HEALTH
CHAPTER

METHODOLOGY

The sector chapters were predominantly designed to present the data that exists, and that was shared with the Multi Sector Needs Assessment (MSNA) team. Annex A provides a summary of the assessments and reports reviewed for the chapter. There is much that sector experts know from experience that is not captured in the assessment reports. To capture some of the expert views within the Sector Working Groups (SWGs), MSNA SWG workshops were facilitated by the MSNA team and sector experts. These views are taken into account throughout the document. However, due to the short notice, attendance was limited in some workshops and the views presented in the chapter cannot be considered as representative of all SWG members.

The MSNA team aimed to provide an objective overview of the available data and SWG views and therefore has not altered the data or language used in the reports and assessments.

The following target groups were used for the purposes of data analysis:

- Syrian refugees registered with UNHCR or awaiting registration
- Syrians living in Lebanon who have not been registered with UNHCR
- Palestinian refugees from Syria (PRS)
- Vulnerable local Communities including Host Communities and Palestinians (PRL)
- Lebanese returnees

Analysis was undertaken at the lowest possible geographic levels for the various target groups, depending on the type of information available. Where possible, information was aggregated to; Mount Lebanon and Beirut, South, Bekaa, Akkar, North/T+5, Palestinian Camps, and Outside Palestinian Camps.

Main Steps

- **Identifying information needs:** In order to identify the relevant research questions for collation, the Thematic Working Group (TWG) combined the indicators of the Syria Regional Response Plan (RRP6) with additional information needs from the SWG. These information needs were used to form the basis of the chapter themes.
- **Secondary data collation:** An assessment inventory was developed and shared for input from as many stakeholders as possible; to encourage sharing of assessment data. A sector focal point was assigned from the TWG and supported the MSNA team to collect data from the sectors. Within the team, analysts were assigned to sector chapters and a number of partners were approached including: INGOs, UN agencies, the Ministry of Social Affairs Lebanon (MoSA), the National NGO forum and the World Bank with requests for assessment reports.
- **Data categorisation:** To facilitate the data analysis component, all data was summarised and categorised into an excel spreadsheet.
- **Analysis and Writing:** The Sector Leads and respective analysts assessed the usefulness of the reports and used them accordingly. For example, a nationwide multi-sector report would have been used to develop broad conclusions, whilst an assessment with a small sample size in one particular location may have been used to provide examples to support/contradict the overall findings.
- **Review and Consultation:** The MSNA team reviewed a number of databases, assessments and reports that were provided by partner agencies. In order to obtain as comprehensive overview as possible a number of consultations were built in with the SWGs.

For more information on the methodology please refer to the main report.

CONTENTS

1. KEY FINDINGS

Summary of Priorities

Based on the data review and inputs from the Sector Working Group we can provide the following preliminary conclusions:

The overall impression gained from the available evidence and focus group discussions is that the sector will face multiple challenges and increasing demands on resources over the next year. Health and healthcare services influence and are influenced by nearly all other sectors, making it a fundamental driver and outcome of the humanitarian response. Health equity must be embedded in the response and a "health in all sectors" strategy must be adopted if population health is to be protected and promoted. The basic health needs and access to services of the refugee population and vulnerable groups are largely being met by the response, with support from the Government of Lebanon (GoL). It is apparent that there are gradual moves within the sector to focus on medium- to long-term programmes and shift to development strategies. This involves strengthening healthcare services and systems, focusing on public and primary health interventions and policies. This will assist refugees in the short term, but will provide cost-effective, long-term and sustainable health improvements for host communities.

Ideally the health response and provision of healthcare services should adopt an equitable, nationwide approach. However, given the increasing response challenges it is currently necessary to focus on those areas which are underserved, most in need and prone to disease outbreaks namely – Akkar, Bekaa and Tripoli. Within these governorates, areas lacking water, sanitation and hygiene (WASH) infrastructure should be prioritised.

Given the predominantly privatised nature of the Lebanese health care system, the response should prioritise and target those who lack insurance and other local payment support mechanisms. Within this a number of groups such as those with chronic conditions, older people, children, pregnant women and local communities vulnerable or exposed to disease outbreaks should be targeted. Given the looming threat of polio and other vaccine-preventable diseases, the blanket immunisation of all children regardless of their nationality or economic status must be employed and sustained over the next year. This will be an extremely cost-effective measure for Lebanon and the region.

Both focus group respondents and the data reviewed confirm that the response requires more accurate and timely data on which to base decisions. In addition, difficulties gathering and thus analysing data has hindered effective identification, targeting and forecasting of needs. Outcome evaluations of health interventions and programmes of the humanitarian community are required to know what works, why and for whom, as well as to improve cost-effectiveness of donor aid.

Three key issues were highlighted that may affect the future development and operation of the sector. Firstly, the likely budget constraints for health will enact a shift toward more targeted assistance. Secondly, a sudden refugee influx as a result of the situation in Syria will further strain government-run public health services and may exceed the capacities of the response. Thirdly, the onset of summer will increase the potential for disease outbreaks and need for access to medical care among refugees in informal settlements where WASH and nutrition conditions are deteriorating. A key preventive intervention that will have immediate effects is the further investment in improving WASH conditions for those living in informal settlements.

1.1 Priority Needs

By targeting a range of priorities across population groups and geographic locations, the health priorities identified below aim to improve and protect the health and wellbeing of the vulnerable and persons of concern, as well as affected host communities. A strategy of public health should be supported focusing on the three pillars of primary healthcare – promotion, prevention and curative services –, which aims to contain costs for the Lebanese government and the UN, but above all to protect and promote the health of all population groups.

The priority needs identified by the data and the MSNA SWG workshop and sector specialists largely mirrored the response needs. They include:

Coordination

- Adopt and promote "health in all sectors". Encourage other humanitarian sectors to see how their actions will impact upon health and wellbeing of their target groups and how health fits into other sectors such as basic needs, education, shelter, WASH, nutrition, livelihoods, food security, and child protection. This essentially involves adopting a cross-cutting and collaborative social determinants of health approach to the response, rather than a "silo-based" mentality.
- Reinforce and promote basic public health measures to tackle the causes of disease and ill health. This involves direct working links between the health sector and WASH, nutrition and shelter programmes. This will act as an effective primary healthcare intervention helping to prevent disease outbreaks, particularly among children living in informal settings.
- All forthcoming assessments and surveys require coordination in terms of using comparable methodologies of data collection and reporting.

Prevention

- Develop and maintain a preventive healthcare strategy and response, as opposed to focusing entirely on expensive curative medical services. This involves directly supporting WASH, shelter and nutrition programmes and interventions. It also involves encouraging the GoL and the Ministry of Public Health (MoPH) to begin adopting more primary healthcare (PHC) measures and a shift toward universal coverage.
- Maintain blanket vaccination coverage for all areas and all groups over the next year. This will involve increased investment in mobile medical units in order to access hard to reach areas.
- Enhance interventions to monitor and tackle communicable disease outbreaks, improve capacities for epidemic preparedness and forecasting, and increase routine low-cost interventions such as tobacco cessation counselling, dietary recommendations to avoid high saturated fat and low nutrient foods and cancer awareness.

Access

- Strengthen PHC in terms of increased availability and access. This will involve creating polyclinics across villages in Lebanon that are able to offer low-cost or free consultations and provide assistance with such issues as reproductive health, maternal health and family planning. This will prevent the unnecessary referral for the majority of conditions to more expensive secondary healthcare (SHC) settings. Sustained investment in PHC will serve to act as a substantial cost-saving measure, reducing pressure on SHC.
- Advocate for healthcare regulations that guarantee access to healthcare in emergencies (free at point of service) for all groups and foreign visitors to Lebanon. Cases where patients have been turned away for life-saving treatment should be followed up by the MoPH and legal authorities.

Treatment

- Enhance interventions and monitoring of non-communicable diseases (NCD) and chronic conditions. It is known from pre-crisis evidence that certain diseases and chronic conditions continue to present key health challenges most notably among the refugee population, yet there is limited treatment for these. Specifically, increase access and funding to cover expensive treatment and medication for NCD and chronic conditions such as cancer, cardiovascular disease (CVD) and renal failure/kidney dialysis.

System quality and capacity

- Enhance the technical capacities and staffing of emergency warning and response networks (EWARN) and sentinel sites across the country to reduce regional disparities in reporting. This will assist in forecasting health challenges.
- Strengthen the Health Information System (HIS) by ensuring all humanitarian partners use the UNHCR complementary HIS to support the HIS of the MoPH. Also, redefine existing measures such as mental and psychosocial health.
- Medical staff need further training on correct diagnosis and recording of cases to decrease the proportion of "other" in HIS reporting.
- Assess and audit the capacity, quality and utilisation rates of public hospitals and clinics across Lebanon.
- Assess the cost effectiveness of interventions and programmes. Set up pilot studies incorporating cost-benefit analysis of health interventions and programmes operated by humanitarian partners.

Specific mental health and psychosocial support (MHPSS) priority needs

- Harmonise the HIM using the seven UNHCR mental health categories.
- Ensure revision of current MoPH essential medications list to include the required essential psychotropic medications.
- Establish a solid referral and feedback system both centrally and locally in the different districts, including pathways for urgent cases that might occur outside working hours.
- Expand mental health gap training at PHC level.
- Train and supervise psychologists in evidence-based psychotherapy methods. Preferably interpersonal psychotherapy (IPT) or cognitive behavioural therapy (CBT).

1.2 Priority Target Groups

Based on the data available, MSNA analysts have found that the majority of currently available assessments predominantly cover Syrian refugees, without necessarily specifying registered or unregistered or PRS. In order to protect and promote health in Lebanon and among vulnerable groups, the health response should address all persons of concern as identified (Syrian refugees, Lebanese host community, PRS and Lebanese returnees). Within this specific group, vulnerable subsets should be targeted:

- Children under five years of age
- Older persons – 60+
- Pregnant and lactating women
- Persons with special needs and disabilities
- Persons with chronic conditions
- Persons with acute psychological and psychiatric conditions
- Those with acute life-threatening diseases
- Persons and communities exposed to critical health events such as disease outbreaks
- Target groups within groups, i.e., take account of refugees' date of arrival/length of residence in assessments and intervention design. Length of residence and registration status has been found in

the available information to be associated with increasing prevalence of mental health issues among certain groups and increased expenditures on healthcare services.

Syrian refugees (registered and unregistered)

- A number of assessments have demonstrated Syrian refugees display elevated birth rates and therefore require enhanced access and care provision for maternal and reproductive healthcare.
- Improve access to treatment and medications for NCDs and chronic conditions particularly cancer, hypertension, cardiovascular disease and diabetes. Within this, the targeting of older age groups and those with disabilities as a result of conflict are of particular concern.
- Improve access and treatment for mental and psychosocial health conditions.

Lebanese returnees

- Continue to collect data on the health status and needs of returnees.

1.3 Geographic Priorities

The majority of Syrian and PRS refugee populations have settled in poor Lebanese communities. These areas already possessed limited or non-existent public service provision such as healthcare, which is now being further stretched in terms of capacity – provision, funding and staffing. This includes Akkar, Tripoli, Baalbek, Hermel, Zahle, Matn, Kesserwan, Baabda, Aley, Saida, Sour, Hasbaya. Bebnine, Halba, West Bekaa, Labweh and Aarsal.

1.4 Response Gap Analysis

Information from the MSNA review and stakeholder participants identified the following response gaps:

- Across the sector there is need to conduct more in-depth analysis of existing data in order to enhance health forecasting.
- There is a need to build in malnutrition screening, detection, and treatment across the sector.

Limited information exists across a range of issues, specifically:

- The prevalence and severity of certain health conditions such as NCDs and mental health issues across target groups and regions.
- Cancer registration/surveillance among refugee groups as well as the capacity of data management systems.
- The drivers/determinant of healthcare access across groups and geographical areas.
- Mortality, morbidity and injuries among the refugee population.
- Response capacities available in terms of the quality of health services available throughout Lebanon, particularly emergency disease outbreak staffing levels and availabilities of laboratories.
- The quality and ability of local NGOs and INGOs to successfully deliver and implement health projects and interventions.
- Awareness campaigns, distribution and uptake of contraceptives/birth control; family planning information among the refugee population, as well as target group levels of awareness. Information is needed on the barriers and determinants of uptake.
- Limited information identified on the availability of medications to refugee populations or the prescription and consumption of medication/pharmaceuticals by refugee populations. As UNHCR medication donations are restricted to refugees, monitoring this could reveal large gaps in MoPH medication provision for host communities.

No data has been identified on the following issues:

- Linking WASH conditions to health outcomes
- The number of people requiring dental care and treatment
- Utilisation rates of hospitals, which means need cannot be matched to capacity

The MHPSS sub-group within the SWG identified the following perceived response gaps/issues:

- There appears to be limited response attention given to where greatest needs currently are and will arise. Within the MHPSS response, the vast majority of interventions fall within child protection. Substantial needs are present across the adult population, especially older persons. Few if any interventions and providers currently focus upon these age groups.
- Lack of coordination within the MHPSS sector has manifested in not only the duplication of efforts in certain geographical areas (and the neglect of other beneficiary groups), but also unhealthy competition between humanitarian partners over beneficiaries. This has led to significant concerns that the response is not only insufficient, but is unnecessarily competitive and hastily implemented.
- Projects are being delivered by undertrained and inexperienced staff. Across Lebanon there is a severe shortage of certified psychiatrists and psychologists.
- Majority of interventions focus on short term/one off programmes, which are often recreational activities that may or may not even qualify as psychosocial interventions.
- Little attention is given to providing long-term support, and to the role and influence of parents within interventions targeted at children.
- Little recognition from sectors such as child protection that their work and programmes have cross-cutting effects, i.e., there remains a "silo" mentality in various sectors that do not recognise that their actions and interventions will have effects on the wider health situation and health service capacities.

1.5 Future Developments with Possible Impacts on Sector

Based on the data available, MSNA analysts have found the following future developments may have an impact on the sector:

- A sudden refugee influx as a result of the situation in Syria may completely overwhelm the public health systems in poor Lebanese communities, leading to increased community tensions and declining health status among refugees and deprived Lebanese host communities.
- Onset of warmer temperatures with an expected water shortage across the country will enhance the potential for disease outbreak. Urgent attention and investment should be given to improving and preventing the further deterioration of WASH conditions and nutrition of those living in informal settings. This is will be an effective preventive measure helping to reduce costs over the coming year and protecting health.

The participants of the MSNA Basic Needs Sector Working Group workshop identified the following future developments may have an impact on the health sector:

- The major concern among respondents was that if the health response budget is not achieved this will greatly affect which groups can be covered by the response. It would mean focusing entirely on the most vulnerable (children) and emergency trauma cases only. The ability of UNHCR to provide health care subsidies would have to be revised, exposing refugees to increased healthcare costs and rates of disease and illness.
- With a shrinking budget situation, care must be taken when making commitments to care for chronic conditions that may have to be abandoned mid-treatment due to funding shortages. This of course has

negative health impacts on patients and does not install trust in healthcare providers or the wider humanitarian response.

- The establishment of a population-based survey on utilisation and drivers of access to healthcare systems may greatly assist in response planning. The major barrier to overcome is accessing the data on utilisation rates, which is deemed financially sensitive in Lebanon.

2. CONTEXT

Over the last two and a half years, Lebanon has experienced an unprecedented influx of refugees from Syria. As of March 2014, Lebanon reached its 2050 projected population figure (4.6 million), which will continue to increase over the next year. The population surge has put severe strains on the finite resources, the already overstretched public services and the capacities of authorities at central and local levels.

As a number of chapters in the MSNA report demonstrate, refugees share the already limited public services such as health and education with Lebanese host communities. It is estimated that the majority of refugees reside in locations where a large proportion of the host population are living below the poverty line.

The refugee crisis has exposed the fragile nature of the pre-existing public health system, where 50% of the Lebanese population possess no formal health insurance, are exposed to "catastrophic" healthcare expenditures and lack basic means of social protection.[1] [2] Lebanese without private medical insurance rely upon the MoPH and the National Social Security Fund to reimburse a portion of their medical bills.[3] According to a recent World Bank assessment, the social security system (SSS) including health was "weak, fragmented and poorly targeted". The World Bank estimates that USD 1.5 billion (3.4% of Lebanon's GDP) will be needed to restore services to pre-crisis levels, of which USD 177million is for health services alone.[4]

The Ministry of Social Affairs (MoSA) and MoPH report an average 40% increase in the use of their services, which ranges between 20-60% across the country.[5] This struggle over access to public services may be a key driver of increased tensions between host communities and the refugee population. The MSNA mapping process has identified a number of geographical areas where community tensions are reportedly increasing as a result of access to public services. These are Akkar, Tripoli, Baalbek, Hermel, Zahle, Matn, Kesserwan, Baabda, Aley, Saida, Sour, Hasbaya. Bebnine, Halba, West Bekaa, Labweh and Aarsal. New initiatives are being established by the GoL in collaboration with UN agencies and the European Union to address these issues. The recent Instrument for Stability – Strengthening Health Care in Lebanon aims to tackle problems over access to healthcare in vulnerable areas of Lebanon.

A privatised health system

The Lebanese healthcare system is dominated by the private sector and suffers from high spending: almost 6.4% of GDP compared to an average of 5% in the Middle East and North Africa (MENA) region. This expenditure is concentrated in high-cost curative technological interventions used by a small number of patients.

Out-of-pocket payments account for 46% of individual public health care expenditures.[6] [7] However, the impacts are disproportionately felt among those on low incomes, who must choose between paying for health

[1] ESCWA (2013) Towards a new welfare mix? Rethinking the role of the state, the market and civil society in the provision of social protection and social services. See also http://www.aljazeera.com/indepth/opinion/2013/10/health-tragedy-levant-costs-opportunities-solidarity-20131021632216561 77.html and ILO (2012) Universal Healthcare in Lebanon.
[2] Salti N, Chaaban J, Raad F (2010) Heath equity in Lebanon: a microeconomic analysis. International Journal for Equity in Health Services
[3] International Labour Organization (2012) Introducing Universal Healthcare in Lebanon.
[4] World Bank (2013)
[5] World Bank (2013) Lebanon Economic Monitoring: The brunt of the Syrian conflict. Poverty Reduction and Economic Management Unit. MENA Region.
[6] Salti N, Chaaban J, Raad F (2010) Heath equity in Lebanon: a microeconomic analysis. International Journal for Equity in Health Services
[7] ESCWA (2013) Towards a new welfare mix? Rethinking the role of the state, the market and civil society in the provision of social protection and social services.

and for other necessities including food. Furthermore, one-off payments for expensive health interventions often push low-income households into financial insolvency.[8] Available evidence suggests that the incidence of "financial catastrophe" occurs when direct payment contributions are above 15-20% of total expenditure on health. In Lebanon today, the required out-of-pocket contribution is considerably higher than this.[9]

In terms of mental health care capacity and provision, the system has been described as under-resourced. A 2010 WHO national audit of services across Lebanon showed that research and government expenditures on mental health were far below national needs.[10]

As Figures 1 – 3 show, the private health care industry dominates the health system and has far more capacity in terms of beds available than the public sector across geographic regions. The data source is the Syndicate of Hospitals in Lebanon 2012. Private sector hospitalisation accounts for 48% of total public health expenditure, which is a significant drain on public sector finances.[11]

Figure [1]: Numbers of public and private hospitals by region (Source: Syndicate of Hospitals 2012)

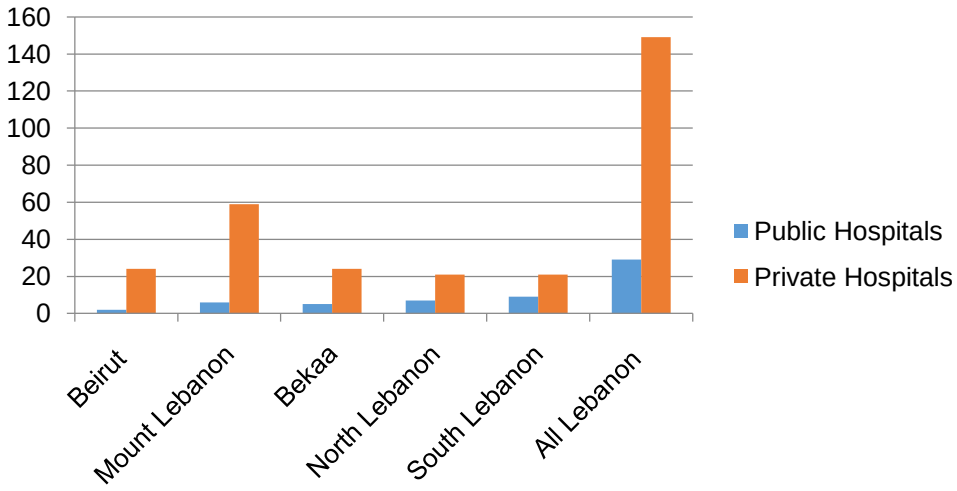
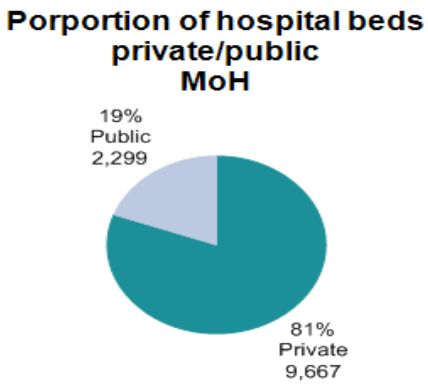


Figure [2]: Hospital beds – Public and private (Source: Syndicate of Hospitals 2012)



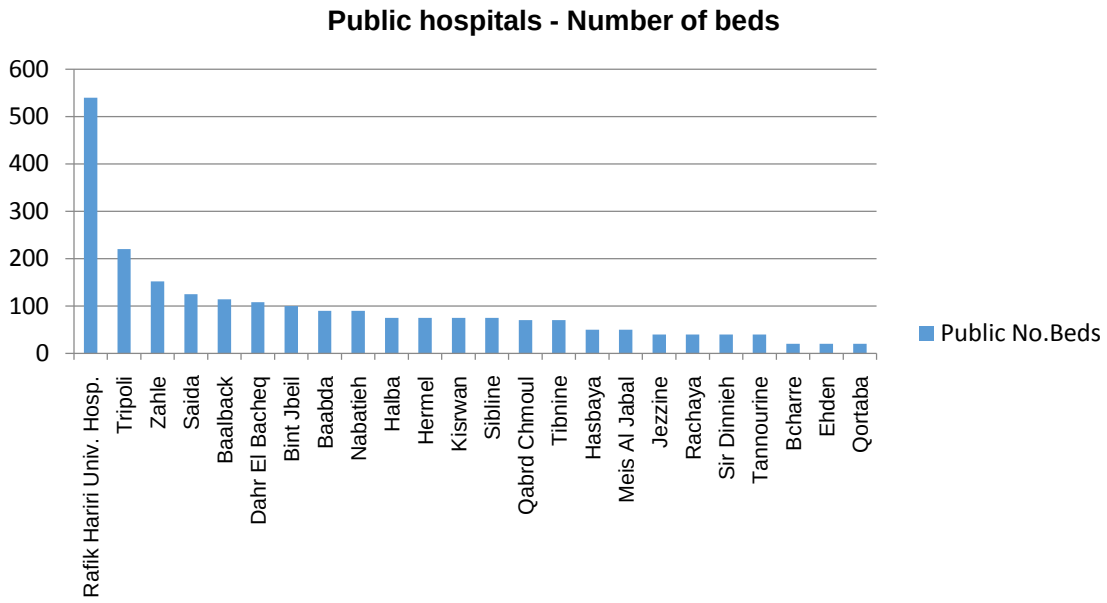
[8] Leive A, Xu K (2008), "Coping with out-of-pocket health payments: empirical evidence from 15 African countries", *Bulletin of the World Health Organization 86*, pp. 849-856. doi:10.2471/BLT.07.049403

[9] Xu K et al (2010), *Exploring the thresholds of health expenditure for protection against financial risk.* World health report 2010 background paper, no. 19 (http://www.who.int/healthsystems/topics/financing/healthreport/whr_background/en).

10 WHO-AIMS (2010) Mental health system in Lebanon. Available at: http://www.who.int/mental_health/who_aims_report_lebanon.pdf

[11] Cammett M (2014). *Compassionate Communalism: Welfare and Sectarianism in Lebanon.* Boston, Massachusetts, United States: Cornell University Press

Figure [3]: Number of beds in all across public hospitals (Source: Syndicate of Hospitals 2012)



The country has more than 950 dispensaries and primary healthcare centres. The former operate with minimal human and physical capacities and offer limited services. Primary healthcare centres are in constant evolution and offer a multitude of services including prevention programs, reproductive health programs, family planning and prenatal care. They also develop training programs and offer logistic support, via a wide network, in buying and distributing essential medication. In spite of this, the public primary healthcare system remains weak. The number of Lebanese individuals making use of these centres remains limited (estimated at a maximum of 20% of the Lebanese population) and the quality of services varies by region and provider.

The MoPH has chosen 193 centres among all the primary healthcare centres operating in the country to establish a primary healthcare network, in which more than 70% belong to NGOs. Less than 10 % belong to the public sector (MoPH or MoSA).

Secondary healthcare services are available to Syrians, but they continue to face large out-of-pocket payments in a system dominated by the private sector. The predominance of the private healthcare sector in is a unique situation compared to other humanitarian contexts. This continues to hamper the ability of the UN to effectively organise and coordinate health services for refugee populations given cost barriers.

Independent academic research in Lebanon[12] has indicated that these fiscal barriers may be forcing increasing numbers of refugees to return to Syria in order to access secondary care services.[13] This has also been supported by qualitative research by Medicine du Monde in the Bekaa valley: El Qaa, El Ain and Kamed el Loz.[14]

In order to address the shortage of capacity as exhibited by the public health system, prior to the refugee crisis, a number of local NGOs and faith-based organisations/political parties have moved to fill this need.[15] Several political parties and movements have operated independent health networks over the past 25 years, with their own hospitals, clinics and dispensaries as well as computerised systems for maintaining medical records.[16]

[12] Coutts A, Fouad M. Fouad (2013) Response to Syria's health crisis—poor and uncoordinated. World Report. Lancet. June 28th
[13] Coutts A, Fouad M. Fouad (2013) Response to Syria's health crisis—poor and uncoordinated. World Report. Lancet. June 28th
[14] MdM (2013) Report on reproductive health assessment Beirut-Bekaa - Lebanon, August 2013
[15] Cammett, M. (2014) *Compassionate Communalism: Welfare and Sectarianism in Lebanon.* Boston, Massachusetts, United States: Cornell University Press
[16] ESCWA (2013) Towards a new welfare mix? Rethinking the role of the state, the market and civil society in the provision of social protection and social services

Syrian refugee health situation

A more detailed account of the health situation across Lebanon will be provided in the rest of this chapter. However, this section highlights a number of the key issues among the refugee population.

In line with rising population numbers, the incidence of various communicable and non-communicable diseases (cardiovascular, diabetes and hypertension) has risen.[17] Measles and increased risk of epidemics such as tuberculosis, polio, and waterborne disease remain. Assessments in Beirut and its suburbs have found that 65% of Syrian refugee patients suffer acute illness, the most common being dental problems and influenza. Chahada et al found that the health needs among elderly Syrian refugees are particularly acute with limited access to care and medications. Older refugees have been found to be suffering from elevated rates of chronic disease, hypertension, diabetes, and cardiovascular diseases.[18.]

The fertility rate among Syrian refugees is reportedly higher than the local host populations, with a number of refugees returning to Syria to give birth in order to avoid the high healthcare costs in Lebanon. [19] [20]

A systematic review on the mental health of Syrian refugees found they predominantly suffer from anxiety, feeling depressed, lethargy, eating and sleeping problems, anger and fatigue[21]. Post-traumatic stress disorder (PTSD) was found at rates of between 36-63% for adults.

[17] Refaat M Mohanna K (2013) Syrian refugees in Lebanon: facts and solutions. *The Lancet*, 382(9894), 763-764; Amel Association International, June 2013, *Rapid Needs Assesment Hart Hreik*, Beirut, Lebanon

[18] Chahada N, Sayah H, Strong J Varady C (2013), *Forgotten Voices: An insight into older persons among refugees from Syria in Lebanon,* Caritas Lebanon Migrant Center.

[19] Coutts A, Fouad M. Fouad (2013) Response to Syria's health crisis—poor and uncoordinated. World Report. Lancet. June 28th; MdM (2013) Report on reproductive health assessment Beirut-Bekaa - Lebanon, August 2013

[20] MdM (2013) Report on reproductive health assessment Beirut-Bekaa - Lebanon, August 2013; See also International Medical Corps (2013) Deliveries analysis. September to December 2013.

[21] Quosh C, Eloul L, Ajlani R (2013) Mental health of refugees and displaced persons in Syria and surrounding countries: a systematic review. *Intervention*, 11(3), 276-294.

3. DATA SOURCES

At the start of the process, SWGs developed a list of information needs (i.e. those themes that they required information on within their sector). These were built from RRP6 indicators and a consultation within the working group. For the purpose of Phase 1, MSNA analysts reviewed and examined the available data on each theme. See Section 4 for results.

The table below highlights the information needs and whether or not they were met by the available data. Note that where data is indicated to be available this may vary in terms of representativeness of local conditions and severity of needs across groups and geographical areas.

Within the health sector there is considerable overlap within the information needs listed. Therefore they have been organised into overall subject headings, which aims to capture information on each of these information needs. These are as follows:

- General health and access to healthcare services and capacities
- Child, reproductive and maternal health
- Non-communicable diseases, chronic conditions and disease outbreaks
- Mental and psychosocial health
- Older persons' health

Table [1]: Information needs and availability of existing data/information

Theme	Information Need
Treatment of acute and chronic conditions in PHC settings	Are target populations able to access a sufficient level of PHC, per geographical area?
Management of childhood illnesses	Are target populations able to access specialist healthcare for childhood illnesses, per geographical area?
Reproductive health and family planning services provided	Are target populations able to access sufficient reproductive health and family planning services, per geographical area?
Mental health/psychosocial services support persons with disabilities	Are persons with physical and mental disabilities able to access sufficient support?
Health promotion and outreach/outbreak prevention	What health outbreaks have occurred amongst the target populations, per geographical area? And what types of health promotion/prevention interventions have been conducted?
Polio campaign	What is the prevalence of polio amongst the target populations, per geographical area? What is the coverage of the vaccination programmes?
Management of neonatal and congenital conditions	Are target populations able to access sufficient support for neonatal and congenital conditions, per geographic area?
Management of obstetric and gynaecological conditions	Are persons with obstetric and gynaecological conditions able to access sufficient support, per geographic area?
Management of surgical conditions	Are persons requiring surgical procedures able to access sufficient

	services, per geographical area?
In- and outpatient management of medical conditions	Are target populations able to access sufficient in- and outpatient services when necessary, per geographic area? What are the main barriers to accessing sufficient healthcare? Disaggregated by population group and geographic area
Strengthen primary healthcare system	What is the current capacity of primary healthcare services to deal with the increase in population, per geographic area? What are the current utilisation rates and trends?
Strengthen secondary/tertiary healthcare system	What is the current capacity of secondary/tertiary healthcare services to deal with the increase in population, per geographic area? What are the current utilisation rates and trends?
Surveillance of diseases of Public Health importance	
Nutrition	Number of malnourished children with severe acute malnutrition (SAM) and moderate acute malnutrition (MAM) treated at primary healthcare facilities as outpatients
	Investigation of SAM and MAM causes?
	Number of healthcare providers (doctors, nurses and pediatricians) trained on infant and young child feeding and management of malnutrition. What screening tools are being used?
	Number of pregnant and lactating women who have received micronutrient supplements.
	Number of individuals reached with key messages on immunisation, malnutrition, breast-feeding and childcare practices.
	Number of children under five years of age screened for anaemia.
	Number of pregnant women investigated and treated for anaemia at the primary healthcare level.

Legend

No data available to the MSNA team at the time of writing
Some data available but may be outdated or lack methodological rigour
The available data addresses the information need

This section aims to highlight the data sources and limitations.

General

Needs assessments and mapping exercises (3Ws, 4Ws, 5Ws and Activity info) have been carried out by various agencies in Lebanon over the last two years. However, these are becoming increasingly outdated and are prone to various data quality issues. The majority are rapid assessments (or snapshots) for certain geographical areas that have been used by INGOs to provide information for their own operational and advocacy purposes as to how funds may be best allocated. Assessments are typically concentrated on documenting the health needs of Syrian refugees, with limited information on other vulnerable groups as identified by the RRP 6, i.e., host communities, Palestinian refugees from Syria and Lebanese returnees.

The three major national sources of health data and information are provided via the UNHCR Health Information System (HIS), the Early Warning and Response Network (EWARN) and the GoL HIS system.

UNHCR Health Information System (HIS)

UNHCR and six key partner agencies use the UNHCR HIS for urban populations adapted for Lebanon, which covers a range of health conditions of Syrian refugees across Lebanon. Reports vary from being on a weekly to monthly basis from areas across Lebanon.

International Medical Corps (IMC) provides comprehensive healthcare access to refugees, including primary healthcare (through both static clinics and mobile medical units), health education, mental health and psychosocial assistance. IMC in collaboration with local partners supports multiple primary healthcare facilities in North Lebanon, Beirut, Mount Lebanon, Bekaa and South Lebanon. The data is captured electronically – either via the MoPH HIS system or the clinic's own electronic medical system – and the health information is coded according to the ICD 10 classifications, used by the MoPH. EWARN systems have been implemented/strengthened at all supported clinics and mobile medical units, and are reported on a weekly basis. In 2013, IMC also managed coverage and support for secondary healthcare for refugees in North, South and Bekaa. During that period, IMC maintained Excel hospital admission databases for each region (North, South and Bekaa). The database was created in 2012, and updated in 2013. Information was collated, analysed, and shared on a monthly basis. IMC's mental health team keeps detailed patient records for each patient that receives individual psychotherapy, and manually enters them into an Excel format. With the recent formation of a mental health department within the MoPH, discussions are planned to include several key mental health indicators in the existing HIS system. If successful, IMC will use the HIS system for data entry of mental health information. However, it is worth noting that, nationwide, the quality (accuracy and completeness) of data collection at clinics varies dramatically. Capacity-building in data collection and entry is therefore needed at all levels of the healthcare system. IMC also supports medical mobile units (MMUs) in all regions and responded to several influxes of refugees in Bekaa and the North.

AMEL Association provides primary healthcare in Beirut, South, and Bekaa. AMEL also delivers healthcare services to refugees living in informal communities in the Bekaa valley of Lebanon. AMEL also provides mental health services in the South and Bekaa. AMEL does not employ an electronic data collection and reporting system. Data is collected using paper forms and aggregated on a monthly basis. Health information is then shared via Excel sheets.

RESTART provide mental health and rehabilitation services in Beirut and the North. For mental health, the basic indicators in the minimum requirements are based on the UNHCR/WHO "Assessing mental health and psychosocial needs and resources in humanitarian settings" toolkit. To meet this requirement, the RESTART reporting tool has been modified so that data can be transferred into the monthly reports.

PU-AMI provide primary healthcare facilities in Beirut and Mount Lebanon. They report to the HIS on a monthly basis.

EWARN and MoPH national health monitoring

The MoPH, with support from the World Health Organization, established the Early Warning and Response Network (EWARN) in 2007. This network monitors the health situation and potential disease outbreaks across the country, and does not disaggregate by demographic groups or vulnerable groups as identified in the RRP. The overall aim is to prevent an increase, or create a decrease, in the numbers of persons affected by communicable diseases nationwide.

The MoPH operates its own system of routine health surveillance, which relies on two main sources of information: hospitals and primary healthcare.

All private and public hospitals, including the labs operating in these hospitals and the PHC centres belonging to the MoPH network, report periodically to the MoPH Epidemiology and Surveillance Unit (ESU) on a list of selected diseases. The time of reporting is either immediate, within 24 hours, within 48 hours, within a week or within a month, depending on the disease or condition being reported. The MoPH periodically issues a surveillance bulletin.

EWARN is in place and is currently being strengthened by the newly established Instrument for Stability project. This monitoring network provides monthly epidemiological information on communities across Lebanon. It has been noted that the EWARN system experiences variable reporting from its sentinel sites due to technical capacities in certain regions.

EWARN is being enhanced to include new diseases such as Leishmaniasis, which have arisen as a result of the Syria crisis. In addition to the system, hospitals and PHC settings will reportedly receive further support in terms of training and staffing in order to cope with infectious diseases. The current focus is on waterborne diseases, vector-borne diseases and vaccine-preventable diseases.

The MoPH stresses that the system needs to be more mobile and flexible to build detection into locations where refugees seek healthcare (primary healthcare centres and mobile medical units).

Activities

Figures 4 and 5 provide an overview of the number of single- and multi-sector assessments across Lebanon in 2013/14. Multi-sector assessments have generally been carried out across the country. There does, however, appear a need for more geographically and locally specific single assessments to provide a clear understanding of local conditions and severity of needs (Figure 4).

Figure 6 highlights the number of MHPSS activities across Lebanon derived from the recent 4Ws MHPSS assessment. As noted, Baalbek contains a high level of PSS activities reflecting the heavy concentration of refugees.

Figure [4]: Health assessments by geographic area

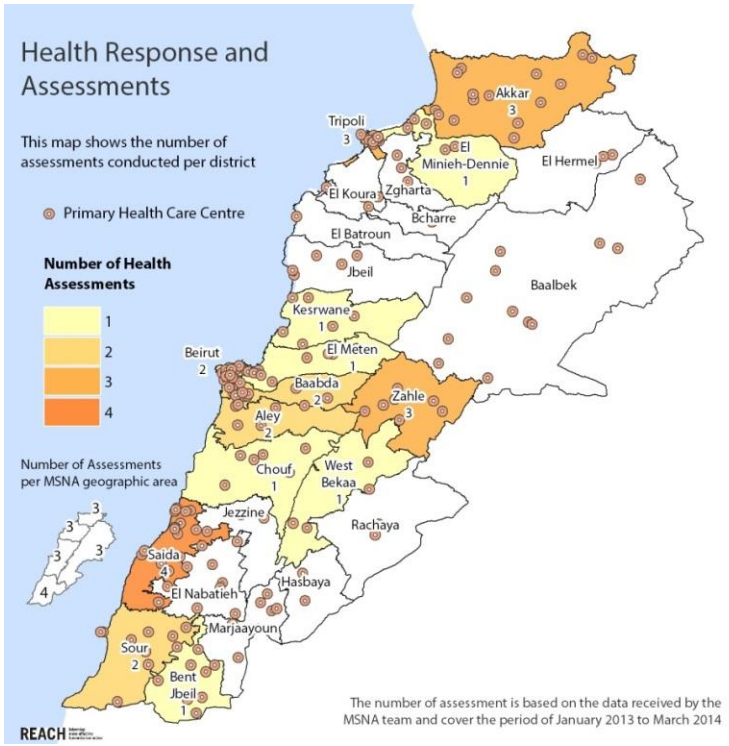


Figure [5]: Multi-sector assessments including a health component by geographic area

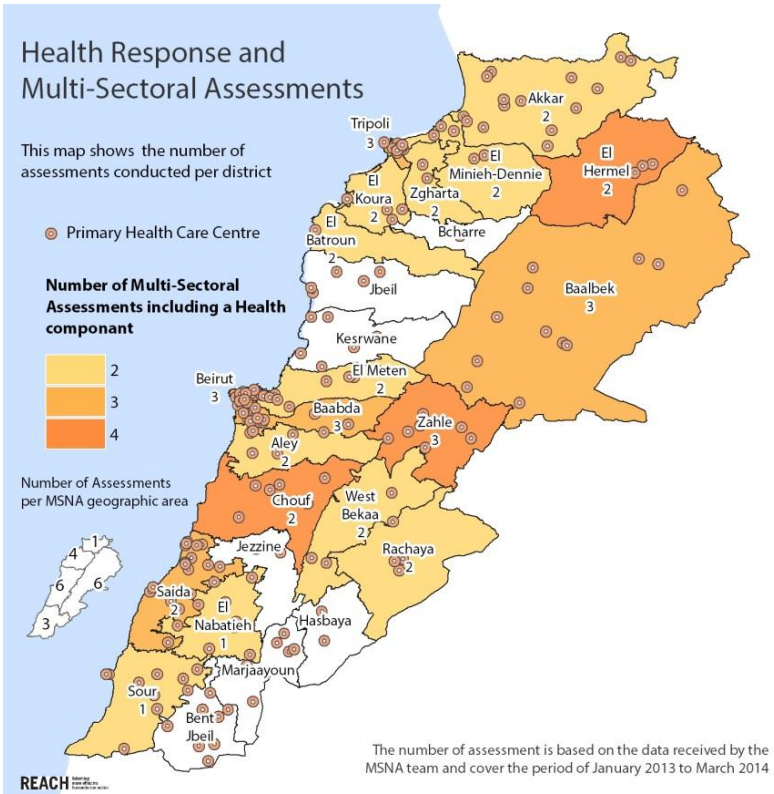
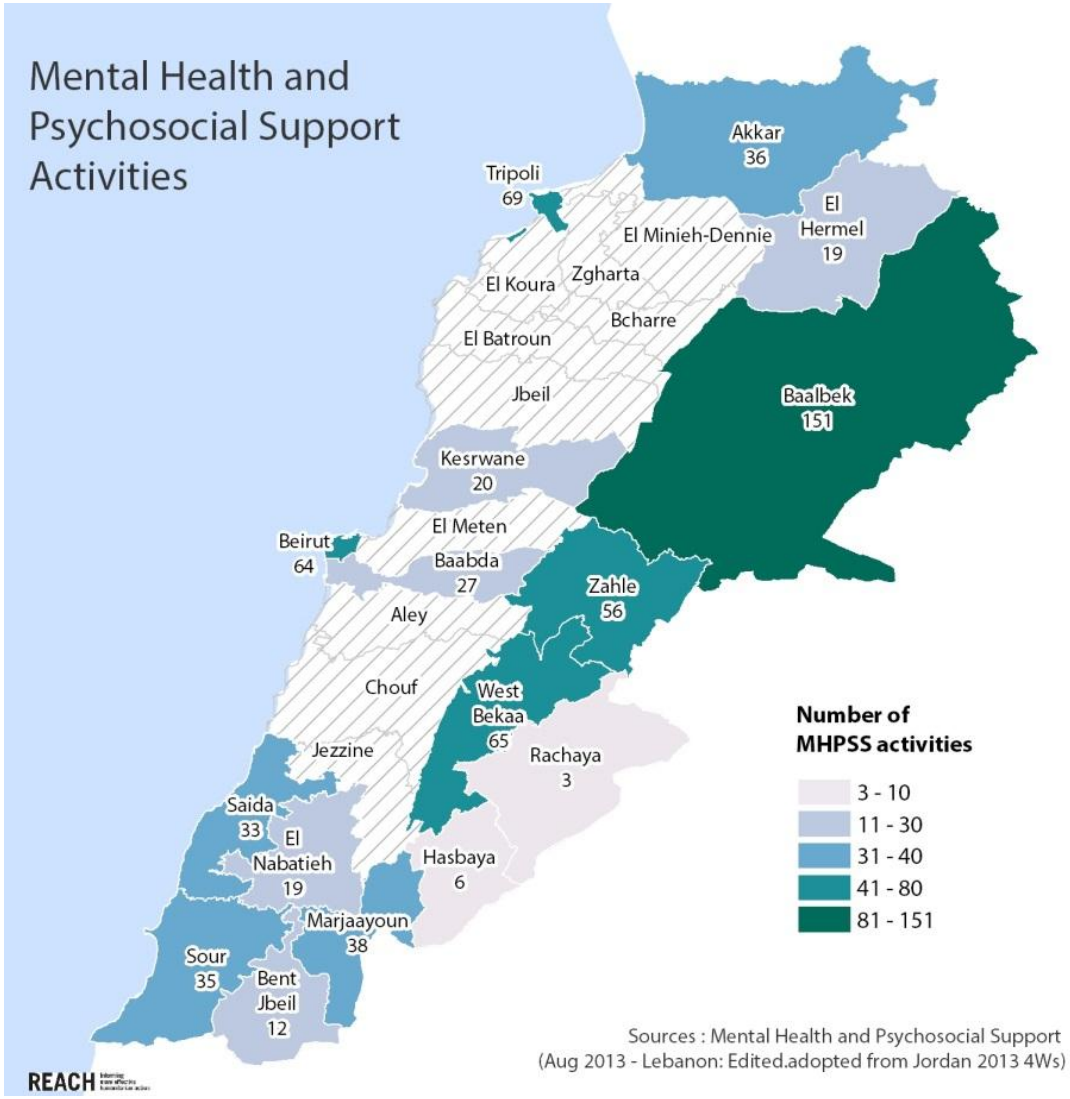


Figure [6]: Mental health and psychosocial assistance programmes by geographic area



SECTION 4

The following section provides an analysis of data according to theme, including a summary table of assessment coverage by target group0 and geographic region.

4. ANALYSIS PER THEME

4.1 General Health Status and Access to Healthcare and Service Capacity

Summary of assessment findings:

- Across the available assessments and information, access to healthcare is repeatedly cited as major issue for refugees and vulnerable groups.
- Primary access barrier identified is financial cost to attend a clinic/hospital, as well as the costs for treatment, especially for chronic conditions and major surgical procedures.
- Older persons are a vulnerable refugee group that have largely been overlooked in the response.
- UNRWA data shows that PRS are able to access PHC services. There are significant differences between groups. Those outside camps access primary healthcare less frequently and were not receiving free hospitalisation as regularly as households in the camps.
- In terms of assessing utilisation rates and capacities of health services in Lebanon, no assessment or information has been identified other than the proxy indicator of the number of beds between private and public hospitals, as noted in Section 3.
- Data on utilisation and occupancy rates of healthcare services is reportedly not accessible due to its financially sensitive nature.

The summary table below shows assessment coverage by geographic area and target group. It does not, however, show the quality of the assessments or the extent of the coverage.

Table [2]: Assessment coverage by geographic area and target population

	Vulnerable Local Communities (Lebanese and PRL)	Lebanese Returnees	PRS	Syrian refugees	
				Registered	Unregistered
National					
North/T+5					
Akkar					
Mt. Lebanon and Beirut					
Bekaa					
South					
Palestinian Camps					
Outside Palestinian Camps					

NB – Grey cells indicate that there is at least one assessment available on the specific area or target group. However, the data may not cover the situation for the entire geographic area or target group.

Syrian refugees registered and awaiting registration

National

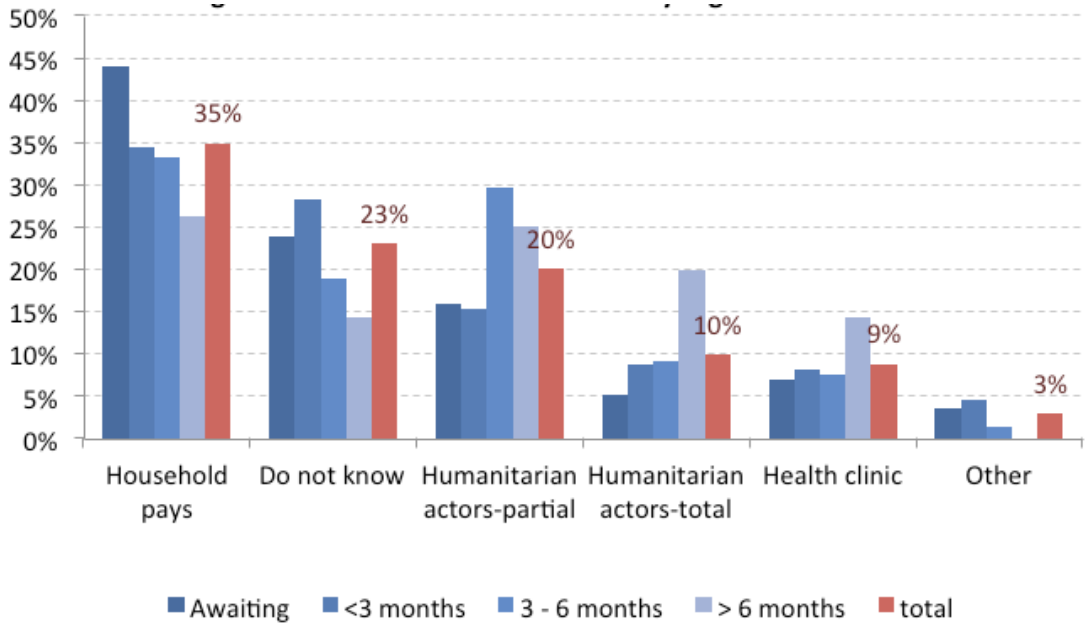
The 2013 vulnerability assessment carried out by UNHCR, UNICEF and WFP[22] interviewed more than 1,400 Syrian registered refugee households between May and June 2013.

The sampling frame consisted of a two-stage cluster of random selection proportional to population size, and a stratified sample according to registration date (awaiting registration, registered between zero and three months, registered from three to six months, and registered for more than six months). In total, 350 households in each category were interviewed.

The study found that 35% of households stated that they were not receiving any kind of health assistance and were covering all health related costs themselves (Figure 7). Figures were higher among those awaiting registration and recently registered, due to lack of knowledge compared to those registered longer ago.

The most common type of healthcare assistance provided by humanitarian actors was cost sharing with patients. 20% of households used this. 10% of households benefited from free healthcare provided by humanitarian actors and almost the same proportion made use of health clinics.

Figure [7]: Type of healthcare assistance



Handicap International and Help Age International[23] undertook a joint representative cluster sample survey (n=1300) in October 2013. They focused on the comparison between the general Syrian refugee population and the more specifically vulnerable older population.

The survey covered the North of Lebanon, Bekaa, Beirut and Mount Lebanon, and examined older Syrian refugees living with an impairment, injury or chronic disease in Lebanon.

[22] VASyR (2013) WFP-UNICEF-UNHCR-GoL, "Vulnerability Assessment of Syrian Refugees in Lebanon," December.
[23] Age International and Handicap International (2014) Situation of Refugees Vulnerable Persons in Lebanon and Jordan.

It was found that:

- 30% have specific needs: one in five refugees is affected by physical, sensorial or intellectual impairment; one in seven is affected by chronic disease; and one in 20 suffer from injury, with nearly 80% of these injuries directly resulting from the conflict.
- Older people account for 10% of this population sub-group, yet they make up 4-5% of the surveyed refugee population. 77% of older surveyed refugees have specific needs.
- Those with and without specific needs have the equivalent basic concerns – a lack of income, availability and quality of shelter, and access to basic health care, food and essential household items.
- The difficulties those with specific needs face in addressing basic concerns and accessing adequate levels of assistance have more severe consequences for their health and living conditions than the general refugee population.
- Older people are twice as likely as the general refugee population to report signs of psychological distress. 65% of older refugees present signs of psychological distress.
- Across areas it was found almost no health education concerning NCDs exists for patients. In addition, there is limited capacity among health staff to properly assess patients with NCDs; limited services available to support early screening for NCDs such as diabetes and hypertension; and no proper monitoring (laboratory tests) or follow up. The findings also showed that, patients often only receive a monthly prescription, with no advice and no monitoring of their condition.

In January 2013, Caritas[24] undertook a study using mixed methods of older Syrian and Palestinian refugees (PRS) via their field offices. The sample consisted of 175 older Syrian refugees and 45 older Palestinian refugees from Syria. This covered (Baalbek, Saida, Sin el Fil, Taalabaya, Tripoli, and Zahleh) and Women's Humanitarian Organization (PALWHO) field office (Bourj el-Barajneh, Mar Elias).

The general health status of most older refugees indicates that they rated their health as bad (54%) or very bad (12%). They report a high burden of chronic illnesses and disabilities.

Most common chronic diseases among all refugees surveyed were hypertension (60%), diabetes mellitus (47%), heart disease (such as angina, coronary artery disease, infarction, or heart failure) (30%), musculoskeletal conditions (including arthritis, bone disease, joint disease, or back pain) (26%), high cholesterol (26%), eye disease (such as cataracts; not glasses) (18%), and lung disease (such as asthma, chronic obstructive pulmonary disease, or chronic cough) (18%).

Burden of diseases was significantly higher in older Palestinians compared to older Syrians, even when controlling for the effects of sex and age. Less common chronic diseases included chronic pain (14%), digestive tract disease including liver disease (12%), kidney or urinary tract disease (6%), and neurological disease (including stroke, epilepsy, or headache) (6%).

79% of older refugees identified financial cost as their primary difficulty in seeing a doctor when then they need medical care. Other barriers included lack of knowledge about where to see a doctor (12%) and the physical inability to travel to see a doctor (4%). Only 1.5% stated they had no difficulties in seeing a doctor when they need medical care. Similar responses were observed when older refugees were asked about their primary difficulty in obtaining medications. 87% reported they had difficulty affording the cost of medication, 7% reported they did not know where to buy medication, and 3% said they were physically unable to go to the pharmacy.

In-depth qualitative interviews highlighted how most elderly refugees were using medicine they had brought with them from Syria, and they did not have the means to access medications in Lebanon when this medicine ran out.

[24] Caritas (2013) Syria. "Forgotten Voices. http://www.caritas.org.au/learn/blog/blog-detail?ID=71915a7f-4c95-4a41-a139-69bd767354c5

Among elderly Syrian refugees, the most commonly needed supplies were mobility devices (such as a walking cane) (25%), eye glasses (18%), personal hygiene items (13%), followed by hearing aids (11%) and wound care supplies (10%). Elderly Palestinian refugees were significantly more in need of all medical supplies included in the survey apart from wound care supplies compared with elderly Syrian refugees.

Older Syrian refugees reported reducing portion sizes 1.9 days per week, skipping a meal 1.5 days per week, and not eating at all 0.5 days per week. In contrast, older Palestinian refugees reported reducing portion sizes 4.9 days per week, skipping a meal 4.6 days per week, and not eating at all 1.5 days per week.

Bekaa

More recently MSF[25] carried out an epidemiological survey in Bekaa – the Masna'a border areas. The survey assessed a range of health conditions – chronic, non-communicable diseases, mental health, access (barriers) to healthcare and perceived quality of care among registered and unregistered refugees. The study will be conducted in three phases. Phase 1: Bekaa Valley, Masna'a border villages; Phase 2: Tripoli and surrounding region; Phase 3: Beirut and the surrounding region. The results have yet to be published.

The design is a double cross-sectional survey of newly-arrived and long-term communities of Syrian refugees. This is divided into two surveys - the Protracted Syrian Access to Care Survey carried out in an area within 30 kilometres of an MSF clinic serving this population, and the New Arrival MSF Survey deployed in a community in the same geographic region as the protracted communities in areas known to have a high density of new-arrival Syrian refugees. Sample size consists of 1,200 hundred households evenly gathered from two communities in the same geographic region. Results will be available in April 2014

Beirut

Amel conducted a rapid assessment (n=188) of healthcare access in Hart Hreik, Beirut[26]. Only 48% of Syrian refugees attended medical consultations and among these, 51.14% indicated going to private clinics while 29% attended public hospitals. Syrian refugees in the Bekaa Valley reportedly had less access to healthcare than refugees in other regions in Lebanon.

High healthcare expenditures were found to be the strongest determinant of accessing healthcare for Syrian refugees[27]. The majority of Syrian refugees lacked the ability to cover healthcare costs[28], which in turn may have prevented them from seeing a physician or led them to suspend their treatment.

NGOs attributed the high healthcare costs to the use of private clinics. Other barriers preventing Syrian refugees from accessing healthcare include distance, short working hours of clinics and health centres, and shortage of medically trained personnel.

<u>PRS (inside and outside camps)</u>

National

During an UNRWA assessment in October 2013, participants in 16 focus group discussions highlighted the following problems encountered by the PRS regarding access to health:

- Overall services provided by UNRWA clinics are insufficient
- Not all medicines are available in UNRWA clinics

[25] MSF (2014) MSF Syrian Refugee Access to Care and Mortality Double Cross--Sectional Study: Lebanon. Results forthcoming.
[26] Amel Association International (2013) Rapid Needs Assessment Hart Hreik, Beirut, Lebanon.
[27] Chahada N, Sayah H, Strong J, Varady C (2013) Forgotten Voices: An insight into older persons among refugees from Syria in Lebanon, Caritas Lebanon Migrant Center
[28] Gulland A (2013) Syrian refugees in Lebanon find it hard to access healthcare, says charity. BMJ: British Medical Journal, 346

- Improper treatment at health facilities
- The majority of PRS are unable to afford treatment in hospitals other than UNRWA clinics

The assessment found that 81% of households had accessed primary healthcare since their arrival in Lebanon. On average, 42% of surveyed households had at least one member who required hospitalisation. 59% were found to be suffering from chronic illnesses (Table 3)

The study found that households living outside of the camps were accessing UNRWA primary healthcare less frequently and were not receiving free hospitalisation as regularly as households in the camps (Figure 8). This may also explain why hospitalisation rates were lower outside the camps than inside. The highest percentage was reported inside the camps of Saida (approximately 90%) and the lowest percentage was in Beirut outside the camps (53%).

Figure [8]: PRS accessing Primary Health Care by region (2013)

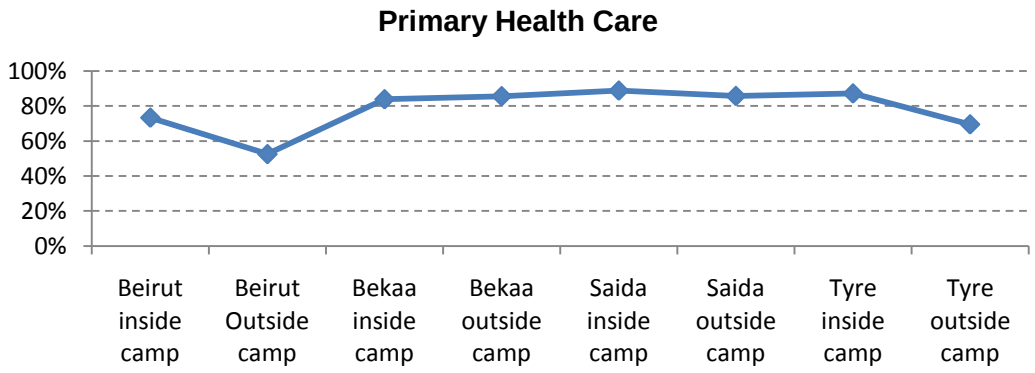
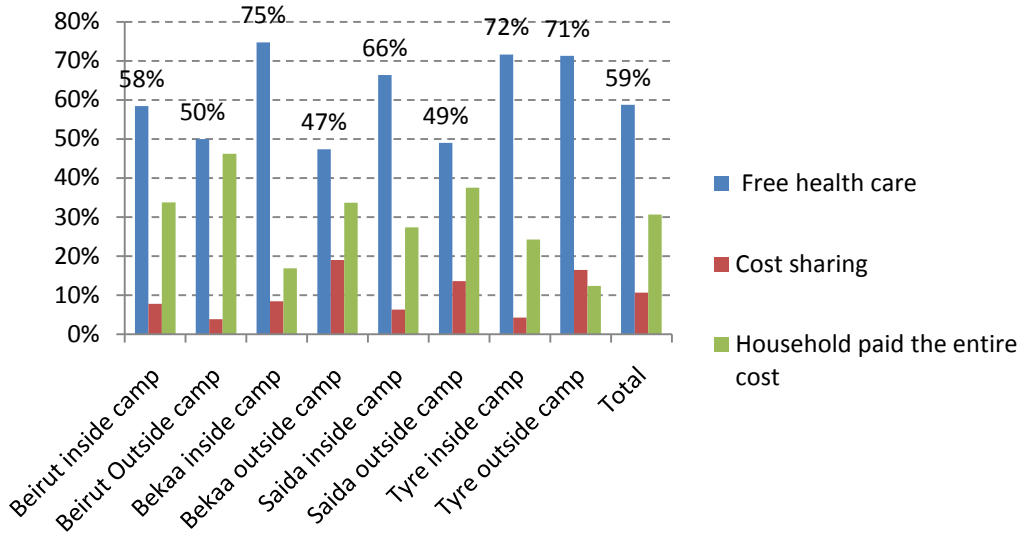


Table [3]: Specific needs among household members by region

Region	Location	Pregnant and Lactating	Disability	Chronic Illness	Temp. Functional Limitation	Toilet Support Needed	Other Needs
Beirut	Inside camp	19.1	4.8	56.2	6.7	4.8	3.8
	outside camp	15.2	7.1	42.4	2.0	2.0	1.0
Beqaa	Inside camp	21.0	11.0	47.0	5.0	5.0	7.0
	outside camp	29.7	20.7	55.9	10.8	13.5	21.6
Saida	Inside camp	31.8	17.8	65.4	14.0	12.2	19.6
	outside camp	25.0	20.5	63.4	7.1	24.1	12.5
Tyre	Inside camp	34.9	22.0	63.3	9.2	7.3	19.3
	outside camp	24.8	12.4	63.8	5.7	3.8	7.6
Total Percentage of HH with Special Needs		**27**	**16.5**	**59.7**	**8.7**	**11.5**	**14.1**

Primary healthcare is offered free of charge at UNRWA health centres. However, 30% reported paying the entire cost. Another 11% reported sharing the cost with humanitarian organisations. Cost sharing was more common among households surveyed in Bekaa outside the camp (Figure 9).

Figure [9]: Method of payment for primary healthcare by geographic region



UNRWA hospitalisation policy applies for both PRS and PRL patients, with the agency covering 100% of the admission cost to secondary care hospitals and contributing to a certain ceiling for admission to tertiary care hospitals. On average, 59% of surveyed households reported that the agency paid the full hospitalisation cost, and 23% reported cost sharing with the agency.

Figure [10]: % of households with at least one member requiring hospitalisation by region

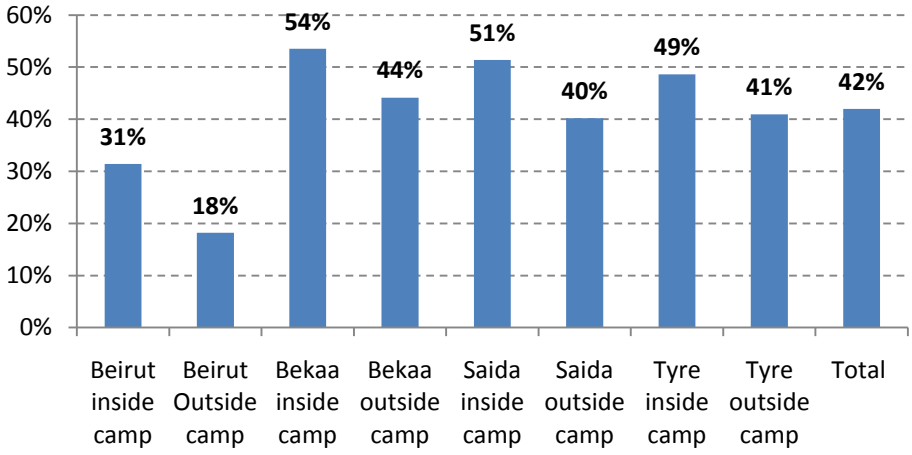


Table [4]: Hospital attendance by region

	Beirut inside camp	Beirut outside camp	Bekaa inside camp	Bekaa outside camp	Saida inside camp	Saida outside camp	Tyre inside camp	Tyre outside camp	Average
Any contracted hospital with UNRWA FREE	45 %	**28 %**	**81 %**	71 %	71 %	31 %	74 %	54 %	**59 %**
Any contracted hospital with UNRWA Cost-sharing	36 %	39 %	13 %	12 %	22 %	**40 %**	6 %	26 %	23 %
Any contracted hospital with UNRWA Paid fully	18 %	22 %	6 %	16 %	6 %	18 %	19 %	19 %	15 %
Public Hospital Free	0 %	0 %	0 %	0 %	0 %	0 %	0 %	0 %	0 %
Public Hospital Cost-sharing	0 %	6 %	0 %	0 %	2 %	4 %	2 %	0 %	2 %
Public Hospital Paid fully	0 %	6 %	0 %	0 %	0 %	7 %	0 %	2 %	2 %

Even though UNRWA has a contract with 40 hospitals (12 of which are public and five are part of the Palestinian Red Crescent Society network), 15% of surveyed households who had members admitted to UNRWA-contracted hospitals paid the full cost. In some cases this could be due to the diagnosis of a condition categorised as a "cold case". Cold cases are those elective surgical procedures, not emergency-based, but which have been determined by the treating doctor/patient (i.e. cataracts, hernia, orthopedic needs). For these cases, the UNRWA Syria field office contributes to the payment. It is also possible that these households were not aware of the procedures and regulations of the health services provided by the agency. Additionally, 4% reported that members were admitted to other public hospitals. It is possible that hospitals contracted by UNRWA were remote or inaccessible.

Lebanese Returnees

South

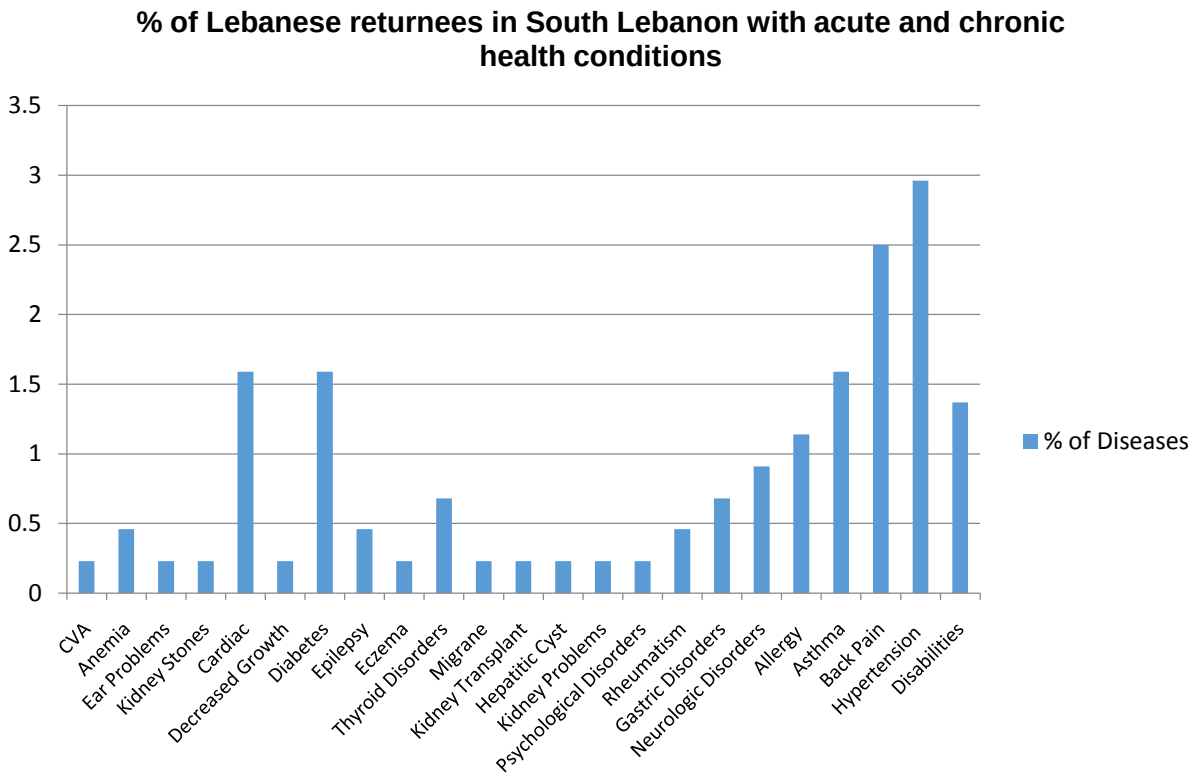
The International Organization for Migration (IOM) community health team surveyed 439 Lebanese returnees in South Lebanon between Dec 2013 and March 2014.[29] The study found that Lebanese returnees are in need of healthcare support, particularly secondary healthcare. Many suffer from chronic diseases with varying degrees of severity.

Healthcare services offered to Lebanese returnees are limited; however, they are receiving primary healthcare services through three IOM-supported primary healthcare centres in Nabatieh, Tyre and Saida.

Figure 11 shows percentages of the type of diseases/health conditions present in the assessed population of Lebanese returnees (the total number of individuals is 439).

[29] International Organization for Migration - IOM (2013) The situation and needs of Lebanese returnees from Syria. In collaboration with the Lebanese Higher Relief Committee. December.

Figure [11]: Lebanese returnees with acute and chronic health conditions



No assessments have been identified for host communities across geographic areas.

4.2 Child, Maternal and Reproductive Health

Summary of assessment findings:

- Reproductive and maternal health needs have been identified as major issues over the past two years, given that women and children make up a large proportion of the refugee population.
- Deliveries (births) account for a large proportion of hospital admissions.
- The c-section rate among refugees is 35% (2013), which is three times that of the WHO recommended rate of 10%.
- Information on contraceptive and birth control awareness and usage among the refugee population appears limited.
- Rates of malnutrition among refugee children appear to be increasing.

Table [4]: Assessment coverage by geographic area and target population

	Vulnerable Local Communities (Lebanese and PRL)	Lebanese Returnees	PRS	Syrian refugees	
				Registered	Unregistered
National					
North/T+5					
Akkar					
Mt. Lebanon and Beirut					
Bekaa					
South					
Palestinian Camps					
Outside Palestinian Camps					

Legend

	Section not applicable		**Data available**

NB – Grey cells indicate that there is at least one assessment available on the specific area or target group. However, the data may not cover the situation for the entire geographic area or target group.

Syrian refugees – registered and awaiting registration

National

The VASyR found that 1% of children (1,690) surveyed aged between six and 59 months were found to be moderately malnourished and 0.4% of children severely malnourished, based on middle-upper arm circumference (MUAC) measurement. This percentage was far below the emergency threshold and similar to that found in the last Nutritional Survey carried out in September 2012.

Almost half of the children under the age of five (45%) were reported as having been sick during the two weeks prior to the survey.

Most common symptoms were fever (63%), coughing (51%) and diarrhoea (35%), while 19% of the sick children showed other symptoms like allergies, infections, asthma and measles.
Children under two were more likely to be sick with diarrhoea.

The percentage of sick children was found to be higher in households awaiting registration compared to those registered for three months or more.

A recent comprehensive assessment of child health was conducted by UNHCR, UNICEF and WHO in February 2014.[30] This examined the nutritional wellbeing of vulnerable Syrian women and children.

120 clusters (26 clusters in Bekaa region, 34 clusters in the North, 27 clusters in the South and 34 clusters in the region of Beirut and Mount-Lebanon) were randomly selected (n=9000).

The SMART (Standardized Monitoring and Assessment of Relief and Transition) and SENS methodology was used for the assessment, due to its reliability and to facilitate comparison of results with a 2012 assessment.

Children under the age of five, as well as women of reproductive age, were assessed for malnutrition. Women and children were also tested for anaemia.

Prevalence of global acute malnutrition (GAM) among children aged 6-59 months in all Syrians in Lebanon, and in the assessments in Bekaa and in the North of Lebanon, were more than 5% (5.9% for all Syrian refugees in Lebanon, 8.9% for Syrian refugees in Bekaa and 6.7% in the North of Lebanon), which is defined as a poor public health situation as per WHO classification. Malnutrition among refugees in South and in Beirut and Mount Lebanon was less than 5%, which is within acceptable WHO levels.

Prevalence of severe acute malnutrition (SAM) found in Bekaa assessment was 1.7%, and 1.1% for refugees in the North of Lebanon. When compared to 2012, the prevalence of GAM increased in 2013 (GAM is 5.9% in 2013 vs. 4.4% in 2012) among children aged 6-59 months. The increase was not statistically significant.

Overall total anaemia prevalence among Syrian refugee children aged 6-59 months was 21.0% in Bekaa: 13.9%; for Syrian refugees in North: 25.8%; in South: 23.4%, and; for Syrian refugees in Beirut and Mount Lebanon 21.2%.

Children aged 6- 23 months in the North of Lebanon were most affected by anaemia (more than 40%). For households that had been in Lebanon for less than 12 months (at the time of the survey), 45.3% of children received their vaccinations in Syria. This proportion was 31.1% among Syrian refugee households that had been in Lebanon for one year or more.

However, for the households that had been in Lebanon for one year or more, more children received their immunisation from the primary healthcare centre (PHC) (45.5% compared to 34.2%).
Among households that had children of less than 24 months of age, 60.4% immunised their children in a PHC and only 18.1% of their children were vaccinated only in Syria. 20% of households with children less than two years of age reported that they received vaccines from different places.

Syrian refugee women aged 15-49 years in the North and in the South presented the highest prevalence of malnutrition (the North for the severely malnourished and the South for the total malnourished).

More than 75% of malnourished women among Syrian refugees in Lebanon were aged less than 35 years old. More than 40% of malnourished Syrian refugee women were between 15-19 years old.

Total prevalence of anaemia for non-pregnant women of reproductive age (15-49 years) was: for all Syrian refugees in Lebanon, 26.1%; in Bekaa, 18.4%; in North, 27.7%; in South, 27.0% and for Syrian refugees in Beirut and Mount Lebanon, 29.3%.

[30] UNICEF (2014) 2013 JOINT Nutrition Assessment Syrian Refugees in Lebanon. October and November 2013

Reproductive and maternal health

Hospitalisations account for a large part of UNHCR's health budget expenses, with 14,546 hospital admissions from January to June 2013 alone.[31] However, it is particularly high for maternal health services (deliveries), with 6,375 births recorded between January to June 2013, accounting for over 47% of the largest implementing partner's (IP) hospital admissions. In 2012 this was 23%. 5.6% of the overall hospital admissions requests were for "neonatal conditions".[32] Combined, this constitutes over 53% of all hospital admissions. Overall, deliveries account for almost 50% of hospitalisations in UNHCR-contracted hospitals, and constitute a large part of UNHCR's health budget.

Over the period January to June 2013 the overall c-section (CS) rate among Syrian refugees was 35% according to UNHCR data. As reported by a recent assessment, "this is much higher than the recommended threshold of 15% given by the WHO, and also more elevated than Syria's reported CS rates of 12-23%".[33] CSs are also associated with higher healthcare costs in comparison to natural vaginal births.

Despite the high birth rates, there appears limited information available on the usage and awareness of contraceptives and family planning. Family planning in pre-crisis Syria was free of charge and utilised relatively widely.[34] The most recent survey by UNFPA shows that only 37% of non-pregnant married women were using contraception.[35]

International Medical Corps[36] (IMC) conducted an analysis of their reproductive health data (September to December 2013) across the 17 national hospitals within which they operate (Table 5).

Table [5]: Hospital admissions and deliveries SRs, September to December 2013 at IMC supported hospitals

Hospital	Hospital Admissions[1]	Deliveries	Percentage
Al Beqaa	328	35	10.7%
Al Rayyan	627	239	38.1%
Chtoura	466	85	18.2%
Dar al Amal	4	0	0.0%
Farhat	722	287	39.8%
Hermel Gov	358	113	31.6%
Taanayel	2599	1454	55.9%
Dar Al Chifaa	713	338	47.4%
Islamic	226	105	46.5%
NDPaix –Qbayat	1311	619	47.2%
Tripoli Gov	1547	672	43.4%
Bent Jbeil Gov	196	90	45.9%
Lebanese Italian	581	297	51.1%
Marjeyoun Gov	190	78	41.1%

[31] Huster K (2013) 'Caesarean section rates among the Syrian refugee population in Lebanon: possible causes, implications and recommendations going forward'. University of Washington.
[32] Huster K (2013) 'Caesarean section rates among the Syrian refugee population in Lebanon: possible causes, implications and recommendations going forward'. University of Washington.
[33] WHO. The Global Number and Costs of Additionally Needed and Unnecessary
Caesarean sections performed per year: overuse as a barrier to universal coverage
(Background Paper, No 30). s.l. : WHO, 2010.
[34] World Health Organization (2011). Syria health profile. Available at: http://www.who.int/gho/countries/syr.pdf
[35] UNFPA (2013) UNFPA Response to the Syrian Humanitarian Crisis in Lebanon
January - April 2013. Available at:
http://www.unfpa.org/webdav/site/global/shared/documents/news/2013/Humanitarain%20Factsheet%202.pdf
[36] International Medical Corps (2013) Deliveries analysis. September to December 2013.

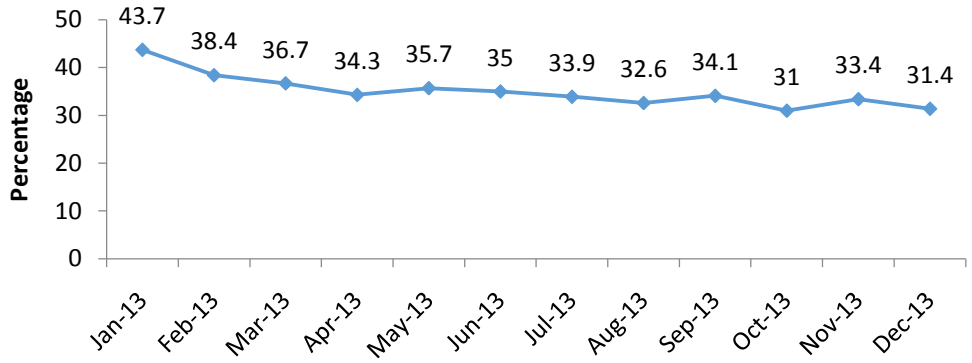
Nabatyeh Gov	590	270	45.8%
Dallaa	8	2	25.0%
Qasab	35	3	8.6%
All Hospitals	10501	4687	44.6%

Admission criteria was limited to either life-saving care or deliveries. Therefore, this sample should not be considered representative of all Syrian refugees seeking hospital services. IMC found that the overall c-section rate dropped from 43.7% in January 2013 to 31.4% in December 2013. The significant drop was achieved during the second half of 2013 as shown in Figure 12.

The primipara c-section rate dropped by 34.5 percentage points between September and December. This change is perhaps reflective of efforts to work directly with physicians and hospitals to ensure appropriate utilisation of c-section for delivery.

Figure [12]: Trend in c-section rate.

Figure 12: Trend in C-section Rate, Jan-Dec 2013



Reasons for c-section
A total of 4,415 deliveries were reported during the period September to December 2013. The reason for c-section was recorded for only 1,371 (31.1%) deliveries. Out of these, 3,044 were normal vaginal deliveries. On the other hand, the majority of c-sections were initiated by a previous c-section (61.6%) while 18.6% of c-sections were due to maternal causes and a similar percentage was due to foetal causes.

PRS

UNRWA have found high rates of pregnant and lactating women among PRS, with more than a quarter (27%) of PRS households reporting at least one such case within the household.

High rates of pregnancy and lactating women are also found in the Saida and Tyre camps.
Chronic illnesses and pregnancy may generate financial and health constraints on the PRS households in the region.

No assessments have been identified for host communities or Lebanese returnees across geographic areas.

4.3 Non Communicable Diseases, Chronic Conditions and Disease Outbreaks

Summary of assessment findings:

- Data and information regarding the magnitude and prevalence of NCDs and chronic conditions among refugees is provided by the UNHCR HIS. Information on NCD among other vulnerable groups is limited.
- Data regarding communicable diseases among Syrian refugees and vulnerable host communities is reported via EWARN, HIS and the GoL health monitoring systems. The available data shows that disease outbreaks have been limited largely due to proactive measures of the GoL and UN agencies.
- Deteriorating WASH and nutrition conditions in informal settlements pose serious health risks for the spread of communicable diseases.
- The constrained social and economic circumstances of many refugees in terms of access to food and negative health and coping behaviours such as smoking and physical inactivity may further exacerbate pre-existing rates of CVD mortality among the Syrian refugee population.
- Data on immunisation and coverage rates in Lebanon prior to the crisis is of variable quality.

Table [6]: Assessment coverage by geographic area and target population

	Vulnerable Local Communities (Lebanese and PRL)	Lebanese Returnees	PRS	Syrian refugees	
				Registered	Unregistered
National					
North/T+5					
Akkar					
Mt. Lebanon and Beirut					
Bekaa					
South					
Palestinian Camps					
Outside Palestinian Camps					

Legend

	Section not applicable		**Data available**

NB – Grey cells indicate that there is at least one assessment available on the specific area or target group. However, the data may not cover the situation for the entire geographic area or target group.

Syrian refugees (Registered)

National

The latest (December 2013) UNHCR HIS reports[37] across a range of health conditions for new cases among registered Syrian refugees – chronic and acute health conditions as well as mental health issues.

178,489 primary healthcare consultations were reported for 2013. Consultations for acute illness were the primary reason for accessing healthcare, accounting for 74% of clinic visits. Approximately 38% of visits for

[37] UNHCR (2013) Health Information System. Inter-agency regional response for Syrian refugees. Preliminary annual health report. Egypt, Iraq, Jordan, and Lebanon.

acute illnesses were by children younger than five years even though they make up only 19% of the refugee population.

Acute conditions: 2,308 cases of acute upper respiratory tract infections were reported among the registered refugee population. This includes: tonsillitis, pharyngitis, laryngitis, Rhinitis, sinusitis.

Of note are 4,659 cases that have been labelled as “other”, indicating case definitions have not yet been made.

Chronic conditions: diabetes (187 cases), hypertension (217), asthma (253) and cancer (309).

- Women are reported to suffer more than men in terms of acute hepatitis C (AHC) and chronic hepatitis C (CHC).
- In terms of mental health, the most prevalent condition is severe emotional disorder.

Figure [13]: Acute health conditions (HIS 2013)

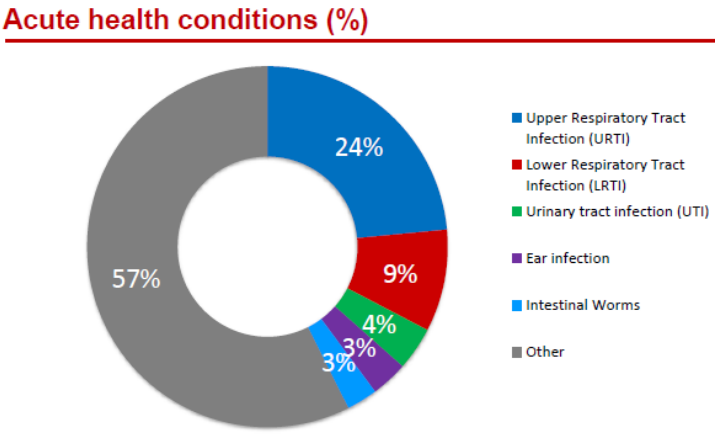
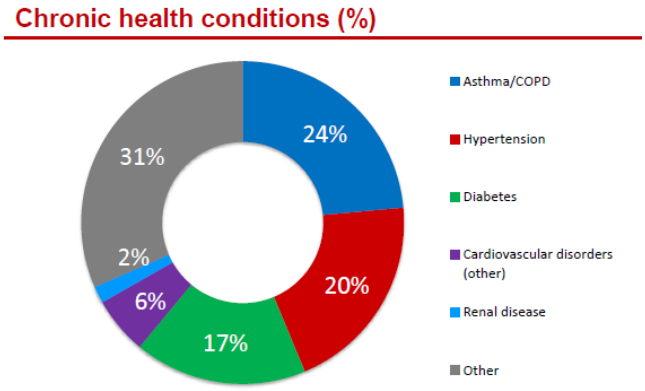


Figure [14]: Chronic health conditions (HIS 2013)



The EWARN system (February 2014) for Lebanon reports that the measles, viral hepatitis A and Leishmaniasis are currently the most common forms of communicable diseases and conditions.[38]

[38] Republic of Lebanon Ministry of Public Health Notifiable Communicable Diseases http://www.moph.gov.lb/Prevention/Surveillance/documents/lebanon.htm

Measles and viral hepatitis A have been reported among Syrian refugees, particularly among the young (0-19 years old) in Bekaa and the North. The highest figures are reported in Bekaa (61/100.000), followed by Mount Lebanon (31/100.000), North (26/100.000) and Beirut (21/100.000).

50% of cases were under five years old, 21% were 5-9 years, 3% aged 10-14 years, 5% aged 15-24 years, and 16% aged 25 years and above. The age-specific attack rate was highest among those under five years (150/100.000) and 5-9 years (59/100.000). The attack rate for the Syrian displaced is estimated to be 18/100.000.[39]

Viral hepatitis A: the highest incidence was found in the Bekaa (95/100.000), North (53/100.000), Nabatieh (23/100.000), Lebanon and the South (13/100.000). The lowest incidence rate was seen in Beirut (8/100.000).[40]

Pre crisis NCDs among Syrians

The demographic and disease profile of Syrian refugees is that of a middle-income country, characterised by a high proportion of chronic or non-communicable diseases (e.g. diabetes, cancer, cardiovascular and respiratory disease), which are costly and complex to manage and which place considerable pressure on the limited resources available for secondary and tertiary care.[41]

Specific studies on NCDs among the pre-crisis Syrian population indicates that they possessed elevated rates of morbidity and mortality from cardiovascular disease as compared to other MENA countries. 45% of all deaths in Syria have been attributed to CVD.[42]

Syria witnessed rapid changes in lifestyles pre-crisis toward more food consumption and less physical activity as a result of increased urbanisation and industrialisation. T his led to what is termed “the dual disease burden”, whereby non-communicable diseases have already emerged while infectious diseases continue unabated.

According to figures from different surveys conducted by the Syrian Center for Tobacco Studies (SCTS)[43], half of 45–65-year-old women had hypertension, and 15% of older men and women had ischemic heart disease. Type II diabetes was also very common in Syria, with one survey indicating more than 15% of population.

CVD was found to be the second leading cause of morbidity and the primary cause of death in Syria, responsible for about 50% of overall mortality.

Indeed, the recent UNHCR HIS report in December 2013 of Syrian refugees shows that the reported non-communicable diseases and cardiovascular diseases account for 21% of caseload, followed by lung diseases (20%), and diabetes (17%). The constrained social and economic circumstances of many refugees in terms of access to food, living and sanitation conditions, as well as negative health and coping behaviours such as smoking and physical inactivity, will further exacerbate rates of CVD mortality among the Syrian refugee population.

[39] http://www.moph.gov.lb/Prevention/Surveillance/documents/epimonitor_20140207.pdf
[40] Lebanese weekly epi monitor (2014) http://www.moph.gov.lb/Prevention/Surveillance/documents/epimonitor_20140215.pdf
UNHCR (2013) From slow boil to breaking point. A real time evaluation of the UNHCR’s response to the Syrian refugee emergency.
[42] Maziak W, Rastamb S, Mzayekc F, Warda K, Eissenbergd T, Keile U (2007)
‘Cardiovascular health among adults in Syria: a model from developing countries’. Annals of Epidemiology. 17(9): 713–720
[43] MEDCHAMP (2011) Project Title: Mediterranean studies of Cardiovascular disease and
Hyperglycaemia: analytical Modelling of Population Socio-economic transitions. European Union, 7th Framework programme.

PRS

South

An UNRWA assessment of specific needs revealed a widespread prevalence of chronic illnesses affecting around 60% of PRS household in Lebanon. Households in Tyre and Saida reported higher rates of chronic illnesses.

Another important finding is the high rates of pregnant and lactating women, with more than a quarter (27%) of PRS households reporting at least one such case within the household.

No assessments or information has been identified for Lebanese returnees across geographic areas

Immunisation and polio prevalence

The information needs requested by the working group referred to *"What is the prevalence of polio amongst the target populations, per geographical area?"* No cases have been identified in Lebanon.

Data is available which shows the incidence of acute flaccid paralysis (AFP) in the population across geographical areas of Lebanon.[44] AFP does not indicate the incidence of polio. All cases of AFP are investigated by the MoPH.

There is some indication that large numbers of Lebanese children may have been at risk of infection, given that vaccination coverage over the past four years has been sporadic. The WHO/UNICEF regional response strategy[45] states that "Vaccination coverage for polio is suboptimal in Lebanon and Iraq. There are enough unvaccinated children and unreached groups across the region to cause concern for virus spread beyond the current outbreak zone" (page 9). A closer examination of the WHO AFP surveillance indicators[46] for Lebanon shows that a number of areas such as Mount Lebanon and Nabatiyeh had below acceptable standards of three or more oral polio vaccine (OPV) doses. In 2013 in Bekaa, this was recorded as 50% coverage.

In general, data regarding immunisation coverage rates in Lebanon has been noted as "unreliable" and of varying quality by internal WHO/UNICEF reviews. In addition, official statistics on pre-crisis vaccination coverage in Lebanon also appear conflicting. According to the WHO database, 96% of the Lebanese population were covered in 2012.[47] Yet UNICEF reports a figure of 77%.[48]

A June 2013 WHO review of the data sources used states that "The WHO and UNICEF estimates of national immunisation coverage are based on data and information that are of varying, and, in some instances, unknown quality".[49] [50]

In response to the Syrian outbreak reported in October 2013, the MoPH has embarked on a nationwide vaccination programme. This is being conducted in collaboration with and support of WHO and UNICEF, and

[44] World Health Organization. Acute Flaccid Paralysis Indicators. count of AFP cases with zero OPV doses and % coverage with 3 or more OPV doses in non polio AFP cases 6-59 months. 2013. http://www.emro.who.int/images/stories/polio/documents/XLS/WEB.xlsx
[45] WHO / UNICEF (2013) strategic plan for polio outbreak response STRATEGIC PLAN FOR POLIO OUTBREAK RESPONSE (2013) The Syrian Arab Republic and surrounding countries – Iraq, Jordan, Lebanon, Turkey, West Bank, Gaza Strip and Egypt.
[46] World Health Organization. Acute Flaccid Paralysis Indicators. count of AFP cases with zero OPV doses and % coverage with 3 or more OPV doses in non polio AFP cases 6-59 months. 2013. http://www.emro.who.int/images/stories/polio/documents/XLS/WEB.xlsx
[47] World Health Organization. WHO vaccine-preventable diseases: monitoring system. 2013 global summary http://apps.who.int/immunization_monitoring/globalsummary/timeseries/tscoveragepol3.html
[48] WHO UNICEF estimates time series for Lebanon (LBN) World Health Organization. WHO vaccine-preventable diseases: monitoring system. 2013
[49] World Health Organization. Review of national immunization coverage pdf for Lebanon. June 2013. http://www.who.int/immunization_monitoring/data/lbn.pdf
[50] Review of national immunization coverage pdf for Lebanon http://www.who.int/immunization/monitoring_surveillance/data/lbn.pdf

the Lebanese Order of Physicians, and the Lebanese Pediatric Society. To date, 600,000 children have been vaccinated against polio as of March 2014.

This campaign was conducted though schools, PHCs, and private clinics. However, door-to-door vaccines were delivered in regions where lack of coverage from previous campaigns was observed.

The upcoming national vaccination campaign in April 2014 will deliver OPV to children aged 0-5 years, and measles and rubella (MR) plus vitamin A to children between nine months and 18 years old.

Leishmaniasis

In 2013, cases of cutaneous leishmaniasis (CL) are increasingly being reported to the MoPH. All cases occur among the Syrian refugees. Incidence has increased with the influx of refugees. According to the WHO, out of the 130 cases reported in 2013, 53% are from Bekaa and 29% from North.

4.4 Mental and Psychosocial Health

Summary of assessment findings:

- Mental and psychosocial health needs are an increasing challenge among the refugee population.
- There is limited data examining the MHPSS situation (prevalence and severity) among the refugee population and vulnerable groups. There is evidence from other humanitarian contexts that around 10% of the refugee population will suffer from severe mental illness.
- The recent MHPSS 4Ws indicates interventions to tackle these issues are widespread across Lebanon with a heavy concentration in Baalbek.
- PRS exhibit particularly high rates of emotional and mental disorders.

Table [6]: Assessment coverage by geographic area and target population

	Vulnerable Local Communities (Lebanese and PRL)	Lebanese Returnees	PRS	Syrian refugees	
				Registered	Unregistered
National					
North/T+5					
Akkar					
Mt. Lebanon and Beirut					
Bekaa					
South					
Palestinian Camps					
Outside Palestinian Camps					

Legend

	Section not applicable		**Data available**

NB – Grey cells indicate that there is at least one assessment available on the specific area or target group. However, the data may not cover the situation for the entire geographic area or target group.

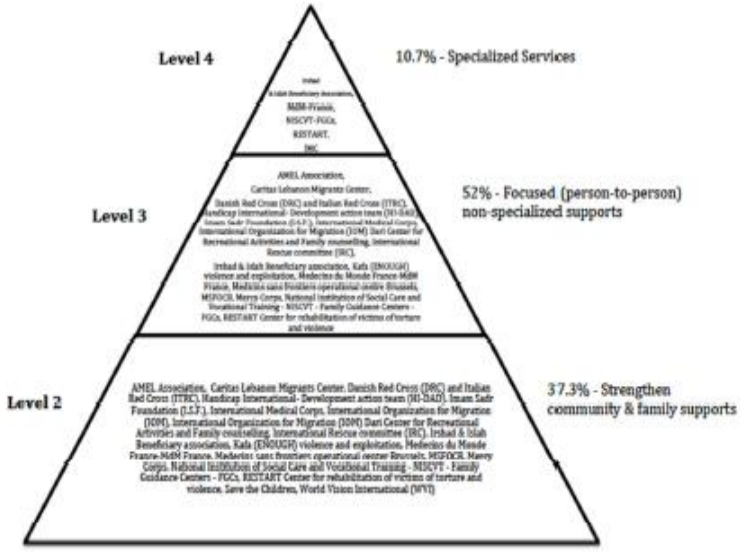
Syrian refugees registered and awaiting registration

National

According to the latest 4Ws assessment[51] over 20 agencies and NGOs are involved in the response to mental and psychosocial health (MHPSS) needs of refugees. The recent UNHCR MHPSS assessment found that 52% of activities fall under Level 3 of the IASC pyramid (Figure 15), 37.3% fall under Level 2, and the remaining 10.7% focusing on specialised services are in Level 4. Baalbek was found to possess the highest percentage of activities, 34% of which are case-focused. In Beirut, the 62% of activities are community-focused MHPSS and protection activities. Akkar and Hermel are among the districts with the least provision.

[51] UNHCR (2013) MHPSS Services assessment for Syrian refugees in Lebanon.

Figure 15: Inter Agency Standing Committee Pyramid and organisation distribution in Lebanon



The assessment noted that there appears to be limited understanding of the extent of the MHPSS situation and its severity across various geographical areas and demographic groups, e.g. between informal settlements and those residing in urban areas, and between the child and adult population.

Medicine Du Monde[52] conducted an assessment in North Bekaa, in El-Qaa and Al-Ain, with a sample of 154 individuals. The study found that the main "stressor" for refugees is financial strain arising from a lack of income (66%) and employment (91.4%). In addition the study reported that 37% of the sample had severe problems in getting enough food, and 18% in obtaining clean water.

PRS

An UNRWA 2013[53] vulnerability assessment found elevated rates of mental health issues among respondents.

Access to MHPSS services

Given the limited amount of information on access to health services and the quality of the response, a detailed description of the MHPSS assessment is provided below. This may serve as an example of how future studies may be conducted.

As noted, discrete psychosocial interventions have been set up by a number of NGOs, whilst other organisations have incorporated a psychosocial dimension in their broader child protection and relief programmes. Within the MHPSS response, the vast majority of interventions fall within child protection only, whereas substantial needs are present across the adult population (especially men aged 16 to 65 and older groups). Few if any interventions and providers currently focus upon these demographic groups.[54]

The recent UNHCR assessment identified 19 organisations undertaking psychosocial programming across Lebanon. Despite the existence of these organisations, a large proportion of MHPSS needs are currently unmet. The assessment[55] indicated that poor design and implementation of programmes is a major concern. Specifically:

[52]Medicine du Monde Assessment of Trauma Experiences, Mental Health and Individual and Community Coping Resources of Refugee Syrian Population Displaced in North Bekaa (Lebanon).
[53] UNRWA (2013) Vulnerability of Palestinian refugees from Syria.
[54] UNHCR (2013) MHPSS Services assessment for Syrian refugees in Lebanon.
[55] UNHCR (2013) MHPSS Services assessment for Syrian refugees in Lebanon

- Projects are being delivered by undertrained and inexperienced staff. As indicated "Most mental health services are being provided in community mental health centres or by multidisciplinary teams based in PHC centres". However, access remains challenging for many refugees, who are scattered over large areas. The total number of specialised mental health professionals (seven to nine psychiatrists, 30-40 psychologists) is low with many of them working with different NGOs.
- Across Lebanon there is a severe shortage of certified psychiatrists and psychologists.
- The majority of interventions focusing on short-term/one-off programmes which are often recreational activities (Level 3) that may or may not qualify or be officially recognised as psychosocial interventions.
- Limited attention is given to providing long-term support, and to the role and influence of parents within interventions targeted at children.
- Limited effort is invested into integrating with the community and building positive and sustainable capacity, particularly after the programme has concluded.
- Different NGOs use different HIS with "widely varying diagnostic categories", making comparisons both within Lebanon as well as with other refugee settings difficult.'

Lack of coordination has manifested in not only the duplication of efforts in certain geographical areas (and the neglect of other beneficiary groups), but also unhealthy competition between NGOs over beneficiaries, which results in overload on the limited number of local implementing partners. This has led to significant concerns that the response is not only insufficient, but in being unnecessarily competitive and hastily implemented.

A further issue identified by the assessments is that NGOs and partners are also often reluctant to share their materials or methodologies, making it difficult to determine what level or quality of work is being done, and where the gaps are. There is also little recognition that sectors such as health have a cross cutting effect, i.e., there remains a "silo" mentality in certain sectors that do not recognise that their actions and interventions will have effects on the health situation.

To complement the MHPSS 4Ws assessment, a further assessment study was commissioned in late 2013 in order to examine the quality of PSS programmes and training directed at refugees.[56]

The study examined; what psychosocial support means or requires,; what the contextual PSS challenges and needs of all populations are in Lebanon, and; a coherent national strategy for addressing PSS needs within the unique context of Lebanon now layered with the Syrian crisis.

The research involved interviews with key INGO stakeholders in the delivery and implementation of PSS projects. The study recommended that:

- Level 1 PSS services should be fortified through increased hiring and training of emergency responders across the sectors.
- Level 2 PSS services and staff qualifications and responsibilities need to be standardised. Proper screening tools should be put in place to determine the intensity and length of services needed by each community member. Current "meals on wheels" interventions should be transitioned into more community-based psychosocial support mechanisms that fully engage existing resources, networks and ideas.
- Level 3 PSS services should be delivered only to those truly in need of focused, non-specialised supports. Level 3 services are currently disproportionately overloaded because Level 1 and 2 capacity is still weak (e.g.: case managers are currently managing child school bullying cases, which should in fact be addressed by teachers in school, who in turn need to be trained in psychosocial support and conflict management).

[56] UNICEF (2014) Psychosocial Support Technical Review. Dec 2013 – Feb 2014 Lebanon.

No assessments or information has been identified for host communities or Lebanese returnees across geographic areas.

5. PERSONS WITH SPECIFIC NEEDS (PwSN)

General

Based on the data and information available and the MSNA SWG workshop discussions, the MSNA analysts have found the following groups who are vulnerable:

- Unregistered, those awaiting registration and newcomers (Syrian refugees)
- Socio-economically deprived Lebanese

Within these groups there are specific persons who are regarded as being highly vulnerable and require specific attention in programming, but also when conducting assessments and surveys:

- Persons with chronic medical conditions, particularly cardiovascular disease, renal failure and cancer
- Older persons
- Persons exposed to disease outbreaks
- Pregnant women
- Malnourished children

All groups require access to affordable medication for chronic illnesses; appropriate mobility aids and medical equipment; support for family members and others that provide care for the older refugees and those with chronic conditions.

6. INFORMATION GAPS

6.1 Target Groups

Based on the data available, MSNA analysts have found that the majority of currently available assessments predominantly cover Syrian refugees, without specifying registered or unregistered or PRS.

In order to protect and promote health in Lebanon, all target groups as identified (Syrian refugees, Lebanese host community, PRS and Lebanese returnees) must be covered where possible. Within this, specific vulnerable subsets should be targeted:

- Children under five years of age.
- Older persons – 60+
- Pregnant and lactating women
- Persons with disabilities
- Persons with acute NCD and chronic conditions – CVD, renal failure and cancer
- Persons with acute psychological and psychiatric conditions
- Those with acute life-threatening diseases.
- Persons and communities exposed to critical health events such as disease outbreaks

6.2 Geographical Focus

Based on the data available, the following geographic regions/geographic levels of aggregation should be prioritised:

- The majority of Syrian and PRS refugee populations have settled in poor Lebanese communities. These areas already possessed limited public service provision such as healthcare, which is now being further stretched in terms of capacity (provision, funding and staffing).
- Vulnerable Lebanese communities and the concentrations of Syrian refugees - Akkar, Tripoli and Bekaa. These contain almost 60% of the entire refugee population. Priority settlements in most need of assistance are informal settlements (IS) and unfinished buildings, due to poor WASH conditions.

6.3 Themes

Based on the data available, MSNA analysts have found the following information gaps:

- The availability of up-to-date/real-time data on specific geographical areas and the current health situation within them is limited, i.e., reporting occurs on a national level and is often delayed by a number of months.
- Limited information on the prevalence and severity of certain health conditions such as NCDs and mental health issues across target groups and regions.
- Limited information on cancer registration/surveillance among refugee groups as well as the capacity of data management systems.
- Limited information on the response capacities available in terms of the quality of health services available throughout Lebanon, particularly emergency disease outbreaks, staffing levels and availability of laboratories.
- No data appears to be available on the current utilisation rates of hospitals, which means need cannot be matched to capacity.

- Limited information on the drivers/determinants of healthcare access across groups and geographical areas.
- Limited information about the quality and ability of local NGOs and INGOs to successfully deliver and implement health projects and interventions. For instance, what are interventions actually delivering (nature of the project) in terms of mental health assistance and support?
- No information or data identified on the number of people requiring dental care and treatment.
- Limited information and data on awareness campaigns, distribution and uptake of contraceptives/birth control and family planning information among the refugee population, as well as target group levels of awareness.
- Limited information identified on the availability of medications to refugee populations or the prescription and consumption of medication/pharmaceuticals by refugee populations. As UNHCR medication donations are restricted to refugees, monitoring this could reveal large gaps in MoPH medication provision for host community.
- No information identified on patient satisfaction among Syrian refugees using UN and INGO services.
- No information or data identified on how the social determinants of health and the actions of other humanitarian sectors such as education, shelter, housing and employment are linked to the health status of Syrian refugees and other vulnerable groups.

6.4 Planned Assessments

Planned Assessment	**Date planned for**
Ministry of Health, European Union, WHO, UNICEF, UNHCR - Instrument for Stability project. Establishing baseline of attitudes toward access to health care among host communities	April 2014 – 18months
IMC	A mini needs/attitudes assessment in the form of key informant interviews and focus groups to determine how to target vulnerable Lebanese in one of our non-UNHCR projects
IMC	Patient Satisfaction Survey to occur between April and October 2014.
IMC	Small-scale participatory assessments (ongoing)
Medical Teams International	MTI and Heart for Lebanon are in the process of completing an in-depth participatory health needs/resources assessment for 9 ITS in Bekaa – analysis to be finished by April
IOM, MIT and Johns Hopkins	The project will focus on establishing hypertension and diabetes guidelines and mHealth records for emergency contexts. Start date: Autumn 2014.
WHO – Anaemia assessment and Health care utilization assessment	In preparation
ICRC	Primary Health Care assessments with Syrian NGOs

7. RECOMMENDATIONS FOR DATA COLLECTION

After reviewing the information needs and the data available for each of them, several recommendations for data collection stood out:

- The most practical and immediate objective is to strengthen the VASyR assessments and disease surveillance (EWARN, and the Health Information Monitoring Systems of UNHCR and the MoPH).
- Establish a national prospective population health survey. This could be an expanded version of the UNHCR prospective surveillance survey to provide a health and wellbeing profile (covering NCDs, chronic conditions and mental health) of Syrian refugees and vulnerable host communities. This survey may follow the methodologies of MSF and Help Age International, in order to allow comparisons to be made.
- Within this, an access to healthcare study should be embedded. This will provide a comprehensive assessment of where the health service quality and capacity gaps are with emphasis on the most vulnerable areas of Lebanon/poor communities. It will also enable the change/trends in capacity of healthcare facilities, drivers of access to healthcare, and the increase or decrease in utilisation of these facilities to be tracked and analysed.
- Establish evaluations/field trials of interventions to measure health outcomes and cost-effectiveness. This will be of direct benefit to donors by enhancing information available when making investment decisions and thereby increasing the sustainability of funding. Humanitarian actors will benefit from increased funds to bring in more qualified personnel, and beneficiaries can ultimately receive a much larger range of assistance with funds and interventions allocated and targeted to meet their changing needs. It will allow donors to know whom they should fund given the increasing interest in cost effectiveness in light of budget constraints. Doing so will not only increase accountability and transparency, but also enhance long-term cost-effectiveness of donor funds. The observatory will provide information as to what is working, why and for whom.
- Where possible, surveys/assessments should be disaggregated for settlement type and population density: house/apartment, IS, unfinished building or building site, public building, warehouse, farm, factory, garage/shop. These categories should, however, be coordinated with the health sector.
- Particular focus should be given to informal settlements and vulnerable local communities who are exposed to deteriorating WASH and nutrition conditions.
- ‘Booster samples’ should be employed to cover specific vulnerable groups such as older persons and the disabled. Comparisons groups of Lebanese host communities in each area should be taken.

MHPSS specific recommendations

- Collect, analyse and use sex, age and disability disaggregated data (SADDD).
- Harmonize the UNHCR HIS using the UNHCR 7 mental health categories.

ANNEX A

ASSESSMENTS/REPORTS CONSULTED AND REVIEWED

Organisation	Name of Report	Data Collection Date	Area	Methodology
Handicap International/Help Age (in process of publication)	Situation of vulnerable refugees in Lebanon and Jordan	01/10/2013	North, Bekaa, Beirut City and Mount Lebanon	1,914 individuals were interviewed. Random cluster sampling for registered refugees. snowball sampling approach to identify and interview non-registered refugees
IMC	C-sections and deliveries	2013	IMC clinics through Lebanon	Information collected and reported via HIS.
IOM	The Situation and Needs of Lebanese Returnees from Syria	Jul-13	Countrywide	Data from registration and profiling exercise conducted across all six governorates by HRC with technical support from IOM. Outreach conducted through municipalities. Questionnaire designed by HRC and IOM.
	Misery beyond the war zone: Life for Syrian refugees and displaced populations in Lebanon	Jun-12	Beqaa, Tripoli, Saida – Syrian refugees (registered/unregistered)	Representative sample survey (N=2,124), Living conditions, general health, access, cost barriers.
UNHCR	Health Information System	2013 / monthly	Areas in which the registered partners are located - national	Partners report weekly / monthly into the HIS.
UNHCR	MHPSS 4Ws	Aug-13	Countrywide	Activities of MHPSS organisations across Lebanon
UNICEF	PSS quality assessment	December 2013 to February 2014.	National	Qualitative interviews with ket stakeholders involved in PSS design and delivery. Assessing quality of programmes and training.
UNRWA	Health assessment	2013	Across all UNRWA sites	No information given

WFP, UNICEF, UNHCR, GoL	VASyR	May-June 2013	Countrywide	Representative random sample stratified by registration date (and pending registration). Over 1,400 households interviewed.
World Health Organization	AFP Indicators	2011 - 2014	Lebanon	World Health Organization. Acute Flaccid Paralysis Indicators by geographical regions of Lebanon