PRELIMINARY PROGRAMME

Strengthening Human Resources for Health

Integration of Refugees into Host Community Health Systems

Center for Mediterranean Integration, Marseille, France
March 30-31, 2017
Background

The Syrian conflict, now in its sixth year, has led to a mass exodus of nearly 5 million people who have sought refuge primarily in neighbouring countries in the Middle East and North Africa (MENA) such as Jordan, Lebanon and Egypt, and OECD countries such as Turkey, Germany, Sweden, and Austria. In the health care sector, the cumulative consequences of the Syrian crisis in the MENA region on displaced populations are particularly profound and enduring, affecting not only the displaced populations but also host communities, and are playing a key role in determining the health security of the entire region. In OECD countries, despite much smaller inflows, public opinion has raised concerns over recent refugee arrivals on the issues of managing and integrating these populations amid ongoing recoveries from recent economic crises. Although there are short-term costs of integrating refugees, evidence suggests they can positively contribute to host societies with the appropriate support.

Despite very different contexts and levels of refugee entry, many host countries are grappling with the provision of basic public services including health care, both for the refugee populations as well as the local host populations. The MENA region has completed a demographic transition and is now undergoing a seismic shift at the governance level that raises a much higher level of expectation for services and engagement from the population. In several OECD countries, health systems have been affected by the financial crisis and can face the challenge of limited human and financial resources. Within this context, it is critical for the health sector to adapt and find innovative solutions, to meet growing expectations, and to address imminent and emerging health needs of local populations and refugees (i.e. non-communicable diseases, reproductive, maternal and child health, mental health, etc.).

International support to address the health needs of Syrian refugees and populations in host countries is critical, and a health workforce that is sufficient in number and adequately trained to respond to prevailing needs a precondition. The fact that many Syrian health workers have fled the violence and become part of the refugee population themselves, coupled with difficulties for practicing outside Syria, has contributed to a gap in service provision both within Syria and in main host communities. In some OECD countries, austerity measures and shortages of health workers have made it challenging to secure appropriate access to care. Health institutions and service providers are stretched to the limits in terms of financing and human resources for health. The workload in most health care units in host countries has increased significantly, which is overstretching the human resource capacity at the central and peripheral levels in many countries.

To address some of the above challenges, this workshop is being convened to discuss current challenges and opportunities for integrating and strengthening the Syrian refugee health workforce within host countries. With appropriate training, accreditation, and other support, refugee health professionals who are currently underutilized or not adequately trained might be better positioned to help address the prevailing health needs of refugees and host populations alike.
**Workshop Aim**

The objective of this workshop, to be held March 30-31, 2017, at the Center for Mediterranean Integration, is to discuss challenges and opportunities for strengthening the numbers and competencies of refugee health professionals in host countries to better address local health needs. Maintaining and developing skills of displaced health workers will also be of critical interest for rebuilding the Syrian health system in the future.

The workshop aims to learn from the heterogeneity of knowledge and experiences of federal and local governments, health workers, educational centers and support organizations, both in MENA and OECD countries and globally, to identify targeted areas for investment and support to the Syrian health workforce, refugees, and host populations.

One immediate output from the workshop will be a joint OECD/WB/CMI synthesis document capturing “innovative practices” with regards to the recognition and promotion of skills and qualifications of Syrian and other refugee health workers in OECD and MENA host communities. The synthesis document will be finalized by May 2017 and disseminated and shared with the CMI host municipality, OECD, and World Bank networks.

**Workshop Synopsis**

The workshop agenda centers discussions on the following three areas:

1. **Identifying the training needs for host countries and for refugee health care workers.** Taking into account the context of a changing burden of disease in host countries, discussions will revolve around mapping the existing numbers, competencies, and training of Syrian and other refugee health care workers in OECD and MENA host countries. Additionally, this part will identify relevant opportunities for scale up and upgrading of competencies as best suited to fill gaps and meet current and future health needs in both the host community and the refugee population.

2. **Identifying challenges related to health workforce participation for refugee health care workers.** This part will establish a dialogue around current policies and requirements for health worker participation in MENA and OECD countries and seeks to identify some of the challenges and opportunities for refugee health workers to resume medical practice in host countries. Because healthcare professions are “regulated professions” in most countries, complete recognition of credentials and skills is neither systematic nor fast. Numerous practical barriers also exist, including language barriers, administrative costs and delays, and a potential mismatch between market demand and provider skills. Opportunities for overcoming or minimizing these barriers will be discussed.

3. **Identifying the potential of pre- and in-service training as well as bridging programmes to support the accreditation of Syrian and other refugee healthcare workers.** Several programmes and policies have been implemented to allow for the partial recognition of foreign qualifications and skills for health care workers and to support the acquisition of further skills. This section will explore several programmes (by government institutions, universities, NGOs, foundations or private companies) that allow refugees to complete their training or to adapt to the national corporate bodies. Bridging programmes, one time certification, and continuous medical education will be discussed in this part.
# Brief Workshop Agenda

**Thursday, March 30, 2017**

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<th>Time</th>
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<tr>
<td>9:00 am to 9:30 am</td>
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| 9:30 am to 10:00 am | **Introduction:**  
Janette Uhlmann, Center for Mediterranean Integration  
**Opening Keynote Address:**  
Former President of Portugal Jorge Sampaio |
| 10:00 am to 10:45 am | **Session 1:** *The Case for Investing in Refugee Human Resources for Health*  
Speakers:  
Jean-Christophe Dumont, Organisation for Economic Co-operation and Development  
Santino Severoni, World Health Organization  
Samer Jabbour, Lancet-American University of Beirut Commission on Syria  
Ernest Massiah, World Bank |
| 10:45 am to 11:00 am | Coffee Break                                                            |
| 11:00 am to 12:30 pm | **Session 2:** *Mapping the Untapped Syrian Refugee Health Workforce*  
Moderator:  
Simon Frostick, University of Liverpool  
Speakers:  
Sharif Ismail, Imperial College London; Adam Coutts, University of Cambridge  
Barbara Schmidt, Federal Ministry of Labour and Social Affairs; Marina Horn, Federal Ministry of Health, Germany  
Erik Magnusson, National Board for Health and Welfare, Sweden  
Discussants:  
Asaad Kadhum, United Nations High Commissioner for Refugees, Jordan  
Christos Varakis, OECD Delegation, Greece |
| 12:30 pm to 2:00 pm | Lunch                                                                   |
| 2:00 pm to 3:30 pm | **Session 3:** *Legal and Regulatory Challenges to Integration*  
Moderator:  
Ibadat Dhillon, World Health Organization  
Speakers:  
Anas Sheikha, Coordination Office for Treatment of Wounded Syrians in Jordan  
Howard Catton, International Council of Nurses  
Patrick Romestaing, Committee of European Physician Associations |
<p>| 3:30 pm to 4:00 pm | Coffee Break                                                            |</p>
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<td>4:00 pm to 5:30 pm</td>
<td><strong>Session 4:</strong> Practical Challenges to Integrating Refugee Health Workers into Host Health Systems</td>
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<td><strong>Moderator:</strong> Charles Ok Pannenberg, Netherlands Government Commission on Global Health Research</td>
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<td><strong>Speakers:</strong> Molham Al-Khan, Syria Al Gad Relief Foundation, Egypt</td>
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<td>Sophie Lemerle, Association d’Accueil aux Médecins et Personnels de Santé Réfugiés en France</td>
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<td>Maggie Lennon, The Bridges Programmes, Scotland</td>
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<td>5:30 pm to 5:45 pm</td>
<td><strong>Day One Review and Reflections: Part I</strong></td>
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<td>7:30 pm to 9:00 pm</td>
<td><strong>Dinner and Reception</strong></td>
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**Friday, March 31, 2017**

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<td>9:00 am to 9:15 am</td>
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<td>9:15 am to 10:30 am</td>
<td><strong>Session 5:</strong> Recognizing Health Worker Credentials from Origin Countries: Options and Examples</td>
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<td><strong>Moderator:</strong> Akiko Maeda, Organisation for Economic Co-operation and Development</td>
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<td><strong>Speakers:</strong> Safwan Alchalati, Syrian Board of Medical Specialists</td>
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<td>Joel Hellstrand, Swedish Public Employment Service</td>
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<td>Me André Gariépy, Office des professions du Québec</td>
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<td>10:30 am to 11:00 am</td>
<td><strong>Coffee Break</strong></td>
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<td>11:00 am to 12:30 pm</td>
<td><strong>Session 6:</strong> Pre- and In-Service Training to Support the Refugee Health Workforce: Options and Examples</td>
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<td><strong>Moderator:</strong> Leonard Rubenstein, Johns Hopkins Bloomberg School of Public Health</td>
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<td><strong>Speakers:</strong> Helena Barroco, Global Platform for Syrian Students</td>
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<td>Ahmad Tarakji, Syrian American Medical Society</td>
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<td>Toril Sundal Leirset, Levanger Arena Arbeid, Norway</td>
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<td>Inge Missmahl, IPSO, Germany</td>
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<td>12:30 pm to 2:00 pm</td>
<td><strong>Lunch</strong></td>
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<td>2:00 pm to 3:00 pm</td>
<td><strong>Session 7:</strong> Facilitated Group Work: Defining Priority Areas</td>
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<td>3:00 pm to 3:30 pm</td>
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<td>3:00 pm to 4:00 pm</td>
<td><strong>Session 8:</strong> Presentation of Priority Areas and Partner Responses/Action Agenda</td>
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<td>Group Presentations and Concluding Remarks</td>
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Participant List

Aaka Pande, World Bank
Adam Coutts, University of Cambridge
Ahmad Tarakji, Syrian American Medical Society
Ahmet Levent Yener, World Bank, Ankara, Turkey
Akihiro Seita, United Nations Relief and Works Agency Health Programme
Akiko Maeda, OECD
Anas Sheikha, Committee for the Treatment of Wounded Syrians in Jordan
Asaad Kadhum, United Nations High Commissioner for Refugees, Jordan
Barbara Schmidt, Federal Ministry of Labour and Social Affairs, Germany
Caroline Berchet, OECD
Charles Ok Pannenborg, Netherlands Government Commission on Global Health Research
Christopher Herbst, World Bank
Christos Varakis, Greek Delegation to the OECD
Erik Magnusson, National Board for Health and Welfare, Sweden
Ernest Massiah, World Bank
Fatih Karayandi, Adana Metropolitan Municipality, Department of Health and Social Affairs, Turkey
Fouad M. Fouad, Lancet-American University of Beirut Commission on Syria, Lebanon
Gulin Gedik, World Health Organization, Eastern Mediterranean Region Office
Helena Barroco, Global Platform for Syrian Students
Howard Catton, International Council of Nurses
Ibadat Dhillon, World Health Organization
Inge Missmahl, IPSO Non-Governmental Organization, Germany
Janette Uhlan, Center for Mediterranean Integration, France
Jean-Cristophe Dumont, OECD, International Migration Division
Joel Hellstrand, Swedish Public Employment Service
Jomaa Aboras, Syrian Board of Medical Specialists
Jorge Sampaio, Former President of Portugal, Global Platform for Syrian Students
Kanuni Keklik, Ministry of Health, Turkey
Leonard Rubenstein, Johns Hopkins Bloomberg School of Public Health, USA
Maher Azzouz, Syrian American Medical Society
Maggie Lennon, The Bridges Programmes, Scotland
Marina Horn, Ministry of Health, Germany
Me André Gariépy, Office des professions du Québec
Molham Al-Khan, Syria Al Gad Relief Foundation, Egypt
Mourad Ezzine, Center for Mediterranean Integration, France
Mustafa Uzun, Ministry of Health, Turkey
Patrick Romestaing, Committee of European Physician Associations
Poonam Dhavan, International Organization for Migration, Geneva
Safwan Alchalati, Syrian Board of Medical Specialists
Samer Jabbour, Lancet-American University of Beirut Commission on Syria, Lebanon
Santino Severoni, World Health Organization, Public Health and Migration Division
Sara Barragan Montes, World Health Organization Europe
Sharif Ismail, Imperial College, London
Simon Frostick, University of Liverpool
Sophie Lemerle, Association d’Accueil aux Médecins et Personnels de Santé Réfugiés, France
Toril Sundal Leirset, Levanger Arena Arbeid, Norway
Session Details and Biographies

Thursday, March 30, 2017

Keynote Address, 9:30 am to 10:00 am

Jorge Sampaio
President of the Portuguese Republic (1996-2006)

Born in 1939, Jorge Sampaio graduated in Law at Lisbon University in 1961. As elected head of the Students’ Union of the Lisbon Law Faculty, he became a leader in the struggle for the restoration of democracy in Portugal, which was eventually achieved through the Carnation Revolution (1974) and the establishment of a liberal democratic constitutional regime in 1976. In the 1960s and early 1970s Jorge Sampaio took numerous cases to the political courts of the dictatorship, defending political prisoners and exposing the abuses of the political police. He defended, on a pro bono basis, several victims of state repression.

He also defended human rights as a member of the European Human Rights Commission of the Council of Europe from 1979 to 1984. From 1976 onwards, Jorge Sampaio became a consistent supporter of the consolidation of Portuguese democracy: as a Member of Parliament; as Speaker of the Labour Party; as Deputy Minister for External Co-operation; as Mayor of Lisbon from 1989 to 1995, and, from 1996 to 2006, as President of the Republic.

As the UN Secretary General’s first Special Envoy to Stop Tuberculosis from 2006 to 2012, Jorge Sampaio has raised the international visibility of this poverty disease’s scale and its impact on the Millennium Development Goals’ agenda. As the UN High Representative for the Alliance of Civilizations from 2007 to 2013, appointed by current Secretary General Ban Ki Moon, he set up an important UN Forum for dialogue and cooperation against hatred and violence and promoted common action at local, national and regional levels to meet the challenges of cultural diversity across the globe.

Most recently he has been involved in two main international fields of action: as a member of the Global Commission on Drugs Policy he has been advocating a major reform on drug policy; he has also launched the Global Platform for Syrian Students, a multi-stakeholders initiative aimed at providing emergency scholarships to Syrian students that allow them to resume their university studies. As Chairman of the Global Platform he has been advocating the international community to set up a Rapid Response Mechanism for Higher Education in Emergencies in order to provide higher education opportunities for refugees and forcibly displaced persons in a sustainable and systemic way.

Jorge Sampaio holds several Portuguese and Foreign Honours. In 2015, he was awarded together with Dr. Helena Ndume, of Namibia, and H.E. Mr. Jorge Sampaio, of Portugal, the United Nations Nelson Rolihlahla Mandela Prize.
Session 1: The Case for Investing in Refugee Human Resources for Health, 10:00 am to 10:45 am

Objective: To assess why investment in refugee health professionals is urgently needed, as well as to highlight the benefits of these investments for meeting refugee and host community health needs and creating economic dividends within host communities.

Key Questions:

- Why is investment in refugee human resources for health needed now? Why is it necessary to facilitate refugee healthcare workers’ integration?
- Who will benefit from these investments? What are the potential dividends to refugee health workers, to local refugee populations, and to host countries?
- How are refugee health workers in some cases uniquely poised to address healthcare challenges created by migration and displacement?

Speakers:

Jean-Christophe Dumont, Organisation for Economic Co-operation and Development (OECD)

Jean-Christophe Dumont is Head of the International Migration Division (IMD) of the Directorate for Employment, Labour and Social Affairs at the OECD. He is responsible for the publication of the OECD Annual Report International Migration Outlook and other OECD publications related to international migration. He joined the OECD in 2000 as an economist. He holds a PhD in development economics and a master degree in mathematics applied to social sciences from University Paris IX Dauphine, France

Santino Severoni, World Health Organization

Santino Severoni has held senior positions at the World Health Organization European Office since 2000 and, since 2013, has coordinated the public health aspect of migration work for the WHO Regional Office for Europe. In the last 22 years he has worked in several countries in Eastern Africa, Balkans, Central Asia and Western Europe, dedicating his professional work to public health, health sector reforms, health system strengthening, health diplomacy, aid coordination/effectiveness, and management of complex emergencies.

Samer Jabbour, Lancet-American University of Beirut Commission on Syria

Samer Jabbour is Co-chair of the Lancet-AUB Commission on Syria and an associate professor of public health practice at the American University of Beirut, in Lebanon. His research interests include public health in the Arab world, non-communicable diseases, health, society, change and politics, and social determinants of health. He earned his M.D. from Aleppo University, and his Masters in Public Health from Harvard School of Public Health.

Ernest Massiah, World Bank

Ernest Massiah is Practice Manager of Health, Nutrition, and Population for the Middle East and North Africa (MENA) region for the World Bank, in Washington, D.C. Previously, he was the UNAIDS Director of Regional Support Team for the Caribbean, and Head of the Health Section at the Commonwealth Secretariat in London. He also worked for more than ten years with the Inter-American Development Bank as the lead advisor on HIV and disability. He holds a PhD in public health from Johns Hopkins University.
Session 2: Mapping the Untapped Syrian and Refugee Health workforce, 11:00 am to 12:30 pm

Objective: To address the state of knowledge on the demographics of the refugee health workforce and examine efforts to map the size and location of refugee health workers in MENA and OECD countries.

Key Questions:
- What are the current refugee inflows in MENA and OECD host countries? What is the size of the refugee health workforce population? Where are these health workers located?
- What are the limitations with our data and reporting systems? How do we collect this data?
- What is the existing need for health professionals in host countries, and to what degree are refugee health workers being engaged to provide services in countries with the greatest needs?

Moderator:
Simon Frostick, University of Liverpool
Simon Frostick is a practicing clinician and Professor of Orthopedics at University of Liverpool. He has been involved in medical education for 25 years with an emphasis on curriculum development. He is a member of Council of the Royal College of Surgeons of Edinburgh and Advisor for International Curriculum Development. He and a colleague, David Pitts, are starting a project to support the training of doctors in Syria which will require innovative teaching and learning developments.

Speakers and Discussants
Sharif Ismail, Imperial College, London
Sharif Ismail is an Academic Clinical Fellow in the Public Health Policy Evaluation Unit at Imperial College London, and a public health physician in the UK. He is a founding member of the Syria Public Health Network. He has worked broadly on health system responses to ongoing instability and conflict in Syria and Yemen and, previously, as an analyst for the European branch of RAND Corporation, focusing on health and biomedical research policy.

Adam Coutts, University of Cambridge
Adam Coutts is a Senior Research Fellow at Magdalene College, University of Cambridge and Research Associate in the Department of Sociology. His research focuses on the social and political determinants of health looking at how non-health sector public policy such as labour market interventions and social protection affect health and wellbeing. He has collaborated with academics and policy-makers from Syria, Lebanon, and Jordan to examine the social and political determinants of health in the Arab region and the Syrian Refugee Crisis. In 2015 he cofounded the Syria Public Health Network with Fouad M. Fouad and Sharif Ismail to address policy challenges arising in the humanitarian health response. He holds a PhD from the University of Cambridge.

Barbara Schmidt, Ministry of Labour and Social Affairs, Germany
Barbara Schmidt has worked in the Ministry of Labour and Social Affairs in Berlin since 2004, joining the Migration and Integration Policies Unit in 2014. From 2008-2014, she coordinated Germany’s first labour market integration programme for asylum seekers and refugees. Since 2014 she has been engaged in the lead team of the network integration through qualification (IQ), a labour market program for the integration of migrants, asylum seekers and refugees.

Marina Horn, Ministry of Health, Germany
Marina Horn is Deputy Head of Unit in the division of Migration, Integration, Demography, and Health in the Federal Ministry of Health in Berlin. She was previously an officer in the Task Force for Migration and Health and in the Project Group Migration and Health Professions. She has held several positions in the ministry’s international department, including lead officer of the Secretary’s Office Greece responsible for health care reforms in Greece in cooperation with the Task Force for Greece (TFGR) of the European Commission and the Greek Government. She has degrees in Economics (Businesswoman), Business Administration, and European Sciences (M. A.).
Session 2: Mapping the Untapped Syrian and Refugee Health workforce, 11:00 am to 12:30 pm
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Speakers and Discussants (continued from previous page)

Erik Magnusson, National Board for Health and Welfare, Sweden
Erik Magnusson is acting director at The National Board of Health and Welfare. He holds a PhD in Economic History from Uppsala University and has a long experience analyzing the public sector and public sector reforms. In recent years, in the light of the increased number of refugees seeking asylum in Sweden, his work has focused on finding new solutions on how to integrate health workforce from countries outside the EU/EES area in the Swedish health care sector.

Asaad Kadhum, United Nations High Commissioner for Refugees, Jordan
Asaad Kadhum is UNHCR public health officer for Jordan. He is a public health expert with experience in health programs design, implementation and monitoring for refugees and populations in emergencies and has worked on the Syrian crisis since 2012 in different countries within the MENA region including Lebanon, Syria and currently Jordan. He has previous experience in horn of Africa and southern Africa, with expertise in health programs design and refugee health, among other areas. He holds a Bachelor of medicine, Bachelor of surgery (MBChB) from Al Mustansiriya University, and Master of Peace Keeping Management (MSc) from University of Torino, and a Diploma in Public Health (PGDip) from University of Manchester.

Christos Varakis, Greek Health Policy Delegation to OECD
Christos Varakis is an economist specializing in Health and Social Policy. He is currently Governor of General Hospital of Athens “Elpis” and Greece’s OECD Health Policy National Delegate. He has been director of the Department of Health Care at the UPOSIM (United Press Organization of Supplementary Insurance and Medicare) for 10 years responsible for the provision of Primary Secondary and Tertiary Health Care. He has a Ph.D. on Priority Setting in Health Care from the University of Athens and has received MSc. in Health Policy Planning and Financing from the London School of Economics and the London School of Hygiene and Tropical Medicine of the London University.
Session 3: Legal and Regulatory Challenges to Integration, 2:00 pm to 3:30 pm

Objective: To explore key technical barriers to refugee health workers practicing in host countries, with a particular focus on licensing, accreditation, and work permits for refugee health providers, as well as to examine country-level differences in legal and regulatory frameworks.

Key Questions:
- What are the current laws and regulations around licensing, accreditation, and health worker permits for refugees? How do legal and regulatory frameworks differ among countries?
- What are the major “barriers to entry” within these areas? To what degree are medical licenses or other forms of documentation from other countries accepted by host countries?
- How do these barriers differ for doctors, nurses, or other types of health professionals?
- What role do challenges accessing support networks, mentors, information networks, etc. play in further cementing the above barriers?

Moderator:
Ibadat Dhillon, World Health Organization
Ibadat Dhillon is a Technical Officer in the Department of Health Workforce at the World Health Organization. His work has focused on human resources for health and health systems at the national and global levels. He has previously served as a health advisor for the Danish and Irish Governments and the US Centers for Disease Control and Prevention. His work with the Aspen Institute contributed to the adoption of the WHO Global Code of Practice on the International Recruitment of Health Personnel. He holds Juris Doctorate (JD) and Master of Law (LLM) from Washington University in St. Louis and the Georgetown University Law Centre, as well as a Masters of Science in Public Health from Emory University.

Speakers:
Anas Sheikha, Coordination Office for Treatment of Wounded Syrians in Jordan
Anas Sheikha left Syria in 2011 after being pursued by the regime for treating injured demonstrators. From 2012 to 2015 he was Head of the Coordination Office to treat Syrians wounded in Jordan. Since 2015, he has been head of the Syrian Polyclinic Center in Istanbul. He holds a master degree in general and laparoscopic surgery and joined the teaching staff in the Damascus University surgery department in 2005.

Howard Catton, International Council of Nurses
Howard Catton is the Director, Nursing & Health Policy for ICN since 2016 and leads the development of ICN policy across workforce, education, regulation, nursing practice and health policy. Previously he held posts at the Royal College of Nursing UK, including as a national policy adviser for workforce research and health policy. From 2005-15 he was Head of Policy & International Affairs at the RCN. He studied social policy in Cardiff (BSc Econ) and Industrial Relations at Warwick (MA) and worked as a Personnel and Organisational Change Manager in the NHS.

Patrick Romestaing, Committee of European Physician Associations (CPME)
Patrick Romestaing is an Ear, Nose, and Throat (ENT) surgeon and he has been the CPME Head of Delegation for the French Medical Council (Conseil National de l’Ordre des Médecins) since 2015. Since 2000, Dr Romestaing has been the President of the Departmental Council of Medical Order of Rhône, which has 10,000 doctors registered. In 2007, he was elected to the French Medical Council. He was President of the CNOM Public Health and Demography Department from 2009 to 2013. In addition, in 2010, he co-created the Joint CEOM, UEMS and FEMS European Observatory of Medical Demography and became in 2015, an expert of the European Joint Action network of experts on health workforce planning and forecasting.
Session 4: Practical Challenges Related to the Integration of Syrian Refugee HRH into Host Health Systems, 4:00 pm to 5:30 pm

Objective: To examine commonly cited contextual challenges—political, social, economic, educational, and others—to integrating refugee health workers into host health systems, including language and cultural barriers, funding shortages, and labor market obstacles.

Key Questions:
- What is the role of language and cultural barriers in the ability of refugee health workers to practice within host countries? How do language proficiency requirements vary?
- How do financial and political stressors affect host country willingness and ability to allow refugee health workers to practice?
- What is the cost of re-training and integrating refugee health professionals into host countries, and how do these costs compare with training nationals?
- To what degree do the skills needed by a host community match the skills that refugee health workers, in general, have been trained to provide?

Moderator:
Charles Pannenborg, Netherlands Government Commission on Global Health Research

Charles Ok Pannenborg is Chair of the Netherlands Government Commission on Global Health Research. Previously he worked for 25 years at the World Bank, where he served mostly in operations in Asia and Africa, and rose to become a manager and then technical director and retired as the Bank’s Chief Health Advisor. He was the architect of the first sector-wide approach in health. Among his many positions, Pannenborg has directed long-range strategic policy and introduced scenario analysis for health policy at the Netherlands’ Ministry of Health, while simultaneously serving as population and health advisor at the Ministry of Foreign Affairs at The Hague.

Speakers:
Molham Al-Khan, Syria Al Gad Relief Foundation, Egypt

Molham Al-Khan is a Syrian medical student in Cairo University Medical School. He has been living in Egypt for the past eight years, and was one of the first student responders to the Syrians streaming into the country as a result of the conflict. Since then, he has founded Syria Al Gad Foundation in 2013. Syria Al Gad, through international and local partnerships, focuses on providing medical, educational, and social services to the Syrian community in Egypt, having benefited over 15,000 families.

Sophie Lemerle, Association d’Accueil aux Médecins et Personnels de Santé Réfugiés en France

Sophie Lemerle is a pediatrician who recently retired from practice after more than 15 years treating adolescents at a hospital pediatric clinic in France. She now provides medical assistance to unaccompanied minors and other migrants in Paris and internationally through her work with Médecins du Monde, as well as APSR.

Maggie Lennon, The Bridges Programmes, Scotland

Maggie Lennon is Founder and Director of the Bridges Programmes, a specialist agency supporting the economic and social inclusion and integration of refugees, asylum seekers, and migrants in Scotland. Her organization has been operational for more than 15 years and is the only specialist agency dealing with employment for this group. With funding from Scottish government, she recently launched the new Refugee Doctors’ Programme to support qualified refugee doctors towards their General Medical council registration and obtainment of a license to practice medicine in the UK. She is a committed advocate for equality and human rights and has successfully campaigned for the right of asylum seeking children to have access to Scottish Universities and on proposals to develop a National Recognition service for the validation and recognition of overseas qualifications.
Session 5: Recognizing Health Worker Credentials from Origin Countries: Options and Examples, 9:15 am to 10:30 am

Objective: To highlight opportunities and new approaches for recognizing health worker credentials from origin countries, including fast-track programs and specialized credentialing bodies.

Key Questions:
- What are current policies for recognizing health worker credentials in host countries? What are some examples of “fast-tracking” that allow health workers to enter the workforce more quickly? How did these programs evolve? What is their level of oversight/regulation?
- What innovative options are available for assessing health worker skills? What form do these assessments take?
- What role can special governing boards or bodies play in expediting health worker credentialing in host countries?

Moderator:
Akiko Maeda, Organisation for Economic Co-operation and Development
Akiko Maeda is a Japanese national and health economist with over 20 years of international experience in health and social policies and development programs. She has advised governments on health policy reforms and managed investment projects in the health sector in over 30 countries in the Middle East & North Africa Region, Asia, and Europe. She has also published global studies covering topics ranging from health financing and health accounts, health sector labour market, and health service reforms. Before joining OECD, Dr. Maeda held positions as lead health specialist and health sector manager at the World Bank. She also served in various field positions with the Asian Development Bank, UNICEF and UNDP. Dr. Maeda has a Ph.D. in Health Economics from Johns Hopkins University, and MA degrees in biochemistry and in Middle Eastern Studies from Harvard University.

Speakers:
Safwan Alchalati, Syrian Board of Medical Specialists
Safwan Alchalati is a Syrian physician currently based in Gaziantep, Turkey, where he is Manager of the Syrian Board of Medical Specialists (SBOMS) as well as a member of the Syrian Expatriate Medical Association (SEMA).

Joel Hellstrand, Swedish Public Employment Service
Joel Hellstrand specializes in the field of skills and labour market integration of immigrants. He has worked for the International Labor Organization and the Swedish Medical Association and is currently working for the Swedish Public Employment Services. During the past years his work has focused on the field of skills and labour market integration of health care workers within and outside the EU/EEA. He holds a master degree in political science and a bachelor degree in sociology.

Me André Gariépy, Office des professions du Québec
Me André Gariépy is the Commissioner for the Recognition of Professional Competence in the Government of Québec, Canada. He plays an oversight role with regards to professional regulatory bodies activities in licensing and qualification recognition, including compliance with agreements on trade in services, international mobility and mutual recognition of qualifications. He has 20 years of experience in relation with professional regulation and mobility. In 2015, he served on a WHO Expert Advisory Group to review the Code of Practice on the International Recruitment of Health Personnel. Before his appointment as Commissioner, he has worked for a few years in international technical assistance as a consultant and project manager in relation to legal reform, international trade, and professional regulation and mobility. He has degrees in Economics and Law.
Session 6: Pre- and In-service Training to Support the Refugee Health Workforce, 11:00 am to 12:30 pm

Objective: To survey innovative solutions for delivering medical education, continued training, and skill development for refugee health workers in host countries, including bridging programs, scholarship opportunities, and targeted medical education or specialized training courses.

Key Questions:
- What programs, policies, or continuing medical education opportunities are available for refugee health workers in host countries to strengthen their skills or demonstrate competency?
- What forms of bridging programs are available in OECD host countries to expedite entry into the workforce? How are these programs funded? Who are the stakeholders?
- For medical students and trainees, what types of higher education programs and scholarships are available to facilitate access to medical education?

Moderator:
Leonard Rubenstein, Johns Hopkins Bloomberg School of Public Health
Leonard S. Rubenstein is Senior Scholar and Director of the Program in Human Rights, Health and Conflict at the Center for Human Rights and Public Health at the Johns Hopkins Bloomberg School of Public Health, and a core faculty member at the Center for Humanitarian Health at Johns Hopkins. Prior to coming to Hopkins in 2009, he was a Jennings Randolph Senior Fellow at the United States Institute of Peace, and for a decade before that, Executive Director and then President of Physicians for Human Rights. He has engaged in extensive research and writing on human rights and health and human resource issues, particularly in situations of conflict. His current work focuses on increasing protection of health services in volatile environments.

Speakers:
Helena Barroco, Global Platform for Syrian Students
Helena Barroco is Secretary-General for the Global Platform for Syrian Students and diplomatic advisor to Former Portuguese President Jorge Sampaio. Under her coordination, the Global Platform for Syrian Students, founded in 2013 by President Sampaio, works with a core group of intergovernmental and institutional partners to provide emergency support to Syrian students to continue and resume their studies.

Ahmad Tarakji, Syrian American Medical Society
Dr. Ahmad Tarakji is the President of the Syrian American Medical Society, a non-profit, non-partisan professional and medical relief organization that provides assistance to Syrians in need and represents thousands of Syrian American medical professionals in the U.S. He is a cardio-thoracic surgeon in California, and a former clinical assistant professor at Stanford University.

Toril Sundal Leirset, Levanger Arena Arbeid
Toril Sundal Leirset has more than 30 years of experience working with refugees as a teacher and principal in the Levanger Adult Teaching Center in Norway. For the past three years, she, along with a researcher, has headed the project Levanger Arena Arbeid, developing a new adult education model that gives immigrant women with little formal education a better chance to obtain regular work in Norway.

Inge Missmahl, IPSO
Inge Missmahl is Founder and Director of IPSO, an internationally recognized NGO active in mental health care and psychosocial support. A trained psychoanalyst, she developed a novel psychosocial counselling approach that has been integrated into the Afghan health system and most recently expanded efforts in Germany to support the mental health of refugees. She holds a Diploma as Analytical Psychologist and Psychoanalyst of the C.G. Jung Institut, Zurich, Switzerland.
Discussion Paper

Mapping Syrian health workforce numbers and labour market access in Jordan, Lebanon and Turkey

Sharif A. Ismail, Adam P. Coutts, Aula Abbara, Ummekulsoom Lalani, Miriam Orcutt, Sophie Roborgh, Fouad M. Fouad

24th March 2017
Executive Summary

- Syria’s health system – historically once one of the better performers in the region – has been crippled by six years of war but the aggregate effect on health workforce numbers, training and ability to practice has not been investigated in depth. This paper aims to help address that deficit, informing the discussion around initiatives to support Syrian health workers in neighbouring countries. It focuses on the evidence and country experiences from Jordan, Lebanon and Turkey.

- The paper is a discussion rather than a position paper. The findings, interpretations and conclusions of this paper are those of the author(s) only and are intended to generate discussion at the “Strengthening Human Resources for Health (HRH): Integration of Refugees into Host Community Health Systems” conference in March 2017.

- Health workforce density in Syria pre-conflict was low by comparison with many other lower-middle income countries, with marked regional inequalities and skills imbalances. Pre-war health worker densities were 1.5 physicians, 1.9 nurses and 0.8 pharmacists per 1000 population according to official statistics from the Syrian Ministry of Health. Although workforce training initiatives were expanding in Syria in a bid to improve access to care, there was a heavy focus on medical training, with relatively less on other professional groups. No formal Continuing Medical Education (CME) schemes existed.

- Syrian health workers practising in Jordan, Lebanon and Turkey faced a range of barriers to labour market entry, including the need to secure and pay for recognition of qualifications, additional licensing and registration arrangements, and – for specialists – a requirement to pass local Specialty Board examinations (in Jordan and Lebanon). Labour market access was challenging in Lebanon but especially so in Jordan where a 2010 government resolution barred access for non-Jordanians to 16 professions, including medicine.

- The impact of the conflict on the health workforce inside Syria has been catastrophic but it remains extremely difficult to quantify the extent of health worker loss and flight. Estimates of health worker flight from Syria vary wildly, from 15,000 up to 27,000 of as many as 42,000 doctors who lived in Syria at the start of the conflict. It is thought that 814 health workers (of all types) had been killed as a result of the fighting as of February 2017.

- Estimating current Syrian health workforce numbers in Jordan, Lebanon and Turkey today is extremely challenging, and what limited data are available relate almost entirely to doctors. In Jordan and Lebanon there are strong political disincentives to data collection so that available information on workforce numbers is mostly ad hoc, collected informally by NGOs. There are no publicly available statistics from Turkey. Although crude workforce number estimates can be derived using pre-war Syrian HCW density statistics, evidence on workforce numbers overall is not presently strong enough to enable realistic assessments of capacity and training needs.

- Forward workforce development and CME initiatives in countries neighbouring Syria are predominantly small-scale, and limited by profound political barriers to Syrian health worker integration into domestic labour markets, especially in Lebanon. There are now small-scale pilot initiatives to enable final year Syrian medical students to attend universities in Jordan to complete their degrees, but these are nascent. Greater progress has been made in Turkey where there are plans for several thousand health workers to be trained (in partnership with WHO and Gaziantep University) to facilitate health service delivery in refugee health clinics. Additional work is underway in partnership with WHO to improve skills among medical professionals in managing mental ill-health.

- Legal and practical impediments for Syrian health workers to practice in these countries are significant, but especially so in Jordan and Lebanon. In Jordan, pre-conflict constitutional and legal barriers to access for non-Jordanians to medical jobs remain in place. It is not clear to what extent recent initiatives to open up the Jordanian labour market (e.g. to 200,000 Syrians in 2016) include health workers. In Lebanon, Syrian health
workers have experienced tightening of legal restrictions on their right-to-work – particularly since December 2014 – and the expense and arduousness of the process for securing professional accreditation and licensing. In Turkey, by contrast, some legal barriers to practice for Syrian health workers have recently been relaxed, but they may practice only in Migrant Health Centres (providing care to displaced Syrians) – not the wider health system – and substantial barriers to labour market integration remain, not least because of language. In reality, Syrian health workers are practising in all three countries on an informal basis, though the scale on which this is occurring is unclear, and activities are unregulated.

About the Syria Public Health Network
The Syria Public Health Network (SPHN) was established early in 2015 in response to calls for an independent and critical assessment of the humanitarian and health response to the Syria crisis, from colleagues working in the country and the wider region. It aims to create an independent and neutral space for discussion and analysis, and to generate policy proposals for the types of health interventions and research that might help to address current and future health needs in Syria and the region. For further information about the Network or this project, please contact Sharif Ismail at sharif.ismail15@imperial.ac.uk or Adam Coutts – apc31@cam.ac.uk.
Purpose

1. This paper summarises findings from the first stage of a research project to review existing workforce numbers, accreditation and training needs, and labour market access for Syrian health workers both inside Syria and in three neighbouring countries (Jordan, Lebanon and Turkey). It is based on results from a rapid evidence review combining literature analysis with exploratory key informant interviews, and focuses solely on the situation in Jordan, Lebanon and Turkey. Details of the methodology may be found in Appendix 1.

Background

2. The conflict in Syria – now in its sixth year – has been characterised by persistent lack of regard for the safety of civilians, health care workers (HCWs) and health facilities by all warring parties. Recent estimates indicate that over 60% of hospitals and clinics inside Syria have been destroyed (1,2), and as of February 2017, 814 medical personnel had been killed since the start of the conflict (3). However, there is considerable regional differentiation in the extent to which health infrastructure and personnel numbers have been affected. The pattern of destruction has also intensified over time: 2016 was the worst year to date in terms of verified attacks on health facilities (3).

3. Detailed evidence on the scale of HCW flight from Syria is limited but by all accounts has been substantial since the outbreak of fighting in 2011 (4). Estimates of health worker flight vary wildly from 15,000 of a pre-war total of 31,000 doctors by the end of 2013 (5), up to 27,000 of as many as 42,000 doctors by 2016 (6). Those qualified Syrian HCWs who have fled to neighbouring countries have found themselves unable to work – and in some, actively prevented from doing so – despite clear demand in the humanitarian response for their skills and expertise (7). At the beginning of 2016, 63% of the Syria’s population were without access to care (8).

4. Evidence on post-conflict reconstruction of health systems from similar settings elsewhere indicates that rebuilding the health workforce should be one of the top priorities for action in the post-conflict period, and indeed that health workforce development challenges should be addressed even as conflicts continue, because of the length of time it takes to develop locally appropriate programmes and train new cadres of health professionals (9). This concern is reflected in regional response plans for Syria and neighbouring countries, in which health system strengthening is viewed as an important foundation for building ‘resilience’ among communities (10,11). However, labour market initiatives in neighbouring countries to date have frequently overlooked health workers1.

5. This paper employs a broad definition of HCWs as all people engaged in the delivery of health services including front-line staff and professionals providing support functions including laboratory analysis and administrative and clerical staff. Data gathering has focused, where information permits, on: doctors, nurses, dentists, pharmacists, midwives, community health workers, allied health professionals such as physiotherapists and psychologists, paramedical staff, laboratory technicians, public health professionals and health administrators. Because of data shortfalls, the predominant focus of this paper is on doctors.

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1 One current, high-profile initiative, supported by the United Nations Development Program, International Labour Organisation and World Food Programme, makes no explicit mention of provision for HCWs (See: https://www.jobsmakethedifference.org/ - accessed 21/3/2017).
Constructing a baseline: the Syrian health workforce prior to the conflict

Workforce numbers, distribution, and development

6. The Syrian health system was one of the better performers in the Middle East and North Africa region in the pre-conflict period. Data to 2010 show relatively high levels of vaccine coverage\(^2\), good infant and maternal mortality figures and demonstrate that Syria was on track to meet MDG targets, although the burden of non-communicable disease was rising (NCD) (12). This relatively strong indicator performance was notwithstanding low, and for some cadres, declining HRH density by comparison with regional neighbours (Table 1, Figure 1) (13).

<table>
<thead>
<tr>
<th>Country</th>
<th>Density (per 1000 population)</th>
<th>Physicians</th>
<th>Nursing and midwifery personnel</th>
<th>Dentistry personnel</th>
<th>Pharmaceutical personnel</th>
</tr>
</thead>
<tbody>
<tr>
<td>Egypt (2009)</td>
<td>2.830</td>
<td>3.520</td>
<td>0.420</td>
<td>1.670</td>
<td></td>
</tr>
<tr>
<td>Jordan</td>
<td>2.558</td>
<td>4.049</td>
<td>0.898</td>
<td>1.444</td>
<td></td>
</tr>
<tr>
<td>Lebanon</td>
<td>3.070</td>
<td>2.330</td>
<td>1.430</td>
<td>1.460</td>
<td></td>
</tr>
<tr>
<td>Syria</td>
<td>1.455</td>
<td>1.869</td>
<td>0.746</td>
<td>0.772</td>
<td></td>
</tr>
<tr>
<td>Tunisia</td>
<td>1.222</td>
<td>N/A</td>
<td>0.294</td>
<td>0.304</td>
<td></td>
</tr>
<tr>
<td>Turkey</td>
<td>1.581</td>
<td>2.115</td>
<td>0.274</td>
<td>0.339</td>
<td></td>
</tr>
</tbody>
</table>

Table 1 (left): HRH density per 1000 population by workforce cadre in Syria in 2010 (a year before the outbreak of the conflict), by comparison with regional neighbours (source: WHO Global Health Observatory).

Figure 1 (right): trends in health workforce density by cadre, 2000-2010 (source: WHO Global Health Observatory).

7. The distribution of HCWs in Syria pre-conflict was uneven in both geographical terms, and by specialism. Eastern regions of the country in particular suffered from long-term, skilled health worker shortages. Specialist doctors practised almost exclusively in large urban centres in Syria. There was one doctor for every 1,906 people in Al Hasakah in the rural North East (see Figure 2), compared with one doctor for every 339 people in Damascus. Similar disparities existed in the distribution of nurses, with one for every 220 people in Latakia in Western Syria compared with one nurse for every 2,000 people in the governorate of Rif Dimashq, a rural governorate surrounding Damascus City. In some instances, large disparities were evident even between urban centres; there were 56 health workers (in this case including doctors, pharmacists, nurses and laboratory technicians) for every 1,000 people in Tartus compared with 4.7 for every 1,000 in Aleppo (14). Secondly, there was a pronounced imbalance in the medical workforce in favour of specialist (rather than generalist or primary care) training, but with major skills shortages in certain health domains. This was particularly the case in mental health, with a ratio of just 0.32 psychiatrists per 100,000 population in 2011 (4), compared with 7.79 per 100,000 in the United States.

8. Health workforce development was an expanding area in Syria in the lead-up to the conflict. There were five public Faculties of Medicine and Dentistry in Syria (and two private Faculties in Damascus and Tartus) with a combined capacity of over 1,200 students, in addition to more than 30 nursing and midwifery schools. The total

\(^{2}\) It should be noted that assessments of vaccination coverage pre-conflict are contested. Most publicly available information is based on official statistics reported to WHO by the Syrian Ministry of Health, but these figures consistently over-estimated coverage by comparison with independent figures from, for example, UNICEF. Further detail on data discrepancies between official Syrian and agency health statistics is given in (39).

5
capacity of all these training institutions was around 4,750, for a pre-war population of approximately 22 million people (13). The sector was also well resourced in staff terms: up to 18% of all university teaching staff in 2004 worked in the medical sciences (15). All were overseen by the Ministry for Higher Education, but there was no formal system of accreditation or regulation for these institutions prior to the conflict (13). There was no School of Public Health in Syria pre-conflict.

9. Duration of training in Syria pre-conflict varied according to specialism. Undergraduate medical training lasted 6 years, but qualifications for pharmacy and dentistry were 5 years long. Post-graduate (residency) training for doctors varied in length from 3 years upwards according to the specialty, but post-graduate training in Public health was provided through a one-year diploma programme offered jointly by the WHO in collaboration with the Syrian Ministry of Health. Data on other specialist training schemes pre-conflict are in very short supply.

Figure 2: Administrative divisions of Syria as of 2007 (image source: University of Texas Libraries)

10. External migration of health workers was a significant problem for the Syrian health sector well before the beginning of the conflict, but it is not clear how many health professionals there were in the wider Syrian diaspora. Emigration rates to the United States were particularly high, where around 3,900 Syrian doctors were practising by 2008 – 0.4% of the total US medical labour force (16), and equivalent to 13% of the medical workforce in Syria at the time. Numbers in the UK were smaller; in 2011, 190 professionally qualified clinical staff of Syrian nationality were working in the National Health Service, of whom 179 were doctors (0.2% of the medical labour force) (17). However, definitive estimates of numbers of trained health professionals emigrating during this period are not available, and it is not possible to say – based on evidence reviewed to date – how many Syrian health professionals were already practising in Jordan, Lebanon and Turkey before the start of the conflict.

Licensing and accreditation for Syrian health workers in Syria and neighbouring countries

11. Medical licensing in Syria pre-conflict was (and is) governed by the Syrian Medical Syndicate, but information on systems of accreditation and continuing professional development are in short supply. Broader systems of
accreditation for healthcare providers, in addition to provision of some health worker training and CME was overseen by the newly established Syrian Commission of Medical Specialties (for doctors)\(^3\), following reforms in the mid-2000s to tackle a perceived absence of regulatory oversight for health professionals.

12. In Jordan, all health professionals required a licence from the Ministry of Health in order to be able to practice, in addition to registration with the relevant professional association (depending on the professional group in question – the Jordanian Medical Association (JMA) in the case of doctors).\(^4\) Professional bodies for each of the major health workforce groups (doctors, dentists, pharmacists, nurses and so on) were responsible for enforcing and monitoring regulations governing professional practice. Overseas graduates required recognition of their educational qualifications in order to be able to secure a licence; this recognition was supplied by the Ministry of Higher Education and Scientific Research. Those with specialist qualifications from overseas were also normally required to pass Jordanian board exams in order to practice in their chosen field (18).

13. In Lebanon, Syrian medical practitioners required a license from the Ministry of Health, in addition to registration with the Lebanon Order of Physicians and Syndicate of Hospitals, if they wish to practice as specialists in tertiary care settings. Doctors providing primary care do not require a licence to practice. Overseas trained clinicians – including Syrians – required formal recognition of their medical qualifications (through the Ministry of Higher Education), and also had to sit Board examinations. Fees associated with this process were high ($50,000 in ordered to practice in tertiary care settings after passing Board examinations, for example) and were a major barrier to workforce integration for overseas-trained medical practitioners.\(^5\) There were some exceptions to this system for overseas-affiliated institutions – notably the American University in Beirut which adhered to US board examination and medical licensing procedures (19).

14. In Turkey, health care practitioners were registered by the Ministry of Health immediately after graduation from Turkish medical schools. There was no compulsory education and certification system supporting the postgraduate professional development of health care personnel, except for doctors for whom specialisation required passing the central medical specialisation examination (which did not apply for those wishing to work in primary care settings) (20). Overseas-trained HCWs required recognition of their qualifications (through the Ministries of Education and Health in the case of doctors) – usually by reciprocal contact with the issuing authority in the country of origin to verify authenticity.

Continuing Professional Development

15. There was no formal system for continuing professional development (CPD) for health workers in any of the three countries considered in this study prior to the start of the conflict, though ad hoc CPD activities did occur – without exclusions for Syrian health workers provided core licensing and accreditation requirements (as outlined above) had been met. In Turkey, for example, the Ministry of Health organised various in-service training programmes of which the largest was the Family Medicine Certificate Programme, a re-training scheme for physicians already working in the health system that was distinct from the 3-year, post-graduate training programme for primary care physicians (21). They also offered certificates in emergency medicine, blood transfusion, family planning, intensive care nursing and emergency care nursing (20).


\(^4\) Stakeholder interviews conducted for this paper.

\(^5\) Research work is ongoing as part of this project to identify the processes through which other HCWs acquired the ability to practice in Lebanon.
The state, and status of Syrian health workers in neighbouring countries today

Current workforce numbers and future workforce development

16. Data on Syrian health workforce numbers in Jordan, Lebanon and Turkey are in very short supply. There are strong political disincentives to national level data collection in many neighbouring countries, and there is widespread acknowledgement that most Syrian health professionals work informally and will not be captured in official figures. For the most part, United Nations and INGO / NGO data provide the only publicly available estimates.

17. It is thought that there are around 2,000 Syrian doctors residing in Jordan currently, but data are not disaggregated by specialty and there is no publicly available information on broader workforce numbers. In Lebanon, UNHCR information on the profession of registered refugees indicates that there are 57 doctors, 305 nurses, 20 associate nurses and midwives, and 68 paramedical staff (defined in this case as pharmacists and physiotherapists) as of January 2017. Given a total, known Syrian refugee population of over 1 million in Lebanon, these figures likely substantially underestimate total numbers. Similarly, although there are over 2.9m registered Syrian refugees in Turkey, we found no publicly available estimates of numbers of HCWs among them. It is not possible to calculate workforce densities in any of these three countries on the basis of these figures.

18. Based on historical health workforce density figures (Table 1) and current estimated refugee numbers, however, it is possible to calculate crude, expected workforce numbers by category in each of the neighbouring countries, presented in Table 2 below. These estimates depend on a number of major assumptions, however, including that (1) pre-conflict HCW densities for Syria presented in Table 1 above still apply; (2) these pre-war estimates are an accurate reflection of true workforce density at the time; and (3) the out-migration rate from Syria among HCWs is comparable with the general population. Finally, they exclude undocumented Syrian refugees. For these reasons, these estimates should be treated as indicative only.

<table>
<thead>
<tr>
<th>Country</th>
<th>Physicians</th>
<th>Nursing and midwifery personnel</th>
<th>Dentistry personnel</th>
<th>Pharmaceutical personnel</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jordan</td>
<td>956</td>
<td>1,228</td>
<td>490</td>
<td>474</td>
</tr>
<tr>
<td>Lebanon</td>
<td>1,472</td>
<td>1,890</td>
<td>754</td>
<td>730</td>
</tr>
<tr>
<td>Turkey</td>
<td>4,234</td>
<td>5,439</td>
<td>2,171</td>
<td>2,101</td>
</tr>
</tbody>
</table>

Table 2: Crude estimated numbers of Syrian health workers, by cadre, in Jordan, Lebanon and Turkey based on current documented refugee numbers in these countries.

19. There has been very little work to date to boost future flow of Syrian HCWs in Jordan, Lebanon or Turkey. Most such work has been carried out by NGOs, and activities continue to be small-scale and largely ad hoc. The International Medical Corps, for example, have trained 100 Community Health Workers and one pharmacist over the past year in Lebanon. Some new initiatives to support students are emerging, however. For example, two Jordanian universities (Jordan University of Science and Technology and Hashemite University) have accepted 35

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6 Stakeholder interviews conducted for this paper.
7 Stakeholder interviews conducted for this paper.
8 Total refugee populations used to generate these estimates are drawn from the Inter-agency Information Sharing Portal for the Syria Regional Refugee Response (UNHCR) - [http://data.unhcr.org/syrianrefugees/regional.php](http://data.unhcr.org/syrianrefugees/regional.php) [accessed on 21/3/17]. Numbers for each country are: 657,000 in Jordan, 1,011,366 in Lebanon, and 2,910,281 in Turkey. Calculations assume the same density of each health worker cadre as applied in pre-conflict Syria (as outlined in Table 1).
9 This last assumption is particularly important and – while potentially applicable to nursing and midwifery personnel, and pharmacists, is unlikely true of doctors for whom the major destinations for those leaving in the first few years of the conflict were the Gulf States. Figures presented in Table 2 for doctors are therefore likely over-estimates.
10 Stakeholder interviews conducted for this paper.
final year medical students from Syria onto their programmes to enable them to complete their training, with support from the Global Platform for Syrian Students (22). Broader access to undergraduate training for Syrians in these countries is non-existent, and the expectation for most Syrian students is that they start their studies again from scratch – irrespective of the amount of time spent in training previously.

20. In Turkey, a collaboration between WHO and Gaziantep University has had greater yield in health workforce terms. As of mid-2016, 1,500 Syrian doctors and nurses were enrolled in training at Gaziantep University (starting from 2015), and by early 2017, 850 Syrian primary care workers had been trained under the mentorship of Turkish doctors to enable them to practice in Migrant Health Centres11 (23).

Changes to licensing and accreditation rules for Syrian health workers in neighbouring countries
21. In Jordan, there has been no formal (i.e. legal or regulatory) change in rules governing practice for health workers trained overseas, and Syrian health workers are prevented from practising (2). Pockets of informal practice have emerged over time, but the Jordanian government has in the main neglected to regulate the work of Syrian doctors operating in this way. These activities are also largely unregulated by the major professional bodies in Jordan; health workers practice unlicensed. There is a consensus among actors working on the ground in Jordan on the need for closer regulatory oversight of these activities to ensure that practice standards are maintained.12

22. In Lebanon, a series of regulations have been implemented which prevent Syrian refugees’ access to legal work (see below). This also applies to other workforce groups. Barriers are for the most part implicit, in the form of prohibitively high fees for work permits, and burdensome residency requirements as a pre-requisite to licensing (24).

23. Recruitment of medical personnel from overseas was, until recently, prohibited in Turkey (20). However, there have been moves to change this for Syrian HCWs partly in response to levels of need among the country’s burgeoning refugee population (see below).

Continuing Professional Development
24. Some progress has been made in terms of CPD for Syrian HCWs in neighbouring countries, but initiatives continue to be ad hoc and there is little systematically gathered evidence on course content, quality or outcomes for participants. Perhaps the greatest progress has been in Turkey, where the WHO has for several years had a link with Gaziantep University near the border with Syria to support training of Syrian health professionals. The stream of HCWs accessing training through this route has steadily increased with a view to health service provision for Syrian refugees in Turkey (see above). There have also been efforts to boost skills in mental health service provision, with a new, WHO-led programme to train 150 registered Syrian doctors in Turkey on mhGAP13 (23). In the main, however, provision for those living in neighbouring countries is limited.

<table>
<thead>
<tr>
<th>Country</th>
<th>Formal Licensing and Accreditation requirements</th>
<th>Continuing Professional Development</th>
<th>Labour Market Access for Syrians</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jordan</td>
<td>• Recognition of educational qualifications</td>
<td>• No formal system</td>
<td>• Not permitted to practice</td>
</tr>
<tr>
<td></td>
<td>• Licensing through the Ministry of Health</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Registration with the relevant</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

11 A network of Migrant Health Centres have been established by the Turkish Ministry of Health to provide services to people under temporary protection in Turkey. They provide a variety of services including outpatient, maternal and child health, health education and vaccination services in addition to limited disease screening. 85 of these have been established to date.

12 Stakeholder interviews conducted for this paper.

13 The WHO Mental Health Gap Action Programme (mhGAP) aims at scaling up services for mental, neurological and substance misuse disorders primarily in low- and middle-income countries worldwide. Further details are available here: http://www.who.int/mental_health/mhgaps/en/ [accessed 18/3/2017].
professional association
- Board examinations for specialist doctors

Lebanon
- Recognition of educational qualifications
- Licensing through the Ministry of Health
- Registration with the relevant professional association
- Board examinations for specialist doctors
- No formal system
- Not permitted to practice

Turkey
- Recognition of educational qualifications
- Licensing through the Ministry of Health
- Limited CPD activities through the Ministry of Health: certificates in family medicine, emergency medicine and others
- To treat Syrians only (in Migrant Health Centres – not in the wider health system)

Table 3. Summary of professional status considerations for Syrian health workers who wish to practice in Jordan, Lebanon and Turkey, as of February 2017 (sources: various – see text)

25. Some NGOs based in neighbouring countries – predominantly Turkey – operate advanced CPD programmes for Syrian health professionals who are still working inside Syria. These courses are designed primarily for doctors from northern Syrian governorates (e.g. Aleppo, Idlib and Hama) coming across the border into Turkey temporarily to receive CME training. The Syrian-American Medical Society (SAMS), for example, has been running training courses every three months for Syrian doctors in Turkey since 2012, focusing on advanced critical care skills such as trauma care, gender-based violence recognition, and renal dialysis. Recent additions include a primary healthcare component and training for nurses. Courses pair medical lectures with hands-on training in order to provide Syrian medical personnel with comprehensive instruction that can be brought back to the field. In 2014 and 2015, SAMS conducted six courses with 163 participants. Similarly, the David Nott Foundation has run courses periodically in Turkey for surgeons travelling in from Hama, Homs, Idlib and Aleppo, providing Hostile Environment Surgical Training (HEST). Again, however, evaluation data are not publicly available at present.

Work permits and labour market access for Syrian health professionals in neighbouring countries

Jordan

26. The Jordanian Ministry of Labour continues to limit work permits for non-Jordanian citizens in high-skilled professions in order to regulate competition and to safeguard the labour market for Jordanian nationals. This approach is constitutionally-enshrined: the Jordanian constitution reserves “the right to work for Jordanian citizens,” refugees and immigrants “who possess legal residency with valid passports must obtain permits from the Ministry of Labour (MoL)” (26). In addition, a government resolution in 2010 barred access for non-Jordanians to 16 areas of professional practice – including medicine (27).

27. Although the Jordanian and Syrian governments had a bilateral workforce cooperation agreement in place with for over ten years prior to the beginning of the conflict to enable participation, and cross-border movement of workers occurred freely during this period, changes in personal status as a result of the conflict have introduced significant new barriers for labour market participation for Syrians. An important feature of Jordanian government policy on labour market integration in this regard has been a tendency not to officially recognise the presence of refugees, instead using terminology such as “visitor”, “irregular guest”, “Arab brothers” or “refugees under the Memorandum of Understanding (MoU) with UNHCR” (26).

28. In 2016, the Jordanian government announced that it would allow 200,000 Syrian workers to join the labour force, but the position of Syrian health workers within this offer is unclear. Indeed, the Jordanian Doctors’ Syndicates network has been a powerful force in lobbying against provisions to enable foreign doctors to participate in the labour force unless they fall under the workforce cooperation agreement and have the proper licensure with JMA. This is despite provisions under the constitution of the Jordanian Doctors’ Syndicate supporting the right of Arab doctors to practice in the country (Law No. 13 stipulates that Arab doctors may
practice provided they are registered in any Syndicate of an Arabic country and with a license to practice provided his/her country that abides by the reciprocity principle) (27).

29. In reality, it is widely acknowledged that Syrian doctors are practising informally under the supervision of Jordanian doctors in clinics. Enforcement of official labour market policy by the Jordanian government has intensified over the same period, with raids on unlicensed practices (28).

**Lebanon**

30. Syrian HCWs are not permitted labour market access in Lebanon unless able to obtain sponsorship and a work permit. A work permit is only granted if residency status has been granted. There are specific, additional requirements for some classes of HCW: in order to practice as a doctor or pharmacist in the country, for example, Lebanese citizenship must have been acquired in the last ten years (29). However, significant legal impediments to labour market access for Syrians exist in Lebanon. Firstly, the country is not a signatory to the 1951 UN Refugee Convention and its 1967 protocol, which establish the rights of refugees to engage in wage-earning employment and self-employment. There is also no explicit right for refugees to work in the labour legislation of Lebanon.

31. In addition, access rights to what limited, formal labour market opportunities previously existed for Syrians have been progressively eroded by the Lebanese authorities as the conflict has continued. First, the system for applying for first-time and renewed permits has become extremely slow and difficult to navigate. In 2013, just 508 first-time work permits were given to Syrian nationals (out of a total of nearly 50,000 first-time work permits) and 725 existing permits for Syrians were renewed in the same year (by this stage, UNHCR had registered nearly 860,000 Syrian “persons of concern” in Lebanon). Syrians are frequently unable to renew their permits in time.

32. Second, the scope of rights available to Syrians has been progressively curtailed. In December 2014, the Lebanese Ministry of Labour implemented Decree number 197 limiting possible work for Syrian nationals to the agriculture, construction and cleaning service sectors – automatically disbaring HCWs from full labour market participation in the country. Until 2015, those Syrian refugees who were able to obtain sponsorship and a work permit had their legal status changed to that of “migrant workers” and were able to work in those industries. Following mounting social unrest and problems with public services provision, the Lebanese government suspended this right in 2015.

33. However, Lebanon has a large shadow economy and the real reach and relevance of formal access requirements, such as work permits, is questionable. Refugees can and do quite easily turn to informal jobs instead. In turn, a restrictive policy of access to the formal labour market for refugees can reinforce informality in the economy, with adverse effects for the country’s growth potential, public finances and workers’ welfare (30,31). There are an unidentified number of informal practices/health rooms run by Syrian doctors in informal settlements in Lebanon.

**Turkey**

34. Efforts to integrate Syrian health workers into the domestic labour market are most advanced in Turkey, but there remains a gulf between changes in law and realities on the ground. Until recently, Turkish labour laws made it very difficult for Syrian refugees to obtain work permits take up employment in the formal labour market (32). Improvements in access to employment opportunities for Syrian health workers have been made partly in response to practical need: language difficulties between Turkish doctors and refugee patients constituted a major barrier to effective care in the initial period of the conflict, and Turkey has taken in by far the greatest number of refugees of any neighbouring country (33,34).

35. Two legislative and regulatory changes passed in 2016 are particularly significant for Syrian health workers in Turkey. In January 2016, the Turkish government passed the “Regulation on Work Permits of Refugees Under
Temporary Protection” allowing for refugees to be granted work permits (35), but with important restrictions. Chief among these is the so-called “10% rule”, which holds that the number of Syrians employed by a given interest cannot exceed 10% of the total number of Turkish citizens employed by that entity (36). By May 2016, around 3,800 Syrian refugees had been granted work permits – of a total of over 2.7 million refugees in the country at the time – although the number granted to health professionals is unclear (36). In June 2016, legislation governing work permits specifically for foreign health professionals was amended to allow foreign medical staff who had completed the requisite validation processes in Turkey to obtain work permits and “serve patients from their native country”. This change was made on the understanding that health professionals would primarily be working in a network of 85 Migrant Health Centres and health facilities in 26 refugee camps across the country (37). Internships for Syrian health workers to support their transition into working in Migrant Health Centres began in January 2017 and are ongoing. However, details of the process for obtaining work permits remains unclear; Syrian medical professionals needed “prior authorization granted by the Ministry of Health” in their work permit applications, apparently granted only once these workers had completed a work-shadowing placement overseen by Turkish doctors (38).
Conclusion – and an agenda for policy discussion

36. This paper has identified major deficits in the evidence base on health workforce numbers, development, accreditation and labour market access for Syrian health workers in surrounding countries both before and during the conflict. There are particular shortfalls in respect of workforce numbers. Political impediments to workforce data collection in neighbouring countries are strong, and make both assessment of current needs and forward workforce planning very difficult. Although forward workforce development and CPD initiatives are underway, these are ad hoc, currently mostly early-stage and have not been systematically evaluated in the main. Finally, while information on labour market access rights for Syrian doctors in Jordan, Lebanon and Turkey is available, the situation in respect of other health professional cadres is much less clear.

37. Broader opportunities for trainee Syrian health worker integration into higher education systems in neighbouring countries, and CME for fully qualified professionals who have been displaced, could be considered in some countries in the interest of supporting future workforce development. Barriers to integration into higher education systems at present include – among others – financing for higher education, and recognition of experience and qualifications gained previously.

38. The opportunities and challenges related to labour market access for Syrian HCWs in Jordan, Lebanon and Turkey both to meet current refugee health needs, and to prevent displaced Syrian health workers progressively de-skilling over time, should be further explored. There have been promising moves towards opening up new opportunities for health workers in Turkey, and it is also evident that many Syrian health workers are practising in all three countries informally – but often in undocumented settings without proper regulatory oversight. Overall, barriers to labour market access remain substantial, and further discussion is needed around legislative, licensing and accreditation barriers, while taking into account the unique political and economic constraints in each country.

39. Work in the next phase of this project will incorporate in-depth key informant interviews and survey work in some of these countries, and others, to try to address information deficits, and build consensus on workable recommendations in some or all of the policy domains identified above.
References


Students: summary report.


34. Turkish Medical Association. War, Migration and Health: experience of Turkey. 2016.


Appendix 1: study methodology
This paper is based on a rapid literature review augmented by secondary data analysis and a selection of exploratory key informant interviews. The review comprised a combination of peer and non-peer reviewed literature sources, identified through keyword database searches (PudMed and Medline, WHO, World Bank and other agency databases), and non-peer reviewed papers, reports and media articles from a range of relevant sources including multilateral bodies, major international aid donors and organisations, and media outlets. In view of the subject matter and the rapidly changing situation on the ground in Syria and neighbouring countries, a formal systematic review approach was not considered appropriate for this analysis – necessitating a broad approach to evidence inclusion and synthesis, and we did not conduct formal critical appraisal of sources used. Key informants for exploratory interviews were identified from an existing contacts list held by Syria Public Health Network based on our work on the conflict over the past 3 years.

Appendix 2: list of interviewees
A series of exploratory interviews were conducted for this paper, to frame discussions and in particular draw together qualitative data on health workforce numbers in countries neighbouring Syria. The list of those interviewed to date is given below. In the body of the text above we have referenced interviewees in general terms rather than directly attributed information to them.

<table>
<thead>
<tr>
<th>Name</th>
<th>Position</th>
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<tbody>
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