Combined Project Information Documents / Integrated Safeguards Datasheet (PID/ISDS)

Appraisal Stage | Date Prepared/Updated: 19-Apr-2017 | Report No: PIDISDSA21517

BASIC INFORMATION

A. Basic Project Data

Country	Project ID	Project Name	Parent Project ID (if any)
Lebanon	P163476	Lebanon Health Resilience Project	
Region	**Estimated Appraisal Date**	**Estimated Board Date**	**Practice Area (Lead)**
MIDDLE EAST AND NORTH AFRICA	06-Apr-2017	11-Jul-2017	Health, Nutrition & Population
Lending Instrument	**Borrower(s)**	**Implementing Agency**	
Investment Project Financing	Ministry of Public Health	Ministry of Public Health	

Proposed Development Objective(s)

The project development objective (PDO) is to increase access to quality healthcare services to poor Lebanese and displaced Syrians in Lebanon.

Components

Scale up the scope and the capacity of the primary health care UHC program
Provision of health Care services in public hospitals
Strengthen project management and monitoring

The processing of this project is applying the policy requirements exceptions for situations of urgent need of assistance or capacity constraints that are outlined in OP 10.00, paragraph 12.
Yes

Financing (in USD Million)

Financing Source	Amount
International Bank for Reconstruction and Development	120.00
Total Project Cost	**120.00**

Environmental Assessment Category

B - Partial Assessment

Decision

B. Introduction and Context

Country Context

Six years into the Syrian conflict, Lebanon a small country of 4 million people, shoulders the highest per capita concentration of refugees in the world. The latest Government of Lebanon (GoL) estimates indicate that the country hosts 1.5 million displaced Syrians (DS), along with 31,502 Palestine Refugees from Syria, and a pre-existing population of more than 277,985 Palestinian Refugees[1]. Accordingly, the population of Lebanon has grown by around 30 percent in the span of just six years. This influx has put enormous pressure on the country's already scarce resources, stretched its public services, and has contributed to rising tensions in a nation vulnerable to conflict and instability.

Because of the prolonged Syrian conflict, Lebanon faces stark economic and social challenges. According to the Economic and Social Impact Assessment (ESIA) carried out by the World Bank in 2013, the fiscal costs related to the Syrian crisis have been considerable, amounting to an estimated USD 2.6 billion over the 2012-2014 period. The ESIA also highlighted the large negative impact on access to and quality of public services due to the substantial increase in demand for these services. In 2014, it was estimated that the dire economic situation have added 170,000 Lebanese to the 1.5 million nationals living under the poverty line. Along with the displaced Syrians and Palestinian refugees, the total vulnerable population in Lebanon today is estimated to be more than 3.3 million representing around 55 percent of the overall population. Lebanon also faces considerable unemployment that is estimated to have increased from 11 percent before the crisis to around 35 percent with the highest rates observed among female and youth.

Lebanon's fragile stability is vulnerable to the spillover of violence especially given the country's history of prolonged conflict. The crisis has deepened the vulnerability of the Lebanese as both displaced Syrians and Lebanese communities compete for limited resources and leading to growing social tension. In addition, separation from families, absence of basic structural and social protections, as well as concerns about access to basic services, has resulted in increased vulnerability among displaced Syrians. Considering that more than 70 percent of displaced Syrians in Lebanon are women and children, gender based violence (GBV) warrants special attention. To date, despite the profound impact of the crisis on the country, Lebanon has done remarkably well to maintain stable community relations and accommodate displaced persons from Syria. However, the impact of population pressure on host communities, exacerbating issues faced by Lebanon before the Syrian crisis, remains key underlying factors for potential instability.

The Syrian refugee influx has resulted in unprecedented increase in demand for health services, putting considerable strain on the health sector. The immense surge in population is putting a strain on the country's resources and public services. As the influx of Syrian refugees continues, the capacity of the existing health system will not meet the increased demand, thus will impose additional burden on Lebanon's already strained public finances and services. According to the latest Lebanon Crisis Response Plan[2] (LCRP 2017-2020), US$308 million and US$300 million will be needed in 2017 and 2018

[1] Lebanon Crisis Response Plan (LCRP), 2017-2020
[2] Lebanon Crisis response Plan, 2017-2020,

respectively, to meet the health needs of vulnerable population in the country (Lebanese, Displaced Syrians, and Palestinian Refugees).

To withstand the crisis, the MoPH is adopting a two-pronged approach aimed at responding to the immediate health needs of the population, while meeting the sector's medium to longer-term development goals. To meet immediate health needs, the MoPH is working with multiple partners, stakeholders and UN agencies, as well as leveraging the private sector and civil society to maintain service delivery, prevent disease outbreaks and sustain utilization and functional institutions. The LCRP 2017-2020 articulates detailed short- term funding needs, as well as activities and coordination mechanisms. The proposed project compliments the programs currently run by UNHCR, UNICEF, UNFPA and other development partners and contributes to the LCRP outcome 1 "Improved access to comprehensive health care (PHC)" and outcome 2 "improved access to hospital and advanced referral care". The MoPH's medium to long-term strategy is to rapidly strengthen its systems to absorb the impact of the crisis and maintain its health outcomes. In 2013, the MoPH articulated its strategic direction with an overall goal of expanding health coverage to the uninsured, with special focus on the poor and underserved population through a Universal Health Care program. Accordingly, the MoPH, with the help of donor community, is currently allocating resources to upgrade the capacity of the primary health care program, strengthen the skills of health workers, and provide coverage for the poor with a package of essential healthcare services.

Sectoral and Institutional Context

Despite the considerable resilience of Lebanon's health system since the start of the Syrian crisis, the health sector indicators are regressing. The gains that Lebanon made in meeting the Millennium Development Goals (MDGs) pre-Syrian crisis are rapidly declining. The latest MoPH hospital data show significant setbacks in neonatal and maternal mortality indicators (this excludes deliveries outside the hospitals). As of 2017, the data indicate that neonatal mortality rate has increased from 3.4 per 10,000 in 2012 to 4.9 per 10,000, with the rate among displaced Syrians (7 per 10,000) almost double that of Lebanese (3.7 per 10,000). Similarly, the maternal mortality ratio (MMR) increased from 12.7 per 100,000 in 2012 to 21.3 per 100,000, with MMR among displaced Syrians (30.4 per 100,000) reaching double that of Lebanese (15.8 per 100,000)[3].

Lebanon also faces epidemiological risks and reemergence of some diseases that have been controlled pre-Syrian crisis. Despite intensive vaccination campaigns, outbreaks of measles, mumps and waterborne diarrheas are increasingly observed, mainly in areas with high concentration of refugees. While the vulnerable population in Lebanon shares a common disease burden, especially on chronic illnesses, the disease burden among displaced Syrians is largely concentrated around maternal and child health, communicable diseases, and mental health. The majority of displaced Syrians' visits to providers are for infections and communicable diseases (40 percent)[4]. There is also a significant demand for antenatal care. According to an assessment conducted in 2015, 20 percent of displaced Syrian households have either a pregnant or lactating women compared to 6.5 percent among Palestinian

[3] Ministry of Public Health, Presentation, Biostatistics Department, March 2017
[4] Lebanon Crisis Response Plan (LCRP) 2015-2016.

refugees from Syria[5]. There is also growing need for specialized mental health services for both Lebanese and displaced Syrians. A research study conducted in 2016, reported a clear increase in mental health disorders in the young and adult displaced Syrian population in association with the crisis[6]. Prevalence rates of depression were found to be 16.8 percent among displaced Syrians and 13.3 percent among Lebanese. Similarly, prevalence rates for anxiety was found to be 56 percent among displaced Syrians and 50.7 percent among Lebanese, suggesting that more efforts are needed to improve mental health services.

Since the onset of the crisis, the MoPH adopted an integrated approach to service delivery by embedding Displaced Syrian's health care within the national health system. This integration of public service is a result of Displaced Syrians settling within Lebanese communities rather than camps. Similar to Lebanese, displaced Syrians access primary healthcare services through MoPH network of 204 Primary Healthcare Centers (PHCCs), 220 Ministry of Social Affairs (MoSA) Social Development Centers (SDCs), and through an estimated 700 dispensaries around the country. Currently, displaced Syrians receive subsidized services at around 100 health facilities, including MoPH-PHCCs, MoSA-SDCs and other health outlets, supported by international partners with UNHCR subsidizing around 85 percent of PHC consultations and laboratory fees. Partners also provide similarly subsidized services to a limited number of vulnerable Lebanese as a way of addressing critical needs and mitigating potential sources of social tension. However, service provision and funding by international partners have been fragmented leading to costly and inefficient coverage of care to displaced Syrians. Currently, UNHCR and other international partners work through international and local NGOs to contract PHC centers for the provision of services to Displaced Syrians based on fee-for-service mechanisms. This modality increases the operating cost by around 25 percent resulting in less value for money.

The MoPH network is the major provider of PHC services for low income and vulnerable populations. Established in the 1990s, the MoPH network has the largest and most comprehensive PHC centers providing a wide range of services (OBGYN, pediatrics, dentistry, cardio vascular conditions) at nominal fees for low-income households. Network centers are mainly run by NGOs (67 percent), municipalities (20 percent) and government institutions (13 percent). The MoPH, UNICEF, and YMCA currently supply the primary healthcare centers (PHCCs) with vaccines, acute and chronic medication, staff support, running costs, as well as laboratory and medical supplies. In return, MoPH network facilities provide a package of services at a discounted rate, ranging from L.L. 8,000 (US$5.33) for a consultation to LL 18,000 (US$ 12) for visits including laboratory and radiology tests. Because of their nominal fee structure, breadth of services, and free drugs, the network plays a major role in the provision of PHC services for the vulnerable population, including low income Lebanese and displaced Syrians. In 2014, the number of visits for both Lebanese and Syrians at the PHC network exceeded 1.2 million, compared to 700,000 in 2009[7]. This sudden increase in demand put significant pressure on the primary health care system in the country.

[5] LCRP 2015-2016, WFP, UNICEF &UNHCR, Vulnerability Assessment of Syrian Refugees in Lebanon (draft), 2015
[6] Lebanon: Mental health system reform and the Syrian crisis. Elie Karam et al. BJPSYCH International, Volume 13, Number 4, November 2016.
[7] Ministry of Public Health, 2016

To meet the increased demand and further strengthen primary care services, the MoPH launched the Emergency Primary Health Care Restoration Project (EPHRP) in 2015. This project is the building block of the MoPH's long-term strategy for Universal Health Coverage (UHC) which aims to "provide a specified package of benefits to all members of a society with the end goal of providing financial risk protection, improving access to health services and health outcomes."[8] Implemented with funding from the World Bank under the Lebanon Syria Multi-Donor Trust Fund (MDTF), the project aims to strengthen and improve access to PHC services especially for the low-income host communities crowded out by the increased demand for PHC services as a result of the influx. The project has three main objectives: (i) strengthen the capacity of 75 MoPH network centers to meet the growing demand for PHC among the vulnerable populations (host communities and displaced Syrians), (ii) expand the package of services to respond to the emerging health needs through contractual agreements with the network centers based on a capitation rate, and (iii) subsidize the cost of the package to 150,000 poor Lebanese enrolled in the National Poverty Targeting Program. However, strengthening the capacity of the network clinics also extends to benefit low income non-subsidized Lebanese and displaced Syrians covered by the international community. The latest MoPH data show that improving the capacity of the network centers through the EPHRP is having a positive impact on access to services for host communities and Displaced Syrians alike. While access to PHC services prior to the project was relatively low, especially for host communities in areas with high concentration of displaced Syrians, it increased steadily after the start of the project for both poor Lebanese (28 percent) and Displaced Syrians (47 percent), with displaced Syrian beneficiaries increasing at a faster rate[9]. The pilot indicates that strengthening the integrated model of PHC care benefits both communities.

While the EPHRP has generated some promising results, it has also highlighted some early lessons including the need to further expand the scale and scope of primary level service delivery. Concerning the *scale*, there is an urgent need to support the government's plan to expand the resilience of the PHC system to meet the growing demand by increasing the capacity and the number of contracted network centers from 75 to 204. The *scope* of the services also requires expansion to take into account the growing needs in the areas of reproductive care (including Gender Based Violence (GBV) dimensions), mental health, Non-Communicable Diseases (NCDs), and elderly care. Due to the growing social and behavioral challenges affecting the Lebanese and Displaced Syrian populations, it becomes critical to expand the activities of community outreach to reach the vulnerable and to generate demand for service. There is also need to strengthen the MoPH accreditation program to ensure the quality of health services and strengthen the capacity at the facility level to meet the accreditation standards. It is noteworthy to highlight that improving the efficiency and the workflow within the PHCs network will not only improve the quality of service provided but also the value for money, which is crucial in achieving the desired health outcomes for both, host and displaced communities.

Similar to PHC services, hospital care for displaced Syrians is integrated in the national hospital system, increasing demand and driving pressure on physical and human resources. Coverage for hospital care for Displaced Syrians is provided mainly by UNHCR through 52 contracted public and

[8] WHO, SDGs, 2016
[9] Ministry of Public Health data, 2017.

private hospitals distributed around the country.[10] UNHCR budgetary constraints limit coverage to obstetric and life threatening conditions with a cap on its reimbursement for these services at 75 percent of hospitalization fees. In 2016, UNHCR covered hospitalization fees for 68,000 admissions for displaced Syrians, 15,405 of which were in public hospitals. Deliveries constitute around half of hospital these admissions[11] for Displaced Syrians. In 2016, the tertiary care of Hariri University Public Hospital admitted 5,210 displaced Syrians (52 percent of total admissions) and 206 cases in the Intensive Care Unit (ICU) representing 55 percent of total ICU admissions.[12] MoPH sources indicate that the increase in demand for hospitalization, especially for emergency and ICU care, is resulting in significant resource shortages in public hospitals.

Despite the support from donors through the UNHCR, coverage for hospital care for displaced Syrians does not meet the growing demand. UNHCR's limited admission criteria leaves a significant number of patients and conditions not covered. Hospitalization rate among displaced Syrians is half (6 percent) that of Lebanese (12 percent)[13] raising concerns about unmet need. The MoPH addressed the demand and authorized the treatment of around 4,000 displaced Syrians[14] with conditions not subsidized by UNHCR, including dialysis, treatment for cancer, catastrophic illnesses, and acute cases. This resulted in accrued fees of $15 million to public hospitals. However, efforts by the MoPH, international agencies and NGOs to fill in the coverage gap remain inadequate. As such, there is a pressing need to support and sustain the ongoing efforts by the Lebanese government to provide hospital care for Displaced Syrians, especially for individuals with serious chronic conditions.

The influx has also exacerbated the challenges the hospital sector was facing before the Syrian crisis. Whereas the Lebanese government covers hospital care for all uninsured nationals (around 1.6 million), the ceiling and the tariffs at which the government reimburses hospitals is historically low. Prior to the crisis (2002-2011), the MoPH had a sizable budget deficit resulting in delayed payments to contracted hospitals reaching US$80 million.[15] This preexisting problem has considerably worsened with the increased demand generated by the crisis, affecting access to uninsured Lebanese. Between 2011 and 2013, the proportion of Lebanese patients admitted to public hospitals decreased from 89 percent to 71 percent. Results from an analysis of unmet need over the last five years[16] indicate that, approximately, 15,847 Lebanese patients were not able to access public hospitals as a result of increased pressure from the Syrian crisis.

The accumulated deficits among public hospitals resulted in inadequate investments in upgrades, large maintenance backlogs, deterioration in quality of equipment, and costly repairs. Unpaid hospital bills over time had a significant impact on the hospitals' cash flow. This limited public hospitals from expanding their technical capacity and maximizing efficiency in a context of growing demand. Many

[10] LCRP 2017-2020.
[11] UNHCR data, 2016
[12] Hariri University Hospital data, 2017.
[13] Lebanon Crisis Response Plan (LCRP) 2017-2020
[14] MoPH data, 2012-2015
[15] Interview with Syndicate of Private Hospitals, Lebanon. March 2017
[16] The analysis is based on a model that examined the change in patient proportions under the assumption that any change in patient proportions from one nationality comes at the expense of patients from another nationality.

public hospitals suffer from obsolete or non-functional equipment and lack of human and technical resources in specific departments with high demand, such as emergency and intensive care units. Considering that the high demand for hospital care is likely to continue in the next several years, immediate investment to upgrade public hospitals to support the resilience of the health sector, and maintain the operation of its institutions, is essential.

Accordingly, in order to lessen the pressure from the influx, there is a critical need to focus on strengthening the capacity and resilience of both primary and hospital level institutions. This involves expanding the package and quality of services provided to vulnerable populations at the primary healthcare level, and strengthening the physical, technical and organizational capacity at the hospital level to generate greater efficiency to address the current budget limitations hampering the provision of care. Given the integrated service delivery model where both Lebanese and displaced Syrians access services in the same facilities, such efforts are expected to benefit both populations in Lebanon affected by the crisis.

The proposed operation will strategically partner with the Islamic Development Bank (IsDB) to strengthen the physical capacity of public hospitals. Under this arrangement, IsDB will fund, through parallel financing ($30 million), the replacement of and upgrading of priority equipment in public hospitals in order to meet the growing demand for hospital services This will entail the replacement of and/or upgrading of equipment, including diagnostic equipment (including medical imaging machines); treatment machines (such as medical ventilators, incubators heart-lung machines); medical monitors (including ECG, EEG, and others); therapeutic equipment (such as CPM machines); and electro-mechanical equipment (such as generators). IsDB's support will prioritize public hospitals located in areas with the highest concentration of displaced Syrians and vulnerable populations, hospitals with the greatest demand for services, and hospitals with the greatest need for critical equipment.

C. Proposed Development Objective(s)

Development Objective(s) (From PAD)

The project development objective (PDO) is to increase access to quality healthcare services to poor Lebanese and displaced Syrians in Lebanon.

Key Results

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

1. Number of primary care beneficiaries (Lebanese and displaced Syrians)
2. Percent female of total beneficiaries
3. Percent of pregnant women receiving at least four antenatal care visits
4. Number of hospital admissions above the MoPH contracted ceiling
5. Number of health facilities accredited
6. Children fully vaccinated under the age of two according to national immunization policy

D. Project Description

The project includes three components, as follows:

Component 1: Scale up the scope and the capacity of the Primary Health Care UHC program (total estimated cost - US$76.5 million). This component builds upon, and scales up the EHCRP. It aims to expand and strengthen the UHC program to reach a larger number of beneficiaries with a more comprehensive package of enrolment-based preventive health services to meet growing needs of the Lebanese poor. Through investment in PHCs, it will also benefit displaced Syrians seeking health care at participating centers under different subsidy arrangements. This component will:

- **Expand the scale of PHC services** by increasing the number of contracted network Primary Health Care Centers (PHCCs) from 75 to 204. This will also increase the number of beneficiaries using the PHC services as follows: the number of poor Lebanese receiving subsidized health services would be scaled up from 150,000 to 340,000, and the number of displaced Syrians accessing services at these centers under different subsidy mechanisms would increase from 130,000 to 375,000 (Table 1), should the subsidies increase from current levels. The scaled-up UHC will collaborate with mechanisms subsidizing Syrians to access healthcare packages in the same health centers to reduce administrative burdens on PHCs and ensure maximum benefit for all beneficiaries.
- **Strengthen the capacity of newly contracted PHCCs to provide quality care** by (i) expanding the package of essential services to include a wellness package, a more comprehensive reproductive health package (with elements addressing GBV), as well as packages for elderly care, non-communicable diseases, and mental health (Table 2). As part of the expanded package, the MoPH provides free drugs and vaccines to both, Lebanese and displaced Syrians provided through UNICEF, WHO and UNFPA; (ii) improving the technical, managerial, and physical capacity of PHCCs to deliver the expanded healthcare packages; (iii) increasing capacity of PHCCs for outreach to the community to assist the target populations enroll and access services; and (iv) expanding the existing accreditation program already implemented in several PHCCs to cover all PHCCs in the network.

Table 1: Targeted Project Beneficiaries

	NUMBER OF PHCCS	UNSUBSIDIZED LEBANESE USING PHCCS	SUBSIDIZED LEBANESE USING PHCCs	DISPLACED SYRIANS USING PHCCs	TOTAL BENEFICIARIES
Current EPHRP	75	70,000	150,000	130,000	350,000
Targeted through Project	204	210,000	340,000	375,000	925,000

Table 2: Description of the Essential Package of Services

Package	*Description*
Wellness Package	0-18 years: ▪ Immunization, doctor consultations, screening for malnutrition and abuse, general health counseling (oral health, sexual health, abuse) 19+ years females: ▪ Immunization, doctor consultations, routine lab tests, mammography, screening for NCDs, counseling on health topics (sexual health, lifestyle, abuse) 19+ years males: ▪ Immunization, doctor consultations, routine lab tests, screening for NCDs, counseling on health topics (sexual health, lifestyle, abuse)
Reproductive Health (including GBV)	▪ Family planning visits, modern contraception methods, counseling on sexual and reproductive health, family planning, and GBV for women and men Pregnant Women: ▪ Additional visits, ante-natal care, counseling on health topics, flu vaccine & Td vaccine
NCD Package	▪ Case management of diabetes (yearly EKG, lab tests, foot exam, medications) ▪ Case management of hypertension (yearly EKG, lab tests, counseling, medications) ▪ Case Management of Coronary Artery Disease (yearly EKG, echo cardio, lab tests, counseling, medications)
Elderly Package	▪ Additional center and home visit, ultrasound for abdominal aortic aneurysm, mini mental test, Activities of Daily Living and Gait & Balance assessment ▪ Medication management, counseling (fall prevention, social & elder abuse)
Mental Health Package	▪ Screening for mental health disorders, Case management of depression, psychosis, development disorder and alcohol / substance abuse ▪ Consultations with psychiatrists, psychologists, general practitioners, and social workers, Lab tests & medication treatment

Component 2: Provision of health care services in public hospitals (total estimated cost - US$36.4 million).

This component will finance the cost of care in public hospitals during the project period beyond the contracted budget ceiling authorized by the MoPH. This will allow the MoPH to respond to the increased demand at public hospitals by authorizing admissions of uninsured Lebanese and emergency cases for displaced Syrians.[17] Currently, MoPH contracts with hospitals are based on pre-set rates for surgical and non-surgical cases, covering medical (cost of medical services) and paramedical services (room and board).[18] Payment authorization is based on two levels: (i) medical auditors verifying admissions based on criteria set for 40 high-cost, high-volume, and/or misuse-and abuse- prone conditions; and (ii) contracted Third Party Administration (TPA) verifying admissions based on the ministry's criteria as well as international guidelines.[19] The MoPH admission criteria will be reviewed as part of the updating of the Project Operations Manual. This component will also finance the strengthening of the technical and organizational capacity of public hospitals. This includes (i) capacity building of clinical and non-clinical staff through relevant training programs; and (ii) strengthening the information system between public hospitals and PHCCs.

Component 3: Strengthen project management and monitoring (total estimated cost - $7.1 million). The objective of this component is to strengthen the capacity of the MoPH in order to ensure the effective and efficient development, administration, regulation, implementation, and monitoring and evaluation of the PHC and hospitals components. Specifically, this component will finance: (i) qualified personnel (non MoPH staff), (ii) training, (iii) incremental operating costs, (iv) external technical and financial audits, (v) improving contract management, (vi) expanding PMU information system (including provision of IT hardware and software), and (vii) the Front-end Fee.

This component will also finance studies including a hospital assessment. This assessment will analyze: (i) more precise weights to increase the accuracy of the hospital case mix index, increase the use of hospitalization data for utilization review in medical auditing, and the development of performance indicators that reflect actual patient outcomes; (ii) possible means to further improve allocative efficiency; and (iii) the institutional/organizational structures to identify areas for improvement.

Lastly, an independent project evaluation will be conducted to assess the impact of the project on the household service utilization and the capacity of providers to deliver services in an effective and cost efficient manner.

E. Implementation

Institutional and Implementation Arrangements

The implementation arrangements for the project are based, in part, on those used under the ongoing EPHRP Project. Project management is supported under Component 3 of the project.

[17] On average hospitalization cost US$1,000. This component could finance additional admissions to approximately 33,000 patients
[18] Salaries are not covered by the contract.
[19] National Institute for healthcare Excellence (NICE), U.K.

The oversight for the project will be ensured through the **MoPH Steering Committee**, which was established under the EPHRP Project. This Committee will continue to coordinate inter-agency policies and programs to ensure a cohesive approach to project implementation and to resolve any strategic and implementation issues which may arise during the project. The Steering Committee is headed by the MoPH Director General and includes representatives from Civil Society, Public Hospitals and Academia as well as the **Project Management Unit (PMU)**, i.e. the PHCC Coordinator and the Hospital Coordinator. Under the proposed project, the Steering Committee would also include a representative from the Council for Development and Reconstruction (CDR). The Steering Committee would meet on a quarterly basis.

The **MoPH,** through the Director General, will have the overall responsibility for project oversight and will be assisted in this task by a project **(PMU)**, managed through a PHCC Coordinator, and a Hospital Coordinator. The PHCC Coordinator is currently responsible for the implementation of the EPHRP Project and will continue in the same role under the proposed operation. Specifically, the PHCC Coordinator will ensure the implementation of Component 1 and relevant parts of Component 3. The Hospital Coordinator will be a new appointment by the MoPH, to manage the implementation of Component 2.

The CDR will be responsible for the procurement of hospital equipment for the IsDB project.

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F. Project location and Salient physical characteristics relevant to the safeguard analysis (if known)

The project will be implemented at the national level.

G. Environmental and Social Safeguards Specialists on the Team

Ehab Mohamed Mohamed Shaalan,Michelle P. Rebosio Calderon

SAFEGUARD POLICIES THAT MIGHT APPLY

Safeguard Policies	Triggered?	Explanation (Optional)
Environmental Assessment OP/BP 4.01	Yes	Given the scale and nature of the project, the environmental risks associate with the project activities are considered “moderate” triggering OP4.01. The project is classified as environmental category “B” in accordance with Operational Policy OP 4.01
Natural Habitats OP/BP 4.04	No	No interaction with any natural habitats or

		ecosystems are expected
Forests OP/BP 4.36	No	No interaction with any forests are expected
Pest Management OP 4.09	No	Not relevant
Physical Cultural Resources OP/BP 4.11	No	No civil works or activities, which interact with physical cultural resources, are expected.
Indigenous Peoples OP/BP 4.10	No	No indigenous people identified.
Involuntary Resettlement OP/BP 4.12	No	The project does not include any land acquisition and will not involve any displacement of people from land or have negative impacts on livelihoods. Because of this, the Bank policy on Involuntary Resettlement OP 4.12 will not be triggered.
Safety of Dams OP/BP 4.37	No	The project does not have any activities related to dams.
Projects on International Waterways OP/BP 7.50	No	The project does not have any activities related to international waterways.
Projects in Disputed Areas OP/BP 7.60	No	The project will not be implemented in any disputed areas.

KEY SAFEGUARD POLICY ISSUES AND THEIR MANAGEMENT

A. Summary of Key Safeguard Issues

1. Describe any safeguard issues and impacts associated with the proposed project. Identify and describe any potential large scale, significant and/or irreversible impacts:

Health care waste (HCW) includes both potential infectious and non-infectious waste materials. Infectious wastes include infectious sharps and infectious non-sharp materials. Infectious Sharps consist of syringe or other needles, blades, infusion sets, broken glass or other items that can cause direct injury. Infectious non-sharps include materials that have been in contact with human blood, or its derivatives, bandages, swabs or items soaked with blood, isolation wastes from highly infectious patients (including food residues), used and obsolete vaccine vials, bedding and other contaminated materials infected with human pathogens. Human excreta from patients are also included in this category. Non-infectious wastes may include materials that have not been in contact with patients such as paper and plastic packaging, metal, glass or other wastes which are similar to household wastes. If no separation of wastes takes place, the whole mixed volume of health care waste needs to be considered as being infectious. Sources of air emissions may include exhaust air from heating, ventilation, and air conditioning (HVAC) systems, ventilation of medical gases and fugitive emissions released from sources such as medical waste storage areas, medical technology areas, and isolation wards. Emissions may include exhaust from medical waste incineration if this waste management option is selected by the facility. In addition, air emissions may result from combustion related to power generation. Contaminated wastewater may result from discharges from laboratories (e.g. microbiological cultures, stocks of infectious agents), pharmaceutical and chemical stores; cleaning activities, and x-ray development facilities. Wastewater may also result from treatment disposal technologies and techniques, including autoclaving, microwave irradiation, chemical disinfection, and incineration (e.g. treatment of flue gas using wet scrubbers which may contain suspended solids, mercury, other heavy metals, chlorides, and sulfates). Depending on the effectiveness of hazardous

waste management practices (in particular waste segregation strategies described above), hazardous health care wastes may enter the wastewater stream, including microbiological pathogens (wastewater with a high content of enteric pathogens, including bacteria, viruses, and helminthes / parasitic worms), hazardous chemicals, pharmaceuticals, and radioactive isotopes.

2. Describe any potential indirect and/or long term impacts due to anticipated future activities in the project area:
The main impacts which can be identified at this stage are direct impacts related to occupational health and safety for the health workers in the primary health care units. In addition, health care wastes which will potentially increase in quantities may affect the capacity of the local authorities to manage these wastes which can then result to indirect and long term environmental and public health impacts. These impacts will be identified and assessed as part of an Environmental and Social Management Framework (ESMF), which will include a Medical Waste Management Plan to fill any gaps and enhance current practices to help manage the increased capacity challenges.

3. Describe any project alternatives (if relevant) considered to help avoid or minimize adverse impacts.
The Task Team has not identified any alternatives to the current project design which can help avoid or minimize adverse impacts. The project contents, geographic scope and activities are not clearly defined yet will be supporting existing health care facilities and will not include construction of any new facilities. The identification of the actual areas to be included into the project will be based on extensive guidance by an ongoing needs assessment. The interventions will be implemented at a national level since targeted facilities, host communities, and displaced Syrians are spread throughout the country.

4. Describe measures taken by the borrower to address safeguard policy issues. Provide an assessment of borrower capacity to plan and implement the measures described.
Given the environmental, health and safety (EHS) impacts associated with health care facilities, basic EHS standards/protocols are mandated at the facility level through an accreditation system. A summary of the accreditation system in place and an overview of general OHS practices on the ground will provide the basis for the development of an Environmental and Social Management Framework (ESMF), which will include a Medical Waste Management Plan, to fill any gaps or enhance current practices to manage the increased capacity challenges. The development of the ESMF is deferred to Implementation stage given the urgent nature of the proposed operation in accordance to Bank policies (OP/BP 12.10). A Safeguards Action Plan (SAP) has been prepared to set out the roadmap for the development of the ESMF i.e. content, timeframe, disclosure and consultation. The Borrower will prepare the ESMF no later than 3 months after Effectiveness. As part of the contracts between the healthcare providers and the PMU, the healthcare providers will be required to provide evidence that existing or planned healthcare waste management, storage, collection, treatment and disposal systems are adequate and can accommodate any additional waste quantities that could occur as a result of the expanded coverage. This requirement would be reflected in the Loan Agreement and Operational Manual. A summary of the accreditation system in place and an overview of general OHS practices on the ground will provide the basis for the development of an ESMF which will include a Medical Waste Management Plan, to fill any gaps or enhance current practices to help manage the increased capacity challenges. The financing package includes parallel financing for the procurement of hospital equipment by the IsBD. Investments include strengthening the physical capacity of public hospitals by scaling up and replacing critical equipment which are not currently identified but may include diagnostic equipment, treatment machines, medical monitors, therapeutic equipment; and electro-mechanical equipment. Impacts related to safe installation, use, maintenance and disposal of such equipment will be assessed and managed in accordance with WB Safeguards policies. CDR will be fully responsible for the application of the World Bank's safeguards policies. IsDB and WB will independently review safeguards documents related to the project, however, the safeguards teams will aim to coordinate comments to the Borrower.

5. Identify the key stakeholders and describe the mechanisms for consultation and disclosure on safeguard policies, with an emphasis on potentially affected people.

The key stakeholders of this project have been identified as follows:

(i) Poor Lebanese and Displaced Syrians. Poor Lebanese and the Displaced Syrians in Lebanon, including women, will benefit from the project through a more comprehensive package of PHC services that addresses the specific health needs of this vulnerable population.

(ii) Primary Health Care Centers (PHCCs). The project will benefit MoPH network PHCCs by upgrading the capacity of the center, and the skills of health workers and managers to effectively manage the increased demand for healthcare while delivering quality care during, and post, the crisis period.

(iii) Public Hospitals. The project will benefit public hospitals by upgrading and refurbishing their equipment, training their staff, and improving the cash flow to improve the quality and efficiency of their operation

(iv) The MoPH. The project will contribute to maintaining MoPH commitment to deliver services to the vulnerable population as well as build the capacity at the central level for planning, and project management.

Once prepared, the safeguard documents will be consulted upon with the key stakeholders. MoPH, through the CDR, will carry out the consultations and incorporate the results into the final documents which will be disclosed on their website.

B. Disclosure Requirements

The review of this Safeguards has been Deferred.

Comments

As the project is prepared under OP10.00 para 12, the preparation of safeguard documents is being deferred into the implementation period. The Borrower will prepare the Environmental and Social Management Framework (ESMF) document no later than three months after project effectiveness.

C. Compliance Monitoring Indicators at the Corporate Level (to be filled in when the ISDS is finalized by the project decision meeting)

OP/BP/GP 4.01 - Environment Assessment

Does the project require a stand-alone EA (including EMP) report?

Yes

If yes, then did the Regional Environment Unit or Practice Manager (PM) review and approve the EA report?

NA

Are the cost and the accountabilities for the EMP incorporated in the credit/loan?

Yes

The World Bank Policy on Disclosure of Information

Have relevant safeguard policies documents been sent to the World Bank's Infoshop?
No
Have relevant documents been disclosed in-country in a public place in a form and language that are understandable and accessible to project-affected groups and local NGOs?
No

All Safeguard Policies

Have satisfactory calendar, budget and clear institutional responsibilities been prepared for the implementation of measures related to safeguard policies?
Yes
Have costs related to safeguard policy measures been included in the project cost?
NA
Does the Monitoring and Evaluation system of the project include the monitoring of safeguard impacts and measures related to safeguard policies?
Yes
Have satisfactory implementation arrangements been agreed with the borrower and the same been adequately reflected in the project legal documents?
Yes

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APPROVAL

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