# HEALTH

**Lead Ministry:** Ministry of Public Health (MoPH)

**Coordinating Agencies:** WHO and UNHCR

**Contact information:** Zeina Ammar *zammar@moph.gov.lb*; Dr. Alissar Rady *radya@who.int;* Dr. Michael Woodman *woodman@unhcr.org*

| PEOPLE IN NEED | PEOPLE TARGETED | REQUIREMENTS (US$) |
|---|---|---|
| 2,565,470 | 1,602,000 | 290.9 million |

| # OF PARTNERS | GENDER MARKER |
|---|---|
| 33 | 1 |

## SECTOR OUTCOMES

| | |
|---|---|
| **OUTCOME 1:** Improved access to PHC services. | $126.4 m |
| **OUTCOME 2:** Improved access to hospital and advanced referral care. | $134.2 m |
| **OUTCOME 3:** Improved outbreak control. | $6.8 m |
| **OUTCOME 4:** Key institutions strengthened. | $23.3 m |
| **OUTCOME 5:** Transparency and account-ability of health partners ensured. | $20,000 |

**INDICATORS**

# of PHC consultations

# of children who received routine vaccination as per MoPH vaccination calendar

# of persons receiving hospital and diagnostic services

# of operational sentinel surveillance sites newly established

# of key institutions strengthened

# of public schools adhering to the school health program

## PRIORITY INTERVENTIONS

1: Ensure access for target populations to a standardized package of basic health services at primary health care level.

2: Continue to provide support for access to hospital and diagnostic services to displaced Syrians for obstetric and life-saving conditions.

3: Prevent and control 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: Strengthen key institutions for enhanced decentralization, strengthening of PHCs and public hospitals' service delivery, and ensure sustainability of services.

5: Reinforce youth health as part of comprehensive reproductive health care well as support the Lebanese school health program.

# 1. Situational analysis and context

The health sector situational analysis and needs are presented in alignment with the two strategic objectives of the Health Response Strategy of the Lebanese 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.

**Current healthcare needs and access to health services**

Access to primary health care (PHC) services is through the MoPH PHC network (219 centres) across Lebanon, as well as through some centres of the Ministry of Social Affairs (MoSA), NGO clinics and others, as well as mobile medical units (MMUs). The MoPH, UNICEF and YMCA currently supply the primary health care centres (PHCCs) with vaccines, acute and chronic medication, staff support, running costs, as well as laboratory and medical supplies. In addition, displaced Syrians receive subsidized PHC services in around 100 PHCCs, mostly within the MoPH network. Some partners also provide similar subsidized services to vulnerable Lebanese as a way of mitigating potential sources of tension. The MoPH PHC network is gradually expanding to meet the increased demand for PHC services. Underserved geographical areas will be prioritized in this expansion.

Access to hospital care for displaced Syrians is primarily through a network of 60 hospitals across Lebanon (public and private), contracted by UNHCR through a third party administrator. The UNHCR scheme is limited to obstetric and life-threatening conditions, and currently covers 75 percent of hospitalization fees with the expectation that the persons registered as a refugee by UNHCR will cover the remaining 25 percent.

According to the 2015 Vulnerability Assessment of Syrian Refugees (VASyR), 27 percent of households among the Syrian displaced population reported at least one member with a specific health need: chronic disease (13 percent), permanent disability (3 percent), temporary disability or another issue. 70 percent of displaced households reported a child needing care in the month prior to the survey. Almost half (47.5 percent) of Palestine Refugees from Syria (PRS) households have at least one member suffering from a chronic condition. 66 percent of PRS had an acute illness in the last 6 months[1].

Displaced Syrians primarily seek care for acute infections and communicable diseases (40 percent), chronic conditions (14 percent), gynecological care (12 percent) and injuries (9 percent). With the disruption of immunization activities in Syria, coupled with the poor living conditions of the displaced in Lebanon, there are heightened risks of disease outbreaks, including measles, mumps and polio, and the introduction of new diseases to the host community such as cutaneous leishmaniasis. Despite the vaccination campaigns and the relentless efforts to accelerate routine vaccination, the risk for an outbreak of vaccine-preventable diseases remains high, especially in areas where there is over-crowding. Rising incidences of tuberculosis (TB, including multi-resistant TB[2]) and waterborne diseases such as hepatitis A, have been noted since the advent of the crisis. Free routine vaccination is needed for around 50 percent of Lebanese children and 100 percent of the displaced children. Introduction of new vaccines is planned (hepatitis A and pneumococcal vaccine/ PCV-13) to reduce the incidence of hepatitis A and severe respiratory infections among children. The epidemiological surveillance unit at MoPH has observed that areas most heavily impacted by the Syrian crisis are the North, Bekaa and Mount Lebanon, where the highest number of cases of communicable diseases are reported.

The most prevalent chronic diseases among the elderly are arthritis and hypertension for displaced Syrians, and hypertension for the Lebanese. The four most prevalent chronic conditions among PRS are diabetes, high blood pressure, heart disease, and bone and muscle problems[3]. Patients with chronic conditions such as cancer and chronic renal failure may require hospital care which is not currently subsidized. Among displaced Syrians and PRS, it is estimated that around 800 cases of cancer need to be treated every year, and an estimated 200 patients are in need of on-going renal dialysis[4].

The hospitalization rate for obstetric and life-saving conditions for the displaced is 6 percent per year[5], which is half the hospitalization rate for Lebanese (12 percent per year). This is explained by the restrictive criteria applied due to limited funds. There are large unmet needs, especially for patients with chronic diseases, cancers and other serious illnesses not currently covered.

Antenatal care and deliveries constitute an important proportion of medical services provided to displaced Syrians. The most recent assessments estimate 20 percent of displaced Syrian households and 6.5 percent of PRS households have either a pregnant or a breastfeeding woman[6]. Among the pregnant displaced Syrian women who received antenatal care, only 53 percent had their first antenatal visit in the first trimester of pregnancy[7]. Thus, there is a need to increase early uptake of antenatal care by pregnant displaced Syrian women. Also, a study conducted in 2013 targeting displaced Syrian women showed that 42 percent were not using any

(1) VASyR 2015. (draft); Johns Hopkins and others, Syrian refugee and affected host population health access survey in Lebanon, 2015; UNRWA and AUB, Profiling the Vulnerability of Palestine Refugees from Syria Living in Lebanon, 2015.

(2) National TB programme report 2014.

(3) UNRWA and AUB, Profiling the Vulnerability of Palestine Refugees from Syria Living in Lebanon, UNRWA 2015.

(4) Based on data from dialysis centers, 2014-2015, MoPH.

(5) UNHCR referral care report 2014.

(6) WFP, UNICEF & UNHCR, Vulnerability Assessment of Syrian Refugees in Lebanon, (draft) 2015; UNRWA and AUB, Profiling the Vulnerability of Palestine Refugees from Syria Living in Lebanon, 2015.

(7) Johns Hopkins and others, Syrian refugee and affected host population health access survey in Lebanon, 2015.

form of contraception prior to pregnancy[8], yet nearly three-quarters of the women wished to prevent future pregnancies, and over half of pregnant women did not desire the current pregnancy. For Syrian women using birth control, birth control pills (23 percent) followed by IUDs (17 percent) were preferred contraceptive methods[9]. The majority of cases referred to hospital level covered by UNHCR were obstetric cases, and represent around 56 percent of all secondary health care admissions. 26 percent of these are referred as high-risk pregnancy. Maintaining adequate access to obstetric care services is therefore important. Another concern is the high rate of C-sections (36 percent) at hospital level that should be further monitored and addressed[10].

In terms of mental health, 3 percent of displaced Syrian households reported having a member with a previously diagnosed mental health condition. One in 10 PRS families (10.5 percent) has at least one member with a physical or psychological disability[11]. It is therefore important to expand access to mental health services.

Overall, limited funds are available for ensuring equitable provision of health services in order to meet essential health needs at the primary, secondary and tertiary health care levels. Consequently, access to health care in the fifth year of the crisis remains a serious concern. Overall, 15 percent of households reported having at least one household member who required primary health assistance and could not obtain it. The main reasons cited for not being able to access PHC were cost (46 percent) and distance (13 percent). Around 31 percent reported that at least one household member required secondary health assistance and 8 percent could not get it. The main reason for not getting required secondary health assistance was the high cost (78 percent)[12].

Displaced Syrian households spend an average of 18 percent of income on health. To put this into perspective, the greatest proportions of expenses are for food/health as well as housing/rent[13]. PRS are particularly vulnerable when it comes to access to health, with 99 percent of the PRS population having no health insurance coverage and dependent on UNRWA health services, including the provision of support for hospitalization[14].

**The burden on healthcare institutions**

The health facilities at primary health care and hospital level across all of Lebanon are heavily strained, as a result of increased demand on services due to the crisis. Geographically, Akkar and Bekaa, which are traditionally underserved areas, are in need of more institutional support, hosting respectively around 10 percent and 25 percent of the displaced Syrians.

Public hospitals suffer the most from underfunding of secondary health care as a result of the inability of displaced Syrians to cover the totality of their hospital bills, even in cases where their hospitalization is subsidized by partners. In fact, data from MoPH records reveals that the uncovered bills due (the remaining 25 percent of total hospitalization bill subsidized by UNHCR) amount to around US$18 million. In addition, the amount due for unfulfilled MoPH commitments to public hospitals for the hospitalization of displaced Syrians and Palestine refugees from Syria (for conditions which are not covered by UNHCR) has accumulated since 2011 to reach US$21 million. These conditions include dialysis, cancer and catastrophic illnesses treatment, and acute hospitalization. That being said, continuous strain without appropriate funding could lead to deficits that are too high for the institutions and MoPH to bear, threatening the financial viability of the public hospital system as a whole, and consequently threatening future provisioning of hospital services.

If the above needs are not fully met, mortality and morbidity will increase due to inadequate access to health care. The risk of outbreaks of communicable and vaccine-preventable diseases will increase. Early detection and control of outbreaks will also be suboptimal, increasing the mortality and morbidity. Underfunding could also cause public hospitals to go bankrupt, thereby affecting access for both the displaced and hosting communities. Social stability could be adversely affected by rising tensions due to competition for scarce resources in health.

## 2. Overall sector strategy

The MoPH Health Response Strategy (HRS), drafted in 2015, serves as the guiding document for the Health Sector. Any activity outside the scope of this strategy has been de-prioritized by the Ministry of Public Health. Available funds should therefore be directed towards addressing the priorities outlined below before considering any other activities in the sector.

The HRS serves two strategic objectives:

•To increase access to health care services to reach as many displaced persons and hosting communities as possible, prioritizing the most vulnerable.

•To strengthen healthcare institutions and enable them to withstand the pressure caused by the increased demand on services and the scarcity of resources.

To ensure the above objectives, MoPH and the health sector as a whole have prioritized interventions as follows:

1. Ensure access to comprehensive primary health care (PHC) to all communities present in Lebanon, primarily

(8) MICS 2009
(9) Benage, Matthew et al., An Assessment of Antenatal Care among Syrian Refugees in Lebanon, Conflict and Health 9 (2015): 8. PMC. Web. 3 Sept. 2015.
(10) UNHCR, Syrian refugees in Lebanon - Referral care at a glance, 2014.
(11) UNRWA and AUB, Profiling the Vulnerability of Palestine Refugees from Syria Living in Lebanon, 2015.
(12) VASyR 2015. (draft).
(13) Johns Hopkins and others, Syrian refugee and affected host population health access survey in Lebanon, 2015.
(14) UNRWA and AUB, Socio-economic report on the living conditions of Palestine refugees in Lebanon (Preliminary findings), 2015.

through the ministry's network of PHC Centres (PHCCs), but also through centers outside the MoPH network in instances when the caseload is too heavy for the network to bear, including through UNRWA services to Palestine refugees. Existing UNHCR and partner programmes which subsidize care at PHCCs should be extended, and the current mechanisms of national drug procurement through UNICEF and YMCA should be maintained (and not duplicated through parallel procurement mechanisms).

2. Ensure the vaccination of 100 percent of displaced Syrian children, Palestine refugee children and Lebanese children in the host community. This necessitates the expansion of the existing vaccination campaigns (polio and MMR) in partnership with MoPH and UNICEF, as well as the acceleration of routine vaccinations. New vaccines need to be introduced, such as pneumococcal and hepatitis A vaccines.

3. Ensure sufficient availability of drugs for chronic and acute conditions via existing MoPH channels and UNRWA services. The MoPH procures medications for chronic non-communicable diseases for Lebanese beneficiaries yearly through the YMCA-operated procurement and distribution system; it also procures directly a list of essential and acute medications to the PHC networks. However, the number of vulnerable Lebanese as well as Syrian beneficiaries referred to the MoPH network is steadily increasing, and the quantities of drugs should increase accordingly.

4. Ensure access to secondary and tertiary care for all displaced Syrians in need of hospitalization, and assist public hospitals in covering the hospital bills of the displaced. This necessitates a double-expansion of the current UNHCR programme to cover (a) 85 percent of the hospitalization bill (for the sake of equity with the MoPH hospitalization subsidization rate for uninsured Lebanese) and (b) treatment of cases such as cancer, renal failure and dialysis, multiple sclerosis and other catastrophic illnesses.

5. Strengthen the Epidemiological Surveillance Unit at MoPH with support by the World Health Organization (WHO). Stocks of contingency laboratory kits for rapid diagnosis of outbreaks, as well as stocks of emergency medications for treatment in case of outbreaks, need to be made available. In addition, there is need for sentinel sites (trained personnel, ICT equipment, etc…) across the country for early warning, surveillance and response to contain outbreaks. WHO has initiated reinforcement of the Early Warning Alert and Response System (EWARS) and will continue further support in terms of training, monitoring timeliness and completeness of reporting, as well as developing the ICT platform.

6. Strongly discourage the creation of additional costly parallel health care structures through MoPH regulation[15]. The displaced population will continue to benefit from the same entry points into health care as the Lebanese population.

In order to achieve these ambitious targets, MoPH urges partners and donors to significantly reduce expenditure on activities which do not provide direct medical services to beneficiaries. This includes health awareness and promotion activities, as well as health surveys and assessments. Such costly undertakings are seen to take away from the more urgent and direct medical service provision. The regular reporting of partners on their activities, as well as the existing MoPH and WHO channels to gather data, are sufficient sources of information for results-based monitoring in the current context.

Transparency and accountability of partners is crucial to ensure an effective and efficient humanitarian response within the health sector. To that end, should the Government of Lebanon (GoL) require information (health budgets, expenditure, etc.) that is not captured by inter-agency mechanisms, bilateral requests can be made from the GoL to partners.

## 3. Sector outcomes, outputs and indicators

The sector's overarching aim is to respond to the health needs (primary, secondary and tertiary care) of the displaced population and host community, and to strengthen national institutions and capacities to enhance the resilience of the health system.

### Outcome 1 – Wider access to a primary health care package of basic services ensured.

This includes access to medication, vaccinations and mental health services. In order to respond to the needs of the increased population, more PHC centers are to be integrated into the MoPH network. PHC centers which respond to a gap in the MoPH network (either due to uneven geographical coverage or to the inability of the network to accommodate the caseload in certain areas) will also be supported, as well as UNRWA health services to Palestine refugees.

### Outcome 2 –Improved access to hospital and specialized referral care.

This is to be done through the expansion of the previously restrictive UNHCR criteria for coverage of hospital bills, and through an increase in the rate of coverage from 75 percent to 85 percent, which is consistent with the MoPH coverage rate for the Lebanese. Another essential component to improving access to hospital care is to financially support the hospitals themselves, by reimbursing losses they have incurred due to the displaced population's inability to pay their bills.

(15) Parallel structures refers to health facilities created to cater to the needs of the displaced where national health facilities already exist.

### Outcome 3 – Improved outbreak control.

This will be done through the expansion of the existing Early Warning and Response System (EWARS), the creation of an Event Management System (EMS), and the procurement of selected contingency vaccines and reagents. Vaccination campaigns will also be carried out if needed.

### Outcome 4 – Key institutions strengthened.

The Ministry of Public Health requires staff support at the central level to enhance its leadership role in the response, and to match other ministries' involvement in the LCRP process for 2017-2020. MoPH district level offices require strengthening in order to enhance decentralization and timely detection and response. Additional PHC staff is also required at the PHC level to deal with the increased patient numbers. The school health programme will be expanded to include more public schools. Public hospitals are to be equipped with water labs, maternity wards and intensive care units, to be able to respond to the caseload.

### Outcome 5 - Transparency and accountability of all health partners ensured.

The Ministry of Public Health will periodically survey partners' expenditures on health, disaggregated as follows: direct reimbursement of health care (primary, secondary and tertiary), public health activities (studies, trainings, public awareness and promotion campaigns), procurement (medicines, equipment), and administrative fees (staffing, operational cost, overhead). This component is crucial to track expenditure in the sector, and thereby guarantee higher effectiveness and efficiency of all partners.

## 4. Identification of sector needs and targets at the individual, institutional and geographical level

The health sector figures for the total population in need are based on economic vulnerability. Available data for 2015 suggests that 70 percent of displaced and 89 percent of Palestine Refugees from Syria (PRS) are living in poverty, and that 9 percent of PRS suffer from extreme poverty[16]. Data also suggests that 1.5 million Lebanese and around 66 percent of Palestine Refugees from Lebanon (PRL) are living below the poverty line, their situation having further deteriorated since the onset of the crisis.

Total population targeted is based on economic vulnerability for displaced Syrians and PRS. For Lebanese and PRL targeted as part of the Lebanon Crisis Response Plan, estimates were provided by MoPH and UNRWA, respectively.

(16) VASyR, 2015; UNRWA and AUB, Socio-economic report on the living conditions of Palestine refugees in Lebanon (Preliminary findings), 2015.

### Total sector needs and targets:

| Category | Total population in need | Targeted – average overall estimate 66% Lebanese, 25% Syrians, 5% PRL and 4% PRS beneficiaries | | |
|---|---|---|---|---|
| | | Male | Female | Total |
| **Displaced Syrians** | 840,000 | 402,434 | 437,566 | 840,000 |
| **Palestine Refugees from Syria** | 42,000 | 20,790 | 21,210 | 42,000 |
| **Palestine Refugees in Lebanon** | 183,470 | 9,900 | 10,100 | 20,000 |
| **Vulnerable Lebanese** | 1,500,000 | 351,838 | 348,075 | 700,000 |
| **Total** | **2,565,470** | **784,961** | **816,951** | **1,602,000** |

| Institutions | |
|---|---|
| **Primary Health Care Centres** | 250 MoPH-PHCs<br>Around 100 PHCs supported by partners NGOs and UN agencies |
| **Public Hospitals** | 27 public hospitals |
| **Public Schools** | 1,375 public schools |
| **Ministries** | MoPH |

# 5. Mainstreaming of Conflict Sensitivity, Gender, Youth, people with special needs (PWSN) and Environment

**Conflict Sensitivity:**

The Health Sector Strategy recognizes that the pressure on healthcare institutions caused by the increased demand for health services is a potential source of conflict. The European Union-funded "Instrument for Stability" (IfS) project implemented in 2014 and 2015 aimed at reducing social tensions by strengthening the MoPH centrally and the PHC system overall, to deal with the increased burden on the system and to ensure access for vulnerable Lebanese.

Another recognized potential source of tension is the differences in out-of-pocket expenses for primary healthcare between vulnerable Lebanese and displaced Syrians. To address this issue, the sector efforts are oriented towards providing the same package of services to both vulnerable Lebanese and displaced Syrians at PHCCs supported by NGOs and the UN.

**Gender, Youth, People with Specific Needs:**

Gender: Differences may exist in equal and equitable access to healthcare between women and girls and men and boys. The sector strategy takes this issue into account, and will ensure that data collected at field level captures age and gender disaggregation, so that differences in access are regularly monitored and reflected in all levels of reporting.

The sector also attends to the specific needs of women and girls through its focus on access to reproductive health services including family planning, and sexual and gender based violence (SGBV) services including the clinical management of rape.

Youth: The 2016 health sector strategy does not specifically target youth (14-25 years) through specialized services aimed at responding to their specific needs. The sector strategy does, however, aim to reach a higher number of youth by expanding the number of public schools which adhere to the joint MoPH, WHO and MEHE School Health Programme, which ensures health awareness and promotion and screening for youth.

People with Specific Needs: At the primary health care level, financial support/subsidies are provided for people with disability, along with other vulnerable groups (children under 5 years of age, pregnant women and people over 60 years of age) to access services. As such, an average contribution of US$2-3 maximum is expected (depending on the health facility), as well 15 percent of the diagnostics fees.

**Environment**

Environmental risk factors, such as lack of safe water, inadequate excreta disposal systems, poor hygiene, poor living conditions and unsafe food influence the incidence and spread of communicable diseases. The sector strategy focuses on improving outbreak detection and control though strengthening disease surveillance systems.

# 6. Inter-sectoral linkages

•**Energy and Water.** Poor hygiene and sanitation conditions have led to outbreaks of food and waterborne diseases. Data on notifiable communicable diseases from the Epidemiological Surveillance Unit (ESU) at MoPH points to a high incidence of viral hepatitis A: 790 cases were reported for the period January-September 2015. As expected, the high incidence is in densely populated areas, mostly in Bekaa, followed by the North, and mostly among displaced Syrians in areas where access to safe water is difficult and sanitation is poor.

The E&W sector's efforts are geared towards improving access to water sources including drinking water, as well as access to sanitation facilities, and hygiene promotion which is tightly linked to the resources available. Preliminary results of VASyR 2015 indicate improvement on different levels in the energy and water sector compared to previous years, with 80 percent of households having access to flush toilets or improved pit latrines, versus 70 percent last year, and less than 1 percent now having no access to any type of toilet facility, compared to 2 percent last year and 7 percent in 2013. Also, the proportion of households sharing a latrine with 15 people or more is 4 percent, down from 9 percent in 2014 and 13 percent in 2013[17].

The health and E&W sectors have a joint Acute Watery Diarrhea/Cholera Response Plan for preparedness and response in case of an outbreak, and the sectors will work closely together with regards to information sharing for timely reporting to ESU and prioritization of response interventions.

The Health sector will be specifically working on improving disease surveillance.

•**Education.** School settings can be used to address and improve the health of children, youth, school personnel, families and other members of the community. In that spirit, a school health programme was launched in Lebanon under a Memorandum of Understanding (MOU) among WHO, MEHE and MoPH, signed in 2007. The different objectives of the programme included: assessing the situation on school health services and supporting regular medical visits, developing a standard package on school health services with special consideration for immunization, strengthening health education activities in schools and

(17) VASyR, 2015.

promoting healthy lifestyles, conducting the Global School-based Student Health Survey (GSHS), developing teacher training programmes to prevent HIV infection and related discrimination through schools, and developing training material for teachers on health education topics such as mental, reproductive and sexual health.

WHO has already provided medical equipment to all public schools and completed the assessment of the school health environment, in addition to introducing two modules on e-learning in 2014. The continuation of this program beyond 2015 is crucial to coping with the increased demand on school enrolment and to improving the health of youth. To avoid any duplication, the education and health sectors have agreed that the School Health Programme is part of the Health Strategy.

Also, school settings can be used to reach a greater number of children for routine immunization, especially when poor immunization constitutes a barrier to school enrolment.

•**Shelter.** Almost a quarter of displaced Syrian households live in buildings considered substandard, and nearly 10 percent live in informal settlements[18]. Poor shelter conditions are likely to negatively impact the health status of individuals, high levels of humidity are linked to higher incidence of pulmonary diseases, and crowding contributes to the spread of communicable diseases. The shelter sector aims at improving shelter conditions through weatherproofing/ insulation kits, as well as by improving water and sanitation facilities. The health sector will consult with the shelter sector for interventions targeting high-risk areas as a result of crowding.

(18) VASyR, 2015.

•**Protection.** Health services facilities constitute the first point of entry for identification, referral and treatment of protection cases. The protection sector addresses SGBV, child protection and mental health/trauma cases, and provides people with disabilities with access to specialized equipment. Both health and protection sectors coordinate for capacity-building of health care providers on how to address protection cases. Both sectors also coordinate for the selection of facilities which will receive training on the clinical management of rape (CMR). In addition to that, referral pathways are jointly discussed at the Mental Health and Psychosocial Support sub-working group.

•**Food Security.** Food security is clearly linked to health through malnutrition. The nutrition status of children, as well as that of pregnant and lactating women is monitored through primary health care centres, where malnutrition is also managed. Currently the institutionalization of acute malnutrition management into the MoPH Primary Health Care (PHC) system as well as the development of national guidelines to manage acute malnutrition are going on and they will be operationalized in all the MoPH PHCCs once they are finalized. Nutrition related activities are jointly coordinated through the nutrition sub-working group. The food sector will also link with the health sector around the emergence of animal-related diseases/zoonoses, as well as for food safety issues.

Photo: UNDP

## PARTNERS PER OUTPUT:

**Health Sector Partners:** UNFPA, UNHCR, MDM, IR Lebanon, AVSI, Medical Teams International , IDRAAC, MoPH, IOCC, UNICEF, RI, AMEL, FPSC, QRC, WVI, CLMC, URDA, IOM, UNDP, ICU, PU-AMI, MAP-UK, IMC, UNRWA, Makassed, Seraphim Global, WHO, RESTART Lebanon, MEDAIR, ANERA, CCP JAPAN, HI, PCPM, Humedica, Makhzoumi

| OUTCOME/OUTPUT | PARTNERS |
|---|---|
| **OUTCOME 1:** Improved access to PHC services | |
| Output-1.1: PHC services received by population in need | AMEL, AVSI, CCP JAPAN, CLMC, FPSC, HI, Humedica, ICU, IMC, IOCC, IOM, IR Lebanon, Makassed, Makhzoumi, MAP-UK, MDM, MEDAIR, Medical Teams International, MoPH, PCPM, PU-AMI, QRC, RESTART Lebanon, RI, Seraphim Global, UNFPA, UNHCR, UNICEF, UNRWA, URDA, WHO |
| Output-1.2: Sufficient chronic diseases medication available | AMEL, ANERA, CLMC, FPSC, Humedica, IMC, IOM, IR Lebanon, Makassed, Makhzoumi, MDM, Medical Teams International , MoPH, PCPM, PU-AMI, QRC, RESTART Lebanon, RI, UNFPA, UNICEF, UNRWA, URDA, WHO |
| Output-1.3: Sufficient acute diseases medication available | AMEL, ANERA, CLMC, Humedica, IMC, IOM, IR Lebanon, Makassed, Makhzoumi, MDM, MEDAIR, MoPH, PCPM, PU-AMI, QRC, RESTART Lebanon, RI, UNFPA, UNICEF, UNRWA, URDA |
| Output-1.4: Routine vaccination coverage increased for all children U5 | AMEL, CLMC, ICU, IMC, IR Lebanon, Makassed, Makhzoumi, MDM, MEDAIR, MoPH, PCPM, PU-AMI, RI, UNICEF, UNRWA, WHO |
| Output-1.5: Implementation of National Mental Health Strategy | IDRAAC, IMC, Makassed, Makhzoumi, MDM, MoPH, PU-AMI, UNICEF, UNRWA, WHO |
| Output-1.6: Expansion of the PHC-MoPH network | AMEL, CLMC, IMC, Makassed, Makhzoumi, MDM, MoPH, PU-AMI, RI, UNFPA, UNRWA, WHO |
| **OUTCOME 2:**Improved access to hospital and advanced referral care | |
| Output-2.1: Population in need receives hospital and diagnostic services | CLMC, FPSC, IMC, IOCC, IOM, Makassed, Makhzoumi, MAP-UK, MoPH, QRC, UNFPA, UNHCR, UNICEF, URDA |
| Output-2.2: Financial gap for public hospital bill reimbursement decreased | IMC, IR Lebanon, MoPH, UNRWA |
| Output-2.3: Public hospitals compensated for the financial losses which they incurred due to the Syrian crisis | MoPH |
| **OUTCOME 3:** Improved outbreak control | |
| Output-3.1: Expand EWARS | MoPH, WHO |
| Output-3.2: Selected contigency vaccines and reagents are procured | Makassed, Makhzoumi, MoPH, PU-AMI, WHO |
| Output-3.3: Support vaccination campaigns | CLMC, IMC, Makassed, Makhzoumi, MoPH, PU-AMI, UNICEF, UNRWA, WHO |

| | |
|---|---|
| **OUTCOME 4:** Key Institutions Strengthened | |
| Output-4.1: Strengthen caza public health office for enhanced decentralization | IMC, IR Lebanon, MoPH, PU-AMI, UNDP, UNFPA, URDA |
| Output-4.2: Public Hospitals service delivery strengthened | IMC, IOCC, MoPH, RESTART Lebanon, UNFPA, URDA, WHO, WVI, UNRWA |
| Output-4.3: School health program expanded (youth health) | MoPH, WHO |
| Output-4.4: Ensure Capacity Building at central level, peripheral level and PHCs | FPSC, IMC, IOCC, IOM, MDM, MoPH, UNDP, UNFPA, UNHCR, UNICEF, UNRWA, WHO |
| Output-4.5: Budget support provided to fund MoPH financial dues to hospitals | MoPH |
| **OUTCOME 5:** Transparency and Accountability of Health Partners Ensured | |
| Output-5.1: Accurate Expenditures on Health by all health partners are available to MoPH. | MoPH, WHO |
| Output-5.2: The bulk of received donations for the health sector is disbursed on direct health services | MoPH, WHO |