Conflict Sensitivity Institutional Capacity Assessment

Primary Healthcare Sector in Lebanon

Assessment Report, Conflict Sensitivity Checklist and Indicators for Community Perceptions

September 2014

INTEGRITY RESEARCH & CONSULTANCY

International Alert.

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Abbreviations

IfS	Instrument for Stability
IMC	International Medical Corps
INGO	International Non-Governmental Organisations
IOCC	International Orthodox Christian Charities
IS	Informal Settlement
LNGO	Local Non-Governmental Organisations
MDM	Médecins du Monde
MoPH	Ministry of Public Health
MoSA	Ministry of Social Affairs
NSSF	National Social Security Fund
PHC	Primary Healthcare Centre
PU-AMI	Première Urgence - Aide Médicale Internationale
ROV	Refugee Outreach Volunteer
SDC	Social Development Centers
UNHCR	United Nations High Commissioner for Refugees
UNICEF	United Nations Children's Fund
WASH	Water, Sanitation and Hygiene
WHO	World Health Organisation
YMCA	Young Men's Christian Association

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Key Messages

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, this 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 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).

[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.

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, "*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 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.

1. Introduction

1.1 Project Background

This research project was commissioned by 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.

This assessment will inform International Alert strategy for enabling health care and humanitarian actors to undertake service delivery in a conflict sensitive manner in Lebanon. The study focuses on three main research questions:

1. To what extent are various healthcare actors integrating the principles of conflict sensitivity in their work?
2. What are the current blockages to conflict sensitive programming?
3. To which extent and how is healthcare provision seen as contributing to (or alleviating) tensions between host and refugee communities?

1.2 Project Objectives

Integrity aimed to assess the ability of primary healthcare service delivery in Lebanon to contribute to conflict/tensions within Lebanon and assess how these services currently incorporate conflict sensitive practices.

As per the ToR, the main objectives of this assessment are:

1. 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 Primary Healthcare Centres (PHC); 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
2. To increase Alert and partners' understanding of the external, internal, individual and institutional blockages to operating in a conflict sensitive manner

3. 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

This assessment will provide analysis of the capacities of key stakeholders in Lebanon's healthcare sector to operate in a conflict sensitive manner. It will also provide analytical tools to support programme monitoring of the conflict sensitivity of healthcare providers and tensions between host and refugee communities.

The assessment has three main outputs:

1. An assessment report outlining the extent to which healthcare providers, including humanitarian actors, are applying conflict sensitivity to their work. The report is broken down by actor for ease of reference.
2. A conflict sensitivity checklist based on the assessment methodology (see Output 2 in the Annex)
3. A list of indicators for measuring the project impact based on community perceptions (see Output 3 in the Annex)

Two presentations of 'Preliminary Findings and Researcher Observations' were also delivered to Healthcare Stakeholders and the programme Technical Committee in mid-July. A Final Findings presentation will be given after the final report has been delivered.[2]

1.3 Terminology: Conflict Sensitivity

For this research, Alert and Integrity used a three-pronged definition of conflict sensitivity:[3]

a) The ability of an organisation to understand the context in which it operates, and
b) Understand the interaction between the context and its intervention; and
c) Act on this understanding in order to minimise negative impacts and maximise positive impacts on conflict.

An Arabic version of the term had to be developed to ensure that Arabic speaking respondents understood the terminology, however, without a direct Arabic equivalent a broader definition was formulated to ensure respondents understood the concept. This was:

1) ادراك دينامكية الصراع

2) وتقييم التأثيرات المحتملة على التدخل (توفير الخدمات الصحية على سبيل المثال) بالصراع

3) لأخذ التدابير اللازمة للحد من التأثيرات السلبية وتعزيز التأثيرات الاجابية.

[2] For more information on the objectives of the assessment please see Annex A.
[3] 'How to Guide on Conflict Sensitivity', The Conflict Sensitivity Consortium, February 2012.

This translates to English as:

a) Being aware of conflict dynamics

b) Assessing the possible impacts from an intervention (for example health care service provision) in a conflict

c) Taking measures to limit the negative outcomes and enhance the positive ones

1.4 Report Structure

Section 2 reviews the methodology used for the research: how conflict sensitivity has been tailored to healthcare; research tools and sampling process; key considerations and limitations. Section 3 provides contextual background to existing tensions as well as healthcare in Lebanon. Section 4 provides an overview of conflict sensitivity concerns in healthcare provision drawing from the perspectives of both healthcare providers and users. This creates a yardstick against which to assess the institutional capacity for conflict sensitivity among healthcare providers. Section 5 focuses on capacity for conflict sensitivity at the level of the PHCs. It draws on interviews with PHC staff, explores attitudes towards Syrians, understanding of and commitment to conflict sensitivity, whether it appears integrated into existing policies and strategies, as well as discusses ad hoc mitigation adopted by the PHCs. Section 6 also looks at the capacity for conflict sensitivity but this time focusing on other healthcare providers in Lebanon. It draws on less data than section 5 and thus provides less depth. Section 7 specifically explores the perception of healthcare users, both Lebanese and Syrians alike, when it comes to healthcare in Lebanon, access, perceptions and issues. The annexes provide more details in relation to the data gathered in this research, informal coping mechanisms adopted in the PHCs to reduce tensions, as well as perspectives on conflict in healthcare. In addition a conflict sensitivity checklist and indicators for capturing community perceptions when measuring the project impact are also annexed to the present report.

2. Methodology

2.1 Research Approach

For this assignment, the Integrity team used a best practice assessment tool, The Conflict Sensitivity Consortium 'How to Guide to Conflict Sensitivity'[4] and specifically tailored it to healthcare provision.[5]

The questionnaires developed for this assignment built on in depth debates by the research team, in addition to a conflict analysis of broader tensions between Syrians and Lebanese in Lebanon using the conflict tree tool. Integrity sought to ensure that the research itself did not inadvertently contribute to tensions. Discussion of conflict and tensions can raise tensions, or make people aware of issues that previously had not been a concern. The research team developed protocols for mitigating such effects.

2.2 Research Methodology

A qualitative research methodology was adopted with an initial literature review and field research through key informant interviews (Government Actors, INGOs/UN Agencies, PHCs), focus group discussions (Lebanese men, Lebanese women, Syrian men and Syrian women), and independent semi-structured interviews.[6]

Building upon the core research questions and desired deliverables outlined above, Integrity organised the research methodology around two main strands of data collection:

1. The capacity of key stakeholders in the healthcare sector in Lebanon to operate in a conflict sensitive manner, assessing both respondents' understanding of the term conflict sensitivity and their practice with regard to it.
2. Perceptions of healthcare users toward healthcare services and whether they exacerbate or mitigate conflict/tensions.

Interviews with both healthcare providers and patients allowed respondents to i) identify potential differences in practice and perceptions, and ii) highlight what potential bottlenecks within the healthcare services impede conflict sensitive working practices (if at all). The data collection focused on gathering data to inform the assessment report (Output 1). The analysis generated from the research informed the production of both the conflict sensitivity checklist (Output 2) and the proposed project indicators (Output 3).

[4] http://www.conflictsensitivity.org/content/how-guide
[5] For more information on the research approach to assessing conflict in healthcare, please refer to Annex D.
[6] For more information on the research methodology please refer to Annex B.

2.3 Sample

2.3.1 Primary Healthcare Centres

The sample size agreed between Alert and Integrity consisted of eight PHCs (roughly five per cent of the MoPH network) in four governorates across Lebanon (two PHCs were chosen from each of these governorates for field visits). Central Beirut, North, Bekaa and South governorates were selected to ensure a geographic spread in the sample. PHCs were then purposively selected according to the following criteria:

- Accessibility: locations were reasonably safe for the research team to access on a daily basis
- High numbers of Syrian refugees in the cadastral of the PHC[7]
- High levels of vulnerability of both Syrian and Lebanese communities in the cadastral:[8] selecting areas where issues of access to healthcare and tensions were likely to be most acute.
- Urban-Rural Environments: a mixture of urban and rural communities, differences in the demographic profile of healthcare users, habitation (apartments or informal settlements)
- Part of the MoPH network or not
- Cross-Section of PHC Management: the sample sought to reflect the composition of the MoPH network by including PHCs under NGO, INGO, Municipality, MoPH and MoSA management. Accordingly, a focus on NGO-run PHCs was prioritised.

An initial shortlist of PHCs was developed, with access to them secured through introductions by our research team and letters from IA, MoPH and MoSA. Unfortunately, half the PHCs had to be dropped during the field research phase due to some situational differences and inaccuracies in the databases used for PHC selection.[9] These were then substituted during the research phase, with elements of the selection criteria streamlined to ensure that the field research could continue on schedule. The final list of the PHCs visited can be seen in Table 1 below.

[7] Distribution of the Registered Syrian Refugees at the Cadastral Level Humanitarian and Non-Humanitarian Support Primary Healthcare Centers, UNHCR, 29 April 2014
[8] Health Matrix, UNHCR, 29 May 2014
[9] A total of four PHCs were substituted during the research phase. The Beirut Health Center - Mazraa, Ghaza PHC and Saadnayl PHC were deselected. In particular, PHCs in Ghaza and Saadnayl were dropped as they had only started serving Syrian refugees a few weeks prior the research phase. As such, staff did not feel able to comment on conflict dynamics between Lebanese and Syrian healthcare users. Unfortunately, the research team was not able to establish contact with staff at the MoSA SDC in Sour.

Table 1. Primary Healthcare Centres Sample[10]

Location	Partner	Funding Agency	Network	Vulnerability	Additional Information
Mazraa, Central Beirut	Makhzoumi Foundation	Makhzoumi Foundation, UNHCR	MoPH	Most Vulnerable (48% SYR Refugees / 39% LEB Poor)	Urban, large, very well equipped. Connections to the National Dialogue Party.
Mazraa, Central Beirut	Hariri Foundation	UNHCR	MoPH	Most Vulnerable (48% SYR Refugees / 39% LEB Poor)	Urban, large, well equipped. Connections to the Future Party.
Bar Elias, Bekaa	MoPH, Municipality of Bar Elias	MoPH, Municipality of Bar Elias	MoPH	Most Vulnerable (48% SYR Refugees / 39% LEB Poor)	Close to informal settlements and the Syrian border. PHC located in the municipality building.
Kamed el Loz, Bekaa	AMEL	MDM	Private with MoPH	2nd Most Vulnerable (18% SYR Refugees / 11% LEB Poor)	Close to informal settlements
Bazourieh, South	Amel, IOCC, ACT	Amel, UNICEF, UNHCR	MoPH	3rd Most Vulnerable (9% SYR Refugees / 6% Leb Por)	Rural. Connected to the Amel Association.
Maarake, South	Maarake Health & Social Association		MoPH	3rd Most Vulnerable (9% SYR Refugees / 6% LEB Poor)	Rural. Connections to the Amal Movement.
Sir El Denniyeh, North	IMC	UNHCR	YMCA	Most Vulnerable (48% SYR Refugees / 39% LEB Poor)	Rural
Mina, North	Islamic Medical Association, IMC	UNHCR	MoPH	Data not available	Urban

2.3.2 FGD Participants

To ensure an adequate sample of respondents from both host and refugee communities, focus group participants were selected from both within the PHC itself and the surrounding areas. Where communities were divided, the research team made sure to visit the different communities, travelling to nearby informal settlements (IS) where necessary. Participant use of the PHC in focus was not a prerequisite to selection so as to provide broader insights into perceptions and issues affecting healthcare use.

[10] Supported by information from UNHCR database on Primary Healthcare Centres, April 2014

2.4 Considerations and Limitations

A number of practical considerations and issues impacted the methodology during the research phase.

2.4.1 Access and Sample

Access to key informants in given ministries and INGOs was difficult due to overall time constraints on the research phase. Time was short and reduced our ability to assess, in-depth, the institutional capacity for conflict sensitivity of selected key actors. When needed, the research team sought to mitigate this by conducting shorter independent semi-structured interviews with key informants from these organisations and triangulating information through other respondents.

Accessing male healthcare users from both Lebanese and Syrian communities proved challenging for primarily three reasons:

- Work commitments often meant that potential male respondents were either unavailable or unwilling to commit time to conduct FGDs
- While it was observed that the majority of PHC users were women attending to their own healthcare needs or those of their children, men appeared to bypass PHCs to seek health services directly from hospitals or pharmacies
- Syrian men (were) reported to have a limited ability to travel, with issues surrounding documentation and residency limiting their movement out of informal settlements (IS) and through checkpoints

The research team could only mitigate this in some locations, coordinating with refugee outreach volunteers to organise FGDs when possible.

The security of the research team was a significant consideration throughout the fieldwork, with a spike in violent incidents immediately prior to and during the research phase affecting movement around the country. This directly impacted the teams' ability to conduct FGDs for two PHCs, with road closures and protests deemed to be too severe to allow safe access by the research team.

Although the research sample sought to distinguish between PHCs run by diverse organisations, distinctions between NGO-managed and INGO-supported PHCs often appeared less relevant in practice. Researchers frequently came across INGOs supporting NGO-ran PHCs, although many of these relationships were not captured in central records.

The timing of the research, during Ramadan, also limited the availability of given respondents who were not able to be part of KIIs or FGDs from early afternoon onwards.

2.4.2 Responses

Respondents, including both healthcare professionals and healthcare users, often under-reported issues relating to known sectarian and political tensions between Lebanese and Syrian communities. It may be argued that both Lebanese and Syrian communities have such a degree of familiarity with inter-communal conflict that understanding of these issues is assumed and unstated. Equally, these topics may be seen to be so serious and deep-seated that respondents often did not wish to dwell on such tensions. However, in many cases, broader communal tensions were only brought up when respondents were asked to expand on specific flashpoints or incidents.[11]

Concerns around legal status and residency also appear to have affected the willingness of some Syrian refugees to engage in the research, with fears that certain answers would impact their status with the UNHCR and Lebanese Government, despite clear reassurances from the research team to the contrary. Similarly, there were a few cases where respondents misrepresented their situation, exaggerating various points so as to enhance their argument or garner support. This issue was seen to be more pronounced amongst Syrian respondents, who sometimes sought to qualify their refugee status by stressing aspects of vulnerability. In one case, a Syrian woman spoke in FGD about the difficulties she faced as a widow, only for our researchers to later speak with a man claiming to be her husband. Where these issues were believed to be at play, researchers sought to clarify claims through further questions or triangulated them with other respondents.

On some occasions, the research team was not able to ensure the privacy of interviews. While limited space in PHCs or availability of staff were sometimes an issue, the research team faced separate instances where a NGO worker and then PHC staff member demanded to be present in interviews with staff and patients, despite our team requesting/suggesting otherwise. As a result, selected informants were seen to censor their initial responses or allow the other party to answer for them. Such problems were corrected in follow up interviews held privately out of the PHC.

Understandably, interviews with some PHC staff were also constrained by their time commitments, with some doctors and nurses required to curtail interviews to attend to their professional duties. Where possible, researchers addressed this by conducting follow up interviews at later point.

[11] A notable example of this included FGD respondents initially failing to recall a recent incident in Bar Elias where the tents of Syrian refugees were burned down during the Syrian presidential elections.

3. Context

3.1 Impact of the Refugee Crisis on Lebanon

A specific conflict assessment was not conducted for this project, yet certain macro-level tensions are important to acknowledge as having a formative impact on social cohesion between host and Syrian communities.

The historical relationship between Lebanon and Syria is particularly significant in this regard, with certain Lebanese communities resentfully viewing the influx of Syrian refugees as a 're-occupation' of the country, referring to the Syrian military presence in Lebanon that extended from 1976-2005. Though many Lebanese subsequently fled to Syria during the 2006 war with Israel, much of this goodwill has dissipated as the conflict in Syria has continued with little signs abating. Armed clashes have spilled over the border, with political and sectarian divisions exacerbating existing intra-Lebanese tensions.

As the conflict in Syria evolves, the number of Syrian refugees currently living Lebanon has reached over 1.1 million people, with that number expected to rise to 1.5 million by December 2014.[12] This increase in population is clearly evident to host communities and is easily apparent in the strain placed on services, employment and housing in Lebanon. In search of affordable accommodation and employment, many Syrian refugees opt to settle in low-income communities or ISs. Although the presence of refugees has resulted in an injection of money into certain areas of the Lebanese economy, the increased consumption of goods and the multiplier effect of humanitarian assistance does not negate the acute pressure felt by host communities on basic services and infrastructure, which are stretched beyond capacity while competition for skilled and unskilled jobs mounts.

Importance of Health:

Focus groups were asked to rank services and issues that were most important to them.

Overall, the ranking was:

1. Rent/ accommodation (most important for Lebanese men, Syrian men and women)
2. Water
3. Employment
4. Health (most important for Lebanese women)
5. Joint: education, security, food, electricity, waste

[12] 'Syrians constitutes third of Lebanese population', The Daily Star, 24 July 2014, http://www.dailystar.com.lb/News/Lebanon-News/2014/Jul-04/262612-syrians-to-constitute-third-of-lebanese-population.ashx#axzz36bG8d1Wm

According to World Bank estimates, the effects of the Syrian refugee crisis will push 170,000 Lebanese into poverty while doubling unemployment rate to above 20 per cent from 2012 to 2014.[13]

In the absence of a government, until very recently, national policies were not put in place in to deal with this influx. Humanitarian coordination efforts led by the United Nations High Commissioner for Refugees (UNHCR) and its partners, face a daunting task and the Humanitarian Appeal for Lebanon is only funded at 35 per cent as of 5th August 2014.

3.2 Healthcare in Lebanon

Healthcare in Lebanon is provided through a mixture of state and non-governmental/ private organisations. This includes MoPH, MoSA, municipalities, private healthcare companies, national charities/ foundations, international organisations and INGOs. The system is governed and regulated by MoPH, but private healthcare providers dominate service provision, delivering 90 per cent of health services through PHCs, hospitals and specialist facilities.[14] State provision was portrayed by many respondents (both healthcare users and professionals) to be fundamentally flawed, citing corruption and mismanagement as reasons for the weakness of state services that is manifest in the growing transfer of patients from state hospitals to private ones. Private healthcare services, however, are seen to be some of the best in the region, with high quality staff, research and facilities allowing those will sufficient money or insurance to access almost all types of specialist care.

Respondents also complained about the existing supply system for medicines in Lebanon, especially for chronic diseases. MoPH has issued an official list of approved drugs and centralised the procurement process in order to increase its leverage over manufacturers and standardise the use of drugs. However, several respondents complained that the list of medicines used for drug procurement was not updated regularly enough, affecting the ability of PHCs to proscribe the latest medicine (which MoPH does not seem to procure) and effectively treat chronic diseases.

Insurance coverage for those seeking to access healthcare can be found through the National Social Security Fund (NSSF), professional unions, company schemes and the MoPH Financing Scheme. The NSSF was established by the Government to provide employees and their dependents national insurance coverage sickness, maternity and work related ailments. This covers claimants for 90 per cent of hospitalisation costs and 80 per

[13] Lebanon Bears the Brunt of the Economic and Social Spillovers of Syrian Conflict, The World Bank, (2013) http://www.worldbank.org/en/news/feature/2013/09/24/lebanon-bears-the-brunt-of-the-economic-and-social-spillovers-of-the-syrian-conflict

[14] Healthcare in Lebanon, http://lexarabiae.meyer-reumann.com/blog/2010-2/healthcare-in-lebanon/

cent of medication or examination costs. The MoPH Financing Scheme is supposed to cover those without other coverage, but a significant proportion of the Lebanese population still remains without coverage. As a result, respondents report that uninsured Lebanese patients receive less support than Syrian refugees, who are supported by UNHCR. As for Syrian refugees, they often complain about the cost of medical coverage, which in Syria is substantially subsidised by the state.

UNHCR Healthcare Assistance Criteria and Coverage for Secondary and Tertiary Healthcare:

Three criteria determine UNHCR healthcare coverage to Syrian refugees in Lebanon:

1. Estimated cost of care
2. Vulnerability status (poverty, pregnant, widowed, child)
3. Type of care (emergency, obstetrics)

For treatment in secondary healthcare facilities (hospitals) estimated to cost under USD 1500, 75 per cent of costs are covered by the UNHCR and 25 per cent is paid by the Syrian healthcare user. If costs are greater than USD 1500, implementing partners are required consult with the UNHCR, which in turn studies the case and grants approval on the basis of prognosis and funding. Complicated cases (non-life/limb saving incidents) are referred to an Exceptional Care Committee that chooses to authorise payment or not. For extremely vulnerable refugees the UNHCR covers 100 per cent of the cost.

General consultations (general medicine, gynecology, pediatrics) in PHCs cost 10USD.
Note: As of June/July 2014

Research respondents, both healthcare professionals and users, indicated that MoPH has inadvertently increased the costs of hospital treatment by setting a precedent of late payment for the treatment of patients using private facilities under state coverage. Delaying payment to hospitals by as much as a year, private healthcare providers have had to charge extra directly to patients to cover the lost revenue, resulting an increase of fees paid up front by users that has priced the most vulnerable out of the market.

Access to Subsidies in Healthcare:
Importance of District Doctors and Political Allegiance

Feedback from respondents suggests the interference of local politics in healthcare provision at the local level, where district doctors effectively hold considerable power over the distribution of resources (supplies, vaccines) to PHCs in their area. One respondent from Tripoli described how competition between two local political families affected resource distribution to PHCs because the district doctor was affiliated to a particular family and PHC, privileging it over that of a rival family's PHC. In this case, the 'rival' PHC was reportedly denied vaccines and after complaining, had some of their activities curtailed.

4. Key Conflict Sensitivity Concerns in Healthcare

A full analysis of the conflict sensitivity of healthcare responses to the Syrian crisis was not requested for this research; however, key concerns have emerged during the research process, which are captured here. This section does not seek to provide interpretations or respond to issues raised but simply to convey the issues that were put forward by informants (both healthcare practitioners and users).

4.1 Assistance Criteria

The targeting of assistance stands out as the most significant conflict sensitivity concern in healthcare. Three different issues were raised in relation to targeting of assistance in healthcare:

1) Using status rather than vulnerability as targeting criteria
2) The re-sale of relief items
3) The inactivation of refugee status

4.1.1 The Relationship Between Status and Vulnerability in Assistance Criteria

As per its mandate, UNHCR's response to the Syria crisis in Lebanon has predominantly targeted Syrian refugees.[15] Beneficiaries primarily receive healthcare support on the basis of their status as refugees, with further vulnerability criteria then applied to determine their eligibility for assistance. However, some Lebanese host communities are themselves vulnerable, or becoming increasingly so, but are not able to access similar subsidies for treatment. The difference in primary healthcare costs for Lebanese and Syrian patients as a result of UNHCR subsidies is thus a major cause of tensions, as these criteria are seen to privilege refugees over host communities.

This is particularly problematic, as many Syrian refugees have settled in areas of Lebanon where the host population are extremely poor, with the presence of the Syrians exacerbating this vulnerability through increased competition for jobs. In several places, respondents have also blamed Syrian refugees for escalating rents, as well as causing a spread of infestations (lice, scabies) or communicable diseases (though not of serious pathogens). Along these lines, many Lebanese informants (both healthcare users and providers) view themselves as victims of the crisis, with tensions caused by increasing competition for jobs, services and rent compounded by the surmised imbalance of international assistance to refugees.

[15] In 2014, UNHCR alone committed USD 42.7 million for direct support to Lebanese institutions and host communities.

Targeting healthcare assistance on the basis of *status* (in the initial healthcare response, provision of support on the basis of nationality) rather than *vulnerability* (targeting support according to need) was raised as a cause of tension between PHC staff and Lebanese host communities on the one hand and end users and UNHCR on the other. As stated by one respondent:

"Syrians are receiving support from the UN while Lebanese patients are not. Syrians are paying less for medications and consultations, things that generate tensions between them and the Lebanese patients who are in real need of help but no one is providing it." - Lebanese PHC staff doctor

It is often staff in the PHCs that have to manage angry Lebanese healthcare users who understandably resent this difference in assistance:

"Many Lebanese get angry and feel that we are being unfair towards them." -Lebanese PHC staff doctor

"No tensions happen between Syrian and Lebanese patients, rather they happen between patients and health workers since they tell us about their anxiety and whenever they are angry or offended they blame and confront us." -Lebanese PHC staff social worker

A head nurse reported that Lebanese patients were *"furious"* with this imbalance and that staff would have to calm these patients down by explaining that the UN system *"requires"* that the PHCs charge Syrians less. A sense of relative deprivation—i.e. horizontal inequality—is thus well established as a cause of tension among poor communities,[16] leaving many Lebanese feeling that they are losers the in the crisis response.

Targeting on the Basis of Status Rather than Vulnerability

The identified problems in Lebanon over targeting are not new. In June 2013 IRC recommended that the international community *"provide assistance to vulnerable Lebanese communities as well as refugees from Syria to meet their humanitarian needs and to minimise the potential for increased tensions stemming from economic competition and strained resources."* World Vision in July 2013 also recommended, *"ensure that adequate aid is directed to those people most in need, regardless of whether they are refugees or members of host communities in Lebanon."*
Conflict sensitivity concerns emanating from the use of status rather than vulnerability criteria have also emerged in other emergency responses – for example in shelter provision in the tsunami response in Sri Lanka and in water provision in displaced peoples camps in Sudan. It is not a new phenomenon.

Sources: 'Reaching the Breaking Point – and IRC briefing note on Syrian refugees in Lebanon', International Rescue Committee, June 2013, Emphasis in the original
'Under pressure – the impact of the Syrian refugee crisis on host communities in Lebanon' World Vision, July 2013

[16] 'Horizontal Inequalities and Conflict: Understanding Group Violence in Multiethnic Societies', Stewart, F. (ed.) (2008)

Healthcare users appear to have a very mixed understanding of the eligibility criteria for free/ subsidised healthcare to Syrian refugees, with Syrian male and Lebanese female focus group respondents demonstrating a 'weak' understanding and Syrian female discussants generally demonstrating a 'strong' understanding.[17] A considerable number of Lebanese respondents appeared think that the Syrians '*got everything for free*.' This misunderstanding is contributing to tensions.

It is generally accepted that if people understand why they have been excluded they are more accepting of that exclusion, so conventional responses to tensions over targeting criteria are explained to them. The healthcare provider interviews confirmed that staff in PHCs are trying to do this. However, this does not appear to be resolving the issue, instead it is resulting at times in the transfer of blame from the PHC to the UN:

"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

This indicates that while increasing communication and awareness of eligibility criteria may be a necessary element of alleviating the tensions over assistance criteria, it is not a sufficient response on its own. It may also be that previous experiences of non-transparent and inequitable provision of financial subsidies in healthcare are influencing how Lebanese perceive the current subsidy system, potentially further exacerbating tensions over exclusion.

4.1.2 Re-sale of Relief Items

Lebanese focus group discussions noted tensions over the re-sale of relief given to Syrians. Re-sale of relief has been widely observed in other emergency responses due to poor targeting (not according to need), duplication (several different agencies providing the same relief items) or when other more pressing needs are not met (in this context often rent). The re-sale of aid may not be specific to the healthcare response; however, it is a wider contextual issue that affects how all assistance to Syrians is viewed. For example, respondents in Bar Elias noted that it was very common for refugees to sell their aid, and this made the Lebanese *"furious about help going to undeserving sides"* (Female Lebanese FGD). Observing this phenomena is therefore fuelling a perception among Lebanese that Syrians are not actually in need but are rather exploiting the Syria crisis by abusing Lebanese sanctuary and hospitality to profit from humanitarian assistance. The re-sale of aid

[17] Insufficient data for Lebanese male respondents

thus compounds the sense of injustice around healthcare assistance, which for a long time has been seen to be based on recipients' status rather than vulnerability.[18]

4.1.3 Ability to Cross the Lebanese-Syrian Border

Considerable numbers of Syrians have and are risking the dangerous return journey to Syria, particularly to access cheaper medical care for major treatments or procedures. However, the movement of Syrians back and forth across the border is seen to agitate many Lebanese, who believe it demonstrates that those Syrians can return home and thus lack the vulnerability to deserve refugee status and support. In June 2014, the Lebanese Interior Ministry claimed that Syrian refugees who travel back to Syria should have their refugee status revoked and lose their entitlement to aid from UNHCR if they then re-enter Lebanon.[19] This announcement did not actually correspond with any UNHCR policy but unfortunately had the effect of confusing many refugees who were concerned that 'new' UNHCR status criteria would force them to choose between cheaper healthcare in Syria and refugee assistance in Lebanon. This claim thus demonstrated the significance of continuing tensions around Syrian movements across the border, with both Lebanese and Syrian communities keenly aware of its importance as a determinant for access to support.

Access across the Lebanon-Syria border is also a cause of tension between certain groups of refugees and the UN. This is because while opposition affiliated Syrians cannot return to Syria to access cheaper healthcare, non-affiliated/ regime-affiliated refugees able to return for longer periods of

Fertility Rates:

There is a significant disparity in fertility rates in Lebanon and Syria. The most recent figures available (2011-2012) indicate a Syrian fertility rate of 3.1, more than double that of the Lebanese, which was 1.5. While Syrian refugees could be expected to have a higher fertility rate than the Lebanese, records of this are likely to be inaccurate for two main reasons:

- Large numbers of Syrian refugees are expected to have returned to Syria to give birth to avoid healthcare costs in Lebanon. Mother and child then often return back to Lebanon.
- Many Syrian refugees are not aware of how they officially register the birth of their child in Lebanon, or do not wish to do so due to fears that it will lead to trouble with the Lebanese authorities. A UNHCR report revealed that since 2011 75% of Syrians born in Lebanon have not been registered.

Sources: UN ESCWA, The Demographic Profile of Lebanon, http://www.escwa.un.org/popin/members/lebanon.pdf
NRC, Legal Assistance – Update on birth registration for refugees from Syria, http://reliefweb.int/report/lebanon/legal-assistance-update-birth-registration-refugees-syria

[18] Although UNHCR has shifted to vulnerability based targeting of assistance to encompass Lebanese beneficiaries, this change has yet to be reflected in community perceptions.
[19] 'UNHCR cuts 45,000 refugees: Interior minister', Daily Star, 7 July 2014, http://www.dailystar.com.lb/News/Lebanon-News/2014/Jul-07/262913-unhcr-cuts-45000-refugees-interior-minister.ashx#ixzz36mHjBHSe

time. Yet, for some, their absence from Lebanon causes their refugee status to be inactivated, meaning that they cannot access certain types of assistance. Some respondents believe that this inactivation is politically motivated, expressing anger at the UN's surmised bias:

"…Those who are pro or anti Assad are being treated differently by the UN. Those who are pro Assad can enter and exit, and thus the UN considers that they aren't refugees so doesn't provide them with help. Politics have intruded into the UN" Syrian Female FGD

4.2 Lebanese Attitudes and Behaviour Towards Syrians

Three areas emerge in relation to Lebanese attitudes towards Syrians: fertility rates, fears over the spread of communicable disease and perceptions of hygiene and dirtiness. The latter two of these issues are playing out in the waiting room in particular, affecting overall usage rates of PHCs.

4.2.1 Fertility Rates

PHC informants commonly reported having to increase their obstetrics and gynaecology services as a result of the Syrians accessing their PHC, and there appears to be a fairly widespread perception that Syrian refugees are continuing to have more children than Lebanese women. There is also a belief amongst Lebanese respondents that Syrian women are incentivised to have more children due to UNHCR eligibility criteria.

"Syrian women are incentivised to get pregnant due to the UN system giving 47,000 LL per person in the family if there are children below one year or if the woman is pregnant." -Lebanese PHC staff

"Some Syrians do not get accepted by UNHCR because they only have two children, so UNHCR says that they can afford to pay for the children themselves. If they have more, all the children receive assistance. This gives an incentive to get pregnant which I consider very wrong since we are in a crisis and we can't keep having more children." -Syrian Female FGD

In this case, a differential fertility rate may contribute to tensions through creating a sense of stress on healthcare services, through creating a perception among Lebanese of Syrians abusing the UN system and making long term family planning decisions on the basis of short term benefits. It also feeds into a wider 'meta-conflict' within Lebanon in which people fear that shifts in the overall demographics of Lebanon will undermine the fragile political compromise between religious/political groups.

The PHCs widely reported on activities to promote contraception (see Annex C). However not all PHCs are doing this - a staff member at one PHC noted that they did not comment on family planning as it was seen to be too culturally sensitive. This fear seems to be significantly misplaced (see box below). Further, those that do promote contraception may not always be handling it well. For example, Syrian focus group discussants highlighted how they had been told it was '*haram*' to have more children, and PHC staff had used language of 'shame' in order to convince them not to have more children.

Family Planning Amongst Syrians:

There appears to be a misconception amongst some PHC staff and health stakeholders interviewed for this project that Syrians either:

a) Consider family planning techniques to be culturally 'sensitive' issue that should not a be breached by a staff, or
b) Do not wish to use family planning techniques.

However, this does not reflect known contraceptive usage in Syria, where 58% of women employed family planning techniques. Yet, while 69 per cent of Syrians in Lebanon reported knowing about family planning techniques, only 34 per cent reported using them suggesting problems in the access and availability of contraception.

Sources: Syria: Multi-Indicator Cluster Survey, Monitoring the Situation of Children and Women, UNICEF, 2006
Assessment of reproductive health and violence against women among displace Syrians in Lebanon, BMC Women's Health'. Masterson et al, 2014

4.2.2 Fears Over the Spread of Communicable Diseases

Although respondents did not appear concerned about specific epidemics, Lebanese healthcare staff in half the PHCs spoke very extensively about fears among their patients over the spread of communicable diseases.

"Lebanese women don't accept that the same equipment be used for them and the Syrian women, because the Lebanese women were concerned that diseases get transmitted through these equipment. One woman wouldn't accept to enter a doctor's clinic until it is sterilised because of scabies. Same for the employees – they were scared for their own health." -PHC staff

"As a result of many contagious diseases, the Lebanese patients decreased in the centre, they avoided coming, and when they did, they segregated themselves from Syrian patients and expressed concern for getting infected." -PHC staff doctor

Interestingly, health users did not feel the issue was acute as health providers. It was only brought up in two Lebanese FGDs, with one Lebanese male commenting there is a *"fear over lice, and a mild fear over epidemics, but there are no campaigns to eliminate any exaggerated fear of such issues."*

4.2.3 Perceptions of Hygiene and Dirtiness

Several PHC staff commented on the lack of hygiene of Syrian PHC users, citing smelliness and examples of unhygienic behaviour such as leaving dirty nappies by doorsteps or bringing semi-naked children to the PHC. The issue of refugees 'dirtiness' also came up with female Lebanese FGD respondents in particular, who made regular comments along the following lines: *"When the Syrians came they were all really smelly" / "Did you smell them in the waiting room? I could barely walk through."* These attitudes are particularly difficult and frustrating for refugees who cannot afford or access soap, clothes powder or most importantly, water. Indeed, although soap can be provided or bought relatively easily, access to water for washing is often dependent upon factors outside their control, such as municipality infrastructure or WASH programming in the area. Even if water is accessible, consideration of acute shortages often means that many refugees do not wash, instead reserving water for cooking or drinking. Unfortunately, PHC staff are not always aware of or understand refugee frustrations around these issues, with one PHC Director reporting that there had been *"mild tensions"* between staff and refugees when they address problems of hygiene and personal care. Though issues around cleanliness may cause low-intensity tensions, it remains one of the most tangible and obvious divisions between communities that serves to reinforce the perception of Syrians as likely disease carriers.

4.2.4 Waiting Times

Syrian women in focus group discussions reported experiencing the disgust of Lebanese patients and discrimination by staff in the PHC waiting rooms. One female Syrian focus group discussant at one PHC stated, *"Lebanese patients show their dissatisfaction in the waiting area, they show their disgust in the way they sit."* These tensions appear to lead many Lebanese to want to be prioritised in appointments. As a PHC staff member noted, *"Lebanese patients are not willing to wait for Syrian refugees to pass and see the doctor. They voice this issue in the waiting room."* The wish of Lebanese PHCs users to be fast-tracked through PHCs is apparently accommodated to varying degrees with PHCs employing variety of different coping mechanisms to placate the frustrations of Lebanese PHC users (please Annex C).

Interestingly though, when asked if waiting times had increased, only 20 per cent of PHC staff informants noted that they had, while 33 per cent of PHC staff stated that the appointment system was working well and waiting time had not increased. This is reflected in the fact that many FGD participants saw waiting time as a non-issue.

Are there tensions over waiting time for appointments?		
	Female	**Male**
Syrian	Non-issue (seven focus group discussions) *"We should wait a bit to get a cheap service, it's totally OK for us."* -Female Syrian focus group discussant	Non- issue (one focus group discussion)
Lebanese	Non-issue (five focus group discussions) Of which one discussant noted the waiting times had increased but remained a non-issue. One further focus group discussion noted: *"Waiting time is disorganised, the priority is for the friends of the PHC staff."*	One focus group discussion considered waiting time very long due to Syrian refugees. A further focus group discussion gave a mixed response (2/6 found it an issue, 4/6 did not).

Though it seems counterintuitive that waiting times would not have risen with the large of numbers of Syrian refugees using PHCs, it is indicative of a broader change in Lebanese use of PHCs, where host communities are simply seeking to avoid those PHCs used by Syrian refugees. This trend (expanded below) suggests that in some cases the increased numbers of Syrian PHC users loosely corresponds with a reduction in Lebanese PHC users, with this displacement serving to neutralise widespread increases in waiting times as host communities use facilities not frequented by refugees.

4.2.5 PHC Usage

In four of the PHCs sampled, staff noted a drop in the number of Lebanese patients, with one in particular claiming to have had a 70 per cent drop in Lebanese users. This trend may be seen to be spurred by the culmination of the negative Lebanese attitudes towards Syrian refugees detailed above. This form of self-segregation reduces immediate tensions between users, with host communities seeking to avoid being aggravated by Syrians by simply choosing different facilities. However, despite a short-term reduction in tensions, self-segregation may damage social cohesion in the mid to long-term by reinforcing divisions between communities.

For PHCs, an increase in Syrian patients can increase revenue and profit in the short term, but several PHC staff were concerned about the longer-term impact on the perceptions and usage habits of their Lebanese users. One Director put the issue quite starkly:

"I was torn between two decisions whether to accept or refuse Syrian patients in general. If I were to accept them I would make use of the ultrasound machine that was rarely used previously. So we are making much profit from the additional services required by Syrians. However in parallel to this profit we would lose our Lebanese patients." PHC Staff - Director

4.3 Availability of Medicines

Further to widespread comments over the unfairness of the disparities in support for Lebanese and Syrians, a large amount of criticism concerned the availability of medicines. Greater demands on the MoPH out-dated medicines list and frustrations over limited supplies are contributing to a sense of competition between communities.

To compound this there have been variations in medications provided, with an initial lack of coordination between Government bodies, UN agencies and INGOs resulting in both over- and under-provision. Additional medicines provided by INGOs have sometimes had different frequency of provision – in Tripoli for instance chronic medication was provided monthly for Syrians, but only once every three months for Lebanese.

Prior to the Syrian crisis there were existing problems concerning the availability of medicines largely as a result of the medicines list, thus there already existed frustration amongst the Lebanese community over this issue. The additional demands on this limited supply of medicines is further contributing to competition between Syrians and Lebanese over resources and wider tensions.

4.4 Perception of Profiteering

Both Syrians and Lebanese respondents voiced widespread criticism of hospitals, which they believe are overcharging and over-treating patients in pursuit of greater profit.

Hospital services, both those paid for directly by users or insurance/subsidy providers, are often subject to additional fees or price rises. Lebanese respondents saw overcharging as a means for recouping the costs of late payments by the MoPH or care for patients with no medical insurance. This was also seen to be done to exploit UNHCR healthcare coverage provided through GlobeMed. As one Syrian FGD participant stated, *"the costs of hospitalisation increase when they know we are supported by the UN."* Unfortunately, many Syrian respondents did not understand the processes for challenging overcharging; or if they did, were unable to trigger an investigation due to difficulties accessing GlobeMed through

its hotline. Some UNHCR medical officers have been able to challenge overcharging by hospitals by directly calling hospitals when the refugee still holds a receipt; but many refugees do not realise they need a receipt or keep it, making challenges to overcharging impossible.

In hospitals, Syrian respondents felt pressured to undergo additional tests or procedures (such as x-rays) that they had to pay for themselves but were not essential. Notably there were reports of Syrian women being pressured into C-sections which hospitals charge more for:

"When a woman is delivering and using the UNHCR coverage the hospitals either raise the price or order a caesarean section in order to raise the bills." Syrian Female FGD

Healthcare providers recognise the problem and call for greater scrutiny of individual cases by UNHCR and its partners.

Claims of overcharging within PHCs were only occasional. Such accusations can be a source of significant tension in the PHC itself, and respondents reported case of Internal Security Forces having to intervene and calm down aggressive Syrian patients who think they are being over-charged.

"Such violent incidents occur around 3 times per month, due to Syrian patients thinking that the PHC is stealing from them, due to their lack of awareness. The Syrian patients are told by the registration unit that they can get free or almost free medication, but they don't understand that not all medicines are available or that the system requires that a GP sees the patient before providing the medication." PHC Staff

5. Conflict Sensitivity Capacity: Primary Healthcare Centres

The PHC capacity assessment is organised at the individual level, the institutional level, and the inter-institutional level. A range of mitigation/ coping measures adopted is also discussed.

5.1 Individual Level

5.1.1 Attitudes of PHC staff towards Syrians

Widespread hostility was expressed towards Syrians by PHC staff from almost all PHCs researched with a few notable exceptions. Anti-Syrian attitudes seem to be particularly strong at one PHC in Mazraa. Several themes emerged:

Perception that Syrians take the jobs, force up rents, put pressure on education: This attitude clearly reflects the wider sentiment across Lebanese society, as PHC staff are but a microcosm of that group: *"They are compromising all job opportunities, they are renting the most expensive places and they are not willing to go back to their country. Some are really abusing our system, and because of them the rental costs went up, the educational costs too. Lebanese parents cannot afford to pay anymore, but the schools don't care because they have their own customers which are rich Syrians."* -PHC staff director.

Perception that Syrians have too many children: There is considerable hostility towards Syrians for having what is deemed to be too many children. PHC staff believe that Syrian women are making family planning decisions to access resources, yet waste these resources on trivial things. As one PHC nurse said *"They get paid by UNHCR for each child they have yet they buy cosmetics instead of food."*

Perception that Syrians are dirty, unhygienic, and uneducated: PHC staff express disgust at Syrian (mostly female) patients, displaying little understanding of the living conditions of many Syrians. *"Syrians don't have good hygiene practices or awareness, even if they are living in good conditions (…) They don't like or want to take their bath, they bring their children in a very bad state, not wearing shoes. They refuse to listen to us or don't even understand the information we provide due to their low educational levels and their cultural differences."* -Lebanese PHC staff Head Nurse

Perception that Syrians are introducing diseases to Lebanon: Many PHC staff indicate that fears over the spread of parasites or contagious illnesses are keeping Lebanese communities from using PHCs used by refugees. As one doctor noted, "*The Lebanese*

patients decreased in the centre, they avoided coming, and when they did, they segregated themselves from Syrian patients and expressed their concern for getting infected." Some PHC staff respondents feel that refugees are bringing these health issues from Syria to Lebanon, expressing fears that greater numbers of Syrian PHC users will worsen the problem in PHCs.

However Syrian informants commented that they had not had scabies or lice back in Syria, even under war conditions and attributed them to the lack of water and poor, overcrowded living conditions they are now facing in Lebanon. To attribute the incidence of scabies and lice to the presence of Syrians not only overlooks the incidence of these afflictions prior to the crisis (noted in Bar Elias Municipality as prevalent in schools), but also indicates a lack of understanding about their transmission (see textbox below).

Belief that all Syrians are pro-Assad – This assertion illustrates a conspiracy theory often heard that Syrian refugees are exploiting the situation to receive benefits and enjoy security in Lebanon, while perpetuating the conflict in Syria (which badly affects Lebanon). Helping refugees is therefore seen as a waste of resources, keeping them from returning home.

A source of profit – Certain PHC respondents talked of patients from both communities in terms of revenues and profit. Accepting Syrians at the PHC was a balancing act between increasing revenues from Syrians and loss of revenues from Lebanese patients.

Empathy and co-existence – In stark contrast to the above attitudes, three PHC staff in senior positions demonstrated degrees of empathy and tolerance towards Syrians:

"I don't think there is a conflict between Lebanese and Syrians as much as there is a risk of sickness due to the unhealthy conditions of the Syrian refugees." -PHC staff director

"The Lebanese are not empathising at all with the Syrian refugees. They are not accepting to live with them and share their resources with them." -PHC staff director

Widespread hostility to Syrians seriously undermines any institutional capacity for conflict sensitivity. Guiding principles for conflict sensitivity, as articulated in the Resource Pack for Conflict Sensitivity,[20] include impartiality. Knowledge, skills and attitudes for conflict sensitivity, as articulated in the How to Guide to Conflict Sensitivity[21] include good inter-cultural sensitivity and understanding. The point of departure for strengthening institutional capacity for conflict sensitivity should be to promote tolerance amongst PHC staff and challenge negative perceptions and stereotyping.

[20] 'Conflict sensitive approaches to development, humanitarian assistance and peacebuilding – a resource pack', APFO, CECORE, CHA, FEWER, International Alert, Saferworld, 2004
[21] 'The how to guide to conflict sensitivity', The Conflict Sensitivity Consortium, 2012

5.1.2 Understanding of the term 'conflict sensitivity'

PHC staff in general had not heard of the term 'conflict sensitivity' before. Despite this, two staff demonstrated a strong grasp of the concept, while others gave a variety of different interpretations such as an awareness of conflict, that conflict causes illness (for individuals or epidemics), or that conflict causes a personal/ emotional loss.

The overall understanding of the different ways in which conflict could occur was poor. When asked whether conflict or tensions in their locality had changed since the arrival of Syrians, many PHC staff (encompassing most locations) asserted that there were *no* tensions in their area. Staff talked of coexistence; however over the course of many of these interviews the narrative changed, often also describing significant tensions and sometimes violent eruptions. This may be because respondents initially interpret questions about conflict to be about war or high intensity violence, and do not see a link to lower intensity conflict as relevant. This is not surprising given the proximity of intense, widespread conflict in Syria, and the recent spike in violence within Lebanon itself.

Informants who said that tensions and conflict did exist in the communities surrounding the PHC noted wider conflict issues of jobs, rents and education (see section 3 above) and the pro-Assad rallies at election time.

5.1.3 Commitment to Conflict Sensitivity

Having explained the term conflict sensitivity to PHC staff, they were asked whether they thought it was relevant to healthcare provision in Lebanon. Of those that answered this question the responses were:

Buy-in to conflict sensitivity	
Stated it is a priority	6 PHC staff interviewed – Of which one felt it would be hard to implement
Stated it is a low priority	1 PHC staff interviewed: Who was particularly concerned to avoid training activities. However some skills development for conflict sensitivity (such as communication) were also identified as needed for staff by this informant.
Masked	2 PHC staff interviewed: The stated response was that conflict sensitivity is important, but wider behaviour indicated that informants were trying to give publically desirable answers, and as such the buy-in was deemed not credible.

5.1.4 Individual competencies for Conflict Sensitivity

Conflict sensitivity was not formally integrated in the understanding of any roles among PHC staff interviewed – Directors, Doctors, Nurses, Pediatricians, Social Workers, or Managers. In general, staff felt that the coping measures they were undertaking (see Annex C) were as

much as they could manage and did not see a need for further conflict sensitivity measures *beyond* these. Nor did they see the need for it to be integrated into staff roles. Instead they saw further measures to be the responsibility of government and UN agencies. However, upon probing they did describe a number of skills and attitudes that they thought would be helpful, captured below. Of all these, communication skills were the most frequently cited. Some staff felt they already possessed these skills and attitudes.

Competencies suggested by PHC staff to enable conflict sensitivity	
Skills	**Attitudes and approach**
• Communication skills • Listening skills • Stress management • Conflict resolution / diplomacy	• Empathy / understanding / compassion • Patience / taking time • Non-discrimination • Humanitarian approach

Healthcare User Communication Preferences:

Communities appear to better respond to different modes of communication. Lebanese respondents were very keen on SMS-borne health messages while Syrians, especially those in IS, preferred face-to-face communication. Many respondents stated that brochures provided the most comprehensive information to users. Several also complained that contact information and health hotlines were often out of date (an issue compounded by high turnover in INGO staff) and that literacy issues amongst rural Syrian refugees limited the effectiveness of written material.

Several PHC staff warned of severe training fatigue, in particular that that many INGO / UN and MoPH trainings are not suited to their needs or duplicated the same basic level of training rather than supporting more advanced competencies. Further interviews highlighted how there is a massive overload simply to deal with the daily running of the PHC, and any additional training would stretch staff beyond capacity.

As PHC staff did not usually see the need for conflict sensitivity competencies be integrated into roles, it was not possible to draw input from them as to how they rated their own performance. Drawing from the focus group discussions several observations can be made[22]:

Impartiality and advocacy: A considerable number of Syrian focus group discussants described discrimination in service provision. However, many focus group discussions from across both Lebanese and Syrian communities identified someone in the PHC who they trusted to be impartial – predominantly a nurse, and occasionally the PHC Director. This person would often be referred to by both communities to guide them through the services available or champion their cause in the PHC or with implementing partners.

[22] Note – This assessment is of capacity according to the individual capacities identified as required by the informants, the section as a whole covers a much broader analysis of individual capacity.

Empathy/ understanding/ compassion: The widespread hostile attitudes described above demonstrate limited capacity.

Communication: Female Syrian focus group discussants reported that topics such as hygiene and family planning were being approached by PHC staff using shaming terminology. This indicates poor communication skills and an inappropriate approach.

5.2 Institutional Level

5.2.1 Conflict Analysis

No PHC staff undertook any formal conflict analysis. Some interactions are happening which could be providing some level of informal insight and analysis, however nothing systematic was described and in general informants saw a total disconnection between the PHC and conflict analysis.

5.2.2 Policies and Strategies for Conflict Sensitivity

There was a unanimous response that there no policies were in place to enable conflict sensitivity. Several respondents highlighted that policies and strategies had to be developed at the Ministry level, and felt that very little they could be achieve at a PHC level without those policies and strategies in place. In particularly, they recommended that targeting be shifted to the basis of vulnerability rather than status so that needy Lebanese were included. In addition respondents suggested the need for faster re-imbursement of hospitals fees from NSSF and a balancing of consultation costs between Lebanese and Syrians at the PHC level.

5.3 Inter-institutional Level

5.3.1 Information Sharing

Various information sharing activities were described, although few of these related specifically to conflict:

- Regular meetings with INGOs (e.g. YMCA or International Medical Corps) where problems are discussed, e.g. lack of medication;
- Regular reports to NGOs (at Al Iman this was weekly). Some informants noted that there was an excessive demand for reports / other paperwork;
- Monthly reports to INGOs on vaccinations, numbers of patients, percentages of women and pregnancies;
- Monthly electronic reports to MoPH – this system was widely commented on as providing significant problems as there has been insufficient training to make it

function efficiently. For example staff in one PHC hand wrote all files and then entered only a percentage of them digitally, as staff are faster doing it by hand. This PHC noted they would need a devoted staff person to keep it up to date, and had no funding for a permanent post to do this. Another PHC was yet to receive either computers or training on the digital reporting programme.

At PHCs in Mazraa Beirut there are offices and teams of social workers within the internal structure of the organisation. If issues or conflict arises in the PHC, the individual cases are referred to these teams who try to help the patient to the degree possible. This often involves clarifying support/medical advice or addressing issues indirectly linked to medical care.

Immunisation – Case of a PHC Mazraa

All medical staff in this PHC were vaccinated against Hepatitis B. It is not clear why these specific vaccinations were given and this research is not able comment on the medical value of this action. However, there are conflict sensitivity issues created by such measures. In the current social climate, if all staff in a PHC are known to have been vaccinated against a disease it is likely to be seen as an extraordinary precautionary measure rather a routine procedure; with other PHCs users (notably Lebanese, but probably also Syrians) likely to assume a heightened medical risk of contracting Hepatitis B from refugees. If the medical purpose of these immunisations were unclear this would needlessly increase PHC users already heightened sense of anxiety while reinforcing their perception of Syrians as disease carriers.

5.4 Mitigation Measures/ Coping Mechanisms

PHC staff described a range of mitigation measures or coping mechanisms they had adopted in their PHC. While some of these measures related to additional capacity (such as hiring new staff members) others were designed to reduce the loss of Lebanese patients, and as such were not necessarily driven by concern for the Syrian patients. A full list of coping and mitigation measures are captured in Annex C.

5.4.1 Segregation

Syrian and Lebanese communities are increasingly self-segregating in everyday life. Syrians are adopting self-imposed curfews (in addition to mandatory ones) and Lebanese are avoiding public spaces that are used predominantly by Syrians, such as parks. Similarly, Lebanese healthcare users appear to be switching PHCs to avoid those where there are Syrian users. Lebanese that continue to use PHCs being accessed by refugees are self-segregating in the waiting area, while staff in some PHCs are actively segregating patients in the waiting area.

"The Lebanese patients are very concerned about diseases. They stand on the balcony instead of sitting in the waiting area and they refuse to use the same equipment as the Syrians." -PHC Staff

"Lebanese patients ask to move away from the Syrians fearing contagious disease and complaining about their smell. We try to guide the Lebanese patients to the 2nd floor to wait, while the Syrians stay on the 1st floor." -PHC Staff

Such segregation also applies to awareness-raising sessions in several PHCs.

"A Lebanese youngster told us 'Are you putting me in the same category as the Syrians? Will you make me sit next to them to give me awareness lectures? I will never do that!' So we divided the sessions."

Measures segregating communities in PHCs should be understood in the wider trend of distancing between the two groups. Yet, although such measures may defuse tensions in the short term, they could also reinforce divisions and mutual mistrust in the mid to long term.

5.4.2 Disinfection

Several PHCs explained having visibly increased their cleaning and disinfection actions in order to allay Lebanese fears over contagious diseases. For example, in one PHC there were many problems with *"Lebanese patients who didn't want to sit next to Syrians and refused to use the same machines and equipment (…) now a cleaning lady sterilises the place and the equipment right after every patient (Lebanese or Syrian) so we don't show bias."* The same cleaning lady also "*who cleans the seat after each Lebanese and Syrian patient as a preventive measure."*

As noted in section 5 above, Syrian and Lebanese communities are increasingly self-segregating in the wider sphere beyond PHCs, as Syrians are adopting self-imposed curfews (in addition to mandatory ones) and Lebanese are avoiding public spaces that used predominantly by Syrians, such as parks. Thus the actions in the PHCs should be understood in a wider trend of segregation between the two groups, reinforcing this trend.

Are segregation and cleaning/ sterilisation conflict sensitive?

Are these mitigation measures actually making matters worse? Lice and scabies are transferred through intimate contact, or through sharing of bedding or clothing. Can transmission occur when sitting next to someone infected in a waiting room?

Within examination rooms, PHC staff adopt usual hygiene measures– a disposable paper sheet is used on the examination couch and removed after each patient. Highly visible segregation and sterilisation are likely to reinforce perceptions that Syrians are dirty, diseased and contagious, and might seem to lend medical justification to what is a derogative perception.

Are there more conflict sensitive mitigation measures that could address the Lebanese anxieties rather than pander to them, for instance through targeted public information efforts?

5.4.3 Appointment Scheduling

Appointment scheduling is seen as a helpful, flexible tool for diffusing tensions between host and refugee PHC users, instilling a sense of equity to the waiting system. At one PHC, in order to prevent tensions in the waiting room and to manage the significant difference between the large numbers of Syrians and small numbers of Lebanese waiting, patients are admitted such that for every one Lebanese seen, two Syrians are seen, in a repeating pattern. Similarly in another PHC, health staff alternate with Syrian and Lebanese patients.

5.4.4 Flat Rates

Price parity for PHC users from both communities may be seen to be a fairer way of providing healthcare, by ignoring the status and (to certain extent) vulnerability of the PHC user. At one PHC, staff decided to charge Syrian and Lebanese patients the same fee (15,000LL) to reduce tensions over access to healthcare. However, the focus group discussions did not bear this out. While the Syrians lamented that they had to pay the full 15,000LL at this PHC with no discount, Lebanese patients were not aware of this policy and still complained that *"The Syrians get more, everything for them is free and they receive aid from UNHCR."* Thus even where status is not being applied in targeting of free/ subsidised healthcare, negative perceptions can persist if this information is not properly communicated.

6. Conflict Sensitivity Capacity: Other Key Healthcare Stakeholders

6.1 Lebanese Government: MoPH and MoSA

The Ministry of Public Health is primarily responsible for the accessibility and quality of health services in Lebanon. Mandated to work across sectors, the MoPH engages other ministries, non-governmental organisations, private sector and civil society in its policy-making and implementation. It is supported in this capacity by the Ministry of Social Affairs, whose mandate includes primary healthcare components that overlap with MoPH mandate. Both ministries have primary healthcare networks that extend across the country, with affiliated or directly managed centres that have been exposed to the impact of the refugee crisis.

6.1.1 Understanding of Conflict and Primary Healthcare in Lebanon

Interviewees in both ministries demonstrate a keen macro-level understanding of the impact of the Syria crisis on Lebanon and its primary healthcare. Civil servant respondents highlighted issues similar to those brought up by healthcare users, listing demographic concerns, rent, self-segregation of communities, and competition for jobs and services as conflict issues. Citing the impact of population density on rises in rent, one respondent recognised that "*people are running through their savings… decreasingly able to afford their rent*", asserting that "*the higher the [population] density the greater the conflict between Lebanese and Syrian communities*". Moreover, recognition of the trend of self-segregation of communities along political-sectarian lines was balanced by awareness of the increased fatigue of Lebanese communities with Syrians, linking that to "*the reason why you see fewer Lebanese actually attending PHCs.*"

Nonetheless, it was also apparent that the understanding of individual members of staff had only partly translated into a comprehensive, strategic government response. Reasons for this are detailed below.

The Impact of Slow Government Response

Initially, political and government actors appeared reluctant to address the growing presence of Syrian refugees early on, and only acknowledged the issue in 2012. The resulting institutional inertia prevented the formulation of a coherent national response to the healthcare issues that the crisis presented.

Three respondents partly attributed this to what they see as the ministries' insufficient institutional capacity to deal with issues created by the growing number of Syrian refugees to begin with, and this capacity being only slowly built in this vacuum, the INGO/NGO response lacked strategy, coordination and effective oversight from the Lebanese Government. Two civil servants specifically criticised INGO/ NGOs for failing to comply with laws and Government procedures and hence making coordination even more difficult. As a result, the Government is perceived to be struggling to provide leadership towards a more coherent healthcare strategy.

The Need to Rebalance the Response

Government respondents unanimously assessed that the Syrian refugee crisis had brought tensions to a critical level, a 'saturation point' that could imminently lead to the "drawing of knives" between communities. Many bemoaned the fact that government records did not allow to distinguish between Syrians who were present in Lebanon before the crisis and genuine refugees. Yet, while Government respondents shared the view that Syrian refugees had put a strain on Lebanese communities, Government and service delivery, they did not distinguish healthcare as a crucial flashpoint in this regard.[23]

When respondents did speak about conflict in healthcare, they stressed the need for crisis response to be rebalanced towards Lebanese host communities, and welcomed what they saw as a shift in that direction in the government 2014 strategy. Informants see this approach as an opportunity to ease tensions and specifically address both the needs of the most vulnerable Lebanese communities and put them "at the centre" of the response to the crisis, as well as rein in INGOs perceived bias in favour of Syrian beneficiaries.

6.1.2 Understanding and Commitment to Conflict Sensitivity

Overall, government respondents had a very limited understanding of conflict sensitivity. They broadly understood the importance of the concept, citing conflict reduction as a means to achieving social cohesion between host and refugee communities. As one civil servant stated, conflict sensitivity concerned "the conflict arising between host and guest populations and the need to mitigate that for the sake of both." However, respondents did not apply the concept to healthcare or PHCs and indicated not having received formal guidance on conflict sensitivity, nor seen it formally introduced into hiring, policies or programming. Respondents did not wish to receive training on the topic, citing "training fatigue" (particularly on protection) as a reason.

[23] They would instead stress the dangers posed by informal settlements for instance.

6.1.3 Approach to Conflict Sensitivity in Primary Healthcare Provision

Despite a lack of formal understanding of conflict sensitivity, a number of initiatives appear to demonstrate informal conflict sensitive components in the ministries' work and activities.

Social Development Centers

MoSA's UNICEF/UNHCR-backed Social Development Centers (SDC) appear as promising platforms for conflict sensitivity, operating much like PHCs to offer both Lebanese and Syrian communities access to primary healthcare practitioners such as doctors, nurses, gynaecologists and dentists, funded through INGOs like the Danish and Norwegian Refugee Councils. Conflict sensitive initiatives include levelling the cost of check-ups for both Lebanese and Syrian healthcare users, who according to one respondent now all pay 3,000LL. Such a measure goes some way to addressing the anger felt amongst Lebanese host communities that support unfairly overlooks vulnerable Lebanese, with further support to such groups also delivered through the 'Poverty Programme' that assists those on less than two dollars a day. There is also funding from the Syria Crisis Response Unit for 72 SDCs to receive two social workers each for work with Syrian refugees, corresponding with work already being done by social workers currently engaging Lebanese communities.

By instituting projects aimed at targeting vulnerability equally, the SDCs appear to be a particularly effective channel for conflict sensitive programming and improving social cohesion. Moreover, civil servants appeared optimistic that the work done by social workers to raise awareness around issues such as hygiene would further ameliorate tensions between the two communities, a notion consistent with respondents from elsewhere.

Reporting Mechanisms and Early Warning

Reporting mechanisms have been developed by the MoPH to record information about healthcare users and cases of acute diseases in PHCs. These systems can have multiple uses for conflict sensitivity. Primarily, they perform an important early warning function for epidemics and diseases, with the information from PHCs used to develop action plans that address outbreaks before wider panic may be caused amongst either community. Longer term, information disaggregated according to nationality can provide important insights into the healthcare needs, satisfaction and access of the different populations, hopefully allowing strategies to be developed for more effective health services within PHCs.

Finally, these forms allow PHC staff to record other information, which can be used to provide feedback on tensions arising in a PHC between different communities. This has yet to be formalised and made systematic and, while several respondents saw these forms as a step in the right direction for the MoPH, others expressed concerns that some district

doctors were manipulating reports to reduce disease statistics in their area. If this were the case, it would severely compromise any early warning and inhibit the ability of the MoPH to respond to potential flashpoints. Furthermore, formulation of an appropriate response to a conflict incident would require staff to have sufficient training in these areas, but this capacity will have to be developed to an advanced stage if responses are to be appropriate.

Limiting the number of Syrian refugees given Refugee Status

Several Government respondents noted that the policies on the admission of Syrians to Lebanon and the recognition of refugee status were to be reformed in line with the MoI instructions detailed above. MoSA has proposed that only Syrians from governorates bordering Lebanon should be given entry to the country,[24] using this condition to stymie the growth in the number of Syrians and by extension ease mounting pressure on services such as primary healthcare facilities. Similarly, the Government has also proposed that Syrians choosing to go back to Syria, to then returning to Lebanon, should forfeit their refugee status.

Civil servant respondents argued that such policies would be conflict sensitive to the extent that they would in fact ease mounting frustration amongst Lebanese host communities at the continued influx of Syrian refugees, as they would reduce the burden on services like PHCs. This may win the support of Lebanese host communities, who frequently cite the fact that many Syrians returned home to receive state-funded healthcare as a demonstration of imbalance of the crisis response.

However, while these policies may help to reduce Syrian access to primary healthcare support in Lebanon, returning Syrians would de facto be even more vulnerable, now lacking refugee status. According to respondents, these policies bear the following risks:

- These policies risk creating a large group of highly vulnerable Syrian refugees faced with a grave dilemma: remain in Lebanon where healthcare is expensive (especially beyond primary healthcare treatment) or jeopardise their refugee status by momentarily returning to Syria to access free health services. One civil servant was particularly concerned about this scenario, stating that these policies risked deliberately overlooking fundamental healthcare and humanitarian principles.
- As these restrictions on entry are unlikely to deter the most vulnerable Syrians from trying to enter, or re-enter the country, these policies are likely to have a limited effect in addressing Lebanese concerns about the growing Syrian population in the mid-long term as well.

[24] This would include Syrian citizens from Tartous, Homs, Rif Damascus, and Quneitra governorates.

- By removing the ability of some Syrian refugees to access primary healthcare, they also increase the chances of acute illnesses spreading untreated.

As such, these policies may be seen to risk displacing conflict. They could reduce demographic pressure on PHCs to only to then expose both the vulnerable Syrians and the broader population to health issues that the Lebanese health system is ill disposed to address.

6.1.4 Conclusion

The MoPH and MoSA appear to be making some improvements to primary healthcare provision in response to Syria crisis in Lebanon, but these developments are at a nascent stage. Conflict sensitivity is not built into institutional processes, and conflict sensitivity components are often implemented ad hoc. While ministry staff acknowledge the importance of conflict sensitivity in primary healthcare provision, efforts to address these issues focus primarily on medication and staffing. These are evidently vital areas for improving healthcare provision but do not, at this stage, address broader issues such as community awareness and PHC staff attitudes towards Syrians. As funding remains below what is needed to tackle a crisis of this magnitude, it is likely that non-medical approaches to conflict sensitivity may prove the most enduring and cost effective.

Coordination

Respondents from all groups acknowledged the integral role of the MoPH in formulating long-term strategy for planning and oversight of primary healthcare provision. Many respondents, including PHC Directors and NGO/INGO staff, expressed the view that current support to PHCs is inefficient, due to a lack of central coordination. Although healthcare providers listed a plethora of health committees and sub-committees, many stated that these were yet to properly address the duplication of services and systematise collaboration. Interviewees all suggested that MoPH has the mandate and authority to address this issue, and called for MoPH to lead the formulation of a sustainable strategy on health services while providers (NGOs/INGOs) focus on short-term projects and funding cycles. This could prove instrumental in assuaging tensions between competing healthcare providers and steer services in a manner that benefits the most vulnerable in both communities.

Communication

Respondents see improvements in communication strategies and procedures as essential, not only to conflict reporting, but also for building a more effective and resilient PHC network.

They specifically suggest that:

- Early warning systems developed for reporting acute diseases can be readily adapted to include conflict reporting mechanisms;
- A stronger presence in health coordination meetings may allow MoPH greater steerage over the Syria-crisis response. This may prove particularly significant in generating unified and coherent policy to the benefit of local PHCs.[25]
- MoPH is uniquely placed to drive the conflict sensitivity agenda. By leveraging their position power over district doctors, MoPH can engage these actors on conflict issues in a way that UN agencies, INGOs and PHCs cannot.

6.2 Municipalities

Municipalities serve an integral role in local service provision and community healthcare, with remits over water, housing, waste/sanitation, community cohesion, and their own PHCs. As such, the breadth of their work ensures that they are exposed to a broader range of local tensions and conflict sensitivity issues arising around health and PHCs.

6.2.1 Understanding of Conflict and Primary Healthcare in Lebanon

Staff interviewed from municipalities in Tripoli, Maarake, Bar Elias and Kamad el-Loz demonstrated varying degrees of concern about conflict between host communities and refugee communities. Respondents in Maarake stated that there were no tensions between the two communities at all, with one staff member suggesting that the Lebanese were happy to advocate for the Syrians conduct and access to subsidised healthcare. Elsewhere, social cohesion appeared to be waning due to the duration of the Syrian conflict and continuing influx of refugees. As one Municipality Health Director observed, “In the beginning of the crisis the Lebanese sympathized with the Syrians, but now Lebanese [have] started considering the Syrians as a burden on them.”

Respondents see tension primarily in relation to the stresses placed on municipality services and the local economy by the influx of Syrians (but not specifically on health). The heads of two different municipalities both agreed that:

- Water, electricity and waste management as coming under critical strain with the on-going crisis

[25] In this regard, respondents highlighted the need to strengthen communications specifically with district doctors, who act as a junction between national bodies and policies on the one hand, and local PHCs on the other.

- Additionally, competition for jobs and subsequent increases in criminality were seen to be both a consequence of Syrians wanting to undercut the wage market and their desperation for money

The majority of municipality respondents displayed an in-depth knowledge of healthcare issues in their area. Indeed, while many described issues around access to drugs and the hygiene of Syrian PHC users, municipality respondents were particularly clear in linking this to deficiencies in WASH infrastructure and access. By distinguishing this area of concern, respondents were able to frame health and hygiene issues in relation to habitation, stressing that even rented accommodation suffered from a lack of water infrastructure that was causing health issues. WASH was therefore noted as the principle issue to address, given its capacity to affect a plethora of health issues and tensions within PHCs.

6.2.2 Understanding of and Commitment to Conflict Sensitivity

Most respondents from municipalities have little or no understanding of what conflict sensitivity is or what it infers for healthcare provision. One head of a municipality considered it to be about understanding of the broader conflict, while another municipality official understood it to be about the unbiased provision of resources. Although municipality officials expressed a broad wish for conflict sensitivity to be employed in primary healthcare provision, responsibility for this was pushed on to INGOs, the media and political leaders. These actors were seen by municipality respondents to have the reach and resources to make the most effective impact on conflict sensitivity at the national level, with few asserting a role for PHCs in this capacity.

None of the municipalities interviewed had formal conflict sensitivity mechanisms in place in their PHCs, whether in general guidance to staff or procedures and processes such as hiring. There were, however, strong security reporting functions fulfilled by the municipalities, particularly in those where curfews were in place. In these areas, municipality staff appeared to act as key brokers between communities, involved in dispute resolution and securing access to medical facilities for Syrian refugees during curfews.

6.2.3 Approach to Conflict Sensitivity in Primary Healthcare Provision

A general lack of understanding of conflict sensitivity amongst municipality respondents is reflected in the absence of clear conflict sensitive approaches to primary healthcare provision. Many municipality respondents could not identify conflict sensitive practices in PHCs and instead framed conflict sensitive approaches to healthcare through broader initiatives to improve municipality services to communities.

The registration of Syrian refugees through ID cards was commonly cited as a way to improve oversight on the needs of healthcare users. The system, commented on by both municipality staff and INGO workers, allows a municipality to record the medical and social needs of individual Syrian refugees so that the municipality can then target medical support from humanitarian organisations more effectively. Respondents hoped such a system could be rolled out comprehensively so that municipalities would be able to focus on patients on the basis of their vulnerability (as opposed to their status) and hence i) prioritise given healthcare issues and outreach[26] and ii) reduce tensions related to inefficient use of medical support.

6.2.4 Conclusion

In the face of insufficient resources and greater demand on their services, municipalities are tempted to put the onus on the Government, UN agencies and INGOs to undertake national level conflict sensitivity interventions. However it should be noted:

- Some of the clearest conflict sensitivity interventions mounted by Government actors so far have been undertaken at the local level, by selected municipalities who have taken the initiative to negotiate access to emergency care during curfew hours, directly with security forces and relevant communities. While these arrangements are often ad hoc, they were successful and suggest that similar initiatives should be cultivated.[27]
- Municipality-level engagement is needed as their remit allows for complementarities between, for instance WASH and accommodation, at the local level. This may return marginal gains in community healthcare and cohesion.
- While municipalities look to MoPH to provide leadership in regard to strategies on the primary healthcare response to the refugee crisis, municipality staff i) do not necessarily realise that, to do so, the MoPH will likely make more requests of municipalities, not less and ii) do not want more on what they feel is an already "full plate."

[26] This would include enhanced and more targeted public information campaigns for both health service suppliers and users.
[27] They might also illustrate how municipalities have a more nuanced understanding of local context, which is key in context of limited capacity and resourcing.

6.3 UN Agencies

UN agencies are playing a major role in primary healthcare provision in Lebanon, working with the ministries, municipalities and a multitude of implementing partners to assist in the coordination and delivery of services in PHCs. UNHCR, WHO and UNICEF are key partners in this IfS funded programme, but most respondents were either from the UNHCR or spoke with specific reference to it.

6.3.1 Understanding of Conflict and Primary Healthcare in Lebanon

Respondents from UN agencies demonstrated a strong understanding of macro-level tensions in healthcare provision, and most gave more detailed insights into tensions that were more closely aligned to the remit of their particular office. This resulted in some notable differences of perspective between headquarters and regional/field offices.

Informants from central offices often highlighted the impact of institutional dynamics in shaping the healthcare response to the crisis, outlining the issues experienced in supporting the reach of Government ministries while coordinating between myriad of PHCs. They also stressed the challenges presented by the demographic profile of Syrian refugees, with healthcare concerns around the vulnerability of large numbers of Syrian women and young children worsened by capacity constraints of PHCs and growing Lebanese hostility to the increasing Syrian presence.

Informants from field offices, however, tended to focus on local tensions, specific flashpoints and practical concerns. Here, cases of diseases such as Measles, Hepatitis A and Leishmaniasis were not seen to have produced an observable increase in tensions between communities. However, events like the tent burnings in Informal settlements in Bar Elias and Qabb Elias after the Syrian Presidential elections were keenly noted as part of the continuing trend of deteriorating relations between host and refugee communities riven along sectarian lines.

All respondents were aware that their interventions, particularly healthcare subsidies, had not only strained relations between Lebanese host communities and Syrian refugees but also contributed to a perceived increase in hostility from Lebanese communities towards the humanitarian/ healthcare organisations. Consequently, most respondents conceded the need to rebalance the national response to address growing social tensions that had emerged due to the initial focus on Syrian communities.

6.3.2 Understanding of and Commitment to Conflict Sensitivity

Understanding of conflict sensitivity was high in UN agencies, with many respondents having been previously exposed to the concept. Those unfamiliar with the term could link it to similar concepts, with one UNHCR respondent linking it to the awareness needed to ensure that 'Do No Harm' principles were maintained to avoid exacerbating 'pre-existing conflict'. The majority of respondents clearly acknowledged the importance of conflict sensitivity, seeing it as an intrinsic part of their work in healthcare. As one UNHCR respondent commented, "*It's included in job description. It's in the daily work culture. Everyone should be conflict sensitive*." It is worth noting that one source disagreed and rather stated that, in the context of an emergency health response, maintaining service delivery ought to be the main priority. As the source stated bluntly, "*conflict sensitivity is the least of everyone's concern.*" This perspective may indicate the extent to which some staff are struggling to see conflict sensitivity's immediate relevance to their work or understand how it could be integrated into healthcare provision.

The use of regular security meetings appears to feed into operational decisions around projects, though these decisions often concern specific incidents or staff security, as opposed to broader tensions between Lebanese and Syrian healthcare users. UNHCR was noted for conducting FGDs as part of its continuous process of assessing potential issues in their programming. However, while results were distributed amongst some actors, these were not provided to MoPH or PHCs. Furthermore, although informants could cite conflict sensitivity studies commissioned from organisations like Search for Common Ground, no respondents could cite specific findings or indicate lessons learnt from these pieces of research, suggesting that they had had limited impact.

Many UN respondents asserted that conflict sensitivity was imbedded in recruitment and human resources policies, yet explanations of these were inconsistent. One field officer viewed the hiring of Syrians as a conflict sensitivity issue, arguing that refugees' emotional involvement in the crisis presented a bias that "*would interfere with his/her work that should be objective.*" Other respondents spoke much more positively about the contributions made by Syrian staff, especially the UNHCR's Refugee Outreach Volunteers (ROV). The ROVs were seen to be key, trusted interlocutors with Syrian refugees, able to communicate effectively with those in IS about a range of issues including health, as many were formerly medical practitioners. As such, their involvement with the UNHCR was seen as a key to more effective dealings with the Syrian community.

6.3.3 Approach to Conflict Sensitivity in Primary Healthcare Provision

UN agencies have a number of conflict sensitivity policies and mechanisms in place, though not all of these are directly linked to primary healthcare provision. These initiatives include:

- Providing information through brochures, posters and SMS messages to raise awareness of healthcare subsidies and support that Syrian refugees can access.
- Paying for transportation for those requiring treatment for TB and Leishmaniasis to ensure patients can reach treatment facilities.
- Using ROVs to hold awareness sessions for Syrians on community issues, such as healthcare and hygiene.
- Conducting reviews of PHCs being supported either directly with UN funding or through implementing partners, to ensure that they are being managed with a certain degree of compliance with UN standards and fulfilling duty of care to their patients.
- Curtailing certain activity, which could antagonise host communities, by not marking events such as World Refugee Day in local offices.

Coordination between various healthcare providers is also a vital role played by the WHO and UNHCR, who have sufficient mandate and resources to support meetings between government ministries, INGOs and NGOs. These are important spaces for healthcare providers to exchange information, compare notes and avoid coverage gaps across the PHC network. It should however be noted that INGO respondents deem that these fora, both general and subject specific sub-groups, are yet to properly function as spaces for strategic planning. An important progression in the longer-term sustainability of these meetings will then be the extent to which UN agencies can integrate them into MoPH practice and encourage Lebanese healthcare providers to attend.

6.3.4 Conclusion

UN agencies have led much of the Syria-crisis response in Lebanon, using their mandate and financial resources to support MoPH in trying to build a more coherent national response to support PHCs. However, respondents perceive that i) the initial prioritisation of the emergency needs of Syrian refugees and ii) the prominence/visibility of UNHCR-funded initiatives reinforce the perception that the crisis response is predominantly configured towards Syrians.

Although the emergency response has evolved from a blanket approach to one slightly more focused on vulnerability, efforts to address these community perception issues are going to become more problematic as funding reductions force tough decisions around healthcare

subsidies, despite continuous new arrivals of Syrian refugees. 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 coherently articulated and understood, and avoid further confusion amongst healthcare users.

6.4 INGOs

There is a range of INGOs working in primary healthcare provision, with specialist healthcare NGOs working alongside those engaged more broadly in humanitarian and development work. Although many of these organisations coordinate centrally with UN agencies, and to lesser extent government ministries, they also work with other donors and NGOs to provide support to PHCs outside the MoPH network. While some are afforded a larger degree of operational autonomy as a result, it also means that many are trying to sustain multiple activities on shorter timelines, creating difficulties in the coordination and sustainability of work.

6.4.1 Understanding of Conflict and Primary Healthcare in Lebanon

INGO respondents were able to demonstrate a good understanding of fault lines between host and refugee communities, discussing the conflict around PHCs between healthcare providers and users in most detail. Many respondents chose not to dwell on macro-level conflict issues; seeing it as unnecessary to expand on tensions that they had either lived with their whole life (national staff) or found to be less applicable to PHC interactions. The tensions elucidated were found at the following levels:

- **Syrian PHC Users and Lebanese PHC Users/Staff**: Syrian PHC users were seen to convey a sense of entitlement when using PHCs, referring to their access to UNHCR coverage and right to certain treatments in a very direct manner. This, INGO respondents asserted, was seen to be insulting to the Lebanese by diminishing the position of the medical staff while lauding their entitlement over other users.
- **Syrian PHC Users and INGOs/PHCs**: INGO respondents expressed consternation at the way in which some Syrian PHC users would claim staff corruption if they were not able to access certain treatments for the amount they expected. Lack of sufficient knowledge of UNHCR coverage was seen to exacerbate the problem, with Syrians demanding that INGO staff investigate PHCs or accusing both parties of these acts. Although respondents acknowledge corruption to be a valid concern more generally, one INGO respondent stated, “the accusations [corruption by PHC or INGO staff] fly around so much that it is either endemic or exaggerated.” The effect of this was seen

to drain PHC staff time and morale, as they had to seek to assuage such concerns with often angry Syrian healthcare users.

- **PHCs and INGOs**: While donors make demands on reporting from INGOs, INGOs reported with some frustration their lack of leverage over PHCs and their inability bring about change in existing policies and procedures.

6.4.2 Understanding and Commitment to Conflict Sensitivity

INGO respondents were familiar with the concept of conflict sensitivity, with many hearing about it through the EU IfS/UNHCR programme. Respondents acknowledged the need to identify conflict sensitivity issues and understood its purpose in supporting social cohesion, but most respondents primarily focused upon individual (personal) conflict sensitivity interventions with institutional and inter-institutional approaches seen to support this. As such, many respondents spoke of conflict sensitivity approaches being employed to help resolve flare-ups and underlying tensions between individuals, rather than improve the overall effectiveness of health interventions.

Commitment to conflict sensitivity was often idealised, yet also seen to be of minor importance when compared to sustaining medical care, with high intellectual and capacity barriers assumed to prevent the easy implementation of conflict sensitivity measures. Few respondents could cite specific conflict assessments, formal mechanisms for reporting conflict indicators, or conflict sensitivity policies. It was also not seen to be an important factor in human resources or recruitment, with more basic requirements around the medical qualifications and competencies seen to override any conflict sensitivity concerns. One INGO respondent added that attempts to instill conflict sensitivity into human resources would prove problematic as PHC staff were often employed directly through local implementing partners, giving INGOs little opportunity to instill processes at the PHC level without greater buy-in from PHC managers and directors.

6.4.3 Approach to Conflict Sensitivity in Primary Healthcare Provision

INGO respondents indicated a variety of conflict sensitivity approaches being employed informally, with initiative often exercised by staff in field offices or PHCs. Certain INGOs have taken very clear steps to instill conflict sensitive approaches in their programmes by trying to balance support and subsidies between host and refugee communities. Notably, IMC has received BPRN funding to evenly support healthcare provision to both communities. NRC has also been piloting the formation of joint committees in certain locations to ensure better coordination and cooperation between communities on issues such as shelter, WASH and health.

Respondents cited the conflict sensitivity role played by staff in frequent interactions with both PHC staff and users. This often involved interventions by INGO staff to ensure that refugees were receiving proper care or mediating between parties where tensions had boiled over. While it was clear that there was a high degree of variance in the tensions experienced in PHCs (NGO-run PHCs generally seen to be more accommodating towards Syrians), informants noted a growing fatigue amongst INGO staff dealing with such issues. This appeared to be particularly pronounced when dealing with common misperceptions around subsidies for refugees, with the unwillingness of certain PHC partners to provide subsidised services exacerbating often-baseless allegations of corruption made against PHC or INGO staff.

Although INGO informants recognised the benefits that could be derived from greater conflict sensitivity in healthcare, most considered it to be a low priority given other more fundamental capacity issues in primary healthcare provision. Lack of adequate resourcing and impending funding cuts were commonly cited as overriding limitations on conflict sensitive programming, absorbing the attention and efforts of INGO healthcare providers who were conscious of looming shortfalls in their capacity and reach. Rather than seeing these shortcomings as creating a greater need for conflict sensitivity around the impacts of these issues, many believed it to reaffirm a focus on purely medical issues.

6.4.4 Conclusion

While INGOs appear to maintain good levels of communication with their major donors, particularly UN agencies, efforts to expand the network of supported PHCs can create competition and confusion between those INGOs and NGOs seeking agreements with potential PHC implementing partners. If not more closely coordinated, such efforts can lead to wasted resources and strained relations with INGOs needlessly duplicating support.

Much can be done to improve relations with Lebanese partners. INGO-PHC relations are often unbalanced, with INGO funding allowing little leverage over how district doctors and PHCs operate, causing the implementation of even the most basic accountability and reporting processes to be frustrated.[28] This creates challenges for instilling conflict sensitivity in PHCs and generates tensions between the various health service providers as lines of responsibility and ownership become muddled and convoluted. Closer engagement with government 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.

[28] Several INGO respondents cited cases where district doctors were seen to have fabricated reports on disease counts or failed to complete reporting altogether.

There is also a need for greater strategic clarity in the direction of healthcare programming in response to the Syria crisis. Although funding gaps loom for INGOs and UN agencies, preparations for this have not been properly discussed or coordinated leaving many INGOs uncertain of how to move beyond emergency planning in what is likely to be a mid-long term crisis-response.

7. Perceptions of Healthcare Users

7.1 Importance of Healthcare vis-à-vis Other Services

Focus groups were asked to rate the importance of healthcare in relation to other services, from which the following observations were made:

1. Rent/ accommodation is the most pressing concern overall, particularly amongst Syrian refugees.
2. Water is a close second to rent/ accommodation, affecting both Lebanese and Syrian communities alike, and strongly featuring for male Lebanese across all locations.
3. "Jobs" is the third priority overall, particularly amongst the Lebanese community.
4. Health does not rank as a "high priority" overall, except for Lebanese women. Some FGD participants noted that health is not a priority need as they already have good enough access/provision. This would be even more so where a PHC is deemed to have exceptionally good services.
5. Where PHCs were in wealthy areas poverty levels will significantly affect people's priority needs.
6. Some are facing very difficult trade-offs; for example one Syrian woman reported removing her daughter from school in order to pay rent.

Causes of tensions in healthcare from the perspective of healthcare users

The following lists the key issues raised by focus group discussants as the causes of tensions in healthcare, with prioritisation according to the number of times it was raised in focus group discussions:

1. Targeting (This issue significantly predominates over all other issues)
2. Corruption / abuse of the system
3. Costs (including transport costs to the healthcare providers)
4. Availability of medication
5. Fear over the spread of disease
6. Behaviours in the waiting room
7. Hygiene/ cleanliness/ smell

Of particular note is that when asked whether there were any specific healthcare related triggers of conflict, focus group discussants said no.

7.2 Access to Healthcare

7.2.1 Awareness

In general, the Syrian respondents were relatively unaware of the different healthcare options available to them, and some were clearly confused by the relative complexity of the Lebanese system when compared to the Syrian state system. Most were accessing only one PHC, and only knew about that immediate access point to primary care. These informants could not tell the difference between a Government run or NGO run PHC, and some simply assumed the UNHCR was providing their entire healthcare. There were some anomalies, with a few Syrian women shifting between PHCs on the basis of the services available. Indeed, one female Syrian had been paying for private clinics herself for three years and had no idea about the UNHCR support available.

Conversely the Lebanese informants accessed several different healthcare providers, and made their selection on the basis of the merit of the services provided and the anticipated number of Syrians using the centre. Again there were anomalies, such as a Lebanese woman who did not know of other PHCs at all.

7.2.2 Impediments to Access

Transport costs to access PHCs were a significant problem for Syrians accessing three of PHCs researched. People have to travel in overcrowded vehicles, making multiple changes in visits to the PHC that can take up much of the day. In some cases the cost of the transport was higher than the medical examination. While most PHC users had no trouble accessing facilities through checkpoints, this was context specific and clearly a bigger concern for Syrian respondents. For example, one Syrian male respondent stated he could not afford to renew his residency permit and so avoided going to the PHC or any other place that would require passing a checkpoint.

7.2.3 Accessing Secondary Healthcare

A common experience amongst both Lebanese and Syrian communities was that hospitals were more expensive and harder to access. For example: *"Entering a hospital is much more difficult, its more expensive and they ask you about a million things and papers before you get in."* -Female Syrian focus group discussant. One male Lebanese recounted a tale of a man with a bleeding hand whom a hospital would not admit as he had no funds to pay up front.

7.2.4 Removal from UNHCR Lists

A large number of Syrian focus group discussants stated that they had been de-registered from the UNHCR and lost support. For example:

"Everyone in my family got UNHCR registration except me. They said it was maybe because I have too few children. I was just taken off the UNHCR list, while other people, some who even have cars, stayed on. Some others were taken off but they had connections to a Sheikh who got them back on again afterwards." -Female Syrian FGD

In general there was confusion over loss of services and loss of refugee status, with many seeming to assume the loss of services equated de-registration. During the research period an SMS was sent, apparently from the Ministry of Interior, stating that Syrians would lose refugee status for crossing back into Syria for any reason. There was considerable confusion over who had sent the SMS and whether or not the UNCHR would actually be implementing the decision.

A considerable number of Syrian focus group discussants mentioned people going back to Syria for medical care. Reasons included lower costs in Syria, as well as avoiding being forced to have a caesarean section birth (in Lebanon) to enable the hospital to charge higher costs. It was highlighted that they were prepared to risk the hazardous security situation, as they could not afford the high costs of healthcare in Lebanon. These women are already marginalised, as they cannot afford healthcare costs in Lebanon. Should they lose refugee status and UNHCR support as a result of seeking cheaper medical care in Syria, their situation and that of their dependants will only get worse once they return to Lebanon.

7.3 Prejudice and Discrimination in Healthcare

Extensive comments were made on this subject by focus group discussants.

It is difficult to generalise from the Lebanese informants as widespread views were expressed. Lebanese tended to interpret questions around prejudice and discrimination in terms of political affiliation, and in addition to comments above on political affiliation affecting access to subsidies.

Across three FGDs, female Lebanese participants shared the perception that Syrians were treated better than them.

In general the Syrian respondents felt that that there is no discrimination in clinical quality (medical standards, time provided, steps taken), but that it might only apply to verbal and non-verbal communication (attitude, tone in communication, etc.). The latter applied

noticeably to administrative staff but usually not to the doctors. These views were not unanimous and one or two felt that the Syrians were actually treated better:

"The staff showed us they are not disgusted by us, and they refuse to talk politics or differentiate between nationalities. This made us feel much more comfortable and alleviated the pressure on us being Syrian." -Syrian Female FGD

The only significant incident reported to the research team was the case of an angry paediatrician who had refused to see a Syrian woman bringing six children to an appointment. It appears that this paediatrician had invented a 'quota' of no more than four children as an excuse not to see this family, which the Syrian woman had felt was discriminatory.

7.4 Competency and Legitimacy in Healthcare Provision

7.4.1 Competency

There was strong consensus among the focus group discussions on competency:

1. Both the Syrians and Lebanese felt that the PHC they went to had competent and qualified staff.
2. Lebanese informants felt that Government (municipality, MOPH) PHCs had poor services and poorly qualified doctors.
3. Syrians commented that the PHCs were costly.
4. Both Syrians and Lebanese felt that the hospitals were incompetent and did not care about patients.
5. Syrians and Lebanese alike complained about high hospital costs, including i) "corrupt practices" to inflate charges, and hospitals refusing to see people if they didn't have money upfront / being financially rather healthcare oriented (see Section 4 above).

At both PHCs researched in Beirut, Syrians and Lebanese felt they could trust the nurse, and if they needed to make a complaint they would turn to the nurse to do this. In another PHC, the director and social worker were highlighted by both Syrians and Lebanese as being very competent and trustworthy. Similarly the Director of another PHC was identified as having wide respect across both Syrians and Lebanese. Thus there are clearly individuals within PHCs who have respect across both Syrians and Lebanese and could play a valuable role spanning the two groups.

7.4.2 Legitimacy

In general Syrian focus group discussants saw the UN as the legitimate healthcare provider, but felt that legitimacy was not as important an issue as the cost of health services. Competency and proximity were other important factors, although they were mentioned less frequently. Only a few Lebanese looked to the MoPH as the legitimate healthcare provider on paper, highlighting how it faced real challenges to be so in practice. One female FGD discussant stated, *"the MoPH should [be responsible for healthcare] but it's not doing anything due to chaos in this country and the lack of organisation."* A male Lebanese FGD participant bemoaned the inappropriateness of politics and religion driving the current system and another highlighted how the vagaries of political actors can affect availability of healthcare:

"A political PHC might stop working if the political leader stops his work. 'X' for instance used to have lots of PHCs and provided help in the education field, yet this all stopped when he stopped running for elections. So the political parties are not trustworthy or sustainable, their help depends on their political agendas." -Lebanese Male FGD

8. Blockages to Conflict Sensitivity

Feedback from key informant interviews and focus group discussions suggests that Drawing from across the research, the following blockages to conflict sensitivity can be identified:

8.1 Individual Level

- A widespread hostile attitude to Syrians among PHC staff, including discriminatory/ prejudicial views and actions. This was most notable amongst administrative staff and responses to the presence and behaviour of Syrian refugees in waiting rooms.
- A 'fire-fighting mind-set:'
    - PHC staff may see their role in managing conflicts in the waiting room, with preventative actions relating to separating groups and the need for awareness raising of Syrians on hygiene and contraception. There do not appear to be comparable efforts to address attitudes of Lebanese healthcare users, including a notable absence of effort to provide sensible and calming information about transmission of prevalent communicable diseases.
    - Healthcare professionals in ministries, municipalities, INGOs and UN agencies demonstrated to varying degrees a focus on responding to the 'emergency.' Though many bemoan the lack of strategic perspective in primary healthcare provision, few are able to clearly elucidate their role (individual or institutional) in rectifying the issues in primary healthcare provision beyond continuing service delivery.
- A disconnect in perspective: PHC staff do not appear to be making linkages between what happens in the PHC and wider tensions between host and refugee communities. Thus they often do not recognise that actions in the PHC can contribute to (mitigating) wider tensions between Lebanese and Syrians, instead citing macro-level conflict drivers as causes for such tensions.
- A widespread belief that having more resources (medical, personnel, financial) would resolve conflict sensitivity issues, combined to a lack of understanding in the way in which people work can equally contribute to tensions. This is often most problematic as PHC staff are unable to quantify such statements, instead referring to an idealised system without the budgetary constraints experienced in practice.
- Limited communication skills, particularly when communicating with Syrian refugees in relation to 'sensitive' issues such as family planning.

8.2 Institutional Level

- Use of ad hoc conflict sensitivity coping mechanisms: Coping mechanisms developed by PHCs to mitigate tensions between Lebanese and Syrian users are often ad hoc with dubious implicit ethical messaging about Syrian PHC users. Many of these measures are configured to try to retain Lebanese patients, rather than enhancing service provision equally to both communities.
- A lack of strategic leadership by the Government in the crisis response has been compounded by the absence of clear political will and tight constraints on ministries institutional capacity.
- A lack of credible data on incidence of disease: Limited and inconsistent use of reporting mechanisms, with additional concerns around the authenticity and credibility of the data means there is a paucity of 'health' data in general. This inhibits effective early warning of disease outbreaks, while restricting the ability of national bodies to allay health-related fears amongst either community.
- UNHCR targeting criteria focus on Syrian refugees (including some who are not vulnerable) while no other operator is undertaking similar support in favour of sometimes highly vulnerable Lebanese communities.
- A significant reduction in donor funding for the Syria-crisis response means that healthcare support will have to be scaled down, increasing the vulnerability of many healthcare users who will struggle to cope with further reductions in targeted assistance.

Annex A: Objectives of the Assessment

This report will look at two main aspects:

1. The capacity of key stakeholders in the primary healthcare sector in Lebanon to operate in a conflict sensitive manner
2. The perceptions that Lebanese residents and Syrian refugees have of healthcare providers and their role in causing or decreasing tensions

The Capacity of Key Stakeholders in the Primary Healthcare Sector in Lebanon to Operate in a Conflict Sensitive Manner

Over 900 clinics that provide primary healthcare services in Lebanon with around 180 of these in the MoPH network, most of which are run by NGOs. Syrian refugees, along with the Lebanese population, are accessing the services of these facilities and therefore, a central research question is:

To what extent are various healthcare actors integrating the principles of conflict sensitivity in their work? What are the current blockages to conflict sensitive programming?

In regard to this question, specific lines of inquiry were addressed in this research as positioned in the ToR, including:

a. What is the level of institutional understanding of, and commitment to, principles of conflict sensitivity among health care actors?
b. To what extent is conflict sensitivity currently embedded in organisational policies and strategies?
c. To what extent is conflict sensitivity integrated in the understanding of various staff roles within agencies, and what are the existing knowledge and skills among key staff at various levels?
d. How is conflict sensitivity integrated into the project/ programme cycle?
e. What is the understanding of drivers of conflict and fragility in Lebanon among healthcare actors? Do they have, or rely on, formal conflict analysis and is this regularly updated?
f. How is conflict sensitivity integrated into recruitment and procurement policies and practice?
g. How are information and data about conflict shared among various actors in the sector? Are they shared across sectors?

The Perceptions that Lebanese Residents and Syrian Refugees have of Primary Healthcare Providers and their Role in Causing or Decreasing Tensions

The increased presence of Syrian refugees in Lebanese communities is putting heightened pressure on the delivery of basic services beyond what state and humanitarian actors can provide. This appears to be creating tensions between Syrian and their host communities. To this end, a central research question is:

To which extent and how is primary healthcare provision seen as contributing to (or alleviating) tensions between host and refugee communities?

In regard to this question, specific lines of inquiry were addressed in this research as stipulated in the ToR, including:

a. How important is healthcare for host and refugee communities vis-à-vis other essential services?
b. What are the main issues in the health sector that are seen as a cause for tension?
c. What are the perceptions of the level of access to primary and secondary healthcare for Lebanese and Syrian refugees? And is there are a difference in the perceptions of PHC users and non-users?
d. Which service providers are seen as legitimate by community representatives and why?
e. Are there perceptions of preferential treatment or discrimination by PHCs or public hospitals?
f. How do Lebanese and Syrian refugees see the staff (competence, identity, gender) in the healthcare sector?

Timeline of the Project

The assessment was conducted over seven weeks in June to August 2014, with a work plan as follows:

Week 1: Project Design and Tool Finalisation
Week 2: Training of Research Team
Week 3-5: Data Collection
Week 6: Data Analysis
Week 7: Report Writing, Quality Assurance and Submission

Annex B: Overview of Methods and Data

Qualitative Research Methodology

Integrity selected a qualitative research approach to this assessment, the use of which has many benefits within fieldwork; namely, it allows researchers to gain greater depth into individual insights, particularly from key informants. The semi-structured interview approach allows researchers flexibility to access information and seek follow up on emergent lines of inquiry.

Because qualitative data collection tools are not orally administered surveys, there was some divergence in the topics covered depending on the participants involved and salient issues and opinions that present themselves over the course of the discussion. Every effort was made to ensure that all researchers thoroughly understood the overall research objectives so that interview or group discussion were sufficiently flexible and rigorous to produce data that could be analysed against the chosen indicators.

For this assessment, Integrity utilised the following research methods: literature review, key informant interviews (KII), focus group discussions (FGD) and independent, semi-structured interviews, explained in detail below.

Respondents were given a full introduction to the research and the researchers, which included:

- Introduction to the researchers, the interview anonymity and length
- Explanation of research objectives and process
- Explanation of who the research was being conducted for
- Reassurance to respondents

All research tools were translated into Arabic, to ensure that informants could respond in their preferred language.

Literature Review

Our technical approach to this assignment has been designed to ensure the research questions and methodologies test, validate and compliment any work already conducted on the themes of healthcare provision, conflict and the Syria crisis response in Lebanon. Integrity has conducted a meta-analysis of the documents provided by Alert, its partners and of other available academic/thematically relevant literature. The literature review, conducted in the first week of the project, was used to inform the formation of the interview guides and analysis.

Key Informant Interviews

The conflict sensitivity expert devised a range of bespoke question guides to provide insights into various healthcare actors. The guides provided a series of open ended and some coded questions regarding basic information according to the research objectives. Further details on the survey tools are provided below.

The three bespoke KII guides developed for this project include:

1. INGO: For UN agencies and Healthcare INGOs
2. PHC: For PHC staff (directors, doctors, nurses, social workers) and NGOs
3. Lebanese Government: MoPH, MoSA, Municipalities

Focus Group Discussions

The FGD guide covered healthcare user perceptions, focusing on the extent to which healthcare provision was seen as either contributing to or alleviating tensions between PHCs, hosts and communities. Discussions were split with separate FGDs held for Lebanese men, Lebanese women, Syrian men and Syrian women.

A warm up exercise was developed as a quick way to reveal insights into each healthcare user, to discover their priorities and reveal group dynamics. During the warm up, healthcare users were asked as a group to rate various services and needs on a scale of importance while researchers observed.

Areas covered during the FGDs included:

- **Perceptions of staffing:** How do Lebanese and Syrian refugees see the staff (competence, identity, gender) in the healthcare sector?
- **Perceptions of legitimacy of health service providers:** Which healthcare providers are seen as legitimate by community representatives and why?
- **Tensions in healthcare provision:** What are the main issues in the health sector that are seen as a cause of tensions?
- **Perceptions over access and preferential treatment:** What are the perceptions over the level of access to primary and secondary healthcare for Lebanese and Syrian refugees? Is there a difference in the perceptions of PHC users and non-PHC users? Are there perceptions of preferential treatment or discrimination by PHCs or public hospitals?

Independent Semi-structured Interviews

A small number of independent semi-structured interviews were conducted with key informants, with questions for these interviews specifically selected or formulated for the informant. These respondents were often either from specialist backgrounds outside the particular scope of a tool, such as academics, or unable to conduct a formal interview due to constraints on their availability.

Data Collation, Translation and Management

Following each interview, our researchers reviewed their notes, cleaning the data as necessary. They then uploaded data to our project and data management platform, Podio, and time was allocated for translation of interviews conducted in Arabic. Notes and comments captured by the researchers were discussed in the Analysis Sessions held at intervals throughout the research cycle, in both individual sessions with the researchers and group sessions. This culminated in a final full day analysis workshop.

No. of FGDs and KIIs conducted in PHCs

PHC	No. FGD Syrian women	No. FGD Syrian Men	No. FGD Lebanese Women	No. FGD Lebanese Men	No. KII PHC Staff
Mazraa; Beirut	2	1	2		3
Ras El Nabeh; Beirut	3		1		5
Bar Elias, Bekaa	1		1	1	1
Kamed el Loz, Bekaa	1	1		1	1
Bazourieh, South	2		2	1	
Maarake, South	2	2	2	3	1
Sir El Denniyeh, North	NOT ABLE TO RETURN	NOT ABLE TO RETURN	NOT ABLE TO RETURN	NOT ABLE TO RETURN	1
Mina, North	1			1	1
Beirut (PHC dropped from research)	N/A	N/A	N/A	N/A	3
Ghazze (PHC dropped from research)	N/A	N/A	N/A	N/A	1

No. of KII conducted with Healthcare Stakeholders

Type of Stakeholder	No. of KII
Lebanese Government	3
Municipalities	4
UN Agencies	4
INGOs	4
Academic - Healthcare Specialists	2

Annex C: Informal Coping Mechanisms for Conflict Reduction in PHCs

Table 1: Informal coping mechanisms

Type of Informal Coping Mechanism	Ways Coping Mechanisms are put into Practice
Increased staff	• Increased number of doctors of most used specialisms: Obstetrics, Gynaecology, Paediatrics, Neurology, Orthopaedics
	• Shifting staff between PHCs notably social workers
	• Increased number of staff and gave them financial incentives to work increased hours
Shifting staff roles	• Trainings for staff so they can cover each other's roles to balance workload
	• Paediatrician now deals only with eight months and younger rather two years and younger GP treats children over eight months
Increased hours	• All staff are working increased hours
	• Doctors working increased hours, notably: Paediatricians and Obstetrics
	• Small bonuses for staff that work overtime
Added new awareness sessions	• Weekly and monthly education and awareness sessions
	• Birth control and family planning
	• Hygiene (and providing soap / shampoo / other)
	• Raising awareness on contacting GlobalMed
	• Pregnancy
	• Work in schools on lice treatment and hygiene
	• Partner with NRC to hold lectures on legal procedures for registering the newly born, marriage and death certificates
	• Women's Health
	• Vaccination and vaccination awareness campaigns
Providing additional information	• Clear explanation of the UN support programme
	• Mosques used to deliver messages/information on primary healthcare
	• Brochures for Syrian patients explaining how healthcare provision works in Lebanon
	• SMS with PHC and health information, but later dropped as deemed ineffective
	• Information to Syrians in collective shelters
	• Provide Lebanese patients with MoPH guidelines on the prevention of contagious disease
	• Segregated waiting area (1st floor for Syrians and 2nd floor for Lebanese) although not mandatory and segregated awareness sessions

Type of Informal Coping Mechanism	Ways Coping Mechanisms are put into Practice
Segregated waiting room / awareness sessions	• Two Syrians admitted for every one Lebanese
Changed appointment system	• Admit patients in rotation one Lebanese for one Syrian
	• Cleaning of equipment, waiting room and examination room after use by every patient (both Lebanese and Syrian) by cleaning lady
Enhanced cleaning / disinfection	• Fortnightly deep clean shifted to weekly
	• Referred two cases of malnutrition with the IOCC
Undertaking referrals / other support received	• Referral of cases to local NGOs
	• Medicine provided by Youth For Christ
	• Contacting NGOs to provide water to the tents and camps sites
	• Cooperating with UNICEF to provide special care for children, whether educational or recreational
	• Referrals to private doctors given – at the same price - if service at the PHC is not available
	• IOCC providing child development services
	• Monthly campaigns distributing medication and providing vaccinations
Mobile Clinics	• Mobile clinic works five days a week, Monday- Friday
	• Psychologist provided by Medicines de Monde
Other support received	• New equipment procured by IMC
	• Free diagnostic tests for under five and over 60 year-olds
	• UN funded equipment
	• Staff vaccinated against Hepatitis B to protect against the surmised health issues associated with coming into contact with Syrian refugees.
Other	• Syrians pay same as Lebanese for check-up, both costing more than the national rate (15,000 LL)
	• Discount / free treatment is offered for those in extreme need
	• Vaccination campaign – measles and polio (UN)

Table 2: PHC location and occurrence of informal coping mechanisms

Location	No. of Times an Informal Coping Mechanism was Reported
Mazraa; Beirut	10
Ras El Nabeh; Beirut	3
Bar Elias, Bekaa	3
Kamed el Loz, Bekaa	5
Maarake, South	3
Sir El Denniyeh, North	4
Mina, North	5
Beirut (PHC dropped from research)	5

Annex D: Analysing Conflict in Healthcare

The conflict sensitivity tool developed by the Conflict Sensitivity Consortium is designed for INGOs, and is not specific to any type of programming, or any particular conflict issues that may be arising. In order to focus the research a set of questions were developed which tailor conflict sensitivity specifically to healthcare provision. The questions draw from the literature on healthcare provision in conflict, as well as from the literature on conflict between Lebanese and Syrians in Lebanon. The research approach was organised in two parts: analysing tensions in healthcare prior to the Syrian crisis, and analysing possible tensions in healthcare provision since the crisis began. These questions are captured below. The hope is that the question guides may be valuable for future work on conflict sensitivity in healthcare provision elsewhere since the guides provide prompts for sector-specific concerns such as collection and publication of public health data, management of the different medical conditions of different groups.

The Situation Prior to the Syrian Crisis:

1. Who provided health services?
2. What is the perception of legitimacy of those healthcare providers? Are they perceived to be biased?
3. Where healthcare is provided by the state, what wider issues of state legitimacy could have been playing out in healthcare provision?
4. Are there concerns over corruption? Or patronage? If so, how has this played out in healthcare provision?
5. Who staffed those health services (ethnic, religious or other make up)? Are they linked to wider conflict issues?
6. Who got access to health services? Who didn't? (there may be a difference between perceptions and reality) Does this relate to wider conflict issues?
7. Has the provision of withholding of health services had any role in earlier conflicts?
8. Has healthcare provision been politicised in any way (including the provision of medical services being accompanied by political or other prejudicial messaging?)
9. Has the distribution of resources in healthcare provision benefitted any particular group e.g. location in one group's region, or disproportionate amount of resources directed to the healthcare of a particular group (e.g. different income groups have different disease/ epidemiological profiles)

Healthcare Since the Beginning of the Syrian Crisis:

1. What are the capacity stretch stresses for existing service providers? Is there a difference between perceptions and reality?
2. Is anyone benefitting (profiting?) from the situation of stretched capacity in healthcare provision?
3. What additional services are provided, and by whom?
4. What is the perception of legitimacy of those healthcare providers? Are they perceived to be biased?
5. How are issues over legitimacy, corruption, patronage or other playing out in this new situation?
6. Is the profile of staff providing healthcare in new additional services different from pre-existing services in any way?
7. Who gets access to the new services? The old services?
8. What services are being provided free of charge? To whom? [need to check this against vulnerability versus status]
9. What information is provided about access to services (paid or free)?
10. What is the experience of the interaction between the healthcare service provider and those who are utilising their services – i.e. perceptions of service quality? Are there perceptions among any user groups that the providers behave with prejudice towards them?
11. What are the attitudes of healthcare service providers towards all users of their service?
12. Are there any behavioural or other symbolic differences such as language, religion or dialects that could affect access or perceptions of partiality (either between provider and user, or between different groups of users)?
13. Has the physical location of health services influenced perceptions of who they are for? Or has it affected actual access between different groups?
14. Is there any politicisation of the location of healthcare services (e.g. proximity to political party HQs, etc.)?
15. Were there private providers of this service whose business is being undermined? (egg private pharmacists)
16. How well are the different medical conditions of different groups managed? Are any inflammatory or defusing messages given (for instance increasing fear through panics over epidemics?)
17. Is there sensitivity over public health data - records of people, or inflammatory messaging given about increasing incidents of certain diseases?

18. Is the provision of medical services being accompanied by any prejudicial or political messaging?
19. How is healthcare responding to stressed behaviour (e.g. survival sex amongst women refugees – is healthcare responding? Is it alienating these women?)
20. What public messages are being given about stresses on healthcare? By whom? What is their interest/ intention in escalating tensions?

Output 2: Conflict Sensitivity Checklist

The conflict sensitivity checklist draws on the structure developed in the Conflict Sensitivity Consortium 'How to' Guide[29]. It focuses on the PHC, with some entries relating to MoPH and the UN.

PHCs
Institutional Commitment
The concept of conflict sensitivity is understood so that: • It is not only seen to be about managing conflicts as they erupt in a PHC ('fire-fighting mindset') but also that that it is a pro-active stance involving taking preventative actions to avoid tensions erupting; • That it is not only about tensions in the waiting room – that actions in the PHC can contribute to wider tensions between Lebanese and Syrians; • That enabling conflict sensitivity is not only about having more resources to increase service provision, but crucially it is about the way in which we work, e.g. how what happens in the PHC can reinforce or challenge negative stereotypes between Lebanese and Syrians.
Organisational accountability mechanisms are in place to address any inappropriate behaviour by staff as identified in the complaints / feedback mechanism (see below)
Policies and strategies
Appointment systems are put in place and functioning effectively to avoid any patient waiting for extensive periods. Where appointment systems are impossible to implement, then the first-come-first-served system is organised to see the Syrians and Lebanese in a system that is accepted as fair by both groups.
Communication strategies are established to provide information to both communities on issues of most concern, notably: • A grounded medical statement on how scabies and lice are spread, and how to prevent transmission;[30] • Actual entitlements available to Syrians through UNHCR. At minimum there should be information posters in the PHC, but additional communication mechanisms such as through awareness raising sessions or pamphlets in the PHC would be beneficial.
Coping or mitigation measures adopted by the PHC are assessed for how they may inadvertently contribute to wider tensions, for instance by reinforcing the perception that Syrians are unhygienic or diseased.
Human resources – staff knowledge, skills and attitudes
Staff have the following attitudes: • Respect for the dignity of every human – without discrimination (in particular among administrative staff); • Acceptance that what happens in the PHC can contribute to wider tensions in society.
Staff have the following skills: • Communication and diplomacy; • Strong inter-cultural sensitivity and understanding; • Self-awareness of own biases, and how individual actions may be perceived in different contexts;

[29] See Annex 3: Benchmarks for Conflict Sensitivity in Conflict Sensitivity Consortium, The How to Guide to Conflict Sensitivity, February 2012

[30] The coping and mitigation measures adopted by PHCs indicate that there may not be a strong medically grounded understanding of how scabies and lice are spread, as the disinfection and segregation actions are disproportionate. Thus the grounded medical statement should *not* be developed individually by each PHC, but handled separately and clearly written to allay fears.

• Ability to identify potentially prejudicial messaging or actions.
Staff have the following knowledge: • Contextual understanding of the circumstances of the Syrian patients such as availability of water (could be achieved through mobile health teams reporting back for instance); • Understanding of widespread use of contraception in Syria prior to crisis, and appropriate ways to discuss the issue of contraception with patients.
Information management
Feedback / complaints mechanism is in place and is understood and used by patients. Complaints are effectively addressed. The PHC tracks the complaints over time.
Integration into service provision
Contraception is available, and awareness sessions are promoting it
External relations
Digital disease reporting mechanism is functioning and regularly updated, to enable the generation of accurate data on incidence of communicable diseases

MoPH
Institutional Commitment
Leadership role in pushing for a Government strategy for the crisis response which recognises that Syrians are likely to remain for some years
Policies and strategies
A policy on conflict sensitivity is established as a framework for all PHCs
Integration into service provision
The medicines list is updated and remains current
MoPH plays a co-ordination role across all respondents in the health sector to prevent duplication
Brochures on contraception are developed and disseminated

UN Agencies
Policies and strategies
Revise eligibility criteria to include vulnerable Lebanese communities and exclude Syrians who are not vulnerable
Revise the eligibility criteria to avoid perverse incentives for Syrians to get pregnant

Output 3: Indicators for Capturing Community Perceptions

"Exploring unintended and unanticipated outcomes is not well accomplished through indicators, which help assess what we had anticipated, not what we had not anticipated. To identify the unintended and unanticipated effects of a programme or policy, ***open-ended inquiry*** *with a range of targeted and non-targeted groups is a more appropriate methodology. Any indicator-based methodology should therefore be supplemented by feedback mechanisms that are more open-ended."*[31]

As such, the term 'indicators' is being widely interpreted, to mean open ended enquiry to understand unanticipated effects

[31] Goldwyn, R., and Chigas, D., (March 2013) Monitoring and Evaluating Conflict Sensitivity – methodological challenges and practical solutions Conflict Crime and Violence Results Initiative, DFID. Page 16 (emphasis in original)

Given that the checklist has a process focus, the indicators emphasise an outcomes focus. The terms of reference stipulate that the indicators should be based on community perceptions. A small addition is also made from PHC data, which draws on the actual data from the complaints / feedback mechanism proposed in the checklist.

Indicators and wider open ended enquiry to measure the project
Community perceptions
Perceptions of the 'other' group – measures of tolerance/ competition
Understanding of UN healthcare subsidy system (can people explain what is covered and what isn't?) – relates to both Syrians and Lebanese
Fear over spread of communicable diseases
Concerns over corruption (is healthcare considered just or equitable? Do people trust the system?)
Assessment of quality of medical service (for example experience of 'disgust' from others)
Where a PHC has implemented mitigation measures then user feedback on the relevance and value of that mitigation measure in preventing tension should also be assessed.
PHC data: to include *both* PHCs that are part of the UNHCR response, and those that are not
Actual number of violence incidents in the PHC
Actual number of complaints and categorisation of these

End of Report


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