EVALUATION STUDY FOR REDUCING ECONOMIC BARRIERS TO ACCESSING HEALTH SERVICES IN LEBANON

EVALUATION REPORT

Economic Development Solutions
EDS

JULY, 2020

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List of Abbreviations

AUB	American University of Beirut
CM	Case Management
DAC	Development Assistance Committee
EDS	Economic Development Solutions
EPHRP	Emergency Primary Health Restoration Program
FFM	Flat Fee Model
FPS	Fundación Promoción Social
FS	Functioning Scale
IMC	International Medical Corps
ITS	Informal Tented Settlement
KII	Key Informant Interview
M&E	Monitoring and Evaluation
MDM	Médecins du Monde
MEAL	Monitoring, Evaluation, Accountability and Learning
MH	Mental Health
MHPSS	Mental Health and Psychosocial Support
MoPH	Ministry of Public Health
MSF	Médecins Sans Frontiers
NCD	Non-Communicable Diseases
NGO	Non-Governmental Organization
NMHP	National Mental Health Program
PHC	Primary Healthcare Center
PU - AMI	Première Urgence-Aide Médicale Internationale
PWD	Person with Disability
REBAHS	Reducing Economic Barriers to Accessing Health Services
ToR	Terms of Reference
UNHCR	United Nations High Commissioner for Refugees
UNICEF	United Nations International Children's Emergency Fund
WFP	World Food Program
WHO	World Health Organization
YMCA	Young Men's Christian Association

Executive Summary

As the REBAHS project continues into its third year of operation, the International Medical Corps UK (IMC), along with consortium partners, Première Urgence-Aide Médicale Internationale (PU-AMI) and Fundación Promoción Social (FPS) are performing an outcome evaluation for the project. The purpose of this evaluation is to allow IMC and its consortium partners to learn from the outcome of program and present results, conclusions, lessons learnt and further recommendations with regards to the program and the implementation of its approach.

The main objectives of the outcome evaluation are to: (1) assess progress towards the outcomes and the factors and limitations affecting them, (2) assess the satisfaction of beneficiaries with the service, (3) document good practices, generate evidence-based lessons, and provide recommendations for future projects with a similar financial model of service provision, and (4) assess the sufficiency of selected outcome indicators in measuring the program outcomes

The main audience of this report are the implementing organizations, donors, and partners who will use the results as part of the organizational learning process aiming to replicate best practices and increase program effectiveness. In addition, the evaluation carries results with policy implications that can be used for future planning and collaboration with government agencies, especially the Ministry of Public Health (MoPH).

The evaluation was focused and narrowed down through a series of key questions that meet the International Organization for Economic Co-operation and Development (OECD) DAC evaluation standards and guidelines, namely, relevance, coherence, effectiveness, efficiency, and sustainability. The following are the main findings pertaining to each of the DAC standards.

Relevance

The activities of the REBAHS project were found to be highly relevant to the needs of Syrian and vulnerable Lebanese residents and respond to the gaps in the Lebanese healthcare system. Reports and analyses on the Lebanese healthcare system illustrate the dual structure of this system, combined with the structure of the social security system, render the vulnerable people unable to access healthcare services because they cannot afford them out-of-pocket and they have no healthcare insurance to cover them (Lee, 2011; Karam, 2019; Diab and Fouad, 2020). This situation is also particularly challenging to Syrian refugees who report challenges in accessing healthcare services mainly due to the high cost of medications and consultation fees. Therefore, working on reducing the economic barriers to healthcare access as the major objective of the REBAHS program indeed tackles the problem directly. All interviewees agreed that the Flat Fee Model (FFM) has allowed access to PHC services to people who did not have access before the program. Although Syrians have been major beneficiaries of the program, there has also been an increase in the number of Lebanese who visit the PHCs, thereby benefitting from the FFM. One partner organization member attributed this in part to the community outreach program that encouraged Lebanese, who would usually go to private clinics, to seek the services of the PHCs.

Regarding mental health, interviewees explained that there has been an increase in awareness regarding MH issues, especially after the MoPH took an interest and established an MH department at the National Mental Health Program. However, interviewees suggest that there are still many gaps to be filled in terms

of service provision, especially that there is an observed increase in the needs of people. One gap is the availability of psychiatrists and psychotherapists at the PHCs, where one psychiatrist and/ or psychotherapist visits the PHC 3 or 4 times a month, and this is not sufficient given the number of clients. Another major gap is in the psychotropic medications that are not being distributed by the MoPH to PHCs. In addition, hospital admission is a major need, where currently there are only a few hospitals with psychiatric wards that can admit MH patients, and thus there is a long waiting period for admission.

Coherence

In terms of coherence, the REBAHS program has operated in synergy with other existing programs and actors in target areas and has a high added value for the PHCs it operates with. After two years of operating with the FFM method, IMC was able to create synergies with other donors and organizations, who also shifted to the FFM. In fact, IMC staff members believe that introducing and applying the FFM in the REBHAS project is the main value added of the MADAD consortium.

Within the REBAHS, each PHC is allocated to one international organization (IMC, PUI, etc.); therefore, the actors are working in coordination and complementarity without duplicating their efforts. There is usually coordination at the PHC level between IMC (or the other implementing partner), MoPH, UNHCR, and YMCA, all of which provide different types of support to the PHC. YMCA provides medications for NCDs, and IMC coordinates the provision of these medications with them.

As for MoPH and UNHCR, coordination, which included both IMC and PUI, began from the design phases of the projects, where MADAD, UNHCR, and MoPH performed a mapping exercise to decide which actor is going to support the various PHC's based on their needs and gaps. During implementation, coordination happens daily, where UNHCR and MoPH send referrals to the REBAHS program.

Regarding the MH program, IMC staff members stated that there is constant coordination with other actors. There is the NMHP taskforce that the MoPH organizes every month, and that gathers MHPSS actors in the area. There is also the working group that the UNHCR organizes and part of it is related to MHPSS to ensure coordination among all the organizations. In terms of complementarity, one INGO per PHC is also followed for the MHPSS program. IMC staff members explained that if IMC wants to support a new PHC, they perform an assessment to avoid duplication in the same PHC and even in the same catchment area, in order to fill the existing gaps.

Effectiveness

The REBAHS project has been largely successful in achieving its goals and objectives, and improvements can be done in the delivery of medications and outreach components. The end line survey results show that most of the intended outcomes have been achieved. PHC staff members agree that the biggest achievements of the REBAHS program have been: (1) Reducing expenditure on health services through the FFM, (2) pregnant women receiving services that covered examinations, echo checks, and other tests that would normally cost much more than they afford, and (3) early detection of NCDs for people aged 40 and above, such as diabetes, cholesterol, etc.

Regarding the MH program, although interviewees agree that there is still a long way to go in terms of changing knowledge and attitudes towards mental health, the current program was able to increase the

level of awareness on mental health among the target communities, and decrease the stigma around mental health conditions. This has been demonstrated through the higher number of people with mental health conditions who reach out the PHC for support.

In terms of inhibiting factors, one of the main inhibiting factors is that doctors at the PHCs are not satisfied with their share of the fee, which is 7,000 LBP. A mitigation action that has been considered in RABAHS II is the use of US Dollars when reimbursing most of the PHCs.

Another inhibiting factor that interviewees discussed is convincing doctors to adhere to the protocols set by the ministry. In order to mitigate this, IMC added some restrictions on pre-approval. In addition, PU organized awareness sessions to talk about these protocols and procedures. Interviewed staff members explain that they were able to restrict preapprovals at the level of lab tests to ensure rational prescribing of diagnostic tests. Interviewees added that they did notice changes in the physicians' behavior during the first quarter of the second year of the REBAHS project; therefore, they do not expect that this challenge will persist in the second phase of the program.

A third inhibiting factor that PHC staff members discussed, which relates to the MH program, was the gap in the provision of psychotropic medications, or the delay in their delivery. The amount of medication that IMC brings is not enough and the MoPH should provide the rest; however, they do not always succeed in doing so mainly due to lack of funds.

In terms of the measurability of indicators, the outcome indicators of the project largely adhered to the SMART criteria, i.e. most of them were measurable. Some issues that have affected or might affect the measurability of the indicator and need to be taken into consideration for better measurement of the indicators are:

1. The outcome indicators were not calculated for the first year of the project due to lack of tools or a health information system designed for adequate data to calculate the indicators. As one interviewee argued, the PHENICS system that has been stet in place for the next phase of the project will resolve these issues and outcome indicators will be measured in a timelier manner.
2. Not all outcome indicators were measured at baseline, which has affected measuring the change of their value over time.
3. Although information on the calculation methods of the indicators was provided upon requesting it, this information is not documented in a clear and unified document. This might affect the measurability of the indicators, as well as the transferability of information between various team members, evaluators, or other individuals who look into these indicators could be affected by the lack of clear documentation on these indicators.

Efficiency

The REBAHS program has been implemented in an efficient manner in terms of adherence to budgeted project costs, timetables, and work plans. According to IMC staff, there was neither overspending nor underspending, and the entire budget was allocated. There were however reallocations within the budget. These reallocations happened towards the end of the project in order to be able to run the program for an additional 2 months to smoothen the transition between Madad 1 and Madad 2. In

addition, there were reallocations in the procurement of medications budget. IMC had budgeted for covering 30% of medication needs since MoPH had set their coverage budget at 70% of needs. During implementation, MoPH faced numerous challenges and could not cover the cost of 70% of required medications as planned. IMC tried to increase the budget and managed to reach 50% coverage, but it was not enough to cover the needs of beneficiaries. This explains that most of the dissatisfaction of patients with the PHC services emerges from the lack of medications or delays in providing them.

The program's activities have been largely within the limits of the work plan; however, as IMC staff explained, there has been a 2 month no-cost extension to the 23 month project in order to avoid a gap in the provision of services between MADAD I and MADAD II. PHC directors and staff also agree that REBAHS project activities were timely, but some PHC's flagged some delays, especially in the provision of acute disease packages.

All interviewees agreed that IMC team is very coordinated, structured, credible, and their communication is transparent. IMC staff also mentioned that there is always internal coordination between the different teams, among the area managers, coordinators and they systematically provide each other with updates.

Sustainability

The elements of the REBAHS project that relate to supporting institutional capacity are contributing to a sustainable improvement in the quality of healthcare services provided at PHCs and increasing their capacity and resilience. Expectedly, access of patients to consultations, medications, and tests in the absence of subsidizing through the FFM is a risk. Interviewees agreed that the equipment that IMC provided will continue to be used to provide quality services for the patients. And the trainings and capacity building activities will be sustained according to interviewees as the increased knowledge from these activities has been incorporated into the daily practices of the PHC staff and members. In addition, the institutional capacity building that relates to setting in place M&E systems, data management systems, and ensuring proper information flow has increase the capacity of the PHCs to take in more patients and provide them with quality services.

In fact, the entire capacity building process has taken place at a very critical time in Lebanon as the financial and currency crisis unfolds. With a large proportion of the Lebanese residents losing much of their purchasing power, Lebanese (and non-Lebanese) residents who used to seek services at private clinics and secondary healthcare providers will not be able to afford these services from the private sector providers and will seek them at the public sector. Having equipped and institutionally capable PHCs at this time is crucial for taking in this new demand. In this respect, the work done in REBAHS is deemed as sustainable, and very important to be continued and supported further.

However, costs will continue to be a barrier for patients. Interviewees from the PHC staff members all agreed that the number of patients from both nationalities will decrease after the end of the program funding. Therefore, access to consultations, medication, and diagnostic tests are all at risk with the end of the funding. The current economic crisis and the devaluation of the Lebanese Lira is going to put further pressure on the vulnerable communities, as well as on the pricing of PHC services. For example, one PHC which used to charge 9,000 LBP for a consultation is now charging 15,000 LBP, and some of the people who used to be able to pay the former rate are not going to be able to afford the new rate. Many

interviewees stated that their patients could barely afford the 3,000 LBP and would definitely stop going to the PHC after funding ends. They expressed their concerns that many patients will go back to coping practices they used to do before the program such as going to the pharmacist for consultations

Recommendations

A series of recommendations were proposed based on the findings of the evaluation.

- In terms of relevance, it is important for the REBAHS program to be more attuned to gendered needs, especially in terms of mental health. While interventions appear to be culturally appropriate and attuned, there is a need to ensure gender mainstreaming within all services including training case managers on issues related to LGBTQ and SGBV survivors.
- The program has been coherent with regards to coordination with the actors in the target areas and avoiding duplication with other efforts. Nonetheless, some supply chain issues faced by partners in the program including MoPH, and YMCA regarding medications has led to delays in the provision of these medications and has led to some dissatisfaction with the program. This issue needs to be tackled in the next phase of REBAHS through setting more realistic and pragmatic expectations from each partner in their ability to deliver medications in a timely manner, and be reflected in the budgets that are set for the provision of medications.
- As the REBAHS approach has been very welcomed and praised by the beneficiaries and PHCs, it is important to document the most evident success stories that can be adopted in the other interventions that are supported by the MoPH.
- MoPH and actors in the healthcare sector in Lebanon can capitalize on the change in the conceptualization of primary healthcare that the REBAHS project has been able to instill among PHC staff and members.
- The introduction of mental health into the primary healthcare system is an achievement that needs to be modelled and adopted by more PHCs in the country. However, more work needs to be done in terms of changing knowledge and attitudes towards mental health; while there has been a de-stigmatization, there is still a need for outreach and sustained community events that target and address sensitive mental health issues, such as suicidal thoughts.
- It is also recommended for IMC to network with local grassroots organizations, such as Embrace Lebanon, to broach the issue of mental health especially in light of the lockdown and increasing economic crisis which is bound to have detrimental effects on vulnerable groups.
- In terms of sustainability, an exit strategy needs to be set in place that provides options for new funding for PHCs as well as negotiates discounts with labs for diagnostic tests.
- Due to the recent inflation and devaluation of the Lebanese Lira, the purchasing power of a large share of residents has decreased significantly, and it is anticipated that many families will shift their reliance on secondary healthcare to more affordable primary healthcare. Having a strong system in place can play a crucial role in absorbing this shock of increased demand and be able to take in the increased number of patients. Therefore, continued funding, institutional support, and

technical capacity building during these times of crisis is key to sustain the ability of a resilient PHC system to provide quality healthcare services.

- The MoPH needs to play a central role in the sustainability of this action through increased investment in this type of healthcare support program. The REBAHS has been successful in setting the platform for future investments that follow a similar model that includes the FFM for beneficiaries accompanied by provision of trainings and wareness sessions aimed at changing attitude and behaviors towards hygiene practices, family planning, and other aspects of healthcare, in addition to various types of support to PHCS

1 Introduction

1.1 Subject and objectives of the evaluation

International Medical Corps UK (IMC), along with consortium partners, Première Urgence-Aide Médicale Internationale (PU-AMI) and Fundación Promoción Social (FPS) have implemented a two- year project under the title 'Reducing Economic Barriers to Accessing Health Services in Lebanon' (REBAHS). The project is funded by the European Union Regional Trust Fund and implemented in coordination and consultation with Ministry of Public Health (MoPH), with the aim of addressing the urgent needs in the Lebanese healthcare sector.

The main aim of this project is to improve access to quality primary health care, community health, and mental health services for Syrian refugees and other vulnerable populations. The project was implemented throughout 2018 and 2019 in the regions of Beirut and Mount Lebanon, Akkar, greater Tripoli, Bekaa, and the South.

As the project continues into its third year of operation, the purpose of this outcome evaluation is to ***allow IMC and its consortium partners to learn from the outcome of program and present results, conclusions, lessons learnt and further recommendations with regards to the program and the implementation of its approach***.

The main objectives of the outcome evaluation are to:

1. Assess progress towards the outcomes and the factors and limitations affecting them
2. Assess the satisfaction of beneficiaries with the services
3. Document good practices, generate evidence-based lessons, and provide recommendations for future projects with a similar financial model of service provision
4. Assess the sufficiency of selected outcome indicators in measuring the program outcomes

Additionally, the below output-outcome links will be examined:

1. Whether the project's outputs or other organizations providing nuanced services can be significantly associated with the achievement of the outcomes
2. If the Flat Fee Model (FFM) and Mental Health (MH) modality of Case Management (CM) were to be replicated in future projects, what is the stipulated timeframe that would allow for a significant association between the outputs provided and outcomes achieved?
3. The extent of sustainability of the overall project implementation (capacity building of staff, financial aspects, etc.)

1.2 The intended use and users of the study

The evaluation results will be used as part of the organizational learning process aiming to replicate best practices and increase program effectiveness. Therefore, the main audience of this report are the implementing organizations, donors, and partners. IMC will follow the findings and recommendations of

this evaluation with a management response approach that will include action points to be implemented in a defined, timely period.

In addition, the evaluation will carry results with policy implications that can be used for future planning and collaboration with government agencies, especially the Ministry of Public Health (MoPH).

1.3 Organization of the report

Following this introductory section on the purpose and audience of this outcome evaluation, the report was divided into 5 sections. Section 2 looks into the project background and evaluation focus; section 3 provides information on the methodology including the methods, technical tools and limitations of the research; section 4 presents the findings, and constitutes of 6 sub-sections, one with a general overview of the findings, and 5 detailing the findings for each DAC criterion; section 5 provides conclusion; and section 6 ends with a series of recommendations pertaining to each DAC criterion.

2 Evaluation Focus and Key Questions

The outcome evaluation of the REBAHS was focused and narrowed down through a series of key questions that meet the International Organization for Economic Co-operation and Development (OECD) evaluation standards and guidelines, namely, relevance, coherence, effectiveness, efficiency, and sustainability. These key questions were developed by IMC in the ToR for this study and were then further fine-tuned by the research team.

1. **Relevance: How significant is the REBAHS project vis-à-vis national priorities and requirements?**
   - 1.1. To what extent are the free of charge services provided relevant to the reduction of the economic barriers to accessing health care services for the target population?
   - 1.2. To what extent are the current activities meeting the health needs in Lebanon?
   - 1.3. Do beneficiaries feel that the assistance provided by the project meets their most important needs?
   - 1.4. How do beneficiaries feel about the services provided?
   - 1.5. How appropriate were the planned results and their associated indicators?
   - 1.6. To what extent is there a need to reformulate the package design given changes in the country, health status of the population and operational context?
   - 1.7. To what extent are the activities conflict sensitive and culturally appropriate?

2. **Coherence: How well does REBAHS project fit into the Lebanese healthcare provision context?**
   - 2.1. Internal coherence: Are there synergies and linkages between the REBAHS project and other IMC and partner interventions performed in the target areas?
   - 2.2. External coherence: Is there complementarity, and co-ordination with other actors in the target areas?
   - 2.3. To what extent is the intervention adding value while avoiding duplication of effort?

3. **Effectiveness: Has the REBAHS project achieved its goals and objectives?**
   3.1. How well did the project achieve its intended outputs and outcomes with respect to indicators, given identified risks? And to what extent did the project performance indicate expected achievements of objectives?
   3.2. What are the critical enabling factors and inhibiting factors that have affected the project (including those beyond the control of the programmes management structures)?
   3.3. To what extent did the changes in the packages implemented by the program contribute to the achievement of the intended outputs and project outcomes?
   3.4. How measurable were the project indicators?
   3.5. To what extent was the programme design adequate and effective in responding to the mental health needs in a way that guarantees results?
   3.6. To what extent did the subsidized services contribute to the reduction the economic barriers to accessing health care services for the target population?
   3.7. To what extent did the programme lead to changes in knowledge, attitudes and access to mental health services in the targeted communities?

4. **Efficiency: Has the REBAHS project achieved its objectives economically?**
   4.1. To what extent are the results being achieved at an acceptable cost?
   4.2. To what extent did project implementation costs differ from budgeted project costs?
   4.3. How well has the programme reached the expected measures as per the targets of the results within the expected time frame?
   4.4. To what extent are the program's activities in line with the schedule of activities as defined in the annual work plans?
   4.5. Was there enough coordination and planning among the program teams to ensure proper and timely implementation of the project?

5. **Sustainability: How likely is it for REBAHS project activities to continue after the funding ends?**
   5.1. How likely are programme activities and results to continue after programme funding, which ones are not likely and why?
   5.2. How well and to what extent have activities throughout the project focused on ensuring sustainability of services post REBAHS funding?

3 Methodology

3.1 Data sources and methods

3.1.1 Research approach

The present outcome evaluation followed a mixed methods approach that relied on data triangulation from several primary and secondary sources of data. The main sources of secondary data were the desk review of the relevant documents shared by IMC, the end line data, and log frame indicators. As for the primary data, it relied on a qualitative method of collecting data through a series of in-depth interviews with various profiles of stakeholders. The remainder of this section will detail these data sources and tools.

3.1.2 Desk review

The study team performed a thorough review of the documents that IMC shared with them. The most relevant documents for the outcome evaluation were:

1. Baseline: The Baseline report conducted by Sayara research for IMC and consortium partners in 2018 a few months after the start of the program.
2. Process evaluation: The Process evaluation report conducted by AUB for IMC and consortium partners in January 2019 after the first year of the REBAHS project.
3. Satisfaction survey: The survey conducted by the IMC MEAL team after the first year of the program

In addition, the log frame indicators formed an important pillar of the analysis.

3.1.3 Key Informant Interviews

A total of 32 KIIs were conducted to collect information on the key questions pertaining to the DAC criteria. The table below depicts the number and profiles of interviewees. The interviews followed KII guidelines that were approved by IMC team members (see annex 1). The detailed interview notes and recordings were used for the analysis.

Table 1: Key informant interviews

Stakeholder Profile	Number of people to be interviewed
IMC staff in PHC program	2
IMC staff in MH program	2
PU-Ami staff	1
MHPSS case managers	6
MHPSS psychotherapists	2
MHPSS psychiatrists	2
National Mental Health Program Focal Point	1
Roving social workers	2
ITS (Informal Tented Settlements) representatives from different regions	4
Management, staff and service providers from PHC	10
Municipalities	1
Total	**33**

3.2 Limitations and mitigations

The COVID-19 lockdown led to a number of limitations during data collection:

- The EDS team could not conduct interviews face-to-face. As such, they were replaced with phone and Skype interviews. Remotely conducted had a potential impact on the quality of data collected as interviews had to be slightly shorter and some elaborations on part of the interviewees could have been missed.

- Focus group meetings with beneficiaries were provisioned in the methodology but could not be conducted due to the lockdown. They could not be replaced with virtual meetings or interviews due to confidentiality issues related to sharing the contact details of beneficiaries, as well as lack of access of the potential participants to the needed technology and internet connection. Therefore, the viewpoint of beneficiaries was not as present in the report results and the study team relied on the results of the end line survey that was conducted with beneficiaries to support some of the results of the study.

4 Evaluation Findings

4.1 Relevance: How significant is the REBAHS project vis-à-vis national priorities?

Finding 1: The activities of the REBAHS project are highly relevant to the needs of Syrian and vulnerable Lebanese residents and respond to the gaps in the Lebanese healthcare system. More effort can be done on enhancing the design and collection of outcome indicators.

❖ ***To what extent are the current activities meeting the health needs in Lebanon?***

Reports and analyses on the Lebanese healthcare system illustrate the structure of this system, combined with the structure of the social security system, render the vulnerable people unable to access healthcare services because they cannot afford them out-of-pocket and they have no healthcare insurance to cover them (Lee, 2011; Karam, 2019; Diab and Fouad, 2020).

Access to healthcare in Lebanon is subject to multiple layers of politics, economy, sectarian interests, and political objectives, and healthcare provision is not based on any meritocratic or inclusive practices (Diab and Fouad, 2020). The dual system of both public and private providers, with a very high rate of privatization, adds even more obstacle to issues of access, as healthcare is expensive to a large part of the Lebanese population, most of whom do not enjoy any type of health insurance. Despite the MoPH efforts to support and increase availability of primary and secondary healthcare for refugees, the cost of consultations, laboratory tests, and medication remains a significant barrier (Hanna-Amodio, 2020).

The situation is even more difficult for Syrian refugees. The 2017 Vulnerability Assessment Report conducted by UNHCR, UNICEF and the World Food Programme (WFP) found that the main reasons that Syrian households did not receive required care were because of the cost of drugs (33%), consultation fees (33%), uncertainty about where to go (17%), and not being accepted at the facility (14%).

Therefore, working on reducing the economic barriers to healthcare access as the major objective of the REBAHS program indeed tackles the problem directly. All interviewees agreed that the FFM has allowed access to PHC services to people who did not have access before the program. Although Syrians have been major beneficiaries of the program, there has also been an increase in the number of Lebanese who visit the PHCs, thereby benefitting from the FFM. One partner organization member attributed this in part to the community outreach program that encouraged Lebanese, who would usually go to private clinics, to seek the services of the PHCs.

Furthermore, the project addresses the state of primary healthcare in Lebanon and aims to strengthen this type of healthcare provision. One interviewee informed us that in 2008, there were only 8 centers

that included primary healthcare services, while the remaining centers were “dispensaries” rather than PHCs. In a dispensary, a patient comes in to take a prescription and leaves while in a PHC, the patient's health is being monitored from head to toe. The approach is preventative and holistic, including mental and physical health. There is also continuity of care. Since 2008, the concept of primary healthcare has started to be applied and improved as there are now approximately 250 PHC centers distributed around Lebanon. IMC's aim is to support those PHCs so that the most vulnerable populations can have access to holistic, affordable, accessible, and quality healthcare.

On another front, interviewed PHC managers and staff reported that IMC has been responsive to their changing needs, thus keeping their support relevant to the local needs. For example, one PHC manager mentioned that IMC provided masks, gloves, and sanitizing detergents when the COVID-19 outbreak began.

Regarding mental health, interviewees explained that there has been an increase in awareness regarding MH issues, especially after the MoPH took an interest and established an MH department at the National Mental Health Program. Currently, there is a taskforce that has been working with different actors; however, the overall number of international organizations who have full case management (case managers, psychotherapist, psychiatrist, and providing medications) is still very low. In this respect, the design and implementation of the REBAHS MH program has been very relevant to the community needs. It provides free mental health, counseling services, and psychosocial support, while also working on the integration of mental health into primary health care centers. It also actively works on raising awareness, training community members to identify mental health needs and primary healthcare providers to diagnose and treat mild to moderate mental health conditions and facilitating safe community spaces for discussion of mental health. Moreover, IMC supports the MoPH’s National Mental Health Programme by helping integrate mental health into PHCs and contributes to improving access to mental health care.

There are still many gaps to be filled in terms of service provision, especially that there is an observed increase in the needs of people. One gap is the availability of psychiatrists and psychotherapists at the PHCs, where one psychiatrist and/ or psychotherapist visits the PHC 3 or 4 times a month, and this is not sufficient given the number of clients. Another major gap is in the psychotropic medications that are not being distributed by the MoPH to PHCs. In addition, hospital admission is a major need, where currently there are only a few hospitals with psychiatric wards that can admit MH patients, and thus there is a long waiting period for admission.

- ***To what extent are the subsidized services relevant to the reduction of economic barriers to accessing health care services for the target population?***

As mentioned, economic barriers are one of the main, if not the primary, reason for people not being able to access healthcare in Lebanon. The main objective of the REBAHS program was to reduce these economic barriers to healthcare through the FFM and free MHPSS services. According to all interviewees this objective is indeed very relevant to the main challenges that vulnerable Syrians and Lebanese are facing in their access to healthcare, as many clients cannot afford required medical tests and consultation fees. For example, one PHC staff member mentioned that pregnant women who do not perform a CBC blood test might have low levels of hemoglobin which might lead to complications in their pregnancy and

delivery. The IMC antenatal coverage package allowed pregnant women to perform all necessary laboratory tests in addition to ultrasound checks and consultations.

Another PHC director mentioned that before the IMC and partners' intervention, many patients would have to choose between paying for a consultation and buying medication, and so would resort to pharmacists to give them a consultation and medicine. Pharmacists would often act unethically, and just give them medications they are commissioned to sell regardless of the patients' needs. The FFM allowed patients to be able to get consultations at the PHC, and thus a more accurate diagnosis for their cases.

Furthermore, according to PHC staff and directors, the (Non-Communicable Diseases) NCD program has allowed people to discover that they have diabetes, or hypertension, or risk of diabetes that they did not know about. Therefore, they were able to get proper care and control the disease at an early stage.

- ***To what extent are the activities conflict sensitive and culturally appropriate?***

The REBAHS project has been mindful of conflict sensitive situations and culturally appropriate practices according to the interviewees. For example, several PHC staff members mentioned that patients sometimes needed female doctors, especially obstetricians and gynecologists, and IMC was responsive to these needs. Another IMC staff member mentioned that one cultural challenge was encouraging women to use contraceptives and the program was trying to change these through health awareness. Certainly, when asked about whether the project has been culturally appropriate, respondents emphasized that a core element of IMC's intervention was to ensure that there is cultural awareness and competence when dealing with the different groups at stake, emphasizing the need to approach issues with sensitivity and confidentiality while at the same time remaining open and safe enough for tabooed topics to be discussed.

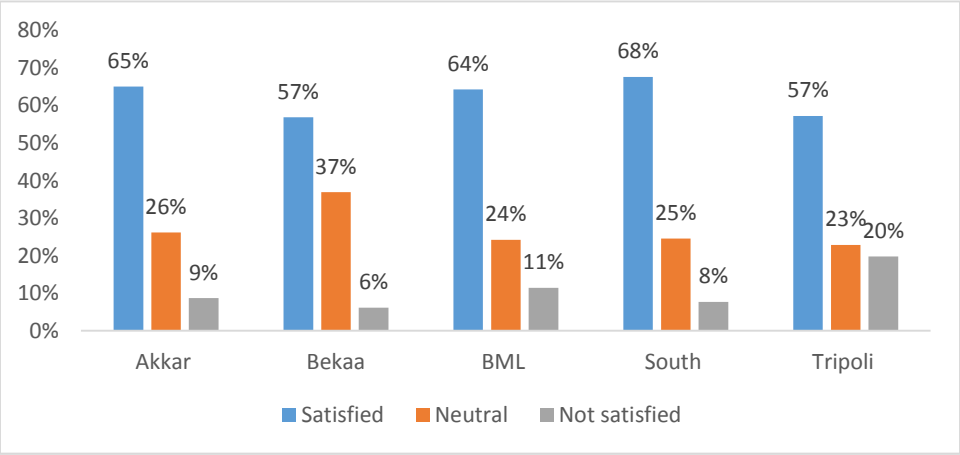
Yet, it should be noted that some respondents emphasized that there is not enough gender mainstreaming in mental health services provided; while there is a focus on "gender" there hasn't been enough training on how to address gender sensitive issues, especially those in relation to mental health conditions. Some case managers mentioned that they would appreciate training that focuses on addressing the specific needs of those from the LGBTQ community or SGBV survivors.

In addition, the REBAHS program has contributed to decreasing tensions between Lebanese and Syrian community members. Interviewees from PHCs mentioned that they were not able to support all families before the REBAHS project, as most of their funds were specific to the Syrian community. This had created tensions between the communities and built a lot of resentment. Since the REBAHS program targeted all vulnerable communities, and the PHCs were able to service both Lebanese and Syrians, these tensions have decreased significantly.

- ***Do beneficiaries feel that the assistance provided by the project meets their most important needs?***

The overall results of the end line survey show that the majority of respondents were satisfied with the services that they had received at the REBAHS supported PHCs. In fact, 61% of beneficiaries reported that they are satisfied with the services provided, a percentage that is slightly lower than the project target of 70%. There were some regional variations in reported levels of satisfaction. The highest levels were observed in the South, while the lowest were in the Bekaa and Tripoli. Tripoli also reported the highest levels of dissatisfaction with the services.

Figure 1: Satisfaction of beneficiaries by region – end line survey



The major source of dissatisfaction among respondents was attributed to lack of or delay in the delivery of medications. This is in fact one of the challenges of the program as IMC and its partners are not the sole providers of medications and have to coordinate their provision with MoPH and YMCA who are responsible for providing part of the medications. Therefore, the lack of satisfaction of some beneficiaries is really due to the inhibiting factors surrounding implementation of the REBAHS project.

❖ ***How appropriate were the planned results and their associated indicators?***

The planned results were largely appropriate and in line with the overall objectives of the program. The interviewed staff did not express concern overreaching the targets that had been set. Most of the outcome indicators set by the program show that the targets had been exceeded (refer to table 3); therefore, one could argue that the planned results were in fact slightly under-estimated.

As for the outcome indicators used to measure the achievement of the planned results, they were evaluated based on whether they were "SMART", i.e. Specific, Measurable, Attainable, Relevant and Timely[1]. The table below presents the evaluation and comments of each of the outcome indicators.

Table 2: Comments on adequacy of outcome indicators

Objective	Indicator	S	M	A	R	T	Comment
Objective #1: Improved access to quality health services for Syrian refugees	Percentage of households who required PHCC services in the last 6 months received the required assistance			**X**	**X**	**X**	Can be more specific by having a separate indicator for each of the packages provided by the program

[1] The first criterion, Specific, means that the indicator needs to be narrow and accurately describe what needs to be measured. Measurable means that regardless of who uses the indicator it would be measured in the same way. Achievable (or attainable) means that collecting the data should be straightforward and cost-effective. Relevant requires that the indicator be closely linked to the relevant outcome. Finally, Time-bound means that there should be a timeframe linked to the indicator (such as the frequency with which it is collected or measured).

and other vulnerable populations in Lebanon (Outcomes)	Percentage of households who required mental health services in the last 6 months received the required assistance	**X**			**X**	**X**	There is need to target a larger sample of PHCs that include MH services in order to obtain a representative sample of respondents to adequately measure this indicator. For instance, this indicator was not calculated at end line as random sampling led to having only 6 respondents who have benefitted from the REBAHS MH program.
	Percentage of beneficiaries reporting decreased expenditure on healthcare services			**X**			Might not be accurate since it reflects only the PHC bill payed during the last visit to the PHC. Therefore, it does not reflect overall decrease in expenditure on healthcare. Variables that rely on the PHC data for payments of patients over time can be used to calculate average bill for REBAHS beneficiaries and how it is changing over time, and also how it is changing with respect to the bills of non-beneficiaries
	Percentage of beneficiaries who report being satisfied with health services			**X**	**X**	**X**	Similarly, to the first indicator, could be divided into the various packages for a better understanding of satisfaction with the specific services
	Percentage of trained health care professionals and PHCC staff who acquire minimum competency standards on the trained topic	**X**	**X**	**X**	**X**	**X**	
	Percentage of referred beneficiaries seek care at the PHCCs	**X**	**X**	**X**	**X**	**X**	
Objective #2: Improved well-being for Syrian refugees and vulnerable Lebanese population participating in mental health and psychosocial	Number of beneficiaries receiving mental health case management services report improvement in their daily functioning throughout the project period	**X**	**X**	**X**	**X**	**X**	A pre-requisite for building this indicator is for the beneficiary to fill a Functioning scale (FS) survey at the beginning and end of treatment. Some beneficiaries might refuse to fill one or both FS surveys, so although they might have improved, the indicator does not capture this. So, it could be overestimating or under-estimating achievement of results.

support activities	Percentage of front-line staff and PHCC providers participating in detection and referral training demonstrating increased knowledge	**X**	**X**	**X**	**X**	**X**	The indicator relies on pre-test and post-test results. The post-test is administered directly after the end of the training, so it can reflect improved understanding of the topic, but not increased knowledge. It is suggested to do the post-test another time after a certain period of time to confirm increased knowledge.
	Percentage of participants in crisis management training who demonstrate increased knowledge	**X**	**X**	**X**	**X**	**X**	Same as above.
	Percentage of participants in Psychological first aid training who demonstrate increased knowledge	**X**	**X**	**X**	**X**	**X**	Same as above.

- ***To what extent is there a need to reformulate the package design given changes in the country, health status of the population and operational context?***

The current program has the Antenatal package and NCD packages that are fixed and in line with the WHO. There is also the general conditions package that has been updated for MADAD II, and it includes top 20 diseases that patients seek PHC services for. MADAD I had 10 to 12 diseases in this package with 3 to 4 tests that were approved per disease. Under MADAD II, the number of covered diseases increased and there are additional tests that are covered per disease. All of this was communicated with the partners, including the MoPH who took this package for general conditions that we created to review. Therefore, the hope, according to IMC staff members, is for the MoPH to also use this updated package in its future projects.

In addition, there is need for a package that supports People with Disabilities (PWDs). It was not implemented in MADAD I. PWDs can have very specific conditions and PHCs are not well equipped to diagnose, test or treat them. Therefore, IMC has introduced these medical conditions to the doctors and staff of the PHC and has a created and shared an SOP (Standard Operating Procedures) for PWD clients. IMC will advocate that this SOP be integrated into the primary healthcare system.

4.2 Coherence: How well does REBAHS fit into the Lebanese healthcare provision context?

Finding 2: The REBAHS program operates in synergy and coordination with other existing programs and actors in target areas and has a high added value for the PHCs it operates with.

- ***Internal coherence: Are there synergies and linkages between the REBAHS project and other IMC and partner interventions performed in the target areas?***

IMC first introduced the FFM model under the REBAHS program based on a recommendation from PUI. After two years of operating with this method, IMC was able to create synergies with other donors and organizations, who also shifted to the FFM. In fact, IMC staff members believe that introducing and applying the FFM in the REBHAS project is the main value added of the MADAD consortium.

After shifting to FFM in the REBAHS project, one IMC staff member recalls that they received calls from Relief International, MDM, MSF, etc. to inquire about the FFM and express their interest in adopting it.

- ***External coherence: Is there complementarity, and co-ordination with other actors in the target areas?***

According to interviewees, the MADAD consortium is currently the largest actor in the healthcare support programs in Lebanon, covering around 60 PHCs. The other actors combined cover no more than 15 PHCs under varying approaches. IMC is part of a working group that works on enhancing the quality of healthcare services provided at PHCs. It also provides technical support to other NGOs when they request it.

Within the REBAHS, each PHC is allocated to one international organization (IMC, PUI, etc.); therefore, the actors are working in coordination and complementarity without duplicating their efforts. There is usually coordination at the PHC level between IMC (or the other implementing partner), MoPH, UNHCR, and YMCA, all of which provide different types of support to the PHC. YMCA provides medications for NCDs, and IMC coordinates the provision of these medications with them.

As for MoPH and UNHCR, coordination, which included both IMC and PUI, began from the design phases of the projects, where MADAD, UNHCR, and MoPH performed a mapping exercise to decide which actor is going to support the various PHC's based on their needs and gaps. During implementation, coordination happens on a daily basis, where UNHCR and MoPH send referrals to the REBAHS program.

Regarding the MH program, IMC staff members stated that there is constant coordination with other actors. There is the NMHP taskforce that the MoPH organizes every month, and that gathers MHPSS actors in the area. There is also the working group that the UNHCR organizes and part of it is related to MHPSS to ensure coordination among all the organizations. In terms of complementarity, one INGO per PHC is also followed for the MHPSS program. IMC staff members explained that if IMC wants to support a new PHC, they perform an assessment to avoid duplication in the same PHC and even in the same catchment area, in order to fill the existing gaps.

❖ ***To what extent is the intervention adding value while avoiding duplication of effort?***

According to interviewees, the MoPH conducts regular meetings among the different international organizations and stakeholders to avoid duplication of efforts. Thus, as mentioned above, PHCs benefitting from such support should have one international organization allocated to each, not more.

Moreover, with the mental health services, IMC is not duplicating efforts as it is pioneering a much-needed approach of integrating mental health into PHCs while ensuring that it provides sustainable training to PHC members and consultants.

COMPLEMENTARITY OF EFFORTS IN TRIPOLI

The director of Tripoli PHC explained that they are receiving support from SHIFT NGO for medical equipment, including dental equipment (IMC does not cover dentistry), otoscopes, oxygen concentrator (which IMC was supposed to provide but could not due to limited funding), additional equipment for the quarantine room for COVID-19, and re-painting of the PHC lab equipment.

"*The support provided by SHIFT is complementary to that provided by IMC, there are things that IMC do not cover especially as their budget has become restricted and needs to be distributed between different PHCs. So equipment that IMC couldn't provide was provided by SHIFT."* – Mohamad Ghemrawi Tripoli PHC director

4.3 Effectiveness: Has the REBAHS project achieved its goals and objectives?

Finding 3: The REBAHS project has been largely successful in achieving its goals and objectives. Improvements can be done in the delivery of medications and outreach components.

❖ ***How well did the project achieve its intended outcomes with respect to indicators, given identified risks?***

The end line survey results show that most of the intended outcomes have been achieved. The following table presents these results. The baseline values have been obtained from the baseline report, the cumulative value for years 1 and 2 presented in column two and were calculated by EDS team in coordination with IMC team, and the target values for years 1 and 2 that have been set by IMC and the consortium partners are presented in the third column, and the calculated progress towards the final value, i.e. the degree to which the project activities have reached their target were calculated by EDS team.

The indicator "percentage of household who required Mental Health services in the last 6 months and received the required assistance" was not included in the table because the end line survey include only

a sample of 6 people who reported needing and receiving mental health services from IMC supported centers, and so the sample is too small to generate a meaningful indicator.

Table 3: Outcome indicators (Source: IMC data)

OBJECTIVE	INDICATOR	BASELINE'S TOTAL	CUMULATIVE VALUE OF Y1 & Y2	TARGET VALUE OF Y1 & Y2	PROGRESS TOWARDS THE FINAL VALUE
Objective #1: Improved access to quality health services for Syrian refugees and other vulnerable populations in Lebanon (Outcomes)	Percentage of households who required PHCC services in the last 6 months received the required assistance	83%	95%	95%	100%
	Percentage of beneficiaries reporting decreased expenditure on healthcare services	47%	67%	65%	103%
	Percentage of beneficiaries who report being satisfied with health services	41%	72%	70%	103%
	Percentage of trained health care professionals and PHCC staff who acquire minimum competency standards on the trained topic	0%	78%	70%gra	111%
	Percentage of referred beneficiaries seek care at the PHCCs	0%	63%	40%	158%
Objective #2: Improved well-being for Syrian refugees and vulnerable Lebanese population participating in mental health and psychosocial support activities	Number of beneficiaries receiving mental health case management services report improvement in their daily functioning throughout the project period	0%	78%	70%	112%
	Percentage of front-line staff and PHCC providers participating in detection and referral training demonstrating increased knowledge	0%	89%	80%	111%

	Percentage of participants in crisis management training who demonstrate increased knowledge		78%	70%	112%
	Percentage of participants in Psychological first aid training who demonstrate increased knowledge		94%	70%	135%

❖ ***What are the critical enabling factors and inhibiting factors that have affected the project?***

One of the main inhibiting factors is that doctors at the PHCs are not satisfied with their share of the fee, which is 7,000 LBP. Given the current economic crisis and devaluation of the Lira, this will become an increasingly big challenge to overcome as doctors might not be willing to treat the program beneficiaries at this rate. A mitigation action that has been considered in RABAHS II is the use of US Dollars when reimbursing most of the PHCs.

Another inhibiting factor that interviewees discussed is convincing doctors to adhere to the protocols set by the ministry. For example, doctors would prescribe antibiotics quite often, and it is very challenging to change their practices. In order to mitigate this, IMC added some restrictions on pre-approval. In addition, PU organized awareness sessions and refreshers to talk about these protocols and procedures. Interviewed staff members from IMC and PUI explain that they were able to restrict preapprovals at the level of lab tests to ensure rational prescribing of diagnostic tests. For instance, urine analysis test is done, if the result is positive, a urine culture is ordered, rather than ordering both at the same time. Interviewees added that they did notice changes in the physicians' behavior during the first quarter of the second year of the REBAHS project; therefore, they do not expect that this challenge will persist in the second phase of the program.

A third inhibiting factor that PHC staff members discussed, which relates to the MH program, was the gap in the provision of psychotropic medications, or the delay in their delivery. The amount of medication that IMC brings is not enough and the MoPH should provide the rest; however, they do not always succeed in doing so mainly due to lack of funds.

❖ ***How measurable were the project indicators?***

As mentioned in the relevance section, the indicators of the project largely adhered to the SMART criteria, i.e. most of them were measurable. Some issues that have affected or might affect the measurability of the indicator and need to be taken into consideration for better measurement of the indicators are:

- The outcome indicators were not calculated for the first year of the project due to lack of tools or a health information system designed for adequate data to calculate the indicators. As one interviewee argued, the PHENICS system that has been stet in place for the next phase of the project will resolve these issues and outcome indicators will be measured in a timelier manner.

- Not all outcome indicators were measured at baseline, which has affected measuring the change of their value over time.
- Although information on the calculation methods of the indicators was provided to us upon requesting it, this information is not documented in a clear and unified document. This might affect the measurability of the indicator and the accuracy of comparison between baseline and end line values. In addition, the transferability of information between various team members, evaluators, or other individuals who look into these indicators could be affected by the lack of clear documentation on these indicators.

❖ ***To what extent did the subsidized services contribute to the reduction of economic barriers to accessing health care services for the target population?***

PHC staff members agree that the biggest achievements of the REBAHS program have been:

1. Reducing expenditure on health services through the FFM
2. Pregnant women receiving services that covered examinations, echo checks, and other tests that would normally cost much more than they afford
3. Early detection of NCDs for people aged 40 and above, such as diabetes, cholesterol, etc.

Furthermore, the outcome indicator shows that 67% have reported a decrease in healthcare expenditures over the past six months compared to 47% in the baseline survey. The increase of 42.5% in respondents within the catchment areas of the project who have lower health expenditures shows that the program has indeed reduced the barriers to accessing healthcare services.

❖ ***To what extent was the program design adequate and effective in responding to the mental health needs in a way that guarantees results?***

Interviewees expressed their satisfaction with the updated program design in terms of having clearer tools and filing systems that helped track cases and facilitate the M&E process. In addition, the need for more staff to cater to the increasing needs of the community has been addressed by increasing the numbers of case managers, psychotherapists, and psychiatrists.

The process evaluation report as well as the thematic evaluation report highlight some of the gaps in the client visit process that could be improved such as:

"We have success stories every month. In the current health crisis, all interviews are being made through calls and video calls. New guidelines have been drafted to apply the code of conduct such as no recording of the interviews, for them to be in a room alone without family members and so on. It is important to continue doing these so that patients do not have any relapse" – Interviewed staff member of MH program

1. Ensuring that the Client Functioning Scale Tool is consistently filled. In fact this is important not only for tracking the client's progress, but also for tracking the improved access to the MHPSS services and progress towards achieving the program goals.
2. Ensuring better documentation of beneficiary files. Accurately documenting consultations is important for maintaining and improving the quality of services

3. Improving the outreach system by increasing the number of staff dedicated to this as well as the number of roving social workers.
4. Increasing the number of sessions for community support groups, as well as the number of overall groups would also contribute to increasing awareness and reducing social stigma surrounding MH issues. The former would lead to more in-depth understanding among group participants, and the latter would create a wider reach.

❖ ***To what extent did the program lead to changes in knowledge, attitudes and access to mental health services in the targeted communities?***

Although interviewees agree that there is still a long way to go in terms of changing knowledge and attitudes towards mental health, the current program was able to increase the level of awareness on mental health among the target communities, and decrease the stigma around mental health conditions. This has been demonstrated through the higher number of people with mental health conditions who reach out the PHC for support. However, one PHC director highlights that it also depends on the MH case at hand. For instance, he explains that people who have suicidal thoughts, or suffer from psychosis, would not reach out. In these cases, the team cooperates with their families, to provide them with psychoeducation, and support them so they can convince the clients to benefit from these services.

The end line study conducted for the MH program showed that outreach remains insufficient as awareness levels are below expectations. 71% of respondents who reported that they required mental health services did not receive them. And the most mentioned reason for not receiving MH services were the perceived costs (59%), followed by concerns related to social stigma (45%). The baseline reported the same reasons for not seeking MH services. However, overall, when asked about the importance of community and family perceptions in preventing someone from seeking MH services, the end line reports show that there is a decrease of 32% in this concern between baseline and end line. This indicates a reduction in stigma surrounding the seeking of MH services.

Therefore, the figures suggest although there has been an increased awareness of MH issues, and some perceptions have changed, there is still more work to be done. Knowing that changing behavior and perceptions is a long-term process that requires years of continued effort, the MH program needs to sustain is efforts through the REBAHS II intervention as well as the NMHP.

4.4 Efficiency: Has the REBAHS project achieved its objectives economically?

Finding 4: The REBAHS program has been implemented in an efficient manner in terms of adherence to budgeted project costs, timetables, and work plans.

❖ ***To what extent did project implementation costs differ than budgeted project costs?***

According to IMC staff, there was neither overspending nor underspending, and the entire budget was allocated. There were however reallocations within the budget. These reallocations happened towards the end of the project in order to be able to run the program for an additional 2 months to smoothen the transition between Madad 1 and Madad 2. These reallocations included, according to IMC staff:

1. Moving part of NCD budget to general consultations budget

2. Removing all ultrasounds from coverage with the exception of those part of the ANC package
3. No longer covering IUD insertion service
4. No longer covering some minor medical procedures
5. Terminating the Quality Performance Incentive program

In addition, there were reallocations in the procurement of medications budget. IMC had budgeted for covering 30% of medication needs since MoPH had set their coverage budget at 70% of needs. During implementation, MoPH faced numerous challenges and could not cover the cost of 70% of required medications as planned. IMC tried to increase the budget and managed to reach 50% coverage, but it was not enough to cover the needs of beneficiaries. This explains that most of the dissatisfaction of patients with the PHC services emerges from the lack of medications or delays in providing them.

PUI staff also faced some changes in the budget and could not follow it exactly because of external inhibiting factors that they faced in the target areas that they were covering. Interviewees mentioned that some PHCs who were supported by other programs exited these programs and thus many patients moved to the REBAHS supported PHCs. Although this was provisioned in the feasibility study of the program, it did put a lot of pressure on the REBAHS supported PHCs.

In addition, the REBAHS project budget was set in collaboration with the MoPH and the EPHRP (Emergency Primary Health Restoration Program) funded by the World Bank[2] that covered preventive measures such as NCD screening, children under the age of 5, pregnant women, and vaccinations

- ***How well has the program reached the expected measures as per the targets of the results within the expected time frame?***

The findings from the end line survey show that all the targets have been achieved and over-achieved.

- ***To what extent are the program's activities in line with the schedule of activities as defined in the annual work plans?***

The program's activities have been largely within the limits of the work plan; however, as IMC staff explained, there has been a 2 month no-cost extension to the 23 month project in order to avoid a gap in the provision of services between MADAD I and MADAD II.

PHC directors and staff also agree that REBAHS project activities were timely, but some PHC's flagged some delays, especially in the provision of acute disease packages. These delays would lead to accumulation of cases and overwhelming physicians at times. They add that these delays are happening more often since the adoption of the PHENICS system because all cases now must be approved online through this system and sometimes non-urgent cases are postponed. Interviewees explain that approvals before the PHENICS system were done through WhatsApp, which they believe was faster, and is still being used now for the approval of more urgent cases. It is important to note here that in REBAHS I only 6 PHCCs were part of this Pilot (Tal Mayaan, Labwe, Bireh, Moasat Nazih Bezri, Karagheusian, Aramoun).

[2] The program budget was $15 Million, and it supported 150,000 poor Lebanese targeted by the NPTP (National Poverty Targeting Program)

❖ ***Was there enough coordination and planning among the program teams to ensure proper and timely implementation of the project?***

All interviewees agreed that IMC team is very coordinated, structured, credible, and their communication is transparent.

IMC staff also mentioned that there is always internal coordination between the different teams, among the area managers, coordinators and they systematically provide each other with updates.

"[IMC] are very dedicated and cooperative. They follow up with us closely on each patient's file. They are very professional. This is the first organization that I witness to have this level of transparency. They execute what they say" – PHC director

4.5 Sustainability: How likely is it for REBAHS activities to continue after the funding ends?

Finding 5: The elements of the REBAHS project that relate to supporting institutional capacity are contributing to a sustainable improvement in the quality of healthcare services provided at PHCs and increasing their capacity and resilience. Expectedly, access of patients to consultations, medications, and tests in the absence of subsidizing through the FFM is a risk.

❖ ***How likely are program activities and results to continue after program funding, which ones are not likely and why?***

Since the program did not hire staff at the PHCs, their activities are expected to continue in terms of providing healthcare services. In addition, interviewees agreed that the equipment that IMC provided will continue to be used to provide quality services for the patients. Furthermore, the trainings and capacity building activities will be sustained according to interviewees as the increased knowledge from these activities has been incorporated into the daily practices of the PHC staff and members. For example, practices such as frequent hand washing, changing doctors' coats, changing paper towels on examination tables, etc. have contributed to building better quality at the centers and there will retention of some patients even if the fee increases to 10,000. T

"The medical record of the Patient is placed on PHENICS which automatically calculates risks and other aspects such as malnutrition. Other training included family planning and vaccinations, quality, drug exchange and prescriptions, communication with patients, assessment... It is very comprehensive. All of this is sustainable even after the funding stops" - PHC director

In addition, the institutional capacity building that relates to setting in place M&E systems, data management systems, and ensuring proper information flow has increase the capacity of the PHCs to take in more patients and provide them with quality services.

In fact, the entire capacity building process has taken place at a very critical time in Lebanon as the financial and currency crisis unfolds. With a large proportion of the Lebanese residents losing much of their purchasing power, Lebanese (and non-Lebanese) residents who used to seek services at private clinics and secondary healthcare providers will not be able to afford these services from the private sector providers and will seek them at the public sector. Having equipped and institutionally capable PHCs at this

time is crucial for taking in this new demand. In this respect, the work done in REBAHS is deemed as sustainable, and very important to be continued and supported further.

However, costs will continue to be a barrier for patients. Interviewees from the PHC staff members all agreed that the number of patients from both nationalities will decrease after the end of the program funding. One interviewee was expecting that only 20% of 30% of current patients will continue to visit the PHC. In fact, most interviewees recall that in February when funding stopped temporarily, the PHCs did witness a decrease in the number of patients visiting them. Some PHCs reported that some nurses and midwives were laid off until funding resumed. Therefore, access to consultations, medication, and diagnostic tests are all at risk with the end of the funding.

> *"The effect on people here in the ITS will be disastrous [if REBAHS project ends]"* – Shawii of ITS in Wadi Khaled

The current economic crisis and the devaluation of the Lebanese Lira is going to put further pressure on the vulnerable communities, as well as on the pricing of PHC services. For example, one PHC which used to charge 9,000 LBP for a consultation is now charging 15,000 LBP, and some of the people who used to be able to pay the former rate are not going to be able to afford the new rate. Many interviewees stated that their patients could barely afford the 3,000 LBP and would definitely stop going to the PHC after funding ends. They expressed their concerns that many patients will go back to coping practices they used to do before the program such as going to the pharmacist for consultations.

> *"Sustainability isn't directly related to implementation but rather to the socio-economic situation. When people do not have money, their first priority becomes nutrition and health comes afterwards"* – Interviewed PHC director

To tackle the lack of sustainability of the FFM, an exit strategy needs to be set in place that would gradually reduce dependency on the donor funding and find ways together with MoPH to continue assisting the vulnerable communities through other interventions. In addition, IMC staff suggested that PHCs can negotiate reduced prices with some labs to maintain affordability of diagnostic tests. IMC have provided the PHCs with some management training and they can benefit from their upgraded management skills to reduce some costs.

That being said, it is important to note that, as any intervention that includes covering a given cost, the end of funding will de facto imply the lack of sustainability of that action. The REBAHS project, through its numerous activities and interventions has provided a platform or model for encouraging future investment that capitalizes on this model. Therefore, ultimately, the sustainability of the entire REBAHS action inherently requires future investment of similar scale, and which needs to be taken upon by the government as part of its national strategy to strengthen the public health sector in Lebanon.

- ***How well and to what extent have activities throughout the project focused on ensuring sustainability of services post REBAHS funding?***

Similar to the analysis above, the activities pertaining to the capacity building aspect of the project have focused on ensuring sustainability in terms of improved quality of healthcare services. As one interviewee explained, the healthcare team working in those PHCs will remain in the healthcare sector in Lebanon, so any capacity building that they receive will transform the way in which they provide healthcare from an instinct-based approach to an evidence-based and standardized (through protocols and guidelines) approach; the public health approach that aims to properly allocate resources to people in need. As such, capacity building, even if they end up working in other places, the knowledge that they gained will remain.

In addition, the REBAHS project has focused on raising awareness of beneficiaries, which is also a way of ensuring sustainability of better healthcare practices and behaviors. Interviewees suggest that awareness changes how beneficiaries think of and behave concerning their health. If they used to believe that there is no need to go to PHCs whether for vaccines or pregnancy or other, through the awareness that REBAHS project raised, people are learning the importance of visiting PHCs. For instance, in pregnancy, they understand that they should come back to the PHC for post-delivery services, family planning, and the importance of birth spacing and breast-feeding. The change in behavior associated with higher health awareness among beneficiaries is sustainable. In fact, this positive influence on some behaviors and attitudes informed the decision of community health clusters in REBAHS II.

As for the FFM pricing and subsidizing of medicine and tests, they are by default dependent on the amount of funding, and they will end when the funding ends. Sustainability of this aspect of the project should be coordinated with the MoPH and other actors who can continue to provide this type of financial support. The interviewees did not mention any active plans or coordination being done in this respect since the project is going into a new phase and it appears that an exit strategy is yet to be set in place.

Regarding the MH program, the integration of mental health into PHCCs is very promising. A core strategy for the MoPH has been to integrate mental health into PHCCs. This approach, which has been backed by multiple evidence, is key to promoting mental health, particularly in humanitarian settings. Although integrating mental health into PHCs is quite complex due to barriers ranging from lack of national policies in PHCCs to financing mechanisms and lack of trainings, interviewees indicated that IMC's experience has been both very promising and successful. This is also largely because the MoPH's strategy emphasizes the importance of this. A case manager noted that PHCCs have become better equipped to deal with mental health because of the training sessions received and the support from IMC. This approach has been particularly helpful in decreasing stigma, as people seeking mental health but "ashamed" of it would feel comfortable visiting a PHCC. Additionally, even within PHCCs, the room designated for sessions is labeled as social services

5 Conclusions and Recommendations

Relevance

The main conclusions in terms of the relevance of the project are:

- The REBAHS project has been very relevant to people's needs, tackling the financial barriers that hamper their access to primary health care. It has also been very relevant to the needs of PHCs in terms of capacity building and provision of needed equipment.
- The REBAHS program has been responsive to the changing needs of the community in light of the COVID 19 outbreak and has provided various types of support to the PHCs and beneficiaries.
- Some of the program outcome indicators can be better designed to be more specific and more accurately measured.

IMC's aim is to support PHCs so that the most vulnerable populations can have access to holistic, affordable, accessible, quality healthcare that is extremely expensive among private sector healthcare providers. This is necessary given the context of Lebanon's healthcare system, which is subjected to rampant privatization and inequality, with multiple obstacles to quality care.

In this respect there is need to:

- Provide continued support to MoPH to increase the sustainability of quality evidence-based primary healthcare being accessible to the most vulnerable populations in the future. The aim is to transform the sector from being purely based in the private sector to one that is also based on the public sector providing public health services to the community.
- It is important for the REBAHS program to be more attuned to gendered needs, especially in terms of mental health. While interventions appear to be culturally appropriate and attuned, there is a need to ensure gender mainstreaming within all services including training case managers on issues related to LGBTQ and SGBV survivors.

Coherence

In terms of coherence, the main findings are:

- The program has been coherent with regards to coordination with the actors in the target areas and avoiding duplication with other efforts. The close coordination with MoPH has contributed to maintaining the coherence of the program throughout its implementation. Moreover, as the largest actor in the healthcare support programs in Lebanon, and with its active work with PHCs and continues technical support to other NGOs, the project has a high value added.
- Some supply chain issues faced by partners in the program including MoPH, and YMCA regarding medications has led to delays in the provision of these medications and has led to some dissatisfaction with the program.

Therefore, in terms of recommendations, there is need to

- Create better coordination mechanisms to tackle the delays in the provision of medications**.** This can be done through setting more realistic and pragmatic expectations from each partner in their ability to deliver medications in a timely manner and be reflected in the budgets that are set for the provision of medications.
- Work on improving the speed of response in terms of procurement of medications

Effectiveness

The main conclusions regarding the effectiveness of the program are:

- The program has been largely successful in achieving its intended outcomes as measured by the 10 outcome indicators.
- Interviewed IMC members and PHC staff all agree that the most important achievement of the REBAHS program has been the reduced expenditure on health services through the FFM through the various packages that is has offered. The obstetric/ gynecology package was the most praised package that patients had benefitted most of.
- Capacity building was also very successful. Interviewees agreed that it changed the entire system of primary health care at the target centers. For example, most centers now know what it means to have data, its importance and that of the HIS, how they can use it to prevent diseases in the community or assess its needs, and accordingly changing or improving their services. In addition, the PHC now have a better understanding of safety in management; for instance, how to avoid the spread of diseases, how to set electrical cables in a safe manner, how to perform infection control practices in making beds, storing syringes, etc.
- The MHPSS program has also ensured adequate response to the needs of clients through the case management system and the referrals to specialists when needed. The Client Functioning Scale tool as well as the improved documentation and filing has contributed to better client follow up and an overall improved response.
- The outreach aspect of the MH program needs to place more efforts into increasing the levels of spreading knowledge and awareness about mental health and reducing stigma surrounding this topic. Behavioral change is a long-term goal that can take years to achieve, so adjusting targets and expectations is also something the MH program can look into.
- Two out of ten set targets were not reached according to the figures generated for the outcome indicators. The rest were achieved and went much beyond the targets set for them, which also implies a need to revisit the target setting process or the means of calculating the outcome indicators.
- The main inhibiting factors for the implementation of the project are related to some practices of physicians not adhering to the protocols set by the ministry such as irrational medication prescription, and over ordering diagnostic tests. The project is working on raising the awareness of physicians and changing their practices, as well as creating systems that can easily identify these issues.
- There were gaps in the measurability of some variables, which led to under-estimating or over-estimating their values, or even rendered their measurement not possible using the end line survey data.

In terms of recommendations,

- As the REBAHS approach has been very welcomed and praised by the beneficiaries and PHCs, it is important to document the most evident success stories that can be adopted in the other interventions that are supported by the MoPH.
- MoPH and actors in the healthcare sector in Lebanon can capitalize on the change in the conceptualization of primary healthcare that the REBAHS project has been able to instill among PHC staff and members.
- The introduction of mental health into the primary healthcare system is an achievement that needs to be modelled and adopted by more PHCs in the country.
- More work needs to be done in terms of changing knowledge and attitudes towards mental health; while there has been a de-stigmatization, there is still a need for outreach and sustained community events that target and address sensitive mental health issues, such as suicidal thoughts.
- It is also recommended for IMC to network with local grassroots organizations, such as Embrace Lebanon, to broach the issue of mental health especially in light of the lockdown and increasing economic crisis which is bound to have detrimental effects on vulnerable groups.

Efficiency

The main conclusions related to efficiency are:

- The project has largely been efficient in the use of time for achieving the planned outcomes. IMC staff noted that there was neither overspending not underspending; however, some reallocations within the budget were done towards the end of the first year in order to ensure a better transition to the second year. This delineates flexibility within the budget, which contributes to the project's efficiency.
- There is proper coordination and structure on an internal level, amongst the IMC team.
- The program's activities were also efficient in terms of timing. Most activities happened within the time framework, with the exception of a two month no-cost extension to the 23-month project in order to avoid a gap in the provision of services between MADAD I and MADAD II.
- Targets have been achieved, with the exception of the indicator pertaining to the number of beneficiaries who reported being satisfied with the health services (87% of target has been achieved).

Recommendations, therefore, include:

- Coordinating better with PHCs and clarifying when and why there will be time delays. Some PHCs flagged some delays with regards to REBAHS project activities, which overwhelmed doctors and led to an accumulation of cases sometimes. It is also important to prioritize the provision of PWD-related equipment, including wheelchairs and physiotherapy machines, as PHC staff reiterated that there was usually a delay in their provision.

As MoPH and actors in the healthcare sector including IMC and partners are working on strengthening the system at the PHC level, there is need to evaluate the quickest and most efficient way to communicate urgent cases. Interviewees noted that previously, using WhatsApp – as opposed to the PHENICS system – to approve cases was faster; however, this is not in line with the overall national strategy. REBAHS I allowed IMC to pilot PHENICS for diagnostic pre-approvals. Lessons learnt in that regard paved the way for expanding the use of PHENICS in all PHCs supported under REBAHS II. Therefore, continued efforts in rendering PHENICS more efficient in dealing with urgent cases is something to be worked on in the future.

Sustainability

In terms of sustainability, the below are the findings:

- The capacity building and training have all been deemed as sustainable activities since they have been incorporated into the upgraded daily functioning of the PHCs. PHCs have also incorporated the skills and knowledge obtained from the trainings into their daily practices. Moreover, the equipment provided by IMC will also be used.
- However, as expected, the FFM model is not viewed as such since many patients are expected to stop going to the PHCs if they have to pay more than the 3,000 flat fee rates.
- The integration of mental health services into PHCs, coupled with the synergizing and coordination with the MoPH, are also sustainable practices that will have long-term impacts.
- The awareness raising amongst beneficiaries, through outreach sessions and community groups, is also a way of ensuring sustainability of better healthcare practices as it might lead to change in daily healthcare practices.
- Costs, however, will remain a huge barrier for patients if IMC's services are no longer provided. This is likely to increase given the current economic crisis and the ongoing devaluation of the Lebanese lira, which will also affect the pricing of PHC services.

In this respect,

- An exit strategy needs to be set in place that provides options for new funding for PHCs as well as negotiates discounts with labs for diagnostic tests.
- Due to the recent inflation and devaluation of the Lebanese Lira, the purchasing power of a large share of residents has decreased significantly, and it is anticipated that many families will shift their reliance on secondary healthcare to more affordable primary healthcare. Having a strong system in place can play a crucial role in absorbing this shock of increased demand and be able to take in the increased number of patients. Therefore, continued funding, institutional support, and technical capacity building during these times of crisis is key to sustain the ability of a resilient PHC system to provide quality healthcare services.
- The MoPH needs to play a central role in the sustainability of this action through increased investment in this type of healthcare support program. The REBAHS has been successful in setting the platform for future investments that follow a similar model that includes the FFM for beneficiaries accompanied by provision of trainings and wareness sessions aimed at changing

attitude and behaviors towards hygiene practices, family planning, and other aspects of healthcare, in addition to various types of support to PHCS

Annex 1

Interview Guidelines for IMC and Partners staff

Interview with IMC staff and partners (including project managers from IMC, PUI and FPS, PHCC management and staff, and service providers)

Introduction

1. Tell us a bit more about your role with IMC/partners?

Relevance: Now we are going to talk a bit about how significant has the REBAHS project been vis-à-vis national priorities and requirements

1. What is your general understanding of Lebanon's healthcare sector? How do you think the recent October 17 events have affected the sector? (Probe to understand how the sector/IMC are adapting to the dollar shortage?)
2. What are the main barriers and gaps in the healthcare sector?
    a. Who has access to the healthcare sector? Who doesn't?
3. To what extent are the current activities meeting the health needs in Lebanon? Can you provide us with specific examples,
    a. Do the project's assumptions match the attitudes and experiences of the target population? How was this assessed?
    b. To what extent are the free of charge services provided relevant to the reduction of the economic barriers to accessing health care services for the target population?
4. Do beneficiaries feel that the assistance provided by the project meets their most important needs?
    a. How do beneficiaries feel about the services provided?
5. How appropriate were the planned results and their associated indicators? (ASKED TO IMC AND PARTNER MANAGEMENT STAFF ONLY)
6. To what extent is there a need to reformulate the package design given changes in the country, health status of the population and operational context?
7. To what extent are the activities conflict sensitive and culturally appropriate?

Coherence: Now we are going to talk a bit about how well the REBAHS project fits into the Lebanese healthcare provision context

8. Are there synergies and linkages between the REBAHS project and other IMC and partner interventions performed in the target areas? (ASKED TO IMC AND PARTNER MANAGEMENT STAFF ONLY)
9. Is there complementarity, and co-ordination with other actors in the target areas?
10. To what extent is the intervention is adding value while avoiding duplication of effort?

Effectiveness: We now move to talk about whether the REBAHS project has achieved its goals and objectives

11. What are the project's intended outputs and objectives according to what you know?
12. How well has the project achieved these outputs and outcomes, considering Lebanon's political, social, and cultural risks?
    a. What were the program's biggest achievements (success stories)?
13. What were the project's main challenges? [Probe on management, community outreach, beneficiary satisfaction, access to mental health care services)
    a. Based on the satisfaction survey, it was shown that nearly half respondents were not satisfied with the availability and provision of pharmaceutical drugs and diagnostic tests coverage. How have these challenges been tackled, if they have?
    b. Visibility and outreach also scored low on the survey. How have these issues been tackled?
    c. How did the program's adaptation and changes help tackle these challenges?
14. To what extent was the programme design adequate and effective in responding to the mental health needs in a way that guarantees results? (FOR MENTAL HEALTH RESPONDENTS)
    a. What is a success story from the mental health services provided?
    b. What have been the main challenges in accessing mental health services?
    c. [For case managers, community health workers, primary healthcare providers, psychotherapists and psychiatrists]. How was the training you received? How does it compare to other training received, if any? What would you have changed?
15. What are other enabling or inhibiting factors that were beyond the control of the programmes management structures?
16. How measurable were the project indicators?
17. To what extent did the subsidized services contribute to the reduction the economic barriers to accessing health care services for the target population?
18. To what extent did the programme lead to changes in knowledge, attitudes and access to mental health services in the targeted communities?

Efficiency: We move to discuss whether the REBAHS project has achieved its objectives economically

19. Are the results being achieved at the expected cost set before project implementation? ASKED TO IMC AND PARTNER MANAGEMENT STAFF ONLY)
20. Has the project implementation differed from the budgeted costs? ASKED TO IMC AND PARTNER MANAGEMENT STAFF ONLY)

a. Is there a proper breakdown of the budget available?

21. Did the project implementation happen according to the timeframe?
22. To what extent are the program's activities in line with the schedule of activities as defined in the annual work plans?
23. Was there adequate coordination and planning among program teams?

Sustainability: Lastly we will talk briefly about how likely it is for REBAHS project activities to continue after the funding ends

24. Will programme activities continue after programme funding? Which activities are likely to not continue?
25. How well and to what extent have activities throughout the project focused on ensuring sustainability of services post REBAHS funding?

Exit

26. Is there anything you would like to add related to our discussion that can be useful for this outcome evaluation?

Interview Guidelines for Municipalities and Community Leaders

Introduce to the municipality member the purpose of the interview, and tell them their opinion in this assessment is an essential way to understand more community and local dynamics, and already existing healthcare interventions.

Introduction

1. What is your role within this community?
2. Which areas do you work in/supervise?
3. What are the main challenges people living in this community face? In particular, what are the challenges vulnerable refugees and Lebanese in this community face? [Probe about gender issues]
    a. What have been the main changes in Lebanon since the arrival of the Syrian refugees? In terms of health mainly, but also access to services, infrastructure, poverty levels, customs/traditions etc.
4. Lebanon's medical practitioners and public officials are warning that hospitals may soon not be able to provide patients with life-saving surgery and urgent medical care because of a financial crisis. How has this impacted your area? How has it impacted the communities within it?

Relevance, accountability, and inclusivity: Community's access to healthcare

1. What are the healthcare facilities and services available in your community? [Probe about government services, NGO coverage, informal "Arab" doctors, and ask about the different hospitals, primary healthcare centers available]
    a. Are hospitals (public, private) and primary healthcare centers well-equipped?
2. Probe to understand whether Lebanese and Syrians access services in the same healthcare centers, or whether they go at different times
3. Probe to understand whether there are tensions between Syrians and Lebanese when accessing and using health care services, if yes, about what?
4. What specific services are available to those with mental health issues? Who can access them? Who does not have easy access to them?
5. How easy is it for girls to go to the doctor if they need to? Are there any barriers for girls to go to the doctor [For example, is it too expensive, too far away, stigma, etc.]
    a. In what ways has the municipality worked on/addressed/knows of GBV concerns in the area?
    b. How easy is it for girls to go to seek specifically SRH services? What about consultations available during cases of GBV?
6. If community members wanted to know more about any "sensitive" health concerns, like menstrual hygiene management or other sexual or reproductive health issues, could they obtain information? Where or to who would they go to get the information?

Knowledge of REBAHS: We are now going to ask you a few questions about the REBAHS project in particular.

7. Have you heard of the REBAHS project implemented by IMC and partners?
    a. Probe on what/whether they've heard of IMSC's emergency response, its support of PHCs, IMC volunteers supporting on community health, GBV response, and its mental health and psychosocial support
    b. Discuss the intervention's outcomes (i.e. community health services, mental health and psychosocial support, and improved access to quality health services).
        i. Ask them what they think the main focus should be when considering community health services – match this in the conversation to what IMC provides (i.e. awareness raising, health screening, referrals)
        ii. Ask them what they think of mental health services provision, whether they perceive it as important, who they think needs it the most, and why
8. In what other ways do you think IMC and partners can support the community, especially in terms of reducing economic barriers to accessing healthcare?

Exit

9. Is there anything you would like to add related to our discussion before we end our meeting?