Health Response Strategy

A New Approach in 2016 & Beyond

MINISTRY OF PUBLIC HEALTH

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Acronyms & Abbreviations

AUBMC	American University of Beirut Medical Centre
CLMC	Caritas Lebanon Migrant Centre
DP	Displaced Population
EPI	Expanded Program of Immunization
ESU	Epidemiological Surveillance Unit at MoPH
EWARN	Early Warning and Response Network
HC	Hosting Community
HIS	Health Information System
HRC	High Relief Council
HRS	Health Response Strategy *(this document)*
HSC	Health Steering Committee
IfS	Instrument for Stability, European Union
IHR	International Health Regulations
IMC	International Medical Corps
IOM	International Organization for Migration
LFPA	Lebanese Family Planning Association
LCRP	Lebanese Crisis Response Plan
LRC	Lebanese Red Cross
MDG	Millennium Development Goal
MdM	Médecins du Monde
MDTF	Multi-Donor Trust Fund
MEHE	Ministry of Education & Higher Education
mhGAP	Mental Health Gap Action Program
MHPSS TF	Mental Health and Psychosocial Support Task Force
MoPH	Ministry of Public Health

MoSA	Ministry of Social Affairs
MSF-CH	Médecins Sans Frontières – Suisse
NAP	National AIDS Program
NCDs	Non Communicable Diseases
NMHP	National Mental Health Program
NGO	Non-Governmental Organization
NPTP	National Poverty Targeting Program
PHC	Primary Health Care
PHCC	Primary Health Care Centre
PMT	Proxy Means Testing
RC	Red Cross or Red Crescent
RHUH	Rafic Hariri University Hospital
SIDC	Soins Infirmiers et Développement Communautaire
TBCP	Tuberculosis Control Program
UNDP	United Nations Development Program
UNFPA	United Nations Population Fund
UNHCR	United Nations High Commissioner for Refugees
Unicef	United Nations Children's Fund
WASH	Water, Sanitation & Hygiene
WHO	World Health Organization
YMCA	Young Men's Christian Association
3RP	Regional Refugee & Resilience Plan

Foreword

With the shift from a state of emergency into a state of protracted crisis in Syria, the humanitarian response in Lebanon ought to take a strategic turn. Funding spontaneous and sporadic humanitarian initiatives, though a necessity at the beginning of the crisis, is no longer an option in 2015.

We call upon the international community to reconsider its approach towards the relief of the impact of this crisis in the region. Resources are scarce and ought to be directed strategically, after careful deliberations with national authorities. Priorities ought to be set at the government level instead of being driven by calls for funding emanating solely from UN agencies and NGOs.

The Ministry of Public Health (MoPH) is the primary national authority in the health sector in Lebanon and will, as such, assume its leadership role in coordinating health response efforts and guiding them in the direction which best fits the national strategy.

This strategy, henceforth the Health Response Strategy (HRS), serves two interdependent strategic objectives:

1. To respond to the essential health needs (primary, secondary and tertiary care) of the displaced Syrians and host community; and
2. To strengthen national institutions and capacities to enhance the resilience of the health system.

We plead the international community to reorganize its aid and efforts to serve this strategy.

The Minister of Public Health

Wael Abou Faour

Health System Resilience

Four years into the Syrian crisis, the Lebanese health system is still showing considerable resilience, despite the unprecedented increase of demand and strain on the system. A resilient system is one that in time of crisis can sustain or improve access to healthcare services, prevent outbreaks, and maintain morbidity and mortality outcomes at desirable levels while ensuring long-term sustainability.[1]

Financing and delivery at the primary, secondary and tertiary levels have been maintained for Lebanese, while primary and secondary care services were expanded to cover Syrians as well. Lebanon has been able to take the necessary measures to face communicable diseases and pandemic threats, preventing major outbreaks.

In terms of health outcomes, and despite the ongoing insecurity climate and socio-political instability for decades, the Lebanese healthcare system has been able to sustain achievements like the decrease in out of pocket expenditures and the lowering of maternal and child mortality, leading to the achievement of MDGs 4 and 5.[2] Finally, the focus on non-emergency reforms in the system shows that progress in achieving strategic goals has been maintained against all odds.

Data from the Maternal Neonatal Mortality Notification System at the MOPH reveal that 31 percent of births occurring in Hospitals in Lebanon are Syrians. Despite the strain caused by high fertility rates among the Syrian population, both maternal and child mortality rates, which include mortality among Syrians, remain low. In fact, in 2013, Lebanon was reported among the only 45 countries in the world to have reached MDG 4 (reducing child mortality by a two thirds) and among the only 16 countries in the world to have reached MDG 5 (reducing maternal mortality by 75 percent).[3]

[1] "A framework for assessing health system resilience in an economic crisis: Ireland as a test case. BMC health services research", Thomas et al., 2013.
[2] "World Health Statistics," World Health Organization, 2013.
[3] "World Health Statistics," World Health Organization, 2013.

A study by the Economist (2014) ranks Lebanon in the second tier (out of six) in health outcomes, directly following Denmark and preceding the United States in its ranking. Astonishingly, the cost per health outcome point in Lebanon is $8 USD while, for slightly better outcomes, Denmark is at $73.2 USD per health outcome point and for slightly worse outcomes, the US is at $107.8 USD per outcome point. This evidence proves first, that Lebanese healthcare ranks well in terms of quality internationally, and second that Lebanese healthcare is not expensive when compared to countries with similar health outcomes.[4]

However, the health sector is not receiving the required emergency aid. As a result, the sector has a reduced capability to meet the demand of the increased population and ensure the continuity of health service provision. The World Bank has in fact estimated the health care expenditure needed to restore the system to its pre-refugee access and quality levels at USD177 million in 2013 and USD216-306 million in 2014, depending on the refugee projections.[5] Inability to secure these funds in the upcoming years would threaten the health system's ability to meet the population's needs, support the health institutions under strain, and maintain the health outcomes achieved to date in the country.

The following pages will detail an analysis of the existing needs on the population and institutional level, and present the MoPH strategy to meet these needs in the upcoming years.

[4] "Health outcomes and cost:A 166-country comparison," The Economist Intelligence Unit, 2014.
[5] "Lebanon: Economic and Social Impact Assessment of the Syrian Conflict," World Bank, 2013.

Population Health Needs

Health Profile of the Displaced Population

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

Table 1: Number of PHC Consultations for DS by condition - MoPH Data (2015)

Month	Syrian Beneficiaries	GP	Pediatric Consultation	EPI	Pregnant Women	Family Planning	Oral Health	Cardio Vascular	Lice	Scabies	Chronic	Non Chronic
January	37,087	7,912	7,739	3,949	3,347	1,435	2,546	901	1,458	1,038	6,336	20,366
February	34,598	7,371	6,793	3,409	2,971	918	2,054	1,067	1,303	934	3,201	16,904
March	36,586	7,497	8,572	5,237	2,523	1,043	2,259	911	1,087	678	4,360	17,213
April	37,457	7,458	8,051	5,434	2,580	1,551	2,384	1,033	648	727	4,628	20,032
May	35,598	7,406	7,466	4,464	2,474	1,559	3,581	732	951	718	4,445	15,421
June	36,444	7,478	6,692	4,196	2,633	1,268	2,803	882	720	582	4,901	17,129
July	30,263	6,109	5,899	3,429	2,203	1,114	2,063	670	711	449	4,467	12,989
August	35,918	7,338	6,648	3,723	2,636	1,502	2,302	768	812	375	5,295	19,015
September	32,272	6,997	5,855	3,874	2,381	1,271	1,804	661	710	301	3,934	15,206
Total	**316,223**	**65,566**	**63,715**	**37,715**	**23,748**	**11,661**	**21,796**	**7,625**	**8,400**	**5,802**	**41,567**	**154,275**

Chronic diseases are evident across the displaced population particularly type 2 diabetes, renal failure, cardiovascular disease, hypertension, chronic obstructive pulmonary disease, cancer, musculoskeletal conditions and epilepsy. The most prevalent chronic diseases are arthritis and hypertension for the Syrian displaced and hypertension for the Lebanese. Patients with chronic conditions need occasionally to be hospitalized. However, their hospital care is severely under-subsidized. This applies to many medical conditions including renal failure and cancer. Among Syrians and Palestine Refugees from Syria

[6] Johns Hopkins and others, *Syrian refugee and affected host population health access survey in Lebanon*, 2015.

around 800 cases (estimates) of cancer need to be treated every year, and around 200 patients need to receive dialysis.[7]

The displaced population also presents with several other health service needs including for communicable diseases and reproductive health. Limited funds are available for equitable provision of health services in order to meet related health needs on primary and secondary health care levels.

Strong demand for hospital care is crowding hospitals and compromising access of hosting community to healthcare. A recent Johns Hopkins study shows that unaffordability of care remains the primary barrier to access.[8] In total, 15 percent of surveyed households reported having at least one household member who required primary health assistance and could not obtain it. The main reasons cited for not being able to access PHC were cost (46 percent) and distance (13 percent). This shows that PHC remains unaffordable even though PHC fees are already very low. Subsidization seems to be insufficient, particularly for the vulnerable. Full coverage is therefore advised.

Around 31 percent of surveyed households reported that at least one household member required secondary health assistance and 8 percent could not get it. The main reason for not getting required secondary health assistance was the cost (78 percent).[9] There is therefore a need to expand coverage to hospital cases that are not considered life-saving by UNHCR, as well as a need to increase the coverage rate from 75 percent to at least 85 percent. Even with 85 percent coverage, some DS will be unable to pay the remaining 15 percent, resulting in increased budget deficits for contracted hospitals.

[7] Dialysis centers data, 2014-2015 , MOPH.
[8] Johns Hopkins and others, *Syrian refugee and affected host population health access survey in Lebanon*, 2015.
[9] VASyR 2015. (draft).

Epidemiological Profile

The disruption of immunization activities in Syria coupled with poor living conditions of the displaced in Lebanon has heightened risks of disease outbreaks, including measles, mumps and polio, and the introduction of new diseases such as cutaneous leishmaniosis with high risk of transmission to the host community. The risk for an outbreak of vaccine-preventable diseases remains high despite the aggressive vaccination campaigns and the relentless efforts to accelerate routine vaccination. Rising incidence of tuberculosis (TB), including multiresistant TB has been noted since the advent of the crisis.

Poor hygiene and sanitation conditions have led to outbreaks of waterborne diseases. Access to water for all needs was reported to be insufficient by 28 percent of households. A third of the households used traditional pit latrines and 7 percent did not have access to toilet facilities and used the open field or springs. Over 10 percent of interviewees reported sharing bathroom and/or toilet facilities with more than 15 people.[10]

The epidemiological surveillance unit at MoPH pointed to high incidence of Hepatitis A in densely populated areas, mostly in the North and the Bekaa. These cases were mostly among Syrians in areas where safe water is difficult to reach and sanitation is poor.

The outbreak of Poliomyelitis in Syria and Iraq in 2013 was particularly alarming. It was faced by a massive mobilization of all health partners and the civil society in Lebanon to undertake a nationwide door to door vaccination campaign. This successful mobilization under the leadership of the MOPH, led to a high level of immunization coverage among Lebanese and Syrian children alike and maintained Lebanon Polio free.

Public health experts also warned against the rise of risk of Cholera outbreak due to overcrowding and lack of proper hygiene and sanitation, particularly after the recent outbreak in Iraq. Population movement and insufficient humanitarian assistance can amplify the risk.

[10] "Vulnerability Assessment of Syrian Refugees in Lebanon," WFP, Unicef & UNHCR, 2013.

Box 1: Outbreak Preparedness Plan (with particular emphasis on cholera)

MoPH has elaborated an evidence-based epidemic preparedness and response plan in Lebanon, particularly in the informal settlements. The plan enables potential outbreaks to be contained quickly and holds further spread of the disease into the susceptible populations.

Specifically, the plan aims to:

- Strengthen surveillance for communicable diseases, including cholera, with universal case reporting at high risk DP camps in Lebanon;

- Standardize procedure for early detection and laboratory confirmation of an outbreak;

- Manage cases properly in the event of an outbreak; and

- Reinforce environmental control measures for outbreak response.

- Stock piling of serums and medicines.

Health Institutions

Primary Health Care Centres (PHCCs)

Lebanon counts more than 900 health centres run by MoPH, MoSA, municipalities and NGOs. MoPH has developed strict standards for eligibility for these centres to become part of the MoPH Network. Today this national network counts 220 Primary Health Care Centres (PHCCs). Each health centre has a defined catchment area with an average of 20,000 inhabitants, varying between less than 10000 in rural areas with sparse population to nearly 30000 in urban high density population areas.

All PHC centres within the MoPH network are committed to providing a comprehensive package of services including immunization, essential drugs, cardiology, paediatrics, reproductive health and oral health, and to play an important role in school health, health education, nutrition, environmental health and water control. MoPH monitors closely service delivery patterns and quality of care within the network. Immunization activities, provision of essential drugs and other services are reported regularly to the MoPH for analysis, evaluation and feedback. MoPH provides considerable support to its PHC network in the form of free vaccines and drugs to satisfy the needs of all patients visiting the PHCs, as well as free capacity building for staff and in-kind support in the form of education materials and guidelines. According to availability of funds the MOPH provides also episodically medical supplies and equipment.

The enhancement of primary healthcare network and collaboration with public hospitals through a well-defined referral system is important to the national health strategy. A Geographic Information System (GIS) maps villages that are at more than 15 minute drive from the nearest primary healthcare centre, in order to include new centres to progressively cover all the Lebanese territory. Following this method, the network is expected to expand from 220 to 250 PHCCs in 2016. Efforts have been made by all partners to integrate the displaced populations into the existing primary health care system. Where

partners have made a case for an unmet need for PHC within the network, centres which can cover this need have been prioritized to be added to the network.

PHC centres are requested not to differentiate between Lebanese and non-Lebanese patients regarding the provision of services and the collection of nominal fees. However, equity concerns remain where certain partners, mainly UNHCR, subsidize PHC for Syrians but not for Lebanese. Services subsidized for the displaced include medical consultations, laboratory tests, immunizations, antenatal care and other reproductive health services and management of chronic diseases.[11]

Table 2: Fees for service in UNHCR Subsidized PHC Services

Service	**Fees for service at a UNHCR partner institution**
Vaccines	Free at all PHC centres and dispensaries
Consultation	3,000 – 5,000 LBP
Acute medications	Free
Chronic medications (diabetes, cardiac conditions, hypertension, asthma, epilepsy, etc.)	1,000 LBP per visit (handling fee)
Family planning (Insertion of IUD, pills, condoms)	Free
2 ultrasounds for pregnant women	Free
Dental care	Subsidized
Laboratory and diagnostic tests	15 percent of the cost for • children under 5 years • Persons over 60 • Persons with disabilities • Pregnant women 10 percent of the cost for those refugees with specific needs who cannot afford it. Other refugees will pay 100 percent of the cost of Laboratory and diagnostic tests.

[11] "Health Services for Syrian Refugees in Mount Lebanon and Beirut: what to do if you need to see a doctor or go to a hospital and what you need to pay," UNHCR, March 2015

To date, PHC has received the most attention from international donors and PHCCs have been able to cope with the crisis considerably well as a result.

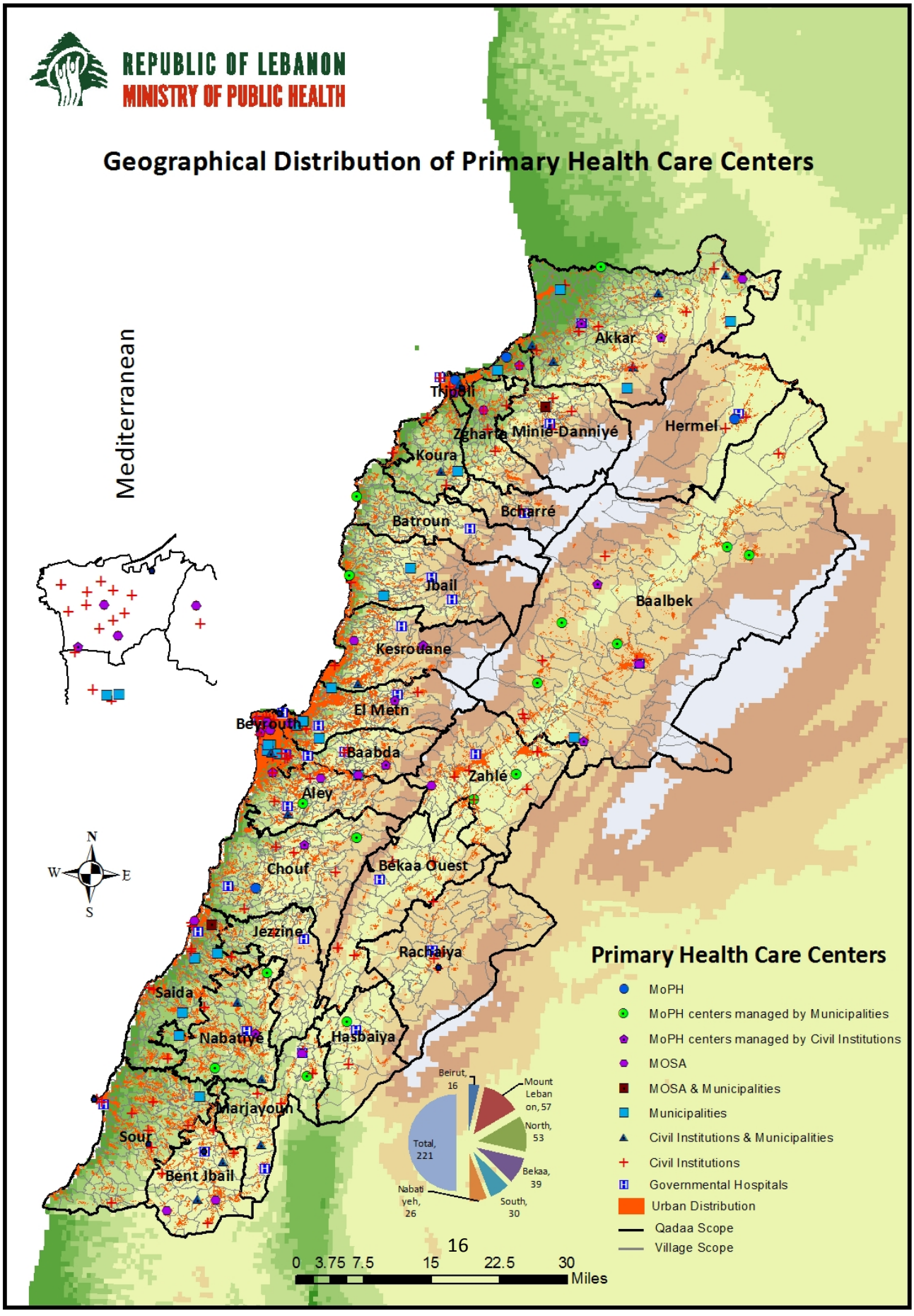
Through a grant from the Multi Donor Trust Fund (MDTF) managed by the World Bank, and the support of the faculty of health sciences at the American University of Beirut, MoPH developed an emergency program aimed at expanding the PHC package while targeting to the poor and near poor population in Lebanon. The project will deliver a package of free primary healthcare services (Essential Benefits Package)[12] to the poor Lebanese, identified by the National Poverty Targeting Program (NPTP).

Another crucial project has been the EU Instrument for Stability project. The IfS equipped the MoPH network with additional vaccine and drug stocks, medical equipment, and lab equipment for water analysis in eight hospitals, and other. This support has considerably increased the capacity of PHCCs to cope with the increased caseload.

In Focus:
Inter-Ministerial Initiative for Integrated Health and Social Plans (IHSP)

On the 15th of September 2014, UNDP, MoPH, MoSA, MEHE and the MoIM signed the agreement titled "Support to Integrated Service Provision at the local Level". The aim of the initiative is to develop Integrated Health and Social Plans (IHSP) and therefore to set up mechanisms for integrated services at local level that are endorsed by the line ministries. The IHSPs are the result of planning with a participatory approach that involves primary health care centers (PHCCs), social development centers (SDCs) and public schools under the umbrella of the municipality at the local level. The communities will benefit from the package of the primary health care services extended and integrated with social primary services.

[12] Developed with the family medicine department at AUBMC.


REPUBLIC OF LEBANON
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Geographical Distribution of Primary Health Care Centers
Mediterranean
Akkar
Tripoli
Zgharta
Minie-Danniyé
Hermel
Koura
Bcharré
Batroun
Jbail
Baalbek
Kesrouane
El Metn
Beyrouth
Baabda
Zahlé
Aley
Chouf
Bekaa Ouest
Jezzine
Rachaiya
Saida
Nabatiye
Hasbaiya
Marjayoun
Sour
Bent Jbail
N
W
E
S
Beirut, 16
Mount Lebanon, 57
North, 53
Bekaa, 39
South, 30
Nabatiyeh, 26
Total, 221
Primary Health Care Centers
MoPH
MoPH centers managed by Municipalities
MoPH centers managed by Civil Institutions
MOSA
MOSA & Municipalities
Municipalities
Civil Institutions & Municipalities
Civil Institutions
Governmental Hospitals
Urban Distribution
Qadaa Scope
Village Scope
16
0 3.75 7.5 15 22.5 30
Miles

Hospitals

Four years into the crisis, hospitals in Lebanon find themselves financially vulnerable, with deficits incurred from unpaid hospital bills as well as unmet MoPH commitments to cover certain admissions, particularly those related to exceptional admission authorizations for non-Lebanese patients (see Tables 3 & 4). These deficits cause medication shortages and delays in salaries payment to hospital staff.

The Rafic Hariri University Hospital (RHUH) has accumulated the highest deficit due to the Syrian crisis since 2011. The deficit amounts to 6,784,069,429 (LBP), as detailed in Annex 1.

Table 3: Deficits Incurred by Public Hospitals as a Result of the Syrian Crisis (excluding RHUH)

Years	Public Hospitals Deficit in LBP (excluding RHUH)
2011	248,713,510
2012	299,716,183
2013	982,746,205
2014	1,147,461,199
2015	611,338,235
Total	**3,289,975,332**

Table 4: MoPH authorisations for full coverage of non-Lebanese patients and the corresponding financial commitments made to hospitals

Year	Number of Non-Lebanese Patients	Total Cost (USD)
2011	6	2,742
2012	801	2,226,805
2013	1,125	3,892,868
2014	962	3,915,782
2015 (1/1-30/6)	524	2,744,412
Total	3,418	12,782,609
	Cost/Patient	**3,740**

Table 5: NCDs drugs procured and dispensed by MoPH for non-Lebanese patients

Year	Syrians	Palestinians	Other	Total Non-Lebanese	Cost (USD)
2011	8	14	7	29	232,000
2012	38	30	28	96	768,000
2013	88	59	47	194	1,552,000
2014	82	66	37	185	1,480,000
2015	59	48	20	127	1,016,000
Total	275	217	139	631	5,048,000
				Cost/Patient	**8,000**

Secondary and tertiary care for displaced Syrians has been mainly financed by UNHCR, with some sporadic contributions by NGOs. UNHCR pays up to 75 percent of the total cost of life-saving emergencies, delivery and care for newborn babies, while few NGOs reimburse the remaining 25 percent of the bill, for a very limited number of patients. In only about 8 percent of cases, UNHCR increases the coverage to 90 or 100 percent based on an assessment of socioeconomic vulnerability. Only 30 percent of all UNHCR patients are 100 percent covered through UNHCR top up and/or contribution of other NGOS. UNHCR has repeatedly stated in its reports that "Even for prioritized life-saving interventions financial resources are severely stretched. Lifesaving interventions in the area of maternal and infant health (surgical deliveries by caesarean section and care of premature infants) are extremely costly."[13] Indeed, the figures illustrate that the needs are much higher than what is currently covered.

Hospitals are overburdened with Syrian patients who are unable to pay the reduced fees required from them (25 percent of their hospital bill) as well as patients whose hospitalization is not subsidized at all. Some hospitals have adopted constraining and sometimes unethical practices to recover as much of the 25 percent as possible (deposits, retaining IDs/corpses, inflating bills). Referral of uncovered Syrian patients with

[13] "Health Update," UNHCR, December 2014

complicated morbidities to public hospitals has also become a common practice by private hospitals.

In 2014, GlobeMed, the third party administrator (TPA) until 2014, accepted 61,982 claims from the displaced to access hospitals, with a claimed amount of $31.5 million USD and a total paid amount (after audit) of some $28.5 million USD (i.e. deductions reached approximately 9 percent). In the same year, GlobeMed rejected around 6,500 claims, amounting to an estimated $5 million USD. Out of the 6,500 rejected, around 2,300 were rejected because cases were not compatible with UNHCR's SOPs (e.g. non-life threatening), 700 because of missing documents (e.g. no registration documents, no medical report, etc.) and 400 were referred back to Primary Care. The share of the patient shown in GlobeMed's records (what theoretically is the 25 percent co-payment) is estimated to around $8.5 million USD. [14]

UNHCR has partially funded 55,566 cases referred to hospital care in six months (January to December 2014).[15] Given that the number of registered refugees is currently 1,178,038, this puts the UNHCR hospital referral rate at approximately 5 percent of the displaced, which is very low as a result of stringent exclusion criteria which in turn are the result of severe underfunding. Indeed, this figure is below the 12 percent hospitalization rate among the Lebanese entitled to MoPH coverage (240,000 admissions per year out of 2 million Lebanese entitled to MoPH coverage) and far below the rate among the Lebanese formally covered by other funds, which reaches 18 percent for some of the covering agencies.

[14] Data collected from GlobeMed.
[15] "Referral at a glance, Preliminary report January to December 2014," UNHCR.

Strengthening of the EWARN System

Under the EU Instrument for Stability (IfS) project, known as "Conflict Reduction through improving Healthcare Services for the Vulnerable Population in Lebanon," the MoPH gave particular care to strengthening of its Early Warning (EWARN) system.

- Standard operating procedures were updated for the surveillance and response of 43 selected diseases and hazards (AFP and polio, Anthrax, Bilharzia, Brucellosis, Cholera, Creutzfeldt-Jacob Disease, Diphtheria, Food Poisoning, Gonorrhoea, Hemorrhagic Fever, Hepatitis A, B, C, D, E, HTLV1, Hydatid Cyst, Influenza new virus subtypes, Intestinal Infections, Invasive Coronavirus infection, Invasive meningococcal disease, Legionellosis, Leishmaniosis, Leprosy, Malaria, Measles, Mumps, Pertussis, Plague, Rabies, Rubella, Smallpox, Syphilis, Tetanus and neonatal tetanus, Typhoid Fever, in addition to tuberculosis and HIV infection).
- 9 newly developed surveillance guidelines will be distributed to hospitals, medical centers, private clinics, laboratories, schools and epidemiology surveillance and response teams; 17 official surveillance reporting and investigation forms were also updated and will be disseminated to hospitals, medical centers, private clinics, laboratories, schools and epidemiology surveillance teams.
- 133 personnel from the Ministry of Public Health response team and epidemiology surveillance team, Caza Doctors, head of health departments at Mohafaza level, airport health team and Rafic Hariri University Hospital teams were trained on Standard Operating Surveillance and Response procedures for the priority notifiable diseases.
- 1,624 health educators from private (477) and public (1,147) schools were trained on school-based surveillance and response system. 8 water laboratories were established across the Lebanese governorates in the following public hospitals: Rafic Hariri University Hospital, Dahr El Bachek, Tripoli, Halba, Zahle, Baalbek, Saida and Marjeoun through the rehabilitation of the water lab and provision of equipment and reagents to monitor water quality and alert for any potential infectious disease outbreaks.
- 16 recruited laboratory staff trained on standard operating procedures, modalities of testing and quality control to ensure regular drinking water monitoring; around 80 municipalities were trained on water sampling techniques.
- 8 negative pressure rooms for outbreak containment were established; 4 rooms in Rafic Hariri University hospital and 1 negative pressure room in each of Baabda, Baalbek, Tripoli and Bent Jbeil Governmental Hospitals.

Health Response (2011-2015)

Evolution of the Health Response Efforts from 2011 to 2015

For the years 2011-2015, the response plans for the Syrian crisis in Lebanon were prepared by the humanitarian community operating in the country, with limited consultations with the concerned ministries. The plans targeted the most urgent needs observed in the field and focused mostly on essential and life-saving health needs of the displaced population.

In 2013, in addition to providing primary health care and limited secondary care to the displaced, some minimal support was provided for the health system, including reinforcing outbreak control, and provision of selected medical equipment and medication. Starting 2014, appeals included more emphasis on supporting part of the host community health needs in the areas most affected by the Syrian crisis.[16]

The numbers previously appealed for in the LCRP were a simple aggregation of individual appeals made by each health partner. The budget was solely driven by fragmented project proposals presented to donors by UN organizations and NGOs. The direct relationship between donors and implementing organizations therefore bypasses the Ministry of Public Health, with the exception of a few cases where an organization or donor, such as the EU, decides to consult the ministry prior to making any plan for available funding. As a result of this existing funding mechanism, the national health priorities are in some cases severely underfunded, or even completely overlooked.

As a result of this process, the LCRP appeal for 2015 did not reflect national priorities; rather, it reflected the capabilities (and shortcomings) of implementing partners in health. For example, the appeal for Primary Health Care, in which most implementing partners are interested and are able to deliver, was $161.8 million. For Secondary and Tertiary Care,

[16]Regional Refugee Response Plan 6 (RRP6), 2014.

where only UNHCR currently has the capacity to deliver, the appeal amounted to $79 million.

In view of the protraction of the crisis, the GoL, with the support of the UN, has started a two-track planning and appeal process. The first track is for 2016 and will serve as a transition into the second longer term track from 2017 to 2020. Both tracks will join the humanitarian and the stabilization components into one integrated plan.

Governance of the Health Response

The Lebanon Crisis Response Plan (LCRP 2015-2016) outlines a shift in the humanitarian approach characterized by the government playing a leadership role while seeking a participatory approach in decision making. This shift requires full engagement from the concerned ministries to steer the humanitarian response in the direction of national priorities.

Local institutions (public, private and NGOs) should be relied on in implementation while, at the same time, they should be supported, monitored and held accountable. With rare exceptions, these national institutions have existed before the Syrian crisis, got an important experience dealing with turmoils and different kind of conflicts, and most importantly have long term objectives and are expected to sustain their activities in the future.

In March 2015, the minister of public health issued decision 1/421 which stipulates the creation of a national Health Steering Committee (HSC) headed by MoPH. The HSC's responsibility is to set the strategic directions for the health sector, prioritize health interventions and steer the allocation of resources within the health sector. The committee reports to the Minister of Public Health and the National LCRP Steering Committee.

The HSC does not replace the already existing Health Working Group which is attended by some representatives from MoPH and a very big number of actors. The Health Working

Group would carry on as it is, with less emphasis on strategy and more emphasis on implementation and monitoring.

Members of the Health Steering Committee have agreed, during their first meeting on 19 March 2015, on the following principles:

A. Better Governance
    a. Enhance the leadership of the MoPH and adopt a participatory approach with all concerned stakeholders;
    b. Realign humanitarian health response with national priorities agreed upon in the Health Steering Committee;
    c. Disclose all sources of funding and budgets of implementing partners;
    d. Create accountability mechanisms to make all the interveners adhere to the priorities set by the steering committee;

B. Cost-effectiveness
    a. Rationalize allocation of resources by setting priorities based on one side the health needs of the displaced Syrians and host communities and on the other hand, the institutional needs to enhance the resilience of the health system;
    b. Build on the existing health system and avoid duplications and parallel systems;
    c. Disburse money directly to providers of essential primary healthcare and hospital services and reduce intermediaries as much as possible and link disbursement to outputs;
    d. Avoid earmarking of funds allocated to healthcare to allow redistribution according to priorities set by the steering committee;
    e. Increase the technical efficiency at all service delivery levels;
    f. Reduce overheads;

C. Decentralization
    a. Upgrade the role of MoPH devolved departments to be able to coordinate activities at the region and district levels;

b. Enhance the role of municipalities in planning and implementation and empower them to address social determinants of health, particularly nutrition, shelter, livelihood, and water, sanitation and hygiene;

D. Sustainability
   a. Strengthen institutional capacity of national health facilities and establishments to ensure the sustainability of all interventions;
   b. Give priority to public hospitals and NGOs that have primary healthcare centres within the MoPH network, as well as public health programs and MoPH departments particularly those concerned by epidemiological surveillance and emergency response.

Health Sector Appeal for 2016

Strategic Objectives

1. To increase access to health care services to reach as many displaced persons and hosting communities as possible, prioritizing the most vulnerable.
2. To strengthen healthcare institutions and enable them to withstand the pressure caused by the increased demand on services and the scarcity of resources.
3. To prevent and contain outbreaks.

MoPH Guidelines

Based on the principles agreed upon by the Health Steering Committee, the MoPH developed the following guidelines:

1. MoPH stands against the creation of costly parallel health care structures. The displaced population will continue to benefit from the same entry points into health care as the Lebanese population.

2. MoPH welcomes the current multiplicity of actors in the health sector but encourages partners to reduce intermediaries as much as possible, i.e. donors are encouraged to finance the health institutions providing health services as directly as possible, with as few partners in between as possible. This is to maximize the use of resources for service delivery and avoid administrative wastage. This would also enhance visibility, transparency and accountability.

3. MoPH strongly advises against conducting any survey, study, assessment in the health sector unless thoroughly discussed and demonstrated value added with the MOPH. Resources have been wasted in the past on such activities while more urgent services, like providing essential inexpensive and effective medications, have remained unfunded or underfunded. All donors are therefore advised to orient their financing to the real needs rather than the competency of the implementing agency.

4. MoPH strongly advises against guideline development, training or workshop; the MOPH has already developed and updated most guidelines, and conducted massive training over the past three years in partnership with the WHO. Any training at PHC, Hospital or as preparedness for health response should be organized in close consultation with the relevant MOPH team.

5. MoPH encourages all partners working on Primary Health Care (PHC) to work with PHC centres that are within the MoPH network (which includes centres that belong to NGOs, MoSA, municipalities and the Lebanese Red Cross), for two reasons. Firstly, these are the centres that meet the minimum standards of care. Secondly, the ministry has a strong monitoring system in place at these centres and can closely track drug utilization as well as capacity building needs. If there is a geographical gap in any area, MoPH is ready to choose a dispensary in that area and assist in rehabilitating it to meet the

criteria to integrate it into the MoPH network. MoPH does not recommend partnering with centres that are outside its network as it cannot guarantee the results of interventions there.

6. MoPH, in collaboration with the WHO, will be the only actor planning, coordinating and implementing epidemiological surveillance and response, as the prevention and control of outbreaks are of national public health concern and a governmental responsibility.

7. The deficits borne by hospitals, notably public ones, as a result of the insufficient funding of the Syrian patients, are too great for any institution to compensate for. Death of a Syrian child because of lack of coverage of cancer patients should not be tolerated. Donors are therefore encouraged to address the inadequate financing of secondary and tertiary health care as this saves lives while supporting the sustainability of health institutions in Lebanon.

Overview of the Appeal for 2016

The Health Steering Committee has been the deciding body during the LCRP planning process. Though chaired by MoPH, decisions have been made based on consensus between all HSC members. Budget estimates are based on data provided to the HSC by MoPH, UNHCR, WHO, UNICEF, UNFPA, as well as representatives of local and international NGOs. The Health Steering Committee has adopted these figures after careful consideration and deliberation with partners.

Outcomes	LCRP 2016 Appeal
1. Improved Access to PHC Services	126,458,321
2. Improved Access to Hospital & Specialized Referral Care	134,259,003
3. Improved Outbreak Control	763,200
4. Key Institutions Strengthened	23,330,610
5. Transparency & Accountability of Health Partners Ensured	20,000
Total	**285,831,134**

Primary Health Care Budget

Following the needs-based approach required in the LCRP, the budget needed for PHC for one year amounts to $126,458,321 (USD), as broken down in the table below. The sums detailed here have been agreed upon by the Health Steering Committee.

Table 6: 2016 LCRP appeal for PHC

Outputs under Primary Health Care	Targets	2016 Appeal (USD)
1. PHC services received by population in need*	3,202,000 individuals	$64,080,000
2. Sufficient chronic diseases medication available**	130,100 individuals	$6,505,000
3. Sufficient acute diseases medication available	1,060,000 individuals	$35,000,000
4. Accelerated routine vaccination	537,982 individuals	$19,513,321
5. Implementation of National Mental Health Strategy	75 PHCCs	$860,000
6. Expansion of the PHC-MoPH network	250 PHCCs	$500,000
Total		**$126,458,321**

*For output 1, the calculation is based on the estimate that each PHC consultation costs $20 (USD), including total operational cost.

**The calculation for output 2 is based on the estimate that chronic medication would cost $50 (USD) per person per year.

Mental Health

In May 2014, the MOPH started the National Mental Health Program with the support of WHO, UNICEF, and International Medical Corps (IMC), with the aim of reforming mental health care in Lebanon and providing services beyond medical treatment at the community level, in line with Human Rights and the latest evidence for best practices.

One year after its setting up, the NMHP is launching a Mental Health and Substance Use Prevention, Promotion, and Treatment Strategy for Lebanon for the period of 2015-2020. The strategy details the following domains of intervention:

1. Leadership & Governance: revising and developing needed mental health laws, revising the mental health budget and establishing a mental health department within the ministry.

2. Reorientation of Services: the main objective is gearing the services towards community mental health through the integration of mental health into primary care and building up a community-based secondary level of specialized services and improving inpatient care.

3. Prevention & Promotion: in this domain attention is geared towards school mental health, maternal mental health, substance use prevention and building a monitoring and prevention framework for suicide prevention.

4. Health Information System & Research: routinely collecting relevant data to monitor the implementation of the strategy and the services provided and conducting researching aiming at service development

5. Vulnerable Groups: including all groups which might be at a higher risk for mental disorder such as survivors of SGBV, survivors of torture, persons in prisons, refugees and displaced, LGBT community.

The implementation of this strategy requires a yearly budget of $0.86M USD, as detailed below.

Table 7: Breakdown of Minimum Budget Required for Mental Health

Components	Yearly Cost (USD)
Integration of mhGAP in 100 PHC centres (training, support and supervision)	280,000
Promotion and prevention	50,000
Universities Curriculum adaptation to mhGAP with training of 40 academicians (social worker, nurse, medical school, psychologist, public health)	35,000
Establishment of a national mental health information system (PHC centres, psychiatric wards, psychiatrists)	100,000
Establishment of a referral system	50,000
Setting/updating the accreditation criteria (outpatient, inpatient, substance use)	7,500
Assessment (MedSPAD, M&E, MH baseline in prison)	37,500
MH Coordination team	250,000
Subtotal	810,000
Overhead (7 percent)	56,700
Total	866,700

Secondary & Tertiary Health Care Budget

Hospitalization cases currently covered by UNHCR follow very restrictive criteria as a result of insufficient funding. This situation could not be sustained because a surgery that could have been deferred one or two years ago, would emerge one day as a life threatening condition. Furthermore, the international community could not tolerate children deaths that could be prevented simply because they do not fit certain criteria.

Notwithstanding financial constraints, we propose three scenarios for funding, one which is based on actual needs of the population and the hospitals at a coverage rate of 100 percent, one which ensures equity between the displaced population and the hosting community by following the MoPH rate of 85 percent, and the third assumes a worst-case scenario by continuing to follow the UNHCR coverage rates of 75 percent. All three scenarios aim to **cover all hospitalization cases** rather than a select few based on current UNHCR criteria.

Following an admission rate of 12%, the population in need of hospitalization is estimated at 128,500 individuals: 120,000 Syrians, 5,000 PRS and 3,500 PRL. The cost per admission is estimated at $977 USD.

Table 8: Hospitalisation Budget per Scenario

Scenarios	Corresponding Budget
Scenario 1: 100% coverage rate	$125,544,500
Scenario 2: 85% coverage rate	$106,712,825
Scenario 3: 75% coverage rate	$94,158,375

Rationale for Scenario 1: Needs-Based Coverage (100% coverage rate)

Cost of care remains the primary obstacle to access to hospital and specialised referral care. The inability of the displaced Syrians to cover their hospital bills has severe consequences on their health but also on the financial viability of the hospital which receives them. Allowing hospitals to fail because of their widening deficits is not an option. It is therefore strongly advised that hospital bills for the displaced are covered at 100%.

Rationale for Scenario 2: Equity-Driven Coverage (85% coverage rate)

MoPH covers 85 percent of the hospital bills for the uninsured Lebanese population. We believe that this coverage rate needs to be matched by the international community for the displaced population, out of concern for equity between the displaced and the hosting community.

Rationale for Scenario 3: Worst-Case Coverage (75% coverage rate)

This strategy outlines the national priorities for the entire health sector. If donors and partners comply with it, resources can be freed up from currently overfunded health activities, which do not constitute a priority, to the currently underfunded hospitalisation and specialised referral care. From this standpoint, we expect hospitalisation to receive greater attention by the international community and a corresponding increase in funding. However, in the event of unfortunate and recurrent underfunding for hospital and specialised referral care, we would maintain the current 75 percent coverage rate used by UNHCR. However, even then, we would reaffirm that this coverage includes all hospitalisation cases and not just so-called life-saving conditions.

Early Warning & Response (EWARS) Budget

Created by MoPH in 1995, the Epidemiological Surveillance Unit is responsible for the surveillance of communicable diseases and national cancer registry. Among the priority ESU diseases: Acute Flaccid Paralysis surveillance in the framework of polio eradication, rash and fever surveillance for measles elimination, food poisoning, meningitis, rabies, typhoid fever, viral hepatitis, dysentery and brucellosis, in addition to diseases constituting a pandemic threat. Diseases of international concern such as Ebola, Mers corona are given the highest priority. The ESU is notified by the medical professionals and health institutions for communicable diseases, it screens epidemiological alerts, conducts field investigations and analytic epidemiological studies, provides feedback to health professionals, and trains them on surveillance tools.

The drastic increase in population in addition to the crowding, the absence of clean water and the bad sanitation, increases the risk of outbreaks and reaffirms the need for a strong Early Warning & Response System.

Table 9: 2016 Appeal for Outbreak Control

ITEM	Cost	Number	Budget (USD)
Social media screening	1,100	1	26,400
Guidelines	4,000	4	16,000
Training sessions for MOPH teams on alert and SOP - 1 day *2	1,000	12	12,000
Advanced training sessions for MOPH teams with national experts	5,000	6	30,000
Human resources for the MOPH district level - 7 new cazas	1,000	7	168,000
Human resources for the MOPH district level - 3 old cazas	1,000	3	72,000
Human resources for the MOPH district level - 1 coordinator	1,200	1	28,800
Transportation logistics for district level	15,000	26	390,000
Training sessions on EMS platform for MOPH staff	2,000	3	6,000
Training sessions on EMS platform for governmental agencies	2,000	2	4,000
International expert on EMS platform	5,000	2	10,000
		TOTAL	**763,200**

Fundraising, Implementation & Accountability Mechanisms

The success of this strategy necessitates the compliance of all partners in the health sector, including donors, international organizations, NGOs, national institutions and the private sector. However, even with every partner's will to comply, ensuring that essential services are covered without duplication or gaps would remain a big challenge. This is why a new mechanism needs to be implemented which would centralize the information on the planned health-related activities for the coming years.

The existing coordination mechanisms are not sufficient to guarantee that the necessary amount of resources is directed to the priorities outlined in this document. With each agency following its own funding mechanism without any legal obligation to disclose its planned activities publicly, they might keep engaging in the same activities they are currently engaged in. Duplication could easily occur and important gaps would remain.

MoPH is currently seeking four commitments from donors and partners:

1. To ensure **alignment** of health-related projects with national strategies and directives which may be issued by the Health Steering Committee;
2. To ensure **predictability** of funding: donors are requested to report ahead of time on available earmarked funding as well as un-earmarked funding;
3. To ensure **flexibility** in the allocation of un-earmarked funds by empowering the Health Steering Committee to make collective decisions on the orientation of funding towards underfunded components;
4. To ensure **transparency** of donors and partners by setting up a mechanism to track funds from the moment they are pledged to the moment they are disbursed.

The Current Mechanism

1. IOs& NGOs apply for project funding
2. Donors approve certain projects for funding
3. Approved projects are implemented
4. Monitoring & Evaluation fragmented

No systematic input from MoPH

No proper accountability

The New Mechanism for 2016

1. **Donors express their interest** to fund – fully or partially - certain outputs
2. The Health Steering Committee provides its feedback to donors by highlighting risks of underfunding for certain outputs and overfunding for others

Participatory

3. Donors inform the Steering Committee about its decision and modalities of implementation
4. The implementing party publishes its progress reports and discloses its financial statements

Transparent

5. Inclusive monitoring and evaluation through the Health Sector Results Framework agreed upon under LCRP 2016 as well as a thorough evaluation against the strategic and operational objectives outlined below.

Accountable

Participatory Evaluation against Operational Objectives

The performance of the health response team, which includes all donors, implementing partners and concerned national institutions, will be assessed by the Health Steering Committee, at the end of 2016, based on the following operational objectives.

1. The needed financial resources for the entire health response are secured. Budget allocations are made in accordance with the priorities set in this strategy, and through appropriate channels of disbursement.

2. Transparency and accountability are observed by all partners. Revenues and expenditures are disclosed to the Health Steering Committee.

3. Access to quality essential health services is ensured, in an equitable manner, to the displaced population and hosting community.

4. Institutional resilience is enhanced through the strengthening of key institutions.

5. Achievements of the health system in terms of health outcomes are sustained: outbreaks are prevented/contained; child mortality, including Syrian children, is further reduced; achievement in terms of maternal mortality is sustained.