HEALTH

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PEOPLE IN NEED	PEOPLE TARGETED	REQUIREMENTS (US$)
3,322,000	2,040,000	249.2 million

# OF PARTNERS	GENDER MARKER
24	1

SECTOR OUTCOME

	INDICATORS	
OUTCOME 1: Improve access, coverage and quality of primary health care (PHC) services	# of consultations at PHC facilities	$161.8 m
OUTCOME 2: Facilitate access to Secondary (SHC) and Tertiary health care (THC)	# of referrals receiving emergency or inpatient care	$79.0 m
OUTCOME 3: Strengthen the prevention, detection and response to outbreaks of public health importance	% of target reached (polio/MMR)	$7.7 m
OUTCOME 4: Strengthen youth health promotion and monitoring through the school health program	% School health program expanded	$0.7 m

PRIORITY INTERVENTIONS

1: Ensuring access for target populations to a standardized package of basic health services at primary health care level
2: Continuing to ensure access for life saving secondary and tertiary health care mainly for the displaced population from Syrian
3: Preventing and controlling outbreaks of epidemic-prone diseases with focus on EWARS reinforcement and vaccination activities, especially in high risk areas with the largest displaced Syrian communities.
4: Reinforcing youth health as part of comprehensive reproductive health care well as supporting the Lebanese school health program

FUNDING STATUS

Funding already received for 2015:	$ 20.3 m
Estimated sector needs for 2016:	$ 198.6 m

1. Situation Analysis and Context

Health services are characterised by a dominant private sector. The primary health care (PHC) system is mainly operated by the NGO sector and based on user fees. Persons displaced from Syria and Lebanese alike are expected to cover the costs of consultations and diagnostics, which can be well beyond their means. Secondary and tertiary care facilities offer around 13,000 hospital beds (85% are private sector). The surplus of medical doctors and shortage of nurses and paramedical staff, leads to a very high cost for health services, both for persons displaced from Syria and for the Lebanese population.

Available data indicates that common childhood illnesses, non-communicable diseases (including cardiovascular diseases, dyslipidaemia, diabetes, and asthma) and mental illnesses are priority conditions for both Lebanese and persons displaced from Syria

The youth population is also affected, especially as public schools have a reduced capacity to maintain the school health program (medical screening for students, health awareness activities and school health environment interventions).

The main achievements include:

- ✓ A 10 per cent increase in the number of PHC centers belonging to the Ministry of Public Health (MOPH) network, from 180 to a 200 PHC benefiting provision of essential acute and chronic medicines and capacity building activities; around 100 additional PHC centers were directly supported. Thus the PHC system can respond to around 40 per cent more patients.
- ✓ From January to September 2014, there were 857,433 primary health care consultations (68% for displaced persons) and 43,432 displaced persons with access to life-saving and obstetric care at secondary and tertiary hospital levels
- ✓ Additional specific services were integrated in the PHC package including: Non Communicable diseases (NCD) screening, early detection and care; mental health and psychosocial support; nutrition screening and care services for boys and girls (equally affected) under five years of age. The PHC chronic medication list was revised, and medications provided in larger quantities, to minimise shortages
- ✓ The Ministry of Social Affairs saw investments and upgrades for its health dispensaries by various donors, mostly equipment related.
- ✓ A total of four polio vaccination campaigns and three 'mop-up' campaigns have maintained Lebanon as a polio-free country to date. 5 rounds of vaccination providing 600,000 doses have been carried out.
- ✓ IFS funding accelerated the expansion of the EWARS including: establishing 8 water monitoring labs; updating the Standard Operating Procedures (SOPs) and guidance related to surveillance, early warning and response; and training of more than 1,000 health professionals both in the private and public sectors. Around 400 PHC centers are now reporting on a selected list of diseases, with at least 40 per cent of them located in the areas where there is a high concentration of *de facto* refugees.
- ✓ Prevention of outbreaks of water-borne diseases.
- ✓ The TPA modality reduced unnecessary hospital admissions and maintained the average cost at around 600USD per admission; a full-time hotline for both persons displaced from Syria and providers was set up.
- ✓ A reduction in the caesarean section rate from around 60 per cent of all deliveries to around 30 per cent, among the Syrian *de facto* refugees, comparable with the Lebanese rate (35 per cent), while ensuring that 21,000 Syrian woman were able to deliver in hospitals from January to September 2014.
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In 2014, health care for Syrian *de facto* refugees was supported through PHC services and hospital admissions subsidized through UNHCR partners and other humanitarian actors. Of the conditions covered by UNHCR for secondary health care, 48 per cent are linked to obstetric care. For secondary and tertiary health care, UNHCR

introduced an innovative use of the private sector country wide in January 2014. A Third Party Administrator (TPA) ensures the management of hospital admissions, with reimbursement rates for specific service packages based on the MOPH flat rates. The EU Instrument for Stability (IFS) funds support to the Lebanese primary health system to prevent or mitigate conflict in health settings. Priority attention was given to outbreak control: significant support was provided: to expand the Early Warning and Response System (EWARS); and intensify vaccination activities especially for children under five (50 per cent boys, 50 per cent girls). The MOPH accelerated the expansion of its PHC network in terms of accredited PHC network facilities and the provision of standardized priority health services.

The key concerns and challenges observed include:

- ✓ Affordability of health care. For example, Syrians registered with UNHCR as refugees who needed care reported spending around US$ 90 on health care in the month preceding the survey*.
- ✓ The impact of the crisis has pushed more than 170,000 additional Lebanese into poverty, necessitating additional subsidies for health care.
- ✓ Low antenatal care attendance, and poor follow-up of persons with chronic diseases.
- ✓ The low precipitation level over the last year increasing the risks of water-borne outbreaks.
- ✓ The increased risks of outbreaks such as cholera, or exacerbation of endemic diseases such as Tuberculosis and viral Hepatitis as well as fear of introduction of vectors for Leishmania which could affect both Syrian and host communities.
- ✓ The security context in parts of the country is impeding access to health services. Currently, *de facto* refugees in Aarsal and Wadi Khaled have difficulties accessing Lebanese hospitals.
- ✓ Addressing equity issues in terms of out-of-pocket expenditures on health between communities displaced from Syria and the host community.

* *Health Access and Utilization Survey Among Non- Camp Syrian Refugees, July 2014*
http://data.unhcr.org/syrianrefugees/download.php?id=7111

2. Overview of 2015 Response

The desired impact, in line with the overall goal of the Government, and building on major achievements in 2014, is to reduce mortality and morbidity of preventable and treatable illnesses and priority NCDs and to control outbreaks of infectious diseases of epidemic potential.

The key strategic shifts for 2015 include:

- The delivery of integrated, standardized and cost-effective service packages in primary healthcare.
- Cost effective access to secondary and tertiary care.
- Developing the national Health information system and data management.
- Targeting special groups including Youth and poorest Lebanese by linking to the National Poverty Targeting program.

This is in line with the overall goal of the Government in the health sector which is to ensure health security and the improvement of the health status of the population by enhancing the performance of the health system and ensuring equity in service provision and financing. The MOPH aims at ensuring access to preventive and curative services for Lebanese and *de facto* refugee populations through the existing health system. The support of humanitarian partners is required to ensure that the Lebanese health system can cope with the additional demand for health services through the influx of unprecedented numbers of displace persons and the increase in vulnerable people among Lebanese host communities.

In accordance with the strategy and objectives of the MOPH, the plan will direct its resources towards the following priority intervention areas:

- Targeting special groups including youth (boys and girls) and poorest Lebanese by linking to the National Poverty Targeting Programme.
- Targeting the most vulnerable populations (women, men, boys and girls) based on the refugee vulnerability.

- The estimations of beneficiaries of host communities are essentially taking into consideration the poorest of the poor identified under the NPTP (around 170,000) and the most vulnerable *de facto* refugees based on the VASyr results and on the current utilization data of the health services.
- Ensuring access for target populations to a standardized package of basic health services at PHC, with a focus on reinforcing the network of PHC (number, geographical distribution, scope of services, new health partners), training, provision of equipment and commodities and medications. This will be done through mainstreaming resources to the key national interventions.
- Continuing to ensure access for life saving secondary and tertiary health care mainly for populations displaced from Syria, with emphasis on harmonized hospital contractual agreements, clear eligibility criteria and cost sharing modalities via the partnership with the private sector. Coordinating with the LRC on patient transportation will be further elaborated.
- Piloting the provision of a standardized minimal service delivery package of priority health services integrated at PHC level for vulnerable Lebanese as part of the Multi Donor Trust Fund.
- Monitoring standards and quality of care considering the rapid expansion of services in terms of scope and human resources surge, with an emphasis on defined MOPH accreditation and performance indicators. This will be done through direct observations of service provision, and periodical surveys.
- Preventing and controlling outbreaks of epidemic-prone diseases with focus on EWARS reinforcement and vaccination activities, especially in high risk areas with the largest communities displaced from Syria.
- As part of comprehensive reproductive health care, reinforcing Youth health as well as supporting the Lebanese School health program, using a combined strategy of outreach services and community-based centres and providing socially and culturally accepted activities in safe spaces.
- Supporting existing national programs (such as Tuberculosis and HIV / STIs).
- Monitoring the results and achievements and evaluating the impact in terms of health coverage and population health status based on a set of health indicators through an improved Health information system and health data management.
- Seeking alternative solutions for cost-effective health services delivery in case the health system capacity is exceeded

3. Overall Sector Target Caseload

Based on core public health vulnerability criteria; boys and girls under 5 years of age, pregnant and lactating women, survivors of SGBV, elderly over 60 years of age, persons with disabilities and mental health conditions, those with acute life-threatening emergencies and people with the most significant group of chronic diseases, are in the greatest need of support and will be prioritised within the sector strategy. The targeted population will include the poorest Lebanese identified through the NPTP as well as Lebanese returnees from Syria, the most vulnerable Syrian *de facto* refugees, and Palestine refugees from Syria. It should be noted that the healthcare needs of the target group will remain high and a significant proportion of these needs may remain unmet. Limited resources mean that the health sector must prioritise and focus on the identified vulnerable groups, estimated at around 10 per cent of the Lebanese population and at least 60 per cent of the Syrian *de facto* refugees.

Over the past year, with funds available from the EU under the instrument for stability, medications for Chronic Diseases (including NCDs, mental conditions, TB) was secured for the MOPH through 430 PHC centers for the treatment of 150,000 of the poorest Lebanese and most vulnerable persons displaced from Syria. Additional funds need to be secured for the same group. The integration of mental health care and psychosocial support was started at PHC level and 45 PHCs were trained on Mental Health Gap, and started providing mental health services; this initiative should be further expanded to cover at least 75 PHC centers.
Health of young people has not received enough emphasis to date and needs to be addressed especially with rising evidence of increase in mental health conditions (including substance abuse) and risk behaviours (poor nutrition, physical inactivity, smoking); a proposed point of entry is the reinforcement of the school health program with its three components (medical screening, health awareness and education, and school health environment).

Prevention and control of outbreak presents a crucial area of intervention; in terms of vaccine preventable diseases, there is need to intensify the routine vaccination , and to introduce new vaccines (Hepatitis A and Pneumococcal vaccine); Early warning and Response system needs also to be further reinforced, with preparedness plans elaborated for the areas most at risk (mainly those with a large number of informal tented settlements), and further development and expansion of the District Health Information system. Hygiene promotion is a cross cutting intervention between health and wash sectors, and will need to be harmonized.

Population cohorts[1]

Category	Female	Male	Total (individuals)
Syrians registered with UNHCR as refugees	675,000	225,000	**900,000**
Palestine refugees from Syria	23,625	7,875	**31,500**
Vulnerable Lebanese & Host Communities	675,000	225,000	**62,100**
Lebanese Returnees	4,500	1,500	**76,085**
Palestine refugees in Lebanon	101,250	101,250	**202,500**

Gateways for service delivery

Category	Number	Modality of implementation/ how the institution is engaged
PHC centers	920 total PHC in the country (of which 435 are in the YMCA network, and of which 200 are in the MOPH network)	PHC Consultations
		Children Vaccinated
		Assessments conducted
		Structures equipped
		Training of health providers
		PHC with quality of services assessed once per year
		Providing information on utilization
Schools	2,000	Schools enrolled in school health program
SDCs	225 CDS across the country of which 57 are supported by UNHCR	PHC consultations
		Structures equipped
		Surveys/assessments conducted
		Training of Health care providers
UNRWA Health care centers	27	PHC Consultations
		Children Vaccinated
		Assessments conducted
		Structures equipped
		Training of health providers
Contracted Hospitals (UNHCR & UNRWA)	66 UNHCR Contracted and UNRWA 18 different than UNHCR ones	SHC Services
		Sentinel sites established
		Structures equipped/rehabilitated
MMUs	23	PHC consultations
		Structures equipped
		Surveys/assessments conducted
		Training of Health care providers
Border Post	1	PHC Consultations

[1] Kindly note that the target figures in the overview sheet don't match the 2,040,000 in the overview sheet for the following reasons:
PHC are consultations not people (1-2 consultation per person)
Vaccinations are doses not people 2 MMR doses per person and 4 doses of polio per person
Nutrition : the sum of people screened for malnutrition ,people undergoing malnutrition management & people receiving micro-nutrient supplements

4. Mainstreaming of Health in other sectors

Health status is closely related to key social determinants of health including socio-economic status, type of shelter/accommodation, living conditions, overcrowding, unemployment and income, access to appropriate WASH conditions, water scarcity, education, sexual and gender based violence and resilience. Harmonization with the social wellbeing activities will optimize health interventions. Health-specific interventions, particularly in terms of referrals to the health sector, and health responses need to be considered in other sectors' activities such as WASH, shelter, education (health promotion), basic needs (winterisation) and protection (Clinical Management of Rape).

The health sector also needs to ensure a coordinated approach with the WASH sector in order to reduce risks of outbreaks and ensure appropriate responses. A harmonized approach in terms of hygiene promotion is to be adopted, with focus on standardized messages and awareness material in addition to considerations with the Basic Assistance group for prioritization of hygiene items. The Acute Watery Diarrhoea (AWD) preparedness and response plan needs to include a clear referral pathway between the health and WASH sectors, preparedness training plan in collaboration with Shelter sector as well, contingency stocks and identification of core activities for the alert and response phases of an AWD outbreak. A strong AWD preparedness plan depends upon a foundation of routine disease monitoring and information sharing mechanism between the two sectors.

5. Partnerships

This Sector is under the leadership of the Ministry of Public Health. It also importantly involves MOSA.

List of Partner Agencies

AMEL	IOCC	PU-AMI	URDA
ANERA	IOM	RI	WHO
ARMADILLA	IRW	UNDP	WVI
CLMC	MAP-UK	UNFPA	
FPSC	Makassed	UNHCR	
Humedica	Makhzoumi	UNICEF	
IMC	Medair	UNRWA	