Disability and Health Situational Analysis Report

Improving Access to Quality Health Care for Persons with Disabilities in Lebanon

Lebanon Report 2019-2020

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This study was conducted by Social Promotion Foundation (FPS) in collaboration with the Ministry of Social Affairs (MoSA) and International Medical Corps (IMC), as a part of Reducing Economic Barriers to Accessing Health Services (REBAHS) under the project Improving Access to Quality Health Care for Persons with Disabilities in Lebanon funded by the European Union, through the EU Regional Trust Fund in Response to the Syrian crisis, the 'Madad Fund'. The Trust Fund was established in 2014 in order to allow for a coordinated response to the Syrian crisis and to provide refugees from Syria and local communities in the countries neighbouring Syria with the needed support. To date, the Trust Fund has mobilised €2.2 billion, including voluntary contributions from 21 EU Member States, Turkey and the United Kingdom, for projects in the spheres of education, livelihood, health, protection and water management.

Social Promotion Foundation (FPS)

The Social Promotion Foundation works to eradicate poverty and to promote sustainable human, social and economic development, in accordance with the dignity of the person, and respectful of the identity of the people and social groups.
Founded in Madrid in 1987, Social Promotion Foundation has implemented more than 200 projects in the humanitarian and development fields in countries across Latin America, Asia, Africa and the Mediterranean Region.

FPS work in Lebanon

FPS has been working since 1995 to manage projects related to people with disabilities (PwDs) and to groups in situations of vulnerability. The Foundation works in the care of people with physical and intellectual disabilities, with the aim of improving their social inclusion and accessibility to better opportunities for decent employment. The work has also materialized in interventions aimed at supporting groups in situations of vulnerability and, therefore, at risk of social exclusion.
It works with a support approach to the sector, contributing innovative elements and helping to establish the following interventions:

- Support for infrastructures and the creation of new centres.
- Vocational training programmes to promote the inclusion of PwDs in the labour market.
- Provision of community services, to facilitate social inclusion and accessibility to employment.
- Specific education and rehabilitation programmes for young people.
- Social awareness-raising campaigns with special attention to families of PwDs and young people with social difficulties which would limit their inclusion in society.
- Institutional support and strengthening of local organisations.
- Give priority attention to the interventions approach, strengthening the capacitiesof public and private institutions working in the sector, seeking complementarity with the social policies of the intervention countries.
- Promote training and the use of assistive technology in order to achieve better living conditions and greater social equity for PWDs.

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Lebanon Report
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Persons with disability have the right to the enjoyment of the highest attainable standards of health without discrimination on the basis of disability

(Article 25 of Convention on the Rights of Persons with disabilities) ———

Acknowledgment

Social Promotion Foundation would like to extend its gratitude to all People with Disability living in Lebanon for allowing access to their lives, sharing their stories, and providing invaluable feedback. FPS hopes that this work will help to improve access to and utilization of critical health services by PwDs.

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The report was translated into Arabic by Mr. George Khoury

Report Design was developed by M.A. Chidiac Studio

Table of Contents

List of Acronyms & Abbreviations

CEO: Chief Executive Officer

CRPD: Convention on the Rights of Persons with disabilities

DC: Disability Card

DPOs: Disabled People Organizations

FGDs: Focus Group Discussions

FPS: Fundación Promoción Social

ICF: International Classification of Functioning, Disability and Health

IMC: International Medical Corps

KIIs: Key Informant Interviews

M&E: Monitoring and Evaluation

MEHE: Ministry of Education and Higher Education

MoPH: Ministry of Public Health

MoSA: Ministry of Social Affairs

NGOs: Non-Governmental Organizations

NIE: National Institution for Employment

PHCC: Primary HealthCare Centre

POs: Project Officers

PwDs: Persons with Disabilities

SDCs: Social Development Centers

SPSS: Statistical Package for the Social Sciences

UN: United Nations

UNESCO: United Nations Educational, Scientific and Cultural Organization

UNHCR: United Nations High Commissioner for Refugees

WHO: World Health Organization

Executive Summary

Persons with disabilities generally have more healthcare needs than others, those that are common to everyone and those linked to specific underlying health conditions and impairments. They are more susceptible to worsening health and, as a result, are more frequently in need of healthcare services. In Lebanon, all PwDs face increased vulnerability due to the impact made by inaccessible healthcare services. At the same time, since they face greater barriers to accessing services, PwDs consistently have a poorer uptake of both general and specialized healthcare services when they are needed.

This research aims to examine health service access and utilization by PwDs in Lebanon and to characterize the barriers they face. This study included a quantitative survey of 1,055 Lebanese and Syrians refugee PwDs along with 14 focus group discussions (121 PwDs). Impairment and geographic diversity was accounted for to ensure the inclusion of a wide range of experiences. In addition, eight face-to-face semi-structured interviews with disability stakeholders and key disability experts were also conducted in order to better understand the overall system by which health services are provided to PwDs in Lebanon.

The results from the survey showed that the two most commonly cited needs amongst both Syrian refugees and Lebanese PwDs were chronic medications and diagnostic tests.
The study also showed that 97% of those who reported needing medications did actually receive them, only 16% of these respondents did so from a PHCCs, while 99% acquired the medications through a private sector health provider. The top two services provided by the PHCCs were diapers (51%) and assistive devices (51%).The two most commonly cited barriers to accessing needed healthcare services were financial and geographic. Furthermore, the FGDs revealed that PwDs frequently have need of rehabilitative services and feel they cannot solely rely on government-provided care, but instead must seek out alternatives in order to have access to the health services they need most. Furthermore, the disability stakeholders from the KIIs described the services provided by their respective organizations and recognized the geographic, transportation and communication barriers faced by PwDs when accessing their centers.

The report concludes with a number of recommendations based on the study findings.

List of Tables

List of Figures

Background

In Lebanon, areas seen as fundamental to modern life, from healthcare, education, and housing to employment, transportation, and political engagement, remain inequitably accessible to a diverse, highly vulnerable population of more than 400,000 persons with disability[1] . Indeed, a lack of access to needed health and rehabilitation services and equipment remains a significant challenge to the overall welfare of the PwDs community. The absence of accessible, widely distributed information on service availability, physically inaccessible health structures, insufficient numbers of quality, empathetic health/PHCC staff, inequitable geographical distribution of health resources, and a lack of accessible transportation are but a few examples of a system not built or maintained with the needs of this vulnerable population in mind. Underlying these concerns, however, is a disability classification system built on an outdated construct, the International Classification of Functioning, Disability and Health, that fails to adequately address prevailing social and environmental barriers and a broken system of entitlement provision that fails to connect each individual PwDs with the services and equipment they most need.

To be sure, the ongoing economic crisis (fueled by a variety of factors) has played a role in maintaining, if not contributing to a further deterioration, of the situation. The implementation of fiscal austerity measures has had an impact on health and social welfare budgets, measures which tend to impact vulnerable populations, such as PwDs, first and most extensively. However, political stagnation, years of financial mismanagement, and an insufficient commitment to addressing PwDs concerns, across all sectors, play the largest roles. In contrast to the requirements set forth in the forward-thinking, yet flawed, Law 220/2000, essential government-provided services and equipment are inconsistently available to the majority of Lebanese PwDs in need of them. The result is that PwDs tend to be among the poorest and most disadvantaged, with the worst health and poverty outcomes, and the lowest access to economic opportunities, quality health care, and needed social services. In the absence of governmental policies that ensure inclusion and the commitment of appropriate resources, civil society organizations have stepped up, providing a significant share of the services to PwDs.

Health Sector

Providing access to quality healthcare is among the foremost objectives of any health system as the utilization of effective, person-centered care can markedly improve many health outcomes and avert premature mortality[2] . From the aspirational Alma Ata Declaration of 1978, wherein WHO called for the achievement of "health for all," to the current Sustainable Development Goals (specifically SDG 3), ensuring the availability of health and rehabilitation

[1] Combaz.E- Situation of persons with disabilities in Lebanon-15 July 2018

services that are broadly accessible and do not create financial hardship is an ambition to which many global and national stakeholders continue to aspire, including in Lebanon.

The national Lebanese Health system, which relies on a fragmented (or diverse) mix of public, private, and NGO health and social service providers, has overlap in some areas of coverage and gaps in others. It has been dominated by the private sector, which is geared towards hospital-based curative care (48% of total public health expenditure) rather than primary and preventive health measures. Nevertheless, important reforms initiated by the MoPH in recent years has moved the sector towards greater evidence-based decision-making and collective governance. Several international healthcare rankings, for example, indicate that Lebanon has made substantial improvements in overall health coverage and system performance. The 2018 Healthcare Access and Quality (HCAQ) index, which used amenable mortality (deaths from causes that should not occur in the presence of effective medical care) to approximate national levels of personal healthcare access and quality, ranked Lebanon 33rd out of 195 countries[3] . Publicly available healthcare, which is prioritized at the MoPH Primary Healthcare Center (PHC) level, now has a stronger emphasis on quality of care with movement away from parallel health services to the provision of intensified support through the PHC network.

The overall spending in the health system, according to the Ministry of Public Health, equates to 7.5 percent of GDP (2017 GDP estimate of $53.4 billion means approximately $4 billion was spent on health services)[4] . This is paid for by three main streams of financing in roughly equal measure: one-third is covered by private insurance and via contribution-based schemes, such as the National Social Security Fund (NSSF), one-third is composed of out-of-pocket payments by patients, and the remaining one-third is government expenditure from tax revenue. This does not include the substantial sums provided by international donors, such as the EU, in support of government and NGO-provided health and social services for the vulnerable. As much as 50 percent of the Lebanese population are without private insurance, are exposed to very high health care expenditures, and lack basic means of social protection such as pensions and unemployment insurance, instead relying heavily on the MoPH and NSSF to cover or reimburse a portion of their medical bills. Yet, despite the reforms made and the financial resources that are available, low-income and other marginalized populations throughout the country, including many PwDs, experience the health system as inequitable and broadly inaccessible, often having to choose between paying for health services and paying for other necessities such as food.

Law 220/2000

In 2000, the Lebanese Parliament passed Law 220/2000 on the Rights of Disabled Persons. This comprehensive law, which remains largely unimplemented, calls on the Lebanese government to ensure a series of rights aimed at integrating Lebanese PwDs into social and economic life through the provision of needed equipment, health services, education,

[2] World Health Organization, Geneva 2007 Everybody's business: strengthening health systems to improve health outcomes: WHO's framework for action.
[3] Healthcare Access and Quality Collaborators, measuring performance on the Healthcare Access and Quality Index for 195 countries and territories and selected subnational locations: a systematic analysis from the Global Burden of Disease Study 2016. Lancet
[4] The Lebanese Healthcare Sector: In Urgent Need of Reforms (Blominvest Bank, 2018)

accessibility initiatives, and employment services, as well as the creation of quotas, fines, and incentives for service providers and employers. To achieve these goals, the law directed the formation of the National Council on Disability, a body designed to take the lead on strategy formulation and decision-making regarding disability issues.

Law 220 also called for the creation of a disability card system, to be administered by the Ministry of Social Affairs (MoSA), in which PwDs who meet narrow, disease-focused definitions for physical, hearing, visual, or intellectual disability (described in the official Disability Classification) can register to receive services and benefits from the government. According to MoSA, approximately 113,000 persons have qualified for and obtained the disability card (as of February 2020), despite a variety of sources placing the actual number of PwDs in the country closer to 400,000.

At this time, the Lebanese government, through MoSA and the disability card system, provides services to Lebanese PwDs primarily based on two adopted policies. In the first, the ministry contracts with national NGOs operating in the field to provide shelter, medical, rehabilitation, educational, and vocational services to Lebanese disability card holders. According to MoSA, approximately 8,600 people (less than 8% of disability card holders) benefited from this scheme in 2018, despite having a yearly cost of more than $44 million USD (Department of Disability Affairs Report, 2019). Unfortunately, this program's diverse array of entitlements, for which holding the disability card is the singular qualification, has resulted in a high cost system wherein a relatively small number of motivated individuals may take advantage of any entitlement, whether related to their disability or not, while the needs of many PwDs continue to go unmet.

The second policy used to provide disability-specific services is the Rights and Access Program, which was adopted by MoSA in 1994. This program provides PwDs with needed equipment and materials, such as cushions, wheelchairs, and crutches. The yearly total number of beneficiaries is around 11,000, with an annual operating budget of approximately $8 million USD (Rights and Access Program Report, 2019). This program is highly unusual in that only those card holders with a physical and/or intellectual disability qualify to receive benefits, despite the fact that, in all other cases, disability card holders have access to the same services and other entitlements, regardless of the type of impairment.

The program's mentioned above provide disability-specific services and equipment to Lebanese disability card holders at a small number of MoSA-contracted centers concentrated around the country's urban centers. Health services, both general and specialized (but not disability-specific), are provided at low cost to all Lebanese, including PwDs, at Primary Health Centers (Ministry of Public Health) and Social Development Centers (Ministry of Social Affairs) distributed across Lebanon. The services provided differ from one center to the next, meaning that proximity to a PHCC (PHC or SDC) does not ensure that the services needed by the PwDs will be available in their area. Regarding hospital admissions, Law 220 stipulates that MoPH should cover 100% of non-emergency related hospitalization charges for PwDs with the disability card. Certain hospitals, however, frequently flout such requirements by refusing to admit anyone for whom MoPH bears financial responsibility, regardless of the medical necessity, citing substantial delays in recouping fees from the ministry.

An inequitable and inconsistent system, combined with the seemingly insurmountable political complications that have prevented the government's ratification of the Convention on the Rights of Persons with Disabilities (CRPD), has contributed to a growing sense of frustration amongst PwDs. The Lebanese government signed the convention in 2007 and sent it to be ratified, but that government was considered by the speaker of the parliament illegal, so he refused to receive it. In November 2015, the Universal Periodic Review - Lebanon called for the Lebanese government to both ratify the Convention and fully apply Law 220[5]. Nevertheless, the CRPD remains unratified and Law 220 continues to be only partially implemented, with major provisions set aside for the time being.

In 2015, following the appointment of a new general director of MoSA and the election of a new National Council on Disability, there was a call to review outgoing policies in order to achieve two main goals: 1) adopt policies that coincide with the spirit of the CRPD and Law 220, policies that are based on inclusion and human rights, and, 2) allow all PwDs the opportunity to benefit from the provision of needed equipment and materials. A major, ongoing concern, however, is that of cost. Financial mismanagement in the years leading up to the 2019 financial crisis, along with a nine-year civil war in Syria that introduced an additional 150,000 Syrian PwDs into the system, have resulted in an extremely challenging situation for social and other services in the country, a situation in which programmatic austerity is not only expected, but politically requisite.

In order to achieve the above goals using the same or smaller budget, the Ministry of Social Affairs began holding consultative meetings with the National Council on Disability, OPDs (Organizations of Persons with Disabilities), and others. Many of the OPDs have argued that, in order to make the costs paid more effective, a review of the official definition of disability and Disability Classification system is necessary. Connecting the provision of services to an individual's impairment (including degree of severity) and documented need is now considered to be the principle strategy for achieving the equitable provision of needed services, equipment, and other entitlements to PwDs in Lebanon.

Definition in Lebanese Law (220/2000)

Law 220/2000 consists of ten parts and 102 articles covering many areas, such as the definition and establishment of a classification system for disability, the establishment of the National Council on Disability, the right to health and health services, the right to a rehabilitated environment (accessibility), the right to accessible transport and parking, driving licenses, the right to adequate housing, the right to education and sports, the right to work, and the right to employment and social benefits, in addition to some special fiscal and miscellaneous rules.
Law 220/2000 defines a person with disability as:

> „…a person whose ability or power to: exercise one or more significant life activity, secure one's personal life requirements by oneself, take part in social activities on an equal footing with others or ensure normal personal or social life according to dominant social standards, has been reduced or completely missed. This is due to the loss, or curtailment, of a total or partial, permanent or temporary, physical, sensory or intellectual function as a result of a congenital or acquired illness or a malady that has lasted longer than it should, medically speaking."

[5]The Universal Periodic Review- Lebanon 2015- Civil Society Reports

Definitions matter because the disability classification system used by a government arises, in part, from the conceptual basis on which "disability" is defined (e.g., a definition whereby disability is seen as a limitation resulting from impairment, a view characteristic of the medical model). The definition employed by the Lebanese government ensures disabilities are viewed through the lens of the medically-oriented International Classification of Impairments, Disabilities, and Handicaps (ICIDH), developed by the World Health Organization (WHO) in 1980. It represents a middle ground between the more expansive western definitions, which produce a high ratio of PwDs to total population (as in United States), and the narrow definitions adopted by many developing countries, which produce a low ratio.

There are four main categories included in the ICIDH and ensconced in Lebanese law:

1. Physical disability
2. Visual disability
3. Hearing disability
4. Intellectual disability

Based on these categories, a diagnostic list of 158 causes of disability was subsequently elaborated by the Ministry of Social Affairs. Acceptance in the MoSA disability card system requires that the applicant be diagnosed with one of these causes by a MoSA center specialist doctor for free.

Despite the relative comprehensiveness of Law 220, it has several serious shortcomings. For example, the Lebanese definition of disability is very much affected by the medical model, wherein various environmental barriers that impede the capacity of PwDs to live normally are fundamentally excluded from consideration, in contrast to the conceptualization of 'disability' employed by the CRPD. As such, those PwDs who do not fall within one of the strict medically-focused disability classes are effectively excluded from accessing available entitlements, including certain health and rehabilitation resources. Additionally, the law addressed the concept of accessibility in a one-dimensional manner, directing the removal of physical barriers from the surrounding environment, while ignoring social, attitudinal, and other barriers and obstacles, such as those experienced within many of the government-run health facilities. Finally, the law failed to appropriately address inclusion and lacked a clear strategy for moving away from the practice of systematic institutionalization to one of building inclusive environments.

Oversight of the law's implementation falls to the National Council on Disability, which is populated by 18 representatives from the OPDs (4), NGOs/OPDs (4), service users (4; elected from amongst the disability card holders), and MoSA (4; Minister chairs the Council) along with two ministerial appointees. In this respect, the law is not far from meeting the basic international standards set by a variety of international conventions, instruments, and charters which are based on the principle of participatory decision-making and the need to ensure real representation of PwDs in all relevant bodies, committees, and decision-making processes. Nevertheless, implementation of the law remains challenging as each section requires a formal decree from the Council of Ministers in order to organize and proceed with the relevant work. Such decrees take significant time and, to date, many have not been issued.

Health Aspects of Law 220/2000

There is little doubt that access to appropriate health services is among the highest priorities for PwDs and, in particular, the young and those with intellectual or physical disabilities. Unfortunately, however, the general lack of medical coverage and the limited and inconsistent availability of disability-related services and equipment remain significant obstacles. Accordingly, PwDs and, most especially, those from very low-income families suffer deeply anytime they face a medical problem. This should not be the case, however, as Articles 27 and 28 of Law 220/2000 call on the Lebanese state to provide PwDs with full medical coverage and health care with all the related medications and medical equipment and devices:

Article 27: The Extent of Rights

A. All persons with disabilities have the right to benefit from the whole health, rehabilitation and support services at the expense of the state represented by the different administrations, agencies and bodies providing such services.

B. Such services include, for example and not restrictively,

1. All surgical operations whether resulting from disability or not: such as transplant, ulcer treatment, limb orthopedic treatment, hospitalization at specialized or non-specialized centers, intensive or regular care. Such coverage includes all instruments, transplants, and others necessary to ensure the success of surgery, whether permanently or temporarily.
2. Medical practice (general practitioners, specialists, dentists, etc.), medicaments, imaging, laboratory tests, and others such as provisional or permanent medication and examinations (special analyses for the newborn: thyroid test, phenylketonuria, G6PD, psychological assessment, audiography, etc.).
3. Specialized external and internal rehabilitative treatment (physiotherapy, occupational therapy, speech therapy, audio-psychotherapy, etc.).
4. Technical aids and equipment such as mobile and stationary prosthetic devices (limb prostheses, artificial eyes, etc.), orthopedic formations, mobility aids (wheelchairs, crutches and canes); aids for double incontinence and for ulcer prevention, plus all transplants used in surgical operations. Such services include maintenance when need arises.

Article 28: Full Coverage

Persons with disabilities shall have the right to make use of the full coverage provided by the Ministry of Public Health. This shall be based on basic coverage in case the person with disability does not benefit from any other coverage, or on additional coverage that is added on top of any other coverage providing services in a partial manner. He/She may remain a beneficiary of other services (family allowances, etc.) provided by the insuring party or agency to which he/she is affiliated.

The level of implementation of the health provisions outlined in these articles is unfortunately very limited. The MoPH continues to finance the cost of artificial limbs, though at a significantly reduced level, while the MoSA, through the Disability Rights and Access Program, contracts

with external organizations to provide to Lebanese PwDs holding a disability card. Both the MoPH and MoSA continue to cover the cost of physiotherapy treatments for Lebanese PwDs. As mentioned above, coverage of hospitalization fees continues to be problematic. On two separate occasions, the Ministers issued circulars to promote and re-enforce the use of the disability card as a legal document to obtain health services (1995 and 2012) and calling on all hospitals to accept PwDs presenting with the MoSA disability card and provide them with medical treatment. Most hospital administrators, however, feel these directives to be impractical as the meager finances allocated for this purpose tend to be consumed quickly (typically by mid-month) and the costs associated with the inpatient treatment of PwDs tends to be high, especially those cases in which pressure sores are present or specialized personnel or medical equipment is required. As a result, the circulars are frequently not respected by hospitals, including those that are government-owned. The government can enforce the hospitals to except PwDs based on their disability card as stipulated in articles 27/28 of the law 220.

Moreover, outpatient medical support, in terms of medical care, laboratory services, and medications, are not currently provided to PwDs with the disability card in accordance with the law (at no-cost) and are often geographically and physically inaccessible. Costs for general and specialized medical care, rehabilitation services, medications, assistive devices, and accessible transportation price consistent, high-quality health care out of reach for most Lebanese PwDs without the disability card.

Syrian Refugees

Lebanon has experienced an unprecedented influx of refugees from Syria, reaching nearly 1.2 million registered individuals at its peak in mid-2015[6] . The population surge has put severe strain on finite resources and already over-stretched public services. This strain has been strongly felt in the health sector, with MoPH and MoSA reporting an average increase in the use of their services of more than 40% at various times.

Primary healthcare services are available to Syrians, whether registered or unregistered, through a variety of healthcare facilities. These include the MoPH's network of 237 Primary Healthcare Centers (PHCs), and an estimated 1,011 other primary healthcare facilities (dispensaries), most of which are associated with national and international NGOs. PHCCs offer a relatively comprehensive primary health services, while the dispensaries, including MoSA's 228 SDCs, typically provide more limited support. The UNHCR 2018 Health Access and Utilization Survey (HAUS) confirms that, for both acute and chronic conditions, respondents seek services through all these facilities, depending upon what is needed and the information they have on services that may be available. Access to hospital care for displaced Syrians is primarily through a network of 40 public and private hospitals across Lebanon, with subsidized care currently limited to obstetric and life-threatening conditions (covers 75 percent of hospitalization fees with Syrians coving the remainder).

Overall, resources available to ensure the equitable provision of quality, essential health services for Syrian refugees is limited. Syrian PwDs face even greater challenges to obtaining needed services from a health sector plagued by inaccessibility at all levels.

[6] Elwood D. Carlson, Nathalie E. Williams, Comparative Demography of the Syrian Diaspora: European and Middle Eastern Destinations, Springer Nature, 2019, Volume 20 of European Studies of Population Series, ISSN 1381-3579 p119

Methodology

1. Study Design

The present study aims to examine health service access and utilization by Lebanese and Syrian PwDs in Lebanon, and to characterize the barriers they face, by using a retrospective cross-sectional study in five regions of the country (Beirut, Mount Lebanon, North, South, and Bekaa) and employing a mixed methods approach comprised of both quantitative and qualitative research tools.

2. Quantitative Method

2.1. Sampling Method

The study targeted non-institutionalized persons with physical, mental, visual and hearing impairments above 17 years old. For the purpose of this study, institutionalization refers to full-time residence within a rehabilitative or educational institution. Please make sure to use the updated version. In order to calculate a representative sample size, the population size was determined based on a literature review and then divided into three groups: Lebanese PwDs registered in the MoSA disability card system, Lebanese without disability cards, and Syrians PwDs. The overall sample of 1,038 was calculated using an online sample size calculator[7].

- For the two Lebanese groups, a population size of 900 000[8] (Prevalence of all impairments and disabilities (physical, sensory, cognitive, mental, or other) in the total population of persons living in Lebanon) was used, with a 95% confidence level, 5% confidence interval or margin of error, and 50 % expected frequency. The final sample size of each group was determined to be 384.
    - The first group "Lebanese PwDs registered in the MoSA disability card system" were recruited based on a list of PwDs provided by the Ministry of Social Affairs (a total of 48,770 who gave prior consent to contact). The participants were chosen proportionally across the five regions in Lebanon and divided into four broad disability categories (physical, mental, vision, and hearing impairments) by using systematic random sampling.
    - The second group "Lebanese PwDs who are not registered with MoSA" were recruited randomly from among those currently receiving services of any kind from area DPOs/NGOs; and from municipalities in each region by contacting them to

[7] Epi info/ STATCALC/population survey
[8] Combaz.E- Situation of persons with disabilities in Lebanon-15 July 2018

take a list of persons known to have a disability.

- For the Syrian group, an expected frequency of 22.6%[9] was used with 95% confidence level, 5% confidence interval or margin of error, to have a sample size of 270 Syrians PwDs.
    - The participants were recruited randomly from among those who are currently receiving services of any kind from area DPOs/NGOs; and from a UNHCR list of the camps in Bekaa using a convenience sampling method.
- Both Syrian and Lebanese PwDs without MoSA disability cards were also recruited through snowball sampling via participants who knew of other PwDs in the same community.
- FPS coordinated extensively with international NGOs and local DPOs/NGOs (IMC, Mousawat, Rahma Medical Center…) who provide health services for persons with disability in order to ensure access to a geographically diverse array of health providers and patient populations.

2.2. Survey design

The survey aimed to examine levels of health service awareness, perceived availability, accessibility, utilization, and satisfaction, as well as looking at barriers to health, types of supports needed and received and levels of coverage for key health indicators (disaggregated by age, sex, and other demographic data). Survey questions were designed after a literature review on this topic, based on the International Classification of Functioning Disability and Health (ICF) and consistent with the CRPD. A face-to-face questionnaire was designed which included a closed-ended questionnaire of multiple-choice questions, open-ended questions, and questions using a 5-point Likert scale with responses ranging from "very satisfied" to "very dissatisfied". The questionnaire consisted of nine sections in total (Annex 1)

Upon finalizing an early draft of questions to be included, the survey was shared and discussed with two FPS partners (International Medical Corps and the International Labor Organization) who provided input on the question set. The finalized questionnaire was translated to Arabic and reviewed by FPS disability experts to ensure correct terminology and then back-translated to English to ensure translation accuracy. The survey was uploaded on tablets using the Magpi mobile data platform (Data Dyne; Washington, DC).

2.3. Data Collection

The data collection was conducted directly with PwDs. For those with intellectual or hearing disabilities, the survey was completed in the presence of a caregiver/family member to assist the respondent in answering the questions. The data collection was conducted by six project officers, two males and four females, in order to ensure quality, gender-sensitive interviews. The project officers were trained by the M&E department for two days in May 2019 to better understand how to administer the survey using Magpi in the field. In June 2019, another two-day training was conducted by the project coordinator and the disability technical advisor on basic disability-related topics, ethical considerations, and survey mechanics.

[9] Humanity & Inclusion- July 2018-Lebanon Report- Disability Assessment among Syrian Refugees in Jordan and Lebanon-Removing barriers

Prior to beginning data collection, a pilot test of the survey was conducted in June 2019 with four participants to ensure that the questions were easy to understand, that the PwDs were comfortable answering the questions asked, and that there were no errors in the skip logic conditions included in the survey. Any findings from the pilot phase were addressed accordingly.

Data collection was conducted over a four-month period, beginning in June and ending in September 2019. The project officers were equipped with tablets to conduct the survey. While filling out the survey, the M&E department did monitoring visits with each project officer to ensure that they were following the guidelines on which they were trained. Any findings from these visits were addressed accordingly.

Most of the potential respondents were contacted by the project officers via telephone prior to going to the field. Some, however, were recruited from each of the regions following on the ground searches of the camps and municipalities for PwDs. Though not preferred, this method was most frequently utilized for Lebanese without disability cards and Syrians, as members of these two groups proved difficult to locate. The PwDs were provided with a full explanation regarding the objectives of the study and the rights of the participants. PwDs who refused to participate and those who were below the age of 18 and did not have a caregiver/family member present to provide consent were excluded from participating in the survey.

2.4. Statistical analysis

Following each day in the field, the collected data was uploaded and reviewed for any missing elements. Before analysis, the gathered data was cleaned and prepared. Descriptive statistics and bivariate analysis were used in order to describe the participant characteristics and to assess healthcare needs, access to healthcare, barriers confronted when accessing healthcare, and to compare the various groups considered by the study. The analysis was conducted using SPSS Statistics version 22 (Statistical Package for the Social Sciences). A 95% confidence interval and p.value ≤ 0.05 was used for statistical significance.

3. Qualitative method

3.1. Focus Group Discussions

In order to gain better insight into the healthcare needs, levels of health service access and utilization, and associated barriers faced by PwDs, focus group discussions were conducted. The group interaction inherent to FGDs allows for a deeper exploration of the experience of obtaining healthcare services in Lebanon for PwDs while simultaneously helping to validate findings from the questionnaire. Furthermore, the open-ended nature of FGDs allows for identification of barriers and challenges specific to this context.

3.1.1. Sample and recruitment

14 FGDs were conducted during the months of September and December 2019, with

each group composed of 7 to 11 participants plus an experienced facilitator and note-taker. An interpreter was also present when those with hearing impairments were present. Focus groups lasted between 30 to 110 minutes. Each FGD took place in an accessible space commonly used by the participants to help ensure comfort and logistical ease.

A total of 121 Lebanese and Syrian FGD participants were randomly selected from:

- The list of PwDs who have a disability card provided by MoSA.
- Those currently receiving services of any kind from OPDs/NGOs.
- The municipalities who provided us with the names of the PwDs in their areas.

Survey respondents and PwDs below the age of 18 were not eligible for participation in the focus groups.

3.1.2. Questions design

The FGD questions were developed by the research associate, with inputs from the inclusion team. The open-ended questions prepared for the discussion included themes from both the literature and the study questionnaire, around the participants' awareness of access to and experience with health services as well as perceptions regarding the attitudes and knowledge-base of health staff with whom they have engaged. The questions were primarily focused around the met and unmet health needs of the participants. (Annex 2) Focus group participants were encouraged to talk amongst themselves so that an interactive dialogue would unfold among them rather than between the facilitator and participants.

3.1.3. Data analysis

The FGDs were recorded, transcribed, and translated into English for the purpose of analysis. A thematic analysis approach was used to synthesize and analyze the data obtained from the FGDs. Codes were then generated based on the seven main sections (need, awareness, utilization, accessibility, affordability, barriers to health services and satisfaction). Moreover, successes, challenges and recommendations were also identified.

3.2. Key Informant Interviews

During November and December 2019, 8 face-to-face semi-structured interviews with disability stakeholders and key disability experts were conducted by an experienced facilitator and note-taker, using semi-structured interview guides including open-ended questions in order to better understand the system by which health services are provided to PwDs in Lebanon, as well as to elicit deeper insights into the accessibility and distribution of health resources, the awareness of service availability amongst relevant groups, opportunities for improvements in the health system, and existing barriers to health service utilization. Interviews lasted between 30 to 70 minutes. The participants of the KIIs are presented in Table 1 Below:

Table 1: Participants in the Key Informant Interviews

ORGANIZATION	POSITION
Ministry of Social Affairs	Right and Access Program Manager
Ministry of Social Affairs	Center Unit Manager
Ministry of Social Affairs	Head of SDCs
Ministry of Public Health	Head of Disability Department
Arc-En-Ciel	Head of Mobility and Accessibility Program Head of Health Program
Moussawat	Director
Médecins Sans Frontières	Field Coordinator
Médecins Du Monde	Primary Healthcare Program Manager

The interviews were recorded, transcribed, and open coded to categorize key themes and identify patterns. Each theme was analyzed to gain a deeper understanding of participants' perceptions and motivations.

4. Ethical considerations

Ethical considerations were present from the onset of research design to the administration of the questionnaire and focus group discussions. During the primary data collection, the project officers explained the survey's purpose, the collected data's intended use, and the personal data anonymization process. Furthermore, the project officers emphasized that participation in the survey was completely voluntary and that, should they choose to do so, participants could skip questions they did not wish to answer or stop entirely at any point. The POs also assured the respondents that their participation in the study would have no negative consequences for them or their families and that their privacy and confidentiality would be maintained.

Subsequently, verbal consent from all participants for the quantitative data collection and for the focus group discussion were taken. As well, the research associate took a written consent from the stakeholders for the key informant interviews. Some of the healthcare providers accepted to do the interview but without recording it, while others did the interview without signing the consent due to restrictions from their organizations.

M. W, 21 Jan. 2020

I'm Lebanese, fifty years old, living independently in the Bassatine village, my parents passed away and my brothers have moved to other regions in Lebanon. I didn't get any formal education, but I have been working in the Bassatine Municipality as a housekeeper for the last four years.

When I was one-year-old I had a fever which hit 41°C; according to my parents it was a typhoid infection. After that, I completely lost mobility in my left arm and foot. It took me 14 years to learn how to walk and that's when I started working in order to support my family.

I have a MoSA disability card and I know that I'm exempted from municipal and car taxes. That's what I know!

When it comes to health services, I needed an adenoidectomy and a CT scan and I was only able to receive them through the help of my relatives. For the time being, I need a psychotropic medication (clonazepam) in order to treat the nerve spasms that I get. However, I cannot afford this medication which costs me 150,000 LBP per month. I rely on the goodwill of the pharmacist who allows me to pay the bill in instalments. I tried to get the medication from MoPH PHCCs and MoSA centers in Baysour and Hadath, but they all told me the same thing, that they do not provide it and that I should buy it at my own expense. If I don't take the six pills that my doctor had prescribed to me every day, my left arm and leg start spasming uncontrollably.

Without the help of my relatives, I wouldn't be able to commute to PHCCs for medical consultations. When none of my relatives are available, I have to take a taxi on my own. The operations inside the PHCCs are particularly frustrating. First, you have to sit for hours in the waiting room. Besides that, the doctors often don't show up on their schedules. I also wait for hours at MoSA centers in order to renew my MoSA card and to complete the file requests for the services I'm entitled to such as municipal tax exemptions. The long waiting hours at PHCCs and at MoSA centers have started to pose a threat to my job. For someone who has a job and lives off his salary like myself, I can't keep on getting off work for hours every time I need to do paperwork at MoSA. At the end of the day, I don't want to lose my job because it's the only thing that's sustaining me.

Quantitative Findings

1. Demographic Characteristics

The data collection took place over a period of four months, between June and September 2019 in five regions of the country: Beirut, Mount Lebanon, North, South, and Bekaa. Although the sample size was initially set as 1038, a total of 1058 questionnaires on healthcare services for PwDs were completed by the project officers, of which 3 were excluded after data cleaning (age <17, from other nationality, no clear answer regarding holding a disability card or not), resulting in a total number of 1055 eligible questionnaires. As Figure 1 shows, the majority of the questionnaires were filled in the Bekaa including Baalbek-Hermel (53.3%), as a majority of the Syrian refugees live in this area. The rest of the questionnaires were filled in Beirut (5.2%), Mount Lebanon (13.4%), the North including Akkar (12.5%), and the South including Nabatiyeh (15.6%).

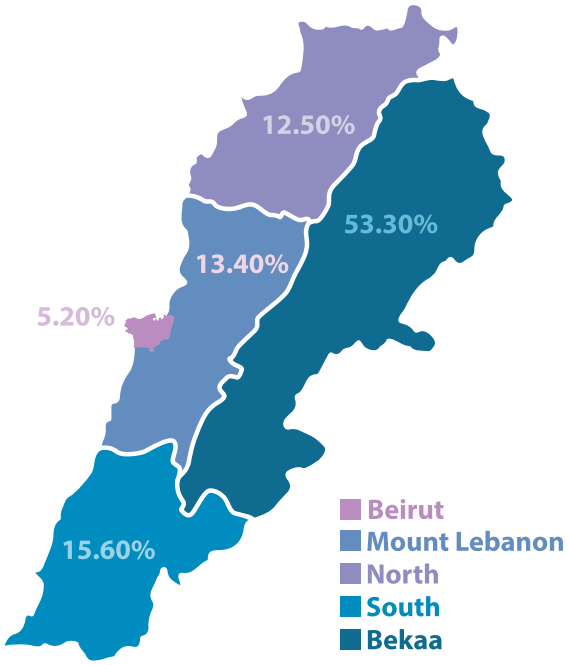


Figure 1: Distribution of PwDs by governorate

Respondents were given the option to fill in the survey directly or, if more comfortable, to utilize the assistance of a family member or other caregiver. No reason for choosing the later was required of the participant. As figure 2 shows, there were 328 participants (31%) for whom the questionnaire was filled by a caregiver. Intellectual (39%), physical (39%), speech (26.8%), and hearing (23.8%) were the groups most represented in this way, as shown in Figure 3.

Figure 2: Distribution of respondents

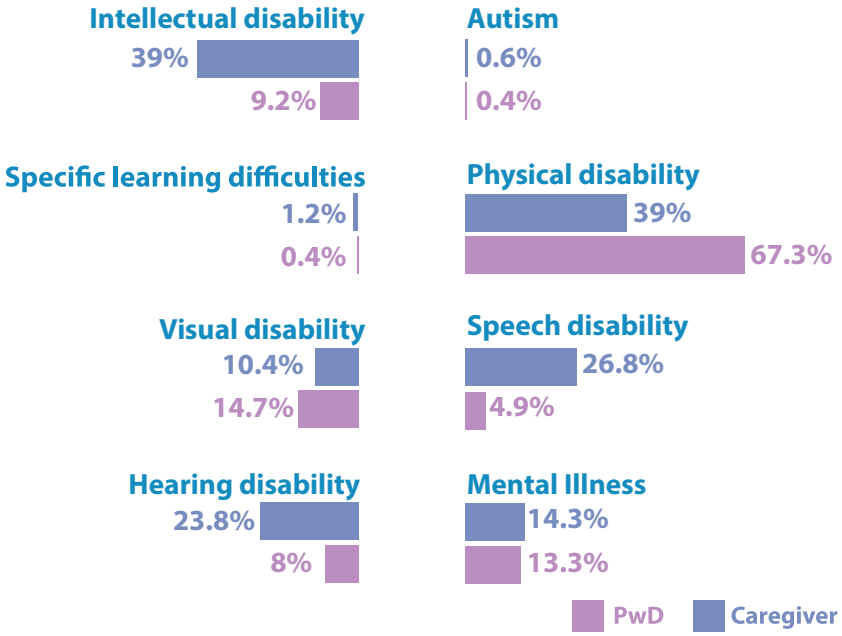


Figure 3: Distribution of respondents by disability type

The age of PwDs respondents ranged between 17 and 100 years, with a mean age of 45.63 and a standard deviation of 18.434 years (Table 2).

Table 2: Age distribution of PwDs

AGE	
N	1055
Mean	45.63
Std. Deviation	18.434
Minimum	17
Maximum	100

Of the PwDs who participated in the survey, 58.8% were male and 41.2% were female. Moreover, 68% of respondents were Lebanese, 32% were Syrians, of which 91% held refugee status following registration with UNHCR. Distribution of respondents by sex, nationality, and marital status are presented in Figure 4 below.

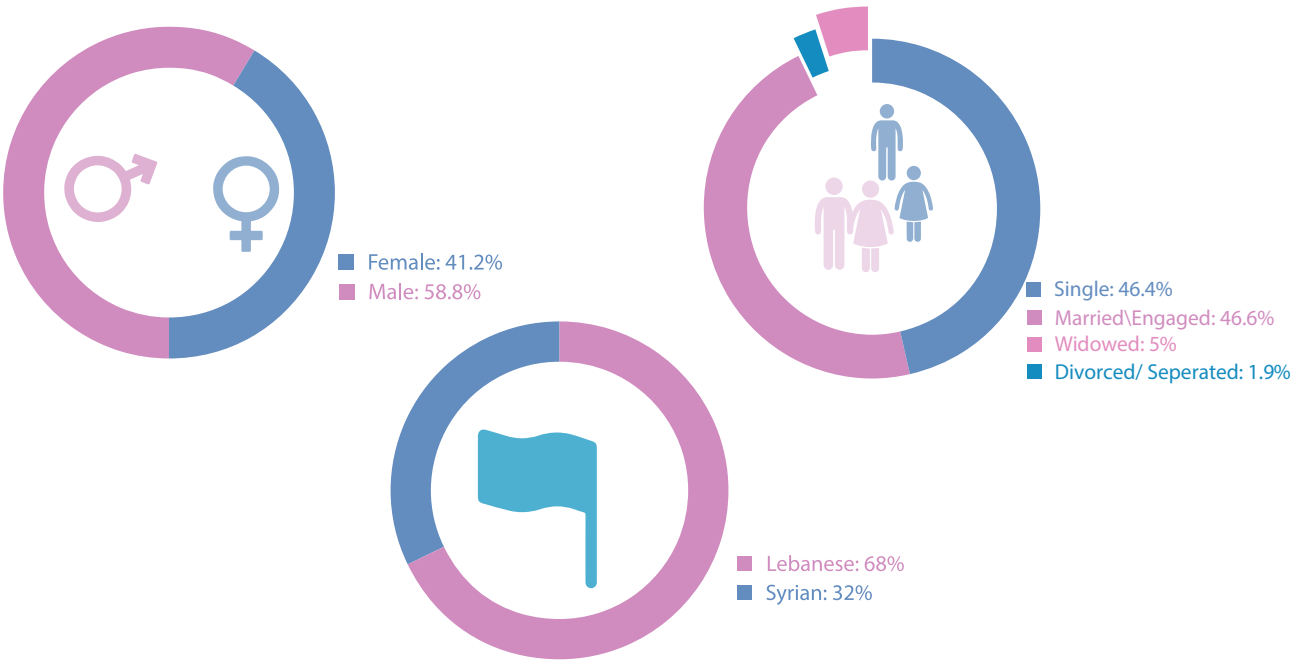


Figure 4: Percentage of Distribution of the Sample by Sex, Nationality & Marital Status (N= 1055)

As Figure 5 shows, a large number of respondents (35.2%) report not receiving any formal education at all (31.2% Lebanese,43.8% of Syrians). However, this study finds that approximately 10% have received some type of vocational training (primary categories: computer repair, electrical, hairdressing, sewing, telecommunication maintenance, English language). Only 1.4% mentioned that they were refused entry into a pre-school, primary school, secondary school, special school or university because of a lack of financial resources.

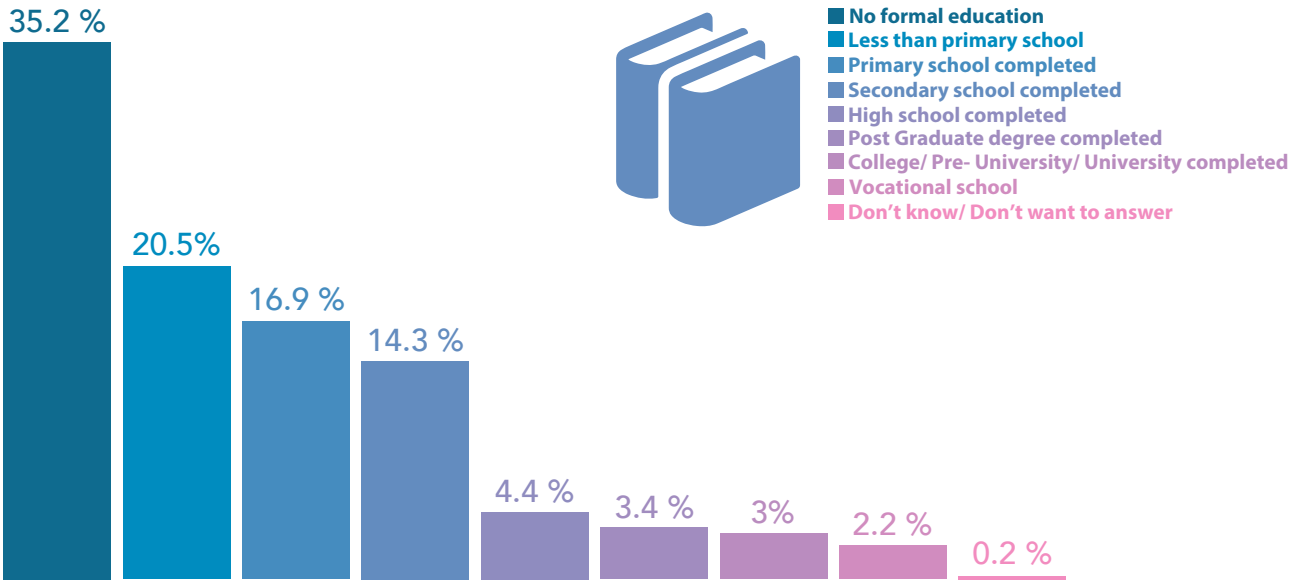


Figure 5: Percentage of PwDs education level

Most of the participants were Lebanese who had disability card (54.9%), while 31.6 % were Syrian refugees, and 13.5% were Lebanese without disability card. Despite significant effort, this last group was largely unreachable as there is no list or clear data to identify individuals in this population. Distribution of PwDs nationality and card holder status, by governorate, are presented in Figure 6 below.

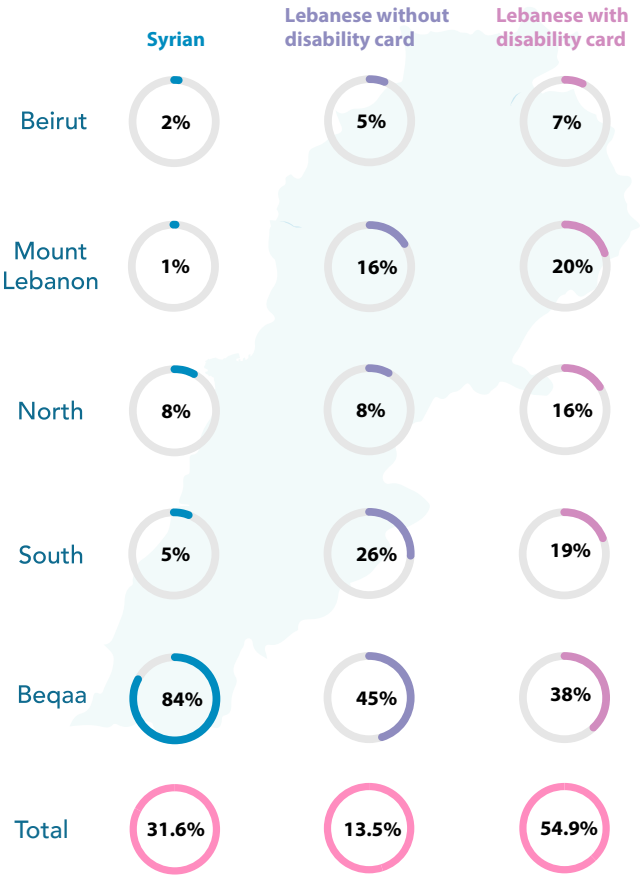


Figure 6: Distribution of PwD nationality and card holder by governorate

Importantly, Figure 7 shows that 82.4% of PwDs are continuing to live with their parents, 0.7% live in institutions partially while only 9% live independently. As illustrated in Table 3, 13.2% of PwDs with mental Illness live independently followed by 11.8% of PwDs with hearing disability. Increasing the number of PwDs who can live independently in their communities remains an important goal for Lebanon. The average household size was 4.09 (±2.834) people, with a maximum of 24 people in the same place (in reference to Syrian refugees who continue to share camp space with others).

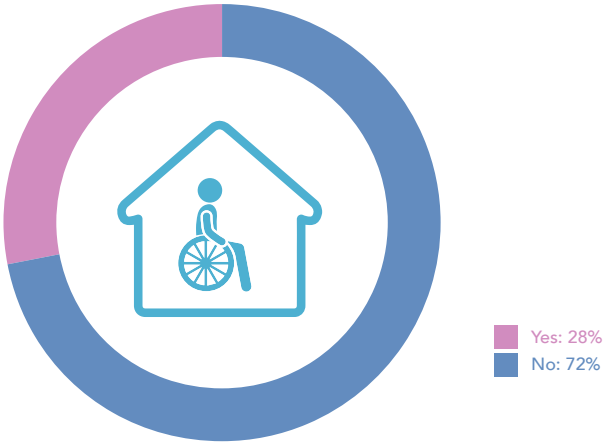


Figure 8: Percentage of PwDs living in the same household

The study found that 297 (28%) households include at least one other family member with disabilities (Figure 8). 57 of these include more than one additional PwDs in the household (max 4 persons) and 240 have only one other person with disability in the household. The primary disabilities of these co-habitants were reported as: physical (32%), intellectual (19.8%), and multiple disabilities (11%).

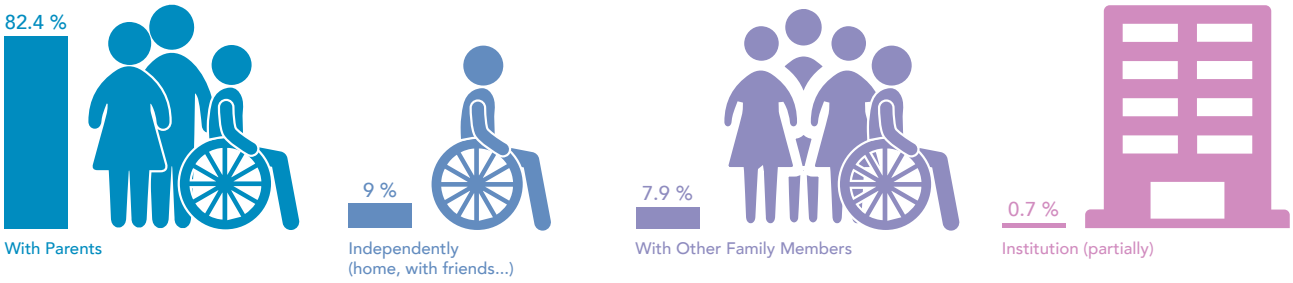


Figure 7: Current living situation of the PwD

Table 3: Current living situation by type of disability

	With Parents	With other family members	Independently (home, with other friends...)	Institution (Partially)
Physical disability	497 (80.6%)	56 (9.1%)	59 (9.6%)	5 (0.8%)
Intellectual disability	175 (89.7%)	12 (6.2%)	6 (3.1%)	2 (1%)
Mental Illness	113 (78.5%)	12 (8.3%)	19 (13.2%)	0 (0%)
Visual disability	120 (85.1%)	11 (7.8%)	9 (6.4%)	1 (0.7%)
Hearing disability	116 (85.3%)	4 (2.9%)	16 (11.8%)	0 (0%)
Speech disability	112 (90.3%)	3 (2.4%)	9 (7.3%)	0 (0%)
Specific Learning Difficulties	6 (85.7%)	1 (14.3%)	0 (0%)	0 (0%)
Autism	4 (80%)	1 (20%)	0 (0%)	0 (0%)

2. Disability and healthcare conditions

Among the surveyed Lebanese and Syrian populations, the majority of PwDs were physically disabled (58.4%). Significantly more Lebanese (21.5%) than Syrians (12%) had an intellectual disability, more Syrians (19.8%) than Lebanese (10.8%) had mental illness, more Syrians (18.6%) than Lebanese (10.9%) had visual impairment and more Syrians (18.3%) than Lebanese (10.4%) had hearing impairment. To note, 24.5% of PwDs surveyed have multiple disabilities (defined as a person who has two or more disabilities), which is why the percentages do not add up to 100%.

Regarding the primary cause of disability, the largest fraction (33%) attributed their disability to illness or disease: 33.7% of Lebanese and 31.5% of Syrians. Significantly more Lebanese than Syrians cited birth complications or congenital defects as the principle cause of their disability, and more Syrians than Lebanese reported injury or environmental factors as a cause for their disability. On this final point it is worth noting that the survey did not ask any specific questions on the nature of injury acquisition, meaning that, for the Syrian PwDs, we are unable to know if the injuries were directly related to the Syrian civil war. (Table 4)

Table 4: Disability type and causes distribution disaggregated by nationality

		Nationalities			
		Lebanese	Syrians	Total	ρ. Value
Type of Ddisability	Physical impairment	430 (59.5%)	187 (56.2%)	617 (58.4%)	ρ = 0.314
	Intellectual disability	155 (21.5%)	40 (12%)	195 (18.5%)	ρ < 0.0001
	Mental Illness	78 (10.8%)	66 (19.8%)	144 (13.6%)	ρ < 0.0001
	Visual impairment	79 (10.9%)	62 (18.6%)	141 (13.4%)	ρ = 0.001
	Hearing Impairment	75 (10.4%)	61 (18.3%)	136 (12.9%)	ρ < 0.0001
	Speech Impairment	90 (12.5%)	34 (10.2%)	124 (11.8%)	ρ = 0.290
	Specific Learning Difficulties	7 (0.9%)	0 (0%)	7 (0.7%)	ρ = 0.105
	Autism	5 (0.7%)	0 (0%)	5 (0.5%)	ρ = 0.333

		Nationalities			
		Lebanese	Syrians	Total	ρ. Value
Cause of the disability	Illness or disease	243 (33.7%)	105 (31.5%)	348 (33%)	ρ = 0.495
	From Birth (birth complications)	201 (27.8%)	69 (20.7%)	270 (25.6%)	ρ = 0.014
	Injury (war, accident…)	150(20.8%)	106(31.8%)	256 (24.3%)	ρ < 0.0001
	Congenital or genetic	77 (10.7%)	19 (5.7%)	96 (9.1%)	ρ = 0.009
	Environmental causes (violence, death or loss in the family)	25 (3.5%)	25(7.5%)	50 (4.7%)	ρ = 0.004
	Exposure to substances (drugs, toxins…)	8 (1.1%)	1(0.3%)	9 (0.9%)	ρ = 0.287
	Preterm Birth	4 (0.6%)	1 (0.3%)	5 (0.5%)	ρ = 1
	Prenatal exposure to substances	1 (0.1%)	1 (0.3%)	2 (0.2%)	ρ = 0.532
	Others (medical malpractice, ageing)	11 (1.5%)	1 (0.3%)	12 (1.1%)	ρ = 0.117
	Don't know/Refuse to answer	10 (1.4%)	6 (1.8%)	16 (1.5%)	ρ = 0.607

When the causes of acquired disability are disaggregated by age group, we find that illness or disease and injury (war, accident…) were most frequently acquired within the 18-59 age range (mean, 32.7 years; standard deviation, 22.474), consistent with the literature (Table 5). As figure 9 shows, 46% of PwDs reported being aware of other health problems in addition to their primary impairment, such as cardiovascular disease, high cholesterol, gastrointestinal disorders, spinal problems, kidney problems, or high/low blood pressure, with a further 20% coping with multiple health problems. Regarding other health problems, survey respondents were not asked to exclude illnesses/diseases that are closely related to the primary impairment (either upstream or downstream). As such, a person with an amputated foot following longstanding, poorly controlled diabetes mellitus with subsequent peripheral artery disease would have included both of the latter problems in their answer to this question.

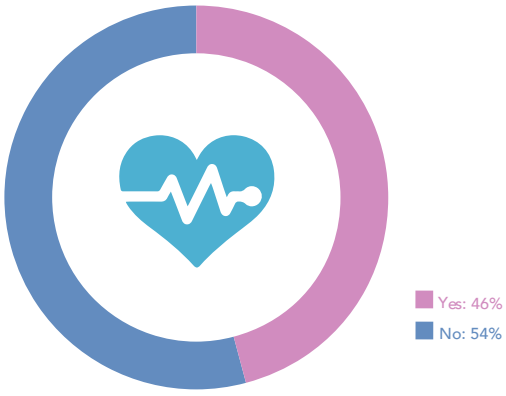


Figure 9: Percentage of PwDs reporting additional health problems

Table 5: Causes of disability by age (N=686)

		Age Groups			
		0-4	5-17	18-59	60+
Causes of acquired disability	Illness or disease	10.9%	5.8%	21.9%	12%
	Injury (war, accident…)	2.2%	6.5%	25.9%	2.6%
	Environmental causes (violence, death or loss in the family)	0.1%	0.8%	6%	0.2%
	Exposure to substances (drugs, toxins…)	0.3%	0.4%	0.6%	0%
	Others (medical malpractice, ageing)	0.4%	0.5%	0.6%	0.1%
	Don't know/Refuse to answer	0.4%	0.5%	1.1%	0.1%

In principle, under Law 220/2000, Lebanese holders of the disability card issued by the Ministry of Social Affairs "are entitled to a wide range of services such as healthcare services, including primary, secondary and rehabilitation services, educational services and tax exemptions to be covered in full by the relevant ministries".

Our study found, however, that out of the 579 PwDs who qualified for and received the MoSA disability card, only 54% had used it to access services of any kind within the past 12 months (Figure 10). Among the 314 PwDs who have used the card during this period, 64% used it for tax exemptions, followed by 47% who used the cared for health services, 4% for educational services, 3% for welfare support, and 1% for legal advice (Figure 11). To note, no one mentioned that he/she benefits from Counselling (e.g. psychologist, psychiatrist, social worker, school counsellor, etc.) or vocational training (e.g. employment skills training etc.). It is unclear if these services were largely unavailable over the last year or if there was a lack of awareness amongst PwDs, but other evidence indicates a substantial need does, in fact, exist.

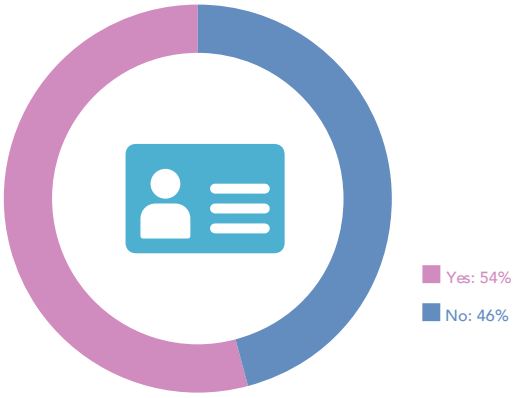


Figure 10: Percentage of PwDs using the disability card within the past 12 months (N=579)

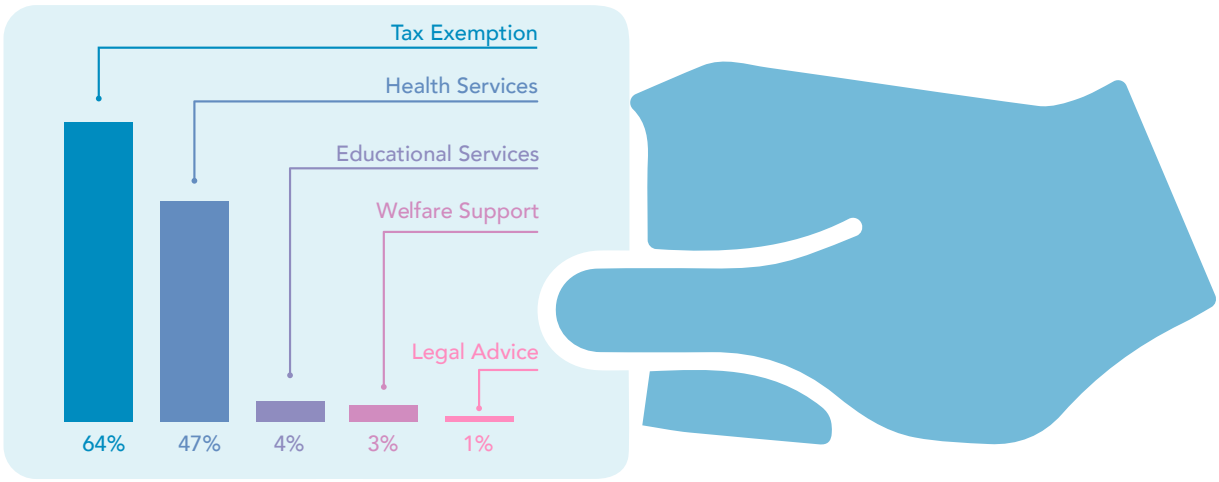


Figure 11: Percentage of accessed services by using MoSA disability card (N=314)

Only 13% (19 out of 143) of Lebanese respondents without a disability card had ever applied for the card. Amongst those who did apply but do not currently have a disability card (Figure 12), 42% were rejected outright while 32% continue to wait for approval. A further 123 Lebanese who do not possess the disability card reported that they had not applied to it as they had never heard of it (48%) or simply felt they would receive no benefit (40%).

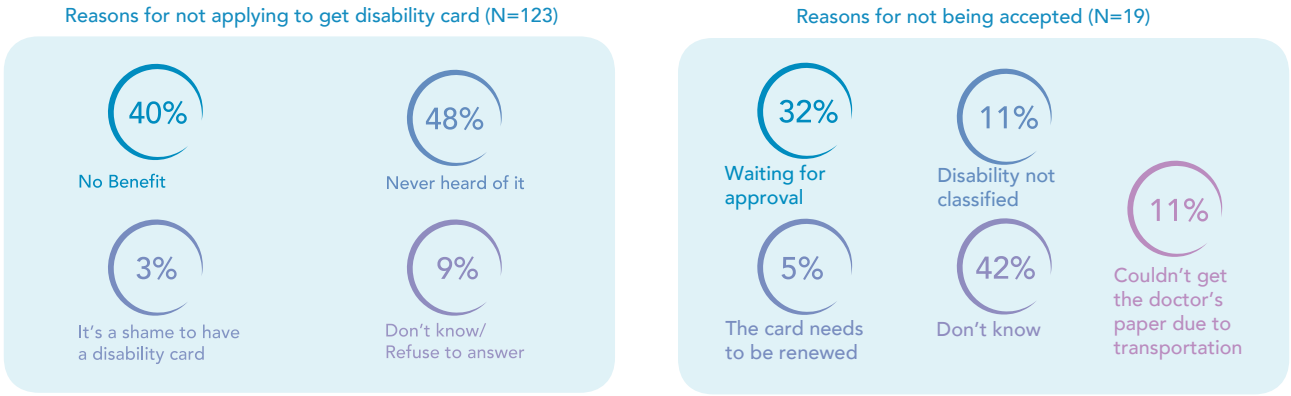


Figure 12: Reasons for not applying and not being accepted to get the card

3. Income and Employment/Livelihood

"The development of the questionnaire included in this section is based on a collaboration between the project and the International Labour Organization. A more comprehensive and in depth analysis of aspects associated with basic needs, employment, social protection and social support – for matters not directly relevant to the topic of this report - will be presented in a separate stand-alone report prepared by the ILO and FPS."

As noted above, not all of the health services used by PwDs in Lebanon are available through public mechanisms at the time and place they may be required. Accessing some of the most needed health services frequently necessitates that individuals pay out-of-pocket

and/or purchase private insurance. As such, issues related to livelihood and income were also specifically addressed by this survey so as to better understand the working situation, monthly income (including any assistance), and expenditures of Lebanese and Syrian PwDs.

Law 220 stipulates that both public and private sector businesses (with an employee count numbering above 60) must reserve 3% of available jobs for PwDs. The law also requires the National Institution for Employment (NIE), together with concerned ministries, to ensure that PwDs have suitable technical training and career guidance opportunities.

Findings from the survey showed that 79.6% of all respondents are currently unemployed (74.4% Lebanese, 91% Syrians) (Table 6). Amongst the critical 18-64-year-old age range, 71% of Lebanese PwDs are unemployed. However, Lebanese PwDs youth (18-29-year-old), the study found an unemployment rate of 83.9%. When disaggregated by gender and nationality (Table 6), we see that females and Syrians PwDs are the most vulnerable groups. Indeed, significantly more male PwDs (26.1%) are working compared to females (12.2%), while Lebanese PwDs appear to have a significant advantage over their Syrian counterparts (25.6% versus 9%, respectively).

When looking at the 20.4% of respondents who are currently employed, only 42% (91 out of 215) enjoy full-time employment, with another 29% (62 out of 215) reporting that they are self-employed (Table 6).

Table 6: Distribution of working situation by nationality and gender

Currently Unemployed			ρ Value
All Respondants		840 (79.6%)	
Nationalities	Lebanese (N=722)	537 (74.4%)	ρ < 0.0001
	Syrians (N=333)	303 (91%)	
Sex	Male (N=620)	458 (73.9%)	ρ < 0.0001
	Female (N=435)	382 (87.8%)	

Currently Working			ρ Value
Gender	Male (N=620)	162 (26.1%)	ρ < 0.0001
	Female (N=435)	53 (12.2%)	
Nationalities	Lebanese (N=722)	185 (25.6%)	ρ < 0.0001
	Syrians (N=333)	30 (9%)	
Current working situation (N=215)	Full time paid employment	91 (42%)	
	Part time paid employment	36 (17%)	
	Self-employed/running a business	62 (29%)	
	Casual worker	20 (9%)	
	Non-paid work, such as volunteer/charity/student	6 (3%)	

Nevertheless, as Figure 13 shows, amongst those currently unemployed, 74% (619 out of 840) stated that they were not working as a consequence of their impairment. There was no differentiation between those unable to work due to a worsening impairment (or related medical concern) and those unable to find a job with an employer willing to make reasonable accommodations to facilitate their employment. Within this group, however, more than half (57.5%) had a physical disability and 23.6% had an intellectual disability (Table 7). A further 22% mentioned other for a lack of current employment, including: 15.3% have never worked (unable or no desire), 3.7% are elderly, and, for a few (1.3%), that they are female. 20% of survey respondents reported that they are actively searching for employment opportunities due to the need for additional income.

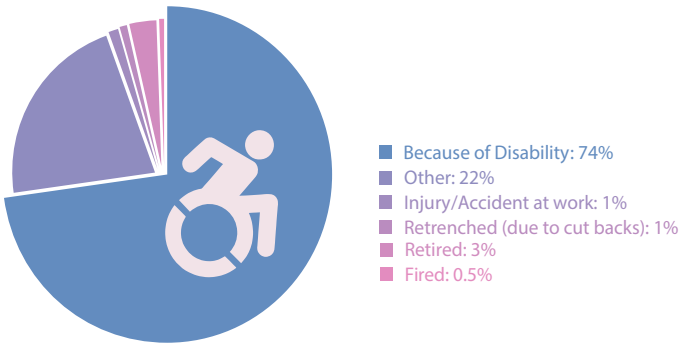


Figure 13: Reasons for not being working

Table 7: Reasons of PwDs for not being working disaggregated by type of disability

Disabilities	Currently working	Reasons for not being working					
		Retired	Retrenched	Fired	Injury/ accident at work	Because of disability	Other
Intellectual	13 (6%)	3 (13%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	146 (23.6%)	33 (18.2%)
Specific Learning Disabilities	2 (1%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	5 (0.8%)	0 (0.0%)
Visual	26 (12%)	5 (21.7%)	1 (11.1%)	0 (0.0%)	1 (16.6%)	84 (13.6%)	24 (13.2%)
Hearing	34 (15.8%)	2 (8.7%)	1 (11.1%)	0 (0.0%)	3 (50%)	72 (11.6%)	24 (13.2%)
Autism	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	5 (0.8%)	0 (0.0%)
Physical	129 (60%)	16 (69.5%)	7 (77.7%)	0 (0.0%)	3 (50%)	356 (57.5%)	106 (58.5%)
Speech	25 (11.6%)	3 (13%)	0 (0.0%)	0 (0.0%)	2 (33.3%)	85 (13.7%)	9 (5%)
Mental Illness	27 (12.5%)	1 (4.3%)	0 (0.0%)	2 (100%)	0 (0.0%)	85 (13.7%)	29 (16%)

When asked about the primary source of income for the household, 21.6% of survey respondents reported a reliance on aid/assistance, followed by a relative or non-family member (19.1%), father (17.3%), themselves (17.2%), and child (13.2%) (Figure 14).

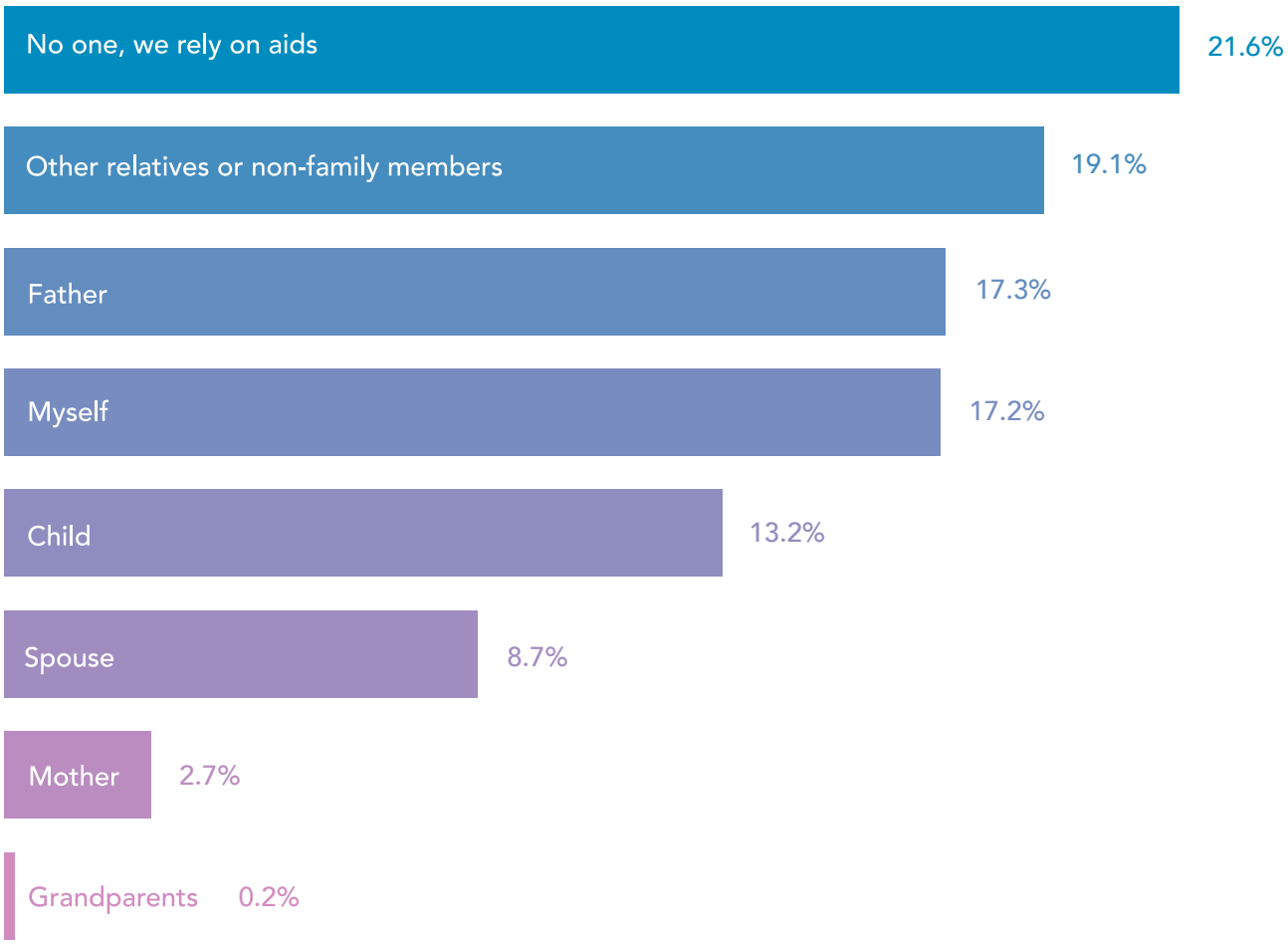


Figure 14: Main income earner

Among Lebanese and Syrians respondents, 62.7% (236 out of 376) and 87.5% (63 out of 72), respectively, had a personal monthly income less than 500,000 LBP, while 26.3% and 12.5%, respectively, had a personal monthly income of 500,000-1,000,000 LBP. On the other hand, 56.4% of PwDs (42.7% Lebanese, 86.2% Syrians) had less than 500,000LBP as a household monthly income, while 28.2% (35% Lebanese, 13.5 % Syrians) had a household monthly income of 500,000 – 1,000,000 LBP (Table 8).

Table 8: Percentage of average of the monthly household income

Average of the monthly household income	Overall	PwDs who are currently working (N=215)	PwDs who are not currently working (N=840)	Lebanese	Syrians
Less than 500 000 LBP	595 (56.4%)	79 (36.7%)	516 (61.4%)	308 (42.7%)	287 (86.2%)
500 000 - 1 000 000 LBP	298 (28.2%)	72 (33.5%)	226 (26.9%)	253 (35%)	45 (13.5%)
1 000 000 - 2 000 000 LBP	107 (10.1%)	40 (18.6%)	67 (8.0%)	107 (14.8%)	0 (0.0%)
2 000 000 – 3 000 000 LBP	43 (4.1%)	20 (9.3%)	23 (2.7%)	42 (5.8%)	1 (0.3%)
More than 3 000 000	12 (1.1%)	4 (1.9%)	8 (1.0%)	12 (1.7%)	0 (0.0%)

As Figure 15 shows, 63.9% of PwDs mentioned they have monthly health-related expenses. When asked about the type of health services needed, 97.6% of respondents reported medications as a primary, ongoing expense followed by medical consultations (33.5%). (Figure 16)

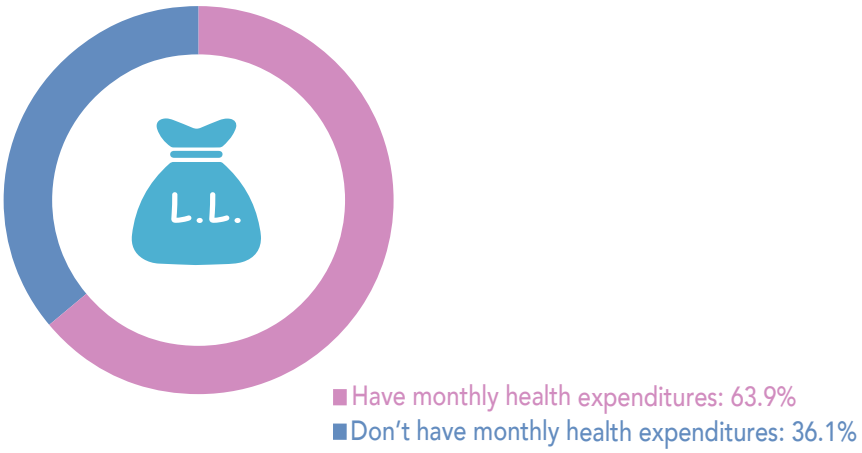
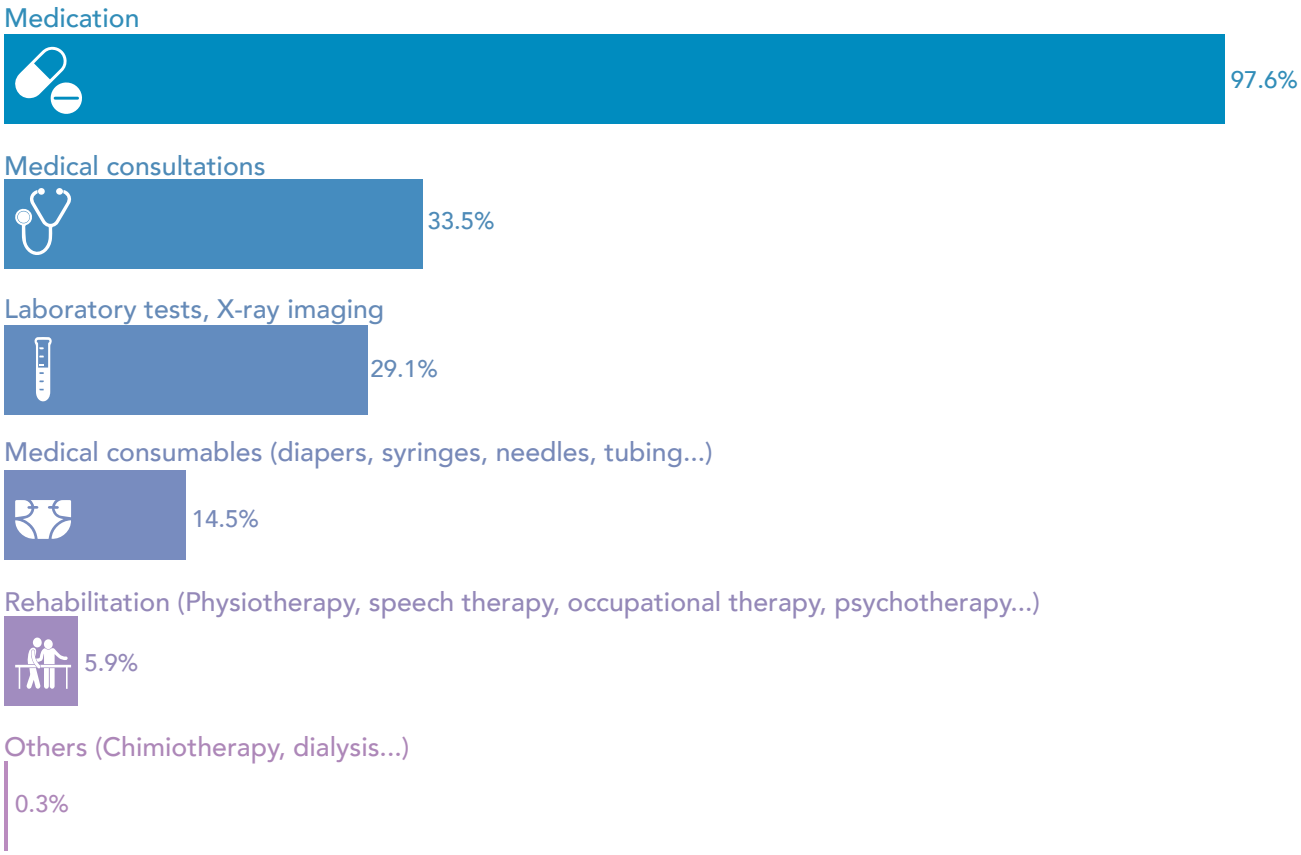


Figure 15: Monthly health expenditures



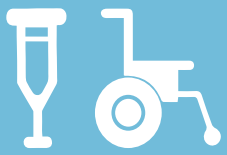
* Note that multiple responses were possible.

Figure 16: Type of health-related expenditure (monthly basis)

All basic needs were measured using a five-point Likert scale in order to better understand the ease or difficulty of meeting specific financial obligations. As the survey results show, a high number of PwDs (42.7% Lebanese, 86.2% Syrians) have a very low monthly income (<500 000 LBP). As such, a high percentage of respondents of both nationalities encounter ongoing difficulties meeting basic needs such as rent/accommodation (46.4%), clothing (65.2%), household necessities (73%), transportation (65.7%), water and food (55.8%), education (19.3%), health services (76.2%), telephone and communications (64.9%), assistive devices (33.8%), and personal assistant care/care (30.3%). The results also show that significantly more Syrians compared to Lebanese have difficulties meeting all their basic needs (97% Syrians, 67.6% Lebanese). Further details about respondent's basic needs are found in Table 9.

Table 9: Basic Needs

			Overall	Lebanese	Syrians	ρ value
Basic Needs	Rent/accommodation 	Easy	36.7%	52.3%	2.7%	ρ <0.0001
		Neither easy nor difficult	16.9%	22.4%	4.8%	
		Difficult	46.4%	25.3%	92.5%	
	Clothing 	Easy	21.4%	30.3%	2.1%	ρ <0.0001
		Neither easy nor difficult	13.4%	17.8%	3.9%	
		Difficult	65.2%	51.9%	94%	
	Household necessities (i.e. water bills, electric bills, other bills etc.) 	Easy	15.7%	22.2%	1.8%	ρ <0.0001
		Neither easy nor difficult	11.2%	14.4%	4.2%	
		Difficult	73%	63.4%	94%	
	Transportation 	Easy	20%	28.3%	2.4%	ρ <0.0001
		Neither easy nor difficult	9.4%	12.3%	2.7%	
		Difficult	65.7%	54.4%	90.1%	
		N/A	4.9%	5%	4.8%	
	Water and food 	Easy	31.1%	41.3%	9%	ρ <0.0001
		Neither easy nor difficult	13.1%	16.9%	4.8%	
		Difficult	55.8%	41.8%	86.2%	
	Education 	Easy	6.5%	8.2%	3%	p <0.0001
		Neither easy nor difficult	14%	16.6%	8.4%	
		Difficult	19.3%	13.7%	31.5%	
		N/A	60.1%	61.5%	57.1%	

			Overall	Lebanese	Syrians	ρ value
Basic Needs	Health services 	Easy	14.7%	20.1%	3%	ρ <0.0001
		Neither easy nor difficult	9.1%	11.9%	3%	
		Difficult	76.2%	68%	94%	
	Telephone and communication 	Easy	21.6%	30%	3.6%	ρ <0.0001
		Neither easy nor difficult	13.5%	18.1%	3.3%	
		Difficult	64.9%	51.9%	93.1%	
	Assistive devices 	Easy	8.8%	12.2%	1.4%	ρ <0.0001
		Neither easy nor difficult	11%	13.4%	5.7%	
		Difficult	33.8%	28.4%	45.5%	
		N/A	46.4%	46%	47.4%	
	Personal assistant care/ care (care for self) 	Easy	14.5%	17.7%	7.6%	ρ <0.0001
		Neither easy nor difficult	6.5%	7.9%	3.6%	
		Difficult	30.3%	25.6%	40.2%	
		N/A	48.7%	48.8%	48.6%	
	Other (personal needs) 	Easy	0%	0%	0%	ρ = 1
		Neither easy nor difficult	0%	0%	0%	
		Difficult	0.3%	0.4%	0%	
		N/A	99.7%	99.6%	100%	
	Overall needs 	Easy	14%	20.2%	0.6%	ρ <0.0001
		Neither easy nor difficult	9.1%	12.2%	2.4%	
		Difficult	76.9%	67.6%	97%	

Over half of PwDs (55.1%) mentioned that welfare support (including in Kind or food support, income support, etc.) was the service most needed over the preceding 12 months, followed by 16.6 % of PwDs who mentioned the need for the counselling (including psychologist, psychiatrist, social worker, school counsellor etc.). Amongst who need the counselling service, 57.1% received it. A significant percentage (41 %) reported receiving this service from MoSA.

4. Awareness of the healthcare services

Having access to health services begins with an awareness of the services that are available in relevant locations. When asked about their awareness of available healthcare services, 68.7% (70.8% Lebanese, 64.3% Syrians) reported they are aware of specific, publicly accessible centers providing such services. This awareness, however, does not appear to be due to a standard source. As figure 17 shows, 74.5% of survey respondents are unaware of a specific, verifiable source for such health information. Of those who are, however, 93% (249 out of 267) found the material easily accessible, with 91 % (244 out of 267) indicating they felt the materials to be useful.

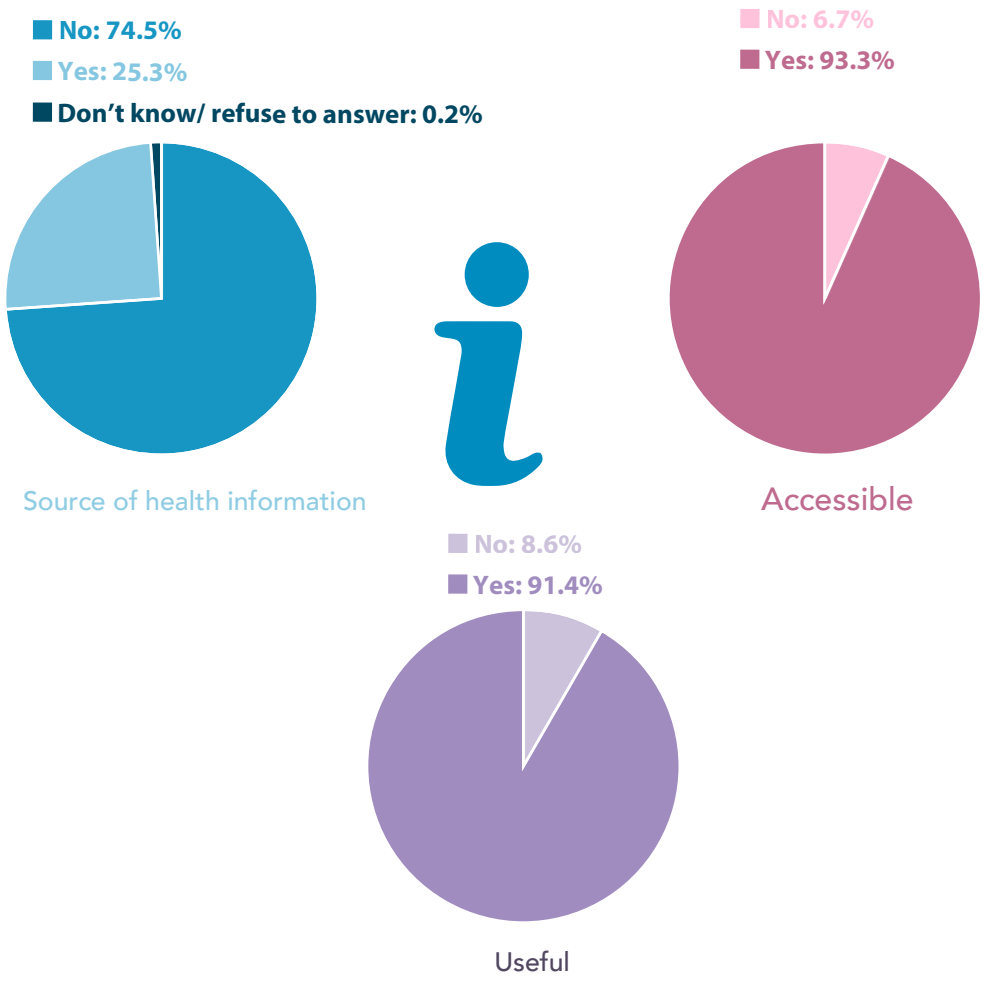


Figure 17: Satisfaction of PwDs about the available health information sources

5. Healthcare need and utilization

The present section explores the need for and utilization of general and impairment-specific healthcare services. As expected, a large percentage of PwDs respondents (82.4%) reported having a need for healthcare services (Figure 18). As seen in Figure 19, the top self-reported healthcare needs by both Syrian refugees and Lebanese PwDs were medications (73.6%) and diagnostic tests (56.9%), with consultations (specialized and general) coming in 3rd and 4th respectively. Those with a physical disability and speech disability reported the general medical consultations as the most needed service with 95% and 53.2 % respectively. While the medications were the top one health service needed by PwDs with Intellectual disability (73.3%), Mental Illness (81.9%), visual disability (68.8%), hearing disability (64.7%) and autism (80%). (Table 10)

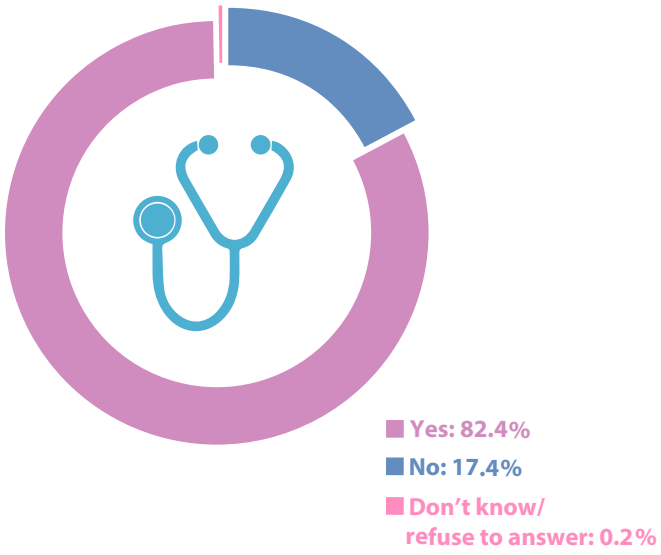
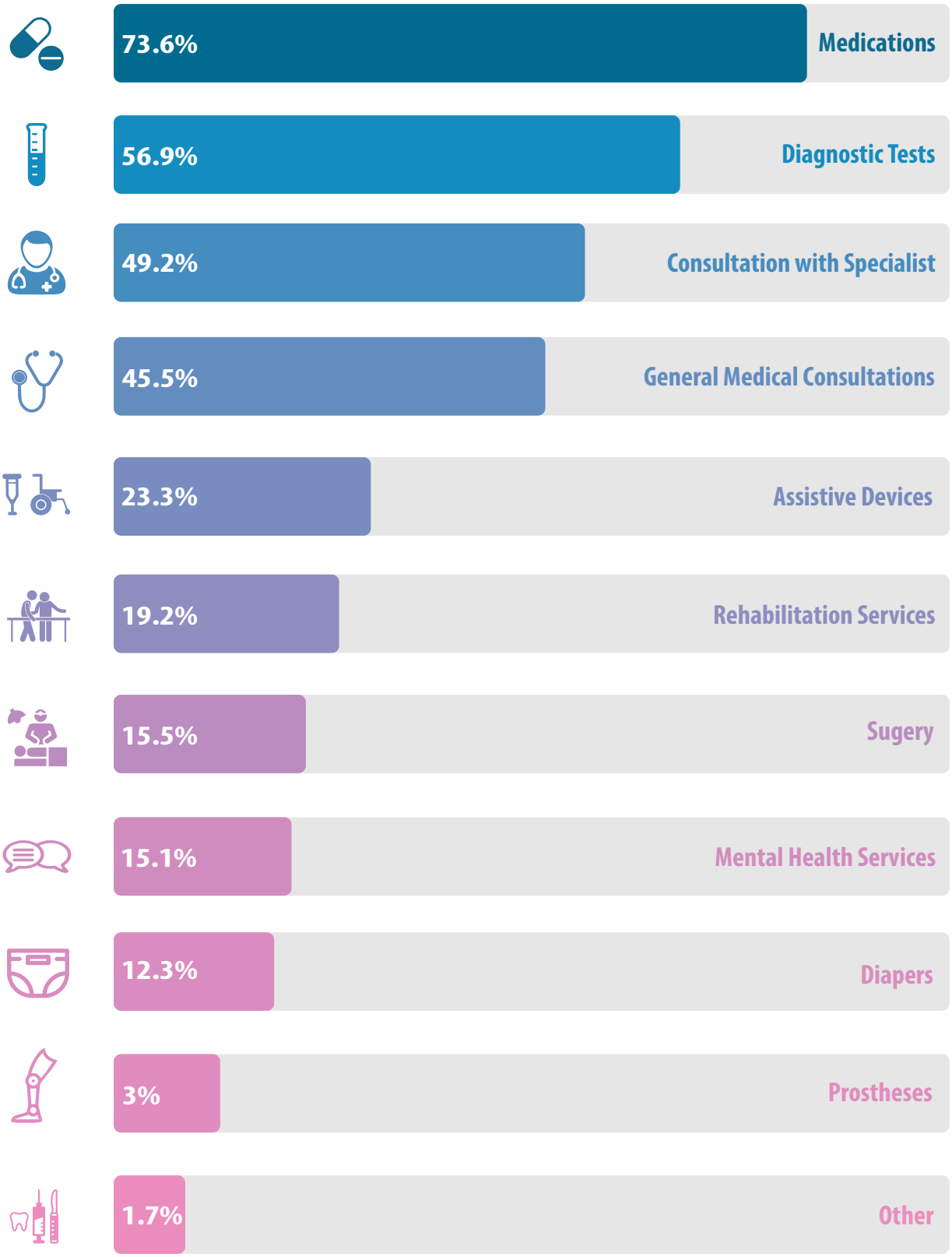


Figure 18: Percentage of PwDs need healthcare services



* To note that multiple response is possible

Figure 19: Services reported as needed by PwDs

Table 10: Health service needs by type of disability

Healthcare Services needed	Physical disability	Intellectual disability	Mental Illness	Visual disability	Hearing disability	Speech disability	Specific Learning Difficulties	Autism
General medical consultations	586 (95%)	83 (42.6%)	69 (47.9%)	54 (38.3%)	66 (48.5%)	66 (53.2%)	2 (28.6%)	3 (60%)
Consultation with specialist doctor	306 (49.6%)	80 (41%)	76 (52.8%)	73 (51.8%)	61 (44.9%)	53 (42.7%)	2 (28.6%)	4 (80%)
Diagnostic tests	369 (59.8%)	107 (54.9%)	84 (58.3%)	73 (51.8%)	71 (52.2%)	65 (52.4%)	3 (42.9%)	2 (40%)
Mental Health services	38 (6.2%)	39 (20%)	98 (68.1%)	10 (7.1%)	10 (7.4%)	11 (8.9%)	2 (28.6%)	1 (20%)
Rehabilitation services	138 (22.4%)	24 (12.3%)	47 (32.6%)	17 (12.1%)	9 (6.6%)	14 (11.3%)	1 (14.3%)	1 (20%)
Medications	452 (73.3%)	143 (73.3%)	118 (81.9%)	97 (68.8%)	88 (64.7%)	88 (71%)	2 (28.6%)	4 (80%)
Assistive devices	184 (29.8%)	16 (8.2%)	13 (9%)	23 (16.3%)	49 (36%)	34 (27.4%)	1 (14.3%)	0 (0.0%)
Prostheses	32 (5.2%)	0 (0.0%)	0 (0.0%)	4 (2.8%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)
Diapers	95 (15.4%)	45 (23.1%)	8 (5.6%)	12 (8.5%)	10 (7.4%)	24 (19.4%)	1 (14.3%)	2 (40%)
Surgery	106 (17.2%)	9 (4.6%)	17 (11.8%)	30 (21.3%)	18 (13.2%)	13 (10.5%)	0 (0.0%)	1 (20%)
Other (dentist, medical consumables)	10 (1.6%)	5 (2.6%)	1 (0.7%)	1 (0.7%)	3 (2.2%)	1 (0.8%)	0 (0.0%)	0 (0.0%)

Respondents were asked about the number of occasions they required specific health services over the preceding 12 months. As noted in Table 11, occasions on which rehabilitation services were needed placed those services at the top, with an average of 26.79 times (standard deviation of 35.282). Rehabilitation services typically include physiotherapy, occupational therapy, speech therapy and are most commonly provided by occupational therapists, physical therapists, and others across multiple sessions over an extended period of time. As such, it was expected that, among those survey respondents for whom the services may be beneficial, the number of occasions needed would be relatively high. Following rehabilitation services, diapers were most frequently needed (mean 12.27, standard deviation 8.194).

Table 11: Mean of occasions each healthcare service was required over the previous 12 months

Healthcare Services needed	Mean (±SD)	Number of respondents needing each service
General medical consultations	4.40 (±6.123)	480 (45.5%)
Consultation with specialist doctor	5.57 (±9.492)	519 (49.2%)
Diagnostic tests	4.07 (±7.917)	600 (56.9%)
Mental Health services	4.82 (±3.960)	159 (15.1%)
Rehabilitation services	26.79 (±35.282)	203 (19.2%)
Medications	10.52 (±4.904)	776 (73.6%)
Assistive devices	1.66 (±1.638)	246 (23.3%)
Prostheses	1.25 (±0.568)	32 (3%)
Diapers	12.27 (±8.194)	130 (12.3%)
Surgery	1.41 (±0.726)	163 (15.5%)
Other (dentist, medical consumables)	4.83 (±4.342)	18 (1.7%)

Respondents who reported needing specific health services were also asked whether they actually received the service and, if so, from where they received it. Utilization of healthcare services was measured using a range of outcomes across two main groups: users of primary health care centers and users of private sector health providers. Notably, most of those who reported needing service(s) mentioned receiving these services from a private sector health provider. For example, although 97% of those who reported needing medications did actually receive them, only 16% of these respondents did so from a PHCCs, while 99% acquired the medications through a private sector health provider. It should be noted that this question allowed multiple entries and so, as in the case above, it is quite likely that even those respondents who received one or more medications from a public health facility also attended a private provider for other medications. The top two services provided by the primary healthcare centers were diapers (51%) and assistive devices (51%).

As Table 12 also shows, not all those who reported needing a specific service received it. For example, 51% reported not receiving assistive devices, while 46% reported not receiving necessary rehabilitation services (in both cases, those who did receive the service were fairly equally split between PHCCs and private sector providers). When asked about the reasons for not receiving the needed services, an average of 78% stated that the services available to them were too expensive and 28% reported not being knowledgeable about locations (public or private) where they could obtain them.

Table 12: Percentage of PwDs reporting a specific service as required and whether or not they received it

	Not received	Received	From PHCC	From Private Sector Health Provider
General medical consultations	15%	85%	17%	91%
Consultation with specialist doctor	15%	85%	20%	93%
Diagnostic tests	19%	81%	23%	86%
Mental Health services	22%	78%	36%	73%
Rehabilitation services	46%	54%	45%	61%
Medications	3%	97%	16%	99%
Assistive devices	51%	49%	51%	53%
Prostheses	78%	22%	14%	86%
Diapers	9%	91%	51%	75%
Surgery	28%	72%	1%	103%
Other (dentist, medical consumables)	22%	78%	7%	100%

*To note that multiple response is possible; each respondent can receive one service from PHCC and Private sector at the same time which is why the percentages will not add up to 100%

When comparing the three groups (Lebanese with DC, Lebanese without DC, and Syrians), the analysis found that a significantly higher percentage of Syrians received services, such as specialist consultations (24.8%), diagnostic tests (28.8%), rehabilitation services (34.4%), and medications (24.8%), from PHCCs. This most likely reflects the efforts made by UNHCR and others to ensure awareness amongst Syrian refugees on the availability and location of free/low-cost services needed by PwDs as well as the extremely limited presence of other options. On the other hand, significantly more Lebanese with a disability card received assistive devices (34.8%) and diapers (68.3%) from PHCCs, compared to those Lebanese without the disability card or Syrians. As several of the key informants pointed out, in Lebanon, the MoSA is responsible for distributing assistive devices and incontinence services, such as diapers, but availing oneself of these services requires registration in the disability card system, which is only possible for Lebanese citizens.

Table 13: Distribution of services received from the PHCCs disaggregated by nationality and card holder

% of PwDs who received these services from PHCCs	Lebanese without disability card	Lebanese with disability card	Syrians	Total	ρ Value
General medical consultations	4 (5.5%)	35 (12.6%)	32 (12.6%)	71(14.8%)	ρ <0.0001
Consultation with specialist	11 (12.1%)	36 (12.7%)	36 (24.8%)	83 (16.0%)	ρ <0.0001
Diagnostic tests	22 (21.2%)	42 (12.5%)	46(28.8%)	110 (18.3%)	ρ <0.0001
Mental health services	14 (28.6%)	11 (19.6%)	20 (37%)	45 (28.3%)	ρ = 0.383
Rehabilitation services	14 (31.8%)	14 (14.3%)	21 (34.4%)	49 (24.1%)	ρ = 0.034
Medications	22 (17.3%)	49 (11.3%)	53 (24.8%)	124 (16.0%)	ρ <0.0001
Assistive devices	3 (8.8%)	47 (34.8%)	12 (15.6%)	62 (25.2%)	ρ <0.0001
Prostheses	0 (0.0%)	1 (4.2%)	0 (0.0%)	1 (3.1%)	ρ =0.693
Surgery	1 (5.9%)	56 (68.3%)	3 (9.7%)	60 (46.2%)	ρ <0.0001
Assistive devices	0 (0.0%)	1 (1.1%)	0 (0.0%)	1 (0.6%)	ρ <0.0001
Other	0 (0.0%)	1 (7.7%)	0 (0.0%)	1 (5.6%)	ρ =0.115

6. Perceived barriers to accessing healthcare services

As per WHO[10], people living with disabilities routinely encounter barriers when seeking healthcare services. The survey addressed many types of barriers to better identify those which most commonly impact access to mainstream healthcare services by PwDs. This study reveals that 68.8% of respondents (significantly more Syrians (81.1%) than Lebanese (63.2%)), are confronted with a variety of barriers when attempting to access healthcare services, frequently facing multiple barriers at a time.

Barriers can take many forms and may relate to the physical environment, to the information and communications technology, to the legislation or policy, or to the societal attitude.[1] As such, the barriers were grouped into the 6 following categories:

1. Geographic access
2. Physical barriers
3. Financial challenges
4. Lack of information
5. Attitudinal barriers
6. Medical service barriers

As illustrated in Table 14 below, the two principle barriers faced by PwDs respondents were financial and geographic. 67% found that specialized services such as imaging and laboratory tests were too expensive (79.6% Syrians, 60.1% Lebanese), while 57% found difficulty in paying the fees required by some centers (66.3% Syrians, 51.5% Lebanese). 25 % found that needed services are too far away and in places which are difficult to access (23.7% Syrians, 26.3% Lebanese). Among Syrians respondents, the top barrier to accessing healthcare were the financial challenges. This result was significantly higher than with the Lebanese respondents. Significantly, more Syrians PwDs (22.6%), compared to Lebanese (18.8%), reported the absence of information as a barrier to accessing needed healthcare, and more Syrians (19.6%) than Lebanese (12.1%) reported a that a lack of accessible, affordable transportation presents a significant barrier to accessing services (Table 15). The least reported barriers to accessing healthcare, regardless of nationality, included attitudinal barriers, specifically related to knowledge of the staff on how to interact with PwDs (3% among all respondents), ease of communicating with the health service providers (4% among all respondents), the use of incorrect, negative terminology by PHCC employees or medical staff when speaking about disability (2% among all respondents), and presence of discrimination and marginalization by employees or medical staff; significantly more Syrians (6.6 %) than Lebanese (2.4%) reported this barrier however.

Table 14: Types of barriers faced to access health services

Geographic Access		
Services are far away and in places which are difficult to reach 184 (25%)	Transportation is not available 108 (15%)	Transportation is not accessible 111 (15%)

[10] WHO (2012) Working to remove barriers to health care for people with disabilities. Retrieved on January 9, 2020, from https://www.who.int/westernpacific/news/detail/10-12-2012-working-to-remove-barriers-to-health-care-for-people-with-disabilities

Physical barriers

Health centers are not physically accessible	Moving difficulties inside the health centers and the inability to use all their divisions because they are inaccessible	Lack of availability of adapted medical equipment that can serve your individual needs related to disability (equipment used in medical examinations or medical treatment and therapies
56 (8%)	36 (5%)	26 (4%)

Medical service barriers

Limited specialized services for persons with disabilities	Difficulty in obtaining appointments	Lack of availability of adaptive copies of forms that must be filled and other documents (such as tests results and medical reports), that meet your individual needs related to disability
68 (9%)	13 (2%)	10 (1%)
Lack of adequate medical care	Lack of medication	Long waiting period to obtain an appointment
135 (19%)	144 (20%)	40 (6%)

Financial challenges

Difficulty in paying fees required by some centers	Specialized services such as imaging and laboratory tests are expensive
414 (57%)	489 (67%)

Lack of information

Absence of information 147 (20%)	Lack of information availability 86 (12%)
Lack of accessibility to available information 71 (10%)	Lack of availability of information adaptive to the needs related to disability 41 (6%)

Attitudinal barriers

Lack of knowledge among employees regarding how to deal with persons with disabilities 25 (3%)	Difficulty in communicating with the health service provider or other staff members 28 (4%)
The use of wrong and negative terminology by the employees or medical staff when talking to you or when speaking about disability 18 (2%)	Your being subject to discrimination and marginalization by employees and medical staff 29 (4%)

Others

27
(4%)

*Multiple response is possible

Table 15: Types of barriers disaggregated by nationality

			Nationalities		
			Lebanese (N=456)	Syrians (N=270)	ρ Value
Barriers	Geographic Access	Services are far away and in places which are difficult to reach	120 (26.3%)	64 (23.7%)	ρ =0.301
		Transportation is not available	55 (12.1%)	53 (19.6%)	ρ <0.0001
		Transportation is not accessible	68 (14.9%)	43 (15.9%)	ρ =0.086
	Physical Barriers	Health centers are not physically accessible	38 (8.3%)	18 (6.6%)	ρ =0.924
		Moving difficulties inside the health centers and the inability to use all their divisions because they are inaccessible	27 (5.9%)	9 (3.3%)	ρ =0.389
		Lack of availability of adapted medical equipment that can serve your individual needs related to disability (equipment used in medical examinations or medical treatment and therapies	17 (3.7%)	9 (3.3%)	ρ =0.735
	Medical Services	Limited specialized services for persons with disabilities	51 (11.2%)	17 (6.3%)	ρ =0.229
		Difficulty in obtaining appointments	11 (2.4%)	2 (0.7%)	ρ =0.207
		Lack of availability of adaptive copies of forms that must be filled and other documents (such as tests results and medical reports), that meet your individual needs related to disability	5 (1.1%)	5 (1.8%)	ρ =0.208
		Lack of adequate medical care	97 (21.3%)	38 (14.1%)	ρ =0.36
		Lack of medication	94 (20.6%)	50 (18.5%)	ρ =0.38
		Long waiting period to obtain an appointment	30 (6.6%)	10 (3.7%)	ρ =0.362

			Nationalities		
			Lebanese	Syrian	ρ Value
Barriers	Financial Services	Difficulty in paying fees required by some centers	235 (51.5%)	179 (66.3%)	ρ <0.0001
		Specialized services such as imaging and laboratory tests are expensive	274 (60.1%)	215 (79.6%)	ρ <0.0001
	Lack of Information	Absence of information	86 (18.8%)	61 (22.6%)	ρ =0.005
		Lack of information availability	61 (13.4%)	25 (9.2%)	ρ =0.604
		Lack of accessibility to available information	40 (8.8%)	31 (11.5%)	ρ =0.023
		Lack of availability of information adaptive to the needs related to disability	26 (5.7%)	15 (5.5%)	ρ =0.48
	Attitudinal	Lack of knowledge among employees regarding how to deal with persons with disabilities	19 (4.2%)	6(2.2%)	ρ =0.41
		Difficulty in communicating with the health service provider or other staff members	20 (4.4%)	8 (2.9%)	ρ =0.73
		The use of wrong and negative terminology by the employees or medical staff when talking to you or when speaking about disability	13 (2.8%)	5 (1.8%)	ρ =0.727
		Your being subject to discrimination and marginalization by employees and medical staff	11 (2.4%)	18 (6.6%)	ρ <0.0001
	Others	Others	22 (4.8%)	5 (1.8%)	ρ =0.14

*Multiple response is possible

Barriers also vary in different geographic and cultural settings. As Figure 20 shows, significantly more PwDs in Bekaa (73.3%) reported the presence of barriers that affect access to health services when compared with the South (69.7%), Mount Lebanon (63.8%), Beirut (63.6%) and North (56.1%). Moreover, significantly more PwDs living in Bekaa mentioned the financial challenges than PwDs living in other regions. The lack of accessibility to available information (11.4%) and the difficulty in communicating with the health service provider or other staff members (6.8%) were significantly stated by PwDs living in North more than the other regions.

Among PwDs living in Beirut, significantly more (18.2%) reported that a lack information availability (18.2%) and long waiting periods to obtain an appointment (18.2%) compared to PwDs living in other regions (Figure 21).

Existing Barriers

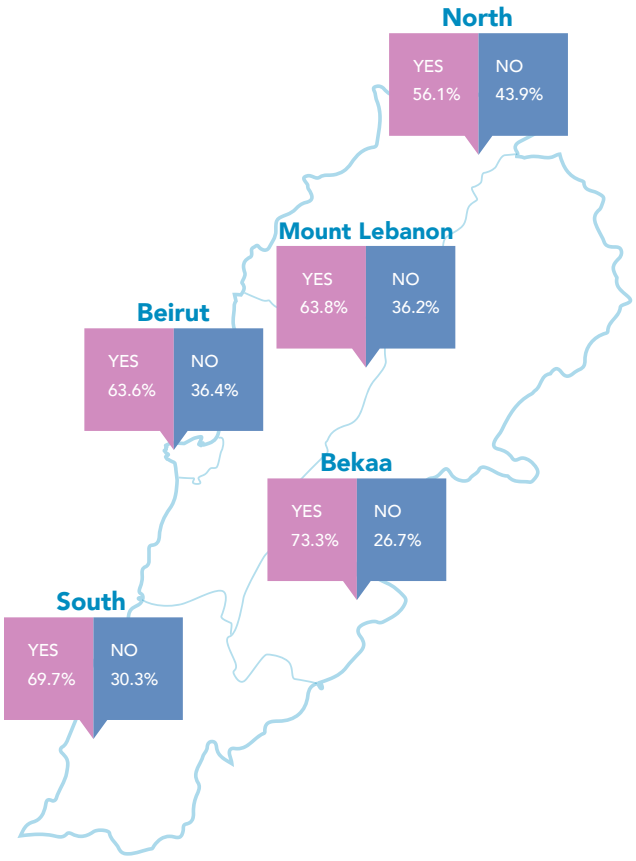


Figure 20: Existing barriers disaggregated by governorate

Geographic access

	Beirut	Mount Lebanon	North	South	Beqaa	ρ Value
Services are far away and in places which are difficult to reach	16.4%	17%	12.9%	19.4%	18.1%	0.602
Transportation is not available	7.3%	9.2%	5.3%	10.3%	11.9%	0.160
Transportation is not accessible	7.3%	11.3%	10.6%	9.1%	11%	0.859

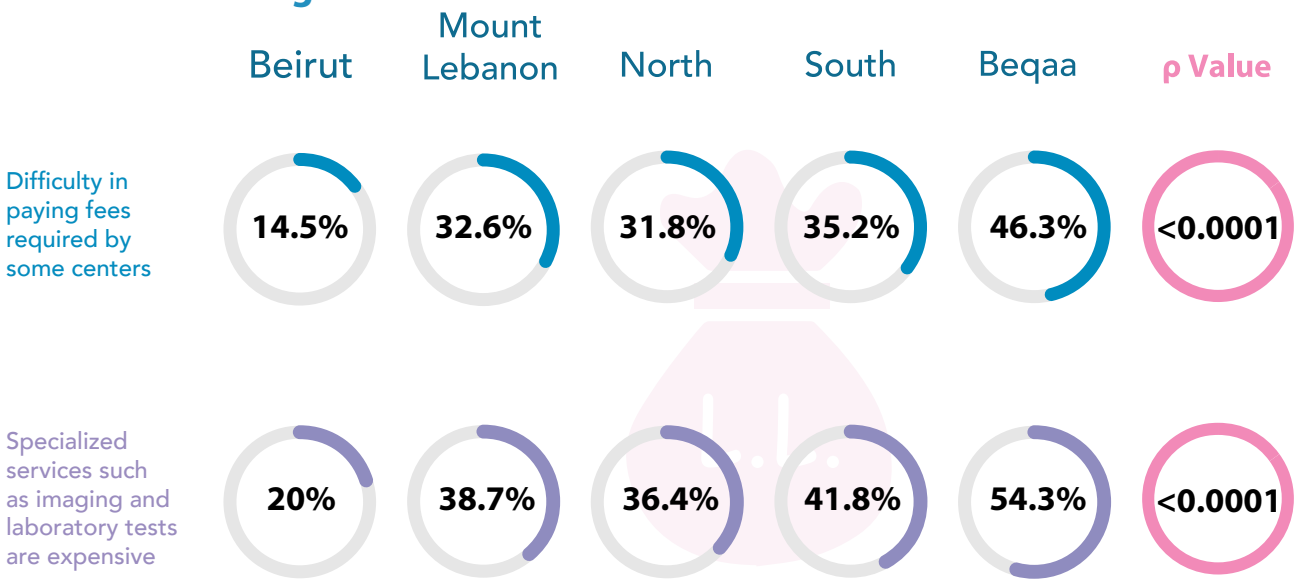
Physical barriers

	Beirut	Mount Lebanon	North	South	Beqaa	ρ Value
Health centers are not physically accessible	5.5%	10.6%	3.8%	4.2%	4.6%	0.096
Moving difficulties inside the health centers and the inability to use all their divisions because they are inaccessible	1.8%	6.4%	2.3%	3.6%	3%	0.354
Lack of availability of adapted medical equipment that can serve your individual needs related to disability (equipment used in medical examinations or medical treatment and therapies	0%	2.8%	5.3%	1.8%	2.1%	0.233

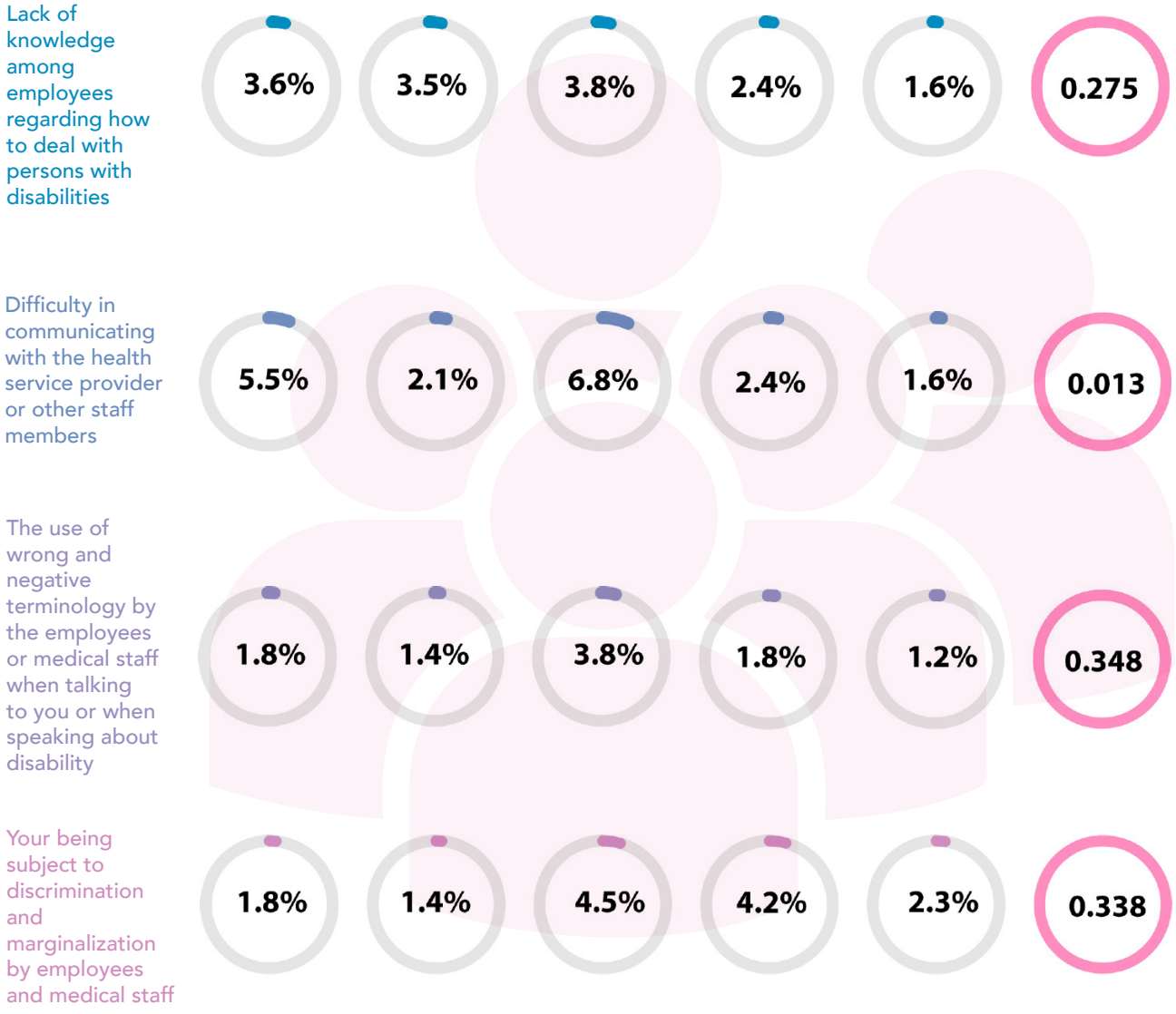
Lack of information

Absence of information	18.2%	12.1%	13.6%	7.8%	15.8%	0.069
Lack of information availability	18.2%	8.5%	12%	7.3%	6.4%	0.030
Lack of accessibility to available information	10.9%	2.1%	11.4%	3%	7.5%	0.002
Lack of availability of information adaptive to the needs related to disability	5.5%	2.1%	6.8%	12.8%	4.1%	0.158

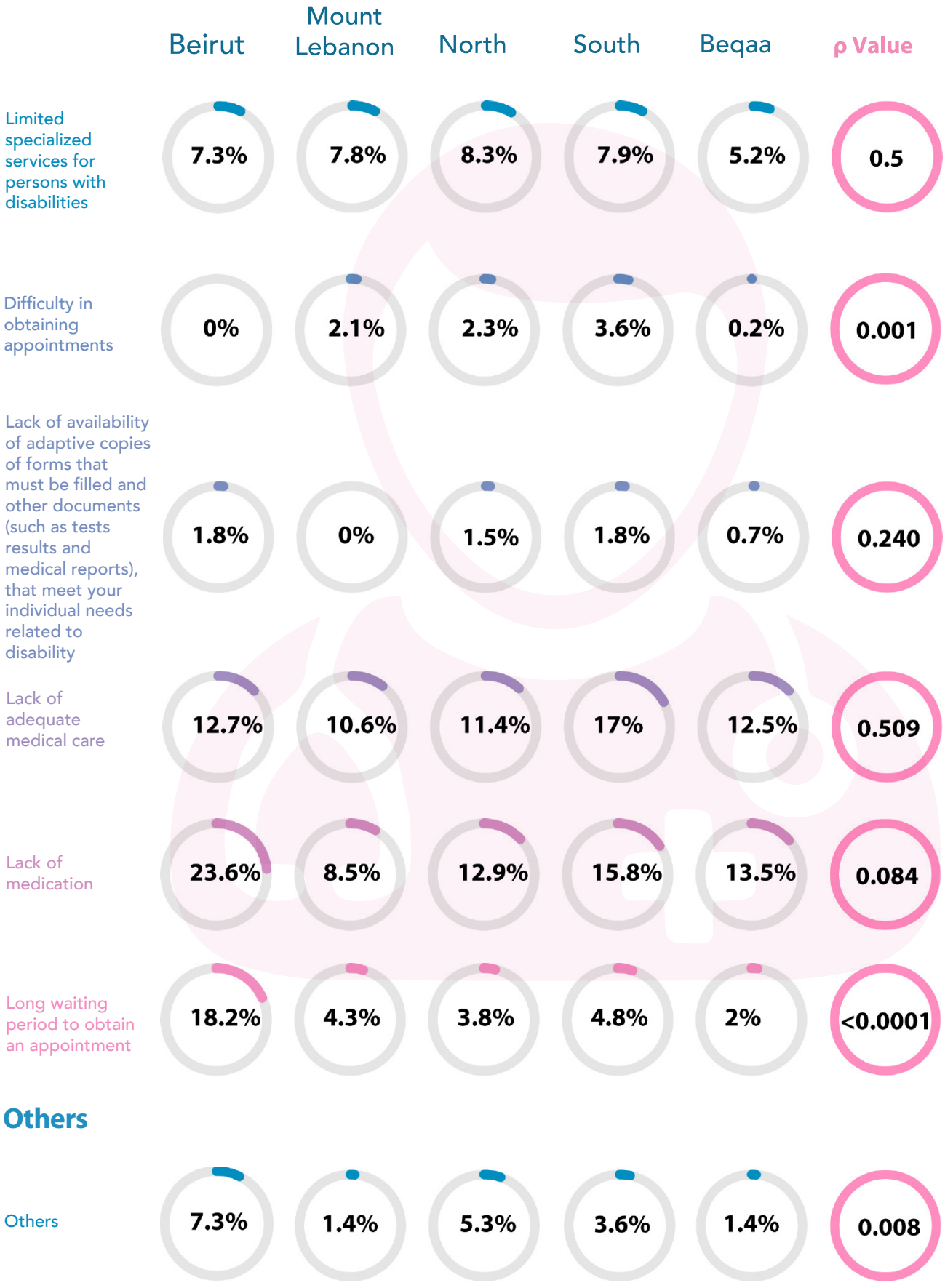
Financial challenges



Attitudinal barriers



Medical service barriers



Others

Figure 21: Type of barriers disaggregated by governorate

7. Satisfaction with specialized and PHCC services and perceptions of quality

In healthcare, patient satisfaction has long been considered an important component when measuring health outcomes and quality of care[11]. Patient satisfaction is generally considered the extent to which patients feel that their needs and expectations are being met by the health services provided. Participants (n=362) in this study were asked about their level of satisfaction with staff interactions and services received from PHCCs over the preceding 12 months.

Figure 22 below demonstrates the impressions left from the respondent's most recent visit to a PHCC for health services. An average of 71% agreed that the staff treated them well. The majority of the patients (80%) reported that the staff used the right terminology regarding their disability, were willing to listen carefully to the individual and provide answers to all their questions, and respected the privacy and confidentiality of the individual during the consultation. About three-quarters (75%) of PwDs who visited a PHCC reported that the staff talked to them directly instead of the person who accompanied them and empowered them with sufficient information regarding their disability. While 35% agreed that the staff reacted in a helpful way when they faced an accident or other unforeseen problem while at the center, 47% report that the staff did provide needed administrative help (e.g., help with calling someone, help reading papers, help getting somewhere…). No major difference regional or gender differences were noted.

47%
The staff asked PwD if they needed administrative help

35%
The staff reacted in a helpful way

74%
The staff asked PwD if they need any physical assistance in the PHCCs

76%
The staff explained to PwD clearly the documents that they need to sign

76%
The staff gave PwD the needed time to ask their questions

79%
PwD felt that they were treated similar as other people

80%
There was privacy and confidentiality during the consultations provided by the health care providers in the PHCCs

[11] Donabedian A. Evaluating the quality of medical care. Milbank Q 2005; 83:691-729.

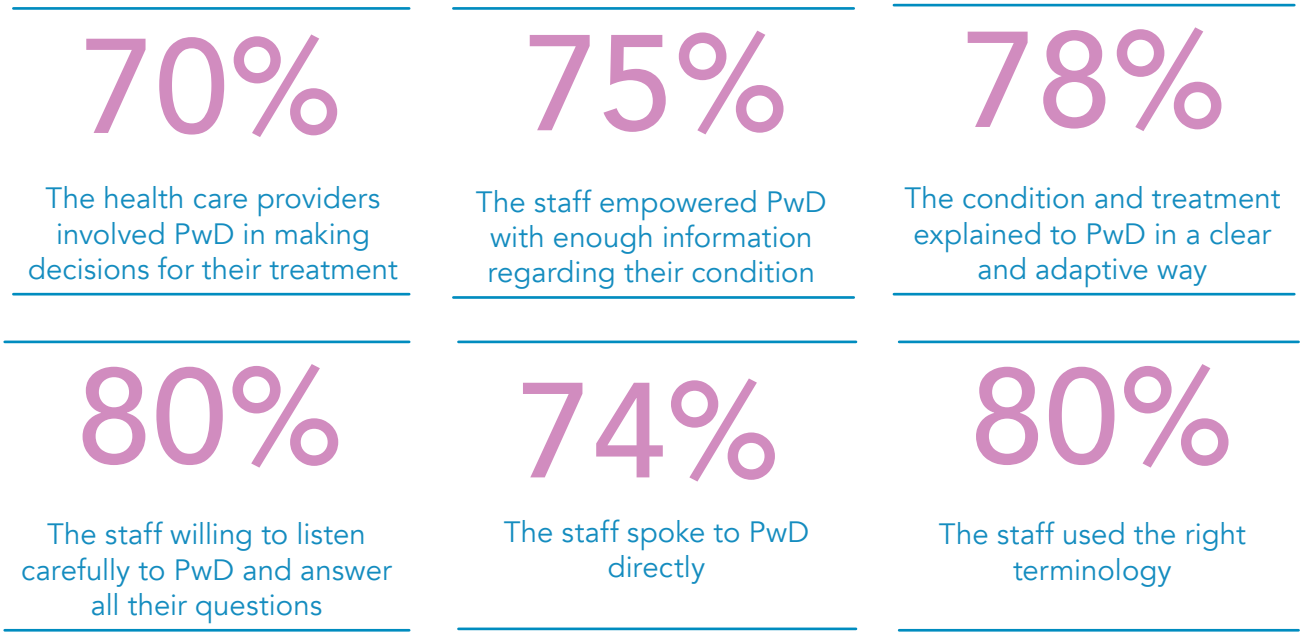


Figure 22: Distribution of PwDs according to their impressions about PHCC

The quality of services provided is also an essential element to measure. The respondents were further asked to rate their satisfaction with the quality of the health services received, as follows: satisfied (1), neither satisfied nor dissatisfied (2), dissatisfied (3). This study showed that the overall satisfaction of PwDs who were satisfied with PHCC services was 67% (Significantly more Lebanese than Syrians). PwDs who received diapers, prostheses and assistive devices were less satisfied with the quality of service respectively with 35%, 6% and 43%. This lower level of satisfaction might be due to genuine problems concerning these services like the issue of continuing of care, the available resources and the lack of a proper maintenance of the devices.

When asked to rate their satisfaction regarding their latest visit to any PHCC, an average of 51% of respondents were satisfied. As Table 16 shows, 60% were satisfied with the cleanliness and orderliness of building and rooms, followed by 57% which were satisfied with the waiting area comfort and capacity, while the least satisfaction was with transportation (36%), with which 23% were dissatisfied.

Table 16: PHCC satisfaction rate by the respondents

	Satisfied	Neither satisfied nor dissatisfied	Dissatisfied
Ease of access (transportation) to the facility	131 (36%)	24 (7%)	83 (23%)
Operational hours of health facility	193 (53%)	34 (9%)	13 (4%)
Cleanliness and orderliness of building and rooms	217 (60%)	17 (5%)	6 (2%)
Waiting area comfort and capacity	208 (57%)	22 (6%)	9 (2%)
Waiting times	172 (48%)	27 (7%)	40 (11%)

8. Activity limitations and social participation restrictions

According to the International Classification of Functioning, Disability and Health (ICF) model, which is approved for use by the World Health Assembly in 2001, functioning and disability are multi-dimensional concepts, relating to:

- The **body functions and structures** of people;
- The **activities** of people and the activity limitations they experience;
- The **participation** or involvement of people in all area of life, and the participation restrictions they experience;
- The **environmental factors** which affect these experiences[12].

Due to this fact, questions on activity limitations and social participation restrictions were added to the survey and asked of PwDs to illustrate how physical and social environments can affect a person's opportunities to participate in everyday life. Among all of the participants, 31.6% expressed a need for full-time assistance to carry out the self-care activities, 31.2% reported they needed no additional help, and 37.3% stated an occasional need for help. Further analysis was carried out to examine the relationship of the respondents' socio-demographic characteristics to the need of help, which showed that significantly 40.4 % older PwDs (60+) are in need of full-time help more than the younger PwDs (28.7%). Significantly more Syrians (40.5%) than Lebanese (27.4%) mentioned the need of full-time help (Table 17).

Table 17: Distribution of respondents according to the relationship between their need for help when performing daily activities and Socio-demographic characteristics

		No help needed	Help needed sometimes	Help needed all the time
All respondents		329 (31.2%)	393 (37.3%)	333 (31.6%)
Nationality	Lebanese	242 (33.5%)	282 (39.1%)	198 (27.4%)
	Syrians	87 (26.1%)	111 (33.3%)	135 (40.5%)
Gender	Male	202 (32.6%)	240 (38.7%)	178 (28.7%)
	Female	127 (29.2%)	153 (35.2%)	155 (35.6%)
Age	18-59	272 (34.3%)	294 (37%)	228 (28.7%)
	60+	56 (21.5%)	99 (38.1%)	105 (40.4%)

[12] The ICF: An overview- Retrieved on January 23, 2020, from https://www.cdc.gov/nchs/data/icd/icfoverview_finalforwho10sept.pdf.

As seen in Figure 23, 93% of those who need assistance either sometimes or all the time (N=726) had someone to assist them. For many people with disability and those who care for them, daily life can be challenging. Meeting the complex needs of a person with a disability can put families under a great deal of stress; emotional, financial, and otherwise. This study shows that the participants were indeed psychologically affected by the issues around limitations in self-care activities, with 31.7 % of PwDs reportedly feeling nervous/ anxious and 20.3% feeling isolated and excluded (Figure 24).

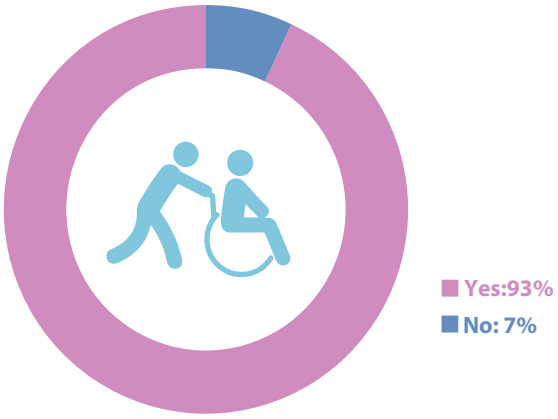


Figure 23: Percentage of respondents who have someone to assist them in their daily activities

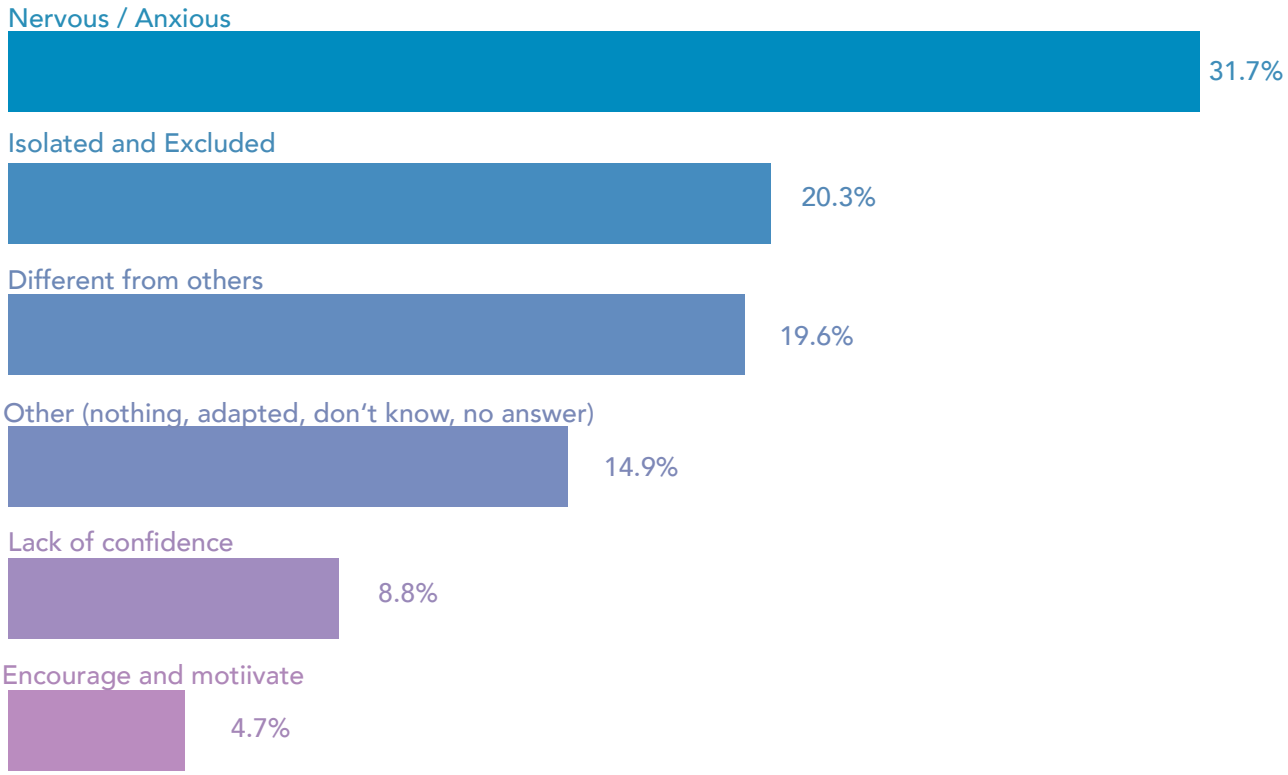


Figure 24: Distribution of respondents feelings when facing activity limitations and social participation restrictions

All people experience difficulties in their lives, but PwDs face additional challenges. As Table 18 reveals, transportation (35.8%) is an important issue for those with disability because of a lack affordable, accessible transport options. Another top concern was the ease of living in and around your dwelling place, with 29.4% reporting that their home was very hard to live in due to insufficient accessibility.

Table 18: Environment satisfaction scale by the respondents

	Very easy	Acceptable	Very hard	Don't know	N/A
Does your workplace make it easy or hard for you to work or learn?	74 (7%)	121 (11.5%)	51 (4.8%)	808 (76.6%)	1 (0.1%)
Does your educational institution make it easy or hard for you to work or learn?	55 (5.2%)	48 (4.5%)	28 (2.7%)	919 (87.1%)	5 (0.5%)
Are places where you socialize and engage in community activities make it easy or hard for you to do this?	153 (14.5%)	369 (35%)	212 (20.1%)	318 (30.1%)	3 (0.3%)
Is the type of transportation you need easy or hard for you to use it?	239 (22.7%)	345 (32.7%)	378 (35.8%)	70 (6.6%)	23 (2.2%)
Is your dwelling make it easy or hard for you to live there?	377 (35.7 %)	364 (34.5%)	310 (29.4%)	3 (0.3%)	1 (0.1%)
Is the toilet of your dwelling make it easy or hard for you to use it?	430 (40.8%)	299 (28.3%)	302 (28.6%)	24 (2.3 %)	0 (0%)
Is the lighting, noise, and crowds in your surroundings make it easy or hard for you to live there?	210 (19.9%)	365 (34.6%)	208(9.7%)	271 (5.7%)	1 (0.1%)

This study further assessed the attitude of persons and families towards those with a disability. Attitude can be one of the most difficult barriers to recreation participation experienced by PwDs. Table 19 presents the analysis of eight items which were addressed with PwDs. 54.6% of respondents do not have problems getting involved in society because of the attitudes of others, while 24.3% experienced sometimes this barrier. 58% of respondents participate in family decisions, while 21.9% do not at all. 52.5% mentioned making the big decisions in their life, while 25.5% do not at all. These metrics indicate that the attitude of others towards to pose a social challenge to many PwDs.

Table 19: People's attitude towards persons with disabilities

	Not at all	Sometimes	Yes, completely	Don't Know	N/A
Do you participate in family decisions?	231 (21.9%)	202 (19.1%)	612 (58%)	7 (0.7%)	3 (0.3%)
Do you have problems getting involved in society because of the attitudes of people around you?	576 (54.6%)	256 (24.3%)	188 (17.8%)	29 (2.7%)	6 (0.6%)
Do you feel that some people treat you unfairly?	578 (54.8%)	321 (30.4%)	134 (12.7%)	18 (1.7%)	4 (0.4%)
Do you make your own choices about your day-to-day life?	134 (12.7%)	215 (20.4%)	699 (66.3%)	4 (0.4%)	3 (0.3%)
Do you make the big decisions in your life?	269 (25.5%)	223 (21.1%)	554 (52.5%)	7 (0.7%)	2 (0.2%)
Do you feel that other people accept you?	55 (5.2%)	306 (29%)	679 (64.4%)	5 (0.5%)	10 (0.9%)
Do you feel that other people respect you?	45 (4.3%)	275 (26.1%)	720 (68.2%)	10 (0.9%)	5 (0.5%)
Do people around you tend to become impatient with you?	659 (62.5%)	316 (30%)	50 (4.7%)	22 (2.1%)	8 (0.8%)

N.AS, 21 Jan. 2020

I'm Lebanese, living alone. I previously worked as a nurse at a governmental hospital in the Aley region. During the day I was taking care of patients and afterhours I took care of my senile mother with whom I used to live and who passed away four years ago.
I got inflammation in my spinal cord and had a stroke that impaired my mobility. As a result, I could no longer continue to work, I was taken off of Social Security and now, after around 40 years of serving others, I find myself alone with no one to take care of me.
I need a wide range of health services which I cannot afford. Starting with a handful of medications, an MRI every six months, laboratory tests, assistive devices, diapers and antiseptic products. I am buying them at my own expense. If you see the wheelchair I own, you'd laugh. I feel embarrassed to show it to anyone so I keep it in my bedroom. I have never received any equipment from MoSA. When I tried to receive them from different MoSA centers, I got the same answer from all of them: "Come back later, we are out of stock." Am I supposed to pay the cab fare over and over again to get the same answer at MoSA centers? [...]
The cheapest taxi that takes me to MoSA Hadath charges 50,000 LBP. I have the MoSA disability card, but it's completely useless. I had to commute to MoSA centers in order to ask about the services I need because either no one answers the phone or I get hung-up on. The expensive fees of this commute makes it more cost-effective for me to simply get these services on my own expense from private providers closer to my place.
I need to receive an MRI regularly in order to monitor my spinal cord inflammation but I couldn't afford it and no healthcare facility can provide it. Some charitable people provided me with a walker and a wheelchair, and I'm very grateful that the pharmacist allows me to pay the medications in installments. However, this dependency does not allow me to access the quality healthcare I need. I had been trying to reduce my debt to the pharmacy by skipping doses of the medications that I need to take everyday. For example, "today I take blood pressure medication, tomorrow I'll take heart medication."
I hope that one day MoSA or MoPH will send social workers to check up on people with disabilities so that I can get back - even if only a fraction - some of the support I provided to others during my decades of service.

Qualitative Findings

Focus Group Discussions

Sample Characteristics

The Focus Group Discussions took place over a period of four months, between June and December 2019 in five regions of the country: Beirut, Mount Lebanon, North, South, and Bekaa. Although 15 FGDs were planned, due to data saturation, 14 FGDs were conducted with a total of 121 PwDs (55 females, 66 males) in the different areas in Lebanon. The participants were aged between 18 and 74 years (mean age = 38.69 years, SD = 15.12 years). 57 % of the participants were Lebanese with a MoSA disability card, 12% were Lebanese without the card, and 31% were Syrian refugees. The largest fraction (48.8%) had a physical disability, while 12% had more than one disability. Brief demographic information about the participants is included in Annex 4.

Although the FGDs were conducted in Arabic, the recordings taken during each session were transcribed and then translated into English to facilitate the thematic analysis, from which three major themes emerged. The first captured the participants' need for and utilization of health services, the second described the barriers and challenges faced by the participants when attempting to access care, and the third expressed the participants' overall level of satisfaction with PHCC services. Figure 25, below, summarizes the three themes and 13 subthemes.

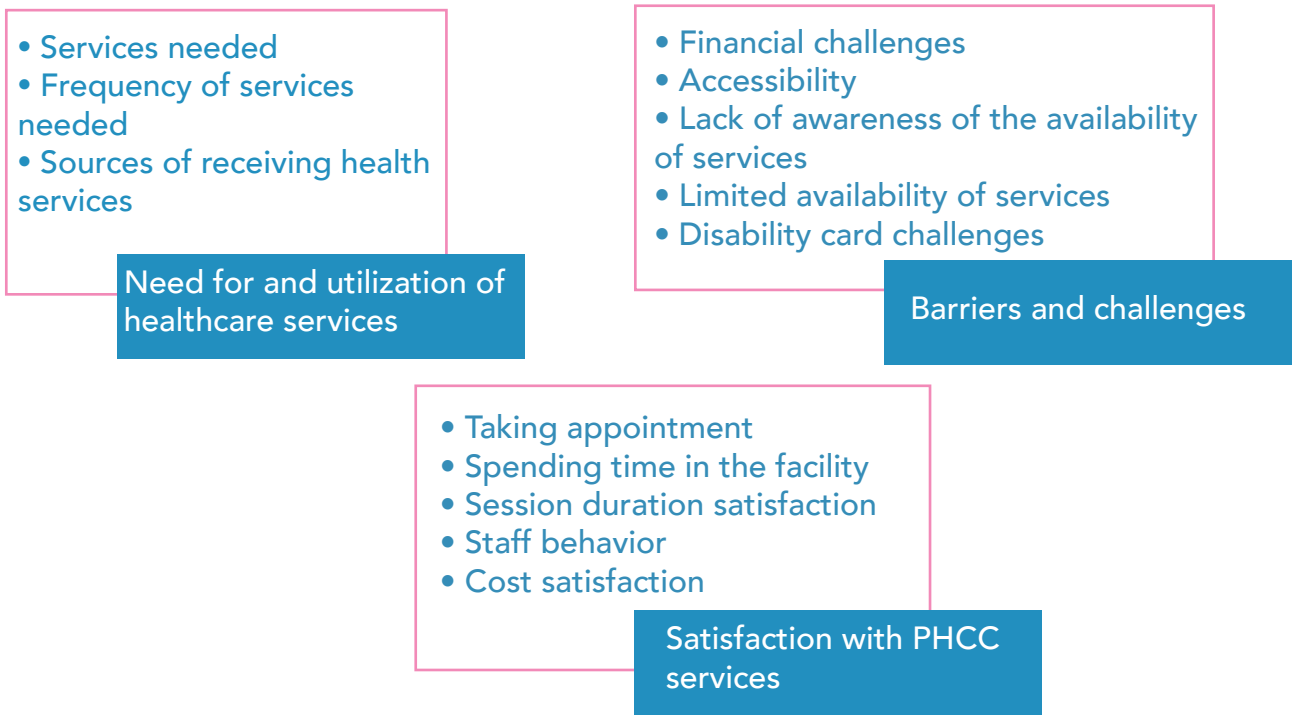


Figure 25: Themes and subthemes obtained from the FGDs

Theme A: Need for and utilization of healthcare services

Subtheme A1: Services needed

Most of the participants mentioned that PwDs, like everyone, require general, preventive, and specialist health services that are unrelated to their impairment, including medications, generalist and specialist physician consultations, dentistry, imaging, and laboratory testing.

> *I get sick normally like any normal person. When I get sick I take medications.*
>
> *(AL11)*

> *I don't need any health services related to disability however I need only health services when I get sick from time to time like everyone else such as headache, dentist, flu…*
>
> *(DL11)*

In addition, PwDs frequently have need of one or more rehabilitative services, such as physical therapy, assistive devices, speech therapy, psychotherapy, and others. For many, the difficulty of obtaining these services can have wide-ranging consequences.

> *I needed a doctor because I was paralyzed for four years. I couldn't move at all. From a year till now I didn't need anything other than the crutches.*
>
> *(BL9)*

As mentioned elsewhere, the health challenges faced by PwDs may be unrelated, directly related, or indirectly related to the specific disability. The resulting complexity can be challenging to properly manage, often requiring more hospitalizations and surgeries, such as open-heart surgery, glaucoma surgery (e.g., trabeculectomy), kidney transplantation, etc., than the general population.

> *I got a stroke in my eye. I need eye surgery and it costs 4,000 USD. That's just for this glaucoma surgery.*
>
> *(ES5)*

> *I did a Kidney transplantation and an installation of a pacemaker*
>
> *(CL8)*

In addition, some of those with a physical impairment have a need for personal assistance to help with activities of daily life, such as personal and home care.

Subtheme A2: Frequency of services needed

The frequency of healthcare needs varies among PwDs, depending on a variety of factors: disability type and severity, overall health condition (acute, chronic, severe), age, gender, life conditions, etc. Table 20 summarizes the frequency of healthcare services needed by PwDs who participated in the FGDs. Many of the participants mentioned the need for health services on a monthly basis, however some spoke of the need for services, such as physiotherapy, medications, and medical supplies, more frequently (daily, weekly, biweekly).

For many of those with a disability, rehabilitation measures are essential to prevent or slow the loss of function, improve or restore function, compensate for lost function, or maintain the current level of function. Typically, rehabilitation occurs regularly over a set period of time with the frequency dependent upon the assessed need. For example, one participant with physical disability reported his need for daily physiotherapy.

> *"I need physiotherapy everyday but If I do them five days a week that would be good."*
>
> *(KS5)*

In addition, when speaking about assistive devices, most of the PwDs with a physical impairment mentioned that they require replacements more frequently than the Ministry of Social Affairs is able to provide them (wheelchairs, crutches, and medical shoes are covered by MoSA for those Lebanese who possess the MoSA disability card). One man described difficulties when trying to request a new wheelchair.

> *"Every five years, we are allowed to submit a request for a new wheelchair or a crutch etc., but I need to change them every three years, it doesn't work out for me to wait for five years, and even if I do, the service might not even be available then. We would have to turn to other institutions or organizations in order to receive these services..."*
>
> *(EL3)*

Table 20: Examples of health services and their needed frequency, as mentioned by FGD participants

FREQUENCY	HEALTHCARE SERVICES
Every 3 to 4 years	Wheelchair, prosthetic leg
Yearly	Assistive devices (Medical shoe, Crutches), Doctor checkup (neurologist, orthopedic..), Blood test
Twice per year	Doctor consultation, Blood tests , Imaging
Three times per year	Blood test, Doctor consultation, Medications
Monthly	Medications, Doctor consultations, Diapers, Batteries for hearing aid
Every 15 days	Psychotropic medications
Weekly	Physiotherapy , psychotherapy
Daily	Personal assistant, Medical supplies (Suction tubes,Oxygen machine, cystostomy bags, gloves), Physiotherapy
When needed	Dentist, Doctor consultation, Blood test, Hospitalization, Medications, Medical supplies

Subtheme A3: Sources from which health services are received

The focus group discussions revealed that most Lebanese and Syrian PwDs feel they cannot solely rely on government-provided care, but instead must seek out alternatives in order to have access to the most needed health services. Lebanese who have the disability card report receiving assistive devices, when they're available, from MoSA, while Lebanese without the card, along with Syrian refugees, spoke of receiving such devices from NGOs, the private sector, or on their own. However, many FGD participants expressed dissatisfaction with the limited quantity (concerning disposable incontinence products, for example), personal suitability, and overall quality of the devices provided, regardless of the source.

> *"We're allowed to get one wheelchair every five years but it barely lasts for two years. When you go to get the wheelchair, it's not like you can cherry pick the one that makes you comfortable or the one that fits your body. They tell you that this is what's available here, deal with it."*
>
> *(AL6)*

The NGOs that provide needed equipment and services, such as assistive devices (crutches, prosthetic limbs, etc.), medications, physiotherapy, psychotherapy, and generalist/specialist doctor consultations, are often a primary means by which FGD participants report obtaining such services.

> *"I'm receiving physiotherapy for free at home (someone comes to my home), same for psychotherapy since I can't commute. I didn't pay for both the physiotherapy and psychotherapy that Mousawat provided."*
>
> *(AS5)*

Only a very small number of PwDs rely on insurance, social security, or military coverage to meet their health service needs:

> *When I need medications I buy from a pharmacy and pay for it. I have insurance to cover these medications.*
>
> *(EL8)*

> *I get medications from the military hospital. Usually, the military hospital covers everything.*
>
> *(JL11)*

Surgical procedures are typically higher cost interventions that may not be provided or fully covered by available sources (government, NGOs, etc.). As such, when a surgery is needed some FGD participants request donations from relatives and others:

> *I did an operation, it wasn't successful. None of the organizations helped me. I got financial help from people.*
>
> *(AS4)*

Two Syrian PwDs described borrowing assistive devices such as crutches or a walking cane from their friends.

Although many of the FGD participants mentioned receiving some services from PHCCs, more than half described significant difficulties that led them to search out alternative sources or, in some cases, go without the needed service. The principle reasons for this, include:

1. Unavailability of services in the PHCC, such as medications and specialist doctors:

> *When I asked them (in the PHCC) they told me that this service was not available. Maybe they do provide it but perhaps they were out of stock of medications.*
>
> *(DL1)*

2. Unsatisfying quality of services

> *This dispensary provides medications but only the cheap ones. The doctor prescribed a painkiller and a really expensive vitamin. I had to buy it myself and it cost me 80,000 LBP.*
>
> *(GS5)*

3. Limited schedule in PHCCs:

> *In the PHCC not all doctors are available all the time. Plus, most of the time, he [the PwDs] gets sick during the night and the PHCCs are closed.*
>
> *(Caregiver AL12)*

4. Lack of awareness regarding service availability

> *I paid for medications because I don't know where to receive these services for free.*
>
> *(IL2)*

5. Unavailability of nearby centers, leading to transportation challenges

> *I would have to pay 30,000 LBP for transportation in order to reach that center, so how exactly am I benefiting? It's not only important that PHCCs provide services or open new centers, their location also is a big factor.*
>
> *(IL3)*

6. The waiting time to be seen in the PHCCs

> *I would prefer to pay a full fee from a private doctor because of all the restrictions around the timing and number of visits per day at PHCCs. Sometimes if you go to a PHCC you would wait for hours and then end up not seeing the doctor, so why would I take this convoluted route? It's just easier to go to a private clinic given all the obstacles surrounding PHCCs.*
>
> *(HL3)*

7. More comfortable with the private sector

> *I have been seeing my doctor for ten years and I got used to him. He is in a private clinic but I wouldn't change him."*
>
> *(HL6)*

8. Unprofessional staff behavior

> *My dad takes me to the doctor at his expense. There are dispensaries but my dad doesn't go there. Because the employees there make fun of me.*
>
> *(AL6)*

A quarter of the participants (25%) described not receiving health services at all due to the same reasons.

> *I need a CT scan but [it wasn't offered at a PHCC and] I couldn't afford it.*
>
> *(CS4)*

> *She needs psychotherapy but I didn't take her to check her mental health because I don't have money to pay for these consultations.*
>
> *(Caregiver HL11)*

Theme B: Barriers and challenges in accessing healthcare

When accessing healthcare, nearly everyone faces difficulties from time to time. For people with disabilities, however, such difficulties are far more frequent and impactful as they tend to arise from underlying attitudinal, organizational or systemic, physical, and communication- and technology-related barriers. The WHO ICIDH provides the following examples:

- a physical environment that is not accessible,
- lack of relevant assistive technology (assistive, adaptive, and rehabilitative devices),
- negative attitudes of people towards disability,
- services, systems and policies that are either nonexistent or that hinder the involvement of all people with a health condition in all areas of life[13].

In this study, when asking about the types of barriers and challenges faced to access health services, most of the participants cited numerous examples in which they struggled to access quality, needed health services. The following five subthemes capture the most common difficulties faced by FGD participants. It should be noted that, due to the cross-cutting nature of these barriers, they are not singularly encountered, a point which was made clear by the FGD participants.

Subtheme B1: Financial challenges

The financial cost of accessing treatment was a commonly identified barrier by the persons with disability who participated in the study's FGDs. Although provided by PHCCs are relatively low cost, they are not completely free (e.g., for doctor consultations, around 7,000 LBP is typically required upon arrival to SDCs; additional fees can also apply depending on the services provided). One participant, for example, mentioned that a recent increase in the fee was difficult for her to manage.

[13] World Health Organization, International classification of functioning, disability and health. Geneva:2001, WHO. p. 214.

> *When it comes to medical shoes, the difference is 20,000 LBP, 3 years ago I used to get them completely for free. When it comes to the crutches, the difference is 15,000 LBP and the same goes for the doctor visits and the same for other services, this was not the case a few years ago.*
>
> *(DL1)*

Regarding surgeries and hospitalization, both Syrians and Lebanese expressed frustration with the hardship of paying the amount not covered by MoPH, MoSA, or NGOs.

> *I got a stroke and no hospital accepted me. Only governmental hospitals accept the MoSA card. And when you go to a governmental hospital they make you pay for the medications they administer. I got a cholecystectomy and even the doctor charged me for the surgery he performed. He told me his fees are not covered by the card. I got a loan in order to do it. The card only covered the fees of the hospital bed but not the medications.*
>
> *(HL10)*

When FGD participants were asked how they afford their health services (whether from government or private facilities), a large variety of sources were cited:

- The majority reported relying on their families, however some PwDs took the decision to stop their treatment so as to not further burden their families.

> *My parents bought the medication I need. But we get to a phase where we don't take the medication so we don't make our parents pay for it.*
>
> *(HL7)*

- A small number of the Lebanese PwDs have National SOcial Security Fund (NSSF) , but in order to benefit from this employment-related entitlement, the holder must pay the full amount upfront and then submit a claim for reimbursement, a process that can take months to conclude.

> *I don't work, my husband has social security and you have to wait seven to eight -8 months to get your money back from them.*
>
> *(IL2)*

- PwDs who are currently working pay the medical fees themselves.

> *The thyroid meds cost 60,000 LBP and the heart meds are also expensive and no one can provide them so I have to pay by myself.*
>
> *(AS5)*

- Some of the PwDs asked their friends for help.

> *I am not working because of my disability. I have a friend who works at a doctor's clinic so she sometimes provides my medications. Other times I buy them from the pharmacy and pay for them in installments.*
>
> *(DL3)*

- A small number of participants stated that indebtedness was their solution.

> *Sometimes the pharmacy accepts to give me a debt and other times they ask me to return the debt before taking more medications. The other day I put my ID up for a mortgage in order to get a loan. The police officers intimidated me to pay the loan back. They started adding two dollars for each day of delay to return the loan.*
>
> *(HL10)*

- The Syrians registered with UNHCR were able to benefit from the agency's help, but the assistance was reported by FGD participants as being insufficient for those families that include a person with disability.

> *The UN is treating us like a normal member of the family. They give us 40,000 LBP/ month! That's not enough. The family that has a PwDs needs to receive more money.*
>
> *(AS5)*

> *We are given 27 USD/month [from UNHCR] which is almost 90 cents/day. Is it reasonable that 90 cents should suffice a human being?*
>
> *(FS5)*

- Many PwDs mentioned that they are simply not able to afford their health needs.

> *I didn't go to the doctor to know if I need any tests. If you want to do medical tests, you'll pay between 100 and 200 USD so I end up saying that it will pass and I will get better.*
>
> *(DL7)*

> *I stopped taking my medication because I can't afford it anymore. I asked a lot in PHCCs but none did provide it.*
>
> *(DL12)*

• Some participants also indicated that they faced a choice between paying for healthcare and their daily living needs:

> *You worry about the living circumstances more than the medical services. Medical services are important but you have to think about the house and if you have debt.*
>
> *(CS4)*

Subtheme B2: Accessibility

The participants in the FGDs mentioned barriers regarding the accessibility of centers providing health services (whether public or private), which include five main obstacles: physical barriers, information barriers, communications barriers, geographic barriers, and transportation barriers.

1. Physical barriers

Many PwDs face physical barriers that hinder their access to health services and prevent them from receiving the care they need. The design and construction of indoor and outdoor facilities can prevent them from going to PHCCs or other health care providers. Uneven access to buildings, inaccessible medical equipment, narrow doorways, multi-storey facilities without working elevators, inadequate bathroom facilities, and inaccessible parking areas create barriers to accessing appropriate healthcare services. During the focus group discussions, many persons with physical impairments described frustrating experiences.

> *They think that the PHCC is accessible just by building a ramp on its entrance, but a ramp is not enough. They don't take into consideration if we need to use the restroom, the wheelchair doesn't fit inside! And they don't take the wheelchair into consideration when building the examination rooms. Sometimes the rooms are too tight for the wheelchair so we get the examination with the door open.*
>
> *(CL3)*

2. Information barriers

PwDs, especially those with visual impairments, also face information accessibility barriers. During the focus group discussions, PwDs with visual impairments reported that health centers in Lebanon are generally inaccessible to them as they are unable to reach the facilities alone and, without the installation of Braille instruction, cannot easily navigate them once there.

> *In Lebanon, centers are not accessible for PwDs. For example, there is no braille writing in the elevator nor any floor or room.*
>
> *(FL7)*

3. Communication barriers

Failure of health care providers to communicate effectively and appropriately is perhaps

the most under-recognized barrier to the delivery of quality health care for people with disabilities. This is a pervasive and alarmingly detrimental challenge for many people with disabilities, particularly for those with intellectual disabilities, hearing impairment, and other developmental disabilities, as it undermines the development of respectful, bilateral relationships that can enable patients to effectively collaborate in their own care. Moreover, deaf participants in this study described their difficulties managing health environments without accompanying interpretation (sign language) or adapted communication tools (easy read information, pictures, symbols).

> *My problem is when I go to a medical center, they don't understand the sign language there. If I go alone without any family members, they're not going to be able to understand what I say.*
>
> *(CL1)*

Some participants reported that when they had communication difficulties they had to resort to writing down what they wanted to say.

> *Sometimes I don't understand the answers even if they write it.*
>
> *(EL8)*

4. Geographic challenges

People living in both rural and urban locations also face geographic barriers when attempting to access needed care as their area may have a limited number of clinics/hospitals, a fact that negatively impacts the diversity of specialist services available. For example, a mother of three children with disabilities couldn't reach any PHCC for services due to their location.

> *We are not going to PHCCs at all, only we go to the dispensary of the municipality. There should be a PHCC near us. I can't take my kids to far places like Beirut or Tripoli.*
>
> *(Caregiver HL11)*

> *I need to take three taxis in order to get here [Zahle]. I made three stops to get here.*
>
> *(IL10)*

Other participants mentioned that the centers they need are unreachable due to distance and cost.

> *I would have to pay LBP 30,000 for transportation in order to reach that center, so how exactly am I benefiting? It's not only important that PHCCs provide services or open new centers, their location also is a big factor.*
>
> *(KL3)*

5. Transportation

Participants repeatedly raised concerns about the lack of accessible and affordable transportation, both for reaching local health care facilities and travelling long distances. Because of their disabilities, many individuals cannot drive and public transportation is frequently either not present (in most places) or simply not accessible. Many participants, especially those with a physical impairment, consistently described how transportation barriers affect their lives in important ways.

> *We need cars equipped for PwDs, we need someone to carry us because we sit on a wheelchair.*
>
> *(FL1)*

One woman with visual impairment described her experience in attempting to obtain transportation services.

> *Especially as people with visual disability, we worry about who's going to take us. You have to make sure to find a companion before finding a PHCC, even if it's close to your house. The PHCC I go to, logically you can walk there. For me, if I didn't find anyone to go with me, I would go by taxi. It's a burden but I overcame it.*
>
> *(DL7)*

Transportation affordability was also a major concern, numerous PwDs reported feeling frustrated from the transportation costs (primarily taxis), with some of them stopping their treatment in response to the overwhelming nature of this challenge.

> *In general, when it comes to transportation it is very challenging. So I have to take a taxi which would cost 20,000 LBP at least. That's why I stopped physiotherapy.*
>
> *(FS5)*

Subtheme B3: Lack of awareness of the availability of services

Many focus group discussion participants spoke of healthcare needs that have gone unmet due to a lack of information or awareness regarding the availability and location of specific needed services. The majority reported receiving health information by word of mouth from their local community.

> *I knew about it through my sister's friend, she's a nurse who works there (PHCC). She asked me why don't you go there? The consultation and laboratory tests fees are 15,000 LBP but the MRI is not included.*
>
> *(BL6)*

Many Syrians reported obtaining information from the UNHCR guide which includes all PHCCs and the services they provide.

> *I go to UNHCR; they give me a list with the names of dispensaries and their numbers. The information is easily accessible but not all medical services are available.*
>
> *(DS4)*

PwDs focus group discussion participants frequently reported that health service information is either not available or not accessible to them, leading them to search for their own health information.

> *I discover health services] By accident. I have to go ask around. Since I have the ability to be socially active, I ask around and know. If I did not have acquaintances, there's no one that just comes to me with the info.*
>
> *(FL1)*

Many sources of communication were suggested by FGD participants to better access relevant information about healthcare services:

a) **Social Media (WhatsApp, Facebook ...)**

> *The media nowadays is the most important method. When a new center is opened in Bekaa, isn't it supposed to be advertised? For both public and private centers. Everyone has WhatsApp nowadays and Facebook as well, so there are means of communication that connect us all.*
>
> *(KL3)*

b) **Website**

> *I prefer that all the organizations cooperate and create a webpage on the internet so that the PwDs can access all the info from a single source.*
>
> *(DL1)*

c) **Calls or SMS / Hotline phone number**

> *If someone at the MoSA or at the MoPH can be employed to call PwDs and let them know about the services and how we can access them that would be great.*
>
> *(FL1)*

d) **Municipality help through household visits**

> *The municipality is their closest accessible source for example if someone needs an eye doctor he has to ask around and then pay for the service at a private clinic. The person, who is staying home, needs to have the information come to him. The municipality should coordinate with MoSA, schedule home visits or call the PwDs to ask about their status and what they need.*
>
> *(GL1)*

e) **Flyers, brochure, list, booklet**

> *The PwDs mostly go to MoSA in order to renew the cards, if some flyers could be put up there or if brochures could be distributed that redirect people to PHCCs.*
>
> *(CL3)*

f) **Television**

> *The best way is on TV because not all people have social media.*
>
> *(DL7)*

Subtheme B4: Limited availability of services

The lack of appropriate services for people with disabilities is a significant barrier to health care. Many participants expressed concern over the lack of needed medications and specialist doctors at PHCCs.

> *All specialized health services like an ophthalmologist or ear doctor, there are many specializations that are not available at PHCCs, so we would have to go to a private clinic... for example, an orthopedic doctor is not available in PHCCs.*
>
> *(KL1)*

One participant reported feeling fearful about service discontinuity at PHCCs.

> *There's no guarantee that they can provide me with the medication that I need for a long period of time. I'm afraid that they won't provide me with the medication that's why I don't go to dispensaries.*
>
> *(DL2)*

Subtheme B5: Disability card challenges

As mentioned previously, the Lebanese government began issuing the disability card (through the Ministry of Social Affairs) in the 1990s. Under this policy, PwDs can apply for enrollment in the program at the MoSA, though they must meet three eligibility criteria to obtain the card:

- The Applicant must hold Lebanese citizenship;
- The Applicant must undergo an examination from a specialized doctor at one of MoSA's centers (of which there are eight distributed across Lebanon);
- The Applicant's diagnosis must be one of those included on the official list of disabilities, as per the classification.

The disability card is given for a maximum of five years, after which time a new examination must be performed in order for the card to be renewed. The registration form should provide updated information on the corresponding person, including age, gender, education, employment status, residence, and disability types.

During the FGDs, the participants' main concerns related to the benefits of the disability card (which are prescribed by law) that go un-provided.

Many PwDs described frustrating challenges when using the MoSA disability card such as:

- Limited use.

> *If the operation you need is covered by the card and if the hospital accepts it, you would still need to pay the doctor's fee! Although his fees should be included in the operation cost and covered by the card. There are also a lot of additional expenses like medications, tests and shots that are also not covered by the card at the hospital, so we end up paying for them.*
>
> *(CL3)*

- No health care benefits, even for hospitalization, despite the fact that all hospitals are required to accept disability card holders for free.

> *We, as PwDs in Lebanon, got the disability card thinking that it will be useful for us. Even for operations, there are some hospitals who accept the card and others don't.*
>
> *(HL2)*

One person mentioned using his connections in the hospitals to be covered by the card.

> *…. I received two surgeries that were covered by the MoSA card; that was back in the 2000s.Ever since the card was first issued, you could use it at hospitals only if you have a connection, either through the manager of the hospital or a really good doctor who works there. I used my connections back then and I was exempted from the amount that the hospital demanded.*
>
> *(HL9)*

Some others preferred not to get the card or to renew it again for several reasons:

- Not aware about the card and its benefits.

> *I have very few information about the disability card, I hear from the people around me saying that it's not useful for health services especially for an operation.*
>
> *(IL2)*

- The long process behind getting or renewing the card.

> *Every time you want to renew the card; you have to go there personally. At MoSA, they tell me that the doctor needs to see you, but he already knows me! Why do you make me come here every time then? My diagnosis would not change; why do I have to go there every four years? It's such a hassle for everyone including my parents.*
>
> *(BL6)*

- The classification of disabilities

> *They made me go there four times and eventually it didn't work out. (non-classified disability). They made me come and go four times for paperwork. I got really upset.*
>
> *(GL3)*

- Not affordable

> *You have to pay when you want to renew the MoSA card*
>
> *(BL12)*

- Shameful: one person reported not having the card due to the social stigma and shame.

> *Maybe sometimes the person is shy and ashamed to go to a center and say that I have the disability card.*
>
> *(IL2)*

Theme C: Satisfaction with PHCC services

Questions on the satisfaction of PwDs with PHCCs services were also asked during the focus group discussions. Patient satisfaction is an important measure of healthcare quality as it tends to offer insights into the quality of services provided, the level of professionalism exhibited by staff, and the subsequent degree of patient engagement. For example, satisfied patients are more likely to attend appointments and complete treatment regimens [14].

Subtheme C1: Taking appointments

Taking an appointment for a consultation in PHCCs can be challenging due to the center's schedule and the availability of specialists who provide services there, as described by some of the FGD participants.

> *The doctor doesn't come every day, sometimes you wait for a month.*
>
> *(CL12)*

A small number of PwDs mentioned that it was easy to take an appointment at certain PHCCs.

> *It's easy to set the appointment*
>
> *(BL6)*

Subtheme C2: Spending time in the facility

When asked about the time spent in the facility, the majority of PwDs had experienced extensive waiting times in the facility to get the service needed.

> *I wait about four to five hours for a five minutes' consultation.*
>
> *(GL7)*

Or sometimes waiting long hours in the centers without getting the service needed.

> *Sometimes we go and wait for hours there and then we find out that the service we want to access is unavailable.*
>
> *(GL1)*

There were two points expressed regarding the prioritization of PwDs when waiting for appointments.

[14] Zapka JG, Palmer RH, Hargraves JL, Nerenz D, Frazier HS, Warner CK. Relationship of patient satisfaction with experience of system performance and health status. J Ambul Care Manage 1995; 18: 73-83 pmid: 10139348.

> *All PHCCs should set PwDs priority over the normal people, because I used to wait a lot and that would make me uncomfortable.*
>
> *(KS5)*

> *There shouldn't be a discrimination though between PwDs patients and non PwDs, the urgency doesn't depend on whether the person is a PwDs or not.*
>
> *(FS5)*

Subtheme C3: Session duration satisfaction

A lot of PwDs reported not being satisfied with the duration of the sessions provided in the PHCCs.

> *There's a big difference between private clinics and PHCCs. In the PHCC, there's a load of people waiting, there's a lot of papers that need to be done, and you need to take an appointment for next week then go and wait for four to five hours and eventually the doctor sees you for five minutes.*
>
> *(GL7)*

Conversely, a few PwDs experienced no wait before receiving the help needed, depending on the center.

> *The time for the treatment is enough, one hour.*
>
> *(HS4)*

> *About the duration of the consultation, it depends on each case. When I had an eye infection, the doctor took his time to examine me. But when I got an infected zit, the visit didn't last ten minutes.*
>
> *(DL6)*

Subtheme C4: Staff behavior

PwDs reported mixed experiences and opinions about staff behavior. Some FGD participants reported a positive experience with the healthcare providers, while others did not, depending on the center. Many reported that the providers were cooperative, friendly and treated them well. One of the women in the FGDs reflected on her positive experience with providers by saying:

> *The employees at PHCCs are helping PwDs, almost 80% are good. So they take care of us at the center and treat us well.*
>
> *(FL1)*

However, as noted above, not all the participants reported that the providers were sensitive to their needs. Some said that providers were not qualified to deal with PwDs, were generally rude, and acted carelessly. Some PwDs stated that the employees made them feel uncomfortable.

> *The employees make me feel really uncomfortable. They make me feel like I am different and I don't like that. No one likes to feel this way.*
>
> *(AL6)*

> *Even the employees in such NGOs are not qualified to deal with PwDs, this is an important note, they're not humane.*
>
> *(HL3)*

Some of the FGD participants reported that providers they encountered did not provide proper explanations or give clear information/options regarding their treatment, sometimes using medical terms which were not understandable.

> *Some doctors answer your questions, others don't, it depends also on the time availability since every doctor has to work elsewhere.*
>
> *(JL7)*

> *Sometimes doctors don't take the time to explain my condition.*
>
> *(AL6)*

Subtheme C5: Cost satisfaction

Some participants reported dissatisfaction with the costs associated with accessing health services at the PHCCs. They stated that it is their legal right to receive no-cost health services, since most PwDs are unemployed/underemployed.

> *Sometimes you worry about providing the money before going. Even if it's 15,000 LBP but because you don't work.*
>
> *(DL7)*

> *I am not satisfied about paying medication expenses and transportation fees. I just paid for a doctor checkup as 10,000 LBP but it should be for free.*
>
> *(CL11)*

On the other hand, other participants felt satisfied with the fees paid at the PHCCs since the amount is very nominal compared to the private sector.

> *I felt comfortable and was satisfied with the amount I paid. At the PHCC, I paid 10,000 LBP, if I want to go to a private clinic, I would have to pay 50,000 LBP.*
>
> *(FL8)*

> *We pay something nominal, 3,000 LBP for a consultation better than paying for a private doctor, 30 or 50 USD.*
>
> *(ES4)*

Key Informant Interviews

Sample Characteristics

During November and December 2019, a total of eight individuals with particularly informed perspectives on disability and the health sector took part in the Key Informant Interviews. They include:

- Four service providers from NGOs (one refused to sign the consent form);
- Two managers from the Ministry of Social Affairs (coded as MoSA1 and MoSA2) who are knowledgeable about the eight centers in Lebanon responsible for implementing the Program for the Rights of Disabled People, under which the MoSA Disability Card is issued;
- Head of Social Developmental Centers (SDCs) from MoSA (coded as MoSA3) who oversees and coordinates the work of the 228 SDCs in Lebanon which provide health services for all populations, including PwDs. 11 of these centers are also under MoPH network;
- The Head of the Disability Department in the Ministry of Public Health (refused to sign the consent form)

As mentioned in the Methods section above, the KIIs were conducted in English and Arabic. Interviews in which the participant agreed to sign the consent (six in total; two participants refused consent) were recorded, transcribed, translated into English (if appropriate), and analyzed for key themes. Figure 26, below, summarizes the four major themes that emerged, along with the 14 subthemes.

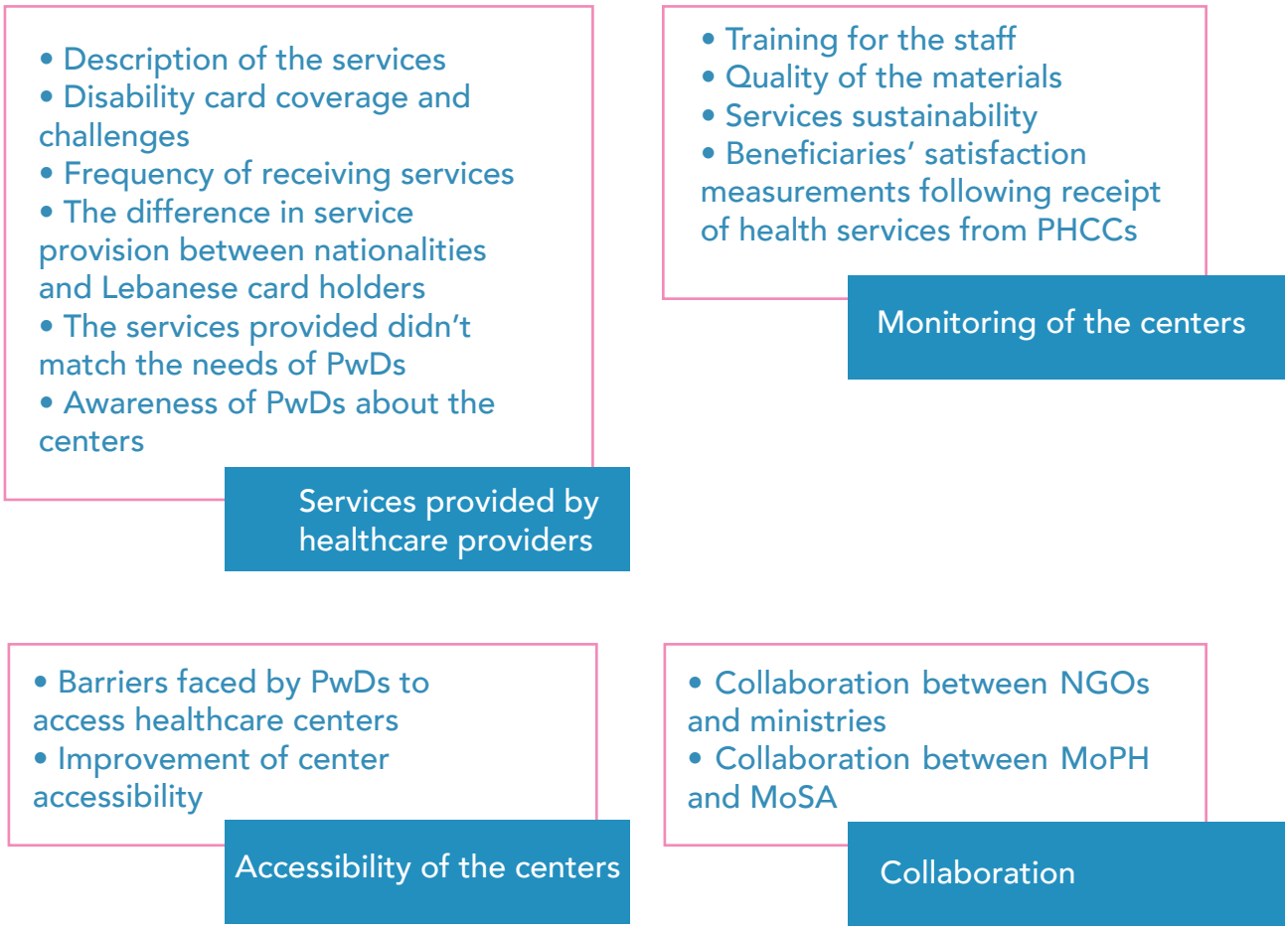


Figure 26: Themes and subthemes obtained from the Key Informant Interviews

Note concerning the Disability Department in the MoPH

Unfortunately, the Disability Department in the MoPH is not active and includes only two persons; the head of the department and an administrator working on monitoring the institutions contracted with the ministry. The main responsibilities of this department are as follow:

- Giving approval for PwDs card holders for hospitalization (by law, PwDs hospitalizations should be covered 100%; notably, emergency hospital services are excluded).
- PwDs can provide feedback about the hospitals (e.g., if coverage was denied) and this department will follow up.
- Monitoring the institutions covered and contracted by the ministry to ensure they are following the standards rules.
- Providing reports on institutions who fail to follow the standard rules

As the interviewee refused to provide consent, her feedback was not included.

Theme A: Services provided by healthcare providers

Subtheme A1: Description of the services

The services provided by the organizations which took part in the KIIs differ based on the respective program's aims. Services from MoSA, for example, were differentiated into two categories: general health services provided through the Social Development Centers and disability-specific services provided through the Disability Rights Program.

As described by two participants, the Ministry of Social Affairs provides services and health equipment through institutions and centers contracted with them. Assistive devices, incontinence and colostomy supplies, and pressure ulcer prevention and treatment supplies are provided, as well as rehabilitation services and some vocational training and education.

> *Assistive services like mechanical bed, walker, all types of chairs except the electric chair, medical shoes… for physical disability, knowing that, in the past, we used to provide assistive services for the visual and hearing disability but we don't anymore, probably because of the lack of budget, the hearing aid is expensive.*
>
> *(MoSA2)*

Other health services, like medical consultations (orthopedic, urologist, psychiatrist, generalist, gynecologist, pediatrician), medications, echography, and simple checks for common ailments (e.g., blood pressure and diabetes) are also provided by MoSA, through the Social Developmental Centers (SDCs). Assistive devices are not provided through this mechanism, but are instead distributed through the Disability Rights Program.

> *We offer doctors consultation such as internal medicine, pediatrics, gynecology, dentistry, and in some centers, mental health. This is when it comes to medical services. Other services are social, cultural, etc.*
>
> *(MoSA3)*

> *The assistive devices are provided at the MoSA centers that implement the Program for the Rights of Disabled People. At SDCs, we don't provide them. At some SDCs, we have a few of these devices in case someone needed them, and they don't necessarily have to be a PwDs, it could be a pregnant woman for example or someone who broke their leg. They can borrow it and return it, but we don't provide more than that.*
>
> *(MoSA3)*

Furthermore, each NGO reported providing health services based on the available budget of the specific program being implemented. Some of the services provided include medical consultations (general and specialized), acute medications (typically not chronic medications), and MHPSS services (one NGO), all of which target vulnerable populations generally. Most NGOs do not enhance or provide PwDs-specific health services.

> *Our services take into account PwDs in the design of the centers and services but there's nothing specific for them.*
>
> *(MdM)*

There are, however, a small number of NGOs currently providing PwDs-specific services, such as assistive devices, chronic care supplies, rehabilitation services, and vocational training.

> *Mainly rehabilitation services (physiotherapy, speech therapy, occupational therapy, orthopedic services like manufacturing ankle-foot-orthoses, splinting material and technical aids).*
>
> *(Moussawat)*

When PwDs are in need of services which are not provided by these centers, a referral to another facility is provided (e.g., specialist providers, laboratory tests, and imaging (X-rays).

Subtheme A2: Disability card coverage and challenges

In addition to these services, and as per Law 220, there are several additional services that should be covered by the MoSA disability card. Hospitalization was the service most spoken about by KII participants.

> *The MoSA card as per the law allows the PwDs to benefit from medical services through the MoPH. The law listed which services. The main benefit is free healthcare from MoPH.*
>
> *(MoSA1)*

> *The hospitalization is covered by MoPH. So people with disabilities can enter the hospital by having the MoSA card but MoPH covers certain materials while the person asks for something else advised by his doctor which is not covered by MoPH's budget.*
>
> *(MoSA2)*

When asking about the challenges voiced by PwDs with the MoSA disability card, two key informants from MoSA replied with skepticism, positing that perhaps the PwDs are simply unaware of the benefits or how to use it.

> *Personally I don't think there are any challenges when it comes to the disability card particularly.*
>
> *(MoSA1)*

> *There are no challenges faced by those who use the MoSA disability card. If the person uses it right and knows his rights and what the card covers. Even if the person has NSSF, the ministry covers the rest. What I'm trying to tell you is that the person with a disability is unaware or ignorant.*
>
> *(MoSA2)*

On the other hand, they are aware that problems do exist with certain hospitals not applying Law 220 appropriately (e.g., ensuring appropriate admission and the proper processing of hospitalization fees for PwDs).

> *When the person has a disability card, the hospital shouldn't receive anything in cash from the patient because it's not allowed to, so the trending approach of private hospitals towards PwDs patients is avoidance.*
>
> *(MoSA1)*

> *There's a problem in applying the laws and the private hospitals abiding to them.*
>
> *(MoSA2)*

The disability classification system currently in use by the Lebanese Government was also a challenge spoken of by one MoSA interviewee.

> *We issue the disability card, the purpose of which is to legally prove that one has a disability which comes in four types and under each type comes a number of classified disabilities as per the minister's decision. If a person has a disability which is not classified, we keep the file of the concerned person in case the disability he has becomes classified in the law. The doctor who examines the PwDs at our centers has the sole responsibility of confirming that the person has a classified disability.*
>
> *(MoSA1)*

One participant mentioned that PwDs may not receive the services to which the disability card entitles them because of strict budget limitations placed on MoPH and MoSA.

> *Both MoPH and MoSA nowadays don't have the means to cover additional services like physiotherapy and speech therapy, unfortunately*
>
> *(Arcenciel)*

Another key informant interviewee, who himself has a disability, expressed his opinion about the disability card.

> *For us as PwDs this card means nothing. On a personal level, I'm Lebanese and I have the MoSA disability card and I never used it. Never tried to use it even in hospitalization because I have my insurance. I hear from others, from beneficiaries, from friends it's always relative, when you have a campaign that hospitals should respond to the needs for PwDs, hospitals they do, whenever this campaign finishes they start pushing them out. The main health service that PwDs need is the emergency services in hospitals which is not covered by the card and it is the main issue. Plus, it's all about if you have connections in the hospitals.*
>
> *(Mousawat)*

Subtheme A3: Frequency of receiving services

In relation to the frequency at which services are provided, all key informants mentioned that the frequency differs from one service to another and is dependent upon budget restrictions. For example, a PwDs can be provided with one new wheelchair every five years.

> *According to the MoSA, they are not allowed with another wheelchair within the five years' period. They should go to receive devices from other organizations.*
>
> *(Arcenciel)*

When asked about the concerns over wheelchair durability that were voiced by PwDs in the focus group discussions, one of the key informants explained that MoSA has quality standards for the devices that contracted-organizations provide to PwDs, but that the ministry does not have the capacity to consistently monitor them.

> *Unfortunately, there are some organizations that import low tier devices (chinese wheelchairs) of course they won't be durable and the ministry doesn't have the capability nowadays to hold the organizations accountable for the quality of the devices they provide.*
>
> *(Arcenciel)*

The provision of other services, such as physiotherapy, medications, and incontinence supplies, depends on the duration of the project and the allocated budget.

> *It's project-based, for example if a Syrian PwDs is sent by UNHCR and they gave him ten sessions, we're limited with these ten sessions.*
>
> *(Arcenciel)*

> *Each service has its own terms and conditions based on practical limitations. We decided based on careful consideration that it's easier for PwDs to receive diapers every two months instead of every year because we are limited with the weight and volume that the people can carry at once. Of course we also take into account the budget of the program.*
>
> *(MoSA1)*

One key informant stated that even with the service and frequency restrictions, exceptions can be made. In such cases, MoSA should perform an investigation prior to issuing a final decision.

> *We have a lot of services around 101, every service has a specific duration. Any person with a MoSA card who needs more services can send a request to get extra. This request can be done in our centers, to try to facilitate things for special cases. For example, if a bed was broken, we investigate what happened to see if we're able to provide another bed. Because in our system, if a person gets a bed, he's not allowed for another one until five years later.*
>
> *(MoSA2)*

In contrast, two NGO key informants mentioned that there are no limits on the services provided by their organizations.

> *There is no limit, anyone can access the service or facility no matter their nationality or age range or number of times they came.*
>
> *(MdM)*

> *We cannot specify but I know some people with disabilities who have been coming to our centers for many years like 20 years, those with spinal cord injuries who are coming for physiotherapy. It depends, it is case by case…We don't have limits nor restrictions. When the service it's not available due to financial issues we apologize and we refer to another NGO.*
>
> *(Mousawat)*

Subtheme A4: The difference in service provision between nationalities and Lebanese card holders

A clear distinction was made when comparing the three groups (Lebanese with disability card, Lebanese without disability card, and Syrian refugees). Although he Lebanese card holders' benefit from services provided by MoSA through contracted institutions and organizations, these services are not completely free.

> *All our services are for the people who have the MoSA card.*
>
> *(MoSA2)*

> *The person with a MoSA card pays 10% so he can be responsible for the service. Because if you give a person free services, he can take the service for granted.*
>
> *(MoSA2)*

Organizations like Arcenciel, which is contracted by MoSA, provides the same services to all three groups, but the costs associated with the services differ by group. For example:

- Lebanese with disability cards receive the services for free.
- Lebanese without disability card pay a small fee (as much as they can) if it's not covered by an ongoing project.

> *For those who don't (without disability card), we either provide the services for free through funded projects or the PwDs pay a small fee.*
>
> *(Arcenciel)*

- Syrians are covered by a project from UNHCR and receive the services and transportation for free.

> *We provide services for all groups, including Syrians, following project-based services (Meaning through UNHCR, UNICEF, etc.). The same services are provided for the three groups. The UNHCR pays for the services provided to Syrians. The one who pay are the Lebanese who don't have a MoSA card or the people we couldn't cover through projects. The Lebanese with MoSA card are covered by MoSA.*
>
> *(Arcenciel)*

The SDCs provide services to everyone, but again, the cost differs:

> *PwDs with a disability card don't pay anything. The person who doesn't have a disability card pays 7,000 LBP. When it comes to the Syrians, they pay the same as PwDs without cards*
>
> *(MoSA3)*

> *There's a long list of persons who receive services for free: The people with disability card, Hala card (the poor ones), orphans, widows, women whose husbands are in jail...*
>
> *(MoSA3)*

Two interviewees from NGOs not contracted with MoSA reported that all their services are provided at the same cost to everyone.

> *There is no difference between beneficiaries either in relation with the nationality or card holders. Since we are an organization working in camps we don't have a contract with MoSA and we don't care about the card. And all our services are completely free.*
>
> *(Mousawat)*

> *There are no differences between the Syrians and Lebanese, no matter what the nationality is, the consultation is 3,000 to 5,000 LBP.*
>
> *(MdM)*

Subtheme A5: The services provided didn't match the need of PwDs

The overwhelming majority of key informant interviewees stated that the services provided by the ministries and NGOs didn't match the needs of PwDs for the following reasons:

- The high number of PwDs in need of health services in contrast with the low number of MoSA-contracted centers and the challenges associated with covering a large geographical area, in addition to the relative absence of MoPH which should cover these services.

> *PHCCs were not developed to respond to the needs of PwDs then MoPH started referring them to specialized centers which are not paid by MoPH.*
>
> *(Arcenciel)*

- MoSA-contracted centers, as well as many NGOs, do not cover all specialized services, such as imaging and laboratory.

> *We can't have radiology and we don't have medical labs, we are not allowed to and there are no plans for it in the future, we can't go into specialized services. There's governmental hospitals for that.*
>
> *(MoSA3)*

> *No, we are a rehabilitation organization, we offer rehabilitation services and technical aids but no primary health care services neither medications or laboratory tests…*
>
> *(Mousawat)*

• One of the interviewees mentioned that there is no specific assessment done by their organization to make sure that the services provided are the ones most needed.

> *Medication-wise, we provide acute medications, nothing specific. Dentistry is one of the basic services we have. There are five main services that have to be present in order to be accredited: General Practitioner, Pediatrician, Gynecologist, Dentistry, and either a Cardiologist or an Endocrinologist. We make sure these services are present in the centers, as well as the extra services which are present upon the need. We haven't done an assessment specifically to make sure that these services are most needed.*
>
> *(MdM)*

The participants from MoSA stated that it is the responsibility of MoPH to provide health services for PwDs and that nothing should be done by MoSA.

> *MoSA shouldn't intervene in the domain of other organizations in terms of health. This concerns MoPH.*
>
> *(MoSA1)*

Subtheme A6: Awareness of PwDs about the centers

When asked how PwDs know about the centers and the healthcare services, each interviewee mentioned the method used by their organization.

Methods used by MoSA include:

• Maintaining a list of all institutions

> *We have charts of all the institutions that provide services for PwDs and we hand them out, the list is area-based and disability-based. There's a printed booklet that has been done - which I opposed because data changes over time - and now it's being updated.*
>
> *(MoSA1)*

• Based on the activities of the centers

> *The centers are known from their activities, they coordinate with the municipalities, hospitals and schools. None in the region don't know about the PHCC.*
>
> *(MoSA2)*

- Guidance from the staff and referrals to PHCCs

> *In the center here, our staff guide people to the PHCCs if they ask about the services.*
>
> *(MoSA2)*

- Media advertisement

> *We tried to advertise through the media but our services are exhaustive. We only advertise in case a service is being provided in a specific spot with a clear procedure.*
>
> *(MoSA1)*

- Dispersal of brochures

> *We distribute brochures and our centers are not new and in the rural areas everyone knows them. We distribute the brochures to the municipalities.*
>
> *(MoSA3)*

According to Arcenciel, a list of all MoSA-contracted institutions is distributed to PwDs when they are issued their disability card.

> *When PwDs issue their MoSA cards, they are given lists. The references of the people who have MoSA cards are the centers of MoSA.*
>
> *(Arcenciel)*

> *There are seven centers for MoSA and three of them are in our offices, meaning we have given MoSA the permission to open their centers in our offices in Halba, Taanayel and Beirut without paying for any expense for the ease of operations. At least 40 % of PwDs in Lebanon consider these MoSA centers as their reference and they know about our services upon visiting these MoSA centers in our offices, the rest don't.*
>
> *(Arcenciel)*

As per MdM, awareness sessions about their supported centers (including services) are provided to Syrians refugees.

> *We have an awareness session component. In every catchment area of the facility we work at, there are community mobilizers who receive training and replicate this training in their community. One of the main components that is discussed in every session is the mapping of services. The community mobilizers inform the people about the UNHCR brochure and which services are provided, where MdM is operating and where other INGOs are operating and even if MdM doesn't support them. But only for Syrians.*
>
> *(MdM)*

Mousawat, on the other hand, does not provide awareness of their centers since they are a well-known provider of rehabilitation in the country.

> *Mainly word of mouth, because we are a very old organization and well known. We started working during the civil war. We should mention that a lot of efforts are done to make the services well known, and we don't really think we have a problem of lack of knowledge.*
>
> *(Mousawat)*

Other methods that could be employed, as mentioned by one of the interviewees, include the use of announcements in other centers and through the government.

> *If we want more people to know about our services, we could announce them in other centers.*
>
> *(Arcenciel)*

Theme B: Monitoring of the centers

Subtheme B1: Training for the staff

In contrast to findings from this study's PwDs survey and focus group discussions, the majority of key informants reported that their staff were trained on how to treat PwDs and how to communicate with them. However, one interviewee from MoSA stated that these kinds of training were conducted previously, but had been stopped due to transportations issues.

> *About how to behave in general with different types of disabilities. They're hints more than specialized training. Since the staff are initially specialized in their technical field. All staff are subject to internal training on how to behave with PwDs. Such trainings are more behavioral than specialized.*
>
> *(Arcenciel)*

> *They took a lot of training, to the point of boredom! Of course we worked on how to communicate with PwDs and how to deliver the services.*
>
> *(MoSA3)*

> *The internal audit and the training are part of our work which we started in 1994. All of our staff used to get a minimum of four trainings sessions per year, that's a minimum. All of this stopped. This year, and as you know all employees receive transportation fees. Since the beginning of this year, our employees have probably only received the transportation benefits of January. When I am going to get people from Akkar to have them sit for training, the least I should do is pay for their transportation. But for a year now, 60% of my staff are day laborers, they get paid by the hour and don't have NSSF nor transportation benefits. Even their contract hasn't got renewed. Why would I give them trainings?*
>
> *(MoSA1)*

Many other training sessions were conducted with the staff, as per one of the interviewees.

> *We do continuous training and workshops. We do many internal training in protection, primary health care issues that they don't receive in the university about case management and referrals. We have a capacity building program.*
>
> *(Mousawat)*

One NGO described that their staff were receiving training, but were not specifically trained on how to communicate or deal with PwDs.

> *Honestly we don't have the capacities to do such training internally and we didn't outsource it. Our staff receive training but not related to PwDs. These are training related to the monitoring of the centers or the checklist of the MoPH or the Canadian accreditation or GBV or mental health or Psychological First Aid (PFA) but nothing related to PwDs.*
>
> *(MdM)*

When asked about their opinion regarding the level of training of PHCCs, one interviewee described his own experience with the staff in the private sector.

> *We have only one PHC and our staff are well trained, but the other PHCCs are not well skilled on how to deal with PwDs, even in the best rated health services providers in the private sector.*
>
> *(Mousawat)*

The skills improvement of organizational staff was reported by interviewees to be measured through evaluation forms and direct supervision. Based on the performance evaluation, corrective measures were taken.

> *If after some time we see that the staff is not interacting well with beneficiaries, we take corrective measures either by giving the employee another training or telling them that they can no longer work with us.*
>
> *(Arcenciel)*

> *From time to time, I pass an evaluation form…I pass by all the centers to see what's happening and to know people's opinions. I schedule meetings with supervisors, investigators, doctors. So I see what's missing and what needs to be improved from the feedback I get and from my own observation.*
>
> *(MoSA2)*

> *We used to do evaluations after each training but now we are working on doing a yearly evaluation for the performance also with the Italian cooperation.*
>
> *(MoSA3)*

> *We do internal evaluation every two years in all levels professional, management and financial. We bring an external consultant to do that and also we have the technical director and managers.*
>
> *(Mousawat)*

One participant from MoSA added that the evaluation of the staff was applied previously, but not anymore.

Subtheme B2: Quality of the materials

The quality of the equipment and consumables provided by institutions is a key component of the overall quality of care. In the KIIs, participants were asked about the quality of the materials used in the items they disperse. One of the interviewees described manufacturing assistive devices in Lebanon and then importing a small sample against which to compare. The products were subsequently improved through quality monitoring procedures and beneficiary feedback.

> *Most of the assistive devices we distribute are either manufactured by us in our workshops or imported. We started manufacturing since 1994. Over time we have improved ever since (We manufacture wheelchairs, walkers, etc. PwDs themselves manufacture them.)*
>
> *(Arcenciel)*

> *We import a sample and compare them to our manufactured devices.*
>
> *(Arcenciel)*

Another interviewee mentioned buying assistive devices from local suppliers and having a quality control committee to check the quality of the devices.

> *We buy them from a local supplier.*
>
> *(Mousawat)*

> *We have a quality control committee, we compare quality and available funds and sometimes we compare it with the needs of beneficiaries. For example, we have four kinds of wheelchairs at different prices, we decide what kind of wheelchair to give depending on their lifestyle if he is an active young man or if he's an old man sitting at home.*
>
> *(Mousawat)*

As per the key informants from MoSA and Arcenciel, MoSA has a booklet of terms and conditions (based on Decree 181/1998) that lists the standards for the assistive devices and technical aids by type. These standards include three main criteria: strength, safety and appropriateness.

Previously, a MoSA control team would conduct home field visits to check the quality of products and devices and to gauge the satisfaction of the beneficiaries regarding the services received from contracted facilities. Based on these findings, MoSA would follow-up with the center/organization. However, in recent years and especially as the financial crisis worsened, this process was discontinued.

When asked about the maintenance of the assistive devices, interviewees responded that their NGOs usually provide these services for free, but there are conditions depending on the NGO.

> *Yes, we do, if someone has paid for the device, we provide the maintenance during the lifespan of the device unless it gets severely damaged due to an accident.*
>
> *(Arcenciel)*

> *We have maintenance services for free in Beirut and Tyr, but people need to come and bring their devices. Sometimes we gather old wheelchairs, to take their good parts and to use them.*
>
> *(Mousawat)*

KI participants from MoSA stated that the ministry couldn't afford the maintenance of the devices, instead insisting that NGOs should do it for free.

> *We wanted to be involved in the maintenance of assistive devices but our budget doesn't allow it. But it might be feasible in the future. The institution or organization that distributes the device is obliged to provide the maintenance during the guarantee period of the device, and in all cases the devices come with a reparation kit. The periods depend on the device, for waterbeds it might be 18 months, I don't remember. Each item has a duration.*
>
> *(MoSA1)*

> *All centers provide maintenance; it's supposed to be free but some centers ask for a financial contribution. Every center is responsible for the services they're providing and if they don't provide the beneficiary with a chair in good condition, for example, they're supposed to give him another one.*
>
> *(MoSA2)*

For the medications, organizations usually follow established procurement processes and the official medication list maintained by MoPH.

> *We have a procurement process, and every medication that is registered at MoPH is certified. If pharmaceutical companies want to certify a medication in Lebanon, they need to provide its equivalent from the EU and USA. Therefore, each medication that's certified from MoSA has a good quality.*
>
> *(MoSA3)*

> *We distribute medications for the centers who are not in the network because they do not receive medications from the MoPH. About the ones in the network, we have the essential list of medications and we talk to the ministry and ask them about the ones that the ministry doesn't cover and we buy these medications and give them to the centers. It's not allowed to have brand medications in PHCCs. It has to be generic. In order for us to abide by the rules and the standards of MoPH we have to follow this guideline. We open tenders and reach the suppliers who are certified by the ministry, meet the standards and have the required items.*
>
> *(MdM)*

Subtheme B3: Services sustainability

In relation to the sustainability of the centers, most of the interviewees from NGOs described how it is difficult to assure sustainability as they are non-profit organizations that rely on the ups and downs of donor funding.

> *Sustainability is difficult and not always assured because we are a non-profit organization and we rely on donors and we are not registered in MoSA to get money as others, even those who are supposed to be sustainable are suffering. Sustainability it's not guaranteed and we should have a strategy to do it.*
>
> *(Mousawat)*

> *About the sustainability of services, this is a major issue we are facing currently because our support we provide to the centers differs from the usual support. We reimburse the salaries of the staff who were not initially present at the centers and who recruited based on our demand to ensure the quality of services: for example, registered nurses were not present in all centers to administer vaccines for free. Once our project ends, I don't know to which extent…So once we leave, the center might have to let go of the healthcare providers who are key in ensuring the quality of services, whether they are registered nurses or midwives, etc. So sustainability is partly out of control.*
>
> *(MdM)*

Subtheme B4: Beneficiaries' satisfaction measurements following receipt of health services from PHCCs

All participants from the KIIs agreed that patient perceptions of treatment and care quality at health facilities were important. The three NGOs interviewees mentioned using FGDs and satisfaction surveys with beneficiaries on a regular basis to evaluate the health care services and to take corrective measures, typically by talking to the staff, conducting additional training, and performing internal monitoring.

> *FGDs and satisfaction surveys in order to identify which services satisfied the beneficiaries in order to improve our services. We use these tools continuously because we are ISO certified. If the satisfaction is not up to par, we take corrective measures when the satisfaction is not as expected like talking to staff and doing additional trainings.*
>
> *(Arcenciel)*

> *We do FGDs with beneficiaries and we have a satisfaction form filled by both current and old beneficiaries on a regular basis or when they finished their treatment. Based on the findings, we do an internal monitoring for the clinics.*
>
> *(Mousawat)*

> *We have two systems, the patient satisfaction survey which we do recurrently: daily or biweekly by monitoring officers and we conduct a survey with everyone who finishes consultation. There's also a beneficiary satisfaction survey which we do annually. The sample is bigger, the mechanism and it's a longer survey. We do it all year round and we go to the camps. There's an equation for it. After the results, we review the main complaints from both surveys and based on this we take corrective measures.*
>
> *(MdM)*

The Ministry of Social Affairs previously conducted field visits to check the satisfaction of PwDs, and based on this result, would issue warnings or reduce funding to the concerned organization if warranted. However, this is no longer applied.

> *This inspector goes on the field and takes a random sample to survey according to the standards we set. He checks if the person is using the device and if he's satisfied with it. Based on the survey results, we perform a quality check and send a warning to the concerned organization if it turns out that their delivered service was not up to par. Depending on the severity of the situation, we sometimes even cut the organization from our budget or shut it down completely. This stopped being implemented since 2004.*
>
> *(MoSA1)*

> *We don't have a procedure to measure the satisfaction of the beneficiaries, and we do have a complaint box which is inactive. There's two points I want to talk about regarding satisfaction: the control team with me were supposed to do home visits and know from people if they're receiving the services, the quality of it and how they're using it. This procedure is inactive now but I'm fighting to get it active again.*
>
> *(MoSA2)*

Theme C: Accessibility of the centers

In contrast to the feedback of survey and FGD participants, all key informants described their centers as accessible. Interviewees from MoSA also talked about the accessibility standards used by the ministry for those centers with which it contracts.

> *There are three types of conditions that accredited institutions should abide by in order for their services to be accessible. The first condition is about physical accessibility, both from the public right of way and inside the institution. The second condition concerns the accessibility of communication, meaning that there has to be an available phone number and the third type of accessibility concerns the working hours of the centers: they need to be reasonable and should be posted on a printed paper outside the center for everyone to know.*
>
> *(MoSA1)*

> *The specialized centers like us have all the accessibility standards like braille, and clearances etc.*
>
> *(Arcenciel)*

> *When it comes to the access, not only because it's one of the criteria of the quality standards or quality services, but also because we want to serve everyone with no discrimination, we work with these centers to make them accessible for people with special needs whether they are people with disabilities or elderly. For instance, in Aley, we constructed an extension for the center on the ground floor with ramps and special restrooms for the PwDs meeting disability criteria. In Kamed el Loz we installed an elevator just for that, in al Ain we installed a chair lift and in al Qaa we started to ease the access in terms of doing ramps instead of stairs and extending the clinics to the ground floor, because it's a two floor center with the reception on the ground floor.*
>
> *(MdM)*

Subtheme C1: Barriers faced by PwDs to access healthcare centers

However, the participants cited different barriers when accessing their centers:

- The KII participants talked about the geographic barriers created by the uneven distribution of a limited number of centers across a large, difficult to navigate area. For example, the interviewee from Arcenciel mentioned that, in contrast to PHCCs, Arcenciel centers are physically accessible, but have geographical challenges.

> *Our center in Damour is on top of a hill. If the PwDs wants to get there, he would have to take a car because of the poor state of public transportations in Lebanon, and the fact that the public taxis and buses don't drop you off exactly where you need to go. So when it comes to specialized institutions, it's the transportation and cost of transportation and not inside the centers.*
>
> *(Arcenciel)*

> *Our centers could be more spread out geographically. We have a center in Halba, in the South, etc. But we could be contracted with more institutions but this necessitates a bigger team. You can't grow in one direction and not provide the necessary infrastructure for it.*
>
> *(MoSA1)*

- Transportation barriers, including cost and accessibility, were also mentioned by two participants from the KIIs.

> *The most important barriers to the access of healthcare for these PwDs is transportation, mainly the cost of transportation to get to the center.*
>
> *(Arcenciel)*

> *All our centers are accessible for sure for all types of disability but we face a challenge regarding the transportation to our centers (the cost and the availability of transportation), we used to have accessible buses to ensure transportation but we had to stop this service for lack of funds. Mainly when we rent a center, we do modifications to be accessible for PwDs (entrance, bathrooms…).*
>
> *(Mousawat)*

- Information and communication barriers are an issue for PwDs with certain disabilities, as per some interviewees, as specific services are not provided for those disabilities.

> *We don't offer services for hearing and visual disability so that's why our centers are not accessible for these kind of services.*
>
> *(Mousawat)*

> *For all types of disabilities? In all of Lebanon, no measures are taken for the accessibility of people with a visual disability. Unfortunately, in this country accessibility is only understood in relation to the wheelchair.*
>
> *(MoSA3)*

> *Our centers are not equipped for people with hearing disabilities. I mean, in all of Lebanon, how many people know how to assist deaf people? When it comes to physical disability, all of our centers are equipped in terms of ramps. There are only 4 to 5 centers that are not well equipped. In general, our centers are leased apartments. In Ashrafyeh for example, we have a center that is allowed with only one parking spot. Same for the center in Mazraa and Msaytbe. In rural areas however, you can park wherever you want.*
>
> *(MoSA3)*

When asked about the accessibility of PHCCs, interviewees from MoSA and associated institutions stated that these centers have a good geographical spread, but are often not physically accessible.

> *If we look at PHCCs, they have the opposite issues. They are easier to get to using public transportation but after getting there, some services are missing and the centers are not accessible inside: they're on the third floor.*
>
> *(Arcenciel)*

> *Not all of our centers are accessible for people with disabilities. Especially the centers in cities that are present on higher floors. However, there are elevators in all of the buildings where these centers are, except for two. But you know, electricity is always an issue.*
>
> *(MoSA3)*

Subtheme C2: Improvement of center accessibility

When asked about the improvement of center accessibility, KI interviewees reported that a lack of financial resources acted as a primary obstacle to ensuring that centers are geographically well-dispersed and physically accessible with accessible transportation and proper equipment present.

> *To be able to improve we need funding to provide the equipment needed and to prepare the centers to become accessible for other disabilities.*
>
> *(MoSA2)*

> *We have to either improve the transportation or improve the centers by making them more geographically accessible. Otherwise we would have to provide all the services that PwDs need through PHCCs, which is what the law mandates, and make the PHCCs accessible.*
>
> *(Arcenciel)*

> *They have to apply all measures of disability, and start thinking about universal accessibility. Now we should not think about accessibility anymore we should think about universal design, we should do everything accessible for everybody.*
>
> *(Mousawat)*

Some improvements in accessibility were already implemented as per two NGO interviewees. In addition, there is a plan to build new accessible centers (SDCs), as mentioned by the head of SDCs.

> *We have a project funded by United Kingdom (UK Aid), we provide a four accessible tuk-tuk with a manual ramp to transport people with disabilities inside the camps (Badawi camp and Nahr el-Bared camp).*
>
> *(Mousawat)*

> *Yes. In Qaa we enlarged the rooms and door clearances so that they are accessible to wheelchairs. In Al Ain and Kamed, the restrooms are not accessible so here lies the problem. Other than that, the services are being given to everyone in the same manner.*
>
> *(MdM)*

> *We are drawing plans for a center that is accessible for all types of disabilities and there is no way we are going to find a place that already meets these standards. We are planning on building 100 of these centers in Lebanon, and shutting down 100 of our SDCs (from 120 to 20). We already handed out the ToR to the companies that are going to execute them. Right now we have the funding to execute four of these centers. And I repeat, these centers do not only provide healthcare, health is one of the many services that will be provided there. We already created the medical model and we are testing it out in a few centers. We want to be able to have updated files on a central database but of course only the doctors would be able to see. At the end of this year, this model would be generalized for all centers.*
>
> *(MoSA3)*

Theme D: Collaboration

Subtheme D1: Collaboration between NGOs and ministries

At the end of the KIIs, participants from NGOs were asked about their collaboration with both ministries (MoSA and MoPH). Arcenciel reported good collaboration with MoSA, adding that the budget provided to them was their singular challenge. On the other hand, the Arcenciel interviewee mentioned that they are trying to collaborate with MoPH, but with no progress.

> *The challenges with MoSA are mandated. We thank MoSA for being able to cover sometimes, but it's not their mandate but sometimes the transfer of the budget gets delayed, sometimes the Ministry of Finance doesn't provide enough coverage.*
>
> *(Arcenciel)*

> *We tried to collaborate with MoPH but it's a long process. We tried but if you want to benefit from MoPH you have to be a PHCC.*
>
> *(Arcenciel)*

There is no collaboration between Mousawat and MoSA, as Mousawat is not financially supported by the ministry like other NGOs or institutions.

> *MoSA does not financially support Mousawat, so there is no collaboration with them.*
>
> *(Mousawat)*

The third international NGO interviewed mentioned that their organization collaborates with MoPH rather than MoSA, since they are not providing specific services for PwDs. They are instead supporting PHCCs more generally with activities that are in line with MoPH priorities.

> *Our collaboration is mainly with MoPH rather than MoSA and all our activities are in line with MoPH. At some point we completed some of the tasks that the ministry had to do: they have one coordinator for 40 PHCC in the Bekaa so we took their MoPH-checklist and reported on it for them. And we always update the MoPH on our activities.*
>
> *(MdM)*

Subtheme D2: Collaboration between MoPH and MoSA

When asked about the collaboration between ministries (MoSA and MoPH), one participant described the duplication of services due to the lack of collaboration and communication. In the case of Lebanese who do not have a disability card, MoPH should be responsible for providing needed health services. Another interviewee further confirmed this lack of collaboration.

> *The MoPH provides urinary incontinence and primary health care services by just receiving a medical report from the person. The person with a MoSA card can get a chair from MoSA and then go get another one from MoPH, so here we have an overlap. The centers with MoPH don't coordinate between each other so the person can get the same service from a different center. In MoSA, we have a system with codes and the reference is the center from where the card was issued.*
>
> *(MoSA2)*

> *MoPH knows about the MoSA card because the 100% free hospitalization is done through MoPH. So MoPH has to take the initiative of letting all her centers know that when people ask for services, to make sure that they don't have the MoSA card and they don't benefit from any service from MoSA. For example, they can communicate with us about the people who have a disability that's not among the MoSA classification, to provide them a bed or a urinary incontinence service.*
>
> *(MoSA2)*

> *There is no collaboration between each other and they don't work together. The matrix of services between MoSA and MoPH, it's a total mess. They should differentiate the services between MoSA and MoPH and the services should be provided from only one side for not confusing the PwDs.*
>
> *(Mousawat)*

Contrary to what other interviewees said, the two KI participants from MoSA reported good collaboration and communication with MoPH, since a small number of SDCs are part of the MoPH network. They also related that there is no service duplication or geographical overlap.

> *We collaborate as much as any two ministries in Lebanon do. We don't provide the services that other ministries provide. We don't hand out prostheses and orthoses because these are covered by NSSF and MoPH. As MoSA, we don't interfere with other services.*
>
> *(MoSA1)*

> *Some of our centers are part of the MoPH network. Effectively, MoPH doesn't have centers. Some healthcare facilities are accredited by them and constitute their network. Their dispensaries were shut down a long time ago and now they accredit certain institutions. In general, we don't open SDCs in areas covered by MoPH. There's no way we are going to be in a competition with MoPH and we cover the areas that MoPH doesn't. If we are present in an area and MoPH accredits a medical facility there, then we change our services from medical to social services.*
>
> *(MoSA3)*

At the end, one interviewee indicated that health actor collaboration/communication could be enhanced, with a resulting decrease in the potential for service duplication, through activation of the "Health, Rehabilitation, and Support Services Committee" that is called for in Article 32 of Law 220.

> *In my opinion, the legal structure that is mandated by the law is the solution. It comprises a specialized committee with MoSA, MoPH, the social security, etc. all the health coverage actors in Lebanon and is supposed to set the standard norms for the quality of services and for the procedures.*
>
> *(Arcenciel)*

Discussions

The primary purpose of this study was to better understand the manner and extent to which PwDs (Lebanese and Syrians) engage with health and rehabilitation resources in Lebanon. Prior to designing the relevant quantitative and qualitative data collection tools, the study team recognized this as an exceptional opportunity for adding to the sparse statistical and narrative evidence available on these populations. To this end, survey and focus group discussion participants were asked questions regarding education, livelihood, and the MoSA disability card/government entitlements, in addition to those focused on health and rehabilitation needs, access to and utilization of needed services, levels of awareness and satisfaction, and perceived barriers to care. This study's results, those unsurprising and otherwise, provide further illustration of a state unable to ensure the financing and provision of appropriate services 20 years on from the passage of Law 220/2000. They also show that, in the absence of central-level leadership on this important issue, most communities, businesses, and institutions have continued to deprioritize the elimination of barriers and the fostering of widespread awareness and inclusion efforts. But, more than this, these results provide a richer framing of an exceedingly vulnerable, yet resourceful population that faces hardship over hardship in a daily battle to live fulfilling and dignified lives.

PwDs continue to face attitudinal, environmental, and institutional barriers that prevent the full realization of the social, economic, educational, and health rights to which they are entitled by international convention and Lebanese law. Although Law 220/2000 codified the right to employment, accessible transport and housing, and health and educational services for Lebanese PwDs, most of these commitments remain unfulfilled by any reasonable measure. Nevertheless, a large percentage of participants in this study were either satisfied or very satisfied with the services provided to them by the government and NGOs and did not recognize the existence of barriers related to the built environment, presentation of information, transport, or societal attitudes. Though seemingly contradictory, this evidence, instead, reveals a consequence of years of bias and discrimination in educational opportunities and social participation. The hard and soft skills elaborated through engagement in formal education processes are key to developing an awareness of one's rights, an expectation that they will be fulfilled, and the ability to properly advocate for them when they are not.

As a group, PwDs are among the poorest and most vulnerable, with little civic engagement and high levels of illiteracy and unemployment. Many PwDs leave their homes infrequently and are totally dependent upon their families, especially those who live in rural areas. In this context, it is little wonder that the PwDs community has a low level of awareness regarding their legal rights and even less ability to demand that these rights be respected, protected, and fulfilled. Meanwhile, the civil society organizations have been providing PwD's with their needs of education, social assistance and health services, in addition, they have been playing a key role in raising awareness among these persons and society regarding the rights related to disability.

Although all children and adults with disabilities have the right to access education on an equal basis with others in all stages and types of education, and despite the fact that education is perhaps the second most important issue after health for young PwDs, a large number of respondents (35.2%) report not receiving any formal education at all (31.2% Lebanese, 43.8% of Syrians). This is in stark contrast to data from a 2014 ILO study showing that only 0.3 % of Lebanese youth (15-29 years old) have never attended school [15]. This difference may be attributed, to some extent, to the median age of the populations studied, as recent years have seen a somewhat modest improvement in access to education by children and youth PwDs when compared to previous times in Lebanon. In addition, many parents of PwDs, especially those in rural areas and with poor education themselves, may be ashamed of their children and want to keep them home, or they may be unaware of their child's right to education and related services. Beyond this, accessible, low-cost transportation, the physical accessibility of the school, teacher and administrator commitment to inclusion, and societal attitudes generally all remain critical barriers impacting this issue.

Unsurprisingly, the absence of formal education and training amongst those in the older generations has had a direct impact on their employability. Only 3% of the respondents declared that they have completed a college/ pre-university/ university degree, and according to MoSA Disability Rights and Access program report on 31 December 2019, there are only 2,265 out of 59,951 disability card holders between the ages of 18 and 64 (3.77%) that declared they have a college degree. In addition, and consistent with the results of this study, UNESCO data[16] reveals that a majority of PwDs are unable to earn a livable wage for these very reasons.

In fact, the lack of formal education impacts on the development of a wide range of skills – from adequate literacy and numeracy to problem-solving and social skills -- which are critical to properly understand and advocate for one's rights, locate and mobilize needed health resources, and fully and effectively participate in society. In addition, the lack of widespread, accessible information further excludes PwDs, especially the many who rarely leave their homes, as it alters their views and expectations regarding government-provided services and entitlements, limiting their capacity to make decisions consistent with their own needs and personal priorities.

Despite the fact that PwDs can register themselves with MoSA and obtain a disability card, many of those who participated in this study have refrained from doing so. The reasons for this are diverse, however, the results of this study indicate a perception amongst many PwDs that the card does not cover the services or equipment they most need. Based on information provided by MoSA and MoPH, this perception has a basis in fact as many needed services, services which were stipulated in Law 220/2000, are in fact not provided or financially reimbursed for at this time. However, when participants were asked about their knowledge of services and entitlements that are available, a large number were unaware. This is likely one reason why only 54% had used the disability card to access services of any kind within the past 12 months and, despite facing health problems, only 47% used the card for health services including obtaining assistive aids. According to the MoSA Disability Rights and Access Program, 39.15% of disability card holders have used the disability card to obtain assistive aids, indicating that a

[15] Intenational Labor Organization (2015) Matching skills and jobs in Lebanon: Main features of the labor market-challenges, opportunities and recommendations. Retrieved on February 13, 2020, from https://www.ilo.org/wcmsp5/groups/public/---Arab states/---RO Beirut/documents/publication/wcms_559673.pdf

[16] UNDP (2012) Livelihood opportunities for persons with disabilities, page 12

large proportion of the 47% who used the card for health services may have done so in order to obtain assistive aids. It is clear that the limited provision of needed services (mainly limited to primary care, certain surgeries and types of therapy) combined with a lack of awareness on those services that are available contributed to the modest numbers associated with health service utilization.

Interestingly, the same MoSA report (Disability Rights and Access Program, December 2019) stated that, of all the services and entitlements available, the largest number of PwDs who used the card did so in order to obtain tax exemptions (43.73%). Likewise, a high number of participants in this study reported using the disability card for the same purpose (64%). The longtime availability of this service, widespread awareness of its existence, financial benefits, and easy procedure implemented by MoSA are some of the most likely reasons behind this. The fact that the disability card provides very limited services in different areas such as education, transportation, etc., explains the low percentages of PwDs used the card to obtain these services (4% for educational services, 3% for welfare support, and 1% for legal advice).

The lack of job opportunities for PwDs in Lebanon remains one of the biggest problems still facing the full implementation of Law 220/2000. There are no clear statistics regarding PwDs who are active in the labor market in Lebanon, however, we can depend on some figures to draw a sort of a picture of the employment of young PwDs.

Results from our study indicated that the overall rate of unemployment amongst PwDs between the ages of 17 and 100 (mean of 45 years old), is currently 79.6%. However, when looking at those within the typical working age range (18 to 64-year-old), the study showed an unemployment rate of 71%. This number is closer to that indicated by the MoSA Disability Rights and Access program (80%, February 20th 2020), but much higher than the 2017 national unemployment rate which was 25%, as reported by the Ministry of Labor [17] . The study also found an unemployment rate of 83.9% amongst young Lebanese PwDs (18-29), which is in line with the findings from 2013 UNESCO Lebanon report which estimated the unemployment rate of the Lebanese young PwDs to be approximately 78% [18] , though still much higher than the overall Lebanese youth unemployment rate which is 37%[6] (Ministry of Labor, 2017).

When disaggregated by gender and nationality, we see that female and Syrian PwDs are the most vulnerable groups. Indeed, significantly more male Lebanese and Syrian PwDs (26.1%) are working compared to females (12.2%), while Lebanese PwDs appear to have a significant advantage over their Syrian counterparts (25.6% versus 9%, respectively). According to UNHCR[19], Syrian refugees (PwDs and otherwise) have a difficult time accessing the labor market in Lebanon, regardless of their residency status, due to current regulations limiting the involvement of Syrian nationals to certain sectors, including construction and agricultural/seasonal work.

[17] Lebanese Republic Economic and Social Council (March2019) Unemployment in Lebanon. Retrieved on December 27, 2019, from http://www.databank.com.lb/docs/Unemployment%20in%20Lebanon%20Findings%20and%20Recommendations%202019%20ECOSOC.pdf

[18] UNESCO (2013) Social Inclusion of Young Persons with Disabilities (PWDS) in Lebanon, Beirut, page 17. Retrieved on December 27, 2019, from http://www.unesco.org/new/fileadmin/MULTIMEDIA/FIELD/Beirut/images/SHS/Social_Inclusion_Young_Persons_with_Disabilities_Lebanon.pdf

[19] UNHCR, UNICEF & WFP. (2017). Vulnerability Assessment of Syrian Refugees in Lebanon. VASYR 2017. Retrieved on December 27, 2019, from https://data2.unhcr.org/fr/documents/download/61312

The Reasons behind the high percentage of unemployment are related to several factors:

- The refusal of the private sector to implement article 74 of Law 220/2000 regarding the Employment Quota in the private sector. Indeed, the government has failed to ensure that this sector employs PwDs, despite the fact that the law has stipulated some measures to penalize those who refuse to implement the quota (article 74, paragraphs C and D).
- The reluctance of the public sector to fully implement article 73 on the Employment quota in the public sector, except for some level 4 jobs. The Council of the Civil Service (CCS) continues to refuse to include job descriptions for jobs that are announced. In doing so, they remove decision-making capacity from PwDs regarding the appropriateness or suitability of particular jobs.
- The lack of reasonable accommodations and failure to ensure accessibility in the workplace, in addition to the attitudinal and institutional barriers that prevent PwDs from joining the labor force to begin with. The current Lebanese employment regulations do not include any clear statement regarding the proper implementation of these measures or even what elements they should include. To some extent these can be concluded from the general direction of Law 220, however, the law did not state who (the government, employers or PwDs themselves) holds this responsibility.

International studies clearly show that PwDs are among the poorest and most vulnerable. In Lebanon, poor families that include one or more children with a disability are struggling to meet the costs associated with their medical and rehabilitative needs.

This study showed that a high percentage of respondents of both nationalities encounter ongoing difficulties meeting basic needs such as rent/accommodation (46.4%), clothing (65.2%), household necessities (73%), transportation (65.7%), water and food (55.8%), education (19.3%), health services (76.2%), telephone and communications (64.9%), assistive aids and devices (33.8%), and personal assistant care/care (30.3%). The results also show that significantly more Syrians compared to Lebanese have difficulties meeting all their basic needs (97% Syrians, 67.6% Lebanese). This result is understandable as Syrian PwDs are refugees and are deprived of the social, educational, and medical services available to Lebanese PwDs. Although Syrians continue to receive similar services from local, regional and international organizations, these services may not be not enough to meet the needs of those who participated in this study.

Concerning poverty, the latest UNHCR data showed that 69%[20] of Syrian refugees currently live below the poverty line, compared to 27-28.5% of Lebanese who are considered poor and struggle to cover their basic needs. Again, this is consistent with their status as refugees, wherein they are largely unemployed. Moreover, they are not covered by the Lebanese social security and medical coverage systems.

Based on this and other studies, it is clear that health concerns remain the first priority for PwDs and, in particular, those with physical and intellectual disabilities. These individuals face a very serious problem related to the lack of medical coverage, social insurance, and the presence and regular availability of disability related medical specialties within the Lebanese hospitals and medical centers.

PwDs, like everyone, require general, preventive, and specialist health services that are unrelated

[20] UNHCR (2019) Lebanon Crisis Response Plan 2017-2020. Retrieved February 13, 2020, from https://www.unhcr.org/lb/wp-content/uploads/sites/16/2019/04/LCRP-EN-2019.pdf

to their impairment, including medications, generalist and specialist physician consultations, dentistry, imaging, and laboratory testing.

Access to these resources is especially critical as there is good evidence that PwDs are more likely to have poorer overall health than the general population, due to a variety of possible mechanisms, which may be different for people with different impairments[21] . In fact, people with disability are at a higher risk of both secondary health conditions, which have a causal link to the primary diagnosis or impairment, and co-morbidities, which although occurring simultaneous to the primary impairment, frequently have a much less direct relationship, if at all. Examples of secondary health conditions include people with spinal cord injuries who are at an increased risk of pressure sores and urinary tract infections[22] and people with Down's Syndrome who are more likely to experience congenital heart disease, impaired hearing and early onset dementia[23]. Comorbidities, on the other hand, can include unrelated conditions like liver disease in a person who has had a stroke, but also conditions that are downstream of life circumstances (i.e. isolation, social exclusion, and poverty) which are related to the primary impairment, such as mental health problems in an individual with a long-term physical disability.

As demonstrated in the quantitative section above, the financial challenges act as a very real and ongoing barrier to accessing needed health service for PwDs. While it is certainly true that the financial obligations associated with accessing the healthcare system affect members of the general population, PwDs frequently experience a host of other disadvantages simultaneously, magnifying this challenge. The current study provides further evidence that barriers to healthcare access are significantly increased for those individuals who are not currently working (82.9%) compared to (17.1%) of those with low-income (Less than 500 000LBP). For a majority of PwDs (61.6%), difficult choices must be made, frequently at the expense of needed health services. Also, the geographic barriers associated with accessing care may necessitate locating/hiring accessible transportation as well as the involvement of a family member (who may need to miss a day of work) or personal assistant (who will need to be paid). These requirements can dramatically increase the overall costs depending on how far the individual is from the medical center. In addition, the provision of health services in physically inaccessible buildings (which includes the majority of PHCCs, hospitals, and private medical clinics/centers), without accessible sources of information (Braille signs, large print, etc.), and in the absence of health staff who are knowledgeable regarding the health challenges faced by PwDs, all actively prevent PwDs from accessing needed services. Finally, poor access to education and the high rate of illiteracy also have a significant impact on obtaining information related to health services and making appropriate healthcare decisions.

Moreover, as demonstrated by the qualitative findings, this study provides substantial evidence that the following barriers faced by PwDs hinder their access to health services and prevent them from receiving the care they need:

- The design and construction of indoor and outdoor health facilities frequently prevents PwDs access to PHCCs and other health care providers. Uneven access to buildings, inaccessible medical equipment, narrow doorways, multi-storey facilities without working elevators,

[21] Froehlich-Grobe, K., et al., Impact of disability and chronic conditions on health. Disabil Health J, 2016. 9(4): 600-8.
[22] Garcia-Arguello, L.Y., et al., Infections in the spinal cord-injured population: a systematic review. Spinal Cord, 2017. 55(6): 526-534.
[23] Malt, E.A., et al., Health and disease in adults with Down syndrome. Tidsskr Nor Laegeforen, 2013. 133(3):290-4.

inadequate bathroom facilities, and inaccessible parking areas create barriers to accessing appropriate healthcare services.

- Health centers in Lebanon are generally inaccessible to people with visual disabilities as they are unable to reach the facilities alone and, without the installation of Braille instruction, cannot easily navigate them once there.
- Health care providers are often not able to communicate effectively and appropriately with PwDs, which is perhaps the most under-recognized barrier to the delivery of quality health care for these individuals. This is a pervasive and alarmingly detrimental challenge for many people with disabilities, particularly for those with intellectual disabilities, hearing impairment, and developmental disabilities, as it undermines the development of respectful, bilateral relationships that can enable patients to effectively collaborate in their own care.
- The health environments are not equipped with interpretation services (sign language) or adapted communication tools (easy read information, pictures, symbols) which causes additional difficulties for people with hearing disabilities in communicating with the staff and receiving needed services.
- The limited number of health care centers, clinics/hospitals in rural areas negatively impacts the geographical distribution of available specialist services.
- The relatively small number and availability of services needed by people with disabilities is a significant barrier to health care.
- The lack of accessible and affordable transportation prevents PwDs from reaching health care facilities and travelling long distances.
- Many of PwDs healthcare needs continue to go unmet due to a lack of accessible information and awareness regarding the availability and location of specific services that may be needed. As such, PwDs tend to receive health information by word of mouth and from their local community.

The PwDs who participated in the survey reported a high level of satisfaction with the available health services. As mentioned above, this finding is inconsistent with other studies as well as this team's own empiric evidence. The high percentage of uneducated PwDs and the high level of exclusion and marginalization go the furthest in explaining this discrepancy.

Furthermore, this study found that a large percentage of PwDs (71%) felt that the staff at the health facilities have treated them well. The majority of the patients (80%) reported that the staff used the right terminology regarding their disability, were willing to listen carefully to the individual and provide answers to all their questions, and respected the privacy and confidentiality of the individual during the consultation. About three-quarters (75%) of PwDs who visited a PHCC reported that the staff talked to them directly instead of the person who accompanied them and empowered them with sufficient information regarding their disability. While only 35% agreed that the staff reacted in a helpful way when they faced an accident or other unforeseen problem while at the center, 47% report that the staff did provide needed administrative help (e.g., help with calling someone, help reading papers, help getting somewhere…).

Considering the situation of disability in Lebanon, and with the knowledge of the harsh conditions that PwDs are living in, the relatively high satisfaction percentages tend to indicate that many respondents don't know their rights and are socially excluded. People living under these circumstances are frequently unable to notice barriers, such as unsuitable or bad behaviors or inappropriate terminology.

And the qualitative findings corroborate this assertion, providing strong evidence of the real situation. Focus group discussion participants, many of whom displayed greater experience with the system and overall level of engagement, expressed dissatisfaction with the available health services, the limited quantity and low quality of the provided devices and products, the extensive waiting times in the facilities to receive the needed services, the inaccessible buildings, the lack of accessible information, and the absence of needed medical services, all of which affects their access to needed services. Moreover, many PwDs described frustrating experiences during health center visits due to the negative attitudes of the health providers towards disability, their poor knowledge and skills about providing accessible services, and the use of inappropriate terminology when interacting with them.

Conclusion and Recommendations

A realistic reading of the results of this study clearly shows that no serious efforts have been made to implement the law 220 despite the need for major reform. The essential rights of PwDs, such as the right to housing, transportation, accessibility, education, work opportunities, unemployment indemnity, and most importantly the right to health, are still being neglected. Moreover, PwDs in Lebanon continue to be deprived of the right to individual growth and personal development, instead being forced to rely on the assistance of others for obtaining their daily basic needs or, worse yet, facing prolonged institutionalization. This reality fundamentally precludes the independence that comes from self-decision-making, living and working in the community, and participating equally in all aspects of life within the society. It must be stated forcefully; the continued use of the social welfare model will neither improve the lives of PwDs nor safeguard their inherent rights.

Regarding the health sector, which was the main concern of this report, a general review of the pertinent aspects of law 220 reveal that the level of implementation remains decidedly low. As such, one aim of the study is to raise this urgent issue on the agenda of the Lebanese government and provide legal, social, economic, and educational recommendations that, if acted upon, could serve to decrease the many barriers faced by PwDs and help to improve health service access and utilization.

Improving the health sector and removing the environmental, attitudinal and institutional barriers that face PwDs requires wide-ranging improvements across a complex system involving numerous organizations and ministries, and will therefore require a great deal of hard work and meaningful political commitment. Because the different sections of the law 220 are connected to and influence each other, they must all be properly implemented in order to have the greatest impact on the current situation. But to achieve this, as well as to define a comprehensive package of health services specific to PwDs which should be covered by MoPH and ensure it considers the health and wellness needs of the different types of impairment, the government must immediately initiate a dialog with PwDs and their representative organizations. Civil society organizations, for example, have long-provided PwDs with education, social assistance, and health services, while simultaneously playing a key role in advocacy and the raising of awareness regarding the rights related to disability. These talks would lay important groundwork for planning and initiating major steps towards building an inclusive society, such as adopting a new human rights-based disability definition and disability assessment and embracing a clear social policy which is based on social protection with all the required social, health and economic provisions. These steps and measures are expressed in more details throughout the recommendations in the following section.

Recommendations for removing barriers and improving access to healthcare service for Persons with Disability in Lebanon

As discussed throughout this report, numerous barriers act to prevent Lebanese and Syrian PwDs from accessing and receiving needed health and rehabilitation services. The following section presents solutions proposed by PwDs who participated in this study and recommends a range of measures that can be taken by the government and other stakeholders to strengthen needed health services and improve access for PwDs in Lebanon.

Recommendations from Persons with disability

In accordance with the international slogan adopted by the disability rights movements "Nothing About Us Without Us," the methodology and tools adopted for this study were designed to ensure the involvement and direct participation of PwDs in the drafting of the report's recommendations. More than half of the PwDs who participated in the survey and focus group discussions related their experience and insight, providing the following recommendations for improving PwDs access to and utilization of health services. These recommendations are divided into short, medium, and long-term recommendations.

1. Health services and coverage:

Short term
Raise widespread awareness about the benefits and services covered by the MoSA disability card.
Improve the quality of the services provided by the PHCCs through the adoption of proper training programs and ongoing supervision procedures.
Increase the responsiveness of PHCC staff to PwDs needs.
Educate and train the staff in the centers on how to appropriately and compassionately communicate with PwDs.

Medium term
Streamline the process of registering for the MoSA disability card program.
Ensure that rehabilitation services are present at PHCCs and covered by the MoSA disability card (e.g., assistive devices, physiotherapy, etc.)

Long term
Ensure that the MoSA disability card provides hospitalization coverage in all public and private hospitals across the country
Ensure that the MoSA disability card covers a wide array of health services outside of PHCCs (e.g., surgeries, private doctors, medications)
Ensure that all specialized health services in the PHCCs are covered for free by the MoSA disability card (e.g., blood tests, imaging, specialist doctors, etc.)

2- Accessibility:

Short term
Providing transportation fees when accessing the health centers

Long term
Ensure that accessible, low-cost public transportation is available for health center visits
Ensure the presence of open, accessible health care centers in the local communities, especially in the rural areas
Ensure the physical accessibility of the roads and sidewalks, hospitals, health centers, public buildings, malls, universities, schools, and businesses
Unify the sign language used by people with hearing disability on the national level

3- Other supports

Medium term
Raise awareness about disability rights across Lebanese society
Provide awareness on disability issues to parents and caregivers of children with disability, including guidance on how best to provide support in line with needs and on the use of appropriate language

Long term
Update and fully implement Law 220/2000
Promote the inclusion of PwDs in the community starting from childhood
Support all schools that provide inclusive education services for PwDs to ensure their long term sustainability
Ensure greater availability of inclusive vocational training and education services
Provide more job opportunities and employment services for PwDs
Provide personal assistance for PwDs who need it in their daily activities
Provide financial support for PwDs and their families

Overall recommendations of the study:

Based on the quantitative and qualitative findings of this study, numerous measures are recommended to be taken by the government and other stakeholders (e.g., NGOs, OPD, private sector, PwDs and their caregivers, etc.) in order to ensure the right to health for PwDs in Lebanon. The recommended measures are grouped and presented on the following three levels:

1- Legislative, policy, and financial frameworks: Lebanese government officials and decision makers are recommended to take the following actions
Medium term
Revise and modify the current classification system for disability in Lebanon, in order to develop a social protection disability assessment and classification system based on the human rights model, and insure it includes and covers all PwDs and enforce its use among all stakeholders
Long term
Ratify the Convention on the Rights of Persons with Disabilities (UNCRPD) and revise/modify all local laws, including aw 220/2000, to be in accordance with this convention
Issue the relevant application decrees, policies, procedures, and budget lines to insure the implementation of the revised national laws
Adopt policies based on social protection and inclusion instead of those based on social welfare and institutionalization
Undertake all appropriate legislative, administrative, and other measures for the full realization of the rights of PwDs
Provide a platform for participatory decision making to ensure that the development process of all future health policies and services provision procedures includes PwDs and their representative organizations (OPDs)
Ensure that all adopted coordination and monitoring and evaluation mechanisms between government bodies and the engaged parties are inclusive
Expand the coverage of the MoSA disability card and ensure adequate financial resources to allow PwDs to access all available health services
Define and adopt a comprehensive package of health services specific to PwDs to be covered by the Ministry of Public Health and ensure it takes into consideration the various health requirements and specific needs of different disability types
Activate the disability monitoring system at MoSA social services centers in order to ensure the monitoring of the disability cards distribution procedure and expand it, in collaboration with MoPH, to include a comprehensive monitoring system to be used by all health partners
Address rural health problems in an inclusive manner, taking into account all dimensions and their respective impacts
Provide social safety nets to protect PwDs, including rolling out health insurance schemes that would ensure universal access to quality PHC services
Introduce a legal mechanism to counteract discrimination against PwDs, especially those related to obtaining private health insurance coverage

2- Access framework -Practice and Data considerations: The following actions, which could lead to more equitable access to health care services, are recommended to be taken by governmental bodies, public and private health care centers and institutions, local and international NGOs/OPDs, schools of medicine and public health, and the broader civil society:
a. Ensure the provision of inclusive health care services:
Medium term
Ensure and monitor the quality of services provided to PwDs in all private and public centers by the MoSA, MoPH, and OPDs.
Provide good quality assistive devices based on the needs of PwDs
Ensure the continuity of services, especially where organizations are not able to provide PwDs with the needed services, through the use of appropriate referral mechanisms
MoSA & MoPH must collaborate and coordinate their services in order to avoid duplications and to provide needed social assistance and quality health care.
Long term
MoPH should provide health services including preventive and curative care in a systematic and equitable manner based on a comprehensive study of the healthcare needs of PwDs in accordance with international standards
MoPH should realize the mainstreaming of health service provision, ensuring a reorientation of health services towards the social and human rights models of disability
Provide specialized health and rehabilitation services in all centers and health organizations across Lebanon through legal instruments, especially those contracting with MoSA and MoPH
b. Ensure that all Healthcare Centers and Organizations are equipped and accessible for all
Long term
Ensure that all public and private medical centers, including healthcare centers, clinics, dispensaries, and hospitals, are structurally equipped in an accessible way which should be done by the Governmental concerned parties
Ensure that all public institutions and buildings as well as health service providers are accessible and structurally equipped to receive PwDs which should be done by the Governmental concerned parties
The relevant ministries should require all public health institutions and private health agencies and organizations to use inclusive designs and standards, taking into account the physical environment, equipment, furniture, and communication and information systems
Introduce incentive schemes to encourage health organizations and service providers to improve accessibility and quality of care
Ensure physical accessibility within shelters to allow refugees with disability to access their rights and benefit from the services on a level equal to those without a disability

c. Ensure that all healthcare staff members are qualified to deal with PwDs needs
Medium term
Encourage healthcare centers to recruit qualified and specialized staff that are aware of the needs of PwDs and well-trained on how to deal with them
Ensure that the medical staff, front-liners, and other employees and volunteers present in hospitals, PHCCs, and dispensaries are educated and continuously trained on the needs of PwDs, how best to interact with them, and the use of appropriate language which should be done by the concerned governmental agencies, OPDs, NGOs, INGOs, and private sector training agencies
Develop the capacity of the social workforce in the MoSA Social Development Centers to assume a regional coordination role and provide integrated case management services
Long term
Ensure that curricula on disability and rehabilitation are integrated into all vocational, undergraduate and graduate health provider training programs which should be done by the Ministry of Education and Higher Education (MEHE)
d. Ensure the provision of relevant and accessible information
Short term
Improve the comprehensiveness of the disability cards benefits by MoSA
Medium term
Activate the Department of Disability within the MoPH and ensure its ability to provide accessible information on organizations providing healthcare services to PwDs in Lebanon, including the types of services available, their cost, and what services are covered, organized by health service provider
Ensure that all information and documents related to health service providers exist on their websites, are accessible for all, and available in multiple and easy to use formats which require cooperation between all actors including government, civil society, OPDs and private institutions.
Ensure that all administrative and medical forms used by the health service providers are accessible for all and available in multiple and easy to use formats

e. Reform the national data collection systems, including health information systems and ensure the availability of up to date data concerning PwDs and their health need by MoSA and MoPH
Short term
Conduct a comprehensive national health and wellness survey, according to the human rights based definition of disability
Adopt measures to ensure that the data collected is regularly updated
Collect data on Syrian refugee PwDs and their additional needs according to specialized and standardized forms, in collaboration with the UNHCR and other international and national organizations working in the field

3-Advocacy actions are recommended to be taken by the OPDs and the NGOs working in the disability field
Short term
Improve the knowledge of PwDs on their rights and build their capacities in order to better advocate for these rights
Raise awareness on disability inclusion across Lebanese society
Provide awareness on disability issues to parents and caregivers of children with disability, including guidance on how best to provide support in line with needs and on the use of appropriate language
Long term
Adopt a rights-based approach, empowering PwDs and their families
Involve PwDs, caregivers, and their organizations in the development of all policies and programs related to PwDs

Strengths and Limitations

Strengths

This mixed-methods study, which explores health service access and utilization by Lebanese and Syrian PwDs, has several strengths.

The use of a maximum variation sampling strategy, in terms of gender, region and impairment, ensured that multiple perspectives were captured.

The quantitative data collection took into consideration three groups: Lebanese with disability card, Lebanese without disability card and Syrians, and we were able to compare the need for and utilization of healthcare services between the three groups.

The Focus Group Discussions enabled an in-depth exploration of factors influencing health-seeking for PwDs. FGD participants, many of whom displayed greater experience with the system and overall level of engagement, provided diverse, thoughtful perspectives. We were able to explore a variety of opinions and viewpoints, better understand the experiences of disabled people, and gather their specific recommendations for change. We interviewed people with a range of impairment types and severities in order to explore different perspectives and reflect the heterogeneity inherent to this community. People with hearing disabilities were also included in the focus group discussions with the help of interpreters for sign-language. In addition, purposeful sampling in the Key Informant Interviews was used to select a wide range of providers with different experiences.

The present study provides a wealth of information needed by the ministries to guide the development of new health and social service provision strategies.

Limitations and challenges

Despite our best attempts, there are indeed some limitations in this study, including:

- In our research, children below 17-year-old and PwDs who are fully institutionalized were excluded. These populations can be candidates for future research.
- The survey was translated into Arabic, carefully checked to ensure fidelity, and then piloted prior to data collection. It nevertheless remains possible that some questions may not have been clearly understood.
- Challenges during the recruitment process of the survey respondents delayed the survey data collection process.
    - The team experienced significant difficulties in obtaining the data of Lebanese PwDs without a MoSA disability card. After several failed attempts to contact OPDs and NGOs in order to provide the data, the team turned to municipalities in each region in order to populate a list of persons who have a disability but do not have a card. This challenge ultimately prevented the team from reaching the sample size already set. Instead, a larger number of Lebanese with a disability card were recruited to participate in the study.
    - The data provided from MoSA for PwDs with the disability card was not up to date. The team had to request that a new list of card holders be provided on several occasions.
- Several key informant interview participants refused to accept interview parameters (signing consent form, recording interview), leading to delays in transcribing and analyzing.
- Certain governmental representatives such as the Head of the PHC Department at the Ministry of Public Health were unable to take part in the key informant interviews. According to Dr. Randa and her assistant, the MoPH does not provide any specific health care services for PwDs.

References

1. Combaz.E- Situation of persons with disabilities in Lebanon-15 July 2018

2. World Health Organization, Geneva 2007 Everybody's business: strengthening health systems to improve health outcomes: WHO's framework for action.

3. Healthcare Access and Quality Collaborators, measuring performance on the Healthcare Access and Quality Index for 195 countries and territories and selected subnational locations: a systematic analysis from the Global Burden of Disease Study 2016. Lancet

4. The Lebanese Healthcare Sector: In Urgent Need of Reforms (Blominvest Bank, 2018)

5. The Universal Periodic Review- Lebanon 2015- Civil Society Reports

6. Elwood D. Carlson, Nathalie E. Williams, Comparative Demography of the Syrian Diaspora: European and Middle Eastern Destinations, Springer Nature, 2019, Volume 20 of European Studies of Population Series, ISSN 1381-3579 p119

7. Epi info/ STATCALC/population survey

8. Combaz.E- Situation of persons with disabilities in Lebanon-15 July 2018

9. Humanity & Inclusion- July 2018-Lebanon Report- Disability Assessment among Syrian Refugees in Jordan and Lebanon-Removing barriers.

10. WHO (2012) Working to remove barriers to health care for people with disabilities Retrieved on January 9, 2020, from https://www.who.int/westernpacific/news/detail/10-12-2012-working-to-remove-barriers-to-health-care-for-people-with-disabilities

11. Donabedian A. Evaluating the quality of medical care. Milbank Q 2005; 83:691-729.

12. The ICF: An overview- Retrieved on January 23, 2020, from https://www.cdc.gov/nchs/data/icd/icfoverview_finalforwho10sept.pdf

13. World Health Organization, International classification of functioning, disability and health. Geneva:2001, WHO. p. 214.

14. Zapka JG, Palmer RH, Hargraves JL, Nerenz D, Frazier HS, Warner CK. Relationship of patient satisfaction with experience of system performance and health status. J Ambul Care Manage 1995; 18: 73-83 pmid: 10139348.

15. Intenational Labor Organization (2015) Matching skills and jobs in Lebanon: Main features of the labor market-challenges, opportunities and recommendations. Retrieved on February 13, 2020, from https://www.ilo.org/wcmsp5/groups/public/---Arab states/---RO Beirut/documents/publication/wcms_559673.pdf

16. UNDP (2012) Livelihood opportunities for persons with disabilities, page 12

17. Lebanese Republic Economic and Social Council (March2019) Unemployment in Lebanon. Retrieved on December 27, 2019, from http://www.databank.com.lb/docs/Unemployment%20in%20Lebanon%20Findings%20and%20Recommendations%202019%20ECOSOC.pdf

18. UNESCO (2013) Social Inclusion of Young Persons with Disabilities (PwDs) in Lebanon, Beirut, page 17. Retrieved on December 27, 2019, from http://www.unesco.org/new/fileadmin/MULTIMEDIA/FIELD/Beirut/images/SHS/Social_Inclusion_Young_Persons_with_Disabilities_Lebanon.pdf

19. UNHCR, UNICEF & WFP. (2017). Vulnerability Assessment of Syrian Refugees in Lebanon. VASYR 2017. Retrieved on December 27, 2019, from https://data2.unhcr.org/fr/documents/download/61312

20. UNHCR (2019) Lebanon Crisis Response Plan 2017-2020. Retrieved February 13, 2020, from https://www.unhcr.org/lb/wp-content/uploads/sites/16/2019/04/LCRP-EN-2019.pdf

21. Froehlich-Grobe, K., et al., Impact of disability and chronic conditions on health. Disabil Health J, 2016. 9(4): 600-8.

22. Garcia-Arguello, L.Y., et al., Infections in the spinal cord-injured population: a systematic review. Spinal Cord, 2017. 55(6): 526-534.

23. Malt, E.A., et al., Health and disease in adults with Down syndrome. Tidsskr Nor Laegeforen, 2013. 133(3):290-4.

Annexes

Annex 1. Survey

Name of interviewer	
Date of interview	
Region/location	
Governorate	

TIME STARTED	

My name is _____ I'm a project officer working with Fundaçion Promoçion Social funded by the European Union(EU). I'm contacting you because we are conducting a survey on the health situation, health service context and barriers to health faced by persons with disabilities in Lebanon and I would like to ask you a number of questions. You have been randomly selected to participate in this survey, and let me assure you that whatever information you provide us is completely confidential and will only be used for research purposes. We will not keep a record of your name or address and your identity would not be identifiable through the results of this survey. Your responses will be part of a bigger pool of almost 900 interviews from around Lebanon.
Your participation in this survey is completely voluntary and should at any point you choose not to continue the survey, you can tell us. Furthermore, if there are any questions you do not wish to answer, you can also let us know.
Do you agree to take part in this interview? Yes No

Note:

1. "You" or "your" all across the survey refers to the PwD participant.
2. If the respondent is the caregiver, please make sure to rephrase the questions targeting PwD participant.
3. Last year or 12 months across the survey refers to period between March 2018 and March 2019.

Section 1 Demographic and Socioeconomic background characteristics			
SECTION A DEMOGRAPHIC PROFILE			
Item	**Question**	**Condition**	**Response Options**
A.1	Is respondent the person with disability or his/her caregiver?	ALL	1 = PwD 2 = Caregiver
A.2	Is the person with disability female or male?	ALL	1 = Male 2 = Female
A.3	How old are you?	ALL	_____ Years
A.4	What is your marital status?	ALL	1 = Single 2 = Engaged/married 3 = Divorced/separated 4 = Widowed 99 = Refuse to answer/Don't know
A.5	What is your current living situation?	ALL	1 = With parents 2 = With other family members 3 = Independently (home, with other friends...) 4 = Institution
A.6	How many people are there in your household?	A.5=1 & A.5=2 & A.5=3	
A.7	What is your nationality?	ALL	1 = Lebanese 2 = Syrian 3 = Other _____
A.8	Do you have a disability card from MoSA?	A.7=1	0 = No 1 =Yes
A.9	Did you use the disability card to access any services in the past 12 months (March 18 – March 19)?	A.8=1	0 = No 1 = Yes 99 = Don't know/ Refuse to answer

Section 1 Demographic and Socioeconomic background characteristics			
SECTION A DEMOGRAPHIC PROFILE			
Item	**Question**	**Condition**	**Response Options**
A.10	If yes, what services did you access?	A.9=1	1 = Health services (e.g. at a primary health care clinic, hospital, home health care Services etc.); medical rehabilitation (e.g. physiotherapy, occupational therapy, speech and hearing therapy etc.) Assistive devices service (e.g. Sign language interpreter, wheelchair, hearing/visual aids, Braille etc.) 2 = Educational services (e.g. remedial therapist, special school, early childhood stimulation, regular schooling, etc.) 3 = Vocational training (e.g. employment skills training, etc) 4 = Counselling for person with disability (e.g. psychologist, psychiatrist, social worker, school counsellor etc) 5 = Welfare support (e.g. in-kind or food support; income support, etc) 6 = Legal advice 7 = Tax exemptions 8 = Other, specify
A.11	Have you applied to get a disability card from MoSA?	A.8=0	0 = No 1 =Yes 99 = Don't know/Refuse to answer
A.12	Why didn't you apply for a disability card?	A.11=0	1 = No benefit 2 = Never heard of it 3 = It's a shame to have a disability card 99 = Don't know/Refuse to answer
A.13	Why was your application to obtain a disability card denied?	A.8=0 & A.11=1	
A.14	Are you registered as a refugee with UNHCR?	A.7=2	0 = No 1 =Yes 99 = Don't know/Refuse to answer
A.15	Have you applied to be registered in UNHCR?	A.14=0	0 = No 1 =Yes 99 = Don't know/Refuse to answer
A.16	Why didn't you apply for UNHCR registration?	A.15=0	1 = No benefit 2 = UNHCR no longer registering 3 = Other, specify

Section 1 Demographic and Socioeconomic background characteristics			
SECTION A DEMOGRAPHIC PROFILE			
Item	**Question**	**Condition**	**Response Options**
A.17	Why was your UNHCR registration denied?	A.14=0 & A.15=1	
A.18	What is your kind of disability?	ALL	1 = Intellectual disability 2 = Specific learning difficulties 3 = Visual impairment 4 = Hearing impairment 5 = Autism 6 = Physical impairment 7= Speech impairment 8 = Mental Illness 9 = Others, specify
A.19	Do you have any other health problems?	ALL	
A.20	What are the other health problems you faced?	A.19=1	0 = No 1 =Yes 99 = Don't know/Refuse to answer
A.21	What is the cause of your disability?	ALL	1 = From Birth process (birth complications) 2 = Preterm Birth 3 = Congenital or genetic 4 = Prenatal exposure to substances 5 = Illness or disease 6 = Injury (war, accident …) 7 = Exposure to substances (drugs, toxins….) 8 = Environmental causes (Violence, Death or loss in the family…) 9 = Others, specify 99 = Don't know/Refuse to answer
A.22	How old were you when this disability started?	A.21=5 or A.21=6 or A.21=7 or A.21=8 or A.21=9	
A.23	Is there anyone else in your household living with a disability?	A.5 =1 or A.5 =2	0 = No 1 = Yes, specify the household member and his/her disability type 99 = Don't know/Refuse to answer

Section 1 Demographic and Socioeconomic background characteristics			
SECTION A DEMOGRAPHIC PROFILE			
Item	**Question**	**Condition**	**Response Options**
A.24	What is your highest level of education?	ALL	1 = No formal education 2 = Less than primary school 3 = Primary school completed 4 = Secondary school completed 5 = Vocational school completed 6 = High school (or equivalent) completed 7 = College/Pre-University/ University completed 8 = Post Graduate degree completed 99 = Don't know/Refuse to answer
A.25	Did you get any vocational training?	ALL	0 = No 1 = Yes, specify 99 = Don't know/Refuse to answer
A.26	Have you ever been refused entry into a pre-school, primary school, secondary school, special school or university because of lack of financial resources?	ALL	0= No 1= Yes, please specify which entry level 99 = Don't know/Refuse to answer

SECTION B – INCOME AND EMPLOYMENT/LIVELIHOOD			
Item	**Question**	**Condition**	**Response Options**
B.1	What is your highest level of education?	ALL	1 = No formal education 2 = Less than primary school 3 = Primary school completed 4 = Secondary school completed 5 = Vocational school completed 6 = High school (or equivalent) completed 7 = College/Pre-University/ University completed 8 = Post Graduate degree completed 99 = Don't know/Refuse to answer
B.2	Did you get any vocational training?	ALL	0 = No 1 = Yes, specify 99 = Don't know/Refuse to answer

SECTION B – INCOME AND EMPLOYMENT/LIVELIHOOD			
Item	**Question**	**Condition**	**Response Options**
B.3	Have you ever been refused entry into a pre-school, primary school, secondary school, special school or university because of lack of financial resources?	ALL	0= No 1= Yes, please specify which entry level 99 = Don't know/Refuse to answer
B.4	Why did you stop working?	B.1 =0	1= Retired 2= Retrenched (due to cut backs) 3= Fired 4= Injury/accident at work 5= Because of disability 6 = Others, specify
B.5	Are you currently actively looking for work?	B.4 =2 or B.4=3 or B.4 =4 or B.4 =6	0= No 1= Yes 99 = Don't know/Refuse to answer
B.6	What is the main reason you would like to work at present?	B.5 =1	1= Need the income 2= Want to feel useful 3= Help my family 4= Others, specify
B.7	Who is the main income earner in your household?	ALL	1 = Myself 2 = Spouse 3 = Father 4 = Mother 5 = Child 6 = Grandparent 7 = Other relative or non-family member 8 = No one, we rely on aids
B.8	What is the average of your personal monthly income in LBP?	B.1=1	1 = Less than 500 000 LBP 2 = 500 000 - 1 000 000 LBP 3 = 1 000 000 - 2 000 000 LBP 4 = 2 000 000 - 3 000 000 LBP 5 = More than 3 000 000 LBP
B.9	What is the total average of the monthly household income in LBP? (NB: this includes all possible incomes)	A.6=1 or A.6=2	1 = Less than 500 000 LBP 2 = 500 000 - 1 000 000 LBP 3 = 1 000 000 - 2 000 000 LBP 4 = 2 000 000 - 3 000 000 LBP 5 = More than 3 000 000 LBP
B.10	Do you have any monthly health expenditures?	ALL	0= No 1= Yes 99 = Don't know/Refuse to answer

SECTION B – INCOME AND EMPLOYMENT/LIVELIHOOD							
Item	**Question**	**Condition**		**Response Options**			
B.11	Specify the type of health services that cost you money on a monthly basis?	B.10=1		1 = Medical consultations 2 = Rehabilitation (physiotherapy, speech therapy, occupational therapy …) 3 = Medications 4 = Laboratory tests, X-ray imaging 5 = Medical consumables (Diapers, syringes, needles, tubing …) 6 = Others, specify			
B.12	In a scale between 1 and 5, how difficult is it to meet your basic needs in the following areas?	ALL					
		0 N/A	1 (very easy)	2 (easy)	3 (Neither easy nor difficult)	4 (Difficult)	5 (very difficult)
B.12a	1 =Rent/ Accommodation						
B.12b	2= Clothing						
B.12c	3= Household necessities i.e. water bills, electric bills, other bills etc.						
B.12d	4= Transportation						
B.12e	5= Water and food						
B.12f	6= Education						
B.12g	7= Health services						
B.12h	8 = Telephone and communication						
B.12i	9= Assistive devices						
B.12j	10= Personal assistant/ care (care for self)						
B.12k	11= Others, specify						
B.12l	12= Overall						

SECTION B – INCOME AND EMPLOYMENT/LIVELIHOOD					
Item	**Question**	**Condition**		**Response Options**	
B.13	I am now going to list a range of support services or assistance that you may have needed/received during the past 12 months (March 18 – March 19) from institutional providers, family or community. Please indicate for each:	ALL			
		In the last 12 mont hs did you need this service?	Are you aware on where you could get this service?	In the last 12 months, did you receive this service?	If received in the last 12 months, who was the provider?
B.13a	Health services (e.g. at a primary health care clinic, hospital, home health care Services etc.); medical rehabilitation (e.g. physiotherapy, occupational therapy, speech and hearing therapy etc.) Assistive devices service (e.g. Sign language interpreter, wheelchair, hearing/visual aids, Braille etc.)	0 = No 1 = Yes 99 = Don't know/ Refuse to answer	0 = No 1 = Yes 99 = Don't know/ Refuse to answer	0 = No 1 = Yes 99 = Don't know/Refuse to answer	1 = UNHCR or other UN agency 2 = NGO 3 = Religious or community group 4 = MOSA or other government 5 = Private provider 6 = Others, specify
B.13b	Educational services (e.g. remedial therapist, special school, early childhood stimulation, regular schooling, etc.)	0 = No 1 = Yes 99 = Don't know/ Refuse to answer	0 = No 1 = Yes 99 = Don't know/ Refuse to answer	0 = No 1 = Yes 99 = Don't know/Refuse to answer	1 = UNHCR or other UN agency 2 = NGO 3 = Religious or community group 4 = MOSA or other government 5 = Private provider 6 = Others, specify

SECTION B – INCOME AND EMPLOYMENT/LIVELIHOOD					
Item	**Question**	**Condition**		**Response Options**	
B.13c	Vocational training (e.g. employment skills training, etc)	0 = No 1 = Yes 99 = Don't know/ Refuse to answer	0 = No 1 = Yes 99 = Don't know/ Refuse to answer	0 = No 1 = Yes 99 = Don't know/Refuse to answer	1 = UNHCR or other UN agency 2 = NGO 3 = Religious or community group 4 = MOSA or other government 5 = Private provider 6 = Others, specify
B.13d	Counselling for person with disability (e.g. psychologist, psychiatrist, social worker, school counsellor etc)	0 = No 1 = Yes 99 = Don't know/ Refuse to answer	0 = No 1 = Yes 99 = Don't know/ Refuse to answer	0 = No 1 = Yes 99 = Don't know/Refuse to answer	1 = UNHCR or other UN agency 2 = NGO 3 = Religious or community group 4 = MOSA or other government 5 = Private provider 6 = Others, specify
B.13e	Welfare support (e.g. in-kind or food support; income support, etc)	0 = No 1 = Yes 99 = Don't know/ Refuse to answer	0 = No 1 = Yes 99 = Don't know/ Refuse to answer	0 = No 1 = Yes 99 = Don't know/Refuse to answer	1 = UNHCR or other UN agency 2 = NGO 3 = Religious or community group 4 = MOSA or other government 5 = Private provider 6 = Others, specify
B.13f	Legal advice	0 = No 1 = Yes 99 = Don't know/ Refuse to answer	0 = No 1 = Yes 99 = Don't know/ Refuse to answer	0 = No 1 = Yes 99 = Don't know/Refuse to answer	1 = UNHCR or other UN agency 2 = NGO 3 = Religious or community group 4 = MOSA or other government 5 = Private provider 6 = Others, specify

SECTION B – INCOME AND EMPLOYMENT/LIVELIHOOD					
Item	**Question**	**Condition**		**Response Options**	
B. 14	In the last 12 months did you receive any other form of assistance or external support?	ALL	0 = No 1 = Yes, specify the kind of support received 99 = Refuse/ Don't know	0 = No 1 = Yes 99 = Don't know/Refuse to answer	1 = UNHCR or other UN agency 2 = NGO 3 = Religious or community group 4 = MOSA or other government 5 = Private provider 6 = Others, specify
B.15	Who was the provider?	B.14=1		1 = UNHCR or other UN agency 2 = NGOs 3 = Religious or community group 4= MoSA or other government 5 - Private provider 6 = Other, specify	
B.16	in the last 12 months (March 18 – March 19): did you receive any financial support, in the form of pension or grant, from an individual/family, public or private institution, religious group, NGO, social security, UN agencies or insurance?	ALL		0 = No 1 = Yes, 99 = Refuse/Don't know	
B.17	From whom did you receive this support and how much was the value?	B.16=1			
		Received (Yes or No)		Monthly Value in LBP (in case the value was not on a monthly basis, please include the average over the last 12 months)	
B.17a	1= Government	0 = No 1 = Yes 99 = Refuse/Don't know			
B.17b	2= National Social Security Fund or other social security institution	0 = No 1 = Yes 99 = Refuse/Don't know			

SECTION B – INCOME AND EMPLOYMENT/LIVELIHOOD			
Item	**Question**	**Condition**	**Response Options**
B.17c	3 = Private/occupational insurance		0 = No 1 = Yes 99 = Refuse/Don't know
B.17d	4= NGO		0 = No 1 = Yes 99 = Refuse/Don't know
B.17e	5 = UN agencies		0 = No 1 = Ye 99 = Refuse/Don't know
B.17f	6= Religious or community group		0 = No 1 = Yes 99 = Refuse/Don't know
B.17g	7 = Family, friend or neighbor		0 = No 1 = Yes 99 = Refuse/Don't know
B.17h	8= Other		0 = No 1 = Yes 99 = Refuse/Don't know
B.18	During the last 5 years did you benefit from any tax relief or exemption?	All	0 = No 1 = Yes 99 = Refuse/Don't know
B.19	If yes, please list which one	B.18=1	1= Municipal fees 2= Property taxes, upon inheritance 3= Customs, vehicle and car registration fees 4= Other, specify
B.20	Have you or any member in your family ever contributed to social insurance through the National Social Security Fund or any other social insurance scheme in Lebanon or elsewhere?	All	0 = No 1 = Yes 99 = Refuse/Don't know
B.21	If yes, please specify for how long (duration)?	B.20=1	

SECTION B – INCOME AND EMPLOYMENT/LIVELIHOOD			
Item	**Question**	**Condition**	**Response Options**
B.22	If yes, are you currently accessing any benefit as a result of your contributions?	B.20=1	0 = No 1 = Yes 99 = Refuse/Don't know
B.23	Specify please what kind of benefits?	B.22=1	1=End-of-service indemnity 2=Old age or survivors pension 3=Disability pension 4=Workmen compensation for accidents at work 5=Unemployment benefit 6=Family allowance or other family benefits
B.24	Why are you not accessing benefit, despite having contributed?	B.20=1 & B.22=0	1 = Not entitled to receive the benefits (e.g. did not contribute long enough) 2 = Delays in delivery of benefits 3 = Benefits cannot be accessed abroad or other restrictions due to nationality 4 = Don't know, Not aware 5 = Other, specify

SECTION 2 AWARENESS OF THE HEALTHCARE SERVICES			
Item	**Question**	**Condition**	**Response Options**
C.1	Are you aware of any publically available centers (PHCC/SDC) /NGOs providing health care services?	ALL	0 = No 1 = Yes 99 = Refuse/Don't know
	If yes, please name such centers	C.1=1	
C.2	Are you aware of any source for health information?	ALL	0 = No 1 = Yes, specify 99 = Refuse/Don't know
C.3	Are the available health information sources easily accessible to you?	ALL	0 = No 1 = Yes 99 = Refuse/Don't know
C.4	Is the accessible information useful?	ALL	0 = No 1 = Yes 99 = Refuse/Don't know

SECTION 3 NEED FOR MOPH/MOSA HEALTH SERVICES			
Item	**Question**	**Condition**	**Response Options**
D.1	Did you need healthcare services from MoPH/MoSA centers during the past 12 months (March 18 – March 19) ?	ALL	0 = No 1 = Yes 99 = Refuse/Don't know
D.2	If yes, what were they?	D.1=1	1 = General medical consultations 2 = Consultation with specialist Doctor (cardiologist, Gynecologist, ophthalmologist….) 3 = Diagnostic tests (Laboratory tests, imaging) 4 = Mental Health Services 5 = Rehabilitation services (physiotherapy, occupational therapy, speech therapy…) 6 = Medications 7 = Assistive devices (hearing-aids, glasses, etc…) 8= Prostheses 9 = Diapers 10 = Surgery 11 = Other

SECTION 3 NEED FOR MOPH/MOSA HEALTH SERVICES			
Item	**Question**	**Condition**	**Response Options**
D.3	Please indicate for each needed service, how many separate occasions has this service been required by you during the past 12 months (March 18 – March 19)?	D.1=1	
D.3a	1 = General medical consultations	D.1=1 & D.2=1	
D.3b	2 = Consultation with specialist Doctor (cardiologist, Gynecologist, ophthalmologist….)	D.1=1 & D.2=2	
D.3c	3 = Diagnostic tests (Laboratory tests, imaging)	D.1=1 & D.2=3	
D.3d	4 = Mental Health Services	D.1=1 & D.2=4	
D.3e	5 = Rehabilitation services (physiotherapy, occupational therapy, speech therapy…)	D.1=1 & D.2=5	
D.3f	6 = Medications	D.1=1 & D.2=6	
D.3g	7 = Assistive devices (hearing aids, glasses, etc…)	D.1=1 & D.2=7	
D.3h	8= Prostheses	D.1=1 & D.2=8	
D.3i	9 = Diapers	D.1=1 & D.2=9	
D.3j	10 = Surgery	D.1=1 & D.2=10	
D.3k	11 = Other	D.1=1 & D.2=11	

SECTION 4 UTILIZATION OF PHCCS			
Item	**Question**	**Condition**	**Response Options**
D.3	Please indicate for each needed service, how many separate occasions has this service been required by you during the past 12 months (March 18 – March 19)?	D.1=1	
D.3a	1 = General medical consultations	D.1=1 & D.2=1	
D.3b	2 = Consultation with specialist Doctor (cardiologist, Gynecologist, ophthalmologist….)	D.1=1 & D.2=2	
D.3c	3 = Diagnostic tests (Laboratory tests, imaging)	D.1=1 & D.2=3	
D.3d	4 = Mental Health Services	D.1=1 & D.2=4	
D.3e	5 = Rehabilitation services (physiotherapy, occupational therapy, speech therapy…)	D.1=1 & D.2=5	
D.3f	6 = Medications	D.1=1 & D.2=6	
D.3g	7 = Assistive devices (hearing aids, glasses, etc…)	D.1=1 & D.2=7	
D.3h	8= Prostheses	D.1=1 & D.2=8	
D.3i	9 = Diapers	D.1=1 & D.2=9	
D.3j	10 = Surgery	D.1=1 & D.2=10	
D.3k	11 = Other	D.1=1 & D.2=11	

SECTION 4 UTILIZATION OF PHCCS			
Item	**Question**	**Condition**	**Response Options**
E.1	Please indicate for each needed service if you received the service required during the past 12 months (March 18 – March 19) ?		
E.1a	1 = General medical consultations	D.1=1 & D.2=1	0 = No 1 = Yes 99 = Refuse/Don't know
E.1b	2 = Consultation with specialist Doctor (cardiologist, Gynecologist, ophthalmologist….)	D.1=1 & D.2=2	0 = No 1 = Yes 99 = Refuse/Don't know
E.1c	3 = Diagnostic tests (Laboratory tests, imaging)	D.1=1 & D.2=3	0 = No 1 = Yes 99 = Refuse/Don't know
E.1d	4 = Mental Health Services	D.1=1 & D.2=4	0 = No 1 = Yes 99 = Refuse/Don't know
E.1e	5 = Rehabilitation services (physiotherapy, occupational therapy, speech therapy…)	D.1=1 & D.2=5	0 = No 1 = Yes 99 = Refuse/Don't know
E.1f	6 = Medications	D.1=1 & D.2=6	0 = No 1 = Yes 99 = Refuse/Don't know
E.1g	7 = Assistive devices (hearing aids, glasses, etc…)	D.1=1 & D.2=7	0 = No 1 = Yes 99 = Refuse/Don't know
E.1h	8= Prostheses	D.1=1 & D.2=8	0 = No 1 = Yes 99 = Refuse/Don't know
E.1i	9 = Diapers	D.1=1 & D.2=9	0 = No 1 = Yes 99 = Refuse/Don't know
E.1j	10 = Surgery	D.1=1 & D.2=10	0 = No 1 = Yes 99 = Refuse/Don't know
E.1k	11 = Other	D.1=1 & D.2=11	0 = No 1 = Yes 99 = Refuse/Don't know
E.2	From where did you receive that service?	E.1=1	1 = PHCC 2 = Hospital (outside of the PHCC) 3 = Doctor (outside of the PHCC) 4 = Pharmacist (outside of the PHCC) 5 = Other 99 = Refuse/Don't know

SECTION 4 UTILIZATION OF PHCCS			
Item	**Question**	**Condition**	**Response Options**
E.3	What was the facility name if it was PHCC?	E.1=1	
E.4	How many times did you get this service from any health facility over the past 12 months (March 18 – March 19)?	E.1=1	1 = Always 2 = Often 3 = Sometimes 4 = Never 99 = Refuse/Don't know
E.5	Please cite the reasons for not receiving these services?	E.1=0	1 = I do not know where the service or support is available or who can help 2 = I got some information but could not read or understand 3 = I do not have documents to access services (e.g. UNHCR card, disability card) 4 = Services are not available 5 = Services are too expensive 6 = Services are far away and transportation is not available 7 = Services are delivered in inaccessible places (e.g. does not have a ramp, wide door) 8 = Staff are not supportive and/or do not know how to communicate with me 9 = Services do not meet my specific needs

SECTION 4 UTILIZATION OF PHCCS			
Item	**Question**	**Condition**	**Response Options**
E.3	What was the facility name if it was PHCC?	E.1=1	
E.4	How many times did you get this service from any health facility over the past 12 months (March 18 – March 19)?	E.1=1	1 = Always 2 = Often 3 = Sometimes 4 = Never 99 = Refuse/Don't know

SECTION 4 UTILIZATION OF PHCCS			
Item	**Question**	**Condition**	**Response Options**
E.5	Please cite the reasons for not receiving these services?	E.1=0	1 = I do not know where the service or support is available or who can help 2 = I got some information but could not read or understand 3 = I do not have documents to access services (e.g. UNHCR card, disability card) 4 = Services are not available 5 = Services are too expensive 6 = Services are far away and transportation is not available 7 = Services are delivered in inaccessible places (e.g. does not have a ramp, wide door) 8 = Staff are not supportive and/or do not know how to communicate with me 9 = Services do not meet my specific needs

SECTION 5 HEALTH ACCESSIBILITY			
Item	**Question**	**Condition**	**Response Options**
F.1	Are you able to physically access the specialized health-care services needed?	E.1=1	0 = No 1 = Yes
F.2	If no, why ?	F.1=0	1= Services are far away 2=transportation is not available 3= Services are delivered in places that are not accessible (e.g. does not have a ramp, wide door) 4= Other (specify)
F.3	How easy are health-care centers to reach?	F.1=1	1 = Very easy 2 = Fairly easy 3 = Neither easy nor difficult 4 = Somewhat difficult 5 = Very difficult
F.4	How long does it take you to reach the nearest health-care services that you need?	F.1=1	1 = Less than 15 minutes 2 = 15 -30 minutes 3 = 30 – 45 minutes 4 = 45 – 60 minutes 5= more than 1 hour

SECTION 5 HEALTH ACCESSIBILITY			
Item	**Question**	**Condition**	**Response Options**
F.5	What method of transportation do you use to access the health-care center that you need?	F.1=1	1 = Public transportation 2 = Private transportation 3 = Other
F.6	Is the method of transportation you used to access the health-care center you need, accessible to the needs related to your disability?	F.1=1	0= No 1= yes

SECTION 6 AFFORDABILITY OF PHCC SERVICES			
Item	**Question**	**Condition**	**Response Options**
G.1	Did you pay for the service received during the past 12 months (March 2018-march 2019)?	E.1=1	0 = No 1 = Yes
G.2	How much did you pay per accessed service on average?	G.1=1	
G.3	How acceptable or unacceptable do you consider the cost paid for this service?	G.1=1	1 = Acceptable 2 = Neither acceptable, nor unacceptable 3 = Unacceptable 99 = Refuse/Don't know
G.4	Do you have access to health through any form of health insurance?		0 = No 1 = Yes
G.5	If yes, which scheme provide cover for your expenses?	G.4=1	1=National Social Security Fund 2=Public Sector Allowances 3=Healthcare Fund for Military Personnel 4=Private Insurance 5=UNHCR 6=Other, specify

SECTION 7 BARRIERS TO HEALTH SERVICES			
Item	**Question**	**Condition**	**Response Options**
H.1	In your opinion, are there any barriers that could affect access to health services?	ALL	0 = No 1 = Yes
H.2	What types of barriers are you facing when trying to access health services?	H.1= 1	1 = Geographic access a) Services are far away and in places which are difficult to reach b)Transportation is not available c)Transportation is not accessible 2 = Physical barriers a)Health centers are not physically accessible b) Moving difficulties inside the health centers and the inability to use all their divisions because they are inaccessible c) Lack of availability of adapted medical equipment that can serve your individual needs related to disability (equipment used in medical examinations or medical treatment and therapies) … 3 = Financial challenges a)Difficulty in paying fees required by some centers b)Specialized services such as imaging and laboratory tests are expensive 4 = Lack of information a)Absence of information b)Lack of information availability c)Lack of accessibility to available information d)Lack of availability of information adaptive to the needs related to disability 5 = Attitudinal barriers a)Lack of knowledge among employees regarding how to deal with persons with disabilities b)Difficulty in communicating with the health service provider or other staff members c)The use of wrong and negative terminology by the employees or medical staff when talking to you or when speaking about disability d)Your being subject to discrimination and marginalization by employees and medical staff 6 = Medical service barriers a)Limited specialized services for persons with disabilities b)Difficulty in obtaining appointments c)Lack of availability of adaptive copies of forms that must be filled and other documents (such as tests results and medical reports), that meet your individual needs related to disability d)Lack of adequate medical care e)Lack of medication f)Long waiting period to obtain an appointment 7 = Other specify

SECTION 8 SATISFACTION WITH SPECIALIZED AND PHCC SERVICES AND PERCEPTIONS OF QUALITY			
I want to know if possible your impressions of your most recent visit during the past 12 months (March 18 – March 19) for health care. I kindly ask you to answer by yes or no for the following questions			
Item	**Question**	**Condition**	**Response Options**
I.1	Did the staff use the right terminology about your disability/ impairment when they talked to you ?	E.1=1	0 = No 1 = Yes 99 = Refuse/Don't know
I.2	Did the staff speak to you directly? (please note that you can elaborate the question by asking if the staff talked to the PWD directly or to the persons that accompanied him)	E.1=1	0 = No 1 = Yes 99 = Refuse/Don't know
I.3	Are the staff willing to listen carefully to you and answer all your questions?	E.1=1	0 = No 1 = Yes 99 = Refuse/Don't know
I.4	Were your condition and your treatment explained to you in a clear and adaptive way that you could understand?	E.1=1	0 = No 1 = Yes 99 = Refuse/Don't know
I.5	Did the staff empower you with enough information regarding your impairment?	E.1=1	0 = No 1 = Yes 99 = Refuse/Don't know

SECTION 8 SATISFACTION WITH SPECIALIZED AND PHCC SERVICES AND PERCEPTIONS OF QUALITY			
I want to know if possible your impressions of your most recent visit during the past 12 months (March 18 – March 19) for health care. I kindly ask you to answer by yes or no for the following questions			
Item	**Question**	**Condition**	**Response Options**
I.6	Did the health care providers involved you in making decisions for your treatment?	E.1=1	0 = No 1 = Yes 99 = Refuse/Don't know
I.7	Is there privacy and confidentiality during the consultations provided by the health care providers in the PHCCs?	E.1=1	0 = No 1 = Yes 99 = Refuse/Don't know
I.8	Did you feel that you were treated similar as other people?	E.1=1	0 = No 1 = Yes 99 = Refuse/Don't know
I.9	Did the staff give you the needed time to ask your questions?	E.1=1	0 = No 1 = Yes 99 = Refuse/Don't know
I.10	Did the staff explained to you clearly the documents that you need to sign?	E.1=1	0 = No 1 = Yes 99 = Refuse/Don't know
I.11	Upon your arrival to the center, did the staff ask you if you need any physical assistance in the PHCCs? (e.g. like where can you have a seat, going to the bathroom…)	E.1=1	0 = No 1 = Yes

SECTION 8 SATISFACTION WITH SPECIALIZED AND PHCC SERVICES AND PERCEPTIONS OF QUALITY					
I want to know if possible your impressions of your most recent visit during the past 12 months (March 18 – March 19) for health care. I kindly ask you to answer by yes or no for the following questions					
Item		**Question**	**Condition**	**Response Options**	
I.12		In case you face an accident at the center, do the staff react in a helpful way?	E.1=1	0 = No 1 = Yes 9= N/A	
I.13		Did the staff ask you if you needed administrative help? (e.g. help with calling someone, help reading papers, help getting somewhere….)	E.1=1	0 = No 1 = Yes 9= N/A	
I.14		How would you rate your satisfaction following:			
		1 Satisfied	2 Neither satisfied nor dissatisfied	3 Dissatisfied	9 N/A
Quality of the health service (please ask the participant to rate the services received within the recent visit in the last 12 months)	Medical consultation				
	Rehabilitation services (physiotherapy, occupational therapy, speech therapy…)				
	Diagnostic tests (Laboratory tests, imaging)				
	Medications				
	Assistive devices				
	Mental health services				
	Diapers				
	Prostheses				
Your overall satisfaction with the health service					
I.15		How do you rate your satisfaction following:			

SECTION 8 SATISFACTION WITH SPECIALIZED AND PHCC SERVICES AND PERCEPTIONS OF QUALITY				
I want to know if possible your impressions of your most recent visit during the past 12 months (March 18 – March 19) for health care. I kindly ask you to answer by yes or no for the following questions				
Item	**Question**	**Condition**	**Response Options**	
	1 Satisfied	2 Neither satisfied nor dissatisfied	3 Dissatisfied	9 N/A
Ease of access (transportation) to the facility				
Operational hours of health facility				
Cleanliness and orderliness of building and rooms				
Waiting area comfort and capacity				
Waiting times				

SECTION 9 ACTIVITY LIMITATIONS AND SOCIAL PARTICIPATION RESTRICTIONS (ENVIRONMENTAL)			
Item	**Question**	**Condition**	**Response Options**
J.1	How often do you need help when performing daily activities?	ALL	1 = No help needed 2 = Help needed sometimes 3 = Help needed all the time
J.2	Do you have someone to assist you with your day to day activities at home or outside?	J.1 = 2 or J.1 = 3	0 = No 1 = Yes
J.3	How do the daily activity limitations and social participation restrictions you face make you feel?	ALL	1 = Lack of confidence 2 = Nervous/ anxious 3 = Isolated and excluded 4 = Different from others 5 = Encourage and motivate you 6 = Other, specify
I am going to ask you some general questions about your environment. I want you to answer the following questions on a scale from 1 to 3, where 1 means very easy and 3 means very hard.			

SECTION 9 ACTIVITY LIMITATIONS AND SOCIAL PARTICIPATION RESTRICTIONS (ENVIRONMENTAL)					
Item	**Question**	**Condition**		**Response Options**	
J.4	1 Very easy	2 acceptable	3 Very hard	99 Don't Know	9 N/A
Does your workplace make it easy or hard for you to work or learn?					
Does your educational institution make it easy or hard for you to work or learn?					
Are places where you socialize and engage in community activities make it easy or hard for you to do this?					
Is the type of transportation you need easy or hard for you to use it?					
Is your dwelling make it easy or hard for you to live there?					
Is the toilet of your dwelling make it easy or hard for you to use it?					
Is the lighting, noise, and crowds in your surroundings make it easy or hard for you to live there?					
I want to ask you some questions about the attitudes of people around you. When answering these questions please tell me on a scale from 1 to 3 where 1 is not at all and 3 means completely.					
J.5	1 Not at all	2 sometimes	3 Yes, completely	99 Don't know Refuse to answer	9 N/A

SECTION 9 ACTIVITY LIMITATIONS AND SOCIAL PARTICIPATION RESTRICTIONS (ENVIRONMENTAL)					
Item	**Question**	**Condition**		**Response Options**	
Do you participate in family decisions?					
Do you have problems getting involved in society because of the attitudes of people around you?					
Do you feel that some people treat you unfairly?					
Do you make your own choices about your day-to-day life? For example, where to go, what to do, what to eat.					
Do you make the big decisions in your life? For example, like deciding where to live, or who to live with, how to spend your money.					
Do you feel that other people accept you?					
Do you feel that other people respect you? For example, do you feel that others value you as a person and listen to what you have to say?					
Do people around you tend to become impatient with you?					

SECTION 10 RECOMMENDATIONS
please share your recommendations for improving access to healthcare for PwDs in Lebanon:

Annex 2. FGDs questions

Name of Facilitator							
Name of Note taker							
Location of Focus group							
Date							
Time Started							
Time Ended							
Focus group participants	Number	Nationality	Age	Gender	Area of residence	Disability Card holder	Types of disability
	1						
	2						
	3						
	4						
	5						
	6						
	7						
	8						
	9						
	10						

Introduction and verbal consent:

My name is_____, and this is my colleague _____. We are working with Fundaçion Promoçion Social. The purpose of this focus group is to better understand your experience in accessing health services, your health needs, your perceptions regarding the attitudes and knowledge-base of health staff with whom you have engaged, and barriers you are facing when trying to access health services.

During the discussion, you will be interviewed for about 1 to 2 hours. I will ask the questions, the answers will be recorded and my colleague will write your answers down. All such notes and records were protected following transcription, and all recordings and notes were deleted after the finalization of the report. We are holding discussions at a number of other communities as well. Your responses will remain confidential, and no names will be included in the final report but we may include the name of this location.

We will be calling each other with our first names. We are committed to maintaining your confidentiality, we are interested in your points of view and not on who said what. We kindly ask you to respect the confidentiality of each other and not to say who said what when you leave this room. If you would like to tell us a relevant story from your community, please do not reveal the names of the people concerned, or any detail that might reveal their identities.

If you are uncomfortable with any of this, you are free to opt out of participating now or at any time during the discussion. You can also choose not to answer any of the questions.

Introduction and verbal consent:

My name is_____, and this is my colleague _____. We are working with Fundaçion Promoçion Social. The purpose of this focus group is to better understand your experience in accessing health services, your health needs, your perceptions regarding the attitudes and knowledge-base of health staff with whom you have engaged, and barriers you are facing when trying to access health services.
During the discussion, you will be interviewed for about 1 to 2 hours. I will ask the questions, the answers will be recorded and my colleague will write your answers down. All such notes and records were protected following transcription, and all recordings and notes were deleted after the finalization of the report. We are holding discussions at a number of other communities as well. Your responses will remain confidential, and no names will be included in the final report but we may include the name of this location.
We will be calling each other with our first names. We are committed to maintaining your confidentiality, we are interested in your points of view and not on who said what. We kindly ask you to respect the confidentiality of each other and not to say who said what when you leave this room. If you would like to tell us a relevant story from your community, please do not reveal the names of the people concerned, or any detail that might reveal their identities.
If you are uncomfortable with any of this, you are free to opt out of participating now or at any time during the discussion. You can also choose not to answer any of the questions.

Is it ok to proceed?
Was verbal consent obtained? Yes No

1. We would like to know what were the healthcare services that you needed during the past 12 months.
    a. How frequently did you need to use these services?
    b. Please indicate for each service you needed if you received it from your local PHCCs?
    c. If not received from your local PHCCs, what could be the alternative?
    d. What is the reason to go to receive services from a private sector? (low quality services in the PHCCs, PHCCs are too far, lack of transportation, lack of information...)
    e. If there is a PHCCs too far from your place and a private clinic near you what would you choose and based on what would you make your decision?
    f. How did you afford the cost of the health services? (a dependent on your families, any form of health insurance, can't afford it …)

2. How did you find out about health services available to you in your community?
    a. Is there enough information available about the service you need?
    b. Is the available information accessible to you?
    c. Where are some places you think it would be good to share information with people with disabilities about services that are available to them?
    d. Who, if anyone, helps you find this information?
    e. What source of communication would you like to add if you wanted to know information about healthcare services?

3. Are you able to physically access the specialized services needed?
   a. If no, why you are not able to access these services?
   b. What type of challenges or barriers do you face when trying to access health services? (Financial challenges/Geographic access/Availability of staff/Availability of medication/Attitudes of medical staff)

4. For those of you who have required health services, and have been able to access facilities, could you please explain the steps that are taken when you first attend a facility center?
   a. How easy or hard was it to take an appointment with someone to check about your health?
   b. How about the amount of time spent in a facility, how long did you have to wait before you got to see someone?
   c. What do the staff do to make you feel comfortable?
   d. How do the staff deal or communicate with you?
   e. Can you get the care you need when you need it?
   f. Are the hours needed to see your provider convenient for you?
   g. Were your condition and treatment explained to you in a way you could understand? If not, how could this be improved?
   h. How satisfied or dissatisfied are you with the cost of money associated with accessing health services at the PHCCs?

5. What would you like people in the community to know about how to best support people with disabilities?
   • What would be the most important thing that you would teach them?

6. Do you have any other feedback to share with us on how to make things better for people with disabilities when they go somewhere in the community for services?

Annex 3. KIIs questions

Name of Facilitator	
Name of Note taker	
Location of Interview	
Date	
Time Started	
Time Ended	
Name of Interviewee	
Position of Interviewee	

1. Does your organization support centers that provide health services for persons with disabilities?
    a. What kind of services are provided?
    b. How many times could a person with disability benefit from these services?
    c. Are these services for free or should they pay an amount? (which ones are free and which ones should they pay for and how much?
    d. What is the difference between the services provided by your organization to the following three groups?
        i. Lebanese with MoSA disability card.
        i. Lebanese without MoSA disability card.
        ii. Syrians.

2. Based on our findings from the FGDs and the survey about the needs of PwDs (assistive devices, medications, doctor consultations, psychotherapy, physiotherapy, dentist, blood test, imaging…) Do the services provided by your organization match the services already mentioned?
    a. What steps does your organization take to ensure that the services you provide are those most needed by PwDs? (and how frequently)
    b. What could your ministry do to make more services available to PwDs? (Question for MoSA,MoPH)

3. What kind of services are covered by the MoSA disability card?
    a. What are the challenges faced by those who use the MoSA disability card? (Not related to MopH)

4. Are the field staff working for your organization specifically trained on how to engage and communicate with PwDs? (Question for NGOs)
    a. What kind of training do they receive?
    b. How do you measure the skill/knowledge improvement of participants and ensure that the improvement is sustained?

5. Do you believe that the staff working in PHCs and SDCs are specifically trained or knowledgeable on how to engage and communicate with PWDs? (Question for NGOs/ MoSA,MoPH)
    a. What kind of training do they receive?
    b. How do you measure the skill/knowledge improvement of participants and ensure that the improvement is sustained?

6. How do PwDs know about the centers where different health services are provided?
    a. What does your organization do to ensure that PwDs know what services you provide and where they can receive them?
    b. What more could be done to increase awareness about service availability?

7. If your organization provides assistive devices, from where are you buying them?
    a. How can you make sure about the quality of the assistive devices?
    b. Does your organization provide maintenance for the assistive devices?

8. What measures or procedures does your organization undertake to monitor their centers, to maintain good quality of services and to maintain sustainability of services provided by the PHCCs?

9. How do you measure the satisfaction of the beneficiaries receiving health services from the PHCCs?
    a. What steps are you taking based on the results of this measurement?

10. What type of challenges or barriers does a PwD face when trying to access health services?
    a. Would you say that a majority of the centers supported by your organization are accessible to all regardless of the type of disability? (braille writing, ramp…)
        i. In your opinion, what improvements do you think are needed around accessibility?

11. In what ways does your organization collaborate/communicate with MoPH/MoSA regarding services provided to PwDs? (Question for NGOs)

12. How do MoSA and MoPH work together to close gaps in the availability of services needed by PwDs? (Question for MoSA,MoPH)
    a. In your opinion, could more be done?

Annex 4. Participants in the FGDs

#	Code	Area	Nationality	Type of disability	Details
FGD 1	L1	Nabatiyeh-South	8 Lebanese (7 with MoSA disability card and 1 without the card)	• 1 Learning difficulties • 3 Physical Impairment • 1 Intellectual disability • 2 Visual Impairment • 1 Multiple disabilities	
FGD 2	L2 acceptable or unacceptable do you consider the cost paid for this service?	Beirut	9 Lebanese (8 with MoSA disability card and 1 without the card)	• 1 Physical Impairment • 4 Visual Impairment • 3 Hearing Impairment • 1 Multiple disabilities	Presence of one Interpreter for sign language
FGD 3	L3	Taanayel-Bekaa	9 Lebanese (8 with MoSA disability card and 1 without the card)	• 6 Physical Impairment • 1 Intellectual disability • 2 Visual Impairment	
FGD 4	S4	Tyre	8 Syrians	• 6 Physical Impairment • 2 Multiple disabilities	Presence of 2 caregivers
FGD 5	S5	Marej-Bekaa	8 Syrians	• 7 Physical Impairment • 1 Multiple disabilities	Presence of 1 caregiver
FGD 6	L6	Bedneyil-Bekaa	7 Lebanese (7 with MoSA disability card	• 7 Physical Impairment (Cerebral Palsy)	Presence of 2 caregivers
FGD 7	L7	Beirut	10 Lebanese (5 with MoSA disability card and 5 without the card)	• 10 Visual Impairment	
FGD 8	L8	Beirut	10 Lebanese (5 with MoSA disability card and 5 without the card)	• 10 Hearing Impairment	Presence of two Interpreters for sign language
FGD 9	L9 S9	Aarsal-Bekaa	5 Syrians 5 Lebanese(4 with MoSA disability card and 1 without the card)	• 9 Physical Impairment • 1 Multiple disabilities	

FGD 10	L10	Zahla-Bekaa	6 Lebanese (6 without MoSA disability card)	• 1 Intellectual disability • 5 Mental disability	Presence of 1 caregiver
FGD 11	L11	Deir Aamar-North	11 Lebanese (8 with MoSA disability card and 3 without the card)	• 3 Physical Impairment • 2 Visual Impairment • 1 Autism • 5 Multiple disabilities	Presence of 2 caregivers
FGD 12	L12	Chehim-Mount Lebanon	8 Lebanese (7 with MoSA disability card and 1 without the card)	• 2 Physical Impairment • 1 Intellectual disability • 2 Mental disability • 1 Visual Impairment • 2 Multiple disabilities	Presence of 6 caregivers
FGD 13	S13	Koura-North	10 Syrians	• 8 Physical Impairment • 2 Multiple disabilities	Presence of 2 caregivers
FGD 14	S14	Koura-North	7 Syrians	• 7 Physical Impairment	Presence of 4 caregivers

Disability and Health Situational Analysis Report

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Lebanon Report
2019-2020

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