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Report No: PAD1205

INTERNATIONAL BANK FOR RECONSTRUCTION AND DEVELOPMENT

PROJECT APPRAISAL DOCUMENT

ON A

PROPOSED GRANT

IN THE AMOUNT OF US$15 MILLION

TO THE

LEBANESE REPUBLIC

FOR AN

EMERGENCY PRIMARY HEALTHCARE RESTORATION PROJECT

March 19, 2015

Health, Nutrition and Population Global Practice
Middle East and North Africa Region

CURRENCY EQUIVALENTS

(Exchange Rate Effective January 31, 2015)

Currency Unit	=	Lebanese Pound (LBP)
LBP 1,510.51	=	US$1.00

FISCAL YEAR

January 1	–	December 31

ABBREVIATIONS AND ACRONYMS

CMU	Central Management Unit	NCB	National Competitive Bidding
CPS	Country Partnership Strategy	NCD	Non-communicable Disease
CQS	Consultants' Qualifications Selection	NGO	Non-governmental Organization
DA	Designated Account	NHA	National Health Accounts
DALYs	Disability-Adjusted Life Years	NPTP	National Poverty Targeting Program
EHCP	Essential Healthcare Package	OOP	Out-of-Pocket expenditure
ESIA	Economic and Social Impact Assessment	OPD	Outpatient Departments
FBS	Fixed Budget Selection	PCM	Presidential Council of Ministers
FM	Financial Management	PDO	Project Development Objective
FO	Financial Officer	PFS	Project Financial Statements
FOT	Fiduciary Operations Team	PHCC	Primary Health Care Center
GOL	Government of Lebanon	PMT	Proxy-Means Testing
HIS	Health Information System	PMU	Program Management Unit
HNP	Health, Nutrition and Population	POM	Project Operations Manual
ICB	International Competitive Bidding	QCBS	Quality-and-Cost-Based-Selection
IFR	Interim Financial Reports	RRP	Regional Response Plans
IPSAS	International Public Sector Accounting Standards	SOE	Statements of Expenditure
		SSS	Single Source Selection
LCS	Least Cost Selection	TOR	Terms of Reference
LSCTF	Lebanon Syrian Crisis Trust Fund	UN	United Nations
M&E	Monitoring and Evaluation	UNHCR	United Nations High Commissioner for Refugees
MENA	Middle East and North Africa Region		
MOF	Ministry of Finance	UNICEF	United Nations Children's Fund
MoPH	Ministry of Public Health	VAT	Value Added Tax
MOSA	Ministry of Social Affairs	WA	Withdrawal Application

Regional Vice President:	Hafez Ghanem
Country Director:	Ferid Belhaj
Global Practice Director:	Timothy Grant Evans
Practice Manager:	Enis Barış
Task Team Leader:	Nadwa Rafeh

LEBANON
EMERGENCY PRIMARY HEALTHCARE RESTORATION PROJECT

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PAD DATA SHEET

Lebanon

Emergency Primary Healthcare Restoration Project (P152646)

PROJECT APPRAISAL DOCUMENT

MIDDLE EAST AND NORTH AFRICA

Report No.: PAD1205

Basic Information			
Project ID P152646	EA Category C - Not Required		Team Leader Nadwa Rafeh
Lending Instrument Investment Project Financing	Fragile and/or Capacity Constraints [X] - Post-Conflict		- Natural or man-made disaster
	Financial Intermediaries [ ]		
	Series of Projects [ ]		
Project Implementation Start Date 20-March-2015	Project Implementation End Date 30-June-2018		
Expected Effectiveness Date 30-June-2015	Expected Closing Date 30-December-2018		
Joint IFC: No			
Practice Manager/Manager Enis Barış	Senior Global Practice Director Timothy Grant Evans	Country Director Ferid Belhaj	Regional Vice President Hafez Ghanem

Recipient: Republic of Lebanon			
Responsible Agency: Ministry of Health			
Contact:	Dr. Walid Ammar	Title:	Director General, Ministry of Health
Telephone No.:	961-1-615-728	Email:	mphealth@cyberia.net.lb

Project Financing Data(in US$ Million)							
[ ]	Loan	[ ]	IDA Grant	[ ]	Guarantee		
[ ]	Credit	[X]	Grant	[ ]	Other		
Total Project Cost:		21.00		Total Bank Financing:		0.00	
Financing Gap:		0.00					

Financing Source	Amount
Recipient	6.00
Lebanon Syrian Crisis Trust Fund	15.00
Total	21.00

Expected Disbursements (in US$ Million)

Fiscal Year	2015	2016	2017	2018
Annual	0.5	3.00	6.00	5.50
Cumulative	0.5	3.50	9.50	15.00

Institutional Data

Practice Area / Cross Cutting Solution Area

Health, Nutrition & Population

Cross Cutting Areas

[ ] Climate Change
[ ] Fragile, Conflict & Violence
[ ] Gender
[ ] Jobs
[ ] Public Private Partnership

Sectors / Climate Change

Sector (Maximum 5 and total % must equal 100)

Major Sector	Sector	%	Adaptation Co-benefits %	Mitigation Co-benefits %
Health and other social services	Health	100		
Total		100		

☑ I certify that there is no Adaptation and Mitigation Climate Change Co-benefits information applicable to this project.

Themes

Theme (Maximum 5 and total % must equal 100)

Major theme	Theme	%
Human development	Health system performance	60
Human development	Injuries and non-communicable diseases	20
Human development	Child health	20
Total		100

Proposed Development Objective(s)
The objective of the project is to restore access to essential healthcare services for poor Lebanese affected by the influx of Syrian refugees.

Components	
Component Name	**Cost (US$ Millions)**
Provision of Essential Healthcare Services Package	9.04
Readiness and Capacity Building of Primary Health Care Centers	3.17
Project Outreach, Management and Monitoring	1.68
Contingency	1.11

Systematic Operations Risk- Rating Tool (SORT)	
Risk Category	**Rating**
1. Political and Governance	High
2. Macroeconomic	Moderate
3. Sector Strategies and Policies	Moderate
4. Technical Design of Project or Program	Substantial
5. Institutional Capacity for Implementation and Sustainability	Substantial
6. Fiduciary	Substantial
7. Environment and Social	Low
8. Stakeholders	Low
9. Other	NA
OVERALL	**Substantial**

Compliance		
Policy		
Does the project depart from the CAS in content or in other significant respects?	Yes [ ]	No [X]
Does the project require any waivers of Bank policies?	Yes [ ]	No [X]
Have these been approved by Bank management?	Yes [ ]	No [X]
Is approval for any policy waiver sought from the Board?	Yes [ ]	No [X]
Does the project meet the Regional criteria for readiness for implementation?	Yes [X]	No [ ]

Safeguard Policies Triggered by the Project	Yes	No
Environmental Assessment OP/BP 4.01		**X**
Natural Habitats OP/BP 4.04		**X**
Forests OP/BP 4.36		**X**
Pest Management OP 4.09		**X**

Physical Cultural Resources OP/BP 4.11		**X**
Indigenous Peoples OP/BP 4.10		**X**
Involuntary Resettlement OP/BP 4.12		**X**
Safety of Dams OP/BP 4.37		**X**
Projects on International Waterways OP/BP 7.50		**X**
Projects in Disputed Areas OP/BP 7.60		**X**

Legal Covenants

Name	Recurrent	Due Date	Frequency
Establishment of the PMU (Schedule 2, section I.A.1)		2 months after effectiveness	Once

Description of Covenant

The Recipient shall not later than two (2) months after the project effectiveness date establish within the MoPH, and thereafter maintain throughout the implementation of the Project, the Project Management Unit (PMU) with qualified staff and adequate resources.

Legal Covenants

Name	Recurrent	Due Date	Frequency
Recruitment of the external auditor (Schedule 2, section I.A.3)		6 months after effectiveness	Once

Description of Covenant

The Recipient shall not later than six (6) months after the project effectiveness date hire an independent external auditor acceptable to the World Bank to cover all aspects of the project, including compliance with the financial management manual, review of the effectiveness of the internal controls systems, and compliance with the Financing Agreement. The audit will be carried out according with International Standards on Auditing.

Legal Covenants

Name	Recurrent	Due Date	Frequency
Adoption of the Project Operations Manual (Schedule 2, section I.B.1)		1 month after effectiveness	Once

Description of Covenant

The Recipient shall not later than one (1) month of the project effectiveness date, prepare, adopt and thereafter implement a Project Operations Manual, in form and substance satisfactory to the World Bank and such manual shall include, *inter alia,* the description of: (i) Project implementation arrangements; (ii) procurement procedures and standard procurement documentation; (iii) reporting requirements, financial management manual and audit procedures; (iv) monitoring and evaluation arrangements; (v) criteria and procedures for the selection of PHCCs and Beneficiaries; and (vi) detailed operating procedures for the provision of Essential Healthcare Services Packages..

Conditions

Source Of Fund	Name	Type
Lebanon Syrian Crisis Trust Fund	Article IV, 4.01	Effectiveness

Description of Condition: The Agreement shall not become effective until evidence satisfactory to the World Bank has been furnished to the World Bank showing that the execution and delivery of this Agreement on behalf of the Recipient have been duly authorized or ratified by all necessary governmental action.

Team Composition

Bank Staff

Name	Title	Specialization	Unit
Nadwa Rafeh	Senior Economist	Team Lead	GHNDR
Lina Fares	Senior Procurement Specialist	Senior Procurement Specialist	GGODR
Elena Gagieva-Petrova	Operations Analyst	Operations Analyst	GHNDR
Rock Jabbour	Financial Management Analyst	Financial Management Analyst	GGODR
Iqbal Kaur	Sr. Social Protection Specialist	Sr. Social Protection Specialist	GSPDR
Tala Khlat	Program Assistant	Program Assistant	MNCLB
Rima Abdul-Amir Koteiche	Sr. Financial Management Specialist	Sr. Financial Management Specialist	GGODR
Alaa Mahmoud Hamed Abdel Hamid	Senior Health Specialist	Senior Health Specialist	GHNDR
Alaa Ahmed Sarhan	Senior Environmental Economist	Senior Environmental Economist	GENDR
Haneen Ismail Sayed	Program Leader	Program Leader	MNC02
John Butler	Lead Social Development Specialist	Lead Social Development Specialist	GSURR
Chaogang Wang	Senior Social Development Specialist	Senior Social Development Specialist	GSURR
Mei Wang	Senior Counsel	Senior Counsel	LEGAM
Mazhar Farid	Legal Analyst	Legal Analyst	LEGAM
Eric Ranjeva	Finance Officer	Financial Management	CTRLA
Moulay Driss Zine Eddine El Idrissi	Sr. Economist (Health)	Sr. Economist (Health)	GHNDR
Fatima-Ezzahra Mansouri	Program Assistant	Program Assistant	GHNDR

Non Bank Staff: N/A

Locations

Country	First Administrative Division	Location	Planned	Actual	Comments
Lebanese Republic	Nationwide				

I. STRATEGIC CONTEXT

A. Country Context

1. **Lebanon has witnessed the largest influx of Syrian refugees compared to the other neighboring countries affected by the crisis.** By July 2014, the refugee influx had expanded dramatically to 1,138,043 people and led to the largest humanitarian emergency operation of its kind for many years. Based on the current data, Lebanon has received 39 percent of all Syrian refugees; almost 1,103,707 Syrians have registered and 34,336 are still awaiting registration with the United Nations High Commissioner for Refugees (UNHCR). By the end of 2014, it is estimated that the number of Syrian refugees will increase to 1.6 million, equivalent to 37 percent of Lebanon's pre-crisis population.[1]

2. **UNHCR and United Nations (UN) partner agencies promptly established operations in Lebanon to respond to the crisis, but the support was primarily targeted to Syrian refugees and not to Lebanese communities whose quality of life and socioeconomic outcomes are mostly adversely affected by the influx.** As of June 2014, contributions to the Regional Response Plans (RRPs) for Lebanon totaled US$390 million,[2] which, despite the large amount, represent only about 23 percent of the estimated need of US$1.7 billion.

3. **However, the effects of the spillover have rapidly moved beyond the humanitarian crisis to the economic and social spheres where large, negative, and growing spillovers are occurring.** The Economic and Social Impact Assessment (ESIA) of the Syrian Conflict conducted by the World Bank in August 2013 concluded that the conflict is expected to negatively and materially affect the poverty, livelihoods, health and human capital conditions of the Lebanese people. The report estimates that by end-2014, some 170,000 additional Lebanese will be pushed into poverty (over and above the current 1 million below the poverty line). Additional 220,000-324,000, primarily unskilled youth, are expected to become unemployed, thus doubling the unemployment rate to over 20 percent. Government revenue collection is expected to drop by US$1.5 billion while simultaneously increasing government expenditure by US$1.1 billion due to the surge in demand for public services, bringing the total fiscal impact to US$2.6 billion. Today, the economic impact of the refugee crisis is already being felt by Lebanese communities as it is reflected in increased food prices, reduced employment opportunities, and higher rental costs.

4. **Due to the large and rising influx of refugees, Lebanon's health sector is under strain.** Syrian refugees are accessing public services extended to Lebanese citizens, thus putting pressure on the delivery and quality of services and public finances. The immediate impact of the rapid increase in patients over such a short time period has primarily been met through existing structures, and an accelerated use and hence depletion of drugs. The Government of Lebanon

[1] The high refugee influx scenario, which is an unlikely scenario used mainly for illustration and sensitivity purposes, is calculated based on a straight line extrapolation from recent refugee inflows. Based on this mechanical approach, by end-2014 the refugee population could reach 2.3 million people and would represent a 54 percent increase in Lebanon's pre-conflict population.

[2] Eighteen donors had contributed US$166.9 million via UNHCR, and 25 other agencies working in Lebanon had contributed US$223.3 million.

(GOL) has borne part of the healthcare costs of refugees by paying for their hospital emergency visits, drugs, immunizations, and disease surveillance while UNHCR and other international organizations subsidize around 75 percent of refugees' outpatient and life threatening inpatient healthcare cost. In parallel, uninsured Lebanese continue to carry the burden of healthcare costs.

5. **As the impact of the Syrian conflict and the refugee crisis has spread, its consequences for Lebanese communities have increased dramatically and led to growing inter-communal discontent.** The large refugee presence, especially in many of the country's poorest regions, has heightened competition for scarce resources, employment, and access to social services, thus deepening the vulnerability of the Lebanese in these areas as both Syrian refugees and Lebanese communities compete for limited resources. The situation deteriorated further after UN agencies and International donors contracted the health facilities (NGOs) for the delivery of care to Syrian refugees with no financial benefits for the affected Lebanese communities thus leaving them with no coverage. Hence, maintaining and promoting greater social cohesion is essential to reducing the negative social and economic impacts of this crisis, especially on the poor Lebanese at this stage.

B. Situations of Urgent Need of Assistance

6. **This project is being prepared and implemented according to paragraph 12 of the World Bank Operational Policy (OP) 10.00**, which allows for certain exceptions to the investment project financing policy requirements if the Bank deems the recipient to be in urgent need of assistance because of a man-made disaster or conflict (among other factors). The situation in Lebanon is characterized as both a man-made crisis (arrival of large refugee population), as well as the result of conflict (taking place in Syria). The justification for processing this operation under paragraph 12 of the OP10.00 stems from the urgent need to address the expected decline of health services for the Lebanese people. Furthermore, it is critical to maintain the progress achieved by the health sector in the past decade and prevent further weakening of the health services in the face of re-emerging health issues. This project will be funded through the Lebanon Syrian Crisis Trust Fund (LSCTF).

7. **In order to rapidly respond to the needs of the GOL in preventing deterioration of the health outcomes of Lebanese people, especially the poor, this project will help provide essential healthcare services to poor Lebanese affected by the Syrian crisis thus maintaining their access to healthcare.** To date, there are no indications that conditions in Syria will change in the foreseeable future, thus it is expected that its negative impact on the health sector will continue to rise. As such, there is a need to assist the Ministry of Public Health (MoPH) to strengthen its systems and build its capacity to respond to the current crisis and the potential prolonged periods of conflict.

C. Sectoral and Institutional Context

8. **Prior to the crisis, Lebanon made significant strides in terms of its health indicators.** Life expectancy for females is 75 years and males is 71 years, infant mortality is 9 per 1,000 live births, under 5 mortality rate is 10 per 1,000 live births, and maternal mortality ratio is 25 per 100,000 live births. Births attended by skilled health personnel and immunization coverage are

high at around 98 percent. Despite overall progress, Lebanon exhibits disparity in terms of geographical, income, and gender as far as health outcomes are concerned. Underserved regions such as the Beka'a and North Lebanon have pockets of depressed rates of socioeconomic and associated health status.[3] Health inputs exhibit similarly stark geographical disparities.[4]

9. **As other similar middle income countries in the region, Lebanon is going through a demographic and epidemiological transition with non-communicable diseases (NCD) accounting for around 84 percent of all deaths in Lebanon.**[5] The prevalence of cardiovascular disease risk factors are high and comparable to western countries. For example, prevalence for hypertension, diabetes and hyperlipidemia were estimated to be 23.1 percent, 13.8 percent, and 20.7 percent respectively. This is further reflected in MoPH inpatient coverage in 2011 where 32.1 percent of admissions were treated for cardiovascular conditions, 16.3 percent for hypertension, 14.5 percent for diabetes, and 16.1 percent for hyperlipidemia.[6] As such, chronic diseases constitute an important public health problem and exert financial burden on the MoPH budget if not properly prevented and managed on time.

10. **The health share of total government spending was declining prior to the Syrian conflict and there is growing concern that without additional financial resources to deal with the crisis, the MoPH will face severe budget shortfalls that will affect its ability to cover healthcare for the Lebanese.** Lebanon's long history of conflict including fifteen years of civil war (1975- 1990), and two large shocks in 2005 and 2006 with the assassination of former Prime Minister Rafik Hariri and a war with Israel, respectively, had significant fiscal implications on the health sector. Today, MoPH budget constitutes 5.8 percent of the total budget, down from 11.9 percent in 2005.[7] The fiscal impact of the Syrian crisis has been estimated to be US$39 million in 2013 and US$48-69 million in 2014.

11. **Lebanon has a pluralistic health system with multiple sources of financing, financing agents, and providers.** Only 50.1 percent of the population is insured under the three main insurance schemes - the National Social Security Fund (47.8 percent), public schemes covering mainly public sector employees and the armed forces (30.8 percent), private sector (16.3 percent), and others (5.1 percent).

12. **With only half of the population receiving health insurance, out-of-pocket expenditures (OOPs) represent a large source of health financing particularly for the poor households.** The burden of household out-of-pocket spending is 37.34 percent in 2012.[8] Lower income groups spent a higher percentage of their income (14 percent) on health than those with higher income (4.2 percent).[9] The obligation to pay directly for services, is subjecting a large proportion of the population to financial hardship, even impoverishment.

[3] A 2009 study shows that the prevalence of maternal deaths in the Bekaa is 21.3 percent, more than double of the national average of 10.7 percent (IGSPS et al, 2012).
[4] For example, Mount Lebanon has the highest density of physicians and nurses (42 percent and 33 percent), compared to Beka'a, with only 7.8 percent of Lebanon's physicians and 19 percent of nurses (Ammar, 2009).
[5] WHO, NCD Country Profile, 2011.
[6] MoPH, Vital Health Statistics, 2013.
[7] National Health Accounts (NHA) data listed in World Bank, World Development Indicators, 2013.
[8] MoPH website, National Health Accounts Summary Table, 2012.
[9] NHA, 2005.

13. **For the uninsured, the MoPH serves as a provider of last resort, providing hospital coverage but with limited primary and outpatient care.** Hospital services to the 1.6 million uninsured Lebanese are provided through contracted public and private hospitals, with MoPH covering 85 percent of the hospital expenses, and 100 percent of medication of chronic and high risk diseases.

14. **Primary healthcare on the other hand, is provided either through private clinics or through a network of primary health centers (PHC Networks) which are predominantly run by non-governmental organizations (NGOs).** As part of MoPH reform efforts in the 1990s to improve access to PHC services for low income groups, the MoPH established the National PHC Network consisting of Primary Health Care Centers (PHCCs) operated mainly by NGOs and municipalities. Participating centers were selected based on their size, coverage, and range of services they provide. The MoPH has contractual agreements with the centers whereby the MoPH provides them with in-kind support including generic drugs, vaccines, training and IT support, and in turn the PHCCs provide their communities with essential healthcare services at discounted rates as well as free essential drugs. To date, the PHC Network includes 204 contracted PHCCs (out of 1,085 PHC centers and dispensaries in the country), of which 67 percent are affiliated with NGOs, 20 percent with local municipalities, 11 percent with MoPH and 2 percent with the Ministry of Social Affairs (MOSA).

15. **For the past decade, the PHC Network has been successful in providing quality primary healthcare to poor and low income Lebanese.** MoPH data show that use of contracted PHCCs by low income groups increased by 73 percent between 2002 and 2012, from 32,6184 visits to 121,2000, respectively. The data further show that the PHC Network played a major role in the delivery of free essential drugs provided by the MoPH while becoming the main provider of prenatal care with the number of pregnancy visits increasing from 5,124 in 2002 to 26,666 in 2012, which constituted 36 percent of total pregnancy visits in the country. As all the PHC network facilities are participating in the MoPH PHC accreditation program, quality of care is closely monitored in these facilities.

Impact of the Syrian Crisis on the Health Sector

16. **As a result of the influx of Syrian refugees, Lebanon's health sector is regressing in several ways.** The country is experiencing the re-emergence of some communicable diseases that have been controlled (measles cases increased from 9 cases in 2012 to 1,760 cases in 2013); and the emergence of new diseases not present in Lebanon before, (leishmaniasis increased from 2 cases in 2012 to 1032 in 2013, 98 percent of whom were Syrians). With assistance from donor and international organizations, the MoPH is launching intense public health efforts and massive immunization campaigns to address public health challenges and control the spread of infectious diseases in the country; however, significant gaps continue to exist in terms of access to primary and ambulatory health services in areas most impacted by the crisis.

17. **The impact of the Syrian Crisis on health differs significantly by region within the country, with the strongest pressure observed in poor Lebanese communities given the strong overlap with refugee density.** Refugees are spread over villages and communities across

the country and their concentration is highest in host communities that are the poorest in the country, such as in the Beka'a and the North Governorates. Given the unequal geographical distribution of refugees in Lebanon, crowding out of public services - such as in public hospitals and in the PHC Network facilities - has materially impacted access for poor Lebanese living in communities with large concentrations of Syrian refugees.

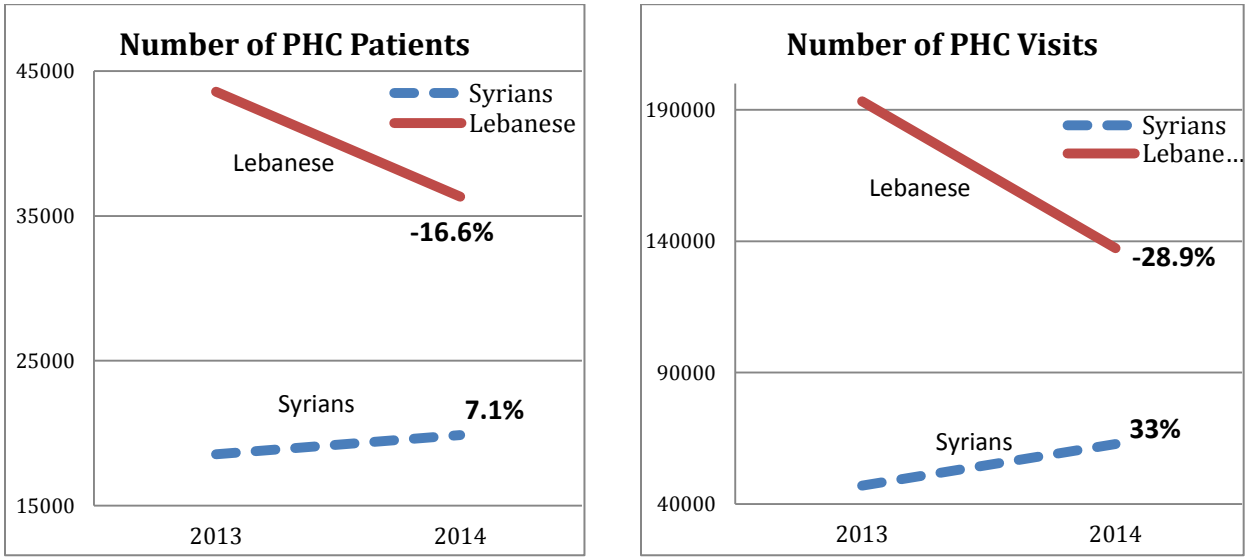
18. **The large influx of refugees led to significant increase in demand for health services and has challenged the primary health sector in the country.** The number of Syrian refugees accessing the PHC Network clinics has been increasing steadily, from 14 percent in 2012, to 35 percent in the first six months of 2014. This varied by region with 52 percent of PHCC visits in the North and 47 percent of visits in Beka'a were for Syrian refugees, with Wadi Khalid health center having the highest percentage of Syrians at 85 percent. The majority of visits were for child care, reproductive health, and dispensing of medications.

19. **While demand for health services is increasing, the supply is not.** Given the pre-crisis capacity and infrastructure constraints of primary health care facilities in Lebanon, the sharp rise in demand generated shortages in PHCCs and human resources. Hence, lack of access to healthcare in communities with the highest concentration of refugees in Beka'a, North and Wadi Khalid is mainly attributed to the limited number of PHCCs and the inability of local communities to pay for private clinics.[10] The 14 Network PHCCs that served the Beka'a governorate before the Syrian crisis are today hosting an additional 35 percent of Syrian refugees. Moreover, UN agencies and international donor organizations contracted the majority of existing PHCCs for the delivery of care to Syrian refugees. As a result, the gap between increased demand and existing supply is deepening the vulnerability of the Lebanese in these areas as competition for health services and resources continues.

20. **The unprecedented rise in demand for PHC services associated with the limited supply is crowding Lebanese out of hospital services and is compromising access to affordable healthcare.** Comparing the MoPH utilization data[11] for the first six months in 2013 with that in 2014, shows that while the number of Syrian patients attending PHCCs increased by 7.1 percent, the number of Lebanese patients attending the same PHCCs decreased by 16.6 percent. This is also the case with the number of visits to PHCCs, where the numbers increased by 33 percent for Syrians and decreased by 28.9 percent for Lebanese. There is an undocumented evidence to suggest that Lebanese are dissatisfied with the long waiting time and lack of financial support for PHC visits, similar to Syrian refugees. This situation is significantly compromising access of Lebanese citizens to healthcare, putting pressure on the delivery and quality of services. In the medium- to long-term, the impact of delayed healthcare for Lebanese, particularly for the vulnerable, could result in increased costs and overall levels of morbidity in the future.

[10] International Medical Corps Lebanon, Syrian Refugee Response, January-June, 2013.
[11] Ministry of Public Health, Primary Care Department, September 2014.

Figure 1: Utilization of PHC Services by Lebanese and Syrians



Source: Ministry of Public Health, 2014

D. Higher Level Objectives to which the Project Contributes

21. **In 2013, the Government of Lebanon articulated its strategic direction with an overall goal of expanding health coverage to the uninsured, with special focus on the poor and underserved population.** In the past decade, Lebanon has been able to provide uninsured citizens (about 1.6 million people) with inpatient care coverage through contracted public and private hospitals with limited in-kind contribution to PHCCs in the form of drugs and vaccines. As a result, Lebanon faces significant coverage gaps in terms of preventive care, primary and ambulatory healthcare, with the poor carrying the higher financial burden.

22. The proposed project will assist the Government to cope with a crisis situation by providing coverage to a package of essential healthcare services comprising of preventive, primary, and ambulatory care to the poor especially those affected by the Syrian crisis. This will also contribute to strengthening government systems and would lay the foundation to launch a number of initiatives recommended by the National Health Strategy, namely, providing primary and ambulatory care coverage to uninsured and poor.

Relationship to Country Partnership Strategy (CPS)

23. **Given the country's political instability over the last decade, the World Bank Group's support to Lebanon has focused mainly on post-war reconstruction and on macro and fiscal recovery to:** (i) maintain a core program of engagement, which consists of selected investments in basic services, as well as technical assistance and analytical work that will serve to inform and build momentum around key reforms; and (ii) stand ready to engage more deeply in additional areas that have been selected because of their critical role in supporting Lebanon's economic growth and social stability.

24. **As a result of major socio-economic changes in Lebanon since the adoption of the CPS in July, 2010 and the issuance of the CPS Progress Report in April 2013, the focus has moved to addressing the poverty impact of the Syrian conflict on poor Lebanese households and containing it through a two-tiered approach:** (i) short-term stabilization of the impact of the crisis on Lebanon, and (ii) building medium-term resilience. The GOL's Roadmap of Priority Interventions for Stabilization from the Syrian Conflict,[12] developed as an outcome of the ESIA, provides a set of priority short-and medium-term interventions targeted towards supporting Lebanese communities, households, and the economy more broadly. As part of CPS Progress Report, the Bank identified health and social protection among the new areas of the strategy requiring intervention and highlighted the exacerbating effect of the Syrian conflict on Lebanon's fragile socio-economic and political environment.

25. **As such, the proposed project is well aligned with both the CPS priorities focusing on short term stabilization of the impact of the crisis and building medium-term resilience as follows:** (i) contributing to the stabilization of the crisis in the short term through the expansion of health coverage to extremely poor households, uninsured individuals and those affected by the Syrian conflict - an essential healthcare package covering both primary care and select disease management services will be provided; and (ii) building medium-term resilience through upgrading the capacity of PHCCs, strengthening the skills of health workers - in the longer term, the project may serve as a platform for strengthening PHCC systems and expanding coverage to achieve MoPH goal of universal health coverage.

Relation to the WBG twin goals in health

26. **The proposed project also aligns with the World Bank Group's twin goals of ending extreme poverty and promoting shared prosperity, and with the Health Nutrition and Population (HNP) strategy that aims to create fair and accountable health systems. With regard to alignment with the Bank's poverty goal,** the project contributes to the reduction of extreme poverty in Lebanon, by directly targeting approximately 150,000 poor and uninsured individuals, identified through the National Poverty Targeting Program (NPTP) which was developed with assistance from the World Bank. The eligible beneficiaries are those individuals living below the poverty line (as defined using Lebanon's Proxy Means Testing (PMT) targeting mechanism), who, in addition, have been most affected by the influx of Syrian refugees. The provision of subsidized healthcare package for this target population will ensure coverage of essential primary healthcare services resulting into: (i) reduced preventable deaths and disability; (ii) improved overall health status; and (iii) reduced catastrophic health expenditures which could push the poor back into the poverty cycle. The proposed project is also aligned with the MENA Regional Strategy, supporting the pillar on social and economic inclusion.

27. By ensuring access to essential primary healthcare services, the project will: (i) increase overall equity in access to healthcare while improving the health status of the bottom 40 percent of the income decile. As established by the mounting evidence from the literature, improvements in health have a positive, sizable, and statistically significant effect on aggregate labor productivity, incomes and living standards.

[12] *Lebanon Roadmap to Mitigate the Impact of the Syrian Conflict*, November 2013.

28. **With regard to alignment with the World Bank's MENA health sector strategy (2013-2018),** the project will support creating fair and accountable health systems through: (i) ensuring the health benefits package for poor; (ii) reducing regional, income and gender discrepancies in access to healthcare; (iv) incentivizing primary care; and (v) addressing the rising burden of Non Communicable Diseases (NCDs) and reemergence of communicable diseases due to the Syrian crisis.

II. PROJECT DEVELOPMENT OBJECTIVES

A. PDO

29. The objective of the project is to restore access to essential healthcare services for poor Lebanese affected by the influx of Syrian refugees.

30. The project aims to provide an essential healthcare package (EHCP) to eligible beneficiaries of the NPTP living in areas most affected by the crisis through the MoPH Network of PHCCs.

Project Beneficiaries

- *Poor, uninsured individuals and those affected by the Syrian conflict.* The beneficiaries of the project are poor individuals enrolled in the NPTP and defined using the PMT targeting mechanism as those living below the poverty line. Priority is given to beneficiaries most affected by the influx of refugees.

- *Primary Health Care Centers (PHCCs):* The project will strengthen the capacity of the Network PHCCs contracted with the MoPH for the provision of the package of essential healthcare services by upgrading the capacity of the centers and the skills of health workers and managers to effectively manage the increased demand for healthcare and deliver quality care during, and post the crisis period.

- *MoPH:* The project will help strengthen the MoPH's capacity for regulating and administering a well-targeted and efficient primary healthcare and ambulatory coverage program to the poor. The MoPH will benefit from the technical assistance that will be provided to expand and monitor the contracting mechanism with PHCCs within the Network.

PDO Level Results Indicators

31. Progress towards the PDO will be monitored through the following key indicators:

1. Direct project beneficiaries (Number) - *(Core indicator)*
    a. Female beneficiaries (Percentage - Sub-Type: Supplemental)-*(Core indicator)*
2. Utilization of services: average no. of visits per beneficiary per year (*Number*)
3. User Satisfaction *(Percentage)*

III. PROJECT DESCRIPTION

A. Project Components

32. The project is comprised of three components: (i) provision of a subsidized package of essential healthcare services to eligible poor beneficiaries; (ii) capacity building of contracted service providers; and (iii) project management and monitoring.

Component 1: Provision of the Essential Healthcare Package (US$9.04 million financed from LSCTF; additional US$6 million financed by MoPH)

33. This component subsidizes a package of essential healthcare services to approximately 150,000 out of the 340,000 poor Lebanese identified by the NPTP as living below the poverty line. The NPTP is based on a PMT targeting mechanism that ensures that the most vulnerable groups within the population would be reached. Priority in the selection of beneficiaries is given to those living in areas most affected by the Syrian crisis. The MoPH provides an in-kind contribution in the amount of US$6 million providing drugs and vaccines to providers

34. Six evidence-based packages will be provided under this project (see Annex V for a description of the packages): (i) three age specific and gender wellness packages (ages 0-18, females 19 years and above, males 19 years and above); (ii) two care packages for the two common NCDs in Lebanon: diabetes and hypertension; and (iii) a reproductive health package focusing on pre and post-natal care.[13] Eligible beneficiaries will be covered for the following: (i) screening, preventive, and health promotion visits; (ii) essential clinical and diagnostic tests; (iii) prenatal and post care visits; (iv) consultation visits for the treatment of diabetes and hypertension; and (v) prescription medications.

35. Services within the package will be provided to beneficiaries through MoPH contracted PHCCs. PHCCs will be responsible for providing the services within the agreed package. Diagnostic tests that are not available at the PHCC will be referred to pre-selected licensed facilities. The PHCCs will be responsible to contract with accessible licensed facilities to ensure that services are provided to beneficiaries. The PHCCs will play a gate keeping role, providing referrals for diagnostic procedures, specialized care and hospitalization. Quality of care will be monitored and maintained as part of MoPH PHCC accreditation program.

36. Provider participation is voluntary and governed by legal agreement between the MoPH and the facility. The project will build on the current contractual arrangements between the MoPH and the NGOs in the National PHC network and will target PHCCs that are already in the network. The project will revise the terms of the agreement between them to reflect a capitation based contract that will include number of targeted beneficiaries, services under the package, contract value, monitoring, reporting requirements, and payments mechanisms.

[13] The reproductive health package provided under the project will not cover the deliveries, and will continue to be financed by MOPH hospitalization budget.

Component 2: Readiness and Capacity Building of Primary Health Care Centers (US$3.17 million financed from LSCTF)

37. This component will finance preparation and scaling-up the capabilities of the contracted PHCCs for the implementation of the program using the results of a rapid facility assessment conducted by the MoPH to identify gaps in PHCCs' capacities and resources to respond to contract requirements. This component will also strengthen the capabilities of selected PHCCs for the implementation of the Project, including: (i) providing technical assistance and training for upgrading the skills of personnel of selected PHCC through short refresher courses to help them cope with additional load and immediate needs of Beneficiaries; (ii) building their capacity through training in the essential healthcare services guidelines, monitoring and evaluation, information system and training of staff in the use of software.

Component 3: Project Outreach, Management and Monitoring (US$1.68 million financed from the LSCTF)

38. The objective of this component is to: (i) ensure an effective and efficient, administration, regulation, and implementation of the project; (ii) improve the effectiveness of the MoPH in contracting with PHCCs; (iii) rigorous monitoring and performance assessment of the project outputs and objectives. To achieve its objectives, this component will finance technical assistance for the following activities:

a) Providing technical support to the Program Management Unit (PMU) in the MoPH.
b) Providing technical assistance in the development and management of contracts between MoPH and selected PHCCs and in the verification and validation of the PHCCs' financial and technical reports as well as the Essential Healthcare Services' packages' payment process.
c) Updating and maintaining Health Information System (HIS) (including provision of IT hardware and software) at MoPH with links to other related agencies involved in the implementation of the Project.
d) Initiating monitoring and assessment of the Project through setting the baseline, collecting the data and setting the parameters for evaluation.
e) Improving the grievance and redress mechanism for improved efficiency and transparency.
f) Launching outreach campaign and communication activities to inform Beneficiaries about their health rights and services provided at the PHCCs in their areas.

B. Project Financing

39. The financing instrument for the project is a grant-based Investment Project Financing (IPF) in the amount of US$15.00 million financed from the World Bank LSCTF.[14]

[14] The LSCTF was established in December 2013, in order to support the impact of the Syrian conflict on Lebanon.

Project Cost and Financing

40. The total project cost is estimated at US$21.0 million, of which LSCTF will finance US$15.0 million (71%) and the Government will contribute US$6.0 million (29%) in the form of in-kind contributions covering medications and vaccines. The project costs and financing by component are summarized in Table 1 below.

Table 1: Project Cost and Financing (millions of US$)

Project Components	LSCTF Financing (%)	MoPH (%)	Project Cost (%)
Component 1: Providing Essential Health care Services Package (EHCP)	9.04	6.00	15.04 *(71.6%)*
Component 2: Readiness and Capacity Building of PHCCs	3.17		3.17 *(15.1 %)*
Component 3: Project Outreach, Management and Monitoring	1.68		1.68 *(8 %)*
Contingency	1.11		1.11 *(5.3 %)*
TOTAL	**15.00 (71%)**	**6.00 (29%)**	**21.00 (100%)**

IV. IMPLEMENTATION

A. Institutional and Implementation Arrangements

41. The **MoPH** will be responsible for overall project coordination and management in close collaboration with implementing partners including PHCCs and the Central Management Unit (CMU) of the Presidential Council of Ministers (PCM).

42. A **PMU** will be established at MoPH, no later than 2 months after effectiveness, staffed with the key positions, including but not limited to project coordinator, financial and accounting manager and procurement officer, to oversee: (i) planning, execution and oversight of the project activities; (ii) financial management of project funds following the Bank Guidelines including data validation and payments to service providers; (iii) monitoring and reporting on project activities and outcomes; and (iv) procurement planning and management. Some of the key PMU staff will be appointed/seconded by the Recipient (salaries financed by the Government budget) and additional personnel if/as needed would be financed by the project.

43. A **Steering Committee** will be formed to coordinate inter-ministerial policies and address strategic and policy level issues that arise during the project period. The committee will be headed by the MoPH Director General and will include various stakeholders.

44. While the Project Operations Manual (POM) will describe detailed implementation arrangements for each component, the following will be the key implementing partners.

- **PHCCs** will be responsible for delivery of the essential healthcare package to targeted beneficiaries. They will also be responsible for the outreach campaigns, beneficiary enrollment, record keeping, reporting on enrollment and clinical health indicators, and will benefit from the capacity building activities under the project.

- The Central Management Unit (CMU) of the NPTP at the Presidency of Council of Ministers (PCM) will provide the list of eligible NPTP beneficiaries to the MoPH.

B. Results Monitoring and Evaluation

45. Monitoring and evaluation will be an integral part of the program to ensure that health services are secured for the Lebanese citizens in this crisis under this project. The project will be monitored and evaluated on the basis of objectives, indicators and targets set out in the attached results framework. The MoPH through PMU will be responsible for monitoring daily progress of the project with key focus on improved accessibility of beneficiaries to the package of health services.

46. The PMU will also be responsible for preparing and submitting quarterly progress reports that, among others, provide detailed reporting on services, procurement, and expenditures. It will also conduct mid-term and post-completion evaluations to gauge progress towards the PDO, and to assess the impact of the project on targeted beneficiaries. The data will be collected and used to: (i) supervise the performance of PHCCs; (ii) monitor beneficiary accessibility progress; and (iii) improve the response of the project and provision of services based on intermediate output and outcome data.

47. An HIS system will be developed by the MoPH by the effectiveness to support the implementation and monitoring of the program. This includes developing the system at the central level as well as updating the current systems at the facility level in order to meet the new requirements for program implementation. Assistance would be provided to the PHCCs to upgrade their recording and reporting systems and strengthen their capacity to implement the program.

48. The Bank will conduct regular implementation support missions during which implementation progress, outputs and work plan updates, will be assessed and adjustments made as necessary. Project M&E will consist of four parts: (i) internal oversight by MoPH of the PHCCs; (ii) independent project evaluation; (iii) beneficiary assessment; and (iv) evaluation by the Bank.

C. Sustainability

49. The project's sustainability is reinforced through three elements: **(a) alignment with GOL priorities and the national health sector strategy**: the GOL strategy emphasizes short-term stabilization, medium-term resilience, while the strategic direction of the MoPH focuses at laying the foundation for Universal Health Coverage with special emphasis on the poor. These will be achieved as follows: i) short-term stabilization will be achieved through targeting the

poor during the crisis and providing them with essential healthcare services while building the capacity of PHCCs to deliver these services; ii) medium-term resilience of the system will be formed by laying the foundation for a more effective and efficient care model sustained beyond the crisis and will aim at shifting the current model which is heavily centered on hospital-based care, to a model based on primary health care, prevention, and outpatient case management; and iii) for the long term, the project is embedded into the Government's 2013 National Healthcare Strategy aimed at providing: (i)universal healthcare coverage; **(b) ownership:** The project was conceived, planned and designed by MoPH with steadfast commitment and ownership demonstrated at all levels of the Ministry. MoPH led the project design and submission to the cabinet for approval. Furthermore, MoPH is planning to continue the services beyond the emergency crisis to achieve universal healthcare goal; and **(c) availability of funds:** Government approved Cabinet of Minister's decree (number 11102, January 24, 2014) which confirmed the shifting of expenditures from expensive hospital care to the more cost effective primary healthcare, confirming the availability of adequate resources for continuing the services after the Bank's support ends.

V. KEY RISKS

A. Risk Ratings Summary Table

Systematic Operations Risk- Rating Tool (SORT)	
Risk Category	**Rating**
1. Political and Governance	High
2. Macroeconomic	Moderate
3. Sector Strategies and Policies	Moderate
4. Technical Design of Project or Program	Substantial
5. Institutional Capacity for Implementation and Sustainability	Substantial
6. Fiduciary	Substantial
7. Environment and Social	Low
8. Stakeholders	Low
9. Other	NA
OVERALL	**Substantial**

B. Overall Risk Rating Explanation

50. The overall risk rating for the project is ***Substantial.*** The key risks, which may impair the effective implementation of the project, are: **(i) political and governance risks** associated with stalemate in the executive and legislative branches of government that may constrain the project approval process in the cabinet; possibility of changes in political leadership that might affect commitment to the sustainability of the program; and risks related to errors and fraud in enrollment; **(ii) technical design of project** associated with contracting process involving NGOs and inability to attract and enroll beneficiaries; **(iii) institutional capacity for implementation and sustainability** associated with: (a) inadequate capacity at central and district levels,

especially for managing the additional load of beneficiaries and enhanced requirements for monitoring and supervision; (b) expected delays in project start date due to the time required in starting the enrollment process, contracting with NGOs, establishing the PMU, and hiring staff; and (c) slow disbursement due to the flow of funds' mechanism between MOF and MoPH; and **(vi) fiduciary risks** associated with a) lack of experienced and dedicated FM specialists; (b) lack of accounting system to record and produce financial reports; (c) weak internal control system; (d) weak external audit function, and (e) insufficient procurement capacity.

51. These risks will be mitigated as follows:

- ***Political and governance:*** This risk affects all World Bank interventions and cannot be fully mitigated. However, unlike International Bank for Reconstruction and Development (IBRD) funded operations, this grant-financed project does not require parliamentary approval that frequently results in significant delays. Furthermore, the project does not include explicit policy reforms that may be hampered by the difficult political environment.

- ***Technical design of the project:*** To mitigate the risk associated with the contracting process, a project implementation readiness plan will be prepared by NGOs based on the results of the ongoing rapid facility assessment and focus group discussions which are focusing on the project's goals, design and expected outcomes. This readiness plan will clearly state the capacity needs, implementation plan, targets to be achieved, quality measures and payment terms and modalities. A draft contract is already prepared by the MoPH. To mitigate the risk regarding the inability to attract and enroll beneficiaries, the project will support: (i) well designed and timely information campaign which is expected to be instrumental in raising awareness among the beneficiaries; (ii) utilization of existing NPTP system and individualized photo identification cards will ensure that the project reaches the targeted poor and avoids potential enrollment errors, and minimizes fraud.

- ***Institutional capacity for implementation and sustainability implementation:*** To mitigate this risk, MoPH is already undertaking measures which will be further supported by the project as follows: (i) providing a lump sum upfront budget to PHCCs as part of their contracts to advance the implementation readiness and provide flexibility to recruit additional health workers and provide training as needed; (ii) completing a facilities survey that will help to identify needs and gaps of the PHCCs to allow for a more targeted capacity building activities including preparing PHCCs for contracting, implementation readiness activities and helping with preparing for new staff selection; (iii) establishing quotas for the number of patients per facility to ensure provision of adequate support for optimal PHCC utilization; (iv) building consensus and sharing project achievements throughout the implementation among all the stakeholders to ensure their ownership of the program in keeping the commitment of key stakeholders to sustain the program; and (v) preparing and maintaining a disbursement plan which will be based on the overall budget and the procurement plan.

- ***Fiduciary capacity:*** To mitigate this risk, the project will: (i) recruit an experienced Financial Officer (FO) according to TORs acceptable to the Bank; (ii) adopt an accounting software with specifications acceptable to the Bank to record daily transactions and produce the periodical financial reports; (iii) prepare a financial management manual; and (iv) ensure that an independent qualified external auditor to provide oversight is contracted according to TORs acceptable to the Bank; the audit report will be delivered to the Bank no later than six months after the end of each fiscal year. In addition, the MOF has recently enhanced the internal procedures by reducing administrative steps which is expected to expedite disbursements. Procurement risks will be addressed through hiring of a full time experienced procurement specialist. A detailed POMwill be developed which will include procurement plan and guidelines for procurement planning and management. The POM will be updated regularly.

52. In addition, the project will conduct periodic technical assessments on project performance, beneficiary enrollment and eligibility to adjust and mitigate any risks.

VI. APPRAISAL SUMMARY

A. Economic and Technical Analysis

53. Due to the lack of relevant data to conduct a meaningful economic analysis, the project is relying on abundance of global knowledge and evidence to support economic gains and positive social impact of investing in basic healthcare. The project is expected to have tangible economic impact from three viewpoints:

a) **Cost-effectiveness:** The project is investing in high impact and most cost-effective interventions pertaining to primary healthcare which are supported significantly and statistically by well-documented evidence on their positive effects on averting maternal and child deaths, and reducing morbidity especially among NCDs. Global evidence from multiple economic evaluations support this assertion through showing a substantial rate of return of similar programs *(primary healthcare services in tandem with social protection for the most vulnerable groups)* on reducing higher rates of infant and maternal mortality.[15] Furthermore, the early screening under the primary care for diabetes and hypertension, represents good value for money compared to 'no screening', as indicated in a recent global evidence. The study's findings also indicate that expanding opportunistic screening (70% coverage of the target population) to universal screening (where 100% of the target population are screened), is likely to be even more cost-effective.

[15] WHO (2008), World Health Report; WB (2010), « Plan Nacer: Health Insurance for the Poor in Argentina »; Cortez R. et al. (2012): World Bank HNP Discussion Paper – « Results Based Financing for Health in Argentina: The Plan Nacer Program »; Knaul F.M. et al. (2012), « The quest for universal health coverage: achieving social protection for all in Mexico », The Lancet, August 16.

[15] Dukpa W. et al. (2014), « Is diabetes and hypertension screening worthwhile in resource-limited settings? An economic evaluation based on a pilot of a Package of Essential Non-communicable disease interventions in Bhutan », Health Policy and Planning, October 8, 2014.

Moreover, using the Disability-Adjusted Life Years (DALYs) methodology, the benefits from subsidizing a package of essential healthcare services for approximately 150,000 poor are estimated to avert years of potential life lost due to premature mortality and the years of productive life lost due to disability. The increased access to the proposed package of services, including screening, preventive, and health promotion visits; clinical and diagnostic tests; prenatal and postnatal care visits; consultation visits for the treatment of diabetes and hypertension; and prescription medications for the target population, is likely to have a direct impact on seven of the top twenty causes of DALYs in the country:[16] ischemic heart disease, stroke, diabetes, chronic obstructive pulmonary disease (COPD), preterm birth complications, congenital anomalies, and lower respiratory infections, which add to 249,500 DALYs countrywide. Assuming the national distribution of DALYs holds for the target population of this project, the proportional number of DALYs subject to the intervention is approximately 6,391. Based on evidence from multiple economic evaluations from around the globe[17], the assessment further assumes that access to the benefits package averts, on average, roughly 50 percent of DALYs attributed to these conditions, thus estimating that the project is likely to avert 3,196 DALYs each year. Using a conservative estimate of one time the national per capita income[18] for the value of each DALY averted, estimates in annual economic returns derived from this project could rise to US$31,727,622.

b) **Social and economic equity:** In addition, redirecting resources from expensive hospital care to basic primary healthcare and targeting the absolute poor would increase the efficiency of the system not just because the impact of the increase can be larger, but because it would reduce spending on higher levels of care which benefit few. This will also significantly contribute to the health equity situation in Lebanon in reducing poorest families' out-of-pocket spending, diminishing burden of catastrophic expenditure and ensuring that all the population of the country (not just the rich and middle income) have equitable access to a basic package of health services while preventing further impoverishment of the most vulnerable population impacted by the Syrian crisis; and

c) **Positive externalities:** preventing ill health and supporting a healthy population positively impacts the economy through increased (i) productivity, labor supply, and human capital;[19] (ii) consumption of or production of goods and services that would otherwise not have been consumed or produced; and (iii) contributing to poverty reduction through increased household earnings.

[16] See Global Burden of Disease (2010) estimations from the Institute for Health Metrics and Evaluation.

[17] Graham et al. (2006) and Jamison et al. (2008) review low-cost interventions to reduce communicable and non-communicable diseases, estimating impacts as measured by averted DALYs ranging from 50% (access to routine maternity care and increased primary-level coverage averted 50% maternal-related DALYs in South Asia and Sub-Saharan Africa) to 66% (use of aspirin, a statin and an antihypertensive drug could reduce the annual risk of major recurrence by two-thirds in developing countries).

[18] GDP per capita in Lebanon is US$ 9,928 for 2014, according to World Bank estimations.

[19] D. Stuckler, S. Basu. M. McKee (2010), Budget Crisis, Health and Social Welfare Programmes; BMJ, 340.
European Commission (2013), Investing in Health, Commission Staff Working Document.
WHO (2003), Increasing investment in health for the poor, Commission on Macroeconomics and Health.

54. The project is technically sound. Despite the emergency nature of the project, the interventions of the project are designed not just to meet the emergency healthcare needs but are focused on governance, accountability, management and expansion of essential healthcare services to uninsured and the poor. The project is aligned with the GOL priorities and with MoPH strategic goals and has aligned the design with other international experiences on effective programs to deliver services while tackling complex management and governance challenges in an emergency situation.

55. The management and governance aspects focus on a results based approach, whereby the participating PHCCs will be paid on a reimbursable basis for the services delivered based on the targets agreed in the contracts. This is a serious attempt to maintain performance even in the face of emergency. This will be backed up by strengthening of the Health Information System and monitoring and evaluation system to generate information for decision making and making improvements along the way.

56. To further enhance the performance and undertake project activities effectively, the project will support fiduciary capacity building, including financial management and procurement, human resource (capacity) development and contract management.

57. The project aims to ensure delivery of packages based on standards and guidelines for essential primary healthcare deliver that are consistent with the current and planned human resource (capacity) development. The design of service delivery has taken into account the rational distribution of services across PHCCs that ensure efficiency and optimum use of limited resources.

B. Financial Management

58. The Financial Management (FM) assessment of the MoPH was carried out in order to ensure that an adequate financial management system is in place that satisfies the Bank's OP/BP 10.00 requirements for the proposed Project. According to the requirements of OP/BP 10.00, the Recipient with MoPH and the project implementing entity should maintain a financial management system, including accounting, financial reporting, and auditing systems, adequate to ensure that they can provide accurate and timely information regarding project resources and expenditures. The overall financial management risk for this Project is assessed as "Substantial".

59. Annex III provides additional information on the financial management assessment, the recommended measures to be maintained and FM arrangements.

60. MoPH will be responsible for preparing quarterly Interim Un-audited Financial Reports (IFRs) detailing the grant: (i) sources and uses of funds; (ii) contract expenditures; and (iii) uses of funds by grant activity, component and consolidated list of assets purchased through the project. The IFRs will be submitted to the Bank no later than 45 days after the end of the quarter to which they relate.

61. The annual Project Financial Statements (PFS) will be prepared by MoPH and audited by an independent private external auditor acceptable to the World Bank, to be engaged within six months after project effectiveness. The audit Terms of Reference (TORs) will be developed by

the project and cleared by the World Bank. The external audit report and project Audited Financial Statements will be submitted to the World Bank no later than six months after the end of each fiscal year and will be made public as per the World Bank disclosure policy. A management letter will also be expected to provide the external auditor's assessment of the project internal controls. The project audited PFS and management letter will be due for submission by no later than 6 months after the end of each fiscal year.

62. MoPH will be responsible for preparing a financial management chapter of POM which will include a detailed description of all activities, roles and responsibilities, flow of information and funds for the project and each of its components. The financial management chapter will be finalized by the project within one month of effectiveness.

63. To ensure that funds are readily available for project implementation, MoPH will open through MoPH a Designated Account (DA) in US Dollars at the Central Bank of Lebanon. The DA will be maintained and managed by MoPH. Deposits into and payments from the DA will be made in accordance with the provisions stated in the Disbursement Letter and as outlined in the World Bank "Disbursements Guidelines for Projects". DA replenishments will be on the basis of Withdrawal Applications. Funds will be channeled from the World Bank to the MOF bank account for grants and donations and then transferred to the DA of the project following internal procedures adopted by MoF. Other disbursement methods will be available as per the project Disbursement Letter.

C. Procurement

64. A **procurement capacity** assessment of the MoPH was conducted to identify risks and mitigation measures. The Ministry had implemented a first project financed by IBRD and an update of the assessment was needed to verify the capacity.

65. The **project proceeds** will be used to: (i) subsidize essential healthcare package to NPTP enrollees; (ii) build capacity of contracted PHCCs; and (iii) support MoPH to administer and monitor PHC coverage program.

66. The procurement risk rating is ***"Substantial"*** based on identified risks. The identified risks are related to: (i) decision centralized at MoPH level with likelihood of delays; (ii) weak experience of civil servants in international procurement; (iii) procurement planning not enforced; (iv) reduced bidding competition; (v) deficiencies in procurement evaluation; (vi) Resolution of complaints is not institutionalized; (vii) contract management deficiency; and (viii) lack of public oversight. Once adopted, the following mitigation measures identified in each area are expected to reduce the overall fiduciary risk during implementation: (i) POM to clearly determine time expected to make procurement related decisions; (ii) appointment of an experienced PMU; (iii) ensure appropriate support (staff, training, tools) to update the project procurement plan to link it to project objectives; (iv) establish advertising policy and develop sample advertisement in line with the Bank Guidelines requirements; (v) develop standard template for evaluation report for project/agency and ensure compliance; (vi) improve addressing complaints; (vii) develop and implement quality assurance arrangements; and (viii) selection of an external auditor.

67. The **project procurement arrangements** will be envisaged (details in Annex III) as follows:

1. Project guidelines: World Bank procurement guidelines apply to the project.[20]
   a) For the procurement of Goods, and Non-Consulting Services, the following methods shall be used: (i) International competitive bidding (ICB); (ii) National competitive bidding (NCB) for which shall be used either ICB -or a translated version- or develop Standard Bidding Documents acceptable to the Bank as mentioned in clauses 3.3 and 3.4 of the procurement guidelines; (iii) Shopping; (iv) Framework agreements; and (v) Direct contract.

   b) For the selection of consultants, the following methods shall be used: (i) Quality-and-Cost-Based-Selection (QCBS), (ii) Selection under a Fixed Budget (FBS); (iii) Least-Cost-Selection (LCS), (iv)Selection based on Consultants' Qualifications (CQS); (v) Single Source Selection (SSS); (vi) Use of Nongovernmental Organizations; and (vii) Selection of Individual Consultants.

   c) Procurement plans: An initial procurement plan dated February 5, 2015 was developed by the Government. It defines the prior review and procurement methods thresholds. It will be updated and reviewed by the Bank at least twice a year or as necessary.

   d) Prior Review threshold: Based on the satisfactory past experience of MoPH, the project shall be subject to moderate risk prior review threshold, making the project mostly subject to post review.

   e) Frequency of supervision mission and post procurement review is foreseen respectively twice and once yearly. In post procurement review, a sample of ten percent (10%) of contracts eligible for post review shall be covered.

D. Social (including Safeguards)

68. The project will have a very positive social impact and respond directly to several social concerns of Lebanese citizens affected by the crisis through: (i) expanding the services to poor who have been crowded out and denied access to services in areas with heavy overlap with the Syrian refuges; (ii) extending services to the uninsured and underserved poor; (iii) reducing out of pocket payments for the poor; and (iv) extending referrals for specialized services in hospitals. More importantly, it will contribute significantly to reduce inter-communal tension and rebuilding the trust and social cohesiveness among the local communities where both Lebanese and Syrians coexist. The project focus on outreach and awareness-raising will allow reaching out to those most in need who are currently not aware of these services and strengthening communication channels between beneficiaries and service providers.

E. Environment (including Safeguards)

69. The proposed project aims to provide a basic health benefits package to the segments of Lebanese citizens in targeted areas who are enrolled in the NPTP and are affected by the Syrian crisis in order to increase their access to primary health care services. This will be essentially

[20] Refer to Annex III for a complete list of these guidelines.

achieved through the provision of a subsidized essential healthcare package as well as through capacity building of health service providers. As such, there will be no new physical investments in health care facilities envisaged under the proposed project. Rather, the proposed project will be utilizing the existing health units, centers and hospital facilities rendering them more accessible to the poor.

70. Given that the proposed project will not involve any physical investments and will have minimal or no adverse environmental impacts, it is classified as a Category "C" project according to World Bank Safeguards Policies. No environmental assessment is required as OP 4.01 Environmental Assessment will not be triggered.

Annex I: Results Framework and Monitoring

LEBANON
EMERGENCY PRIMARY HEALTHCARE RESTORATION PROJECT

Results Framework

Project Development Objectives

PDO Statement

The objective of the project is to restore access to essential healthcare services for poor Lebanese affected by the influx of Syrian refugees.

The project aims to provide an essential healthcare package (EHCP) (preventive, primary, and ambulatory care) to eligible beneficiaries of the National Poverty Targeting Program (NPTP) living in areas most affected by the crisis. The services will be delivered through MoPH Network of PHCCs and Outpatient Departments (OPD) of public hospitals.

These results are at | Project Level

Project Development Objective Indicators

Indicator Name	Baseline	Cumulative Target Values			
		YR1	YR2	YR3	End Target
Direct project beneficiaries (Number) - (Core)	0.00	50,000	120,000	150,000	150,000
Female beneficiaries (Percentage - Sub-Type: Supplemental) - (Core)	0.00	50	50	50	50
User Satisfaction (Percentage)	0.00	60	70	75	75
Utilization of services: average no. of visits per beneficiary per year (Number)	0.5 *(less than 1 visit)*	1.0	1.5	2.0	2.0

Intermediate Results Indicators

Indicator Name	Baseline	Cumulative Target Values			
		YR1	YR2	YR3	End Target
Pregnant women receiving at least four antenatal care visits - (Percentage)	0.00	65	80	90	90
Women aged 40 years and above screened for breast cancer- (Percentage)	0.00	65	80	90	90
Children immunized (number)[21] (Number) - (Core)	0.00	1,600	5,300	10,000	10,000
Children immunized - under 5 years against Polio (number - Sub-Type: Breakdown)	0.00	1,600	5,300	10,000	10,000
Target population 40 years and above who were screened for Diabetes Mellitus- (Percentage)	0.00	70	80	90	90
Health personnel receiving training (number) (Number) - (Core)	0.00	200	350	400	400
Health facilities contracted (Number)	0.00	75	75	75	75
Timely transfer of contract payments to contracted Health Facilities (months)	0	3.5	2.5	2	2
Grievances registered related to delivery of project benefits addressed (Percentage) - (Core)	0.0	75	80	80	80
Grievances registered related to delivery of project benefits addressed (Number) - (Core)	0.0	30	60	90	90

[21] Baseline is based on current immunization rates in targeted regions (around 82%) adjusted to 150,000 population. End Target is estimated to reach 95%.

Indicator Description

Project Development Objective Indicators

Indicator Name	Description (indicator definition etc.)	Frequency	Data Source / Methodology	Responsibility for Data Collection
Direct project beneficiaries	Eligible NPTP beneficiaries who enroll with contracted providers and are eligible for the essential healthcare services package.	Bi-annually	NPTP Database	PMU
Female beneficiaries	Percentage of direct project beneficiaries that are female.	Bi-annually	NPTP Database	PMU
User Satisfaction (percent)	Share of users satisfied by the received health care services.	Bi-annually	User Satisfaction Survey	External Technical Audit
Utilization of services: average no of visits per beneficiary per year (number)	Utilization of services provided by health care service providers that will be calculated as a weighted average of the number of visits per beneficiary per year.	Bi-annually	HIS	PMU

Intermediate Results Indicators

Indicator Name	Description (indicator definition etc.)	Frequency	Data Source / Methodology	Responsibility for Data Collection
Health personnel receiving training (number)	Cumulative number of health personnel receiving training through the project.	Bi-annually	HIS	PMU
Women aged 40 years and above screened for breast cancer- (Percentage)	Percent of women above the age of 40 *(from among 150,000*) receiving a mammogram to screen for breast cancer as a result of project activities.	Bi-annually	HIS	PMU
Target population aged 40 years and above screened for Diabetes Mellitus- (Percentage)	Percent of beneficiaries above the age of 40 *(from among 150,000)* screened for Diabetes Mellitus according to MoPH guidelines.	Bi-annually	HIS	PMU
Children immunized (number)	Cumulative number of children receiving vaccines purchased through the project, as well as the cumulative number of children immunized with vaccines purchased with other resources that are delivered through a Bank-supported program.	Bi-annually	HIS	PMU
Pregnant women receiving at least four antenatal care visits- (Percentage)	Percent of pregnant women *(from among 150,000)* who receive at least four antenatal visits during their complete term of pregnancy.	Bi-annually	HIS	PMU
Health facilities contracted	Health facilities contracted under the program to deliver the essential healthcare package to the project beneficiaries.	Bi-annually	HIS	PMU

Timely transfer of contract payments to contracted Health Facilities (months)	Number of months that will take the MoPH to reimburse payments to contracted facilities according to claims and invoices submitted by the facilities.	Bi-annually	HIS	PMU
Grievances registered related to delivery of project benefits addressed (Percent) – (Core)	This indicator measures the transparency and accountability mechanisms established by the project so the target beneficiaries have trust in the process and are willing to participate, and feel that their grievances are attended to promptly.	Bi-annually	Grievance database	PMU

Annex II: Detailed Project Description

LEBANON
EMERGENCY PRIMARY HEALTHCARE RESTORATION PROJECT

1. This program is designed by the MoPH in Lebanon to assist in reducing the social, economic, and health impacts of the Syrian crisis on poor Lebanese by subsidizing a package of essential healthcare services to NPTP beneficiaries. In doing so the project achieves several objectives: (i) it targets the most vulnerable population whose geographic distribution is concentrated in areas that are most adversely affected by the Syrian crisis; (ii) it focuses on primary healthcare which has been noted to be the cornerstone for any effective healthcare system; and (iii) it fills in the financial gap and addresses basic inequity in the current health sector coverage safety net. As secondary and tertiary care in Lebanon is covered, for the most part, through the various schemes available in the country, primary healthcare, including outpatient diagnostic services, continue to constitute a financial burden on many segments of the Lebanese population. The influx of the Syrian refugees associated with a significant increase in demand for health services has exacerbated this problem and is jeopardizing the ability of poor Lebanese to access primary healthcare services at the MoPH network clinics.

2. The program will be implemented through three main components:

Component 1: Provision of Essential Healthcare Services Package (US$9.04 million financed from LSCTF; additional US$6 million financed by MoPH)

Beneficiaries

3. This component subsidizes a package of essential healthcare services to around 150,000 out of the 340,000 poor Lebanese identified by the National Poverty Targeting Program (NPTP) as living below the poverty line. The NPTP is based on a PMT targeting mechanism that ensures that the most vulnerable groups within the population would be reached.

4. Priority in the selection of beneficiaries is given to those living in areas with highest concentration of NPTP enrollees and most affected by the Syrian crisis. Accordingly, catchment areas with more than 500 NPTP beneficiaries were first selected. As poverty areas tend also to overlap with areas with high concentration of refugees, regions such as the North and Beka'a comprises the highest concentration of beneficiaries (72.2%) in this project. Similarly children and adolescents and women constitute 45 and 29.5 percent of beneficiaries respectively. Table 2 below outlines the distribution of targeted beneficiaries in the project by age, gender and region.

Table 2: Targeted NPTP population by region, age and gender

	CHILDREN & ADOLESCENTS				FEMALES				MALES				TOTAL
REGION / AGE	**0-2**	**3-6**	**7-12**	**13-18**	**19-39**	**40-49**	**50-64**	**65+**	**19-39**	**40-49**	**50-64**	**65+**	
North Lebanon	4,694	7,744	12,748	12,154	11,803	4,911	3,767	1,990	10,554	4,443	3,260	1,600	**79,668**
Bekaa	1,570	2,585	4,130	4,023	4,235	2,263	1,778	1,158	3,347	1,730	1,379	935	**29,133**
Mount Lebanon	1,035	2,007	3,491	3,513	2,979	2,016	1,462	655	2,460	1,636	1,234	603	**23,091**
South Lebanon	609	1,112	1,831	1,965	1,768	1,062	827	359	1,560	848	672	341	**12,954**
Nabatieh	220	439	711	811	567	371	203	90	486	336	185	115	**4,534**
Beirut	58	135	244	232	139	101	62	23	144	76	68	34	**1,316**
Total	***8,186***	***14,022***	***23,155***	***22,698***	***21,491***	***10,724***	***8,099***	***4,275***	***18,551***	***9,069***	***6,798***	***3,628***	***150,696***

Source: NPTP Database, Ministry of Social Affairs

Essential Healthcare Package (EHCP)

5. The project will provide beneficiaries with a package of essential healthcare services comprising of the following: (i) three age specific and gender wellness packages (ages 0-18, females 19 years and above, males 19 years and above); (ii) two care packages for the two common NCDs in Lebanon; diabetes and hypertension; and (iii) a reproductive health package. Eligible beneficiaries will be covered for the following: (i) screening and preventive and health promotion visits; (ii) essential clinical and diagnostic tests; (iii) prenatal and post care visits;[22] (iv) consultation visits for the treatment of diabetes and hypertension; and (v) prescription medications. Members will receive the EHCP according to their age and gender. Individuals diagnosed with diabetes and hypertension will receive treatment, follow-up visits and medications.

6. As for diagnostic tests, the MoPH has a list of pre-approved lab and radiology tests that can be provided at the PHCC level. Other tests that require additional capabilities and advanced technology (such as mammography) will be referred to pre-selected certified facilities in their catchment area. Annex V presents the different packages and services provided under each package.

Providers

7. The package of essential healthcare services will be provided to beneficiaries through contracted PHCCs. Selection of PHCCs is based on two main criteria: (i) participation in the National PHCC Network; and (ii) geographical proximity to communities with high concentration of NPTP enrollees and most affected by the influx of Syrian refugees. To ensure that the selected PHCCs are adequately and equitably distributed in communities with high concentration of poor households, the MoPH matched the NPTP enrollees with facilities in the PHC Network. A total of 75 PHCCs are selected for the provision of services in this project (see Annex VI for the distribution map). Table 3 below provides the distribution of targeted providers and beneficiaries by region.

[22] The reproductive health package provided under the project will not cover the deliveries, and will continue to be financed by MoPH hospitalization budget.

Table 3: Distribution of Contracted Providers and Beneficiaries by Region

Governorate	Number of PHCC	Number of beneficiaries
North Lebanon	27	79,668
Beka'a	14	29,133
Mount Lebanon	17	23,091
South Lebanon	8	12,954
Nabatieh	6	4,534
Beirut	3	1,316
Total	***75***	***150,696***

8. Provider participation is voluntary and governed by legal agreement between the MoPH and the facility. Contracted PHCCs will be responsible to provide beneficiaries with preventive, primary services and management of diabetes and hypertension. Pre-selected licensed facilities will provide diagnostic tests that are not performed at the PHCCs. As such, the PHCCs will play a gate keeping role referring patients to appropriate facilities for diagnostic procedures, and, if needed, for hospitalization. Hospital admissions will not be financed by the project but will be covered through the current MoPH's hospitalization budget.

9. In general, network PHCCs are selected based on their size, coverage, and level of services which include general medical care, pediatrics, dental and oral health, maternal and child health, reproductive health, and cardiovascular medical care. Accordingly, the 75 participating PHCCs are better prepared and have adequate capacity to build on to provide the EHCP to the targeted population (PHCCs readiness and capacity building is further elaborated in Component 2).

10. Quality of Care will be monitored and maintained through the MoPH PHCC accreditation program. The PHC accreditation program was initiated in 2009 by the MoPH in collaboration with Accreditation Canada International (ACI). With support of local experts, the program was developed, piloted and implemented in a phased approach in PHC network facilities. Currently, 34 out of the 75 PHCCs are accredited and the other 42 are preparing for accreditation in 2015. Moreover, quality of clinical care will be monitored by the MoPH through the EHCP clinical indicators listed in Annex V.

Enrollment

11. Contracted PHCCs will receive from CMU of PCM through the MoPH the list of beneficiaries in their catchment area and will be responsible for enrolling those beneficiaries through marketing and outreach campaigns. Once enrolled, individuals will be exempted from payment for EHCP services as they will be fully subsidized by the government. A nominal fee of around US$12 will be paid by each household for registration. Upon enrollment, each member of the household will receive a photo identification enrollment card which will be saved in the system for proper verification of beneficiaries.

12. The average per-capita cost of providing the EHCP was estimated through an in-depth study based on the actual prices that prevail in the markets for medical goods and services, NSSF rates, and current MoPH rates. These costs have been brought to a per-capita average accounting for the size of the beneficiary pool. These costs are considered to be reliable for actual costs of delivering the EHCP. The estimated average cost of the EHCP is about US$ 60 per capita.

Contracting and Provider Payment Mechanism

13. The MoPH will be the purchaser of the package of services for the beneficiary population from PHCCs. The contractual agreement between the MoPH and PHCCs will define the responsibilities and obligations of each party and will specify the number of NPTP beneficiaries that shall be targeted, services that shall be offered by the facility, the contract value that will be paid, the targets that should be achieved, clinical and financial reporting requirements, disbursement requirements and payment mechanisms. A key aspect of the agreement is that it allows providers to determine how the funds they receive should be spent. The PHCCs will be responsible for ensuring that all diagnostic tests are received according to clinical guidelines. As such, tests that are not available at the PHCCs will be referred to pre-selected licensed facilities. The PHCCs will be responsible for following up on referred beneficiaries, and for payment and reporting of these tests. Disbursement from the MoPH to the PHCCs will be made on a capitation basis for each eligible beneficiary actually enrolled in the center. To set correct incentives to PHCCs, the per-capita payment will be divided into three parts: the first payment relates to PHCCs' success in enrolling eligible NPTP beneficiaries, the second is based on use of services by beneficiaries, and a third is based on achievement of user satisfaction.

14. Accordingly, disbursement will be made according to the following installments: (i) 20 percent of the contract amount would be disbursed immediately upon signing. In addition, one-time payment to PHCCs to assist them in preparing for project implementation including recruitment of additional staff, as needed; (ii) 40 percent would be disbursed periodically (3 months) for the actual number of enrollees attending clinic after verification through cross-checking of PHCCs registers with existing NPTP enrollee databases; (iii) 30 percent will be disbursed periodically (3 months) for enrollees completing a second visit; and (iv) a final disbursement of 10 percent will be offered in two installments at the end of second and end of third year as a reward based on achieving user satisfaction (Table 4).

15. The user satisfaction will be monitored through third party assessment and will include analysis of the following: (i) enrollment; (ii) knowledge of the benefits plan; and (iii) utilization of the grievance system.

Table 4: MoPH Payment Modalities to Contracted PHCC

	Payment justification	**Frequency of Payment**	**Amount Paid (%) For the life of the project**	**Formula** **X = contract amount= # Target beneficiaries x $60**
Payment 1	Contract Advance	Once upon contract signing	20% of total contract value	P1= 20 % x X
	Readiness Payment	Once within first 3 months	$26,150	
Payment 2	Actual Enrollment	Periodically (every 3 months)	40% of total beneficiaries enrolled and received first visit	P2= # Enrollees x 0.4 x $60
Payment 3	Use of Services	Every 3 months	30% for reaching an average utilization of 2 visit per enrollee	P3=# Enrollees who received a second visit x 0.3 x $60
Performance payment	Enrollees	Once at the end of year 2 and 3 the project	10% of contract amount for patient satisfaction	0.1 x X

16. Annually, MoPH and the Bank would hold discussions regarding the experience and lessons of implementation of the capitation system in general and the capitation amount in particular and would make specific adjustments as appropriate.

Component 2: Readiness and Capacity Building of PHCCs (US$3.17 million financed from the LSCTF)

17. This component will finance PHCC readiness, technical assistance and capacity building to implement the new package of services. In order to better assess and plan for supply side readiness, the MoPH launched a rapid facility assessment to identify capacity gaps among the PHCCs, and engaged in several focus group discussions with PHCCs to explore their willingness and suggestions to participate in the program. PHCCs were then provided with a concept note describing the new program and the targeted number of enrollees in their catchment area. Accordingly, each PHCC was better able to assess its gaps and determine its capacity needs to respond to the projected increase in demand. As a result of this exercise, it was agreed that this component will finance the following:

(i) Improvements in basic capacity of PHCCs and in areas where shortages of supply may hamper the capacity to deliver the EHCP, primarily through hiring of additional health workers, providing new and upgraded medical equipment supporting the delivery of the package; excluding investments in infrastructure or complex equipment.

(ii) Short-term refresher courses to train healthcare professionals in diagnosis and delivering of the newly introduced essential health care packages, clinical protocols that pertain to the EHCP, technical on the job training, and use of equipment. Special emphasis will be

given to training staff on shifting the service delivery model from its current emphasis on curative care to prevention.

(iii) Technical assistance and personnel training that supports program management such as contract management, monitoring clinical and the fiduciary requirements of the contract, and reporting requirements.

(iv) Upgrading and expanding the health information system and training of staff in the use of software.

Component 3: Project Management and Monitoring (US$1.68 million financed from the LSCTF)

71. The objective of this component is to: (i) ensure an effective and efficient, administration, regulation, and implementation of the project; (ii) improve the effectiveness of the MoPH in contracting with PHCCs; (iii) rigorous monitoring and performance assessment of the project outputs and objectives. To achieve its objectives, this component will finance technical assistance for the following activities:

a) Providing technical support to the Program Management Unit (PMU) in the MoPH through training, hiring qualified personnel (non MoPH staff), and covering operating costs and equipment;
b) Providing technical assistance in the development and management of contracts between MoPH and selected PHCCs and in the verification and validation of the PHCCs' financial and technical reports as well as the Essential Healthcare Services' packages' payment process;
c) Updating and maintaining Health Information System (HIS) (including provision of IT hardware and software) at MoPH with links to other related agencies involved in the implementation of the Project;
d) Initiating monitoring and assessment of the Project through setting the baseline, collecting the data and setting the parameters for evaluation;
e) Improving the grievance and redress mechanism for improved efficiency and transparency. An external firm will be contracted to upgrade the current system with focus on hotline operations;
f) Launching outreach campaign and communication activities to inform Beneficiaries about their health rights and services provided at the PHCCs in their areas. This would also include support consultant services, event organization, and communication services.

Project Cost

Table 5: Project Cost Summary by Component (US$ millions)

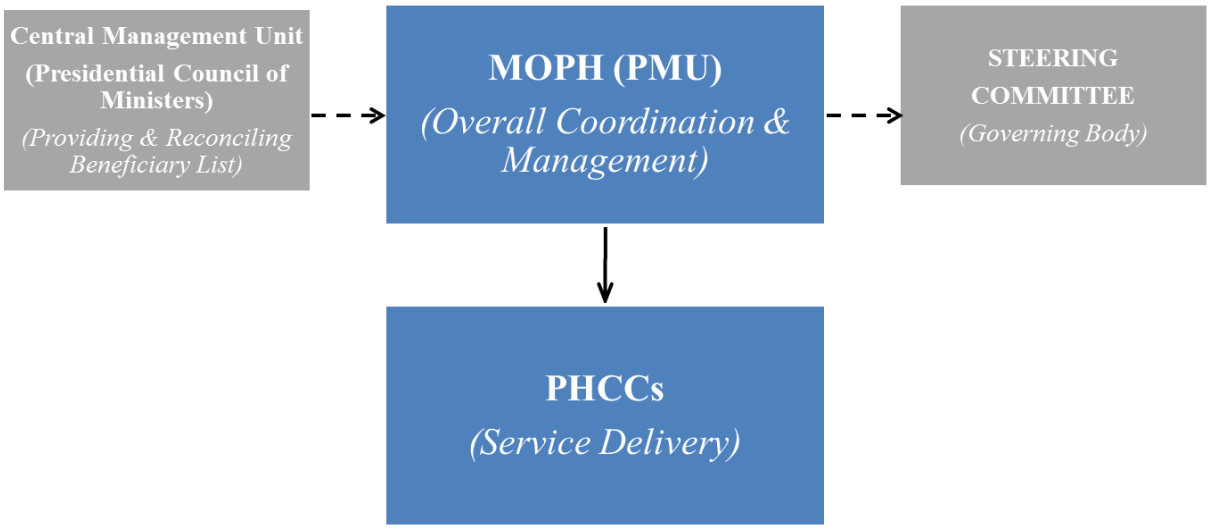
Activities	Quantity	Unit	Unit Rate (US$)	Total Cost (US$)
COMPONENT 1. Essential Health Care Pacakges (EHCP)				
A. Essential Health Care Package				
PHCC (based on capitation)	150,696	per beneficiary	60.00	$ 9,041,760
Sub-Total Comp 1: Provision of Subsidized Essential Health Care Package				**$ 9,041,760**
COMPONENT 2. Readiness and Capacity Building of PHCCs				
A. Readiness of PHCCs				$ 1,741,250
B. Capacity Building				$ 747,500
C. Health Information System (HIS) Strengthening and Management				$ 682,500
Sub-Total Comp 2: Readiness and Capacity Building of PHCCS				**$ 3,171,250**
COMPONENT 3: Project Outreach, Management and Monitoring				
A. Personnel				$ 903,600
B. Furniture & Office Equipment (at MOPH)				$ 23,620
C. M&E and HIS				$ 330,000
D. Communication Design & Implementation				$ 95,000
E. Operation/running costs	3	per year	$ 50,000	$ 150,000
F. External Financial Audit	3	per audit	$ 10,000	$ 30,000
G. Upgrading the Grievance System	1	lumpsum	$150,000	$ 150,000
Sub-Total: Project Management and Monitoring				**$ 1,682,220**
TOTAL				**$ 13,895,230**
Contingency				**$ 1,104,770**
GRAND TOTAL				**$ 15,000,000**

Annex III: Implementation Arrangements

LEBANON
EMERGENCY PRIMARY HEALTHCARE RESTORATION PROJECT

Institutional and Implementation Arrangements

Figure 2: Project Institutional Set Up



1. The **MoPH** will be responsible for overall project coordination and management in close collaboration with multiple strategic and implementing partners including PHCCs, CMU of the PCM.

2. A **PMU** will be established at MoPH, no later than 2 months after effectiveness, staffed with the key positions, including but not limited to project coordinator, financial and accounting manager and procurement officer to oversee: (i) planning, execution and oversight of the project activities; (ii) financial management of project funds following the bank guidelines including data validation and payments to service providers; (iii) monitoring and reporting on project activities and outcomes; and (iv) procurement planning and management. Some of the key PMU staff will be appointed/seconded by the Recipient (salaries financed by the Government budget) and additional personnel if/as needed would be financed by the project.

3. A **Steering Committee** will be formed to coordinate inter-ministerial policies and address strategic and policy level issues that arise during the project period. The committee will be headed by the MoPH Director General and will include various stakeholders.

4. While the POM will describe detailed implementation arrangements for each component, following will be the key implementing partners:

- **PHCCs** will be responsible for delivery of the essential healthcare package to targeted beneficiaries. They will also be responsible for the outreach campaigns, beneficiary enrollment, record keeping, reporting on enrollment and clinical health indicators, and will benefit from the capacity building activities under the project.

- The CMU of the NPTP at the PCM will provide the list of eligible NPTP beneficiaries to the MoPH.

Table 6: Summary of Functions by Institutions

Institution / Entity	**Regulation & Strategic Leadership**	**Verification**	**Validation**	**Payment**	**Enrollment**	**Provision of services**	**Clinical audit**	**Community Survey**
MoPH (PHC Dept)							Internal	
PMU		Random						
Field Coordinators		Random					Random	
PHCCs Network								
Steering Committee								

Capacity Building

5. **MoPH and PMU.** Capacity building of the relevant staff in MoPH and PMU will be done through a combination of knowledge building activities and external technical assistance about contracting, provider payment mechanisms, grievance redress, fiduciary requirements. Other capacity building activities envision hiring and training of relevant PMU staff, improvement of the HIS, providing and maintaining IT equipment, etc. The MoPH is experienced in World Bank procurement processes and used to employing consultants in the implementation of its projects and will draw on this experience in the Second Emergency Social Protection Implementation Support Project (ESPISP II, Project ref. P111849).

6. The **PMU** will be staffed with the following key positions: Project Coordinator; Operations & Technical Manager, Financial and Accounting Manager; Monitoring & Evaluation (including field monitoring), HIS and Data Management Specialists; Procurement Officer, and Administrative Assistant. A number of current MoPH staff will form the core of the PMU on a full time or part-time basis, and will be financed by the MoPH. Also, MoPH Caza Coordinators who are responsible for supervising healthcare in their jurisdictions would support the PMU as specified above. Additional core PMU staff will be recruited to support key functions, namely, operations, IT, fiduciary, and administrative. Additional consultants will be hired on an as-needed basis for tasks such as contracting, medical review of claims, verification, revalidation of verification, etc.

7. **PHCCs.** To address the potential capacity constraints, the PHCCs will be provided with a series of training courses focusing on the specifics of the essential healthcare packages, reporting and M&E, accounting and financial management and administration, as well as the upfront payment upon contract signing that can be used for start-up preparatory activities.

Other Implementation Arrangements

8. A Project **Operations Manual** (POM) for the Project will be prepared within one month after effectiveness and will cover all aspects of the program's design, implementation and processes, payment mechanisms, stakeholder responsibilities, procedures, and other guidelines to be followed under the project.

Financial Management and Disbursements

Financial Management

9. The Bank assessed the adequacy of the project FM arrangements proposed by the implementing entity on the basis that this project is an emergency operation. The arrangements are considered acceptable if the entity budgeting, accounting, internal controls, funds flow, financial reporting, and auditing arrangements are: (a) capable of correctly and completely recording all transactions and balances relating to the project; (b) facilitate the preparation of regular, timely, and reliable financial statements; (c) safeguard the project's assets; and (d) are subject to auditing arrangements acceptable to the Bank.

10. The FM risk was assessed as "**Substantial**" before mitigation measures; however this rating is expected to be lowered to "Moderate" when the proposed mitigation measures are effectively implemented. The key risks are the following: (i) no experienced and dedicated staff

member to undertake the FM activities; (ii) lack of accounting system to record and produce financial reports; (iii) weak internal control system; and (iv) weak external audit function.

11. The MoPH will need to implement the following mitigating measures to reduce the FM risk level to moderate: (i) to recruit an experienced Financial Officer (FO) according to TORs acceptable to the Bank; (ii) adopt an accounting software with specifications acceptable to the Bank to record daily transactions and produce the periodical financial reports; (iii) to prepare a financial management manual; and (iv) to ensure that an independent qualified external auditor is contracted according to TORs acceptable to the Bank; the audit report will be delivered to the Bank no later than six months after the end of each fiscal year.

Financial Management Arrangements

12. **Staffing & Organization.** The MoPH is understaffed and has limited experience in implementing Bank financed projects. Therefore for the purpose of the project, a Financial Officer (FO) will be recruited to carry out the FM implementation of the Project as part of the PMU team. The World Bank team will provide the necessary training and support in FM procedures and reporting guidelines for the newly recruited FO.

13. **Internal Controls.** The MoPH has limited internal controls functions. The internal controls are set as per the internal bylaws of the MoPH. For this purpose, the project will prepare a financial management chapter containing detailed information about the FM procedures and rules governing the flow of activities, internal control procedures in addition to specific responsibilities undertaken by each member of the unit. The FM Chapter will be part of the POM.

14. **Budgeting.** Grant's funds will be channeled through the MOF bank account for grants and donations and they will be transferred to the DA of the project. This is the procedure to be adopted for all donors' grants as per the circulars issued by Councils of Ministers and MOF. For the purpose of the project, a project annual budget and disbursement plan will be produced and maintained by the project based on the project procurement plan and implementation schedule to ensure timely availability of funds. It will be used as an effective monitoring tool for comparing planned expenditures with actual ones and monitoring the existing variances.

15. **Accounting System and Financial Reporting.** The MoPH does not have an accounting information system to process accounting transactions. The MoPH currently has an information system for public health which does not contain a financial module. For the purpose of the project, the MoPH will integrate a financial module in the current information system with specifications acceptable to the Bank. The financial module will be used to record daily transactions and to generate the required Project Interim Un-audited financial reports (IFRs) and the Project Financial Statements (PFS). The documentation and supporting documents shall be maintained at MoPH for subsequent review and audit. The Bank will provide further trainings and guidance as needed. The Interim Un-audited financial reports (IFRs) will be in compliance with International Public Sector Accounting Standards (IPSAS) format of financial statements as the Project will be recording the grant transactions using the cash basis of accounting. The IFRs will be composed of the following:

a) A "Statement of Cash Receipts and Payments by component" and;

b) Accounting policies and explanatory notes including a footnote disclosure on schedules: (i) detailed expenditures by component; (ii) "the list of all signed Contracts per component" showing Contract amounts committed, paid, and unpaid under each contract; (iii) Reconciliation Statement for the balance of the Project's DA; (iv) Statement of Cash payments made using Statements of Expenditures (SOE) basis; (v) a list of payments by region, healthcare center, type and beneficiary; and (vi) Statement of Fixed Assets.

16. These Project IFRs will be prepared on a quarterly basis and submitted to the Bank within 45 days at the end of each quarter.

17. The PFSs, prepared in accordance with IPSAS - Cash Basis - should contain the same information as the quarterly IFRs but cover an annual period. The audited PFS would be submitted to the Bank no later than six months after the end of each fiscal year (see External Audit Arrangements below). [23]

18. **Flow of Funds and Cash Management.** The funds will be transferred from the Bank to the project in accordance with the provisions of the Grant Agreement. The funds will be channeled first from the World Bank to the MOF account for grants and donations and then transferred to the DA opened for the project under the treasury account. MoPH will open through MoF a separate DA under Treasury in US$ at the Central Bank of Lebanon to receive the Grant proceeds. Deposits into, and payments from the DA will be made in accordance with the provisions stated in the Grant Agreement and disbursement letter and as outlined in the World Bank *"Disbursements Guidelines for Projects".*

[23] Project fiscal year ends December 31.

19. **Payments under Component 1 (US$9 million).** Payments under Component 1 will subsidize the Essential Healthcare Package (US$60 per beneficiary) for a total of 150,636 beneficiaries.

20. The PHCCs payment computation and schedule will be as follows:

- Phase 1: payment advance consisting of 20% of the cost of the package: 20% x 150,636 x US$60.
- Phase 2: actual enrollees' payment: 40% x actual enrollees x US$60.
- Phase 3: enrollees receiving a second visit: 30% x second visit enrollees x US$60.
- Phase 4: User satisfaction: 10% payment end of year 2 and end of year 3.

21. In addition, each PHCC will also receive support for an amount of US$ 26,150 divided between an advance of US$10,500 covering start up logistics, and administrative charges for outreach and enrollment activities and US$15,650 to support facilities in recruiting additional needed personnel and purchasing basic equipment to implement the EHCP, as needed and based on the results of the rapid facility survey.

22. **External Auditing.** The PFS will be audited by an independent private external auditor acceptable to the World Bank. The audit will cover all aspects of the project, including compliance with the financial management manual, review of effectiveness of the internal controls system, and compliance with the Financing Agreement. The audit will be carried out in accordance with International Standards on Auditing. The audit report and audited PFSs, along with management letter, will be submitted to Bank no later than six months after the end of each fiscal year. In addition, the project management letter will contain the external auditor assessment of the internal controls, accounting system, and compliance with financial covenants in the Grant Agreement. The audit TORs will be finalized and agreed upon with the Bank three months after project effectiveness. The external auditor is expected to be engaged within 6 months of project effectiveness. Moreover, the Bank makes publicly available the borrowers' audited annual financial statements for all investment lending operations.

23. **Disbursement Arrangements.** To ensure that funds are readily available for project implementation, MoPH through MOF will open a DA in US Dollars under the treasury account at the Central Bank of Lebanon. Deposits into, and payments from, the DA will be made in accordance with the provisions stated in the Grant Agreement and as outlined in the World Bank *"Disbursements Guidelines for Projects"* by means of advances, replenishment and reimbursements. Replenishments of the DA will be against Withdrawals Applications. The Ceiling of the DA is set at US$4 million for the first 9 months after effectiveness of the project then US$3 million for the 9 following months, and US$2 million thereafter. MoPH will be responsible for submitting monthly replenishment applications with appropriate supporting documentation. Other disbursement methods will be available as per the project Disbursement Letter. The categories of eligible expenditures that will be financed out of the proceeds of the Grant are provided below.

Category	Amount of the Grant Allocated (expressed	Percentage of Expenditures to be Financed

	in US$)	(inclusive of Taxes)
(1) Eligible Expenditures of Essential Healthcare Packages, Goods, Non Consulting Services, Consultants Services, Training and Workshops and Operating Costs	15,000,000	100%
TOTAL AMOUNT	**15,000,000**	**100%**

24. The proceeds of the Grant will be disbursed in accordance with the traditional disbursement procedures of the Bank and will be used to finance project activities through the disbursement procedures currently used: i.e. Advance, Reimbursements, Direct Payments and Special Commitments. Applications for Designated Account replenishment and Reimbursement will be accompanied by Statements of Expenditure (SOEs) in accordance with the procedures described in the Disbursement Letter and the Bank's "Disbursement Guidelines". Interim Unaudited Financial Reports and Annual Financial Statements will be used as a financial reporting mechanism and not for disbursement purposes. The minimum application size for reimbursements, direct payments and Special Commitment Issuance will be the equivalent to 20 percent of the DA ceiling.

25. **E – Disbursement**. The World Bank has introduced e-disbursement for all Lebanon supported projects. Under e-disbursement, all transactions will be conducted and associated supporting documents scanned and transmitted on line through the Bank's Client Connection system. E-disbursement will considerably speed up disbursements and facilitate project implementation. Necessary supporting documents will be sent to the Bank in connection with contracts that are above the SOE thresholds, except for expenditures under Contracts with an estimated value of: (a) US$500,000 or less for goods and non-consulting services; (b) US$200,000 or less for Consulting Firms; and (c) US$100,000 or less for Individual Consultants as well as incremental operating costs, training, workshops and study tours which will be claimed on the basis of SOEs. The documentation supporting expenditures will be retained by the project and will be readily accessible for review by the external auditors and periodic Bank Implementation Support missions. The Bank will honor eligible expenditures completed, services rendered and goods delivered by the project closing date. A four months' grace period will be granted to allow for the payment of any eligible expenditure incurred (i.e., services, goods or works, received and accepted) before the Grant Closing Date.

26. **Authorized Signatories.** Authorized signatories will be nominated by MoPH to sign the Withdrawal Applications (WAs). Names and corresponding specimen signatures will be submitted to the Bank prior to the receipt of the first WA (advance to DA). Each WA will be approved and signed by the authorized signatories.

27. **Governance and Anti-Corruption.** Fraud and corruption may affect the project resources, and thus impact negatively the project outcomes. The World Bank Financial Management Specialist (FMS) worked closely with the project's Task Team Leader (TTL) as well as with the project consultants, developed with the team an integrated understanding of possible vulnerabilities, and agreed on actions to mitigate the risks. The above proposed fiduciary arrangements, including the financial management manual, reporting and external audit are expected to address the risk of fraud and corruption that are likely to have a material impact on the project outcomes.

Financial Management Action Plan

Action	Date Due	Responsible
Open a separate designated bank account	1 month from effectiveness	MoPH
Prepare a financial management chapter	1 month from effectiveness	MoPH
Integrate a FM module in the MoPH information system	1 month from effectiveness	MoPH
Quarterly IFRs submitted to the Bank	45 days after the end of each quarter	MoPH
Appoint an external auditor with TORs acceptable to the Bank	Within 6 months from effectiveness	MoPH
Audit of project financial statements and management letter	Within 6 months after the end of each fiscal year	MoPH

28. **World Bank Implementation Support.** An Implementation Support mission will be conducted at least twice a year based on the risk assessment of the project. Among the Implementation Support mission objective is to ensure that strong financial management systems are maintained throughout the life of the project. The IFRs will be reviewed on a regular basis by the World Bank team and the results and issues will be followed up during Implementation Support missions. Financial audit reports will be reviewed and issues will identified and followed up on by the Project FO. Additionally, during Implementation Support missions, the Project's financial management and disbursement arrangements (including a review of a sample of SOEs and movements of the DA) will be reviewed to ensure compliance with the Bank's requirements.

Procurement

29. **Components.** The project will subsidize services at PHCCs and financing capacity building of PHCCs as well as support MoPH in administrating and monitoring the PHCC coverage program. The project comprises three components as following:

- **Component 1:** Provision of subsidized PHCC services to the poor US$9.0 (61 percent of the grant proceeds). Six packages of primary care will be provided by the identified poor. MoPH will be contracting the PHCCs, and payments shall be issued upon delivery of the services. Medicine and vaccines shall be the contribution of the government. No competition shall be observed to identify the centers.
- **Component 2:** Provision of technical assistance and training for upgrading the skills of personnel of contracted health centers. The HIS at PHCC level shall be as well

upgraded through provision of IT related equipment and training.

- **Component 3:** Provision of technical assistance to MoPH to ensure an effective and efficient administration and implementation of PHCC programs, and upgrading the HIS at MoPH.

Procurement Capacity Assessment

30. **Implementing agency.** MoPH through the PHC department will be implementing the project. MoPH abides by the Public Accounting Law No. 14969 dated December 30, 1963, supplemented by several decrees, which constitutes the legal foundation of Lebanon's organizational and institutional framework for procurement. For internationally financed projects, ministries can operate using donor's guidelines. The Ministry had implemented a first project financed by IBRD and an update of the assessment was needed to verify the capacity.

31. **Past experience** of the implementing agency in internationally funded projects: MoPH has implemented a first project (financed by IBRD) and has extensive experience in implementing other internationally funded projects. MoPH establishes a project management unit that outsources qualified staff for implementing projects, the ministry team has proven to be diligent in record keeping, quality of evaluation, staffing. MoPH has been exposed to international procurement for selection of consultants, purchase of goods and execution of Works.

32. **Record keeping;** Assets Inventory. The ministry, in implementing projects, has a proven experience in record keeping and the accounting system contain an inventory field.

33. **Current ministry staffing.** Two committees process procurement; Supply Committee and Acceptance committee. The department of PHC processes purchase of medicine and other related material by commissioning UNICEF for procurement processing. The position of procurement officer is not institutionalized and is handled through the department of finance/accounting.

34. **Procurement methods thresholds.** By Public Accounting Law, MoPH operates under the ceiling of L.L.100 million (US$67,000 equivalent). Above this threshold, the procurement must be processed centrally at the Central Tender Board, which, nevertheless, submits back to the concerned ministry, the recommendation to award. The budget law 715 of 2005 allows the implementing agencies to follow the donors' guidelines, when needed. EDP I and II implementation followed Bank guidelines.

35. **Audit.** The ministry does not observe internal auditing but is subject to ex-ante and ex-post reviews conducted by the Court of Accounts.

36. **Applied taxes.** The following taxation is observed: (i) Stamp Duties of (a) three per thousand (3‰) of the contract price for contract registration at MOF, and (b) three per thousand (3‰) on each payment; (ii) Value Added Taxes (VAT) of ten percent (10%) applied on consultants and contractors who are registered and eligible for VAT; and (iii) Income Taxes that are a flat rate of seven and a half percent (7.5%) for non-registered consultants and variable for

registered consultants (Taxpayer Identification Number-TIN), depending on their job classification at MOF. Exemption of consultants from Income Taxes may be observed if they are registered in countries that have entered with Lebanon into agreements prohibiting double taxation. Contracts financed by international donor proceeds are exempted from VAT (Law No. 379 dated December 14, 2001).

Overall Procurement Risk Assessment

37. **The procurement risk rating is Substantial.** The identified risks are related to: (i) decision centralized at minister level with likelihood of delays; (ii) weak experience of civil servants in international procurement; (iii) procurement planning not enforced; (iv) reduced bidding competition; (v) deficiencies in procurement evaluation; (vi) resolution of complaints not institutionalized; (vii) contract management deficiency; and (viii) lack of public oversight.

38. Once adopted, the following mitigation measures identified in each area are expected to reduce the overall fiduciary risk during implementation: (i) POM to clearly determine time expected to make procurement related decisions; (ii) appoint an experienced PMU; (iii) ensure appropriate support (staff, training, tools) to update the project procurement plan; (iv) establish advertising policy and develop sample advertisement in line with the Bank Guidelines requirements; (v) develop standard template for evaluation report for project/agency and ensure compliance; (vi) improve addressing complaints; (vii) develop and implement quality assurance arrangements; and (viii) select an external auditor.

Proposed Procurement Arrangements

39. **Project guidelines.** The following shall be applied to the project: (i) "Guidelines On Preventing and Combating Fraud and Corruption in Projects Financed by IBRD Loans and IDA Credits and Grants" dated October 15, 2006 revised in January 2011; (ii) World Bank "Guidelines: Procurement of Goods, Works and Non-consulting Services under IBRD Loans and IDA Credits and Grants by World Bank Borrowers" dated January 2011 revised July 2014; and (iii) World Bank "Guidelines: Selection and Employment of Consultants under IBRD Loans and IDA Credits and Grants by World Bank Borrowers" dated January 2011 revised July 2014.

40. **Methods of Procurement and prior review threshold:**

- For the procurement of Goods, and Non-Consulting Services, the following methods shall be used: (i) international competitive bidding (ICB); (ii) national competitive bidding (NCB) for which shall be used either ICB -or a translated version- or develop Standard Bidding Documents acceptable to the Bank as mentioned in clauses 3.3 and 3.4 of the procurement guidelines; (iii) shopping; (iv) framework agreements, (v) direct contract.
- For the selection of consultants, the following methods shall be used: (i) Quality-and-Cost-Based-Selection (QCBS), (ii) Selection under a Fixed Budget (FBS); (iii) Least-Cost-Selection (LCS); (iv) Selection based on Consultants' Qualifications (CQS); (v) Single Source Selection (SSS); (vi) Use of Nongovernmental Organizations; and (vii) Selection of Individual Consultants.

- Based on the satisfactory assessment, the project shall be subject to **substantial risk prior review threshold**; the project is mostly subject to post review (Table 7 recapitulates the project thresholds).

Table 7: Initial Methods and Prior Review thresholds for Procurement Moderate risk project

LEBANON Substantial Risk project- THRESHOLDS (US$)	Procurement categories and methods								
	Consulting firms		Individual Consultants	Goods			Works		
	QCBS	*Others*		*ICB*	*NCB*	*Shopping*	*ICB*	*NCB*	*Shopping*
Procurement Method Thresholds	No threshold	<0.3 million	No threshold	No threshold	<1 million	<0.2 million	No threshold	<10 million	<0.3 million
Prior review thresholds	>0.5 million	NA	>0.2 million	>1 million	NA	NA	>10 million	NA	NA

41. **Proposed project Staff.** Staffing for the project will be outsourced and will be supported by the ministry staff in order to build internal capacity. The procurement shall involve the engagement of Procurement and Financial officers.

42. **Project Operations Manual (POM).** A POM shall be developed to respond to this emergency operation.

43. **Procurement plan.** An initial procurement plan dated February 5, 2015 was developed by the Government. It defines the prior review and procurement methods thresholds. It will be updated and reviewed by the Bank at least twice a year or as seen necessary. Table 9 recapitulate the main activities.

Table 8: Consultancy for major Assignments with Selection Methods and Time Schedule

Proc. System Ref. #	Comp	Sub-Comp	Location/ Description of Assignment	Estimated Cost (US$)	Selection Method	Bank Rev.	TOR Start Date	Short Listing Report Date	Contract negotiation/Award-Draft	Contract Start Date	Execution in months	Completion Date (original)
FC001	C3	3.6	Independent External Project Audit (1 contract till end grace period + 2 Months)	30,000	LCS	PR	4-Jul-15	22-Aug-15	10-Dec-15	28-Dec-15	35.2	5-Dec-18

Table 9: Procurement of major Goods and Works with Procurement Methods and Time Schedule

Proc. System Ref. #	Comp	Sub-Comp	Location/ Description of Assignment	Estimated Cost (US$)	Selection Method	Bank Rev.	Bid. Doc/Specs prep. Start Date	Bid Opening Date	Evaluation & Recomm.	Start Date	Execution in months	Completion Date (original)
PG001	C2-C3	2.3-3.3	Upgrading of the management systems HIS (at 75 PHCC), Computers and connections, Magnetic card readers, camera & (at MOPH), Network & security hardware; Servers; Enrollment Cards, cartridges, printers	712,500	NCB	PO	3-Jun-15	15-Aug-15	12-Sep-15	29-Sep-15	4	29-Jan-16

44. **Frequency of Supervision.** The frequency of supervision mission and post procurement review is foreseen respectively twice and once yearly. In post procurement review, a sample of ten percent (10 percent) of contracts eligible for post review shall be covered.

Environmental and Social (including safeguards)

45. The project will have a very positive social impact and respond directly to several social concerns of Lebanese citizens affected by the crisis through: (i) expanding the services to poor in areas who have been crowded out and denied access to services in areas with heavy overlap with the Syrian refuges; (ii) extending services to the uninsured and underserved poor; (iii) reducing out of pocket payments for the poor; and (iv) extending referrals for specialized services in hospitals. More importantly, it will contribute significantly to reduce inter-communal tension and rebuilding the trust and social cohesiveness among the local communities where both Lebanese and Syrians coexist. The focus on outreach and awareness-raising will allow reaching those most in need who are currently not aware of these services and strengthening communication channels between beneficiaries and service providers.

46. Given that this proposed project will not involve any physical investments and will have minimal or no adverse environmental impacts, it will be classified as a Category "C" project according to World Bank Safeguards Policies. Accordingly, no environmental assessment is required as OP 4.01 Environmental Assessment will not be triggered.

Monitoring & Evaluation

47. In general, the PMU will be responsible for planning and implementing the M&E system in coordination with other implementing partners (CMU, PHCCs and Hospitals). This will involve:

a) Monitoring the implementation of project activities as per the implementation work plan in a timely and high quality manner;

b) Monitoring the project performance with regard to achievement of project activities and if necessary, modify and/or redirect activities to maximize the potential impact of the project;

c) Establishing a basis for evaluating the project with regard to achievement of the overall development objective;

d) Establishing working partnerships with PHCCs, Prime Minister's (PM) office responsible for the NPTP program, Hospitals (OPD) to gather and/or access the relevant data to optimize the M&E outputs for each component and sub-component under an integrated M&E plan;

e) Organizing data collection from different stakeholders and facilitating verification, analysis of the data/information received from various stakeholders;

f) Liaising with implementing agencies and partners required for implementation of key technical instruments (i.e. facility surveys, beneficiary assessments etc.); and

g) Generating progress and monitoring reports.

48. **Under this project, two types of monitoring are envisaged:** (i) monitoring the project performance with regard to day-to-day progress of project activities (including targets and intermediate results) as per the implementation plan; and (ii) evaluating the project with regard to achievement of the overall development objective.

Monitoring

49. Monitoring will be a continuous function carried out by MoPH/PMU with support from the MoPH HIS team. Specifically, it will comprise of two aspects as follows:

a) **Establishing a monitoring system (*as part of health information system*) which will include:** (i) annual work plans, targets, outputs, indicators, and outcomes for each component; (ii) baseline data, if available, for each outcome indicator; and (iii) user friendly data entry format and built in methodology that will automatically update the targets, outputs, and signal the achievement gap to alert the implementing agencies. The focus will be on systematic data collection on specified indicators and related deliverables to provide management and the main stakeholders the extent of progress and achievement of results and progress in the use of allocated funds. The data will be collected and reconciled with the PHCCs databases with specific focus on beneficiary enrollment and packaged delivered. This will enable management decisions to be made based on an assessment of whether the program is moving towards its objectives. A periodic financial audit will be conducted which will also help to identify and mitigate any potential sign of fraud and governance issues. The program monitoring system will rely on regular and accurate data collection and analysis to identify the timely implementation of activities, the achievement of intended results, and positive and negative unintended effects.

   i. **HIS** will form the basis for a well-functioning monitoring system and will comprise: (i) design of a program database; (ii) development of registers and forms to gather data (enrollment registers, provider data collection forms); (iii) development of the claims processing system, which will feed data into the HIS; (iv) collection and analysis of program indicators; (v) design of wider monitoring and verification activities (such as spot checks of providers, user satisfaction surveys through sampling of beneficiaries at the household level) which will provide data with which to counter-check the HIS data; and (vi) capacity building of MoPH in monitoring of the EHCP program.

   ii. **Sources of Data:** (i) the routine data collected through the claims processing system; (ii) data routinely collected at health facility level; (iii) additional data collected by MoPH such as from enrollment registers, spot checks and ad-hoc surveys; (iv) information collected during the verification processes; and (v) data from the MoPH rapid facility assessment.

iii. **Data Validation and Verification:** Data validation and verification will be done internally by MoPH. Internal verification will be aligned with the system used by the MoPH and will take place at two levels: (i) at the district level (Caza), the Caza Coordinator verifies a sample of 5 percent of all claims made through a combination of telephone and/or home visits (the sample is generated monthly by the HIS and sent through the Coordinator tasked with this activity; and (ii) at the central level, a random sample of 2 percent of claims validated at the district level is then re-validated by the central team at MoPH. Also at the central level, the MoPH will conduct trend and pattern analysis of the claims being processed to identify outlying data as an established anti-fraud tool.

b) Developing reporting mechanisms which will include: (i) monthly reports from implementing partners to PMU; (ii) quarterly reports from PMU to the Bank; and (iii) an Annual Project Implementation Report, consolidating progress in the project implementation by each of the institutions involved, based on administrative data, survey data, beneficiary assessments and independent evaluations.

Evaluation

50. Evaluation will comprise mainly of an independent project evaluation, beneficiary assessment and evaluation by the Bank. The aim is to determine the relevance and fulfillment of objectives, development effectiveness and sustainability. ***Independent Evaluation*:** The independent project evaluation will be contracted by the MoPH, using the Word Bank procurement processes and with Terms of Reference (TORs) acceptable to the Bank. The purpose of the independent evaluation will be to: (i) verify project's progress towards achievement of the development objective; (ii) ensure the correct use of funds on a six monthly basis; (iii) verify the services received by project beneficiaries through independently checking a sample of health facilities for enrollment registers, volume, quality of services, reporting and payments, and sample of beneficiary households for verification of enrollment, receipt of services and satisfaction; and (iv) look at different levels of monitoring as undertaken by MoPH to ensure that payments are being verified adequately against claims and services are actually provided. Evaluation report will be submitted once per year and will include recommendations on how to further improve project implementation and prevent fraudulent behavior or abuse. ***Beneficiary Assessment.*** A beneficiary assessment will be carried out to determine the impact of the project on the household service utilization, the cost of the services used, and the capacity of PHCCs to deliver services in effective and cost efficient manner. ***Evaluation by the Bank.*** As part of regular supervision, the Bank will conduct an evaluation at the mid-year to (i) undertake its own assessment of the project achievements and progress towards development objective; (ii) review the results of both the independent evaluation and beneficiary assessment reports, and reconcile the results with its own assessment; and (iii) suggest any changes to be made to the evaluation methods, scope and frequency as needed.

51. **Steps for Evaluation:** In order to meet the assessment requirements, the following steps should be taken to prepare for evaluation: (i) data collection and analysis process, formally institutionalized; (ii) baseline data established per targeted indicator; (iii) clarity regarding the definition and collection of each indicator; (iv) defining indicators must be a participatory effort

linked to the country yearly work plan and taking into consideration the Component Objectives linked to the Project Goal; (v) strategies should be developed to ensure that each indicator is properly employed in the context of the M&E Plan; (vi) project management level and component teams trained to coordinate and participate in the assessment process; and (vii) coordination with partners from other sectors, as well as with local authorities to support project evaluation.

52. **Grievance Redress Mechanism (GRM):** As part of monitoring the user satisfaction, the project will support the MoPH in upgrading the hotline operations to improve complaints and citizen feedback handling mechanism. It will help MoPH to better manage, respond and monitor complaints within its activities as part of an ongoing process to improve its accountability and program management.

Role of Partners

53. Because of the Syrian crisis, several UN and international agencies are on the ground providing support to the GOL in managing the influx of the Syrian refugees, and stabilization and resilience efforts for the Lebanese communities. As such, the WB engaged, and will continue to engage in discussions with the WHO, UNHCR, UNICEF on aid coordination activities and exchange of information of respective programs to ensure coordination and complementarity of interventions. To further strengthen the coordination efforts, the MoPH is taking the lead in setting up regular donor coordination meetings all partners.

Annex IV: Implementation Support Plan

LEBANON
EMERGENCY PRIMARY HEALTHCARE RESTORATION PROJECT

Strategy and Approach for Implementation Support

1. The implementation support plan for the project has been developed based on the specific nature of the project activities, the existing capacity of the implementing agencies and the project risk profile. Given the new design of the essential healthcare package and PMU's lack of experience with the WB-type projects, the Project will require close support of the WB team to the MoPH and the PMU in designing some of the implementation elements, developing contractual agreements with the service providers, and overall implementation support and capacity building, especially at the initial stages of project implementation.

2. Also, due to the substantial risk rating and emergency nature of the project, the WB team will need to provide continuous implementation support to the project by organizing at least two missions per year throughout the project duration. The supervision plan outlined here provides an overall strategy, the co-ordination arrangements with other donors, likely costs, and the staffing composition.

Implementation Support Plan

Table 10: Project Support

Time	***Focus***	***Skills Needed***	***Resource Estimate***	***Partner Role***
First twelve months	1- Building the capacity of the PMU & relevant staff in MoPH on project implementation matters 2- Support in contractual agreement design and PHC contracting 3- Launch workshop 4- Grievance redress system improvement.	- Senior Health Specialist - Health Economist - Social/ Citizen Engagement Specialist - Health Provider Contracting Specialist - Financial Management Specialist - Procurement Specialist - Operations Analyst - Program Assistant	*150,000*	WHO will provide funding for technical assistance to support the MoPH to assist in preparation of the Project Operation Manual. UNHCR assisting the MoPH in building the infrastructure and capacity building in select PHCs that will be part of this project.
12-48 months	Full-fledged implementation of the essential healthcare services in targeted areas.	- Senior Health Specialist - Health Economist - Social/ Citizen Engagement Specialist - Financial Management Specialist - Procurement Specialist - Operations Analyst - Program Assistant	*300,000*	Coordination of activities, knowledge exchange to avoid overlap and ensure complementarity with UNHCR, WHO, UNICEF and other donors.

Table 11: Skills Mix Required

Skills Needed	***Number of Staff Weeks (per year)***	***Number of Trips***
Senior Health Specialist	12	At least 6 trips during project implementation
Health Economist	4	
Social/ Citizen Engagement Specialist	3	
Health Provider Contracting Specialist	4	
Financial Management Specialist	2	
Procurement Specialist	2	
Operations Analyst	6	
Program Assistant	8	

Table 12: Partners

Name	***Institution/Country***	***Role***
WHO	International	Coordination of activities, knowledge exchange to avoid overlap and ensure complementarity with donors.
UNICEF	International	
UNHCR	International	

Annex V: Description of Essential Healthcare Package

Package	Age Group	Target	Description	Period	# of Visits	Content of visits	Laboratory	Radiology	Other Tests	Equipment	Medical Human Resources	MoPH Clinical Indicators
Wellness (Children & Adolescents)		Children & Adolescents from birth to 18 years	A multi-component package that covers well baby/well adolescent medical consultations, health education & counseling, immunizations, laboratory tests and medications. The delivery of services is based on the number of doctors visits, which are in turn based on the national immunization schedule of the Ministry of Public Health.	Package covers from birth to age of 18 years. Services will be used based on the age of the beneficiary.	Total of 11 visits detailed below by	doctor assessment, doctor & nurse counseling, immunization, and medication as needed	A total of 3 tests detailed below	None	None	Clinic Equipment & Laboratory Equipment (check second sheet).	Family Doctor (or General Practitioner or Pediatrician) AND Nurse for direct provision of services. IN case laboratory is available in the center, then laboratory staff (doctor & technician) are needed.	One indicator by age group detailed below
	0 -2				8 visits		CBC, Platelets					% of 12 month old children who have received all routine vaccinations as per Lebanese Ministry of Public Health Requirements
	3 - 6				1 visit		Urinalysis					% of 5 years old children who had their vision screened
	7-13				1 visit		Lipid Profile					% of adolescents 12 years old who have received their Tetanus-Diphteria Booster vaccine
	14 - 18				1 visit							% of adolescents 16 to 18 years old who had their Body Mass Index calculated
Wellness Package adult Females		Adult females aged 19 years and up	A multi-component package that covers preventive medical consultations, health education & counseling, immunizations, laboratory tests , radiology tests, other preventive tests and medications. The package is divided by age groups of 5 years each starting the age of 19 years.Only one preventive doctor visit will be covered by age-group category. Majority of other services are linked to the 5 years intervals; however, some needed to be delivered on yearly basis such as Mammograms or stool guaic or flu vaccine; in this case, requests can be handed to beneficiaries through nurses and doctors will be checking results intervening in case of abnormal findings.	Package covers from 19 years of age onwards in a group of 5 years each. Services will be used based on the age of the beneficiary.	1 visit per age group category	doctor assessment, doctor & nurse counseling, immunization, and medication as needed	Lipid profile,FBS, Cr, SGPT, CBC, U/A starting age of 19 years, stool guaic starting age of 50 years	Mammogram starting age of 40 years on yearly basis	Pap smear as of 21 years Q 3 years until age of 64 years, EKG as of 40 years Q 5 years, BMD once after 65 years of age.	Clinic Equipment & Laboratory Equipment & Radiology equiment (check second sheet) in addition to Osteodensitometry.	Family Doctor (or General Practitioner) AND Nurse for direct provision of services. IN case laboratory or Radiology or Osteodensitometry are available in the center, then laboratory and radiology staff (doctor & technician) are needed.	One indicator starting age of 19 years and 2 indicators for those aged 40 years and above
	19-24				1 visit		Package of tests done once during the 20 years	None				% of target population aged 19 years and above who were screened for Hypertension
	25-29				1 visit							
	30-34				1 visit							
	35-39				1 visit							
	40-44				1 visit		Package of tests done Q 5 years except stool guaic yearly	Mammogram every 1 year				1. % target population 40 years and above screened for Diabetes Mellitus. 2. % of women aged 40 years and above screened for breast cancer.
	45-49				1 visit							
	50-54				1 visit							
	55-59				1 visit							
	60-64				1 visit							
	65-69				1 visit							
	Q 5 years				1 visit Q 5 years							

Package	Age Group	Target	Description	Period	# of Visits	Content of visits	Laboratory	Radiology	Other Tests	Equipment	Medical Human Resources	MoPH Clinical Indicators
Wellness Package adult Males		Adult males aged 19 years and up	A multi-component package that covers preventive medical consultations, health education & counseling, immunizations, laboratory tests , radiology tests, other preventive tests and medications. The package is divided by age groups of 5 years each starting the age of 19 years.Only one preventive doctor visit will be covered by age-group category. Majority of other services are linked to the 5 years intervals; however, some needed to be delivered on yearly basis such as stool guaic or flu vaccine; in this case, requests can be handed to beneficiaries through nurses and doctors will be checking results intervening in case of abnormal findings.	Package covers from 19 years of age onwards in a group of 5 years each. Services will be used based on the age of the beneficiary.	1 visit per age group category	doctor assessment, doctor & nurse counseling, immunization, and medication as needed	Lipid profile,FBS, Cr, SGPT, CBC, U/A starting age of 19 years, stool guaic starting age of 50 years	U/S abdomen for aortic aneurysm once between 65-69 years	EKG Q 5 years starting at 40 years of age, BMD once after 65 years.	Clinic Equipment & Laboratory Equipment & Radiology equiment (check second sheet) in addition to Osteodensitometry.	Family Doctor (or General Practitioner) AND Nurse for direct provision of services. IN case laboratory or Radiology or Osteodensitometry are available in the center, then laboratory and radiology staff (doctor & technician) are needed.	One indicator starting age of 19 years and 1indicator for those aged 40 years and above
	19-24				1 visit		Package of tests done once during the 20 years	None				% of target population aged 19 years and above who were screened for Hypertension
	25-29				1 visit							
	30-34				1 visit							
	35-39				1 visit							
	40-44				1 visit		Package of tests done Q 5 years except stool guaic yearly					% target population 40 years and above screened for Diabetes Mellitus
	45-49				1 visit							
	50-54				1 visit							
	55-59				1 visit							
	60-64				1 visit							
	65-69				1 visit			U/S abdomen once				
	Q 5 years				1 visit Q 5 years							
Antenatal Package	Any age	Pregnant women	A multicomponent package that covers medical consultations, health education & counseling, laboratory tests and other required tests during pregnancy as well as medications. Please note that some tests such as Pap smear might have been delivered in the wellness female package.	This package is to be repeated with each pregnancy	A total of 5 visits: 4 visits during pregnancy and 1 post-partum	doctor assessment, doctor & nurse counseling, and medication as needed.	CBC, U/A, Blood Group, Rubella IgG, Toxoplasma, HBSAg, HIV, VDRL, Urine culture, OGTT- All done once depending on weeks of gestation except CBC & U/A to be done twice. An Indirect Coombs test is requested ONLY for Rh negative mothers	Obstetric U/S to be done twice during pregnancy	Urine Dipstick done in clinic (3 times) & Pap smear if not done before	Clinic Equipment & Laboratory Equipment & Radiology equiment (check second sheet)- Obstetric U/S can be done by the Obstetrician	Obstetrician AND Midwife (or nurse). If U/S is not done by obstetrician and available as part of radiology unit in the center, then radiology staff are needed (doctor & technician)	Two indicators: 1. % of Pregnant women attending at least 4 antenatal visits 2. % of Pregnant women whose Blood Pressure was checked at first antenatal visit

Package	Age Group	Target	Description	Period	# of Visits	Content of visits	Laboratory	Radiology	Other Tests	Equipment	Medical Human Resources	MoPH Clinical Indicators
Diabetes Package	Any age	Diabetic Patients	A multicomponent package that covers medical consultations, health education & counseling, laboratory tests and immunization as well as medications. Please note that some tests and immunizations could have been covered in the wellness packages	This is a yearly package repeated on yearly basis	A total of 5 mandatory doctors'visits per year (3 Family Doctor, 1 Endo & 1 Ophtalmo). There is an additional optional visit for a sub-specialist depending on the complications of the patient. There is also 1 dentist visit per year. The clinical dietician might not be available in all centers; in this case, the nurse (should be trained) will be delivering the diet advice. Please note that scheduling of visits can be done in such a way that the patient will come only 4 times per year to the clinic, having combined visits in same day.	doctor assessment, doctor & nurse counseling, and medication as needed.	FBS, Hba1c, Lipid Profile, Na, K, Cr, SGPT, SGOT, CBC, Spot urine Microalbumin, U/A all to be done once except FBS & Hba1c repeated 3 times per year. A TSH test is requested only once upon diagnosis, so it will not be included on yealy basis in the package.	None	EKG once.	Clinic Equipment & Laboratory Equipment (check second sheet)	The case manager here will be the Family doctor (or general Practitioner) supported by the Nurse. Other specialties needed are endocrinologist and ophtalmologist. The other sub- specialties (Cardio, Nephro or vascular surgeon can be in the clinic or the referral hospital). Dentist is necessary. Clinical dietician is optional (can be replaced by a well trained nurse or can be present in the referral hospital)	Three indicators are defined: 1. % of patients, 18 years and over, with Diabetes mellitus for a duration of at least one year who had their eyes examined by an ophtalmologist. 2.% of patients, 18 years and over, with Diabetes mellitus for a duration of at least one year who did microalbumin test in urine. 3. % of patients, 18years and above, with Diabetes mellitus for a duration of at least one year, who did Hba1c at least twice per year.
Hypertensive Package	Any Age	Hypertensive Patients	A multicomponent package that covers medical consultations, health education & counseling, laboratory tests and immunization as well as medications. Please note that some tests and immunizations could have been covered in the wellness packages	This is a yearly package repeated on yearly basis	A total of 5 mandatory doctors'visits per year {3 Family Doctor, 1 nephro (or Cardio for better availability in clinics) & 1 Ophtalmo}. There is an additional optional visit for a sub-specialist depending on the complications of the patient. There is also 1 dentist visit per year. The clinical dietician might not be available in all centers; in this case, the nurse (should be trained) will be delivering the diet advice. Please note that scheduling of visits can be done in such a way that the patient will come only 4 times per year to the clinic, having combined visits in same day.	doctor assessment, doctor & nurse counseling, and medication as needed.	FBS, Hba1c, Lipid Profile, Na, K, Cr, SGPT, Uric Acid, Ca, CBC, Spot urine Microalbumin, U/A all to be done once . A TSH test is requested only once upon diagnosis, so it will not be included on yealy basis in the package.	None	EKG once.	Clinic Equipment & Laboratory Equipment (check second sheet)	The case manager here will be the Family doctor (or general Practitioner) supported by the Nurse. Other specialties needed are nephrologist or cardiologist (if readily available)and ophtalmologist. The other sub- specialties (Cardio/Nephro, endocrinologist, vascular surgeon can be in the clinic or the referral hospital). Dentist is necessary. Clinical dietician is optional (can be replaced by a well trained nurse or can be present in the referral hospital)	Three indicators are defined: 1. % of patients, 18 years and over, with Hypertension for a duration of at least one year who did microalbumin test in urine. 2. % of patients, 18 years and over, with Hypertension for a duration of at least one year who had an electrocardiogram (EKG) done. 3. % of patients, 18 years and over, with Hypertension for a duration of at least one year who had their eyes examined by an ophtalmologist.

Annex VI: Map

LEBANON
EMERGENCY PRIMARY HEALTHCARE RESTORATION PROJECT