



HEALTH SECTOR

PEOPLE IN NEED



2,473,800

PEOPLE TARGETED



1,563,800

REQUIREMENTS(US\$)



2019 267.5
million

2020 TBD

PARTNERS



38

GENDER MARKER



2a

CONTACTS

LEAD MINISTRY

Ministry of Public Health (MoPH)

Dr. Rasha Hamra

rashahamra@yahoo.com

COORDINATING AGENCIES

WHO and UNHCR

Dr. Alissar Rady

radya@who.int

Stephanie Laba

labas@unhcr.org

SECTOR OUTCOMES

Outcome #1

\$ \$97.05 m

Improve access to comprehensive primary healthcare (PHC).

Indicators

Percentage of displaced Syrians, vulnerable Lebanese, Palestinian Refugees from Syria (PRS) and Palestinian Refugees from Lebanon (PRL) accessing primary healthcare services.

Percentage of vaccination coverage among children under 5 residing in Lebanon.

Outcome #2

\$ \$169.5 m

Improve access to hospital (incl. ER care) and advanced referral care (advanced diagnostic laboratory & radiology care).

Indicators

Percentage of displaced Syrians, Lebanese, Palestinian Refugees from Syria (PRS) and Palestinian Refugees from Lebanon (PRL) admitted for hospitalization per year.

Outcome #3

\$ \$0.8 m

Improve outbreak and infectious diseases control.

Indicators

Number of functional Early Warning, Alert and Response System (EWARS) centres.

Outcome #4

\$ \$0.1 m

Improve adolescent & youth health.

Indicators

Prevalence of behavioural risk factors and protective factors in 10 key areas among young people aged 13 to 17 years.

POPULATION BREAKDOWN

POPULATION COHORT	PEOPLE IN NEED	PEOPLE TARGETED	51% Female	49% Male
Lebanese	1,500,000	750,000	382,500	367,500
Displaced Syrians	765,000	765,000	390,150	374,850
Palestinian Refugees from Syria	28,800	28,800	14,688	14,112
Palestinian Refugees from Lebanon	180,000	20,000	10,200	9,800

Situation analysis

The Health sector situation analysis and needs are presented in alignment with the two strategic objectives of the Health Response Strategy of the Ministry of Public Health (MoPH), which are: to increase access to health services for displaced Syrians and vulnerable Lebanese and to strengthen healthcare institutions and enable them to withstand the pressure caused by the increased demand on services and the scarcity of resources.

While maintaining a direct service delivery component to cover critical needs for vulnerable people, the priority of the Health sector is increasingly shifting towards continued investments in health system strengthening and enhancement of institutional resilience to sustain service provision and quality of services, and achieve a positive and sustainable impact on health indicators for the long term.

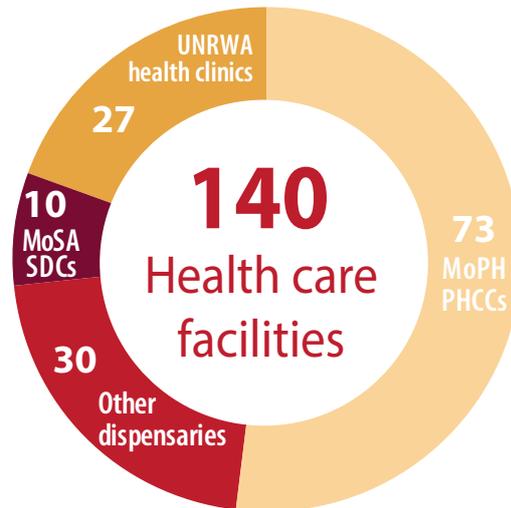
Availability of primary healthcare services

In Lebanon, Primary Healthcare (PHC)¹ is available to vulnerable Lebanese as well as displaced Syrians, whether registered or unregistered with UNHCR, through a variety of healthcare facilities. These include the Ministry of Public Health's network of 218 Primary Healthcare Centres (PHCCs), and an estimated 1,011 other primary healthcare facilities, referred to as dispensaries, most of which are NGO clinics. Primary healthcare centres offer a relatively comprehensive package of primary healthcare services, while the dispensaries, including the Ministry of Social Affairs' (MoSA) 220 Social Development Centres (SDCs), typically provide more limited support.

In the identified facilities, basic health services such as general medical consultations for acute and chronic diseases, mother and child, mental health and reproductive health services including antenatal, postnatal and contraception / family planning care are offered for a nominal fee, compared to private clinics. In a large number of these facilities, routine vaccinations, medications for acute and chronic diseases as well as reproductive health commodities are available free of charge. These are supplied through the Ministry of Public Health with the support of partners to address increased needs. Services are offered on an equitable basis to women, men, girls, boys and persons with disabilities.

as refugees or not by UNHCR, at around 113 primary healthcare facilities (including 73 Ministry of Public Health's primary healthcare centres, and 30 dispensaries including 10 Ministry of Social Affairs-Social development centres)² distributed across the country with the support of international and local partners, which aims at reducing out of pocket expenditures in light of the high economic vulnerability levels of displaced Syrians.

Facilities where subsidized primary health care is available in Lebanon



Similarly, subsidized care is available to vulnerable Lebanese as a way of addressing critical health needs and mitigating potential sources of tension in almost 94 per cent of these facilities. From January to September 2018, approximately 940,179 subsidized consultations were provided at the public healthcare level by LCRP partners, out of which 18 per cent were consultations for vulnerable Lebanese.³

In parallel to the provision of public healthcare services through the Ministry of Public Health's primary healthcare centres and dispensaries, specific primary healthcare services are made available to displaced Syrians through approximately 25 Mobile Medical Units (MMUs) operated by NGOs, which provide free consultations and medication and often refer patients back to primary healthcare centres for services which are not available through mobile medical units. Though fewer in number than at the onset of the crisis, mobile

Availability of vaccines, medication and reproductive health (RH) commodities supplied by MoPH

Facilities	Vaccines	Acute Medication	Chronic Medication	RH commodities
MoPH-PHCCs (208)	All 218	All 218	202	All 218
Dispensaries (Approx. 1,011 including 220 MoSA-SDCs)	633	220 (all MoSA SDCs)	218	58

In alignment with the Lebanon Crisis Response Plan (LCRP) Health sector strategy, subsidized healthcare is available to displaced Syrians, whether registered

medical units continue to be operational primarily in areas with high distributions of informal settlements and/

(1) Primary healthcare includes services such as: vaccination, medication for acute and chronic conditions, non-communicable diseases care, sexual and reproductive healthcare, malnutrition screening and management, mental healthcare, dental care, basic laboratory and diagnostics as well as health promotion.

(2) Based on Activity Info, September 2017 data.

(3) Organizations which are not LCRP partners such as Médecins Sans Frontières (MSF) Switzerland and MSF-Belgium are providing an important number of primary healthcare services free of charge for displaced Syrians, vulnerable Lebanese as well as other population groups.

or in distant rural areas where primary healthcare centres are hard to reach. Mobile medical units serve to mitigate access constraints to healthcare because of a lack of and/or expensive transportation and freedom of movement restrictions particularly for those with no legal status. From January to September 2018, approximately 152,000 free consultations were provided through mobile medical units by LCRP partners representing 14 per cent of the total consultations supported by partners.⁴

Meanwhile, primary healthcare services are also widely available to displaced Syrians through private doctor clinics, pharmacies or even hospitals. According to the 2018 Vulnerability Assessment of Syrian Refugees,ⁱ the percentage of households consulting private doctors/clinics increased from 16 to 23 per cent in 2017, indicating a higher cost in terms of out-of-pocket expenditures. Medical services are also available to displaced populations through a number of informal practices run by Syrian doctors or midwives in informal settlements. The latter exacerbates protection risks since uncertified midwives are unable to provide new-borns with birth certificates, limiting their chances of birth registrations.

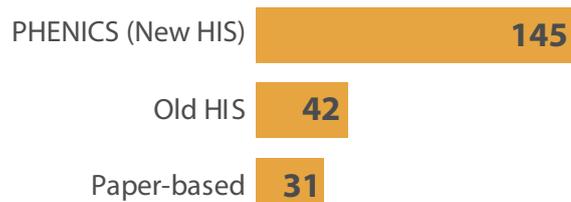
Similarly, to Palestinian refugees from Lebanon (PRL), primary healthcare is available to Palestinian refugees from Syria (PRS)⁵ primarily through the 27 UNRWA health clinics which offer free of charge healthcare services. From January to September 2018, approximately 101,851 free consultations were provided to Palestinian refugees from Syria through UNRWA clinics.

Health Information System in primary healthcare

The Ministry of Public Health's primary healthcare Health Information System (HIS) has come a long way since it was established due to crucial investments that have and continue to be made in improvements and expansion. The objective of the health information system is to provide individual, facility, population, and age and gender-segregated data on health outcomes, necessary for health planners and decision makers.

A total of 218 facilities in the Ministry of Public Health's primary healthcare centres network currently provide monthly reporting to the Ministry. Reporting is conducted through three different channels: 145 facilities report to the Ministry of Public Health through PHENICS, the most elaborate version of the Ministry's public healthcare centres health information system software, 42 facilities report through an older version of the health information system software and 31 facilities through paper-based reports. Facilities that are still using a paper-based reporting system have either recently joined the Ministry of Public Health's primary healthcare centres network, face a shortage in human resources for reporting, or have their own private health information systems in place.

218 Health facilities Reporting to MoPH through:



That said, an important number of primary healthcare facilities (mostly dispensaries) do not report to the Ministry of Public Health limiting the extent to which the available data is nationally representative of the vulnerable population at large.

Access to primary healthcare services

Multiple sources of information point to varying levels of access to primary healthcare services among displaced Syrians. Data from the Ministry of Public Health's primary healthcare centres, shows that 30 per cent of service recipients through the Ministry's primary healthcare centres are displaced Syrian women, men, boys and girls. These include both beneficiaries receiving subsidized or nonsubsidized services through the Ministry's primary healthcare centres.

The UNHCR 2018 Health Access and Utilization Survey (HAUS) confirms that, for both acute and chronic conditions, respondents seek services through a variety of facilities. For acute conditions, 45 per cent of interviewed persons sought care at primary healthcare outlets/private clinics, 47 per cent at pharmacy level and 7 per cent went straight to the hospital. While for chronic conditions, 59 per cent of interviewed persons sought care at primary healthcare outlets/private clinics and 35 per cent at pharmacy level.

According to data from the 2018 Vulnerability Assessment of Syrian Refugees in Lebanon, 54 per cent of households reported the need to access primary healthcare services in the last six months. Of those, 87 per cent reported being able to access the required care. This is a slight decrease from 2017, where 89 per cent of households could access required care. For the 13 per cent of households who are not able to access care, barriers are mainly related to cost of medications or treatment, doctors' consultations fees, staff attitude, distance to the healthcare facility, transportation costs and lack of knowledge about available services.

Gender based accessibility challenges such as social stigma and lack of gynaecologic health seeking behaviours for adolescent and unmarried girls were also reported. Focus group discussions with persons of concern revolved around the above-mentioned challenges, especially for people with specific needs such as child spouses and socially marginalized groups, as well as those living in remote areas.⁶

Interestingly, based on the Vulnerability Assessment of Syrian Refugees in Lebanon results, while knowing

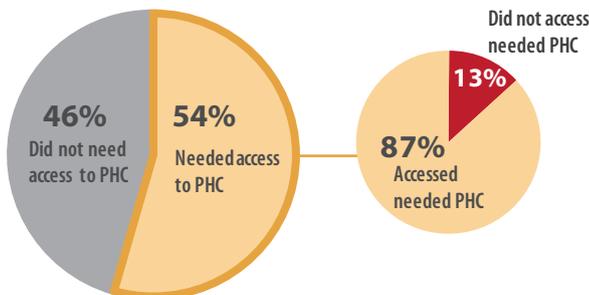
(4) Currently, LCRP and non-LCRP partners operate an equal number of mobile medical units.

(5) According to UNRWA 2018 data, there are approximately 18,000 Palestinian refugees from Syria in Lebanon.

(6) Findings from participatory assessments with working children, child spouses, female-headed households, women alone, detained persons minorities and stateless persons in Lebanon, 2017-2018, UNHCR.

that they not only reflect on services provided by the Ministry of Public Health network, households in the governorates of Mount-Lebanon and Beirut followed by Al Nabatieh, were less able to access required care. This is quite different compared to results of the 2017 Vulnerability Assessment of Syrian Refugees in Lebanon which showed that households in the governorates of Mount-Lebanon and Beirut followed by Akkar were less able to access required care. The very high percentage of reported accessibility to primary healthcare services in Akkar (98 per cent) could be explained by the high number of charity-based organizations and politically-supported NGOs providing primary healthcare in the area. In addition, low access rates in Nabatieh governorate compared to those in the South is likely due to fewer public services providers and partners in Nabatieh, as opposed to the South which has several mobile medical clinics and good coverage of primary healthcare centres.

Access to Primary Healthcare (PHC) (VASyR 2018) in 6 months period



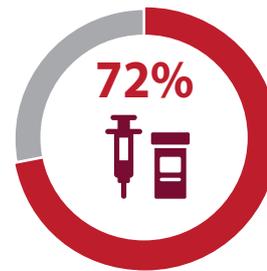
Based on the findings from participatory assessments involving children, child spouses, female-headed households, women living alone, detained persons, minorities and stateless persons in Lebanon (UNHCR, 2018),ⁱⁱ persons of concern reported being frustrated with the health referral pathways due to lack of clarity around types of services covered, non-coverage of certain cases, moving between service providers without treatment, expensive medical fees, advanced payment requests from hospitals and the perceived inability or unwillingness of the Third Party Administrator, managing hospital admission for displaced Syrians, in providing guidance.

Access to specific primary healthcare services

Vaccination: Routine vaccinations are widely available across the country and accessible to both displaced Syrians and vulnerable Lebanese through all 218 Ministry of Public Health's primary healthcare centres as well as approximately 600 dispensaries. Results of the 2016 WHO Expanded Programme on Immunization (EPI)⁷ coverage survey showed that 47 per cent of Lebanese and 72.7 per cent of displaced Syrians received vaccinations at primary healthcare centres.ⁱⁱⁱ Alternatively, and specific to localized vaccination campaigns, vaccinations are also accessible through mobile medical units. Moreover,

measles, mumps, rubella and polio vaccinations are provided at UNHCR reception centres and at the four Syria border crossings for all children under 18 entering officially to Lebanon. Oral polio vaccinations are also provided at the same border crossings for all children under 18 officially returning to Syria.

Percentage of displaced Syrians who received vaccination at Primary Health Care Centres (EPI Survey 2016)



While great strides have been made in the overall vaccination coverage, considered to be high in Lebanon, the expanded programme on immunization survey, together with localized field assessments, point to lower coverage in certain districts.⁸ In addition, a measles outbreak was declared by the Ministry of Public Health on 15 March 2018 with 867 confirmed cases between January 2017 and mid-October 2018. With 81 per cent of the cases affecting vulnerable Lebanese (19 per cent Syrians), the situation reflects a vaccination coverage gap for the country and children from all nationalities. This will require strengthened efforts to support the Ministry of Public Health in delivering free vaccinations in all areas of Lebanon to all at-risk populations.

Various barriers to optimal vaccination coverage have been identified. In many Ministry of Public Health primary healthcare centres, a consultation fee is often charged for vaccination despite an official Ministry of Public Health Circular instructing facilities to provide vaccinations free of charge. The Circular is therefore perceived by partners to be poorly implemented and enforced. Noncompliance with the Ministry of Public Health's Circular on providing free vaccinations is an issue in all the Lebanese governorates. Indeed, 39 per cent of interviewed households reported having paid for vaccination (UNHCR Health Access and Utilization Survey, 2018)^{9,iv}. Access challenges to vaccinations voiced by displaced Syrians are vaccination costs followed by transportation costs to the facility. Poor knowledge about available services seem to play a role in low vaccination coverage as only 59 per cent of households were aware that vaccination for children under 12 years is free at the Ministry of Public Health's primary healthcare centres. Furthermore, UNICEF's 2017 Knowledge, Attitudes and Practices (KAP)^v survey indicates that 45 per cent of Syrian

(7) 2016 WHO Expanded Programme on Immunization (EPI) survey was conducted by the Connecting Research to Development Centre, contracted by and under the guidance of WHO, with the overall supervision of the Ministry of Public Health team.

(8) The WHO Expanded Programme on Immunization (EPI) Cluster survey shows that, at a national level, completed vaccination (three doses at least) for polio is 90.1 per cent, DTP 87.3 per cent, Hib 88.7 per cent and Hepatitis B 89.9 per cent. More specifically, a polio coverage of less than 85 per cent is reported in the districts of Jbeil, Metn, Akkar, Minieh-Dennieh, Bcharreh and Jezzine.

(9) Health Access and Utilization Survey among Syrian refugees from Lebanon was conducted in 2018 among persons of concern living in Lebanon, to monitor their access to and utilization of available healthcare services.

caregivers reported a lack of knowledge as a reason for not vaccinating their children compared to 39.1 per cent in the 2016 Knowledge, Attitudes and Practices survey. Although not a barrier, the lack of vaccination documentation/records (vaccination booklets are often lost), remains an issue as healthcare providers are unable to properly assess a child's vaccination status and as such, would have to assume that the child was never vaccinated.

The surveillance system in Lebanon detected 69 acute flaccid paralysis up to mid-October 2018, none being polio-related, with sporadic cases of vaccine-preventable diseases still being observed/reported.¹⁰ From January to mid-October 2018, 867 cases of measles, 99 of mumps, and 53 cases of pertussis were confirmed. The highest numbers of cases of vaccine-preventable diseases were reported in Bekaa, Beirut/Mount-Lebanon and South governorates. Although reporting has improved, the actual number of cases is believed to be higher. Considering population movement across borders, crowded living and poor sanitation conditions, as well as direct disposal of untreated waste water, heightened risks of vaccine-preventable diseases exist, together with the risk of introduction of new diseases into the country. Surveillance and accelerated immunization activities are therefore critical.

Malnutrition: The prevalence of Global Acute Malnutrition (GAM) among displaced Syrian children aged 6-59 months in Lebanon is stable at around 2 per cent, with a similar trend of boys being slightly more wasted (low weight for height) than girls (Vulnerability Assessment of Syrian Refugees in Lebanon 2016). Accordingly, the prevalence of Global Acute Malnutrition in Lebanon falls under the "acceptable" severity category on the WHO Crisis Classification. Screening for and management of both moderate and severe acute malnutrition (without complications) among children under five and Pregnant and Lactating Women (PLW), along with the provision of micro-nutrient supplements has been integrated at the level of the Ministry of Public Health's primary healthcare centres.¹¹ At this level, systematic screening for acute malnutrition of all children under five is often hampered by overstretched staff. There is also a missed opportunity for screening for both children under five as well as pregnant and lactating women outside of those facilities and possibly within communities as the Ministry of Public Health figures do not reflect estimates of children with acute malnutrition based on prevalence rates and population figures.

Infant and Young Child Feeding (IYCF): Based on data from the Vulnerability Assessment of Syrian Refugees in Lebanon 2018, less than half (44 per cent) of infants under

6 months were exclusively breastfed and 17 per cent of children between 6 and 23 months had the minimum diet diversity and the figures decrease as the households become poorer. The rate of exclusive breastfeeding is higher among displaced Syrians than it is among Lebanese, and Palestinian refugees from Lebanon and Syria. Furthermore, 54 per cent of displaced Syrian children (age 6-23 months) received solid, semi-solid or soft foods the minimum number of times, compared to 64 per cent of Lebanese children^{vi} indicating sub-optimal complementary feeding. Moreover, 43 per cent of displaced Syrian children (age 6-9 months) have received breastmilk and a solid or semi-solid food the previous day, and 58 per cent of displaced Syrian children (aged 12-15 months) were fed breastmilk the previous day providing some indication of continued breastfeeding of children beyond six months.

At facility level, barriers to raising awareness and counselling are related to overwhelmed or lack of available relevant staff. Moreover, most significant self-reported barriers to exclusive breastfeeding of children (0-6 months) among displaced Syrians relate to poor maternal health and nutritional status, the baby being sick or hospitalized followed by stress and/or crowding. As per UNICEF's Knowledge, Attitudes and Practices 2017^{vii}, the top three reasons among Syrians for not breastfeeding are: not having enough breastmilk (63 per cent), time to stop breastfeeding (37 per cent), and baby being still hungry and needing more food (29 per cent). Barriers to complementary and diversified feeding for children aged 9 to 23 months include; baby gastrointestinal issues, access to food variety, remembering to give the child 4+ food groups.¹²

As part of health system strengthening and for the Government of Lebanon, at national and regional levels, to have the evidence and management capacity to improve child feeding practices, the Ministry of Public Health with the support of health partners, developed a three to five-year national infant and young child feeding policy that was launched mid December 2018. Furthermore, building on previous efforts with the Ministry of Public Health on reviving the Baby Friendly Hospital Initiative, and with the aim to protect, support, and promote exclusive breastfeeding in health facilities, health actors will continue supporting the reinvigoration of Baby Friendly Hospital Initiative in multiple Lebanese governorates.

Other than the above-mentioned initiatives, there are relatively limited efforts by partners to promote, protect and support infant and young child feeding at the community, primary healthcare and hospital level for optimal growth despite findings indicating those interventions are much needed. Likewise, addressing some specific barriers warrants cross-sectoral interventions.

Acute and chronic conditions: Syrians primarily seek care to treat infections and communicable diseases, followed by chronic conditions and Non-Communicable

(10) According to Ministry of Public Health's Epidemiologic Surveillance Unit (ESU), from January to September 2017, nationally, 198 cases of mumps (36 among displaced Syrians), 238 cases of Hepatitis B (38 cases among displaced Syrians), 63 cases of acute flaccid paralysis (13 cases among displaced Syrians), 76 cases of pertussis (17 cases among displaced Syrians) and 89 cases of measles (29 cases among displaced Syrians) were reported.

(11) According to Ministry of Public Health's Health Information System (HIS), from January to July 2017, 127,814 children under five were screened for malnutrition in all Ministry of Public Health primary healthcare centres, and 424 children received treatment for moderate or severe acute malnutrition (without complications) in the 52 healthcare centres that are malnutrition management centres. Also, 12,422 children under five and pregnant and lactating women were receiving micro-nutrients.

(12) International Mercy Corps, 2016.

Diseases (NCD).^{viii} Preliminary data from WHO's non-communicable disease stepwise survey¹³, a national non-communicable disease prevalence survey targeting Lebanese and displaced Syrians in Lebanon, shows almost similar prevalence of impaired fasting glycaemia, diabetes, obesity, and hypertension. However, the study reveals that smoking and cholesterol levels are higher among Lebanese. Moreover, the study showed that more Syrians had more than three risk factors (59.8 per cent) for non-communicable disease compared to Lebanese (51.4 per cent). This warrants special attention to ensure continued access to non-communicable disease medication and good quality of care including early detection and outreach on health behaviours.

Currently, approximately 180,000 Lebanese and displaced Syrians access non-communicable disease medication through the joint Ministry of Public Health Young Men's Christian Association (YMCA) chronic medications programme. It is estimated that around 10,000 displaced Syrians are also accessing non-communicable disease medications procured separately through partners.

Findings from the 2018 UNHCR Health Access and Utilization Survey¹⁴ indicate that 30 per cent of interviewed persons reported having an acute condition during the preceding month out of which 36 per cent did not seek healthcare either because they could not afford clinic fees (66 per cent) or because they did not think it was necessary (27 per cent). Moreover, the study indicates that 11 per cent of interviewed individuals reported a chronic condition. Of those, only 66 per cent had been able to access medical care and/or medicines during the last 3 months. Of those who could not access care, the main reasons were not being able to afford the clinic fees (66 per cent), not being able to afford transportation (16 per cent) and not thinking it was necessary to go (14 per cent). The study also points to poor knowledge related to available services as a barrier to primary healthcare access; results showed that only 60 per cent of interviewed households knew that they could obtain primary healthcare consultations for between 3000 and 5000 LL and only 34 per cent knew that drugs for acute conditions could be obtained for minimal fee at primary healthcare facilities.

Another access barrier to acute and chronic disease medication is doctors prescribing brand name medications that fall outside the generic list of the Ministry of Public Health/WHO for essential medication and the Young Men's Christian Association's list of medication for chronic diseases, rendering them ineligible for subsidized fees at the primary healthcare level. Another barrier is the lack of proper forecasting of medication needs/consumption which often results in both shortages and stocks of expired medication. Even though medications are provided at subsidized fees,

(13) WHO Non-Communicable Disease stepwise survey is a national non-communicable disease prevalence survey targeting Lebanese and displaced Syrians in Lebanon with the objective of monitoring disease trends, predict future public health project caseloads, estimating the burden of non-communicable diseases leading to the planning of evidence-based interventions.

(14) The Health Access and Utilization Survey among Syrian refugees from Lebanon was conducted in 2018 among persons of concern living in Lebanon, to monitor their access to and utilization of available healthcare services.

challenges persist in relation to hidden consultation costs and the inconsistency of the costing system across the Ministry of Public Health's primary healthcare centres network.

Sexual and Reproductive Health: According to UNHCR's registration data,^{ix} displaced Syrian women of childbearing age (15-49) constitute 25 per cent of the total registered population of displaced Syrians.¹⁵

As a reflection of the existing needs in pregnancy care, Ante-Natal Care (ANC) and Post-Natal Care (PNC) constitute an important proportion of services currently provided to displaced Syrian women at the primary healthcare level. Results of the UNHCR 2018 Health Access and Utilization Survey shows that 72 per cent of women who had delivered in the past two years reported going for ante-natal care. The survey also shows that 30 per cent of women who were pregnant in the last two years had received ante-natal care in more than one facility. The results of the survey indicate that an alarming 28 per cent of women did not receive ante-natal care during their pregnancy. Among this percentage of pregnant women, the majority (38 per cent) reported being unable to afford doctor's fees and 26 per cent thought ante-natal care was not necessary. Among women who accessed ante-natal care, 72 per cent reported four or more visits, a significant increase compared to 55 per cent in 2017. Yet, with the high percentage of women not accessing ante-natal care at all, the overall uptake of ante-natal care is considered low.

Moreover, the survey shows that the most common barriers to ante-natal care are financial or knowledge/attitude related. Significant barriers to ante-natal care during the first trimester include: not being able to afford the fees, lack of time/or having to care for other children, not remembering to attend an ante-natal care visit, or not being aware of the importance of seeking care during first trimester.^x Moreover, only 26 per cent of women who delivered reported receiving post-natal care. Of those women who did not attend post-natal care, 56 per cent indicated that they did not think it was necessary and 35 per cent said that they could not afford clinic fees. These findings demonstrate the need to increase the uptake of ante and post-natal care and address the most common barriers through financial support and increased outreach.

The uptake of family planning by displaced Syrians is also low. Based on the UNHCR 2018 Health Access and Utilization Survey, among those couples who report using a family planning method, contraceptive pills are most commonly used (38 per cent) followed by intrauterine devices (31 per cent), traditional methods (25 per cent), and condoms (13 per cent). The most common reported reason for the lack of family planning are planned pregnancies. Another recent study on the barriers to contraceptive use points to cost as the main barrier to contraceptive use.^{xi}

(15) Results of the UNHCR 2017 Health Access and Utilization Survey indicate that 43 per cent of women of reproductive age were pregnant during the last two years.

Mental Health: Around 2.5 per cent of displaced Syrians reported needing access to mental healthcare in the last six months, out of which 62 per cent were not able to receive the care they needed (Vulnerability Assessment of Syrian Refugees in Lebanon, 2017).^{xii} One of the main reasons for not accessing care is that mental health is still stigmatized in Syrian and Lebanese communities. In many cases, these conditions are often ignored or trivialized, sometimes resulting in serious long-term consequences. In addition, other accessibility barriers vary from cost, to transportation issues, as well as lack of knowledge on where to seek help. Despite a significant number of non-governmental organizations providing mental health and psychosocial support, access is not equally distributed and areas like Baalbak- Hermel remain without any support (Vulnerability Assessment of Syrian Refugees in Lebanon, 2017).

In 2014, the Ministry of Public Health launched the National Mental Health Programme (NMHP), with the mission of reforming the mental health system in the country. To achieve this mission and guide system reforms, in 2015 the National Mental Health Programme launched the first national strategy for mental health, covering the period of 2015-2020.

Services provided by local and international NGOs range from case management (including for survivors of sexual and gender-based violence) to more specialized care (psychotherapy and psychiatry). These are provided free of charge however, remain insufficient to respond to existing needs. From January to September 2018, partners provided a total of 39,149 specialized mental health consultations to vulnerable Lebanese, displaced Syrians, and Palestinian refugees from Lebanon and Syria. Mental health service needs are most acute in Akkar, Hermel, Dennieh and South of Lebanon. Due to the lack of psychiatric hospitalization facilities outside of Beirut, proper management of psychiatric emergencies at the hospital level as well as transportation support are required.

In conjunction, both displaced Syrians and vulnerable Lebanese alike, can access essential psychotropic medications via the Young Men's Christian Association network and some specialized medications via the humanitarian list provided by the Ministry of Public Health. The ongoing efforts of the Ministry's National Mental Health Programme and its partners seek to expand mental health services through their integration into primary healthcare. To date, due to accelerated initial training on mental healthcare, more than 800 health workers in around 300 primary healthcare centres and dispensaries were introduced to the WHO Mental Health Gap Action Programme (mhGAP). Of these, around 75 received advanced training, whereby at least one nurse and one general practitioner are well trained on the Programme. In addition, a community mental health centre in the Bekaa has been piloted over the past three years. Over the next four years (2018-2020), the delivery of mental health packages will gradually be piloted in 40 selected primary healthcare centres, of which, 12 were

identified to provide more specialized mental health services via a multi-disciplinary team. This links to various case management services offered by protection, child protection and gender-based violence teams who work at lower tier to follow up, in action planning, and provide group psychosocial session structures and basics to address mental health concerns.

Tuberculosis (TB) and Human Immunodeficiency Virus (HIV): In Lebanon, tuberculosis and HIV care is not integrated within primary healthcare and have separate vertical programmes within the Ministry of Public Health.

All tuberculosis services are provided for the Lebanese host population and displaced Syrians (hospitalizations, diagnostics, treatment, follow up tests and sanatorium hospitalizations) through the National Tuberculosis Programme (NTP). The Programme's nationwide screening campaign detects active tuberculosis in informal settlements and collective shelters in the North, South and Bekaa and Mount Lebanon. In addition, the National Tuberculosis Programme provides screening for active cases of tuberculosis in five Palestinian camps, including; Rachidieh in the South, Burj El Barajneh in Mount Lebanon, Mar Elias and Shatila in Beirut and Naher El Bared in the North. From January to September 2018, 527 tuberculosis cases were registered with the National Tuberculosis Programme, of which 80 were displaced Syrians. With funds available from the Global Fund, active Directly Observed Therapy Strategy (DOTS), free of charge treatment of patients with tuberculosis was expanded, with special focus on areas with the highest vulnerability levels of displaced Syrians and host communities. The free of charge care of latent tuberculosis cases (screening and management) was decentralized within 15 public hospitals through an information technology system guided by a clear management protocol based on the updated 2016 Clinical Treatment Protocols of tuberculosis.

The main activities and achievements of the National Acquired Immune Deficiency Syndrome (AIDS) Programme (NAP), focus around prevention, testing, diagnosis, care, and treatment. Anti-Retroviral Therapy (ART) is available free of charge through the Programme to HIV positive Syrian and Lebanese patients, and treatment is provided according to the updated 2016 HIV antiretroviral protocols. From January to September 2018, a total of 1,295 persons with HIV were receiving treatment through the programme out of which 1,188 are Lebanese, 57 displaced Syrians, 42 Palestinian refugees and 8 from other nationalities.

With regards to Palestinian refugees from Syria, data from UNRWA's Health Information System points to each refugee visiting UNRWA clinics five times per year on average. In general, Palestinian refugees from Syria are worse-off compared to Palestinian refugees from Lebanon on all health-related indicators.^{xiii} Respectively, 10 per cent, 75 per cent and 83 per cent of households report at least one family member who has suffered from a disability, acute illness in the past six months, together with longer term chronic illnesses. The four most prevalent chronic conditions are diabetes, high blood pressure, heart disease, and bone and muscle complications.^{xiv}

Although in theory, displaced Syrians and Palestinian Refugees from Syria can access primary healthcare services from a variety of health outlets, the main barrier is cost. Data from the 2018 Vulnerability Assessment of Syrian Refugees in Lebanon indicates that displaced Syrians' health expenditure is relatively high and represents 12 per cent (compared to 13 per cent in 2017) of the total expenditures of a household (average total expenditure is US\$ 403 per household per month, a decrease of \$56 from 2016).^{xv} The UNHCR 2018 Health Access and Utilization Survey¹⁶ also points to an average monthly household expenditure of \$157 on health with the median monthly household expenditure on health being \$87. Compared to 2017, the monthly household expenditure and the median monthly household expenditure have both slightly increased from \$154 and \$75 respectively. Considering the increasing economic vulnerability of both displaced Syrians and Palestinian refugees from Syria, further financial support for access to primary healthcare is critical.

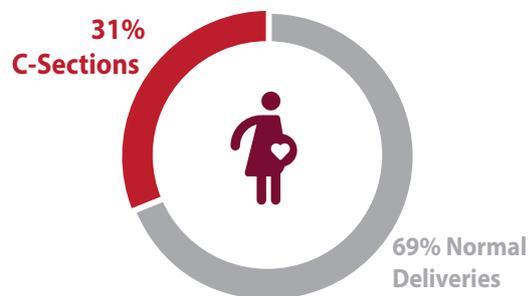
Secondary and tertiary healthcare (hospital care)

Access to hospital care for displaced Syrians, whether registered or unregistered with UNHCR, is primarily through a network of 40 public and private hospitals across Lebanon. Subsidized care is limited to obstetric and life-threatening conditions, which were prioritized in light of available funding, and currently covers 75 per cent of hospitalization fees. Coverage not only increased to 90 per cent for severely vulnerable households, but also for patients with acute burns and psychiatric conditions, as well as infants in need of neonatal and paediatric intensive care. The remaining 10 to 25 per cent of fees are covered by displaced Syrians. Survivors of gender-based violence, particularly survivors of rape are fully covered. As of July 2018, changes were implemented in relation to the Referral Secondary Healthcare Programme to reduce the overall cost of the referral care program, to increase protection for beneficiaries whose patient shares are substantially high and to simplify and improve the efficiency of the process. The new cost-sharing mechanism requires displaced Syrians to first contribute \$100 with the remaining 75 per cent of the cost being

covered. Nevertheless, beneficiaries never pay more than \$800. The impact of this change is being monitored through a number of admissions before and after implementation of the new mechanism. There were no noted decreases in admissions rates up to September 2018, however careful analysis of trends to evaluate the impact of the change in system on displaced Syrians is ongoing.

From January to September 2018, a total of 60,926 displaced Syrians (average of 6,769 admissions per month) were admitted for hospital care representing a 10.4 per cent increase from 2017 admissions.^{xvi} Based on data from previous years, it is estimated, that 59 to 57 per cent of total admissions are pregnancy-related. Though hospital-based deliveries are covered, assessments indicate that an increasing number of women are delivering at home, assisted by either a skilled or traditional birth attendant. It is also estimated that 31 per cent of deliveries were through C-section, which is considered high.¹⁷ Though it is lower than the C-section rate amongst Lebanese, estimated at around 44 per cent,¹⁸ it is higher than the rate reported in Syria (23 per cent),^{xvii} and confirms findings of a 2007 study by the American University of Beirut pointing to a policy environment encouraging C-sections in Lebanon^{xviii}. As the practice carries risks, with concerns that unnecessary C-sections are taking place, the rate should be further monitored and addressed. Another estimate is that 14 per cent of all new-borns are admitted or kept in hospitals for special care^{xix}. The rate of admission to Neonatal Intensive Care Unit (NICU) is also considered high and requires further monitoring. Specific to maternal and child outcomes, Ministry of Public Health reports in the first quarter of 2018 indicate that non-Lebanese¹⁹ (displaced Syrians included) are likely to be worse off compared to Lebanese on maternal and neonatal mortality indicators.

Percentage of normal deliveries vs. C-sections for displaced Syrians in Lebanon



Reported challenges linked to hospital admissions are: financial constraints,²⁰ delays in hospital admissions of persons with psychiatric conditions, limited spaces (hospital beds), and the retention of dead bodies or personal identification documents thereby pushing the

(17) According to WHO, the ideal rate for caesarean sections is between 10-15 per cent.

(18) The Ministry of Public Health's 2013 Public Health bulletin showed that the rate of C-sections reached 44-45 per cent of total deliveries covered by the Ministry.

(19) The Ministry of Public Health started disaggregating maternal and child data by nationality in mid-2017. Prior to that, two categories were used: Lebanese and non-Lebanese.

(20) UNHCR Participatory Assessment, 2017-2018.

(16) UNHCR's Health Access and Utilization Survey in Lebanon was conducted in 2018 among persons of concern living in Lebanon, to monitor their access to and utilization of available healthcare services.

patient to pay his share. Presently, a limited number of health actors provide support to cover the patient's share and this is done on a case by case basis with the financial ceiling for support varying amongst supporting NGOs. In some hospitals, admissions are subject to a cash deposit and retention of identification or UNHCR registration documents of displaced Syrians until the hospital bill is settled. Whilst this has a clear psychological and traumatic impact on patient's personal well-being, it also breaks down trust with health service providers. In addition, confiscation of personal identification documents can lead to prominent protection risks for patients particularly those without legal status who can face risk of arrest and/or detention when crossing checkpoints and is a barrier to accessing other services.

A limited number of LCRP health partners provide access to hospital care support. Conditions which are covered include but are not limited to: surgeries for congenital malformations including cleft lip and palate and orthopaedic surgeries including club feet, hip displacement, reconstructive surgery for burns, dialysis for patients with chronic renal failure, blood transfusions for thalassemia patients, treatment for haemophilia patients, and chemotherapy for breast cancer patients. Yet, this support is limited and more often than not, a significant number of patients eligible for support are turned down. Although not LCRP partners, other organizations²¹ also provide additional support to displaced Syrians as well as other population groups for access to hospital care.

Overall, the hospitalization rate for obstetric and life-saving conditions for displaced Syrians is 8 per cent per year.²² Even with the support provided by partners, the hospitalization rate for displaced Syrians remains lower than that of Lebanese (12 per cent per year) due to restrictive criteria applied due to limited funding. It is therefore estimated that a significant number of displaced Syrians are not able to access needed hospital care, with the results of the 2018 Vulnerability Assessment of Syrian Refugees in Lebanon confirming that 23 per cent of displaced Syrian households in need of hospital care were not able to obtain it. The main reason cited was their inability to cover the cost of treatment.

Palestinian refugees from Syria and Palestinian refugees from Lebanon, benefit from hospital care through UNRWA with 100 per cent coverage in Palestinian Red Crescent Society (PRCS) hospitals and 90 per cent in public and private hospitals respectively and 60 per cent coverage for tertiary services (with a ceiling of \$5,000 per intervention).^{xx} Many families face access to healthcare challenges since 99 per cent of the population has no health insurance coverage and rely solely on UNRWA services. Despite different barriers (legal status, movement restrictions, limited resources), access to UNRWA hospitalization services is high.^{xxi} The hospitalization rate of Palestinian refugees from Syria

similarly to that of Lebanese is 12 per cent. However, funding is required to maintain the current subsidies provided by UNRWA.

To maintain current subsidies, address the large number of unmet needs and the underlying financial barrier to hospital care access, increased financial support is needed, particularly for cases which do not fall under current coverage, especially catastrophic illnesses (cancer) and chronic conditions (dialysis, multiple-sclerosis, etc)²³ as well as advanced diagnostics.

Overall, limited funding is available to ensure equitable provision of quality health services to meet essential health needs at the primary, secondary and tertiary healthcare levels. Consequently, access to healthcare in the eighth year of the crisis remains a serious concern.

Impact on healthcare institutions

Despite the institutional support provided, including staffing support, trainings, on the job coaching, equipment support and rehabilitation, health facilities at primary healthcare and hospital levels across Lebanon are heavily strained with an increased demand on services due to the crisis. Akkar and Bekaa, traditionally underserved areas, are hosting around 10 per cent and 25 per cent of the displaced Syrians respectively, and are in need of further institutional support.

Public hospitals are impacted by the inability of displaced Syrians to cover the totality of their hospital bills, and by the unfulfilled Ministry of Public Health commitments to public hospitals to cover, on an exceptional basis, the hospitalization fees of displaced Syrians and Palestinian refugees from Syria for conditions which are not subsidized by partners. These conditions include dialysis, cancer, catastrophic illnesses treatment and acute hospitalization. According to Ministry of Public Health records for 2016, public hospitals accumulated a deficit amounting to \$15 million since the onset of the Syria crisis, threatening the financial viability of the public hospital system as a whole and consequently, the future provision of hospital services.

If the above needs are not fully met, mortality and morbidity will increase due to inadequate access to healthcare. The risk of outbreaks of communicable and vaccine-preventable diseases will increase. Early detection and control of outbreaks will also be suboptimal.

Adolescent and youth health

It is estimated that 35 per cent of the Lebanese population are children (0-19), 20.6 per cent adolescents (10-19) and 19.8 per cent are youth (15-24)^{xxii}. Based on data from UNHCR Lebanon' registration database, 57 per cent of displaced Syrians registered with UNHCR as refugees are children (0-18), 23 per cent are adolescents (10-19) and 17 per cent are youth, indicating that both populations are relatively young.

(21) International Committee of the Red Cross (ICRC) mainly provides support to weapon wounded individuals, both Médecins Sans Frontières (MSF) Switzerland and MSF-Belgium support deliveries and MSF-France acute paediatric conditions.

(22) UNHCR Referral Care Report 2018.

(23) It is estimated that around 800 cases of cancer among displaced Syrians need to be treated every year, and an estimated 200 patients need on-going renal dialysis.

The Global School-based Student Health Survey (GSHS), a collaborative surveillance project designed to help countries measure and assess the behavioural risk factors and protective factors among young people aged 13 to 17 years, was conducted in Lebanon by WHO in 2016 in close collaboration with the Ministries of Education and Higher Education and Public Health.²⁴ Displaced Syrian children enrolled in public schools were included in the survey. For the first time, the Global School-based Student Health Survey addressed risky health behaviours following the impact of the Syria crisis on both the Lebanese and displaced Syrian school aged children. A total of 5,708 students participated in the Lebanon Global School-based Student Health Survey. While results of the study will further be disaggregated by population groups, key prevalence estimates from the survey indicate serious issues in relation to mental health, bullying, cigarette and alcohol use, activity level, and malnutrition among adolescents and youth.

Indicator	Prevalence
Percentage of students who seriously considered attempting suicide during the 12 months before the survey	14.2
Percentage of students who were bullied on one or more days during the 30 days before the survey	16.6
Percentage of students who currently used any tobacco products (used any tobacco products on at least 1 day during the 30 days before the survey)	36.6
Percentage of students who spent three or more hours per day sitting and watching television, playing computer games, or talking with friends, when not in school or doing homework during a typical or usual day	47.6
Percentage of students who currently drank alcohol (at least one drink of alcohol on at least one day during the 30 days before the survey)	18.9
Percentage of students who were underweight (<-2SD from median for BMI by age and sex)	4.0
Percentage of students who were overweight (>+1SD from median for BMI by age and sex)	24.6

Through collaborative efforts with the Government of Lebanon, the sector is committed to supporting adolescent and youth health in Lebanon through the National School Health Programme focusing on three main areas; medical screening, health awareness and education, and healthy school environments.

Overall sector strategy

The Ministry of Public Health Response Strategy, drafted in 2015 and updated in 2016, serves as the guiding document for the LCRP Health sector.^{xxiii} Activities in the LCRP fall within the scope of this strategy starting from community outreach, awareness and preventive activities to curative and referral services. By 2020, the strategy aims for the progressive integration of services in the existing national healthcare system.

The Ministry of Public Health Response Strategy serves

four strategic objectives:

1. Increase access to healthcare services to reach as many displaced persons and host communities as possible, prioritizing the most vulnerable;
2. Strengthen healthcare institutions and enable them to withstand the pressure caused by the increased demand on services and the scarcity of resources;
3. Ensure health security including a strengthened surveillance system for the control of infectious diseases and outbreaks;
4. Improve child survival rates.

In 2019, additional attention will be placed on strengthening the Health sector's commitment to mainstreaming protection within its activities to reduce the above-mentioned access barriers to services and improve Accountability to Affected People (AAP). This will be especially in relation to communication and transparency, participation and inclusion, organizational learning and adaptation, and feedback and response which will serve to complement the Vulnerability Assessment of Syrian Refugees in Lebanon and other surveys and strengthen protection outcomes of the Health sector programme and activities, especially for women, girls and other at-risk groups. Health sector partners will uphold the principles of transparency and accountability to ensure an effective and efficient humanitarian response within the Health sector. To that end, should the Government of Lebanon require information that is not captured by interagency mechanisms, bilateral requests can be made from the Government to the Health sector partners.

To strengthen good governance practices within the health system in achieving improved health outcomes and document best practices for Lebanon, the Ministry of Public Health established the Health Policy Support Observatory in April 2018.²⁵ The Observatory has three lines of work, including: providing direct analytical and informational support to the Ministry's policy-making; establishing communities of practice whose prime focus is to facilitate interaction between key stakeholders and; organizing a National Health Forum where civil society can engage in balancing needs, resources and expectations, in an evidence-based conversation with health authorities. Such initiatives will not only harness the contribution of the various networks and enhance the resilience of the health system, but also impact the wide spectrum of healthcare activities while helping meet the objectives of the LCRP.

Sector outcomes, outputs and indicators

The Health sector's overarching aim is to respond to the health needs (primary, secondary and tertiary healthcare) of displaced Syrians (whether non-registered or registered as refugees by UNHCR) and Palestinian refugees from Syria as well as the most vulnerable within

(24) The Global School-Based Student Health Survey (GSHS) was conducted in Lebanon in 2005 and 2011.

(25) The Policy Support Observatory is a tripartite partnership agreement with the American University of Beirut and the World Health Organization, hosted by the Ministry of Public Health.

the Palestinian refugees from Lebanon as well as the Lebanese host communities, and strengthen national institutions and capacities to respond to those needs while simultaneously enhancing the resilience of the health system as a whole.

The Health sector's strategy aims to provide equitable and quality primary, secondary and tertiary healthcare to displaced persons from Syria and to vulnerable Lebanese population through direct service delivery and national health systems (LCRP impact 3). All activities, outputs and outcomes will serve in achieving positive health impacts for populations in need and ensure immediate humanitarian needs are being met (LCRP impact 2). In addition, inter-sectoral linkages efforts will be geared towards providing a safe protective environment (LCRP impact 1) for vulnerable groups and will make sure programmes are implemented in an integrated manner to fulfil the different rights of people in need.

Outcome 1 – Improve access to comprehensive primary healthcare (PHC)

Assuming that LCRP health actors will continue providing support to the Ministry of Public Health's Primary Healthcare network in providing quality affordable access to health and nutrition services, including free immunization services to people in need, the first outcome will be achieved through the following outputs.

Output 1.1 – Financial subsidies and health promotion provided to targeted population for improved access to a comprehensive primary healthcare package

The sector aims to ensure access to comprehensive²⁶ quality primary healthcare to displaced Syrians (whether non-registered or registered as refugees by UNHCR) as well as vulnerable Lebanese, primarily through the Ministry of Public Health network of primary healthcare centres and dispensaries (including the Ministry of Social Affairs' social development centres in instances where there is uneven geographical coverage, or where the caseload is too heavy for the network to bear).²⁷

In the face of increasing economic vulnerability, new complementarity models that offer more coverage to displaced Syrians and vulnerable Lebanese patients seeking primary healthcare services are being implemented to ensure meaningful access, further addressing cost-related barriers such as doctors' fees, treatment or transportation costs.

One such model is implemented throughout 2018-2019²⁸ and consists of supporting an equal ratio of vulnerable Lebanese and displaced Syrians patients in accessing primary healthcare (including mental health) through

an initial 45 primary healthcare centres. Beneficiaries' contribution is of 3,000LBP (equivalent to \$2) as a consultation fee, while medication and diagnostics are fully covered for all population groups. Palestinian refugees from Syria and Lebanon will continue receiving free primary healthcare services through UNRWA clinics.

Though external to the LCRP, it is important to mention the ongoing Ministry of Public Health's pilot²⁹ "Emergency Primary Healthcare Restoration Project (EPHRP) - towards Universal Health Coverage". The pilot targets 150,000 vulnerable Lebanese registered with the Ministry of Social Affairs' National Poverty Targeting Programme (NPTP) with an essential preventive healthcare package through 75 Ministry of Public Health's primary healthcare centres. Six evidence-based packages are provided under this project: three age specific and gender wellness packages (ages 0-18, females and males 19 years and above), two care packages for the two most common non-communicable diseases in Lebanon; Diabetes Mellitus (DM) and Hypertension (HTN), and a safe motherhood package. So far, the project has contracted all 75 targeted primary healthcare centres. The number of beneficiaries enrolled to date is 103,752 and, 68,649 users benefitted from project services. The project enrolled 13 per cent of adults in diabetes mellitus package, 20 per cent of adult users in hypertension package and 4 per cent of females of reproductive age in the antenatal package. The project vaccinated 3,445 children under 5 thus far with the percentage of children fully immunized at 86 per cent. Eighty-seven per cent of adults above 40 were screened for diabetes mellitus and hypertension. 522 women benefitted from antenatal services under the project. Throughout 2019, the Ministry of Public Health plans to scale up and expand the project to all primary healthcare centres, targeting all 300,000 vulnerable Lebanese enrolled in the National Poverty Targeting Programme with packages for both preventive and curative services.

In parallel to the provision of subsidies, the Health sector will strengthen facility-based health promotion and community outreach efforts addressing knowledge and attitudes related to various health topics (i.e. vaccination, pregnancy care, family planning, infant and young child feeding, communicable and non-communicable diseases, mental health, etc.). Efforts will also aim at increasing awareness on the availability of services (including gender-based violence services) thereby contributing to increased demand for primary healthcare and decreased social stigma. This will be conducted through increased coordination of partner activities, harmonization of health messages as well as targeting of both women and men within communities to influence decision-making and ensure an environment that is supportive of positive health seeking behaviours. It will also be done by developing and designing information packages and employing various dissemination methods, in consultation with affected communities to ensure that they are appropriate and accessible to all groups, including people with specific needs. Where

(26) Comprehensive primary healthcare is inclusive of vaccination, medication for acute and chronic conditions, non-communicable disease care, sexual and reproductive health, malnutrition screening and management, mental health, dental care as well as health promotion.

(27) Palestinian refugees from Syria and Lebanon are an exception as their access to primary healthcare is through UNRWA clinics.

(28) The model is implemented throughout 2018-2019 by International Medical Corps (IMC), Première Urgence-Aide Médicale Internationale (PU-AMI) and Fundación Promoción Social de la Cultura (FPSC) through funding from European Union (EU)-Madad in complementarity with the Emergency Primary Healthcare Restoration Project

(29) The Ministry of Public Health pilot project is funded by the World Bank

possible, inter-sector linkages will be made to maximize health-education dissemination channels including through education facilities and after-school accelerated learning programmes for children who work.

With the crisis entering its eighth year, activities of mobile medical units such as vaccination campaigns, outbreak investigation and response, and the provision of primary healthcare services will be limited to exceptional security-related and emergency situations. Provision of primary healthcare services through mobile medical units will be particularly deprioritized as mobile medical units have proven to be costly, providing limited services, often relying on referrals to primary healthcare centres and are generally counter-productive to instilling health seeking behaviours and promoting health facility utilization.

The target for 2019 is a total of 2,150,000 subsidized or free consultations to be provided to displaced Syrians, vulnerable Lebanese, Palestinian refugees from Syria and Lebanon at the primary healthcare level. This output will be measured by an indicator on the “number of subsidized or free primary healthcare consultations provided” which will be disaggregated by age and sex to allow for gender analysis of potential barriers for access to primary healthcare to be addressed.

Within the next two years, the sector will explore in detail further optimizing the package of services offered and models of delivery including financing mechanisms to ensure an effective, cost-efficient and sustainable response. Special attention will be paid to interventions that meet the specific health needs of girls, boys, women, and men, including children under five years of age, pregnant and lactating women, adolescents including adolescent girls married before the age of 18, youth, persons with disabilities, older persons, survivors of gender-based violence, persons living with HIV/AIDS, persons facing gender-based discrimination, and other vulnerable groups. To assess challenges around access to health services, girls, boys, women and men will be equally consulted. Access of such groups to information on services and primary healthcare in general will be regularly monitored through consultations, assessments and other forms of engagement, as well as through existing complaints systems. 70 out of 218 Ministry of Public Health’s primary healthcare centres do have active complaints and feedback mechanisms to ensure patients can report any challenges faced. In addition, the Ministry’s 24/7 hotline is circulated on regular basis to displaced Syrians which they can call to provide feedback and complain. The feedback received from all levels will be used to adjust and enhance programmes and activities, as relevant. Even though the Ministry of Public Health, uses all possible resources to respond to all queries after prioritizing them, support from the Health sector is still needed to strengthen and expand the current feedback mechanism.

Output 1.2 - Free of charge chronic disease medication provided at primary healthcare centre level

As the displaced Syrian population will continue to benefit from the same entry points to healthcare as the Lebanese population, it is essential that the current mechanisms of national drug procurement for chronic disease medication be aligned with the existing needs of vulnerable Lebanese, displaced Syrians as well as other population groups, as to avoid any duplication for parallel procurement mechanisms by health partners. To that end, it is expected that over the span of the next two years the Ministry of Public Health’s procurement system, management and distribution of chronic disease medication, will specifically be able to progressively absorb vulnerable Lebanese as well as referred Syrian beneficiaries.³⁰

Reflections were made on the political situation and postponement on forming the cabinet that delayed fund transfers from Ministry of Finance to the Ministry of Public Health leading to severe shortages of chronic medications. Contingency funds are unavailable and it is challenging to secure funds to fill the gaps in a timely manner. Institutional support and health system strengthening initiatives such as training on medications and stock management are key in improving the existent network.

The target for 2019 is 180,000 individuals (147,000 Lebanese and 27,000 displaced Syrians) receiving chronic disease medication through the Ministry of Public Health/ Young Men’s Christian Association channels of procurement and distribution system, as well as 5,400 individuals (3,600 Palestinian refugees from Syria and 1,800 Palestinian refugees from Lebanon) receiving chronic medication free of charge through UNRWA clinics. This output will be measured by an indicator on the “number of persons receiving chronic medication” which will be disaggregated by sex.

Output 1.3 - Free of charge acute disease medication, medical supplies and reproductive health (RH) commodities provided at primary healthcare centre level

As in the procurement of chronic disease medication, it is essential that the current mechanisms of national drug procurement for acute disease medication, medical supplies and reproductive health commodities (including family planning commodities and Post-Exposure Prophylaxis (PEP) kits) be aligned with the existing needs of vulnerable Lebanese, displaced Syrians as well as other population groups, and any duplication for parallel procurement mechanisms by health partners be avoided. Discussions reflected on the importance of updating the list of medications for acute diseases provided by the Ministry of Public Health.

The targeting for 2019 remains around 1.5 million displaced Syrians and vulnerable Lebanese within the

(30) This is partly due to a sizeable number (10,000-15,000) currently benefiting from parallel projects that are currently phasing out or expected to phase out in the coming years.

existing primary healthcare channels, as well as around 50,000 Palestinian refugees from Syria and Palestinian refugees from Lebanon through UNRWA clinics.

Output 1.4 - Free of charge routine vaccination provided for all children under five at the primary healthcare centre level and through vaccination campaigns

The sector aims to achieve 100 per cent vaccination coverage of displaced Syrian children, Palestinian refugee children from Syria and Lebanon, and vulnerable Lebanese children³¹. This requires the enforcement of the Ministry of Public Health's policy relating to free vaccinations at the primary healthcare level as well as the expansion/ acceleration of routine vaccination activities with a focus on low vaccination coverage areas, as per the results of the annual WHO Expanded Programme on Immunization coverage cluster survey. In addition, a more systematic vaccination process needs to be developed and endorsed for official return activities. This output will be measured through an indicator on the "number of children under five receiving routine vaccinations" which will be disaggregated by population cohort and sex.

Output 1.5 - Primary healthcare institutions' service delivery supported

In order to strengthen the capacities of the Ministry of Public Health at central and local levels to respond to primary healthcare needs, the expansion of the Ministry's primary healthcare centres network to up to 250 centres is prioritized to ensure greater geographical coverage and accessibility of vulnerable populations, including people with disabilities, to quality primary healthcare services at an affordable cost.³² Moreover, support is required in terms of human resources at the central and local levels of the Ministry of Public Health as well as primary healthcare centres which are understaffed and overloaded. This includes staffing for the Ministry of Public Health's National Mental Health Programme as well as staff for polio surveillance. The provision of equipment is also needed, to not only respond to current needs, but also to replace old and deteriorating equipment. Additionally, staff capacity building is needed through ongoing training, follow-up and supervision according to identified gaps. These trainings will include modules on soft skills³³, safe identification and referral of survivors of sexual and gender-based violence and survivor-centred approaches with a focus on privacy and confidentiality. Other trainings aim to build the capacity of health providers on mental health, family planning, maternal and child health, vaccine management, etc. The sector will encourage an equal ratio of female/male staff trained³⁴. The sector will focus

on capacity building trainings as well as monitoring of key quality indicators for improved quality of care through increased coordination between partners and the use of common tools. Complaints or feedback mechanisms will be strengthened to enhance primary healthcare centres, including those received from call centres, participatory assessments and surveys.

Furthermore, in 2008, the Ministry of Public Health initiated work on an accreditation mechanism for primary healthcare centres aiming to include all network centres to increase monitoring and ensure quality services in primary healthcare centres. The accreditation programme is fully funded by Ministry of Public Health and implemented by the primary healthcare department where the Ministry provides all the training, logistic and administrative support, and expert consultation visits to ensure the quality of the process. Since the beginning of the accreditation programme and with limited resources, the Ministry of Public Health has trained 132 primary healthcare centres on accreditation standards, and 52 healthcare centres have been fully accredited to date.

As an additional mitigation measure, the Ministry of Public Health would benefit from the Health sector's support to strengthen its accreditation programme and internal monitoring and evaluation measures at the primary healthcare level focusing on the compliance of the healthcare with Ministry of Public Health's national health strategy and memos especially in relation to a unified costing system, including the provision of free immunization services.

Additionally, the Health sector prioritized, along with the Ministry of Public Health, exploring ways to support the expansion of the existing health information system. Through supported projects³⁵ at the Ministry's primary healthcare centre level, electronic medical files for beneficiaries under the project were established, along with an electronic monitoring system, known as PHENICs. Further expansion of the health information system is envisioned in both the number of health facilities reporting in a harmonized way within the Ministry's health information system (i.e. tools and indicators) as well as the quality (relevance, accuracy, completeness, timeliness, etc.) of the data reported and generated. This will ensure that regular access to data is available to support proactive management of future healthcare priorities. Another indicator to be used is "number of facilities reporting on the Ministry of Public Health's Health Information System".

Risks associated with the above-mentioned outputs include the non-compliance of primary healthcare centres with the Ministry of Public Health's memos including hidden costs (Ex. Immunization) which results in decreased access to primary healthcare services. Efforts from LCRP health actors is needed to support the Ministry in strengthening its internal monitoring and evaluation measures at the primary healthcare level in compliance with the Ministry's national health strategy including the provision of free immunization

(31) It is estimated that 50 per cent of vulnerable Lebanese children receive vaccination through the public health system while the remaining 50 per cent receiving vaccination through private health system

(32) The Ministry of Public Health plans on adding 50 additional primary healthcare centres to the Ministry's primary healthcare network per year.

(33) As an example, the Clinical Management of Rape Training targeting health staff includes a module on soft skills

(34) It is observed that more female health staff attend trainings compared to male health staff – this is reflective of the general health workforce.

(35) World Bank Project

services. With time, and as the Ministry of Public Health's capacities are strengthened, the institutional support is expected to progressively decrease.

Outcome 2 – Improve access to hospital (incl. ER Care) and advanced referral care (advanced diagnostic laboratory and radiology care)

Taking into consideration that LCRP health actors will continue providing support to secondary and tertiary healthcare access, outcome 2 will be achieved through the following outputs:

Output 2.1 – Financial support provided to targeted population for improved access to hospital and advanced referral care

The sector aims to ensure access to hospital and specialized referral care for all displaced Syrians (whether registered or non-registered as refugees by UNHCR) and Palestinian refugees from Syria in need of hospital care.³⁶ Considering the high cost of hospital care services in Lebanon and the increasing economic vulnerabilities amongst displaced Syrians and Palestinian refugees from Syria, Health sector partners need financial resources to maintain current levels of financial support provided. Additional resources are also needed to expand the support to medical conditions which do not fall under the current schemes.

It is crucial to explore further efficiencies to expand coverage in terms of both hospital services and financial support. The main indicator used to measure this outcome is "per cent of displaced Syrians, Lebanese, Palestinian refugees from Syria and Palestinian refugees from Lebanon admitted for hospitalization per year".

In 2019, the sector will target 114,307 displaced Syrians³⁷, 4,700 Palestinian refugees from Syria and 2,400 Palestinian refugees from Lebanon receiving hospital services. The targets are calculated based on a 12 per cent hospitalization rate for all population cohorts.³⁸ The main activity under this output is the provision of financial support to access hospital services. This is currently done primarily through the UNHCR Referral Care programme which covers 75-90 per cent of the hospital bill and targets displaced Syrians and through UNRWA's hospitalization policy for Palestinian refugees from Syria. Health actors also provide financial support to cover 10 to 25 per cent of the patient's share, and those conditions which fall outside of UNHCR or UNRWA hospitalization schemes.³⁹

Output 2.2 - Public and private hospital service delivery supported

The sector aims to provide support to 27 public hospitals

(36) This includes advanced diagnostics, laboratory tests and radiology (on an outpatient basis) and admission to hospital, including emergency room care.

(37) This figure is based on the number of displaced Syrians registered by UNHCR as refugees, equivalent to 952,559 (as of end of September 2018). It is important to note however that all displaced Syrians (Government of Lebanon estimates are of 1,500,000 displaced Syrians in Lebanon), whether registered or non-registered with UNHCR as refugees, are eligible for hospital coverage according to UNHCR Standard Operating Procedures for Referral Care.

(38) The hospitalization rate does not include health interventions done on an outpatient basis such as dialysis.

(39) In 2018 UNHCR, initiated expert consultations for possible health insurance schemes for refugees in country. Although not yet final in terms of actual implementation, packages and estimated cost per individual, discussions about piloting one proposed scheme are currently ongoing.

by providing equipment to hospitals to fill shortages, replacing old and deteriorated equipment and establishing psychiatric wards in public hospitals in the North, South and Bekaa governorates. Interventions will also include supporting the staffing capacity of hospitals as well as building the capacity of hospital staff through trainings and supervision (including management of psychiatric emergencies). The sector will encourage training on an equal ratio of female to male staff.

The risks associated with the above-mentioned outputs are decreased funding and the lack of interest in the support of unsustainable services such as dialysis, cancer, thalassemia and others which implicates decreased access and therefore, may contribute to an increase morbidity and mortality. Efforts from LCRP health actors are required to mitigate the associated risks where strengthened coordination is needed between health partners in addition to innovative funding models with the least negative effects. An additional mitigation measure would be to increase and strengthen the preventive primary care such as vaccinations, antenatal, postnatal care, family planning, early detection and non-communicable diseases programmes.

Outcome 3 – Improve outbreak and infectious diseases control

While assuming LCRP health actors will continue providing support to the health security system through surveillance systems and outbreak preparedness and response, outcome 3 will be achieved through the following outputs:

Output 3.1 The national Early Warning, Alert and Response System (EWARS) expanded and reinforced

The sector aims to contribute to strengthening outbreak control through building the capacity of the Ministry of Public Health in surveillance and response. The focus will be on public health Early Warning, Alert and Response System (EWARS)'s strengthening and expansion. In 2017, support was provided for the development of an Information Technology (IT) platform (DHIS2) established in a selected number of health facilities. The national Early Warning, Alert and Response System provides critical data in a timely manner for all concerned authorities at the Ministry for an appropriate response to ensure monitoring, planning and decision-making within the Health sector for any outbreak containment and response. In addition, in 2017 a detailed situation assessment was completed and a Strategic Framework and Plan of Action with priority interventions was recommended. These focused mainly on the harmonization of the health reporting system, the expansion of the National Early Warning and Response System to multidisciplinary stakeholders (such as the Ministry of Agriculture), information flow improvements within the Ministry of Public Health departments on one side and between the Ministry and the concerned stakeholders on the other side.

The expansion of the national Early Warning, Alert and Response System and its decentralization are initiated

by targeting all primary healthcare centres within the Ministry of Public Health's network, laboratories and hospitals, as well as the Ministry's Epidemiologic Unit at the central level. Activities for 2018 include the reinforcement of 50 existing surveillance sites, the expansion of the system through the establishment of 100 new surveillance sites, staffing support, logistical support, IT system development, equipment provision and technical support missions, joint trainings for surveillance and response teams, as well as monitoring accuracy, timeliness and completeness of reporting. The outcome will be measured by the "number of functional/operational Early Warning, Alert and Response System centres".

Output 3.2 - Availability of selected contingency supplies ensured

The sector will ensure that a one-year stock of selected contingency vaccines, emergency medications, laboratory reagents, response kits and Personal Protective Equipment (PPE) for quick and effective response to outbreaks is available and maintained.

Output 3.3 – The National Tuberculosis and AIDS Programmes strengthened

The sector aims to improve tuberculosis prevention, diagnosis and treatment outcomes particularly among the Syrian population. The National Tuberculosis Programme includes: staffing, capacity building, procurement of necessary material, centres renovation and the procurement of anti-tuberculosis drugs, ancillary medicines and other consumables. These activities will be mainly measured by the following indicator: "Number of beneficiaries receiving tuberculosis medication through the National Tuberculosis Programme".

As for the National AIDS programme, the sector aims at supporting the development of a protocol for testing including screening for HIV and sexually transmitted infections in key population groups, doing confirmatory testing for positive cases and starting Antiretroviral Therapy (ART) for all HIV diagnosed cases as soon as diagnosis is established. The related activities will be mainly measured using the following indicator: Number of beneficiaries receiving Antiretroviral (ARV) medication through the National AIDS Programme.

A major risk associated with the above-mentioned outputs is the jeopardized ability to respond to outbreaks which could lead to increased outbreaks and subsequent morbidity and mortality. Hence, the need to maintain the level of support provided to the national surveillance system, to increase trust towards public services, strengthen the preventive care and increase outbreak preparedness.

Outcome 4 – Improve adolescent and youth health

Investments in adolescent and youth health, in parallel with building the capacity of local institutions including community centres and schools, is considered an added value to the community that will have lifelong positive effects on both the individuals and the local institutions.

Consequently, outcome 4 will be achieved through the following outputs:

Output 4.1 – School health programme (MoPH/WHO/MEHE) maintained

The Health sector will continue supporting the Ministry of Education and Higher Education/Ministry of Public Health/WHO's School Health Programme which will expand to 1,250 public schools in 2019. Activities within this programme contribute to a healthy environment and comprise of school health education, opportunities for physical education and recreation, and programmes for counselling, social support and mental health promotion. Other activities include the provision of support for the school E-health medical records (procurement of information technology equipment and capacity building) as well as support for the healthy school environmental project. The related output indicator is the "number of public schools adhering to at least one component of the school health program".

Whereas, the increased turnover may be a risk factor associated with the above-mentioned output, building the capacity of the locally active institutions is a key mitigation measure required to sustain the available services at different levels. In line with these assumptions, associated risks and mitigation measures, needs prioritization remains a key issue allowing the Health sector to respond in a timely manner to any funding gaps. The prioritization will be based off the most essential life-saving interventions and critical public health and system functions. In line with LCRP Steering Committee guidance, the Health sector Steering Committee will ensure the alignment of unearmarked funds to key priorities and underfunded needs of the LCRP.

In addition, supplementary research is still needed for increased evidence-based programming and decision making. This is particularly applicable in the case of developing cost-effective strategies for the provision of subsidized packages of care that are harmonized and complemented to strengthen the national health system.

Identification of sector needs and targets at the individual/household, institutional and geographic level

The Health sector calculates the number of displaced Syrians in need based on economic vulnerability, whereby data from the 2018 Vulnerability Assessment of Syrian Refugees in Lebanon indicates that 69 per cent of displaced Syrians are living below the poverty line compared to 76 per cent in 2017. As such, the number of displaced Syrians in need and targeted by the sector is 765,000.

Although a recent economic vulnerability study led by UNRWA points to 89 per cent of Palestinian refugees from Syria living in poverty, all 28,800 Palestinian refugees from Syria are considered in need and targeted by the Health sector. The number of Palestinian refugees from Lebanon considered in need is based on

economic vulnerability data indicating that 65 per cent of Palestinian refugees from Lebanon (equal to 180,000) are living below the poverty line. Although 180,000 Palestinian refugees from Lebanon are considered in need, 20,000 are targeted under the LCRP, with the remaining eligible for support through UNRWA.

The number of vulnerable Lebanese in need is estimated 1,500,000. This is the Government of Lebanon's estimate of Lebanese who are economically vulnerable. The Health sector however is targeting 50 per cent of the population in need which is equivalent to 750,000 individuals for general health services (vaccination, medication, etc.) and not specifically for subsidies, especially since there are other instruments which target vulnerable Lebanese external to the LCRP.

It is important to note that there is a wide array of health services provided by actors outside of the LCRP who therefore do not report against the LCRP targets. Solid coordination, consolidation, and exchange of health information is to be strengthened under the LCRP 2019.



Informal settlement, Haouch Mandara, West Bekaa. 26/11/2017

Mainstreaming of conflict sensitivity, gender, age, youth, protection and environment

Conflict sensitivity

The Health sector strategy recognizes that the pressure on healthcare institutions caused by the increased demand for services is a potential source of conflict. In addition, the differences in out-of-pocket expenses for primary healthcare between vulnerable Lebanese and displaced Syrians remains a source of tension. To address this, efforts are geared towards strengthening the Ministry of Public Health's centrally and peripherally as well as the primary healthcare system overall, including the Ministry of Social Affairs' social development centres, to deal with the increased burden on the system and to ensure continued access for vulnerable Lebanese.

Protection, gender, gender-based violence and accountability for affected populations

In 2019, the Health sector will strengthen the mainstreaming of the core protection principles of; 'meaningful access without discrimination', 'safety, dignity and do-no-harm', 'accountability' and 'participation and empowerment' within its sector, through the development of a Protection risk analysis (inclusive of risks due to age, gender, diversity, do-no-harm and accountability). The Health sector will work closely with the Protection working group and cross-cutting representatives of mainstreaming initiatives to receive technical support. Thus, both Health and Protection sectors, specifically the gender-based

Sector needs and targets 2019

Population Cohort	Total Population in Need	Targeted Population	No. of Females	No. of Males	No. of Children (0-17)	No. of Adolescents (10-17)	No. of Youth (18-24)
Lebanese	750,000	750,000	382,500	367,500	234,000	122,250	
Displaced Syrians	765,000	765,000	390,150	374,850	393,314	140,155	75,581
Palestinian Refugees from Syria	28,800	28,800	14,688	14,112	11,530	5,072	
Palestinian Refugees from Lebanon	180,000	20,000	10,200	9,800	7,620	3,680	
GRAND TOTAL	2,777,193	1,535,297	780,332	754,965	646,464	271,157	

Type of Institutions	Total	Targeted
Municipalities		0
Hospitals	27	17
Schools	1,279	1,250
Water Establishments		0
Social Development Centres	233	12
Central Ministries		1
Ministry of Public Health - Primary Health Care Centers	218	218

violence sub-sector will coordinate capacity-building of healthcare providers on gender-based violence referral pathways and will work to eliminate gender-specific barriers to access such as protection risks on the road, including harassment of women or freedom of movement associated with check-points for men. Acceptability barriers will also be tackled, including social stigma, mainly gynaecologic health seeking behaviours for adolescent girls.

Youth

The 2017-2020 Health sector strategy aims to contribute to improvements in youth health (14-25 years) recognizing that the population in the 20-24 age brackets has a considerable higher percentage of women.^{xxiv} The sector will target youth by promoting healthy practices through outreach activities from primary healthcare centres. Alcohol or tobacco use, lack of physical activity, unprotected sex and/or exposure to violence can jeopardize youth health and result in long-term impacts. The 2016 Global Health School Survey, reported high rates of substance use (tobacco and alcohol) and mental health conditions (bullying, suicide ideation) among youth.^{xxv} The sector will also target youth through public schools and community centres adhering to the School Health Programme.

People with specific needs

Many of the Ministry of Public Health's primary healthcare centres and dispensaries are currently not accessible to persons with physical disabilities. This is gradually being addressed by the accreditation process. Moreover, in several healthcare centres, financial support/subsidies to cover the cost of laboratory and diagnostics tests is provided to people with disabilities. Specialized NGOs also provide physical therapy to people with disability in addition to rehabilitative support, prosthetic and orthotic devices, hearing aids and eye glasses.

Environment

Lack of safe water, poor waste water management, solid and medical waste management, hygiene and living conditions, and unsafe food all influence the incidence and spread of communicable and non-communicable diseases. Lebanon has been struggling with a national waste management crisis since 2015. This is dealt with by the multidisciplinary national committee for waste management in coordination mostly with the WASH sector. The Health sector strategy focuses on providing technical advice to the WASH sector, supporting the Ministry of Public Health to manage medical waste and strengthening disease surveillance systems to contribute to improved outbreak control.

Cross-sectoral linkages

Overall, the Health sector aims to improve Lebanon's health security through multi-sectoral coordination in line with the 2005 International Health Regulations.^{xxvi} The efforts

of health actors are geared towards strengthening the integration of the response aiming for a strategic and sustainable outcome. Therefore, health actors are increasingly interested in strengthening the health system while keeping the necessary direct service delivery interventions ongoing.

Direct service delivery

Direct inter-sectoral health service delivery is provided through integrating Health with Water, Food Security, Protection, Education, Shelter and Basic Assistance sectors as follows:

Water: The Water sector works to improve access to water sources, sanitation facilities and hygiene promotion which directly contributes to decreased morbidity and mortality from water borne diseases.

Food Security: The Food Security and Agriculture sector, along with the integration of malnutrition services into the Ministry of Public Health's primary healthcare network and awareness activities on infant and young child feeding, promotes food utilization through good nutritional practices and improvements to the dietary diversity of the most vulnerable population groups.

Protection: Healthcare facilities often constitute the first entry point for the identification and referral of girls, boys, women and men survivors of gender-based violence. Although the focus is on women and girls, reproductive health and sexual and gender-based violence services are also available to men and boys. Nonetheless, exposure to sexual and gender-based violence still remains an underreported issue.

Education: As part of the integration between Health and Education sectors, school settings can be used to address and improve the health of children, youth, school personnel, families and other members of the community.

Shelter: The Shelter sector aims at improving shelter conditions through weatherproofing/insulation kits, as well as by improving water and sanitation facilities. The Shelter sector refers health cases to the Health sector linked to poor housing conditions and contributes to spreading messages related to fire and burn injury prevention.

Basic Assistance: Households targeted with cash assistance provided by the Basic Assistance sector benefit from the multi-purpose grants to cover additional health expenditures their families might have. Thus, support is needed from Basic Assistance and Health sectors to raise awareness on the availability of free or subsidized health services, so that families can reprioritize their expenditures.

Health system strengthening

In addition to the institutional support provided by health actors to the Ministry of Public Health, inter-sectoral initiatives are being reinforced for a more sustainable impact on the Lebanese health system. Inter-sectoral system strengthening linkages are mainly

represented by the joint efforts between the Health, Water, Protection, Education and Social Stability sectors.

The Health and Water sectors have a joint Acute Watery Diarrhoea/Cholera Response Plan for preparedness and response in case of an outbreak. The sectors work closely together for health and water related referrals as well as disease surveillance and prioritization of response interventions. In addition, Health and Protection sectors prioritize capacity building for Ministry of Public Health staff on protection cases including sexual and gender-based violence and Clinical Management of Rape (CMR). With the aim of building a peaceful environment, the Health and Social Stability sectors will work with municipalities and primary healthcare centres to enhance their inter-personal skills and strengthen their role in addressing social tensions. Focus will also be placed on building inter-sectoral linkages to promote mental health and trauma healing with a peacebuilding objective in mind.

Endnotes

- i. UNHCR, UNICEF, WFP (2018), *Vulnerability Assessment of Syrian Refugees 2018, Lebanon*.
- ii. UNHCR (2018). Participatory assessments with working children, child spouses, female-headed households, women alone, detained persons, minorities and stateless persons in Lebanon.
- iii. MoPH/WHO (2016), *Expanded Programme on Immunization (EPI) Cluster Survey, Lebanon*.
- iv. UNHCR (2018), *Health Access and Utilization Survey among Syrian refugees from Lebanon*.
- v. UNICEF (2017), *Knowledge, Attitudes and Practices (KAP) Study*.
- vi. UNICEF (2016), *Situation Analysis of Women and Children, Lebanon*.
- vii. UNICEF (2017), *KAP Study*.
- viii. JHU, et al. (July 2015), *Syrian Refugee and Affected Host Population Health Access Survey in Lebanon*.
- ix. UNHCR (2018), As of 30 September 2018: <https://data2.unhcr.org/en/situations/syria/location/71>
- x. IMC (2016).
- xi. Cherri, Z. et al. (2017), *Early Marriage and Barriers to Contraception Among Syrian Refugee Women in Lebanon: A Qualitative Study*.
- xii. UNHCR, UNICEF, WFP (2017), *Vulnerability Assessment of Syrian Refugees 2017, Lebanon*.
- xiii. American University of Beirut, UNRWA (2016), *Survey on the Socioeconomic Status of Palestinian Refugees in Lebanon, 2015*.
- xiv. American University of Beirut, UNRWA (2015), *Profiling the Vulnerability of Palestinian Refugees from Syria Living in Lebanon*.
- xv. UNHCR, UNICEF, WFP (2016), *Vulnerability Assessment of Syrian Refugees in Lebanon (VASyR) 2016*.
- xvi. UNHCR (2016), *Lebanon Referral Care Report*
- xvii. Huster, et al. (2014), *Caesarean Sections among Syrian Refugees in Lebanon from December 2012/ January 2013 to June 2013: Probable Causes and Recommendations, The Yale Journal of Biology and Medicine, 87(3), 269–288*.
- xviii. Kabakian-Khasholian, et al. (2007), *The Policy Environment Encouraging C-section in Lebanon, Health Policy, 83, (1), 37 – 49*.
- xix. UNHCR (2018), *Lebanon Referral Care Report*.
- xx. UNRWA (2015), *Lebanon Field Office Revised Hospitalization Policy*, amended on June 2016.
- xxi. American University of Beirut, UNRWA (2016), *2015 Survey on the Socioeconomic Status of Palestinian Refugees in Lebanon*.
- xxii. Central Administration for Statistics (CAS)/UNICEF (2009). *MICS- Population Characteristics*.
- xxiii. Lebanon, Ministry of Public Health (2016)-*Health Response Strategy*: <http://www.moph.gov.lb/en/Pages/9/3447/health-response-strategy>.
- xxiv. UNHCR, UNICEF, WFP (2016), *Vulnerability Assessment of Syrian Refugees 2016, Lebanon*.
- xxv. Lebanon, Ministry of Education and Higher Education, Ministry of Public Health, CDC, WHO (2016), *Lebanon 2016 Global School-based Student Health Survey (GSHS)*.
- xxvi. WHO (2005), *International Health Regulations*, <http://www.who.int/ihr/publications/9789241596664/en/>.



Immunization programme, Lebanon. Photo credit: UNICEF, Fouad Choufany; 8/9/2018

Sector Logframe

Outcome 1: Improve access to comprehensive primary healthcare (PHC)

Indicator 1	Description	Means of Verification	Unit	Frequency
Percentage of displaced Syrians, vulnerable Lebanese, Palestinian Refugees from Syria (PRS) and Palestinian Refugees from Lebanon (PRL) accessing primary healthcare services.	Number of displaced Syrians, vulnerable Lebanese, Palestinian Refugees from Syria (PRS) and Palestinian Refugees from Lebanon (PRL) accessing primary healthcare services out of those who report needing primary healthcare services	Vulnerability Assessment of Syrian Refugees (VASyR) UNHCR Health Access and Utilization Survey (HAUS) Ministry of Public Health (MoPH) Health Information System (HIS) UNRWA Assessments UNRWA Health Information System	Percentage	Yearly

 Lebanese				 Displaced Syrians				 Palestinian Refugees from Syria (PRS)				 Palestinian Refugees from Lebanon (PRL)			
Baseline:	Result 2018	Target 2019	Target 2020	Baseline:	Result 2018	Target 2019	Target 2020	Baseline:	Result 2018	Target 2019	Target 2020	Baseline:	Result 2018	Target 2019	Target 2020
		100%	100%			100%	100%			100%	100%			100%	100%

Indicator 2	Description	Means of Verification	Unit	Frequency
Percentage of vaccination coverage among children under 5 residing in Lebanon		MoPH/WHO Expanded Programme on Immunization (EPI) Cluster survey	Percentage	Yearly

 Lebanese				 Displaced Syrians				 Palestinian Refugees from Syria (PRS)				 Palestinian Refugees from Lebanon (PRL)			
Baseline:	Result 2018	Target 2019	Target 2020	Baseline:	Result 2018	Target 2019	Target 2020	Baseline:	Result 2018	Target 2019	Target 2020	Baseline:	Result 2018	Target 2019	Target 2020
		100%	100%			100%	100%			100%	100%			100%	100%

Outcome 2: Improve access to hospital (incl. ER care) and advanced referral care (advanced diagnostic laboratory & radiology care)

Indicator 1	Description	Means of Verification	Unit	Frequency
Percentage of displaced Syrians, Lebanese, PRS and PRL admitted for hospitalization per year	Number of displaced Syrians, Lebanese, PRS and PRL admitted for hospitalization per year over total population	Measurements/tools: MoPH Hospital data, UNHCR Annual Referral Care Report, UNRWA Hospitalisation data Responsibility: MoPH, UNHCR, UNRWA	Percentage	Yearly

 Lebanese				 Displaced Syrians				 Palestinian Refugees from Syria (PRS)				 Palestinian Refugees from Lebanon (PRL)			
Baseline:	Result 2018	Target 2019	Target 2020	Baseline:	Result 2018	Target 2019	Target 2020	Baseline:	Result 2018	Target 2019	Target 2020	Baseline:	Result 2018	Target 2019	Target 2020
12%	12%	N/A	N/A	7%	6%	12%	12%	12%		12%	12%	12%		12%	12%

Outcome 3: Improve outbreak and infectious diseases control

Indicator 1	Description	Means of Verification	Unit	Frequency
Number of functional EWARS centers	Functional EWARS centers are those that report through the EWARS system Baseline: 50 Target: 396 (i.e.100 new + 50 existing)	MoV: - MoPH periodical bulletins and alerts on website - MoPH list of EWARS functional centers every 6 months Responsibility: MoPH, WHO	Functional EWARS centers	Yearly

 Lebanese				 Displaced Syrians				 Palestinian Refugees from Syria (PRS)				 Palestinian Refugees from Lebanon (PRL)			
Baseline	Result 2018	Target 2019	Target 2020	Baseline	Result 2018	Target 2019	Target 2020	Baseline	Result 2018	Target 2019	Target 2020	Baseline	Result 2018	Target 2019	Target 2020

 Institutions			
Baseline	Result 2018	Target 2019	Target 2020
50	296	396	

Outcome 4: Improve adolescent & youth health

Indicator 1	Description	Means of Verification	Unit	Frequency
Prevalence of behavioural risk factors and protective factors in 10 key areas among young people aged 13 to 17 years.	The 10 key areas are: Alcohol use, Dietary behaviours, Drug use, Hygiene, Mental health, Physical activity, Protective factors, Sexual behaviours, Tobacco use and Violence and unintentional injury.	WHO Global school-based student health survey (GSHS)	Percent	Every 5 years

 Lebanese				 Displaced Syrians				 Palestinian Refugees from Syria (PRS)				 Palestinian Refugees from Lebanon (PRL)			
Baseline	Result 2018	Target 2019	Target 2020	Baseline	Result 2018	Target 2019	Target 2020	Baseline	Result 2018	Target 2019	Target 2020	Baseline	Result 2018	Target 2019	Target 2020

 Institutions			
Baseline	Result 2018	Target 2019	Target 2020
78%	94%	95%	