



Conflict Sensitivity Institutional Capacity Assessment

Primary Healthcare Sector in Lebanon

Key Messages

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Project Background

1. This research project was commissioned by International Alert (Alert) in the framework of the project 'Support to Conflict Reduction through Improving Health Services in the Context of the Syrian Crisis.' The project is funded by the European Union, through the United Nations High Commissioner for Refugees (UNHCR) and under the leadership of the Ministry of Public Health (MoPH). Project partners include: WHO, UNICEF, International Relief and Development and International Alert. The project aims to reduce tensions between Lebanese host communities and Syrian refugees through improved healthcare services.
2. This research assessment was carried out in and around eight primary healthcare centres (PHCs) across Lebanon, with a view to:
 - a. To provide analysis of the capacities of key stakeholders in the primary healthcare sector to operate in a manner that is conflict sensitive. The targeted healthcare actors include PHCs, local NGOs, the Ministry of Public Health (MoPH), the Ministry of Social Affairs (MoSA) and municipalities that run such PHCs; relevant UN agencies and international NGOs that support the provision of primary healthcare to Lebanese citizens and Syrian refugees in Lebanon.
 - b. To increase Alert and partners' understanding of the external, internal, individual and institutional blockages to operating in a conflict sensitive manner.
 - c. To develop analytical tools to support project monitoring related to the project's impact on the tensions between host communities and Syrian refugees and the conflict sensitivity of healthcare providers.

3. In addition to the main findings summarised below, the report also includes a conflict sensitivity checklist (see Output 2 in the Annex of the main report) and a list of indicators to capture community perceptions when measuring the project impact (see Output 3 in the Annex of the main report).
4. The research was conducted using qualitative methodologies, with 34 key informant interviews/ informal semi—structured interviews (PHC staff, government, municipalities, UN agencies, INGOs, academics) and 31 focus group discussions (Lebanese men, Lebanese women, Syrian men, Syrian women). The research sample centred around eight PHCs, about five per cent of the 180 PHCs in the MoPH network. As such, the findings below cannot be seen as statistically representative and rather should be taken as an illustration of some of the challenges at play in relation to delivering health care in a conflict sensitive manner in Lebanon. It should also be noted that access to key informants in given ministries and INGOs was difficult due to the overall time constraints on the research phase, reducing our ability to assess in-depth the institutional capacity for conflict sensitivity of selected key actors.

I. Conflict Sensitivity Issues in Healthcare

Competition Driving Host-Refugee Tensions

5. Many Syrian refugees have settled in areas of Lebanon where the host population are extremely poor. Syrian presence has exacerbated the vulnerability of these communities with increased competition for jobs, rising rent and greater strain on utilities such as water and electricity.

Consequently, health did not rank as a high priority issue for most FGD participants with the exception of Lebanese women. More important to FGD participants were concerns around i) rent/ accommodation, ii) water and sanitation, iii) employment.

6. Along these lines, many Lebanese informants (both healthcare users and PHC staff) view themselves as much as victims of the crisis as the Syrian refugees. Most Lebanese interviewees portrayed the Syrian refugees in negative terms and blamed them for placing severe pressure on services, including education and healthcare. PHC staff in almost every PHC researched demonstrated some degree of hostility towards Syrian refugees.¹

Assistance Criteria & Healthcare Costs

7. The targeting of assistance is the most significant conflict sensitivity issue in the health sector. Although health insurance is available in Lebanon, a significant proportion of the Lebanese population cannot afford adequate coverage. As per its mandate, UNHCR is primarily providing support to Syrian refugees in Lebanon, with healthcare subsidies for primary, secondary and tertiary care. This causes tensions between PHC staff, host communities and refugees, as Syrians are seen to be unfairly privileged in their access to cheaper healthcare.
8. The initial prioritisation of the emergency needs of Syrian refugees led to targeting on the basis of *status* (provision of support on the basis of nationality) more than *vulnerability* (support according to need, irrespective of nationality). As the crisis has continued, this prioritisation

¹ This is not to say all staff demonstrated such hostility. In stark contrast to the above attitudes, three PHC staff in senior positions demonstrated empathy and tolerance towards Syrians.

has been questioned. The prominence/ visibility of UNHCR-funded initiatives reinforces the perception that the crisis response is predominantly configured towards Syrians (despite the focus of the current IFS programme, for instance).

9. Tensions over healthcare subsidies are exacerbated by common misperceptions about the level of coverage provided for refugees. Conflicts in PHCs can arise when Syrians demand access to services or subsidies that are not covered by the UN or when Lebanese users express outrage at inequalities in assistance. For instance, a considerable number of Lebanese patients appeared to think that Syrian refugees 'get everything for free.'
10. Lebanese focus group discussions noted tensions over the re-sale of relief given to Syrians. Respondents in Bar Elias stated that refugees routinely re-sold their aid, and this made the Lebanese *"furious about help going to undeserving sides."* (female Lebanese FGD). Though relief is often sold to pay bills (rent, water, medicine), this practice is seen to compound Lebanese grievances with i) refugees, who are seen to be exploiting the Syria-crisis and Lebanese hospitality for their own gain; and ii) UN agencies/ INGOs who are seen to overlook support for vulnerable host communities.
11. Although this was not the focus of the research, respondents voiced widespread criticism of hospitals, which both Syrians and Lebanese interviewees accused of overcharging and profiteering. Lebanese patients feel that overcharging by hospitals is a strategy for recouping costs of late NSSF payments or instances where patients have no medical insurance. Syrian respondents specifically stated that they feel pressured to take additional tests (such as x-rays) that they must pay for themselves, or procedures (caesarean section births were

repeatedly mentioned), which can be charged to GlobeMed/ UNHCR. Syrian patients also do not understand the processes available to challenge overcharging.

12. As a result, most Syrian FGD participants tell stories of Syrians going to seek more affordable medical consultations back in Syria, despite the physical danger involved.

Access to Medicines

13. Interviewees commented at length on issues of availability of medicines, citing continuing issues with the out-dated medicines list. Respondents also suggested that an initial lack of coordination between government bodies, UN agencies and INGOs had resulted in both over and under provision for selected medicines, causing tensions between PHC staff, Lebanese and Syrians PHC users when more up-to-date drugs were “earmarked” specifically for Syrian patients.

Fertility Rates

14. Lebanese fears over growing numbers of Syrians in Lebanon are being reinforced by seemingly higher fertility rates amongst refugees. These tensions are clearly apparent in PHCs, where staff cite an increased need for gynaecology and obstetric services. Family planning techniques are often not discussed or provided for, with cultural sensitivity concerns and frustrations over the surmised incentivisation of childbirth (for increase access to subsidies) affecting medical advice on this issue.

Perceptions of Hygiene and Dirtiness

15. Several PHC staff and Lebanese PHC users complained about the lack of hygiene amongst refugees, citing ‘smelliness’ and examples of unhygienic behaviour such as leaving dirty nappies by doorsteps or bringing semi-naked children to the PHC. However, such perceptions

rarely account for the difficulties faced by Syrians trying to access water for washing or, more importantly, cooking.

Communicable Diseases

16. In half of the PHCs researched, Lebanese health staff spoke very extensively about fears among their patients over the spread of infestations or communicable diseases (though not serious pathogens). It is worth noting that patients themselves (including Lebanese respondents) did not report this as an acute issue.

Waiting Times & PHC Usage

17. Waiting times were generally seen to be a non-issue by focus group participants, though Lebanese patients expressed displeasure at having to wait with Syrians.
18. The absence of widespread increases in waiting times, which may have been anticipated with greater numbers of Syrian PHC users, may be attributable to host communities avoiding centres used by refugees. The displacement and self-segregation of Lebanese PHC users serves as a short-term conflict reduction mechanism, but may also have negative impacts on social cohesion in the mid-long term.

Perception of Healthcare

19. Both Lebanese and Syrian respondents felt that the PHC staff were generally competent. Syrian respondents felt that there was no discrimination in clinical quality (medical standards, time provided, steps taken), but that it is felt in verbal and non-verbal communication with staff (attitude, tone in communication, etc.).

II. Coping Mechanisms in PHCs

20. PHCs are trying to account for the fact that many Lebanese patients are not willing to wait behind Syrian patients. PHCs employ a range of

formal and informal queuing and appointment measures to help expedite the process for Lebanese patients.

21. The segregation of Lebanese and Syrian patients in PHCs is increasingly common. Different arrangements depend on the resources of the PHC, with waiting rooms split or awareness raising sessions held separately. Again, although these measures assuage immediate tensions between PHC staff, host and refugee communities, they may damage longer-term cohesion between these parties by institutionalising preferential practices.
22. Several PHCs have also visibly increased cleaning and disinfection to allay Lebanese fears over contagious diseases or infestations. However, highly visible sterilisation may reinforce perceptions that Syrians are dirty, diseased and contagious instead of mitigating tensions.
23. PHC staff appear to deflect conflict by using UNHCR as a convenient scapegoat to explain to angry Lebanese patients that *“the UN system requires”* that they charge Syrians less.

“We mitigate these problems by explaining the truth and providing details about the UN system... now they blame the UN instead of blaming us.” –Lebanese PHC staff, social worker

III. Institutional Capacity for Conflict Sensitivity

PHCs

24. The institutional capacity of PHCs to provide conflict sensitive services is very limited. PHC staff in general had not heard of the term ‘conflict sensitivity’ and had a confused understanding of conflict dynamics in

their community, sometimes speaking of coexistence between communities and then referencing significant tensions and flashpoints.

25. Adopting conflict sensitive practices was not seen to be priority linked to medical care, but the responsibility of other international and national actors. Informal conflict sensitivity measures were present but rarely institutionalised in coherent policies, often relying instead on certain 'champions' (sensitive members of staff) to resolve tensions or disputes. PHC staff also noted severe training fatigue, with workshops often repeating the same basic level of training, limiting the effectiveness capacity building.

Government Ministries

26. The two ministries providing healthcare services – MoPH and MoSA – demonstrated limited understanding and capacity for conflict sensitivity. Interviewed staff broadly acknowledged the importance of the concept, citing conflict reduction as a means to achieving social cohesion between host and refugee communities. In particular, respondents were in favour of measures to reduce tensions by recalibrating the crisis response to better support vulnerable host communities.
27. Respondents did not apply the concept of conflict sensitivity to healthcare provision, nor could they cite conflict sensitivity measures in formal processes such as hiring, programming and policies.
28. A number of initiatives, however, demonstrate informal capacity for conflict sensitivity. This is seen in the levelling of the check-up costs in MoSA's UNHCR/ UNICEF-supported Social Development Centres (SDCs) and the hiring of social workers to work with Syrian refugees. Furthermore, MoPH reporting systems such as EWARN allow PHC staff to record information, which can potentially be used to provide feedback on tensions arising in a PHC between different communities and staff.

29. Respondents from all groups look to MoPH to lead the formulation of a sustainable and conflict-sensitive health strategy, while primary healthcare providers (NGOs/INGOs) focus on short-term projects and funding cycles.

Municipalities

30. Respondents at the municipality level did not identify health as the salient conflict issue. They mainly saw the stresses placed on municipality services and the local economy in terms of water, electricity and waste management. Municipality respondents were particularly clear in linking health issues to deficiencies in WASH infrastructure and access, stressing that even rented accommodation suffered from a lack of water infrastructure that, in turn, would cause health issues. WASH was therefore noted as the principle issue to address at the local level, given its impact on a range of health issues and tensions within PHCs.
31. PHC and municipality staff in general had a very poor understanding of 'conflict sensitivity' and what it may entail for healthcare. In the face of insufficient resources and greater demand on their services, they put the onus on the government, UN agencies and INGOs to undertake national level conflict sensitivity interventions.

UN Agencies

32. Respondents demonstrated a strong understanding of macro-level tensions in healthcare provision, as well as a good understanding of conflict sensitivity. They broadly acknowledged the need to rebalance the national response to address growing social tensions that had emerged due to the initial focus on Syrian communities.
33. The extent to which conflict sensitivity was being operationalised could not be fully assessed within the parameters of this research. While respondents could cite conflict sensitivity studies, none could reference

specific findings or lessons. Similarly, respondents could often cite some formal conflict sensitivity policies but not necessarily the full range of known implemented measures.

34. Practical conflict sensitivity mechanisms being implemented include support to Lebanese health authorities, the use of Refugee Outreach Volunteers for healthcare and hygiene promotion and public information campaigns to raise awareness of healthcare subsidies and support for Syrian refugees.

INGOs

35. INGO respondents were able to demonstrate a good understanding of fault lines between host and refugee communities, discussing the conflict in PHCs between healthcare providers and users in most detail. Respondents acknowledged the need to identify conflict sensitivity issues in healthcare provision and understood its purpose in supporting broader social cohesion.
36. Most INGO respondents primarily focused on individual approaches to address tensions, rather than seeing institutional or inter-institutional space to build conflict sensitivity into improved healthcare provision. While NGOs recognise the benefits of conflict sensitivity, sustaining medical care with stretched resources and pending funding cuts is seen as the main priority. Certain INGOs have, however, taken very clear steps to instil conflict sensitive approaches in their programmes by trying to balance support and subsidies between host and refugee communities.
37. Space for learning from tested conflict sensitivity approaches and closer engagement with ministries may allow for greater coherence in policy implementation and increase the sustainability of conflict sensitivity

measures by institutionalising these as formal processes for all healthcare providers in Lebanon.

38. Efforts to limit the number of Syrian refugees being granted refugee status in Lebanon were mentioned as possibly risky endeavours from a conflict sensitivity perspective. While they may limit official numbers and mounting frustration amongst Lebanese host communities at the continued influx of Syrian refugees, interviewees nonetheless suggested that such efforts risk creating more vulnerabilities and worsening the health coverage.

IV. Blockages to Conflict Sensitivity

Research findings suggest the following:

39. A widespread hostile attitude to Syrians among Lebanese patients and PHC (mostly non-medical) staff, including discriminatory/ prejudicial views and actions.
40. A narrow focus on managing the PHC and service delivery: PHC staff may see their role as managing the flow of patients and medical care efficiently (hence segregation), but not as addressing attitudes of Lebanese healthcare users (e.g. a notable absence of sensible information about transmission of prevalent communicable diseases) or mitigating wider tensions between communities.
41. A lack of strategic leadership by the Government in the crisis response is compounded by an insufficient institutional capacity. This is particularly problematic as many healthcare providers look to the MoPH to guide the crisis response and instil conflict sensitivity measures.
42. A widespread belief, both at the central and local level, that reducing tensions can only be done through committing extra resources

(medical, personnel, financial), resulting in a lack of understanding and appetite for addressing conflict sensitivity through changes in work practice.

V. Public Information Messages & Coordination

43. The importance of public information became apparent throughout this research and findings suggest room for improvement to counter existing perceptions. While this IfS grant is an investment in purely Lebanese structures and personnel, PHC users and personnel still believe that healthcare support is focussed on Syrian refugees.
44. Most respondents (FGD participants and PHC staff) were unaware that the emergency response has evolved from a blanket approach to one more focused on vulnerability. They had a very mixed understanding of the eligibility criteria for free/subsidised healthcare to Syrian refugees.
45. Efforts to improve healthcare provision and address community perception issues are going to become even more problematic as funding for the crisis decreases and the flow of Syrian refugees continues to rise.
46. This situation is calling for even closer links between international and Lebanese actors involved in health provision, both at the centre and the periphery, to ensure that new policies are not only articulated but also understood by the end users.
47. It is against this background that donors, UNHCR and selected partners have designed this IfS programme, so as to invest in the Lebanese health sector as a whole, and increase its capacity to treat patients at the PHC and hospital level, Lebanese and Syrians alike.



The full report is available at www.international-alert.org/lebanon/conflict-sensitivity-assessment.