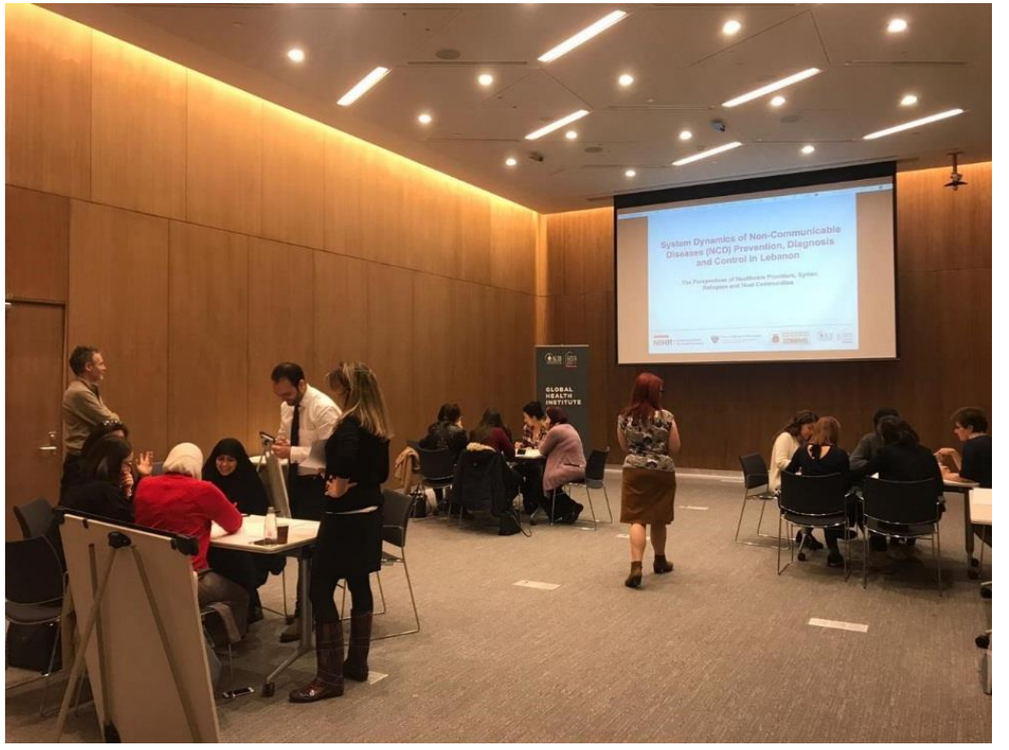
Policy Brief

Dynamics of Non-Communicable Diseases: Prevention, Diagnosis and Control in Lebanon



Our Next Steps

- **To determine service quality and coverage among vulnerable populations in Lebanon, the NIHR RUHF will undertake an appraisal of the delivery of diabetes and hypertension service at the primary care level in Greater Beirut and Beqaa.**
- **The appraisal will use a mixed method approach and will tackle current service capacity, structure, quality and impact, as well as patient experiences.**
- **The goal of this project will be to elaborate evidence-based recommendations for improved services and scale-up of NCD service delivery for vulnerable populations to national level.**

NIHR Research Unit on Health in Situations of Fragility (RUHF)

The National Institute for Health Research (NIHR) RUHF seeks to identify sources of resilience within formal health systems and local community processes to facilitate effective provision for health priorities – particularly mental health and non-communicable diseases (NCDs) – in situations of fragility.

To this end, the Global Health Institute at the American University of Beirut (AUB), has joined with the Institute for Global Health and Development, Queen Margaret University (QMU), and the College of Medicine and Allied Health Sciences (COMAHS), University of Sierra Leone, in a research programme initially funded between 2017 and 2021.

The RUHF will support the Ministry of Public Health and key stakeholders to effectively address the non-communicable disease needs in Lebanon.

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NIHR Research Unit on Health in Fragility

Queen Margaret University INSTITUTE FOR GLOBAL HEALTH AND DEVELOPMENT

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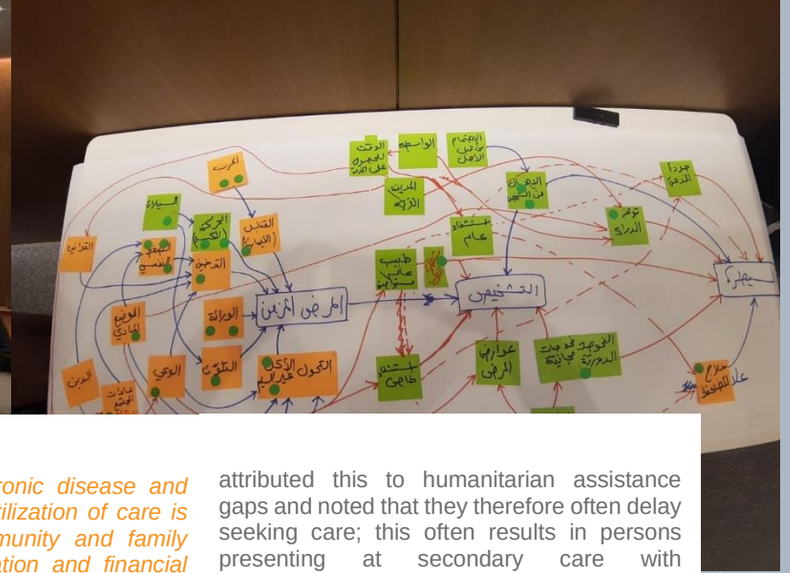


Country Profile and Key Challenges

Lebanon, a middle-income country situated in the unstable region of the Middle-East, is currently the home of around 4.5 million nationals and more than 1.5 million refugees, of whom the majority escaped an ongoing armed conflict in Syria (MOPH 2017a; UNHCR 2018). The regional instability, marked mainly by the Syrian crisis, contributed to a sudden influx of refugees to an already growing Lebanese population. Over the last decades, the country has faced increasing challenges, including population ageing and high rates of uncontrolled urban growth.

The burden of Non-Communicable Diseases (NCD) remains the largest component of Lebanon's health profile. In 2012, around 85% of all deaths were attributed to this category of diseases (WHO 2014). Cardiovascular diseases top the list, accounting for almost half of all deaths. While NCD surveillance systems are still weak in the country, several studies suggested a steady increase in the prevalence of NCD and their metabolic and behavioural risk factors over time (Nasreddine et al, 2012; Sibai et al, 2013; Maziak et al, 2013; Zeidan et al, 2016; Bou-Orm and Adib 2018; Waked et al, 2011; MOPH 2017b).

Access to NCD care varies in Lebanon depending on people's health coverage status. Vulnerable Lebanese communities who are likely to be without any formal public or private insurance scheme, usually rely on a network of NGO-run health centres delivering essential NCD ambulatory care and on the limited support of the MOPH for hospital care. As for refugees, the UN Refugee Agency (UNHCR) supports primary care in those same centres and only life-threatening hospital emergencies.

Research Methods

The preliminary findings outlined in this brief are based on 60 semi-structured interviews (conducted primarily at primary health care centres (PHCCs)) and six group model building sessions (conducted at AUB) with health care providers offering chronic disease care and Lebanese and Syrian community members in the Greater Beirut and Beqaa regions of Lebanon. All fieldwork was conducted between February and April 2019.

Regions were chosen purposively to reflect different fragility profiles, including different socio-economic profiles of populations and availability and accessibility of health services. Poverty rates are reported by the Central Administration of Statistics (CAS) to be the lowest in the Greater Beirut (GB) area (between 16% and 22%) and the highest in the Beqaa governorate (38%) (CAS & WB 2015).The Beqaa region, which hosts around 35% of the Syrian refugee population, was considered by the UN-Lebanon Interagency taskforce to be in major need of health institutional support (UN Lebanon 2017).

Key Findings

1- The occurrence of chronic disease and subsequent access and utilization of care is strongly shaped by community and family culture, as well as education and financial resources

Health care providers, the Lebanese community and Syrian refugees clearly acknowledged that cultural traditions, educational levels and lack of financial resources drive individuals to practice unhealthy lifestyles and hinder their access to health care services. This is exacerbated in Beqaa given higher levels of poverty and fragility in the region.

Participants additionally identified urban life and difficult family relationships (e.g. as shaped by violence or early marriage) as factors leading to chronic disease onset.

2- Gaps in health coverage exist for both Lebanese communities and Syrian refugees, compromising access and utilization of care

Lebanese participants in Greater Beirut and the Beqaa noted issues relating to coverage status affecting their ability to seek and utilize health care for chronic conditions. Vulnerable persons that are not covered by the existing health insurance funds (e.g. National Social Security Fund, Civil Servants' Cooperative or Military Health Funds) are unable to afford outpatient care at private clinics and may instead access civil society run health care centres. The Syrian community additionally noted gaps in coverage specifically for catastrophic chronic conditions – for example cancer care and hemodialysis. Refugees attributed this to humanitarian assistance gaps and noted that they therefore often delay seeking care; this often results in persons presenting at secondary care with complications, incurring higher out of pocket expenditures and leading to poverty.

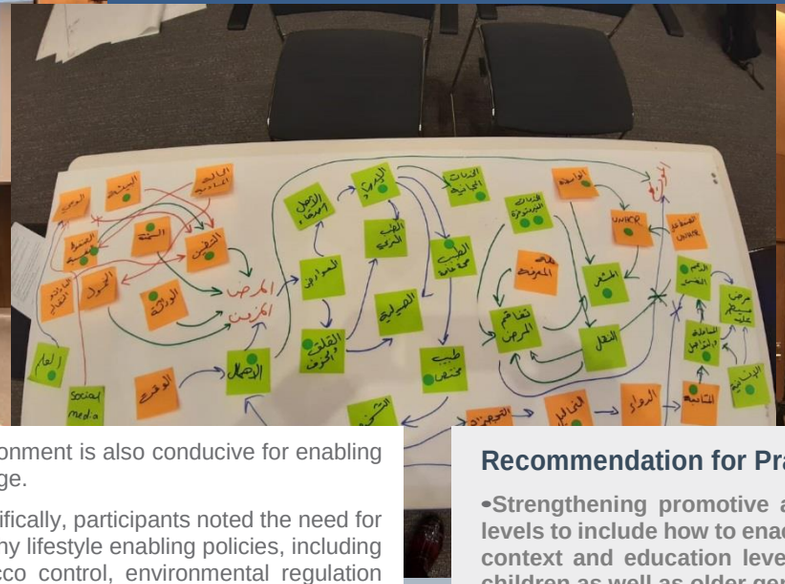
3- Pathways to seeking care for chronic diseases are highly varied

Pathways to care-seeking are shaped by community beliefs, trust in diverse providers and immediacy (i.e. proximity and affordability) of health providers: e.g. the pharmacist seems to be the first point of contact among vulnerable communities given the availability and low cost of services.

Similarly, trust in informal care and religious beliefs may mean that persons residing in rural areas such as the Beqaa seek care from the heads of religious orders (i.e. Sheikhs) and practice Arabic traditional medicine. Gender norms, particularly within the refugee community, additionally determine how/when women access health care services.

4- Quality of services is perceived differently in Beqaa vs Greater Beirut

Health providers active in rural areas such as the Beqaa acknowledged difficulties in delivering care given shortages of qualified medical professionals. High utilization among rural clinics places additional pressure on the health system, compromising quality of care. Community members identified that instances of poor communication with health providers affected their adherence to treatment.



Empowering patients by providing more comprehensive education on chronic conditions (including lifestyle advice for prevention of onset and guidance on disease management) as well as continued psychological support were noted as promising interventions to strengthen quality of care.

5- Gaps in policy inhibit healthy living

Both health providers and Lebanese and Syrian community members felt that many aspects of reducing risk of chronic disease development went beyond their control. For example, while they acknowledged lifestyle change was possible and within most people's ability, participants spoke of the need to ensure that the wider social and physical environment is also conducive for enabling change.

Specifically, participants noted the need for healthy lifestyle enabling policies, including tobacco control, environmental regulation (i.e. control of pollution) and urban and rural planning (i.e. to ensure appropriate hygiene conditions and availability of green spaces for exercise).

Recommendation for Practice:

- **Strengthening promotive and preventive services and initiatives at primary care levels to include how to enact a healthy lifestyle tailored to the cultural and traditional context and education level. This may take the form of education among school-children as well as older generations.**
- **Review coverage schemes for vulnerable populations in Lebanon, acknowledging that NCD care is a key priority for these communities.**
- **Given peoples' diverse care-seeking patterns, referral systems need to be strengthened. This may include clarification of pharmacist roles and strengthening their ability to refer and/or counsel chronic disease patients as appropriate.**
- **In-service training on chronic disease care, including communication with patients and necessary time for case-management and psychological support are recommended.**
- **Communities and civil society actors should advocate for policy change sensitive to healthy lifestyles and chronic care needs.**