Islamic Development Bank (IDB)

Project Appraisal Document (PAD)

Country: Lebanon
Project Number:

LEBANON HEALTH RESILIENCE PROJECT

Department : Human Development Department
Division : Health Division
Date : April 2017

Acronyms and Abbreviations

BED	:	Board of Executive Directors
CDR	:	The Council for Development & Reconstruction
CPD	:	Country Program Department
CUC	:	Cumulative Undisbursed Commitments
GCFF	:	Global Concessional Financing Facility
ECG	:	Electro Cardiogram
EEG	:	Electro Encephalogram
EPCRP	:	Emergency Primary Health Care Restoration Project
EHCP	:	Essential Healthcare Package
EPHRP	:	Emergency Primary Healthcare Restoration Project
GDP	:	Gross Domestic Product
GOL	:	The Government of Lebanon
HDE	:	Human Development Department
HLT	:	Health Division
HMIS	:	Hospital Management Information System
HRS	:	Health Response Strategy
ID	:	Islamic Dinar
IDB	:	Islamic Development Bank
ICB	:	International Competitive Bidding
IMF	:	International Monetary Fund
ISA	:	Implementation Support Agencies
LSCTF	:	Lebanon Syria Crisis Trust Fund
LGL	:	Legal Department
MENA	:	Middle East and North Africa
MOPH	:	Ministry of Public Health
MOSA	:	Ministry of Social Affairs
NGO	:	Non-Governmental Organization
NHSG	:	National Health Strategic Goals
NFSS	:	The National Social Security Fund
NCB	:	National Competitive Bidding
NTPT	:	National Poverty Targeting Program
NCD	:	Non-Communicable Disease
MDGs	:	Millennium Development Goals
PHCC	:	Primary Health Care Center
PHENICS	:	Primary Healthcare Network Information and Communication System
UNDP	:	United Nations Development Program
US$	:	United States Dollar
WB	:	World Bank
WHO	:	World Health Organization
UHC	:	Universal Health Coverage
UN	:	United Nations
UNHCR	:	United Nations High Commissioner for Refugees
UNRWA	:	United Nations Relief and Work Agency for Palestinian Refuge
VASyR	:	Vulnerability Assessment of Syrian Refugees
WHO/EMRO	:	World Health Organization/East Mediterranean Regional Office

Currency and Measurement Conversions 1 **(As of April 2017)**

Currency Unit	**:**	US$
Currency Equivalent	**:**	US$ 1.00 = LBP 1,506.50
		ID1.00 = US$ 1.40

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Table of Contents

List of Technical Annexes

1. Country and sector / program background
2. Results framework and monitoring
3. Program Implementation Structure
4. Tentative list of Government Hospitals and Equipment
5. Implementation arrangements/Progress reporting
6. Financial management, disbursement and audits arrangements
7. Environment and Social risk
8. Map(s)

A. STRATEGIC CONTEXT AND RATIONALE

I. Introduction

1. The Government of Lebanon (GOL) has included in its pipeline of projects to be considered by the Global Concessional Financing Facility (GCFF) Steering Committee, the Emergency Project to Support the Healthcare Services in Lebanon. The GOL also requested the Islamic Development Bank (IDB) to become the Implementing Support Agency (ISA[2]) by extending its financing to support the project. In February 2017, the GOL submitted an official letter reiterating its request for the Islamic Development Bank (IDB) to participate in the financing of the project under the Global Concessional Financing Facilities (GCFF).

Box 1. Global Concessional Financing Facility

The 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 refugee 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.

2. The proposed project will support the Government of Lebanon (GOL) to address the impact of the influx of refugees on its health system by providing vulnerable populations with effective delivery of basic services through the provision of concessional financing.

3. The Project appraisal document (PAD) is prepared based on the information gathered during the joint IDB and World Bank (WB) mission in Lebanon during the period 26 February - 4 March 2017, the Concept note prepared by the WB and the information submitted to the Bank by the Executing Agency (the Ministry of Public Health).

[2] The CFF provides upfront funding (the Concessionality Amount) for a Benefitting Country to an ISA in an amount that would cover, on a net present value basis, a pre-defined Concessionality Spread for the disbursement period of an ISA loan. The relevant ISA is responsible for implementation of the Concessionality Amount as described in the corresponding Funding Request submitted by the Benefitting Country and approved by the Steering Committee. To provide concessionality through the Concessionality Amount, the ISA transfers funds in the amount received from the CFF to the Benefitting Country at the time of each loan disbursement on a pro rata basis. The Benefitting Country is responsible for repaying the ISA loan on its original terms, whereas the additional funds have no cost to the Benefitting Country. The additional funds do not become part of the loan (but can become part of an overall financing package) and are not used by the ISA to pay down interest or principal on the ISA loan.

4. The project processing schedule to Board Approval provided in Table-1:

Table 1: Processing Schedule to Board Approval

1. OCM Clearance of the PAD	March 28th 2017
2. GCFF Steering Committee Meeting	April 20th, 2017
3. RRP & PAD submitted to BS for BED 320	June 8th, 2017
4. Board Meeting	July 2nd, 2017

II. IDB Operations in Lebanon

5. As of 8 March 2017, IDB Group approved for Lebanon a total amount US$1,802 million. This includes US$1,347 million of Ordinary Operations (encompassing US$9.8 million of Special Assistance Operations) approved by IDB, US$221.5 million trade operations, US$234.1 million worth of insurance commitments (exports and imports) approved by ICIEC. ICD is yet to approve an operation in Lebanon.

6. IDB Ordinary operations include 60 financing operations (total US$1,337 million), out of which 39 operations have been completed (total US$ 504 million). The active portfolio consists of 21 operations (total US$ 833.1million), out of which eight operations are currently disbursing, while 13 operations are yet to start disbursement.

7. Mode-wise, out of total IDB financing, Istisna'a operations represent the highest percentage with around 81%, Leasing and Loan operations rank second and third at around 8.7% and 7.3%, respectively.

8. Sector-wise, the highest percentage went for operations in the Water, Sanitation & Urban Development Sector amounting to 42.7%. Transportation, Education and Health sectors stand at 25%, 18.1% and 10.8%, respectively.

III. Country Economic Background

9. Lebanon is located in the Levant, on the eastern-most part of the Mediterranean Sea. Lebanon's Mediterranean shoreline extends 210 km from north to south; its greatest width from West to East is 85 km. At US$11,270 per capita income in 2016, Lebanon is classified as an upper middle-income country. Lebanon was ranked 67 out of 188 in the HDI in the UNDP 2015 Human Development Report. (Country Economic Indicators are given in **Annex-1**)

10. The total population of the country was estimated at 4.6 million in 2016, with an annual population growth rate of about 1%. However, Lebanon is currently hosting around 1.5 million Syrian refugees, including 1.017 million registered as refugees with the United Nations High Commissioner for Refugees (UNHCR) as well as 31,500 Palestinian refugees from Syria, 35,000 Lebanese returnees, and a pre-existing population of more than 277,985 Palestine Refugees in Lebanon[3]. This means that Lebanon has the highest per-capita concentration of

[3] Lebanon Crisis Response Plan 2017-2012, January 2107

refugees worldwide, where one person in four is a refugee.

11. The spillovers from the conflict in Syria and the domestic political situation remain the major challenges that currently face Lebanon. The conflict in Syria has significantly affected Lebanon's social and economic growth, caused deepening poverty and humanitarian needs, and exacerbated pre-existing development constraints in the country. The World Bank estimates that Lebanon has incurred losses of US$ 13.1 billion since 2012, of which US$ 5.6 billion pertains to 2015 alone[4].

12. The key growth drivers in Lebanon such as construction, tourism and the service sector have been negatively affected by the current circumstances. Real GDP growth in 2015 decelerated to an estimated 1.3% compared to 1.8% in 2014. In 2016[5], the real estate sector as well as the continued increase in tourist arrivals (Lebanese expatriates) are expected to lead to a small growth in economic activity, which nonetheless would continue to be sluggish and below potential[6].

13. The country's fiscal balance has deteriorated significantly in the last few years. Lebanon's current account deficit (as a percentage of GDP) stood at 20.37% (equivalent to US$10.56 billion) in 2016[7]. Fiscal reform is needed to reduce the large public debt stock that has grown as a percentage of GDP from 130% in 2012 to about 144% in 2016[8]. Structural economic reform to address these fiscal challenges has not progressed well in the last few years due to political tensions. Lebanon is vulnerable to a further slow-down in net foreign asset accumulation in the face of persistent and sizable fiscal and current account deficits.

14. The Low oil prices have had a net positive impact on the Lebanese economy via higher private consumption and an improved balance of payments. However, the sustained low oil prices in the GCC countries would be negative for Lebanon through lower remittances and capital flows.

15. Despite its numerous challenges, Lebanon is still resilient. However, public concern is growing with regard to the impact of hosting the Syrian refugees in Lebanon. Challenges are greatest in the most vulnerable and deprived parts of the country, especially in the north of Lebanon, which is hosting significant numbers of displaced persons from Syria.

16. Moreover, the social cohesion has been negatively affected after UN agencies and international donors supported the access of the Syrian refugees to the nation's health services with no financial benefits for the poor Lebanese in the hosting communities affected by the situation. Obviously, supporting Lebanon in order to maintain and promote greater social cohesion and to reduce the negative economic impacts of this crisis is became increasingly critical in terms of Lebanon's stability.

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4 Lebanon Crisis Response Plan 2017-2012, January 2107

5 IMF, World Economic Outlook Database, October, 2016

6 World Bank, Lebanon's Economic Outlook, October, 2016

7 IMF, World Economic Outlook Database, October, 2016

8 IMF, World Economic Outlook Database, October, 2016

IV. Sector Background/Issues

17. **Policy and Strategy**: The National vision of the Ministry of Public Health (MOPH) of Lebanon is to insure an equitable health system that identifies and addresses the key determinants of health and promotes, develops and sustains the highest attainable health status of all Lebanese. In 2014, the MOPH embarked in a large exercise of developing a strategic plan (2015-2020) for the health sector. The National Health Strategic Goals (NHSG, 2016-2020) have been identified as follows: (i) Modernize and strengthen Sector Governance, (ii) Improve Public Health and Promotion, (iii) Continue progress towards universal healthcare coverage, (iv) Develop and maintain emergency preparedness and health security.

18. In order to address the emergency situation engendered by the Syrian crisis in Syria, the MOPH has developed a Health Response Strategy (HRS) for maintaining health security, preserving population Health and saving children and women lives (a new approach 2016 & beyond). This strategy has two interdependent strategic objectives: (i) to respond to the essential health needs (primary, secondary and tertiary care) of the displaced Syrians and host community; and (ii) to strengthen national institutions and capacities to enhance the resilience of the health system.

19. **Health System Organization and Management**: The health system, which is built around hospitals and specialists, and primary health care (PHC) services is a public-private partnership with multiple sources of funding and channels of delivery. Although the MOPH does not cover ambulatory care services, it provides in-kind support to a national network of PHC centers all over Lebanon. The centers provide consultations with medical specialists at reduced cost, as well as medicines for chronic illness and vaccines funded by the MOPH Around 68% of the PHC centers in the national network are owned by NGOs while 80% of hospitals belong to the private sector. The strong presence of the private sector in service delivery has led to an oversupply of hospital beds and technology. (Health Sector Background is given in **Annex-1**).

20. **Human Resources for Health**. The fluctuating pattern in the number of physicians started before the Syrian Refugee crisis as a result of a mismatch in supply and demand, with persistent oversupply. By contrast, the number of nurses working in Lebanese health system increased steadily and was not affected by the Syrian crisis. The steady rate of increase in the number of nurses occurred as a result of deliberate MOPH policies, such as the establishment of a career path for nurses, financing of training of more nurses by the Lebanese university, supporting the bridging between vocational and academic training, and increasing nursing wages in the public sector.

21. **Access to Healthcare Services**: Almost one-half of the population is financially covered by the National Social Security Fund (NSSF), an autonomous public establishment or by other governmental (civil servants cooperative and military schemes) or private insurance. All those schemes provide financial coverage with variable patient copays. The non–adherents are entitled to the coverage of the MOPH for secondary and tertiary care at both public and private institutions. Refugees are covered through the United Nations Relief and Work

Agency for Palestinian Refugees (UNRWA) for their health care services.

22. Lebanon has 28 hospitals with 2550 beds. These hospitals are autonomous enterprises under a 1996 law. There are now 150 hospitals and (specialist) clinics in the country in total. Since May 2000, all hospitals are subject to common external (quality) accreditation (contracted-out by MOPH).

23. **Health Care Financing:** all financing modes contribute to the Lebanese health system: public, semi-public and private. The main financing source remains however the household itself. Spending in the Lebanese medical sector is majorly financed by the private sector. In fact, the latter nearly contributed 68.9% (or U$ 2.11 million) of the total health expenditure in 2012, while the public sector and donors expenditure on health took the remaining contribution, which almost totaled 31.1% of the total. In details, households funded roughly half of total health expenditures, of which 37.6% as out of pocket and 15.8% were contributions or premiums. Private employers funded almost 15.5% of the Lebanese health bill in contributions or premiums during 2012. The National Social Security Fund (NSSF) and the Ministry of Public Health (MOPH) are also amongst the biggest public spenders, as they approximately disbursed respective shares of 14.9% and 14.0% in 2012.

24. **Health Status of the Population:** Life expectancy is high for both males and females (80.27 and 82.11 years, respectively). However, information from public (subsidized) health services would indicate that, in common with higher income populations, non-communicable diseases account for the major burden of disease with diseases of the circulatory system, neoplasms (cancer) and disease of the respiratory system the primary causes of (public subsidized) hospital admission.

25. In terms of key public health (and vertical program) indicators, Lebanon achieved the MDG goals related to maternal and child health. Rates of immunization are reported as high. Immunization rates have increased between 2009 and 2015 in three key areas: polio (93 – 99.85%), measles (93 – 99%) and pentavalent vaccines (93 – 98%). There was a significant outbreak of measles in 2013. Recorded maternal and child health indicators are also strong: the infant mortality rate is estimated at 9/1000 live births (2009); the under 5 mortality rate at 9/1000 live births (2009), and the maternal mortality rate (/100,000 live births) reduced from 25 to 18 between 2011 and 2013.

26. **Primary Healthcare (PHC) Services**: Lebanon counts more than 900 health centers run by MOPH, MOSA, municipalities and NGOs. MOPH has developed strict standards for eligibility for these centers to become part of the MOPH Network. Today this national network counts 220 Primary Health Care Centers (PHCCs). Each health center has a defined catchment area with an average of 20,000 inhabitants, varying between less than 10000 in rural areas with the sparse population to nearly 30000 in urban high-density population areas. All PHC centers within the MOPH network are committed to providing a comprehensive package of services including immunization, essential drugs, cardiology, pediatrics, reproductive health and oral health, and to play an important role in school health, health education, nutrition, environmental health and water control. MOPH monitors closely service delivery patterns and quality of care within the network. Immunization activities, provision

of essential drugs and other services are reported regularly to the MOPH for analysis, evaluation, and feedback. MOPH provides considerable support to its PHC network in the form of free vaccines and drugs to satisfy the needs of all patients visiting the PHCs, as well as free capacity building for staff and in-kind support in the form of educational materials and guidelines. According to the availability of funds, the MOPH provides also episodically medical supplies and equipment.

27. **Secondary Healthcare (SHC) Service**: There are now 150 public and private hospitals and (specialist) clinics in the country. Since May 2000, all hospitals are subject to common external (quality) accreditation (contracted-out by MOPH). While there is some variation, public and private hospital services provide the highest quality of healthcare service with advanced technologically in the Middle-East and attract clients from throughout the region.

The impact of the Syrian Crisis on the Health System:

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

29. Lebanon health system has shown considerable resilience since the start of the Syrian crisis, and has been to date able to provide health services to an additional 1.5 Syrian displaced. Despite the tremendous strain on the health system, both in case load and financially, the MOPH succeeded in maintaining the gains of the MDGs, keeping maternal mortality and infant mortality and morbidity relatively low. However, and despite reaching high overall vaccination coverage, outbreaks of measle, mumps, and watery diarrhea are still observed, mainly in areas with the highest concentration of refugees.

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

31. Lebanon government took the decision in 2015 to limit the number of new refugees into the country. This has relatively stabilized the size of the displaced population to around 1.5 million, of which around 1 million are registered with UNHCR and benefit from direct assistance. Around 53% of displaced population are children less than 15 years of age; and 51% of the population are women, around half of them are women of childbearing age. It is estimated that the displaced population will remain stable at this level for the coming 4 years. However, the health sector is now threatened with under-funding and a resulting reduced capacity to meet the demand of the increased population and ensure the continuity of health service provision; the health response at national level should be tailored accordingly.

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

33. **Development Partners Supporting the Lebanon Syria Crisis:** To date, the Lebanon Syria Crisis Trust Fund (LSCTF) has about US$ 75 million in contributions from donor governments (UK, France, Norway, Finland, the Netherlands, Sweden and Switzerland) and the World Bank-managed State and Peace Building Fund. The Government of Denmark is expected to contribute to the LSCTF in early 2017. Four emergency projects (Education, Health, Municipal Services and the National Poverty Targeting Program) are financed by the LSCTF.

34. **Major Challenges and Needs:**
    - Poor access to PHC and specialized referral care for the vulnerable people and Syrian refugees.
    - The health facilities are under-funded and has reduced capacity to meet the demand of the increased population and ensure the continuity of health service provision.
    - The influx of Syrian refugees has increased the risk and exposure to communicable diseases, including those that previously did not exist in Lebanon.

V. Rationale for IDB Involvement

Alignment with Country and Sector Strategy:

35. The project is in line with the National Health Strategic Plan (NHSP, 2016-2020), which aims at insuring an equitable health system that identifies and addresses the key determinants of health and promotes, develops and sustains the highest attainable health status of all Lebanese. The project conforms to the National Health Response Strategy (NHRS, 2016) for maintaining health security, preserving population Health, saving children, and women lives and respond to the increasing demand and strain on the health system. In addition, the project conforms to the National Poverty Targeting Program (NTPT) for the delivery of social assistance and social services, aiming at improving living standards of the population, and in particular of the poor and vulnerable.

Alignment with IDB Strategy:

36. The project is in line with the Thrusts III of the IDB Vision 1440H aiming at promoting Human Development through investing in Health. The project is also in line with IDB 10-Years Strategic Framework, Pillars1 “Economic and Social Infrastructure”, aiming at providing access to basic social services.

B. THE PROJECT

I. Project Objectives and Key Indicators

37. The project will increase access to quality healthcare services to poor Lebanese and Displaced Syrians.

38. Specifically, the project aims to strengthen the primary healthcare system and community outreach to address basic health needs of Lebanese and displaced Syrians affected by the crisis, as well as address the immediate capacity constraints of public hospitals servicing high concentration of displaced Syrians and Lebanese.

39. **Beneficiaries of this project will be:**
    - **Poor Lebanese and displaced Syrians.** Poor Lebanese and the displaced Syrians in Lebanon will benefit from improved health services and a more comprehensive package of PHC services that addresses the health needs of these vulnerable populations.
    - **Primary Health Care Centers (PHCCs).** The project will benefit MOPH network by upgrading the capacity of the Primary Health Care centers, and the skills of health workers and **managers** to effectively manage the increased demand for healthcare while delivering quality care during, and post-crisis.
    - **Public Hospitals.** The project will benefit public hospitals by upgrading and refurbishing their equipment, training their staff, and improving the cash flow to improve the quality and efficiency of their operation.
    - **The MOPH.** The project will contribute to maintaining MOPH commitment to deliver services to the vulnerable population as well as building the capacity level for planning, and project management at the central level.

40. **Key Development Results of the project:** Some of the key indicators (both outcome and output level) are presented below:
    - The number of poor Lebanese receiving subsidized health services scaled up from 150,000 to 340,000, and the number of displaced Syrians accessing services increased from 130,000 to 375,000.
    - Percentage of women receiving at least four antenatal care visits increased from 35% to 70%.
    - Hospital admissions above the MOPH contracted ceiling is 34,000
    - The number of contracted network PHCCs expanded from 75 to 204.
    - The capacity of 28 Public General Hospitals strengthened to meet the increase in demand for inpatient care among displaced Syrians.
    - The capacity of 1000 health personnel in the PHCCs and Public General Hospital strengthened through training.

41. **Project Location:** The project will be implemented in 204 PHCCs and 28 General Public Hospitals distributed over the whole country. The selection of the project sites has taken into account the population identified by the NTPT as living below the poverty line. Priority in

the selection of beneficiaries is given also to those living in areas most affected by the Syrian crisis. Project location is given in **Annex-8**.

II. Project Scope/Components

1. Description of Project Components

42. The IDB financing will include the following component:

a. Component 1*:* strengthen the physical capacity of public hospitals. IDB will finance, under parallel co-financing with the World Bank, the procurement of essential equipment in public hospital in order to maximize the efficiency in the context of growing demand for hospital services. This will entail the replacement of and/or upgrading of equipment, including diagnostic equipment (including medical imaging machines); treatment machines (such as medical ventilators, incubators heart-lung machines); medical monitors (including ECG, EEG, and others); therapeutic equipment (such as CPM machines); and electro-mechanical equipment (such as generators). IDB's support will prioritize public hospitals located in areas with the highest concentration of displaced Syrians and vulnerable populations, hospitals with the greatest demand for services, and hospitals with the greatest need for critical equipment. A tentative list of hospitals and medical and non medical equipment is provided in **Annex-4**.

43. Under the proposed operation, the World Bank will co-finance through parallel financing the following components:

Component 2: Scale up the scope and the capacity of the Primary Health Care UHC program (total estimated cost - US$76.5 million). This component builds upon, and scales up the EHCRP. It aims to expand and strengthen the UHC program to reach a larger number of beneficiaries with a more comprehensive package of enrolment-based preventive health services to meet growing needs of the Lebanese poor. Through investment in PHCs, it will also benefit displaced Syrians seeking health care at participating centers under different subsidy arrangements. This component will:

- **Expand the scale of PHC services** by increasing the number of contracted network Primary Health Care Centers (PHCCs) from 75 to 204. This will also increase the number of beneficiaries using the PHC services as follows: the number of poor Lebanese receiving subsidized health services would be scaled up from 150,000 to 340,000, and the number of displaced Syrians accessing services at these centers under different subsidy mechanisms would increase from 130,000 to 375,000 (Table 2), should the subsidies increase from current levels. The scaled-up UHC will collaborate with mechanisms subsidizing Syrians to access healthcare packages in the same health centers to reduce administrative burdens on PHCs and ensure maximum benefit for all beneficiaries.
- **Strengthen the capacity of newly contracted PHCCs to provide quality care** by (i) expanding the package of essential services to include a wellness package, a more comprehensive reproductive health package (with elements addressing GBV), as well as packages for elderly care, non-communicable diseases, and mental health (Table 3). As part of

the expanded package, the MoPH provides free drugs and vaccines to both, Lebanese and displaced Syrians provided through UNICEF, WHO and UNFPA; (ii) improving the technical, managerial, and physical capacity of PHCCs to deliver the expanded healthcare packages; (iii) increasing capacity of PHCCs for outreach to the community to assist the target populations enroll and access services; and (iv) expanding the existing accreditation program already implemented in several PHCCs to cover all PHCCs in the network.

Table 2: Targeted Project Beneficiaries

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

Table 3: Description of the Essential Package of Services

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

Component 3: Provision of health care services in public hospitals (total estimated cost - US$36.4 million).

- This component will finance the cost of care in public hospitals during the project period beyond the contracted budget ceiling authorized by the MoPH. This will allow the MoPH to respond to the increased demand at public hospitals by authorizing admissions of uninsured Lebanese and emergency cases for displaced Syrians.9 Currently, MoPH contracts with hospitals are based on pre-set rates for surgical and non-surgical cases, covering medical (cost of medical services) and paramedical services (room and board).10 Payment authorization is based on two levels: (i) medical auditors verifying admissions based on criteria set for 40 high-cost, high-volume, and/or misuse-and abuse- prone conditions; and (ii) contracted Third Party Administration (TPA) verifying admissions based on the ministry's criteria as well as international guidelines.11 The MoPH admission criteria will be reviewed as part of the updating of the Project Operations Manual. This component will also finance the strengthening of the technical and organizational capacity of public hospitals. This includes (i) capacity building of clinical and non-clinical staff through relevant training programs; and (ii) strengthening the information system between public hospitals and PHCCs.

Component 4: Strengthen project management and monitoring (total estimated cost - $7.1 million). The objective of this component is to strengthen the capacity of the MoPH in order to ensure the effective and efficient development, administration, regulation, implementation, and monitoring and evaluation of the PHC and hospitals components. Specifically, this component will finance: (i) qualified personnel (non MoPH staff), (ii) training, (iii) incremental operating costs, (iv) external technical and financial audits, (v) improving contract management, (vi) expanding PMU information system (including provision of IT hardware and software), and (vii) the Front-end Fee.

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

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

[9] On average hospitalization cost US$1,000. This component could finance additional admissions to approximately 33,000 patients

[10] Salaries are not covered by the contract.

[11] National Institute for healthcare Excellence (NICE), U.K.

III. Project Costs

44. The total cost of the project is US$ 150.00 Million. The IDB contribution is estimated at US$30.00 million (20% of the total cost of the project) to cover the acquisition of medical and non-medical equipment. The contribution of the World Bank (in parallel co-financing) is estimated at US$120.00 million as shown in Table-4 below**.**

Table-4: Project Costs **US$ million**

	Components	GCFF						Total
		IDB*				WB**		
		Step 1 S. Ijara	Step 2 I. Sale	Total	%	Total	%	
1	**Component 1**: Strengthen the physical capacity of public hospitals by scaling up and replacing critical equipment	1.36	25.91	27.27	100			27.27
2	**Component 2**: Scale up the scope and the capacity of the PHC UHC program					76.50	100	76.50
3	**Component 3**: Strengthen the Capacity of Public Hospitals to meet increased demand					36.40	100	36.40
4	**Component 4**: Strengthen project management and monitoring capacity					6.86	100	6.86
Total base cost		**1.36**	**25.91**	**27.27**	**18.5**	**119.76**	**81.5**	**147.03**
Contingency (IDB) Front End Fee (WB)		0.14	2.59	2.73	92	0.24	8	2.97
Total		**1.50**	**28.50**	**30.00**	**20**	**120.00**	**80**	**150.00**

*IDB Financing includes a GCFF Concessionality Amount of US$ 5.9 million (Section E of this document provides more details on the Terms & Conditions) to render the financing concessional according to IDA terms.

** WB financing includes a GCFF Concessionality Amount of US$ 24.2 million) to render the financing concessional according to IDA terms. The main external partners engaged in the health sector are UNFPA, UNICEF, WHO, USAID, WB, IDB etc.

IV. Financing Arrangements/Lending Instruments

45. It is proposed that IDB contribution will cover the medical and non-medical equipment of public hospitals through Service Ijara of US$ 1.50 million (to cover the cost of the consultancy services) and Installment Sale financing of US $ 28.50 million (for the acquisition of the medical and non-medical equipment and related services) including a Concessionality Amount of US $ 5.9 million from the GCFF (i.e. net contribution of IDB financing is US$ 1.20 million and US$ 22.80 million under the Service Ijara and the Installment, respectively).

46. The WB will contribute 80% of the total project cost for a tune of US$ 120 million including a Concessionality Amount of US$ 24.2 million from the GCFF to cover the remaining items of the project. The effectiveness of the IDB agreements will be subject to the fulfillment of the effectiveness conditions as specified in Section E of this document: Terms and Conditions for Installment Sale financing.

C. IMPLEMENTATION ARRANGEMENTS

I. The Executing Agency

47. The Council for Development and Reconstruction (CDR) will be the Executing Agency of IDB financed components and will be responsible for overall project coordination and management related to the acquisition and installation of medical equipment in close collaboration with implementing partners including MOPH, PHCCs and, Governmental Hospitals. The MOPH will be the Executing Agency of the remaining components (mainly soft components) covered by the WB financing. Details of project implementation arrangements are given in **Annex-5**.

Project Organization

48. The CDR will be responsible for the implementation and of the supervision of the acquisition and installation of medical equipment and non-medical, coordination with the MOPH and the WB.

49. A PMU, on behalf of MOPH, will oversee the project activities under WB financing. It will be staffed with the key positions including but not limited to project coordinator, financial and accounting manager and procurement officer, specialists in accreditation, communications, and Non Communicable Diseases. The Project Organization Structure of the PMU is shown in **ANNEX-3.**

II. Project Implementation Program

1. Project readiness

50. The 204 health centers have been identified for expanding the scale and scope of essential health services**.** The lists of medical and non-medical equipment for the 28 existing hospitals targeted by the project have been established.

2. Project Implementation Schedule

51. The project implementation period is estimated at two (2) years after the declaration of effectiveness of the Financing Agreement.

52. The selection of the consultant for the procurement and installation of equipment and non-medical equipment will commence after project approval. Duration of supply of goods is estimated at 6 months from the date of contract signing.

III. Procurement Arrangements

53. As per IDB Management approval, IDB financing under GCFF will be subject to World Bank rules, procedures and guidelines related to procurement, environmental and social safeguards. The WB and IDB will support the Executing Agency to prepare the Procurement Strategy

and Plan for all Project's components including the items under IDB financing.

54. The Mode of Procurement for IDB financing will be as follows (as per WB procurement rules):
    - 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).
    - Consulting Services: the project is expected to use request for proposals with the following methods (i) Quality Cost-Based Selection (QCBS), (ii) Fixed Budget-based Selection (FBS); (iii) Least Cost-based Selection (LCS); (iv) Consultants' Qualification-based Selection (CQS); (v) Direct Selection (old single sourcing); and (vi) Selection of Individual Consultants.

55. The bulk of procurement will be related to purchasing and installing equipment at the hospitals sites. There are a number of suppliers of medical equipment in Lebanon, representing manufacturers of Germany, Japan, Europe, United States and China, who can participate in both national and international biddings. Based on meetings with six public hospitals, and based on CDR experience in similar activities, as well as this being an emergency project that requires fast procurement, the equipment will be packaged by specialty items..

IV. Financial Management

56. Disbursements will be in accordance with the IDB disbursement procedures. Payments will be made by the Bank directly to the suppliers and service providers as per the IDB disbursement procedures. The following Table-5 summarizes the disbursement targets of the project. The Project disbursement plan per year is shown in Table 5. Details on project financial management is given in **Annex-6**.

Table 5: Disbursement Schedule (Amounts in US$ 30.00 Million)

Year	2017	2018	2019	Total
GCFF / S. Ijara	0.30	0.60	0.60	**1.50**
GCFF / I. Sale	-	10.00	18.50	**28.50**
Total	**0.30**	**10.60**	**19.10**	**30.00**
Percentage	**1%**	**33.7%**	**65.3%**	**100%**

V. IDB Project Monitoring and Implementation Support Plan

57. A joint IDB and WB project's launching workshop will be organized to provide full information about the IDB disbursement procedures.

58. The PMU in consultation with CDR will prepare six-monthly and annual reports detailing the progress relating to the key performance indicators and issues that are relevant to the project implementation. These reports will indicate whether the IDB and WB project implementation guidelines were adhered by the two EAs and will also highlight key issues

that may hinder the successful implementation of the project.

59. The regular project supervisions and Midterm reviews will enable the WB, IDB and the Government to carry out effective follow up and smooth implementation of the project. These will review the status of the project and flow of disbursements and will also identify generic issues affecting the portfolio performance and agree on actions for the smooth implementation of the concerned projects.

V. Monitoring and Evaluation of Outcomes/Results

60. Details on monitoring and evaluation of outcomes and outputs are shown in **Annex-2** "Results Framework". Monitoring will be done through the project implementation assessment visits in collaboration with the WB, MOPH and CDR.

61. The CDR will be handling the financial reporting. CDR has already an established accounting system that records transactions and generates financial reports for all World Bank financed projects executed by CDR. For the purpose of this project, a new module will be added in the CDR system to allow the recording of contracts and related expenditures in addition to the production of the quarterly financial reports. These reports will be submitted to IDB and the WB 45 days after the end of each quarter. CDR will be coordinating with MOPH regarding the financial information.

VI. Critical Risks and Mitigation Measures

62. The usual risks anticipated are those faced by all IDB projects in Lebanon: namely: (i) political and governance risks associated with stalemate in the executive and legislative branches of government, (ii) technical design of project associated with contracting process involving NGOs and inability to attract and enroll beneficiaries, (iii) institutional capacity for implementation and sustainability and (iv) Delay in the project effectiveness . The project risks and mitigation measures are summed up in the Table-6:

Table-6: Critical Project Risks

Risk	Rating	Mitigation
Political and Governance Risks	Medium	• Possibility of changes in political leadership that might affect commitment to the sustainability of the program • This risk affects all IDB interventions and cannot be mitigated. Nonetheless, the project will be submitted in July Board at the earliest. This will give the time to see outcomes of the discussions on the Parliamentary elections planned in May-June.
Implementation Risks	Low	• Concept designs are ready. • The lists of medical and non-medical equipment are ready

		• The acquisition of equipment will be procured by the CDR, which has large experience in implementing projects.
Institutional capacity for implementation and sustainability	Low	• The Lebanese Ministry of Public Health launched in 2009 the PHC accreditation program to expand and improve quality across the continuum of care. • Public Hospitals in Lebanon are financially and administratively autonomous, yet, overall supervision, auditing and periodical accreditation is imposed on Public Hospital by the MOPH. • The scopes of equipment-supply-contracts shall include provisions for extending necessary operation training and defects liability period of two years which include preventive maintenance during this period.
Delay in the project effectiveness	High	• The Financing Agreement will be ratified by the Parliament. • Regular discussions facilitated by the WB team in Beirut with political officials and CDR Chairman will be undertaken to accelerate the process of ratification and effectiveness.

D. PROJECT JUSTIFICATION

I. Technical Feasibility

63. Currently 25% of the population in Lebanon is refugee/displaced, the highest worldwide compared to its population size. 85% of registered refugees live in 182 localities in which 67% of the host population is living below the poverty line. However, and despite reaching high overall vaccination coverage, outbreaks of measles and mumps and waterborne diarrheas and other main communicable diseases outbreaks are still observed, mainly in areas with highest concentration of refugees.

64. Lebanon health system has shown considerable resilience since the start of the Syrian crisis, and has been to date able to provide health services to an additional 1.5 million Syrian displaced. This sudden and dramatic increase in population has exerted a lot of pressure on the country's infrastructure and institutions with serious repercussions on the country's economic stability. The health system is now threatened with under-funding and reduced capacity to meet the demand of the increased population and ensure the continuity of health service provision to the poor.

65. In addition to the emergency nature of the project, the interventions will focus on expansion of essential healthcare services to uninsured and the poor communities in Lebanon. The

project will support the health system, which is now threatened with under-funding and a resulting reduced capacity to meet the demand of the increased population and ensure the continuity of health service provision.

66. The project will address the increased pressure on the health system especially on the public hospitals, which constitutes a significant burden that could jeopardize sustainability of the health centers and public hospitals that are most affected financially.

II. Socio-economic Feasibility

67. The project will have a high impact and most cost-effective interventions related to primary and secondary healthcare, through avoiding maternal and child deaths, and reducing morbidity related to NCDs. Evidence from multiple economic evaluations shows a substantial rate of return of similar programs on reducing higher rates of infant and maternal mortality for the most vulnerable groups. In addition, the early screening of non-communicable and communicable diseases will contribute to greater effectiveness in the health sector and reduce the burden infectious diseases place on the economy.

III. Environment Sustainability/Social Safeguards

68. As per IDB Management approval, IDB financing under GCFF will be subject to World Bank rules, procedures and guidelines related to environmental and social safeguards. Details on environmental and social safeguards are given in **Annex-7**.

69. **Social safeguards**: 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 project includes civil society in its steering committee, which increases the voice of beneficiaries in project management.

70. The project does not have any significant social risks. Risks of exclusion of certain groups are mitigated by a strong targeting mechanism and risks related to tensions between Lebanese and Syrian communities are mitigated by project mechanisms to ensure both groups benefit from activities.

71. The project does not include any land acquisition and will not involve any displacement of people from land or have negative impacts on livelihoods. Because of this, the World Bank policy on Involuntary Resettlement OP 4.12 will not be triggered.

Environment (including Safeguards):

72. Given the nature of environmental, health and safety (EHS) impacts associated with health care facilities i.e. primary health care centers, hospitals, etc., 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.

73. The development of the ESMF is deferred to Implementation stage given the urgent nature of the proposed emergency operation and in accordance to Bank policies (OP/BP 12.10). A Safeguards Action Plan will be developed in collaboration with the World Bank which sets out the roadmap for the development of the ESMF i.e. content, timeframe and disclosure and consultation for the ESMF. The Borrower will prepare the ESMF no later than 3 months after Effectiveness.

74. The IsDB and World Bank will independently review safeguards documents related to the project, however, the safeguards teams will aim to coordinate comments to the Borrower.

IV. Project Sustainability

75. The GOL strategy emphasizes short-term stabilization, medium-term resilience, while the strategic direction of the MOPH focuses at laying the foundation for Universal Health Coverage with special emphasis on the poor. The HRS aims at maintaining health security, preserving population Health and saving children and women lives and respond to the increasing demand and strain on the health system. In addition, the NTPT for the delivery of social assistance and social services, aims at improving living standards of the population, and in particular of the poor and vulnerable.

76. All the stakeholders including the MOPH, CDR and the MOF have participated in the conception and design of the project with a strong commitment and ownership demonstrated at all levels of the Ministries. Furthermore, the GOL will continue to provide healthcare services beyond the emergency crisis to achieve universal healthcare goal.

77. Maintenance of medical equipment in Lebanon is usually undertaken through contracts with suppliers who provide corrective, preventive and predictive maintenance. Indeed, the budget devoted by many existing health facilities to equipment maintenance ranges between 8-10% of their budget. Moreover, the ministry of health has skilled biomedical engineers, electrician engineers and technicians to ensure daily maintenance and urgent equipment failures.

E. TERMS AND CONDITIONS FOR SERVICE IJARA FINANCING

1. FINANCING FACILITY

Recipient:	Republic of Lebanon
Project Title:	**The Health Resilience Project**
Financing Mode:	**SERVICES IJARAH**
Financing Structure:	The Bank shall, in compliance with the principles of Shariah, at the request of the Recipient, provide certain services to the Recipient through the service provider and sell the services to the Recipient in consideration of

payment of the service price. The Bank shall appoint the Recipient as its agent in procuring the goods/services under the Project.

Financing Amount:	**USD 1,500,000.00 (US Dollar One Million and Five Hundred Thousand) as blended financing comprising ordinary financing ([USD 1,200,000]) and Concessionality amount ([300,000])**
Maturity:	20 years from the date of first disbursement to the due date of last installment, comprising a sale price payment period of **18 (eighteen)** years after a gestation period of **2 (two)** years.
Mark up Rate:	1. To be applied to each disbursement, the sum of: (a) Reference rate of 10-year USD Libor mid swap rates as of the disbursement date fixed for the entire duration of financing; (b) Contractual spread of 60 bps fixed for the entire duration of financing; and (c) Funding spread prevailing at the time of disbursement, which from **1 April to 31 December 2017** is 110 bps. 2. The funding spread is subject to semi-annual update by the Bank to reflect cost of funding as published on the Bank's website. 3. In the event that the reference rate is negative, the reference rate shall be deemed to be zero. 4. A mark-up rate cap of 12% per annum shall apply and documented in the financing agreement.

2. FINANCING AGREEMENTS

2.1 The Services Ijarah Agreement and Agency Agreement (the **Financing Agreements**) have to be signed within 6 (six) months from the approval date of the Project by the Bank.

2.2 **Effectiveness Conditions:** The effectiveness of the Financing Agreements and the obligations of the Bank are conditional upon the Recipient providing the following documents to the satisfaction of the Bank:

(i) Evidence satisfactory to the Bank to the effect that the execution and delivery of the Financing Agreements on behalf of the Recipient has been duly authorized or ratified**;**

(ii) Legal opinion acceptable to the Bank emanating from the Legal Authority of the Recipient;

(iii) Instruction to the Central Bank or department/unit charged with the servicing of debt that payment of the services price instalments by the Recipient under the Financing Agreements shall be effected on the dates on which they fall due and an acknowledgement of the Central Bank that it has received the said letter of instruction; and

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3. PROCUREMENT

3.1 The Recipient, as an agent of the Bank, shall follow the World Bank's Procurement Regulations in procuring the services.

3.2 The procurement of the services for the Project shall be as follows:

(i) Consultancy services for procurement of medical and non-medical equipment as per WB procurement rules and procedures**.**

3.3 The Bank may suspend and/or cancel the approved amount if at any time, the Bank determines that any person or entity has engaged in a corrupt practice, a coercive practice, a collusive practice, a fraudulent practice or an obstructive practice without the Recipient (or the Guarantor, if applicable) having taken timely and appropriate action satisfactory to the Bank to remedy the situation or to address such practice when they occur.

4. **IMPLEMENTATION**

4.1 The Executing Agency for the Project shall be **The Council for Development and Reconstruction (CDR), Lebanon**.

4.2 The Recipient, in its capacity as the agent shall, on behalf of the Bank;

(a) negotiate and agree with the service provider for the price, specifications and delivery of the services.

(b) take delivery of the services on behalf of the Bank unless otherwise indicated and issue notice of delivery of the services to the Bank (the **Delivery Notice**).

(c) ensure that the service contract to be concluded between the service provider and the Recipient, as the Bank's agent, shall provide for the service provider's all risks insurance with a reputable insurance company acceptable to the Bank, and the Bank is named as a loss payee under the insurance policies so made.

4.3 The Recipient, in its capacity as the Bank's agent, has to submit a request for the first disbursement within a period of 6 (six) months from the effectiveness date of the Financing Agreements or any other period approved by the approving authority of the Bank.

4.4 The approved amount shall be disbursed by the Bank in accordance with the terms of payments indicated in the service contracts and in conformity with the Bank's Disbursement Procedures.

4.5 **Any other implementation provision (e.g. Special Account): Not applicable.**

5. **MISCELLANEOUS:**

5.1 In the event of termination of the Financing Agreements, prior to the delivery of the services, or breach of the terms of the Financing Agreements resulting in failure to achieve the delivery of the services after the Bank has made disbursements, the Recipient shall reimburse the Bank the total disbursements made by the Bank pursuant to the procurment of the services.

5.2 The Recipient shall pay to the Bank a late payment charge in respect of the overdue amount in accordance with the Bank's rules.

5.3 The Recipient shall be responsible for arranging all costs not covered by the Bank financing for the Project and shall bear all the taxes, charges and duties related to the Project.

5.4 If any time bound obligation of the Recipient is not fulfilled within the stipulated time, the Bank has the right to terminate the Financing Agreements and all obligations of the parties.

5.5 Other specific condition(s): **Not Applicable.**

F. Terms and Conditions for Installment Sale Financing

6. **FINANCING FACILITY**

Recipient:	**Republic of Lebanon**
Project Title:	**The Emergency Support to the Healthcare Services**
Financing Mode:	**INSTALMENT SALE**

Financing Structure:	The Bank shall, in compliance with the principles of Shariah, at the request of the Recipient, purchase the Project assets from a supplier and sell the Project assets to the Recipient in consideration of payment of the sale price in instalments. The Bank shall appoint the Recipient as its agent in procuring the goods/services under the Project.
Financing Amount:	**USD 28,500,000.00 (US Dollars Twenty-Eight Million and Seven Hundred Thousand) as blended financing comprising ordinary financing (USD 22,800,000) and Concessionality amount (USD 5,700,000)**
Maturity:	20 years from the date of first disbursement to the due date of last installment, comprising a sale price payment period of **18 (eighteen)** years after a gestation period of **2 (two)** years.
Mark up Rate:	5. To be applied to each disbursement, the sum of: (a) Reference rate of 10-year USD Libor mid swap rates as of the disbursement date fixed for the entire duration of financing; (b) Contractual spread of 60 bps fixed for the entire duration of financing; and (c) Funding spread prevailing at the time of disbursement, which from **1 April to 31 December 2017** is 110 bps. 6. The funding spread is subject to semi-annual update by the Bank to reflect cost of funding as published on the Bank's website. In the event that the reference rate is negative, the reference rate shall be deemed to be zero.

7. **FINANCING AGREEMENTS**

7.1 The Instalment Sale Agreement, Agency Agreement, and Purchase Undertaking (the **Financing Agreements**) have to be signed within 6 (six) months from the approval date of the Project by the Bank.

7.2 **Effectiveness Conditions:** The effectiveness of the Financing Agreements and the obligations of the Bank are conditional upon the Recipient providing the following documents to the satisfaction of the Bank:

(i) Evidence satisfactory to the Bank to the effect that the execution and delivery of the Financing Agreements on behalf of the Recipient has been duly authorized or ratified**;**

(ii) Legal opinion acceptable to the Bank emanating from the Legal Authority of the Recipient;

(iii) Instruction to the Central Bank or department/unit charged with the servicing of debt that payment of the sale price instalments by the Recipient under the Financing Agreements shall be effected on the dates on which they fall due and an acknowledgement of the Central Bank that it has received the said letter of instruction.

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8. **PROCUREMENT**

8.1 The Recipient, as an agent of the Bank, shall follow the World Bank's Procurement Regulations in procuring the assets.

8.2 The procurement of the goods and services for the Project shall be as follows:

(ii) Procurement of Medical Equipment shall be as per WB procurement rules and procedures.**)**

8.3 The Bank may suspend and/or cancel the approved amount if at any time, the Bank determines that any person or entity has engaged in a corrupt practice, a coercive practice, a collusive practice, a fraudulent practice or an obstructive practice without the Recipient (or the Guarantor, if applicable) having taken timely and appropriate action satisfactory to the Bank to remedy the situation or to address such practice when they occur.

9. **IMPLEMENTATION**

9.1 The Executing Agency for the Project shall be **The Council for Development and Reconstruction (CDR), Lebanon**.

9.2 The Recipient, in its capacity as the agent shall, on behalf of the Bank;

(d) negotiate and agree with the supplier for the price, specifications and delivery of the assets.

(e) take delivery of the assets on behalf of the Bank unless otherwise indicated and issue notice of delivery of the assets to the Bank (the **Delivery Notice**).

(f) ensure that the contract to be concluded between the supplier and the Recipient, as the Bank's agent, shall provide for the supplier's all risks insurance with a reputable insurance company acceptable to the Bank, and the Bank is named as a loss payee under the insurance policies so made.

9.3 The Recipient, in its capacity as the Bank's agent, has to submit a request for the first disbursement within a period of 6 (six) months from the effectiveness date of the Financing Agreements or any other period approved by the approving authority of the Bank.

9.4 The approved amount shall be disbursed by the Bank in accordance with the terms of payments indicated in the contracts and in conformity with the Bank's Disbursement Procedures.

9.5 **Any other implementation provision (e.g. Special Account): Not applicable.**

10. **MISCELLANEOUS:**

10.1 In the event of termination of the Financing Agreements, prior to the delivery of the assets, or breach of the terms of the Financing Agreements resulting in failure to achieve the delivery of the assets after the Bank has made disbursements, the Recipient shall reimburse the Bank the total disbursements made by the Bank pursuant to the procurment of the assets.

10.2 The Recipient shall pay to the Bank a late payment charge in respect of the overdue amount in accordance with the Bank's rules.

10.3 The Recipient shall be responsible for arranging all costs not covered by the Bank financing for the Project and shall bear all the taxes, charges and duties related to the Project.

10.4 If any time bound obligation of the Recipient is not fulfilled within the stipulated time, the Bank has the right to terminate the Financing Agreements and all obligations of the parties.

10.5 Other specific condition(s): **Not Applicable**

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ANNEX-1

Country and Sector / Program Background

I. Country Context

UNDP, Human Development Report for Lebanon, 2015

Life expectancy at birth	79.3
Adult mortality rate, female (per 1,000 people)	46
Adult mortality rate, male (per 1,000 people)	70
Deaths due to malaria (per 100,000 people)	n.a.
Deaths due to tuberculosis (per 100,000 people)	1.5
HIV prevalence, adult (% ages 15-49), total	n.a.
Infant mortality rate (per 1,000 live births)	7.8
Infants lacking immunization, DTP (% of one-year-olds)	16
Infants lacking immunization, measles (% of one-year-olds)	21
Public health expenditure (% of GDP)	7.2
Under-five mortality rate (per 1,000 live births)	9.1
Expected Years of Schooling (years)	13.8
Adult literacy rate (% ages 15 and older)	89.6
Gross enrolment ratio: pre-primary (% of preschool-age children)	101.6
Gross enrolment ratio, primary (% of primary school-age population)	113.5
Gross enrolment ratio, secondary (% of secondary school-age population)	75
Gross enrolment ratio, tertiary (% of tertiary school-age population)	47.9
Mean years of schooling (years)	7.9
Population with at least some secondary education (% aged 25 and above)	54.2
Primary school dropout rate (% of primary school cohort)	6.7
Primary school teachers trained to teach	91
Public expenditure on education (% of GDP)	2.6
Pupil-teacher ratio, primary school (number of pupils per teacher)	12
Gross national income (GNI) per capita (2011 PPP$)	16,509.30
Consumer price index (2010=100)	111.9
Domestic credit provided by financial sector (% of GDP)	187.6
Domestic food price level index	n.a.
Domestic food price level volatility index	n.a.
External debt stock (% of GNI)	68.9
Gross domestic product (GDP) per capita (2011 PPP $)	16,622.90
Gross domestic product (GDP), total (2011 PPP $ billions)	74.3
Gross fixed capital formation (% of GDP)	27.9
Inequality-adjusted HDI (IHDI)	0.609
Coefficient of human inequality	20.2
Income inequality, Gini coefficient	n.a.
Income inequality, Palma ratio	n.a.
Income inequality, Quintile ratio	n.a.

Inequality in education (%)	24.1
Inequality in income (%)	30
Inequality in life expectancy (%)	6.7
Inequality-adjusted education index	0.491
Inequality-adjusted income index	0.54
Inequality-adjusted life expectancy index	0.852
Overall loss in HDI due to inequality (%)	20.8
Gender Development Index (GDI)	0.899
Adolescent birth rate (births per 1,000 women ages 15-19)	12
Estimated gross national income per capita, female (2011 PPP$)	7,334.40
Estimated gross national income per capita, male (2011 PPP$)	25,390.80
Expected years of schooling, female (years)	13.6
Expected years of schooling, male (years)	13.9
Gender Inequality Index (GII)	0.385
Human Development Index (HDI), female	0.718
Human Development Index (HDI), male	0.8
Labour force participation rate, female (% ages 15 and older)	23.3
Labour force participation rate, male (% ages 15 and older)	70.9
Life expectancy at birth, female (years)	81.3
Life expectancy at birth, male (years)	77.6
Maternal mortality ratio (deaths per 100,000 live births)	16
Mean years of schooling, female (years)	7.6
Mean years of schooling, male (years)	8.2
Population with at least some secondary education, female (% ages 25 and older)	53
Population with at least some secondary education, male (% ages 25 and older)	55.4
Share of seats in parliament (% held by women)	3.1
Multidimensional Poverty Index (MPI), HDRO specifications	n.a.
Population in multidimensional poverty (%)	n.a.
Population in multidimensional poverty, headcount (thousands)	n.a.
Population in multidimensional poverty, intensity of deprivation (%)	n.a.
Population in severe multidimensional poverty (%)	n.a.
Population living below income poverty line, PPP $1.25 a day (%)	n.a.
Population near multidimensional poverty (%)	n.a.
Working poor at PPP$2 a day (% of total employment)	n.a.
Employment to population ratio (% ages 15 and older)	44.4
Child labour (% of ages 5 to 14)	1.9
Domestic workers, female (% of total employment)	n.a.
Domestic workers, male (% of total employment)	n.a.
Employment in agriculture (% of total employment)	n.a.
Employment in services (% of total employment)	n.a.
Labour force participation rate (% ages 15 and older)	47.6
Labour force with tertiary education (%)	22.5
Long term unemployment rate (% of the labour force)	n.a.

Mandatory paid maternity leave (days)	49
Total unemployment rate (% of labour force)	9
Vulnerable employment (% of total employment)	27.8
Youth not in school or employment (% ages 15-24)	n.a.
Youth unemployment rate (% of labour force ages 15-24)	22.1
Homicide rate (per 100,000 people)	2.2
Birth registration (% under age five)	100
Homeless people due to natural disaster (average annual per million people)	0
Old age pension recipients (% of statutory pension age population)	0
Prison population (per 100,000 people)	118
Refugees by country of origin (thousands)	4.2
Suicide rate, female (per 100,000 people)	0.6
Suicide rate, male (per 100,000 people)	1.2
Violence against women ever experienced (%)	n.a.
Exports and Imports (% of GDP)	138.7
Foreign direct investment, net inflows (% of GDP)	6.8
Net official development assistance received (% of GNI)	1.4
Private capital flows (% of GDP)	-6.5
Remittances, inflows (% of GDP)	17.7
Mobile phone subscriptions (per 100 people)	88.4
International inbound tourists (thousands)	1,274
International student mobility (% of total tertiary enrolment)	6.9
Internet users (% of population)	74.7
Net migration rate (per 1,000 people)	21.3
Carbon dioxide emissions per capita (tonnes)	4.7
Electrification rate, rural (% of rural population)	100
Forest area (% of total land area)	13.4
Fresh water withdrawals (% of total renewable water resources)	24.3
Impact of natural disasters, population affected (average annual per million people)	0.3
Natural resource depletion (% of GNI)	0
Population living on degraded land (%)	1.2
Primary energy supply, fossil fuels (% of total)	95.5
Population, total (millions)	5
Dependency ratio, old age (65 and older) (per 100 people ages 15-64)	12.3
Dependency ratio, young age (0-14) (per 100 people ages 15-64)	27.1
Population, ages 65 and older (millions)	0.4
Median age (years)	30.7
Population, under age 5 (millions)	0.3
Population, urban (%)	87.6
Sex ratio at birth (male to female births)	1.05

II. Health Sector Context

1. Health System Resilience & Achievements

Four years into the Syrian crisis, the Lebanese health system is still showing considerable resilience, despite the unprecedented increase of demand and strain on the system. A resilient system is one that in time of crisis can sustain or improve access to healthcare services, prevent outbreaks, and maintain morbidity and mortality outcomes at desirable levels while ensuring long-term sustainability. Financing and delivery at the primary, secondary and tertiary levels have been maintained for Lebanese, while primary and secondary care services were expanded to cover Syrians as well. Lebanon has been able to take the necessary measures to face communicable diseases and pandemic threats, preventing major outbreaks.

In terms of health outcomes, and despite the ongoing insecurity climate and socio-political instability for decades, the Lebanese healthcare system has been able to sustain achievements like the decrease in out of pocket expenditures and the lowering of maternal and child mortality, leading to the achievement of MDGs 4 and 5.2 Finally, the focus on non-emergency reforms in the system shows that progress in achieving strategic goals has been maintained against all odds.
Data from the Maternal Neonatal Mortality Notification System at the MOPH reveal that 31 percent of births occurring in Hospitals in Lebanon are Syrians. Despite the strain caused by high fertility rates among the Syrian population, both maternal and child mortality rates, which include mortality among Syrians, remain low. In fact, in 2013, Lebanon was reported among the only 45 countries in the world to have reached MDG4 (reducing child mortality by a two thirds) and among the only 16 countries in the world to have reached MDG5 (reducing maternal mortality by 75 percent).2

A study by the Economist (2014) ranks Lebanon in the second tier (out of six) in health outcomes, directly following Denmark and preceding the United States in its ranking. Astonishingly, the cost per health outcome point in Lebanon is US$ 8 while, for slightly better outcomes, Denmark is at US$ 73.2 per health outcome point and for slightly worse outcomes, the US is at US$107.8 per outcome point. This evidence proves first, that Lebanese healthcare ranks well in terms of quality internationally, and second that Lebanese healthcare is not expensive when compared to countries with similar health outcomes.3

"A framework for assessing health system resilience in an economic crisis: Ireland as a test case. BMC health services research", Thomas et al., 2013.
2"World Health Statistics," World Health Organization, 2013
3 "Health outcomes and cost: A 166-country comparison," The Economist Intelligence Unit, 2014.

2. Epidemiological Profile

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

noted since the advent of the crisis. Risks for Sexually transmitted infections (STIs) including HIV are on the rise as well.

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

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

The outbreak of Poliomyelitis in Syria and Iraq in 2013 was particularly alarming. It was faced by a massive mobilization of all health partners and the civil society in Lebanon to undertake a nationwide door to door vaccination campaign. This successful mobilization under the leadership of the MOPH, led to a high level of immunization coverage among Lebanese and Syrian children alike and maintained Lebanon Polio free. Public health experts are warning against the risk of reintroduction of polio, especially with the new outbreak in Nigeria and the large mobile diaspora of Lebanese there.

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

3. Primary Health Care Centers (PHCCs)

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

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

The enhancement of primary healthcare network and collaboration with public hospitals through a well-defined referral system is important to the national health strategy. A Geographic Information System (GIS) maps villages that are at more than 15 minute drive from the nearest primary healthcare centre, in order to include new centres to progressively cover all the Lebanese territory. Following this method, the network is expected to expand from 220 to 250 PHCCs in 2016. Efforts have been made by all partners to integrate the displaced populations into the existing primary health care system. Where partners have made a case for an unmet need for PHC within the network, centres, which can cover this need, have been prioritized to be added to the network. PHC centers are requested not to differentiate between Lebanese and non-Lebanese patients regarding the provision of services and the collection of nominal fees. However, equity concerns remain where certain partners, mainly UNHCR, subsidize PHC for Syrians but not for Lebanese. Services subsidized for the displaced include medical consultations, laboratory tests, immunizations, antenatal care and other reproductive health services and management of chronic diseases.

To date, PHC has received the most attention from international donors and PHCCs have been able to cope with the crisis considerably well as a result.
Through a grant from the Multi Donor Trust Fund (MDTF) managed by the World Bank, and the support of the faculty of health sciences at the American University of Beirut, MoPH developed an emergency program aimed at expanding the PHC package while targeting to the poor and near poor population in Lebanon. The project will deliver a package of free primary healthcare services (Essential Benefits Package) to the poor Lebanese, identified by the National Poverty Targeting Program (NPTP).

Another crucial project has been the EU Instrument for Stability project. The IfS equipped the MoPH network with additional vaccine and drug stocks, medical equipment, and lab equipment for water analysis in eight hospitals, and other. It also allowed intensive training and capacity building of health staff on case management of medical conditions at , integrated management of childhood illnesses PHC, rational use of medications, NCD care and mental health care. This support has considerably increased the capacity of PHCCs to cope with the increased caseload.

4. Hospitals

Five years into the crisis, hospitals in Lebanon find themselves financially vulnerable, with deficits incurred from unpaid hospital bills as well as unmet MoPH commitments to cover certain admissions, particularly those related to exceptional admission authorizations for non Lebanese patients. These deficits cause medication shortages and delays in salaries payment to hospital staff. The Rafic Hariri University Hospital (RHUH) has accumulated the highest deficit due to the Syrian crisis since 2011. The deficit amounts to 6,784,069,429 (LBP).

Secondary and tertiary care for displaced Syrians has been mainly financed by UNHCR, with some sporadic contributions by NGOs. Before 2016, UNHCR paid up to 75% of the total cost of life-saving emergencies, delivery and care for newborn babies, while few NGOs reimburse the remaining 25% of the bill, for a very limited number of patients. Only 30% of all UNHCR patients are 100% covered through UNHCR top up and/or contribution of other NGOS. UNHCR has

repeatedly stated in its reports that “Even for prioritized life-saving interventions financial resources are severely stretched. Lifesaving interventions in the area of maternal and infant health (surgical deliveries by caesarean section and care of premature infants) are extremely costly.”7 Indeed, the figures illustrate that the needs are much higher than what is currently covered.

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

In 2015, the third party administrator (TPA) on behalf of UNHCR accepted 58,474 claims) 94.6% of all referrals) from the registered refugees to access hospitals, with a total paid amount (after audit) of some 31,813,837.50 $; around 4,265,170.80 $ were deduced from the originally claimed bills. 20 hospitals subcontracted by UNHCR admit around 70% of refugees. In the same year,130 (around 5%) claims, Given that the number of registered refugees is currently 1,06400, this puts the UNHCR hospital referral rate at approximately 6 percent of the displaced, which is very low as a result of stringent exclusion criteria which in turn are the result of severe underfunding. Indeed, this figure is below the 12% hospitalization rate among the Lebanese entitled to MoPH coverage (240,000 admissions per year out of 2 million Lebanese entitled to MoPH coverage) and far below the rate among the Lebanese formally covered by other funds, which reaches 18% for some of the covering agencies.

III. Socio-Economic and Financial Indicators of Lebanon Source: IMF, World Economic Outlook Database, October, 2016

Lebanon - Selected Macro- Economic & Financial Statistics									Projected
Subject Descriptor	**Units**	**2010**	**2011**	**2012**	**2013**	**2014**	**2015**	**2016**	**2017**
Gross domestic product, constant prices	Percent change	8	0.9	2.8	2.5	2	1	1	2
Gross domestic product, current prices	U.S. dollars (Billions)	38.01	40.076	44.1	47.598	49.914	50.807	51.815	53.366
Gross domestic product, deflator	Index	100	104.494	111.856	117.784	121.093	122.038	123.227	124.427
Gross domestic product per capita, current prices	U.S. dollars	8,755.85	9,143.86	9,966.39	10,654.63	11,066.71	11,157.45	11,270.57	11,497.46
Gross domestic product based on purchasing-power-parity (PPP) valuation of country GDP	Current international dollar (Billions)	69.923	72.008	75.388	78.521	81.525	83.226	85.162	88.73
Gross domestic product based on purchasing-power-parity (PPP) per capita GDP	Current international dollar	16,107.15	16,429.79	17,037.30	17,576.43	18,075.33	18,276.93	18,524.19	19,116.55
Gross domestic product based on purchasing-power-parity (PPP) share of world total	Percent	0.079	0.076	0.076	0.075	0.074	0.073	0.072	0.071
Gross national savings	Percent of GDP	3.847	11.821	0.202	-2.155	-1.591	1.077	1.979	2.005
Inflation, average consumer prices	Index	97.249	102.083	108.802	114.047	116.162	111.807	111.024	113.244
Inflation, average consumer prices	Percent change	3.983	4.971	6.581	4.821	1.854	-3.749	-0.701	2
Volume of imports of goods and services	Percent change	-1.594	-3.607	3.151	4.982	-0.843	6.646	6.953	3.141
Volume of Imports of goods	Percent change	3.058	-0.433	7.514	1.101	-2.572	3.269	8.91	5.801
Volume of exports of goods and services	Percent change	-18.394	5.111	-12.072	3.388	-5.931	9.277	4.674	3.149
Volume of exports of goods	Percent change	-7.586	0.132	2.913	-2.548	-8.459	-4.255	-9.777	3.853
Population	Persons (Millions)	4.341	4.383	4.425	4.467	4.51	4.554	4.597	4.642
General government revenue	Percent of GDP	21.933	22.791	21.753	19.788	21.792	18.844	19.26	19.341
General government total expenditure	Percent of GDP	29.484	28.714	30.172	28.478	27.783	26.198	27.345	28.825
General government net lending/borrowing	Percent of GDP	-7.551	-5.923	-8.418	-8.69	-5.99	-7.355	-8.085	-9.484
General government structural balance	Percent of potential GDP	-13.785	-13.289	-18.238	-14.267	-13.805	-12.296	-11.665	-11.973
General government primary net lending/borrowing	Percent of GDP	2.754	3.454	-0.198	-0.718	2.401	1.422	1.068	0.969
General government gross debt	Percent of GDP	138.391	133.888	130.803	133.36	133.357	138.407	143.867	149.17
Current account balance	U.S. dollars (Billions)	-7.857	-6.06	-10.52	-12.691	-14.01	-10.652	-10.556	-10.983
Current account balance	Percent of GDP	-20.671	-15.121	-23.856	-26.663	-28.068	-20.966	-20.372	-20.58

ANNEX-2

Results Framework and Monitoring

Project Development Objectives

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

Project Development Objective Indicators

Indicator Name	Core	Unit of Measure	Baseline	End Target	Frequency	Data Source/Methodology	Responsibility for Data Collection
Name: Number of government hospitals equipped		Number	0	28	Bi-annual	MoPH, CDR	PMU
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
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	80.00	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	170.00	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	0.00	80.00	Annual	MoPH	PMU
Description: Percentage of enrolled children under the age of two receiving all routine vaccinations as per national calendar							

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		Number	0.00	22000.00	Annual	MoPH	PMU
Description: Number of children vaccinated at least once 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.							
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: Client Satisfaction (PHCCs & Hospitals)		Percentage	75.00	90.00	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

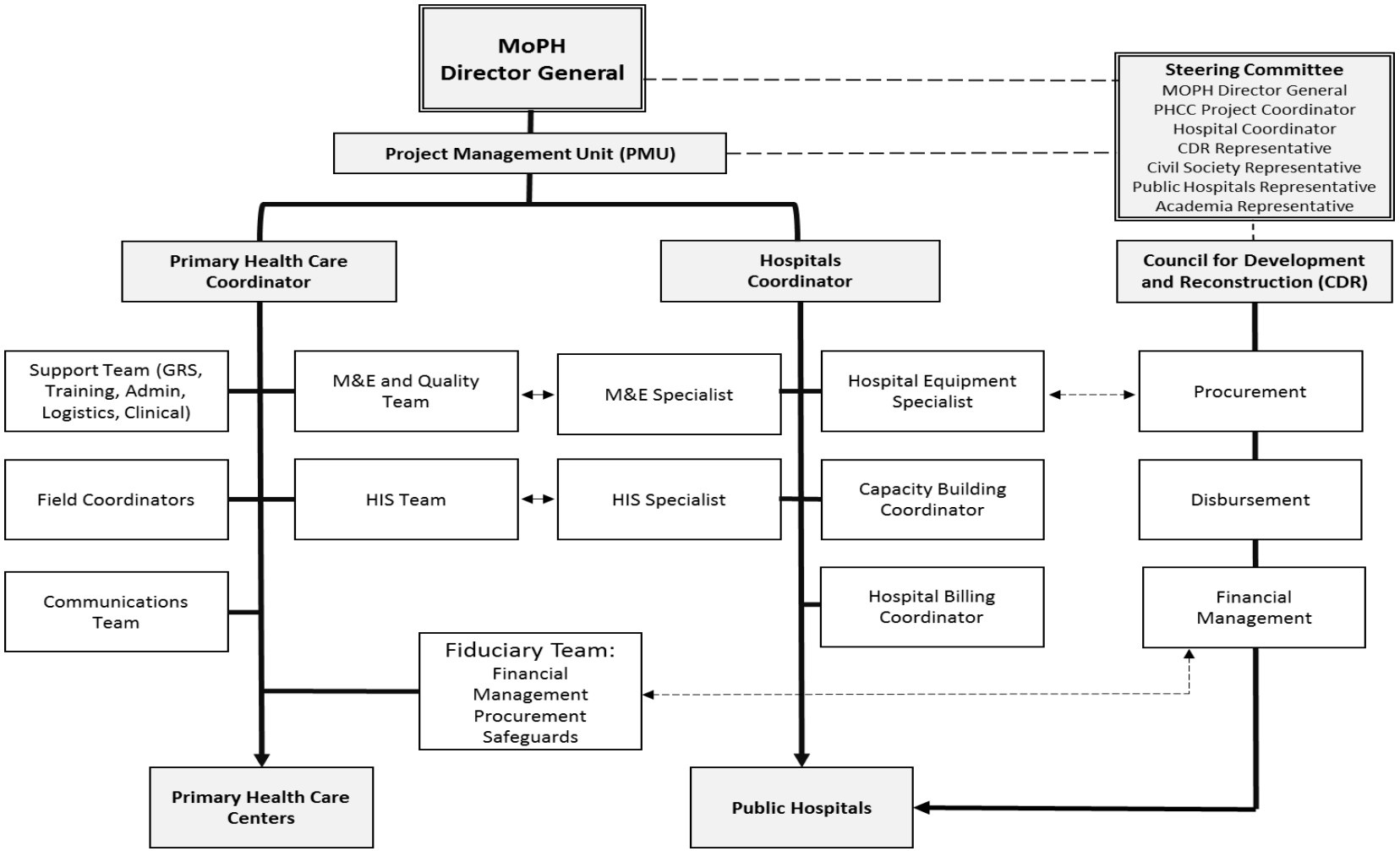
Project Development Objective Indicators FY

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	60.00	65.00	70.00	80.00	80.00
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	170.00	170.00
Children fully vaccinated under the age of two according to national immunization policy	0.00	65.00	70.00	75.00	80.00	80.00	80.00

Intermediate Results Indicators FY

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	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
Client Satisfaction (PHCCs & Hospitals)	75.00	75.00	80.00	85.00	90.00	90.00	90.00
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	Completed				Assessment completed

PMU Organization



ANNEX-4

LIST OF TARGETED HOPSITALS

HOSPITAL	TYPE	DISTRICT
Baabda Governmental Hospital	Governmental Hospitals	Baabda
Baalbeck Governmental Hospital	Governmental Hospitals	Baalbeck
Beirut Governmental Hospital	Governmental Hospitals	Beirut
Bent Jbeil Governmental Hospital	Governmental Hospitals	Bent Jbeil
Daher El Bachek Governmental Hospital	Governmental Hospitals	EL Maten
Dr.Abdullah Al Rassi Governmental Hospital	Governmental Hospitals	Akkar
Ehden Governmental Hospital	Governmental Hospitals	Zgharta
Ftouh keserwan Governmental Hospital	Governmental Hospitals	Kesseroune
Governmental Hospital of Beirut Quarantine	Governmental Hospitals	Beirut
Hasbaya Governmental Hospital	Governmental Hospitals	Hasbaya
Hermel Governmental Hospital	Governmental Hospitals	Hermel
Jezzine Governmental Hospital	Governmental Hospitals	Jezzine
Kana Governmental Hospital	Governmental Hospitals	Nabatiyeh
Kartaba Governmental Hospital	Governmental Hospitals	Jbeil
Marjaayoun Governmental Hospital	Governmental Hospitals	Marjaayoun
Mays El Jabal Governmental Hospital	Governmental Hospitals	Marjaayoun
Nabatieh Governmental Hospital	Governmental Hospitals	Nabatiyeh
Orange Nassau Governmental Hospital	Governmental Hospitals	Tripoli
President Elias Harawi Governmental Hospital	Governmental Hospitals	Zahle
Rachaya Governmental Hospital	Governmental Hospitals	Rachaya
Saida Governmental Hospital	Governmental Hospitals	Saida

Shahar Gharbi Governmental Hospital	Governmental Hospitals	Aley
Siblin Governmental Hospital	Governmental Hospitals	EL Chouf
Sir Denniye Governmental Hospital	Governmental Hospitals	El Minieh-Dennie
Sour Governmental Hospital	Governmental Hospitals	Sour
Tannourine Governmental Hospital	Governmental Hospitals	El Batroun
Tebnin Governmental Hospital	Governmental Hospitals	Bent Jbeil
Tripoli Governmental Hospital	Governmental Hospitals	Tripoli

List of Medical Equipment

MRI (1.5 T)
Digital Panoramic Unit
Equipment for Coronography
CT Scan 16 slices
C-arm
Fluoroscopy DRF
Routine X-Ray
CR System
Digital Mammography
Echography + pediatric sonde
OBGYN Ultrasound
Lithotripsy
Arthroscopy
Laparoscopy
Complete Endoscopy
External Pacemaker Invasive
External Pacemaker Non-Invasive
Defibrillator
Foetal monitor
EKG
EEG
EMG
Rythm Holter With Base
Blood Pressure Holter with Base
Sterilization Unit (Autoclave Steam) 250 l
Sterilization Unit (Autoclave oxyde ethylen) 136 l
New born and infant Warmer Table
Intensive care Table
Scanner for archiving
catering equipment
Trolleys
Cleaning equipment for large areas
OR Table
OR Instrument
OR Light
Anesthesia
Microscope
Emergency trolleys + Defibrillators

Neonatal respirator
Mobile Monitor
Incubator
Radiant Warner
Ventilator Transport
Monitor ICU
Ventilator ICU or Ped
Electrics beds for Patient
Chariot transport
Electrics beds for ICU
Infusion pump, syring pump
Equipment for delivery unit
Equipment for OR
Equipment for Pediatric
Equipment for Laboratories
Equipment for Laundry
Equipment for Kitchen
Divers Equipment
IT equipment (computers + Printers)
Generator 250KVA ~500

ANNEX-5

Implementation Arrangements/Progress Reporting

The implementation arrangements for the project are based, in part, on those used under the ongoing EPHRP Project. Project management is supported under Component 4 of the project, estimated at US$7.1 million.

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

The MOPH, through the Director General, will have the overall responsibility for project oversight and will be assisted in this task by a project (PMU), managed through a PHCC Coordinator, and a Hospital Coordinator. The PHC Coordinator is currently responsible for the implementation of the EPHRP Project and will continue in the same role under the proposed operation. Specifically, the PHCC Coordinator will ensure the implementation of Component 2 and relevant parts of Component 4. The Hospital Coordinator will be a new appointment by the MOPH, to manage the implementation of Component 3.

The responsibility for the implementation of the hospital equipment (Component 1) will rest with the Council for Development and Reconstruction (CDR), which is the implementing agency in Lebanon for the IDB.

Results Monitoring and Evaluation

The project will be monitored and evaluated on the basis of objectives, indicators and their targets set out in the Results Framework. The current 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 to validate appropriate funding of emergency hospital admissions; and (v) project final evaluation to assess how the interventions affected the intended outcomes of the project.

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

The 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. The data will be collected and used to: (i) supervise the performance of PHCCs; (ii) monitor beneficiary accessibility progress; (iii) monitor hospital improvements; and (iv) improve the response of the project and provision of services based on 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.

ANNEX-6

Financial Management, Disbursement and Audits Arrangements

Disbursements will be in accordance with the IDB disbursement procedures. Payments will be made by the Bank directly to the suppliers and the authorized Government authorities as per the IDB disbursement procedures. The tentative disbursement schedule is given below:.

Year	2017	2018	2019	Total
GCFF / S. Ijara	0.30	0.60	0.60	**1.50**
GCFF / I. Sale	-	10	18.50	**28.50**
Total	**0.30**	**10.60**	**19.10**	**30.00**
Percentage	**1%**	**33.7%**	**65.3%**	**100%**

Staffing & Organization. The MOPH, same as all public institutions, is understaffed, and the civil servants working in the accounting department have limited capacity and knowledge on the WB requirements. Nevertheless, the PMU that is formed under the existing WB financed EPHRP project has a FO that has gained adequate experience in carrying out FM arrangements as per WB requirements. This same PMU will be implementing the new project but will hire additional support staff to ensure meeting the additional load work and serve the new project implementation milestones adequately. Therefore, for the purpose of the project, an FM staff will be recruited to support the existing FO in carrying out the FM implementation of the Project's components as part of the PMU team. The World Bank will provide the necessary training and support in FM procedures and reporting guidelines for the newly recruited FM staff. With respect to component 1 to be financed by the IDB, the implementation will be coordinated by CDR that will handle component 1 for acquisition of assets to the hospitals. Financial data and reporting will be submitted and shared with MoPH PMU so that a comprehensive consolidated reporting is carried out for the whole project including all components and financing sources.

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

Budgeting. The project will have parallel financing where the World Bank will finance components 2, 3 and 4 and will be implemented by the MOPH PMU, while the (IDB) will finance component 1 that will be implemented by CDR. The World Bank funds will be channeled through the Ministry of Finance (MOF) F Treasury account for "Loans" and they will be transferred to the Designated Account (DA) of the project. IDB will contribute to the project through parallel financing and will be implemented by CDR. A procurement and a disbursement plan for WB financing will be an effective monitoring tool to compare planned expenditures with actual ones and monitor the existing variances. IDB will do the same separately.

Accounting System and Financial Reporting. The MOPH does not have an accounting information system to process accounting transactions. The MOPH currently has an information system for public health that connects the public health centers to it. In the existing project, the financial module of the Health Information System (HIS) was activated where each health center has been recording the daily transactions and submitting request for payments received by the PMU for clearance. The connection has been installed in all centers and ongoing training and follow up are conducted by the PMU. For the purpose of this new project and specifically for component , 2, 3, and 4, the same financial module will be used to the expanded number of public health centers to record daily transactions, account for the financial data and to generate the required Project Interim Un-audited financial reports (IFRs) and the Project Financial Statements (PFS). The documentation and supporting documents shall be maintained at MoPH for subsequent review and audit.

For component 1 under IDB, CDR will be handling the financial reporting. CDR has already an established accounting system that records transactions and generates financial reports for all World Bank financed projects executed by CDR. For the purpose of this project, a new module will be added in the CDR system to allow the recording of contracts and related expenditures in addition to the production of the quarterly financial reports. These reports will be submitted to IDB and the World Bank 45 days after the end of each quarter. CDR will be coordinating with MoPH regarding the financial information.

As for component 3 related to hospital expenditures, representing patients' bills exceeding the ceiling set per the MOPH budget as well as emergency room admissions expenses that are currently not covered by the MOPH, the Bank Loan will finance those eligible expenditures incurred starting from project effectiveness. No retroactive financing will be used to cover for similar expenditures in arrears as the legitimization process is very lengthy (may take up to 18 months for one year expenditure) and it involves the review of several control bodies that includes the CoA, the legal advisory committee within the Ministry of Justice and the Expenditures Directorate within MOF before they can be paid. Nevertheless, the expenditures incurred during the project implementation period according to the existing control system in place at the MOPH, will be reviewed by a contracted third party administrator (TPA) that conducts this technical service for the MOPH for an annual fixed fee. Moreover, the MOPH medical audit team also reviews and audits these expenditures to ensure compliance and accuracy. In addition, in order to gain even greater assurances, the Bank will require a technical audit to review the Bank's financing portion of such expenses, either through an independent technical/medical auditor to be hired, or through expanding the ToRs of the financial external auditor.

The Bank will provide further trainings and guidance as needed on FM arrangements implementation. The Interim Un-audited financial reports (IUFRs) will be in compliance with International Public Sector Accounting Standards (IPSAS) format of financial statements as the Project will be recording the grant transactions using the cash basis of accounting. The IFRs will be composed of the following:

a) A "Statement of Cash Receipts and Payments by component" and;
b) Accounting policies and explanatory notes including a footnote disclosure on schedules: (i) detailed expenditures by component; (ii) "the list of all signed Contracts per component" showing

Contract amounts committed, paid, and unpaid under each contract; (iii) Reconciliation Statement for the balance of the Project's DA; (iv) Statement of Cash payments made using Statements of Expenditures (SOE) basis; (v) a list of payments by region, healthcare center, type and beneficiary; and (vi) Statement of Fixed Assets.

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

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

External Auditing. The PFS will be audited by an independent private external auditor acceptable to the World Bank. The audit will cover the World Bank financing separately from that of the IDB. The latter financing is implemented by CDR that has its own external audit arrangements for all donor's financing and will include accordingly that of IDB. The auditor will need to ensure compliance with the financial management chapter of the POM, review of effectiveness of the internal controls system, and compliance with the Financing Agreements. The audit will be carried out in accordance with International Standards on Auditing. The audit report and audited PFSs, along with management letter, will be submitted to Bank no later than six months after the end of each fiscal year. In addition, the project management letter will contain the external auditor assessment of the internal controls, accounting system, and compliance with financial covenants in the financing Agreements. The audit TORs will be finalized and agreed upon with the Bank three months after project effectiveness. The external auditor is expected to be engaged within 6 months of project effectiveness.

Annex-7

Environment and Social Risks

The project including IDB financing will be subject to WB Environment and Social Safeguard standards.

- **Environment:** The project aims at increasing the number of users and types of services provided including comprehensive package of services. The essential packages of services will include activities such as immunization, lab tests, mammography and screening. The above activities are expected to have environment 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 associate with the project activities are considered "Moderate". It is therefore classified as environmental category "B", in accordance with World Bank Operational Policy OP 4.01. In addition, since the IDB operation will comply with the World Bank safeguard requirements, the IDB will prepare an appropriate safeguard action plan to address possible mitigation measures related to the investments planned under the IDB operation (Component 1). The investments include the strengthening the physical capacity of public hospitals by scaling up and replacing critical equipment which are not currently identified but may include diagnostic equipment, treatment machines; medical monitors, therapeutic equipment; and electro-mechanical equipment (such as generators).

- **Social:** The project's design comprehensively addresses social issues. Given project activities, key issues to address include: (1) ensuring that the project targets the poor, and especially those belonging to social groups who for one reason or another 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) assuring that the project does not create or increase tensions between social groups. In the case of this project, targeting mechanisms are in place that ensure that the most vulnerable Lebanese benefit from increased access to quality health care. These populations will also benefit from reduced out of pocket payments. The project design also includes communications and outreach activities that would actively inform and educate vulnerable populations on the services and benefits available. The inclusion of civil society in the project Steering Committee also ensures that the voices of beneficiaries are heard in the project and that activities can adapt to respond to their needs. The project also includes a strong grievance redress mechanism, put in place for the EPHRP. In addition, the results of the EPHRP project also show that although the project directly targeted vulnerable Lebanese, refugees also benefitted from an increase in access and quality of health care. This result points to the project having potentially positive impacts on social cohesion. The project does not include any land acquisition and will not involve any displacement of people from land or have negative impacts on livelihoods. Because of this, the Bank policy on Involuntary Resettlement OP 4.12 will not be triggered.

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ANNEX-8

Map of Lebanon and project location