



**THE DEVELOPMENT OF AN OPTIMAL REMOTE
SUPPORT MODEL FOR HOSPITAL CARE IN A WAR-
TORN SETTING:**

A CASE STUDY IN SYRIA

By

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***Thesis
Submitted to Flinders University
for the degree of***

Doctor of Public Health

College of Medicine and Public Health

2 August 2022

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ACRONYMS AND GLOSSARY

ANC	Antenatal Care
DC	Data Collection
DoH	Directorate of Health
DRC	Democratic Republic of Congo
EPI	Expanded Programme on Immunisation
EPREP	Emergency Preparedness
EWARN	Early Warning, Alert and Response Network
FGD	Focus group discussion
GoS	Government of Syria
HI	Handicap International
HIS	Health Information Systems
HMIS	Health Monitoring and Information Systems
HR	Human resources
HSP	Health Survey Program
IASC	Inter-Agency Standing Committee
IC	Infection Control
ICRC	International Committee of Red Cross
IDP	Internally Displaced People/Population
IHL	International Humanitarian Law
INGO	International Non-Governmental Organisation
IPD	In-patient Department
IS	International Staff
LNGO	Local Non-Governmental organization
MCH	Maternal and Child Health
MCP	Multiple/Mass Casualty Plan
MDM	Medicine Du Mond
ME	Middle East/Eastern
MEU	Middle East Unit
MH	Mental Health
MOH	Ministry of Health
MOU	MoU Memorandum of Understanding
MSF	Médecins Sans Frontières
NCD	Non-Communicable Diseases
NFI	Non-Foods Item
NGO	Non-Governmental Organisation
NICU	Neonatal Intensive Care Unit
OCBA	Operational Centre Barcelona
OCA	Operational Centre Amsterdam
OCB	Operational Centre Brussels
OPD	Out-Patient Department
OT	Operation Theatre

PHC	Primary Health Centre/Care
PI	Principle Investigator
RH	Reproductive Health
RSM	Remote Support Model
SAMS	Syrian American Medical Society
SEMA	Syrian Expatriate Medical Association
SGBV	Sexual and Gender-Based Violence
SRH	Sexual and Reproductive Health
UN	United Nations
UNHCR	United Nations High Commissioner for Refugees
UNICEF	United Nations Children's Fund
UNOCHA	United Nations Office for the Coordination of Humanitarian Affairs
VSAT	Very Small Aperture Terminal
WHO	World Health Organization

Glossary

Definition

FOCAL PARTNER STAFF INTERNATIONAL STAFF (MSF)	Partner hospital staff paid by MSF, to undertake a defined liaison and coordination role. MSF staff going on an assignment outside of their own country of domicile and receiving an international contract. They can work within a program (at project or coordination level). MSF term is 'internationally mobile staff'.
LOCAL STAFF (MSF)	Staff working in the project or coordination office in a country with a local contract which they are issued by the Operational Centre. Previously known as 'National staff' the locally hired staff (programmes) does not include daily labourers, staff on incentives or consultants. Local staff in this study can mean local staff in Amman as well as in Syria.
MoU	Memorandum of Understanding: A formal agreement between two or more parties. Companies and organisations use MoUs to establish official partnerships. MoUs are not legally binding, but they carry a degree of seriousness and mutual respect.
PARTNER STAFF	Partner staff working in MSF supported hospitals. Locally hired by the partners on MSF incentives as a part of comprehensive support to hospital.
PARTNERS	Partners are organisations (hospitals) working in collaboration with MSF through a working MoU or agreement signed by involved parties.
REMOTE SUPPORT TEAM	Remote support team is the team supporting the field team inside Syria remotely from the neighbouring countries of Syria and Turkey. Team based in Amman and Gaziantep.
TECHNICAL MEDICAL TEAM	Technical medical team in MSF comprises of both technical and professional medical staff. Technical team at field level comprise of doctors, nurses, pharmacists, midwives, supervised by respective technical managers.

SUMMARY

Introduction

In Middle Eastern (ME) conflict settings with restricted access for 'normal' modalities of health service delivery, remote health care programming has emerged as a legitimate and valid approach to providing health care in response to the changing context of the civil war. There has been a paradigm shift in approach from risk avoidance to risk mitigation (Egeland et al., 2011). Amid much debate about the shrinking humanitarian space and implementation challenges, there is a lack of rigorous research to provide evidence for good operational policy and practice in remote health programming.

Since 2014 Médecins Sans Frontières (MSF), a medical humanitarian organization, has been supporting health facilities in Syria remotely from Turkey and Jordan. This case study research has explored the operational challenges faced by MSF Operational Centre Barcelona (MSF-OCBA) and the practices used by them in the process of implementing a remote support model (RSM) in war afflicted regions of Syria controlled by forces opposing the Syrian regime ('opposition-controlled regions'). This study aimed to document the MSF Syrian experience, to formulate an optimal RSM for this conflict setting, and to develop a framework of potential relevance in other war-torn regions.

Methods

A qualitative case study design has been used for this study. Two Focus Group Discussions (FGD) and thirty-seven individual in-depth interviews were conducted, during August and September 2018, with MSF-OCBA staff and partner staff involved in the implementation of a RSM in Syria. The data were collected face-to-face in Amman and thereafter online until June 2019. The past experience of the researcher working with MSF, her reflective notes created during this study and review of MSF policies and operational guidelines, have also informed this thesis. Primary focus group and interview data was organised using NVivo 12 and was then interrogated using thematic analysis to identify themes. A narrative literature

review on the topic of remote health programming was also carried out. This involved a systematic search of multidisciplinary electronic databases, reference lists and relevant organizations and the online grey literature. Ethics approval was obtained from the Flinders University of South Australia and from the MSF Ethics Review Board.

Findings

This study has identified many barriers, challenges, and enablers during the implementation of the RSM in Syria. This proved helpful in identifying the core requirements for optimising the remote support health programs in the ME war conflict region.

Access was a major challenge in providing humanitarian assistance to the population inside Syria. Restrictive government policies and security constraints in an active conflict zone posed major constraints to humanitarian access. Border restrictions hindered cross border activities in relation to the shipment of medical supplies and people movement for trainings and meetings organized outside Syria. Lack of MSF registration, in Syria and Turkey, limited MSF operations to the opposition-controlled areas, and language challenges, along with a clan/group-based societal makeup and gender disparity were identified as significant cultural barriers.

MSF's presence in Jordan, supporting Syrian refugees, enabled MSF to better understand the local context and culture. Networking and negotiation [from Amman] with stakeholders enabled access, protection [security of staff and resources] and collaboration inside Syria. The MSF strengths in terms of flexibility, funding independence, and the innovative nature and commitment of MSF OCBA, along with a strongly motivated and skilled staff base and a functional infrastructure inside Syria, enabled MSF to shift to a RSM of service delivery. RSM was implemented in MSF projects through experienced MSF local staff in the North and in South Syria as part of a unique hospital support approach (including, medical supplies, logistics support and building rehabilitation), and was implemented through partner staff.

Operating in a ME Middle-Income Country was new for MSF. The decision to remotely support secondary (hospital) care in South Syria, using local partnerships to gain access, was a deviation from the traditional MSF approach of direct action and therefore required a lot of adaptations for implementation.

There was a need for protocols and practices to be adapted and contextualised for the Syrian war, with concise protocols preferred. Human resource challenges included a limited number of staff available for implementation of planned interventions inside Syria and a high turnover of staff due to insecurity and demotivation. Remote recruitment of the local staff inside Syria was complex and for security reasons required the use of a consultative process.

This study found that effective communication, trust, and technical competency are crucial in remote partnerships with local actors. The induction of local specialists into a remote health service team was helpful in establishing communication and gave insight into the health system that operated inside Syria. Joint activities, such as the development of protocols, tools, and assessments, together with consistent engagement with partners online and face to face [in cross border meetings and training], were instrumental in building a close and mutually trusting relationship with health service partners.

Monitoring of project activities was found to be challenging, because MSF monitoring has tended to be based more on field presence and direct observation. Initially data reliability (especially medical data) was questionable, due to mistrust, unadapted tools, ill-defined indicators, and poor information sharing, while a heavy load of administrative reporting burdened staff. However, the use of innovative tools and mobile based data collection (DC); a multimodal approach to web monitoring; triangulation; and induction of partner focal staff improved data reliability and information sharing.

Humanitarian principles were found to be compromised [especially principles of neutrality and impartiality] and proved difficult to implement and monitor in a war zone. The MSF principle of bearing witness by being present (direct action) and speaking freely on behalf of the suffering population was compromised, because of security constraints and because MSF needed to maintain a low profile and use a low-key advocacy strategy in order to maintain access to operations inside Syria.

This study highlighted the need for careful planning to optimise future remote health programs, with attention to: operational planning of projects in scope and scale of interventions, in terms of selection of region/sector and focus of intervention, and contingency and exit plan with clear strategies. Tools and technology needed to be adapted; attention was needed to ensure staff had appropriate skills and experience (language skills, interpersonal and communication skills and remote management experience); along with a robust monitoring system with indicators relevant to the setting. It is also important to invest

in developing key local and partner focal staff (especially their management capacities to empower and ensure sustainability) with decentralized decision making for senior local staff (MSF) for an expedited response. To build effective remote partnerships, it is important that relationships are well negotiated and formalised, with the involvement of partners in planning, designing and implementation of the projects including their exit and closure.

Conclusion

In conflict settings where humanitarian access is restricted, the provision of remote support through local actors is an effective way of service delivery to vulnerable populations. This case study provides an insight into the core requirements for successful remote health programming and highlights the importance of external partnerships, networking and collaboration with stakeholders, the development of local capacity and the reinterpretation of humanitarian principles for war zones.

DECLARATION

I Nilza Angmo certify that this thesis does not incorporate without acknowledgment any material previously submitted for a degree or diploma in any university; and that to the best of my knowledge and belief it does not contain any material previously published or written by another person except where due reference is made in the text.

Signed:



Date: 29/12/2021

ACKNOWLEDGEMENTS

I would like to take this opportunity to extend my gratitude and appreciation to all the individuals who made this research project possible. First and foremost, I would like to express my sincere gratitude and appreciation to my supervisors Professor Judith Dwyer, Dr. George Tsourtos and Dr. Paul Aylward for their invaluable input, relentless support, and encouragement throughout this study. Professor Dwyer's healthcare management background, experience and understanding of the health systems and interest in the topic has contributed immensely to the concept development and to how this complex study was shaped and became more manageable. Dr. Tsourtos's contribution has been strong on the methodology and academic aspect of the study and has provided me with necessary support to build my academic and research knowledge. Dr Aylward's well thought through inputs always complemented the thesis development. I appreciate my supervisors for their commitment and unfaltering supervision and timely feedback on multiple drafts, even after Professor Dwyer and Dr. Tsourtos retired.

I would also like to extend my gratitude to Associate Professor Darlene McNaughton for her initial guidance, as the DrPH program coordinator at Flinders University.

This study would not have been possible without the participation of MSF staff in Amman, Syria and Ghanzientip in Turkey and partner staff who gave their valuable time and shared personal experiences openly. I am truly grateful to them and sincerely hope this body of work authentically echoes their voices. I acknowledge the support received from MSF OCBA to carry out this research and would like to express my appreciation to medical director OCBA Dr Jean François Saint-Sauveur, and Cristian Casademont, Manuel Pece Garcia and Elodie Andrault. Manuel Lopez Iglesias, Khalid Ahmad and Dariha Erketaeva thanks for your constant support and encouragement, sharing indepth knowledge of MSF in the region, ideas and inputs that contributed to the study.

I would also like to acknowledge the contribution of Gil Dwyer for copy editing the thesis and the support received from Ashleigh Merriel Office of Graduate Studies, Nicole Harris from Higher degree research progression and from my colleagues Sudarshan Subedi, Elissa Mortimer, Hailay Abrha Gesesew and Yane Novina Tarigan from the College of Medicine and Public Health, Flinders.

Above all I would not have managed to complete this thesis had it not been for the constant support, encouragement, and motivation from my son KAISER KALON, who believed in me

and has stood by me rock fast at every step. I have also received constant support from my siblings and my mother Mrs ESHEY ANGMO from whom I draw a lot of strength.

DEDICATION

Dedicated to all the MSF front line health care workers who strive to provide quality healthcare to the vulnerable populations in conflict and war zones

CHAPTER 1: INTRODUCTION

1.1 Background

In the year 2015-2016 while I was working in Amman Jordan as a program manager for MSF-OCBA, I supervised and managed a team that remotely supported a secondary hospital in Daraa province in South Syria. We aimed to understand and meet the population's medical needs, which were constantly shifting with the conflict, through the lens of hospital in Daraa. This study was precipitated by the challenges of providing remote support in this rapidly changing context. Through exploring the experiences of MSF staff and partners involved in the implementation of remote support projects in Syria, this study aims to contribute to the further development of remote support operation in conflict zones. I seek to clarify the barriers and facilitators to: best practice, efficient use of resources, and accountability of remote support operations, as well as to analyze the implications for future MSF engagements in this, and potentially for other similar regions.

1.1.1 The conflict in Syria

The Syrian Arab Republic is situated in the middle east, covering an area of 185,180 km² and sharing a border with Turkey, Lebanon, Jordan and Iraq. The population in 2010 was estimated at 21 million but has been steadily falling to an estimated 16.9 million in 2018 (Worldbank., 2020). According to the 2009 Syrian Family Health survey the population was relatively young: 38% under 15years and only 4% 65 years and above (Masek, 2020). The overall estimated male to female ratio was almost 1:1 (Worldbank., 2020). The religion and ethnic group composition of the population is 74% Sunni Muslims (majority arabs, 10% Kurds, 1% Turks), 13% Shia Muslims (mostly Alawites, and Ismailis), 10% Christians and 3% Druze and other minorities (Masek, 2020). The Alawi regime in Syria headed by President Assad, is opposed by the anti-government opposition rebel groups: the Free Syrian Army, the Muslim Brotherhood, and the Islamic State; all being Sunni Muslims. The opposition is against what it perceives to be an 'unjust political and economic treatment by the regime'. (Masek, 2020)

The crisis situation in Syria started in March 2011 and has continued for more than eight years (PHR, 2019). What began as a protest has escalated to a full-scale war between the government and the rebel-armed groups (Svoboda & Pantuliano, 2015). Eight years later, the country was still facing its biggest humanitarian challenge as 11.7 million people were

still in dire need of assistance, including 6.2 million displaced people, of whom 5 million were in acute need (UNHCR, 2019). The population in the rebel-controlled areas did not have access to basic health care (World Health Organization, 2016), as the health system inside Syria has been seriously hampered by the crisis: “Half of the public hospitals in the country are destroyed or badly damaged” (Cousins, 2015, p. 931). Systematic targeting of the health facilities and medical personnel has been part of the war strategy of the Syrian regime (Fouad et al., 2017), to weaken the population in opposition-held areas (PHR, 2019, 2020). The security situation and strict regulation of cross border aid and assistance in rebel-controlled areas have caused severe shortages of resources (Coutts et al., 2015). All these factors led to a ‘collapse of the health system’ (Abbara, Sahloul, Fouad, Coutts, & Maziak, 2015). Conflict and war have a huge impact on health equity. “Geographical and financial barriers to access to health care are seen as the major drivers to inequity” (Ranson, Poletti, Bornemisza, & Sondorp, 2007, p. 38), as is evident in Syria.

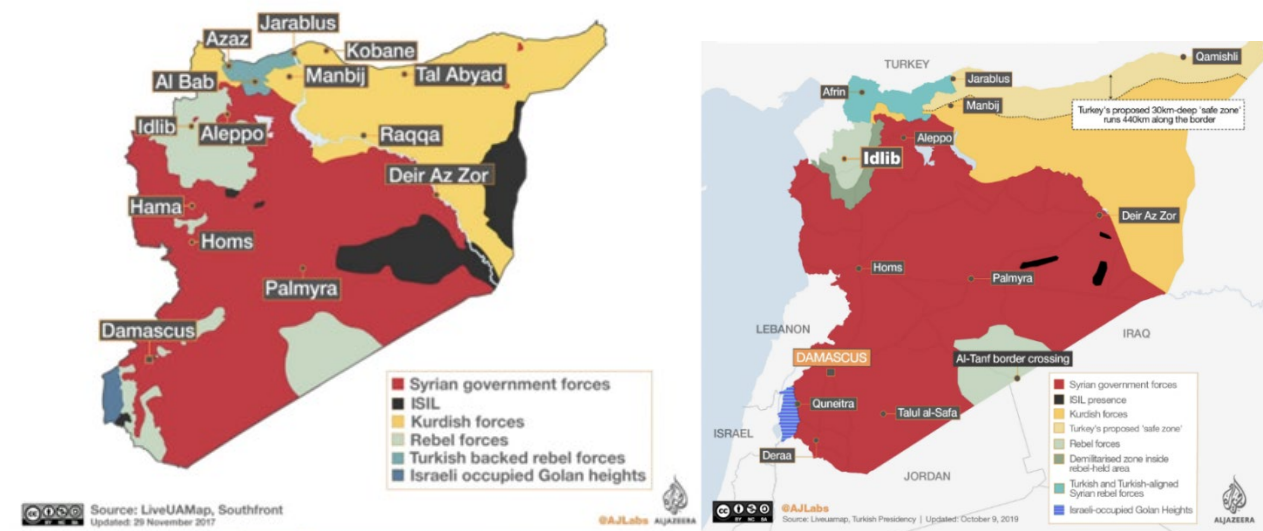
The International humanitarian presence has increased since 2012 (Slim, 2014). Regarding the humanitarian response there is a dual system of operations in Syria. United Nation (UN) agencies¹ and around 14 international organizations, including the International Committee of the Red Cross (ICRC), are legally registered and obligated to work through Syrian Red Cross in Damascus (Slim, 2014; Svaboda, 2014). There is also the illegal system of cross-border assistance by unregistered International Non-Government Organizations (INGOs) working mainly in opposition areas through local organizations and the Syrian diaspora.

The humanitarian response inside Syria has more than 70% of its funding supplied by five member states: United States, European Commission, United Kingdom, Kuwait and Germany. This multi-donor pooled fund is available for humanitarian assistance for UN agencies, and International and national organizations (SHF, 2019). Untied private funds are available through Syrian diaspora (20-30% of private funds) and international organizations that provide cross border assistance through Turkey, Jordan and Lebanon (Duclos, Ekzayez, Ghaddar, Checchi, & Blanchet, 2019; Els, 2016). Since 2014, following the 2165 UN resolution (UNSC, 2014) cross-border operations are now formalized. However, challenges in access for international humanitarian agencies due to severe bureaucratic restrictions necessitates, the use of remote modalities and partnerships with local actors.

¹ UN Development Programme (UNDP), UN Children’s Fund (UNICEF), UN Population Fund (UNFPA), UN High Commissioner for Refugees (UNHCR), World Health Organization (WHO), World Food Program (WFP), Food and Agriculture Organization of UN

Besides profound practical logistic constraints in collaboration and communication, cultural and linguistic challenges have also hindered a shared understanding and meaningful collaboration with and between International and local partners (Svoboda & Pantuliano, 2015).

Following a major offensive in mid-2018 (PHR, 2020), most of the rebel-held areas (green) were taken over and came under regime control (red in map) as shown in Figure 1.1 below.



Source: Aljazeera (2017,2019)

Figure 1.1 Comparative Map of Syria showing government-controlled and rebel areas before and after July 2018

1.1.2 Remote health programming approach in Syria

The MSF Operational Centre in Barcelona (MSF-OCBA) used a remote program approach: Remote health programming and monitoring involved a shift in responsibility from international staff to local staff, who become the project implementers, while the program was managed by a team of international staff from a secure remote location (Choudhary, Cordes, & Miller, 2017, p. 17). MSF staff were based in Amman, Jordan for South Syria and in Ghanzientip, Turkey for North Syria projects.

There are four recognized remote service modalities in the literature: remote control, remote management, remote support and remote partnership, depending on the role and responsibilities of the local and the international staff (Chaudhri et al., 2019; Herbert, 2013). In South Syria the MSF approach in Daraa Hospital [which was previously a Ministry of

Health (MoH) referral centre] was to provide remote support to the partners, who were the implementers. While in the North Syria project it was a 'shared remote management strategy'(Operational Center Barcelona, 2017) also called 'mirror strategy', where the objective was to provide quality medical services in MSF health facilities through building the capacity of MSF Syrian local staff as the implementers. This strategy had international staff in matching job responsibilities and hierarchy, mirroring positions of national staff who oversaw the implementation of protocols/tools on the ground and supervision of these activities, in the absence of the international staff.

This change is not solely due to increasing conflicts, especially in the Middle East. There has also been a paradigm shift in approach, from risk avoidance, or "when to leave", to risk mitigation or "how to stay" (Egeland, Harmer, & Stoddard, 2011, p. 22). For international health aid agencies like MSF, this means a changing focus from refugees to internally displaced populations (A. Stoddard & Harmer, 2006). There were over 320,700 registered displaced people in Dara province (Syrian Arab republic, 2016), a situation which required MSF to negotiate for better access in order to reach the vulnerable population.

Please note that in the literature 'remote management' and 'remote programming' are widely used terms for all the remote modalities (Choudhary et al., 2017; A. Stoddard & Harmer, 2006), so 'remote health programming' has been used in this study to signify both management and programming modalities.

1.1.3 MSF in Syria

MSF is an international medical humanitarian organization founded in 1971, assisting populations in distress due to natural or man-made disasters or armed conflict, irrespective of race, religion, creed, or political convictions. MSF's actions are guided by medical ethics and the humanitarian principles of independence, impartiality, neutrality and 'temoignage' (bearing witness)(Médecins Sans Frontieres, 1995).

MSF's objective, design, and strategy in Syria have evolved since it began in 2011, in response to high humanitarian needs inside Syria. The evolution happened in phases, from donation of medical supplies, to direct support, and finally to remote health programming. The first phase involved the donation of medical supplies and consumables to a network of doctors in medical facilities, to support their work with the war wounded. The second phase started in 2012, when MSF was able to go inside North Syria and explore the opportunities

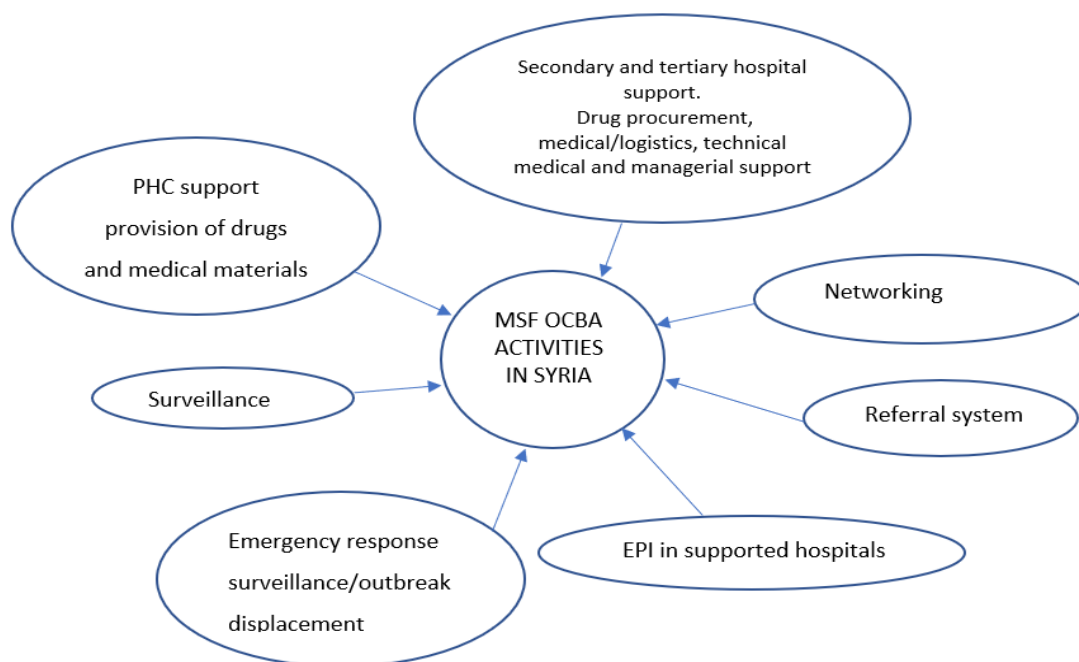
after it came under opposition control (opposition to the Syrian regime/government). This phase started in classic MSF style, with the setting up of a 32-bed hospital designed, run, and owned by MSF, to take care of the war- wounded in Azaz, Aleppo governorate.

In mid-June 2013, following the kidnapping of MSF staff (Arie, 2014), a decision was made to completely withdraw all international staff from Syria, marking the beginning of the third phase of remote health programming. The international staff based in Turkey supported the local staff (MSF) inside North Syria, through innovative shared management. Within MSF the shift to remote health programming was initially seen as a reactive and temporary measure, and the organisation has struggled to accept it as a valid longer-term approach (Hofman & Pérache, 2014). Even though long-term remote programming is now recognized as a valid and appropriate approach rather than a last resort or temporary measure (Price, 2017) it is still a much-debated topic in MSF.

Meanwhile, as the frontline expanded immediately after the war began in 2013 MSF started supporting more than 100 facilities with donations of essential medical supplies, equipment and relief material (Medecins Sans Frontieres, 2013), by 2015 it was more than 150 health facilities (Medecins Sans Frontieres, 2021). In response to the public health crisis in rebel-controlled areas in South Syria, in March 2014 MSF-OCBA started the remote hospital support project covering a population of 297,000 in East Daraa province. This project initially provided medical donations to six health facilities including three Primary Health Care (PHC) centres, two Field hospitals and the referral hospital for Daraa region. The opportunity to engage further in Daraa hospital came when the opposition took Daraa region from the Syrian government regime. Although partially destroyed by bombings, the hospital had survived the war with staff ready to function. MSF decided to support this hospital, with its dire need for secondary and tertiary services (Dialysis, neonatal Intensive care unit (NICU)) (Operational Centre Barcelona, 2018).

MSF saw an opportunity for a new approach, to provide full support to Daraa Hospital including rehabilitation of the facility. Salary tops up of 98 staff and technical support were provided with the objective of improving the quality of care. I was part of a team of five international and local staff (MSF) directed by the coordination team in Amman, Jordan that remotely supported implementation of the activities as listed in Figure 1.2 in collaboration with the partner hospital team inside Syria. The MSF team continuously monitored, supervised, and evaluated the project activities through data collection, reporting and regular meetings using Skype and telephone. In 2016 the Regional Middle East unit (MEU) of

OCBA, along with a decentralized operational headquarter in Amman were established, with the objective of providing close technical and operational support to the projects in the region. Figure 1.2 below illustrates the range of functions involved.



Source: MSF OCBA (2016)

Figure 1.2 MSF activities implemented in Syria through RSM

Full support to Daraa Hospital continued until July 2018, when the Government of Syria (GoS) launched military operations and took control of East Daraa. This brought the remote support phase to an abrupt end, as MSF was not registered or legally recognised by the GoS. Due to border closures, humanitarian access and cross border activities then stopped in South Syria, resulting in the project's closure in August 2018. However, MSF intervention continues in North Syria amid escalating conflicts.

1.2 The challenge for MSF: the need for an effective operational approach

MSF faced many constraints in the remote support model of intervention that hindered optimal service delivery given that, as previously mentioned, these hospitals were, either destroyed or partially functional (World Health Organization, 2016), and half of the 30,000 Syrian physicians had fled the country (Hampton, 2013). A further challenge was posed by inadequate governance of the health system in the rebel-controlled areas meaning that

they were unable to ensure quality in the hospitals that were still functioning (Douedari & Howard, 2019).

At the project level, the multicultural remote team struggled to gain insight and understanding of the constantly changing context and needs of the project. This was compounded by the lack of adequate tools to ensure proper supervision and monitoring and assess the quality of care provided. At times attempts to engage and effectively interact with partner staff of the Syrian hospitals proved futile due to non-aligned priorities and objectives (Howe, Stites, & Chudacoff, 2015).

At the organizational level, this program involved not only the shift to a remote support model, but also a long-term debate within MSF (Hofman & Pérache, 2014), as the remote approach was seen as a major deviation from the MSF's 'Chantilly principles' (Medecins Sans Frontieres, 1995) of direct action and Temoignage. Those who opposed adoption of the remote programming model thought MSF's identity, mission and principles were at stake and questioned the lack of proximity to the patient, and the impact of remoteness on the principles of neutrality and impartiality (Hofman & Pérache, 2014).

Despite these debates, remote management of projects has been successfully implemented by MSF in other contexts. However, the Middle East context was new. MSF did not have full access to the vulnerable population as it was not legally registered through the regime in Damascus and therefore operations were restricted to rebel-controlled areas. There was also a lack of detailed knowledge of how the health system works inside Syria. All these difficulties had led to an inadequate capacity to optimally respond and work in the Middle East context (Operational Center Barcelona, 2015)). Yet remotely programmed humanitarian interventions may be the only appropriate approach, when considering the enormous barriers to a more direct intervention within a context like Syria (Hofman & Pérache, 2014). Therefore, this research was proposed in order to explore, understand and contextualise how MSF can further develop and build capacity in similar settings to that of war-torn Syria.

1.3 Significance of research impact

This study was conceived in response to the operational challenges faced in the implementation of the remote support model of engaging with hospitals in Syria. It is anticipated that, the primary practical impact of the study will be to inform MSF regarding

the further development of effective remote health interventions in conflict areas in Syria and within the broader Middle Eastern context. Through an internal report to MSF, this study will contribute to the MSF OCBA understanding of experience in Syria and provide insights into some of the fundamental changes that the MSF organization might need to make in order to adapt to the Middle East context.

The study will also contribute to the body of knowledge about the experience of international humanitarian organizations like MSF in remotely supporting hospitals and health care in the Middle East context. There are very few published studies about remote health programming/management of hospitals. There is also a lack of rigorous research and evidence on good practices, guidelines or other details on how remote health interventions are implemented (Choudhary et al., 2017), and on what strategies, policies or operational guidelines are effective in remote programming (Abby Stoddard, Harmer, & Renouf, 2010). There is a need to know more about the level of effectiveness of different sectors and their impact on humanitarian access (Schreter & Harmer, 2013).

I therefore propose to use the example of MSF-OCBA project in Syria as a case study. Overall, the study aims to explore and clarify the barriers and facilitators to best practice, and potential strategies for a more efficient use of resources in a remotely programmed model. The study aims to characterize the challenges of providing remote health programming in relation to the founding mission, and to analyse the implications for future MSF-OCBA engagements in the region, and MSF itself.

1.4 Researcher background and Reflexivity

I am a middle-aged woman, from the Himalayan region of North India, now settled in Australia. I am a medical practitioner with a public health background, and more than two decades of health care delivery experience in resource-limited settings of Asia, the former Soviet Union and recently the Middle Eastern (ME) region with both MoH and MSF. My medical background and experience has been an advantage in undertaking this research. My work with MSF for more than 13 years and my involvement in strategic operational planning, designing, implementing, and monitoring of MSF projects over all these years, means that I am acutely aware of the organizational culture, strengths and weaknesses. With an insider's knowledge (Cooper & Rogers, 2015), I also had easier access to people

and information that further enhanced that knowledge (Costley, 2010). It was easier to get technical support, negotiate for collaboration and agreement for conducting the study, and I was able to gain access MSF projects and resources through the proper channels. My background and familiarity with some of the study participants also helped to create a good rapport and to build trust (Saidin, 2017), as I had existing relationships and familiarity. This research has given me the opportunity to reflect on and analyse my own experiences in the past and in the Middle East region, and I am aware of how my perspectives and experience informs and shapes my interpretation of my data. I hope that the insights I have gained will continue to inform my future endeavours.

While working in Jordan in 2015-2016, following MSF missions in Iraq, Syria and Jordan, I came to realize how different the Middle East context and culture were and the need to understand and change /adapt our approach in the region. One incident was enlightening. While trying to get access to set up a Cholera Treatment Centre and Units (CTC, CTU) in the Mid Euphrates region of Iraq, in response to a cholera outbreak, the local Public Health Director asked me: Why does MSF need to set up CTC and CTU units here like you do in Africa and Asia regions? We have infrastructure, hospitals with isolation sections, why waste resources? ...What we need is training of health personnel in infection control (IC) and awareness generation in the population, and in the research field, these are the gaps.

Following this conversation and discussion with mission and headquarters, we switched strategies to focus on Infection Control (IC), and successfully implemented IC interventions in the identified health facilities. I had a similar experience in Syria. We organised with World Health Organization (WHO) in 2016 to train 19 surgeons from South Syria in Amman, Jordan including some from MSF-OCBA supported hospitals. The surgeons collectively voiced their concerns about the urgent need for MSF to provide support based on the reality of the situation in Syria, where following peacetime protocols for care was not possible. For example, a major vascular surgery case did not stay for more than 4-5 days in a Syrian hospital, due to targeted attacks, and this reality required adaptation of the protocols.

All these experiences and challenges, and those of various team members and partners in Syria, motivated me to explore further how MSF could best adapt interventions and its approach in the ME region for maximum effectiveness of its remote programs, and optimum use of resources.

1.5 Research Question

The overarching research question for this study is: ‘How can the remote health programming and monitoring for hospitals be optimized to equitably address the medical humanitarian aid needs of war-torn regions?’

1.5.1 Aim and Objectives 1

To identify the nature of the past and current operational remote health program models serving in a war-torn region in terms of strengths and assets, and weaknesses and deficits, by undertaking a systematic search of the relevant public health literature.

Objectives:

1. To understand the strategies, approaches, and scope of interventions for remote health programming documented in the public health literature, as well as the broader humanitarian organizational literature.
2. To understand the barriers and enablers with regards to remote health programs specific to conflict settings in the humanitarian field by undertaking a systematic search of the published academic and grey literature.

1.5.2 Aim and Objectives 2

Informed by Objective 1, to explore and identify the strategies and practices, barriers and enablers specific to remote support model of MSF OCBA humanitarian medical operational actions in Syria.

Objectives:

1. To describe the remote support model of MSF- OCBA implemented in Syria and to identify effective strategies and practices through conducting in-depth semi-structured interviews with program managers and service provider staff.
2. To identify lessons learnt by MSF, and how the MSF remote support model was adapted, and evolved in response to war-torn Syria through in-depth semi-structured interviews with program managers and focus group discussions with service provider staff in Amman, as well as interviewing selected collaborating partners inside Syria.
3. To identify barriers and enablers associated with MSF remote support model via semi-structured interviews with program managers and focus group discussions with

service provider staff in Amman, as well as undertaking semi-structured interview with collaborating partners and selected staff inside Syria.

1.5.3 Aim and Objectives 3

To propose a refined and optimized remote support model for inaccessible conflict affected areas like Syria.

Objectives:

1. Drawing on findings from Aims 1 and 2, develop a draft model or practical policy guidance for remote support models for health facilities, including short and long-term strategies, to optimize effectiveness and minimize barriers to implementation
2. Develop knowledge transfer strategies that could enable the adoption of a refined and optimized remote program model for health facilities by humanitarian stakeholders involved in war-torn regions.

CHAPTER 2: LITERATURE REVIEW

2.1 Introduction:

The purpose of this narrative literature review was to explore and identify the nature of the past and current operational remote health modalities used in serving in a war-torn region. This review was conducted in relation to study objective one: To understand the operational modalities, strategies, approaches, and scope of interventions for remote health programming and to understand the barriers and enablers with regards to remote health programs in conflict settings in the humanitarian field.

The chapter starts at section 2.2, with a description of the systematic search method and strategies used and gives an overview of the retrieved data. Section 2.3 presents the main findings of the reviewed data outlined under eight themes: contextual barriers and access issues, remote management definition and concepts, remote service delivery modalities, remote partnerships, networking, coordination and collaboration, monitoring and technology, humanitarian access and principles, and finally, programmatic guidance.

Section 2.4, the conclusion, summarizes the main concepts and identifies the gaps in the literature, as well as the justification for this study.

2.2 Systematic search and Narrative review

The selection of the literature review method depends on the nature of enquiry, purpose of review, research question and the search strategies used (Booth, Sutton, & Papaioannou, 2016). Review methods fall under a range of categories, from narrow and selective systematic reviews to broad explorative scoping reviews and traditional narrative reviews (Booth et al., 2016).

Scoping reviews provide broad, descriptive overviews of the literature during the initial phase of the research in 2017. A scoping review was carried out to explore the extent, range and nature of relevant research activity and to identify gaps in the literature (Arksey & O'Malley, 2005) on the topic of 'remote health programming'. The research question guided the review and the findings then helped to further define and revise the research question (Arksey & O'Malley, 2005) and formed part of the study proposal preparation (Punch, 2016).

In the later part of my research, in October 2020, a narrative literature review using a systematic search approach was carried out. To ensure that updated studies related to remote health programming were included, an additional search was undertaken on the databases between November 2020 and October 2021. A narrative literature review was considered best suited for this research topic and addressed many issues and queries within the topic (Ferrari, 2015). It also encompassed a broad search of evidence from a wide range of sources of varying quality (Collins & Fauser, 2005). Both peer-reviewed and grey literature, comprising of organizational policy and the practice documents deemed necessary to understand the implementation of remote programs by the humanitarian organizations in the region, were included in this review (Adams et al., 2016)

Since narrative reviews do not follow a defined strategy or level of transparency for selection of relevant evidence, a systematic search methodology was adopted as a component of the systematic review methodology (Collins & Fauser, 2005; Ferrari, 2015). This was pursued to ensure rigour and clarity of process (Booth et al., 2016) in relation to searching of relevant literature, collecting and collating the data and presenting the thematic findings.

2.2.1 Systematic search methods

The search strategies used to identify relevant research studies were sourced through electronic databases, reference lists and relevant organizations (Arksey & O'Malley, 2005) and online Grey source of literature.

Multidisciplinary electronic databases including ProQuest, Scopus, Web of science and PubMed were used, which covered a wide range of public health studies including health policy, systems, and management.

Grey literature is defined as the information that is produced at all levels of the government, academia, business and industry, in print and electronic formats, but it is not controlled by commercial publishers (Booth et al., 2016; Paez, 2017; Pappas & Williams, 2011), neither is it peer reviewed (Adams et al., 2016), as publishing is not the primary activity of the producing body. (Booth et al., 2016, p. 306). Grey literature provided useful contextual information (Adams et al., 2016; Pappas & Williams, 2011) relevant to this case study and assisted with understanding the nature and range of remote health interventions in practice in this context and their effectiveness (Adams et al., 2016). Organizational documents, reports (including evaluation reports), bulletins and newsletters were important to understanding the implementation of the remote programs in the humanitarian sector (Adams et al., 2016).

For this narrative review the grey search engines used were Google and Google Scholar, Open Doar, Popline and Open Grey (Booth et al., 2016). A search for relevant materials on the websites of the International non-governmental organizations (INGOs), such as WHO, MSF, Alnap.org and UNOCHA, was also conducted.

Search strings for databases relating to the research question about ‘remote health programming to optimize medical humanitarian needs in war torn regions’ were developed. The key words used were “conflict”, “remote” (all modalities and location), and “health services” (departments and care providers). Synonyms of the keywords were also used as shown in Table 1. Grey sources were searched with key words: “remote management”, “remote programming” and health in humanitarian “conflict settings”.

The inclusion criteria for the searching of academic literature included peer reviewed journal articles published in English from the beginning until October 2020. While there were not many articles prior to 2009, from then on there was an exponential increase in the amount of relevant literature. Given the sparsity of peer reviewed articles related to remote programming emanating from Syria or the Middle East regions, the search was expanded to include all countries and regions. Primary studies with all designs were included to add variations and different perspectives. A few secondary studies were also included for the remote programming concepts and search of primary literature.

Minor changes in search string configuration and connectors were made specific to websites such as replacing W/4 in Scopus with NEAR/4 in ProQuest and Web of Science to broaden the search. Table 2.1 shows the search strings of keywords and Boolean operators used for ProQuest and Web of science.

Table 2.1 Search string for databases

((fragile OR crisis OR crises OR conflict OR conflicts OR precarious OR insecure OR unstable OR “high risk” OR volatile* OR dangerous OR wartorn OR “war-torn”) NEAR/2 (state* OR area* OR region* OR countr* OR setting* OR situation* OR zone* OR affected)) AND (((remote* OR “cross-border*” OR “limited access*” OR inaccess* OR tele* OR ehealth* OR “e-health*” OR virtual*) NEAR /4 (support* OR partner* OR collaborat* OR manag* OR supervis* OR program* OR intervention* OR operation* OR control* OR delivery OR model* OR care OR servic* OR organi* OR facilit*)) OR humanitarian OR NGO* OR INGOs OR “non-government”) AND (health* OR surg* OR medic* OR pediatric* OR paediatric* OR obstetric* OR disease* OR casualt* OR hospital* OR doctor* OR clinic* OR nurs*)

Table 2.2 shows the search results related to the different databases. PubMed yielded by far the highest number of studies which were mainly on health sciences topics on remote

patient management because health and health care providers were included in the search string.

A total of 2372 peer reviewed articles were retrieved from all the databases, including 387 retrieved between October 2020 to October 2021. These were then reduced by excluding 872 duplicates, a further 1120 by title relevancy, 316 by abstract relevancy, while 27 were excluded after reading the full text (see Figure 2.1 below). A total number of 36 peer reviewed articles were selected. Twenty-one articles were gathered from grey sources of literatures. All steps followed for the selection of data are shown in Figure 2.1, PRISMA flow chart below (Moher, Liberati, Tetzlaff, & Altman, 2009).

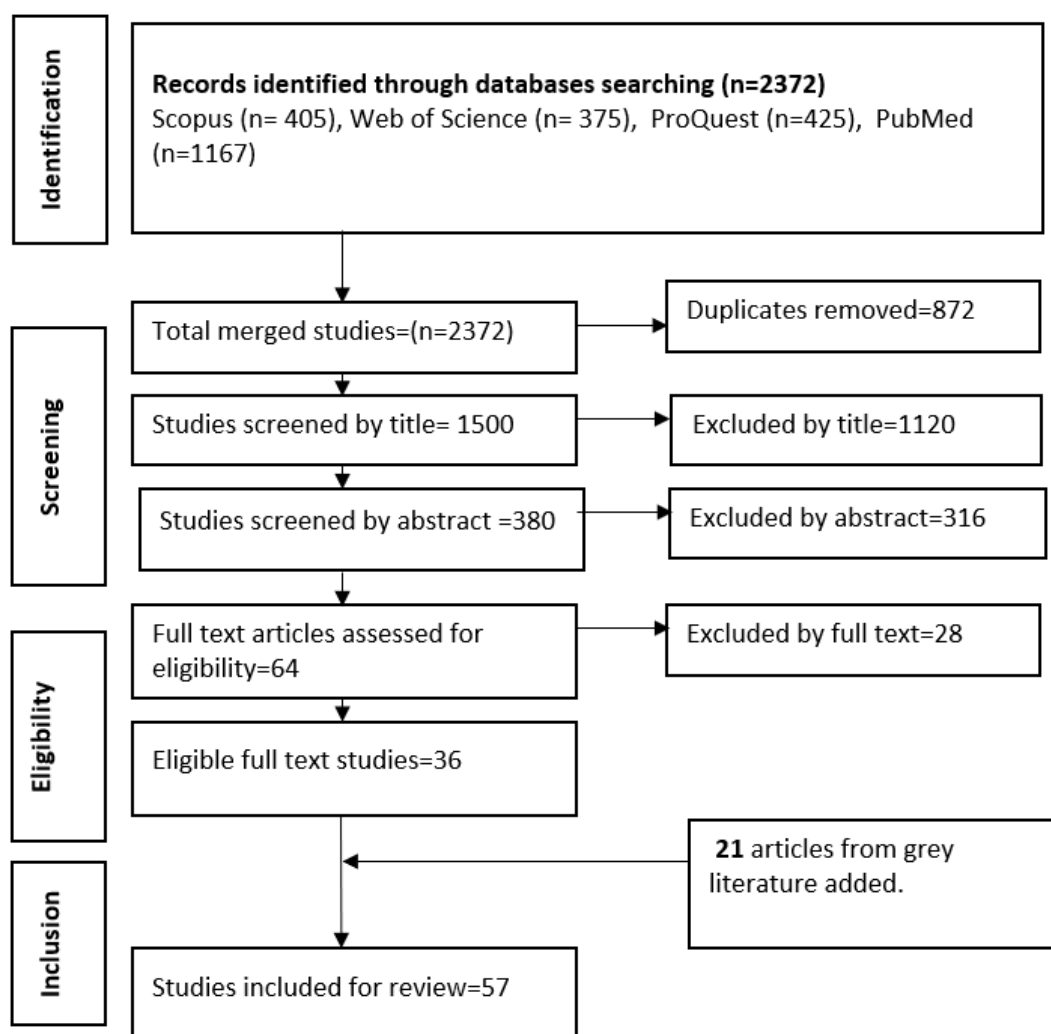


Figure 2.1 PRISMA chart

2.2.2 Literature Review Analysis:

In the course of this literature search not much peer reviewed data relevant to remote health programming was found in the academic databases (Pappas & Williams, 2011). This was

because most of the practice (Interventions and evaluations) in the humanitarian field were primarily carried out to inform and practice, subsequently remaining unpublished or not formally documented (Adams et al., 2016). A total of fifty-seven documents were reviewed and analysed for this literature review. Retrieved and selected articles were then arranged in a descriptive map created in an excel file listing the author, title, country, type of document, study design/method, project intervention and main findings. The extraction was approached thematically with studies distributed accordingly.

Publication dates of the thirty-six peer reviewed articles included ranged from 2008 to 2021. More than a third of the studies were case studies, five used cohort analysis (perspective and retrospective), five were surveys (cluster and electronic), one was a literature review, while the rest were qualitative studies with no specific design mentioned. More than 35 percent of the studies were conducted on MSF projects. Almost 40 percent of the health programs involved in remote service delivery were specifically maternal and child health programs, followed by tuberculosis, malaria control, and sleeping sickness programs. Five were described as other primary health care services.

As per the analysis, the countries involved in remote programs were from an African context, Middle East and Asian settings as shown in Table 2.2. It is interesting to note that, during the previous scoping review in 2017, Somalia and Afghanistan were extensively studied in peer reviewed literature, followed by Democratic Republic of Congo (DRC) and Syria. However, the recent literature search of databases in October 2021 showed an exponential increase of studies (on remote programs) in Syria after 2019, possibly associated with more experience gained in remote programming in the region by the humanitarian actors. The Covid pandemic may have also contributed, given the associated decrease in field activities thereby allowing more time to review, compile and publish articles.

Table 2.2 Distribution of studies according to the region and countries

Region	Individual studies	Combined studies	Total	Countries included
African	12	3	15	Cameroon, CAR, DRC, Mali, Nigeria, South Sudan, Somalia
Asian	5	4	9	Afghanistan, Myanmar, Pakistan, Philippines
Middle East	13	2	15	Iraq, Syria, Yemen
Total	30	6*	36*	

**Combined studies are merged*

The grey literature included six evaluations and seven policy research reports, with the remaining grey literature comprised of desk reports, policy briefs and notes. Middle Eastern countries of Syria and Iraq were found with the highest number of grey literatures. In addition to those mentioned above countries involved in remote management, included Darfur, Palestine, North Caucasus, Somaliland, Chechnya, Lebanon, Niger, and Kenya.

2.3 Findings:

2.3.1 Contextual Barriers and Access Issues

Political and security constraints provide the main barriers and/or act as triggers for the humanitarian agencies to shift to remote operations (Donini & Maxwell, 2013; Abby Stoddard et al., 2010; A. Stoddard & Harmer, 2006; Svoboda & Pantuliano, 2015). Restrictive government policies are imposed, such as refusal of international presence without registration in government-controlled areas and an obligation to work through recognized channels. For example, in Syria INGOs are directed to work through Syrian Red Crescent (Akik et al., 2020; Abby Stoddard et al., 2010). Government exercises the power to control the humanitarian aid, though, for example, blocking an essential immunization campaign and suggesting redirecting funds to meet their priority areas of intervention (Tappis et al., 2020), which creates lot of problems for organizations dependent on donors with inflexible funding (Ataullahjan et al., 2020).

Security constraints such as bombing and attacks on the health facilities and ‘weaponization of health care’(Fouad et al., 2017) are seen as the war strategy and they deprive the population of access to basic health care while acting as an ultimate show of power and

control (Fouad et al., 2017). Armed groups also exercise power by setting up physical barriers through roadblocks and check posts (Tappis et al., 2020) and imposing restrictions on activities (Abby Stoddard et al., 2010; Svoboda & Pantuliano, 2015). Then there is additional threat to the health care workers of International organizations which use kidnapping and extortions, or monetary demand, for the safety of staff and resources (Ataullahjan et al., 2020). The kidnapping of five MSF staff in Latakia in Syria in 2014 (Garcia, 2015) and the killing of three MSF staff in Somalia in 2008 in a roadside bombing were the main reasons for MSF withdrawal and the shift to a remote approach of health service delivery (Belliveau, 2013). All these incidents, along with unpredictable disruptive intra ethnic group clashes (Ataullahjan et al., 2020; Lee, 2008), make the context very insecure in conflict settings. This leaves international organizations with little choice for health service delivery except through the use of remote modalities. Stoddard further adds that remote modalities and operations are needed to ensure there is more focus on internally displaced populations (IDP) that require significant negotiations with armed groups for access (A. Stoddard & Harmer, 2006).

There is a common consensus among researchers that remote management of operations provides the benefit of continuing aid and that it is possibly easier to re-enter the country and fosters closer relations with a community that has known the organization before (A. Stoddard & Harmer, 2006). Donnini agrees and adds that the remote approach improves the capacity and ownership of local actors as well as the implementing body. He does however stress that this is not the optimal modality and he fears that physical presence will be replaced by a solely virtual relationship (Donini & Maxwell, 2013). Stoddard also agrees that it is possible to get into a remote trap whereby it will be impossible to go back to the original way of working due to lack of information from the field and a loss of trust and credibility (A. Stoddard & Harmer, 2006).

2.3.2 Remote management definitions and concepts

Remote management is seen as an operation modality whereby the responsibility is shifted towards the national or local staff, with withdrawal of the international staff as an adaptation to insecurity to ensure continuity while accepting that, in the process, program quality might suffer. It is also often perceived as:

- A reactive, temporary, suboptimal measure (Donini & Maxwell, 2013; Egeland et al., 2011; Hansen, 2008; A. Stoddard & Harmer, 2006);

- A deviation from normal programming and as an anomaly or aberration (A. Stoddard & Harmer, 2006);
- As a last resort short of suspending operations (Egeland et al., 2011; Herbert, 2013));

An objective fulfilled by a third party (Donini & Maxwell, 2013) which could be a local partner, or community based organization (A. Stoddard & Harmer, 2006).

Remote management was also seen as a tool to ensure program continuity (Rivas A, 2015) with a series of “trade-offs and compromises” around access (Howe et al., 2015).

However, according to the latest literature remote programming is no longer realized as a last resort or temporary measure for international donors working in insecure contexts but has become the new norm (Price, 2017; Rivas A, 2015), with the choice of programming approaches depending on the capacity of the organization, the location and type of the project (Donini & Maxwell, 2013; Hansen, 2008).

2.3.3 Remote service delivery modalities

Four modalities of remote operations are identified across the literature, depending on the extent to which decision making is delegated by the international staff to the local staff. The four modalities are remote control, remote management, remote support and remote partnerships and their salient features are presented in Table 2.3.

The remote control and remote management modalities are viewed as reactive stances which are used for a short to medium time frame. In the remote-control model, decision making is centralized and involves relocated international managers, with a good oversight and control over the local staff who implement the program in the field. Under the remote management model there is partial or temporary delegation of activities and responsibility to local staff for implementation of operational activities, while financial oversight is retained by the remote managers. There is more investment in transferring skills and in building the capacity of the local actors within remote management and support modalities (Hansen, 2008; Rivas A, 2015; A. Stoddard & Harmer, 2006) to aide smooth implementation. MSF projects have elements of both remote control and management, since the quality of the program is difficult to maintain through the remote approach. The MSF Operational centre Amsterdam (MSF_OCA)² mission in Somalia is a good example of remote control with

² MSF has 5 operational centres (OC): Amsterdam (OCA), Barcelona (OCBA), Paris (OCP), Geneva (OCG) and Brussels (OCB)

centralized decision making and micromanagement with a top-down approach (Belliveau, 2013). Medical activity control is provided through central supply and pharmacy management, consumption reports; detailed follow up of patient management, such as prescription controls; exit interviews of patients; financial control on budget and local purchases and expenditures; HR control in recruitments (Belliveau, 2013; Operational Center Amsterdam, 2012) to ensure program quality is maintained. However, intensive support and capacity building was also provided through training. Remote management and more recently remote programming are the most widely used terms (A. Stoddard & Harmer, 2006) for all the remote approach modalities.

The remote support modality (mostly donor driven programs) is defined in the literature as a proactive engagement with the goal to hand over decision making and authority to local staff/actors, while retaining financial management, donor reporting and capacity building with high investment in skills transfer, capacity building and mentoring in preparation of the handover (Hansen, 2008; Rivas A, 2015; A. Stoddard & Harmer, 2006). MSF Operational centre Brussels (OCB) has successfully supported a network of local doctors and health care providers in Syria remotely, by procuring and supplying essential drugs, medical material and equipment, and through the provision of technical support from the neighbouring remote locations in Jordan, Lebanon and Turkey (Garcia, 2015).

Remote partnership is seen as a long term, more sustainable modality based on equal partnership and an almost complete handover to partners to operationalize the programs, with international bodies remaining as financial intermediaries with more involvement in administrative and advocacy. (Hansen, 2008; Rivas A, 2015; A. Stoddard & Harmer, 2006). This is discussed under the partnership section below.

Overall, there is a common consensus that remote health programming could be the operational modality, if properly planned to ensure continuity of health services in conflict settings (Belliveau, 2013; Garcia, 2015). Table 2.3 shows the main features of the remote modalities for practice in the humanitarian sector

Table 2.3: Remote service delivery modalities

	Remote control	Remote management	Remote support	Remote partnerships
Nature of approach	Reactive	Reactive	Proactive	Proactive
Implementers	Local staff (LS)	local staff, local partner, organization	local staff/authorities and communities	Local NGOs, Community based organizations (CBO), MoH
Decision making (DM)	Centralized to International managers, delegate implementation to LS	Shared or partial delegation of authorities to the LS	Long term strategy to handover decision making to LS /local actors, financial and strategic oversight retained	Significant handover to local partners
Time frame	Short term	Short to Medium term	Long term	Long term
Investment required	Low	Low	High	High
Sustainability	Low	Moderate	High	High
Type of programs	Emergency	Semi-emergency,	Developmental	Developmental
Benefits	Continuity of program, better control and oversight. Perception of Neutrality and impartiality	Continuity of program, better control and oversight, capacity building, Perception of Neutrality and impartiality	Continuity and sustainable, flexibility and adapted better to changing context	Continuity and stable program with long term development, sustainable, better adapted to context.
Risks	Communication difficulties, Inflexibility, limited delegation, risk transfer to local staff, high turnover of staff, unsustainable,	Communication difficulties, risk transfer to National staff. High turnover of staff.	Corruption risk, lack of oversight, limited capacity of national staff, risk transfer. Neutrality and impartiality may be undermined.	Corruption risk, lack of oversight, limited capacity of national staff, risk transfer and reluctance of donors to fund. Neutrality and impartiality may be undermined.

Adapted from (Hansen, 2008; Rivas A, 2015; Abby Stoddard et al., 2010)

2.3.4 Remote partnerships

Effective partnerships with local actors are crucial and fundamental for access and successful remote programming within insecure settings (Chaudhri et al., 2019; Howe et al., 2015; A. Stoddard & Harmer, 2006; Svoboda & Pantuliano, 2015). Sharing common goals and objectives is important (Hammadi K, 2012), along with flexibility to adapt to the continuously changing contexts in conflict zones (Gaffey et al., 2020; Howe et al., 2015; Pavanello S, 2018; Svoboda & Pantuliano, 2015). A strategically planned and invested local partnership can allow more security for humanitarian interventions (A. Stoddard & Harmer, 2006). However, Svaboda, while acknowledging the importance of partnership, points out

that local partnerships are basically viewed as contractual service delivery and, as such, perceived by international actors to be ineffective, due to power imbalances, as most of the resources are controlled by the donors (Hammadi K, 2012; Howe et al., 2015; Svoboda & Pantuliano, 2015). In MSF partnerships are perceived to be associated with a loss of independence (Hammadi K, 2012). However when formed with policies in place: *“Partnerships in MSF are mutually beneficial, planned and formalized alliances made with diverse organizations who espouse the same humanitarian values to achieve commonly defined objectives”* (Hammadi K, 2012, p. Page 5).

Overall, four subthemes were identified in the literature: Partnership types and stakeholders, identification and selection, capacity building and relationship building through ‘communication and trust’.

Partnership types and stakeholders

Some agencies use only one type of partnership (bilateral) with different stakeholders as shown in Table 2.4 below; others use several depending on the access, capacity of the partner and project type and location (Donini & Maxwell, 2013; Hansen, 2008; Rivas A, 2015). Hammadi states that partnerships are defined by the purpose of the projects; for gaining access (Hammadi K, 2012; Howe et al., 2015; Svoboda & Pantuliano, 2015), finding an exit strategy, advocacy and complementing activities to cover gaps (Hammadi K, 2012).

Table 2.4 Partnership types based on purpose and stakeholder’s features

Types of alliances	Purpose of alliance	legality	advantages	Drawbacks
Diaspora	Capacity building	Registered locally/internationally	Visibility, communication skills, experience and adaptability with INGOs, well connected.	Limited access to community and acceptance, lack of legal knowledge and implications on programs
LNGO/ Local actors	Short subcontracts for providing services or pilot trials	Unregistered/ Registered locally	Access and community acceptance, local knowledge, insights, development of civil society, open to capacity building	Less visibility and experience with INGO, language barrier, Less participatory Lengthy selection process, limited capacity, and accountability, perceived positive or negative by authorities
Community bodies	Advocacy, involved in recruitment, aid distribution etc	Unregistered/ Registered locally	Promote community participation, interest in right implementation, Community ownership	Very local level small scale projects, lacks impartiality, language barrier, corruption
MoH authorities	Advocacy, Long term programs	Legal authority	Capacity building and sustainability, Value	Undermines neutrality and impartiality, weak accountability, corruption risk.

	consultation/ Exit strategy handover			
Multiparty (Triparty alliances)	Capacity building, to implement components of program	Registered local/Diaspora /international	Complementary to comprehensive program, free up resources, mutually beneficial, positive impact on beneficiaries	Different objectives, need for clarity in responsibilities

Adapted from (Hammadi K, 2012; Howe et al., 2015; Abby Stoddard et al., 2010)

Diaspora organizations are seen as credible and legitimate (Fouad et al., 2017) partners and have successfully covered gaps by providing manpower and technical support in partnership with regional and international donors (Aburas, Najeeb, Baageel, & Mackey, 2018). Diaspora organisations, such as the Syrian American Medical Society (SAMS) and the Syrian Expatriate Medical Association (SEMA), specialise in implementation of health interventions, capacity building through formal education, as well as technical skill-based training for physicians and health workers (Bdaiwi et al., 2020; Fouad et al., 2017). They have the advantage over the local actors in terms of language, flexibility, and ability to adapt to international partners (Howe et al., 2015).

Local actors are effective partners in conflict settings (Ataullahjan et al., 2020; Khan et al., 2021; Singh et al., 2021) as they have insights and understanding of the context, culture, language and barriers (Ataullahjan et al., 2020; Fradejas-García, 2019). Partnership with locals is synergistic because they have necessary contacts and are aware of the needs and type of support required (Aburas et al., 2018). They have also reshaped coordination in a way that helped establish communication, procurement, and logistics routes for continued operations (Duclos et al., 2019). A recent study conducted through a series of case studies in ten conflict ridden countries, including Colombia, DRC, Mali, Nigeria, Pakistan, Somalia, South Sudan, Syria, and Yemen, for the assessment of MCH services, established that partnerships and implementation of outreach and mobile service delivery through local partners were effective in conflict settings and that recognising and valuing local actors was linked to improved service delivery (Singh et al., 2021)

Evidence showed that approaches focussed on strengthening ties with the local community were linked with improved community acceptance (Hawkes, Katsuva, & Masumbuko, 2009; Lee, 2008; Liddle, Elema, Thi, Greig, & Venis, 2013). These included investing in ongoing local consultations, involving communities in hiring of local staff (Belliveau, 2013; Chaudhri et al., 2019; Egeland et al., 2011; Hawkes et al., 2009; Tong, Valverde, Mahoudeau, Yun, &

Chappuis, 2011), outreach strategies and strategic partnerships with local (Abby Stoddard et al., 2010) and community based organizations (CBO) (Mullany et al., 2010). A multiparty partnership with ethnic community groups in Eastern Myanmar to implement outreach maternal health services through community health workers was assessed through a two-stage cluster survey. Comparing with the baseline antenatal and postnatal services had doubled over 3year period of program, contraceptive prevalence rate increased by 24% and unmet need for contraception reduced by 35%. In DRC in remote partnership with MoH, MSF complemented and covered gaps in Tuberculosis (TB) services, to manage drug resistant (DR)TB cases and the project was successfully handed over to the MoH (Shanks et al., 2012). In Syria, where INGOs formed partnerships with local NGOs and Diaspora for access (Howe et al., 2015; Svoboda & Pantuliano, 2015), MSF worked directly with the facilities management to support the doctors and health care providers in opposition controlled areas in North Syria (Garcia, 2015).

Identification and selection of partner

Selection of the local partner and staff is reported as a crucial step with an emphasis on more proactive selection (Howe et al., 2015; A. Stoddard & Harmer, 2006). This is preferred over traditional selection methods, followed by a formalization of the alliance through an agreement or Memorandum of understanding (MoU) (Hammadi K, 2012; Howe et al., 2015). Potential partners should be identified through earlier mapping rather than last minute selection on an emergency basis (Hammadi K, 2012; Schreter & Harmer, 2013; Svoboda & Pantuliano, 2015). Selection is bidirectional, as local partners also assess the international potential partners looking for reputed, flexible organizations that can adapt to the contexts changes due to escalations in war (Howe et al., 2015; Pavanello S, 2018; Svoboda & Pantuliano, 2015). The selection of local partners can be biased (Howe et al., 2015; Svoboda & Pantuliano, 2015) and skewed towards the Diaspora, because of networking and language skills as discussed before. However, Svaboda argues Diaspora and local staff lack operational skills and are in reality less accepted by the community and face local resentment (Svoboda & Pantuliano, 2015). Overall, there seems to be a common consensus on planning and selection of partners with a focus on localization and that alliance is formalized. (Svoboda & Pantuliano, 2015, p. Page 21).

Capacity building and sustainability

Professional development of the key staff should be a priority (Norman, 2012; A. Stoddard & Harmer, 2006) and can lead to better ownership of the project and trust in the organization (Teela et al., 2009). Evidence showed that capacity building has been top down, driven by

priorities of INGOs and does not respond to local organization needs (Howe et al., 2015; A. Stoddard & Harmer, 2006). Also, high staff turnover within INGOs and LINGOs threaten the retention of capacity and knowledge (Pavanello S, 2018). International organizations have organizational capacity, while partners have more operational or implementing capacity (Howe et al., 2015). There is a common consensus among all the researchers that it is important to invest in the organizational capacity of the partners including; strategic planning, developing management skills, proposal writing, monitoring and evaluation (Howe et al., 2015; A. Stoddard & Harmer, 2006; Svoboda & Pantuliano, 2015). It is also important to build security and negotiation skills and to use humanitarian principles (Egeland et al., 2011; Schreter & Harmer, 2013; Abby Stoddard et al., 2010; A. Stoddard & Harmer, 2006), while keeping in mind the requirement for cultural and linguistic adaptation (A. Stoddard & Harmer, 2006; Svoboda & Pantuliano, 2015). Hammadi also emphasises the need for MSF to include training on management [not common in MSF] in collaboration with partners (Hammadi K, 2012). Local organizations preferred less time consuming training as per their needs (Howe et al., 2015). Besides organizational training, it is important to build the technical capacity for task shifting in order to ensure the sustainability of specialized programs where there are less specialized human resources (Chu, Ford, & Trelles, 2011; Hawkes et al., 2009; Mullany et al., 2010; Shanks et al., 2012). Some capacity building methods that were successfully used were: workshops, secondment models (Howe et al., 2015) through focal points (Hammadi K, 2012; Howe et al., 2015) and pilot projects and joint collaboration and coordinated across border trainings (Mullany et al., 2010) and using technology and distance learning. (Donaldson et al., 2011; Zachariah et al., 2012).

Building relations through communication and trust:

Trust is essential to building relations with local partners (Howe et al., 2015; Pavanello S, 2018; A. Stoddard & Harmer, 2006). Personal ties and a trusting environment are critical in remote programs (Pavanello S, 2018). Communication is key in the building of trust, which in turn facilitates open communication, collaboration and joint problem solving (Pavanello S, 2018). The lack of trust is an overarching issue at all levels. Absence of effective feedback mechanisms decreased the motivation of local staff and their inclusion in reporting systems (Turashvili, 2012). At the organizational level, information between NGOs regarding needs assessments and approaches to negotiations were seldom shared because of mistrust (Donini & Maxwell, 2013; Howe et al., 2015; Abby Stoddard et al., 2010; A. Stoddard & Harmer, 2006). Current improvements rely more on personal attitudes rather than policy and systems (Turashvili, 2012). Evidence showed that many factors built or eroded trust,

as shown in Table 2.5. Conducting frequent face to face meetings, either in person or via technology, has improved trust building and advances in technology have made it possible to stay connected (Donini & Maxwell, 2013). Using a ‘bottom up’ approach, where the feedback and suggestions of the local staff are valued, rather than a top down approach, fostered meaningful relation and trust building (Garcia, 2015). Consistent engagement through a ‘dedicated focal point’ has been helpful in building trust with the local teams (Garcia, 2015; Howe et al., 2015; Pavanello S, 2018; A. Stoddard & Harmer, 2006). Evidence also showed that the interpersonal and communication skills of the international staff and their knowledge and understanding of the context have sustained effective partnerships in remote program (Pavanello S, 2018).

Table 2.5 Factors affecting trust at organizational and personal level in remote programming

	Trust building	Trust eroding
Organizational level	-well established organization -stable staff turnover -key staff well known to local staff -bottom-up approach	-remotely located -lack of transparency -top-down approach
Interpersonal level	-face to face meetings -dedicated focal person -joint problem solving -language and interpersonal skills of international staff -value opinion of local staff	- Inexperienced and young staff - lack of cultural sensitivity - lack of timely feedback

Adapted from (Garcia, 2015; Howe et al., 2015; Pavanello S, 2018; A. Stoddard & Harmer, 2006)

Trust building with community is equally important for acceptance, especially with new interventions that take time to establish. Community trust builds from communication, engagement and awareness generation (Tong et al., 2011), developing relations and the demonstration of evidence of competence (Teela et al., 2009).

2.3.5 Networking, coordination, and collaboration

Effective coordination and collaboration between organizations can ensure efficient use of resources and information sharing. In the literature coordination is largely provided around the cluster systems, with coordination platforms between the UN agencies and INGOs mostly inside Syria. UN Office for Coordination of Humanitarian Affairs (OCHA) coordinates humanitarian operations inside Syria and UN High Commission for Refugees (UNHCR) coordinates regional refugee response including Internally displaced populations (IDP) (Slim, 2014). The UN Cluster system was created in 2005 for better coordination of NGOs (OCHA, 2020a) with the aim to strengthen system-wide preparedness and technical capacity to respond to humanitarian emergencies,(OCHA, 2020a) The Inter-Agency

Standing Committee (IASC) under the leadership of Emergency Relief coordinator is the inter-agency forum for coordination, policy development and decision-making body for UN and UN partner organizations. In Syria there are 8 clusters that are mostly centred around water, health and logistics. IASC designates the organizations into the clusters and OCHA facilitates inter-agency coordination in implementation, need assessments and planning, and resolves inter-agency issues (OCHA, 2020b). Security and protection are largely UN and ICRC mandate (Slim, 2014). However, the cluster approach was not perceived so efficient as UN was not transparent about security related issues' and since UN was viewed as political, INGOs were also concerned about how they were perceived by the authorities (Abby Stoddard et al., 2010; A. Stoddard & Harmer, 2006). NGOs also refrained from sharing security information due to lack of trust and sensitivity of information (A. Stoddard & Harmer, 2006).

When cross border operations were started by INGOs across the Turkey border in 2012, an NGO forum was established in Turkey that was similar to the UN cluster system, and mainly focussed around protection. This was further streamlined into a more formal humanitarian coordination monthly meeting. UN organizations without GoS permission were unable to support cross border coordination or sharing information before 2014 (Svoboda & Pantuliano, 2015); but later established hubs in Turkey following the UN resolution 2615 in 2014 that formalized cross border activities (UNSC, 2014).

Local coordination mechanisms were found to be better in the Middle East. Local coordination platforms, such as the National Coordination Committee of Iraq (NCCI), formed a network of 24-field NGOs as focal points that collected and disseminated mainly security related information from all the eighteen provinces of Iraq (Abby Stoddard et al., 2010). In Syria a similar platform called Syrian NGO alliance (SNA) was created in 2013 and situated in Turkey, which has better organized, formalized, more visible LNGOs representation. This platform has been useful in sharing information and streamlining local Syrian NGOs. (Svoboda & Pantuliano, 2015). It has also helped organizations to stay informed and updated about the activities being delivered by other organizations in the region and to use LNGOs as a source of information on emerging funding opportunities (Ataullahjan et al., 2020). So these coordination structures, rooted in the context, were not only useful in information gathering but also had the potential to ensure sustainable local capacity (Abby Stoddard et al., 2010).

Evidence showed the importance of coordination and collaboration between stakeholders when operating remotely. A lack of coordination among international donors was found to affect remote program implementation, especially when more organizations were involved with a specific reporting and monitoring requirement (Abby Stoddard et al., 2010). It is therefore important that the stakeholders improve their coordination mechanisms with more structured guidelines and especially to promote a 'centralized response to emergencies' (Ataullahjan et al., 2020). Coordination at field level is also important when operating remotely, as local level coordination is complex and driven by personal relations. However, to be effective there needs to be a bottom-up mechanism of coordination (Duclos et al., 2019; Garcia, 2015). Singh also emphasized that local collaboration with actors is vital for service delivery (Ataullahjan et al., 2020; Singh et al., 2021), especially in remote service delivery in Syria where "coordination among a variety of actors also led to improved data collection as well as unconventional data collection (e.g., eHealth, telephones, and informants)" (Singh et al., 2021).

Networking, coordination and collaboration with authorities are all important, especially in remote interventions. Participation, coordination and collaboration of the MoH with international and local actors were responsible for successful public health interventions with improved quality of care for displaced population in camps in Iraq (Khan et al., 2021). Another study highlighted that for long distance collaboration with partners it is very important to have common vision and mutual ownership with authorities. The leadership and steering role of national partners contributed to success in the TB control program in Afghanistan (Seddiq, Enarson, Shah, Haq, & Khan, 2014) and malaria control across the Myanmar border (Zhang et al., 2016).

Overall lessons learnt include that coordination structures should be rooted in the cultural context for acceptability and success and that coordination mechanisms need to be based on field realities with a bottom-up approach. Coordination and collaboration with stakeholders need to be harmonized for efficient use of resources and improved remote service delivery.

2.3.6 Monitoring and Technology in remote

Monitoring is an integral part of the program, and it ensures accountability. In the literature upward monitoring towards the donors is given more attention compared to downward monitoring towards the beneficiaries (Choudhary et al., 2017; Howe et al., 2015; Abby

Stoddard et al., 2010; A. Stoddard & Harmer, 2006). A monitoring culture is absent in some contexts and this can present as a significant challenge (Abby Stoddard et al., 2010). Remote monitoring introduces additional challenges both logistically and operationally in conflict settings (Howe et al., 2015).

Monitoring is often ineffective (Turashvili, 2012) because there is a lack of well-defined monitoring indicators and the monitoring tools are mostly not adapted to the context (Martin Braaksma, 2009; Turashvili, 2012). This is compounded by the language barrier and the limited capacity of local staff, resulting in poor reporting (Martin Braaksma, 2009). Pavanello raised concerns around the ethical and legal questions of capturing information through remote means, which could put staff and beneficiaries at risk. Concerns were also raised around the heavy burden of reporting and the need to simplify reporting (Pavanello S, 2018), while Byron emphasized the need to develop a robust monitoring frame and for investing in the capacity building of the local staff (Norman, 2012).

Besides the regular data collection and reporting, internal project activities are also monitored through other methods such as photo video distribution, web based monitoring, sms mobile (Donini & Maxwell, 2013; Egeland et al., 2011; Howe et al., 2015; Abby Stoddard et al., 2010), daily verbal reports, debriefing sessions and even peer observations (Howe et al., 2015) As Donnini states “ the future of humanitarian action as a compassionate endeavour is likely to hinge between the promise of technology and the reality of the people on ground” (Donini & Maxwell, 2013, p. 421)

Third party monitoring (TPM) is used by the INGOs to monitor and evaluate their projects in remote locations (Donini & Maxwell, 2013; Howe et al., 2015; Pavanello S, 2018; Rivas, 2015; Schreter & Harmer, 2013; Abby Stoddard et al., 2010). Some INGOs have even made third party monitoring a reporting requirement in Syria (Duclos et al., 2019). There are advantages of TPM in being independent which assists with a critical assessment of the quality of implementation, since the contractors are not linked to the project. However, Howe points to some of the drawbacks, in terms of the need for skilled personnel and tools, resource intensity, the high cost and the lack of neutrality that can follow, if the same firm is used many times and finally not involving the project staff (Howe et al., 2015; Markets, 2018a). In some cases, it was reported that private firms disrupted relations between donor, NGO and the beneficiaries (Duclos et al., 2019). Rivas also felt that TPM is underutilised as it is seen as micromanagement by the field with the fear of losing funds if requirements and quality are not met (Rivas, 2015). TPM has been used with triangulation of information

and feedback from community members such as key informants, community leaders and members of the social committee (Donini & Maxwell, 2013; Pavanello S, 2018; Schreter & Harmer, 2013).

Technology in remote programming:

Technological development has enabled remote programming by rendering it unnecessary for humanitarian agencies and staff to work in dangerous locations (Kalkman, 2018; Price, 2017). Technology has significantly aided remote health program monitoring (Corlazzoli, 2014; Duclos et al., 2019; Kalkman, 2018; Price, 2017), as mentioned in the internal monitoring section, in providing technical medical support through Telemedicine and has also enabled interventions such as cluster surveys and program assessments conducted remotely with the use of technical devices. However, technology only works as long as there is access. Restrictions around internet use and surveillance by authorities hampers technologies and information dissemination; Inequities in access to technological resources by local organizations in low-income countries and lack of involvement of locals in evaluation and development of technologies result in low uptake.(Mesmar et al., 2016).

Technology is primarily used in the humanitarian field for security purposes. Security related information sharing, data collection and crowd sourcing, quick dissemination of information and geo-tracking (Kalkman, 2018; Price, 2017), Global positioning system (GPS) locations; and digital tracking have all has been used to track cross border movements of supplies in Syria (Duclos et al., 2019).

Key technologies in use for the humanitarian field include mobile devices, handheld devices and media. Social media, such as WhatsApp, has been extensively used in Syria, has promoted effective communication between INGOs and local partners (Markets, 2018b) and has also allowed beneficiaries to provide feedback and maintain contact (Markets, 2018b; Price, 2017).

Telemedicine has been extensively and successfully used in conflict settings for conducting trainings (Donaldson et al., 2011; Hamza & Hicks, 2021), providing ongoing technical support and consultation on patient management (Almoshmosh, Jefee-Bahloul, Abdallah, & Andres, 2020; Maalim et al., 2014; Zachariah et al., 2012). In one of the recent telemedicine programs used in the military, teleconsultations had significantly reduced the referred cases from Syria and Iraq by 50 percent and saved the cost of preparation and execution of referral (Nguyen, Mbuthia, & Dobson, 2020).

Technological advancements have also enabled quick need assessments, and data collection (Kalkman, 2018; Price, 2017).

There is common consensus among researchers on the usefulness and potential of basic and more advanced technologies, as they have improved security management, communication and networking, remote monitoring and real time monitoring. This has allowed rapid data collection, rapid analysis of emerging patterns and technical support in patient management in conflict settings, as discussed above. Local actors relaying on mobile apps, such as Wapp to record information and networking in Syria presents further opportunities. Overall, there is a huge potential for technology in humanitarian remote programming in inaccessible contexts, in spite of the downside of high costs, unreliable networks, possible misuse and security issues (Donini & Maxwell, 2013; Price, 2017).

2.3.7. Humanitarian access and principles in insecure environment:

Adhering to humanitarian principles is key to negotiations for access and security (Egeland et al., 2011; Abby Stoddard et al., 2010) along with low profile strategies such as de-branding (avoid using organizational logos, flags on vehicles and buildings, using commercial transports) (Duclos et al., 2019; Egeland et al., 2011; A. Stoddard & Harmer, 2006). This assists in being less visible and doing measured advocacy for staff protection and is also useful to ensuring continuity of the programs. Active advocacy has not been a priority even for organizations like MSF, known for their visibility, and for speaking out on behalf of the population, especially in Syria (Garcia, 2015).

Humanitarian principles of neutrality, impartiality and independence have often been compromised due to high political pressure and insecurity (Turashvili, 2012), and do not offer protection in some settings such as Afghanistan, Iraq, Darfur and Somalia (Donini & Maxwell, 2013; A. Stoddard, 2009; A. Stoddard & Harmer, 2006), where international organizations are frequently perceived as political adversaries. For example, UN agencies have dual political and humanitarian roles (Donini & Maxwell, 2013) or they are assumed to be part of western agenda (Donini & Maxwell, 2013; Egeland et al., 2011; A. Stoddard, 2009).

There is a general consensus that neutrality and impartiality are compromised in conflict setting where access is limited to one side of the conflict region. Local staff are perceived to be partial just by virtue of their religious, ethnic, or political background and affiliation (Donini & Maxwell, 2013; Norman, 2012; Abby Stoddard et al., 2010). However, cross checking admissions in an MSF hospital in Somalia did not find any decreases in the number of

patients from minority clans that were not represented well among MSF local staff (Operational Center Amsterdam, 2012). A survey in Afghanistan showed 94 percent of local staff responded positively on the usefulness of the humanitarian principles in insecure settings (Egeland et al., 2011).

There is lot of emphasis in the literature on the importance of ensuring that staff understand and are trained in humanitarian principles (Egeland et al., 2011; Norman, 2012) and that staff recruitment is clan based (Belliveau, 2013) to ensure impartiality. Local NGOs in Syria, while striving for impartiality, affirmed that their actions are based more on showing solidarity rather than neutrality (Svoboda & Pantuliano, 2015). In extreme contexts the humanitarian imperative principle of ensuring assistance reach to those who are in need is followed. (A. Stoddard & Harmer, 2006).

Overall, in spite of security and access challenges, INGOs have been able to gain access in most difficult contexts through keeping a low profile, using measured advocacy, sticking to humanitarian principles and maintaining a neutral stance (Lee, 2008). For example, MSF and ICRC are perceived as neutral and able to gain access in Afghanistan (Donini & Maxwell, 2013; A. Stoddard, 2009; Abby Stoddard et al., 2010)

2.3.8. Program planning and management

Evidence has shown that significant planning needs to be done before deciding on a remote mode of service delivery. Planning is needed on the scale and scope of the program, Protocols/tools, staffing, monitoring, security and an exit criteria.

Scale and scope

In addition to the level and duration of insecurity, Stoddard emphasised the need to consider aspects such as type, scale, sector focus; availability of choice of partners; skills and operability of the local staff within program design (Abby Stoddard et al., 2010; A. Stoddard & Harmer, 2006). Smaller, simpler projects, such as food distribution, are easier to handover to the partners than the complex technical medical programs that need skilled staff (Rivas A, 2015). MSF in DRC suspended their Sleeping Sickness project, as it could not be handed over to the partners, due to a lack of trained staff and complexity of diagnosis (Tong et al., 2011). However, Shanks argued that small scale complex intervention is possible through remote management (Shanks et al., 2012).

There is also a need to prepare and put in place checklists, documents and procedures for quick remote implementation (Abby Stoddard et al., 2010). An exit strategy needs be part of the design (Abby Stoddard et al., 2010; A. Stoddard & Harmer, 2006) with a clear organization position around when to suspend or resume (Egeland et al., 2011). For the ease of implementation, Stoddard suggests that it's good to have a medium to long term view with a two-pronged approach in policy guidance. A narrow field project implementation should be based within a broader approach with organizational value and mission (Abby Stoddard et al., 2010).

Protocols and Tools

Evidence has shown that tools need to be locally adapted translated adding local interpretations for acceptance (Hamza & Hicks, 2021; Lee, 2008; Robitaille, 2014; Turashvili, 2012) In literature well adapted and clear Literature highlighted needs for context specific monitoring, and assessment tools as well as specific tools for emergency (Robitaille, 2014; Turashvili, 2012). Evidence has also shown that adapted, simplified, and clear protocols and tools for treatment, monitoring and referral services have contributed to the success of the remote health programs (Chu et al., 2011; Shanks et al., 2012; Zachariah et al., 2012)

Staffing in remote

The literature has shown that it there are lot of issues related to staffing that need to be addressed in remote health programs in conflict settings. There are staff shortages and high turnover of the staff at the field level (Singh et al., 2021; Zhang et al., 2016) resulting from displacement, as well as pressure from the armed group, pressure from the community (Singh et al., 2021), the unpredictable context and security threats such as kidnapping and the external brain drain.

This results in service disruption and the need to continuously train new staff (Aburas et al., 2018; Ataullahjan et al., 2020). Many effective strategies were implemented to overcome staff shortages, such as localization of the staff through the recruitment of local staff and Diaspora staff, given that local staff are better accepted by the local communities. Consultative recruitment in consultation with stakeholders and community has also been shown to allow better acceptance and protection of the staff and improvements in interventions. Staff have to be culturally adapted, with clan representation, in Syria, to avoid any clan issues in the team. One study highlighted the need to strengthen staff numbers in conflict settings as reduced mobility translates into a need for more staff. Task shifting is

another strategy employed to overcome staff shortages (Akik et al., 2020; Chu et al., 2011; Hawkes et al., 2009; Liddle et al., 2013; Lutwama, Kok, & Jacobs, 2021; Mullany et al., 2010; Singh et al., 2021; Teela et al., 2009).

Security

In all modalities remote operations entail a considerable security risk transfer to the local staff and the partners, with the transfer of responsibilities from the international staff/organizations (Belliveau, 2013; A. Stoddard, 2009; Abby Stoddard et al., 2010). The literature shows that risk assessment for local staff is inadequate, with a lack of security training and resources. (Egeland et al., 2011; Martin Braaksma, 2009; Abby Stoddard et al., 2010). There are inequities in support for local staff such as lower levels of physical security measures for residences and vehicles and off-hours connectivity compared to IS (A. Stoddard & Harmer, 2006), with risk mitigation skewed more to international staff (Turashvili, 2012) (Egeland et al., 2011). Egeland and Stoddard emphasize that risk management must be included in programme planning, design and budget, with duty of care for local staff including thorough risk assessment, capacity building and mentoring of staff, conducting joint assessment with partners and mutually determining the structure and resources needed. (Chaudhri et al., 2019; Egeland et al., 2011; Abby Stoddard et al., 2010).

In order to avoid risk transfer, security risk management needs be recognised as an integral part of programming (Egeland et al., 2011), prioritising security for both local and international staff. A contingency plan (Howe et al., 2015) and a budget for contingencies (security, logistics, communication) need to be in place prior to remote implementation, along with training of staff regarding security (Egeland et al., 2011; Abby Stoddard et al., 2010). Lastly there is a need to invest in relationship building with local staff and partners prior to shifting to remote programming and therefore to include a focus on recruiting international staff with experience in RM, communication and language skills; with long term contracts (Abby Stoddard et al., 2010).

2.4 Conclusion

Long-term remote health programming has emerged as a legitimate and valid approach to providing care, given the changing contexts and increasing conflicts, especially in the Middle East region, that hinder the normal modalities of service delivery. In this review two main concepts have emerged. One is the paradigm shift in approach from risk avoidance to risk

mitigation (Egeland et al., 2011). Thus, amid much debate about shrinking humanitarian space there is an increased presence of aid agencies because of the improved security planning and management. Strategies have been formed around gaining access (which came out as the major barrier), community acceptance [through community involvement, consultation and decentralised outreach services through locals,] and practicing the humanitarian imperative, while striving for independence, impartiality, and neutrality

The second concept was around 'localization' (Duclos et al., 2019; Markets, 2018a; Pavanello S, 2018). Well organized and coordinated, local actors (LNGOs, Diaspora) (Svoboda & Pantuliano, 2015) are enabling local partnerships and collaboration to gain access to the vulnerable population (Howe et al., 2015; Markets, 2018a; A. Stoddard & Harmer, 2006). Svaboda stresses that a "formal system cannot respond to the needs in Syria alone and must seek partnership and explore creative ways of responding by involving a new player" However, this review has highlighted that a thorough selection process, capacity building, communication and trust building, along with joint assessments to mitigate against risk transfer, are important for sustainable and ethical partnerships with local actors (Egeland et al., 2011; Howe et al., 2015). Coordination and harmonization of international organizations are deemed necessary in order to streamline procedures to reduce the burden on locals and optimise resources. This review also highlighted the need for program planning in advance including exit strategy, adapted tools and optimal staffing, along with investment in robust monitoring system and technology for communication and technical support.

There is a common consensus among the researchers that remote health programming is an upcoming field and that there is a lack of rigorous research to provide evidence of good practice and lessons learnt (Egeland et al., 2011; Rivas A, 2015; Abby Stoddard et al., 2010) on guidelines, tools, critical needs and challenges of local partners (Choudhary et al., 2017; Howe et al., 2015). A lack of policy and operational guidance is evident as well (Abby Stoddard et al., 2010; A. Stoddard & Harmer, 2006). Researchers highlighted the need to know more about the effectiveness of different sectors, (Chaudhri et al., 2019; Donini & Maxwell, 2013) the impact on humanitarian access and how humanitarian principles are implemented in practice, as well as the role and methods of collaboration with local actors and their perspectives (Hammadi K, 2012; Kalkman, 2018; Schreter & Harmer, 2013).

There are not many studies about remote programming published in the literature or peer reviewed by the humanitarian agencies. Most of the studies in the past were conducted in

African and Asian region. Although studies from Syria and Middle East region have picked up lately, the volume is not sufficient to inform practice or policy change. Syria is a unique setting because of the multiple adversarial conflicts it has both internally and externally, making it a particularly important region to investigate. MSF has emerged as one of the important players in remote health programming with decades of remote experience in contexts like Africa and Asia. Middle East experience is new and challenging and MSF needs to adapt (Garcia, 2015; Robitaille, 2014).

While a third of the studies are case studies and most have a program focus the context is not analysed in depth and lacks methodological details. Case studies are valued for representing local expertise and knowledge (Korjonen & Hughes, 2016). Case reports provide insights into the human condition along with context (Stake, 2005), which was not reflected in these studies.

Keeping all the facts in view and given the clear gaps of knowledge in the literature, this study will contribute to the body of literature to understand the challenges and strategies used to work with local actors in a rapidly evolving context of war in South Syria and how the humanitarian mandate is applied to preserve or change the institutional culture and principles for a Dunantist organization like MSF.

CHAPTER 3: METHODS

3.1 Introduction

This chapter explains the methodological approaches and the methods used to answer the research question: ‘How can remote programming and monitoring for hospitals be optimised to equitably address the medical humanitarian aid needs of war-torn regions?’ A qualitative case study design was used to study the implementation and evolution of MSF-OCBA operations in Syria, and the barriers to and facilitators of the remote health programming. This study explores the experiences of the selected MSF-OCBA staff and partners (described as participants) with the implementation of the remote health program model in Syria, among other sources.

3.2 Methodology

Methodology is the framework within which a research study is conducted, and guides the researcher on the use of methods for data collection and analysis, to produce ‘valid knowledge’ (Braun, 2013). A Qualitative Case Study was used for this study as it takes into account a ‘contemporary phenomenon within a real life context’...‘especially when the boundaries between the phenomenon and context are not obvious’ (Robert K. Yin, 1994, p. 13). A case study design was considered appropriate for this study as it allowed in-depth exploration of remote health programming in the current Syrian context, given the complex and unpredictable nature of the constantly evolving civil war.

Creswell presents the case study as one of the five main approaches for qualitative inquiry (Creswell, 2018), and defines it as “qualitative approach in which the researcher explores a real life contemporary bounded system (a case) or multiple bounded systems (cases) over time, through detailed in-depth data collection involving multiple sources of information (interview, observation, documents and reports) (Creswell, 2018, p. 96). Driven by the research question in a pragmatic way (Punch, 2006) it draws on a constructivist perspective. This approach recognizes that there can be ‘multiple mental constructs of realities’ influenced by experiences and social interactions (Guba & Lincoln, 1994, p. 110) from a range of positions, in this instance those held by MSF staff members working remotely in the Syria context.

In-depth individual interviews and focus group discussions (FGD) were undertaken to qualitatively examine these perceptions and constructed realities with selected MSF staff in

Amman and key partner staff in Syria. The objective of gathering this detailed information was not only to help better understand the qualitative questions of the 'how and why' (Green, 2014) of remote health programming in Syria, but also to examine 'what aspects of the program worked effectively and which components did not and for whom under these peculiar circumstances' (Pawson, Tilley, & Tilley, 1997), in this case of war and conflict in Syria. The study was also guided by the realist concerns of the research question. The program documents were reviewed and used to help identify the discrete elements within the program (Newcomer, Hatry, & Wholey, 2015) that then had to be explored qualitatively, (through informed data collection questions), in order to understand how they operate and how people attach meanings to these elements.

3.2.1 Role of the researcher

It is usually the case that there is a close relationship between the observer and the observed reality (Liamputtong, 1999, p. 31) It is very much applicable in my case. Born and brought up in a Muslim dominated region (Kashmir) in constant conflict for more than 30yrs, and my past work experience and familiarity with the region as a staff member of MSF is likely to have influenced my understanding and analysis of the study setting, context and culture (Liamputtong, 1999, p. 41). I have reflected on my experience of working with MSF in relation to my role as the primary researcher involved in this study through a reflective diary. This enhanced the construction and development of my own interpretations to allow for exploration of new evolving concepts and meanings based on my personal experiences and background knowledge of MSF and the context (Creswell, 2018; Stake, 1995). Therefore my interpretations as a researcher recognize the 'multiple subjectivities' of self and my historically constructed self with experience of MSF, as the one currently experiencing change with emerging new perspectives, and as a reflexive observer of the whole research process (Grbich, 2004). Entries in the reflective diary and the notes have been used to supplement the primary data with interviews and FGD during analysis.

3.3 Study design

For this qualitative Case Study Design, the case under exploration was 'MSF-OCBA implementing remote support model supporting health facilities in Syria'. This puts the MSF-OCBA organization and the remote support model intervention in Syria as a bounded integrated system (Creswell, 2018; Stake, 1995; Robert K Yin, 2009). There is no clear consensus among researchers as to whether case study is a methodology (Creswell, 2018;

Merriam, 2016), a method for data collection (Baum, 2008; Crotty, 1998), a comprehensive research strategy (Denzin & Lincoln, 2005) with emphasis on a logical research design (Robert K. Yin, 2018) or just a choice of what is being studied (Stake, 1995). Given the history, nature and complexity of case study research, Stakes and Yin's research design refined by Creswell was adopted as a clear research strategy to address this study's research question and objectives (Robert K. Yin, 2018, p. 27). Figure 3.1 below shows the conceptual boundaries and appropriate procedural steps used to add research rigour (Rosenberg & Yates, 2007). Figure 3.1 illustrates the overall approach taken in this study. The rationale for the case study design and for defining the MSF implementation of the remote support model as a case has been explained above. Further steps of data collection and details of thematic analysis and presentation are explained in the following sections.

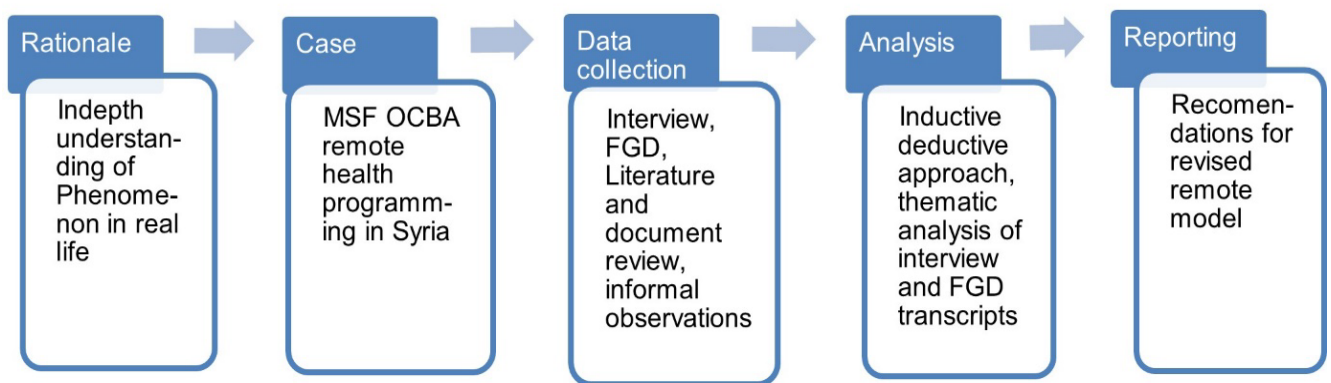


Figure 3.1 Case study design components

3.3.1 Research Agreement with MSF

Prior to commencement of the study a formal agreement was reached with MSF-OCBA, providing for participation in the study by MSF staff and partners, access to the MSF policy and program documents, project sites and databases, and the formation of a reference group to support implementation. A focal person and two interpreters were assigned by MSF-OCBA for the project.

3.3.2 The target population

Staff eligible for inclusion in this study were MSF-OCBA staff working for Syrian remote projects based in Amman Jordan, Gaziantep Turkey and inside Syria, as well as collaborating formal partners of MSF in these projects. The target population included programme managers, responsible for designing, planning, and strategizing the program implementation; technical managers responsible for supervision and monitoring of the activities; and technical staff responsible for frontline program implementation.

3.3.3 Study participants and Sampling

The MSF Human Resource Department provided the nominated focal person with a list of the staff eligible for recruitment (working on the remote projects), including details of staff position, level, location and contact details including work email address and mobile phone number for each worker. The focal person was given the recruitment goal of selecting a balanced range of the participants on the basis of position in the organisation (both level of seniority and nature of work [technical], gender, ethnicity and site or location. The focal person then went through the list according to this recruitment goal (see Table 3.1 below) to identify potential participants, thereby ensuring a range of information-rich participants, and avoiding researcher selection bias.

Table 3.1 Recruitment basis and source of the participants according to the profile and study location

Basis of recruitment	Programme Managers	Technical Managers	Technical staff
Position in the organization	Management positions involved in Middle East, as program directors, country directors, program coordinators	Technical managers/supervisors of departments MSF is involved in, (Middle East and Syria)	Technical staff of the departments MSF is involved in, (remote hospitals in Syria)
Level of hierarchy	Decentralized Headquarters, regional level and country level	Regional level, country level and project level	Project level
Work experience	Working with MSF-OCBA Remote project in Syria and experience of working with MSF and other remote projects	Working with MSF-OCBA Remote project in Syria and experience of working with MSF and other remote projects	Working with MSF-OCBA Remote project in Syria and experience of working with MSF and other remote projects
Sites/Institution supporting the remote health programs in the region	MSF OCBA decentralized headquarters Amman MSF OCBA Regional Middle East Unit (MEU) Amman MSF OCBA Mission Amman Jordan MSF OCBA Mission Gaziantep Turkey	MSF OCBA Regional MEU Amman MSF OCBA Mission Amman Jordan MSF OCBA Mission Gaziantep Turkey MSF OCBA South Syria project Amman MSF OCBA North Syria project Gaziantep	MSF OCBA South Syria project Amman (remote site) MSF OCBA North Syria project Gaziantep (remote site) Busra hospital, Dera South Syria, MSF OCBA Azaz and IDAL project North Syria

3.3.4 Recruitment of participants

The sampling strategy undertaken was purposive (Liamputong 2005), with the selection of the key participants aimed at gaining ‘information rich cases’ that ‘illuminate’ the issues (M. Q. Patton, 1990) around the implementation of remote programs in Syria. Variation and diversity in the sample was ensured by including participants from different levels and positions (see Table 3.2). Other factors like age, gender and cultural background of the participants were also added to ensure a range of perspectives on the remote health programming experience in the context of Syria. The participants were information rich cases as they were involved in all the aspects of the remote support model including planning, designing, implementation, monitoring and supervision.

A snowballing sampling technique (Braun, 2013) was also used to reach the potential participants in South Syria, where many of the staff were displaced due to conflict. During the interviews the researcher asked each participant if they knew someone else who might want to take part (M. Patton, 2002) in the study, provided they worked in the MSF remote support program and fit the recruitment criteria. The invitation to take part was either sent through each participant or through the focal person (Braun, 2013) who also followed up with scheduling of the interviews. Three additional participants were included through this technique. The strategy of ‘sampling to saturation’ (Green, 2014) was undertaken to the point where no new knowledge was added and ‘conceptual depth’ was established. Data saturation was achieved with 37 interviewees across the groups, as shown in Table 3.2.

Table 3.2 Sample size according to the research methods and profile of the participants included in the study

Participant profile	In-depth interviews	FGD	Total participants included
Program managers	Interview sessions=18 Interview participants=17	X	17
Technical manager/supervisor	Interview sessions= 14 Interview participants=12 (2 participants from FGD)	FGD sessions=1 FGD participants=5	15
Technical staff	Interview sessions=9 Interview participants=8 (2 participants from FGD)	FGD sessions=1 FGD participants=5	11
Total	41 interviews with 37 participants	2 FGD with 10 participants	43

A general staff meeting was organized in the Amman coordination office, where the researcher introduced herself, and informed all staff, about the purpose of the study and recruitment process, emphasizing the voluntary nature of participation. From the MSF list a

total of 70 potential participants were identified by the focal person, based on the recruitment goal (Table 3.1) and their availability. Non-technical staff (driver, cleaner, etc.) were not included. From the sample of 70 staff, 43 agreed to participate in in-depth interviews and FGD. The focal person then emailed the study information package including an information sheet, an introduction letter and a ethics approval and consent form to the selected list of potential participants in Amman and Syria projects, while also making all the materials available within MSF offices. The focal person also shared the researcher's email and phone so that the staff were able to contact directly if they had queries or to provide further clarification regarding the study. Due to limited time availability in Jordan (given the requirement for a resident visa for stays beyond two months), those participants that agreed to participate, were contacted directly by the researcher in Amman Jordan. In Syria the Arabic speaking focal person contacted participants by phone and an information package and consent form were formally resent by the researcher to willing participants. All the information documents were translated in Arabic and validated before distribution. Meeting date, time and venue was then fixed according to the participants' choice and schedule and followed up by the focal person. As almost all the participants expressed a preference for the MSF premises designated meeting room was booked for the interviews as per the schedule.

Only the remote support team of South Syria based in Amman was included in the focal group discussions. The researcher had a meeting with the Field Coordinator at the project site and briefed him about the study purpose and potential participants' requirements for the FGD and shared full information package. It was a difficult period for the project due to the escalation of war in Syria, and almost all the staff were busier than normal, however, willing participants contacted the researcher expressing their free will to participate in study. The researcher saw this as an opportunity to observe the real team dynamics and interaction during conflict. The focal person followed up with the time and venue for the two FGDs. One of the FGDs was organized in MSF office premises and another took place in one of the MSF guesthouses.

3.3.5. Data sources and collection methods

The use of multiple sources of data gathering is one of the important aspects of the case study method (Soy, 1997). To achieve the study objectives two sources of data were used: the primary source was the opinions and knowledge of staff and internal documents, and records were the secondary source. Data from different sources assisted in enabling an 'in-

depth understanding of the phenomenon' (Denzin & Lincoln, 2005) of the MSF remote approach in Syria.

Document review

Organizational documents are the 'key repositories and measures for the case' (Stake, 1995). MSF-OCBA's internal procedural and policy documents were reviewed, to get the understanding of MSF OCBA's position and engagement in relation to remote health programming in the region. The document review provided essential information, as well as fleshing out the context for the reflections of staff. The documents were also used to cross-check some factual information provided by the staff during interviews. Four evaluation reports of MSF_OCBA and other MSF sections on remote health programs were reviewed in detail with the findings included in Chapter 2.

Focus Group Discussions (FGDs): organized among the technical managers and staff, allowed the researcher to explore a range of operational and administrative issues arising in the implementation of remote support model in Syria, and also permitted observation of team dynamics and team interactions (Krueger, 1994) during this stressful period of the Syrian crisis. It enabled the researcher to gain a broad overview of the remote program in Syria while also assisting with the quick identification of flaws and problems (Stewart, 1990). The clear advantage of the FGD method was the synergistic and interactive effect of group discussion, which allowed shared meanings to emerge through a wide range of information, insights, and ideas, while the serendipitous nature of discussions brought to light new issues to explore further (Stewart, 1990). It also allowed participants to discuss issues freely as they identified as a group rather than solely as individuals while also proving to be a more culturally appropriate process (Winslow, Honein, & Elzubeir, 2002).

Individual in-depth interviews: organized among the participants allowed the researcher to explore particular perspectives (experiences, attitudes, and feelings) towards the challenges/barriers and lessons learnt, as well as investigating the decision-making processes involved when staff were faced with new challenges in providing remote support. Interviews also enabled the exploration of deeper meanings participants attached to the common issues raised during the FGDs. Utilising interviews as the 'main road to multiple realities' (Stake, 1995) allowed the discovery and presentation of multiple views on the remote support model in Syria.

The case and the context were studied using these methods to triangulate and 'increase credence in the interpretations' (Stake, 1995, p. 112), thereby overcoming the bias of a

single method and enabling 'methodological integration' and validity (Denzin & Lincoln, 2011) of the study.

3.3.6 Data Collection

The researcher spent two and half months onsite in Amman collecting primary qualitative data through FGD and in-depth semi structured interviews for all the participants based in Amman. Thereafter data collection continued online through Skype from Adelaide, where the researcher is based. For details about the individual interview participants see Appendix 15 and for details about interview guide see Appendix 16. The interview guide or protocol (Creswell, 2018) was specifically developed in relation to the research question, informed by current literature, the work-related experiences of the researcher and drawing from discussions with the researcher's supervisors. The FGDs facilitated further development and refinement of the interview guide, as did the iterative process of analysing the data as it was being collected from the interviews. The interview guide questions traversed the views and the experiences of the participants regarding implementation of the remote programme in Syria

Focus Group Discussion (July- August 2018)

In Amman, two FGDs were organized on the topic of Implementation of the remote health program in Syria. The first FGD was conducted with five MSF staff from different departments in one of the MSF guesthouses. The second FGD, with five Supervisors/technical managers (at the same level of seniority), was conducted in MSF office premises.

A 'permissive environment' (Krueger, 1994; Stewart, 1990) where participants could discuss issues freely was enhanced through forming them into relatively homogenous groups (differentiated by level: supervisors and staff) while the researcher, as FGD moderator, established a rapport and encouraged everyone to participate. Assertive techniques (Stewart, 1990) were used occasionally if the group discussion deviated from the research topic. FGDs highlighted multiple pertinent issues around the implementation of remote health programs, which were used as reference and contributed to data triangulation for in-depth interviews. The whole session was audio-recorded. Short memos were taken by the researcher. The FGDs sessions lasted 90-120min. Refreshments and beverages were provided during the FGDs.

When four participants expressed their willingness to share more details on some of the issues, they had more experience with, they were invited for in-depth interviews using a modified interview guide.

Individual Interviews: (August-June 2019)

Face to Face interviews

Almost 40% of the in-depth semi structured interviews were conducted face-to-face in a comfortable location onsite in Amman. Permission was sought for audio recording of the interviews and interpreters for the Arabic speaking participants were introduced before commencing the interview. Interviewees were made comfortable by first establishing rapport through an informal chat. While the researcher presented herself as an independent researcher, further reference to her background of previous work with MSF appeared to evoke a more trusting and comfortable rapport with the interviewees.

Open ended questions were asked regarding participants' views and experiences of implementing MSF strategies and practices through the remote support project in Syria and how the context influenced practices or the approach taken. A focus on the barriers, challenges and enabling factors in implementing different aspects of the program was included. Prompts were used and long periods of silences noted (Saks & Allsop, 2013). Leading questions were avoided and the 'socio-cultural context' was kept in mind when asking questions (Saks & Allsop, 2013). This was particularly important given the tense and a sensitive environment due to the conflict situation inside Syria. Short memos of important points and observations were taken during interview and the interviews concluded with a request for an opportunity to re-interview the participant if required for further clarification or elaboration (e.g., of new concepts that emerged from the interviews). The average duration of an interview was 60 minutes, with a range between 30-90 minutes.

Skype interviews

More than half of the interviews were conducted online from Australia through Skype. This is a valid means of data collection as it allows interaction between the researcher and the participant, and can make it easier to reflect while transcribing (Lo Iacono, Symonds, & Brown, 2016). As the different time zones provided the main challenge, most of the interviews were conducted from the researcher's home at night. Despite logistic and connectivity barriers, to the use of Skype instead of telephone interviews, the use of Skype made it possible to observe the participant's facial expressions, body language, response to prompts and surroundings. Additional benefits included the comfort and ease of interviewing in privacy. The duration of interviews ranged from 30 to 60 minutes.

Telephone interviews

Interviews for three displaced South Syrian participants were conducted by telephone. The displaced staff had no access to computers, so they were interviewed on the telephone through an interpreter. The interpreter followed the steps as briefed by the researcher and the sessions were audio recorded. Two of the consent forms and demographic forms were received prior to the interview through the 'WhatsApp' (application). The interviews proved very useful, even though they were brief (less than 30 minutes) due to operational disruptions in an active conflict zone.

3.4 Ethics

3.4.1 Approvals and Guidelines

The Social and Behavioral Research Ethics Committee (SBREC) of the Flinders University granted ethical approval for this research in June 2018 (Project No. 7953). MSF ethics approval was granted in July 2018 (Project no. 1843). Due to the escalation of war in Syria, data collection accessibility was denied at the original research site (South Syria). It was decided in agreement with MSF-OCBA to include additional sites (in North Syria) with a similar remote model. Modification approvals from SBREC were received on the 3rd of August 2018 and the 29th of August 2018 and MSF ethics modification was received on the 27th of October 2018.

The research was conducted according to the guidelines set by National Health and Medical Research Council of Australia (NHMRC, 2007 (updated 2015)). Ethical principles of informed consent and confidentiality and the process of weighing up the risks and benefits of the study were followed. The researcher as Principal Investigator has taken overall responsible for ethical compliance of the study.

3.4.2 Ethics Documents

There was a requirement for all relevant documents to be finalized and approved by SBREC prior to commencing the data collection. These documents included consent forms and a participant information sheet describing and outlining the purpose of the study and introducing the researcher. Once prepared, these documents were translated into Arabic and certified before approval. These documents were provided to the participants before commencing interviews.

3.4.3 Consent and voluntary participation

The process of informed consent was followed to ensure that participation in the study was entirely voluntary. Two consent forms were shared with the potential participants including one to be returned to the researcher. No incentives or inducements were provided to any respondents. Participants could opt out or refuse participation in the study at any time without penalty. Everyone who was approached for the study was completely free to participate or not.

3.4.4 Confidentiality and Anonymity

Due to the nature of Focus Group discussion and since most of the interviews onsite were conducted in MSF premises in Amman Jordan, it was not possible to ensure full anonymity. The researcher carried out the transcriptions herself, with some transcribed through a NVIVO transcriber tool, thereby ensuring confidentiality. Data was completely de-identified and stored according to the provisions of the Australian Code of Responsible Conduct of Research. De-identified data only was shared with the supervisors and some informants for validity testing subject to those who agreed during interview. However, Syrian participants were not able to verify their transcripts due to for security issues. At the field site the researcher had access to appropriate conditions, including the choice of the optimal location, to maintain confidentiality during the interview process.

3.4.5 Strategies to minimize potential conflict of interest:

The researcher's personal involvement with MSF was declared to all potential participants and the voluntary nature of participation and the ability for participants to choose to opt out at any point during the study were highlighted. Supervisors from Flinders University, who have no affiliation with MSF and thus no conflict of interest, helped minimize or prevent adverse impacts from any potential conflict of interest.

3.4.6 Risks and benefits of the study

No social, economic, or legal risks were foreseen, as the participants were already involved in the remote project. No other information besides that relating to the outlined interview guide and basic demography was collected from participants. However, the researcher was asking participants to relive their work experiences in a war-torn area, and the potential to raise emotionally disturbing memories was anticipated. To address this, participants were provided with contact details of a psychologist in the information form.

3.5 Data analysis:

Qualitative data analysis aims to develop a 'deeper understanding' of the gathered data and to provide some 'concepts' around it (Braun, 2013). Data analysis in this research started early in the data collection phase, when analysis was conducted in tandem with field work. New pertinent issues raised during the initial interviews were explored further in subsequent interviews. So the iterative process of analysing the data as it was being collected from the interviews not only helped in adapting the interview guide (Stewart, 1990) but also provided understanding of emerging key issues and concepts in remote health programming in Syria.

3.5.1 Data analysis strategy

Drawing from constructivist epistemology, the methods for this study took both an inductive and a deductive approach in analyzing the data. An inductive approach was taken to qualitatively analyze the primary data. In an inductive approach, themes and meanings are derived from primary data and not from a predetermined theoretical basis (Green, 2014). But it is widely acknowledged that researchers bring prior concepts and skill sets (Charmaz, 2014) as 'it is impossible to come to data completely fresh' (Green, 2014, p. 205). I used a reflexive diary, discussions with supervisors and learnings from the literature to be aware of and reflexive about my own inductively derived interpretations. Having worked with MSF for many years as a program manager, I was well aware of my 'insider' role and guarded against imposing my own views on one hand through reflexivity (Cooper & Rogers, 2015), but recognising in making sense of the participants account I need to draw on these informed understandings

3.5.2 Thematic analysis method

For this study an inductive thematic analysis method (Braun, 2013; Braun & Clarke, 2006), was used for analysis of the primary data.

'Thematic analysis is a method of identifying themes and patterns of meaning across a dataset in relation to the research question' (Braun, 2013) that 'aims to generate [meanings] from the primary data but also takes into consideration the researcher's stand point, disciplinary knowledge and underlying epistemology'(Braun, 2013). In the context of this study, 'meanings relevant' to remote programming issues in Syria emerged from the data (Creswell, 2018).

Computer assisted qualitative data analysis software (CAQDA), Nvivo 12 for Windows, 'an online filing system' was created to store the large amount of data (Braun, 2013) and

organize and analyse the study materials including the transcripts, field notes and related documents and literature. NVivo software, though a reliable search tool (Creswell, 2018), was supplemented with manual analysis on a sample of the transcripts.

Thematic analysis was carried out in a stepwise manner: by familiarizing, coding, identifying patterns across themes and finally analyzing and interpreting patterns across the data (Braun & Clarke, 2006).

3.5.3 Transcriptions and Familiarizing with the data:

The stage of 'familiarizing with data' (Braun & Clarke, 2006; Gale, Heath, Cameron, Rashid, & Redwood, 2013) started with transcriptions of the primary data from interviews and FGDs.

First, all the audio recordings of the in-depth interviews and the FGDs were transcribed 'verbatim' (spoken words and sounds) to capture the essence of the interviews. Initial interviews were transcribed in the field as soon as possible and the rest were completed afterwards. All the transcriptions were done in English by the researcher, except for the last few interviews that were initially transcribed on Nvivo 12 with checking and correction done manually. For the Arabic-speaking participant interviews the researcher used the interpreted English audio for transcription. Transcriptions were very time consuming, taking on average six hours per hour of audio recording. During the transcription notes were taken on material and ideas for coding (Braun & Clarke, 2006) or for interpretation later during analysis. The first three transcripts were reviewed by supervisors and improvements were made based on their suggestions. To ensure methodological triangulation with the researcher's observations and interpretations and to enhance authentication, 'member checking' (Stake, 1995) or participant validation was sought. Six transcripts with initial key findings and codes were shared with the relevant participants to confirm that the findings accurately reflected their perspective and experiences. All these steps were used to help build theory and add rigour to the analysis. For the transcription itself a '*transcription notation system*' (Braun 2013) was followed throughout the primary data analysis.

Through undertaking the transcriptions, herself, the researcher became quite familiar with the data. The transcribed data was then read and reread in an 'active way' (Braun, 2013) broadly searching for patterns and meanings and with the researcher completely 'immersing in the data' (Liamputtong, 1999).

3.5.4 Coding

Data was coded to represent a ‘concept or abstraction of potential interest’ (Robert K. Yin, 2018). ‘Complete coding’ of the whole dataset was done line by line “to identify anything and everything of interest or relevance to answering the research question” (Braun, 2013). Later, more focussed coding was done as shown in Table 3.3. Three transcripts were shared with the supervisors using the initial codes to ensure ‘investigators triangulate’ their different perspectives on the same data, before defining the final codes.

Table 3.3 Example of open and focused coding

	Transcribed interview data	Open codes	Focused codes
TM2	All this was managed remotely. It was through staff training from Jordan. They were being deployed in the field and were already living in those areas. We were using mobile data collection tools. Data was being uploaded to a password protected cloud server and we were receiving the results in real time. The findings were very valuable and helped us to gain a better understanding of the overall situation. We sought to understand the problems related to access to health care and the absence of or the need for extra service and If we were not covering this properly, was this being addressed by another actor. We also incorporated learning from the initial surveys. For example, through the follow up surveys we were able to identify a very, very clear and accurate mapping of immunization coverage for all children under five in that area, including the number of missing doses per age category. We were able to tell By that time the data was well dated and we were able to tell how many children in that area have been vaccinated and how many were missing doses on which antigen. We shared that information with other stakeholders like UNICEF and WHO and they promised to take appropriate action. We were identifying needs in women’s health and access to health care. We were even able to understand how valuable the facilities that we were supporting were. We found that a large percentage of the people who were hospitalised over the past 12 months, were actually hospitalized in the facilities that we were supporting namely Busra hospital. the type of data collected was helpful for assessing the quality of the projects we are doing, we lacked information of how to make improvements. That was one type and the other type was very facility oriented.	Surveys managed remotely Staff remotely trained from Jordan Staff selection criteria: local mobile tools Ethically sound tool (data protection) Real time data Survey results valuable – understand context Better insight and coverage with reliable and accurate data from HSP tools Identified valuable information (about child vaccination and women health needs) Collaboration with other actors through shared data. Understood value of health facilities they were supporting Identified many people hospitalised in facilities we supported - Busra Hospital High utilization of selected facility Data useful to assess quality of our projects (weaknesses and strengths of our projects) Facility based data collection project	Remote-training Staff recruitment Ethics Collaboration stakeholders Selection criteria for facilities Remote – facility data collection

3.5.5 Generating themes

Once the manual coding was complete the parent (Dominant) and child codes were formed in Nvivo 12, making it much easier to manipulate and visualize ‘individual based sorting’ for similar codes, to group under a cluster, category (Adu, 2019) or a theme as shown in Figure 3.2. The broader themes and subthemes were analyzed. The identified themes were further developed by constantly comparing themes with the data sets (within and between interview transcripts, and with the FGD transcripts) using the Constant Comparative Method of contrasting within and between transcripts (Thomas, 2011).

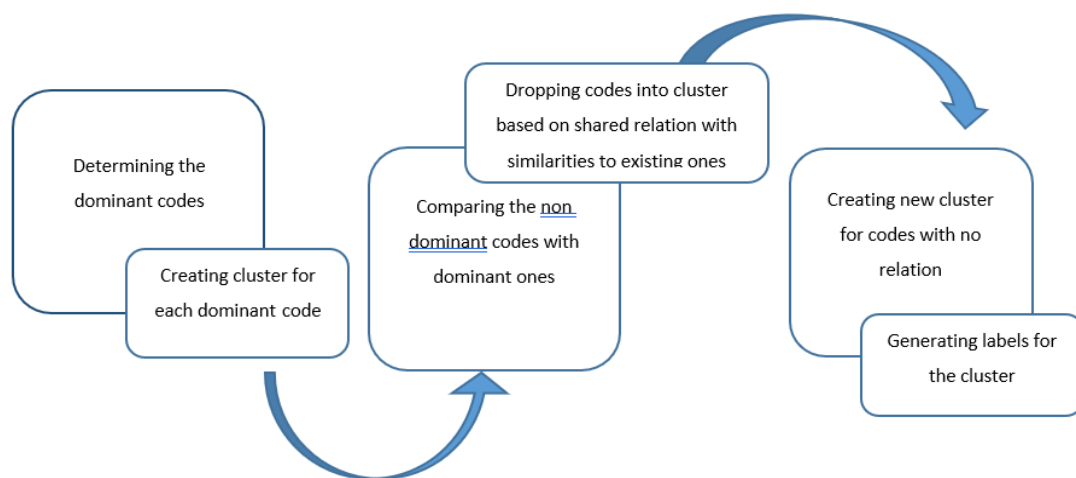


Figure 3.2 The process of clustering the codes using the individual based sorting

(Adu, 2019) Reproduced with permission

3.5.6 Reviewing themes

Once the themes and sub themes were clustered the analysis was further refined with similar themes consolidated and a map of final themes constructed. The construction of each theme was tested to see “if it can describe the scope and content of the theme” (Braun & Clarke, 2006) or needed further refinement. Finally, the themes were analyzed and named in an informative manner. As analysis is a recursive process, there was back and forth movement between different phases throughout the process. Finally, there were four overarching themes and 16 themes and 56 subthemes. An example of the theme of ‘barrier’ is as shown in Figure 3.3

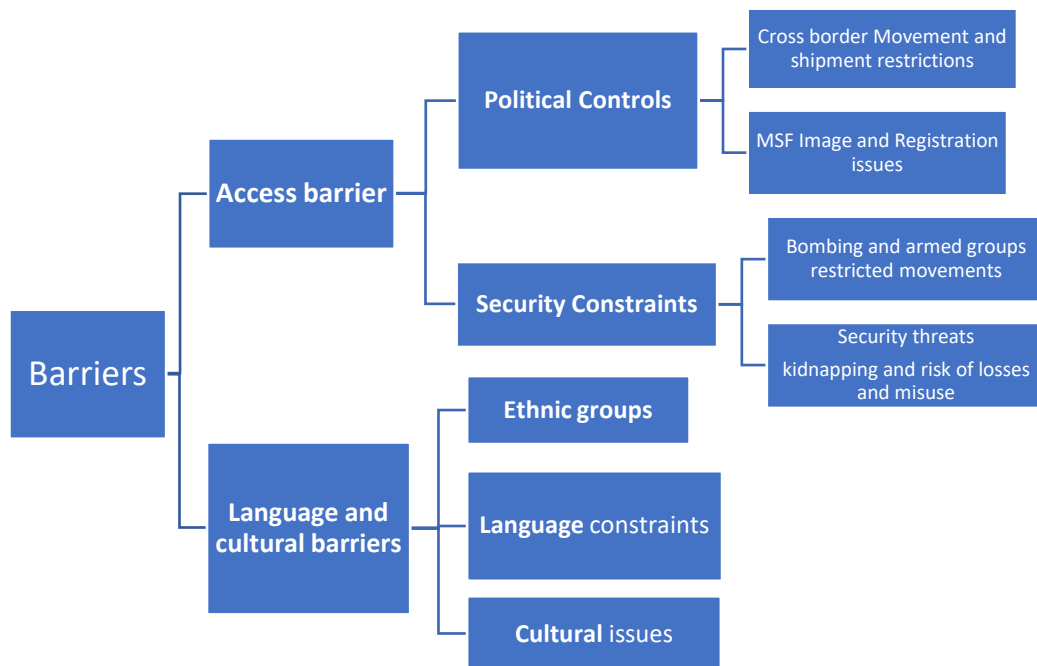


Figure 3.3 Map with final overarching theme, theme, subtheme, and categories

The last step was to define and describe the final themes and subthemes and to complete interpretation of the data and the description of relationship between the themes. Vivid and compelling data extracts were compiled for later use in illustrating the meaning of the theme.

CHAPTER 4: RESULTS

4.1 Introduction

This chapter presents the results of the study, addressing the question: “how can the limited approach of remote support for hospitals be optimized to equitably address the medical humanitarian needs in Syria”? The data on which this chapter is based are thirty-seven in-depth individual interviews, two focus group discussions (FGDs) and MSF documents. The main findings are presented in sections 4.4 to 4.6.

Section 4.2 provides a brief description of the demographic profile of the study participants, and

Section 4.3 addresses how the participants contextualized the remote operations in Syria and the nature of the barriers and the enablers that influenced operations. Section 4.4 describes the remote support model (RSM), as it evolved in North and South Syria. Section 4.5 presents the reported strategies and practices used to implement the remote support model in Syria. Section 4.6 presents a thematic analysis of the main challenges encountered and lessons learnt in remote implementation. The Annex shows selected demographic and other characteristics of each participant.

In each section a short summary of the main themes emerging from both the interviews and focus groups is presented, with a diagram showing themes and subthemes followed by more detailed exploration of each, with extensive quotes from participants. Participants are identified through codes (ID number, role designation, and gender) which are presented in the Annex to this chapter.

4.2 Characteristics of the study participants

In-depth individual interviews were conducted with thirty-seven participants regarding their experiences of working in remote programs in Syria. Key characteristics of the participant group for interviews are shown in Table 4.1

Table 4.1. Characteristics of the study participant group for in-depth interviews (n=37)

Demographic Characteristics		Service Characteristics	
Gender		Total Participants	
- Male	23 (62%)	- Program managers	17
- Female	14 (38%)	(46%)	
		- Technical managers/ Supervisor	12
		(32%)	
		- Staff	8
		(22%)	
Age distribution		Affiliation	
>25-35	15 (41%)	Middle East Unit/Cell	6
>35-45	11 (29%)	(16%)	
>45-55	10 (27%)	North Syria	14
>55	1 (3%)	(38%)	
		South Syria	17
		(46%)	
Marital status		Work experience with MSF	
- Married	22 (59%)	<1-3yrs	14
- Unmarried/NA	15 (41%)	(38%)	
		>3-5yrs	12
		(32%)	
		>5-10yrs	5
		(14%)	
		>10-20yrs	6
		(16%)	
Ethnicity		Prior experience in remote programs	
Arab	22 (59%)	Yes	13
European	10 (27%)	(35%)	
Asian	4 (10%)	No	24
African	2 (5%)	(65%)	
Education		Professional profile	
Masters or higher	20 (54%)	Doctor	14
Bachelors	11 (30%)	(38%)	
Diploma	5 (14%)	Nurse	10
Certificate course	1 (2%)	(27%)	
		Paramedical:	03
		(8%)	
		Non-medical:	10
		(27%)	

Among the participants there were more men than women. The age distribution was in the range of twenty-five to fifty-seven years, with almost a third of the participants above the age of thirty-five years. It was a well-educated cohort with more than half of the participants holding a master's degree or above and another half with a bachelor's degree or a diploma. One participant had a certificate course only, as his degree had been interrupted by war. Almost two thirds were doctors or nurses. The participant group had a balanced mix of local

staff (i.e. Syrian, or Jordanian) and international staff. Almost two thirds of the participants were Arabs, with ten of European origin, four of Asian origin and two African participants, including one of North African (Arabic) background.

Almost half of the participants were program managers, a third were technical managers and the rest were technical staff. Half of the participants were working remotely on the South Syria project based in Amman or in Daraa. A further one third were affiliated with the North Syria mission based in North Syria or Turkey, with the rest working from the regional unit (Technical) and regional headquarters (Operational) in Amman, Jordan.

Most of the local staff had experience of working with MSF for 1-3yrs. Only one third had previous remote work experience, and they were mainly program managers, with only two technical managers and one technical staff member in this group. The previous remote experience was largely based in Africa, though some had experience in the Middle East region as well. Refer to the Annex for details.

Two FGDs were held in Amman Jordan, one with the technical staff and another with the technical managers. The composition and the characteristics of the participant group in the two FGDs are provided in Table 4.2.

Table 4.2. Characteristics of the study participant group for FGDs

FGD	Venue	Participants	Characteristics
FGD 1 (n=5)	Amman	Technical Staff (Medical, supply-logistics department)	Demographic: Two of the participants were female. All were local Arabs with only one international staff member. Of these three were doctors, one was a nurse while the other was a non-medical person. Service: While one person had the experience of working with MSF for almost 5yrs, the experience of the other four ranged from 1-3 years. None of the staff had any previous experience of working on remote projects.
FGD 2 (n=5)	Amman	Technical supervisors (medical, pharmacy, supply-logistics department)	Demographic: All the participants were male: four local Arabs and one international. Three had master's degrees while the other two had bachelor's degrees. Service related: Three of the supervisors had 3-5 years' experience of working with MSF, while one had less than a year and another had more than 5-10yrs of experience. Only two supervisors had had the experience of working in a remote project (in Africa and Palestine).

4.3 The Syrian Context: Barriers, Enablers

There were many factors, analysed as barriers and enablers, which were specific to the regional context that had implications for the planning, design, and implementation of remote support programs inside Syria, as shown in Figure 4.1 Access barriers, arising from both restrictive government policies and security constraints in active conflict zones, posed the major constraint, according to many³ participants, in providing humanitarian assistance to the population inside Syria. Language and cultural barriers, arising from language and ethnic differences and gender disparity, were also important.

4.3.1. Barriers

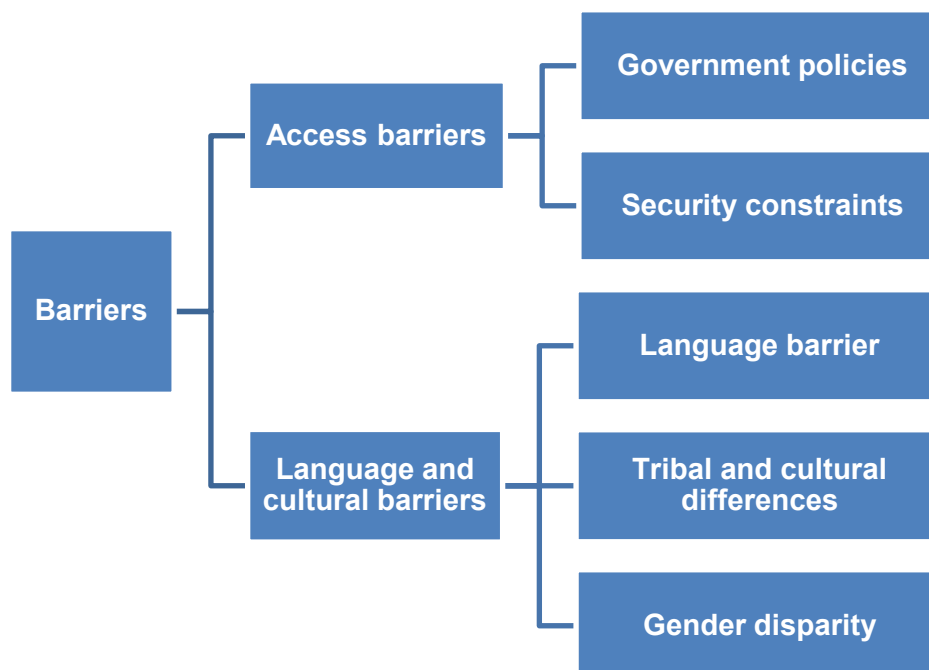


Figure 4.1 Contextual barriers to the implementation of remote support model in Syria

Access barrier: Government policies

Almost half of the participants reported restrictions imposed by Jordan and Turkey, on movements across the border, for both people and shipments. Restricting population

³ Many – 18-22/37 participants
Some - 11-14/37
Few <7/37
Almost all- 24-29/37

movement across the border was seen as “a measure to contain the economic burden created by the influx of the displaced population” (6PMM) into the neighbouring countries. Control on movement across the border, through strict visa regulation and lengthy permission procedures, caused administrative difficulties in organizing Syrian staff and stakeholders’ visits in the neighbouring countries, for face-to-face training and meetings.

It was very difficult for people crossing the border for meetings or training. We managed a couple of times, for a very limited time, because the permit from the Jordanian government was very, very measured (1PMM).

A few participants reported that movement of both referred and non-referred patients across borders was also affected. Patients were referred if sick or if the services were not available. However, strict protocols for referrals were applied, “resulting in delays and untoward outcomes even death sometimes “. (6PMM) Health facilities were established at the border, for screening of non- referral cases, and fees were charged. These strict policies, and the associated financial burden, negatively affected the health seeking behaviour of the population.

If we don't have services, the patient may go to Turkey. If go to the border without permission, they make him wait one or two months and then he may go or not go. If the person goes to Turkey, he should pay around four thousand dollars, which is not possible for 99 percent of the people (25STM).

In interviews and FGD 2, a few program managers and most of technical managers reported encountering challenges with the cross-border shipment of medical supplies and equipment from Jordan and Turkey into Syria. The border closure and collapse of regular importation procedures resulted in the need to deal and negotiate with multiple authorities at different levels, making the process complex and challenging. Permit and clearance were required for the movement of each shipment across the border. Stringent procedures were imposed at the border, including vigorous screening of the content and quality of the cargo. Participants stated that all these procedures resulted in significant delays and disruption in service delivery, though the Turkish border was reported to be less restrictive, and importation of vaccines was allowed “in the North in Idlib [where] MSF did vaccinations” (2PMM).

It was long process sometimes, to send to ship used to get two to three weeks to just get a permit from the authorities. That was a constraint.

Military controls the border, so they are the ones who allow or not allowed when to pass and these are the challenges we are facing because for the process (shipment) we don't have direct contact with the authorities (1PMM).

Control [by military] of every little aspirin and their expiry date and not realizing that by actually doing that they were creating stock rupture in health facilities (6PMM).

Participants reported that there was a list of items and important medications which were not permitted to be brought over and had to be procured inside Syria. This was a challenge. There was strict regulation of the movement of controlled drugs ⁴and electronic equipment across the border.

They didn't give us permission to send this laptop across the border, to cross the border from Jordan to Syria, that's why we purchase from inside.

In Jordan regulations, we are not allowed to buy the controlled drugs because we're not using it inside Jordan, and you cannot cross the border (FGD2).

Restrictions were also imposed on the number of people accompanying the cargo for shipment, which posed logistic challenges in handling large cargos.

The intelligence and third-party organisation allowed only two persons to be with this cargo. Usually the logistics manager and someone from the medical team will be at the border, for example, they ask about this drug, so a medical staff would answer, and the logistics for counting (FGD 2).

Government Policies in relation to MSF

Some of the participants reported that MSF was not granted permission or officially registered to serve in the government-controlled areas, as MSF was not recognised by the governments of Syria and Turkey. Participants said that the Government of Syria (GoS), perceived MSF's advocacy strategy, and their work in rebel area as demonstrating that they were aligned with the rebels who opposed to the GoS. This created a negative image, evidenced in terms like "western spies" (3PMF) and classification of MSF among the blacklisted organizations in Damascus.

MSF does not have a positive image with Government of Syria. They consider that MSF has been supporting the terrorists, in general (5PMF).

We pointed out some abuses of the IHL (International Humanitarian Law) in the side of the regime. People are not going to allow us to do things and be in places because we are uncomfortable, because they know that we will speak up (6PMM).

⁴ Controlled drugs included hypnotics and psychotropic medications.

Participants reported that non-registration in Damascus and Turkey had implications on the operations and coordinating activities inside Syria with government recognised organizations.

This [no-registration] puts a lot of restriction on the set up of the mission and operational strategy, limitations on how we are operating from Turkey. Their cross border is affected a lot, because of this (11PMM).

As an NGO without any permission, we cannot go back to the camps and make an assessment of how we carry our activities, and we cannot ask permission from Turkey because we are not following their legislation (29TMM).

We cannot purchase regulated drugs from Turkey and then send it to Syria; it is impossible. It is only possible through Turkish Red Crescent, but because we are not registered, we cannot collaborate with Turkish Red Crescent (29TMM).

Access barriers: Security constraints

Barriers reported by participants included security constraints such as targeted bombings of health facilities, armed group clashes and security threats and risks to the staff.

Participants believed that the Syrian Government targeted hospitals and bombed strategic locations on the pretext that they were “harbouring combatants” (1PMM), creating movement restrictions and communication challenges in the vicinity of these attacks. These issues around access to the health facilities affected the health seeking behaviour of the population.

Authorities targeted communication, infrastructure, roads... sort of things, so communication with these facilities was also very, very complicated (1PMM).

They were afraid that the hospital was going to be bombed or neighbours who didn't want the hospital to be near them because they knew that the hospitals were going to be the targets (6PMM).

In addition, two participants reported that there were “night movement restrictions” (34TMM), and “internal barriers created by the dynamics of armed groups, such as check points and economic interest of armed groups” (6PMM). Restrictions of staff movements resulted in disruption and delays in the regular planned activities of the project.

When we, did the survey, we realized suddenly that they were bombing an area through which our interviewers had to manage (27TMM).

Supervising the facilities is not easy... the staff inside cannot travel because of security. There were like weeks that they cannot move (15PMM).

I think the hospital staff had to cross the Frontline to come and get the medication, it was very, very dangerous and difficult. I remember it took about one and half months for them to get the medication because it was difficult (1PMM).

Security risks of transfer to the MSF and partner staff due to GoS hostility and blacklisting and the lack of recognition of MSF services were seen by the staff as serious impediments to MSF fulfilling its duty of care. As one of the program managers said:

You're putting people under the name of MSF, and we are not readily accepted as we are not registered in Damascus. So tomorrow under the authorities and government these people working here illegally, you're putting those people at risk. This is a challenge because anything can happen to them and you're still responsible. This is a very, very, very, very complicated situation (1PMM).

Other security risks reported by the participants included kidnappings and security related critical incidents. They noted that “kidnapping of MSF staff in 2013” (2PMM), was followed by complete withdrawal of all international staff from inside Syria. This was the trigger to initiate the remote support approach, whereas a “critical security incident” (3PMF) in North affected all the activities and contributed to the closure of the project.

Language and Cultural barriers

Language barrier proved to be a significant barrier to effective communication between the local staff who spoke Arabic, and most of the international staff who spoke English. It was reported that differences in the regional Syrian dialect made it difficult even for the interpreters and the Arabic speaking staff, especially when it came to technical communication and training. Syria was seen to be unique “as the only country in the world that is teaching medicine in Arabic” (8PMM). One international manager found it challenging to train the medical staff through interpreters.

The language barrier was one of the major things for me. I don't speak Arabic. Syrian Arabic language is different especially when it comes to medical terms. Okay so we have to find a different way of trying to interpret what they really mean (13PMF).

This language challenge was very well summed up by one of the technical managers during the interview:

I'm Syrian. But the team inside is from different backgrounds. So sometimes the Arabic that I am used to or maybe the terms I'm using, either it's maybe understood in a different way or might not be very much clear, and also for me sometimes they are using some words that I'm not used to it, and I need to ask for explanations (36TMF).

Participants also stated that the language and cultural barriers posed a significant hindrance in understanding and assessing the real needs.

There are so many cultural and language barriers that we do not understand what kind of protocols or guidelines they are following at the moment and what we can actually add to this or what you can propose to this (10PMF).

Tribal and cultural differences Syrian society was reported to be a clan or tribe-based society, where relations are built based on affiliation to a tribe. So, one tribe did not necessarily treat or accept the other tribe as well as its tribal member. These intricate issues around the tribe/clan-based structure of the Syrian community had influence on the team dynamics. One program manager believed that affiliation to a specific ethnic group and “micro identities may influence their decision making and information sharing” (15PMM).

I remember in our hospital if there are 150 staff, for example, the tribe where they came from were quite organized among themselves and there were inter-tribe issues among the staff. This was a clear indication everyday life or routine is influenced by where you belong to (5PMF).

Another program manager suspected that low utilization of the Daraa hospital A from specific areas in South Syria could have been due to ethnic divide or tribal issues that limited the population access.

...different factions and military groups different tribal areas, hospital A was quite isolated, maybe people didn't dare to come, we didn't have any data to show that (7PMM).

Gender disparity was reported as a barrier by three female participants. While one of the participants felt that “being female it was easier to get into the female work environment” (20STF), others felt they had to strive more for acceptance compared to their male colleagues.

Also, at the population level the participants were concerned that the sexual and reproductive health (SRH) needs of the female population were not expressed adequately, and even when identified were not well accepted by the population. Therefore, SRH services such as sexual gender-based violence (SGBV) and post abortion care were not prioritised despite being identified as gaps.

It was difficult for me because the culture is mostly male. So, I'm female. Acceptance is mostly less, usually as in this Syrian culture was mostly male dominated. So, they look at females at the lower level (13PMF).

I think it's more related to cultural things, for example, working on SGBV. It's a big barrier. Abortion, yes people do not even speak about it (11PMM).

One Program Manager found it difficult to comprehend the cultural norms and institutional practices, such as early marriage, as these compounded the issues and remained hidden.

I had the information there was a pregnant woman of 13 years. For me the first thing I think is sexual violence. But then when we ask is “no, no they are a couple, its marriage and culturally it’s like this”. For me it was shocking. But that’s a cultural barrier for me (15PMM).

4.3.2 Enablers

The participants highlighted many factors which created an enabling and motivating environment and allowed MSF to continue to support the vulnerable population for many years in the opposition-controlled areas in Syria. As shown in Figure 4.2 many enablers represented strengths of MSF and of MSF commitment. Half of the participants thought it was the underlying ethos and competence of MSF and the financial independence and commitment of the MSF Operational centre for Barcelona (OCBA) to investing in the remote support program that was enabling. They also cited consistent support as contributing to the perception that MSF was a reliable partner. The infrastructure, available human resources, and the skilled MSF local staff, as well as the leverage MSF gained from having a presence in Jordan were further identified as contributing to the strengths of work within Syria (see Figure 4.2).

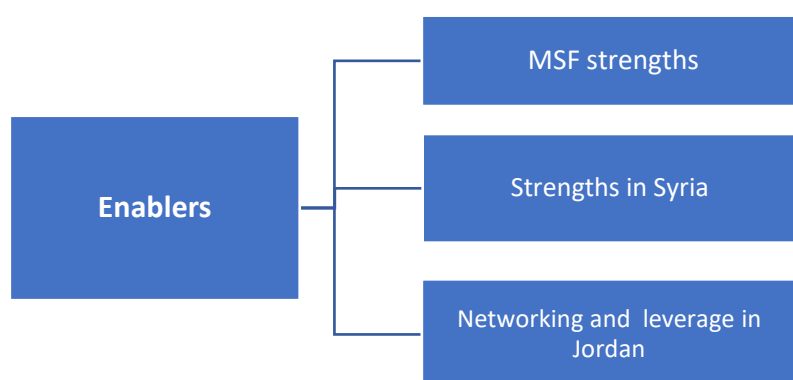


Figure 4.2 Enablers for the implementation of remote support model in Syria

MSF strengths

Participants reported that MSF is recognized as an experienced and reputable organization. Knowledge of MSF's vast experience in working on emergencies in conflict settings was enabling and gave "MSF a positive image" (35TMM) in the rebel-controlled area. The competent work force of MSF, comprised of qualified and dedicated professionals, was seen both as "reassuring and motivating for the team" (6PMM) and therefore MSF's image and reputation encouraged partners to be more collaborative and value its association with MSF.

I think it was good because they felt they were doing something very valuable because they were dealing with a respectful humanitarian organisation like MSF (27TMM).

Participants also appreciated the open and innovative nature of MSF in reaching vulnerable population through different modalities.

I think, I like a lot about MSF, that we try things, and of course remote control, remote support, remote supervision, and remote training is never the ideal, but it is one possibility. One alternative is better than not trying (6PMM).

MSF funding independence was seen by most of the participants as enabling. They felt that the fact that MSF is not dependent on external funds, allowed MSF to be more independent and flexible in terms of rapid response to crisis situations, independent decision making and in risk acceptance.

Having a hospital and the donation program. You can say it is only MSF, who has the capacity to support other facilities. I mean in terms of capacity, funds, support, drugs (18 STM).

MSF was also perceived as a stable and a reliable organization by the partners inside Syria, due to its consistent support in providing essential drugs and supplies and financial commitment. The policy of staff incentives that ensured the presence of the work force on the ground and continuity of care also contributed to this perception.

With international [supply] order, I will do a lot of feedbacks, I will question a lot, but once we arrive to an agreement, you will have your order. It's not that you will have a four-month delay or whatever. We purchase and send, and they receive it (4PMF).

Staff is right now stable because they know we are offering different things and they know we are with the commitment to provide all of that we are talking (14PMF).

And for example, the trust, we were sending for them the fuel every month. The money for the fuel. The incentives every month. Other NGOs they were not doing like that (19STM)

MSF OCBA's commitment was viewed by many program managers as one of the enabling factors. Financial investments in new technology (for example, for real time surveys and data collection), internal MSF networking for implementing technical tools, the decentralized support model and, above all, investing in the experience of remote service delivery were perceived as evidence of a high level of commitment by OCBA. However, one program manager acknowledging the commitment of OCBA, felt that the commitment was limited beyond financial support.

I think we have internally in MSF the network for telemedicine, the ability to look for the technology like Dharma (Real time survey), and I would say the commitment to financially invest in these was enabling (2PMM).

The whole Middle East unit was designed to help with this [remote support], so there was a possibility there was some commitment. I think the financial commitment was more than the commitment from the house [OCBA] to what we were doing (2PMM).

Program managers stated that the commitment of OCBA was their willingness to take risk in spite of compromises and to invest in the remote support model and thereby explore and build on the new experiences which were still being debated within the organization and not formalized. Participants emphasized the need to capitalize on this experience and the importance of investing further in remote support modalities based on OCBA's experience.

I think there was a decision to accept certain number or level of care and say we change the mortality, approach, we change the methodology, and we start the implementation of Remote Programming (8PMM).

I think it was a great investment [South Syria]. I think we learnt a lot. I think we need to ... consolidate what we learnt and become better at it (9PMF).

Remote programming in MSF is taken as a painfully as something new... as in most of the classic commissions we see the patients and that's what is portrayed as image of MSF and when it comes to remote there is a bit of nervousness and anxiety. But remote programming works and it should be considered as one of the models [service delivery] if there are no other better options and I think we should be open to all kinds of models based on the context, based on the constraints, based on the result (P5PMF).

Strengths in Syria:

Almost all the participants spoke about the high level of education and the advanced health systems in Syria as compared to other underdeveloped nations. Good infrastructure and the

availability of highly educated skilled and motivated staff were perceived as enabling for MSF engagement.

The hospital, when moved from the hands of the government to the opposition, was hundred percent intact and with almost ready staff to function. It was seen by MSF as opportunity for new approach (2PMM).

Although lack of Ministry of Health (MOH) governance was perceived as a challenge by most, one program manager felt that the existence of functional hospitals without bureaucratic hassles was enabling.

These facilities are well functioning, There is no proper authority management, DoH (Directorate of Health), and that was quite interesting and we became quite curious to find a way somehow to get involved with these facilities (1PMM).

Availability of skilled and motivated human resources inside Syria was perceived as an important enabling factor for MSF engagement by almost all the participants. The experience and contribution of the local staff in the crisis was well appreciated. However, some felt that MSF did not recognize their skills and therefore they were not used to their full potential.

These are doctors who are surgeon for 12 years, 10 years. These are people who have a lot of knowledge and they've been doing amazing work, during the crisis and somehow, we didn't, we weren't able to give them the credit and the recognition that I think they deserved (9PMF).

Two of the Syrian participants highlighting the adequacy of skilled human resources inside Syria, emphasising the need to better utilize local capacities to decrease reliance on international staff.

In Syria we had sufficient number of very professional and efficient doctors. If we have some crises in another country and we want to support it remotely, we have to think about this HR. Here is for example 100 doctors, if you go to Africa you will not have, you will need expats to work (19STM)

The Syrian staff and partners were perceived by some participants as very committed and motivated to meet the health needs of the population. Most felt that having the Syrian and MSF staff sharing the common objectives of serving the population was enabling for the program.

I think in general Syrians are having very strong commitment, very strong wish to work and wish to assist their own population. It's one of the very pragmatic communities, they are very entrepreneurial (5PMF).

The spirit of people in Daraa (province) and MSF was shared in many ways. Both of us thinking about the Syrian populations and challenges of the population, in terms of health care provision and health care needs and that helped (6PMM).

MSF national staff were perceived as a valuable resource, especially the staff in the North who were seen as an asset in terms of their experience and knowledge and because they were very well versed in MSF protocol and practices. The technical managers in North Syria also had dual citizenship with Turkey and that was enabling, as they could freely cross the border for meetings and training and to enhance their skills.

I mean the national (local MSF) staff ...they are very professional, well experienced and focussed, super focus on what we are doing now even with all the inside constraints political, ideological, they are focused on what we are doing, and this made a difference (16PMF).

Networking and leverage in Jordan

Good networking in Jordan and the leverage this provided for the implementation of MSF program on both sides of the border; with the Jordanian border community as well as the connections with the tribes and communities on the Syrian side of the border were seen as enabling. This leverage allowed MSF to understand the cultural dimensions inside Syria and to negotiate with the relevant Syrian stakeholders for access and security of staff and programs.

One program manager discussed extensively how the MSF presence and connections in Jordan enabled the remote support model implementation in Syria.

We had Jordanian dimension of network. So, we had the contacts, we were helping both the Syrian patients and their relatives. That was an enabling factor. People were very much connected on both sides of the border, because they belonged to the same clan and the same tribes. So tribal factor being very, very important in this region helped also. There was something we looked into very carefully, on how to make it play in our advantage for safety and security of our teams as well inside city, and our operations inside Syria (6PMM).

Frequent contacts with armed groups and the community to discuss access and protection were organized in Amman, Jordan as noted above.

We talked to the heads of the armed groups in Daraa. We had meetings with some people in Jordan. These people have license to cross more fluently than us. They would come into Jordan and we would take advantage to have meetings with them (6PMM).

In summary, the remote health model was necessitated and at the same time made difficult for staff, working in the context of Syria in a time of conflict. MSF itself brought many

strengths but its ways of operating also brought its own difficulties. These contextual factors shaped the models in practice.

4.4: Remote Support model in practice

In Syria, the characteristics of the remote support model changed over the years 2012 – 2018. In the North, Syrian staff who had been trained by MSF first utilised an approach best characterised as the remote-control model. The Remote Support Model in South Syria evolved to a partnership and was implemented through the local partner staff.

4.4.1. Development of RSM model in North Syria

In North Syria from 2012-2014, MSF started with a donation program and implementation of MSF hospital and outreach activities, to support the internally displaced populations, with primary, secondary and referral services.

MSF commenced with an emergency donation and later in 2013 moved to “regular donation to more than 30 facilities to cover the gaps“. (29TMM) The emergency donation program was stopped for security reasons and to avoid being perceived as a supplier or “pharmacy of the region“. (11PMM) So, the strategy was adapted to a more focused donation in MSF supported facilities.

When MSF opened the project in Syria in 2012, all the international staff were based inside the project running the hospital. The unstable context meant that “security became the top priority, and every decision was based on security considerations” (5PMF). In February 2014, following the loss of several MSF staff and evacuation of the expatriate team, the program was adapted, and local management positions were created to fill the gaps of international staff. This was the evolution to the remote shared management strategy, known as ‘Mirror- strategy’. The objective was to support remote implementation and build the capacity of the local managers through face-to-face and online meetings. While the needs assessment and implementation were conducted by the local managers, the final decision-making power was held by the international staff to ensure local staff protection.

It was “based on shared management between international staff in Turkey and national staff inside Syria by mirroring of the same position” (18 STM).

Every department has a manager inside Syria, a Syrian manager, and he has to follow everything in his department. Also, at the same time in parallel the other manager in Turkey the expat. one, also has to know everything, every step, and

the decisions are made between the expats. and the Syrian manager, but the last decision is always the expat. (29TMM).

A few participants reviewed shared management through 'mirroring' positively because it improved the management skills of the local staff and potentially allowed wider responsibility for local managers.

The decision making of the national managers has improved since the Mirrors,because at least... we are sitting with him and we are discussing with him and he is seeing, so also my vision more or less improved (34TMM).

However, most of the participants found centralized communication and decision making and high turnover of the expatriates [remote support team] challenging.

In summary, the MSF program in Syria evolved from emergency donations during wartime to more focussed, direct hospital interventions during the stable period. Following the security incident (in 2013), the program evolved to remote shared management with local staff. Though predominantly controlled remotely by the international staff, it proved useful in continuing MSF interventions and building local capacity in management. The remote model evolved further in South Syria into partnerships with local actors, as discussed below.

4.4.2. Development of RSM in South Syria

The South Syrian health project was fully remote from the beginning in the opposition controlled Daraa region. The project was implemented in two phases. In phase 1, OCBA supported six health facilities with donations of medicines and supplies. Later, the strategy was adapted to phase 2 using remote support methods, with a focus on secondary (rather than primary) health care. The objective was to "invest in the quality of care" (5PMF) due of clear gaps. This was also seen as an opportunity to go beyond donation and understand the functioning of health facilities inside Syria. The decision to opt for secondary (hospital) care was supported by many participants, as PHCs were unstable and field hospitals were being demoted to PHCs which were being lost to regime control and/or rendered non-functional due to lack of staff.

I remember sometimes it was like "but is this facility functioning or not functioning" because of the situation there, so finally it is falling into the hands of another group, so the staff left, and it was very difficult to stabilise (1PMM).

However, some felt that the "community component was neglected" (4PMF) at the expense of community involvement which was perceived as "important for community acceptance and ownership" (8PMM).

Evolution of RSM in South Syria: Partnership with hospitals

A secondary hospital in East Daraa (Hospital A) was selected for comprehensive remote support through partnership, including logistic, financial, and technical support, with the objective being to improve the quality of care. Later, a more specific and planned support was extended to the second hospital (Hospital B) in Daraa. The selection of facility was based on “patients, the patient needs ratio, the strategic position and location of the health facilities” (13PMF). The concept of the partnership approach in East Daraa was summed up by one Project Manager as:

To have a good set up of a hospital inside Syria, run through a strong or detailed MOU with the key partner hospitals, with strong commitment from MSF to keep this hospital functioning, which means that the staff should have some sustainable means to function, in terms of salaries. That there is a partnership for the hospital that can guarantee MSF influence on the practices, protocols that they are using, and that the quality and the skills of the medical staff can be improved through training (2PMM).

The partnership approach was implemented through the existing hospital staff, “MSF supported with incentives, with one or two MSF staff inside to oversee the activities”, (1PMM) Participants stated that the remote partnership “depended on the trust of the hospital directors” (6PMM), with whom the agreements were negotiated, as there was no formal representative of MoH, or Minister of Labour and no contract. Coordination with the partners was built at three levels as described by one of the technical managers from North Syria:

One is the level of the members of the project like the logistic, medical team and the coordination team. They do the coordination and networking inside [Syria]. Second level from the MSF managers [remote] to managers of the facility [in Syria], for strategies and general management issues. And then there is third level in Gaziantep in Turkey with the DoH and all the partners of the organisation that are usually here (35TMM).

A comprehensive support approach with logistics and, financial support was perceived as innovative and positively reviewed by most of the participants, who thought it built the grounds for sustainable operations.

OCBA did very well in the South which was taking one facility and engaging in it fully, I thought was genius. We engaged in one hospital, that we didn't scatter ourselves everywhere. I think that was very important. We created a very healthy system, and that's why I think it was sustainable (9PMF).

Technical support was provided in the field of MSF expertise, such as Maternal and Child health (MCH), surgery, inpatient department (IPD) and fields new to MSF, such as dialysis and Neonatal intensive care. Participants reviewed dialysis support positively as being effective with wide coverage.

I think dialysis support was effective because Daraa region, the Southeast there were only three services and Hospital "A" was the biggest one. (31TMF).

However, participants stated that support to Hospital B was better planned and selective (MCH and Surgery) with incentives only for staff in selected roles (focal staff). This planned selective support was perceived as more efficient with better "identification of needs" (2PMM), "reception to training" (27TMM) and "overall trust and acceptability" (31TMF) compared to hospital A.

In hospital A for one year, it went for only financial support and then we started to improve the quality of care, to train the staff and start implementing our guidelines so the change for the staff was difficult. (20STF)

RSM in South Syria evolved from donation to partnerships with local actors. Both the comprehensive and focused approaches were seen to be effective. However, the better planned focused support was seen to be easier to implement, as well as being more acceptable and accountable.

Comparison of remote support approaches in North and South Syria

The main characteristics of the two approaches in North and South Syria are summarised in Table 4.3 below. The primary differences are the use of mirroring to enable more control of management in the North, and the use of a partnering approach in the South, with more autonomy for local management, within MSF guidelines and protocols.

Table 4.3 Remote support characteristics in North and South Syria.

	North Syria	South Syria
Area covered	Azaz, Afrin, Aleppo Idlib (North Syria)	East Daraa, (South Syria)
Population covered		Catchment: 54000, Referral: 360,000 (MoU 2018)
Approach based on	Secondary care, Security and tracking internally displaced population (IDP)s	Secondary Care, Improving the quality of care
Hospital services	MSF hospital 32 bed Maternity (MCH), Emergency 24 hrs, Mental health (MH), Immunization (EPI), inpatient and outpatient (IPD, OPD) services, referral services Partner hospital support(partial): MCH, EPI, Donation/Logistic support/financial support	Comprehensive support hospital A 38 bed Secondary and tertiary care MCH, Surgery, Dialysis, Neonatal ICU provision IPD services Focused Support hospital B 20 beds(1) MCH, Surgery Donation/Logistic /financial support
Outreach services	IDP Camps + donation/EPI Donation program: 25+Health facilities	X
Project activities	Monitoring, Assessment, Data collection, Reporting, Training, some Technical Support partner.	Technical support, Monitoring, Assessment, Data collection, Reporting, Trainings
Staff	MSF National staff (NS)	Partner staff with incentives
Access	Expats till 2014, Shared management strategy 2015-2017 with Syrian staff access to Turkey, Remote control after 2017	Fully remote since 2015-2018
Remote locations	Gaziantep, turkey till July 2019, after Amman Jordan	Amman Jordan
Present situation	Project continues with expansion	Project closed due to conflict escalations

To conclude this section, the changing approaches over time and within the two regions were seen to reflect both the evolving conflict situation and MSF's learning through experience and adapting its work accordingly to maintain access and to continue to meet the health care needs of the population.

4.5 RSM strategies and practices

This section describes and explains the major strategies and practices employed by MSF and its partners in operationalising the remote support model in Syria, as experienced by the study participants. The effective strategies and practices implemented through RSM were: the medical specialist strategy for engagement and technical support; staffing and capacity building through training; strategies to gain access including security and risk mitigation strategies and networking with relevant stakeholders. However, monitoring was perceived to be weak and inefficient in MSF remote missions.

4.5.1. Medical specialist strategy

The Medical specialist-based strategy was viewed by the participants as effective, with technical competency identified as a key prerequisite. Participants described three main elements of the strategy that enhanced the perception of MSF as a competent provider, namely technical support based on technology that met real needs, consistent engagement which built team dynamics, and joint practices that were helpful in the implementation of interventions. These are listed below in Figure 4.3.

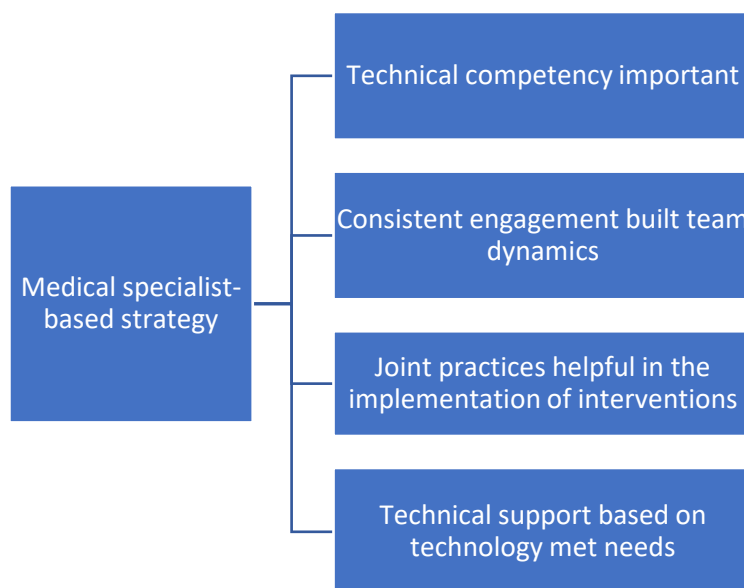


Figure 4.3 Medical specialist strategy in RSM in Syria

Technical competency important

Participants stated that technical competency is important when providing remote support to experienced medical professionals. It was seen as a prerequisite for building and establishing communication and relation with partners.

We were [working] with very well- trained surgeons in that hospital. It's human nature, when you reach a certain level of experience you will find it difficult to deal with someone who seems to be either very junior or not professional enough. And by this you lose your communication with that remotely supported project (27TMM).

I was only working with a nurse. And if I have to do kind of training, you are at this level (gesture low). So it was not possible at the beginning ...to have like a...kind of relationship with them. So that's why I introduce a medical doctor (15PMM).

Participants described the medical specialist-based strategy as “*unique that gave the project [a] push forward*” (FGD 1). Participants noticed that engaging specialists with their shared, consistent communication, through a common technical language and level of experience, improved the overall acceptability.

They are speaking a language that they share, they know what they are talking about and what they are trying to do together and why, so I think at the end of the day it helped a lot (6PMM).

Engagement between our medical teams, the medical side was the most evident. When they realised that she's a doctor like them, they have the same level of experience all of this, that was the cement you know, that was the reason then why everything else then worked (9PMF).

Consistent engagement-built team dynamics

Unconditional and consistent engagement of the medical team was seen by some participants as a positive step in building both personal and professional relationships, establishing trust and transparency between the teams and improving accountability. This was particularly important as “*people had started to feedback and report on an individual basis*” (10PMF).

We used to call the employees in WhatsApp or IMO, they know us, they know my informal name and I know their informal names (FGD1).

I think personally at my level and even at the project level [our engagement] built a better trust between us. We were really insisting in everything even for like three minutes talk. Even if they'd decide not to have this meeting we would keep insisting and we would stay late to continue the meeting (30TMM).

One technical manager who successfully engaged with the partner team emphasized the need to have a partnering approach, to encourage exchanging of experiences rather than a supervisory approach, in building a trusting relationship.

Show that you are learning as well, you are not knowing all, and they are not there to push everything. This is important when we start to build the trust, because I was someone completely new for them (31TMF).

Joint practices helpful in the implementation of interventions

Joint practices were reported as useful in the implementation of the program interventions and were found to be an effective approach for introducing and improving protocols tools, and activities. Professional staff stated that jointly implemented tools, such as the assessment tools, not only helped in understanding and identifying the gaps, but also helped in joint prioritization of needs. Partners also viewed joint activities positively, noting that hospital assessments were ‘very scrupulous and comprehensive’ (12PMM).

When we started to fill in these assessment forms jointly, the results were much different. Usually when you give assessment to the people, who were not trained enough to fill these forms, the common thing that we got was the things are rosy, perfect, but once you see things with your own eyes [assessing together], things begin to change (FGD1).

Professional staff reported that the jointly reviewed and adapted clinical protocols and guidelines that were implemented in MSF supported facilities were particularly well received. A few participants emphasized the need to have a wider discussion around the protocols and to jointly review and adapt them, based on local policy and guidelines. However, it was also stated that “few existed (clinical guidelines), and most were hard to trace” (31TMF)

For the pain management and the prophylactic antibiotics before surgery we sat with them and we translated our protocols. It was not very much different from their daily practice. And they sat together and adapted with our protocol (19STM).

You should have a session with all of the doctors from different specialities, to listen to them, rather than to tell one person “look this is the best option you should do this” (18STM)

Technology based technical support

More than two thirds of the participants discussed MSF OCBA’s strategy to implement innovative mobile based technology for conducting community-based health surveys and facility-based data collection. They also referred to the standard MSF tools for pharmacy management and patient management (telemedicine). Close technical support, including training and supervision by the professional team in Amman, had reportedly ensured successful implementation of these interventions.

Participants reported that Health Survey Program (HSP) was conducted ‘twice a year’ (10PMF) covering a population of 200,000. Most of the participants reviewed HSP surveys

positively, finding them helpful in identifying real health needs in the region and in enabling staff to assess the quality of projects (MSF supported).

We were able to identify [through HSP] a very, very clear and accurate mapping of immunization coverage for all under five children in that area, even the number of missing doses per age category (27TMM) .

We were able to easily, very easily, filter how many war-wounded patients received in three given days [ER admissions], how many of them were under 18— basically children. So, this type of data collected was helpful for us to assess the quality of projects we are doing (27TMM).

An innovative software-based DC tool was implemented in MSF supported Darra hospitals. Participants reported that the tool was user friendly, well adapted and led to improved reliability and accuracy of the data. One professional remote manager (MSF Champion) who was involved in designing and implementing the tools, reflected that:

We did our best to design the tools in a way [that] it can be useful in such an extreme environment The hospital-based data collection tool, we made it very generic, yet MSF specific, so that ideally we can easily implement in any new remote support project. Also, a binding solution that works for Arabic and English at the same time (27TMM).

Participants reported that training of the local people [HSP] and non-medical staff and engaging them in data entry enabled 'task shifting'. The training was conducted by the professional staff and reduced the burden on the medical team.

Survey [HSP] was done by local people, that didn't require a lot of expertise and training, simply done by interviewing the population with this tablet over 5 days (6PMM).

It [DC] involved data entry into physical registers by the medical staff, then two trained admin staff transferred data from physical registers uploading to digital platform, which was linked to the dashboard, where real time changes were visible. Training of the staff was done in collaboration with partner (27TMM).

"This is much easier and much useful for us'. We don't feel that it is a burden anymore"(27TMM).

It was also reported by a champion manager that involving the partner managers and giving them access to the databases, to enable closer analysis of the data, improved acceptability, accountability and reliability.

Password to database was shared with them [partner managers]. Partner managers spent one or two hours per week looking into what has been

changed over the week. They [partner staff] were making sure they filled, complete the data entry by day 2 or 3 of each month for the previous month (27TMM).

MSF standard pharmacy and patient management (telemedicine) tools were also reportedly successfully implemented in Daraa hospital, closely supported from Amman. It was reported that the tools were not well adapted and were complex to use, thus requiring lots of training and full support in the implementation by the professional remote team.

Participants reported that training and follow up of the pharmacists in implementation of the tool enabled them to better estimate the level of need for drugs and was helpful in streamlining drug orders.

I think when we started training the pharmacy supervisor, still it wasn't fully 100 percent reliable (consumption), but with time with more trainings and with more follow up... we can say that we reached like 70 percent 80 percent accuracy (28TMF)

So, there was a proper system in place, and they were sending us the quantity amount, based on easy stock. Easy stock was a big thing, control of consumption and then kind of informed decision about the amount for order and budget (7PMM).

There were mixed responses from participants about the uptake of telemedicine, to directly communicate with the local doctors in the management of complex cases. A few participants felt there was inadequate support and therefore low uptake as “telemedicine was a new concept” (32TMM), while others felt its use was based on personal relations, therefore not consistently used. However, overall it was seen as a good concept and strategy, contributing to improvements in patient care and gains in “technical trust building and acceptance of MSF” (2PMM)

MSF acceptance as technically competent partner

Most of the participants agreed that towards the end MSF gained acceptance as a technically competent partner. With more face-to-face engagement and after getting to know the organization better, partner staff started to get more interested in the possibilities. Participants felt that they finally accepted the efforts of improvements from MSF in terms of technical quality beyond donations. Also, MSF medical specialists were “included in the WhatsApp groups of Syrian doctors” (32STF) and were thereby accepted as part of the wider medical community. Innovative and technical tools contributed to this acceptance.

It was good because we finally did medical order based on consumption from the tool (4PMF).

I met them, for example, in Jordan, they start to have formalized and relevant questions about the practices, for example, upgrade of the lab, about the related

units, about Infection control, questions on telemedicine. They start to develop interest. So, it is the value of MSF not only as a donor, the value of MSF as a technical body (2PMM).

4.5.2. Staffing and capacity building

Participants reported that the strategy to recruit local medical specialists [in remote team in Amman] to engage with the teams inside Syria was effective. Induction of focal staff was seen as improving information sharing and reliability. Capacity building through training was a key factor in RSM, but training requirements were reported to be broad. Training modalities were implemented through cross -border and online, as shown in Figure 4.4 and described below.

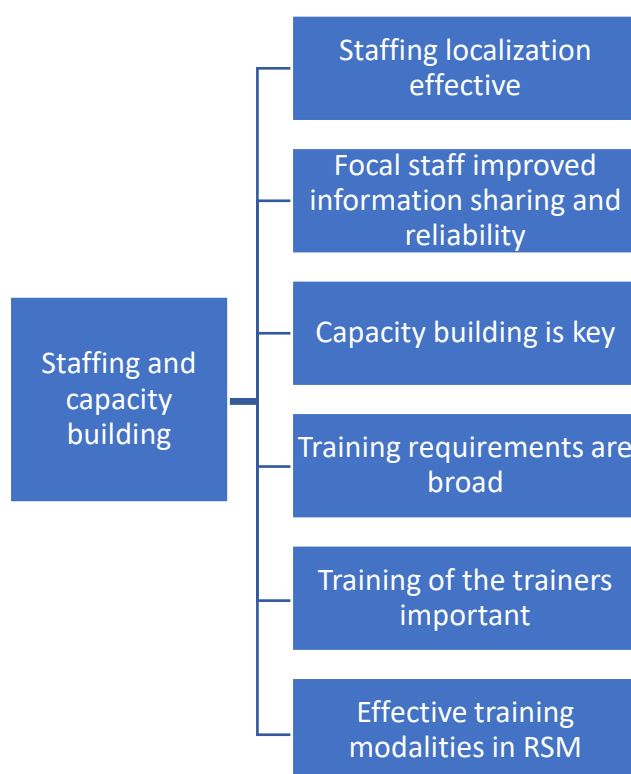


Figure 4.4 Staffing and capacity building strategy in RSM in Syria

Staffing localization effective

Participants reported that the strategy was to recruit local and regional staff, partly to overcome cultural and language barrier and also to conform to the “*MoH policy to promote local recruitment*” (6PMM). The recruitment of local medical specialists and partner focal staff to the MSF team in Amman was seen as an effective strategy for engagement with partner staff (see sec 4.5.1 Medical specialist strategy)

Focal staff improved Information sharing and reliability

Almost one third of the participants discussed the importance of identifying and investing in key partner staff to act as the focal point, when working in partnerships. Gaining insights and accurate detailed information and building trust, while working remotely with partners, were reported to be difficult. It was noted that a staffing strategy had been adapted, to recruit focal staff from key departments and to incentivize them. This strategy proved to be effective leading to improved insights into program activities through reliable information sharing.

I think that is very hard to develop a trusting relationship, but you need to invest. You need to invest time; you need to invest several meetings identifying the focal or the key staff.

(16PMF).

At the beginning was a total mess because they have a lack of information, but we are now working with a data entry specialist to develop this task. Now it's like the 100 percent that the information that they are sending to us is more real (16PMF).

However, another participant felt that there was also an internal drain of skilled partner staff with the change of role and responsibilities.

There was transparency and I think that's right. But he [partner focal staff] was of great value for the facility. He is not entering the operation theatre (OT) anymore; he is one senior nurse. So yes, there is added value and there is negative side of it (30TMM).

Capacity building is key

Training of the local staff for the implementation of program interventions (protocol and tools), in the context of a strong relationship with MSF, provided a significant advantage for quality of care, as noted by two-thirds of the participants, who saw training as “key in remote health programs” (6PMM).

Relevant MSF technical training was valued and very well accepted and appreciated by the partners. In North Syria Turkish the MoH was reported to be more open to collaborate on technical trainings with MSF.

They (partners) implemented infection control. They did some RH courses. Before MSF... they use to get material, but they did not know how to handle it, how to implement the procedure. But after MSF they started implementing the procedures, learning them properly, and the results were amazing, genuinely unbelievable. That was one of the biggest positive aspects from MSF work with them (12PMM).

Our second partner was the Directorate of Health. They were quiet, quite open for us to ask to provide any training or to implement any new protocol. We didn't have any problems with that (16PMF).

Training requirements are broad

Most of the training was seen as being standard MSF medical technical training, rather than being based on the needs of the partner staff. Technical managers stressed the need for more training both to develop management capacities and to ensure sustainability.

We should have done more related to management. I think maybe we were more passive in this way, and not reactive enough. It was not put as a priority, this administrative, this managing thing. My suggestion would be to empower the management and focus on capacity building for them [partner staff] to be able to work in different circumstances with more background (31TMF).

We need the trainings for us to develop managerial skills. We did not receive any training for this; it took a long time (35TMM).

I did not receive any training for this remote-control management (35TMM).

Professional remote staff also identified the potential benefits of more needs based medical training.

I wanted more advanced training for anaesthesia technician because there were no anaesthesia doctors in these facilities.

They wanted training on dialysis; we were more focussed on mass casualty (30TMM).

Training of the trainers important

Participants emphasized the need to train the key local and partner staff as trainers to continue with subsequent training, supervision and local monitoring. This need was identified across all the levels.

If you have key couple of staff whom you train, they know that this is their objective, this is their performance. They will learn, they will take it and then they are the one who is constantly refreshing and passing the knowledge, monitoring, checking on the indicators. I think it will be more efficient (5PMF).

Many participants highlighted the importance of building the skills of the local trainers right through from induction to subsequent refresher training on a regular basis, as a strategy for effective implementation of the training locally (inside Syria).

When I was new in this position, I asked for many supports to provide me training and to be aware about the protocols, also because we were alone. As 'national staff' [local staff] we asked for many supports to understand the protocols from time to time when we recruited more and more [local staff] (35TMM).

If you don't understand how to fill the partogram [tools], how are you going to tell the midwives? First this you start with us [trainers] (FGD1).

Effective training modalities in RSM

Cross border training and exchanges were reviewed as being effective, even though it was not always possible to conduct the training face-to-face. Some of the participants thought it was important to invest in the time and organisation required to bring Syrian staff to Amman for these trainings. They valued the building of strong interpersonal relations and improved team dynamics developed during these exchanges. Further, the staff acquired skills and motivation to apply and transfer their skills on their return, which was seen as beneficial for the project.

Many staff visited Jordan and knew Amman team personally, so it built friendships (22STF).

Pharmacy supervisor visited Amman and was trained on Isystock (pharmacy tools) and then he went to train four other pharmacists inside Syria for two weeks and then supervised (37TMM).

After the workers came back from Jordan where took the courses, they asked for the courses to be supplied through Skype to the workers on the ground. It was very helpful that they were trained in Amman (PPM 12).

The MSF team exchange program was piloted within MSF missions in the region and was perceived as an effective strategy. One program manager from North Syria spoke extensively about the successful exchange program between MSF missions in Syria and Jordan, focused on non-communicable diseases (NCD). This exchange of experiences and resources between missions was much valued, well accepted, and found to be helpful, especially before the implementation of new projects or changes to existing ones.

I think this is another strategy that it's really- really, important ...to have more acceptance, to have this interchange of experience, have contacts between the [MSF] projects.

Thanks [to]this experience in Ramtha (Jordan project) we are trying to keep some of their strategies too, for example, to complete the adherence of the patients to this program, to integrate the referral system and to integrate mental health system in the NCD program (14PMF).

She further suggested that training opportunities for the local and partner staff should not be limited to MSF but that other organizations, both regionally and locally in Syria, should be explored for relevant training opportunities.

We are trying is to take advantage of trainings from other organizations but physically in Syria and outside, we are checking for the information that they will provide, identifying some priorities and we are sending our team to receive these trainings (14PMF).

Online team discussions and regular meetings were viewed as another relevant modality

as a part of ongoing training. One program manager saw these team discussions as important, as they provided mutual learning for both partner and MSF staff and skill development for both.

The meetings on the Skype that the medical team was having with the medical team in the hospital or... with the directors of the health facilities, every two weeks was very important because these discussions were real study of cases that were happening and that was training as well. It was developing the skills of the people in management and medical practices; I think that was as important as a webinar... [and were]big important training for both in the sense they allowed us and them to change the attitude, and to find attitudes, that were the most impactful (6PMM).

Lastly, remote trainings were reported to be challenging, especially when conducted through interpreters, and it required preparation time and different methodologies to be effective.

We start to discuss before, especially with the medical terms like in training and evaluation. Time [needed] to search for the Arabic terms. I think when you work with a translator it's really good to have this kind of ... preparation (31TMF).

Online training, it just requires a different methodology, you need attendance in your body language and in your tone and your activities, you need to be very creative to make the team engaging not only listening (37TMF).

In spite of challenges, remote online training was preferred at times; when there were cross-border access issues [refer to section 4.3.1] or connectivity challenges [refer to section 4.6.6].

4.5.3. Monitoring in RSM

Monitoring within RSM was seen as inefficient and difficult due to the lack of a robust monitoring system given the absence of monitoring tools, unadapted indicators, and data reliability issues and overly burdened administration. However, participants also noted that triangulation, using multiple methods and innovative web-based monitoring and data collection, improved reliability. These themes are illustrated in Figure 4.5 and described below.

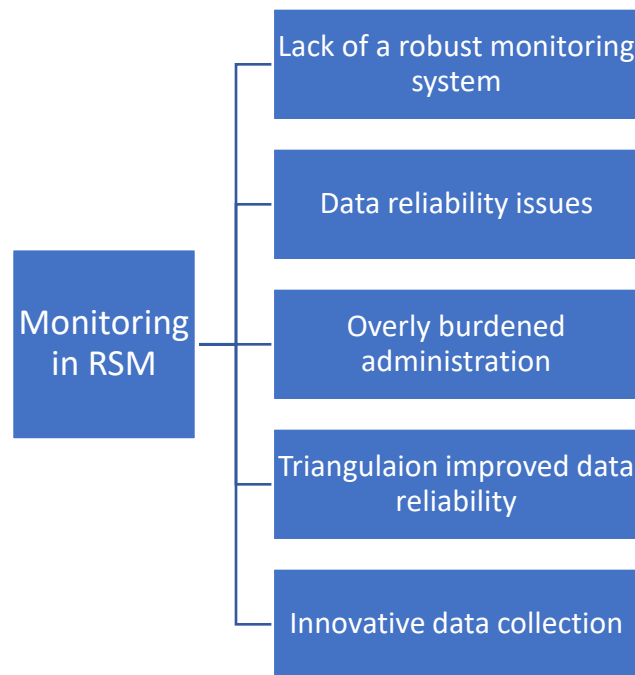


Figure 4.5 Monitoring in RSM in Syria

Monitoring in RSM

Standard monitoring in MSF was based on data collection and regular reporting, and daily reporting in unstable contexts. Multiple methods were employed to ensure a better overview, as reported by the participants. Weekly and monthly situation reports including technical reporting of activities, such as pharmacy tool backup and report were required. Technical managers based in neighbouring countries followed up with the technical teams inside Syria to conduct monthly analysis and reporting and later shared this with technical lines (medical advisor and pharmacy advisor), at the headquarters in Barcelona.

We send monthly pharmacy analysis report. We check the stock levels, sleeping stock; over- stock ... expiry stock... monthly analysis of the pharmacy was the key (29TMM).

In North Syria additional surveillance and reporting was done on regular disease outbreak “EWARN (early warning) and Nutrition” status (15PMM).

Regular Skype meetings, between the remote support team and the partner teams inside, were used as the main means of communication and monitoring. Mobile apps (WhatsApp) were used to keep track of daily activities.

Every day, I received the information from the field about the IPD (indoor patient)... maternity IPD, about the cases and there are more briefs about the activities and what happened in the day in this WhatsApp group. I have different groups ... can ask for different things (14PMF).

Monitoring in North Syria also included field visits by the technical managers (TM) based in Turkey. TMs had citizenship [Syrian] and so they were able to go for short visits to the hospitals in Syria for direct monitoring and to then share their observations with the international teams in Turkey.

We did flash visit to projects [inside North Syria] (33TMM).

We had regular meetings... organized once per week or bi-weekly with the coordination team... in Turkey. So, I think in that time we reflected on a clear picture of the situation here in this area. We found that they were closer to the mission (35TMM).

However, there were many challenges encountered in monitoring in RSM, as described below.

Lack of a robust monitoring system

Monitoring in RSM was seen as inefficient and weak due to the lack of a robust monitoring system. This was linked with the absence of a strategy, specific tools or realistic indicators for monitoring having been negotiated with partners before implementation.

Some of the program managers noted that: “Monitoring is weak in MSF” (2PMM).

There is no systematic monitoring, what is monitoring, how to do this monitoring, who to do this, how often, how to evaluate change, how to establish baseline and ... end line. I don't see this in MSF (5PMF).

We were just trying to monitor even after all the discussions. We didn't have a strategy for monitoring (16PMF).

There was not a real system in place about good monitoring and follow up of the implementation of guidelines and protocols (10PMF).

Another program manager felt that, since the monitoring terms had not been negotiated with the partners previously, it was difficult for the team to implement any monitoring activities.

I think that unfortunately monitoring was such a challenge but again was our fault as we didn't agree on what to do and what to implement [for monitoring] (16PMF).

A few participants said that indicators for monitoring were not well defined or adapted to reflect field reality, creating challenges for the teams and conflict between the reporting lines [MSF].

Instead of monitoring of the projects, we are monitoring the objectives and we are seen all the time by the mission and the project as almost harassing them. Maybe sometimes not understanding the reality instead of developing, because it was totally theoretical (2PMM).

If I want to monitor the antibiotic prophylaxis, given that we didn't have this element, we have indicators (monitoring) like a phone book. It has a lot of numbers, but it doesn't have the whole country numbers (30TMM)

Participants also reported the lack of cost-effective monitoring tools.

The problem, the main problem I think is monitoring [tools]. We have [a] lack of tools for monitoring and applying it at a local cost (10PMF).

Participants at all levels emphasized the need to develop well adapted monitoring protocols, tools, and well-defined indicators specific for the monitoring of remote support programs as well as developing the monitoring capacity of the implementing teams.

Need to implement protocol for monitoring the activities inside, as well as monitoring of the proper use of resources that we have been sending in and ... a lot of tools to use, to monitor the quality of the services (36TMF).

They have to improve their monitoring capacity. They have to really develop some tools for those type of contexts ...well adapted ones (7PMM).

Data reliability issues

The service delivery and management data that was collected was seen to be of poor quality and inaccurate, due to mistrust and other challenges in data collection and analysis.

Participants reported that they did not trust the data they received when direct observation of conditions was not possible.

Not easy to not touch the field, don't see what is happening in the field and to have to trust the staff there because you can imagine several things: Maybe they are hiding information, maybe they are giving more than, or yes created some extra ideas, to get what they want (14PMF).

This problem of the reliability of the data was always a big issue. We spend a lot of time discussing the quality; is it true, can we rely on that? (FGD 2).

The standard data collection tools (health information system HIS/HMIS) and technical data collection tools (pharmacy and patient management) of MSF were reported as not having been adapted to the context. They were assessed as time consuming and difficult for the local staff to complete. [See section 4.6.6 Technology in RSM: software issues]

Most of the technical managers reported that data extraction was a challenge that overburdened the teams, because of the mismatch between the standard indicators and the real activities of the project.

Basically, the data that was needed or extracted from the HIS (health information system) was not fulfilling the indicators, so we needed to create more forms to collect more data to report on the medical indicators of the project. So, we started to create our own spreadsheet, our own forms and sent to different departments to fill in... it was [a] burden rather than benefit (FGD 2).

Two of the participants nominated human factors, such as the manipulation of data associated with high workloads and entry errors due to misdiagnosis, as also contributing to data reliability issues.

I understand the meaning of their workload they had ... they just fill some data for us to be happy. So Data accuracy, it was always a doubt for everybody (4PMF).

It's not the same, like urinary tract infection is not same as colitis. And we know that we have some people dependent on this diagnosis or this data. So, we have missed some data (34TMM).

One program manager noted that not enough attention was given to medical analysis because the context analysis was prioritized.

Overly burdensome administration

Participants reported that the use of poorly defined indicators for data collection and reporting created lots of extra work in regular reporting. Continuous, heavy reporting requirements were especially negatively perceived by the participants in the context of the challenging security situation.

You know you had no time to tell strategically next move, you have to write papers and papers and papers, and you're stuck with papers. That was a very negative point I found with MSF Spain [MSF Regional Headquarters]. You know for Sitrep you write ten lines, but there were indicators, monthly indicators for Sitrep, we had to reflect on data, oh man! At the end you had no time to look at the project (7PMM).

I think we are even more demanding because you're asking them to report on daily basis. With the design of the south Syria project, it was designed for not only daily reporting but continuous reporting (2PMM)

In response to all the above-mentioned challenges, participants said they relied on triangulation of written data with other sources of information. They used innovative data collection involving multiple methods, as described below. The need for multiple data

sources, to enable triangulation and reality checking in the remote support model, is an important learning.

Innovative Data Collection

One program manager remarked that innovative software based and adapted data collection tools improved data accuracy.

I think we did a big breakthrough for the data collection; [innovative] it was first time in Syria in remote supported facility where we get a set of data with certain level of reliability and the tool was very helpful, was very clever tool (2PMM).

Another technical manager spoke of what they perceived as an ‘amazing’ way of doing web-based monitoring using multiple sources to get better insights in South Syria.

First ask for a video or doing the video visits. I would identify the main gaps [for example, infection control, cold chain]. I mean to have a plan to follow and to see the main procedures for this area. Visits are mostly guided, tours through Skype. Sometimes I just do this Skype and call together, to make it easy. When not able to do at all, we just ask them to do a lot of micro videos.

I regret a lot that I took so much time to realize how to do this, because it was amazing. I think even for nurse supervisor, when we found a way to get more connected with them, they took you around with no problem. So, after I just pointed main things, the fault and the gaps according to each point to be improved. I did my opinion and my suggestion (31 TMF).

Triangulation improved data reliability

Participants noted that different methods were used for triangulation, such as coordinating and comparing information with other stakeholders, cross checking information with data sets, and the inclusion of additional sources of evidence. This improved their confidence in the data and information received.

The most important is also to coordinate with others. ...be more open to coordinate with other organization. Because in remote ... to follow up... the source of information are the people in the ground, so cross-checking information is very, very important. Triangulation of information is important (26 TMM).

The information that we receive from the partners, we verified it. We check the consultation numbers and the consumption ...we verified through the hospital also (6PMM).

When we do the analysis, and if I see very weird information in the data, I go and check it, case by case with the midwives. Sometimes I ask them to send registry book images to check what is written here. And sometimes I send the data checklist (16PMF).

4.5.4 Security and Risk mitigation

Participants discussed the security strategies including efficient emergency preparedness and response, risk mitigation strategies implemented to avoid risk of delivery delays and disruptions and risk mitigation for losses and risk acceptance, as shown in Figure 4.6

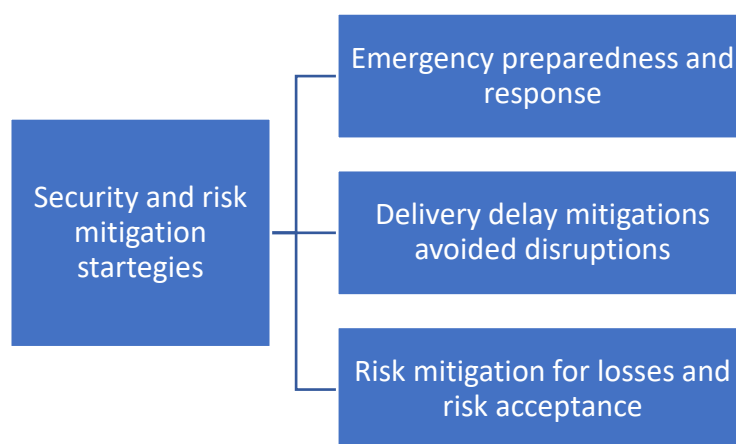


Figure 4.6. Security and risk mitigation in RSM in Syria

Emergency preparedness and response

Emergency preparedness using a ‘Bunkerization strategy’ in South Syria was seen as a crucial step in adapting to warfare, as was the prepositioning of emergency stock. This proved to be efficient in spite of some losses.

Some participants reported that in South Syria Daraa hospital a ‘*Bunkerization strategy*’ (6PMM) was used to operate through three basements instead of a single building. Under this strategy, high dependency services were shifted to the basements to ensure functionality, even in the event of the buildings being bombed. This was one of the crucial steps in adapting to the conflict setting, although it was challenging to set up.

The dialysis was in the basement of old building. The OT was in the second building basement and IPD was in the second building. And we made the third building for NICU and the gynaecology (19STFM).

If you're talking about underground, logistically it's a nightmare to manage. Really, get talking about infection control, water, all these things it's almost impossible and there's no proper lighting, electricity, big challenges (1PMM).

Participants reported that the prepositioned stocks of medical supplies and equipment, called EPREP (Emergency preparedness) stocks, allowed for rapid responses to

emergencies. However, the South Syria project reportedly experienced challenges in stocking up in partners' warehouses due to the risk of losses. Nevertheless this “*eventually proved to be efficient*” (5PMF).

Another strategy was to distribute emergency kits, to targeted facilities for continuity of care. This proved to be very effective, as reported by one program manager in North.

I think that we were super effective because we're sending a specific kit like ER (emergency) kits or ambulance kits to the facilities around the one that was targeted. So, it means that all the population that cannot reach the hospital, because it's closed or targeted, can go to the next PHC or First Aid point and get the consultation and the medication (16PMF).

A few participants reported that this emergency response strategy was implemented through designated highly trained local staff, as the focal points in North, with well-defined lines of communication and protocols to follow.

We have a security focal point, and a medical focal point. First preference is to maintain the security of the staff, then we have to call the responsible person and ask for advice. The field coordinator has to be available 24 hours for this thing (29TMM).

Also, in each health facility there already “existed a basic evacuation plan for the patients” (16PMF) which proved very efficient

However, participants stressed the need for a more comprehensive emergency strategy and the requirement for flexibility to be more responsive to the needs of the population in an unstable context.

That's my big lesson learnt. I am going to push more and more for good planning. In these kinds of things, the emergency is going to be there forever. I mean an emergency is basically the medical needs of the IDPs (16PMF).

...need to be more flexible and adapt to the context (35TMM).

One nurse stressed the need for updating the emergency plans and to continuously train the staff in order to respond to any emergencies effectively.

The MCP (mass casualty plan) we have... we are weak in it. We have not updated in a correct way. So we have put some points ...to have a lot of training for the staff to be aware of every step of the MCP (34TMM)

Another technical manager suggested that effective communication strategies needed to be incorporated in the emergency response plan, in order for it to be more comprehensive.

The emergency plans, emergency preparedness and all are focusing on medical needs and supplies, but I think they need to focus on everything, like how could

you maintain the communication with your field team in the project in a proper and safe way (27TMM).

This is particularly pertinent to the South of Syria, where closure of the remote support project in response to GoS occupation of formerly rebel-controlled territory was reported to be sudden and unplanned.

Following the GoS occupation of Daraa and reconciliation of Daraa Hospital with the regime, the remote support project was closed to minimize the risk to the hospital staff, as ‘non-recognition of MSF’ posed a security threat. Most participants agreed with the security rationale and closure.

The reasons for closure are very practical, primary safety and security of the staff (MSF) inside as well as hospital staff, because we know the Government of Syria are controlling the area. There are arrests and military conscripts that are happening (5PMF).

A few technical managers felt that MSF was too focused on emergency preparedness rather than exit, which needs to be part of program design.

I think, when it comes to remote setting, project closure can happen much more suddenly, So we need to plan this from the beginning (P27TMM).

Another technical manager stressed the need for a comprehensive exit plan with involvement of the staff and stakeholders in planning.

Sudden closure of the project has a very bad negative impact on all. So involve people like beneficiary, national staff, everyone in the planning (26TMM).

Delivery delay mitigations avoided disruptions

Participants reported that delays in the delivery of essential medicines, due to shipment restrictions, non-availability of medications and delays in approvals of non-MSF items, threatened to disrupt patient care. Efficient pharmacy management involving consumption analysis, local purchasing policy (including expedited validation) and the streamlining of drug orders and shipments through a recognised third party were all reported as effective measures to mitigate against disruptions to care.

In order to streamline and regularize the drug orders, it was first necessary to meet the challenge of identifying the real level of drug consumption need, as reported by participants. Effective pharmacy management included the “*setting up of pharmacy*” (FGD1), “*assigning teams to investigate the discrepancies*” (FGD2), implementing pharmacy tools and

recruiting and training pharmacy staff. This led to improved consumption levels as detailed by the technical staff.

Technical managers reported that medications that were unavailable from MSF suppliers, or were on the restricted list for shipment, were procured locally through implementation of an exceptional local purchase policy and expedited validation, thereby falling outside the regular procedures.

We have exceptional validation in the pharmacy department, where information (of requested medicine) is sent to medical director and the section pharmacist for their validation, looking at it more technically, and giving us quick validation considering the situation in Syria (FGD2).

Participants reported that the challenges of shipment delay, due to lengthy permission procedures resulting in potential stock ruptures, were overcome by regularizing drug order frequency.

We used to do that every two months, as sending it every month was quite challenging because you have to go through permits from the authorities. We tried as much as possible to make consumption of two months (1PMM).

Two participants reported that a third party “commercial company with special permission was identified” (1PMM) to facilitate the cross-border shipments of medical supplies, food, and non-food items (NFI) into South Syria and that this collaboration proved helpful.

It allowed us to do distribution of NFI kits, winter kits and hygiene kits in a middle of a crisis, which we managed in record time. We were innovative in that and of course we took some risk (6PMM).

Risk mitigation for losses and risk acceptance

The risk of loss and misuse of resources were also identified by some participants who shared their experiences. Participants reported that loss of shipment items was difficult to predict or monitor, since there was no security system inside Syria.

We could not say if all the shipment was received inside the hospital in Syria, as sometimes some boxes were missing, some items are missing, and we could not find where they were missed or lost. This is the most important challenge from the supply that we have faced (FGD2).

There were many things disappearing: logistics resources, NFI (Non-food item) items and other things disappearing from stocks (6PMM).

Misuse of vehicles was detected when there was high consumption of fuel that did not match the number of patients referred. It was later reported that “the vehicles were used by local groups and authorities too” (1PMM).

Participants discussed the ethical dilemma of providing access to information and technology (IT) services, while knowing the risk of misuse. However, a level of risk was accepted in order to ensure continuity of services.

Usually, we do not share the passwords with others, but remotely I had to because of the need to install and upgrade the programs and without this password they cannot download the outlook. So, my challenges, the risk, if I share this password, they're able to download from the internet unregistered software (FGD2).

The risk of losses during shipments was mitigated through effective interdepartmental collaboration.

Technical managers in FGD2 reported that interdepartmental collaboration and coordination was helpful in eliminating the risk of losses during shipments.

So it's always the pharmacy is responsible for the number of boxes and the content, transportation is logistics and supplies. So, this action plan, it worked, after they didn't lose any boxes. So, it was a good collaboration between supply, pharmacy and logistics (FGD2).

The security response was found to be effective everywhere, even though the North Syria mission was run through MSF and the South Syria mission was provided through their partners.

Participants noted that given the context, risks need to be accepted when planning to implement remotely, and that despite some losses, the prepositioned stock proved to be efficient for rapid responses to the emergencies.

It is real. You have to get ready to get robbed, you have to get ready to have losses and you have to be ready to make mistakes. And if you are not ready for that, you better not go with your humanitarian intentions into a conflict area because it is not going to be easy at all (6PMM).

I was just thinking that if this aid goes there, and if fifty percent of this aid are wasted, still the fifty percent of the aid will be given to the eligible people. And still fine given the context...because you cannot control the context (7 PMM).

4.5.5 Networking and collaboration with stakeholders

The fundamental problem of gaining and maintaining access on the ground in Syria was a constant challenge, due to the warfare and internal conflict. More than half of the participants reflected on the importance of networking and collaboration with stakeholders and saw it as one of the more effective strategies to overcome barriers in the planning, implementation, and continuation of the RSM. The major themes are shown in Figure 4.7. MSF had built a

good network and acquired a detailed understanding of the dynamics of the regions through this network.

Networking with community leaders and the armed groups was helpful in improving community acceptance and negotiating for protection of staff and projects. Networking and collaboration with key NGOs was useful in security management, information sharing, and coordination of activities. One participant summed up the importance of this strategy:

Establishing new network with people, institutions with entities, Arab Middle East entities, who could support us with these challenges was an important decision; also challenging because we were talking with new partners, new friends, new people, that we were not used to work with or consult before taking. But I think that was also very important added value and we also learnt on the way (6PMM).

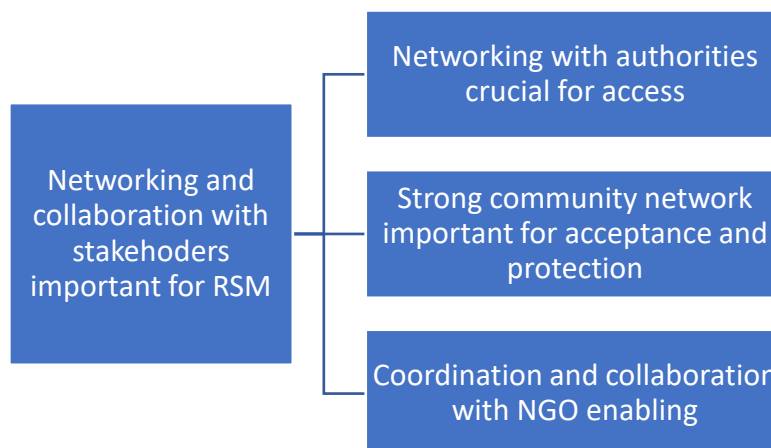


Figure 4.7 Networking and collaboration with stakeholders in RSM in Syria

Networking with authorities crucial for access

Good networking and relations with the authorities was reported to play a very important role in gaining access. Establishing a transparent relationship with the authorities was crucial to overcoming access barriers and facilitating cross-border activities.

We disclosed very clearly where the goods are going and the authorities will never give you permission to send, unless you provide all this information, where it's going, you have to be open on that (1PMM).

Participants reported that coordination and collaboration with authorities was carried out at all levels, allowing MSF to carry out activities inside Turkish controlled areas in North Syria. Otherwise, this would have been complicated.

Our field co [coordinator] working in Kilis...has very, very good contacts here with Turkish Government and at the same time with authorities in Azaz area. Our workers, our managers are also having very good contacts. So we are working ... coordinating well (14PMF).

MSF was the supporter of this campaign (measles), which was carried out with the help of the health management in the area (SIG Syrian Immunization Group). So, it was completely supported by the MSF (24STM).

One participant noted that relations with authorities determined the scope and design of the programme.

We are networking with Turkish authorities, you know things. So, this networking is letting us know things that we can do. Our relation with Turkish authorities in Azaz is growing very well, but in Afrin? (35TMM).

Strong community networking important

Participants emphasised the importance of having a strong community network, to gain their acceptance and support, to avoid complications and to ensure smooth implementation of activities. Participants also stated that meeting with the community leaders and the armed groups was helpful in negotiating for access, protection of staff and to mitigate the risk of losses.

Good collaboration with the local authorities, we never faced any problem, they didn't steal or loot our caravan. So, they respected a lot MSF and I think that is an important factor like a good collaboration with the city council, also the local health department of the rebel area, we had very good relation with them and that was really important (7PMM).

In the reception centres the authorities they didn't want MSF to work, but it was the request by the Syrian local council they request that to Kilis governorate (authorities in Turkey). (11PMM)

Coordination and collaboration with NGOs

More than a third of the participants discussed the coordination and collaboration with international and local actors for interventions inside Syria. Collaboration with specialized organizations was seen as mutually beneficial and enabling. One participant in Darra project reported that the coordination and collaboration with diaspora organizations for dialysis technical support was effective.

The good connection with other organizations specifically with Handicap international (HI), Medecine Du Monde (MDM), other sections of MSF was

enabling. Our leverage with ICRC people and our connection with them is enabling factor as well and it helped implementation inside Syria (6PMM).

For dialysis, I think it was in Hospital A, we were in better coordination with other organization, they are specialized in that. So, we are supporting part of it. For example, the infection control where ... we are strong. And for the technical maintenance, for example, of this equipment for dialysis is supported by other organization (2PMM).

Collaboration with organizations involved in security analysis and management, like ICRC (with security and protection mandate in GoS controlled areas), was helpful in planning staff security, especially after disengagement from Daraa. Coordination with specialized organizations familiar with MSF's security requirements was also helpful.

ICRC has the mandate of follow up prisoner's condition, treatment condition creating contact between prisoner and family. There is a focal person for that and to so pass this number to the staff so that their family can keep this number in case one of them disappears (5PMF).

Participants emphasized the importance of networking and collaboration with NGOs in identification of needs through information sharing and triangulation.

Talking with NGOs involved inside Syria, this information is where we base our proposals for the project. So, you needed to triangulate to have good networking and lot sources of information from whom to gather this information, which was not only medical, like winter kits, non-food items kits and hygiene kits (6PMM).

Related to the needs we are following also the organisations managing the camps, example arrival of the IDPs at the reception centres... and the requests from other organisation to us also reflects needs of the health in the area (35TMM).

When discussing the process of coordination of NGOs one of the partner program managers talked about the ease of coordination of activities. In contrast another technical manager reported implementation challenges and accountability issues with multiple donors

They are used to coordinate among themselves. So, there was no overlap, each of the NGOs provided specific types of medication, these were coordinated by the NGO representatives themselves. We had nothing to do with it (29TMM).

I think full [sole] support facility it's better for us because, what should be the goals and guidelines, MDM protocols or MSF protocols or WHO protocols? We have a lot of monitoring tools. They have their own monitoring tools, their evaluation tools, they are different. So, I think we've confused the people. They will pay incentives, might be that will be much more than us. This is more like a competition and not a healthy environment inside the facility. And how we can segregate like supplies? Like we send medical supplies, we say 'this is for surgical department, this is not for paediatric', because paediatric is supported by other organizations. So it's not it's not that easy to do that (26TMM).

To conclude, the RSM in Syria required MSF to develop new ways of working, necessitating change to some of its embedded systems and processes. This section has explored the

major strategies employed by MSF and its partners to meet these requirements, and to effectively operationalise and secure the remote support model. The participants outlined the measures put in place to enable good management, monitoring, maintenance of access and security and to work effectively in partnership across borders, organisations, and cultures; and discussed the level of success with which they were implemented.

The next section presents participants' reflections on the challenges they faced, and on underlying or cross-cutting issues that were important in the implementation of RSM.

4.6 Challenges and learnings

Participants reflected on seven main challenges to the effectiveness of the RSM model that they believed MSF or other providers of essential health care in conflict settings need to address, and where established methods and tools are often not effective.

4.6.1. Information for management and care is less reliable in remote support

Health care services rely heavily on data about the level and nature of needs for care and the resources required to meet them. But the normal methods were not seen to be effective in Syria. Two thirds of the participants found identifying needs through the remote support approach difficult, due to challenges in the assessments and in managing drug supply, issues around data reliability and poor information sharing. These themes are depicted in Figure 4.8.

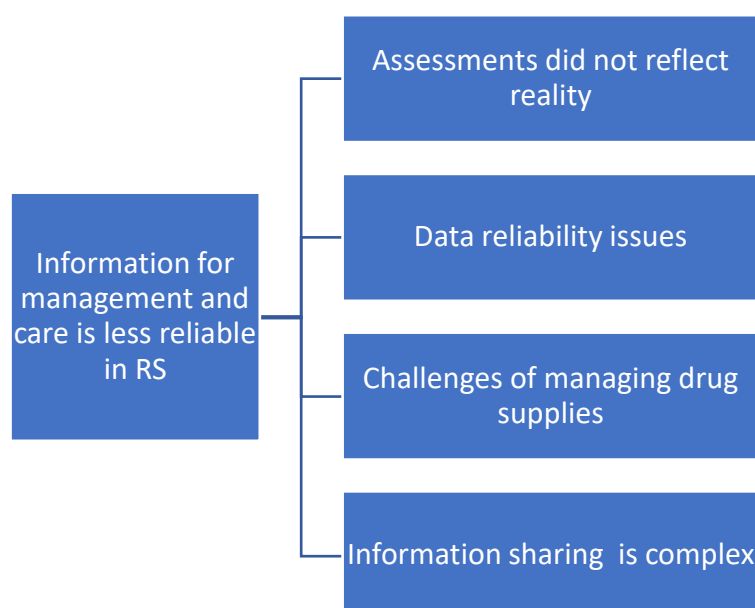


Figure 4.8 Information issues for management and care in RSM in Syria

Assessments did not reflect reality:

Participants noted that it was difficult to identify the real needs of the population through assessments in the RSM context, with initial assessments considered inadequate and not reflective of the reality on the ground. They articulated two main reasons for this difficulty.

Firstly, it is difficult to conduct realistic needs assessments in a conflict situation, particularly one that is rapidly changing and with many people fleeing to avoid sites of conflict.

One program manager, acknowledging the importance of ongoing assessments of the existing projects, described how challenging it is to follow regular programs with new needs emerging during the course of the war in an unstable context that requires constant adaptation.

Sometimes you needed to review that what you were doing was still relevant. We changed several times our strategy for example, going from phase 1 to phase 2 and Then we have another situation, how do you go about the analysis of the needs, when there is a battle for days or weeks, or intensification of the bombing in an area. You don't have the medical tools of data collection and analysis that we use in the longer terms, you cannot use for the decision to be taken here (6PMM).

Another program manager highlighted the challenges of identifying the needs of the internally displaced populations (IDP) in this unstable setting, given that they were mobile and hence not available for a more systematic assessment.

Our main objective was following the IDPs ... their needs and in Idlib was our concentration of IDPs, first, second, third, fourth, fifth time that they would be flying around, from Aleppo, from the south, from Gouta, from Damascus, from Hama. So, for me was difficult at the beginning trying to identify, to prioritize their needs (16PMF).

Secondly, while participants stressed the need for adaption and simplification of the assessment tool and the value of conducting joint assessments (i.e. with MSF staff participating virtually), standard MSF needs assessment tools had not been adapted for local use.

The challenges that they don't speak the same professional language as you and they do the assessment, so, it's not the trust, well you can't translate the professional language you are looking for assessment. Need to adapt to get the right response (FGD1).

Participants noted that MSF lacked suitable tools for rapid needs assessment during war and emergencies and “*many (tools for rapid assessment) were developed*” (16PMF) by the

project staff such as rapid health assessment, rapid facility assessment and NFI need assessment.

Data reliability issues

The service delivery and management data that was collected was assessed as inaccurate and of poor quality, due to mistrust and other challenges in data collection and analysis [see section 4.5.3 monitoring].

Challenges of managing drug supplies

It was reported that the real rate at which drugs were used/consumed inside Syria was unknown, prohibiting an accurate assessment of the need for drug donations. Poor pharmacy management, consumption level variations, lack of staff and lack of tools were some of the reasons given for this

Control of consumption, this is difficult thing; I think it's very important because if you are looking for quality you would have to manage your resources (30TMM).

When you have the pharmacy management issue you cannot know your needs, you cannot identify your needs (FGD 2).

Inadequate staffing was cited as a contributing factor:

Nurses working hours were much less than required some of them were not qualified... Sure they will feel so busy and have no time for records (37TMM).

The use of informal and undocumented practices of exchanging drug supplies with other hospitals was also identified as a contributing factor:

Consumption variation was the hospital 'A' was using some of the drugs for exchange with Hospital 'B' and other external hospitals (FGD2).

The challenge of measuring drug consumption and needs remotely was summarised by the pharmacist manager:

So, OK I can see what I receive in Jordan, but I still can't see exactly or in reality what is consumed inside. And so, I was the only one doing it at the beginning. That's why it wasn't really accurate (28TMF).

Information sharing is complex

As the specific problems outlined above indicate, information sharing in general was seen as complex. Participants reported that many factors, including levels of trust, security, and

cultural factors, negatively affected the information sharing between the remote teams and MSF staff in Amman. Slow flow of information also delayed decision making. However, while information censoring (by local teams) was perceived as a problem, most relied on the information received from the field and some reported that too much questioning was “negatively perceived” (11 PMM).

I mean challenges in terms of getting the correct information. We have to rely on what the people inside were telling us exactly. And so, it was really difficult to establish what was the real situation with no visual perspective (13PMF).

In general, I trust but I am not trusting a lot of the information. For example, at the hospital they'll tell you that the people don't die, it is a mystery zone I think that they don't want to share that kind of things (15PMM).

There were many reported reasons for reticence on the part of local staff in Syria, given the nature of the relationship (between recipients of essential support and resources and the organisation that controls supply).

Maybe they were trying to hide some information, so they can get more supplies from you, or more time, or more team to work with them. Sometimes you have this feeling that they are hiding information. Maybe they are fearful of from punishment. Maybe they don't want you to tell them you did this wrong. So yes, to seek information was a challenge (20STF).

However, good communication was also noted to help in overcoming this reticence:

After I explained to them many times, that I'm doing this to try to provide you with maybe more staff or provide you with a blood bank, fridges, I need to know what is really missing there. So, they started telling this information clearly (20STF).

Management of complaints about staff was noted as another very sensitive area for MSF.

If one person is doing more work and another person is doing less work and if someone complains about it, you cannot address it directly. Because, giving feedback in the security context even if you know the information, you have to be very, very sensitive in giving your feedback (1PMM).

Some participants expressed frustration at the slow pace of information flow in the delivery of remote support which resulted in delayed decisions and implementation of activities.

In remote management information flow is always challenging. The flow of information in the remote management is very, very slow. You ask questions then you come with the answers. So that's why it takes a long time but at the end of the day issue is addressed (FGD2).

4.6.2. Different medical cultures and practices

Participants reported that it was difficult for MSF to effectively influence practice inside Syria via remote support due to a lack of understanding and clarity of the medical cultural and

practice inside. They said that this was difficult to change. They also reported low accountability and poor documentation and the need to adapt the protocols. However, the protocols were reported to be applied more successfully in MSF hospitals in the North (see Figure 4.9).

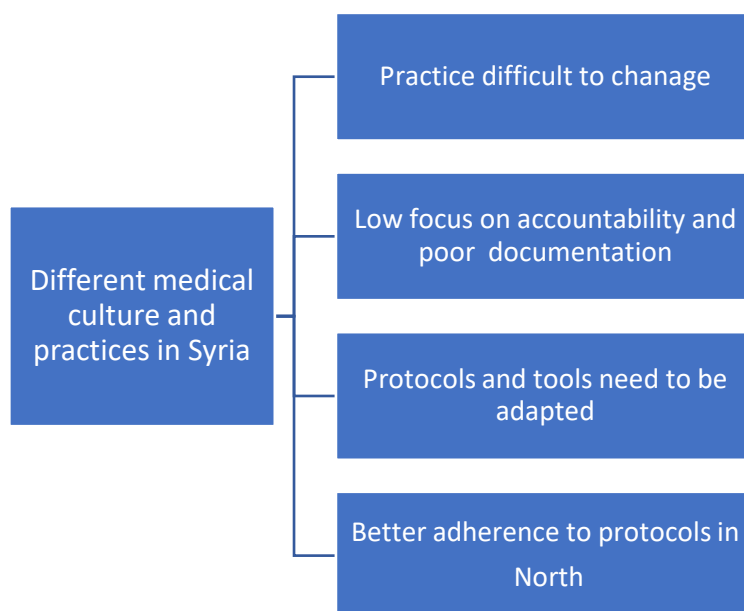


Figure 4.9 Different medical culture and practices in Syria

Practice difficult to change

Almost a third of the participants were of the view that it was difficult to influence and change medical practices inside Syria. The three main reasons cited were related to practices specific to the war context, distinct regional practices associated with the hierarchical medical culture and the entrenched knowledge and attitude of the practice staff.

Firstly, the medical practice priorities of MSF and their Syrian counterparts were reported to differ. While MSF focused on improving the quality of care, not necessarily taking into account the precarious war situation, the Syrian's primary objective was to respond to the immediate need resulting from war and the safety of the staff. For example, the length of stay for patients in the hospital was shorter because of security concerns and follow up was difficult.

IPD care, for example, for me is a complete failure. For IPD care we didn't know how to insist. They were used to war times, so people are not in IPD for enough time, so finally didn't develop with them how to do a proper IPD care. This is one of the real failures (3PMF).

One program manager shared the experience on how MSF was not able to convince partner specialists to change practice based on protocols, for example, fracture management during war.

They are saying, "listen we have a lesion [fracture], we have a problem we need to operate" and you [MSF] are saying "okay but the infection, osteomyelitis"... "Okay we will solve later but we have this patient, you need to solve". So, there are different points of view, and it is very difficult to change this point of view (3PMF).

Secondly, In Syria the medical practice was reported to be specialist doctor oriented, and it was therefore very difficult to implement interventions requiring clinical task shifting in the absence of the medical doctors.

We've been trying hard with the director of the hospital to let midwives ... run the clinic, because they believed that the midwives cannot run the clinic and should be run by a Gynaecologist. It is very difficult to change the mentality (FGD 1).

The OPD, it was not the OPD that we always think about, it was more like a specialist clinic. It was hard to change this concept to more community OPD (2PMM).

Participants also noted distinct practices specific to the region, such as high use and prescription of stronger antibiotics. One technical manager from the North reported that control measures such as close supervision of stronger antibiotic prescription was implemented to overcome this issue.

Using the Vancomycin is a big issue for MSF, for the Vancomycin. I don't let the doctors write before going back to me. I will sign on a prescription of Vancomycin to get from the central pharmacy (35TMM).

It was also reported that in the Middle East, patient confidentiality (Ethics) is not fully respected and that was culturally acceptable.

The understanding of patient privacy, confidentiality is not well established, that if you're working as a doctor here in Jordan, someone who is not related to the patient, maybe someone from the city will ask you, "what's wrong with this person or what's his diagnosis". So, it's sort of like a cultural thing (30TMM).

Thirdly, a few participants reported that it was difficult to change the knowledge, attitude, and behaviour of practice staff, as most were older and quite experienced. It was therefore difficult for MSF to convince practice staff to follow more evidence-based practices.

It was the practice; I mean the doctors there are not young; they have a few years from experience. So, a few things were really hard to change. I think it was more because they were used to do something for years and didn't want to change (31TMF).

Midwives with at least 20 years of experience and all of them had set long back, old ages knowledge, you couldn't change that easily. So, it was a bit difficult to convince them to use the new technique or to use new methods (20 STF).

Participants noted that practice change takes time; especially when support is provided remotely and they suggested that staff need time to understand and adapt their practice.

Practice change through remote support has to be gradual (FGD1).

We have held meetings to try to bring the experience of doctors closer and that of MSF. Doctors know that medical protocols need a period of time of practicing so the staff can adopt them (32TMM).

The medical culture in South Syria is totally different. Change will be a bit slow this time (2PMM).

Low focus on accountability and poor documentation

A third of the participants reported that protocols and tools and the reporting requirements were not prioritised by the partner staff. Reasons given for this included that the use of protocols and tools and paperwork were seen as an administrative burden and an additional responsibility. The use of software based complex tools was especially perceived as extra work requiring “additional staff” (37TMM).

We have this ANC protocol, which is very simple and easy and any midwife can follow it. They were resistant to doing this, because maybe they thought ... running this clinic it be a burden. We will have to go for clinic, so it was difficult (31TMM).

For the pharmacy staff, they initially were more reluctant because when you give them more responsibility, documentation, more accountability, so people are reluctant (FGD 2).

Secondly, staff in FGD raised the issue of governance inside Syria, where the lack of MoH control resulted in the absence of any systems for accountability and poor documentation. Participants linked this to the war situation, where patient care is clearly prioritized over paperwork.

If you tell them that this document has a medical legal purpose, they will tell you “Hey there's no medical legal aspect in our region”. However it would be happening when they re-establish their state (FGD1).

In Syria the field hospital means illegal one, with poor staff, drugs and consumables. It's targeted any time, so no need apply protocols and no need for registries or computers (22STM).

Thirdly, it was recommended that the paper-based protocols and tools be specifically adapted for use to the context, as this had not occurred, as described below.

Protocols and tools need to be adapted

MSF standard protocols and tools had not been adapted to the Middle East context. Paper based protocols, guidelines and tools were described as not applicable in the war context or to the region and translation of the materials was seen as too time consuming.

We can't say it is 100% suitable or adapted to Syria because sometimes we need medicine for one case that MSF doesn't offer or doesn't have and some patients require, like specialized care [guidelines]. Specific specialization that MSF hospital doesn't offer (23PMM).

Participants emphasized that the protocols should be a user friendly, involve less paperwork, and be adapted to the reality on the ground. They wanted simplified, familiar and concise tools that could be used by all the staff.

Because for the anaesthesia chart ...with lots of lines and things, for the anaesthesia technicians it was easy to do it, because they are used to see it before. So if it is simple, if it is familiar it will be easier, and if it is really serving a purpose (FGD 1).

I can understand if I was the only doctor in ER ward and go for urgent surgeries; I would not be able to take care of documentation (FGD 1)

One of the technical staff referred to having learnt not to send heavy guidelines and reference books, as there is no time for staff to read them.

I don't think ... they get any benefit from these books even the Arabic versions as they don't have time. If a doctor, a young GP (General Practitioner) is spending six days in hospitals and clinics, seeing his family for one day in a week or six hours or 12 hours of clinic, who would be able to read? (30TMM).

Participants suggested involving partner specialists early on in the process of joint adaptation and development of protocols to improve their acceptability (See section 4.5 headed 'Medical-specialist-strategy').

Better adherence to protocols in North

Most of the participants agreed that protocols are followed better in the North in the MSF hospital because the staff were experienced and had been trained in MSF protocols.

Yes, it works very well as in sharing with Azaz project. The protocols there are totally MSF. So, I know that the medical staff working there doesn't have any complaint about that (15 PMM).

4.6.3. Staffing challenges for remote support

Participants highlighted many staffing problems in RSM, including inadequate and badly coordinated staffing; difficulties in finding staff to meet the broad requirements for working remotely, and the complex recruitment process (see Figure 4.10). Participants nominated a need for forward planning to meet the capacity and composition needs of remote teams.

They also recommended investment in local staff, with staff retention policies to fill gaps due to international staff turnover and the external drain of local staff, and to ensure better MSF representation inside Syria.

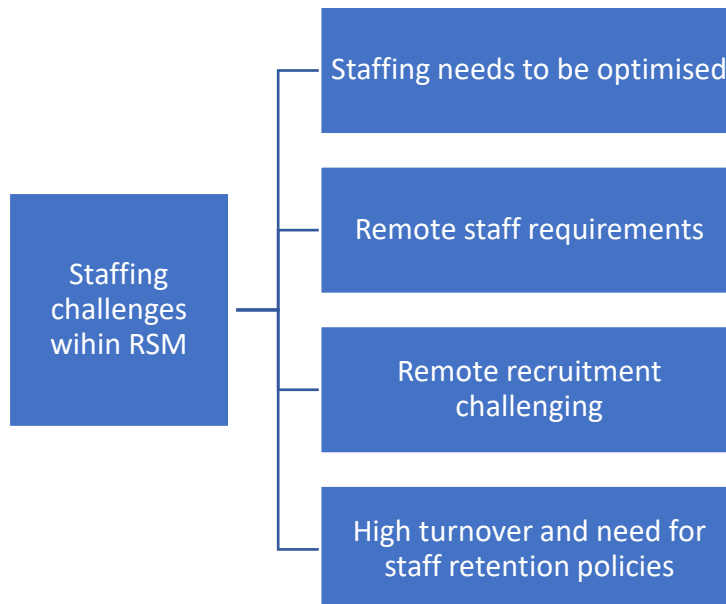


Figure 4.10 Staffing challenges within RSM in Syria

Staffing needs to be optimised

Participants reported that the human resources (HR) were not optimised, as there was not enough staff inside Syria, as well as in remote locations, to adequately support teams. Teams were multi-tasking and were not available to effectively complete all the planned activities.

We only had two staff inside [Syria] and they were busy with so many other things. We didn't have enough resources inside to be able to do, people I mean, to do outreach, go and meet people (9PMF).

We [Remote support team] were only the PMR [program medical referent], surgeon, gynaecologist and a nurse activity manager (NAM). This is in the medical team. and the liaison officer of course, five guys. And it's really difficult. Like then if you want to control that much a facility you have to think about the number of your team (32TMM).

One program manager clearly stated that concerns about workers not being able to fulfil their duty of care was the reason that there were not more MSF staff inside Syria [see section 4.3.1 Access barrier]

Participants stressed the importance of capacity and team composition pre-planning for the

successful implementation and follow up of remote strategies, especially in relation to remote technical support.

Managing remote control like South Syria without having full team inside is quite challenging. Make sure you have enough team inside from the first day (8PMM).

I think having MSF staff inside helped a lot. HR is very important, to have in remote programming. Because having more people related to the organization inside helps a lot in implementing these standards or following up with people inside (28TMF).

Remote staff requirements

Most of the program managers referred to the lack of technical expertise, at all levels, in remote management in MSF. They emphasized the need for remote management experience and the need for more management profiles, hospital management skills to coordinate and collaborate better with partners for remote hospital support.

I think the quality of the staff, remote management is difficult, we don't have people who are experienced in Remote management. We bring a lot of people with a lot of experience, but they are used to seeing and observing. You bring someone with a lot of experience, but they have no idea what Remote management is. It is very, very difficult and frustrating (1PMM). Remote manager who is more a designer or a thinker of the project, who can provide the project with the ideas with percept and getting it refined. It should not be run by classical MSF expat, but more hospital managers (2PMM).

I think.... we really need to have staff who are knowledgeable, understanding clear remote management. I think you need to understand what your management in the first place is (1PMM).

Participants also stressed the need for remote and local staff to have communication skills and language skills, and for partner staff to have basic computer skills and to receive technical support.

So, one of the biggest issue is the communication skills. If you are setting a remote support project you need to hire within your team people who speak the native language (27TMM) .

We have to make sure that the people inside Syria to have at least basic knowledge of English, so they can understand the word like the delivery or local purchase (28TMF).

Remote recruitment challenging

More than thirds of the participants raised the issue of the recruitment of the staff in Syria. In general, the remote recruitment process was perceived as complex and challenging because of difficulties in the identification of the most relevant staff and with the logistics of organizing remotely. "Trust" was viewed as integral to remote recruitment.

It was really challenging not only for us, but for all the humanitarian NGOs to identify and hire staff. How do you know this is not the other group? so difficult, it's a big challenge you cannot tell (1PMM).

Participants suggested that contrary to MSF practice, recruitment should be done in such a way as to ensure that known and trusted staff are recruited. They also emphasised the need for consultation with, and the involvement of, local staff to ensure staff security. The 'clan based' selection of local staff from the region, who were known to others and were in a position of influence, was viewed as more acceptable.

In the Middle East it is better to trust someone that you know and hire that person. For us (MSF) it was the opposite way around We didn't want to hire anybody that was known to any in the team and we preferred to do a very aseptic recruitment process (6PMM).

Staff should be chosen at least with the help of the local team. You are going to work in another country. You should rely on other people even from that country (35TMM).

One of the... important things we will have, is MSF staff inside will be from the region. The nurse supervisor inside was also very much important because he was head of nurses. He knows everything, every millimetre in the hospital and the staff like him (19STM)

High turnover and need for staff retention policies

The high turnover of staff members, both international and local, proved to be challenging and was seen as having a negative impact on the continuity of the remote projects in Syria.

International staff were contracted to work for shorter periods, reportedly due to the unstable context and pressure, resulting in high turnover and the loss of institutional memory.

The high turnover of MSF is an issue. Now the expats stay six months sometimes nine months (18STM).

When you read the reports from other people who were here before, you can find a lot of things that they had started a discussion to implement. And currently they are not really implemented. You need to re keep these ideas and to restart. There is some lost information in all this time because there were gaps at capital level, several gaps at capital level (14PMF).

High turnover of international staff was perceived as detrimental to the building of trust. Therefore, participants recommended a longer minimum commitment for international staff, to ensure stability and to allow time to build trusting relationships between international and local staff. A re-engagement strategy was positively viewed, as a way of sustaining a trusting relationship with the team.

The problem with MSF, we have frequent turnover, and new guys start to come and to build the trust again with the national staff [local staff], they have to get used to them, his way of working, so it's wasting the time. So, I think with MSF, with remote we need more commitment from people for a long time (26TMM).

The MTL (medical team leader) she was working for us for six months, she goes to another project in another country for few months and come back for six months, so she knows everything about the project and knows who to trust. So it was very, very good idea to do this (29TMM).

Retention of skilled local staff proved challenging in RSM. Program managers reported that NGO market competition had created a constant drain on the skilled and trained staff, resulting in staff shortages and occasionally in the disruption or discontinuation of project activities.

We have several problems about HR issues. They stop; resign because they have other opportunities in the area. We have more actors trying to work in the MH and offering our staff their salaries better. Of course, we tried to keep up to motivate the team to stick to stay but it was really difficult (14PMF).

One of the NGO opened a clinic two kilometres away from Hospital B. So since then the doctors have gone away from the hospital to those clinics, because they were more comfortable there, which negatively affected the Hospital B (12PMM).

A few program managers also felt that a lack of career goals and development had demotivated local staff.

I think we lost Y, we lost A, because we did not keep him for some reason; they didn't get the money they needed or they didn't see a future beyond, "I'm an assistant, am I to stay an assistant with MSF all my life?" We lost good people because we weren't willing to invest in them to kind of show them, you have a voice (9PMF).

They recommended investment in key local staff, including the adoption of a staff retention policy, and further work on their professional growth plan. This they reported would assist the staff to: 1) retain institutional memory to cover gaps in international staff positions; 2) stay motivated, develop skill sets, and have the capacity to take additional management responsibilities and; 3) better advocate and network for MSF inside Syria.

National staff [following development] will have the capacity to continue the program if expats are deported for security reasons (26PMM)

What I need is somebody inside who can assist or represent me and organization inside [networking and advocacy with partners]. The people inside could have been deputy field Co, could have been able to go and meet you could have a medical activity manager inside (9PMF).

Lastly, in view of the psychological challenges for staff and the difficult working environment for participants in a war context, they stressed the importance of having a mental health

(MH) support strategy for staff. While participants acknowledged that there was a general centralized MH staff support policy, they reported that there was “no clear strategy” (P28) specific to the conflict ridden region. The need for mental health support was quite evident from the account of one of the staff reflecting on the experience after the RSM project closure.

You go back home, sit with the other friends. In your mind there is a war going on, you are worried about your friends and colleagues (inside Syria) and you are thinking. You have adrenaline because you are in a war context. And when you get out of the office, you feel that, I am the only one in the world and nobody's there (20STF).

4.6.4 Partnership challenges and needs

Participants identified many challenges MSF faced in relation to partnerships including governance issues, a perception by partners that MSF were merely donors and the limited involvement MSF had in management and decision-making. Stressing the importance of external partnerships for access and to ensure their effectiveness, participants highlighted the need for a well-defined strategy and plan for engagement with them, including a clear MoU and integration of partners in project planning and implementation. These are listed in Figure 4.11.

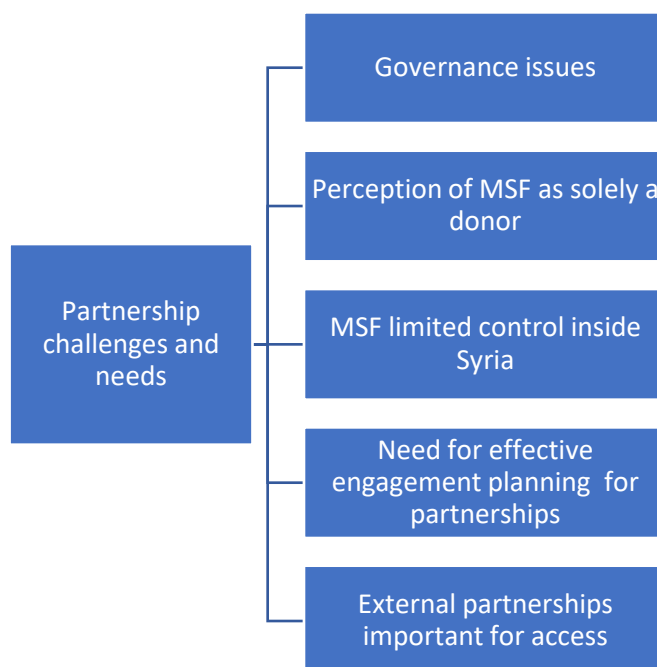


Figure 4.11 Partnership challenges and needs in RSM in Syria

Governance issues

Lack of MoH governance, administrative control by rebel groups and the poor management

skills of the hospital managers, were the main reasons given for governance problems inside the hospitals in South Syria. Participants reported that hospital directors didn't have much control over hospital administration and legal authority or control over staff, and therefore were less accountable.

Let's face it they don't have a system. Even the director wouldn't have this strong power to punish, to force them to keep with regulations. I mean he wouldn't be able to deduct from this salary to giving extra calls. They have a failed or a collapsing system, there is not, what they call it the strength of the law (30TMM).

Staff were not accountable for mistakes (22STM).

The rebel groups controlled the administration of the health system in the opposition-controlled areas and therefore had a strong influence on major decisions.

These hospitals are 100% controlled by the opposition groups and the decision-making, administration wise, in these hospitals are mainly linked to them (8PMM).

They removed Dr Y and put Dr M, where I thought there was no need [to change] the Directors and staff. But it is their decision (9PMF).

The lack of management skills of the program managers (appointed by the rebel administration) was another reason given for poor management of hospitals inside South Syria.

What I understood is that this hospital manager as such never managed a hospital before. So he was a doctor who had his own practice. He was put in power by the controlling body at this time in order to have somebody they could also control (10PMF).

I'm a doctor, a urologist and a hospital doctor for general surgery, but in other matters (administration) my role is secondary (32TMM).

Perception of MSF as solely a donor

A mind set amongst the partners, of MSF as merely a donor organisation was nominated as one of the main challenges MSF faced while implementing strategies to improve the quality of care through remote support. Participants reported that it was difficult to negotiate and collaborate beyond donations due to the general perception of NGOs as donors inside Syria and because the way MSF functions and provides support was not clear to partners.

They understood a little bit more like we are donors.... "express the cow as much as possible". But it is true to sell this technical aspect they are quite tricky. So, all what they wanted is "give the material and leave me alone" (3PMF).

There are a lot of mechanisms that you have in other organizations that you don't have in MSF. As you are not funding as a funding body to the partner, it is difficult to have the commitment of sharing reports, sharing information. Sometimes culturally is difficult to explain to a partner, as his normal way of working is to

receive funds and to implement and just to submit report or be accountable to the report (35TMM).

MSF limited control inside Syria

It was reported that MSF had less control within remote partnerships, with a limited role in the decision-making (DM) and in the management of the supported hospitals, resulting in challenges in implementation. There were mixed perceptions of the extent of MSF involvement in decision making, with one program manager reporting that MSF had no control over management decisions inside Syria. In a contrasting view, another program manager reported that, though the final decisions rested with the local administration, most decisions were discussed and mutually agreed.

They were autonomous by default, because they were not listening to us, and we had no power to make them listen to us. It was because of lack of physical presence; we don't know how to do thing (7PMM).

Decision was done mutually, we never imposed things, we always tried to explain why we wanted it, convince them, and if they needed something they would try to convince us. So I felt it was very good kind of healthy interaction (9PMF).

One of the technical managers (partner) clearly stated that MSF had a limited influence on local decisions. This was perceived to be because MSF had not agreed or negotiated a formal process of decision-making with partners, which in turn led to implementation challenges. Participants emphasised a view that MSF needed to be more involved in the local management and decision-making inside Syria, in order to ensure some accountability. This was especially important in relation to decisions regarding partner staff incentivised by MSF.

There were no clear mechanisms for MSF to implement its point of view without the consent of the hospital. When the views differed between Hospital A and MSF, MSF always adopted the view of the hospital, and this was sometimes wrong. MSF's intervention is weak, and the hospital's view had always prevailed even if it was wrong, causing problems (32TMM).

I think MSF should find a way to interfere in choosing or replace staff; I was informed that remote management system didn't allowed MSF to interfere with this (37TMM).

Another program manager felt that MSF missed the opportunity to influence hospital management, though not involving the influencing bodies (rebel groups) in Daraa that had authority on hospital decisions (as mentioned earlier) and were open to MSF support. Participants emphasized the need for MSF to negotiate with important stakeholders if they were to have an influence on decision-making with partners.

I think it was both a very strategic and political place at this moment. So, power control [rebel groups], also I think was influencing the hospital in order to keep the support they have gotten from this INGO (MSF), but we were not connected to the controlling party. So, it is very difficult to build a house from the roof (10PMF).

Need negotiation with key people before intervention (FGD1).

Need for effective engagement planning for partnerships

Many strategies to have an effective remote partnership with local actors and hospitals inside Syria were suggested and discussed by participants. All of them highlighted the need to have a clear strategy of engagement with partners right from the beginning. This included defining the scale and scope of the intervention with clear objectives to ensure better acceptability and to avoid facing implementation challenges for the team. Tertiary care interventions in Hospital A had confronted such challenges.

MSF tried to take a step bigger than the leg. Like dialysis, I think it's new for MSF, as MSF is more focussed on PHCs and runs lot of facilities, but what they were trying to do was bigger than offered in terms of budget, capacity, equipment. We faced this on a daily basis (FGD1).

They also emphasised that any change in the planning of the intervention needed to be effectively communicated with clear instructions to follow.

Hospital B was really easy for us to deal with because from the beginning we wanted to do improvement of the quality of care. In hospital A for one year it went for doing only financial support and then we started to improve the quality of care, to train the staff and start implementing our guidelines. So the change for the staff was difficult (28TMF).

The need for clarity and good communication was also emphasised in relation to the program objectives with the teams inside [both MSF and partner]. It was important for them to understand the scale and scope of the intervention and not raise false expectations.

I feel this is a barrier "why you're not doing more" [partner's expectation]. You know when you're [MSF support] doing your best. So you see different levels of understanding (32TMM).

To change the mind of the team, in the sense that it was a pure donation program and now they have to change their mind to be a support program... is to make them understand that you cannot respond to all the needs of the population of the health facilities. We need to explain again to those who implement the support part (35TMM).

Participants also stated that the purpose and justification, as well as the steps towards implementing the intervention needed to be clearly communicated, because this enhanced their level of motivation and would consequently increase the likelihood of implementing the intervention effectively.

Once they understood why, and once they understood how to do it, they were willing to do it (9PMF).

I think to find good justifications to have this tool. So, they needed to follow with translation, training, explaining why we are using these tools or what is our aim, what is our objective, what is our target. If the staff buys it, then it could be implemented (26TMM).

Secondly, on formalizing remote support partnerships, many participants stressed the importance of having a clear and detailed MoU. They highlighted the need for MSF to have a facility-specific MoU, negotiated beforehand with the parties, with specified partnership terms and conditions. This would enable a more defined role of MSF in decision-making and management in MSF supported hospitals.

We should have a very good MOU with the hospital director. This is very important. The clearer MOU we have with the hospital director or with the hospital...more we are clear [to partners] about our vision and what we exactly want to do inside (28TMF).

So, if we have a very good MOU. The hospital director would say that the hospital doctors would ...cooperate, more with MSF (3PMF).

Thirdly, participants emphasised the need for integration of partners in the planning and decision making, in order to improve the acceptability and effective implementation of remote support interventions. Strategies for successful Integration of partnerships required joint development and review of protocols and tools. (See section 4.5.1 headed Medical specialist strategy)

Ultimate thing for me is to put the options in front of the field eyes and integrate them in decision making, but this must be a very careful process. I have to talk about integration, because even if Barcelona one [decision] is more MSF standard and more MSF objective wise, Daraa one will help us to be more successful (FGD1).

External partnerships important for access

In spite of all the above-mentioned challenges, there was a consensus among all the program managers that remote partnerships with local actors are necessary for access and sustainability of MSF projects inside Syria. This is helped by a change in the local scenario, with the emergence of local actors with better access.

MSF is not sustainable development organisation, this is also clear as much as emergence of local organisation, that day by day as we progress, it is very important talk about sustainability little bit, to see that whatever you're putting in place can last for some time (1PMM)

If they [MSF] are not able to access then they may intervene through a second NGO, through a partner NGO instead of directly trying as there are plenty of local NGOs inside, most of other NGOs do it. This is important (7PMM).

Local Ngo in Daraa are now registering with Damascus [GoS], when border opens, they will be able to come to Jordan (9PMF).

4.6.5. Communication and trust important in remote support

Almost two third of the participants stated that communication and trust are crucial for the implementation of remote support programs. However, remote communication was seen as challenging. While centralized communication with partners was reported to be inefficient, participants stressed the need for effective communication strategies in remote projects, as described in Figure 4.12.

Trust was reported by participants to be a crucial part of building relationships, with both individual and organizational trust being built over time and with variations at different levels. While transparency, consistent engagement and face to face contacts are all crucial to building trust, high turnover of staff proved detrimental in building a trusting relationship. Mistrust of local staff was seen as an organizational barrier.

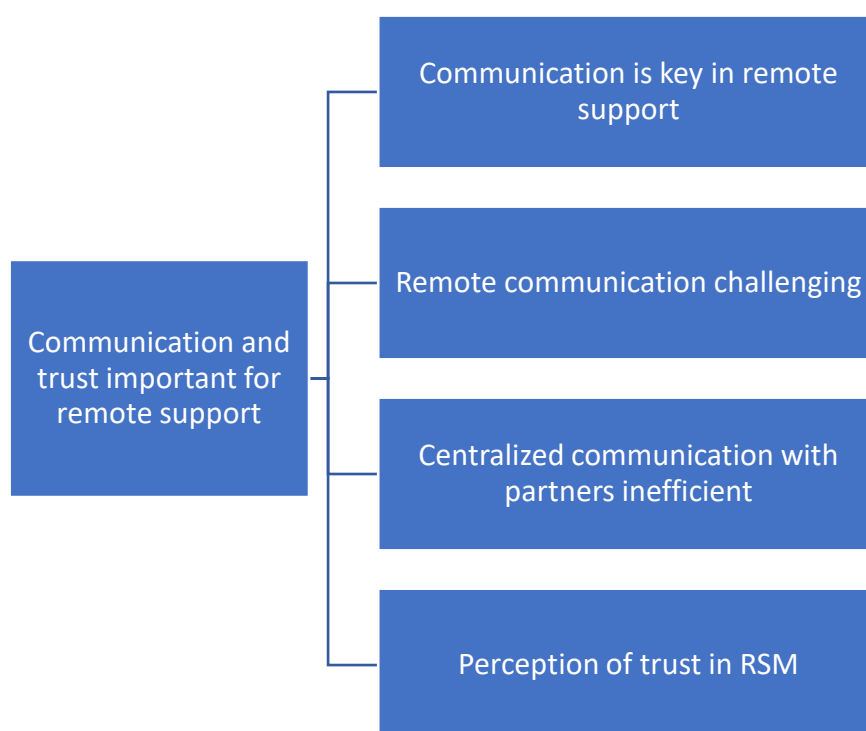


Figure 4.12 Communication and perception of trust in RSM in Syria

Establishing good communication was perceived as crucial for remote implementation. Participants reported that in spite of the initial challenges, the communication strategy was adapted and developed and was viewed positively towards the end.

The most effective strategy that we adopted and implemented was efficient and effective use of communication. Changing a lot in terms of how, when, and where to do this communication, it was very fruitful in the end (8PMM).

This project was based on the communication, communication, communication, and communication... without first building communication and trust we wouldn't be able to do nothing (FGD2).

Remote communication challenging

Remote communication through an online medium was perceived as inefficient, leading to a lack of an overview, as well as being time and energy consuming.

When you are in communication through Skype, you may become focused on such details and lose the overview, lose very strategic important ideas, you get very lost in this because this communication is very complicated. You cannot give any feedback that is more critical, so it is very difficult, challenging and always you have to be extra diplomatic (5PMF).

It's time consuming. The thing that might take 10 minutes in explaining face to face seem for remote online communication it might need more time. You need to be very careful to deliver the message... your voice tone, how you are communicating, so it's also energy consuming (36TMF).

Participants also stated that communication skills are important for remote support programs, as one has to adapt and develop fine-listening skills while at the same time being an effective communicator through different modes of communication.

I guess it is like when you live near the airport you just get use to stop talking on the phone when the plane is passing above. So, you learn to deal with this kind of dynamics but it's always a challenge. You have to learn to listen to the people on phone, and you have to learn to read in between the lines when they write mails and reports, and you have to learn to use tools that you will use with them in meetings (6PMM).

Centralized communication with partners inefficient

Participants reported that the process for communication with partners was centralized, with the management (hospital directors) serving as the conduit for communication with the local staff, for security purposes. Centralized communication strategy was seen as inefficient as it interfered with daily frontline communication and exchanges between the teams.

One of the reasons for centralized communication was that we did not want to so much get our staff engaged into discussion with the staff directly, because this can create a security implication on them. So, they have to report to Amman, and we find a way to address it from here [Amman]. So, you'll have to go through the management team. Imagine going through the management to address something to do with the cleaner, to expect hospital director to talk to the cleaner...doesn't really make sense (1PMM).

The centralized communication process and the direct engagement of specialists in all decision making created mixed feelings. One participant felt that *“the director had to be convinced to give the green light” (20 STF)*. Others doubted, *“if the director had enough influence” (31TMF)*, therefore suggesting that, for efficiency purposes, communication should be decentralized.

It would be better to discuss directly with the doctors, involve the director as well (31TMF).

There should be a distribution of responsibilities, at least the department heads should be more involved so that the decision and responsibility are distributed because each officer in charge of a department knows about its problems in detail, and it is difficult for one person to grasp all the details (32TMM).

Participants emphasised the need for more efficient communication with partners; formal, focussed, well organized and documented, especially around protocol implementation. A technical manager who had successfully managed to communicate and engage with the respective partner team inside Syria said:

I think we should keep it more formal [meetings], more documented and more formal approach, If this meeting was about to discuss protocols. It might be better, like infection control committee, we have the minutes, you have everything, and it was effective in terms of action (31TMF).

I mean if it was only talk for 15 minutes for me it was 30 because they had translation, so we tried to go straight to the point. We didn't have a lot of chit-chat time. But it was good because it was a straight to the points also then they didn't want to focus to open a lot [many topics] . I tried to keep everything recorded (31TMF).

I will say that need more supervision and meeting because we need to hear more from the field in remote management (36TMF)

Perception of trust in remote support

Trust was perceived as an important factor and as the “baseline for communication” (FGD1), as well as being key to building relationships within the MSF and the partner remote teams. There was a consensus between participants that they trusted teams on the ground (frontline teams), however trust building took time and varied at the different levels. The perceptions of trust among participants are as described below.

Firstly, while participants expressed mixed feelings on the issue of trust of teams on the ground, most of the participants trusted the staff inside Syria. This was couched by some in terms of not having much choice other than to trust the team due to the lack of an oversight

and the inability to observe when communicating remotely. Others felt that teams on the ground should be trusted because of their knowledge of the real situation there.

The challenge you have with this type of management is that you're not able to really see...you must rely a lot on the documents that you see, visibly you can see from, you have quite a lot of trust with the person that is sending that (1PMM).

I think you are faced to trust on team on the ground nearer to the problem than yourself as we cannot be always on top of things, monitoring, supervising every detail. We need to trust the teams on ground, nearer to the problem, even if we did not know them, even when they were not really our staff (6PMM).

A technical manager, stressing the importance of trust in remote operations, shared her positive experience of trusting the team feedback.

The most important thing is the trust in remote management. I need to trust the team inside and trust the feedback. I remember we were planning to intervene in the camps and ... they were saying, "if you want to intervene in this camp, you start from the far tents, not the close one, because after one month we start to have the rain and then it will be muddy and it would be very hard". So normally we start from the closer and go to the far tents, but this small comment was really appreciated and very important. So, I think these are the things that's helped to continue" (36TMF).

Secondly, almost all the participants agreed that trust was developed gradually over a period of time, took lot of efforts at all levels, and once built improved team dynamics. The level of trust varied at different levels.

I think step by step. So, we had a lot of work done regarding to build trust. First between the doctor and directors, it was a huge work, a huge effort... for both the parties, to be open to establish this partnership beyond donations and afterwards all the staff because okay. After the director give us the green light, it was another trust step to take it with the doctors' team, the nurse team, the technician team, the cleaners (31TMF).

I think it took them a while to trust us, and when they trusted us we touched the transparency. I don't recall at any time that I ask that question and they lied (FGD1).

Another program manager felt that a lack of trust, and the variation in the level of trust at different levels and distance from the field, meant that headquarters was less receptive to field suggestions.

Us in the field had much more trust, the mission as much trust maybe a little bit less but as much. But it was a HQ which was very far away which was not really listening to what has been told to them, guys we need to engage (9PMF).

Thirdly, at the cultural level participants reported that trust was more of an existential concept, characteristic of being a Syrian, so the level of trust of a partner team once built was felt to be high and much stronger.

When you say that you are a Syrian; you say that you rely on me. Because everybody, medically, logistically everybody is known for it. I mean Syria. They have this reputation in the Arab countries especially (18STM)

Technical staff within FGD 1, reported that trust and respect were important for the team inside, once committed.

One of the busiest surgeons in SSY, he was doing surgeries everywhere, he used to take files home to fill up just because he was in good relation with me, and he trusted me and respected me. I'm always telling this 'respect and trust in such conditions is the greatest'. It's the cornerstone (FGD1).

However, it was found that while international staff developed confidence and trust with the team, they relied more on triangulation and tools.

We want to trust. Yeah. We want to trust with facts (11PMM).

Lastly, participants highlighted many other factors that had an impact on building a trusting relationship between the teams and ultimately on gaining both interpersonal and organizational trust, as shown in Table 4.4. All these trust building factors have been discussed under section 4.3 and 4.5 under the respective topics and are marked [...]. Trust issues with MSF local staff are detailed below.

Table 4.4 Factors affecting trust in RSM in Syria

Interpersonal trust	Organizational trust
+ Transparency/honesty + Competency of team + Consistent engagement + Joint activities [All above see section 4.5.1 Medical specialist strategy] + Face to face meetings [sec 4.5.2 capacity building strategy]	+ Consistent support + Quality of supply + Reputation and + Flexibility [All above see section 4.3.2 Enabler: MSF strength]
Interpersonal mistrust - High turnover of international staff [sec 4.6.3 staffing challenges in RSM]	Organizational mistrust - Trust issues with local staff

The perception of MSF local staff was one of the factors that negatively affected trust. Several participants stated that MSF's approach is more oriented to the international staff

(IS), with reliance on them, rather than on the local staff, for management and decision making. MSF's perception that the local staff cannot lead and manage a program, without international staff to monitor and evaluate them, was perceived as an organizational barrier that often generated a sense of mistrust by local staff.

It was also strongly felt that skills required inside Syria should be recognised and management and decision-making decentralized, with more involvement and investment in the development of key local staff in order to gain the trust of the staff. This would also assist with improving motivation and staff retention (see section 4.6.3 headed 'Staffing challenges for remote support').

We somehow still have this aversion of...I mean, it is sad in my opinion of trusting the national staff if there are no expats around. It is the idea that if the expats aren't there then the national can't do it or they're not able to do it. In the North, the only reason why they were given some space was because the staff were trained by the expats who were able to go into Syria. They had more credibility. There was this idea that if you aren't trained by expat MSF, then you are somehow less worthy, less able (9PMF).

I mean here in MSF until now there are strict rules of approval and decision making and you know your tasks and you cannot take decisions. But other NGOs they started from the very beginning to give management and responsibility to Syrian people and put them inside Turkey (29 TMM)

4.6.6. Technology is essential for remote support

The essential role of modern technology for remote operations was noted. Participants perceived the use of technology as enabling access to the field, through creating an interface for team exchanges and web monitoring, as well as in providing technical support through implementation of various software tools, as discussed earlier. This is shown in Figure 4.13 below. There were connectivity issues and challenges with implementing software tools that had not been adapted and were subject to frequent change. Participants discussed their preference for mobile technology for communication and technical support in Syria, which MSF eventually adapted. Participants stressed the need for better technology and tools for communication and technical support, and that these needed to be user friendly, easy to maintain and preferably mobile based.

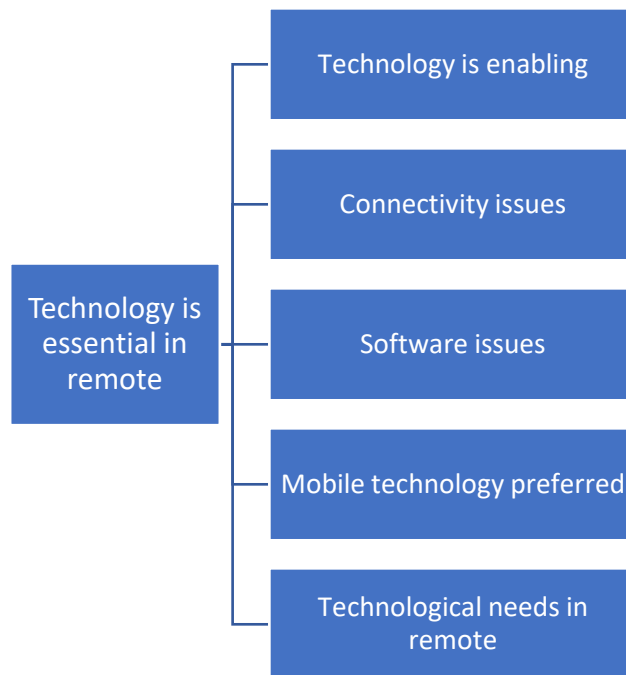


Figure 4.13 Technology in remote support model in Syria

Technology when it comes to tools, especially in remote program is essential. As we were talking about having the cameras and having the virtual field visit, we are talking now about collecting tools; even we were talking about adapting some technological tools. So, I think when it comes to tools, they are essential in remote programs (FGD2).

Technology is enabling

Some participants said that they found modern technology to be enabling, with various modes of communication being available to create an interface where teams can better connect. However, significant challenges were raised as well.

These regular Skype, phone, WhatsApp, all type of application meetings is very grateful. Like you will see the face of the person you talk to them, you describe, they see the body language. You can know what person is interested and what person is not interested in doing the job. This is what really help (30TMM).

Connectivity issues

More than a third of the participants stated that poor online internet connectivity and communication malfunctions led to disruption and delays in implementing activities and with follow-up. It was stated that there were challenges in connectivity due to “non-availability of internet connections inside Syria” (1PMM). VSAT, a fixed satellite connection for secure communication, was installed by a Damascus based company resulting in logistic challenges and delays. Connectivity challenges were more frequent in Daraa hospital, where the high dependency activities were carried out from the basements.

Sometimes we have disconnection for the whole day. So, I could not manage to have the phone or send messages or Skype or e-mails. If they have the bad connection even the phone call is difficult to get. For me the SRH department was in the basement. So most of the time as the midwife is in the delivery room I cannot reach her by phone, or send text messages to get things done (20STF)

A few technical managers reported that poor quality internet connection led to disruption to routine planned patient care meetings and administration activities. This led to delays and adversely affected patient care.

Because I need to have the translator available for me, and we had lot of meetings, it was really frustrating when it's supposed to last two hours and we spent two hours just trying to have a good connection and the people got tired of "Okay let's try again", "Let's try again" "Let's try again... The connection, the quality of the communication was a huge barrier (31TMF).

We are updating the ER files regarding the patients that came and received the services in OPD as well as in OT. So, if the connection is bad it's not gonna be updated and not gonna be referred to the capital and so we are facing this from time to time (34TMM).

However, this online connectivity challenge was mitigated through the use of multiple means of communications.

We face a lot of problems with the internet connection as we did this guided tours through Skype. Sometimes I just do this Skype and call together, to make it easy. When are not able to do at all, we just ask them to do a lot of micro videos and keep for like two hours on the phone (31TMF).

Software issues

Additional challenges to implementation and follow-up were encountered with software platforms that had not been adapted and were changed frequently. Some of the participants reported that the MSF software programs for data collection (HMIS), pharmacy management (Isystock), and telemedicine were not adapted for the local setting, as the “*Arabic modification was not available*” (27TMM). Thus, a complex process with a series of translations was undertaken, to share information through software packages with technical advisors. This proved to be inefficient.

It was a problem that this software (Isystock) is only in English, and this is even when we discussed with HQ. It was difficult for them to enter a new language on the software (28 TMF).

If we are talking about medical data, both tools were very complicated. And we couldn't fully implement these two tools. (26TMM).

There was huge jump from HIS, HMIS, Dhis 2. You need technical experts; you need lots of trainings to use these tools (27TMM).

Table 4.5 lists the technology and tools implemented by MSF in Syria and the advantages and disadvantages of each.

Table 4.5 Technical software tools and technology implemented in remote program in Syria

Software tool	Indication	Advantages	Disadvantages	Comments
Internet set up	Skype	Fair connectivity	Unavailable internet in Syria, Jordanian-line interruptions	
Telemedicine store and forward	Clinical-case discussion online	- Insight into cases -Technical acceptability	Not adapted (Ar) Complex process	Training in Amman/online
Isystock	Pharmacy software management tool	Real drug consumption+	Not adapted (Ar)	Training pharmacy supervisor in Amman
HMIS	Data collection tool	Analytic	Not adapted (Ar) Complex process Field activities not reflected High turnover of tool	Online training and training in Amman
Innovative Data collection	Data collection tool	User friendly Adapted bilingual tool Task shifting Improved data reliability	Paperwork for staff Nonmedical- data entry errors	Online training from Amman
HSP Survey	Real time surveys	User friendly adapted bilingual tool Jointly implemented Insights in health needs	Not cost effective IPADS-restricted shipment	Online training over 5 days from Amman
TM VHS	Real time platform	Secured line for training sessions	Not cost effective Supplier Damascus based (security concerns) Delayed installation	
Silo	Mobile based tool	Secure replacement of WhatsApp chat	Delayed implement	Planned
React	Mobile-based (TM)	To replace email-based TM	Delayed implement	Planned
WhatsApp	Mobile based	Extensive use in Syria Used for networking Used for case discussions	Not secure	Highly popular for networking, technical case discussions, information sharing
Protocols	Indication	Advantages	Disadvantage	Trainings
IC protocols	IC	Adapted, joint development	-	Training Amman (Sy Team)
Hospital assessment	In-depth assessment	Joint assessments	-	
OT Protocols	Surgery	Adapted, Joint development	-	Training online (Sy)
STD drug list	Medicine	Adapted, Joint development	Restrictive list	
Pharmacy-mgn protocols	Pharmacy	Adapted, joint implementation	Too detailed	Local pharmacists trained

Supply validation	Supply procedures	Adapted for emergencies	Regular procedure continued with delays	
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Mobile technology preferred

Some participants reported that mobile technology (WhatsApp, IMO) was the preferred mode of communication, used by the Syrian doctors and staff for communication and networking, and as a technical tool in patient management. This was seen as the “most effective communication” means (30TMM).

Traditionally, WhatsApp was excessively in use by the Syrian doctors, in form of groups linking different levels of doctors in and outside the country. In these forms, a lot of exchange of patient's details cases was happening and senior opinions were obtained. Some Syrian NGOs was using this platform as official way to technically support teams inside (2PMM).

The MSF technical team effectively used mobile technology, with the technical group networks forming linkages between and across both the facilities supported by MSF.

WhatsApp is good for very fast conversations, we used WhatsApp. We have WhatsApp groups, one for hospital A and one for hospital B. We had this group of midwives and the doctors. I was also using phone and IMO program most of the time. It's (IMO) another program, in Syria they like to use this one (20STF).

We started texting via WhatsApp and we ended up having a lot of communication means, we ended including everybody in the loop and creating different technical groups and like this things started moving smoothly. This applying technology to communication was good idea (8PMM)

It was reported by one program manager that the partner and local teams had a preference for mobile based technology, WhatsApp, for communication and technical support. Building on the lessons learnt from this experience, MSF implemented ‘Silo’, a mobile based software, to replace WhatsApp for more secure communication and ‘Reacts’, a mobile based telemedicine for technical support. Nevertheless, there were “implementation delays” (7PMM), as listed in Table 4.5.

Technological need

Most of the participants spoke of the need to have better communication tools to effectively connect with the teams inside Syria and to have a greater presence there. Participants also spoke of the need to have better technologies for technical support, such as real time and use friendly, mobile based software tools.

I think is the ability to function in a remote area, how to be present there by the help of technology, help of social media, phone calls. Maybe if you have more technology, advanced technology, we can have more presence and more function (FGD1).

We were looking also at some technologies for remote management. Technician there can be sitting in Daraa in front of the generator with the technician in Amman looking at what is happening and then advising him. "I think could you open that and we check with the cameras". We need that kind of technology and tools (1PMM).

To be able to have surgery and in the same time to have specialist through real time in another part of the world supporting the team (4PMF).

However, some participants stressed the importance of having the basic communication tools in place before upgrading to advanced new technology.

I think it is also important to establish the standard tools, should be working, if the phone is not working...well with a phone call if you cannot handle well, how are you going to handle with the tools like 'React' (mobile based tool)? I think we need to have a good base, to go to next advanced level" (FGD1).

One technical manager summed up the prerequisites for remote technological solutions, stressing the need for simplified technology that can be implemented with ease.

I think, when you think about of remote settings don't think only about technology, but the ease of use, user friendly phase, the easy to learn the maintenance of it, also that even turnover of staff will not have significant effect on what you are doing (27TMM).

4.6.7. Challenges to MSF's values and principles, in remote support

The humanitarian principles of neutrality and impartiality were perceived by most of the participants as being compromised and difficult to follow in conflict settings. However, they were reported to be better followed in the North, as the staff were more aware and were trained. Low visibility and advocacy challenged the MSF values of being present and speaking out. However, principles were viewed as important tools for negotiation which required adaptation to the war context followed by implementation through staff training. Relevant themes are presented in Figure 4.14 and described below.

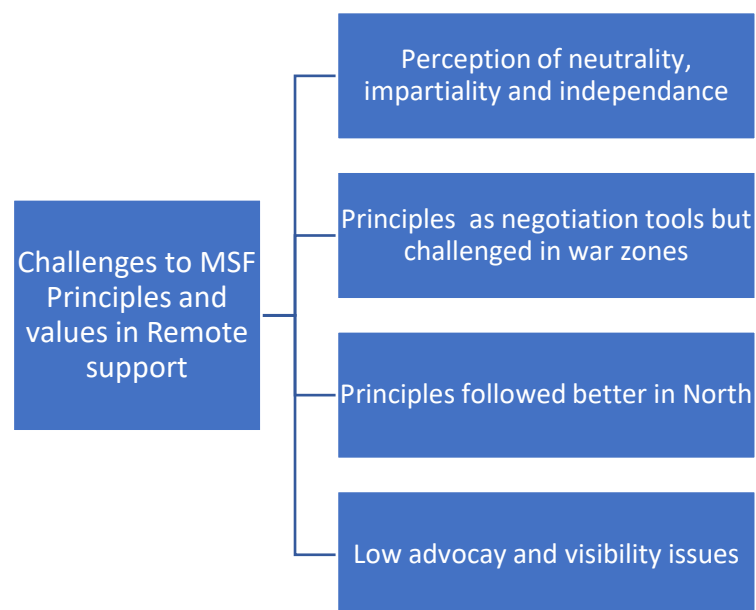


Figure 4.14 MSF Principles and values compromised through RSM in Syria

Perception of neutrality, Impartiality, and Independence in conflict setting

Principles related to neutrality and impartiality were perceived as compromised by most of the participants. This was framed in terms of MSF operations only being provided in rebel-held areas, with staff also being perceived as affiliated to controlling groups.

The problem mainly is that the hospitals inside Syria are managed by those who are more friendly to opposition. So, I don't think we know really how they are respecting our principles and remote, it's a little bit more difficult (3PMF).

If you are in a conflict zone, don't look for impartial employees Make sure, at least, that they are impartial towards the patients. If you are looking for impartiality in a conflict zone it's better not to put employees (30TMM).

However, one program manager interpreted neutrality differently; as population-wide access to health care, maintaining that MSF was in fact neutral inside Syria. One of the technical staff stated that clear messages were sent to partners to present the neutral stance of MSF.

For me neutrality means the respect for the IHL for the basic rights of population. Protection of these people is the centre of neutrality. Whoever attacks one side, or the other is the one who losing the neutrality. We keep the neutrality because we keep distance, so of course we are going to denounce abuse of IHL not only on the regime side but also on the other side (6PMM).

I remember one of them once talked bad about the regime [during a meeting] and I was very firm "mention everything by its own name. You don't accuse or call bad

names because it's not our job [as MSF] to judge or even to say bad words. We call by the official name". So, they got the message (30TMM).

Two program managers stated that MSF retained independence in terms of independent assessment and was not pressurized. However, some restrictions were inevitable due to security constraints.

So, we were able to do any service or assessment the way we wanted. In that sense we were quite independent. But in general, I think we were quite independent in decision making [about choice of intervention] and humanitarian programs implementation inside Daraa (2PMM).

Principles as negotiation tools, but challenged in war zones

One participant, highlighting the importance of principles as negotiation tools in a conflict setting, said:

Principles many times they are good tools to have, to get protection of the operations, respect of the operations that you are doing, protection for the people, for the beneficiaries, for the staff (6PMM).

These principles helped us to continue, as all know that MSF [does] not following any government. It is independent and provides health services. They know MSF provides donation to all the facilities, but they don't accept drugs from others [organizations] (33TMM).

A few program managers discussed the limitations of principles in a war zone, noting that it was unrealistic to expect to follow peacetime principles in a war context, and stressing the need for them to be adapted.

It was not implemented 100% because it was very, very difficult. Sometimes military personnel would enter the hospital, so yes there was impartiality, but sometimes they have to give extra care to a higher military Personnel, just so that they will not be under fire from them (12PMM).

MSF cars and MSF hospitals we put this label of, "No guns inside" It doesn't hold realistic that no guns will enter in a context of war like Syria (4PMF) .

Remotely it is very difficult to verify principle followed. I have a picture of no guns and somebody sitting with guns next to it.(1PMM

However, another program manager had contradicting views on follow-up of principles in MSF facilities.

We managed to stop arms inside the hospital, which was not the case [before MSF]. We managed to put some rules in terms of who is visiting and who is not. We managed to stop prioritizing anybody, so everybody is equal; people are coming when they are injured or sick (8PMM).

Principles followed better in North

Participants also reported that though the principles were followed better in Northern Syria due to MSF staff being more experienced, there was still a need to reinforce principles and train the staff.

I'm sure in the North perhaps it's a little bit easier, because they understand much better and have more experience with MSF, so they are respecting as well different ideas (3PMF).

They receive one briefing when they start work on the contract. But then we need to refresh, of course. Only one staff receive Sanou (Training about MSF) and we need to work on it to replicate them, about the commitment of the staff about what is the essence of MSF and principles. That's the part of the need for training of the staff (14PMF).

Low advocacy and visibility

Participants reported that a low visibility was maintained, and a very measured advocacy was practiced, in order to protect access to the population in difficult circumstances.

From Syria side because of various security issues like kidnapping, and also because of politics in North Syria, we are keeping low profile sometimes zero profile. Even for quite a long period we didn't use visibility method in hospital" (11PMM).

However, many participants did not understand the logic of this strategy, as they associated sensitization and knowledge about the role of MSF with better acceptance by the community and better presence, which MSF is known for.

In the population no one knows that MSF is there, or MSF is supporting this hospital. We need to work on the acceptance from the population, and this is that we are trying with health promotion because we get the brochures; we got new tools to communicate to the population. They are trying to provide this information; we are trying to have more presence in the outreach activities (14PMF).

For an organization that speaks out and does advocacy based on evidence, participants found it extremely difficult especially towards the end. They were obliged to witness the humanitarian crisis when GoS took over Daraa province in South Syria but were constrained in responding publicly. Also, it coincided with critical incidents related to the security of staff inside Syria which negatively affected the advocacy strategy.

One specific event related to a critical incident... finalized the decision from the coordination, I mean the management team of the crisis, that there is no declaration, there is no speak out about the condition of the civil population (3 PMF).

It's striking as UN and world community are still watching, also painful that me as I join that group, I cannot do anything, I cannot speak out. It's painful but after analysing all the options and the possibilities one has to take a decision what is realistically possible (5PMF).

However, this shift was regretted by some of the participants.

Because we have a low profile, we are just observer. So in this sense we were like being so more shy than usual. We are ... more pro advocacy and pro bracing things, that in Syria is very difficult. Because sometimes you are saying things, they are taking in a wrong way; even then you have to say (16PMF).

To conclude, this section highlighted the various contextual and programmatic challenges faced by MSF in the implementation of RSM and how MSF was able to gain and maintain access through some of the innovative and effective strategies, and establish a meaningful relationship with the local partners, deemed crucial for access to the vulnerable population.

How this learning and findings will contribute to characterisation of RSM models for future implementations will be discussed in the following chapter.

CHAPTER 5: DISCUSSION AND CONCLUSION

5.1 Introduction

This case study has identified and explored the enablers and barriers that shaped the development of the remote support model used by MSF in Syria, and the effective strategies and practices with which it responded. Capturing and documenting the many lessons learnt is important as MSF and other organisations are likely to need to use the RSM again in future crisis situations.

This chapter presents the researcher's interpretation of the results, within the context of her own knowledge and experience of working with MSF in the region and globally. The chapter first discusses the methodological approach and limitations of the case study. A discussion of findings in relation to the Syrian context, MSF strengths, the implications for MSF for future implementations and for the interpretation of MSF values and principles follows. These findings are drawn together in the concluding section, which addresses the need for MSF to develop and adapt to changed ways of operating in complex war contexts such as the Middle East.

5.2 Methodology and limitations of the study

A pragmatic approach to the study was taken driven by the research question (Punch, 2016), theoretically interpreted from a constructivist perspective, within a case study design [discussed in detail in chapter 3, Methods]. This reflexive methodology, helped the researcher to understand, review, and reflect on the lived experiences of the participants (MSF and partner staff), and their perspectives on the challenges in the RSM implementation and in co-constructing knowledge (Guba & Lincoln, 1994) of how best this mode of service delivery could be optimized for a M conflict setting. It is evident from the study that the context has played an important role in the actions taken and experienced by the participants during the adaptation and evolution of the RSM project. This pragmatic approach and case study design allowed freedom to use multiple methods and means to gain in-depth knowledge (Creswell, 2018); such as Focus group discussions (FGD), face to face and online interviews (Skype), telephone conversations and follow-up clarification of meanings through use of emails to the participants. However, while the case study design

and methods has helped to gain an in-depth understanding and enabled showcasing of MSF OCBA's RSM implementation it also had limitations, as discussed below.

It is important to acknowledge here the limitations of this study, due to the very nature of the inquiry, and the impact of the conflict on data collection at the study settings.

Firstly, data collection from the MSF partners inside South Syria was limited and challenging; many partner staff had left, due to the escalation of the conflict situation and related dangers, and interviews conducted online with Syrian participants had security constraints. However, key partner staff members (some from displaced locations) were nonetheless able to provide their valuable perspectives to the study. While data collection in Amman was also interrupted when the South Syria project was forced to close on security grounds, those participants who decided to continue reported that the interview provided a welcome opportunity to reflect on their experience. In this study, the interpreters/translators were Jordanian, and some subtle differences in Arabic dialect used by Syrian participants may have affected the fidelity of interpretation and translation, even though checks for conceptual equivalence were used.

Secondly, this case study was specific to MSF OCBA projects in collaboration with partners and MSF staff, so while much of it is relevant to other organisations, the normal limitations of case study applicability or the ability to generalise (Stake, 1995) to other remote humanitarian and health programs apply.

5.3 Syrian context challenging for MSF

The Syrian context was very challenging for MSF and the decision to provide support through a remote approach was taken, prior to the commencement of work on this case study. There was, in fact, no other option. MSF's purpose and culture are built on the idea of direct intervention based on physical presence in the field and working remotely is never its first preference. However, the Syrian situation provided an opportunity for MSF to fulfil its purpose and do exactly what it aims to do: to engage where the need is, whether due to man-made or natural disasters

Clearly this sort of situation is likely to arise again, as it already had in Afghanistan, Somalia, Democratic republic of Congo (DRC), Pakistan and Palestine, where MSF relied on using a remote approach (Belliveau, 2013; Donini & Maxwell, 2013; Martin Braaksma, 2009).

Nevertheless, providing a remote support program in a Middle Eastern middle-income country with advanced health systems, in the context of ongoing modern warfare, was new and challenging.

According to the current literature, long-term remote management of humanitarian and health programs has been established as a mode of service delivery and a new norm (Price, 2017; Rivas, 2015) and the question for MSF was about 'how to stay' and ensure care was delivered (Egeland et al., 2011; Abby Stoddard et al., 2010). So, this study was about understanding how MSF was able to stay (remotely) for as long as it did in the face of fundamental instability and insecurity, a crumbling formal health system and significant political and cultural barriers (Abbara et al., 2015)

5.4 MSF's enabling strengths

This study has shown that MSF brought particular strengths and resources and that staff were able to experiment with the RSM in order to adapt and optimise the approach. The key strengths identified are MSF's knowledge base, funding independence and innovative nature.

MSF has a knowledge base in health care, with particular experience and expertise in responding to emergency health care needs arising from humanitarian crises, including responding to trauma and communicable disease outbreaks, rolling out vaccinations and addressing malnutrition. Often these interventions have been based in Africa (Abu-Sada, 2011). MSF also has expertise in negotiation and adaptation to contextual change (Magone, Neuman, & Weissman, 2012). For example, this case study demonstrates how MSF used its presence in Jordan to build connections and networking in Syria and utilised its negotiation expertise with Jordanian authorities to adapt and organize program activities, especially cross border activities, for South Syria.

The majority of MSF funds come from private donations and therefore MSF enjoys funding independence without having to rely on state or other donations (Medecins Sans Frontieres, 2017). This funding independence allowed MSF to flexibly adapt their programs and respond to context changes to a greater extent than many other (state) donor-based organizations, and this proved crucial in this constantly changing context. Financial independence and the resulting flexibility in the use of funds allowed MSF to fulfil its financial commitments with the

partners (providing supplies and incentives) and to address new needs and therefore be seen as independent and a reliable partner.

These resources, opportunities and assets allowed MSF (OCBA) to be creative (Scott, 2015) and innovative and to invest and experiment with new approaches to service delivery, support systems and new technology. This included, for example, investment in innovative surveys which were very useful in identifying gaps in addressing the health care needs of the population in the region (MSF health surveillance programme, 2017)) and in providing effective remote support so that local health facilities could reach vulnerable populations in Syria (Garcia, 2015).

5.5 RSM brings the need for adaptation and has implications for MSF

While MSF had experience in using some remote support methods, the Syrian situation presented a larger challenge, because of both the greater scope of remote activities and the active modern day conflicts (Kellenberger, 2004) that hindered access. This led to a gradual realisation amongst MSF (OCBA) staff of the implications of this challenge for its ways of operating, including the scope of the many changes that needed to be accommodated. The necessary adaptations required engagement with partners, capacity building and program planning to cover protocols/tools, human resource (HR) adaptations, monitoring innovations and engagement with other stakeholders. Table 5.1 shows the strategic and operational characteristics of the RSM that emerged from this study in comparison to the classical MSF model of implementation.

Table 5.1 Characteristics of MSF Models: Classical vs. Remote Support Model in Syria

Elements	Classical MSF model	Remote Support Model
	Hands-on approach is preferred, with direct delivery of care, using international staff in the field, and local staff.	Where security risk is high and access is restricted, RSM is used with skilled local staff [MSF] and local partners delivering care.
1. Engagement and relationship-building with partners	MSF works with partners on aspects of projects where it is mutually beneficial; and MSF enjoys seniority in many relationships based on both resourcing and expertise.	Mutual agreement with partners is needed, on roles, objectives and the plan of intervention, formalized with a well negotiated MoU including agreement about MSF's role in management. Communication and development of mutual trust is more important, and more mutual decision-making is needed, particularly when shaped by local conditions.

2.Capacity building	Capacity building for local staff focuses on use of MSF protocols and tools and specific technical skills.	Capacity-building and training requirements are broader, including some management and monitoring skills, as well as knowledge of MSF values and principles. Mutual training for International and local staff may be needed. Local/regional cross border (face-to-face) training is helpful, along with on-line training.
3.Program planning and design Orientation Scale and scope	International staff (IS) are responsible and make the decisions in consultation with the technical and project staff. Achieved in a short period, using a set prototype, clear policy, and guidance on implementation.	Traditional centralized authority for operational decision making applied but proved problematic, calling for further delegation to local staff. Careful planning and well-defined focus and scope of intervention better accepted by the partners. Need to include exit strategy in the program design.
Human Resources	Focus is on IS, a workforce that is highly skilled and a core MSF strength. Recruitment process clear and transparent in MSF. In conflict settings, MSF uses shorter employment contracts, experiencing high turnover	Staffing needs to be localized and optimized. Skills and knowledge in RSM, remote management and communication are required, along with knowledge of the region, for remotely located support team (international or local). Recruitment process complex needs to be more consultative. Staff retention policies such as extending career development opportunities to local staff are needed. Enabling Local staff to work in management roles.
Protocols and tools	Standard MSF protocols and tools are used, suited to traditional arenas of intervention (e.g. Africa and primary care).	Locally adapted, concise, checklist-based protocols and tools as well as user friendly technical tools (for data collection and assessments) are needed. Mobile technology preferred for technical support and communication. Quality standards may need to be adapted for war context.
Monitoring System	Based on standard reporting and data collection databases, enacted by directly employed MSF staff	Monitoring system needs to be adapted to situation in the field, with well-defined indicators and data collection tools. May need to adapt reporting requirements. Triangulation and innovative web-based methods of monitoring improved reliability.
Risk Management	MSF policies and procedures provide protection in the field for staff and resources.	Risk situation is complex in war context. More risk acceptance is required. Risk mitigations need to involve the local and partner staff and include them in the planning for exit and project closure.

4. Networking, coordination and collaboration with stakeholders	MSF engagement with stakeholders is preferably limited to international NGOs.	Networking and collaboration with stakeholders (authorities, local actors, groups, diasporas, and NGOs) are more important, for improved access and accountability and protection to staff and projects.
5. Neutrality, advocacy and Temoignage	Principles of neutrality, impartiality and independence implemented by international staff. Their presence on the ground enables temoignage and strong advocacy.	The challenge of maintaining neutrality is complex in a war context. Advocacy may need to be less prominent in order to maintain access to operate in the region. Temoignage remains an important function.

As the remote support project unfolded there was an increasing awareness among those involved that ‘business as usual’ approaches needed to be radically adapted to create a new humanitarian space (Scott, 2015). This necessitated the development of new ways of working, as discussed below.

5.5.1 Engagement and relation building with partners and stakeholders

It was necessary to work with local actors, in a partnering rather than in a controlling way, that is, not treating them solely as implementers (Howe et al., 2015). This had many implications, most importantly it became necessary to attend to the question of building a strong communication system and mutual trust between the partners (Chaudhri et al., 2019; Howlett, Gabrys, Musial-Gabrys, & Roach, 2011; Pavanello S, 2018) and a good understanding of each partner’s capacities. This study showed that consistent engagement through a professional team with technical competency (Garcia, 2015), maintaining transparency, face to face contact and joint review and implementation of activities such as protocols and tools are all essential in establishing communication and trust— thereby building relations and improving acceptance and accountability (Chaudhri et al., 2019; Howe et al., 2015; Martin Braaksma, 2009). Identification and induction of selected focal partner staff with well-defined roles not only enhanced communication but also increased the reliability of the shared information. It is also important to ensure that relationships are built at all levels. As evidenced in this study, the program managers at the project level were better informed and more involved in decision making inside Syria, when compared to the central managers. This was probably due to their closer relationships and level of engagement.

This study demonstrates the importance of finding mutual agreement on the objectives and plan of intervention within remote support interventions, through partnerships. MSF needs to find a common ground of interest and understanding with the partners, where MSF can explain (possibly face to face) what they believe they can provide support and add value. They also need to respond when a partner proposes a better healthcare package or way of delivering care that would be more agreeable to all the relevant parties; ensuring a working partnership where each brings their own expertise in their field. Both the objectives of engagement with the partners and the role of the partners need to be clear from the beginning. This is particularly pertinent to the MSF role in management and decision making locally (inside Syria) in key areas, such as hiring and firing of the staff [who are paid incentives by MSF]. The use of emergency resources and any change in decisions also need to be mutually justified and communicated well (Hammadi K, 2012). Indeed, a well-planned and a focussed intervention with integration of partners in designing, and program planning, including exit strategy and project closure (Hunt et al., 2020), with clear roles formalized through a negotiated MOU is required. The definition of clear roles formalized through a negotiated MOU is also required to ensure effectiveness and accountability (Egeland et al., 2011; Hammadi K, 2012; Abby Stoddard et al., 2010)

5.5.2. Capacity building

A focus on capacity building through training is necessary to ensure the smooth implementation of the remotely supported interventions, once the partnership terms have been agreed. This study demonstrates a tendency to underestimate the capabilities of partner staff, signalling the importance of identifying training needs and of setting joint agendas based on the needs assessment. This study also identified that training needs were much broader and beyond MSF's standard technical (medical) training for the implementation of the protocols and tools; and included management and monitoring skills (Howe et al., 2015; A. Stoddard & Harmer, 2006; Svoboda & Pantuliano, 2015) as well as knowledge of MSF values and principles. (Chaudhri et al., 2019; Abby Stoddard et al., 2010)

Local/regional cross border (face to face) training of the partner staff, as well as MSF team exchanges, were seen as useful training approaches because they improved team motivation, team dynamics, upgraded skills and created a platform for discussion of issues. While remote training was challenging for the trainers based in Amman it was considered useful for follow up after face-to-face trainings. Ongoing medical team discussions and analysis of case management were also seen as providing opportunities for mutual learning for both local and international staff, enabling an understanding of different perspectives and

subsequently bringing changes in attitudes, as the rationale for actions became clearer. Investing and building the capacity of key local staff as trainers (training of the trainers) was helpful in the continuity of training and follow up and monitoring, when other modalities of training were not possible due to restricted access and technological challenges.

5.5.3. Program Planning and design

Many program components were adapted during the implementation of RSM to be relevant to the context of war and the region and in so doing many lessons were learnt. But firstly, it is important for MSF to recognise that RSM is a fundamentally different service delivery model that will require practical and policy guidance within the organisation (A. Stoddard & Harmer, 2006). This includes articulating both the basis for decisions to use the RSM or its variants and the 'rules of engagement' with partners and allies. Then, MSF needs to develop and define a framework for RSM and articulate its operational and strategic requirements. This will help to ensure that the lessons learned in Syria are built upon and adapted as needed to the specific context. Future projects using RSM should be planned and designed with attention to the following design elements.

1 Scale and scope:

One of the clear lessons learnt is that RSM planning and design should take into consideration the scale and scope of the program in terms of region/sector and focus of intervention, with clear cut strategies (Abby Stoddard et al., 2010). This study showed that a carefully planned and well-defined focus and scope of intervention was much easier to implement, more accountable, and better accepted by the partners (Hospital B Daraa), as compared to a large-scale intervention with wider scope (Hospital A Daraa). Indeed MSF support to tertiary care in Daraa was perceived by study participants as beyond the MSF range of resources and capabilities making it challenging for the team to implement.

In defining the scale and scope, there should be a contingency plan and exit strategy included in the program design, with a clear threshold or criteria that can be used to assist in determining when to suspend, resume, or withdraw support (Martin Braaksma, 2009). In Daraa, where MSF lacked a well-planned exit strategy, a quick contextual change led to a sudden shutdown. A plan for such a contingency would have enabled better management of resources for a phased and organised exit.

2. Human resources

While recruitment and training of sufficient numbers of staff is always a crucial requirement for effective implementation of a program, this was more complex in the RSM due to insecurity and remote skills requirement and required careful planning. This study found that in order to meet all the set objectives, staffing had to be optimized and matched to the scale and scope of the program. The literature demonstrates both the need for adequate staffing to meet project requirement as it develops (Rivas A, 2015), but also that staffing needs are higher in remote projects in conflict settings, as staff are less mobile due to insecurity and movement restrictions (Egeland et al., 2011).

Both International and local staff would benefit from skills, knowledge and experience in remote management in the region. Strong interpersonal and communication skills are important for maintaining effective communication and a trusting relationship with the remote partners (Pavanello S, 2018). In this study, among the thirty-seven individually interviewed participants, only a third had previous remote health work experience (PM and TM), and that was mostly in an African context. Over time, there is a need to emphasize the importance of experience and knowledge in managing remotely in the region, as well as effective communication and interpersonal skills, when recruiting staff for remote support programs.

The need for a change from the traditional transparent and open recruitment approach of MSF for local staff [based on assessments], to a more consultative approach was highlighted in this study. Recruitment of the staff inside Syria (local and partner focal staff) was more complex both in terms of remote organization and the process of selection. It was found to be important for the recruitment of the local staff to be conducted in a more collaborative way, taking advantage of existing relations and trust (Howe et al., 2015) to avoid any clan/group related security issues and to ensure the recruitment of known and trusted staff with clan representation (A. Stoddard & Harmer, 2006) for better local acceptance. Though this was a deviation from MSF's traditional approach of recruitment of local staff, it was however deemed necessary under the insecure circumstances in Syria. In other MSF missions in similar conflict settings, consultative recruitment of local staff has involved community elders and local administration, to ensure clan balance (Belliveau, 2013) and has resulted in better acceptance by the local community (Chu et al., 2011).

Lastly, localization of the induction of local staff is important when providing support through the remote health program, as they have in-depth knowledge of the cultural context and

needs of the population, and are better accepted by the community (Egeland et al., 2011; Elkahlout & Elgibali, 2020). This study highlighted the role of building local staff capacity to allow decreased dependence on international staff (IS) for support. Knowledgeable local staff also contribute institutional memory and are able to fill the gaps left by the high turnover of the international staff. This study also showed that the quality of the RS program in North Syria, implemented through experienced and skilled local staff, was well maintained compared to South Syria. This indicates the need to invest in developing the management capacities of the experienced local and partner staff when implementing future remote health programs. It also serves to empower these staff with skills to ensure sustainability in the changing conflict settings

3. *Protocols and tools*

As the relationship with partner staff progressed and practices became clearer the need to either adapt existing tools and resources in routine use, or to develop entirely new, more relevant ones, became evident to MSF staff. While this was one of the first important needs to become evident to MSF staff, it arises from many factors and has several implications.

Medical practice in the war context was different. Given the precarious situation, clinical staff, unable to follow MSF's best practice protocols and guidelines were forced to focus on basic and immediate patient care needs. Trauma surgery was prioritised, and other medical and cultural factors made task shifting to non-specialist staff (for example, involving midwives in case management) challenging. The requirement to provide reports to government had also lapsed due to the absence of a functioning Ministry of Health. Partner staff, often overworked, were unable or unwilling to complete elaborate reporting requirements. Hence, it became necessary to adapt protocols, tools and resources according to the relevance and the profile of care needs.

In the other settings, MSF had already successfully implemented complex programs remotely using well adapted and simplified protocols (Chu et al., 2011; Shanks et al., 2012; Zachariah et al., 2012). In this case, MSF's effective response was to work with partner staff to jointly adapt and/or develop simplified, concise protocols and tools (such as for infection control, OT and surgical protocols/tools) based on checklists. This was an important step in building the effectiveness of the RSM and is likely to be both necessary and useful in other contexts, when the RSM is used.

A related lesson learnt from this study was not to invest in complex technology for technical data collection (for example, pharmacy and patient management systems). It is important

that technical software-based tools for data collection are locally adapted and user-friendly and that they preferably involve mobile-based technology. The use of mobile based apps for case discussions, networking, and exchange of information between the medical teams was seen as a distinct advantage. This is likely to continue as the norm in future RSM projects.

4. Monitoring System

MSF has traditionally relied on direct observation, backed up with data collection and reporting, to monitor the quality, reach and cost of its services. However, as this study found, when RSM is in use, other methods may be required for better monitoring of services. There is a need to develop a robust monitoring system adapted to the reality of the situation in the field, with functional technology to aid effective communication and web-based monitoring.

This study showed that STD MSF software-based DC tools did not include indicators to reflect project activities (for example, war wounded cases). As a result, this information was not systematically collected and data extraction from different sources for analysis and reporting became challenging. Therefore, there is a need for well-defined and adapted indicators for data collection and reporting. Furthermore, data and information reliability were questionable because of the lack of an overview, trust, and control over activities (for example, drug management and distribution inside Syria). Information sharing in general was also found to be complex in RSM, due to security concerns in the insecure context. This study found that military controlled and targeted communication and information sharing in Syria and humanitarian agencies [staff] and community were 'soft targets' (A. Stoddard & Harmer, 2006). That cultural factors such as clan/group affiliation of the local staff could affect reliable information sharing and that the management of complaints also needs to be handled sensitively in such a context was also highlighted in this study.

Finally, while technology was found to be enabling for communication and web monitoring, there were nevertheless connectivity issues for daily monitoring. Therefore, new approaches to monitoring and accountability for the effectiveness of care and the good use of resources were needed. This study showed that triangulation and innovative web-based methods, with a multimodal approach [more than one method used to overcome connectivity issue], joint virtual tours (with partner staff) with shared videos and simultaneous phone calls, improved monitoring.

5. Risk management in RSM

Some of the strengths of MSF apply in both standard and RSM modes of delivery. For example, these include careful attention and effectiveness in risk management through thorough risk assessments and by setting security levels and thresholds for evacuations, as well as extensive emergency preparedness and contingency plans, as detailed in the security guidelines. However, more risk acceptance is required when operating through remote support modalities and risk mitigations need to be planned to prevent resource losses, misuse, and disruptions of activities and to avoid transfer of risk to staff. It was found that risk mitigation needs to involve both the local and partner staff, through including them in the planning of exit and project closure. This should become standard practice in future RSM projects.

5.5.4 Networking, coordination, and collaboration with stakeholders

Networking and collaboration with stakeholders (authorities, local actors, groups, diasporas and NGOs) are more important for successful use of the RSM, particularly for improved access, accountability and protection for staff and projects. Success depends on a wide range of stakeholders.

This study showed that it was crucial to effectively engage with authorities at all levels, including Health, Customs, Military and Drug regulatory authorities in Jordan and Turkey, with a multi-sectoral approach, in order to implement cross border activities.

Coordination and collaboration with INGOs were also needed in RSM implementation. For example, MSF successfully collaborated with diasporas-INGO (SAMS) to provide technical support and trainings on dialysis in Daraa hospital, while MSF took care of dialysis supplies. Also, collaboration with other INGOs with a security mandate (ICRC, Handicap International) was useful in security management and training of the local and partner staff. However, when more organizations are involved in a facility, there is a need for better coordination and harmonization (of, for example, supply systems and reporting) to decrease workload and duplication. While it is usually hard to predict which stakeholders will be important at the planning and design stage, early consideration of these matters and their inclusion in project planning and monitoring are needed.

5.6 Implications for MSF values and principles:

The differences in requirements for success in RSM, compared to normal planning and operating procedures, as described above and summarised in Table 5.1, provide the basis for further development of MSF's effectiveness as a provider of essential health care using the RSM. However, effective use of the model will also have implications for the way MSF interprets and embeds its values and principles.

It is evident from this study that working remotely in some ways challenges MSF culture, values and principles as well as requiring different ways of working with partner staff who are not direct MSF employees. Perhaps the greatest challenge that has confronted MSF has been the inability to fully follow the humanitarian principles of neutrality, impartiality, and independence. Enacting the principle of *temoignage* – being present and actively bearing witness – has also been compromised.

5.6.1 Neutrality, advocacy and Temoignage:

MSF's traditional approach has been to take "direct action" with the notion of "being there" for identity, quality, and impartiality (Hofman & Pérache, 2014). MSF follows the international humanitarian principles of independence, impartiality, and neutrality as expressed in the Charter and Chantilly Principles (Medecins Sans Frontieres, 1995) which entails MSF having freedom of choice of operations in a non-discriminatory, apolitical way. In addition to the international humanitarian principles, MSF has also had the policy of 'Temoignage' ('active witnessing') and to speak on behalf of the vulnerable as a core component of MSF philosophy (Medecins Sans Frontieres, 1995). However, in contexts like Syria, principles need to be interpreted and articulated differently for application within RSM.

Neutrality and Impartiality are defined in the Principle of Chantilly as MSF not taking sides in armed conflicts and non-discrimination [in the context of medical action and care] with regards to politics, race, religion, sex, and proportionality of assistance according to the level of needs.

Neutrality and impartiality were perceived by most of the participants as compromised in the war context of Syria. Due to political barriers, MSF's access in Syria was one sided (that is, based in opposition-controlled areas). Therefore, participants felt that it was unrealistic to expect neutrality and impartiality from the staff, who belong to the same area and are affiliated to certain groups, as they may also be coerced by these community and controlling groups (Chaudhri et al., 2019; Elkahlout & Elgibali, 2020). However, Rony Bauman [ex-

president of MSF] has argued that the concept of neutrality was vague and could be interpreted in many ways in a war context (Brauman, 2012). A few of the programme managers (PMs) interpreted neutrality differently, as providing access to care for the population and denouncing whichever side abused human rights and international law affecting population protection.

Efforts were made by the remote support team to reinforce principles of neutrality and impartiality with partners, as impartiality was also difficult to maintain with changing priorities due to security reasons. However, monitoring and implementation/compliance were challenging. For example, messages such as '*no guns in hospitals in a warzone*' were viewed as unrealistic.

Independence is defined as an independence of spirit which is a condition for independent analysis and action, namely the freedom of choice in its operations and the timing and means of carrying them out; with strict independence from power structures, whether political, religious or economic and also including financial independence. MSF maximises the use of private resources, and makes choices about where to work solely on the basis of where the needs are greatest (Medecins Sans Frontieres, 2017).

Independence, in terms of freedom of choice, was compromised due to political barriers and the restriction of MSF to opposition areas. However, in this study, program and technical managers strongly felt that MSF's independence was maintained within the region [of operation] in terms of carrying out independent assessments, choice of intervention and in selection of facilities in which to implement these interventions.

This study found that adhering to organisational principles is important for organizational value and identity (Hilhorst & Schmiemann, 2002), and for negotiations in a war context. However, the concepts of neutrality and impartiality need to be made clear. It is therefore important to reinterpret principles of neutrality and impartiality for RSM in the war/conflict context, as well as defining ways to enact these principles in practice.

Temoignage and advocacy

Temoignage is expressed in MSF Chantilly principles 1995 as: 'the presence of volunteers (MSF workers) with people in danger as they provide medical care which implies being near and listening; a duty to raise public awareness about these people and the possibility to openly criticise or denounce breaches of international conventions'(Medecins Sans

Frontieres, 1995, p. 11), based on evidence, that is, eyewitness accounts, medical data and experience (Medecins Sans Frontieres, 2006).

This study showed that operating remotely in the absence of physical proximity to the vulnerable population while sustaining a low profile and low visibility with 'de branding', [not using MSF logo, identity](Egeland et al., 2011; A. Stoddard & Harmer, 2006) compromised Temoignage. Bearing witness and speaking out in the war context of Syria was not seen as a priority (Garcia, 2015), as it was necessary to keep a realistic attitude (Magone et al., 2012) with low advocacy in order to maintain access, protect staff and resources and for continuity of services. This was not unusual for MSF, as similar low advocacy strategies were adopted for access in other war contexts such as Sri Lanka and Myanmar (Kellenberger, 2004).

Temoignage, especially speaking out, is integral to MSF identity (Brauman, 2012). Therefore, there is a need to develop well-defined external communication and advocacy strategies, to train staff regarding these strategies, and to have clear messages to be shared with the stakeholders.

5.6.2 A changing relationship with local staff

MSF traditionally relies more heavily than other NGOs on international staff and has tended to locate decision-making and leadership with international staff, who are working with the local staff in the field, delivering care, monitoring, and witnessing events. MSF therefore has more international staff (11%) in the field compared to other INGOs (2-3%) (A. Stoddard & Harmer, 2006). However, when the RSM is used international staff are not in the field and thus cannot fulfil the operational requirements for timely decision-making that rely on hard-to-get local intelligence about conditions in the field and local assessment of problems and risks.

The perception that the local staff (MSF) were not able to lead or manage the programs without international staff to monitor and evaluate was seen as a barrier to both effective management of the Syrian projects and to local staff job satisfaction and career progress and adversely affected their motivation and retention. It is therefore suggested that the RSM should provide a framework for MSF to test its capacity to decentralise decision-making and to enable local staff to work in management roles. This applies both in the field and in regional offices in order to improve efficiency and better represent MSF through negotiations, networking, and advocacy at local level.

The characteristics of the remote support model have potential relevance to agencies other than MSF, although tailoring and adaptation to the agency itself, as well as the context, will be required. The table 5.2 below presents a generic description of RSM for health care and possibly for other human services.

Table 5.2 Generic RSM Characteristics

Elements	Direct intervention model	Remote Support Model
	Hands-on approach, direct delivery of care, using international staff in the field.	Where security risk is high and access is restricted, skilled local staff and local partners deliver care in the field supported from a remote regional office.
Engagement and relationship-building with partners	Agency works with partners on aspects of projects where it is mutually beneficial, and typically enjoys seniority in relationships based on both resourcing and expertise.	Mutual agreement with partners is needed on roles, objectives and plan of intervention, formalized with a MoU including agreement about agency's role in management. Communication and development of mutual trust are more important, and more mutual decision-making is needed, particularly when shaped by local conditions.
Capacity building	Local staff require training in use of agency protocols and tools and specific technical skills.	Capacity-building and training requirements are broader, including management and monitoring skills, as well as agency/international values and principles. Mutual training for agency and local staff may be needed. Local/regional cross border (face-to-face) training is helpful, along with on-line training.
Program planning design and management	Senior agency staff are the planners and decision-makers, using advice from technical staff and based on established policy and prototypes.	Decision-making is negotiated with local partners and more devolved to the remote support team. Joint planning approach is used, with well-defined focus and scope of intervention, along with exit strategy.
Staffing and Human Resources	Existing skilled and experienced workforce is deployed using standard recruitment and assignment processes.	Agency staff operate remote support office. Partner and agency staff need skills and knowledge in remote management and communication, along with knowledge of the region. Recruitment process more consultative. Staff retention policies such as extending career development opportunities to partner staff are needed.
Protocols and tools	Standard protocols and tools are used, suited to traditional arenas of intervention.	Locally adapted, concise, checklist-based protocols and user-friendly technical tools (for data collection and monitoring) are needed. Mobile technology preferred for technical support and communication. Quality standards may need to be adapted for war context.
Monitoring System	Based on standard reporting and data collection, enacted by agency staff.	Monitoring system and reporting requirements are adapted to situation in the field, with relevant indicators and data collection tools, using available data sources and web-based methods of monitoring.
Risk Management	Agency policies and procedures provide protection in the field for staff and resources.	Risk situation is more complex, risk acceptance is higher. Risk mitigation involves partner staff, including in planning of exit and project closure strategies.
Networking, coordination, and collaboration with stakeholders	MSF engagement with stakeholders is preferably limited to international NGOs.	Networking and collaboration with stakeholders (authorities, local actors, groups, diasporas, and NGOs) are more important for improved access and accountability and protection to staff and projects.
Neutrality advocacy and witnessing	International humanitarian principles applied by agency staff, who also act as witnesses.	The challenge of maintaining neutrality is complex. Advocacy may need to be balanced with maintaining access. Witnessing remains important.

5.7 Conclusion

RSM has been a radical learning experience for MSF in Syria, especially in the South. Unlike remote models reported in the literature, where four distinct remote models are described,⁵ MSF has attempted to maintain principles and values in relation to being 'hands on'. MSF's version of RSM is also distinguished through having elements of both remote management and remote partnership.

This case study provides insight into core requirements of a successful remote support program, to optimise resources and equitably address the medical humanitarian needs of the population in a conflict setting. The Syrian experience documented in this thesis provides a strong basis for further development of the RSM and has several implications for MSF, and potentially for other agencies.

Firstly, access is a major issue in conflict situations and agencies seeking to assist local populations need to engage in partnerships with local actors in building relations through careful attention to communication and the development of trust, along with mutual capacity building based on joint assessments of population need and planning of interventions. Secondly, there was a need for RSM programs to be jointly planned and designed, with well-articulated scale and scope of the intervention. Tailored protocols and tools are required, with a robust monitoring system based on relevant indicators. Project closure and an exit strategy are also required, to be negotiated and planned with partner staff and the remote support team. Thirdly, networking with broader stakeholders is crucial for access. Coordination and collaboration within NGOs (international, diasporas, local) are important, with harmonisation of activities (supplies, reporting and data collection) to optimise resources and avoid duplication and for more effective, collaborative implementation of remote interventions.

Lastly, investing in local staff and partner staff development and capacity building in management with decentralized decision making and key management positions inside Syria are important to retaining, empowering, and sustaining experienced local workforce in conflict settings.

MSF is unique, not just as a medical humanitarian organisation with strengths in terms of expertise, flexibility and innovation, but also as a mission movement with strong values and

⁵ Remote control, remote management, remote support and remote partnership

well-articulated methods, where evidence-based debates and discussions are valued. It has demonstrated its capability to succeed in reaching, serving and standing by vulnerable populations in distress. MSF has the basis of expertise and infrastructure from which to fully explore and engage in the Middle East Region directly, and remotely if required. The experience garnered by MSF and its staff during its engagement in Syria has been documented and analysed in this thesis, and potentially will enable MSF to better define, lead and manage services using the Remote Support Model, where it is necessary.

5.7.1 Knowledge transfer strategy

Public health research aims at creating evidence-based knowledge that can be used to influence change in policy and practices that improve the overall health of the population. To ensure effective knowledge translation the research statement has to be of relevance and of priority (Armstrong et al., 2013).

The need for this research on optimizing remote health programming for hospitals in conflict setting like Syria, was very much highlighted as a gap in literature on the topic and in the Middle East policy of the organization, so in many aspects the research findings are useful and could be utilized to inform future projects in MSF. The implications for adopting the refined remote programming model in Syria will be for knowledge translation and theoretical discussion, more internally within as it will answer some of the queries raised in Middle East policy. In the conduct of the study as the knowledge was gained it was shared with the reference group. MSF OCBA and other similar humanitarian organizations working in the context will be the end users of this study.

The strategies adopted and to be used for knowledge transfer and dissemination are as follows:

1. Internal reporting to MSF OCBA: Since this was a study on the experience on MSF OCBA project, a full report with the findings and any implications from it related to project or policy change or organizational approach towards operations in Syria, will be submitted to the medical/operational department.

2. Engagement of relevant actors: From the very beginning, the reference group was engaged. This group is also involved in developing strategies and advising about the policy change within the organization. Therefore, their involvement has been very useful in conduct of this research and will be useful for translation of knowledge. Apart from the reference

group, the findings will be shared with the collaborating partners in the form of translated reports in Arabic.

3. Other platforms for dissemination: presentations of the research findings with interactive sessions will be done with the technical/ operational program managers on the larger international meetings in MSF-OCBA headquarters in Barcelona such as in Coordination Week to sensitize with the research findings, and the reports will be available too.

4. Academic Publication: Research articles will be written and published to contribute to the body of knowledge, thereby reaching the wider academic audience. Published articles will be available on MSF websites too. The results will also be shared with other humanitarian organizations working with in similar context of Middle East during the cluster and inter organizational meetings.

5.7.2 Personal Reflection

Conducting the research and writing this thesis and then reflecting retrospectively (Attia & Edge, 2017) has made me realise how important this process and learning have been for me, and how much it has changed me from before: both in understanding qualitative research and the remote support programs.

In 2015-2016 when I undertook this remote support mission it was difficult. Although I knew the story before I commenced this thesis, I didn't have a complete understanding of the depth of complexity: including geopolitical, cultural influences; complex interplay between power groups within Syria and the influence of all these interacting factors on humanitarian action.

I have also realised that this mission was built and sustained by the persevering work of the project team, their dedication and relentless determination to make this intervention work to reach the vulnerable populations, while enacting in the true spirit of MSF.

Being a part of the organisation and identifying with the culture and the values of the Organization, I believe there is a need for change. As this study has shown there is an opportunity for growth for MSF with changing times. As warfare and conflicts, as well as the likelihood of climate and pandemic emergencies increase, access becomes more complex and health needs change as a result. It is important to acknowledge and understand the growing need for remote support for service delivery and how to optimise it. I believe it is

here to stay. Partnership modalities for delivery of care with local actors are not new for MSF, but usually when they are present in the field and observing. However, it is crucial to have a meaningful remote relationship with partners with clear responsibilities and terms of engagement in order not only to improve access but also to increasingly understand the needs and gain insight into how things function inside the conflict zone.

I also feel that, as an organization, we are not well enough prepared or ready for the diverse Middle Eastern context where civil unrest turned into modern warfare, as in the case of Yemen and Syria, has unmasked basic and specialised tertiary care and mental health care needs. This is especially the case for health staff. Clearly much work is needed in developing resources, tools, technologies, and capacities to adapt to working remotely in regions of active conflict.

Utilizing the local workforce is important for local acceptability, as well as for an expedited response to emergencies. This means not only hiring local and regional staff, as we did in Syria, but also incorporating changes in the organizational approach to be more focussed on empowering local staff. The response is less likely to be delayed when the model includes devolved decision-making and integration of local staff, rather than being totally reliant on international staff that don't have the access to be able to observe what's happening in real time.

The evolved health system infrastructure in Syria with its contingent of skilled workforce was valuable for MSF. However, specialized needs in tertiary care highlighted an important limitation and need for growth in MSF. While Jordanian connections were used for effective cross border activities and engagement with stakeholders from inside Syria, there was a missed opportunity to explore medical technical expertise further in Jordanian medical institutions. This may have enabled more sustainable technical support for the Syrian health facilities in the region.

Finally, MSF needs to devise ways to gain more recognition and legal access in Syria on a broader and bigger platform, and to reinterpret humanitarian principles and advocacy strategies for the war context, with well curated content for the stakeholders and partners. There is also a need to build on the collective experience of MSF in the region and share more within and outside MSF, through documentation. The need for further research to understand trust building and effective collaboration in partnerships with local actors in the region is also clear.

I am grateful to MSF for allowing me to conduct this case study, and I hope its results will make a difference.

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APPENDICES

APPENDIX 1: ETHICAL APPROVAL FROM FLINDERS UNIVERSITY, AUSTRALIA

The Chair of the [Social and Behavioural Research Ethics Committee \(SBREC\)](#) at Flinders University considered your response to conditional approval out of session and your project has now been granted final ethics approval. This means that you now have approval to commence your research. Your ethics final approval notice can be found below.

FINAL APPROVAL NOTICE

Project No.:	7953		
Project Title:	Remote Programming and Monitoring of Hospitals in Conflict Setting: A Case Study of Syria		
Principal Researcher:	Dr Nilza Angmo		
Email:	Nilza.angmo@flinders.edu.au		
Approval Date:	6 June 2018	Ethics Approval Expiry Date:	28 February 2021

The above proposed project has been **approved** on the basis of the information contained in the application, its attachments and the information subsequently provided with the addition of the following comment(s):

Additional information required following commencement of research:

1. Other Ethics Committees
Please provide a copy of the ethics approval notice from the MSF Ethics Review Board *on receipt*. Please note that data collection should not commence until the researcher has received the relevant ethics committee approvals (items E3 and G1 and Conditional approval response – number 12).
2. Translations
Please ensure that copies of Arabic translations of all documents for participants, as well as the signed copy of the *Translation Accuracy Certification* document, available from the [Guidelines, Forms and Templates](#) web page, are submitted to the Committee *on receipt*. Please note that data collection should not commence until the researcher has provided the relevant documents (item D3 and Conditional approval response number 11).

RESPONSIBILITIES OF RESEARCHERS AND SUPERVISORS

1. Participant Documentation
Please note that it is the responsibility of researchers and supervisors, in the case of student projects, to ensure that:

- all participant documents are checked for spelling, grammatical, numbering and formatting errors. The Committee does not accept any responsibility for the above mentioned errors.
- the Flinders University logo is included on all participant documentation (e.g., letters of Introduction, information Sheets, consent forms, debriefing information and questionnaires – with the exception of purchased research tools) and the current Flinders University letterhead is included in the header of all letters of introduction. The Flinders University international logo/letterhead should be used and documentation should contain international dialling codes for all telephone and fax numbers listed for all research to be conducted overseas.
- the SBREC contact details, listed below, are included in the footer of all letters of introduction and information sheets.

This research project has been approved by the Flinders University Social and Behavioural Research Ethics Committee (Project Number 'INSERT PROJECT No. here following approval'). For more information regarding ethical approval of the project the Executive Officer of the Committee can be contacted by telephone on 8201 3116, by fax on 8201 2035 or by email human.researchethics@flinders.edu.au.

2. Annual Progress / Final Reports

In order to comply with the monitoring requirements of the [National Statement on Ethical Conduct in Human Research \(March 2007\)](#) an annual progress report must be submitted each year on the **6 June** (approval anniversary date) for the duration of the ethics approval using the report template available from the [Managing Your Ethics Approval](#) SBREC web page. *Please retain this notice for reference when completing annual progress or final reports.*

If the project is completed *before* ethics approval has expired please ensure a final report is submitted immediately. If ethics approval for your project expires please submit either (1) a final report; or (2) an extension of time request and an annual report.

Student Projects

The SBREC recommends that current ethics approval is maintained until a student's thesis has been submitted, reviewed and approved. This is to protect the student in the event that reviewers recommend some changes that may include the collection of additional participant data.

Your first report is due on **6 June 2019** or on completion of the project, whichever is the earliest.

3. Modifications to Project

Modifications to the project must not proceed until approval has been obtained from the Ethics Committee. Such proposed changes / modifications include:

- change of project title;
- change to research team (e.g., additions, removals, principal researcher or supervisor change);
- changes to research objectives;
- changes to research protocol;
- changes to participant recruitment methods;
- changes / additions to source(s) of participants;
- changes of procedures used to seek informed consent;
- changes to reimbursements provided to participants;
- changes / additions to information and/or documentation to be provided to potential participants;

- ☐ ☐ ☐ ☐ ☐ ☐ changes to research tools (e.g., questionnaire, interview questions, focus group questions);
- ☐ ☐ ☐ ☐ ☐ extensions of time.

To notify the Committee of any proposed modifications to the project please complete and submit the *Modification Request Form* which is available from the [Managing Your Ethics Approval](#) SBREC web page. Download the form from the website every time a new modification request is submitted to ensure that the most recent form is used. Please note that extension of time requests should be submitted prior to the Ethics Approval Expiry Date listed on this notice.

Change of Contact Details

Please ensure that you notify the Committee if either your mailing or email address changes to ensure that correspondence relating to this project can be sent to you. A modification request is not required to change your contact details.

4. Adverse Events and/or Complaints

Researchers should advise the Executive Officer of the Ethics Committee on 08 8201-3116 or 8201-7938 human.researchethics@flinders.edu.au immediately if:

- ☐ ☐ ☐ ☐ ☐ any complaints regarding the research are received;
- ☐ ☐ ☐ ☐ ☐ a serious or unexpected adverse event occurs that effects participants;
- ☐ ☐ ☐ ☐ ☐ an unforeseen event occurs that may affect the ethical acceptability of the project.

Kind regards
Wendy

On behalf of Andrea Mather

----- **Ms Andrea Mather (formerly Fiegert) and Ms Rae Tyler**

Ethics Officers and Executive Officers, Social and Behavioural Research Ethics Committee

Ms Andrea Mather Monday - Friday	T: +61 8201-3116 E: human.researchethics@flinders.edu.au
Ms Rae Tyler Monday, Wednesday and Friday mornings	T: +61 8201-7938 E: human.researchethics@flinders.edu.au
A/Prof David Hunter SBREC Chairperson	T: +61 7221-8477 E: david.hunter@flinders.edu.au
Dr Deb Agnew SBREC Deputy Chairperson	T: +61 8201-3456 E: deb.agnew@flinders.edu.au
SBREC Website	Social and Behavioural Research Ethics Committee (SBREC)

[Research Development and Support](#) | Union Building Basement

Flinders University

Sturt Road, Bedford Park | South Australia | 5042

GPO Box 2100 | Adelaide SA 5001

CRICOS Registered Provider: The Flinders University of South Australia | CRICOS Provider Number 00114A

This email and attachments may be confidential. If you are not the intended recipient, please inform the sender by reply email and delete all copies of this message.

Appendix 2: Ethical approval MSF

Ethics Review Board Instituted by Médecins Sans Frontières

Dr Jean François Saint-Sauveur, MD, MPH
Medical Director
Médecins Sans Frontières / OCBA.
C/Nou de la Rambla, 26. 08001.
Barcelona – Spain

21 July 2018

Re: Ethics approval of the research protocol “Remote programming and monitoring of hospitals in conflict setting: A case study of Syria”, Version updated on 19/07/2018, (ID 1843)

Dear Dr Saint-Sauveur,

Thank you for your reply to our review of the above-mentioned protocol. We are happy with the answers provided by the investigators and thus approve the protocol. Please ensure that all people associated with the research receive a copy of the final, approved protocol.

Please note that:

- *if the study is not started within the next twelve months*, this approval will not be valid anymore, and you should submit a *Request for Amendment* (with the new schedule and the rationale for the delay);
- *after the study has started*, any planned substantial revisions/changes to the protocol must be submitted to the Ethics Review Board through a *Request for Amendment*, for further review and approval;
- any occurrences *during the research* that may affect its ethical acceptability, such as serious adverse events or other unforeseen events, must be reported to the Ethics Review Board;
- *once the study is completed or if it is stopped prematurely*, the Ethics Review Board should be notified with an *End of Study Notification*. Please also send us copies of the final research report and any related publications.

Please send us in due time the approval by the Local Ethics Committee if this has not been done yet, and notify us once this study is initiated.

We wish you much success with the research.

Yours sincerely,



Raffaella Ravinetto
Chairperson, Ethics Review Board

Members of the Ethics Review Board

Dr Raffaella Ravinetto, Chair
Antwerp, Belgium
raffaella.ravinetto@gmail.com

Dr John Pringle, Vice-chair
Canada
john.pringle.ethics.review@gmail.com

Dr Grace Marie Ku, Executive Officer
MSFERB-Secretariat@msf.org

Prof Aasim Ahmad, Pakistan
Dr Sunita Sheel Bandewar, India
Dr Matthias Borchert, Germany
Dr Adelaide Doussau, Canada & France
Prof Yali Cong, China
Dr Ama Edwin, Ghana
Dr Vijayaprasad Gopichandran, India
Prof Calvin Ho, Singapore
Dr Amar Jesani, India

Prof Eunice Kamaara, Kenya
Prof Lisa Schwartz, Canada
Prof Michael J. Selgelid, Australia
Dr Jerome Amir Singh, South Africa
Prof Edwin Were, Kenya

Special advisors
Prof Doris Schopper, Switzerland
Prof Ross Upshur, Canada

Appendix 3: Agreement signed between MSF and Flinders university, Australia

FLINDERS UNIVERSITY and MSF-OCBA Doctorate Research Agreement

Nilza Angmo –Remote programing and monitoring of hospitals in Syria

Introduction

This agreement sets out the responsibilities and expectations of Flinders University and Médecins Sans Frontières, Operational Centre Barcelona (MSF-OCBA, hereon referred as MSF) concerning the Doctorate Research Project being undertaken by Nilza Angmo (Flinders University Doctor of Public Health student). Nilza is supported by Commonwealth grants as internal candidate to pursue a full time, higher research degree of 'Doctor in Public Health' (DrPH) at Flinders University from February 2017 to 2020. Her 2nd and 3r years are dedicated to undertaking her dissertation.

This agreement will mark the beginning of collaboration between Flinders University and MSF and it is hoped that more research opportunities will emerge in the future. The aim of this document is to provide a clear outline of the commitments and inputs needed from both MSF and Flinders University with regard to the expected project outcomes. We hope it will form the basis of a productive and mutually beneficial Research study.

Overview of the project

The title of the research is: Remote Programing and monitoring of hospitals in conflict setting: A case study of Syria

This predominately qualitative case study will be focused on using: a literature review, primary data from interviews, observations and secondary data from MSF project archives. The individual interviews, Focal group discussions (FGD) will be conducted with selected MSF staff in Amman Jordan and hospital managers in Syria through email, Skype or phone. Observations during these activities and during meetings whenever feasible will also be taken. Some visits to MSF Headquarters in Barcelona will be required too. Most of the communications will be online.

The overarching theme of the research is to determine 'how can the limited approach of remote programming for hospitals be optimized to equitably address the medical needs in Syria'? Overall the study aims to clarify the barriers and facilitators to: best practice, efficient use of resources, and accountability of a remote programming model following the example of MSF project in South Syria. The study also aims to characterize the challenges remote approach raises for the founding mission and analyses the implications for future MSF engagements- in the region. The collective main objectives of the above aims are: (for detailed Aims and objectives please refer to the study draft attached)

1. To describe the remote program model of MSF- OCBA implemented in South Syria and identify effective strategies and practices through conducting semi-structured interviews with program managers and selected staff (service providers) and document analysis.
2. To understand lessons learnt, adaptation, and evolution of remote programming in response to war-torn Syria through undertaking semi-structured interviews with



program managers and focus group discussions with selected staff in Amman, as well as interviewing selected collaborating partners inside Syria.

3. To identify effective strategies, barriers and enablers, via undertaking semi-structured interviews with program managers and focus group discussions with selected staff in Amman, as well as undertaking semi-structured interview with collaborating partners and selected staff inside Syria.
4. To compile a refined draft model or practical policy guidance (framework) of remote programming for health facilities, including short and long-term strategies, to optimize benefits and minimize barriers to implementation

Expected Outcomes:

1. Best practice review:

- a. Establish the most effective and feasible remote practices in the humanitarian field through a literature review
- b. How remote programming has evolved in Syria and to identify effective and non-effective strategies and practices that MSF engages in

2. Propose a refined remote model approach

To identify short and long-term effective strategies that optimally addresses the present needs and gaps in hospital services.

3. Recommendations

To understand and convey the Implications of the refined model for MSF

Points of contact

Most of the contact and communications between Flinders University and MSF will be made directly by the student, Nilza Angmo. Nilza's research supervisors, Prof. Judith Dwyer and Dr. George Tsourtos from Flinders University may also be involved.

Hospital management advisor will represent MSF in Barcelona will be MSF point-of-contact. At Amman, the Remote support Manager for Syria and TESACO at regional coordination will be engaged. All relevant contact details are provided at the end of this document.

Responsibilities and expectations of Flinders University

1. General

Nilza and her supervisors will endeavor to reduce the impact on MSF staff time ☐

2. Data ☐

- a. The student will carry out all collecting of data, extraction and sorting of project data from archives, with support and facilitation by the reference group, especially during the early stages. ☐
- b. All data will be stored securely at Flinders University ☐
- c. Specific project location names will be anonymous, to avoid identification
- d. All hospital and patient related data will be dealt with confidentiality (details of the data required will be discussed later).
- e. All reporting will remain internal to Flinders University and will be shared externally only with MSF unless additional specific exceptions are agreed



upon. ☐

3. Field Visit:

- a. All travel costs, including accommodation and living arrangements related to the visits to MSF project site will be covered by the student / Flinders.
- b. The dates for visits will be proposed and agreed upon before the start of the research, scheduled for June/July 2018 (subject to ethics committee approval).

4. Interviews

No names of people or other identifiers from the interviews will be used in any reports, presentations or other related documentation

5. Feedback

Preliminary results of the findings will be shared with the MSF reference group as well as participants - to review the transcripts and findings from the interviews to ensure accurate representation. Feedback will also be sought with the reference group on the developed refined remote support model.

Responsibilities and expectations of MSF

• **Use of documents and data**

- a. MSF will provide access to relevant MSF project documents, reports and relevant hospital data.

• MSF will facilitate the data collection process by: ☐

- a. Providing access to the field
- b. Providing field contact information
- c. MSF will ensure that the focal points in Amman and advisor in Barcelona (for presentations and meetings) is present for all pre-planned visits
- d. MSF will inform at the earliest opportunity if a visit needs to be rescheduled or cancelled for any reason.

2. Interviews

MSF will suggest potential participants for individual interviews and FGD and support in the recruitment for the key participants.

3. Feedback

MSF will provide timely feedback on the preliminary findings of the study.

Handwritten notes in blue ink on the left margin, including a large 'b' and some illegible scribbles.

Handwritten signature in blue ink.

Handwritten signature in blue ink.

Handwritten signature in blue ink.

Appendix 4: Letter of introduction (English)



Dr George Tsourtos

Lecturer
Discipline of Public Health
School of medicine
Faculty of Health sciences

Level 2.2.11, health sciences Building,
Flinders University, Bedford
GPO Box 2100
Adelaide SA 5001

Tel: +61 8 72218418
Fax: +61 8 72218424

George.tsourtos@flinders.edu.au

LETTER OF INTRODUCTION

Dear Sir/Madam

This letter is to introduce Ms Nilza Angmo who is a student researcher of 'Doctor of Public Health' (DrPH) at College of Medicine and Public Health, Flinders University. She will produce her student card, which carries a photograph, as proof of identity.

She is undertaking research leading to the production of a Doctor in Public Health degree on the subject of Remote programming and monitoring of the hospitals in Syria through the experience of humanitarian organization of Medecine Sans Frontiers and its collaborating partners.

As a volunteer participant, you would be invited for either a one to one interview or a focus group discussion, which includes topics related to this research. Each session of interview or focus group discussion will take around 60-90 minutes. Be assured that any information provided will be treated in the strictest confidence, however within a focus group we can ask participants to keep what is said confidential but we cannot guarantee this. Also anonymity cannot be guaranteed both for focus group and individual interviews, as they will be conducted in the employment location. None of the participants will be individually identifiable in the resulting thesis, report or other publications. You are, of course, entirely free to discontinue your participation at any time or to decline to answer particular questions.

The student will seek your consent on the attached form to document the interview using an audio recording device, which will be analysed in preparing the thesis, report or other publications, on condition that your name or identity will not be revealed.

Any enquiries you may have concerning this project should be directed to me at the address given above or by telephone on +61872218418, by fax on +61872218424 or by e-mail George.tsourtos@flinders.edu.au

Thank you for your attention and assistance.

Yours sincerely

Dr George Tsourtos
Lecturer
Discipline of Public Health
School of medicine
Faculty of Health sciences

This research project has been approved by the Flinders University Social and Behavioural Research Ethics Committee. For more information regarding ethical approval of the project the Secretary of the Committee can be contacted by telephone on 8201 5962, by fax on 8201 2035 or by email human.researchethics@flinders.edu.au

5th March 2018

inspiring
achievement

- Whether I participate or not, or withdraw after participating, will have no effect on my current employment.
- ☐ I want to receive feedback about the outcome of the study.

Participant's signature.....Date.....

I certify that I have explained the study to the volunteer and consider that she/he understands what is involved and freely consents to participation.

Researcher's name..... Nilza Angmo.....

Researcher's signature.....Date.....

NB: Two signed copies should be obtained.

This research project has been approved by the Flinders University Social and Behavioural Research Ethics Committee (Project number 7953). For more information regarding ethical approval of the project please contact the Executive Officer on (08) 8201 3116 or human.researchethics@flinders.edu.au

Appendix 5: Letter of introduction (Arabic)

د. جورج تسورتوس
مُحاضر
اختصاص الصحة العامة
كلية الطب
قسم العلوم الصحية

جامعة فليندرز

الطابق 2، 11-2، مبنى العلوم الصحية
جامعة فليندرز، بيلفورد
عنوان مكتب البريد العمومي 2100
أديلايد، جنوب أستراليا 5001

الهاتف: 618 722 18418
الفاكس: 618 722 18424
البريد الإلكتروني: George.tsourtos@flinders.edu.au

خطاب توصية

السادة الأعزاء،

يُسعدنا في هذا الخطاب أن نقدم لكم الأنسة نيلزا أنغمو، طالبة البحث في اختصاص الصحة العامة لدى كلية الطب والصحة العامة في جامعة فليندرز. سنقوم الأنسة أنغمو بإظهار بطاقتها الطلابية التي تحمل صورتها، كإثبات لهويتها.

إن الأنسة أنغمو تقوم حالياً بإجراء بحث لدرجة الدكتوراة في الصحة العامة حول الدعم عن بُعد ومتابعة المستشفيات في سوريا، عبر دراسة تجربة منظمة أطباء بلا حدود الإنسانية وشركائها المتعاونين.

بصفتك مشاركاً متطوعاً، سنتم دعوتك إما إلى مقابلة فردية أو مناقشة جماعية مع مجموعة تركيز حول المواضيع المرتبطة بهذا البحث. سنأخذ كل مقابلة أو مناقشة مجموعة تركيز حوالي 60-90 دقيقة.

نؤكد لكم كل البيانات التي ستقومون بتقديمها ستعامل بسرية تامة؛ ولكن يجب التنويه أننا سنطلب من المشاركين في مجموعة النقاش أن يحافظوا على سرية ما سيُقال خلال المقابلة، ولكننا لا نستطيع ضمان ذلك. كما لا يمكننا ضمان إغفال هوية المشاركين في المقابلات الفردية أو مناقشات جماعات التركيز، فهي ستقام في أماكن عملهم. لن تُحدد الهوية الشخصية لأي من الأطراف الذين سيتم إجراء مقابلة معهم في الرسالة، أو التقرير، أو المنشورات التي قد تصدر بناء عليها. ولديكم، بالطبع، الحرية التامة للتوقف عن المشاركة في أي وقت، أو رفض الإجابة عن أي أسئلة معينة.

سنلتزم الطالبية موافقتكم الخطية في النموذج المرفق لتوثيق المقابلة باستخدام جهاز تسجيل صوتي، حيث سنقوم بتحليل الوثيقة الصوتية عند العمل على الرسالة، أو التقرير، أو المنشورات الأخرى، بشرط ألا يتم الكشف عن الأسماء أو الهويات.

إذا كانت لديكم أي أسئلة حيال المشروع، فبإمكانكم التواصل معي عبر العنوان المكتوب أعلاه، أو عن طريق الهاتف رقم: 618 722 18418 أو الفاكس رقم: 618 722 18424، أو عن طريق البريد الإلكتروني: George.tsourtos@flinders.edu.au.

نشكركم على حسن انتباهكم،
مع أطيب التحيات،

د. جورج تسورتوس
مُحاضر
اختصاص الصحة العامة
كلية الطب
قسم العلوم الصحية

تمت الموافقة على هذا المشروع البحثي من قبل جامعة فليندرز ولجنة أخلاقيات البحوث الاجتماعية والسلوكية. للمزيد من المعلومات حول الموافقة الأخلاقية على المشروع، يمكن التواصل مع الموظف التنفيذي عبر رقم الهاتف: 8201 3116، أو الفاكس: 8201 2035، أو البريد الإلكتروني: human.researchethics@flinders.edu.au.

Appendix 6: Information sheet for interview (English)



Ms Nilza Angmo
School of Medicine
Faculty of Health Sciences
Level 2, 2.11 Flinders Medical Centre
Flinders Drive, Bedford Park SA 5042
Tel: +61 469016766
Fax: +61 8 72218424
Nilza.angmo@flinders.edu.au
CRICOS Provider No. 00114A

INFORMATION SHEET (Interview)

Title: 'Remote Programming and monitoring of hospitals in conflict setting: A case study of Syria'

Investigator:

Dr. Nilza Angmo
Public Health Department
Flinders University
Ph: +61469016766

Supervisors

Dr George Tsourtos
Public Health Department
Flinders University
Ph: +61 8 72218418

Prof. Judith Dwyer
Health System Management Department
Flinders University
Ph: +61 8 82017769

Dr Paul Aylward
Public Health Department
Flinders University
+61 8 7221 8426

Description of the study:

This study is part of the project entitled 'Remote Programming and monitoring of hospitals in conflict setting'. Remote programming is providing full support with supervision and monitoring of hospitals through a remote team based in a neighbouring country. This project will investigate remote programming, in particular barriers and enablers in supporting hospitals in Syria remotely through the team based in Amman, Jordan. This project is supported by Flinders University Public Health department.

Purpose of the study:

This project aims to:

1. Identify the nature of the past and current operational program models in terms of

inspiring
achievement

strength, limitations and difficulties of serving in a war-torn region through situations of humanitarian medical operational actions.

2. Explore and identify barriers and enablers specific to remote programming to south Syria
3. Propose a refined and optimized remote program model/ practical policy guidance (framework) for health facilities in inaccessible conflict affected areas like Syria.

What will I be asked to do?

You are invited to attend a one to one **interview** with the researcher, who will ask you questions about your experiences and views about remote programming in Syria. The interview will take about 60- 90 minutes. The interview will be recorded using a digital voice recorder to help with looking at the results. Once recorded, the interview will be transcribed (typed-up) and stored as a computer file. Transcripts of the interview will not be shared with the participants for review or edit, therefore voice recordings will be saved for the verification of results and/or secondary data analysis on. This is voluntary participation.

What benefit will I gain from being involved in this study?

There are no direct benefits to you for taking part in the research. The sharing of your experiences will improve the planning and delivery of future programs. We are very keen to deliver a service and resources which are as useful as possible to people.

Will I be identifiable by being involved in this study?

While all information provided by you will be treated with the strictest confidence and no identifying information will be published, complete anonymity cannot be guaranteed since the interviews will be undertaken in your place of employment, also any major malpractices or exploitative behaviours information provided, would be reported to OCBA, in line with protocols routinely in place, with protection of the confidentiality of the reporting person. Any identifying information will be removed and the typed-up file and voice recordings will be stored on a password-protected computer that only the researcher (Nilza Angmo) will have access to. Your comments will not be linked directly to you

Are there any risks or discomforts if I am involved?

The investigator anticipates few risks from your involvement in this study. If you have any concerns regarding anticipated or actual risks or discomforts, please raise them with the investigator. You can also directly contact either of the counselling services mentioned below. All counselling services are provided free of charge:

MSF mental health Advisor, Amman unit

Dr. Maria Crisbal, Telephone: +962791304625

Email: Maria.crisbal@barcelona.msf.org

Appointments- Sunday to Friday 9am to 5pm

OR

Flinders University counselling services

Tel: 8201 2118,

Email: counselling@flinders.edu.au (provide your full name, phone number and a counsellor will contact you by phone).

Appointments – Monday to Friday; 8:45am to 5:00pm.

How do I agree to participate?

Participation is voluntary. You may answer 'no comment' or refuse to answer any questions and you are free to withdraw from the interview at any time without effect or consequences. A consent form accompanies this information sheet. If you agree to participate please read and sign the form and send it back to investigator at above address.

How will I receive feedback?

On project completion, outcomes from the project will be summarised and shared with you through email, if you would like to see them. The option to indicate if you would like to be informed about the outcome is in the consent forms. It will also be available on MSF-OCBA website.

Thank you for taking the time to read this information sheet and we hope that you will accept our invitation to be involved.

This research project has been approved by the Flinders University Social and Behavioural Research Ethics Committee (Project number 7953). For more information regarding ethical approval of the project the Executive Officer of the Committee can be contacted by telephone on 8201 3116, by fax on 8201 2035 or by email human.researchethics@flinders.edu.au

Appendix 7: Information sheet for interview (Arabic)

الانسة نيلزا أنعمو
كلية الطب
قسم العلوم الصحية
الطابق 2.11، مركز فليندرز الطبي
فليندرز درايف، بيدفورد بارك، جنوب أستراليا 5042
الهاتف: +61 4 69016766
الفاكس: +61 8 72218424
البريد الإلكتروني:
Nilza.angmo@flinders.edu.au

جامعة فليندرز

ورقة البيانات

(المقابلة)

العنوان: "الدعم عن بُعد ومتابعة المستشفيات في مناطق النزاع: دراسة في حالة سوريا"

الباحثة:

نيلزا أنعمو
كلية الصحة العامة
جامعة فليندرز
الهاتف: +61469016766

المشرفون:

د. جورج تسورتوس
اختصاص الصحة العامة
جامعة فليندرز
الهاتف: +61872218418

د. جوديث دواير
قسم إدارة النظام الصحي
جامعة فليندرز
الهاتف: +61882017769

د. بول أيلوارد
اختصاص الصحة العامة
جامعة فليندرز
الهاتف: +61872218426

وصف الدراسة:

تعتبر هذه الدراسة جزءاً من مشروع يحمل عنوان "الدعم عن بُعد ومتابعة المستشفيات في مناطق النزاع". يقضي الدعم عن بعد بتقديم الدعم الكامل، بالإضافة إلى خدمات الإشراف والرصد للمستشفيات، من قبل فريق بعيد في بلدة مجاورة. سيبحث هذا المشروع في مسألة الدعم عن بُعد، ويقوم بالتركيز على عوائق وعناصر تمكين دعم المستشفيات داخل سوريا عن بُعد من قبل فريق مقره العاصمة الأردنية عمان. سيتم هذا المشروع بدعم من كلية الصحة العامة في جامعة فليندرز.

هدف الدراسة:

يهدف هذا المشروع إلى:

1. تحديد طبيعة نماذج البرامج التشغيلية القديمة والمعاصرة، من حيث قدرتها، ومحدوديتها، والصعوبات التي تواجهها في تقديم الخدمات في المناطق التي مزقتها الحرب، من خلال واقع الأعمال التنفيذية الإنسانية والطبية.
2. استكشاف وتحديد العوائق والمُمكنات المتعلقة بالدعم عن بُعد في جنوب سوريا.
3. اقتراح نموذج مُحسن للتحكم عن بُعد / توجيه السياسات العملية (إطار العمل) للمنشآت الطبية في مناطق النزاع التي لا يمكن الوصول إليها، مثل سوريا.

ما الذي سيُطلب مني فعله؟

سيتم دعوتك لحضور مقابلة فردية مع الباحثة، التي ستقوم بطرح مجموعة من الأسئلة عليك؛ تدور هذه الأسئلة حول تجربتك وآرائك بالدعم عن بُعد في سوريا. مدة المقابلة 60-90 دقيقة، سيتم تسجيل محتواها باستخدام آلة تسجيل صوتي تُعين الباحثة على النظر في النتائج. بعد التسجيل، سيتم تدوين نص المقابلة وحفظها على ملف حاسوب. لن تتم مشاركة نص المقابلة مع المشاركين لمراجعتها أو التعديل عليها؛ لذلك سيتم الاحتفاظ بالتسجيلات الصوتية للتأكد من النتائج و/أو للقيام بتحليل البيانات الثانوية. هذه المقابلة اختيارية.

ما هي الفائدة التي ستعود عليّ من المشاركة في هذه الدراسة؟

لن تعود المشاركة في هذه الدراسة بفائدة مباشرة. لكن خبرتك ستساهم بشكل إيجابي في التخطيط والتنفيذ للبرامج المستقبلية. فنحن حريصون على تقديم مجموعة من الخدمات والموارد المفيدة قدر الإمكان.

هل سيكون من الممكن التعرف عليّ كمشارك في هذه الدراسة؟

سيتم المحافظة على سرية كل البيانات المُقدمة، كما سنطلب من المشاركين الآخرين أن يحافظوا على سرية ما سيقال. مع ذلك فإن السرية وإغفال الهوية لا يمكن ضمانهما بشكل تام نظراً لطبيعة مجموعات التركيز، ولأن المقابلات ستقام في أماكن عمل المشاركين، كما أن أية معلومات رئيسة عن الممارسات الخاطئة أو السلوكيات الاستغلالية يتم تقديمها، سيتم إبلاغها إلى منظمة أطباء بلا حدود - إسبانيا، بما يتماشى مع البروتوكولات المعمول بها بشكل روتيني، مع حماية سرية الشخص المبلغ. سيتم إزالة أي معلومات قد تكشف عن هويتك، وحفظ الملف النصي والتسجيلات الصوتية في جهاز حاسوب محمي بكلمة سرية لا يعرفها إلا الباحث (نيلزا أنغمو). كما سيتم ربط تعليقاتك بهويتك بشكل مباشر.

هل من المحتمل أن أتعرض إلى الخطر أو المضايقات بسبب مشاركتي؟

تتوقع الباحثة وجود شيء من المخاطرة في مشاركتك في هذه الدراسة. إذا كانت لديك أي مخاوف حيال المخاطر المتوقعة، فيرجى مناقشتها مع الباحثة. كما يُمكنك التواصل بشكل مباشر مع مستشارة الصحة النفسية في مركز برشلونة لإدارة العمليات، الدكتورة ماريّا كريسبال؛ هاتف: +962791304625، عنوان إلكتروني: Maria.crisbal@barcelona.msfg.org، المواعيد: الأحد - الجمعة، 9 صباحاً - 5 عصرًا.

أو خدمات المشورة لدى جامعة فليندرز؛ هاتف: +6182012118، عنوان إلكتروني: counseling@flinders.edu.au (اذكر اسمك الكامل، ورقم هاتفك، وسيقوم أحد الاستشاريين بالتواصل معك عبر الهاتف)، المواعيد: الاثنين – الجمعة، 8:45 صباحاً – 5 مساءً.

كيف أقبل بالمشاركة؟

المشاركة طوعية. بإمكانك أن تجيب بـ "لا تعليق" أو أن ترفض الإجابة على أي سؤال، كما أن لديك الحق بالانسحاب من المقابلة في أي وقت ودون أي تبعات. نموذج القبول ملحق بورقة البيانات هذه. إذا قبلت بالمشاركة، فيرجى منك أن تقوم بقراءة النموذج وتوقيعه وإرساله إلى الباحثة في العنوان المذون أعلاه.

كيف سأقوم بتلقي التعقيبات؟

حال إتمام المشروع، سيتم عمل مختصر لنتائج، ويتم إرسال نسخة منه إليك عبر البريد الإلكتروني في حال رغبت بالاطلاع عليه. كما أن خيار توضيح ما إذا كنت ترغب في الاطلاع على النتيجة موجود في نموذج الموافقة. وسيكون متاحاً على الموقع الإلكتروني لمنظمة أطباء بلا حدود – برشلونة.

شكراً لاطلاعك على ورقة البيانات هذه، ونأمل أن نتقبل دعوتنا لمشاركتك.

تمت الموافقة على هذا المشروع البحثي من قبل جامعة فليندرز ولجنة أخلاقيات البحوث الاجتماعية والسلوكية (المشروع رقم 7953). للمزيد من المعلومات حول الموافقة الأخلاقية على المشروع، يمكن التواصل مع الموظف التنفيذي عبر رقم الهاتف: 3116، أو الفاكس: 2035، أو البريد الإلكتروني: human.researchethics@flinders.edu.au

Appendix 8: Information sheet for focus group (English)



Ms Nilza Angmo
School of Medicine
Faculty of Health Sciences
Level 2, 2.11 Flinders Medical Centre
Flinders Drive, Bedford Park SA 5042
Tel: +61 8 72218418
Fax: +61 8 72218424
Nilza.angmo@flinders.edu.au
CRICOS Provider No. 00114A

INFORMATION SHEET (Focus Group)

Title: 'Remote Programming and monitoring of hospitals in conflict setting: A case study of Syria'

Investigator:

Dr. Nilza Angmo
Public Health Department
Flinders University
Ph: +61 469016766

Supervisors

Dr George Tsourtos
Public Health Department
Flinders University
Ph: +61 8 72218418

Prof. Judith Dwyer
Health System Management Department
Flinders University
Ph: +61 8 82017769

Dr Paul Aylward
Public Health Department
Flinders University
+61 8 7221 8426

Description of the study:

This study is part of the project entitled 'Remote Programming and monitoring of hospitals in conflict setting'. Remote programming is providing full support with supervision and monitoring of hospitals through a remote team based in a neighbouring country. This project will investigate remote programming, in particular barriers and enablers in supporting hospitals in Syria remotely by a team based in Amman, Jordan. This project is supported by Flinders University Public Health department.

Purpose of the study:

This project aims to:

1. Identify the nature of the past and current operational program models in terms of strength, limitations and difficulties of serving in a war-torn region through situations of

inspiring
achievement

humanitarian medical operational actions.

2. Explore and identify barriers and enablers specific to remote programming to south Syria
3. Propose a refined and optimized remote program model/ practical policy guidance (framework) for health facilities in inaccessible conflict affected areas like Syria.

What will I be asked to do?

You are invited to attend a **focus group interview** with the researcher, who will ask you questions about your experiences and views about remote programming in Syria. The interview will take about 60- 90 minutes. The interview will be recorded using a digital voice recorder to help with looking at the results. Once recorded, the interview will be transcribed (typed-up) and stored as a computer file. Transcripts of the interview will not be shared with the participants for review or edit, therefore voice recordings will be saved for the verification of results and/or secondary data analysis. This is voluntary participation.

What benefit will I gain from being involved in this study?

There are no direct benefits to you for taking part in the research. The sharing of your experiences will improve the planning and delivery of future programs. We are very keen to deliver a service and resources which are as useful as possible to people.

Will I be identifiable by being involved in this study?

Any information provided will be treated in the strictest confidence, and we can also ask other participants to keep what is said confidential, however confidentiality and anonymity cannot be guaranteed due to the nature of focus groups and also because they will be conducted in the employment location, also any major malpractices or exploitative behaviours information provided, would be reported to OCBA, in line with protocols routinely in place, with protection of the confidentiality of the reporting person.

Any identifying information will be removed and the typed-up file and voice recordings will be stored on a password-protected computer that only the researcher (Nilza Angmo) will have access to. Your comments will not be linked directly to you.

Are there any risks or discomforts if I am involved?

Other group members may be able to identify your contributions even though they will not be directly attributed to you. The investigator anticipates few risks from your involvement in this study. If you have any concerns regarding anticipated or actual risks or discomforts, please raise them with the investigator. You can also directly contact either of the counselling services mentioned below. All counselling services are provided free of charge:

MSF mental health Advisor, Amman unit

Dr. Maria Crisbal, Telephone: +962791304625

Email: Maria.crisbal@barcelona.msf.org

Appointments- Sunday to Friday 9am to 5pm

OR

Flinders University counselling services

Tel: +618201 2118,

Email: counselling@flinders.edu.au (provide your full name, phone number and a counsellor will contact you by phone).

Appointments – Monday to Friday; 8:45am to 5:00pm.

How do I agree to participate?

Participation is voluntary. You may answer 'no comment' or refuse to answer any questions and you are free to withdraw from the focus group at any time without effect or consequences. A consent form accompanies this information sheet. If you agree to participate please read and sign the form and send it back to investigator at above address.

How will I receive feedback?

On project completion, outcomes from the project will be summarised and shared with you through email, if you would like to see them. The option to indicate if you would like to be informed about the outcome is in the consent forms. It will also be available on MSF-OCBA website.

Thank you for taking the time to read this information sheet and we hope that you will accept our invitation to be involved.

This research project has been approved by the Flinders University Social and Behavioural Research Ethics Committee (Project no. 7953). For more information regarding ethical approval of the project the Executive Officer of the Committee can be contacted by telephone on 8201 3116, by fax on 8201 2035 or by email human.researchethics@flinders.edu.au

Appendix 9: Information sheet for focus group (Arabic)

الأستاذة نيلزا أنعمو
كلية الطب
قسم العلوم الصحية
الطابق 2.11، مركز فليندرز الطبي
فليندرز درايف، بيدفورد بارك، جنوب أستراليا 5042
الهاتف: +61 469016766
الفاكس: +61 8 72218424
البريد الإلكتروني:
Nilza.angmo@flinders.edu.au

جامعة فليندرز

ورقة البيانات

(مجموعة التركيز)

العنوان: "الدعم عن بُعد ومتابعة المستشفيات في مناطق النزاع: دراسة في حالة سوريا"

الباحثة:

نيلزا أنعمو
كلية الصحة العامة
جامعة فليندرز
الهاتف: +61469016766

المشرفون:

د. جورج تسورتوس
اختصاص الصحة العامة
جامعة فليندرز
الهاتف: +61872218418

د. جوديث دواير
قسم إدارة النظام الصحي
جامعة فليندرز
الهاتف: +61882017769

د. بول أيلوارد
اختصاص الصحة العامة
جامعة فليندرز
الهاتف: +61872218426

وصف الدراسة:

تعتبر هذه الدراسة جزءاً من مشروع يحمل عنوان "الدعم عن بُعد ومتابعة المستشفيات في مناطق النزاع". يقضي الدعم عن بُعد بتقديم الدعم الكامل، بالإضافة إلى خدمات الإشراف والرصد للمستشفيات، من قبل فريق بعيد في بلدة مجاورة. سيبحث هذا المشروع في مسألة الدعم عن بُعد، ويقوم بالتركيز على عوائق وعناصر تمكين دعم المستشفيات داخل سوريا عن بُعد من قبل فريق مقره العاصمة الأردنية عمان. سيتم هذا المشروع بدعم من كلية الصحة العامة في جامعة فليندرز.

هدف الدراسة:

يهدف هذا المشروع إلى:

1. تحديد طبيعة نماذج البرامج التشغيلية القديمة والمعاصرة، من حيث قدرتها، ومحدوديتها، والصعوبات التي تواجهها في تقديم الخدمات في المناطق التي مزقتها الحرب، من خلال واقع الأعمال التنفيذية الإنسانية والطبية.
2. استكشاف وتحديد العوائق والمُمكنات المتعلقة بالدعم عن بُعد في جنوب سوريا.
3. اقتراح نموذج مُحسن للتحكم عن بُعد / توجيه السياسات العملية (إطار العمل) للمنشآت الطبية في مناطق النزاع التي لا يمكن الوصول إليها، مثل سوريا.

ما الذي سيُطلب مني فعله؟

سيتم دعوتك لحضور مقابلة مجموعة نقاش مع الباحثة، التي ستقوم بطرح مجموعة من الأسئلة عليك؛ تدور هذه الأسئلة حول تجربتك وأرائك بالدعم عن بُعد في سوريا. مدة المقابلة 60-90 دقيقة، سيتم تسجيل محتواها باستخدام آلة تسجيل صوتي تُعين الباحثة على النظر في النتائج. بعد التسجيل، سيتم تدوين نص المقابلة وحفظها على ملف حاسوب. لن تتم مشاركة نص المقابلة مع المشاركين لمراجعتها أو التعديل عليها؛ لذلك سيتم الاحتفاظ بالتسجيلات الصوتية للتأكد من النتائج و/أو للقيام بتحليل البيانات الثانوية. هذه المقابلة اختيارية.

ما هي الفائدة التي ستعود علي من المشاركة في هذه الدراسة؟

لن تعود المشاركة في هذه الدراسة بفائدة مباشرة. لكن خبرتك ستساهم بشكل إيجابي في التخطيط والتنفيذ للبرامج المستقبلية. فنحن حريصون على تقديم مجموعة من الخدمات والموارد المفيدة قدر الإمكان.

هل سيكون من الممكن التعرف علي كمشارك في هذه الدراسة؟

سيتم المحافظة على سرية كل البيانات المقدمة، كما سنطلب من المشاركين الآخرين أن يحافظوا على سرية ما سيقال. مع ذلك فإن السرية وإغفال الهوية لا يمكن ضمانهما بشكل تام نظراً لطبيعة مجموعات التركيز، ولأن المقابلات ستقام في أماكن عمل المشاركين، كما أن أية معلومات رئيسية عن الممارسات الخاطئة أو السلوكيات الاستغلالية يتم تقديمها، سيتم إبلاغها إلى منظمة أطباء بلا حدود - إسبانيا، بما يتماشى مع البروتوكولات المعمول بها بشكل روتيني، مع حماية سرية الشخص المبلغ. سيتم إزالة أي معلومات قد تكشف عن هويتك، وحفظ الملف النصي والتسجيلات الصوتية في جهاز حاسوب محمي بكلمة سرية لا يعرفها إلا المُنسق (نيلزا أنغمو). ولن يتم ربط تعليقاتك بهويتك بشكل مباشر.

هل من المحتمل أن أتعرض إلى الخطر أو المضايقات بسبب مشاركتي؟

قد يتمكن أعضاء المجموعة الآخرين من تحديد مساهمتك حتى لو لم ترتبط بهويتك بشكل مباشر.

نتوقع الباحثة وجود شيء من المخاطرة في مشاركتك في هذه الدراسة. إذا كانت لديك أي مخاوف حيال المخاطر المتوقعة، فيرجى مناقشتها مع الباحثة. كما يُمكنك التواصل بشكل مباشر مع مستشارة الصحة النفسية في مركز برشلونة لإدارة العمليات، الدكتورة ماريا كريسيال؛ هاتف:

+962791304625، عنوان إلكتروني:

Maria.crisbal@barcelona.msf.org، المواعيد: الأحد – الجمعة، 9 صباحاً – 5 عصرًا.

أو خدمات المشورة لدى جامعة فليندرز؛ هاتف: +6182012118، عنوان إلكتروني:

counseling@flinders.edu.au (اذكر اسمك الكامل، ورقم هاتفك، وسيقوم أحد الاستشاريين بالتواصل معك عبر

الهاتف)، المواعيد: الاثنين – الجمعة، 8:45 صباحاً – 5 عصرًا.

كيف أقبل بالمشاركة؟

المشاركة طوعية. بإمكانك أن تجيب بـ "لا تعليق" أو أن ترفض الإجابة على أي سؤال، كما أن لديك الحق بالانسحاب من مجموعة النقاش في أي وقت ودون أي تبعات. نموذج القبول مُلحق بورقة البيانات هذه. إذا قبلت بالمشاركة، فيرجى منك أن تقوم بقراءة النموذج وتوقيعه وإرساله إلى الباحثة في العنوان المُدون أعلاه.

كيف سأقوم بتلقي التعقيبات؟

حال إتمام المشروع، سيتم عمل مُختصر لنتائجه، ويتم إرسال نسخة منه إليك عبر البريد الإلكتروني في حال رغبت بالاطلاع عليه. كما أن خيار توضيح ما إذا كنت ترغب في الاطلاع على النتيجة موجود في نموذج الموافقة. وسيكون متاحاً على الموقع الإلكتروني لمنظمة أطباء بلا حدود – برشلونة.

شكراً لاطلاعك على ورقة البيانات هذه، ونأمل أن نتقبل دعوتنا لمشاركتك.

تمت الموافقة على هذا المشروع البحثي من قبل جامعة فليندرز ولجنة أخلاقيات البحوث الاجتماعية والسلوكية (المشروع رقم 7953). للمزيد من المعلومات حول الموافقة الأخلاقية على المشروع، يمكن التواصل مع الموظف التنفيذي عبر رقم الهاتف: 3116، أو الفاكس: 2035، أو البريد الإلكتروني: human.researchethics@flinders.edu.au

Appendix 10: Consent form interview (English)



CONSENT FORM FOR PARTICIPATION IN RESEARCH (By interview)

'Remote Programming and monitoring of hospitals in conflict setting: A case study of Syria'

I

being over the age of 18 years hereby consent to participate as requested in the
..... for the research project on

1. I have read the information provided.
2. Details of procedures and any risks have been explained to my satisfaction.
3. I agree to audio recording of my information and participation.
4. I am aware that I should retain a copy of the Information Sheet and Consent Form for future reference.
5. I understand that:
 - I may not directly benefit from taking part in this research.
 - Participation is voluntary and I am free to withdraw from the project at any time; and can decline to answer particular questions.
 - While the information gained in this study will be confidential and published as explained, on the basis that the interview will be undertaken in my place of employment, anonymity cannot be guaranteed.
 - Any major malpractices or exploitative behaviours information provided during the interview, would be reported to OCBA, in line with protocols routinely in place, with protection of the confidentiality of the reporting person.
 - Whether I participate or not, or withdraw after participating, will have no effect on my current employment..
 - I may ask that the audio recording be stopped at any time, and that I may withdraw at any time from the session or the research without disadvantage.
6. ☐ I want to receive feedback about the outcome of the study.

Participant's signature.....Date.....

I certify that I have explained the study to the volunteer and consider that she/he understands what is involved and freely consents to participation.

Researcher's name..... Nilza Angmo.....

Researcher's signature.....Date.....

NB: Two signed copies should be obtained. The copy retained by the researcher may then be used for authorisation of Items 8 and 9, as appropriate.

This research project has been approved by the Flinders University Social and Behavioural Research Ethics Committee (Project number 7953). For more information regarding ethical approval of the project please contact the Executive Officer on (08) 8201 3116 or human.researchethics@flinders.edu.au

Appendix 11: Consent form interview (Arabic)

جامعة فليندرز

نموذج الموافقة على المشاركة في البحث (مقابلة؛ مجموعة نقاش)

"الدعم عن بُعد ومتابعة المستشفيات في مناطق النزاع: دراسة في حالة سوريا"

أنا البالغ من العمر أكثر من 18 سنة، أوافق بموجب هذا النموذج على المشاركة في من أجل مشروع البحث حول

1. لقد قرأت البيانات المرفقة.
2. لقد تم شرح التبعات وتفاصيل العمليات لي بطريقة مرضية.
3. أنا أوافق على إجراء تسجيل صوتي لمشاركتي والبيانات التي سأدلي بها.
4. أنا مدرك تماماً أنه ينبغي علي الاحتفاظ بنسخة من ورقة البيانات ونموذج الموافقة للرجوع إليها في المستقبل.
5. أنا على دراية بالتالي:
 - أنني لن أستفيد بشكل مباشر بالمشاركة في هذا البحث.
 - أن المشاركة طوعية تماماً، ولدي الحق بالانسحاب من المشروع في أي وقت. وأن بإمكانني أن أرفض الإجابة على بعض الأسئلة.
 - بالرغم من أن المعلومات المجموعة في هذه الدراسة ستبقى سرية وستنشر على النحو الموضح، نظراً لأن المقابلة ستجرى في مكان عملي، فإن عدم كشف الهوية لا يمكن أن يُضمن بشكل تام.
 - كما أن أية معلومات رئيسية عن الممارسات الخاطئة أو السلوكيات الاستغلالية يتم تقديمها، سيتم إبلاغها إلى منظمة أطباء بلا حدود - إسبانيا، بما يتماشى مع البروتوكولات المعمول بها بشكل روتيني، مع حماية سرية الشخص المبلغ.
 - سواء شاركت أم لم أفعل، أو انسحبت بعد المشاركة، فإن ذلك لن يؤثر بأي شكل على عملي الحالي.
 - بإمكانني أن أطلب إيقاف التسجيل الصوتي في أي وقت؛ وبإمكانني أن انسحب في أي وقت من الجلسة أو البحث، دون أن يلحق بي أي ضرر.
6. أُرغب في تلقي ملاحظات حول نتائج الدراسة.

توقيع المشترك التاريخ

أقر بأنني قد شرحت الدراسة للمتطوع بالتفصيل، وأنه قد فهم ما تتطوي عليه، ويقبل بكل حرية الاشتراك فيها.

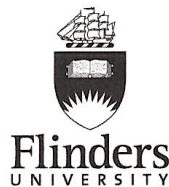
اسم الباحث نيلزا آتغمو

توقيع الباحث التاريخ

ملاحظة: ينبغي الحصول على نسختين. يمكن استخدام نسخة الباحث لمنح الإذن على البندين 8 و 9 عندما تقتضي الحاجة.

تمت الموافقة على هذا المشروع البحثي من قبل جامعة فليندرز ولجنة أخلاقيات البحوث الاجتماعية والسلوكية (المشروع رقم 7953). للمزيد من المعلومات حول الموافقة الأخلاقية على المشروع، يمكن التواصل مع الموظف التنفيذي عبر رقم الهاتف: 3116، أو الفاكس: 8201، أو البريد الإلكتروني: human.researchethics@flinders.edu.au

Appendix 12: Consent form focus group (English)



CONSENT FORM FOR PARTICIPATION IN RESEARCH (Focus Group)

'Remote Programming and monitoring of hospitals in conflict setting: A case study of Syria'

I

being over the age of 18 years hereby consent to participate as requested in the
..... for the research project on

1. I have read the information provided.
2. Details of procedures and any risks have been explained to my satisfaction.
3. I agree to audio recording of my information and participation.
4. I am aware that I should retain a copy of the Information Sheet and Consent Form for future reference.
5. I understand that:
 - I may not directly benefit from taking part in this research.
 - Participation is voluntary and I am free to withdraw from the project at any time; and am free to decline to answer particular questions.
 - While I can withdraw from participation at any time, I cannot withdraw the information I have provided or ask that the recording be stopped.
 - While no identifying information will be published, due to the nature of focus groups anonymity cannot be guaranteed.
 - Any major malpractices or exploitative behaviours information provided during the focus group discussion would be reported to OCBA, in line with protocols routinely in place, with protection of confidentiality of the reporting person.
 - Although participation will not be anonymous, I should protect the identity of participants and confidentiality of all discussions that occur within the group to minimise risks to participants.

Appendix 13: Consent form focus group (Arabic)

جامعة فليندرز

نموذج الموافقة على المشاركة في البحث

(مجموعة تركيز)

"الدعم عن بُعد ومتابعة المستشفيات في مناطق النزاع: دراسة في حالة سوريا"

أنا البالغ من العمر أكثر من 18 سنة، أوافق بموجب هذا النموذج على المشاركة في من أجل مشروع البحث حول

1. لقد قرأت البيانات المرفقة.

2. لقد تم شرح التبعات وتفاصيل العمليات لي بطريقة مرضية.

3. أنا أوافق على إجراء تسجيل صوتي لمشاركتي والبيانات التي سأدلي بها.

4. أنا مدرك تماماً أنه ينبغي علي الاحتفاظ بنسخة من ورقة البيانات ونموذج الموافقة للرجوع إليها في المستقبل.

5. أنا على دراية بالتالي:

- أنني لن أستفيد بشكل مباشر بالمشاركة في هذا البحث.
 - أن المشاركة طوعية تماماً، ولدي الحق بالانسحاب من المشروع في أي وقت. وأن بإمكانني أن أرفض الإجابة على بعض الأسئلة.
 - يمكنني الانسحاب من المشاركة في أي وقت، ولكن لا يمكنني أن أطلب سحب المعلومات التي قُمت بتقديمها، أو أن يتم إيقاف التسجيل.
 - بالرغم من أن البيانات التي سيتم نشرها لن تكشف هوية المشاركين، إلا أن عدم كشف الهوية لا يمكن أن يُضمن بشكل تام نظراً لطبيعة مجموعة التركيز.
 - كما أن أية معلومات رئيسية عن الممارسات الخاطئة أو السلوكيات الاستغلالية يتم تقديمها، سيتم إبلاغها إلى منظمة أطباء بلا حدود - إسبانيا، بما يتماشى مع البروتوكولات المعمول بها بشكل روتيني، مع حماية سرية الشخص المبلغ.
 - بالرغم من أن المشاركات لن تتضمن الحفاظ على سرية هوية المشاركين، إلا أن من واجبي حماية هوياتهم وسرية كل النقاشات التي ستتم ضمن المجموعة، لتقليل المخاطر التي قد يتعرضون لها.
 - سواء شاركت أم لم أفعل، أو انسحبت بعد المشاركة، فإن ذلك لن يؤثر بأي شكل على عملي الحالي.
6. أُرغب في تلقي ملاحظات حول نتائج الدراسة.

توقيع المشترك التاريخ

أقر بأنني قد شرحت الدراسة للمتطوع بالتفصيل، وأنه قد فهم ما تتطوي عليه، ويقبل بكل حرية الاشتراك فيها.

اسم الباحث نيلزا أنعمو

توقيع الباحث التاريخ

ملاحظة: ينبغي الحصول على نسختين.

تمت الموافقة على هذا المشروع البحثي من قبل جامعة فليندرز ولجنة أخلاقيات البحوث الاجتماعية والسلوكية (المشروع رقم 7953). للمزيد من المعلومات حول الموافقة الأخلاقية على المشروع، يمكن التواصل مع الموظف التنفيذي عبر رقم الهاتف: 3116، أو الفاكس: 2035، أو البريد الإلكتروني: 8201، أو البريد الإلكتروني: human.researchethics@flinders.edu.au

Appendix 14: Consent form interpreter



CONFIDENTIALITY AGREEMENT Interpreter/Translation Services

'Remote Programming and monitoring of hospitals in conflict setting: A case study of Syria'

I, _____, Interpreter/ translator, agree to maintain full confidentiality with regards to any verbal interpretation during the interviews and translation of all documentation received from Nilza Angmo related to her doctoral study on title 'Remote Programming and monitoring of hospitals in conflict setting: A case study of Syria'.

Furthermore, I agree:

1. To hold in strictest confidence the identification of any individual that I will interpret during the interviews, or mentioned in any associated documents;
2. To not make copies of any translated documents, unless specifically requested to do so by Nilza Angmo.
3. To store all study-related documents and materials in a safe, secure location as long as they are in my possession;
4. To return all study-related documents to Nilza Angmo in a complete and timely manner.
5. To delete all electronic files containing study-related documents from my computer hard drive and any backup devices.

I am aware that I can be held legally liable for any breach of this confidentiality agreement, and for any harm incurred by individuals if I disclose identity of the interviewee or any identifiable information contained in documents to which I will have access.

Interpreter/Translator's name (printed) _____

Interpreter/Translator's signature _____ Date _____

Appendix 15: List of individual Interview participants

Code	Age	Gender	Ethnicity	Profession Background	Education	Position	Duration of work with MSF	Remote experience Previous	other remote Location
1PMM	>45-55	M	African	Non-medical	Bachelor	PM	>10yrs-20	YES	Somalia
2PMM	>35-45	M	African	Doctor	Masters	PM	>10yrs-20	YES	
3PMF	>45-55	F	European	Nurse	Bachelor	PM	>20yrs	YES	Somalia
4PMF	>45-55	F	European	Nurse	Masters	PM	>3-5yrs	NO	
5PMF	>25-35	F	Asian	Non-medical	Masters	PM	>3-5yrs	YES	North Syria
6PMM	>55-65	M	European	Non-medical	Masters	PM	>10yrs-20	YES	
7PMM	>45-55	M	Asian	Doctor	Masters	PM	>10	NO	
8PMM	>45-55	M	Arab	Non-medical	Masters	PM	<1year	YES	Somalia, Yemen
9PMF	>35-45	F	Arab	Non-medical	Masters	PM	>3-5yrs	YES	Sudan
10PMF	>35-45	F	European	Nurse	Bachelor	PM	>10yrs-20	NO	
11PMM	>25-35	M	European	Non-medical	Bachelor	PM	>5-10yrs	NO	
12PMM	>45-55	M	Arab	Doctor	Masters	PM	<1year	NO	
13PMF	>45-55	F	Asian	Doctor	Bachelor	PM	1-3yrs	YES	Ethiopia
14PMF	>35-45	F	European	Doctor	Masters	PM	>5-10yrs	NO	
15PMM	>35-45	M	European	Nurse	Bachelor	PM	>3-5yrs	NO	
16PMF	>25-35	F	European	Doctor	Masters	PM	>3-5yrs	YES	North Syria
17PMF	>45-55	F	European	Non-medical	Masters	PM	>3-5yrs	YES	Gaza Kenya
18STM	>35-45	M	Arab	Non-medical	Diploma	ST	1-3yrs	NO	
19STM	>35-45	M	Arab	Doctor	Masters	ST	>3-5yrs	NO	
20STF	>25-35	F	Arab	Doctor	Masters	ST	1-3yrs	NO	

21STM	>45 -55	M	Arab	Nurse	Bachelor	ST	1-3yrs	NO	
22STM	>45 -55	M	Arab	Nurse	Bachelor	ST	1-3yrs	YES	
23STM	>35 -45	M	Arab	Doctor	Masters	ST	1-3yrs	NO	
24STM	>25 -35	M	Arab	Nurse	Certificate	ST	>5-10yrs	NO	
25STM	>25 -35	M	Arab	Non-medical	Diploma	ST	>3-5yrs	NO	
26TMM	>35 -45	M	Arab	Doctor	Masters	TM	1-3yrs	NO	
27TMM	>35 -45	M	Arab	Doctor	Bachelor	TM	>5-10yrs	NO	
28TMF	>25 -35	F	Arab	Paramedic	Diploma	TM	1-3yrs	NO	
29TMM	>25 -35	M	Arab	Paramedic	Bachelor	TM	>3-5yrs	NO	
30TMM	>35 -45	M	Arab	Doctor	Masters	TM	1-3yrs	NO	
31TMF	>25 -35	F	European	Nurse	Masters	TM	1-3yrs	NO	
32TMM	>25 -35	M	Arab	Doctor	Masters	TM	<1year	NO	
33TMM	>25 -35	M	Arab	Nurse	Diploma	TM	>3-5yrs	NO	
34TMM	>25 -35	M	Arab	Nurse	Diploma	TM	>5-10yrs	NO	
35TMM	>25 -35	M	Arab	Doctor	Bachelor	TM	>3-5yrs	YES	Iraq
36TMF	>25 -35	F	Arab	Medical	Masters	TM	>3-5yrs	YES	Iraq
37TMM	>25 -35	M	Arab	Paramedic	Masters	TM	1-3yrs	NO	

Appendix 16: Interview Guide

Opening question

1. Tell me about your background, about your experience with MSF and what motivated you to work for MSF/(Hobbies asked in FGD)
2. What are your responsibilities towards South Syria mission regarding MSF.
1. With your experience of working with South/North Syria remote project, how do you see the remote support provided by MSF, what do you think about MSF strategies and practices inside Syria? Which ones you think are the most effective and why?
 - a. Have you experienced circumstances where it cannot be applied or
 - b. Are there any particular group in whom it works better?
2. Thinking about protocols and tools you used. Do you think it works well in a way or do you think ways in which it is not suitable? What is different for Syria.
 - a. What needs to be changed to make it more effective (? specific new tools developed or adapted tools)
 - b. What are main lessons learnt, best practices and why?
3. Thinking about monitoring and follow up of the programme with technical things you are involved with, what do you think works well in the model and why? (contextualize)
4. Based on your experience do you think we have a good way of picking up what the needs really are? How were the needs identified?
 - a. Were there needs that were identified but not pursued and why? (Factors that should have been considered but have missed)
 - b. Do you think we have the right people involved?
 - c. Do you think that in any ways in which we innovated, to adapt to the circumstances? (If they say they have lot of ideas but its hard to even get those on agenda then ask really? Why its hard, is there lot of process for explaining what the problem is, they will care if there are inefficiencies in their department)
5. Practice in MSF is always guided by the principles of impartiality, neutrality and independence, do you think there are any ways it is particularly difficult or different in Remote programme, any particular challenges in remote situations or things we have to do differently.
6. Are there barriers (things that get in way of fixing challenges) and challenges (things that are difficult to do)faced in particular to remote programming? If so, what are they? Why do you think they have become barriers (Lesson learnt is how came over a barrier, stg used)
7. Are there enabling factors that you think are responsible for the continuity of the program. If so, what are they? Why do you think they have become enablers
8. What in your views are the critical needs of the program and why?
9. What kind of support do you think is needed for the services to be more focussed and acceptable? Why is that.
10. Would you like to talk about recent changes and your experiences of closure of the Syria remote project?