service.

The addition of a flexible retractable roll of thick cloth to the mobile clinic allowed two key advantages: protection from harsh weather (hot and rain) and proper distancing between patients waiting to receive the service.

Additionally, large gatherings were suspended and training for staff was delivered online when possible. Lastly, instead of distributing brochures, posters were put up in public places.

Service Provision With Mobile Teams

The medical services were introduced in November 2020. When planning the schedule, adequate time was given (approximately one month). This was to account for the changing projects and schedules of humanitarian actors and partners.

Healthcare providers actively sought out patients in new camps by visiting tents. Patients were then referred to the clinic, and where appropriate, they could receive awareness sessions. After the CHWs had visited each tent, the camp was considered screened, and once all the patients had received the necessary attention, the team would move on to the next camp.



Transition to Semi-Fixed Units

The mobile teams faced significant challenges. These included concerns about clients' privacy and follow ups on identified patients. Moving toward a better delivery model, in the beginning of 2021, SR's parent organisation Action for Humanity (AFH) initiated a large-scale fundraising campaign to raise 10,000 GBP to purchase and convert two trailers, containing a total of four consultation rooms. The trailers, which were designed by SR in the absence of ready-made trailers in the region, could be moved using a tractor or SUV, but would remain stationary in the camp. The trailers were guarded by guards from the same camp for the duration of the stay in the camp. Selecting the guard from the same camp helped to strengthen the sense of ownership and involvement of IDPs in service delivery. In addition, it provided financial support for one IDP family by securing a job opportunity.

Service Provision from the Semi-Fixed Clinic

The semi-fixed clinics (Nov 2021 - June 2022) provided essentially the same services as the mobile teams. The major difference was that, in the new approach, the clinics enabled proper follow up routine on identified cases and eliminated privacy concerns. It had continuous access to electricity through a generator, could run air conditioning during the summer and had reliable access to ultrasound.

The clinic stayed in one camp for a longer period than the teams, usually for approximately one month. This contributed to an increase in patient trust.

The new schedule also freed up time for the staff to return to previous camps with a separate vehicle and provide follow-up visits. The increased timespan inspired a new approach by the CHWs. Rather than taking the whole month to screen the camp, they began a new assignment with a brief screening of the whole camp. They identified all cases which required attention and put off the awareness sessions until later. This prevented delay in identification and allowed CHWs to return to cases who had not shown up to the clinic towards the end of the assignment.





Lessons Learned

Working from semi-fixed trailers provides significant advantages in the context of NWS. It was clear that working from the trailers improved the privacy and quality of the services as well as the trust of the beneficiaries. Although moving trailers through rough terrain will not be possible in every environment, in the context in NWS it is feasible.

The most important obstacle to the deployment of trailers is that it is difficult to convince donors to invest in procuring such trailers as a sustainable asset for health service delivery in times of emergencies. This has contributed to the big debate about emergency vs development in crisis like the Syrian one. Reports like this one is part of Syria Relief's effort to advocate for similar approaches which bring better quality and less operational cost in the long run. Key health indicators were enhanced because of this model such as ANC/PNC follow ups and NCD patients follow ups. Academic and scientific evidence derived from such pilot projects are fundamental to support advocacy efforts.

Importantly, purchasing clinics significantly reduces the monthly running costs of the project, because the alternative is renting vehicles for the whole month. By designing them ourselves we could significantly reduce building costs. And owning the vehicles within the organisation meant a reduced reliance on donor support which can channelled into other priorities. If funds run low in the future, the clinic can continue running at decreased capacity, and is not limited by the availability of the facilities.

It is possible to conduct follow-up visits in a mobile clinic

The intermittent nature of service provision is a marked downside to mobile service delivery because chronic diseases can often not be followed-up well, and the clinic is not continuously available to respond to urgent medical needs. The ICRC even cautions against the use of mobile clinics for this reason (du Mortier, 2007). However, considering that it is not realistic to provide continuous services to each camp, and residents can often not afford to travel to nearby clinics, some form of mobile service delivery must remain part of the health strategy in NWS.

By planning several dates in the next month to return to previous camps means part of this problem could be overcome. Patients could receive a follow-up appointment for nutrition support, antenatal care or a chronic condition the next month. They would be contacted again several days before the visit, to remind them. The team arrive in vans on the day of the follow-up and conduct either home-visits or arrange a tent for more privacy when necessary. In case a patient required additional examinations, they could be taken to the semi-fixed clinic in the vehicles the staff came in.

For this approach to work, it was important that the camps were geographically close to one another, so that the teams could easily reach the main camp again. It is also important to consider the limit of the total number of camps that can be served in this way, so that the backlog of follow-up visits does not distract from providing health services at the semi-fixed clinics. From our experience, this is likely about 3-4 different camps (taking into consideration the size of the camp and number of residents), meaning a routine of visiting 4 camps 3 times a year would be feasible.

Issues Faced in Delivering This Service

The primary challenge complicating the use of the semi-fixed clinic is intermittent funding. Projects are usually funded for no more than six months. Therefore, the schedule for the clinic cannot be made more than 6 months ahead. The semi-fixed approach is founded on the idea that one consistent set of camps is being serviced by the clinic over the course of a year. Only then can care be provided on a more or less continuous basis, can beneficiaries gain a degree of trust in the services and can a therapeutic relationship be established. When the project can only plan six months ahead, it is possible that camps we previously serviced by the semi-fixed clinic will subsequently be serviced by different organisations. Because we cannot guarantee funding past one project's duration, it is not responsible to stop other service providers from stepping into the service gap. Therapeutic relationships, patient files and beneficiary trust are lost in this way. To get most out of the semi-fixed approach, the project needs an annual funding model.

A second problem we continue to face is that the dire conditions on the ground inhibit healthcare seeking behaviour in camp residents. In our experience, chronic conditions are often neglected, and people no longer prioritise taking care of their health after having lived in hopeless circumstances for years on end, without any signs of change. They don't take medications for conditions that do not immediately threaten them, don't prioritise a healthy lifestyle, miss healthcare appointments and often do not safely store important medical documents.

CHWs have found it key to the success of the project to visit people personally in their tents, because their experience is that many people would not have visited the clinic without encouragement. Only by an integrated response which raises living standards for all people living in IDP camps might people gain a sense of hope and responsibility again.

Finally, sound data collection and record keeping remains an issue. Most records are kept on paper or in excel files. Excel files easily become clogged and too large to open when they are used for patient record keeping, and they do not allow for cumulative data collection, such as individual patient files. With the current data collection methods, basic project indicators can be traced. However, patient histories and treatment records cannot be stored. In fixed clinics, SR used to work with acceptable software, which had an offline mode fit for the unstable internet connection on the ground. But a budget had so far not been available to use such software on the small scale of the mobile clinic. The software would also not allow for data sharing between organisations and healthcare providers. Integrated and freely available medical record software would make a major difference, but it is not realistic to expect that such systems would be available in the short-term.



What Opportunities Do We Foresee in the Future?

The semi-fixed clinics have been run with success for the past few months, and the medical staff which has been involved with SR over the years has repeatedly expressed how proud they have been of the evolution of the project and its ensuing success. The clinic became more appropriate for patients and more pleasant to work in for staff. It clearly has long-term potential. Still, the most important feature of this approach still needs to be tested. We still need to try what happens when we run the clinic for a full calendar year, and in that way re-visit camps, get acquainted with the population and really take up the role of a semi-permanent health facility.

We want to conclude this brief with two take-home messages. Firstly, we want to draw attention to all the stakeholders throughout this project who have welcomed innovation, and stress how important it is to be willing to try new things. These include the CHWs who invented a new visitation routine coordinated with the GP and the midwife and leading to increased follow up rate, our headquarters who were willing to fund trailers and the engineer in SR who proactively volunteered to support in the design.

Secondly, we were glad that our headquarters and donors saw the value of a long-term investment, and want to stress that the protracted nature of the crisis calls for much more long-term planning than is currently the case. Camps remain designated 'temporary', which means no permanent facilities can be established there.

Donors are reluctant to make guarantees for the future - because they themselves don't have secure funding - which consequently means implementing organisations lack incentives to make long-term plans. Especially for a project like ours, which aims to establish reliable access to quality healthcare, such long-term funding is vital. We hope that despite ever-increasing donor fatigue, the awareness of the need for a long-term strategy will increase.





References

Alhaffar, MHDBA, Janos, S. 2021. Public health consequences after ten years of the Syrian crisis: a literature review. *Global Health*. 17(111)

Ramadan A, Fouzia A, Barbour A, Assaf H, Khazneh J et al. 2020 Revisiting the Essential Health Service Package (EHSP) for northern Syria (internal document)

Abujaber N, Alajlan S, Jordan G, Abujaber S, Vallieres F. (2021) Towards a comprehensive framework for the design and implementation of agile Mobile Health Units in humanitarian crises: A case study in Northwestern Syria. *Int J of Disaster Risk Reduction*. 66

McGowan CR, Baxter L, Deola C, Gayford M, Marston C et al. 2020. Mobile clinics in humanitarian emergencies: a systematic review. *Conflict and Health*. 14(4)

Du Mortier S, Coninx R. 2007. Mobile Health Units in emergency operations A methodological approach. London: Humanitarian Practice Network (Overseas Development Institute).

**ACTION
F•R
HUMANITY**



syriarelief.org.uk

0161 860 0163

Charity Number: 1154881

Syria Relief is a trading name for Action For Humanity an incorporated charity registered with the Charity Commission in England and Wales under registration number 1154881