**Provision Of Emergency Mobile Primary Health Care Services for Syrian Refugees In The South Of Lebanon**

**IDEALS/Blue Mission June 2014**

**Background**

More than 2.8 million Syrians are now hosted in Lebanon, Jordan, Egypt, Turkey and Iraq, placing unprecedented strain on communities, infrastructure and services in these countries. There has been a massive escalation of the crisis in the past 12 months, with 70% newly registered as refugees during this period. The highest number, 1.1 million, are hosted in Lebanon. With ongoing violence and a worsening humanitarian crisis inside Syria this figure is predicted to rise to 1.6 million by December 2014.

To date 131,600 refugees are registered in the south of Lebanon, including those awaiting registration (there is currently a one week processing period, except for cases classified as health and/or social emergencies). However, the situation is changing rapidly: the UN Refugee Agency (UNHCR) is reporting the secondary migration of refugees from the north, as there is less overcrowding in the south, cheaper accommodation and a relatively more stable security situation.

Women and children under five years of age constitute 70% of the refugee population, the vast majority of whom are completely dependent on humanitarian aid, arriving in Lebanon with little more than the clothes on their backs.

UNHCR has prepared a Response Plan for Lebanon with an estimated budget of US$1.72 billion: to date only 23% of this has been received. In addition the Lebanese government is desperately trying to raise funds to support its response to the challenges faced by refugees and host communities.

***Coordination of the humanitarian response in Lebanon***

The government of Lebanon has primary responsibility for coordinating the response, working through the Inter-Ministerial Committee and Ministry for Social Affairs. UNHCR co-leads coordination of the response, and co-leads the Protection, Shelter, Non-Food Item (NFI), Water/Sanitation/Hygiene (WASH), Education and Health Sector Groups, together with UN partner agencies such as the UN Children’s Fund (UNICEF – WASH) and World Health Organisation (WHO – Health). These Sector Groups, established at national and regional levels, attempt to coordinate the activities of all government, UN and non-governmental organisations (NGOs) operational in that sector.

***Living conditions and health status of refugees***

The host communities in Lebanon are those characterised by the highest levels of poverty and deprivation even prior to this crisis. Competition for already limited social services and jobs against a background of rising inflation and security concerns is already reaching critical levels.

In the absence of properly established camps the early refugees were fortunate enough to find themselves shelter in rented accommodation, with host families or in the already overcrowded Palestinian refugee camps. However, as numbers have increased and prices have escalated these options have largely been exhausted. Increasingly the new arrivals are forced into small, informal “tented settlements” or to squat disused buildings. These improvised shelters are often substandard, with limited or no water or sanitation facilities, and located in areas prone to flooding and at risk of fires. The fact that refugees are so widely dispersed within host communities creates difficulties in terms of access and coordination, placing greater emphasis on community based outreach activities.

Many refugees have been hugely traumatised by their experiences in Syria and subsequent escape. They have no personal possessions (including food and essential NFIs) or the means to purchase them. Within such a vulnerable population there are particular concerns for women and young children, the elderly, persons with disability and those with existing health problems.

Acute respiratory infections (ARIs) and diarrhoea remain the major causes of illness, with these two conditions also the major causes of death in young children worldwide. The number of measles cases, again a major cause of morbidity and mortality in vulnerable children, continue to rise. This is despite a UNICEF coordinated vaccination programme at registration sites, targeting measles, polio and vitamin A supplementation. Reported cases of cutaneous leishmaniasis (a disease transmitted by sandflies and causing persistent and occasionally disfiguring skin ulcers) have also been increasing in Lebanon over the past year, almost all among Syrian refugees.

There is limited evidence of acute protein-energy malnutrition (with a high proportion of underlying congenital and metabolic problems among those children presenting with acute malnutrition), but the majority of children are stunted (under-height for age: evidence of chronic malnutrition). The World Food Programme (WFP), lead agency within the Food Security Sector Group, is providing food vouchers (redeemable in pre-selected shops throughout Lebanon) or food parcels distributed directly to refugee families. However, such assistance is already insufficient and unreliable and is likely to be reduced further due to lack of funds.

As well as physical illnesses, the witnessing of atrocities, forced displacement, exploitation and risk of sexual/gender based violence all significantly increase the risk of psycho-social distress and mental illness. 62% of school aged refugee children are not enrolled in formal education, leaving them more vulnerable and frustrated.

***Health services for refugees***

UNHCR is subsidising the cost of primary health care (PHC) for registered refugees (particularly for young children, the elderly, pregnant women and those with disabilities), using pre-selected government and NGO managed PHC centres. However, refugees still have to make a variable contribution to the cost of this care and accessing services remains difficult because of the distances involved and cost of transport. Furthermore, the availability of medication for chronic diseases (eg. diabetes, heart disease) is extremely limited, despite an undertaking by the national YMCA programme to supply these PHC centres with essential drugs, and even simple acute treatments are not always available.

For those patients with life threatening conditions, subject to approval by GlobeMed Lebanon (the recently appointed “referral contractor”), UNHCR will also cover 75% of the cost of secondary care at pre-selected hospitals (100% if the patient is classed as “vulnerable”). However, this still leaves the refugee having to cover 25% of the cost of life saving hospital treatment, and non-emergency cases are not covered at all.

This means that PHC is vitally important for the refugee population, with free, mobile services certainly able to overcome the current barriers created by cost and distance.

In the south the largest refugee populations are to be found in the following cazas (districts): Saida; Tyre; El Nabatieh; and Bent Jbeil. However, the only Health Sector Group partner providing any form of mobile PHC services in the region is International Medical Corps (IMC), and there is an urgent need to improve coverage.

**Project Goal**

To improve the health status of both refugees and host communities within the target area

**Project Objectives**

Within the target area:

* To prevent avoidable death, disease and disability through the provision of free, high quality, outreach PHC services
* To specifically address the essential health needs of women and young children
* To address emerging public health threats through the delivery of health/hygiene educational programmes and active disease surveillance

**Project Implementation Strategy**

We have already staffed and equipped a mobile medical unit (MMU) to provide outreach PHC services for a widely dispersed target population of refugees and members of host communities in Saida and Tyre districts, south Lebanon. Target sites are a mix of tented settlements, squats and villages/communities known to host significant numbers of refugees. All sites are at least five kilometres from the nearest UNHCR supported PHC centre. To improve coordination and avoid duplication the target sites have been agreed with UNHCR, other Health Sector Group partners in the south and beneficiaries, and are reviewed on a regular basis.

The MMU operates from 0800 to 1400, five days a week. The MMU visits at least ten target sites, returning to each site at least once every two weeks (according to a monthly schedule agreed with beneficiaries and shared with UNHCR). Additional sites are visited on a more ad-hoc basis, depending on need and requests from UNHCR or other Health Sector Group partners. Where existing health facilities are available in a target site we try to utilise them, working with and supporting any health workers present. However, if functioning health facilities are not available within the target site we use whatever community buildings/tents are available: aiming to provide as much privacy/confidentiality for patients as possible. Community mobilisers have been recruited from the refugee population to improve coordination, help organise all health and related activities, and increase beneficiary ownership of the project. Although services are targeted at refugees we do not refuse care to any member of the host community who attends. Patients requiring chronic disease medication, further investigation and/or specialist assessment are transferred to PHC centres in Saida and Tyre, with onward referral to secondary care consistent with UNHCR’s current policy.

All services are implemented in a manner consistent with UNHCR’s operational guidance for MMUs and the SPHERE Humanitarian Charter and associated Standards for Health Services in Emergencies. Specifically:

* All staff have been thoroughly briefed prior to deployment, ensuring their familiarity with the situation in the field and both clinical and administrative requirements.
* There is regular, standardised data collection, with the collated information used to monitor trends, respond to changes/possible epidemics, evaluate the effectiveness of interventions and ensure appropriate resource allocation.
* All staff reflect the cultural profile of the beneficiary population.
* Gender equity is preserved through the following actions: the presence of a suitably trained female health worker (nurse) within the MMU; the targeting of women within the health/hygiene education programme; and the age/sex disaggregation of all routinely collected health data.
* We routinely use WHO/government approved protocols/guidelines for the diagnosis and treatment of priority diseases, including the integrated management of neonatal and childhood illness (IMNCI) guidelines.
* Clinical equipment and drug/consumable provision is based on the essential standards recommended by the Health Sector Group.
* Key elements of the minimum initial services package (MISP) are provided (see below for details).

**Project Activities**

We:

* Deliver free, high quality, outreach PHC services, incorporating the following:
	1. the management of all acute health problems in the target population;
	2. The provision of key reproductive health care services for women (family planning advice, HIV/AIDS/STD health education, condom and contraceptive pill distribution, ante-natal and post-natal care), with referral to a PHC centre and/or secondary care for specialist/emergency reproductive health care as appropriate. Micronutrient supplements are provided to all pregnant women;
	3. the management of childhood illness, including the routine assessment of the nutritional status of young children aged six months to five years using mid upper arm circumference. Acutely malnourished children are referred to designated PHC centres supported by International Orthodox Christian Charities (IOCC) for detailed nutritional assessment and treatment;
	4. the management of mild mental health problems (anxiety and somatisation disorders), and the referral of those with more severe mental health problems (depression, self harm, high suicidal risk and psychotic illness) to designated mental health care providers;
	5. the support of all vaccination initiatives, liaising with the Ministry of Public Health and UNICEF and prioritising polio and measles vaccination (with accompanying vitamin A supplementation). All vaccinations are recorded on approved vaccination cards;
	6. the possible distribution of chlorine tablets (depending on the level of water contamination/water-borne diseases in the target site);
* Refer patients to a PHC centre for specialist consultations, diagnostic tests and chronic disease management.
* Transport patients with immediately life-threatening conditions to secondary care.
* Deliver health/hygiene education sessions to those attending the MMU, targeting women and with a focus on safe hygiene practices, nutrition (including the benefits of breastfeeding and requirements for growth), reproductive health care, communicable disease control and mental health awareness.
* Provide regular training sessions for health staff and existing health workers in the target sites, with a focus on maternal and child health care.
* Established robust data collection, monitoring and reporting systems, with aggregate data submitted to UNHCR, the Ministry of Public Health and Health Sector Group partners on a weekly basis.
* Ensure the rapid reporting of possible communicable disease outbreaks to UNHCR, the Ministry of Public Health and Health Sector Group partners.
* Liaise closely with all other agencies, particularly Health Sector Group partners and UNDSS (regarding security issues within the target area).

**Expected Results**

* Improved access to PHC services for all beneficiaries (refugees primarily, plus members of host communities).
* Improved access to key elements of reproductive health care for women.
* Improved identification/management of malnutrition in young children.
* Improved communicable disease control.

**Evaluation Indicators**

* Increasing activity levels for the MMU (as beneficiaries become increasingly aware of the services provided).
* Improved rates of ante and post-natal care (compared to baseline).
* Reduced childhood global acute malnutrition rate (compared to baseline).
* Immediate (same day) reporting of suspected communicable disease outbreaks to appropriate agencies.

**Project Monitoring and Evaluation**

We trained all staff in the use of standardised data collection forms, and submit aggregate data to the relevant agencies on a weekly basis.

The health coordinator visits the MMU on a regular basis (without prior notification) to validate progress with project staff and beneficiaries and discuss existing/potential problems, with further supervision provided by IDEALS’ health adviser during monitoring visits.

The health coordinator and/or project manager attend regional and national Health Sector Group meetings (and other Sector Group meetings as required). Monthly monitoring reports are submitted to IDEALS’ health adviser (and donors as required), gauging progress against all planned activities and incorporating feedback from the field visits.

In the final month the project manager will liaise with all stakeholders to compile a final project evaluation gauged against the objectives and expected results/evaluation indicators. Our own data will contribute to this process, but by necessity will need to be supplemented by data collected by all other agencies involved in the delivery/monitoring of health care in the target area. This final report will be submitted to key stakeholders and donors within one month of project completion.

**Project Management**

The overall management of the project (administrative, financial and human resource issues) is the responsibility of the project manager, but all clinical issues are the responsibility of the health coordinator. Both are accountable to IDEALS’ health adviser.

A dedicated project account has been established to manage the finances. Monthly statements of expenditure accompany the monitoring reports.

**Human Resources**

***IDEALS:***

Health adviser

***Blue Mission:***

Project manager

Health coordinator

Doctor

Nurse

Health/hygiene promoter

Community mobilisers x 10

**Project History/Planning**

The first phase of this project began at the end of April 2014, with funding secure until the end of October 2014. The MMU is already fully integrated with UNHCR, Ministry of Public Health and Health Sector Group partners, and has gained the trust of our beneficiaries. Thus there will be no delay in delivering services or any need to spend time building momentum or establishing relationships with project partners. This proposal covers an additional six month period. Although rapid and unpredictable fluctuations in beneficiary numbers and status will continue and target sites are likely to change, the level of need in the region will continue to significantly outweigh the services available for the foreseeable future.

We will continually assess the situation on the ground, planning for a further project extension or an exit strategy at the earliest opportunity.