Action Document for EU Trust Fund to be used for the decisions of the Operational Board

1. IDENTIFICATION

Title/Number	Lebanon Health Programme for Syrian refugees and vulnerable Lebanese population		
Total cost	Total estimated cost: EUR 70 million		
Aid method / Method of implementation	Project Approach Direct Management – grants - direct award Indirect Management – Delegation agreement Direct Management – Procurement of services		
DAC-code	121 122	Sector	Health, general Basic health

2. RATIONALE AND CONTEXT

2.1. Summary of the action and its objectives

The proposed action document is largely based on the outcome of the discussions of the **Joint Humanitarian Development Framework (JHDF)** workshop, which has been held at the EU Delegation to Lebanon in June 2016. The JHDF has been the opportunity for DG NEAR, DG ECHO and the EEAS to redefine and identify strategic priorities, as well as to ensure programmatic coordination and cooperation modalities, so as to align to all the EU instruments responses in building a more resilient and long-term response to the Syria crisis in Lebanon addressing the humanitarian, mid-term and development priorities in the country.

The outcomes of the JHDF workshop feed into the priority setting under the Compact (operational priorities to be achieved in ensuring an appropriate and safe environment for refugees from Syria through mutual commitments), notably under its Pillar 3 'Fostering Growth and Social Development', which the EU signed with the Government of Lebanon (GoL) on 15 November 2016, in line with the Partnership Priorities 2016-2020 (political principle steering EU-Lebanon Partnership), the revision of the European Neighbourhood Policy and as follow up to the February 2016 London Conference on Syria. The agreement between the EU and Lebanon on the Compact conditions the level of funding to Lebanon from the London pledge (EUR 1 billion for Jordan and Lebanon for 2016/2017).

The JHDF has identified **health** as a key priority sector, with primary and secondary health care costs substantially affecting the vulnerability of Syrian refugees and vulnerable Lebanese. This action plans to fill the existing gaps in the sector, which had been less covered by the Lebanon Crisis Response Plan 2015-2016[1] due to funding gaps.

The **Overall Objective** of the Action is to contribute to increase access to quality, equitable and affordable health services (care and drugs), and increase the capacities of primary and secondary health sectors with a particular focus to reduce tension among communities while accessing health services. and respond to vulnerable Lebanese and Syrian refugees' demand.

[1]According to the latest available data of the dashboard of the Inter-Agency Coordination (January-May 2016) the funding Status of the health sector as of 12 April 2016 received only 55.7 million over the 290.9 million required. Only 391,634 people of the 1.602.000 targeted have been reached.

Based on an analysis the current and future needs, three main areas of interventions are proposed, whose **Specific Objectives** are:

- **Area of intervention 1:** To ensure continuity of supplies of essential acute medicines, chronic disease medications and vaccines to the Lebanese Ministry of Public Health (MoPH) and the Primary Health Care Centres (PHCCs) thus guaranteeing essential acute medicines, and chronic disease medications and vaccine pipelines [2]; while at the same time, strengthening the health system and building the capacity of the MOPH as also recommended in the review of the previous actions finalized in spring 2017.
- **Area of intervention 2**: To pilot a Basic Package of primary health care Services (BPS) (including primary health care, mother and child care, reproductive and mental health as well as assistance to disable people) for both Syrian refugees and vulnerable Lebanese at an equitable, affordable and predictable rate, whilst strengthening key health institutions including the MoPH and targeted PHCCs. This pilot will integrate a strong data and research part, with the option to scale up support, should the approach demonstrate results and successes.
- **Area of intervention 3:** To initiate a pilot programme in secondary health care for life-saving medical and surgical cases in line with the MoPH strategy calling for support to address secondary and tertiary health care financing shortfalls, covering for example care for life-savings, whilst supporting the sustainability of health institutions in Lebanon.
- In addition to the areas of interventions mentioned, a **cross-cutting** component will be added, related to the establishment of an appropriate monitoring of the whole MADAD Health intervention, considering the country health information and monitoring systems.

These objectives are in alignment with the strategic objectives of the Lebanon Crisis Response Plan (LCRP) 2015 – 2016, with Pillar 3 ' Fostering Growth and Job Opportunities ' of the EU/Lebanon Compact as well as the Health Response Strategy of the Lebanese Ministry of Public Health (MoPH)[3].

2.2. Context

2.2.1 Country context, if applicable

Lebanon is a fragile state characterised by weak institutions that are prey to entrenched confessional divisions. This makes the adoption and implementation of key government policies difficult. Furthermore, the political system is designed to cement multi-confessional co-existence through checks and balances that provide for short-term stability but restrict the scope for reform.

Since the 1990 armistice, Lebanon has been continuously subject to enormous internal and external pressures and shocks, including the on-going presence of Palestinian refugee camps, outbreaks of conflict with Israel, politically sponsored internal violence and terrorist attacks. The current regional political dynamics have added significantly to those pressures and shocks, with a refugee influx, which has swollen the country's population, generating serious social and economic pressures in border areas and host communities. The Syrian conflict – and its wider regional and global underpinnings – is spilling over to Lebanese territory. These dynamics together threaten to stretch Lebanon's fragile politico-social equilibrium to breaking point.

[2] Currently only available until March 2017, as per ENI Special Measures – Decision ENI/2014/025-043

[3] The strategic objectives of the Health Response Strategy of the Lebanese Ministry of Public Health (MoPH) are: to increase access to health services for displaced Syrians and vulnerable Lebanese; and to strengthen healthcare institutions and enable them to withstand the pressure caused by the increased demand on services and the scarcity of resources.

The Syrian crisis has led to further polarization and weakening of governance; the parliamentary elections scheduled for November 2014 were postponed and the country has remained without leadership for two years. The Government of Lebanon (GoL) has been unable to agree on the appointment of a President nor on terms for a fresh legislative election. This has limited the scope for legislative process or policy formulation and implementation.

By October 2014, the Government of Lebanon clarified its policy towards the refugees and activated a crisis cell lead by the Ministry of Social Affairs (MoSA) with the Ministry of Foreign Affairs (MoFA), Ministry of Interior and Municipalities (MoIM) and Ministry of Labour (MoL). It clearly defined the main objectives of the government: i) to reduce the number of refugees by promoting their return, ii) to address rising security concerns and iii) to expand the humanitarian response to include a more development and institutional approach. In follow up to the activation of the Crisis Cell the GoL asked UNHCR to indefinitely suspend the registration of refugees, which was implemented as of 5 May 2015. The release of such a policy, combined with measures to impose border restrictions, have been the first significant GoL reaction to this crisis. This constitutes a challenging environment for refugees from Syria in obtaining legal stay and refugee protection. For those that are registered though, the required and unaffordable USD 200 renewal fee per family member for residence permits, combined with the cumbersome paperwork, drives the majority of refugees into illegal stay, indecent working conditions, puts their movements in the country at high risk of arrest by law enforcement authorities and leads to dependence on negative coping strategies.

The GoL participated in the 2016 London Conference on "Supporting Syria and the Region", where they put forward a Statement of Intent to improve certain regulatory conditions affecting Syrian refugees negatively: the periodical waiver of residency fees and simplifying documentary requirements such as waiving the "pledge not to work". Since then they have been backsliding on these commitments. In the national political context, any policy that alleviates the plight of refugees and provides them with any sense of permanency in Lebanon is contentious. Lebanon is not a signatory to the 1951 Refugee Convention and its 1967 protocol, and the GoL affirms this is not a country of asylum or final destination for refugees. Thus, concessions made in London are downplayed at home in Lebanon.

In the meantime, the operational space for international non-governmental organizations (INGOs) is increasingly shrinking. Restrictive and unpredictable administrative procedures are significantly hampering the ability of the INGOs to meaningfully participate to the optimization of the response. The role of the INGOs as valid contributors is challenged by unclear regulations on the issuance of visa and work permits to international staff, registration of the organizations in the country, limited participation to ad-hoc coordination fora led by the Government institutions and UN system. Currently less than 40% of the INGOs international staff has a valid permit (out of smaller sampling) and 21 INGOs are awaiting registration. Most of them are EU partners. This deliberate restriction posed on INGOs significantly affects the operational and technical capacity of INGO partners to operate at quality and at high technical standards.

To the general unfavourable political environment surrounding the presence of the Syrian refugees in Lebanon, it is worth noting the difficulties in developing any meaningful policy, which could ignite some positive change. On the contrary, technical indications from Ministries on the modality of the response further limit the wished prospects of sustainability of both humanitarian and development assistance provided.

Socio-Economic impact of crisis on target population

Over the last 5 years, the situation in Lebanon has reached a critical level with nearly 1.1 million registered Syrian refugees (and an estimated 200,000 – 300,000 unregistered) of a population estimate of near 4.1 million, together with 40,739 Palestinians from Syria, adding to the approximately 270,000 – 280,000 Palestinian refugees already hosted in Lebanon. No country has taken in as many refugees in proportion to its population, equalling a 25% increase. The no-camp policy imposed by GoL since the beginning of the crisis resulted in the scattering of refugees all over the country. More than half of

refugees have settled in the long neglected regions of Akkar and the Bekaa, prompting competition for the same scarce resources, such as jobs, houses and basic services.

As a result of the cumulative effect of a reduction of assistance, depletion of savings, prolonged presence and increased difficulty to access income, the average monthly expenditure of refugees has drastically decreased between 2014 and 2015, from USD 138 to USD 107 per person per month. The increased reliance of refugees on debt is adding to the pressure on the Lebanese shop owners (and other small businesses) as the refugee population counts them amongst the top three moneylenders. Refugee households have an average debt of USD 990 – according to the UN Inter Agency factsheets - and are caught up in a cycle of poverty and debt, leaving them few options but to try to survive from one day to the next.

According to the UN, some 70% of registered Syrian refugees in Lebanon now live below the Lebanese extreme poverty line (equal to USD 3,84 per day), and increase from 50% in 2014.
Despite Lebanon being considered an upper middle income country, the World Bank reports that 27% of Lebanese live below the poverty line.

Social tension and security

The Syrian conflict remains highly divisive in Lebanon. Some groups are actively engaged in the conflict across the border despite the official "disassociation policy" adopted in 2012 with the so-called Baabda Declaration. Since August 2014, fighting in the border town of Arsal between Lebanese security forces and fighters associated with the Islamic State and Al-Nusra Front has brought the conflict onto Lebanese territory. It prompted a rapid rise in the tensions between communities leading to increased hostility towards Syrian refugees, including restriction of movements, increased evictions, raids, and police searches in refugees' settlements.

Moreover, already weak public services, like health care, education, water and electricity provision are overwhelmed, economic growth has faltered and unemployment is rising. Social tensions are increasing in areas of Lebanon where large numbers of Syrian refugees coincide with a pre-crisis history of weak service delivery for the local population. Municipalities are in the front line and struggling to bear burdens.

2.2.2 Sector context: policies and challenges (one paragraph)

HEALTH

The Lebanese health sector is hospital-centred and physician-driven. It is characterised by a dominant private sector, a very active NGO sector and a public sector attempting to regain its leadership and regulatory role over the past two decades. The public health sector was already facing major challenges before the Syrian crisis. Approximately 15% of Lebanese need financial support to access minimum levels of care. Long queues in public health centres are also limiting access to public health care for Lebanese.

At least 60% Syrian refugees need to utilise some level of humanitarian assistance for healthcare. Vulnerable families, including Syrians, report being turned away from hospitals and health centres or charged unaffordable rates. An estimated 54% of Syrian refugees borrow money to pay medical bills, further depleting savings; this gives rise to a cycle of negative coping mechanisms at household level (notably female headed households), pushing them further into vulnerability. [4]

[4] Lebanon Crisis Response Plan 2015-16, Government of Lebanon and the United Nations, 15 December 2014, 99: https://data.unhcr.org/syrianrefugees/download.php?id=7722

The Ministry of Public Health (MoPH) and the Ministry of Social Affairs (MoSA) manage the primary healthcare system through 218 Primary Health Care Centres[5] (PHCCs, under the supervision of MoPH) often run by Lebanese NGOs, religious and political affiliated institutions as well as 200 Social Development Centres (SDCs, under the supervision of MoSA) countrywide. These centres provide a range of primary health care services, counselling as well as referrals to secondary health care. At PHCCs health, fees for vary between US$ 4.5 and US$ 8. Despite the fact that medications and vaccines are supposedly provided for free, affordability and predictability remain primary barriers for affected populations to access public-sponsored basic health services. Consultation costs are often coupled with the cost of diagnostic tests; medications that might not be available at all time and travel. This could place healthcare out of reach for many.

Both MoPH and MoSA apply a minimum complimentary services package, as part of the National Poverty Targeting Programme (NPTP), for the most vulnerable Lebanese. This targets children under five years old, women of reproductive age, older persons, persons with disabilities, and persons with mental health disorders. Support provided at the current rate is expensive, and its maintenance requires significant funding.

Syrian refugees currently pay around US$ 2-3 per consultation; the difference is covered by international assistance. Lebanese patients are asked to pay full price. The situation might incur conflict between Syrian and Lebanese patients, despite efforts to employ conflict sensitive approaches.

Since 1993, as part of its national strategy to ensure equity and quality of care to the most vulnerable Lebanese population, the MOPH started a contractual agreement with the Medical Assistance Program at YMCA to procure, distribute and monitor chronic medications free of charge to the network of NGO/PHC centres with the aim of reaching chronically ill patients with acute poverty as well as internally displaced Lebanese as a result of the civil war. A significant increase of beneficiaries has been observed over the past years caused by the influx of Syrians refugees. According to the health Quarter dashboard, 13.305 Syrian refugees were reached with YMCA chronic medications versus 135,551 Lebanese[6].
Since 2014, UNICEF signed an agreement with the MOPH to ensure that vulnerable Lebanese and Syrian refugees have access to an expanded programme for immunization.

Access to hospital care for Syrian refugees, is primarily through a network of 60 hospitals across Lebanon (public and private), contracted by UNHCR through a third party administrator (semi-insurance scheme). The UNHCR scheme is limited to obstetric and life-threatening conditions, and currently covers 75 percent of hospitalization fees with the expectation that the persons registered as a refugee by UNHCR will cover the remaining 25 percent. As a result of the inability of the majority of Syrian refugees to cover the totality of their hospital bills, public hospitals suffer from underfunding of secondary health care. In fact, MoPH estimates that the uncovered bills due (the remaining 25 percent of total hospitalization bill subsidized by UNHCR) amount to around US$18 million[7]. In addition, the amount due for unfulfilled MoPH commitments to public hospitals for the hospitalization of Syrians and Palestine refugees from Syria (for conditions which are not covered by UNHCR) has accumulated since 2011 and is estimated at US$21 million. These conditions include dialysis, cancer and catastrophic illnesses treatment, and acute hospitalization.

The complexity of the Lebanese healthcare system, with multiple un-coordinated financing mechanisms, limited public funding and lack of planning for hospital services lead to chronic deficits and are limiting factors to access services. Social stability could be adversely affected by rising tensions due to competition for scarce resources in health.

[5] Currently there are a total of 920 PHCCs in Lebanon. Only 218 are accredited by MOPH and run by NGOs. Accreditation is performed by MOPH on the basis of Health Guidelines, where certain standards and requirements have to be respected by the PHCCs.
[6] http://data.unhcr.org/syrianrefugees/download.php?id=11349
[7] Source: LCRP 2015-2016

Evidence suggests that more efforts are necessary to assure that health care is accessible, affordable, and predictable to the most vulnerable households – both Lebanese and Syrian, and especially female headed households – in order to generate public health impact, but also quality and standardised service provision, in a highly private context.

As indicated in the Lebanon Crisis Response Plan 2016 (LCRP), launched on 17 December 2015, under the leadership of Minister of Social Affairs and the UN Resident Coordinator and Humanitarian Coordinator, funding requirements of the plan amount to USD 2.48 billion for 2016 of which USD 290.9 million was required for the health sector. According to the latest available data of the dashboard of the Inter-Agency Coordination (January-May 2016) the funding Status of the health sector as of 12 April 2016 received only 55.7 million over the 290.9 million required. Only 391,634 people of the 1.602.000 targeted have been reached.

Total sector needs and targets:

Category	Total population in need	Targeted – average overall estimate 66% Lebanese, 25% Syrians, 5% PRL and 4% PRS beneficiaries		
		Male	Female	Total
Displaced Syrians	840,000	402,434	437,566	840,000
Palestine Refugees from Syria	42,000	20,790	21,210	42,000
Palestine Refugees in Lebanon	183,470	9,900	10,100	20,000
Vulnerable Lebanese	1,500,000	351,838	348,075	700,000
Total	2,565,470	784,961	816,951	1,602,000

Institutions	
Primary Health Care Centres	250 MoPH-PHCs Around 100 PHCs supported by partners NGOs and UN agencies
Public Hospitals	27 public hospitals
Public Schools	1,375 public schools
Ministries	MoPH

Source: LCRP 2015-2016[8]

The 2017-2020 LCRP is under preparation and is expected to be released in December 2016, for the first time covering a multi-year timeframe.

Within this context, differences may exist in equal and equitable access to healthcare between women and girls and men and boys. The LCRP, and with it the proposed action, aims to also take this issue into consideration by ensuring that data collected through assessments, participatory assessment and surveys, from health facilities (consultations, hospital admissions) and from health-related interventions (i.e. vaccination campaign, trainings) captures age and sex disaggregation, so that differences in needs, access, including gender-specific barriers to access (i.e. protection risks on the road, such as harassment for women or freedom of movement associated with check-points for men), or persons reached or health staff trained are regularly monitored, reflected in reporting and addressed.

The sector approach more widely also aims to attend to the specific needs of women and girls through its focus on access to reproductive health services, specifically antenatal care (ANC), postnatal care (PNC), family planning, referrals for sexual and gender based violence (SGBV) services and the clinical management of rape. Although the focus is on women and girls, reproductive health and SGBV services are also available to men and boys. Nonetheless, exposure to SGBV still remains a largely underreported issue.

[8] URL: www.un.org.lb/english/lcrp.

2.3. Lessons learnt

In general, one of the main lessons learnt has been the need to ensure a regular coordination and implication of the MoPH in the relationship between donors and implementing partners in order to guarantee the adequate financing of the national health priorities and continue the dialogue over the overarching structural issues.

The last five years since the crisis erupted have been challenging for the health sector but Lebanon has not faced a major health crisis and no major outbreaks due to an already existing health care system and the reinforcement of the Early Warning Systems through the Instrument for Stability (Ifs). However, access remains a concern due to the lack of affordability of health care, availability of medications, equity when accessing services and quality of services provided.

Affordability remains a central issue and the early results of the equitable and predictable rate fee model suggest a strong correlation between transparent, affordable and patient focused pricing and increased demand. Hospitalizations implied 'catastrophic payments' for refugees.

The access health surveys conducted in 2015 have shown that access to medications appears particularly challenging and that refugees incur high out-of-pocket payments to obtain drugs. A predictable and medication supply chain has been key to make sure medications are available at the PHCCs level and are being delivered free of charge to patients thus reducing the burden of vulnerable populations. Enhancing the supply chain management system is critical to mitigate stock depletion and proper delivery of medications to patients.

Quality of health service delivery remains an issue, although through the MoPH accreditation process and INGO efforts to build capacities there is continuous support to ensuring better patient care and better control and management of patient files. This can also be in the centre of managing an equitable, affordable and predictable rate based system with targeted PHCCs where INGOs can be of a substantial added value.

Equity of service delivery has become easier to manage since many donors are now accepting a certain percentage split between refugees and vulnerable Lebanese. There are however tensions between the two target groups and it seems that vulnerable Lebanese avoid certain health clinics due to over-crowding or target their visits as NCD patients seeking YMCA subsidized, free medication. Any health care system strengthening efforts for longer-term programming must clearly show the impact on a stronger health care system benefitting the Lebanese population while supporting refugee populations.

One of the barriers to better policy dialogue and coordinated action is the lack of reliable data despite the Health Information System (HIS). Often the discussions are rather anecdotal and bottom up data from the PHCCs as well as qualitative data from the beneficiaries through HH surveys is not routinely aggregated and analysed for coordinated action. Often it is not shared with all stakeholders.

The link between water, environmental sanitation and hygiene (WASH) failures in wastewater treatment, water provision and solid waste management cannot be overlooked, in relation to outbreaks of vector-borne diseases and diarrheal diseases associated with poor hygiene conditions as the deteriorating conditions in neighbouring Syria. Therefore, the support to the disease surveillance (routine health information system and early warning and response system) should be continued whilst being linked to an improved WASH situation at local and national level.

The proper coordination between MoPH and MoSA, MEHE and MoIM, at national and local levels, should also be encouraged particularly with a view to integrating sectoral policies at the local level, improving quality of service delivery and enhancing referral mechanisms.

All responses to the crisis, including previous responses through the European Neighbourhood Instrument (ENI) and the Instrument for Stability (IfS), have shown that the situation on the ground develops fast and often beyond projections made. For that reason, a large degree of flexibility will be required for any intervention addressing medium to long term needs in order to allow for an effective response to the evolving needs of the beneficiary populations.

Finally, Madad support to the sector builds on ongoing programmes in the sector, notably that respond to the impact of the Syria crisis, to which the EUTF Madad offers an opportunity to scale up the EU's engagement in a timely and substantial manner, thus delivering on political commitments most recently made (Partnership principles and the Compact of 15 November 2016) with the Government of Lebanon.

2.4. Complementary actions

In response to the consequences of the Syrian crisis in Lebanon, substantial assistance has been provided under various EU-funded programmes.

Since 2014, through ENI (more than EUR 10 Million EUR)[9] and IcPS (EUR 20 Million)[10] Decision ENI/2014/025-043 funding, the EU has significantly contributed to supporting the Lebanese authorities' ability to meet basic health needs of Syrian refugees and vulnerable Lebanese. EU funding has supported MoPH with trained medical staff at ministerial and PHCC levels, provided for adequate medical supplies to 218 Primary Health Care Centres, affordable consultations and health awareness sessions, routine vaccines and related medical equipment and medication regardless of nationality, gender and age, provided medical staff with training with a focus on understanding tensions, dealing with stress and enhancing their communication skills. PHCCs also stock up their essential acute medicines, and chronic disease medications and vaccinations through EU funding.

The Japanese Government will sustain chronic medications supply to the MOPH/PHC system operated by YMCA; by ensuring continuous supply of chronic medications through mid-2017, complementing the ENI project support, currently only available until March 2017.[11]

Since 2014, ECHO contributed with EUR 56 Million to the health sector by supporting access for Syrian refugees to secondary health care and covering lifesaving medical and surgical cases. Given the criticality and magnitude of the needs, the current humanitarian support is not financially capable to guarantee adequate support to cater for the critical medical needs of the refugees. Further, the secondary healthcare requires technical and policy assistance to the sector that goes beyond the humanitarian capacity to address the structural needs. Hence, a sustainable support through longer term funds needs to be mobilised to sustain assistance and provide adequate policy support. Other interventions include support to primary healthcare centres and the provision of first aid and transport to healthcare facilities to Syrian refugees and host communities through the Lebanese Red Cross. Finally, ECHO supports Handicap International to provide specific care to people suffering from injuries.

The Madad Health support includes two projects that are currently in preparation, one aimed at Addressing Vulnerabilities of Refugees and host communities in 5 countries affected by the Syrian crisis (LB, JO, IQ, TK, EG) and one other aimed at 'Strengthening Protection mechanisms for Syrian Refugees and Vulnerable Host-communities in Jordan and Lebanon' for a total of USD 8.4 million for the Lebanon component.

The World Bank has just started a project with MoPH of USD 15 million for preventative care in 75 PHCCs targeting 150,000 vulnerable Lebanese over 3 years, to test Universal Health Coverage, through provision of equitable quality health services without incurring additional cost or financial burden by targeted population.

[9] Decision ENI/2014/025-043
[10] Project reference: IfS 2013/14
[11] ENI Special Measures – Decision ENI/2014/025-043

In total, according to the latest available data, the donor community is currently financing only USD 56.7 million of a total of USD 290.9 million estimated as necessary for the sector in the LCRP 2015-2016.

The proposed Action aims to bridge this funding shortfall in a coordinated and coherent manner, closely complementing other EU instruments and donors to the sector. The proposed Action is fully in line with the current EU interventions in the health sector and aims at building on these previous projects, and to continue and widen the initial humanitarian funding towards a more sustainable resilience-based response in the sector.

2.5. Donor co-ordination

Technical partners and donors in the health sector include: EU including ECHO, UNDP, UNFPA, UNHCR, UNICEF, OCHA, WHO, WB; bilateral donors such as BPRM (United States), GAC (Canada), DIFID, DFAT (Australia), Japan and Kuwait.

A general multisector coordination between EU Member States is undertaken regularly within the frame of the EU Development Counsellor meetings. This is complemented with broader donor coordination undertaken on a regular basis in the Informal Donor Group of EU Member States, Australia, Norway, Switzerland, Canada, USA and Japan where exchange of information takes place and guest speakers are invited on occasion to brief on particular issues of concern to the wider international community.

The Madad Trust Fund Management is in the lead in order to ensure coordination with MS contributing to the fund at central level. Moreover, the Fund Management will also coordinate with its selected implementing partners or other stakeholders on regional level or cross border issues.

Especially with regards to the health sector, the EU delegation participates in two mechanisms of dialogue with the MoPH:

1. On country level, all donors operate within the regulatory boundaries of the countries and in agreement with the relevant authorities. Thus, there is coordination with the national authorities. More in particular, in March 2015, the MoPH stipulates the creation of a national Health Steering Committee chaired by the Ministry and composed by above-mentioned UN agencies, WB, WHO, EU, Lebanese NGOs and Lebanese Humanitarian International NGOs Forum (LHIF) operating in the health sector. The primary responsibility of this Steering Committee is to set strategic directions for the health sector, prioritize health interventions and steer the allocation resources within the health sector. The committee reports to the Minister of Public Health and the National LCRP Steering Committee.

   This Steering Committee does not replace the existing Health Working Group established under the LCRP process which meets regularly both at central (Beirut) and regional level and are open to all parties involved in the sectors, including donors.

2. A technical coordination for the health care sector is made through the Steering Committee created under the EU-funded IfS Programme[12] which is continued under the current EU Support to the MoPH through three projects implemented by UNICEF,[13] UNCHR[14] and WHO,[15]under ENI Special Measure – Decision ENI/2014/025-043.

[12] Project reference: IfS 2013/14
[13] Project reference: ENI/2015/367-663
[14] Project reference: ENI/2015/369-106
[15] Project reference: ENI/2015/371-621

3. DETAILED DESCRIPTION

3.1. Objectives

The **Overall Objective** of the programme is "To contribute to improved access to quality, equitable and affordable health care for refugees and impacted local populations both through direct interventions and through bolstering national systems in Lebanon".

3.2. The Specific Objectives are:

- **Area of intervention** 1: To continue guarantying essential acute medicines, chronic disease medications and vaccine pipelines, trough the provision of needed supplies to the Ministry of Public Health (MoPH) and the Primary Health Care Centres (PHCCs) while at the same time, strengthening the health system and the building the capacity of the MOPH as also recommended in the review of the previous actions finalized in spring 2017 and perfectly in line with the EU Madad Trust Fund mandate.
- **Area of intervention 2**: SO2.1To pilot a Basic Package of primary health care Services (BPS), including- inter alia-primary health care, mother and child care, reproductive and mental health as well as assistance to disable people, made available to both Syrian refugees and vulnerable Lebanese
  This pilot will integrate a strong data and research part, with the option to scale up support, should the approach demonstrate results and success at an equitable, affordable and predictable rate.
- SO2.2 To strengthen key health institutions including the MoPH and targeted PHCCs, through tailored capacity-building of main stakeholders.

- **Area of intervention 3:** To initiate a pilot programme in secondary health care for life-saving medical and surgical cases in line with the MoPH strategy.
  This objective intends to align to the MoPH call for support to address secondary and tertiary health care financing shortfalls, covering for example care for life-savings, whilst supporting the sustainability of health institutions in Lebanon.

In addition to the mentioned areas of intervention, **a cross-cutting component** will be added, related to the establishment of an appropriate monitoring of the whole MADAD Health intervention, considering the country health information and monitoring systems. During the negotiations to implement the Madad Health Action and through a constant dialogue with all the counterparts, it has been made evident the need for a sound monitoring and evaluation framework, to ensure the best use of resources and document lessons, in terms of health outcomes and strategic developments.

3.2.1 The **expected results** are:

For area of intervention 1: Improved access to primary health care services and especially to essential acute medicines, chronic disease medications and vaccines, among the target groups while strengthening the Lebanese health sector in order to transit from pure humanitarian relief to more durable and sustainable one by having an improvement of the governance, technical coordination and regulatory as well Health financing / strategic purchasing functions of the MOPH.

Main activities may include:

- Strengthening the MoPH drug supply chain: assist the PHCCs in their drug order to cover Syrians and non-Syrians caseloads, flag and document irregularities and advocate for continued drug availability.
- Procurement of medical supplies (essential drugs and consumables) to support consultations in healthcare centres, including mental health, psychological support and RH/STI/HIV services.

- Procurement and supply MoPH with vaccines as per the national immunization standards.
- Health-related awareness raising activities such as development, production and supply of education materials to support health awareness sessions.
- Support the MoPH in developing capacities on the key functions that the MOPH identifies as priorities such as PHC governance and the continuation of support on HMIS / M&E.
- Capacity building on any specific field could include:
    - Training of staff at central and local levels.
    - institutionalized professional training (revising / updating curricula)
    - mentoring technical assistance, with clear targets and timeframe to transfer skills and responsibilities
    - peer-to-peer collaboration, even across the Region,
    - development of tools, their testing, use and monitoring
- attention to institutional capacities and identification of possible actions (e.g. specific legislation to be developed or enforced)
- implementation of strategies previously developed (e.g. NCD strategy, Tuberculosis control, etc) and use of related tools
- development of leadership and mentoring abilities (e.g. to increase compliance to standard diagnostic and treatment protocols and preventive measures, as immunization, or HIV testing in TB patients, health determinant lifestyle, ….)
- Develop existing and new links with the national academia, supporting the advisory group already in place.
- Automation of the NCD Chronic medications program management system
- Possibility of funding human resources at MOPH level who are essential for the development process has to be taken into consideration, with a clear purpose and with a plan to incrementally transfer the staff into a payroll of the national health sector

It has to be mentioned that some of these activities are part of the recommendations made during the review of the previous actions implemented by WHO and UNICEF and finalized in spring 2017.

For area of intervention 2: Increased capacities of targeted PHCCS to address the real demand for PHC Services in the catchment areas.
An effective referral system linking communities with PHCCs is established to improve demand and access to health care. Primary health care and mental health services are offered as a comprehensive package. Patient surveys demonstrate high-level satisfaction with PHCC services at a transparent equitable, affordable and predictable fee based pricing.

Main activities may include:

- Under SO2.1 : Supporting the provision of health care consultations, hire adequate staff and provide discounted rates to Syrian refugees and vulnerable Lebanese patients equally. This Action will support a pilot for reduced, equitable and predictable consultation fees ($2-3) to beneficiaries and access to free medications, diagnostics, and laboratory services.
- Provision of mental health services, at no cost to the beneficiaries, through case management teams as per MoH mental health strategy.
- Community based outreach and awareness raising activities for Syrian refugees and vulnerable Lebanese population will be implemented.

- Under SO2.2 : Capacity building activities for PHCC staff aimed at improving quality of care. Trainings will be conducted based on needs identified by the PHCC management in coordination with the MOPH and other health actors, including other local and international NGOs, in order to avoid duplication. Focus will also be given to more conflict sensitive care, in order PHCC staff to understanding tensions, dealing with stress and enhancing their communication skills.

For area of intervention 3: Improved access to secondary health care service and especially to life-saving interventions.

Main activities may include:

- Improving the referral system to secondary healthcare by strengthening the communication between the different referring bodies and documenting lack of access.
- Supporting admission of Syrian to needed/lifesaving secondary healthcare services through an already established network of hospitals. Supporting the cost sharing model (75% UNHCR and 25% beneficiaries) whilst granting flexibility of increased coverage for those most vulnerable households.
- Strengthening the monitoring of quality, geographical coverage and cost effectiveness of the system. Continue to rely on a good performing TPA.

For the Cross-cutting component: sound monitoring and evaluation framework, to ensure the best use of resources and document lessons, in terms of health outcomes and strategic developments

Main activities may include:

- A third party monitoring, implemented by an external agency in collaboration with one or two national institutions.
- Strengthening and capacity building actions on the MoPH health information system (in synergy with other HSS activities)

Since the programme has the ambition to strengthen the country system, monitoring measures on health service provision should use as much as possible the MoPH monitoring system and strengthen it where needed.

3.3. Risks and assumptions

The main risks are:

- The Syrian conflict could further spill-over into Lebanon. This could jeopardise the action and cut off access to Lebanese territory for international organisations and implementing partners;
- Tensions between Lebanese hosts and refugees from Syria lead to violence in one or several locations;
- The Lebanese authorities will be hampered in dealing with the crisis due to political constraints and limitations on capacities and resources;
- Increased demand for public services and lack of financing leads to a collapse of certain public services;
- The operational space of key INGO partners is curtailed by irregular on the issuance of visa and work permits to international staff and unreliable registration of the organizations in the country;
- Return of refugees to Syria due to end of conflict and improvement of living conditions in the country (positive "risk");
- Competition at local level with other service providers/donors (faith-based or other).
- Rejection of activities by target beneficiaries.

The assumptions for the success of the project and its implementation include:

- The security situation is sufficient for safe implementation;
- Willingness of host communities to engage in the action;
- Political support of the MoPH will continue, and that evidence built through the Action will be reported to government leadership for resource allocation decisions;
- Approval of the Action by local and national authorities, under the assumption that the MoPH will continue approving the various models of service delivery which are currently tested including the flat fee model;
- Action activities in the selected countries are in line with the national health strategies;
- Selected health institutions will collaborate in planning and implementing the activities;
- A close collaboration with ECHO on the secondary health care sector intervention is ensured;
- A minimal degree of operational space is retained by INGO partners so as to operate in Lebanon, with regards to the issuance of visa and work permits to international staff and registration of the organizations in the country;
- Appropriate staff identified and appointed.

Mitigating measures have been considered, including:

- In case of a severe deterioration of the security situation in certain areas of Lebanon either due to a further spill-over of the Syrian conflict into Lebanon or violent tensions between refugees and hosts, the activities of the intervention would be moved to areas deemed safe. In case of a severe deterioration of the security situation in the entire Lebanese territory, the intervention might have to be halted until the situation improves;
- Very close coordination with local and national authorities at all stages of the planning and implementation; close coordination with local community leaders;
- In case of further political constraints for the Lebanese authorities in responding to the needs of the populations living in Lebanon or in case of a partial or complete collapse of public services delivery, basic public services could be continued through local authorities as well as local NGOs and CSOs;
- The risk of duplication of support is to be mitigated through continued and active participation in donor coordination for a as well as pro-active outreach to non-traditional donors;
- In case of an end to the violence in Syria and a substantial return of Syrian refugees the activities can continue as foreseen as the needs of the most vulnerable communities in Lebanon for improved public services are believed to persist;
- Continued advocacy of the international community towards the GoL, on the need to preserve operational space and access to all actors as part of the response to the Syrian crisis in Lebanon, notably through the establishment of an Access Task Force.

3.4. Cross-cutting issues

During implementation of the Action it will be ensured that all financed initiatives respect principles in particular human rights, gender equality, good governance and environmental impact as core elements. Conflict sensitivity, conflict mitigation and conflict resolution will also be considered and promoted to the furthest possible extent.

Projects funded under this Action will integrate a Rights-Based Approach in each step of the project cycle from identification, formulation, implementation, monitoring to evaluation. A particular attention will be given to the people with disabilities as well as to gender equality. More specifically, subsidized PHC and Secondary Health Care (SHC) services will be available for all ages and genders.

Gender sensitive programming forms part and parcel of this Action. Promoting family planning, antenatal care and post-natal care and child care will be of utmost concern for all supported-facilities. This Action will make every effort to reach women and girls through health education programming; community health workers (CHWs) will be women recruited from the community to provide relevant

information on basic rights, as well as where services will be available. CHWs will facilitate safe and confidential referrals to services, informing the community on availability of services and basic practices in disease prevention and well-being. CHWs will conduct community outreach activities in the catchment areas of MADAD-supported facilities. Professional skills trainings are offered to PHC providers to ensure first responders have the skills and competencies to offer survivor-centered care and referrals. These trainings may include clinical management of rape survivors for health professionals and guiding principles of responding to gender based violence (GBV) in humanitarian and protracted emergencies.

3.5. Stakeholders

The primary stakeholders include the MoPH whose support will be critical for the Action to strengthen the health care system of Lebanon, the PHCCs, the SHCCs and their supporting NGOs and municipalities. UNHCR is a key implementing agency for secondary health care service to Syrian refugees- including therefore women, girls and men,- and the main coordinating body for the health sector. Refugees from Syria and vulnerable host communities residing in the catchment areas of the supported PHCCs and SHCCs are the prime beneficiaries, benefiting from improved access to the health public services, irrespective of nationality and gender.

Indirect beneficiaries include the general Lebanese population, as increased support for the most vulnerable communities will alleviate pressure on public finances and reduce the risk of tension and conflict caused by lack of access to basic services.

4. IMPLEMENTATION ISSUES

4.1. Financing agreement, if relevant

In order to implement this action, it is not foreseen to conclude a financing agreement with the partner country, referred to in Article 184(2)(b) of Regulation (EU, Euratom) No 966/2012.

4.2. Indicative operational implementation period

The indicative operational implementation period of this action, during which the activities described in section 3.2 will be carried out is 36 [16] months from adoption of this Action Document by the Operational Board. All activities have to be implemented before 14/12/2021.

Extension of the implementation period may be agreed by the Manager. This will be immediately communicated to the Operational Board.

4.3. Implementation

Following a preliminary identification potential implementing partners may include: WHO, UNICEF, UNHCR, a consortium composed by the INGO International Medical Corps (IMC) Première Urgence - Aide Médicale Internationale (PU-AMI) on the basis of an assessment of technical capacity and the absorption capacity in-country. The cross-cutting component of Monitoring and Evaluation / health information will be implemented through service providers via procurement procedure

More in particular:

Area of intervention 1: The identified potential implementing partners are UNICEF and WHO. These two agencies have been selected because the import of drugs is, by law, limited to: chronic diseases

[16] The implementation period of the contract must remain within the duration of the Trust Fund (December 2019). In case the Trust Fund is extended, this action document may also be considered to be extended.

medication through WHO/YMCA, while UNICEF imports vaccines and drugs. Moreover, UNICEF and WHO are implementing the current ENI intervention on vaccinations, acute and chronic medications and this will ensure continuity and coherence with the ongoing activities allowing a smooth passage between programs. The extra 7 million that will be allocated to this component will be implemented by WHO given its global mandate to support health systems development and the expertise to provide this support. WHO is the International Agency for Health and it will be the only global health institution to remain in Lebanon after the end of the Syrian Crisis. Given the fact that, once the crises will end the international donor community will not continue to finance the health sector, it is important to strengthen the role of the institutions who will remain in Lebanon assuring the transition from pure humanitarian relief to more durable and sustainable interventions. This is coherent with the longstanding collaboration between European Commission and WHO. In addition, the EU-Lux-WHO UHC Partnership managed at HQ level is very actively present in the region, with seven countries already involved, and may soon include also Lebanon, thus pursuing synergies toward the common aim of strengthening systems.

Area of intervention 2: IMC-PU have been identified as potential implementing partners as these organizations worked and developed an equitable, affordable and predictable rate healthcare approach which at the moment is implemented on small scale basis. Other potential actors could be identified as concerning more specifically mental health and disability issues.

Area of intervention 3: The identified potential implementing partner is UNHCR as it is the only actor which currently intervenes in the secondary health system. UNHCR has put in place a system through a private operator,which guarantees the reimbursement of the 75% of live-saving interventions for Syrians. As the system is already in place and it is the only existing one the programme will be build on this structure and thus be implemented through this UN agency.

Cross-Cutting component of Monitoring and Evaluation / health information: the component will be implemented through service provider via procurement procedure. Given the large envelope to be implemented (69 M EUR) a strong monitoring system of the Health Madad Action in Lebanon is necessary.

4.3.1. Grants: direct award (direct management)

In order to be able to respond to needs for interventions in the context of the Syrian crisis in favour of Health provisions of targeted population the direct award of grants is foreseen.
The Fund has been established under Article 187 of the Financial Regulation as 'emergency' trust fund, and is therefore covered with flexible procedures applicable to crisis situations.
Direct Management is foreseen for activities under areas of intervention 2 as well as the cross-cutting component.

b) Eligibility conditions

The lead applicant needs to be a legal entity, be non-profit making and non-governmental organisation. Specialised European or International non-profit operators and CSOs will be the envisaged partners.

c) Essential selection and award criteria
Essential selection criteria are the financial and operational capacity of the applicant. The essential award criteria are relevance of the proposed action to the objectives of the Action Document; design, effectiveness, feasibility, sustainability and cost-effectiveness of the action
Presence and experience in the region, immediate intervention capacity, and the ability to work in multi-actor approaches and inclusive partnerships aimed at recognising the value of different stakeholders' contributions and synergies will be part of the evaluation criteria.

d) Maximum rate of co-financing

The maximum possible rate of co-financing for the grants is 80% of the total eligible costs of the action.
If full financing is essential for the action to be carried out, the maximum possible rate of co-financing may be increased up to 100%. If full funding is essential, the applicant has to provide adequate justification to be accepted by Manager, in respect of the principles of equal treatment and sound financial management.

f) Indicative trimester to conclude the grant agreements is 1st trimester of 2017.

4.3.2 Delegation Agreement (Indirect Management)

Eligible institutions will be selected on the basis of their experience in the field, and possibility to scale up their existing operations and/or introducing new activities within their portfolio. As such the selection of these entities may justified by their unique position as lead agencies in the sector, coupled with their ability to absorb considerable funds in a short period whilst maintaining the required accountability standards.
Indirect Management is foreseen for activities under areas of intervention 1 and 3

4.3.2 Procurement for services (Direct management):

The cross-cutting component of Monitoring and Evaluation / health information will be implemented through procurement for services, following the contracting procedures as described in the EU Financial Regulations, including the specific rules applying to the Trust Funds as described in the Companion and the Practical Guide for contracting procedures applying to EU external actions.

4.3.4Management structure

The management structure of the overall programme will depend on the implementation bodies that will be chosen. The Madad Fund liaison officers in the relevant EU Delegations shall ensure coordination between different partners and with the Delegation, including ECHO, and that implementation of activities are in line with host governments guidelines and national plans.

4.4. Indicative budget

HEALTH	**Amount in EUR million**
Area of intervention 1 Indirect management	EUR 19 million
Area of intervention 2 Direct management	EUR 35 million
Area of intervention 3 Indirect management	EUR 15 million
Cross-cutting component Direct Management	EUR 1 million
TOTAL	**70 million EUR**

***** Communication and visibility funds will be included in the various areas of intervention Performance monitoring

4.5 Performance monitoring

Monitoring shall be ensured primarily through EU Delegations in-country and in particular with the assistance of specific Trust Fund field and liaison officers posted within the EU Delegations. In addition, the EU Trust Fund is planning to launch an independent M&E exercise or external consultancy to accompany all Fund programmes and ensure that targets are met and lessons learnt can be incorporated into other EUTF actions.

The purpose of the Madad EUTF Monitoring and Evaluation Framework would be to assess, across various levels, the degree to which the Overall Objective of the Trust Fund has been achieved, with a particular attention to gender issues.

The Madad Trust Fund M&E Framework will assess the effective delivery of programmes, contribute to improved project design, and develop a knowledge base of 'what works' to allow for continuous improvement of aid delivery. Above all and in the spirit of the Agenda for Change, the Madad Trust Fund M&E Framework aims to ensure upward and downward accountability and transparency of EU support towards the Madad Trust Fund Board and end beneficiaries, respectively.

The Trust Fund and actions financed by it are subject to the monitoring and evaluation rules applicable to EU external programmes, in order to ensure the respect of the principles of economy, efficiency and effectiveness, as per Article 13 of the Agreement Establishing the Madad Trust Fund.

4.6 Evaluation and audit

Projects shall carry out an obligatory final evaluation, and one external audit per year. Whenever possible, evaluations will be jointly carried out by partners. This will also contribute to harmonise further and higher education support to Syrian refugees and to the host countries in the region, in order to make technical co-operation more effective in line with current EU guidelines.17

Without prejudice to the obligations applicable to contracts concluded for the implementation of this action, the Commission may, on the basis of a risk assessment, contract independent audits or expenditure verification assignments for one or several contracts.

4.7 Communication and visibility

While communication and visibility of the EU is a legal obligation for all external actions funded by the EU, to date the visibility of the EU's support to the Syrian crisis, in particular in neighbouring countries affected by the crisis, has been insufficient. The public perception is that the EU is not addressing the Syrian crisis, when in fact it is the largest donor. The lack of visibility to the EU's actions weakens the EU's political traction in the region and its standing in Europe.

Therefore, communication and visibility is an important part of all Madad Fund programmes factored into the implementation in order to underline its importance at all stages of the planning and implementation of the Programme.

All visibility actions by Madad Fund implementing partners outside areas of conflict should be stepped up. Each implementer will have to draw up a comprehensive visibility and communication plan for their respective target country/community and submit a copy for approval to the Madad Fund and relevant EU Delegation. The related costs will be covered by the budgets of the contract as part of the project.

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17 EC Guidelines No. 3, *Making Technical Co-operation More Effective,* March 2009.

The measures shall be implemented by the implementing consortium/ia, its contractors, and/or its grant beneficiaries. Appropriate contractual obligations shall be included in, respectively, procurement and grant contracts.

The Communication and Visibility Manual for European Union External Action together with specific requirements to highlight the Madad Trust Fund shall be used to establish the Communication and Visibility Plan of the Action and the appropriate contractual obligations.