الجمهُوريـّة اللبنـانـيـّة
وزارَة الصـحـّة العـَامّـة

# Health Response Strategy

## Maintaining Health Security, Preserving Population Health & Saving Children and Women Lives

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A New Approach 2016 & Beyond

**Lebanon, MINISTRY OF PUBLIC HEALTH**

**Edited: October 2016**

# Acknowledgements

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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 five years after the start of the crisis.

We call upon the international community to reconsider its approach towards the relief of the impact of this crisis in Lebanon. Resources are scarce and ought to be directed strategically, after careful deliberations with national authorities. Priorities ought to be set at the government level and calls for funding should be emanating in consultation with 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 this national crisis response 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

# General context

Currently 25% of the population in Lebanon is refugee/displaced, the highest worldwide compared to its population size. 85% of registered refugees live in 182 localities in which 67% of the host population is living below the poverty line This sudden and dramatic increase in population has exerted a lot of pressure on the country's infrastructure and institutions with serious repercussions on the country's economic stability.

Lebanon health system has shown considerable resilience since the start of the Syrian crisis, and has been to date able to provide health services to an additional 1.5 Syrian displaced. Despite the tremendous strain on the health system, both in case load and financially, the MOPH succeeded in maintaining the gains of the MDGs, keeping Maternal mortality and infant mortality and morbidity relatively low.

In addition, despite the health risks, Lebanon has been spared from the reintroduction of polio, has not experienced other main communicable diseases outbreaks, and vaccination was accelerated and intensified. However, and despite reaching high overall vaccination coverage, outbreaks of measles and mumps and waterborne diarrheas are still observed , mainly in areas with highest concentration of refugees.

In terms of health services access and quality of care, Lebanon health system has been able to adapt to the sudden and sustained increase in demand ; however, certain services are overstretched such as obstetrics and neonatal wards, and some PHC services (NCD, routine vaccination…); in addition the increased financial pressure on the health system especially on the public hospitals , constitutes a significant burden that could jeopardize sustainability of the public hospitals that are most affected financially.

Lebanon government took the decision in 2015 to limit the number of new refugees into the country. This has relatively stabilized the size of the displaced population to around 1.5 million, of which around 1 million are registered with UNHCR and benefit from direct assistance. Around 53% of displaced population are children less than 15 years of age; and 51% of the population are women, around half of them are women of childbearing age.

It is estimated that the displaced population will remain stable at this level for the coming 4 years; However, the health sector is now threatened with under-funding and a resulting reduced capacity to meet the demand of the increased population and ensure the continuity of health service provision ;the health response at national level should be tailored accordingly.

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.

## *Health System Resilience & Achievements*

*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.*

*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 MDG4 (reducing child mortality by a two thirds) and among the only 16 countries in the world to have reached MDG5 (reducing maternal mortality by 75 percent).[2]*

*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.[3]*

*"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 "Health outcomes and cost: A 166-country comparison," The Economist Intelligence Unit, 2014.*

# Population Health Needs

## Health Profile of the Displaced Population

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

**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** |

According to the most recent assessments (VASyr 2015 and Johns Hopkins 2015):

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

- 47.2 of the displaced population needed PHC services over the last 6 month.
- 83% of displaced who needed PHC services were able to receive them.
- Infection and communicable diseases were the most common reason for needing care.
- Around 12% (13,000 beneficiaries) of all patients receiving Chronic essential medications supported by the MoPH through the YMCA are Syrian displaced; it is estimated that an additional 10,000 to 15,000 refugees are receiving chronic medication outside the YMCA operated chronic medications program.
- The presence of hypertension, cardiovascular disease, diabetes, chronic respiratory disease, or arthritis in one or more household members was reported by 50% of Syrian refugee household.
- 20% of refugee households reported one or more hospitalizations of a household member in Lebanon for reasons other than childbirth, the most common being injury, digestive problems and acute illness/infection.
- pregnancy related hospitalizations account for around 56.9% of all hospitalizations among refugees in 2015, constituting around 40% of total hospital bill for refugees.
- 23% of all hospitalizations among refugees were children less than 5 years of age.
- 61% of all deaths occurring in hospitals among refugees registered with UNHCR were in children under one mainly in the perinatal period of which 26% were attributed to prematurity.

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 around 800 cases (estimates) of cancer need to be treated every year, and around 200 patients need to receive dialysis.[2]

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.

This 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.[3] In total, 15% 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%) and distance (13%). This shows that PHC remains unaffordable even though PHC fees are already very low.

[2] Dialysis centers data, 2014-2015 , MOPH.
[3] Johns Hopkins and others, *Syrian refugee and affected host population health access survey in Lebanon*, 2015.

Subsidization seems to be insufficient, particularly for the vulnerable. Full coverage is therefore advised.

Around 31% of surveyed households reported that at least one household member required secondary health assistance and 8% could not get it. The main reason for not getting required secondary health assistance was the cost (78%).[4] 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% to at least 85%. Even with 85% coverage, some DS will be unable to pay the remaining 15%, resulting in increased budget deficits for contracted hospitals.

[4] 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. Risks for Sexually transmitted infections (STIs) including HIV are on the rise as well.

Other sectors like Water, Sanitation and Hygiene (WASH), Shelter and Food Security have a high impact on the health of the population and their need to use a health service. In fact, poor hygiene and sanitation conditions have led to outbreaks of waterborne diseases such as Hepatitis A and other diarrheal diseases. Recent evidence points towards poor access to safe drinking water (JMP 2016) ; moreover, in 2016 nearly 41% of households lived in substandard shelters, with very poor sanitation,; although Malnutrition rate remains stable, around 2% of the refugee population less than 5 years of age, around 35% of households among the displaced were found to be moderate to severe food insecure (VASyr, 2016).

Misallocation and inefficient use of resources within each of these sectors therefore constitutes another concern for MoPH.

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 are warning against the risk of reintroduction of polio, especially with the new outbreak in Nigeria and the large mobile diaspora of Lebanese there.

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 outbreaks in Iraq and Yemen. Population movement and insufficient humanitarian assistance can amplify the risk.

**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 educational 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.[5]

[5] "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

**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% of the cost for<br>• children under 5 years<br>• Persons over 60<br>• Persons with disabilities<br>• Pregnant women<br>10% of the cost for those refugees with specific needs who cannot afford it.<br>Other refugees will pay 100% of the cost of Laboratory and diagnostic tests. |

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)[6] to the poor Lebanese, identified by the National Poverty Targeting Program (NPTP).

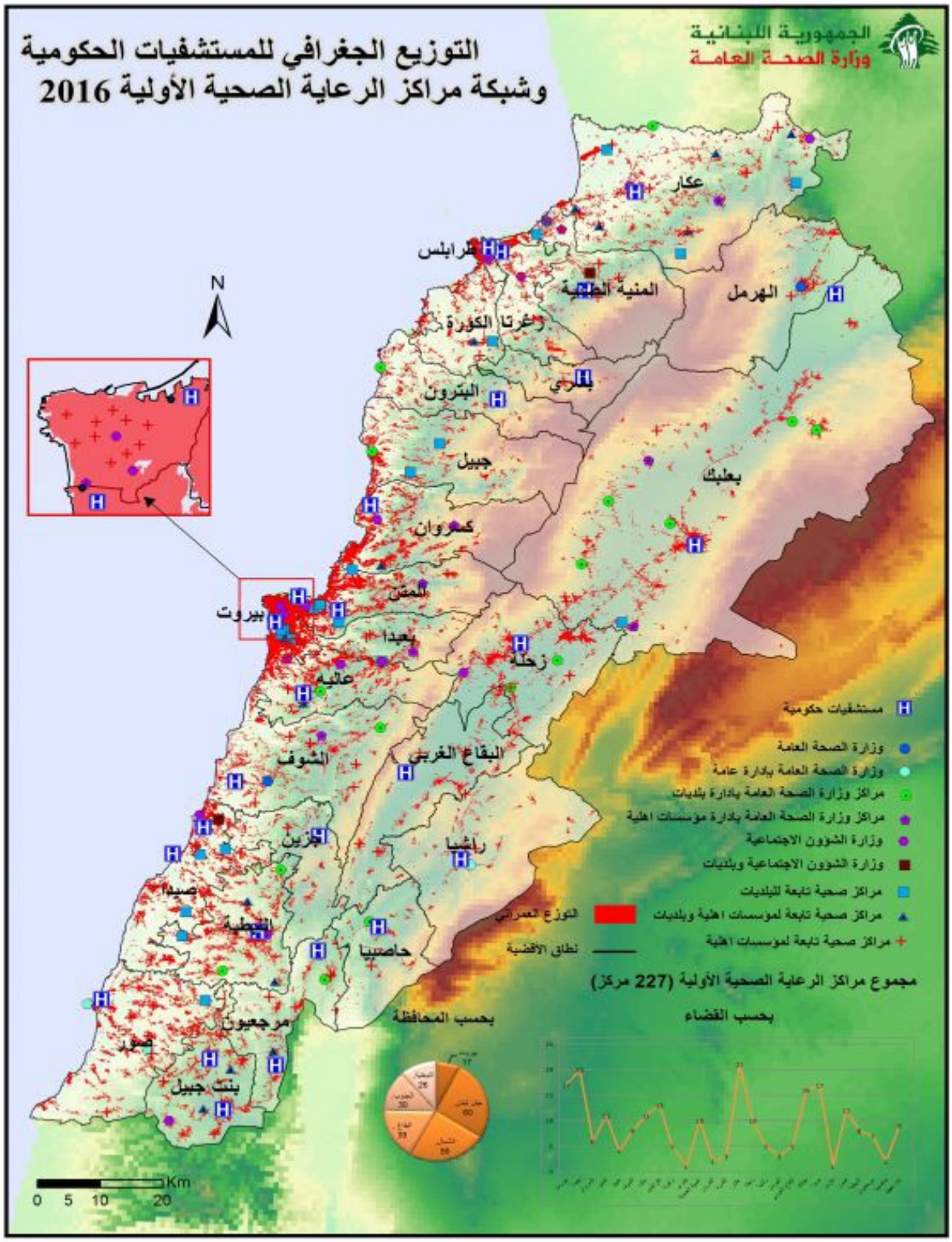
[6] Developed with the family medicine department at AUBMC.

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. It also allowed intensive training and capacity building of health staff on case management of medical conditions at , integrated management of childhood illnesses PHC, rational use of medications, NCD care and mental health care. 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.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## Hospitals

Five 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) | Public Hospitals Deficit in USD (excluding RHUH) |
|---|---|---|
| 2011 | 248,713,510 | 165,809 |
| 2012 | 299,716,183 | 199,810 |
| 2013 | 982,746,205 | 655,164 |
| 2014 | 1,147,461,199 | 764,974 |
| 2015 | 611,338,235 | 407,559 |
| **Total** | **3,289,975,332** | **2,193,316** |

**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** |

Secondary and tertiary care for displaced Syrians has been mainly financed by UNHCR, with some sporadic contributions by NGOs. Before 2016, UNHCR paid up to 75% of the total cost of life-saving emergencies, delivery and care for newborn babies, while few NGOs reimburse the remaining 25% of the bill, for a very limited number of patients. Only 30% of all UNHCR patients are 100% 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."[7] 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% 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% as possible (deposits, retaining IDs/corpses, inflating bills). Referral of uncovered Syrian patients with complicated morbidities to public hospitals has also become a common practice by private hospitals.

In 2015, the third party administrator (TPA) on behalf of UNHCR accepted 58,474 claims) 94.6% of all referrals) from the registered refugees to access hospitals, with a total paid amount

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

(after audit) of some 31,813,837.50 $; around 4,265,170.80 $ were deduced from the originally claimed bills. 20 hospitals subcontracted by UNHCR admit around 70% of refugees. In the same year,130 ( around 5%)claims, Given that the number of registered refugees is currently 1,06400, this puts the UNHCR hospital referral rate at approximately 6 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% 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% for some of the covering agencies.

**Strengthening of the EWARS 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 2011-2013, the response plans for the Syrian crisis in Lebanon were prepared by the humanitarian community operating in the country, with limited consultations with the 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. Appeals were initially made for three months, then on 6 months basis. Then for one year. In 2013 and 2014, funding for strengthening the health system and increasing its resilience capacity were introduced

In view of the protraction of the crisis and the huge size of the displaced population in Lebanon, the government of Lebanon towards the end of 2014 , and with the support of the humanitarian community, prepared a two year national Lebanese Crisis Response Plan (LCRP) for 2015-2016.

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 2015- 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 and beyond

### Overarching goals:

- Improve host and displaced population general health status in line with SDGs
- Support health system resilience and further development
- Promote child and youth health at all levels of health system & across all sectors
- Develop and maintain health security

### 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 control outbreaks of epidemic-prone diseases with focus on EWARS reinforcement

**4. To reinforce child and youth health as part of a comprehensive health approach as well as support to school health program** MoPH Guiding Principles

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

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 and beyond

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.

The assumptions are as follows:

- The population targeted remains stable, and includes: the most vulnerable Syrian displaced (70% of the 1.5 million displaced in Lebanon, i.e 1 million displaced), the Palestinian refugees from Syria (50,000), and the most vulnerable host community (450,000)
- Hospital reimbursement is maintained at 85% of the bill
- No major pandemics or outbreaks occur
- Support to improve determinants of health such as housing, water and sanitation, and basic assistance to the displaced is maintained

| Outcomes | Year 1 budget estimated in USD | Yearly estimated budget for period 2017-2020 |
|---|---|---|
| 1. Improved Access to PHC Services | 102, 200,000 | 102,200,000 |
| 2. Improved Access to Hospital & Specialized Referral Care * | 183,644,500 | 183,644,500 |
| 3. Improved Outbreak Control | 8,100,000 | 7,120,000 |
| 4. Key Institutions Strengthened, including transparency and accountability improvement | 30,000,000 | 10,000,000 |
| 5. Youth health | 6,000,000 | 4,500,000 |
| **Total** | **329,944,500** | |

*Assuming 100 %of total bill reimbursement

## Primary Health Care budget including Mental health

The MOPH has initiated the expansion of the national network of PHCC both in terms of number and package of services, to include, in addition to general health care, early detection and management of NCDs and integration of Mental health services ; moreover, the mental health program would need direct support for the implementation of its various components including: laws update, awareness and promotion, expansion of the registry for MH, training HCW on MHGap and emergency MH care, training HCW on care for groups with special MH needs such as prisoners, survivors of torture, victims of rape, etc....

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 5:** 2016 LCRP appeal for PHC

| **Outputs under Primary Health Care** | **Targets per year** | **Yearly Appeal (USD)** |
|---|---|---|
| 1. Subsidized PHC services, including NCDs and MH, received by population in need* | 1,500,000 individuals | $60,000,000 |
| 2. Sufficient chronic diseases medication available** | 170,000 individuals | $8,500,000 |
| 3. Sufficient acute diseases medication available*** | 1,000,000 individuals | 12,000, 000 |
| 4. Sufficient Reproductive health commodities available | 500,000 individual | 5,000,000 |
| 5. Accelerated routine vaccination | 600,000 individuals | $8 ,000,000 |
| 6. Implementation of National Mental Health program | 75 PHCCs | $700,000 |
| 7. Expansion of the PHC-MoPH network | 50 new PHCCs | $500,000 |
| 8. capacity building training/ equipment | 250 PHC | 1,500,000 |
| 9. support staff to MOPH | 250 staff | 6,000,000 |
| **Total** | | **102,200,000** |

*For output 1, the calculation is based on the estimate that each PHC consultation costs $20 (USD), including total operational cost, and that each beneficiary would at least need 2 consultations per year

**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 $0.7M USD as indicated in the table above.

## 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%.
- one which ensures equity between the displaced population and the hosting community by following the MoPH rate of 85%
- and the third assumes a worst-case scenario by continuing to follow the UNHCR coverage rates of 75%

All three scenarios aim to **cover all hospitalization cases** rather than a select few based on current UNHCR criteria.

Following an expected 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.

the funding pledged for direct hospital reimbursement , estimated either 75%, or 85% will need to be topped by NGOs ( 25% or 15% respectively), in order to avoid unpaid bills

### Table 6: Hospitalisation Budget per Scenario

| Scenarios | Yearly Corresponding Budget | Topped up budget by NGOs |
|---|---|---|
| Scenario 1: 100% coverage rate | $125,544,500 | |
| Scenario 2: 85% coverage rate | $106,712,825 | $18,831,675 |
| Scenario 3: 75% coverage rate | $94,158,375 | $31386125 |

It is important to note that patients suffering from chronic catastrophic illnesses (such as cancer necessitating chemotherapy and advanced care, and renal failure needing dialysis and thalassemia needing transfusion and deferral ) are not included in the above estimates.

It is estimated that around 2,400 Syrian patients will need dialysis, that some 700 patients would need cancer management and around 200 thalassemia patients will need special expensive care. the cost estimated is roughly described in table below

**Table 7:** Estimate of Chronic catastrophic illnesses

| **Disease Diagnosis** | **Estimated number of cases** | **Frequency of sessions per year per case** | **Estimated total number of sessions** | **Cost per unit (US$)** | **Total cost per year (US$ MM)** |
|---|---|---|---|---|---|
| Renal failure (needing dialysis) | 2,400 | 156 (3/week) | 374,400 | 127 | 47,500,000 |
| thalassemia | 200 | 156 | 31,200 | 250 | 7,800,000 |
| cancer | 700 | 10 | 7,000 | 400 | 2,800,000 |
| Total Estimate | | | | | 58,100,000 |

***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% 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 8:** yearly Appeal for Outbreak Control

| ITEM | first year budget USD | Yearly budget subsequent years (USD) |
|---|---|---|
| Reinforce EWARS ( staffing, logistics, IT system development and equipments)* | 1,500,000 | 550,000 |
| Staff training | 45,000 | 45,000 |
| Supplies stocks (lab reagents, response kits, PPEs...) | 500,000 | 500,000 |
| Technical support missions | 55,000 | 25,000 |
| Support Implementation of vaccination campaigns | 6,000,000 | 6,000,000 |
| total | 8,100,000 | 7,120,000 |

### Key Institution strengthening budget

The proposed budget would cover the unpaid bills to the public system, as well as rehabilitation cost of selected institutions, including accountability and transparency capacity building and development

**Table 9:** Estimates of support to key institutions

| ITEM | first year budget USD | Yearly budget subsequent years (USD) |
|---|---|---|
| Reimbursement of unpaid bills to public hospitals | 15,000,000 | 5,000,000 |
| Rehabilitation and other support to key institutions | 15,000,000 | 5,000,000 |
| total | 30,000,000 | 10,000,000 |

### Youth Health

The youth health initiative will be developed and implemented and the school health program would be further reinforced, including expansion of school health data base, of e health and selected health awareness and education in public schools

**Table 10:** Estimates for supporting Child and Youth health improvement

| ITEM | first year budget USD | Yearly budget subsequent years (USD) |
|---|---|---|
| Youth Health initiative implemented | 5,500,000 | 4,000,000 |
| School health program reinforced | 500,000 | 500,000 |
| Total | 6,000, 000 | 4,500,000 |

## 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

No systematic input from MoPH

3. Approved projects are implemented
4. Monitoring & Evaluation fragmented

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.

## Annex 1

### Deficit Incurred by Rafic Hariri University Hospital since 2011, in Lebanese Pounds (LBP)

| Third Party Payer | Total Invoice | Company Share | Patient Share | Patient Paid | Patient Unpaid | Deficit from Under Pricing | Total Deficit |
|---|---|---|---|---|---|---|---|
| UNHCR | 12,940,216,786 | 9,607,518,205 | 3,332,698,581 | 2,193,240,766 | 1,139,457,815 | 1,687,854,363 | 2,827,312,178 |
| No Coverage | 7,735,746,377 | - | 7,735,746,377 | 4,961,931,005 | 2,773,815,372 | 1,009,010,397 | 3,782,825,769 |
| MoPH | 307,153,629 | 265,796,674 | 41,356,955 | 27,017,570 | 14,339,385 | 40,063,517 | 54,402,902 |
| NGO | 120,432,275 | 105,096,389 | 15,335,886 | 11,258,553 | 4,077,333 | 15,708,558 | 19,785,891 |
| UN | 89,239,451 | 68,300,162 | 20,939,288 | 17,428,077 | 3,511,212 | 11,639,928 | 15,151,140 |
| Insurance | 525,436,393 | 437,032,217 | 88,404,176 | 76,873,196 | 11,530979 | 68,535,182 | 80,066,161 |
| GOV | 34,694,639 | 34,694,639 | - | - | - | 4,525,388 | 4,525,388 |
| Grand | 21,752,919,549 | 10,518,438,285 | 11,234,481,264 | 7,287,749,167 | 3,946,732,096 | 2,837,337,332 | 6,784,069,429 |