Health Sector

1. Situation analysis

The Health sector situation analysis and needs are presented in alignment with 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.

1.1 Primary healthcare

Availability of PHC services

In Lebanon, primary health care (PHC)[1] is available to vulnerable Lebanese as well as displaced Syrians, whether registered or unregistered with UNHCR, through a variety of primary health care facilities. These include the Ministry of Public Health (MoPH) network of 208 Primary Healthcare Centres (PHCCs), and an estimated 1,011 other primary health care facilities, referred to as dispensaries, most of which are non-governmental organizations (NGO) clinics. PHCCs offer a relatively comprehensive package of PHC 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, services are offered for a nominal fee, compared to private clinics. In an important number of these facilities, routine vaccination, acute and chronic medications as well as reproductive commodities are available free of charge. These are supplied through MoPH with the support of partners to address increased needs at PHC level.

	Availability of vaccines, medication and reproductive health (RH) commodities supplied by MoPH			
Facilities	Vaccines	Acute Medication	Chronic Medication	RH commodities
MoPH-PHCCs (208)	All 208	All 208	201	All 208
Dispensaries (Approx. 1,011 including 220 MoSA-SDCs)	633	220 (all MoSA SDCs)	218	58

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

In alignment with the LCRP Health Sector Strategy, subsidized primary health care is available to displaced Syrians, whether non-registered or registered as refugees by UNHCR, at around 111 primary health care facilities (including 62 MoPH-PHCCs, and 49 dispensaries including 13 MoSA-SDCs)[2] distributed across the country with the support of international and local partners to reduce out of pocket expenditure in light of the high economic vulnerability levels of displaced Syrians. Similarly subsidized care is available to a number of vulnerable Lebanese as a way of addressing critical health needs and mitigating potential sources of tension in almost three-quarters of those facilities. From January to September 2017, approximately 1,058,412 subsidized consultations were provided at the PHC level by LCRP partners, out of which 17 percent were consultations for vulnerable Lebanese. It is to note also that organizations which are not LCRP partners such as Medecins Sans Frontières (MSF) Switzerland and MSF-Belgium are providing an important number of PHC services free of charge for displaced Syrians, vulnerable Lebanese as well as other population groups. From January to August 2017, MSF-Switzerland and MSF-Belgium had provided approximately 225,000 additional consultations, representing an additional 21 percent of the caseload supported by LCRP partners.[3]

In parallel to the provision of PHC services through MoPH PHCCs and dispensaries, specific primary healthcare services are made available to displaced Syrians through approximately 25 Mobile Medical Units (MMUs), operated by various NGOs, which provide free consultations and medication and often refer patients back to PHCCs for services which are not available through MMUs. Though fewer in number than at the onset of the crisis, MMUs continue to be operational primarily in areas with high distribution of Informal Settlements (ISs) and/or in distant rural areas from which PHCs are hard to reach. From January to September 2017, approximately 216,266 free consultations were provided through MMUs by LCRP partners representing an additional 17 percent of the total consultations supported by LCRP partners.[4]

Meanwhile, PHC services are also widely available to displaced Syrians through private doctors' clinics, pharmacies or even hospitals. However, these come at a much higher cost in terms of out-of-pocket expenditure. Medical services are also available to the displaced population through numerous informal practices run by Syrian doctors or midwives in Informal Settlements (ISs).

Similarly to Palestine Refugees in Lebanon (PRL), primary healthcare is available to Palestine Refugees from Syria (PRS)[5] primarily though the 27 UNRWA Health Clinics which offer free of charge primary healthcare services. From January to September 2017, approximately 101,473 free consultations were provided to PRS through UNRWA clinics.

[2] Based on Activity Info, September 2017 data.
[3] From January to August 2017, MSF-Switzerland supported 119,694 free primary health care consultations, with the majority of beneficiaries being displaced Syrians while MSF-Belgium supported a total of 104,750 consultations.
[4] Currently, LCRP and non-LCRP partners operate an equal number of mobile medical units
[5] According to UNRWA, there are approximately 34,000 Palestine Refugees from Syria (PRS) in Lebanon (UNRWA, 2017)

Health Information System in Primary Health Care

The MoPH primary health care Health Information System (HIS) has come a long way since it was established thanks to important efforts that have been, and continue to be, invested in its improvement and expansion. The objective of the HIS is to provide individual, facility and population level data as well as data on health outcomes, which are necessary for health planners and decision makers.

Currently, a total of 206 facilities in the MoPH-PHCC network provide monthly reporting to MoPH. Reporting is done through three different channels: 74 facilities report on to MoPH through PHENICS which is the most elaborate version of the MoPH-PHCC health information system software, 83 facilities report through an older version of the health information system software and 49 facilities through paper-based reports. Facilities still using a paper-based reporting system have either recently joined the MoPH-PHCC network, have a shortage in human resources for reporting, or have their own private health information systems in place.

That said, an important number of primary health care facilities (mostly dispensaries) do not report to MoPH. As such, their data is not captured by the current system, limiting the extent to which the data available at MoPH is nationally representative and can be used for analyses related to health outcomes.

Accessibility to PHC services

Various sources of information point to varying levels of access to primary health care services among displaced Syrians as well as challenges and barriers to primary health care access.

Data from MoPH-PHCCs, shows that 30 percent of users of services through MoPH-PHCCs are displaced Syrians. These include beneficiaries of services through MoPH-PHCCs whether supported or not for subsidies.

The UNHCR 2017 Health Access and Utilization Survey (HAUS) confirms that displaced Syrians seek services through a variety of facilities; for both acute and chronic conditions, the majority of interviewed displaced Syrians had sought care at a primary health care outlet/private clinic (57 percent of persons with acute conditions and 51 percent of persons with chronic conditions), followed by a pharmacy (23 percent of persons with acute conditions and 34 percent of persons with chronic conditions) and then a hospital 16 percent of persons with acute conditions and 14 percent of persons with chronic conditions). According to results of the 2017 Vulnerability Assessment of Syrian Refugees (VASyR), 46 percent of households reported the need to access PHC services in the last 6 months. Of those, 89 percent reported being able to access needed care. This is a slight improvement from 2016, where 83 percent of households were able to access needed care. For the 11 percent of households not able to access care, barriers mainly relate to cost of medications or treatment and the doctors' consultations fees, not being accepted at the facility, the distance to the health facility and associated transportation costs, not knowing where to obtain the services as well as a feeling of inadequate welcoming or treatment at facility level.

Interestingly, households in the governorates of Mount-Lebanon and Beirut followed by Akkar were less able to access needed care. This is quite different compared to results of VASyR 2016 which showed that households in the governorates of Bekaa, the North and Akkar were less able to access needed care. Though not captured by the VASyR, field consultations with partners point to the areas of Masharii' el Qaa and Arsal, both close to the Lebanon-Syria borders, having suffered from difficulty in access to health services due to the security reasons that prevented the movement of displaced Syrians or health actors' provision of assistance.

The access to specific primary health care services is outlined below:

Vaccination: Routine vaccination is widely available across the country and can be accessed by both displaced Syrians and vulnerable Lebanese through all 208 MoPH-PHCCs as well as approximately 600 dispensaries. Indeed, results of the 2016 WHO Expanded Programme on Immunization (EPI) coverage survey showed that 47 percent of Lebanese and 72.7 percent of Syrian refugees received their vaccination at primary healthcare centres.[i] Alternatively, and specific to localized vaccination campaigns, vaccination is also accessible through mobile units. Moreover, measles and polio vaccination is accessible at UNHCR registration centers and at the four Lebanon/Syria border crossings. While great strides have been made in the overall vaccination coverage which is considered to be high in Lebanon, the EPI survey points to lower coverage in certain districts.[6] This is further confirmed by localized field assessments which indicate that a number of children are not up-to-date as per their immunization calendars or that a number of children have not received a single dose of vaccine since birth.

Various barriers to optimal vaccination have been identified. In many MoPH-PHCCs, a consultation fee is often charged for vaccination despite an official MoPH Circular instructing facilities to provide vaccination for free. The circular is therefore perceived by partners to be poorly implemented and poorly enforced. Indeed, 51 percent of displaced Syrian households reported having paid for vaccination (UNHCR HAUS, 2017). Challenges to vaccination as voiced by displaced Syrians are the cost of the vaccine followed by the cost of transportation to the facility. Poor knowledge about services available also seems to play a role in low vaccination coverage as only 59 percent of households knew that vaccination for children under 12 years is free at MoPH-PHCCs. Furthermore, the UNICEF 2016 Knowledge, Attitudes and Practices (KAP) showed that 39.1 percent of Syrian caregivers reported lack of knowledge as reason for not vaccinating their children.

Although not a barrier, the lack of documentation of vaccination (vaccination booklets are often lost), is an issue as health care providers are unable to properly assess a child's vaccination status and as such would have to assume that the child has never been vaccinated.

[6] The WHO EPI Cluster survey shows that, at a national level, completed vaccination (three doses at least) for polio is 90.1 percent, DTP 87.3 percent, Hib 88.7 percent and Hepatitis B 89.9 percent. More specifically, a polio coverage of less than 85 percent is reported in cazas for Jbeil, Metn, Akkar, Minieh-Donnieh, Bcharre and Jezzine

The surveillance system in Lebanon has detected 64 acute flaccid paralysis in 2017, none of them being polio related and sporadic cases vaccine-preventable diseases are still observed/reported.7 From January to September 2017, 76 cases of Measles, 165 cases of Mumps, and 66 of Pertussis have been confirmed. The highest number of cases of vaccine-preventable diseases are reported in Beirut/Mount-Lebanon, South and Bekaa governorates. Although reporting has improved, the actual number of cases is believed to be higher.

Considering populations' movement across borders, crowded living conditions, poor sanitation conditions as well as direct disposal of untreated waste water, there are heightened risks of outbreak of vaccine-preventable diseases, and the introduction of new diseases to the country. Surveillance activities 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 percent, with the similar trend of boys being slightly more wasted (low weight for height) than girls (VASyR 2016). Accordingly, the prevalence of GAM 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, along with the provision of micro-nutrient supplements has been integrated at the level of MoPH-PHCCs.[8] At primary health care level, systematic screening for acute malnutrition of all children under five is often hampered by staff being overloaded with tasks. There is also a missed opportunity for screening of both children under five as well as pregnant and lactating women (PLWs) outside of those facilities and possibly within communities as the numbers of MoPH do not reflect estimates of number of children with acute malnutrition based on the prevalence rates and population figures.

Infant and Young Child Feeding (IYCF): Thirty-four percent of displaced Syrian children (age 0 to 6 months) are exclusively breastfed. The rate of exclusive breastfeeding is higher among displaced Syrians than it is among Lebanese, Palestine Refugees in Lebanon (PRL) and Palestine Refugees from Syria (PRS). Further, 54 percent of displaced Syrian children (age 6-23 months) received solid, semi-solid or soft foods the minimum number of times, compared to 64 percent of Lebanese children ïiindicating sub-optimal complementary feeding. Also, 43 percent of displaced Syrian children (age 6-9 months) have received breastmilk and a solid or semi-solid food the previous day and 58 percent of displaced Syrian children (age 12-15 months) were fed breastmilk the previous day providing some indication of continued breastfeeding of children beyond 6 months.

[7] 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), 89 cases of measles (29cases among displaced Syrians) were reported. Source: MoPH/ESU.

[8] According to MoPH HIS, from January to July 2017, 127,814 children under 5 were screened for malnutrition in all MoPH-PHCCs and 424 children have received treatment for moderate or severe acute malnutrition (without complications) in the 52 MoPH-PHCCs that are malnutrition management centers. Also, 12,422 children under 5 and pregnant and lactating women (PLW) were receiving micro-nutrients.

At facility level, barriers to raising awareness and counseling 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. Other barriers relate to misconceptions about exclusive breastfeeding not being enough or sufficient for a child's growth and husbands not being supportive of their wife breastfeeding (IMC, 2016). Barriers to complementary and diversified feeding for children aged 9 to 23 months related to baby gastro-intestinal (GI) problems, access to food variety, remembering to give the child 4+ food groups (IMC, 2016).

Currently, there are relatively limited efforts by partners to promote, protect and support infant and young child feeding at community, primary health care as well as hospital levels for optimal growth yet, findings indicate those interventions are much needed. Furthermore, 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 diseases.[iii] Preliminary data from the WHO NCD stepwise survey, a national NCD prevalence survey targeting Lebanese and displaced Syrian in Lebanon shows almost similar prevalence of impaired fasting glycemia (4.2 percent among Lebanese and 5.2 percent among Syrians), diabetes (known and/or on treatment 10.2 percent among Lebanese and 9.4 percent among Syrian), obesity (37.9 percent among Lebanese and 34.2 percent among Syrian), hypertension (38.2 percent for both Lebanese and Syrian). However, the study showed that prevalence of smoking is higher among Lebanese (38 percent compared to 31.1 percent among Syrian) as well as higher cholesterol levels (65.4 percent among Lebanese compared to 48.8 percent among Syrians). Moreover, the study showed that more Syrian had more than 3 risk factors (59.8 percent) for NCDs compared to Lebanese (51.4 percent). This warrants special attention as to ensure the continued access to NCD medications and good quality of care including early detection and awareness raising on health behavior.
Currently, approximately 149,000 Lebanese and 16,000 displaced Syrians access NCD medication through YMCA. It is estimated that around 10,000 displaced Syrians are also accessing NCD medication procured separately through partners.

Findings from the 2017 UNHCR HAUS showed that 8 percent of persons reported having an acute condition during the preceding month out of which 23 percent did not seek health care either because they could not afford clinic fees (59 percent) or because they did not think it was necessary (20 percent). Moreover, the study indicates that 16 percent of individuals reported a chronic condition. Of those, only 65 percent 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 (65 percent), not being able to afford transportation (13 percent), did not like the staff (10 percent) and did not think it was necessary to go (10 percent).

The study also points to poor knowledge related to available services as a barrier to PHC access; results showed that only 55 percent of displaced Syrian households knew that they could obtain primary health care consultations for between 3000 and 5000 LL and only 42 percent knew that drugs for acute conditions could be obtained for free at primary health care facilities.

Other barriers related to access to both acute and chronic medication which are supplied free of charge by MoPH relate to doctors' practice of prescribing medications which are outside of the MoPH/WHO list of essential medication or the list of chronic medication available through YMCA and which imply further out of pocket expenditure by patients on branded medication which are otherwise obtainable in their generic form. Another barrier reported is the lack of proper forecasting of medication needs/consumption which often results in both shortages and stocks of expired medication.

All of the above indicate that further support is needed in order to increase access to PHC for both acute and chronic conditions while improving system-related issues.

Sexual and Reproductive Health: According to UNHCR Registration data, displaced Syrian women of childbearing age (15-49) constitute 25 percent of the total registered population of displaced Syrians. Moreover, results of the UNHCR 2017 HAUS indicate that 43 percent of women of reproductive age were pregnant during the last 2 years.

As a reflection of the existing needs, pregnancy care, including ante-natal care (ANC) and post-natal care (PNC) constitutes an important proportion of services currently provided to displaced Syrian women at primary healthcare level. Results of the UNHCR 2017 HAUS study showed that 73 percent of women who have been pregnant in the past two years report accessing antenatal care, representing an increase in access compared to 2016. The survey also shows that 52 percent of the women who were pregnant in the last 2 years had received ante-natal care (ANC) in more than one facility. The results of the survey indicate that an alarming 27 percent of women have not received ANC during their pregnancy. Among the 27 percent of pregnant women who did not receive ANC, the majority (47 percent) reported being unable to afford doctor's fees and 21 percent thought ANC was not necessary. Among women who accessed ANC, only 55 percent reported four or more visits, a slight increase compared to 2016, yet indicating that the uptake of ANC by pregnant women is low.

Most common barriers to ANC are financial or knowledge/attitude related. Significant barriers to ANC 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 a ANC visit, or not being aware of the importance of seeking care during 1st trimester (IMC, 2016).

Moreover, only 28 percent of women who delivered reported receiving post-natal care. Of those women who did not attend PNC, 73 percent indicated that they did not think it was necessary and 22 percent said that they could not afford the clinic fees. The findings above demonstrate the need to

increase uptake of ante-natal care and post-natal care by displaced Syrian women and addressing its most common barriers through financial support and increased outreach.

As for family planning, the uptake of family planning methods by displaced Syrians is also low. Based on the UNHCR 2017 HAUS, among those couples who report to be using a family planning method, contraceptive pills are most commonly used (38 percent), followed by traditional methods (24 percent), IUDs (22 percent) and condoms (15 percent). The most common reported reason for lack of use of family planning is planning a pregnancy. Another recent study on the barriers to contraceptive use points to cost as the main reported barrier to contraception use[iv]. This is echoed by partners in the field who point to the inconsistent implementation of the MoPH Circular related to reproductive health services at MoPH-PHCC level which places a ceiling on the cost of reproductive health services and reiterates that family planning commodities are to be distributed free of charge as a contributing factor

Mental Health: Around 2.5 percent of displaced Syrians reported needing access to mental health care in the last 6 months, out of which 62 percent were not able to receive the care they needed (VASyR, 2017). Reasons for not accessing care vary from cost, to transportation issues, as well as lack of knowledge on where to seek help. Despite a significant number of NGOs providing mental health and psychosocial support, access is not equally distributed and areas like Baalbak-Hermel remain without any support (VASyR, 2017).

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 and remain insufficient to respond to the existing needs which are high, a matter which is reflected in the patients' waiting time to consult with a mental health professional. From January to September 2017, partners provided a total of 31,994 specialized mental health consultations to vulnerable Lebanese, displaced Syrians, PRL and PRS. The need for mental health services is highlighted in Akar, Hermel, Dennieh and South of Lebanon as well as lack of psychiatric hospitalization outside of Beirut, the need for proper management of psychiatric emergencies at hospital level as well as support in transportation to services.

In addition, beneficiaries, both displaced Syrian and vulnerable Lebanese alike, can access essential psychotropic medications via the YMCA network and some specialized medications via the humanitarian list provided by the MoPH. It is therefore important to expand access to mental health services. The ongoing efforts of the MoPH National Mental Health Programme (NMHP) and its partners seek to address the expansion of mental health services through the integration of mental health services into primary health care. To date, as a result of the accelerated initial training on mental health care more than 800 health workers in around 300 PHCs and dispensaries have been introduced to the WHO Mental Health Gap Action Programme (mhGAP); of these, around 50 received more advanced training, whereby at least one nurse and one General Practitioner are well trained on the mhGAP. In addition a community mental health center in the Bekaa has been piloted over the past 3 years. Over the next four years (2018-2020), the delivery of mental health packages will gradually be piloted in 40

selected MoPH-PHCCs, of which, 12 were identified to provide more specialized mental health services via a multi-disciplinary team.

Tuberculosis (TB) and HIV: In Lebanon, tuberculosis and HIV care are not integrated within primary health care and have separate vertical programmes within the MoPH. From January till September 2017, 481 new TB cases were registered at the National Tuberculosis Programme (NTP), among which 103 are displaced Syrians. With funds available from the Global Fund, active directly observed therapy strategy (DOTS) for the free of charge treatment of patients with TB has been expanded, with special focus on areas with most vulnerability of displaced Syrians and host communities. The free of charge care of latent TB cases (screening and management) has been decentralized within 15 public hospitals through an IT system established by WHO and is guided by a clear protocol of management based on the updated 2016 Clinical Treatment Protocols of TB.

As for HIV patients among displaced Syrians, and similarly to HIV patients among Lebanese, anti-retroviral therapy (ART) is available free of charge through the National AIDS Programme (NAP) and treatment is provided according to updated 2016 HIV/ARV protocols. Until September 2017, a total of 1,273 persons with HIV were receiving treatment through the NAP out of which 1,174 are Lebanese, 51 displaced Syrians, 40 Palestine Refugees and 8 from other nationalities.

With regards to Palestine Refugee from Syria, data from UNRWA's Health Information System points to each PRS visiting UNRWA clinics on average five times per year. In general, PRS are worse-off compared to PRL on all health-related indicators.[v] Respectively, 10 percent, 75 percent and 83 percent of households report at least one family member who suffers from a disability, acute illness in the past six months, and chronic illness. The four most prevalent chronic conditions are diabetes, high blood pressure, heart disease, and bone and muscle problems.[vi] Moreover, 85 percent reported poor mental health.

Although displaced Syrians and Palestine Refugees from Syria, in theory, can access primary healthcare services from a variety of health outlets, the main barrier is cost. Data from the 2017 VASyR indicates that displaced Syrians' health expenditure is relatively high and comprises 13 percent (up by 1 percent from 2016) of the total expenditures of a household (average total expenditure is US$ 403 /HH/month, down by 56 USD from 2016).[vii] The UNHCR 2017 HAUS study also points to an average monthly household expenditure of 154 USD on health with the median monthly household expenditure on health being 75 USD. Compared to 2016, the monthly household expenditure has slightly increased from 148 USD and the median monthly household expenditure decreased from 100 USD.

In light of the increasing economic vulnerability of both displaced Syrians and PRS, further financial support in access to primary health care is needed.

1.2 Hospital Care

Access to hospital care for displaced Syrians, whether registered or unregistered with UNHCR, is primarily through a network of 50 hospitals across Lebanon (public and private), contracted by UNHCR through a

third party administrator; NEXtCARE. Subsidized care is limited to obstetric and life-threatening conditions, which have been prioritized in light of available funding, and currently covers 75 percent of hospitalization fees. Coverage is increased to 90 percent 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 percent is to be covered by displaced Syrians. Survivors of gender-based violence, particularly survivors of rape are fully covered.

From January-September 2017, a total of 61,257 displaced Syrians (average of 6,806 admissions per month) were admitted for hospital care through UNHCR representing a 10.4 percent increase from admissions in 2016.[viii] It is estimated, based on data from previous years, that 53 to 57 percent of the total admissions covered by UNHCR are pregnancy related. Though hospital-based deliveries are covered by UNHCR, 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 32 to 36 percent of deliveries were through C-section. The C-section rate is considered high.[9] Though it is lower than the C-section rate amongst Lebanese which is estimated at around 44 percent,[10] it is higher than the rate reported in Syria (23 percent)[ix] and confirms findings of a 2007 study by the American University of Beirut pointing to a policy environment encouraging C-sections In Lebanon[x]. As the practice carries risks, and there is a concern that unnecessary C-sections are taking place, the rate should be further monitored and addressed. Another estimate is that 16 percent of all newborns are admitted or kept in hospitals for special care[xi]. The rate of admission to neonatal intensive care unit (NICU) is also considered high and requires further monitoring. Specific to maternal and child outcomes, MoPH reports for the first quarter of 2017 indicate that non-Lebanese[11] (displaced Syrians included) are likely to be worse off compared to Lebanese on maternal and neonatal mortality indicators.

Various challenges are linked to hospital admissions. Once such challenge lies in delays in the hospital admissions of persons with psychiatric conditions. These often exceed a month and result from a limited number of available psychiatric beds. Another common challenge is the inability of displaced Syrians to pay the 10-25% patient share of admissions covered by UNHCR. Presently, a limited number of health actors provide support to cover the remaining costs. This is done on a case by case basis with the financial ceiling for support varying amongst supporting international and national NGOs. It has been observed that in some hospitals, admission is pending a deposit is provided and the identification documents or UNHCR registration documents of displaced Syrians are retained until the hospital bill is settled.

Parallel to the support provided by UNHCR, an additional, yet limited, number of LCRP health partners provide support in access to hospital care. Conditions which are covered include by are not limited to: surgeries for congenital malformations including cleft lip and palate surgeries and orthopaedic surgeries

[9] According to WHO, the ideal rate for caesarean sections is between 10-15 %.
[10] MoPH 2013 Public Health bulletin showed that the rate of CSs reached 44-45 % of total deliveries covered by MoPH.
[11] MoPH started disaggregating maternal and child data by nationality mid-2017. Prior to that, two categories were used: Lebanese and non-Lebanese.

including club feet, hip displacement, reconstructive surgery for burns, dialysis for patients with chronic renal failure, blood transfusions for thalassemia patients, treatment for hemophilia patients, chemotherapy for breast cancer patients etc. 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 organizations such as the International Committee of the Red Cross (ICRC), MSF-Switzerland, MSF-Belgium and more recently MSF-France also provide additional support to displaced Syrians as well as other population groups in access to hospital care. While ICRC mainly provides support to weapon wounded individuals, both MSF-Switzerland and MSF-Belgium support deliveries and MSF-France acute paediatric conditions.[12]

Overall, the hospitalization rate for obstetric and life-saving conditions for displaced Syrians is 6 percent per year.[13] Even by adding the support provided by partners, the hospitalization rate for displaced Syrians remains lower than that of Lebanese (12 percent per year). This is explained by the restrictive criteria applied due to limited funds. It is therefore estimated that an important number of displaced Syrians are not able to access needed hospital care. Indeed, the results of the 2017 VASyR confirm that 22 percent 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 (56 percent).

Palestine Refugees from Syria, similarly to Palestine Refugees in Lebanon, benefit from hospital care through UNRWA with 100 percent coverage for secondary care in Palestine Red Crescent Society (PRCS) hospitals and 90 percent in public and private hospitals respectively and 60 percent coverage for tertiary services (with a ceiling of $5000 per intervention).[xii] Many families therefore experience high vulnerability in the health sector especially since 99 percent of the population has no health insurance coverage other than access to UNRWA health services for hospitalization. Despite different barriers (irregular legal status, movement restrictions, limited resources), the access to UNRWA hospitalization services is high.[xiii] The hospitalization rate of Palestine Refugees from Syria is equivalent to 12 percent and therefore similar to that of Lebanese. However, funds are needed to maintain the current subsidies provided by UNRWA.

In order to maintain current subsides and address the large 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 (such as cancer) and chronic conditions (i.e. dialysis for chronic renal failure, treatment for multiple-sclerosis patients etc.)[14] as well as advanced diagnostics.

[12] From January-September 2017, ICRC supported a total of 80,218 persons in access to hospital care. From January to August 2017, MSF-Switzerland and MSF-Belgium supported a total of 3,072 and a 4,807 deliveries respectively mostly among displaced Syrians, and MSF-France supported a total of 333 acute paediatric admissions for children (3 months to 15 years).

[13] UNHCR referral care report 2014.

[14] It is estimated that around 800 cases of cancer among displaced Syrians need to be treated every year, and an estimated 200 patients are in need of on-going renal dialysis.

Overall, limited funds are available to ensure equitable provision of health services in order to meet essential health needs at the primary, secondary and tertiary healthcare levels. Consequently, access to healthcare in the seventh year of the crisis still remains a serious concern.

1.3 Impact on healthcare institutions

Despite the institutional support provided, health facilities at primary healthcare and hospital level across Lebanon are heavily strained with an increased demand on services due to the crisis. Akkar and Bekaa, as traditionally underserved areas, and hosting respectively around 10 percent and 25 percent of the displaced Syrians, are in particular need of more institutional support.

Public hospitals are impacted by the inability of displaced Syrians to cover the totality of their hospital bills, even in cases where their hospitalization is subsidized by partners, and unfulfilled MoPH commitments to public hospitals to cover, on an exceptional basis, the hospitalization fees of displaced Syrians and Palestine refugees from Syria for conditions which are not subsidized by partners. These conditions include dialysis, cancer and catastrophic illnesses treatment, and acute hospitalization. According to MoPH records for 2016, public hospitals had accumulated a deficit amounting to $15 million since the onset of the Syrian 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.

1.4 Adolescent and Youth Health

It is estimated that 35 percent of the Lebanese population are children (0-19), 20.6 percent adolescents (10-19) and 19.8 percent are youth (15-24)[xiv]. Based on data from UNHCR Lebanon Registration database, 57 percent of displaced Syrians registered with UNHCR as refugees are children (0-18), 23 percent are adolescents (10-19) and 17 percent are youth indicating that both populations are relatively young.

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 by WHO in 2016 in Lebanon in close collaboration with the Ministry of Education and Higher Education (MEHE) and MoPH.[15] Displaced Syrian children enrolled in public schools were included in the survey. The GSHS addressed for the first time risky health behaviours following the impact of the Syrian crisis on both the Lebanese and displaced Syrian school age children. A total of 5,708 students participated in the Lebanon GSHS. While results of the study will further be disaggregated by population group, key prevalence estimates from the survey indicate serious issues in

[15] The Global School-Based Student Health Survey (GSHS) had also been conducted in Lebanon in 2005 and 2011.

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 (GoL), the sector is committed to supporting adolescent and youth health in Lebanon through the National School Health Program focusing on three main areas; medical screening, health awareness and education, and healthy school environment.

2. Overall sector strategy

The Ministry of Public Health (MoPH) Health Response Strategy, drafted in 2015, and updated in 2016, serves as the guiding document for the LCRP Health sector.[xv] 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 at the progressive integration of services in the existing national healthcare system.

The MoPH-Health Response Strategy serves four strategic objectives:

- Increase access to healthcare services in order to reach as many displaced persons and host communities as possible, prioritizing the most vulnerable
- Strengthen healthcare institutions and enable them to withstand the pressure caused by the increased demand on services and the scarcity of resources
- Ensure health security and control of outbreaks
- Improve child survival rate

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 (GoL) require information that is not captured by inter-agency mechanisms, bilateral requests can be made from the GoL to the Health sector partners.

2.1 Sector outcomes, outputs and indicators

The Health sector's overarching aim is to respond to the health needs (primary, secondary and tertiary health care) of displaced Syrians (whether non-registered or registered as refugees by UNHCR) and Palestine Refugees from Syria as well as the most vulnerable within the Lebanese and Palestine Refugees in Lebanon host communities, and to strengthen national institutions and capacities to respond to those needs while simultaneously enhancing the resilience of the health system as a whole.

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

This 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 (PHC) package

The sector aims to ensure access to comprehensive[16] quality primary healthcare (PHC) to displaced Syrians (whether non-registered or registered as refugees by UNHCR) as well as vulnerable Lebanese, primarily through the Ministry's network of primary healthcare centers (PHCcs), but also through health facilties outside the MoPH network which are referred to as dispensaries (including the Ministry of Social Affairs (MoSA) Social Development Centres (SDCs)) in instances where there is uneven geographical coverage, or where the caseload is too heavy for the network to bear.[17]

Existing health partner programmes which subsidize care in a number of those facilities will be maintained for displaced Syrians as well as vulnerable Lebanese populations. These programmes typically rely on a small contribution by patients towards consultation fees while subsidizing laboratory diagnostics to certain population groups only; children under five years of age, pregnant and lactating women, persons with disabilities and older persons. In the face of increasing economic vulnerability, new models that offer more coverage to displaced Syrians and vulnerable Lebanese patients seeking PHC services will be implemented to ensure meaningful access to primary healthcare, further addressing cost-related barriers such as doctors' fees, cost of treatment or transportation costs.

One such model will be implemented throughout 2018-2019 by partners International Medical Corps (IMC), Première Urgence-Aide Médicale Internationale (PU-AMI) and Fundacion Promocion Social de la

[16] Comprehensive primary healthcare is inclusive of vaccination, medication for acute and chronic conditions, Non-Communicable Diseases (NCD) care, sexual and reproductive health, malnutrition screening and management, mental health, dental care as well as health promotion.

[17] Palestine refugees for Syria and Palestine refugees in Lebanon are an exception as their access to primary healthcare is through UNRWA clinics.

Culturra (FPSC) through funding from EU-Madad. The model consists in supporting an equal ratio of vulnerable Lebanese and displaced Syrians patients in access to primary health care (including mental health) through initially 45 PHCCs. Beneficiaries' contribution is of 3,000 LBP (equivalent to 2 USD) as a consultation fee and medication and diagnostics are fully covered for all population groups.

Another model will be implemented as part of the THRIVE initiative; a comprehensive and collective approach to child survival in Lebanon, under the leadership of MoPH and the Ministry of Energy and Water (MoEW,) to refocus energy and resources on critical risks of child survival and development. THRIVE seeks to provide an integrated Mother and Child Core Health Package of services including preventive and curative maternal and child health care services to 80% of the most poor and deprived Lebanese as well as the displaced Syrian communities and Palestinians refugees through MoPH-PHCCs to further address cost-related barriers to health care and respond to critical needs of this specific population at risk. Should these projects prove to be successful, further adoption at the level of MoPH-PHCCs will be considered.

Palestine Refugees from Syria and Palestine Refugees in Lebanon will continue receiving free primary health care services through UNRWA clinics.

Though external to the LCRP, it is important to mention the ongoing MoPH pilot project funded by the World Bank entitled "Emergency PHC Restauration Project (EPHRP) - towards Universal Health Coverage". The pilot project targets 150,000 vulnerable Lebanese registered with the MoSA- National Poverty Targeting Program (NPTP) with an essential preventive healthcare package through 75 MoPH-PHCCs. Throughout 2018, MoPH plans to scale up and expand the project to all MoPH-PHCCs, targeting all 300,000 vulnerable Lebanese enrolled in the NPTP with packages of both preventive and curative services. The THRIVE model will be aligned in content, delivery and financing mechanisms with the EPHRP packages.

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 diseases, non-communicable diseases, mental health, etc.). Efforts will also aim at increasing awareness on the availability of services (including gender-based violence (GBV) services) thereby contributing to increased demand for primary health care. This will be done through increased coordination of partner activities, harmonization of health messages as well as targeting of both women and men within communities as a way to influence decision-making and ensure an environment that is supportive of positive health seeking behaviors.

With the crisis entering its eighth year, activities of mobile medical units (MMUs) such as vaccination campaigns, outbreak investigation and response and provision of primary health care services will be limited to exceptional security-related and emergency situations. Provision of primary health care 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 PHCCs and are generally counter-productive to instilling health seeking behaviors and promoting health facility utilization.

The target for 2018 is a total of 2,152,000 subsidized or free consultations to be provided to displaced Syrians, vulnerable Lebanese, Palestine Refugees from Syrian and Palestine Refugees in Lebanon at primary healthcare level. This output will be measured by an indicator on the "number of subsidized or free PHC 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 three years, the sector will explore in detail further optimizing the package of services offered and models of delivery including the 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, elderly, 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.

Output 1.2 - Free of charge chronic disease medication provided at PHC level

As the displaced Syrian population will continue to benefit from the same entry points into 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, and any duplication for parallel procurement mechanisms by health partners be avoided. To that end, it is expected that over the span of the next three years the MoPH system for procurement, management and distribution of chronic disease medication, will specifically be able to progressively absorb numbers of vulnerable Lebanese as well as Syrian beneficiaries referred.[18]

The target for 2018 is 175,100 individuals (145,000 Lebanese and 25,000 displaced Syrians) receiving chronic disease medication through MoPH/YMCA channels of procurement and distribution system, as well as 5,100 individuals (3,400 Palestine refugees from Syria and 1,700 Palestine Refugees in 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 PHC level

As the displaced Syrian population will continue to benefit from the same entry points into healthcare as the Lebanese population, it is essential that the current mechanisms of national drug procurement for acute disease medication, medical supplies and reproductive health commodities (including family

[18] 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.

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.

The targeting for 2018 remains around 1.5 million displaced Syrians and vulnerable Lebanese within the existing PHC channels, as well as around 50,000 Palestine refugees from Syria and Palestine refugees in Lebanon through UNRWA clinics.

Output 1.4 - Free of charge routine vaccination provided for all children under 5 at PHC level and through vaccination campaigns

The sector aims to achieve 100 percent vaccination coverage of displaced Syrian children, Palestine Refugees from Syria as well as vulnerable Lebanese children[19] and Palestine Refugees in Lebanon. This necessitates the enforcement of the MoPH policy relating to free vaccinations at 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 Program on Immunization (EPI) coverage cluster survey. This output will be measured through an indicator on the "number of children under five receiving routine vaccination" 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 MoPH at central and local levels to respond to primary health care needs, the expansion of the MoPH-PHCC network to up to 250 centers is prioritized to ensure greater geographical coverage and accessibility of vulnerable populations to quality primary health care services at affordable cost.[20] Moreover, support is needed in terms of human resources at MoPH central and local levels as well as PHCCs which are understaffed and overloaded. This includes staffing for the MoPH-National Mental Health Programme as well as staffing for polio surveillance. The provision of equipment is also needed to respond to 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 skills[21], identification and referral of survivors of sexual and gender-based violence and survivor-centered 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 trained[22].

[19] It is estimated that 50% of vulnerable Lebanese children receive vaccination through the public health system while the remaining 50% receiving vaccination through private health system
[20] MoPH plans on adding 50 additional PHCCs to the MoPH-PHC network per year.
[21] As an example, the Clinical Management of Rape training targeting health staff includes a module on soft skills
[22] It is observed that more female health staff attend trainings compared to male health staff – this is reflective of the general health workforce.

Even more so, 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.

Additionally, the Health sector has prioritized, along with MoPH, exploring ways to support the expansion of the existing health information system (HIS). Through the WB supported project at MoPH-PHCC level, electronic medical files for the beneficiaries of the WB project have been established, along with a medications electronic monitoring system, known as PHENICs. The expansion of this electronic health information system is planned for an additional 150 PHC centers in the coming two years. [23] Further expansion of the health information system is envisioned in both the number of health facilities reporting in a harmonized way within the MoPH HIS (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 which will support proactive management of future healthcare priorities. Another indicator which will be used is "# of facilities reporting on the MoPH HIS".

Yet, with time, and as the MoPH capacities are strengthened, the institutional support shall progressively decrease.

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

This 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 Palestine Refugees from Syria in need of hospital care. [24] Considering the high cost of hospital care services in Lebanon and the increasing economic vulnerabilities amongst displaced Syrians and Palestine Refugees from Syria, health sector partners need financial resources to maintain the current financial support provided. Additional resources are also needed to expand the support to medical conditions which do not fall under the current schemes and which include dialysis for chronic renal failure, thalassemia, advanced cancer care such as radio and chemotherapy and care for other catastrophic illnesses.

Within the four year span, 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 "% of population cohort admitted per year".

[23] Currently, with few exceptions, only the PHCCs within the MoPH Network report basic data via the HIS and public health early warning sentinel surveillance sites exist in selected PHCCs

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

For 2018, the sector will target 120,126 displaced Syrians[25], 4,700 Palestine Refugees from Syria and 2,400 Palestine Refugees in Lebanon receiving hospital services in 2018. The targets are calculated based on a 12% hospitalization rate for all population cohorts. [26] 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 percent of the hospital bill and targets displaced Syrians and through UNRWA's hospitalization policy targeting Palestine Refugees from Syria. Financial support is also provided through health actors' support in the coverage of the 10 to 25 percent patient share for UNHCR supported hospital admissions, as well as through health actors' support in covering conditions which do not fall within UNHCR or UNRWA hospitalization schemes.

Output 2.2 - Public and private hospital service delivery supported

The sector aims to provide support to the 27 public hospitals. Interventions will consist in providing equipment to hospitals to fill shortages in equipment, in replacing old and deteriorating equipment as well as in 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 of an equal ratio of female staff trained.

Outcome 3 – Improve Outbreak Control

This will be achieved through the following outputs:

Output 3.1 The National Early Warning and Response System (EWARS) expanded and reinforced

The sector aims to contribute to strengthening outbreak control through building the capacity of the MoPH in surveillance and response. The focus will be on public health Early Warning and Response System (EWARS) strengthening and expansion. In 2017, WHO supported the development an IT platform (DHIS2) that was established in a selected number of health facilities. The EWARS would provide the critical data in a timely manner for all concerned authorities at the MoPH for timely response for monitoring, planning and decision-making within the health sector for any outbreak containment and response. In addition, in 2017 a detailed situation assessment was also completed with the support of WHO for the Surveillance System and a Strategic Framework and Plan of Action with priority interventions were recommended. Those focused mainly on the harmonization of the health reporting system, the expansion of EWARS to multidisciplinary stakeholders (such as the Ministry of Agriculture), the improvement of the flow of

[25] This figure is based on the number of displaced Syrians registered by UNHCR as refugees equivalent to 1,033,513 (as of end of June 2016). It is important to note however that all displaced Syrians (GoL 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 (SOPs) for Referral Care.

[26] The hospitalization rate does not include health interventions done on an outpatient basis such as dialysis.

information within the MoPH departments on one side and between the MoPH and the concerned stakeholders on the other side.

WHO has initiated the expansion of the EWARS and is supporting its decentralization through targeting all PHCCs within the MoPH network, laboratories and hospitals, as well as MoPH-Epidemiologic Unit at central level. Activities include the reinforcement of 50 existing surveillance sites, the expansion of the system through the establishment of 246 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 through the "number of functional/operational Early Warning and Response System (EWARS) centers".

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 are available.

Outcome 4 – Improve Adolescent & Youth Health

This will be achieved through the following outputs:

Output 4.1 – School Health Program (MoPH/WHO/MEHE) maintained

The Health Sector will continue supporting the MEHE/MoPH/WHO School Health Programme which achieved its expansion to 1,200 public schools in 2017. Activities within this programme contribute to a healthy environment and include, school health education, opportunities for physical education and recreation and programs for counselling, social support and mental health promotion. Other activities include provision of support for the school E-health medical records (procurement of IT equipment and capacity building) as well as support for the healthy school environment project.

2.2 Identification of sector needs and targets at the individual, institutional and geographical level

In the Health sector, the number of displaced Syrians in need is calculated based on economic vulnerability whereby data from the 2017 VASyR indicates that 76 percent of displaced Syrians are living below the poverty line. [xvi] As such, the number of displaced Syrians in need and targeted by the sector is 760,800.[27]

[27] This figure is based on the number of displaced Syrians registered by UNHCR as refugees equivalent to 1,001,051 (as of end of June 2017). It is important to note however that all displaced Syrians (GoL estimates are of 1,500,000 displaced Syrians in Lebanon) whether registered or non-registered with as refugees by UNHCR, are eligible for support in access to both primary health care as well as hospital care.

Although a recent economic vulnerability study led by UNRWA points to 89 percent of Palestine Refugees from Syria living in poverty, all 34,000 Palestine Refugees from Syria are considered in need and targeted by the Health sector.[xvii] The number of Palestine Refugees in Lebanon considered in need is based on economic vulnerability data indicating that 65 percent of Palestine Refugees in Lebanon[28] (equal to 180,691) are living below the poverty line.

Although 180,691 Palestine Refugees in Lebanon are considered in need, 20,000 are actually 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 GoLs estimate of Lebanese who are economically vulnerable. The Health sector however is targeting 50% 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 that are 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. These include INGOs such as MSF, the ICRC and which provide critical healthcare outside of the LCRP. Better coordination, consolidation under the LCRP 2018 and exchange of health information is an urgent priority.

Note for IM - Insert table total sector needs and targets (See Sector PIN/Target Excel document in dropbox)

3. Mainstreaming of conflict sensitivity, gender, youth, people with specific needs 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. To address this, efforts are geared towards strengthening the MoPH centrally and peripherally as well as the PHC system overall, including MoSA-SDCs, to deal with the increased burden on the system and to ensure continued access for vulnerable Lebanese.

Another potential source of tension is the differences in out-of-pocket expenses for primary healthcare between vulnerable Lebanese and displaced Syrians as some supported facilities only provide subsidies to displaced Syrians. To address this issue, sector efforts are oriented towards providing vulnerable Lebanese with the same package of subsidized services provided to displaced Syrians at primary healthcare centres supported by LCRP partners.

[28] Total number of Palestine Refugees in Lebanon is 277,985. Source: UNRWA - Department of Relief and Social Services - October 2014

Gender

Differences may exist in equal and equitable access to healthcare between girls, boys, women and men. The sector strategy takes this issue into account by ensuring that data collected through assessments and surveys, from health facilities (consultations, hospital admissions) and from health-related interventions (i.e. vaccination campaign, trainings) captures age and sex disaggregation, so that differences in needs, access including gender-specific barriers to access (i.e. protection risks on the road, such as harassment for women or freedom of movement associated with check-points for men), or persons reached or health staff trained are regularly monitored and addressed.

The sector also attends to the specific needs of women and girls through its focus on access to reproductive health services, specifically antenatal care (ANC), postnatal care (PNC), family planning, referrals for sexual and gender based violence (SGBV) services and the clinical management of rape. Although the focus is on women and girls, reproductive health and SGBV services are also available to men and boys. Nonetheless, exposure to SGBV still remains an underreported issue.

Youth

The 2017-2020 Health sector strategy aims to contribute to improvements in health of youth (14-25 years) recognizing that the population in the 20-24 age brackets has a considerable higher percentage of women.[xviii] The Health 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 Surveys, reported high rates of substance use (tobacco and alcohol), mental health conditions (bullying, suicide ideation) among youth.[xix]

The Health sector will also target youth though public schools adhering to the School Health Programme which fosters health and learning through the engagement of health and education officials, teachers, students, parents, health providers and community leaders in efforts to make the school a healthy place.

People with Specific Needs

Many of the MoPH-PHCCs and dispensaries are currently not accessible to persons with physical disabilities. This is gradually being addressed by MoPH-PHCCs which are undergoing the accreditation process. Moreover, in a number of primary healthcare centres financial support/subsidies to cover the cost of laboratory and diagnostics tests is provided to , people with disabilities, similarly to other vulnerable groups such as children under five, pregnant women and people over 60 receive. Also, specialized NGOs provide people with disabilities with specialized services such as physical therapy, rehabilitative support such as prosthetic and orthotic devices, hearing aids and eye glasses for vision correction.

Environment

Environmental risk factors, such as lack of safe water, poor waste water management, poor solid waste management, poor hospital waste management, poor living conditions and hygiene 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 including medical waste management.

This is dealt with by the multidisciplinary national committee for waste management in coordination mainly with the WASH sector. The health sector strategy focuses on providing technical advice (especially on medical waste management) to the WASH sector, and strengthening disease surveillance systems as way to contribute to improved outbreak control, such as the WHO supported polio environmental surveillance.

4. Inter-sector Linkages

Overall, the Health sector aims to improve Lebanon's health security through multi-sectoral coordination in line with the 2005 International Health Regulations, namely with the Ministry of Agriculture and Ministry of Environment to help prevent and respond to acute public health risks whether occurring naturally or due to deliberate or accidental events.[xx]

Water. The Water sector efforts are geared towards improving access to water sources including drinking water, as well as access to sanitation facilities and hygiene promotion. The Health and Water sectors have a joint Acute Watery Diarrhea/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 for timely reporting to the Ministry of Public Health Epidemiological and Surveillance Unit (ESU) and prioritization of response interventions. Reporting on notifiable communicable diseases, specifically those which are water-borne, will include cadaster level information to further guide Water sector interventions.

Energy: The Energy sector's interventions aim at enhancing public service delivery (including health care services) through the reduction of electricity cost and the provision of cleaner energy. Coordination between both Energy and Health Sectors will take place in initiatives aiming at installing renewable energy and energy efficient measures at health facility level. This will reduce the healthcare institutions' electricity bills, thereby easing their financial burden and leading to positive return on investment.

Education. School settings can be used to address and improve the health of children, youth, school personnel, families and other members of the community. The School Health Programme is one such initiative with activities related to the medical screening of students at school, the development of an electronic data base (health information system) for the students' medical screening files, the provision of schools with information technology (IT) equipment, capacity building for health staff on the medical screening guidelines and for administrative staff on data management and health promotion activities targeting staff, students and teachers.

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 burns prevention resulting from home accidents especially amongst children during the winter.

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 to health or protection actors. Healthcare facilities also provide specialized services to survivors of SGBV including clinical management of rape (CMR). The Protection sector addresses issues related to SGBV, child protection and mental health, and provides people with disabilities with access to specialized care and refers cases in need of health services to the Health sector. Both Health and Protection sectors, specifically the gender-based violence (GBV) sub-sector coordinate for capacity-building of healthcare providers on GBV referral pathways and will collaborate around the integration of GBV risk mitigation measures in the health sector as per the 2015 Inter-Agency Standing Committee (IASC) Guidelines on Integrating Gender-Based Violence Interventions in Humanitarian Action.[xxi] Both sectors also coordinate for the selection of facilities which will receive training on CMR as well as for Health and Protection related referrals.

Food Security. Food insecurity, inadequate access and availability of sufficient safe and nutritious food to meet dietary needs is one of the contributing factors to malnutrition. With the integration of malnutrition into primary healthcare, following the Ministry of Public Health as well as the Ministry of Social Affairs' collaboration with partners, children aged 6-59 months as well as pregnant and lactating women (PLW) are expected to be screened for acute malnutrition at all MoPH-PHCCs and MoSA SDCs. Those in need will receive micro-nutrient supplements, and will be referred for outpatient malnutrition management in a number of MoPH-PHCCs or in-patient treatment in public hospitals. The Food Security sector will promote food utilization through promotion of good nutritional practices and improve dietary diversity of most vulnerable population groups including female-headed households, pregnant and lactating women, women in reproductive age and children under five. Food security is also addressed in the Health sector through awareness sessions and counseling on breastfeeding as well as infant and young child feeding (IYCF).
Further, the sectors are linked in their approach to address the emergence of animal-related diseases which can affect human health (zoonosis), as well as for food safety issues that can lead to food borne illnesses.

Social Stability: The Health and Social Stability sectors will work together to strengthen the capacities of municipalities in their role in addressing social and health needs of communities. This will support decentralization, in strengthening the link - as well as communication - between ministries and social institutions and will in turn contribute towards enhancing social stability.

Basic Assistance: The Health Sector relies on results of the "Desk Formula" which determines the socio-economic vulnerability levels of displaced Syrians registered as refugees by UNHCR in the provision of financial support for hospital care.

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