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Report No: PAD2358

INTERNATIONAL BANK FOR RECONSTRUCTION AND DEVELOPMENT

PROJECT APPRAISAL DOCUMENT

ON A

PROPOSED FINANCING

IN THE AMOUNT OF US$120 MILLION
(INCLUDING AN IBRD LOAN AND SUPPORT FROM THE CONCESSIONAL FINANCING FACILITY)

TO THE

LEBANESE REPUBLIC

FOR A

LEBANON HEALTH RESILIENCE PROJECT

June 13, 2017

Health, Nutrition & Population Global Practice
Middle East And North Africa Region

CURRENCY EQUIVALENTS

(Exchange Rate Effective April 30, 2017)

Currency Unit =	Lebanese Pound (LBP)
LBP 1,507.5 =	US$1

FISCAL YEAR
January 1 - December 31

Regional Vice President:	Hafez M. H. Ghanem
Acting Country Director:	Kanthan Shankar
Senior Global Practice Director:	Timothy Grant Evans
Practice Manager:	Ernest E. Massiah
Task Team Leader(s):	Nadwa Rafeh

ABBREVIATIONS AND ACRONYMS

CDR	Council for Development and Reconstruction
GCFF	Global Concessional Financing Facility
CPF	Country Partnership Framework
EHS	Environmental, Health, and Safety
EPHRP	Emergency Primary Healthcare Restoration Project
ESIA	Environmental and Social Impact Assessment
ESMF	Environmental and Social Management Framework
ESMP	Environmental and Social Management Plan
FM	Financial Management
FO	Financial Officer
GBV	Gender-Based Violence
GDP	Gross Domestic Product
GOL	Government of Lebanon
HIS	Health Information System
ICU	Intensive Care Unity
IPSAS	International Public Sector Accounting Standards
IsDB	Islamic Development Bank
LCRP	Lebanon Crisis Response Plan
M&E	Monitoring and Evaluation
MCH	Maternal and Child Health
MENA	Middle East and North Africa Region
MOF	Ministry of Finance
MoPH	Ministry of Public Health
MoSA	Ministry of Social Affairs
NCD	Non-Communicable Disease
NGO	Nongovernmental Organization
NPF	New Procurement Framework
NPTP	National Poverty Targeting Program
OHS	Occupational Health and Safety
PDO	Project Development Objective
PFS	Project Financial Statements
PHCC	Primary Health Care Center
PMU	Project Management Unit
POM	Project Operations Manual
PPSD	Project Procurement Strategy for Development
SAP	Safeguards Action Plan
TOR	Terms of Reference
TPA	Third-party Agency
UHC	Universal Health Coverage
UN	United Nations
UNFPA	United Nations Population Fund
UNHCR	United Nations High Commissioner for Refugees
UNICEF	United Nations Children's Fund
VAT	Value-Added Tax
WB	World Bank
WHO	World Health Organization

BASIC INFORMATION

Is this a regionally tagged project?	Country(ies)	Financing Instrument
No		Investment Project Financing

[✔] Situations of Urgent Need of Assistance or Capacity Constraints

[ ] Financial Intermediaries

[ ] Series of Projects

Approval Date	Closing Date	Environmental Assessment Category
26-Jun-2017	30-Jun-2023	B - Partial Assessment

Bank/IFC Collaboration
No

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

Component Name	Cost (US$, millions)
Scaling up the scope and the capacity of the primary health care UHC program	76.50
Provision of health Care services in public hospitals	36.40
Strengthening project management and monitoring	6.80

Organizations

Borrower : The Republic of Lebanon

Implementing Agency : Ministry of Public Health

Safeguards Deferral

Will the review of safeguards be deferred?

[✔] Yes [ ] No

PROJECT FINANCING DATA (US$, Millions)

[ ] Counterpart Funding	[✔] IBRD	[ ] IDA Credit [ ] Crisis Response Window [ ] Regional Projects Window	[ ] IDA Grant [ ] Crisis Response Window [ ] Regional Projects Window	[✔] Trust Funds	[ ] Parallel Financing

Total Project Cost:	Total Financing:	Financing Gap:
120.00	120.00	0.00
	Of Which Bank Financing (IBRD/IDA):	
	95.80	

Financing (in US$, millions)

Financing Source	Amount
Concessional Financing Facility	24.20
IBRD-87710	95.80
Total	**120.00**

Expected Disbursements (in US$, millions)

Fiscal Year	2017	2018	2019	2020	2021	2022	2023

Annual	0.00	5.00	7.00	20.00	23.00	30.00	35.00
Cumulative	0.00	5.00	12.00	32.00	55.00	85.00	120.00

INSTITUTIONAL DATA

Practice Area (Lead)

Health, Nutrition & Population

Contributing Practice Areas

Gender Tag

Does the project plan to undertake any of the following?

a. Analysis to identify Project-relevant gaps between males and females, especially in light of country gaps identified through SCD and CPF

Yes

b. Specific action(s) to address the gender gaps identified in (a) and/or to improve women or men's empowerment

Yes

c. Include Indicators in results framework to monitor outcomes from actions identified in (b)

Yes

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	Moderate

8. Stakeholders	Substantial
9. Other	
10. Overall	Substantial

COMPLIANCE

Policy

Does the project depart from the CPF in content or in other significant respects?

[ ] Yes [✔] No

Does the project require any waivers of Bank policies?

[ ] Yes [✔] No

Safeguard Policies Triggered by the Project	Yes	No
Environmental Assessment OP/BP 4.01	✔	
Natural Habitats OP/BP 4.04		✔
Forests OP/BP 4.36		✔
Pest Management OP 4.09		✔
Physical Cultural Resources OP/BP 4.11		✔
Indigenous Peoples OP/BP 4.10		✔
Involuntary Resettlement OP/BP 4.12		✔
Safety of Dams OP/BP 4.37		✔
Projects on International Waterways OP/BP 7.50		✔
Projects in Disputed Areas OP/BP 7.60		✔

Legal Covenants

Sections and Description

The Borrower shall, through the MoPH, not later than four (4) months after the Effective Date, prepare and adopt a Project Operations Manual (POM) in form and substance satisfactory to the Bank.

Sections and Description

The Borrower shall, through the MoPH, prepare an Environmental and Social Management Framework (ESMF), in

form and substance satisfactory to the Bank, no later than three months from Loan Effectiveness.

Sections and Description

The Borrower shall, through the MoPH, not later than 1 (one) month after the Effective Date, establish and thereafter maintain at all times during the implementation of the Project, a Steering Committee with a composition, mandate, terms of reference and resources satisfactory to the Bank

Sections and Description

The Borrower shall, through the MoPH, not later than (1) one month after the Effective Date, engage Third Party Agents to conduct independent verifications of admissions of Uninsured Lebanese and Eligible Beneficiaries to Participating Public Hospitals under Part 2.1 of the Project, prior to the delivery of the said services, all in accordance with the provisions of the POM.

Conditions

PROJECT TEAM

Bank Staff

Name	Role	Specialization	Unit
Nadwa Rafeh	Team Leader(ADM Responsible)		GHN07
Lina Fares	Procurement Specialist(ADM Responsible)		GGO05
Rima Abdul-Amir Koteiche	Financial Management Specialist		GGO23
Andrianirina Michel Eric Ranjeva	Team Member		WFALN
Christine Makori	Counsel		LEGAM
Christopher H. Herbst	Team Member		GHN05
Concepcion Aisa Otin	Team Member		FABBK
Ehab Mohamed Mohamed Shaalan	Safeguards Specialist		GEN05
Haneen Ismail Sayed	Team Member		MNC02
Maria E. Gracheva	Team Member		GHNGE
Mariam William Guirguis	Team Member		GHN05

Michelle P. Rebosio Calderon	Safeguards Specialist		GSU05
Mickey Chopra	Team Member		GHNDR
Rock Jabbour	Team Member		GGO23
Saba Nabeel M Gheshan	Counsel		LEGAM
Sameera Maziad Al Tuwaijri	Team Member		GHNDR
Sepehr Fotovat Ahmadi	Team Member		GGO05
Toni Joe Lebbos	Team Member		GHN05
Wissam Harake	Team Member		GMF05

Extended Team

Name	Title	Organization	Location

Lebanon Health Resilience Project

TABLE OF CONTENTS

I. STRATEGIC CONTEXT

A. Country Context

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

2. **Lebanon faces stark economic and social challenges due to the impact of the prolonged Syrian conflict**. According to the Economic and Social Impact Assessment (ESIA) carried out by the World Bank (WB)[2], the fiscal costs related to the Syrian crisis have amounted to an estimated US$2.6 billion over 2012-2014. The ESIA also highlighted the large negative impact on access to and quality of public services that is due to the substantial increase in demand for these services. In 2014, it was estimated that the dire economic situation has added 170,000 Lebanese to the 1.5 million nationals living below 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, which is estimated to have increased from 11 percent before the crisis to around 35 percent, with the highest rates among women and youth.

3. **Lebanon's fragile stability is vulnerable to the spillover of violence.** The crisis has deepened the vulnerability of Lebanon as both displaced Syrians and Lebanese communities compete for limited resources, leading to growing social tension. In addition, separation from families, absence of basic structural and social protection, and concerns about access to basic services have increased the vulnerability of displaced Syrians. Because more than 70 percent of the displaced Syrians in Lebanon are women and children, these groups warrant special attention[3]. Despite the profound impact of the crisis, Lebanon has done remarkably well in maintaining stable community relations and accommodating displaced persons from Syria. However, the impact of population pressure on host communities, exacerbating the issues Lebanon faced before the Syrian crisis, remains the key underlying factor for potential instability.

4. **The Syrian refugee influx has resulted in an unprecedented increase in demand for health services in Lebanon, putting considerable strain on the country's resources and public services.** The capacity of the health system is still falling short of demand, further straining Lebanon's public finances and services. According to the latest Lebanon Crisis Response Plan[4] (LCRP 2017-2020), US$308 million

[1] Lebanon Crisis Response Plan (LCRP), 2017-2020.
[2] The World Bank. (2014). Lebanon Economic and Social Impact Assessment of the Syrian Crisis.
[3] Lebanon Crisis Response Plan (LCRP), 2017-2020.
[4] Ibid.

and US$300 million will be needed in 2017 and 2018, respectively, to meet the health needs of vulnerable populations in the country (Lebanese, displaced Syrians, and Palestinian refugees).

5. **The Ministry of Public Health (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 details short-term funding needs, activities, and coordination mechanisms. The proposed project complements the programs currently run by UNHCR, UNICEF, UNFPA, WHO, and other development partners and contributes to LCRP outcome 1, "Improved access to comprehensive health care" and outcome 2, "Improved access to hospital and advanced referral care." The medium- to long-term strategy of the MoPH is to rapidly strengthen its systems to absorb the impact of the crisis and maintain health outcomes. In 2013, the MoPH articulated its strategic direction: an overall goal of expanding health coverage to the uninsured, with special focus on the poor and underserved Lebanese population through a Universal Health Coverage (UHC) program. Accordingly, with the help of the donor community, the MoPH is allocating resources to upgrade the capacity of the primary health care (PHC) program, strengthen the skills of health workers, and subsidize health costs for poor Lebanese through a package of essential health care services. The MoPH is also working with the UN and donor partners to align current subsidization modalities of primary health services for Syrians to the UHC model to improve quality and retention and reduce implementation costs.

Situations in Urgent Need of Assistance

6. **This project has been prepared and will be implemented under paragraph 12 of the WB Operational Policy (OP) 10.00, Investment Project Financing**. The situation in Lebanon is both a man-made crisis (arrival of large refugee populations) and a result of conflict (taking place in Syria). Currently, around half of the displaced Syrians in Lebanon are unable to meet their survival needs. This humanitarian crisis – which has morphed into a development crisis – has also affected the lives and socioeconomic outcomes of Lebanese communities as pressure on public services, especially education and health, is reaching unsustainable levels. With no end to the Syrian conflict in sight, and therefore no near prospect that refugee communities will be able to return safely to their homes, Lebanon continues to endure the most of hosting the world's largest per capita number of refugees. The number of refugees accessing Lebanon's PHC network and hospitals has increased significantly since the start of the crisis, straining the health system and leading to such deleterious effects as a rising incidence of infectious diseases and limited capacity to address non-communicable diseases (NCDs). With severely strained resources, therefore, the GoL is relying mainly on support from the international community to continue to provide support for the refugee and Lebanese populations, and to maintain the provision of public services. The justification for processing this operation under paragraph 12 of OP 10.00 is the urgent need to address the capacity needs of both primary and hospital-level institutions to respond to growing health demands and reemerging health concerns in the face of the refugee crisis.

7. **This project is also eligible for funding under the Global Concessional Financing Facility (GCFF),** which was established to support the middle-income countries in the Middle East and North Africa (MENA) Region that are most affected by the presence of large numbers of refugees. Lebanon meets all of the GCFF eligibility criteria, including hosting a significant number of refugees (substantially higher

than 0.1% of country's population) that have had a direct socioeconomic impact on host communities. Furthermore, Lebanon has been, and still is, committed to developing sustainable long-term programs and solutions that benefit both refugees and host communities through, for instance, strengthening the PHC program and investing in increasing hospital capacity. Lebanon's s fiscal constraints have been further exacerbated by the refugee crisis. Despite support from donors, the Government still faces a stark gap between the total financing needed to respond to the crisis—estimated at US$2.48 billion in 2016—and the actual assistance received (US$1.04 billion, or 46%).

B. Sectoral and Institutional Context

8. **The Lebanese health system is highly diverse, including a mix of public and private payers and providers.** Health financing comes from a range of resources, including general government revenues, social security contributions, and the private sector. Total health expenditures constitute 6.4 percent of national GDP, 40 percent of which is accounted for by hospitals alone. The private sector also accounts for 71 percent of health care financing, of which 37 percent are out-of-pocket payments made by households. PHC is provided either through private clinics or through a network of primary health centers, which are mainly run by non-governmental organizations (NGOs) (see Box 1).

Box 1. Lebanon's National PHC Network

As part of reform efforts in the 1990s to improve access to PHC services for low-income groups, the MoPH established the National PHC Network of Primary Health Care Centers (PHCCs). Participating centers were selected on the basis of their size, coverage, and the range of services they provide. Under contractual agreements with the centers, the MoPH and UNICEF, provide them with in-kind support, including generic drugs, vaccines, medication for acute and chronic conditions, staff support, running costs, laboratory and medical supplies, training, and IT support. In return, the PHCCs provide their communities with essential health care services at discounted rates, as well as free essential drugs.

Today 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). The network has the largest and most comprehensive PHC centers providing a wide range of services (obstetrics/gynecology, pediatrics, dentistry, cardiovascular) at nominal fees for low-income households.

The network plays a major role in the provision of PHC services for vulnerable populations, including low-income Lebanese and displaced Syrians. In 2016, the number of visits for both Lebanese and Syrians at the PHC network exceeded 1.5 million, compared to 700,000 in 2009.[a] This sudden increase in demand put significant pressure on the country's PHC system.

[a] Ministry of Public Health, 2016.

9. **In terms of hospitals, though the public sector is the main payer for hospital care, the private sector dominates hospital service provision.** Of the 165 hospitals in Lebanon, 82 percent are privately owned and managed by physicians or by charitable organizations. Public hospitals operate under a semi-autonomous model: the hospital boards are composed of various stakeholders so they have a certain

degree of autonomy. Around 47 percent of the Lebanese population have health insurance coverage; and 53 percent who lack any formal coverage are covered by the MoPH, which serves as an "insurer of last resort." This means a strong role for the ministry, not only in preventive care, public health leadership, and regulation, but also in curative care. To provide hospital coverage to about 250,000 cases per year, the MoPH contracts 26 public and 105 private hospitals. Individual patient copayment to the hospital constitutes 5 percent (public hospital) or 15 percent (private hospital) of the hospitalization costs, and the MoPH directly reimburses the hospital for the 85–95 percent difference.

10. **Despite the considerable resilience of Lebanon's health system, the health sector indicators are regressing since the start of the Syrian crisis**. The gains that Lebanon made in meeting the Millennium Development Goals (MDGs) before the 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 the 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 among Lebanese (3.7 per 10,000). Similarly, the maternal mortality ratio increased from 12.7 per 100,000 in 2012 to 21.3 per 100,000, with the rate among displaced Syrians (30.4 per 100,000) double that among Lebanese (15.8 per 100,000).[5]

11. **Lebanon also faces epidemiological risks, the reemergence of some diseases that had been controlled before the Syrian crisis, and a growing need for mental health services.** Despite intensive vaccination campaigns, outbreaks of measles, mumps, and waterborne diarrheas are increasing, mainly in areas with high concentrations of refugees. While the vulnerable population in Lebanon shares a common disease burden, especially from 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 visit providers for infections and communicable diseases (40 percent).[6] 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 a lactating woman, compared to 6.5 percent among Palestinian refugees from Syria.[7] There is also a 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 among the displaced Syrian youth and adult population.[8] 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 were found to be 56 percent among displaced Syrians and 50.7 percent among Lebanese.

12. **Since the onset of the crisis, the MoPH has used an integrated approach to service delivery by embedding displaced Syrians' health care in the national health system.** This integration of public service is a result of displaced Syrians settling in Lebanese communities rather than in camps. Like Lebanese, displaced Syrians access PHC services through the MoPH network of 204 primary health care centers (PHCCs), 220 MoSA Social Development Centers (SDCs), and 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

[5] Ministry of Public Health; Presentation, Biostatistics Department, March 2017.
[6] LCRP 2015-2016.
[7] LCRP 2015-2016; WFP, UNICEF, and UNHCR, Vulnerability Assessment of Syrian Refugees in Lebanon, 2015.
[8] Lebanon: Mental health system reform and the Syrian crisis. Elie Karam et al. *BJPSYCH International* 13 (4). November 2016.

partners 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 become more fragmented as the crisis continues, affecting cost efficiency and quality. 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. UNHCR has held discussions with the MoPH since 2016 to reduce these costs through a more direct link with PHCCs, avoiding layers and harmonizing PHC services to refugees with the current UHC under the National Poverty Targeting Program (NPTP). In addition, a new modality under development through MoPH with UNICEF, UNHCR, and WHO – the "THRIVE Lebanon" initiative – will shift subsidization for Syrian Maternal and Child Health (MCH) services to a direct contracting and prepayment model. Since MCH services account for at least half of all preventive and curative health-seeking among Syrians, this model is expected to reduce service costs substantially, while supporting retention and quality.

13. **To meet the increased demand and 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 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."[9] Financed from the Lebanon Syria Multi-Donor Trust Fund, 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 from refugees. The project strengthens the capacity of 75 MoPH network centers, expands the package of services provided, and subsidizes the cost of care to 150,000 poor Lebanese enrolled in the NPTP (see Box 2). However, strengthening the capacity of the network clinics also extends benefits to 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 before the project access to PHC services 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).[10] The project demonstrates that strengthening the integrated PHC model benefits both communities.

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

Box 2. Lebanon Emergency Primary Healthcare Restoration Project (EPHRP)

Objective

The objective of the EPHRP is to assist the GoL in reducing the social, economic, and health impacts of the Syrian crisis on poor Lebanese by subsidizing a package of essential health care services.

Beneficiaries

This project targets 150,000 of the 340,000 poor Lebanese identified by the NPTP as living below the poverty line, using a proxy means testing targeting mechanism.

Essential Health Care Package

The project provides beneficiaries with a package of essential health care services comprising the following: (i) three age- and gender-specific wellness packages (age 0-18, females 19 years and above, males 19 years and above); (ii) two care packages for the most common non-communicable diseases in Lebanon, diabetes and hypertension; and (iii) an antenatal package.

Providers

Services are provided to beneficiaries through 75 of the 204 MoPH network centers. Network facilities are managed by NGOs (67 percent), local municipalities (20 percent), MoPH (11 percent), and MoSA (2 percent). Provider participation is voluntary and is governed by the legal agreement between the MoPH and the managing entity.

Quality of Care

Quality of care is monitored through the PHCC accreditation program implemented by the MoPH in collaboration with Accreditation Canada International. Currently, all 75 PHCCs are within the accreditation program. The quality of clinical care is also monitored by the MoPH through clinical indicators captured in the Health Information System.

Contracting and Provider Payment Mechanism

The MoPH purchases the package of services for the beneficiary population from PHCCs. Provider payment is based on capitation and is output-based. The average per capita cost is estimated at US$60, based on the actual prices that prevail in the markets for medical goods and services and MoPH rates. Contracts between the MoPH and PHCCs define the responsibilities and obligations of each party, the number of NPTP beneficiaries to be targeted, services offered, contract value, clinical and financial reporting requirements, disbursement requirements, and payment mechanisms. The PHCCs are responsible for ensuring that all diagnostic tests are received according to clinical guidelines set by the MoPH. To set correct incentives for PHCCs, the per capita payment is divided into three parts: (i) one part is a contract advance, (ii) the second is based on the use of services by beneficiaries, and (iii) the third is based on user satisfaction, which is monitored through third party assessment and internally by the MoPH.

14. **While the EPHRP has generated some promising results, it has also highlighted some early lessons, including the need to 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 ability of the PHC system to meet the growing demand by increasing the capacity and the number of contracted network centers from 75 to 204 and the number of beneficiaries from 350,000 to 925,000 for both displaced Syrians and host communities (see Table 1). The *scope* of the services also requires expansion to take into account the growing needs in the areas of reproductive care (including GBV dimensions), mental health, NCDs, and elderly care. Because of the growing social and behavioral challenges affecting

the Lebanese and displaced Syrian populations, it is critical to expand the activities of community outreach to reach the vulnerable and to generate demand for service. There is also a need to strengthen the MoPH accreditation program to ensure the quality of health services and strengthen facilities' capacity to meet the accreditation standards. Improving the efficiency and workflow within the PHC network will improve not only the quality of services provided, but also the value for money, which is crucial in achieving the desired health outcomes for both host and displaced communities.

15. **Like PHC services, hospital care for displaced Syrians is integrated in the national hospital system.** Coverage for hospital care for displaced Syrians is provided mainly by UNHCR through 52 contracted public and private hospitals across the country.[11] UNHCR budgetary constraints limit coverage to obstetric and life-threatening conditions, and it reimburses up to 75 percent of hospitalization fees for these services. In 2016, UNHCR covered hospitalization fees for 73,000 admissions for displaced Syrians, 15,405 of which were in public hospitals. Deliveries account for around half of these hospital admissions.[12] In 2016, the tertiary care unit of Hariri University Public Hospital admitted 5,210 displaced Syrians (52 percent of total admissions) and intensive care unit (ICU) admitted 206, representing 55 percent of total ICU admissions.[13] 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.

16. **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 leave a significant number of patients and conditions not covered. The fact that the hospitalization rate among displaced Syrians (6 percent) is half that of Lebanese (12 percent)[14] raises concerns about unmet needs. The MoPH authorized the treatment of around 4,000 displaced Syrians[15] with conditions not subsidized by UNHCR, including dialysis, treatment for cancer, catastrophic illnesses, and acute cases. This resulted in accrued fees of US$15 million to public hospitals. However, efforts by the MoPH, international agencies, and NGOs to fill the coverage gap remain inadequate. Thus, there is a pressing need to support and sustain the Government's efforts to provide hospital care for displaced Syrians, especially for those with serious chronic conditions.

17. **The refugee situation has also exacerbated the challenges the hospital sector was facing before the Syrian crisis.** Although the GoL covers hospital care for all uninsured nationals (around 1.6 million), the ceiling and the tariffs at which the Government reimburses hospitals are historically low. Before the crisis (2002-2011), the MoPH had a sizable budget deficit, delaying some US$80 million in payments to contracted hospitals.[16] This problem has worsened considerably with the increased demand generated by the refugee crisis, affecting access by 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 needs over the last five years[17] indicate that approximately

[11] LCRP 2017-2020.
[12] UNHCR data, 2016.
[13] Hariri University Hospital data, 2017.
[14] LCRP 2017-2020.
[15] MoPH data, 2012-2015.
[16] Interview with Syndicate of Private Hospitals, Lebanon. March 2017.
[17] 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.

15,847 Lebanese patients were not able to access public hospitals because of increased pressure from the Syrian crisis.

18. **The accumulated deficits among public hospitals resulted in inadequate investments in upgrades, large maintenance backlogs, deterioration in quality of equipment, and costly repairs.** Over time unpaid bills had a significant impact on the hospitals' cash flow, keeping public hospitals from expanding their technical capacity and maximizing efficiency even as demand was growing. Many 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 ICUs. Since the high demand for hospital care is likely to continue for the next several years, immediate investment in upgrading public hospitals, to support the resilience of the health sector and maintain the operation of its institutions, is essential.

19. **Accordingly, there is a critical need to focus on strengthening the capacity and resilience of both primary and hospital-level institutions.** This requires expanding the package and quality of services provided to vulnerable populations at the PHC level, and strengthening the physical, technical, and organizational capacity at the hospital level to address the budget limitations hampering the provision of care. Given the integrated service delivery model under which both Lebanese and displaced Syrians access services in the same facilities, such efforts are expected to benefit both populations in Lebanon.

C. Higher-level Objectives to which the Project Contributes

20. **The proposed project is aligned with the priority of the Lebanon Country Partnership Framework** to mitigate the immediate and long-term impacts of the Syrian crisis, and specifically with its objective to ensure improved delivery of health services. It is also directly aligned with the World Bank Group's twin goals of ending extreme poverty and promoting shared prosperity in a sustainable manner, and with the Health, Nutrition and Population strategy, which aims to ensure UHC and equitable financial protection.

21. **The proposed project is aligned with the World Bank Group's MENA strategy**. It will support the pillar on renewing the social contract by providing access to health care to Lebanese and displaced Syrians. It will also assist with resilience to shocks by expanding the package of services available to address the needs of host communities and displaced population and by providing technical support to create a more efficient health system for all. In addition, the MENA strategy calls for a "strategic shift" in engagement and identifies the need to leverage partnerships with other regional development institutions.

22. **The project is also aligned with Lebanon's Health Strategy, and with the WB's MENA health sector strategy (2013-2018).** The project will support the MoPH strategy for achieving UHC and long-term institutional development. It will also support creating fair and accountable health systems through: (i) ensuring a health benefits package for the poor; (ii) reducing regional income and gender discrepancies in access to health care; (iii) incentivizing primary care; (iv) addressing the financing and capacity constraints of the public hospital sector; and (v) addressing the rising burden of NCDs, GBV, mental health, and reemerging communicable diseases in Lebanon.

23. **The Islamic Development Bank (IsDB) will provide parallel financing to strengthen the physical capacity of public hospitals.** Under this arrangement, IsDB will provide parallel financing (US$30 million) to fund the replacement and upgrading of priority equipment in public hospitals: diagnostic equipment (including medical imaging machines); treatment machines (such as medical ventilators, incubators heart-lung machines); medical monitors (including electrocardiograms, electroencephalograms, and others); therapeutic equipment (such as continuous passive motion machines); and electro-mechanical equipment (such as generators). IsDB's support will give priority to 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.

II. PROJECT DEVELOPMENT OBJECTIVES

A. PDO

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

B. Project Beneficiaries

25. **Beneficiaries of this project will be:**

(i) **Poor Lebanese and displaced Syrians.** These vulnerable populations will benefit from improved health services and a more comprehensive package of PHC services that addresses their health needs.

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

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

(iv) **The MoPH.** The project will contribute to maintaining the MoPH's commitment to deliver services to vulnerable populations and will build central-level capacity for planning and project management.

C. PDO-level Results Indicators

26. Progress toward the PDO will be monitored through the following key indicators:

1. Number of primary care beneficiaries (Lebanese and displaced Syrians)
2. Percent of total beneficiaries who are female
3. Percent of pregnant women receiving at least four antenatal care visits
4. Number of public hospital admissions above the MoPH contracted ceiling
5. Number of health facilities accredited

6. Percent of children fully vaccinated under the age of two according to national immunization policy

III. PROJECT DESCRIPTION

A. Project Components

27. **Component 1: Scaling up the scope and capacity of the PHC UHC program (US$76.5 million).** This component builds on and scales up the ongoing EPHRP which provides subsidized package of PHC services to poor Lebanese through capitation payment mechanisms. This project aims to expand and strengthen the ongoing UHC program to reach a larger number of beneficiaries with a more comprehensive package of enrollment-based preventive health services to meet the growing needs of poor and vulnerable[18] Lebanese. The displaced Syrians will benefit from the increased network of participating primary healthcare facilities as well as the expanded package of health services to be provided by the increased network. It is expected that the number of displaced Syrians that will access the centers and the scaled up package of services under various subsidy mechanisms will increase from 130,000 to 375,000 (Table 1). More specifically, this component will:

- Scale up the provision of capitation payments to participating PHCCs for delivery of output-based packages of essential health services to vulnerable Lebanese, as elaborated in the respective Health Service Provider Agreements. This will increase the number of Lebanese receiving subsidized PHC services from 150,000 to 340,000 and the number of contracted network PHCCs from 75 to 204 (Table 1).
- Strengthen the capacities of participating PHCCs for provision of quality healthcare services, through: (i) expanding the scope of said output-based packages of essential health services to include, inter alia, core preventive and curative healthcare services in areas such as reproductive health, non-communicable disease case management, healthcare for the elderly, general wellness, mental health and provision of medication to patients (Table 2); (ii) improving the technical, managerial and physical capacities of participating PHCCs for delivery of said output-based packages of essential health services; (iii) supporting communications and outreach to targeted communities to facilitate enrolment and/or access to said output-based packages of essential health services; and (iv) strengthening the accreditation program to, inter alia, include all participating PHCCs.

[18] Vulnerable Lebanese means Lebanese nationals who have met the eligibility criteria set out in the Project Operations Manual (POM) and are the beneficiaries of Packages of Essential Health Services under Part 1.1 of the project.

Table 1. Targeted Project Beneficiaries

	NUMBER OF PHCCS	*SUBSIDIZED LEBANESE using PHCCS*	*DISPLACED SYRIANS using PHCCS*	*TOTAL beneficiaries*
Current EPHRP	75	150,000	130,000	350,000
Targeted through project	204	340,000	375,000	715,000

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, antenatal care, counseling on health topics, flu and Tetanus-Diphtheria (Td) vaccines
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 and balance assessment ▪ Medication management, counseling (fall prevention, social and elder abuse)
Mental health package	▪ Screening for mental health disorders, case management of depression, psychosis, developmental disorder, and alcohol / substance abuse ▪ Consultations with psychiatrists, psychologists, general practitioners, and social workers; lab tests and medication treatment

28. **Component 2: Provision of health care services in public hospitals (US$36.4 million).** This component will finance:

- Provision of special capitation payments to participating public hospitals for delivery of medical and paramedical services to uninsured Lebanese and delivery of emergency healthcare services to eligible beneficiaries, as elaborated in the respective Health Service Provider Agreements.
- Strengthening of the technical and organizational capacities of participating public hospitals for provision of quality healthcare services, through: (a) provision of training to clinical and non-clinical staff; and (b) strengthening the health information management system targeting participating public hospitals, participating PHCCs and the MoPH.

29. The project will allow the MoPH to respond to the increased demand at public hospitals by authorizing admissions of uninsured Lebanese and will alleviate the financial burden of non-covered emergency cases based on post-review by the MoPH.[19] Currently, MoPH contracts with hospitals are based on pre-set rates for surgical and fee-for-service payments for non-surgical cases, covering medical (cost of medical services) and paramedical services (room and board).[20]

30. In this project, payment authorization for hospital admissions will be based on two levels: (i) contracted third party agency (TPA) which verifies eligibility of all admissions based on the ministry's criteria and international guidelines, and conducts prior verification of invoices; and (ii) medical auditors who would review a sample of admissions based on criteria set for 40 high-cost, high-volume, and/or misuse- and abuse-prone conditions.[21] At the request of the World Bank, an additional technical audit may be conducted to review expenses covered by Bank financing (refer to Financial Management section). The MoPH admission criteria will be further elaborated as part of the Project Operations Manual (POM) that will be adopted by the borrower no later than four months after loan effectiveness.

31. **Component 3: Strengthening project management and monitoring (US$6.8 million).** This component will finance:

- Strengthening the capacities of the MoPH and Project Management Unit for implementation, coordination and management of activities under the project (including, inter alia, procurement, financial management, technical and financial audits, environmental and social safeguards, grievance redress mechanisms, monitoring and evaluation, health information management, supervision and reporting aspects), all through the provision of consulting services, non-consulting services, training and workshops, operating costs, and acquisition of goods for the purpose.
- Carrying out of a comprehensive assessment of hospitals focusing on accuracy of hospital case mix, use of hospitalization data in medical auditing, development of performance indicators incorporating actual patient outcomes, resource allocation decisions, and institutional/organization structures, so as to identify gaps and make recommendations for improvement. Results of the assessments will inform the MoPH in refining their hospital

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

contracting reforms to ensure more efficient reimbursement system. Implementation of revised contracting measures is contingent on legislative approvals by the government.

- Carrying out of an independent evaluation of project activities and results. An independent project evaluation will be conducted to assess the achievements of the project on household service utilization and the capacity of providers to deliver services effectively and cost-efficiently.

B. Project Cost and Financing

32. **The total project cost is US$120 million, and the financing instrument is Investment Project Financing.** The financing will be provided by IBRD in the amount of US$120 million, including a concessional part of the loan to be financed by the GCFF (see Box 3). The financing will be supported by an IBRD loan in the amount of US$95.80 million, and the GCFF will extend US$24.20 million on concessional terms approved by the GCFF Steering Committee on April 20, 2017. The concessional portion of the loan shall be made on a grant basis.

33. **The Islamic Development Bank (IsDB) will provide parallel financing in the amount of US$30 million, which will also include a concessional part of the loan to be financed by the GCFF.**

Box 3. Global Concessional Financing Facility

The Global Concessional Financing Facility (GCFF) is a partnership sponsored by the World Bank, the UN, and the Islamic Development Bank Group to mobilize the international community to address the financing needs of middle-income countries hosting large numbers of refugees. By combining donor contributions with multilateral development bank loans, the GCFF enables eligible middle-income countries that are facing refugee crises to borrow at concessional rates for providing a global public good. The GCFF represents a coordinated response by the international community to the Syrian crisis, bridging the gap between humanitarian and development assistance and enhancing the coordination between the UN, supporting countries, multilateral development banks, and benefitting (hosting) countries. The GCFF is currently supported by Canada, Denmark, the European Commission, Germany, Japan, Netherlands, Norway, Sweden, the United Kingdom, and the United States.

Project components	**IBRD financing (US$)**
Component 1	76,500,000
Component 2	36,400,000
Component 3	6,860,000
Total costs	
Total project costs	119,760,000
Front-end Fee	240,000
Total financing though IBRD	**120,000,000**
IsDB parallel financing	**30,000,000**

C. Lessons Learned and Reflected in the Project Design

34. **In emergency situations, temporary support to meet essential health needs through integrated, pro-poor interventions can mitigate the potential for social instability.** Experience in Lebanon has demonstrated that strengthening integrated, pro-poor PHC interventions can benefit both refugee and host populations. Increased access for both populations decreases the possibility that one group accumulates grievances against another, reducing problems with social cohesion. In addition, access to quality care increases trust in the government, creating a stronger social contract that can also improve government accountability and citizen engagement.

35. **Building on existing initiatives and delivery mechanisms can facilitate quick preparation and implementation.** Reliance on existing programs, structures, and tested implementation approaches can help facilitate rapid and effective disbursement and response to a crisis. Evaluation of the WB's experience in responding to the global financial crisis indicates that, in the interest of providing timely assistance, 74 percent of responses were channeled through existing programs. This operation builds on the interventions supported under the ongoing EPHRP, and relies on the MoPH and existing national systems and structures for implementation.

36. **Lessons from past projects provide useful guidance for the technical design of new projects.** Key lessons from the ongoing EPHRP have been taken into account in the technical design of the proposed project: (i) the need to invest more in outreach and communication activities to stimulate demand for health services; (ii) the need to expand the package of services to make it more comprehensive and responsive to the health needs of vulnerable populations affected by conflict; and (iii) the need to also invest in the hospital sector to improve the overall cohesion of services provided as well as the functionality and efficiency of hospital management and operations. The ongoing project, with a significantly smaller size and shorter timeframe, did not invest in the hospital sector.

37. **Effective implementation requires intensive and sustained WB support.** Experience from rapid responses undertaken in the context of the global financial crisis emphasizes the importance of sustained implementation support from the WB. The ongoing health project, as well as similar operations in the Democratic Republic of Congo, Ethiopia, and Jordan, needed careful implementation support to introduce project modifications and to resolve unanticipated issues. In Lebanon, the WB's existing working relationship with the MoPH is expected to permit the necessary intensive and sustained technical and fiduciary implementation support. In addition, the WB expects to provide intensive and frequent implementation support throughout the project, drawing on multi-sectoral staff based in Washington and the Lebanon Country Office.

38. **The inherent flexibility of OP 10.00 helped expedite project preparation and the WB's overall ability to respond to a situation of urgent need.** This operation was prepared under condensed procedures according to OP 10.00, paragraph 12 (Projects in Situations of Urgent Need of Assistance or Capacity Constraints). As the WDR 2011 noted, the imperative to respond quickly in fragile situations places a "particular premium on speed" in an overall attempt to build confidence in the state's ability to respond to challenging circumstances. The project has made full use of the additional flexibility permitted under OP 10.00 provisions and the streamlined processing to enable the WB to pivot effectively in responding to GoL's request for assistance.

IV. IMPLEMENTATION

A. Role of Partners

39. **The interventions proposed under this project will complement ongoing support by other partners at both the PHC and the hospital level to support the refugee and host population in Lebanon.** Because the project was prepared in close collaboration with international partners—UNHCR, UNFPA, UNICEF, WHO, and IsDB—the project design reflects a cohesive and integrative approach to strengthening the health sector, with no duplication of activities between the UN organizations and other partners.

40. **IsDB.** As mentioned above, IsDB will finance the cost of procuring essential equipment in a set of public hospitals whose bed utilization rate has increased over the past few years. This will entail scaling up and replacing critical equipment which may include diagnostic equipment, treatment machines, medical monitors, therapeutic equipment, and electro-mechanical equipment (such as generators). The prioritized list of equipment will be agreed on between IsDB and MoPH. The IsDB will apply the World Bank Procurement Regulations for the procurement of activities it finances. Impacts related to the safe installation, use, and maintenance of such equipment and the disposal of any old equipment will be assessed and managed in accordance with World Bank safeguards policies which IsDB has committed to as part of its engagement under the GCFF.

41. The Council for Development and Reconstruction (CDR) will be the implementing agency for IsDB funding. The World Bank will have no liability for procurement and safeguards for the IsDB-funded project. The World Bank and IsDB will each supervise their respective projects and will coordinate their supervision. Each party will have clear lines of responsibility with respect to their respective operational requirements, and issues related to the operationalization of this procedure, if any, will be discussed by both parties during implementation. With respect to the IsDB's application of the WB procurement regulations and environmental and social safeguards, as committed to by the IsDB in support of its engagement under the GCFF, the IsDB will operate on the basis of terms agreed with the World Bank. These terms reflect the IsDB's responsibility for all procurement and safeguards decisions related to IsDB-financed activities, including with respect to any claims or remedies, while also clarifying the scope of any World Bank advisory or other appropriate support.

42. **UN organizations**. The THRIVE Lebanon initiative, a joint UN program, will introduce an enrollment-based package of preventive and diagnostic MCH services for Syrians, directly contracted with PHCCs across the MoPH network and free at point of uptake. This package is aligned with the child and reproductive health packages offered to Lebanese under the UHC, with a defined number of curative visits also covered for pregnant women and children under five years old. UNHCR will continue to cover the cost of other non-MCH PHC services and diagnostic procedures for Syrian refugees through a similar modality. At the secondary and tertiary levels, UNHCR covers 75 percent of all emergency life-saving care and cost of deliveries for refugees. UNICEF will continue to support the PHC system to benefit both refugee population and Lebanese, including by financing nationwide immunization services, vaccination campaigns, life-saving medical supplies and essential drugs, and screening for malnutrition and provision of micronutrients. UNFPA will continue to promote and support access to reproductive

health and GBV services. WHO will continue to support the Government and health authorities at the center and local levels in strengthening health services, especially disease surveillance and early warning systems, and addressing public health issues.

43. **Other partners.** Other donors and agencies, such as the European Union and some bilateral programs (Belgium, France, Greece, Italy, Spain, Sweden, and Turkey) will finance interventions in health that will be complementary to the interventions proposed under this project. NGOs will continue to provide complementary subsidies for PHC assistance to Syrian refugees and some vulnerable Lebanese households.

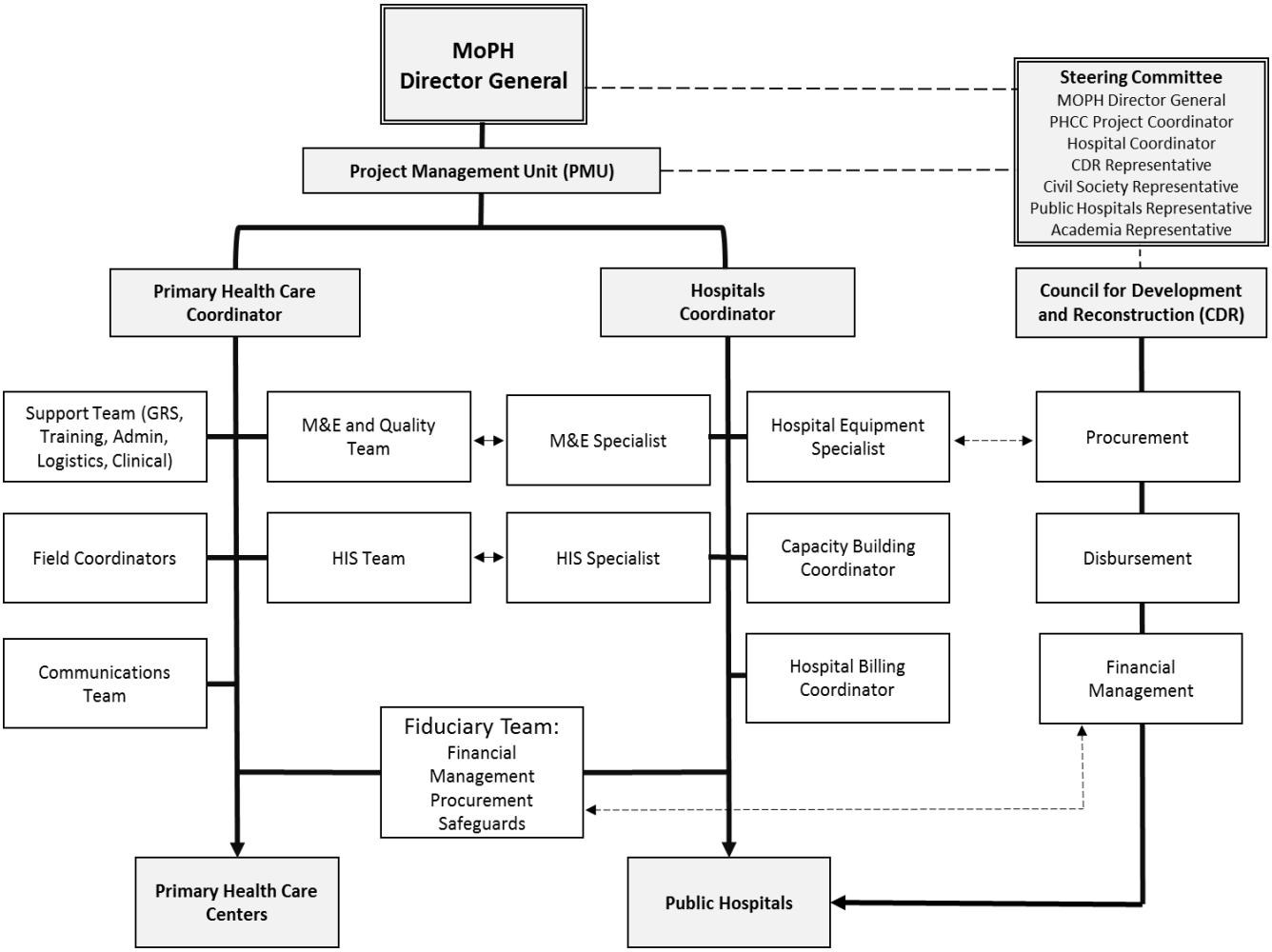
B. Institutional and Implementation Arrangements

44. **The implementation arrangements for the project** are based, in part, on those used under the ongoing EPHRP. Project management is supported under Component 3 of the proposed project. The specific roles, responsibilities, and staff of the PMU and CDR are reflected in Figure 1.

45. **The oversight for the project will be provided by the MoPH through MoPH Steering Committee,** which was established under the EPHRP. However, under the proposed project, it would be expanded to include a representative from the MoPH hospital sector and CDR. The new expanded Steering Committee will be established no later than one month after project effectiveness. This committee will continue to coordinate interagency policies and programs to ensure a cohesive approach to project implementation and to resolve any strategic and implementation issues that may arise during the project life. The Steering Committee is headed by the MoPH Director General and includes representatives from civil society, public hospitals, and academia, as well as the PMU—that is, the PHCC Coordinator and the Hospital Coordinator. The Steering Committee would meet quarterly.

46. **The PMU will be responsible for managing the day-to-day implementation of the project.** The PMU includes two project coordinators - a PHCC Coordinator and a Hospital Coordinator, a financial and accounting manager, and a procurement officer. The PHCC Coordinator is currently responsible for the implementation of the EPHRP 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.

Figure 1. Project Implementation Arrangements



C. Results Monitoring and Evaluation

47. **The project will be monitored and evaluated on the basis of objectives, indicators, and their targets set out in the results framework.** The ongoing EPHRP developed a detailed monitoring and evaluation (M&E) plan and established a system for routine reporting and follow-up, supported by the upgraded health information system (HIS). This project's M&E will build on the EPHRP M&E system, and will consist of five parts: (i) internal oversight by MoPH of the PHCCs and hospitals, including continuous monitoring of the activities to inform program implementation and day-to-day management decisions; (ii) independent project evaluation, including periodic and objective assessments of planned and ongoing project activities; (iii) beneficiary assessment and grievance redress mechanisms; (iv) external medical auditing will be conducted as post-review, as explained in paragraph 71, to validate appropriate funding of emergency hospital admissions; and (v) project's final evaluation to assess how the interventions affected the intended outcomes of the project.

48. **The MoPH, through the PMU's two coordinators (PHCC and hospital), will be responsible for monitoring the daily progress of the project,** focusing on improved accessibility of beneficiaries to the package of services, proper procurement, and capacity building of hospitals. The PMU will be responsible for preparing and submitting semiannual progress reports that, among other things, provide detailed reporting on services, procurement, and expenditures. It will also conduct mid-term and post-completion evaluations to gauge progress toward the PDO and assess the impact of the project on targeted beneficiaries.

49. **The HIS system developed by the MoPH will be further refined and expanded under the project to all newly enrolled PHCCs to support the implementation and monitoring of the program**. Data will be collected and used to: (i) supervise the performance of PHCCs; (ii) monitor the progress of beneficiary accessibility; (iii) monitor hospital improvements; and (iv) improve the provision of services on the basis of intermediate output and outcome data. The data will be verified directly by MoPH supervisory systems and external evaluation, and indirectly through triangulation with other data sources such as hospital claims.

50. **Beneficiary feedback and grievance redress mechanisms will also play an important role in monitoring the project.** The EPHRP made significant progress toward establishing grievance redress mechanisms at the central and facility levels. This project will continue to strengthen the system by supporting the MoPH hotline and finalizing the automated Grievance Module to create one platform that integrates registration databases from the different sources to track and manage grievances. This will provide the MoPH with timely access to grievance data to address grievances.

51. **The WB will conduct regular implementation support missions** during which implementation progress, outputs, and work plan updates will be assessed, and adjustments made as necessary. On the basis of these missions, regular implementation status and results reports will be prepared.

D. Sustainability

52. **The project's sustainability is reinforced through three elements.**

(a) **Alignment with GoL priorities and the national health sector strategy.** This alignment will be achieved as follows: (i) short-term stabilization by addressing the immediate health needs of poor Lebanese and displaced Syrians through an expanded package of services and improved staff and physical capacities at the PHC and hospital levels; (ii) medium-term resilience of the system to ensure sustainability by laying the ground for a more effective PHC model focusing on prevention and outpatient case management; and (iii) long-term support to the MoPH strategy for UHC.

(b) **Ownership.** The project was conceived, planned, and designed by MoPH, and all levels of the ministry have demonstrated steadfast commitment and ownership. MoPH will have an overall responsibility for project implementation and oversight.

(c) **Strengthened MoPH management capacity.** The project supports MoPH management capacity in critical areas such as contracting, financial management, M&E, procurement, and grievance redress mechanisms.

V. KEY RISKS

A. Overall Risk Rating and Explanation of Key Risks

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	Moderate
8. Stakeholders	Substantial
OVERALL	**Substantial**

53. The overall risk rating for the project is substantial. The key risks and mitigation measures are described below:

a) **Political and governance risks** associated with stalemate in the executive and legislative branches of the Government are high and may affect the project approval process by the Cabinet of Ministers or lead to delays in parliamentary approval of the proposed loan. This could significantly delay project effectiveness. In addition, failure to reach an agreement on a new election law may result in a parliamentary vacuum, as a third extension for the current Parliament has been ruled out by both the President and the Speaker of Parliament. Changes in political leadership could also potentially affect commitment to the sustainability of the project. *Mitigation:* This risk affects all WB-financed operations and cannot be fully mitigated. Lebanese politicians at the highest level have expressed to the donor community and the WB their readiness to expedite and facilitate the approval of development loans and grants, especially those linked to the GCFF. The WB has also been engaging with government counterparts to raise awareness of the importance of timely implementation and to seek political commitment to ensure swift loan ratification and approval that are required for effectiveness and the commencement of activities.

b) **Technical design risks** associated with the contracting process involving NGOs and the inability to attract and enroll targeted beneficiaries is substantial. There are also risks related to potential errors and fraud in enrollment of beneficiaries. *Mitigation:* The proposed project builds on the existing interventions and lessons learned from the ongoing health project. Risks related to the contracting process will be mitigated by requiring PHCCs and hospitals to develop a detailed project implementation readiness plan, based on the results of rapid facility assessments that focus on the project's goals, design, and expected outcomes. The readiness plans will clearly

state the capacity needs of the PHCCs while the contract will state the targets to be achieved, quality measures, and payment terms and modalities. Contracting with PHCCs will rely on the existing draft contracts already used by the MoPH. To mitigate the risk of inability to attract and enroll beneficiaries, as well as possible fraud and errors in enrollment of beneficiaries, the project will support: (i) expanding the outreach program; (ii) a timely information campaign at the community level, engaging community volunteers for outreach and demand generation; and (iii) utilization of the existing NPTP system and individualized photo identification cards to ensure that the project reaches the targeted poor, avoids potential enrollment errors, and minimizes fraud.

c) **Institutional capacity for implementation and sustainability risks** are substantial and are associated with: (i) inadequate capacity at the central and facility levels, especially for managing the additional load of beneficiaries and enhanced requirements for monitoring and supervision; (ii) expected delays in implementation due to the time required to start the enrollment process, and contracting with PHCCs; and (iii) slow disbursement due to the flow of funds mechanism between the Ministry of Finance (MOF) and MoPH. *Mitigation:* Component 3 of the project will strengthen the capacity of the existing PMU. In addition, the MoPH is already undertaking tested measures that will be further supported by the project, including: (i) providing a lump sum up-front budget to PHCCs as part of their contracts to advance their implementation readiness and provide flexibility to recruit additional health workers and provide training as needed; (ii) completing a facility survey that will help identify needs and gaps among the PHCCs and hospitals to allow for targeted capacity strengthening; (iii) preparing and maintaining a disbursement plan that will be based on the overall budget and the procurement plan; and (iv) integrating the interventions supported under the project into existing government structures and plans to sustain the project.

d) **Fiduciary risks** are substantial and are associated with: (i) limited dedicated staff to undertake the FM activities within MoPH and within the current PMU; (ii) lack of an accounting system within MoPH to record and produce financial reports according to WB reporting requirements; (iii) limited internal control system; and (iv) limited external audit function where the Court of Accounts mandate is mainly consumed on ex-ante control. *Mitigation:* The project will draw on and expand the existing fiduciary capacity of the PMU and will expand existing mechanisms—the accounting software with specifications acceptable to the Bank to record expanded daily transactions and produce the periodic financial reports, as well as appropriate FM manuals—and will ensure that an independent qualified external auditor to provide oversight is contracted according to terms of reference (TOR) acceptable to the Bank, including a requirement that the audit report will be delivered to the Bank no later than six months after the end of each fiscal year. Procurement risks will be addressed through the expansion of procurement capacity in the PMU (under Component 3), and the development of a detailed and regularly updated POM that will include a relevant procurement plan and guidelines for procurement planning and management for each component.

e) **Stakeholder risks** are substantial and are associated with a potential duplication of activities, but more importantly, a potential reduction in funding by partner institutions that currently cover service provision for displaced Syrians and others at PHC and hospital levels. This includes

UN organizations such as UNHCR, which might no longer subsidize service delivery for the refugee population at both levels. *Mitigation:* Throughout implementation, the project will build consensus and share project achievements among all the stakeholders to ensure ownership of the project and integration with partner activities.

VI. APPRAISAL SUMMARY

A. Economic and Financial Analysis

Economic Analysis

54. **The proposed project aims to enhance the resilience of the health sector in Lebanon to provide quality health care services to populations affected by the Syrian crisis.** The project will contribute to Lebanon's long-term development agenda through the following pathways: improving Lebanese and displaced Syrians' survival and reducing mortality related to communicable and non-communicable diseases; saving unnecessary health care costs and social care costs; increasing the productive labor force; improving health system efficiency; and promoting equity and shared prosperity.

55. **The interventions financed by the project will contribute to improving the health status and survival of Lebanese and displaced Syrians, and to reducing mortality related to communicable and non-communicable diseases.** 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) is expected to have a direct impact on the top causes of disability-adjusted life years in the country.[22] As a result, the project will contribute to saving health care costs related to disease treatment by focusing on cost-effective preventive and curative measures, and to saving the socioeconomic burden that is related to the extra care needed for preventable diseases. Preventing disease and supporting a healthy population will affect the economy positively in several ways: (i) increased productivity, labor supply, and human capital; (ii) increased consumption or production of goods and services that would otherwise not have been consumed or produced; and (iii) increased household earnings.

56. **The project will contribute to improved technical and allocative efficiency in the health service delivery system.** As institutional capacity is strengthened and the availability and quality of key inputs are improved, more facilities will be pushed to the production function frontier, and will therefore deliver better services at a given cost. The project will also contribute to improved allocative efficiency at health facilities by shifting funding from hospital-level to PHC facilities. Component 1 in the project focuses on PHC, which is the most cost-effective modality for providing a defined package of high-impact services. Countries with robust primary care systems are associated with improved population health outcomes for all-cause mortality, all-cause premature mortality, and cause-specific premature mortality from major respiratory and cardiovascular diseases.[23] More specifically, primary care has been

[22] Institute of Health Metrics and Evaluation (2015), Global Burden of Disease Lebanon. Retrieved from *http://www.healthdata.org/lebanon*. See also Graham et al. (2006) and Jamison et al. (2008), who review low-cost interventions to reduce communicable and non-communicable diseases.

[23] Atun, R. (2004). What are the advantages and disadvantages of restructuring a health care system to be more focused on primary care services? World Health Organization.

associated with reduced infant and maternal mortality[24] and reduced morbidity from NCDs, all of which are very relevant to Lebanon. Early screening under primary care for diabetes and hypertension has been shown to be highly cost-effective.[25] Furthermore, improving hospital capacity through the procurement of needed equipment and training of health personnel will play a disproportionately influential role in enabling diagnostic and clinical efficiencies. Finally, the project will also support the Lebanese health system in being more results-focused and getting greater value for money. By building capacity and supporting the M&E system, it will enable decision-makers and managers at all levels to be more efficient in planning and implementing activities.

57. **The project will contribute to promoting equity in access to health care services and reducing the financial burden on poor households.** The evidence shows that primary care, in contrast to specialty care, is correlated with a more equitable distribution of health services: a finding that holds in both cross-national and within-national studies.[26] Studies from various countries demonstrate that a health care system oriented toward specialist care creates inequity in access. However, health systems in low-income countries with well-established primary care systems tend to be more pro-poor, equitable, and accessible. In addition, it is expected that redirecting resources from expensive hospital care to relatively inexpensive basic PHC would reduce spending on higher levels of care, as well as the out-of-pocket payments poor individuals would incur.

58. **Public sector engagement is justified by the critical role of the MoPH and public health facilities in providing affordable health care services to poor Lebanese and displaced Syrians.** Investments funded through the project will strengthen health service delivery and improve institutional capacity. Public sector intervention is vital to provide PHCCs with critical inputs so that they can in turn provide essential health care services to communities, along with free essential drugs. Project interventions are also expected to have positive externalities for health system resilience, management of epidemiological risk and public health, and important spillovers—all of which advocate for public sector intervention.

59. **The value-added of WB support to Lebanon is:** (i) the WB's technical input based on international experience in strengthening health systems and managing emergencies, and (ii) its experience from the implementation of the EPHRP.

Financial analysis

60. **Lebanon's economy is severely affected by the Syrian crisis.** Up to 1.5 million Syrians have taken refuge in Lebanon since the conflict started in March 2011. This has strained Lebanon's public finances, service delivery, and environment. The crisis is expected to worsen poverty incidence and

[24] 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; 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.
[25] Dukpa W. et al. (2014), op. cit.
[26] Starfield B, Shi L, Macinko J. (2005). Contribution of Primary Care to Health Systems and Health. *The Milbank Quarterly* 83(3): 457-502. doi:10.1111/j.1468-0009.2005.00409.x.

widen income inequality among Lebanese. In this challenging environment, GDP growth in Lebanon is estimated to have decelerated to 1.3 percent in 2015 from an estimated 1.8 percent in 2014, despite continued Central Bank stimulus, an improved security stance, and lower oil prices. Public finances remain structurally weak, and they are in urgent need of reforms. Public debt is projected to continue to rise (148 percent of GDP by end-2017) because of low growth and the relatively high cost of debt financing.[27]

61. **It is expected that this project will be financially sustainable, but close monitoring of the macroeconomic and budget situation will be needed.** The proposed project investment, US$120 million over a five-year period, accounts for 5 percent of the annual government expenditure on health.[28]

B. Technical

62. **The technical design of the project is based on the ongoing EPHRP in PHC, with an additional focus on the hospital sector.** The interventions are designed not just to meet urgent health care needs, but also to focus on governance, accountability, management, and expansion of essential health care services to the poor. The pro-poor interventions supported under this project are well-known and have been tested in numerous countries around the world. In addition to reflecting the priority needs identified in the national health plan, the investment rationale is supported by a large body of global evidence, including recent analyses of the benefits of prioritizing PHC to reach the poor, and connecting sectors and systems to achieve health results. The particular focus on strengthening health care services at the lowest level, addressing both demand- and supply-side constraints while providing some support to ensure functioning services at higher levels of the health system, builds on this knowledge as well as in-country experience. Strengthening the continuum of care, from community to health center to hospital, to address the many health challenges of refugees and host populations, building critical capacity, and freeing resources at all levels, is the basic premise for this operation.

C. Financial Management

63. **The Bank assessed the adequacy of the project FM arrangements at the MoPH,** the implementing entity for the components financed by the WB (IsDB will parallel-finance separate activities through the CDR). The MoPH is currently carrying out the implementation of the EPHRP through a PMU that includes a Financial Officer (FO). The FM performance of this project at the start was Moderately Satisfactory, and was upgraded to Satisfactory during the last mission in October 2016. The same PMU will carry out the implementation of the proposed project, but additional staff will be hired to carry out the additional work required. In particular, additional FM staff will need to be hired to support the FO who has gained adequate experience in handling FM arrangements and WB reporting requirements.

64. **The FM risk is assessed as substantial before mitigation**. The key risks are the following: (i) limited dedicated staff to undertake the FM activities within MoPH and within the current PMU; (ii) lack of an accounting system within MoPH to record and produce financial reports according to WB reporting

[27] . IMF Lebanon Country Report No 17/19, January 2017.
[28] Based on World Bank Development Indicators (2014).

requirements; (iii) limited internal control system; and (iv) limited external audit function where the Court of Accounts mandate is mainly consumed on ex-ante control.

65. **The MoPH will need to implement several mitigating measures to reduce the FM risk level to Moderate:** (i) recruit an FM staff with adequate experience, in addition to the current FO, based on TOR acceptable to the Bank; (ii) adopt accounting software with specifications acceptable to the Bank to record daily transactions and produce the periodic financial reports; (iii) prepare an FM chapter of the POM; (iv) ensure that an independent qualified external auditor is contracted, based on TOR acceptable to the Bank, with the audit report to be delivered to the Bank no later than six months after the end of each fiscal year; and (v) expand the scope of the TOR of the Third Party Agency (TPA) to a level acceptable to the Bank, to include the audit of hospital expenditure bills financed under Component 2 of this project.

Financial Management Arrangements

66. **Staffing and organization.** The MoPH is understaffed, and the civil servants working in the accounting department have limited capacity and knowledge of the WB requirements. Nevertheless, the PMU for the ongoing EPHRP has an FO who has gained adequate experience in carrying out FM arrangements in line with WB requirements. This same PMU will be implementing the new project, but additional staff will be hired to cover the additional workload. Among the additional staff will be FM staff, recruited in addition to the FO as part of the PMU team, to carry out the FM arrangements under the project's components. The WB will provide the necessary training and support in FM procedures and reporting guidelines for the newly recruited FM staff.

67. **Internal controls.** The MoPH has limited internal controls functions. The internal controls are set according to the MoPH's internal bylaws. For this operation, the PMU will prepare an FM chapter for the POM, containing detailed information about the FM procedures and rules governing the flow of funds and internal control procedures, as well as the specific responsibilities of each member of the unit.

68. **Budgeting** The WB funds will be channeled through the Ministry of Finance Treasury Account for "Loans" and will be transferred to the designated account of the project as follows:

i. To facilitate the efficient management of the financial management system, the Borrower shall, through MOF, channel the proceeds of the Loan from the loans treasury account in the Loan Currency at BDL to the Designated Account of the Project by a letter signed by both the Head of Treasury and the Central Treasury Cashier of the MoF. Upon each withdrawal of the proceeds of the Loan, the Borrower shall, through MoF, open Additional Budget Lines (budget classification number 1-12-1-734-14-1-3, 1-12-1-734-16-9-1, 1-12-1-732-16-7-1) equivalent to the amount of such withdrawal of the Loan proceeds, provided that the total amount allocated to all such budget lines during the life of the Project up until the disbursement deadline date (as defined in the Disbursement Guidelines and the additional instructions of the Bank referred to in Section IV.A.1 of Schedule 2 to the Loan Agreement) shall not exceed the amount of the Loan.

ii. For the purposes of this Loan, the said Additional Budget Lines could be opened in the budget of a specific year up until 31 January of the following year and those contracted or not contracted are carried forward per the request of the MoPH.

69. **Accounting system and financial reporting.** The MoPH does not have an accounting information system to process accounting transactions. However, it has an information system for public health that connects to the PHCCs. In the EPHRP, each health center has been using the financial module of the HIS to record daily transactions and submit requests for payments. The connection has been installed in all centers, and training and follow-up are conducted by the PMU. For Component 1, which scales up activities under the existing emergency project, the same financial module will be used by the expanded number of PHCCs to record daily transactions and account for the data on treated patients.

70. **The system allows the MoPH to monitor and control expenditures made by the PHCCs in the context of the project.** The flow of activity and expenditure cycle is as follows:

- Any contract to be signed by the PHCCs with a third party is submitted in the system to the MoPH for clearance.
- Once the contract is cleared by the MoPH and then signed, any subsequent payment on this contract will be through a "payment request" submitted by the PHCC in the system to the MoPH for review and clearance.
- Once the payment request is cleared by MoPH, the FO prepares the payment (check or bank transfer) to be signed by the project coordinator and the Director General.
- The funds are then transferred from the Designated Account to the PHCC's bank account (which is a segregated bank account opened exclusively for the project). Payments are made on a periodic installment basis.
- Once the payment request is sent to the MoPH, the PHCC cannot modify or alter any data from the system.
- All the data entered at the PHCC level are available at the MoPH. In addition, the PHCCs submit semi-annual bank reconciliation statements to MoPH.
- These activities are checked by the reviewing unit at the MoPH, which regularly visits a sample of centers to audit and check the accuracy of what is fed into the system. The findings of the review have been satisfactory; no material misstatements have been found in what relates to the EPHRP.

71. **For Component 2, which will finance patient bills exceeding the ceiling set under the MoPH budget,** as well as other emergency admissions expenses that are not covered by the MoPH (defined criteria will be set to ensure eligibility), the Bank loan will finance the eligible expenditures incurred, starting from project effectiveness. Retroactive financing up to an aggregate amount of US$3,600,000 may be made for eligible expenditure under Component 2, for payments made prior to signing of the Loan Agreement but on or after September 1, 2016. Under the control system in place at the MoPH, the expenditures incurred during the project implementation period will be reviewed prior to payment by a TPA contracted to conduct this technical service for the MoPH for a fixed annual fee. The MoPH medical audit team will also review a sample of admissions and audit these expenditures to ensure compliance and accuracy. In addition, to gain even greater assurance about the use of Bank funds under this project, the PMU will negotiate an increased scope of the TPA TOR to ensure that the expenditures incurred

from the WB financing are eligible, are in compliance with the criteria set, and are accounted for once, and in an appropriate way, given that the health sector is supported by multiple donors. Once implementation starts, the Bank may at any time request a technical audit to review the portion of such expenses that is covered by Bank financing, either through an independent technical/medical auditor to be hired under TOR that are acceptable to the Bank, or through the financial external audit.

72. **The PMU at the MoPH will be required to prepare** the project interim unaudited financial reports for submission to the WB by no later than 45 days after the end of each quarter.

73. **The Bank will provide further training and guidance, as needed, on the implementation of the FM arrangements.** The interim unaudited financial reports will be in compliance with the International Public Sector Accounting Standards (IPSAS) format of financial statements, as the project will record the loan transactions using the cash basis of accounting. The interim financial reports 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 Designated Account; (iv) statement of cash payments made using Statements of Expenditures; (v) a list of payments by region, health care center, type, and beneficiary; (vi) a list of payments by hospital, type, and beneficiary; and (vi) Statement of Fixed Assets.

74. **The Project Financial Statements (PFSs), prepared in accordance with IPSAS - Cash Basis - should contain the same information as the quarterly interim financial reports (IFRs) but cover an annual period.** The audited PFSs would be submitted to the Bank no later than six months after the end of each fiscal year (see External Audit Arrangements below).

75. **Flow of funds and cash management.** The project funds will be channeled from the World Bank to the MoF Treasury account for "Loans" and then transferred to the Designated Account opened for the project at the Central Bank of Lebanon in US dollars. Deposits into and payments from the Designated Account will be made in accordance with the provisions set out in both the Loan Agreement and disbursement letters and as outlined in the WB's "Disbursement Guidelines for Projects''. For the purposes of the Loan, transfer of funds between different budget lines will be carried out and approved by both the Minister of Finance and the Minister of Public Health. The Borrower shall, through MoF, open an account for the Loan in its Chart of Accounts to record all disbursement amounts that are channeled to the Designated Account mentioned in paragraph 1 of the Loan Agreement. The said account shall be settled periodically based on expenditures statements in the loan currency signed by the Minister of Public Health and provided to MoF before end of each fiscal year for expenditures incurred up to October 31 of said Fiscal Year, and before end of January 31 of the following year for expenditures incurred in November and December for the previous fiscal year.

76. **External auditing.** The PFSs will be audited by an independent private external auditor acceptable to the WB. The audit will cover the WB financing to the MoPH and will be carried out in

accordance with International Standards on Auditing. The audit TOR will be cleared by the WB and will cover, among other things, compliance with the FM chapter of the POM, the effectiveness of the internal controls system, and compliance with the Loan Agreement. The audit will be accompanied by a management letter that contains the external auditor's assessment of the internal controls, accounting system, and compliance with the financial covenants in the Loan Agreement. The audit report and audited PFSs, along with the management letter, will be submitted to the WB no later than six months after the end of each fiscal year. The external audit TOR will be finalized and agreed with the Bank within three months after project effectiveness, and the external auditor is expected to be engaged within six months after project effectiveness. The Bank makes publicly available the Borrower's audited annual financial statements for all investment operations. According to the WB disclosure policy, the PMU will ensure that the yearly project audit report is made public in a manner satisfactory to the WB.

77. **Disbursement arrangements.** To ensure that funds are readily available for project implementation, the MoPH through MOF will open one Designated Account (DA) in US dollars at the Central Bank of Lebanon to receive the transfers from the Treasury account at the Central Bank of Lebanon for the portion of the loan financed by the World Bank. Deposits into, and payments from, the DA will be made in accordance with the provisions set out in the Loan Agreement and as outlined in the WB's "Disbursement Guidelines for Projects" by means of advances, replenishment, and reimbursements. Replenishments of the Designated Account will be against Withdrawal Applications. Retroactive financing up to US$3,600,000 may be made available for eligible expenditures under Component 2 for payments made prior to signing of the Loan Agreement but on or after September 1, 2016.

Financial Management Action Plan

Action	*Responsible*	*Due date*
Recruit FM staff to support the FO	MoPH	During the first 3 months of implementation
Prepare the FM chapter as part of the POM	MoPH	During the first 3 months of implementation. The POM will be adopted no later than 4 months after loan effectiveness.
Expand the current information system to cover the additional PHCCs	MoPH	During the first 3 months of implementation
Expand the TPA TOR to cover the hospital bills related to Component 2.	MoPH	During the 3 months of implementation
Recruit an external auditor to audit PFSs for WB financing.	MoPH	During the first 6 months of implementation

D. Procurement

78. **Project proceeds.** The proposed project will be implemented by the PMU and financed by the IBRD loan, and the IsDB-financed project will be implemented by the CDR following WB procurement regulations. Each financier will be responsible for procurement associated with activities subject to its own financing. Given that the project is prepared under emergency procedures, the Project Procurement Strategy for Development (PPSD) resulting in the final procurement plan will be prepared

during implementation. Meanwhile, a preliminary procurement plan was prepared and included as part of the Loan Agreement.

79. **The procurement capacity assessment** covers the MoPH using the expanded PMU of the EPHRP for goods and related works and for non-consulting and consulting services.

(a) **Implementing agency and past experience.** The MoPH will use an expanded PMU of the ongoing EPHRP. MoPH abides by Public Accounting Law No. 14969, dated December 30, 1963, supplemented by several decrees, allowing for internationally financed projects to use the donor's guidelines. MoPH is currently implementing the EPHRP that supports services provided by the PHCCs, and it also has extensive experience in implementing internationally funded projects. It continues using a PMU that outsources qualified staff for implementing projects. The PMU has proven to be diligent in processing activities under the ongoing project and has made itself familiar with implementation obstacles, maintained satisfactory records, and produced evaluations of acceptable quality. However, the nature of activities under the EPHRP differs from the proposed project, and additional skills may need to be put in place.

(b) **Current ministry staffing.** Two committees process procurement: Supply Committee and Acceptance Committee. The PHC department processes purchases of medicine and related material by commissioning UNICEF for procurement processing. The PMU is staffed with three procurement personnel. More resources will be allocated for an expanded project.

(c) **Applied taxes.** The following taxation principles would be observed: (i) stamp duties of three per thousand (3‰) of the contract price for contract registration at MOF, and three per thousand (3‰) on each payment; (ii) value-added taxes (VAT) of 10 percent applied on consultants and contractors who are registered and eligible for VAT; and (iii) income taxes at a flat rate of 7.5 percent for non-registered consultants and variable for registered consultants, depending on their job classification at MOF. Consultants may be exempt from income taxes 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).

80. **Risks and mitigation measures.** The identified risks are related to: (i) the capacity of PHCC/PMU to undertake a more sophisticated procurement than the one under the EPHRP; (ii) limited bidding competition; (iii) the implementing agency's weak familiarity with the WB's new procurement framework (NPF), effective in July 2016; and (iv) weak public oversight. The following mitigation measures will be taken to reduce risk during implementation: (i) the POM will clearly define the relevant NPF process and map procurement decision-making; (ii) the Ministry will ensure that the PMU has appropriate support (staff, training, tools) to carry out project procurement planning, implementation, and monitoring; (iii) the PMU will establish advertising policy and develop sample advertisements in line with the requirements of Bank regulations; (iv) the PMU will develop a standard template for the evaluation report for the project/agency and ensure compliance; (v) the PMU will improve its system for addressing complaints; (vi) the PMU will develop and implement quality assurance arrangements; and (vii) an external auditor will be recruited.

Market Analysis Summary

81. **Consultants.** The required consultants are mainly individual consultants for the PMU who are already hired under the EPHRP. Any additional consultancies are expected to be small contracts under which both local and international capacity may be tapped as needed.

82. **Goods.** The project will purchase simple equipment and supplies, and will commission information systems to strengthen the ministry's capacity in managing the hospitals and PHCCs. Most such goods are available locally, and the external market may be called on for the information systems.

83. **Proposed Procurement Arrangements** are as follows:

- **Procurement Regulations.** 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 and revised in January 2011, and as of July 1, 2016 ("Anti-Corruption Guidelines"); (ii) "World Bank Procurement Regulations for Borrowers under Investment Project Financing," dated July 1, 2016 ("Procurement Regulations"), and the provisions of the Borrower's procurement plan for the project ("Procurement Plan") provided for under Section IV of the Procurement Regulations, as it may be updated from time to time in agreement with the WB.

- **Procurement methods.** Selection methods and arrangements:

  (a) *Goods and non-consulting services.* The project is expected to purchase equipment using" (i) Request for bids (RFB) for both international (replacing ICB) and national markets (replacing NCB), (ii) Request for quotations (or Shopping); and (iii) Direct selection (old Direct contracting).
  (b) *Consulting services.* The project is expected to use Request for Proposals with the following methods: Quality- and Cost-Based Selection (QCBS), Fixed Budget-based Selection (FBS), Least-Cost-based Selection (LCS), Consultants' Qualification-based Selection (CQS), Direct Selection (formerly, single sourcing); and Selection of Individual Consultants.
  (c) *Particular contracts.* The PHCCs will continue to use a performance-based contract under which they will account for enrolled patients receiving services, and for the return of the same patients to the center based on their satisfaction with the services.

- **Prior review thresholds.** Based on the procurement assessment risk rating, the project will be subject to moderate risk prior review thresholds as defined under NPF.

84. **STEP.** The Government leads the development of the Project Procurement Strategy Development (PPSD), which will define the market approach options, the selection methods and contractual arrangements, and the WB's reviews. The main outcome of the PPSD is a well-informed procurement plan for the life of the project. A preliminary procurement plan was prepared as part of the Loan Agreement and will be uploaded in the Systematic Tracking of Exchanges in Procurement (STEP) system. Procurement activities shall be packaged in an efficient and economic manner.

85. **Frequency of supervision.** Implementation support missions will take place twice yearly. Post-procurement review will be carried out once a year and cover a sample of 10 percent of contracts eligible for post review.

E. Social (including Safeguards)

86. **The project is expected to have positive social impacts.** The project will improve access to health services for vulnerable individuals living in Lebanon. The project design includes mechanisms to ensure that project beneficiaries are well targeted and are aware of their eligibility for services, and a solid grievance redress mechanism that will provide information on any aspects of the project that are problematic or could be improved. The MoHP Steering Committee will include civil society, increasing the voice of beneficiaries in project management.

87. **The project does not have any significant social risks that cannot be mitigated.** Given project activities, key issues to address include: (1) ensuring that the project targets the poor, and especially those belonging to social groups that may be excluded; (2) guaranteeing that those eligible to receive project services, and especially the most vulnerable among them, are aware of their eligibility and of the ways they can access services; (3) putting in place a strong grievance redress mechanism that is accessible and responsive; and (4) ensuring that the project does not create or increase tensions between social groups. Risks that certain groups will be excluded are mitigated by a strong targeting mechanism, and risks related to tensions between Lebanese and Syrian communities are mitigated by project mechanisms to ensure that both groups benefit from activities. The project design also includes communications and outreach activities that would actively inform and educate vulnerable populations on the services and benefits available.

88. **The project does not include any land acquisition and will not involve any displacement of people from land or have negative impacts on livelihoods.** Thus OP 4.12, *Involuntary Resettlement*, is not triggered.

F. Environment (including Safeguards)

89. **Given the nature of environmental, health, and safety (EHS) impacts associated with health care facilities**—PHCCs, hospitals, and so on—basic EHS standards/protocols are mandated at the facility level through an accreditation system. A summary of the accreditation system in place in Lebanon as well as an overview of general occupational health and safety (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 help manage the increased capacity challenges. The project aims at increasing the number of users and types of services provided including comprehensive package of services (Component 1). The essential packages of services will include activities such as immunization, lab tests, mammography, and screening. These activities are expected to have environment, health, and safety impacts on the surrounding environment, including the generation of medical health care wastes, air emissions, wastewater, occupational health and safety concerns, and community health and safety concerns. Given

the scale and nature of the project, the environmental risks associated with the project activities are considered moderate, and the project is therefore classified as environmental category B, in accordance with OP 4.01.

90. **In accordance with Bank policy (OP 10.00, paragraph 12), the development of the ESMF is deferred to the implementation stage,** given the urgent nature of the proposed operation. A Safeguards Action Plan (Annex 1) sets out the roadmap for the development of the ESMF: content, timeframe, disclosure, and consultation for the ESMF. The borrower, through the MoPH, will prepare the ESMF no later than three months after effectiveness.

G. Other Safeguard Policies (if applicable)

91. The project activities do not trigger any other safeguard policies.

H. World Bank Grievance Redress

92. **Communities and individuals that believe that they are adversely affected by a WB-supported project may submit complaints** to existing project-level grievance redress mechanisms or the WB's Grievance Redress Service, which ensures that complaints are promptly reviewed and project-related concerns addressed. Project-affected communities and individuals may submit their complaint to the WB's independent Inspection Panel, which determines whether harm occurred, or could occur, as a result of the WB's non-compliance with its policies and procedures. Complaints may be submitted at any time after concerns have been brought directly to the World Bank's attention and Bank Management has been given an opportunity to respond. For information on how to submit complaints to the World Bank's corporate Grievance Redress Service, please visit http://www.worldbank.org/en/projects-operations/products-and-services/grievance-redress-service. For information on how to submit complaints to the World Bank Inspection Panel, please visit www.inspectionpanel.org.

VII. RESULTS FRAMEWORK AND MONITORING

Results Framework
COUNTRY : Lebanon
Lebanon Health Resilience Project

Project Development Objectives

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

Project Development Objective Indicators

Indicator Name	Core	Unit of Measure	Baseline	End Target	Frequency	Data Source/Methodology	Responsibility for Data Collection
Name: Primary care beneficiaries		Number	280000.00	715000.00	Bi-annual	HIS	PMU
Poor Lebanese		Number	150000.00	340000.00			
Displaced Syrians		Number	130000.00	375000.00			
Description: Number of beneficiaries who will have access to the essential healthcare services package.							
Name: % female of total beneficiaries		Percentage	50.00	50.00	Bi-annual	HIS	PMU

Indicator Name	Core	Unit of Measure	Baseline	End Target	Frequency	Data Source/Methodology	Responsibility for Data Collection
Description: Percent of female beneficiaries of the total number of beneficiaries who will have access to the essential healthcare services package.							
Name: Pregnant women receiving at least four antenatal care visits		Percentage	50.00	70.00	Annual	HIS	PMU
Description: Percent of pregnant women (from among the cumulative number of enrolled beneficiaries) who receive at least four antenatal visits during their complete term of pregnancy.							
Name: Public hospital admissions above the MoPH contracted ceiling		Number	0.00	34000.00	Annual	MoPH	PMU
Description: Number of admissions at public hospitals above the MoPH contracted ceiling with hospitals							
Name: Health facilities accredited		Number	30.00	140.00	Annual	MoPH	PMU
Description: Number of PHC contracted health facilities that receive accreditation							
Name: Children fully vaccinated under the age of two according to national immunization policy		Percentage	50.00	80.00	Annual	MoPH	PMU
Description: Percentage of enrolled children under the age of two receiving all routine vaccinations as per national calendar							

Indicator Name	Core	Unit of Measure	Baseline	End Target	Frequency	Data Source/Methodology	Responsibility for Data Collection

Intermediate Results Indicators

Indicator Name	Core	Unit of Measure	Baseline	End Target	Frequency	Data Source/Methodology	Responsibility for Data Collection
Name: Health facilities contracted		Number	75.00	204.00	Bi-annual	HIS	PMU
Description: Number of Health facilities contracted under the program to deliver the essential healthcare package to the project beneficiaries.							
Name: Number of children vaccinated per year		Number	0.00	22000.00	Annual	MoPH	PMU
Description: Number of children vaccinated per year							
Name: Target population 40 years and above who were screened for diabetes mellitus		Percentage	0.00	60.00	Annual	HIS	PMU
Description: Percent of beneficiaries above the age of 40 (from among the cumulative number of enrolled beneficiaries) screened for Diabetes Mellitus according to MoPH guidelines.							

Indicator Name	Core	Unit of Measure	Baseline	End Target	Frequency	Data Source/Methodology	Responsibility for Data Collection
Name: Health personnel receiving training		Number	0.00	1000.00	Bi-annual	PMU	PMU
Description: Number of health personnel receiving training through the project							
Name: Maintain Client Satisfaction (PHCCs & Hospitals)		Percentage	75.00	75.00	Annual	Client satisfaction survey	PMU
Description: Share of users satisfied by the received health care services							
Name: Grievances registered related to delivery of project benefits addressed		Percentage	40.00	75.00	Bi-annual	Grievance database	PMU
Description: Percentage of grievances registered related to the delivery of project benefits that were addressed							
Name: Hospital Assessment carried out		Text	NA	Assessment completed	Once	MoPH	MoPH/PMU
Description: Hospital Assessment carried out							

Target Values

Project Development Objective Indicators

Indicator Name	Baseline	YR1	YR2	YR3	YR4	YR5	End Target
Primary care beneficiaries	280000.00	290000.00	390000.00	500000.00	625000.00	715000.00	715000.00
Poor Lebanese	150000.00	150000.00	200000.00	250000.00	300000.00	340000.00	340000.00
Displaced Syrians	130000.00	140000.00	190000.00	250000.00	325000.00	375000.00	375000.00
% female of total beneficiaries	50.00	50.00	50.00	50.00	50.00	50.00	50.00
Pregnant women receiving at least four antenatal care visits	50.00	50.00	55.00	60.00	65.00	70.00	70.00
Public hospital admissions above the MoPH contracted ceiling	0.00	5000.00	12000.00	19000.00	27000.00	34000.00	34000.00
Health facilities accredited	30.00	30.00	50.00	85.00	125.00	140.00	140.00
Children fully vaccinated under the age of two according to national immunization policy	50.00	65.00	70.00	75.00	80.00	80.00	80.00

Intermediate Results Indicators

Indicator Name	Baseline	YR1	YR2	YR3	YR4	YR5	End Target

Indicator Name	Baseline	YR1	YR2	YR3	YR4	YR5	End Target
Health facilities contracted	75.00	75.00	130.00	170.00	204.00	204.00	204.00
Number of children vaccinated per year	0.00	2000.00	7000.00	12000.00	17000.00	22000.00	22000.00
Target population 40 years and above who were screened for diabetes mellitus	0.00	30.00	35.00	45.00	55.00	60.00	60.00
Health personnel receiving training	0.00	500.00	750.00	850.00	950.00	1000.00	1000.00
Maintain Client Satisfaction (PHCCs & Hospitals)	75.00	75.00	75.00	75.00	75.00	75.00	75.00
Grievances registered related to delivery of project benefits addressed	40.00	40.00	50.00	55.00	60.00	75.00	75.00
Hospital Assessment carried out	NA	NA	NA	Completed			Assessment completed

ANNEX 1. ENVIRONMENTAL AND SOCIAL SAFEGUARDS ACTION PLAN (SAP)
LEBANON HEALTH RESILIENCE PROJECT

I. Objectives

1. **The Environmental and Social Safeguards Action Plan (SAP)** is a time-bound plan for the environmental and social safeguards instruments, the preparation of which has been deferred into the project implementation period under paragraph 12 of OP 10.00. This SAP provides general policies, guidelines, codes of practice, and procedures to be integrated into the implementation of the World Bank-financed Lebanon Health Resilience Project.

2. **The objective of the SAP** is to ensure that the proposed project activities and related environmental and social (E&S) assessment and management instruments and processes are in compliance with the national legislation of Lebanon as well as the World Bank's operational safeguards policies, and are duly and diligently implemented in a logical sequence with the environmentally and socially relevant project activities. This means that, as a general principle, E&S assessments and instruments will be completed, disclosed, and consulted on before: (i) project-funded activities with relevant E&S footprints may commence; and (ii) in case of more complex/large-scale activities, before designs are finalized and contracts awarded.

3. **This SAP, prepared by the task team, complies with World Bank safeguards policies,** specifically OP 10.00, paragraph 12, and OP 4.01, paragraph 12.

II. Project Scope and Context

4. **The project scope** is described in detail in Section III of the PAD. The project aims to strengthen the primary health care (PHC) system and community outreach to address the basic health needs of poor Lebanese and displaced Syrians, and to address the immediate capacity constraints of public hospitals serving high concentrations of displaced Syrians. The project development objective is to increase access to quality health care services by poor Lebanese and displaced Syrians in Lebanon.

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

6. **The Syrian refugee crisis has resulted in an unprecedented increase in demand for health services, putting considerable strain on the country's resources and public services.** As the number of displaced Syrians continues to increase, the capacity of the health system will no longer be sufficient to meet the excess demand, imposing further burdens on Lebanon's already stretched public finances. According to the latest Lebanon Crisis Response Plan (LCRP 2017-2020), coping with the health needs of vulnerable populations in Lebanon will require some US$308 million in 2017 and US$300 million in 2018.

7. **The Ministry of Public Health (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 networked with multiple partners, stakeholders, and UN agencies and leveraged the private sector and civil society to maintain service delivery, prevent disease outbreaks, and sustain utilization and functional institutions. The LCRP 2017-2020 details short-term funding needs, activities, and coordination mechanisms. The proposed project contributes to LCRP outcome 1, "Improved access to comprehensive health care" 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 health outcomes. In 2013, the MoPH articulated its strategic direction: an overall goal of expanding health coverage to the uninsured, with special focus on the poor and underserved population, through a Universal Health Care (UHC) program. Accordingly, with the help of the donor community, the MoPH is allocating resources to upgrade the capacity of the PHC program, strengthen the skills of health workers, and provide coverage for the poor with a package of essential health care services.

III. Compliance with World Bank Safeguards Policies

8. Considering the nature and magnitude of the proposed project, the potential negative environmental impacts from project activities are expected to be moderate to low; therefore, the proposed operation is classified as category B. This SAP has been developed specifically for these proposed activities to ensure due diligence, avoid causing harm, and ensure consistent treatment of environmental and social issues by the GoL. The purpose of this plan is also to assist the Lebanese MoPH/PMU and CDR in screening all the subprojects for their likely environmental and social impacts, identifying E&S management requirements, and prioritizing the investments. The World Bank's policy on Environmental Assessment (OP/BP 4.01) is triggered for this project. No subcomponents or subprojects that fall into category A will be eligible for funding.

9. Given the nature of the EHS impacts associated with health care facilities—PHCCs, hospitals, and so on—basic EHS standards/protocols are mandated at the facility level through an accreditation system. A summary of the accreditation system in place in Lebanon as well as 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 help manage the increased capacity challenges.

10. Because the proposed project triggered OP10.00, paragraph 12, the requirement to carry out an Environmental and Social Management Framework (ESMF), including a medical waste management plan, is deferred to project implementation. At the same time, before subprojects are appraised, the implementing agency will agree to implement environmentally and socially sound options for disposal of health care wastes, and to include environmental requirements in the procurement/maintenance of medical equipment, provisions for adequate budget, and satisfactory institutional arrangements for monitoring effective implementation.

11. For any project components/subcomponents that may include rehabilitation activities, a social and environmental safeguards screening tool, part of the ESMF, will be applied along with the specific subproject-level instruments, including a subproject-specific Environmental and Social Management Plan (ESMP), that may be necessary to cover both social and environmental aspects. Additional

measures will support the implementation and monitoring of, and compliance with, the ESMF, and Bank implementation support missions will include E&S implementation expertise to support the client during the entire project cycle.

OP 4.01, *Environmental Assessment*

12. The proposed project aims to strengthen the PHC system and community outreach to address both the basic health needs of Lebanese and displaced Syrians affected by the crisis, and the immediate capacity constraints of public hospitals serving high concentrations of displaced Syrians. This will be achieved by scaling up the scope and capacity of the PHC UHC program; providing health care services in public hospitals, and strengthening project management and monitoring.

13. The project will support existing health care facilities and will not include the construction of any new facilities. The identification of the actual areas to be included in the project will be based on extensive guidance by an ongoing needs assessment. However, the focus of the Bank's interventions is host communities in areas with high concentrations of displaced Syrians.

14. As part of the contracts with the PMU, the health care providers will be required to provide evidence that their existing or planned health care waste management, storage, collection, occupational health and safety (OHS), 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 will also be reflected in the Project Operations Manual (POM).

IV. Sequencing and Tentative Implementation Schedule for Safeguards Processing

15. As a general principle, the implementing agency will agree to apply provisions for adequate and satisfactory budget and institutional arrangements for monitoring effective implementation. The following time-bound deployment of the safeguards instruments is anticipated to manage and mitigate potential adverse impacts:

(a) ***Immediately after project effectiveness, during the first quarter of implementation:*** Start of development of the ESMF, which will be the overarching safeguards document governing approach, processes, and specific instruments for all the project components.

(b) ***During implementation phase, from the second quarter onwards:*** Implementation of the ESMF requirements, including the medical waste management plan, will take place. For the expected scope of the project components, a simple checklist-type ESMP may need to be used, especially if minor rehabilitation civil works are to take place, especially under component 3. The checklist ESMP would become part of the works contracts, set the E&S standards and compliance mechanisms, and serve as a contractual basis for supervision and enforcement of good E&S practice during the works. This may entail filling any gaps for sound E&S management at the facilities, or measures to enhance current practices to help manage the increased capacity challenges. Comprehensive ESIAs or ESMPs will not be required.

16. **Preparation time for safeguards instruments, including Bank review, revisions, clearance, and approval steps.** The preparation of the ESMF, including the health care waste management plan, is estimated to require about three months, including Bank review and approval, disclosure, consultations, and finalization. The ESMF will be adopted by the borrower no later than three months after loan effectiveness. The preparation of checklist ESMPs will not require more than one month, including any Bank review, approval, and disclosure needed.

17. **Consultations and disclosure.** The ESMF will be the subject of consultations with key stakeholders and will be disclosed in-country and at the Infoshop after Bank review as a final draft version for a period no less than 30 days, during which the client will organize consultations for the affected stakeholders. The consultation mechanism for checklist ESMPs will be designed with appropriate depth and breadth, depending on the complexity and dimensions of the specific situation.

18. **No further safeguards instruments are foreseen to be required.** No tender package will be issued without an attached ESMF and no contract signed without respective clauses obliging the Contractor to the ESMF's use and implementation.

19. **Implementation monitoring.** Safeguards compliance will be monitored throughout project implementation. The PMU will dedicate an E&S officer/consultant to ensure compliance with the E&S safeguards requirements. The TOR for the assigned officer/consultant will specify the approach for safeguards monitoring, recording, and reporting, as well as measures for rectification in case of non-compliance. The TOR will be reviewed and cleared by the Bank safeguards specialists.

V. Consultation and Disclosure

20. **The ESMF will be prepared** and consulted upon with key stakeholders, who may include health care workers and regulatory agencies. The ESMF will identify the key stakeholders to be consulted, methods of consultation, and the process for addressing E&S concerns and grievances. The implementing agency will initiate consultations as early as possible, and for meaningful consultations, will provide relevant material in a timely manner prior to consultation, in a form and language that are understandable and accessible to the groups being consulted.

VI. Roles and Responsibilities

21. **The responsibility for the implementation of the safeguards instruments and processes will be with the implementing agency** that will be responsible for compliance with national environmental regulations and the Bank's E&S safeguards policies. The PMU will assign the MoPH Medical Engineer to follow up on the preparation and implementation of the safeguards instruments and may recruit qualified consultants as needed.

22. **The Bank task team will monitor timely commencement** of the preparation of the required safeguards instruments by the client. The task team will ensure that no works that have negative environmental impacts will commence unless the required safeguards instruments are in place.

23. **The Bank will also review TORs and the ESMF** to ensure that their scope and quality are satisfactory to the Bank. In addition, the Bank task team will review tender documents and contracts to ensure that they give due consideration to the safeguards instruments and include effective and

enforceable contractual clauses. Finally, the ESMF will determine the monitoring parameters, responsibilities, and frequency in alignment with the existing regular EHS monitoring, which will also be assessed under the ESMF.

VII. Estimated Costs for the Safeguards Preparation and Implementation Process

24. **The cost of preparing the required safeguards instruments** is estimated to be about US$20,000 for the preparation of the ESMF and approximately US$20,000 for the subsequent safeguards instruments.

25. **The implementation of safeguards is expected to cost only a small fraction of the design and construction cost,** as most mitigation measures will be generic, off-the-shelf, and implementable without specialized skills, experience, or equipment. Assuming a proportion of about 0.5 percent for every US$1 million spent on components 1 and 3, therefore, approximately US$500,000 would be sufficient to implement environmental mitigation and management measures.

VIII. Safeguard Screening and Mitigation

26. **The selection, design, contracting, and monitoring and evaluation of the project components and subcomponents** will be consistent with the following guidelines, codes of practice, and requirements:

- A list of negative characteristics rendering proposed subcomponents ineligible for support, Attachment 1; and
- A proposed checklist of likely environment and social impacts to be filled out for each subcomponent or group of subcomponents, Attachment 2.

Attachment 1

List of Negative Subproject Attributes

Subcomponents with any of the attributes listed below will be ineligible for support under the proposed Health Resilience project.

Attributes of Ineligible Subprojects
GENERAL CHARACTERISTICS
• Involves significant conversion or degradation of critical natural habitats.
Damages cultural property, including any activities that affect the following: • Archaeological and historical sites • Religious monuments, structures, and cemeteries
Requires pesticides in WHO classes IA, IB, or II.
Drinking water supply New, expansion, or rehabilitation of piped water schemes.
Sanitation New, expansion, or rehabilitation of wastewater treatment plants.
Solid Waste New disposal site or significant expansion of an existing disposal site.
Irrigation New, expansion, or rehabilitation of irrigation and drainage schemes.
Dams
Construction of dams more than 5 meters high. Rehabilitation of dams more than 15 meters high.
Power New power generating capacity of more than 10 MW.
Income-generating activities Activities involving the use of fuel wood, including trees and bushes. Activities involving the use of hazardous substances.

Attachment 2

Checklist of Possible Environmental and Social Impacts of Projects

I. Subcomponent-related Issues

S No	ISSUES	YES	NO	Comments
A.	**Zoning and Land Use Planning**			
1.	Will the subproject affect land use zoning and planning or conflict with prevalent land use patterns?			
2.	Will the subproject involve significant land disturbance or site clearance?			
3.	Will the subproject land be subject to potential encroachment by urban or industrial use or located in an area intended for urban or industrial development?			
B.	**Utilities and Facilities**			
4.	Will the subproject require the setting up of ancillary production facilities?			
5.	Will the subproject require significant levels of accommodation or service amenities to support the workforce during construction (e.g., contractor will need more than 20 workers)?			
C	**Water and Soil Contamination**			
6.	Will the subproject require large amounts of raw materials or construction materials?			
7.	Will the subproject generate large amounts of residual wastes or construction material waste, or cause soil erosion?			
8.	Will the subproject result in potential soil or water contamination (e.g., from oil, grease, and fuel from equipment yards)?			
9.	Will the subproject lead to contamination of ground and surface waters by herbicides for vegetation control or chemicals (e.g., calcium chloride) for dust control?			
10.	Will the subproject lead to an increase in suspended sediments in streams affected by road cut erosion, decline in water quality, and increased sedimentation downstream?			
11.	Will the subproject involve the use of chemicals or solvents?			
12.	Will the subproject lead to the destruction of vegetation and soil in the right-of-way, borrow pits, waste dumps, and equipment yards?			
13.	Will the subproject lead to the creation of stagnant water bodies in borrow pits, quarries, etc., encouraging mosquito breeding and other disease vectors?			
D.	**Noise and Air Pollution Hazardous Substances**			
14.	Will the subproject increase the levels of harmful air emissions?			
15.	Will the subproject increase ambient noise levels?			

16.	Will the subproject involve the storage, handling, or transport of hazardous substances?			
E.	**Fauna and Flora**			
18.	Will the subproject involve the disturbance or modification of existing drainage channels (rivers, canals) or surface water bodies (wetlands, marshes)?			
19.	Will the subproject lead to the destruction of or damage to terrestrial or aquatic ecosystems or endangered species, directly or by induced development?			
20.	Will the subproject lead to the disruption/destruction of wildlife through interruption of migratory routes, disturbance of wildlife habitats, and noise-related problems?			
F.	**Destruction/Disruption of Land and Vegetation**			
21.	Will the subproject lead to unplanned use of the infrastructure being developed?			
22.	Will the subproject lead to long-term or semi-permanent destruction of soils in cleared areas not suited for agriculture?			
23.	Will the subproject lead to the interruption of subsoil and overland drainage patterns (in areas of cuts and fills)?			
24.	Will the subproject lead to landslides, slumps, slips, and other mass movements in road cuts?			
25.	Will the subproject lead to erosion of lands below the roadbed receiving concentrated outflow carried by covered or open drains?			
26.	Will the subproject lead to health hazards and interference with plant growth adjacent to roads by dust raised and blown by vehicles?			
G.	**Cultural Property**			
27.	Will the subproject have an impact on archaeological or historical sites, including historic urban areas?			
28.	Will the subproject have an impact on religious monuments, structures, and/or cemeteries?			
29.	Have Chance Finds procedures been prepared for use in the subproject?			
H.	**Expropriation and Social Disturbance**			
30.	Will the subproject involve land expropriation or demolition of existing structures?			
31.	Will the subproject lead to induced settlements by workers and others, causing social and economic disruption?			
32.	Will the subproject lead to environmental and social disturbance by construction camps?			

II. Site Characteristics

S.No	ISSUES	YES	NO	Comments
1.	Is the subproject located in an area with designated natural reserves?			
2.	Is the subproject located in an area with unique natural features?			
3.	Is the subproject located in an area with endangered or conservation-worthy ecosystems, fauna, or flora?			
4.	Is the subproject located in an area falling that is within 500 meters of national forests, protected areas, wilderness areas, wetlands, biodiversity, critical habitats, or sites of historical or cultural importance?			
5.	Is the subproject located in an area in which it would create a barrier for the movement of conservation-worthy wildlife or livestock?			
6.	Is the subproject located close to groundwater sources, surface water bodies, watercourses, or wetlands?			
7.	Is the subproject located in an area with designated cultural properties such as archaeological, historical, and religious sites?			
8.	Is the subproject in an area with religious monuments, structures, and/or cemeteries?			
9.	Is the subproject in a polluted or contaminated area?			
10.	Is the subproject located in an area of high visual and landscape quality?			
11.	Is the subproject located in an area susceptible to landslides or erosion?			
12.	Is the subproject located in an area of seismic faults?			
13.	Is the subproject located in a densely populated area?			
14.	Is the subproject located on prime agricultural land?			
15.	Is the subproject located in an area of tourist importance?			
16.	Is the subproject located near a waste dump?			
17.	Does the subproject have access to potable water?			
18.	Is the subproject located far (1-2 km) from accessible roads?			
19.	Is the subproject located in an area with a wastewater network?			
20.	Is the subproject located in the urban plan of the city?			
21.	Is the subproject located outside the land use plan?			

Signed by Environment Specialist
Name: _____
Title: _____
Date: _____

Signed by Project Manager
Name: _____
Title: _____
Date: _____