

# Improving the Implementation of UN Sustainable Development Goal 3:

## Enhancing Access to Healthcare by Syrian Refugees Through Community Health Shows

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### Background

Access to healthcare in developing countries varies due to social inequalities (Gulliford et al., 2002). Inequalities seem to decrease access to healthcare services. Quality and equity of care can be improved by optimising acceptability of services beneficiaries' attitudes and expectations, where negative attitudes could disempower community members accessing the healthcare system. Improving access to healthcare entails addressing barriers that influence community

members' ability to perceive, seek, reach and engage with services (Levesque, Harris, & Russell, 2013). This is especially true for marginalized communities, such as refugees, who are accessing foreign healthcare systems. For example, perceived negative attitudes of providers reproductive health services at primary healthcare clinics in Lebanon towards Syrian refugees were found to be the main barrier for refugees access to these services (Talhouk et al., 2016). These perceived negative attitudes rendered women unable to ask healthcare providers key health questions and often made

women actively avoid requesting reproductive care (Talhouk et al., 2016). Such findings indicate that for marginalized refugee communities enhancing the quality of interaction between beneficiaries and healthcare providers is essential in improving health and wellbeing (UN Sustainable Development Goal 3, SDG3).

In low-middle income countries, high penetration of technologies, including internet and mobile phones, has allowed for mobile health interventions to provide reproductive and maternal health through (1) patient reminder systems, (2) communication platforms, (3) test result turn around, (4) peer group support and (4) psychological interventions (Lee et al., 2016). However, there is a need for m-health interventions to not only disseminate health information but also facilitate and enhance relationships between refugee beneficiaries and healthcare providers. In this paper we report on a pilot of a community health show, "Allo Sohtik", mediated through synchronous interactive voice technologies as a means of enhancing interactions between Syrian refugees and reproductive healthcare providers in rural Lebanon. We aim for the findings of this paper to support the European Health Psychology Society in their role as consultants in the Economic and Social Council at the United Nations.

### Methods

Four community health shows were piloted with 15 Syrian refugee women of reproductive age (age range: 18-60 years) residing in an informal tented

settlement in rural Lebanon. Through an app, designed to initiate and aid the women in hosting community health shows, four healthcare providers were dialled in as guests for each show. The show was structured so that the healthcare provider delivered knowledge and skill based information on topics selected by the women, divided into two subtopics, and each subtopic is followed by a 'Questions and Answers' segment where women would dial in to ask questions regarding their health concerns.

All the shows were audio recorded and transcribed. Focus groups evaluating the interactions between them and healthcare providers were conducted after each show. Thematic analysis was conducted on show and focus group transcripts (Braun & Clarke, 2006).

## Findings

We identified 15 topics of health concern expressed by the women through their questions including issues on: periods, family planning (oral contraceptive pills, natural contraception, and intrauterine devices), fear of labour, foetal health (foetal movement, foetal death), fibroids, asthma, kidney diseases, anaemia, breast-feeding, genital infections, heartburn, diet during pregnancy, nausea and vomiting, blood pressure, and medication intake during breastfeeding. A total of 41 questions were asked and the live nature of the shows allowed for 14 follow up questions to be asked.

Results from the focus groups indicated that women perceived a higher level of engagement by the healthcare provider than those experienced by them when visiting healthcare clinics. The women reported that they felt more comfortable and able to ask questions. The women were able to provide details regarding their medical history when asking their questions, *"I am missing my period, meaning it is late by 15 to 20 days...I am not pregnant...I go*

*to the doctor and she give me medicine and says there is no pregnancy...I want to know why this is happening to me...I have miscarried. Every time I go to the doctor she gives me medicine that makes my period come. What am I supposed to do? Wait?" [W2].* Such questions in turn led to a high level of engagement by healthcare providers as they probed for detailed symptoms.

The women's perception of a higher level of engagement by healthcare providers, in comparison to engagement when at face to face clinics, enhanced their trust in the health care providers even to the point that they requested to know which clinics the doctors work in, in order to go for face-to-face consultations. Several of the women used the shows to validate health advice they had previously received from healthcare providers in clinics. Ten of the questions asked (24%) were instances where the women sought to seek a second opinion regarding health advice they had previously received at clinics. For example, W4 asked *"when the doctor placed the coil she was telling me that it is not good for the first baby for her to put the coil and that it affects it. Is this correct or not?"*. One listener even asked if the healthcare provider on the show recommends that she go to another doctor than the one she is currently seeing in the clinic: *"Doctor I went to a specialized doctor and he told me I have a fibroid, in this case should I go consult another doctor?" [W10].* When health care providers were asked by women about advice given to them at clinics, responses ranged from requesting that the women go back to their doctor and request further clinical tests to that of refuting/confirming the previous healthcare advice given. The validation of health advice re-enforced trust in the existing healthcare clinics being accessed by the women and consequently encouraged them to follow up with their current healthcare providers. In the one case where the healthcare provider refuted health advice given in the clinic the doctor encouraged the woman to seek out a new doctor.

## Conclusion

Through the community health shows validation of advice previously given and encouragement to follow up with healthcare providers enhanced women's willingness and likelihood to seek healthcare, and increased their levels of trust which have been identified as facilitators for overcoming barriers to accessing healthcare (Levesque et al., 2013). Additionally, the community health shows provided a new platform of engagement with healthcare providers that was perceived by the women to be better than the engagements they were experiencing in primary healthcare clinics. The piloting of 'Allo Sohtik' highlighted the potential for m-health technologies to, not only disseminate health information, but also provide a medium in which interactions between marginalized communities and healthcare providers may be enhanced thus improving access to healthcare and ultimately health and wellbeing (SDG3).

Further research should be conducted to gain a deeper understanding of the key reasons associated with refugee women's perceived levels of trust in their health care providers. We would expect to explore the role of legal, cultural, language and beliefs issues.

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