HEALTH
SECTOR

PEOPLE IN NEED

2,445,986

PEOPLE TARGETED

1,535,297

REQUIREMENTS(US$)

2017 308 million

2018 300 million

PARTNERS

43

GENDER MARKER

2a

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SECTOR OUTCOMES

Outcome #1 — $83.4 m

Improved access to comprehensive primary healthcare (PHC)

Indicators

Percentage of persons of concern accessing primary healthcare services

Outcome #2 — $211.6 m

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

Indicators

Percentage of population cohort admitted for hospitalization per year

Outcome #3 — $8 m

Improved outbreak control

Indicators

Number of functional early warning and surveillance system (EWARS) centers

Outcome #4 — $5 m

Improved child, adolescent & youth health

Indicators

Percentage of public schools adhering to at least one component of the School Health Program

POPULATION BREAKDOWN

POPULATION COHORT	PEOPLE IN NEED	PEOPLE TARGETED	51% Female	49% Male
Lebanese	1,500,000	750,000	372,750	377,250
Displaced Syrians	733,795	733,795	381,573	352,222
Palestine Refugees from Syria	31,502	31,502	15,909	15,593
Palestine Refugees in Lebanon	180,691	20,000	10,100	9,900

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): a) increase access to health services for displaced Syrians and vulnerable Lebanese; and b)strengthen healthcare institutions and enable them to withstand the pressure caused by the increased demand on services and the scarcity of resources.

Primary healthcare

Similarly to Lebanese, displaced Syrians access primary healthcare services through MoPH network of 220 Primary Healthcare Centres (PHCCs)[1], the 220 MoSA SDCs and through an estimated 700 health outlets/dispensaries, most of which are NGO clinics. In addition there are an unidentified number of informal practices/health rooms run by Syrian doctors in informal settlements. In the identified facilities, medical consultations can be received for a nominal fee. In an important number of these facilities, routine vaccination, acute and chronic medications as well as reproductive commodities are available free of charge.[2] These are supplied through MoPH with the support of partners.

In parallel, and with the onset of the crisis, displaced Syrians can access primary healthcare services, through Mobile Medical Units (MMUs) which provide consultations, dispense medication free of charge and often refer patients back to PHCCs.

Alternatively, medical services are available through private clinics, or through one of the 2,928 pharmacies in the country.[i] However, these come at a much higher expense in terms of out-of-pocket expenditures.

Currently, displaced Syrians can receive subsidized services at around 100 health outlets (including MoPH-PHCCs, MoSA-SDCs and other health outlets/ dispensaries)[3] supported by international and local partners. These partners currently also provide similarly subsidized services to a limited number of vulnerable Lebanese as a way of addressing critical needs and mitigating potential sources of tension.

Child Health: According to the 2016 Vulnerability Assessment of Syrian Refugees (VASyR), the prevalence of global acute malnutrition (GAM) among displaced Syrian children aged 6-59 months in Lebanon seems to be stable at around 2 percent, with the similar trend of boys being slightly wasted more than girls.[ii] The prevalence of GAM falls under the "acceptable" severity category on the World Health Organisation (WHO) Crisis Classification.[iii] In order to address malnutrition, screening for and management of both moderate and severe acute malnutrition (without complications) have been integrated at primary healthcare level.[4] Currently, all children being screened for malnutrition are expected to be given micro-nutrients. MoPH-PHCCs are also expected to report on malnutrition related indicators via the MoPH Health Information System.

At 34 percent, the rate of exclusive breastfeeding for children age less than six months is the highest for Syrians registered as refugees with UNHCR compared to Lebanese, Palestine Refugees in Lebanon and Palestine Refugees from Syria. Furthermore, the percentage of displaced Syrian children age 6-23 months who received solid, semi-solid or soft foods the minimum number of times is at 54 percent, compared to 64 percent among Lebanese children[iv] indicating the need for interventions to promote both exclusive breastfeeding (0-6 months) as well as proper infant and young child feeding (6-23 months) which positively impacts child health.

Vaccination: 47 percent of Lebanese and 72.7 percent of persons registered as refugees by UNHCR received their vaccination at primary healthcare centres.[v] Overall, the vaccination coverage in Lebanon is high, with a lower coverage reported in certain cazas.[5] Despite the vaccination campaigns and the relentless efforts to accelerate routine vaccination, a number of children are not up-to-date as per immunization calendars. Considering the poor living conditions of vulnerable populations, there are heightened risks of outbreak of vaccine-preventable diseases, and the introduction of new diseases to the host community, especially in areas where there is crowding. Indeed, vaccine-preventable diseases are still observed/reported.[6] The highest number of cases of vaccine-preventable diseases are reported in Mount-Lebanon, Bekaa and South governorates. Although reporting has improved, the actual number of cases is believed to be higher.

While a significant number of Lebanese and displaced Syrian children under five benefited from free routine vaccination (620,291 children) through MoPH,[7] only 71 percent of households knew that displaced Syrian children have free access to vaccination at MoPH facilities[vi].

Adult Health: In general, displaced Syrians primarily seek care for infections and communicable diseases (40 percent), chronic conditions (14 percent), gynecological

(1) According to MoPH, in 2015, 30% of beneficiaries of PHCCs in the MoPH-PHC network were displaced Syrians.
(2) Currently, routine vaccines are available in all 220 MoPH-PHCCs as well as around 600 dispensaries which include a number of MoSA-SDCs. Acute medications are available in all 220 MoPH-PHCs as well as all 220 MoSA-SDCs. Chronic medications are available in around 410 health outlets out of which 187 are MoPH-PHCCs. Reproductive Health commodities are available in all 220 MoPH-PHCCs as well as in 57 dispensaries.
(3) Based on Activity Info, from January to August 2016, health partners provided subsidized services through around 100 outlets out of which 55 MoPH-PHCCs, 12 MoSA SDCs, and 62 dispensaries.
(4) According to MoPH records, from January to June 2016, 29,056 children (50 percent Lebanese and 50 percent non-Lebanese) have been screened for malnutrition in all MoPH-PHCs and 424 children have received treatment for moderate or severe acute malnutrition (without complications) in the 60 MoPH-PHCs which are malnutrition management centres. 46 children were referred for inpatient treatment.
(5) 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
(6) From January to October 2016, nationally, 455 cases of mumps (71 among displaced Syrians), 294 cases of Hepatitis B (36 cases among displaced Syrians), 85 cases of acute flaccid paralysis (9 cases among displaced Syrians), 83 cases of pertussis (15 cases among displaced Syrians), 40 cases of measles (16 cases among displaced Syrians) were reported. Source: MoPH/ESU.
(7) Data from MoPH for the period January to August 2016.

care (12 percent) and injuries (9 percent).[vii] Though it may not be representative, findings from a recent survey showed that 8 percent of household members reported having a chronic disease, of which 37 percent were unable to access medicines or health services needed.[viii] The most common chronic diseases reported by displaced Syrians are arthritis, hypertension, diabetes, Asthma/COPD, and heart disease and the prevalence of all chronic conditions is significantly higher in displaced Syrians who are over 40 years old with hypertension being the most common chronic condition.[ix]

Reproductive Health: Antenatal care (ANC) constitutes an important proportion of medical services provided to displaced Syrians at primary healthcare level. The UNHCR 2016 HAUS study showed 70 percent of women aged 15-49 years and who have been pregnant in the past two years reported accessing antenatal care, representing a decrease in access compared to 2015. Of those women who accessed ANC, 73 percent reported three or more visits with 53 percent reporting more than four visits, a slight increase compared to 2015. Among the 30 percent of pregnant women who did not receive ANC, most reported being unable to afford fees and/or transport costs. Moreover, only 26 percent of women who delivered reported receiving postnatal care. Therefore there is a clear need to increase uptake of post-natal care by displaced Syrian women.

With regards to family planning the study showed that 38 percent of couples with one of the partners between 15-49 years of age were using a family planning method.[8] Amongst the reasons for not using contraceptive methods, 48.8 percent stated they are planning a pregnancy, whereas 39.7 percent stated not wanting to use a contraceptive method, followed by five percent who stated the costs are too high.

Mental Health: Three percent of displaced Syrian households reported having a member with a previously diagnosed mental health condition. Despite a significant number of NGOs providing mental health and psycho-social support, the need for specialized mental health services including for survivors of sexual and gender-based violence (SGBV) remains high and the waiting lists long. It is therefore important to expand access to mental health services.

Although displaced Syrians can, in theory, access primary healthcare services from a variety of health outlets, they main barrier to accessing services is cost-related. Data from the 2016 VASyR shows that displaced Syrians' health expenditure is relatively high and comprises 12 percent of the total expenditures of a household (average total expenditure is US$ 459/H/month).[x] Additionally, observations from the field point towards social and protection barriers to access to health services which vary by gender; harassment, lack of documentation, reception by medical staff, fear of getting out from the house due to illegal stay etc. Poor knowledge about available health services also constitutes a barrier for access; 57 percent of the UNHCR HAUS survey respondents knew that refugees should pay between LBP 3,000 and 5,000 LBP ($ 2-3.30) for a consultation at a primary healthcare centre (PHCC) a lower proportion (49 percent) knew that medication for acute illnesses are free at PHCCs.[xi]

Percentage of **displaced Syrians** household **expenditure on healthcare** out of total (VASyR 2016)

Palestine Refugees from Syria primarily access primary healthcare though the 27 UNRWA clinics offering free of charge primary healthcare services including vaccination and acute and chronic medication. On average each Palestine Refugee from Syria visits UNRWA clinics five times per year. Palestine Refugees from Syria are worse-off compared to Palestine Refugees in Lebanon on all health-related indicators.[xii] 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.[xiii] Moreover, 85 percent reported poor mental health.

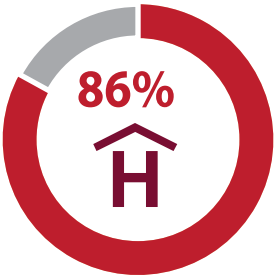
Hospital Care

Access to hospital care for displaced Syrians is primarily through a network of 53 hospitals across Lebanon (public and private), contracted by UNHCR through a third party administrator. 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. Survivors of gender-based violence, particularly survivors of rape are fully covered. 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. Accordingly, beneficiaries of the support are expected to cover the remaining 10 to 25 percent patient share. Securing the funds is a challenge for displaced Syrians. Observed practices, which raise protection concerns, are of hospitals retaining displaced Syrian IDs or UNHCR registration documents until the hospital bill is settled or hospitals requiring that a deposit be paid prior to admission. Various health actors provide support to cover the 10 to 25 percent patient share, however the

(8) The preferred family planning method was the intra-uterine device (IUD) (31%) followed by the pill (20%), traditional methods (16%) and the condom (12%).

support remains limited, and is on a case by case basis with each I/NGO having its own ceiling for financial support per case.

Percentage of **displaced Syrians** who **received** needed **primary health care services** (VASyR 2016)



In 2016, 50,121 displaced Syrians were admitted for hospital care.[xiv] Of the total admissions, 52 percent were pregnant women admitted for obstetric care of whom 30 percent gave birth 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)[xv] and confirms findings of a 2007 study by the American University of Beirut pointing to a policy environment encouraging C-sections In Lebanon.[xvi] 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.

Considerable additional hospital care is provided through LCRP partners and other non-LCRP actors; surgeries for congenital malformations and other conditions through medical missions, dialysis for renal failure and thalassemia patients, treatment for hemophilia patients, as well as hospital care for injuries from firearms or explosive weapons.

Overall, the hospitalization rate for obstetric and life-saving conditions for displaced Syrians is six percent per year,[11] which is half the hospitalization rate for Lebanese (12 percent per year). This is explained by the restrictive criteria applied due to limited funds. In order to 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 as well as diagnostics. 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.[12]

Palestine Refugees from Syria, similarly to Palestine Refugees in Lebanon, benefit from hospital care through UNRWA with 100 percent 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).[xvii] 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.[xviii] The hospitalization rate of Palestine Refugees from Syria is equivalent to 12 percent and therefore similar to that of Lebanese.

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 healthcare levels. Consequently, access to healthcare in the sixth year of the crisis still remains a serious concern.

Impact on healthcare institutions

The health facilities at primary healthcare and hospital level across Lebanon are heavily strained, as a result of 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 need of more institutional support.

US$ **15 million**

Financial deficit accumulated by **public hospitals** since the onset of the **Syria crisis** (MoPH records)

Public hospitals are impacted by: 1) the inability of displaced Syrians to cover the totality of their hospital bills, even in cases where their hospitalization is subsidized by partners, and 2) unfulfilled MoPH commitments to public hospitals to cover 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, public hospitals have 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.

(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) UNHCR referral care report 2014.
(12) Based on data from dialysis centres, 2014-2015, MoPH.

Overall sector strategy

The MoPH Response Strategy (HRS), drafted in 2015, and updated in 2016, serves as the guiding document for the LCRP Health sector.[xix] Activities within the LCRP must fall within the scope of this strategy starting from community outreach, awareness and preventive activities all the way to curative and referral services. By 2020, the strategy aims at full integration of services in the existing national healthcare system.

The HRS serves four strategic objectives:

- To increase access to healthcare services to reach as many displaced persons and host 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 health security and control of outbreaks; and
- To improve child survival.

Health sector partners are expected to uphold the principles of transparency and accountability to ensure an effective and efficient humanitarian response within the health sector. To that end, should the GoL require information that is not captured by inter-agency mechanisms, bilateral requests can be made from the GoL to partners.

2.1 Sector Outcomes and Outputs

The Health sector's overarching aim is to respond to the health needs (primary, secondary and tertiary care) of displaced Syrian and Palestine Refugees from Syria populations and 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 – Improved access to comprehensive primary healthcare (PHC)

The sector aims to ensure access to comprehensive[13] quality primary healthcare to displaced Syrians as well as vulnerable Lebanese, primarily through the Ministry's network of PHCs, but also through centres outside the MoPH network[14] including MoSA's SDCs in instances where there is uneven geographical coverage, or where the caseload is too heavy for the network to bear.[15] Hence, the expansion of the MoPH-PHCC network is prioritized.[16] The establishment of Mobile Medical Units (MMUs) will be limited to exceptional security and emergency situations such as vaccination campaigns, outbreak investigation and lack of PHCCs in the geographic area.

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, including reproductive health commodities and post-exposure prophylaxis (PEP kits), be aligned with the existing needs for both Lebanese and non-Lebanese, and any duplication for parallel procurement mechanisms by health partners be avoided. To that end, it is expected that over the span of four years the MoPH system for procurement, management and distribution of chronic disease medication operated through the non-governmental organization (NGO), Young Men's Christian Association (YMCA), will be able to progressively absorb numbers of vulnerable Lebanese as well as Syrian beneficiaries referred to YMCA.[17]

Existing partner programmes which subsidize care at PHCCs will be maintained for the most vulnerable populations (displaced Syrians as well as vulnerable Lebanese). The current package provided which includes financial subsidies for consultations, subsidies for laboratory and diagnostic tests for pre-defined vulnerable groups, free vaccination, free acute and chronic medication, as well as two free ultrasounds for pregnant women will be evaluated regularly to make sure it responds to needs and ensures meaningful access for primary healthcare, addressing potential barriers for access.

Within the four year span, 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 women, girls, boys and men, including pregnant and lactating women, 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, women, girls, men and boys will be equally consulted.

In order to strengthen the capacities of MoPH at central and local levels as well as MoSA SDCs to respond to needs, support is needed in terms of human resources, provision of equipment and capacity building according to identified needs to ensure quality care. Yet, with time, and as the MoPH capacities are strengthened, the institutional support shall progressively decrease.

Additionally, the Health sector has prioritized exploring along with MoPH ways to support the expansion of the existing health information system (HIS) and the public health early warning sentinel surveillance sites, especially since they provide the critical data for monitoring,

(13) Comprehensive primary healthcare is inclusive of vaccination, medication for acute and chronic conditions, NCD care, reproductive health, malnutrition screening and management, mental health, dental care as well as health promotion.
(14) This includes dispensaries, many of which belong to NGOs, municipalities or the Lebanese Red Cross.
(15) Palestine Refugees for Syria and Palestine Refugees in Lebanon are an exception as their access to primary healthcare is through UNRWA clinics.
(16) MoPH plans on adding 50 additional PHCCs to the MoPH-PHC network per year.
(17) 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 and decision-making within the health sector. [18] The expansion envisioned is both in the number of health providers reporting as well as the quality and reliability of the data generated. This will ensure that regular access to data is available and proactive management of future healthcare priorities.

Output 1.1 - Comprehensive primary healthcare package received by the population in need.

The target for 2017 is 1,956,786 subsidized consultations to be provided at primary healthcare level. This output will be measured by an indicator on the "number of subsidized 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. Activities under this output are the provision of subsidized medical consultations, the screening, referral and management of acute malnutrition and the provision of health awareness at health facility level or at community level through outreach from the health facility.

Output 1.2 - Sufficient chronic disease medication available.

The target for 2017 is 175,100 individuals there are around 145,000 Lebanese and 25,000 displaced Syrians receiving chronic disease medication through the MoPH/ YMCA[19]operated procurement and distribution system, as well as 3,400 Palestine Refugees from Syria and 1,700 Palestine Refugees in Lebanon receiving chronic medication 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 - Sufficient acute disease medication, medical supplies and reproductive health commodities available, targeting around 1.5 million displaced Syrian and vulnerable Lebanese within the existing MoPH channels, as well as around 50,000 Palestine Refugees from Syria and Palestine Refugees in Lebanese through UNRWA clinics.

Output 1.4 - Routine vaccination coverage increased for all children under 5 – with a target of 100 percent of displaced Syrian children, Palestine Refugees from Syria as well as vulnerable Lebanese children[20] and Palestine Refugees in Lebanon vaccinated. This necessitates the enforcement of the MoPH policy relating to free vaccinations at primary healthcare level as well as the expansion of existing routine vaccinations. This output will be measured through an indicator on the "% of children under five receiving routine vaccination" based on the annual WHO Expanded Programme on Immunization (EPI) cluster survey, as well as through an indicator on the "number of children under five receiving routine vaccination" both of which will be disaggregated by sex.

Output 1.5 - Primary healthcare institutions' service delivery strengthened, targeting 50 new PHCCs to be added to the MoPH-PHCC network. Activities under this output include the provision of equipment and supplies, staffing as well as capacity building trainings (including on soft skills[21] and survivor-centred approaches to avoid that health staff attitudes would constitute a barrier to access health services). The sector will encourage an equal ratio of female/male staff trained[22] and the indicator is on the "number of primary healthcare staff trained" and will be disaggregated by sex.

Outcome 2 – Improved access to hospital and advanced referral care

The sector aims to ensure access to hospital and specialized referral care for all displaced Syrians and Palestine Refugees from Syria in need of hospitalization and to assist public hospitals in covering the hospital bills of the displaced populations. [23] Indeed 75 to 90 percent of the hospital fees for life-saving and obstetric care is currently covered by UNHCR, leaving 10 to 25 percent of the hospital bill uncovered for an important number of hospitalizations. Health sector partners need resources to cover this gap as well as conditions not covered by the current scheme (including 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.

Output 2.1 - Population in need receives hospital and diagnostic services, targeting 124,022 displaced Syrians[24], 3,780 Palestine Refugees from Syria and 2,400 Palestine Refugees in Lebanon receiving hospital services. The targets are based on a 12 percent hospitalization rate for all population cohorts. [25] The main activity under this output is the provision of financial support to access hospital services. This is currently through the UNHCR Referral Care programme, health actors' support to cover the 10 to 25 percent patient share, and/or health actors providing financial support to cover conditions outside of the UNHCR scheme. This will be measured through an indicator on the "number of persons receiving hospital services". The indicator will be disaggregated by sex to

(18) 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

(19) Benefiting from chronic medications through YMCA is subject to patients' enrolment in the YMCA system, funded by MoPH and constituted by 447 partner clinics and dispensaries across Lebanon.

(20) 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

(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.

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

(24) This figure is based on the number of displaced Syrians registered with 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.

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

allow for gender analysis of potential barriers for access to hospital care. Another activity is the provision of financial support for access to specialized diagnostics on an outpatient basis.

Output 2.2 - Public hospitals compensated for financial losses incurred due to Syria Crisis with target of 100% of public hospital losses retroactively reimbursed. The losses have accumulated since 2011 as a result of displaced Syrian's inability to pay the totality of their hospital bills as well as MoPH's inability to cover its financial dues to hospitals for MoPH approved hospital admissions.

Output 2.3 - Public and private hospital service delivery strengthened with target of 27 public hospitals strengthened. Interventions consist in equipping hospitals (filling urgent gaps in equipment and replacing depreciated equipment), as well as providing capacity building trainings to public hospital staff. The sector will encourage a certain ratio of female staff trained.

Outcome 3 – Improved outbreak control

The sector aims to strengthen outbreak control and build the capacity of the MoPH Epidemiological Surveillance Unit. The outcome will be measured through the number of functional Early Warning and Response System (EWARS) centres.

Output 3.1 - Reinforce and expand the national Early Warning and Response System (EWARS), for which the target is 296 (50 existing and 246 new) operational surveillance sites newly established. WHO has initiated expansion of the EWARS and will continue further support in terms of training, monitoring timeliness and completeness of reporting. Furthermore, all PHCCs within the MoPH network, laboratories and hospitals, as well as MoPH-Epidemiologic Unit at central level will be targeted as part of the decentralization of EWARS. Activities include reinforcing, expanding and decentralizing the EWARS sentinel sites through staffing, logistics support, IT system development, equipment and technical support missions and conducting joint trainings for surveillance and response teams.

Output 3.2 - Ensure availability of selected contingency supplies, for which the target is a one-year stock of select contingency vaccines, emergency medications, laboratory reagents, response kits and personal protective equipment (PPE) for quick and effective response to outbreaks.

Output 3.3 - Support the implementation of vaccination campaign, for which the target is to reach areas with low coverage specifically for vaccine-preventable diseases such as polio and measles.

Outcome 4 – Improved Adolescent & Youth Health

With children (0-18 years of age) constituting 54 percent of the population of displaced Syrians and the displaced Syrian population being relatively young with a higher proportion of women in the 20-24 age bracket, the health sector aims at improving child and youth health.[xx]

Output 4.1 - School Health Programme expanded with a target to expand to an additional 200 public schools in 2017 reaching a total of 1,200 public schools adhering to at least one component of the School Health Programme. [26] The programme includes activities that contribute to a healthy environment, 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 school environmental health program.

Output 4.2- Child Survival Initiative developed and implemented with a target of developing the Child Survival Initiative in 2017. The initiative targets both displaced Syrian and Lebanese children (0-5 years of age) and is in its early stages of design. Implementation is expected for end of 2017, beginning of 2018.

Sector needs and targets

Population Cohort	Total Population in Need	Targeted Population	No. of Female	No. of Male	No. of Children (0-17)	No. of Adolescent (10-17)	No. of Youth (18-24)
Lebanese	1,500,000	750,000	372,750	377,250	234,000	122,250	
Displaced Syrians	733,795	733,795	381,573	352,222	393,314	140,155	75,581
Palestine Refugees from Syria	31,502	31,502	15,909	15,593	11,530	5,072	
Palestine Refugees in Lebanon	180,691	20,000	10,100	9,900	7,620	3,680	
GRAND TOTAL	**2,777,193**	**1,535,297**	**780,332**	**754,965**	**646,464**	**271,157**	

(26) The School Health Programme was launched in 2007 under a Memorandum of Understanding (MOU) between WHO, the Ministry of Education and Higher Education (MEHE) and MoPH.

Type of Institutions	Total	Targeted
Municipalities		0
Hospitals	27	27
Schools	1,279	1,200
Water Establishments		0
Social Development Centers	220	14
Central Ministries		1
Ministry of Public Health - Primary Health Care Centers	220	220

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 2016 VASyR indicates that 71 percent of displaced Syrians are living below the poverty line.[xxi] As such, the number of displaced Syrians in need and targeted by the sector is 733,395.[27]

Although a recent economic vulnerability study led by UNRWA points to 89 percent of Palestine Refugees from Syria living in poverty, all 31,502 Palestine Refugees from Syria are considered in need and targeted by the Health sector.[xxii]

The number of Palestine Refugees from Lebanon considered in need is based on economic vulnerability data indicating that 65 percent of PRL[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 PRL eligible for support through UNRWA.

The number of vulnerable Lebanese in need is 1,500,000. This is the GoL's 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.[29]

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. INGOs such as MSF, the ICRC and other institutions provide critical healthcare outside of the LCRP. Better coordination, consolidation under the MoPH Health Response Strategy 2020 and exchange of health information data is an urgent priority.

(27) This figure is based on the number of displaced Syrians registered with 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.

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

(29) There are other instruments which target vulnerable Lebanese which are external to the Lebanon Crisis Response Plan (LCRP). The Emergency Primary Healthcare Restauration project – towards Universal Health Coverage targets 150,000 beneficiaries of the National Poverty Targeting Program (NPTP) through the national primary healthcare centres network. The 750,000 vulnerable Lebanese covered through LCRP are targeted for general health services (vaccination, medication, malnutrition) and not specifically for subsidies.

Mainstreaming of conflict sensitivity, gender, youth, people with specific 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. To address this, efforts are geared towards strengthening the MoPH centrally and 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. To address this issue, sector efforts are oriented towards providing a number of the most vulnerable Lebanese with the same package of subsidized services provided to displaced Syrians at primary healthcare centres supported by LCRP partners.

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 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.[xxiii] The Health sector will target youth, 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 2005 and 2011 Global Health School Surveys, reported an increase in smoking, substance abuse, violence and mental health conditions among youth, including depression and suicide ideation.[xxiv]

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

In a number of primary healthcare centres, people with disabilities, similarly to other vulnerable groups such as children under 5, pregnant women and people over 60 receive financial support/subsidies to cover the cost of laboratory and diagnostics tests. Moreover, 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 diseases. The sector strategy focuses on improving outbreak control though strengthening disease surveillance systems.

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.[xxv]

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 MoPH Epidemiological and Surveillance Unit (ESU) and prioritization of response interventions.

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.

Protection: Healthcare facilities often constitute the first entry point for the identification and referral of women and girls and men and boys 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 sub-sector coordinate for capacity-building of healthcare providers on GBV referral pathways and will collaborate around the contextualization and the roll-out of the 2015 Inter-Agency Standing Committee (IASC) GBV Guidelines to implement GBV risk mitigation measures in the health sector.[xxvi] 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 MoPH as well as the Ministry of Social Affairs' (MoSA) 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 inpatient 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 at reproductive age and children under 5. Food security is also addressed in the Health sector through awareness sessions 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 foodborne 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 social stability.

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Sector Logframe

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

Indicator 1	Description	Means of Verification	Unit	Frequency
Percentage of persons of concern accessing primary healthcare services		VASyR 2017 UNHCR Health Access and Utilization Survey (HAUS) MoPH HIS data	Percentage	Yearly

Lebanese				Displaced Syrians				Palestine Refugees from Syria (PRS)				Palestine Refugees in Lebanon (PRL)			
Baseline	Target 2017	Target 2018	Target 2020	Baseline	Target 2017	Target 2018	Target 2020	Baseline	Target 2017	Target 2018	Target 2020	Baseline	Target 2017	Target 2018	Target 2020
				83% (VASyR 2016)											

Outcome 2: Improved access to hospital and advanced referral care

Indicator 1	Description	Means of Verification	Unit	Frequency
Percentage of population cohort admitted for hospitalization per year		Measurements/tools: MoPH Hospital data, UNHCR/Partners Annual Referral Care Reports, UNRWA Hospitalisation data Responsibility: MoPH, UNHCR, UNRWA	Percentage	Yearly

Lebanese				Displaced Syrians				Palestine Refugees from Syria (PRS)				Palestine Refugees in Lebanon (PRL)			
Baseline	Target 2017	Target 2018	Target 2020	Baseline	Target 2017	Target 2018	Target 2020	Baseline	Target 2017	Target 2018	Target 2020	Baseline	Target 2017	Target 2018	Target 2020
12%				6.5% (based on UNHCR coverage)				12%				12%			

Outcome 3: Improved Outbreak Control

Indicator 1	Description			
Number of functional EWARS centers	Baseline: 50 Target: 296 (i.e. 246 new + 50 existing)	**Means of Verification** Responsibility: MoPH, WHO	**Unit** Functional EWARS centers	**Frequency** Yearly

Lebanese				Displaced Syrians				Palestine Refugees from Syria (PRS)				Palestine Refugees in Lebanon (PRL)			
Baseline	Target 2017	Target 2018	Target 2020	Baseline	Target 2017	Target 2018	Target 2020	Baseline	Target 2017	Target 2018	Target 2020	Baseline	Target 2017	Target 2018	Target 2020

Outcome 4: Improved Child, Adolescent & Youth Health

Indicator 1	Description	Means of Verification	Unit	Frequency
Percentage of public schools adhering to at least one component of the School Health Program	This indicator intends to measure the reach of the School Health Program (SHP). It is measured by calculating the number of public schools adhering to the SHP over the total number of public schools Number of public schools adhering to SHP in 2016: 1,000 Target number of schools adhering to SHP in 2017: 1,200 Total number of public schools (2017 Population Package): 1,279 Baseline is 78 % and target is 94%	Responsibility: MoPH, WHO, MEHE	Percentage	Yearly

Institutions

Baseline	Target 2017	Target 2018	Target 2020
78%	94%		