

Assessing healthcare needs in an inaccessible conflict zone: remote surveying in southern Syria

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Introduction

Accessing populations with medical needs in a conflict zone is often impossible due to security, political or logistical issues. During the Syrian conflict, lack of access has become the norm and not the exception. Assessing medical and humanitarian needs in such settings therefore often needs to use remote approaches, which technological innovations can help. We describe our experience of assessing health care needs in southern Syria (SS), using a remote model to collect both quantitative and qualitative data.

Methods

In May-Oct 2017, we established a network with stakeholders working with SS programmes, including directors of health, nine health providers and 12 non-governmental organizations (NGOs); data collection took place during Nov-Dec 2017. Stakeholders based in Jordan were interviewed in person; those in Syria were interviewed over Skype. We identified a third party NGO working in SS which could implement household (16 enumerators and 3 supervisors), hospital and key informant surveys. Cross border parties enabled 14 tablet devices to be brought to the third party NGO, and for Syrian surveyors to attend face-to-face training in Jordan. An electronic data collection platform was used to collect data about medical needs and barriers to health care on a hospital or household level. Remote communication was established to carry out supervision, and arrange logistics using social media and Skype.

Ethics

This study was approved by the MSF Ethics Review Board.

Results

The quality of remote surveying was strengthened by: enabling continuous communication with health actors (n=22), which allowed us to triangulate information about health gaps to be included in the survey; establishing a network of cross-border service providers; use of tailor-made questionnaires within the electronic data collection platform, which enabled real-time data monitoring; and finally use of day-to-day communication via social media to inform quality assurance. This model was proven to be successful and revealed a gap in non-communicable disease care, secondary war trauma care and vaccination coverage.

Conclusion

This remote model helped identify disease prevalence, important gaps in medical needs and barriers to access health care in the context of SS. Qualitative and quantitative data collection was enabled by internet-based platforms for communication and data collection. The triangulation of information regarding gaps in health care informed MSF operations and other health actors. It was necessary to work collaboratively with third parties, provide comprehensive training and enable internet access in order to deliver this project. Despite technological innovations, remote activities rely on the willingness of different actors to cooperate with each other. This model of remote epidemiological assessment may be valuable for similar future operations.

Conflicts of interest

None declared.