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Reducing Economic Barriers to Accessing Health Services in Lebanon

THE EUROPEAN UNION REGIONAL TRUST FUND IN RESPONSE TO THE SYRIAN CRISIS 'The Madad Fund'

Process Evaluation Report – 2019

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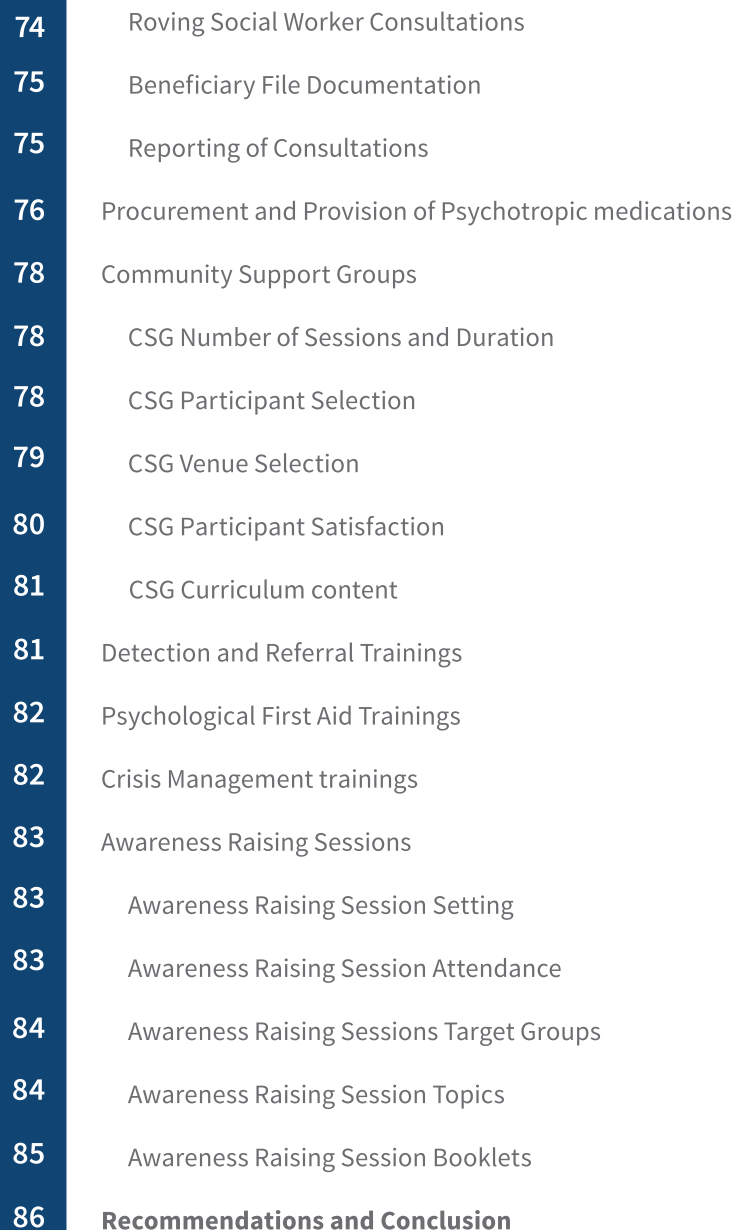

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Health Program

International Medical Corps

Acknowledgement

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List of Abbreviations

ANC: Antenatal care

CHOs: Community Health Officers

CHSs: Community Health Supervisors

CHWs: Community health workers

EPHRP: Emergency Primary Healthcare Restoration Project

FFM: Flat Free Model

FGD: Focus Group Discussion

FMA: Field Medical Advisor

FPS: Fundación Promoción Social

IMC: International Medical Corps

IUD: Intra-Uterine Device

KII: Key Informant Interview

MEAL: Monitoring, Evaluation, Accountability and Learning

M&E: Monitoring and Evaluation

MHPSS: Mental Health and Psychosocial Support

MoPH: Ministry of Public Health

MRI: Magnetic Resonance Imaging

NFI: Non-Food Item

NGO: Non-Governmental Organisation

Ob/Gyn: Obstetrics and Gynecology

PHCC: Primary HealthCare Centre

PU-AMI: Première Urgence - Aide Médicale Internationale

PSS: Patient Satisfaction Survey

PNC: Postnatal Care

SOPs: Standards Operating Procedures

UNHCR: United Nations High Commissioner for Refugees

Executive Summary

As part of IMC's continuous effort to ensure proper implementation, a process evaluation study was conducted to identify the main elements of achievements, and challenges in addition to the recommendations.

The aim of this study is to improve current activities, provide support and evidence for sustainability, provide insight into why certain activities are or are not being accomplished, and help project management teams make informed decisions.

A series of workshops were conducted with consortium partners; Première Urgence - Aide Médicale Internationale(PU-AMI) & Fundación Promoción Social (FPS) during August & September 2018 to review some of the main areas of the REBAHS project implementation. Accordingly, an evaluation matrix was developed including the main questions to be addressed, the focal points, the tools and the timeframe. As a result, quantitative and qualitative data were collected from beneficiaries, clinic managers, field and central IMC staff by the MEAL team between October and December 2018.

The PHCC level analysis concluded that the current selection of clinics covered most of the vulnerable areas in need of primary health care. Challenges related to follow up with clinics, the FFM and the newly supported staff at the clinics were noted. Additionally, the compliance of PHCCs to the contract terms, and beneficiaries' expectations were raised.

Overall, there was a general consensus that the current team structures have the capacity to implement the project. However, it was highlighted that there is a need for additional staff in several departments per area to assist with the monitoring and verification of activities.

The diagnostic test packages provided under the REBAHS projects were described as successful and aligned with the needs of the beneficiaries. However, some concerns were raised regarding the process of approval and the lack of flexibility of the packages. Furthermore, the status of the acute illness medication was generally described as in shortage with the main reasons attributed to the lengthy process of the first medication procurement and the widening gap of MoPH initially proposed support of acute illness medications.

Regarding the quality component of REBAHS, the were some concerns raised about the sustainability and the practicality of meeting some of the suggested standards of the quality program.

As for the community health program, the implementation of awareness sessions and referrals were regarded as the main activities though some limitations regarding the processes of beneficiary selection for awareness sessions, and follow up on referrals were highlighted by program teams and will be discussed below.

In summary, all program activities have been implemented with significant attention and follow up from International Medical Corps staff to ensure proposal commitments have been achieved. Based on the findings, several recommendations and action points were set in order to improve the general implementation of the REBAHS project and ensure proper integration of lessons learned into implementation.

Introduction

Throughout 2018, International Medical Corps implemented a project entitled 'Reducing Economic Barriers to Accessing Health Services in Lebanon' (REBAHS) funded by the European Union Regional Trust Fund in response to the Syrian crisis. International Medical Corps worked during 2018 with identified consortium partners, PU-AMI and FPS, to improve access to quality primary health care, community health, and mental health services for Syrian refugees and other vulnerable populations in Beirut and Mount Lebanon, Akkar, Tripoli, Bekaa, and the South.
The overall objective of the proposed intervention is to reduce the vulnerability of crisis affected populations through the provision of health and mental health services across Lebanon, with a focus on Syrian refugees. Consortium partners, work to bolster the capacity of the local health system to better deliver an affordable and comprehensive package of quality health services in Lebanon to improve the physical and mental health of refugees and vulnerable members of the host population. The specific objectives outlining the project are as follows:

1- Improved access to quality health services for Syrian refugees and other vulnerable populations in Lebanon: Activities related to this specific objective include the support of 31 PHCCs all over Lebanon, provision of comprehensive primary health care, training of PHCC staff and promoting quality improvements at PHCCs.
2- Provision of community health services focusing on health promotion, disease prevention and health seeking behaviour: Activities related to this specific objective include conducting awareness campaigns, health screenings, and health referrals.
3- Improved well-being of Syrian refugees and vulnerable Lebanese population receiving mental health and psychosocial support services: Activities related to this specific objective include the provision of MHPSS services through case management teams and roving social workers, Mental Health Capacity building for front-line staff and PHC providers, awareness raising sessions and community support groups.

As part of the MEAL strategy and activities, the process evaluation has been proposed to review some of the main implementation components of the first two specific objectives listed above. In addition to monthly follow up on program targets, satisfaction surveys and post distribution monitoring, the Health Program Team could rely on the findings below to modify certain implementation modalities accordingly.

The sections below detail the methodology of the process evaluation conducted by IMC MEAL team regarding the Health program component of the REBAHS project. This section includes details on study development, data sources, tools identification, ethical consideration, and data collection and analysis.
The results are then presented per theme or indicator with respective recommendations.

Methodology

Evaluation Design

Due to the complexity of the REBAHS intervention from the number of groups and organizations involved, to the diversified target population, a process evaluation research study using a mixed method approach was adopted. These evaluations are recommended to identify key success factors, areas in need of optimization, and failures of the intervention[1].

The objectives of this activity are:

1. Determines whether program activities have been implemented as intended

2. Improve current activities

3. Provide guidance on replication of the intervention

4. Provide insight into why certain activities are not being accomplished

5. Help project management teams make informed decisions

Four main pillars were examined under the umbrella of the process evaluation:

1- Appropriateness: measures the appropriateness of the implementation process and answers whether it is replicable

2- Fidelity: measures how much are we in line with the design

3- Satisfaction: understanding stakeholder satisfaction

4- Logistics: analyses the workflow and order of tasks as well as the available logistics for the project implementation.

Several workshops were organized by International Medical Corps MEAL Team with round table discussions on the project implementation during August and September 2018. The attendees included the main central staff; Deputy Country Director, Health Program Coordinator, Deputy Health Coordinator, Senior Medical Advisor, and Community Health Manager from the program team in addition to the MEAL manager, Regional M&E coordinator, and M&E Officer.

Attendees were able to identify several issues related to the process of implementation of the REBAHS project that were transcribed into questions under four process evaluation pillars. The questions were logged under the respective process evaluation pillar and used to create the health evaluation matrix. The latter was used to design and or modify, primary data collection sources (quantitative and qualitative) as well as secondary data collection sources (Desk reviews of available documents and datasets) based on the suggested questions.

[1] https://www.bmj.com/content/337/bmj.a1655

Sampling Method

Quantitative data (PSS) for was collected from 11 clinics selected out of the 31 supported clinics under the REBAHS project using a multi-stage sampling strategy. Based on International Medical Corps regional guidelines, around 35% (11) of the supported facilities were covered. The selection of clinics per area was based on the proportion of clinics per area, and the final clinic to be selected in each area was identified using simple random sample. Clinic managers of the same 11 clinics were interviewed as part of the qualitative data collection.
The results of the clinic selection are presented in the table below.

The total number of consultations provided across 11 selected health facilities during June, July & August served as survey population. An online sample size calculator[2] was used to determine the number of surveys to be collected based on population size 25,848 (during June, July, August 2018), 95% confidence level, 50% response distribution and 5% margin of error. Additional details are found in Table 1 below.

Table 1: List of the 11 REBAHS supported clinics selected for Quantitative data collection.

Area	Clinic Name	Average Monthly Number of patients	Number of Surveys Actually Collected	Number of Surveys Collected (7% additional surveys accounting for non-response rate)
Tripoli	1. Iman Medical Association- Sir Dinniye	1142	34	38
Akkar	2-Iman Medical Association- Bebnine	986	47	50
	3-Advanced Medical Center–Mashta Hassan	447	22	25
Beqaa	4-MoSA Social Development Center Baalback	496	11	16
	5-Bar Elias Governmental Center	2219	55	55
	6-Al Enaya Medical Dispensary	1572	37	40
Beirut Mount – Lebanon	7-Al Zahraa Zokak el Blat	727	33	35
	8-Al Kayan Association Haret Hreik	1275	58	59
	9-Wadih El Hage Medical Center Baskinta	285	12	12
South	10-Mowasat Charity Association - Nazih Bizri	597	40	44
	11-Caritas Center - Saida	430	29	33
Total	**11**	**10176**	**378**	**407**

[2] http://www.raosoft.com/samplesize.html

For the qualitative data collection, the following stakeholders were approached for interviews or discussions. The selection of the below candidates was based on the workshop discussions and health evaluation matrix. The selected candidates were considered as the most knowledgeable with regards to certain areas of implementation. Table 2 below summarizes the participants in qualitative data collection.

Table 2: List of Participants in the Qualitative data collection.

Key Informant Interviews		Focus Group Discussion Participants	
Informant	Location	Informant	Location
11 Clinic Managers	11 selected clinics out of 31 clinics	39 Community Health Workers	5 Discussions / one per area
Health Program Coordinator	Central Staff	4 Community Health Officers	One CHO per area, except for Tripoli who couldn't attend
Senior Medical Advisor	Central Staff	6 Quality Officers	One per area, except for BML (2 Officers)
Senior Pharmacist	Central Staff		
Community Health Manager	Central Staff		
Quality Program Manager	Central Staff		
5 Area Managers	Field Staff		
5 Senior Health Officers	Field Staff		

Design of Tools

For the quantitative data collection, a previously tested Patient Satisfaction Survey was used. The survey was designed by International Medical Corps Middle East regional office and is the recommended quantitative methodology to elicit information from the perspective of beneficiaries and measure satisfaction with health services. Demographic questions covering age, sex, and disability are included in addition to the 11 dimensions of satisfaction addressing ease of access, operational hours, cleanliness of the facility, waiting area, personal conduct of the medical and non-medical staff, waiting times, quality and comprehensiveness of information provided regarding the services, access to educational material, privacy and confidentiality during consultations, availability of pharmaceuticals and coverage of diagnostic tests.

The qualitative data collection tools were designed following the process evaluation workshops. The discussions during these workshops were consolidated into a program specific matrix with all the important issues and questions in need of clarification and discussions amongst various stakeholders. The evaluation matrix was used as a blueprint for the design of the various qualitative data collection tools such as the interview guides for the KI and FGDs. The resulting health matrix was then reviewed by the MEAL team with the collaboration of the Regional M&E coordinator. Each tool included an outlined script with the main aim of this study and a list of open ended questions relevant to the topic in discussion.

For International Medical Corps Staff, the guide included questions about their job description, actual tasks, workflow within respective departments as well as the main REBAHS project components (FFM, Supported clinics, Medications, Diagnostic test packages and others). For Clinic managers, the guide included questions regarding the inception phase of the project. All participants were asked about their satisfaction with the project and its implementation as well as the main elements of success and areas in need of improvement.

The design of the tools was mainly led by the Health M&E Officer with review from the MEAL manager, regional M&E advisor, and consortium partners who adopted and adapted the tools.

Data Collection

The quantitative data collection was led by the M&E assistant and officer after the design of a timetable. The MEAL team recruited and trained four enumerators (Three for Health data collection and One for Mental Health) who assisted in the PSS data collection from October 19th to November 2nd, 2018. The M&E Assistant was the team leader on the field responsible for all review of data collected and the final review was done by the M&E Officer.

Beneficiaries were approached as they were leaving the health facility as an exit survey. Individuals were given full explanation regarding their participation and the objectives of this study. Beneficiaries who refused to participate and those who were under the age of 18 and showed absence of a parent or caregiver were excluded from participation.

Based on availability, all data collection was conducted in private rooms at the PHCCs or patients were asked to exit the facility and the survey was administered privately outside the PHCC.

Prior to all data collection activities, the approval of the MoPH was obtained. Subsequently, central staff coordinated with the selected 11 clinics and discussed the purpose of the data collection.

In parallel, interviews with clinic managers were being conducted by the M&E officer and assistant starting November 2nd 2018. Scheduling of the remaining interviews and focus group discussions took place in parallel based on staff availability and all data collection activities were finalized by December 2018.

Interviews and Discussions were only recorded in case participants approved. The recordings were used to develop transcripts.

Documents selected for desk review, such as program SOPs or other national documents and reports were requested from assigned focal points or retrieved from official online websites.

Ethical Considerations

For the quantitative and qualitative data collection, patients and participants were asked for their consent to participate in the PSS, KII or FGD. Participants were given full explanation about the objectives of the study. Individuals were also told that participation is optional and not obligatory and that it does not guarantee the addition of any health service to the current package delivered to them by the consortium partners and does not affect their employment status with the consortium partners. Respondents were also assured that the only utilization of the data provided would be to improve the quality of care they receive at the centres and that reporting on the findings will be confidential. After their consent, the data collection began.

Because of our continuous efforts to ensure patient and data confidentiality, the following measures were adopted by the MEAL team. For the quantitative data collection, all surveys were collected anonymously without any patient identifiers. For the qualitative data collection, an informed consent was provided to all participants. During all the interviews and group discussions, detailed notes were taken and based on the participants' preferences, a recording of the session was made. The recordings were only accessible to the M&E Office, M&E assistant, and an external research assistant who worked on transcribing, coding and reporting of qualitative data. All recordings and notes were deleted after the finalization of the report.

Data Analysis

After the completion of PSS data collection, data cleaning was conducted by the M&E assistant to ensure correct and complete data prior to the analysis. Descriptive and Bivariate analysis were conducted on the finalized data set.

All focus groups and in-depth interviews were transcribed and translated into English. A thematic approach was used to conduct the analysis of the data lead by a recruited Research Assistant. As an initial step, each transcript was read and re-read to familiarize with the information. The codes were then generated based on the six main aspects of the project activities, where each indicator was sub-categorized into four main pillars of process evaluation (appropriateness, fidelity, satisfaction, and logistics). Findings were provided a narrative with some quotes from the interviewees supporting the theme or sub-themes.

Results

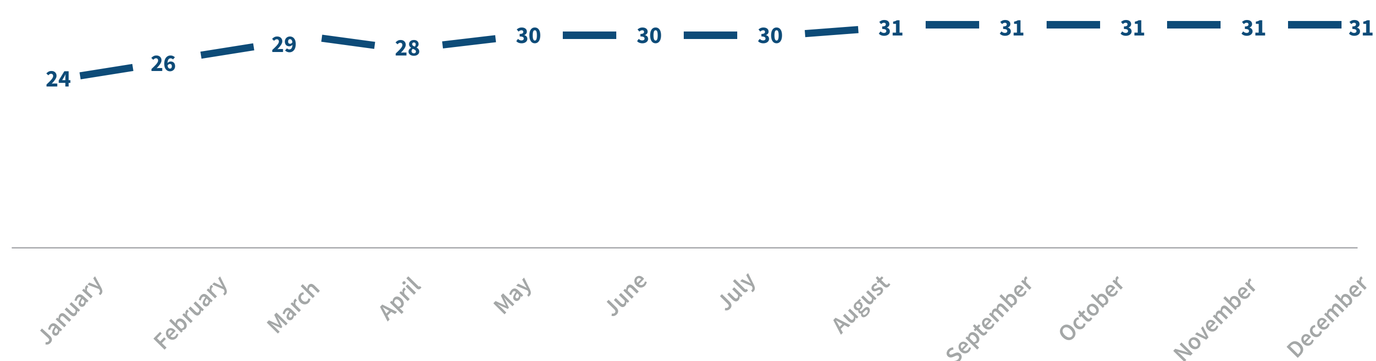
I. PHCC level analysis

As a first step towards understanding the implementation of the project; the layout, contract and work of the PHCCs were investigated. The analysis below identifies the main elements of success with International Medical Corps' approach to the facilities as well as the components in need of improvement.

In order to provide affordable quality primary healthcare services for refugees and vulnerable Lebanese, IMC worked through contracting PHCCs all over Lebanon. This section includes an analysis of the selection of the 31 supported facilities delivering the majority of the project's intended services.

During the project's preparation phase, a discussion with UNHCR and the MoPH resulted in a shortlisting of 31 clinics were selected to participate in this project. The list was then edited after discussions with health and consortium partners. The project was launched with a final list of clinics including 27 previously supported PHCCs by International Medical Corps under different grant's and 4 new ones. In January 2018, International Medical Corps was able to launch the project with 24 out of the 27 clinics mainly due to previous support in 2017. Delays in re-contracting of the 3 out of the 27 clinics were mainly due to ministry approvals and the 31 facilities were finalized by August 2018. The 4 clinics newly contracted by IMC were Al Enaya Medical Dispensary, Ghazze Health Centre, Al Zahraa Zokak el Blat and Emergency Association Bent El Hoda – Sabra. Dar El Wafaa – Ghawth for Relief was later contracted as a replacement for a clinic in Mount Lebanon area. Figure 1 below represent the scale up of supported facilities throughout 2018. The list of the 31 REBAHS supported clinics per area during December 2018 is presented in Annex A.

Figure 1:SCALE UP OF REBAHS CLINICS THROUGHOUT 2018



The 2018 supported facilities all over Lebanon covered many of the highlighted gaps in the VaSyR 2017 report. For example, the repartition of clinics addressed the mentioned needs in the report in all areas. An example would be the Beqaa area with several clinics working towards maintaining a relatively low level (4.8%)[3] of households that are not receiving the required health care services.

On the other hand, issues related to the geographical spread of the services were noted. The VaSyR3 report stated that a quarter of the households who required health care in Mount Lebanon did not receive any service. Although 9 clinics are supported in Mount Lebanon Governorate, no clinic is contracted in Aley despite the fact that the area within the governorate had the highest rate (Greater than 40%) of households in need of primary health service but did not have access. In addition, some of the clinics contracted are located near facilities supported by consortium partners or other NGOs noting that they may be offering similar health services completely free of charge. Program teams were made aware of these issues and will be addressing them in the future to ensure the optimal allocation of available resources and geographical spread, thus allowing more individuals to benefit from available services when needed.

During the preparation phase, International Medical Corps program staff drafted new contracts for the clinics which included all project details. Program teams also prepared guidelines for staff during field project implementation to help guide some of the newly introduced packages and models under the REBAHS project. Despite the efforts put during the preparation phase in drafting these documents, several issues were reported.

At the beginning of the project, a half day inception orientation was given to the senior field staff who in return briefed the field and clinic staff. The orientation was reported as not sufficient by almost all informants claiming that it contributed greatly to the confusion associated with the launch of the project up to 6 months. Full day trainings were suggested by staff for future projects to ensure smoother implementation.

During the first half of Year 1, several changes were made to the original contract signed with the PHCCs. These changes, represented in Table 3 below, have contributed to the confusion reported above. International Medical Corps staff had to increase their follow up with the clinics to ensure proper implementation of the contract changes. No contract changes were made during the second half of Year 1.

Table 3: Main changes to PHCC contracts during 2018.

First Half – Year 1						
Contract Changes	January	February	March	April	May	June
IMC stopped reimbursing Vaccinations performed by Doctors as peran MoPH circular				X		
Amendment of PNC timeframe coverage from 6 to 8 weeks					X	
Allow Coverage of Lebanese EPHRP Patients based on specific conditions following consultation with MoPH						X

[3] https://reliefweb.int/sites/reliefweb.int/files/resources/VASyR%202017.compressed.pdf

In terms of the influence of these changes on the clinics and health services, opinions varied between those who viewed these changes as a beneficial expansion of the REBHAS projects and others who believed that the complications introduced by the changes outweigh the benefits. For example, although an MoPH circular was previously circulated regarding vaccinations, several KIs noted that once the contract included such clause, 'we faced resistance from 50% of the PHCCs to shift the task from doctors to nurses'.

Despite the fact that the majority of the clinics participating in the project were previously contracted by IMC, the shift to the FFM model was challenging. Implementation preparedness varied greatly between clinics where in some clinics, the load of patients received was higher than the clinic's capacity. As a result, field staff had to allocate resources to make sure the needed support is available and many reported an increase in the workload especially due to the many grants working in parallel.

In addition, some clinic managers reported concerns regarding the strict policies of contract termination, the limitation on performance it implies and the threat of sustainability. On the other hand, International Medical Corps staff raised concerns of fraudulent behaviour at the PHCCs were raised as main risk factors for the project due to its financial model. Patient file monitoring and medical records assessments are being conducted on monthly and quarterly basis as medical and non-medical auditing to selected patient files at the clinics.

For the patient file monitoring, a fixed number of 16 files are selected randomly each month from the raw data for auditing by the field pharmacist. Since this activity started in June 2018, almost 5% of the audited files (191 out of 3449) were classified as Ghost Files, file numbers found in health information system with no supporting medical record found. International Medical Corps is currently in the process of revising this activity and considering the possible follow up actions once ghost files are identified.

Some logistical challenges were reported by several clinic managers regarding the immense administrative work required, such as the added documentation required for diagnostic tests which was perceived as a distraction from the main service provision. In light of that, one clinic manager requested the need for 'less administrative work and more humanitarian work'.

The project proposed to compensate one staff member per PHCC to cover the additional workload on clinics. Based on needs, a nurse, a midwife or a data entry clerk was recruited by the clinic. When clinic managers were asked about the new staff, some reported content with the new recruits since they are supporting the clinics to cover a gap. Others highlighted the need for additional recruits in specific fields including nurses, as well as personnel for data entry and/or administrative duties. Almost all KIs stated that the decision to allow the PHCCs to recruit the staff was appropriate. However, few International Medical Corps field staff noted that they had no involvement in the recruitment process and hence the staff recruited does not have all the needed skills.

Based on qualitative findings, some PHCCs prioritized patients who are seeking services that are not subsidized over project beneficiaries. These beneficiaries were provided with the services at the end of the working day. Evidently, this causes a service delivery barrier as some field staff claimed that beneficiaries would rather pay an extra amount of money rather than wait for extended periods. However, there were some opposing views reported by clinic managers noting that they have clearly instructed their staff to provide services similarly to all beneficiaries.

As a result, International Medical Corps has launched the Community Based Feedback and Response Mechanism through all clinics in order to identify these issues and address them. This policy was designed by International Medical Corps Lebanon team, reviewed by regional teams and implanted throughout Lebanon.

In summary, with regards to clinic selection, preparation, and early phases of implementation, some improvement to the project's launching strategy should be adopted when considering future projects. Such improvements could help ensure a smoother launching period especially when the project is relatively new to the various implementing partners. The following action points are suggested:

1- Meetings with PHCC managements in order to address increased workload (administrative).

2- Revision of recruitment of PHCC staff and level of involvement of International Medical Corps staff in the process.

3- Conduct quality meeting to address complaints and feedback raised through the CBFRM and address them jointly with PHCC management.

4- Reduce the possibility of several contract changes throughout the project implementation to ensure minimal confusion amongst implementing stakeholders.

5- Several full day trainings are suggested for future projects to ensure all staff (Field & Central, Management & Operational) understand the various project implementation elements.

6- Further initial assessments before clinic selection to reduce the duplication of work in some areas and ensure catchment areas in need are well served.

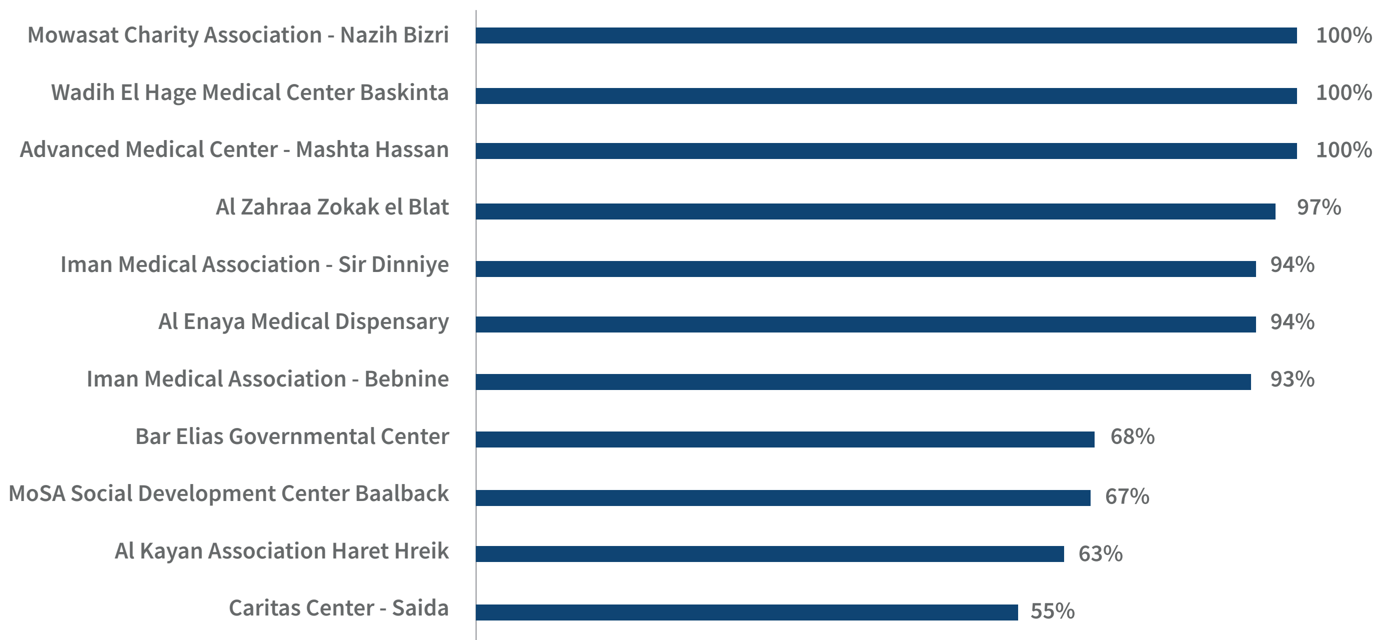
II. Satisfaction of Stakeholders

When asked about the overall satisfaction with the program, many KIs, central, field and clinic staff highlighted the importance of all services provided under this project as crucial and benefitting. One main success factors of the project were the reproductive health services in terms of ANC, PNC, and family planning, where more family planning packages such as IUDs have been made available to women free of charge. Another factor was the FFM itself with several participants noting that services beneficiaries receive for 3,00 L.L (2 USD) could help reduce their vulnerability. Many participants indicated achievements in the efficiency of the provided packages which were made 'more accessible and convenient for beneficiaries'. and that 'the major success is the decrease burden on refugees, not in terms of consultations but in terms of diagnostics and minor procedures'.

A patient satisfaction survey was conducted in 11 out of the 31 supported PHCCs selected using a multistage sampling strategy to capture the satisfaction of the beneficiaries. Individuals exiting the health facilities after finalizing the service were approached and asked to participate in the survey following a brief explanation of the purpose of survey. Beneficiaries were asked about sociodemographic characteristics as well as various aspects of the service received in addition to the 11 dimensions of satisfaction. The dimensions were then used to calculate the overall satisfaction and dimension specific satisfaction across the sample and by clinic.

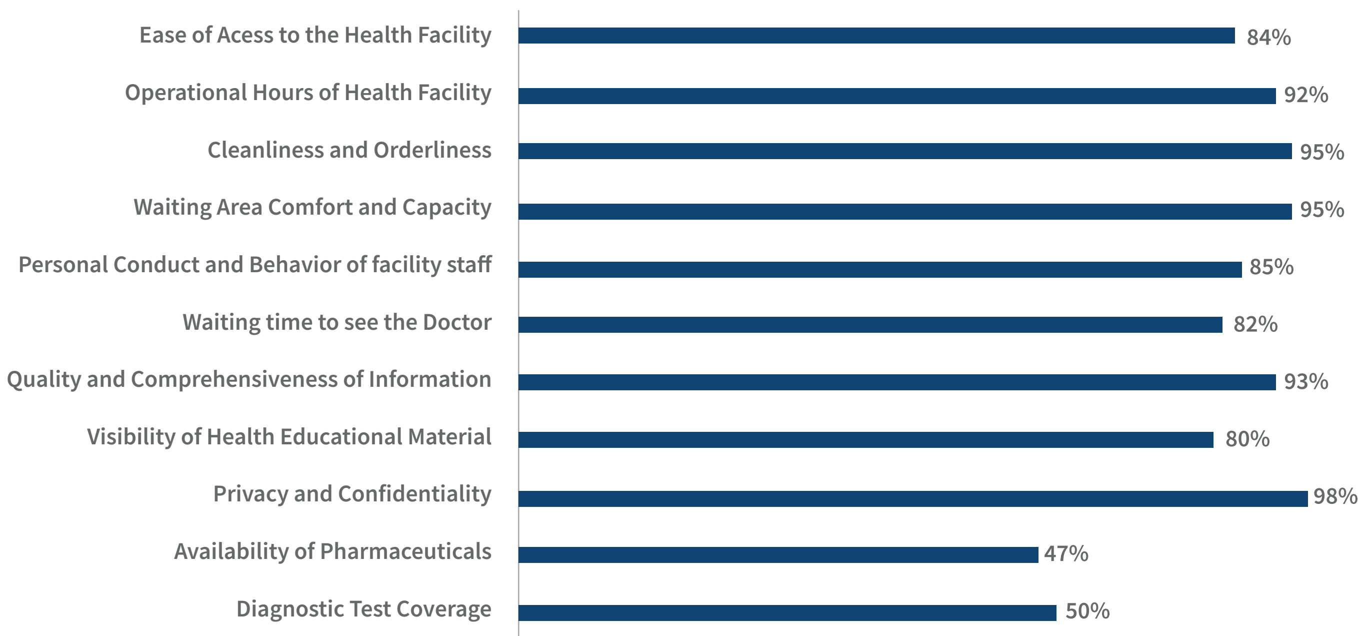
82 % of beneficiaries exiting the selected 11 REBAHS supported facilities reported an overall satisfaction with at least 8 out of the 11 (~75%) dimensions of satisfaction. The centers that scored the highest means of satisfaction were the Advanced Medical Center – Mashta Hassan, Mowasat Charity Association - Nazih Bizri and Wadih El Hage Medical Center Baskinta (100%) while the centers scoring the lowest rates were Al Kayan Association Haret Hreik (63%) followed by Caritas Center – Saida (55%) as per Figure 2below. To note that, a 100% satisfaction does not mean that all patients visiting the centres are satisfied with all aspects of the service.

Figure 2: Percentage of patients surveyed expressing satisfaction with services provided.



Itemized satisfaction shows that patients were highly satisfied (above 90%) with the structure of the PHCCs (cleanliness, waiting area comfort, operational hours and others) while the diagnostic test coverage scored a 50% satisfaction among the beneficiaries, followed by medications availability and prices with a satisfaction rate of 47% as per Figure 3 below.

Figure 3: Level of satisfaction per dimension



A standardized approach in collecting the PSS data was adopted in an attempt to reduce possible reporting bias by participants as per the regional guidelines. Despite the team's best efforts to collect impartial and accurate findings, there is always a possibility that participants did not feel empowered enough to express all their feelings towards the centre. This was further confirmed by some CHWs who reported dissatisfaction of some beneficiaries about the health services in the clinics stating that 'we provide referrals, and sometimes people get angry because when they get to the PHCC it's different than what we tell them'. One KI indicated that 'sometimes the project is misunderstood by the community, where beneficiaries have higher expectations and thus feel disappointed'.

In summary, most stakeholders were satisfied with the overall project and service delivery stating that the services provided were suitable for the target population. An element contributing to the success as reported by some staff was the constant follow up from IMC staff while several challenges were noted. Accordingly, the below recommendations are suggested:

1- Revision of the PSS tool due to the ceiling effect to ensure a more specific tool.

2- Discussion with programs on further needs assessment regarding pharmaceuticals and diagnostic tests to identify emerging needs.

III. Organizational structure, workload and coordination

Building on what was mentioned regarding the challenges faced due to the relatively fast transition to the new project model (Flat Fee Model), PHCC staff have reported an increased workload due to the increased influx of beneficiaries to the clinic. Moreover, workload complaints were also raised by several International Medical Corps staff stating the relatively intense follow up needed during the initial period of the project which launched in parallel with others.

Although the majority of program staff have stated that the current human resources are sufficient to implement the REBAHS project, it is important to mention that some key staff have recommended having a specific staff member per project covering all procurement and logistics requests.

Evidently, during the launching period, several issues related to coordination and staffing were faced particularly related to key contractual changes, unavailability of clinic staff (Doctors, nurses and others), and miscommunication between PHCCs and IMC staff as well as within IMC. For instance, some IMC Staff indicated that 'contract changes by IMC were not directly shared with the community workers causing miscommunication'. As a result, some of the shared information with the beneficiaries might not have been accurate or timely. Moreover, lack of proper coordination between IMC departments was pointed and the speed of information sharing within and outside of IMC might have a negative impact on service delivery. Another factor affecting the optimal service delivery was 'the lack of PHCC physicians' compliance with the packages at PHCC'. Moreover, 'the turnover of doctors in the PHCC' was also viewed by one KI as an obstacle 'because they [doctors] are not full-timers'.

As a conclusion, it was noticeable during the beginning of Year 1 of the project that there were some significant delays in coordination between different departments which delayed the communication of key messages (contractual changes) to the PHCCs and beneficiaries. Furthermore, findings have shown a lack of sufficient number of PHCC physicians and their limited schedules (Part-time). The below recommendations are made for future projects:

1- Frequent meeting (bi weekly meeting with program teams to ensure proper dissemination of messages)

2- Agree on minimal required staff at clinics contractually

3- Recruitment of additional staff to help with quality related activities and procurement.

IV. PHC Consultation provided for Syrian and other vulnerable populations at the supported PHCCs

Table 4: Logframe Consultation Indicators, Targets and Achievements for Year 1.

	Indicator	Baseline Value	Y1 Target	Y1 Achievement
Output 1.1.1	Number of PHC consultations provided for Syrian and other vulnerable populations at the supported PHCCs	595,284	192,407	313,735
Output 1.1.2	Number of antenatal consultations provided at the supported PHCCs	37,503	12,122	33,674
Output 1.1.5	Number of women attending at least one postnatal care visit at the supported health facilities	4,582	1,663	3,190

Through the contracting of the 31 PHCCs, International Medical Corps provided affordable quality primary healthcare services for refugees and vulnerable Lebanese beneficiaries. According to the proposal, under the FFM, patients will pay a subsidized consultation fee of 3,000 LBP and will receive all medically necessary imaging, diagnostic, and laboratory tests for free, as well as free medications on the Ministry of Public Health's 'Essential Medication List' during their visit to the PHCC. The proposal also indicates that consultations fees will be waived for certain groups identified as vulnerable by the PHCC staff.

The consultations provided at the PHCCs could be considered as one of the core activities of this project. From a monitoring perspective, the targets for Antenatal, Postnatal and PHC consultations were met by May, June and August 2018 by the time this report was finalized.

According to the data monitoring, qualitative & quantitative findings, the following reasons contributed to this early achievement:

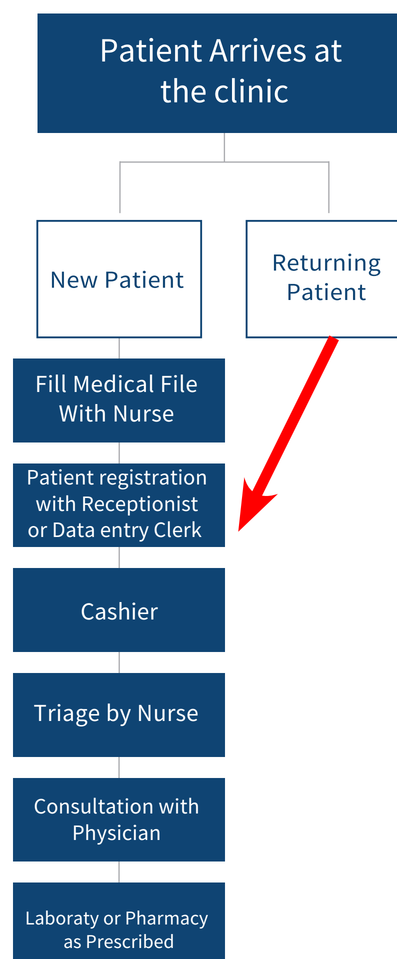
1- The underestimation of the targets set for each indicator . As an example, during 2018, the target for the Number of PHC consultations provided for Syrian and other vulnerable populations at the supported PHCCs in the table above was achieved by 163% compared to 278% of achievement for the ANC related indicator and 192% for the PNC indicator.

2- The number of visits of beneficiaries to the PHCCs. Routine monitoring of project data estimated that each unique patient visited the center around 1.6 times throughout the year. Similarly, the PSS data showed that 41% of the survey respondents visited the center around 2 to 4 times in the previous quarter, 20% visited the center more than 9 times, 13% for 5 to 8 times while the remaining 26% were either on their first visit or have visited the center only once before. In addition, 52% of survey respondents reported that the availability of subsidized services is the main reason for their visit as well as good quality services (mentioned by 47% of respondents). This was also confirmed by the qualitative data noting the availability of diverse health specialists as an important element for recurrent patients.

Despite this achievement, some respondents have highlighted that there are some reservations regarding the quality of the services provided by physicians at some of the supported clinics were beneficiaries noted that they were not given enough time. This can be attributed to the increased demand on services.

In terms of the process implementation at the level of clinics, almost all clinic managers reported correct implementation of consultations, from reception and opening new files to new patients or retrieving files of previous patients, to triage by the nurse, consultations by physicians and referral to pharmacies and/or diagnostic tests. Figure 4 below describes the mentioned patient flow.

Figure 4: Patient flow at the supported PHCCs.



However, there were some concerns with services not being in line with the information provided to the beneficiaries by CHWs due to the following reasons..

1- The lack of proper application of processes related to the identification of the vulnerable population as reported by most clinic managers and International Medical Corps field staff.

2- The non-compliance of certain PHCC to the contract despite the follow up of the field teams where some clinics provide REBAHS services to patient only after 2 p.m while others limit the services to specific days of the week.

3- Inefficiency of the echography being conducted by the Ob/Gyn who only attend some of the PHCCs once a week for 2 hours.

4- Inefficient Physician schedules in some clinics with certain specialists attending one a week for a limited time period causing excessive crowding at the PHCCs.

In summary, the activities discussed in this paragraph have been achieved with regards to project targets. However, several concerns were raised and below are the respective recommendations:

1- Further efforts should be made by field teams to ensure appropriate implementation of all contract terms especially the proper identification and documentation of vulnerable cases to make sure beneficiaries benefit from the full REBAHS packages when applicable.

2- The unification of some aspects of the service delivery should be considered to improve the quality of service provision especially with regards to physician scheduling and availability.

V. Diagnostic tests provided for Syrian and other vulnerable populations at the supported PHCCs

Table 5: Logframe Diagnostic Test Indicator, Target and Achievement for Year 1.

Indicator	Output 1.1.7 Number of patients receiving diagnostic tests disaggregated by children under 5, acute, chronic & pregnant women
Baseline Value	64,324
Y1 Target	26,937
Y1 Achievement	47,324

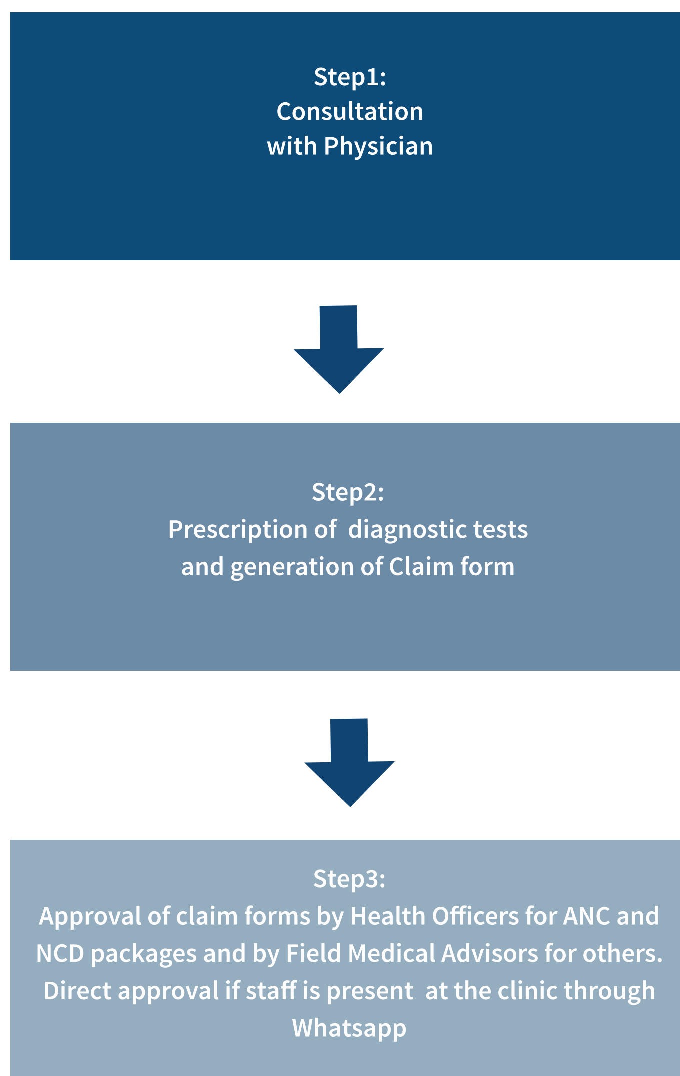
To ensure access to the full services supported by the REBAHS project, a diagnostic referral network has been established where PHCCs contracted nearby diagnostic centres. Accordingly, patients had easier access to diagnostic services thus access to affordable laboratory, x-ray, and other diagnostic services. Medical advisors and field teams worked on ensuring compliance to protocols and non-abuse of diagnostic tests through a pre-approval process. A Standard Operating Procedure document has been prepared by the central Health program team and shared with the health field teams. The document detailed the process of preapproving diagnostic tests by International Medical Corps field teams and was put into effect by January 1st, 2018. Program teams also shared with the clinics the list of the ANC & NCD packages as well as the Laboratory tests and Radiology procedures not covered by IMC to be used as guidelines. Most key informants highlighted the success of the project in providing access to affordable laboratory, x-ray, and other diagnostic services to the beneficiaries. Most CHWs noted that beneficiaries are happy and relieved, 'they don't have to pay a big sum but rather 3,000 LL'. However, the PSS noted that only 50% of respondents were satisfied with the diagnostic test coverage.

Challenges were mentioned regarding the processes pertinent to diagnostic tests as per the below.

1- Unclear guidelines with regards to diagnostic test coverage. Reservations regarding the implementation of the packages and knowledge of these packages by PHCC staff were noted by various interviewees. For instance, some CHWs stated that they are 'go[ing] with the beneficiaries to the centre to check coverage and to make sure they are given the tests covered by IMC for free'.

2- Concerns regarding the diagnostic tests' pre- approval mechanism. Figure 5A represents the pre-approval process used for all types of diagnostic tests covered by International Medical Corps.

Figure 5A: Pre-approval process for diagnostic tests based on Program SOPs.



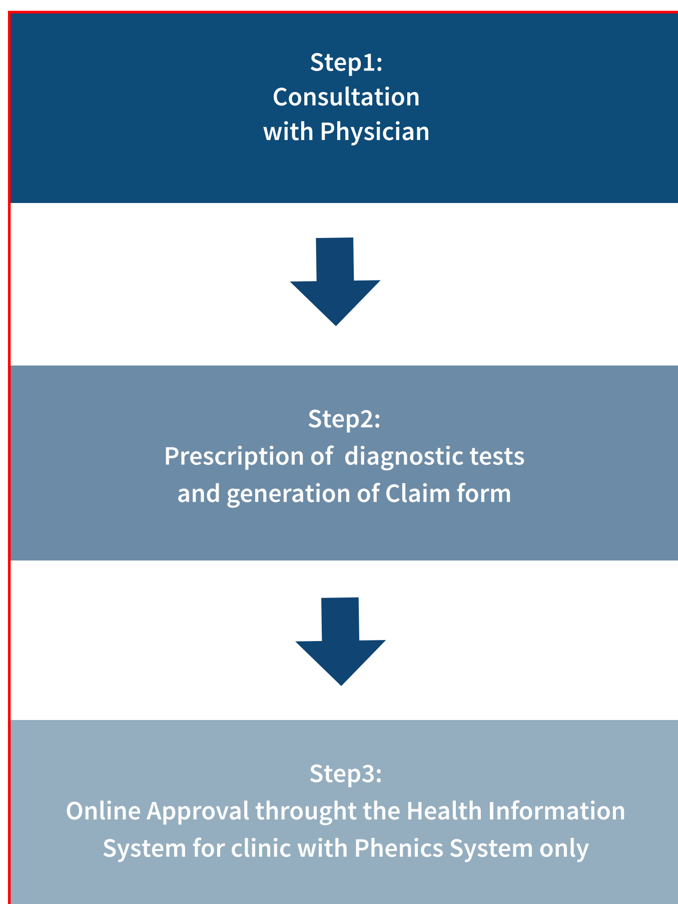
With regards to Step 2, several clinic managers noted that documentation process and claim forms required to process the diagnostic tests are extensive and inexplicable. In addition, the work involved in processing each test is increasing the clinics' staff work from an administrative perspective rather than attending to the increased patient load due to the project's model and expansion. These processes were considered 'complicated and impractical' by some clinic staff.

Additionally, the approval mechanism was described as long and inefficient by several interviewees. The program SOP did not specify a specific timeframe for the diagnostic test approvals. Rather, for the non-urgent tests, field medical advisors approve these tests during their weekly field visits. Patients are sometimes asked to wait at the facility if the International Medical Corps personnel in charge is available for approval. Otherwise, they are sometimes asked to return on other days.

On the other hand, urgent tests could be approved instantaneously by phone or via WhatsApp mobile app after case review.

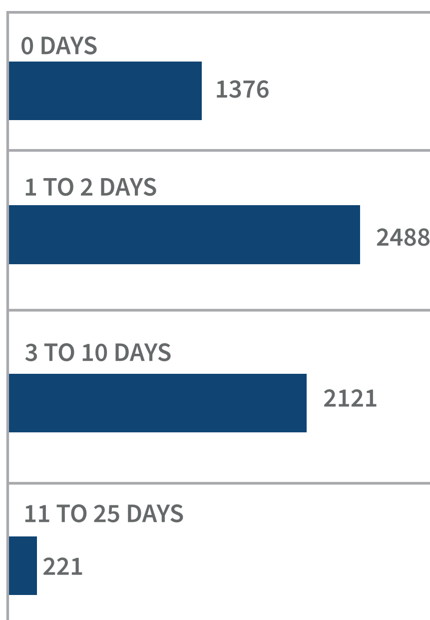
In October 2018, IMC launched a pilot for the online referrals and approval system online. The process was designed through the MoPH online Health Information System called "PHENICS". The data entry clerk at the PHCC requests the tests online and the medical advisor responds online as per Figure 5B below.

Figure 5B: Proposed Pre-approval process online.



A brief analysis was done on the online extracted data sets and the results are presented below for Labwe and Talmaayan clinics, for a total of 6,206 tests requested in November and December 2018.

Figure 6: Waiting time for Diagnostic Test online responses (N=6,206)



Based on Figure 6, 22% of the requested tests were approved/ rejected on the same day, 40% of the requested tests took around 1 to 2 days, 34% of the requested tests took around 3 to 10 days, while 4% took between 11 to 25 days. Based on the findings, we have been able to identified that in urgent cases approvals are given immediately. However, the urgency of the requested tests is a huge factor in approval timeframe. In addition, technical issues related to the online approval process have been considered. However, the current system allows for easier reporting and reduces the data entry burden on International Medical Corps staff.

The program teams are looking into further expanding this pilot to include all clinics using the online reporting system Phenics. Reservations were made regarding the capabilities of all supported clinics to transition to an automated online system due to the variable qualifications of clinic staff.

Many clinic managers reported that the complicated approval process is problematic for beneficiaries who travel long distances to reach the PHCCs. One clinic manager stated that 'To reduce transportation costs, the patient is asked to pay the full amount; if we receive approval, we give them back their money'. Findings from the PSS also supported some of these claims with 18% (16 respondents) of beneficiaries who were prescribed diagnostic tests by the physician, left the clinic without knowing the status of their prescribed tests. In addition, the satisfaction with the diagnostic test coverage had a rate of 50% among the survey respondents stating that the 'tests that are not supported are too expensive' and 'the long waiting time for the diagnostic test approval' as main reasons for their dissatisfaction.

Other concerns were raised concerning the coverage of the diagnostic tests. With the FFM, fixed diagnostic test packages were designed, and shared with the PHCCs for implementation. Several interviewees noted that some physicians are not compliant with requesting the full packages while others request tests that are not medically justifiable. According to health program data, 3,959 tests were rejected by field medical advisors between January and August 2018. The majority of these rejected tests were classified as "medically unnecessary" by FMAs. For example, many abdominal ultrasounds are requested for simple

diarrhoea or acute Gastroenteritis. Review of results of such ultrasounds showed that they are almost always negative.

This finding, while significant, does not serve as a proxy indicator for the out of pocket expenditure on health experienced by the beneficiaries since some of the prescribed tests (MRI, CT-Scans and others) are not sent to International Medical Corps FMAs as they are not within any pre-determined package.

In summary, while the diagnostic packages are considered as one of the project's most important services, improvements can be made to provide better results for beneficiaries. The following recommendations could be considered:

1- Further monitoring of the waiting time of beneficiaries and revisiting already existing SOPs to include an adequate timeframe for approval.

2- Revisiting the design and implementation of the diagnostic test packages in light of this experience as well as the analysis of the rejected tests.

3- Capacity building trainings, in collaboration with MoPH, for clinic physicians to ensure the proper diagnostic tests are requested and approval mechanism will allow improved service provision.

VI. Acute illness medications provided for Syrian and other vulnerable populations at the supported PHCCs

Table 6: Logframe Acute Illness Medication Indicator, Target and Achievement for Year 1.

	Output 1.1.8
Indicator	Number of beneficiaries receiving acute illness medications at the supported PHCCs on monthly basis
Baseline Value	297,643
Y1 Target	96,204
Y1 Achievement	63,131

The project proposal stated that acute illness medications will be provided at PHCC within the MoPH network in an effort to cover any gaps in medications and supplies provided by the MoPH to all health care centers supported by the consortium partners, in order to prevent or minimize stock outs. For the PHCCs outside of the MoPH network, the medications provided are based on the MoPH National Essential Drug List. According to the proposal, all acute medications provided at the PHCC are free of charge if presented along with a prescription from a physician within the PHCC.

The first batch of REBAHS medications were delivered to the clinics in May 2018 instead of January 2018. Factors contributing to the delay are as follows:

1- Clinic medication assessments were done in December 2017 and January 2018.

2- The official confirmation for MoPH regarding their medication coverage was delayed till end of January 2018.

3- The procurement process for the first medication batch took around 40 days.

The clinics, however, were utilizing acute medication stocks from previous 2017 IMC projects. The consumed medications were not contributing to the REBAHS target and hence, the Y1 target was not met with a progress towards the target by December 2018 set at 65.62%.

A mitigation measure was proposed by central staff who suggested preparing the procurement paper work 3 months before stock out and intended distribution. This proposition could lead to relatively inaccurate estimates of the needed medication but could help prevent significant delays and ensure compliance with proposal commitments.

The various challenges are presented in the table below.

Table 7: Summary of main challenges associated with the provision of acute illness medications at the clinics.

Challenges	Stakeholder	Description
Procurement Process	International Medical Corps Central Staff	Delayed first procurement of medication batch
Reduced support from MoPH	Ministry of Public Health	MoPH has not been supplying the medications as per the agreement with International Medical Corps
Lack Availability of medications at PHCCs	Beneficiaries & Clinic managers	Lack of availability of prescribed medications
Lack of coverage of some of the expensive medications	Beneficiaries & Clinic managers	Prescribed chronic medications or others are not available for free at the PHCCs

The PSS results showed that 133 respondents received acute illness medications. Only seven respondents reported paying for the acute medication received with six paying between 1,000 to 3,000 L.L. (0.67 to 2 USD) while only one reported paying between 9,000 to 12,000 L.L. (6 to 8 USD) for the acute medication they received during their visit. According to the program team, an MoPH circular allows the clinics to request anywhere between 1,000 to 5,000 L.L. (0.67 to 3.33 USD) for the MoPH medications dispensed. On the other hand, although the project model does not provide chronic medications at the PHCCs, several stakeholders noted the need for such medications to be available for free or subsidized at the PHCCs. The PSS noted that 55% (85 respondents) of respondents who reported receiving medication from the PHCC during their visit, will need to purchase other medications from outside the PHCCs compared to 44% (97 respondents) amongst those who did not receive any medication from the PHCC.

In general, several participants pointed to the various issues regarding the availability of the medications at the PHCCs. For instance, some CHWs reported shortage of medications and that 'sometimes the medications prescribed are more expensive than the doctor's consultation fee. Others even stated that 'the only issue that is still not solved with the REBAHS project is the shortage in medication'.

Central staff noted also the variability in the education of physicians at the PHCCs and hence the different prescription patterns.

In summary, the coordination with the MoPH, although challenging sometimes, has succeeded in reducing the gap related to the availability of acute illness medication. However, several factors related to procurement, dispensing, and prescription have limited the opportunity of standardizing this activity across the areas of implementation. As a result, the following recommendations could be adopted in future planning to mitigate some of the noted challenges:

1- A revision of the procurement process (Especially for the first procurement) is strongly advised to make sure the medications are available on time for project implementation and reduce the expenditure on medication.

2- Additional meeting with MoPH to secure the promised support. An additional budget might be requested in case the MoPH support was not secured.

3- Coordinate with stakeholders responsible for the delivery of chronic medications to provide beneficiaries with a holistic service since RBEHAS is covering the needed consultation, diagnostic tests, and acute medication.

VII. Quality Program

As part of the comprehensive quality assessments to be conducted on a quarterly basis, the proposal stated that IMC will continue to utilize a standard PHC assessment and medical record assessment tool developed and utilized by IMC based on MoPH and WHO guidelines. The quality program relies on the efforts of the entire health team in addition to their own assessment to design a comprehensive action plan tailored to each PHCC. During the weekly visits of the health officers to the PHCCs, gaps and improvement areas related to the quality of service provision and facility management are recorded. The Field Medical Advisors conduct quarterly assessments of the medical records evaluating the documentations of the services provided and patient outcomes. The quality team functions as a third party player with regards to the quality standards and components. As a result, all findings are translated into recommendations and action points with limited power or enforcement capacity over the clinics.

The incentive based program was newly implemented under the REBAHS project. PHCCs are evaluated and scored based on key quality indicators that may be related to health outputs as well as processes. These key indicators include data entry, medication management, ANC/PNC attendance, risk screening among others. Score sheets are used to ensure a standardized method of monitoring across and within areas as well as to measure the performance on the key performance indicators selected and used to calculate the incentives paid per clinic. It is important to highlight that the quality incentive program was based on remodeling a pre-existing system of supporting running costs for clinics (these costs used to cover electricity and paper work and etc.). In previous projects, running costs were given on a monthly basis to clinics without the need to achieve standards. Currently, the clinics are receiving a reduced running costs accompanied with the incentive money allocated each month based on the achievements.

The standards used for monthly assessment by quality officers were selected in collaboration with clinic managers. Accordingly, several clinic managers reported that the standards are appropriate, where some are easily achievable, and others need more work and effort. Some also noted that the standards are somewhat familiar given their similarity with those of the accreditation process with MOPH. Conversely, some clinic managers indicated that some requirements are not applicable or 'too perfect'. One clinic manager highlighted the fact that some of the standards will require additional staff member for proper implementation. Accordingly, clinic based standards were revisited to make sure the appropriate basic standards are evaluated with further advancement considering the clinic progress.

Some quality officers reported 'lack of tolerance of some clinic staff and directors', where 'in some PHCCs, we [quality officers] are not allowed to explain further procedures or information regarding the program even if we noticed a wrong procedure being done by the PHCC staff'. This could be explained by the fact that the health team allocated the health officer in charge of the clinic to be the main focal point with which all communication lines with the PHCCs should pass by.

The incentive program was designed to encourage implementation of guidelines and standard processes that are key for quality outcome of patient care. Most clinic managers highlighted the importance of this program in making the clinic staff more motivated and excited to do their best in the field adding that noticeable improvements in staff performance. However, some clinic managers and IMC staff reported inefficient processes of providing these clinics with the incentive payments at the start of the project. Some clinic staff are not receiving their payments for various reasons including clinic managers delaying the distribution of allocated incentives, and bureaucracy at the level of the governmental institutions. Meetings with clinic managers to overcome such challenges are occurring continuously to follow up with the PHCCs.

Another concern regarding this program was the significant discrepancies in the incentive amount when distributed to the clinic staff. For example, the same amount of money could be divided between 2 nurses in one small clinic compared to 5 in another relatively bigger clinic. The quality program arranged accordingly the sum allocated to respective standards to mitigate this challenge in accordance with the PHCCs.

With regards to the perception of the quality officers regarding this program, opinions varied. Some believe that the improvements are not sustainable and that the involvement of clinics in standards selection is a significant bias. Others consider that the quality incentive program has improved a lot the quality of work with clinics becoming more productive and cooperative, which is reflected in the quarterly reports. Almost all quality officers believed that the impact and the results are not sufficiently reflective of their real efforts and hard work and that greater results and improvements were expected in some clinics. This could be explained by the fact that quality improvements require longer duration of time to be sustained. Follow up from the quality program regarding the sustainability of performance for a certain standard is done continuously through revisiting some of the previously selected indicators and when necessary, in cases of regression, re-selection of the indicator after consulting with the PHCC.

When asked about the staffs' receipt of information regarding the quality and incentive program, almost all clinic managers stated that clinic staff were very well informed and trained and provided support to the clinics, even among clinics which had no previous experience in that field. Conversely, one clinic manager believed that more training and follow-ups are needed. Few quality officers believed that clinic staff were well trained when the program launched. Similarly, other KIs noted that health team members were not well trained at the initial stage of the project. As a result, the Quality manager launched capacity building activities with International Medical Corps staff on implementation of the incentives and then, International Medical Corps field staff did capacity building for PHCC focal points on the selected indicators. As a result, no standard is implemented before capacity building of staff in an effort to ensure sustainable performance changes.

A logistical challenge was raised by some quality officers, stating the shortage in transportation for the quality team and the need to coordinate with health team creating challenges at times.

In summary, the quality program and its staff have worked tirelessly to ensure proper implementation of several quality standards that can promote adequate, safe and quality service deliver. The newly introduced quality incentive program was noted to be the driver of several achievements with several challenges reported related to the model, preparation, implementation and follow up. Accordingly, the following recommendations could be considered:

1- All involved staff in the incentive program should undergo and inception training on the program and possible standards to be selected prior to project implementation

2- Further data should be collected to identify the extent of the program's impact on long term staff behavior and commitment to the proposed standards. This could be done through follow up on some of the standards that have been achieved and are no longer part of the incentive package during a given quarter. Findings from the collected data could shed the light on the need for such program in the future, the best implementation strategy and the appropriate sum of money that should be allocated in total and per standard.

3- Continuous meetings and follow ups should be done with clinic managers to ensure a continuous feedback loop amongst the various stakeholders.

4- A revision of the scope of work of quality officer to make sure that their level of work effort is reflected in observed results.

VIII. Provision of Community Health Services

Table 7: Logframe Community Health Indicators, Targets and Achievements for Year 1.

	Indicator	Baseline Value	Y1 Target	Y1 Achievement
Output 1.2.1	Number of Community Health Workers trained on key health topics each year	N/A	62	62
Output 1.2.2	Number of beneficiaries participating in awareness raising activities	N/A	28,615	32,004

IMC recruited and trained 62 CHWs (two per PHCC catchment area) all over Lebanon. The Community Health Teams provided a series of trainings and toolkits to the CHWs, including essential referral forms, monitoring and reporting tools, guidance documents on health messaging, educational games and health information brochures, and a list of services provided by IMC and other services available in the area. The recruitment of the CHWs was hand in hand with the expansion of the supported clinic since 2 CHWs were assigned 1 PHCC rotating between clinic itself and catchment area.

A training package was designed by International Medical Corps. The full day trainings took place in Beirut and covered a range of health topics as well as an overview of main project activities, target population and package designs. The majority of CHWs said that the trainings were efficient due to their perceived increase in knowledge. While several stated that the trainings helped 'correct some of our own [CHWs] misconceptions', other reported the need to cover additional health topics raised by some beneficiaries such as chickenpox as well as more clarity on the provided services.

During the Focus Group Discussions, almost all CHWs were not satisfied with the long and condensed training sessions. During the training day, several topics are covered in back to back sessions. The CHWs reported that due to the design of the sessions and the relatively big group of participants, there were little chances for questions and lack of practical examples. In addition, the location of the training was inconvenient for many CHWs who live in rural distant areas.

Similary, CHWs requested the need for more capacity building excersises such as First aid and Computer Skills Trainings.

Based on the aformentioned, a revision of the process of training of the CHWs is advised to ensure proper program inception as well as increased prepardeness of the field staff. Several full day trainings in the various implementation areas with the addition of practical examples are some of the suggested improvements to the trainings. The program teams are also advised to consider capacity building opportunities for volunteers.

When KIs were asked about their introduction to the CHWs, most clinic managers reported being well informed about this team and its role and the referral processes. Conversely, other clinic managers indicated that they were not informed about the CHWs' roles in the PHCC during the inception meetings or through the contracts. Rather, they were introduced by the health officers during a field visit. Moreover, when KIs were asked about the performance of CHWs in tasks pertinent to their duties, most clinic managers indicated that 'CHWs fulfil their tasks in an effective manner, 'are very helpful to the beneficiaries', and 'are an assist to the centre given that they are closer to the patients'. Most clinic managers stated 'not facing any problems with CHWs', but requested that CHWs 'only refer urgent cases rather than all beneficiaries regardless of their main needs'.

As part of their volunteer work, CHWs raise awareness about key health topics on which they were trained. Each CHW targets 500 beneficiaries from different population age groups, including children and youth, male and female adults, and the elderly.

Based on a brief assessment, the CHWs selects the most appropriate health topic and directs the session accordingly. Several concerns were mentioned with regards to this activity:

1- Finding an appropriate time and location for the session, especially given that some villages get alarmed by the groups or gatherings

2- Difficulties in giving sessions about sensitive topics such as the session on lice where beneficiaries were reported to feel uncomfortable when discussing personal hygiene habits

3- Willingness of beneficiaries to participate in awareness sessions. Some beneficiaries will not attend except if kits are provided. It was reported that, although beneficiaries are pleased with the awareness sessions, they are conditioning their attendance on NFIs stating the need for compensation since they might be missing work in order to attend.

4- Need to adapt some of the training materials or concepts to beneficiaries who need a simpler training tool

5- Difficulties in finding new unique beneficiaries and hence the need to travel greater distances.

6- The need to carry heavy equipment (all awareness session guidelines, pens, papers, and supporting materials such as pictures or others)

7- Pre & Post-tests mildly accepted amongst beneficiaries participating in awareness raising sessions especially for the illiterate participants

Accordingly, a revision of the current approach of awareness raising session activities from design to implementation is highly suggested to ensure beneficiaries are optimally benefiting from the project.

CHWs were also trained to recognize when to refer beneficiaries (danger signs, additional treatment needed, lack of vaccination, lack of ANC visits, breastfeeding complications, and malnutrition etc.) as well as the usage of a standardized referral form, referring beneficiaries in need of additional health or non-health services.

When asked about referrals and follow-up on referrals, most CHWs indicated inefficiency in these processes, stating that some beneficiaries tend to convey falsified personal information, or do not consent to providing CHWs with their IDs (which may be needed to obtain accurate spelling of names) or phone numbers. In some cases, loss to follow-up might occur due to some beneficiaries not having personal phone lines. One CHW stated that 'Some beneficiaries refuse to register their names or phone numbers as they are warned by UNHCR not give personal numbers or identifiers'.

CHWs also noted that the frequency of follow up with beneficiaries is relatively high. Some referred patients find it beneficial while others report discomfort and as a result, CHWs feel that there is a great need to reduce the interactions with beneficiaries. While the intent of the CHWs is to follow up on cases and identifying further beneficiary needs, some beneficiaries believed that CHWs receive financial incentives for this follow up , where one CHW narrated that a woman told her 'if you get paid for this referral, I want money too''.

CHWs provide beneficiaries with referral slips. While these slips are not a guarantee for service delivery at PHCCs, they help track referral and identify patients who received the health services. According to all CHWs, the referral slips is 'useless'; clinic staff are throwing the papers away. As a result, beneficiaries are discouraged to do further follow up with CHWs.

Regarding the tasks pertinent to the CHWs, most perceived their volunteer work as beneficial to beneficiaries and essential to the project's success. However, the following challenges were raised.

1- All CHWs stated the inappropriateness of providing beneficiaries with their personal phone number, and some CHOs also raised this concern.

2- Many CHWs were not satisfied with the vest requested to be worn, noting that the vests tend to raise some concerns and unwanted attention of locals in several areas.

3- CHWs reported dissatisfaction with the incentives, unanimously agreeing about the immense expenses paid by the CHW, mainly because of high transportation, communication and stationary fees.

4- Working beyond the expected hours

All CHWs believed that 'We [they] are always over loaded. Our [their] working hours are not enough to complete all our [their] tasks' and that they 'are working much more than the requested 48 hours per month'.. All CHWs felt 'unappreciated' and 'wished that the payment was more reflective of our level of effort'.

Program team noted that the incentive rate is based on UNHCR's Health Outreach Volunteer Terms of References (200 USD per month). Accordingly, the incentive is designed as a stipend rather than a salary. However, since the CHWs are part of the target vulnerable population, program team believe that 'CHWs consider it [their incentive] as a salary and don't think they use it for transportation and communication costs. But they count on it to raise families and make a living hence why they think it's not enough'.

As a result, it is suggested to consider for future proposals and budget planning, a transportation/communication cost allocated to CHWs to ensure that the compensations they receive is somewhat reflective of their level of effort on the field.

CHOs were also asked about the project activities and the following concerns were raised.

1- Logistical challenges were faced including the shortage of cars, driver, and security staff members, especially when travelling to informal tented settlements. Currently Community Health team is sharing transportation with the Health team. This was reported to be challenging for overall project implementation.

2- Difficulties were also faced in finding proper locations for technical and zonal meetings

3- Shortage of storage spaces for the NFIs which prevents continuous purchasing and distribution to the community

4- Communication challenges with International Medical Corps teams and clinic staff. Some CHWs reported that 'we [CHWs] are not always welcomed at the PHCCs as they are considered spies'.

In summary, the trainings received by the recruited CHWs could be updated more to help improve CHWs ability to communicate health messaging and reach out to the population they serve. Training materials should be also adapted to cater for some beneficiaries while covering a broader range of topics to meet their emerging needs. In addition, additional educational programs or trainings could be considered to meet the needs of the staff.

As for the awareness sessions, considerations should be made as to the level of effort CHWs are investing in identifying new patients. In addition, while referrals are significantly important for the beneficiaries in need, the importance of thorough follow up of beneficiaries should be considered in the light of resentment by both the beneficiaries and CHWs.

Future project planning should account for the reported complaints of staff regarding incentives, transportation and security concerns.

Conclusion

The current implementation processes adopted by program teams are achieving the targets for all indicators except for the Acute illness medications for the reasons mentioned above.

While the project is new in its model, several of the implementation processes have remained the same. Careful revision of these processes is suggested to ensure evidence based decision for ultimate implementation of the project. Implementation processes based on the findings of this process evaluation could help ensure the equality of service delivery amongst beneficiaries.

The below tables summarize the main findings of the research study in terms of achievements, challenges & recommendations. The take home messages listed below highlight main considerations for future projects of similar design.

Table 8: Summary of main project achievements

PHCC Level Analysis

- Coverage of many areas in need as per the UNHCR Vulnerability Map of 2017
- Recruitment of additional staff to support PHCC implementation of REBAHS project

PHC consultations

- Access to affordable Consultations, ANC and PNC consultations

Diagnostic tests

- Access to affordable Diagnostic test packages

Acute illness medications

- Access to free acute medications purchased by IMC

Quality program

- Achievable Quality Standards that are in line with MOPH accreditation requirements
- Quality incentive program motivating clinic staff to improve performance and productivity

Community Health Services

- Provision of health awareness campaigns based on needs assessment
- Referral network and follow up of beneficiaries

Table 9: Summary of main project achievements

PHCC Level Analysis

- Duplication of efforts in catchment areas across other NGOs
- Improper coordination between community health members and PHCC staff
- Improper PHCC implementation of some health services mentioned in the contract
- Immense caseload on some PHCCs
- Added administrative workload on clinic staff and the need for additional personnel in some clinics
- Discrimination of beneficiaries in some PHCC clinics

PHC consultations

- Resistance of some clinics in proper implementation of processes (vaccination)
- Limited availability in quantity and scheduling of some physicians at the certain PHCCs

Diagnostic tests

- Complicated diagnostic referral and approval process (delayed response of approvals)
- Lack of compliance of some physicians to guidelines and proposed packages

Acute illness medications

- Limited range of medication availability
- Lack of proper communication between MOPH and PHCC clinics causing shortage in some medications
- Lack of coverage of chronic or expensive medication

Quality program

- Some quality standards considered impractical by certain PHCCs
- Challenges in the receipt of quality incentives by the clinic staff
- Concerns about the sustainability of quality health services beyond the quality incentive program
- Questionable progress related to clinic selection of standards

Community Health Services

- Location and duration of CHWs training sessions
- I ncentives of CHWs (transportation and communication expenses)
- Logistical preparations of health awareness campaigns
- Lack of supply and storage spaces for NFIs
- Security and Transportation of CH team

Table 10: Summary of main project achievements

Staff trainings and meetings

- Incorporating practical training activities for CHWs
- Increasing frequency of trainings and meetings between IMC & Clinic staff

IMC Staff incentives

- Increasing the incentives of CHWs to cover their expenses entailed with field work
- Providing field officers with work phone lines, instead of personal lines

Program Implementation

- Maximizing the number of kits provided after attending awareness sessions
- Minimizing referral documentation requirements

Additional health services

- Medications for chronic diseases
- Dental health
- Physiotherapy sessions
- Additional Laboratory and Imaging tests
- Additional focus on the vulnerable Lebanese population

Administration duties

- Simplifying paper work & documentation processes
- Re-evaluation of the processes of quality incentives program
- Evaluation of procurement processes for acute illness medications

Logistical support

- Provision of additional transportation support
- Additional IMC support staff at central and field level

Internal networking

- Encourage IMC team meeting and coordination

Annex A: List of the 31 REBAHS supported clinics during December 2018.

Area	IMC Clinics
Tripoli	1- Iman Medical Association- Sir Dinniye
	2-Iman Medical Association- Mina
	3-Al Nahda Association – Minieh
	4-Al Nahda Association – Bedawi
Akkar	5-Iman Medical Association- Bebnine
	6-Advanced Medical Centre–Mashta Hassan
	7-Municipality of Talmaayan Medical Centre
	8-Advanced Health Centre – Mashta Hassan
	9-Bireh Health and Social Centre
Beqaa	10-MoSA Social Development Center Baalback
	11-Bar Elias Governmental Centre
	12- Al Enaya Medical Dispensary
	13-Labwe Municipality Centre
	14-Al Farouk Medical Association
	15-Islamic Health Society Ali Nahri
	16-Ghazze Health Centre
Beirut & Mount – Lebanon	17-Al Zahraa Zokak el Blat
	18-Al Kayan Association Haret Hreik
	19-Wadih El Hage Medical Centre Baskinta
	20-Lebanese Association of Early Childhood Development –Tayyouneh
	21-Karagheusian for Children Care
	22-Jbeil Qadaa Governmental PHCC
	23-Islamic Health Society Zein el Abeddine – Amrousiye
	24-Dar El Wafaa – Ghawth for Relief and Emergency Association
	25-Bent El Hoda – Sabra
South	26-Mowasat Charity Association - Nazih Bizri
	27-Caritas Centre – Saida
	28-MOSA Bent Jbeil
	29-Islamic Health Society– Tyre Maachouk
	30-Islamic Health Society–Burj Kalaway
	31-Islamic Health Society– Siddikine
Total	**31**

Health Program

Premiere Urgence Internationale

List of Abbreviations

ANC: Antenatal care

CH: Community health

CHWs: Community health workers

CRP: C-reactive protein

DHIS2: District Health Information System 2

ECG: Electrocardiogram

FFM: Flat Free Model

FGD: Focus Group Discussion

GP: General Practitioner

HFO: Health Field Officer

IEC: Information, Education and Communication

KI: Key Informant

KII: Key Informant Interview

LBP: Lebanese pound

MoPH: Ministry of Public Health

NCDs: Non-Communicable Diseases

NGO: Non-Governmental Organisation

OB/Gyn: Obstetrician/Gynaecologist

PHCC: Primary HealthCare Centre

PM: Project Manager

PNC: Postnatal care

PSS: Patient Satisfaction Survey

PUI: Première Urgence Internationale

REBAHS: Reducing Economic Barriers to Accessing Health Services

SMS: Short Message Service (text message)

SOPs: Standard Operating Procedures

UNHCR: United Nations High Commissioner for Refugees

YMCA: Young Men's Christian Association

Executive Summary

Background and Introduction

This Process Evaluation was carried out in collaboration with IMC UK as part of the REBAHS project in order to inform project implementation. This report will briefly describe the context and the REBAHS project health system strengthening actions referred to from this point onwards as the Flat Fee Model (FFM). Then go on to describe the evaluation methodology and summarize the findings. Finally, it will describe the resulting conclusions and recommendations.

The specific evaluation objectives, which were developed by the consortium were::

• Was the REBAHS ntervention implemented as intended?

• Did the intervention reach the targeted population?

Methods

This process evaluation focuses on the implementation process and attempts to determine how successfully the project is following the strategy laid out in the logic model using a framework developed by the consortium that looks at four pillars: appropriateness/quality, fidelity, satisfaction and logistics as detailed below. It utilises a mixed methods approach triangulating data from multiple sources included the project related quantitative and qualitative data, project SOPs and key documents,Patient Satisfaction Surveys including 390 respondents, 4 focus group discussions and 7 key Informant interviews as well as a desk review of performance of the project against the objectives outlined in the MADAD proposal.

Summary of Key Themes and Corresponding Recommendations

Overall the REBAHS project was seen as a positive force for providing immediate access to health care for Syrian Refugees and vulnerable Lebanese as well as providing a core health system strengthening functions across the six building blocks (Service Delivery, health workforce, health financing, health information systems, governance and leadership and access to essential medications). The limitations of the project was mostly concentrated around the implementation of the support for availability of essential medications and the breadth and depth of the service package. This process evaluation has highlighted key areas that at the time of writing this report have already been addressed such as the depth and breadth of the package offered which was more specifically outlined within the FFM review.

Based on the analysis detailed in the report, the evaluation team offers the following key findings and conclusions, followed by associated recommendations

Table 1: Key Findings and Recommendations

Findings	Recommendations
Service Delivery	
The FFM is a useful, relevant, efficient, and needed model for providing health care to Syrian Refugees and Vulnerable Lebanese. With the incorporation of the recommendations included in this report there will likely be even greater access to healthcare through it	1.Continue current intervention increasing breadth and depth of coverage to encompass more types of consultation and diagnostic tests
Vulnerable populations are felt to have access to affordable quality health services	2.PUI MEAL teams to continue to conduct regular field monitoring visits to observe staff and collect patient feedback
PUI's activities are seen as enhancing PHCC services in a country dominated by expensive private health care providers	3.PUI staff and Community health team to raise awareness of PUI's Complain Response Mechanism to ensure that any disrespectful encounters are reported and appropriately managed
PHCC services are seen as reaching the target population both in terms of ensuring access to healthcare for Syrian Refugees and ensuring that specific groups i.e. pregnant women and people with NCD's receive preventative and curative health services	4.A review of current vaccination practice at PHCC level should be conducted by PUI medical advisors and the team manager to liaise with the MoPH coordinator to ensure appropriate training.
Pregnant women are felt to have very good access to affordable ANC and PNC services including free antenatal laboratory tests and ultrasounds.	5.Review Pre-Approval Process to ensure maximal efficiency on implementation.
Beneficiaries have access to free diagnostic /laboratory tests at supported PHCCs	6.Quality Assurance Advisors and Health Field Officers to support PHCCs to introduce an appointment system in PHCCs to reduce waiting time
There have been incidences when beneficiaries felt that PHCC staff were disrespectful in their approach towards them	
Concerns have been raised that vaccinations are not being given as per MoPH guidance in some PHCCs	
Some delays were reported within the pre-approval process but SOPs ensure there is needed control over diagnostic test utilisation	
Waiting times are reported as being reduced in PHCCs which have an appointment system	
Health Workforce	
There are challenges at PHCC level in the identification of vulnerable cases	7.Providing refresher trainings, including awareness/training on assessment of vulnerable cases
There is insufficient staff support (PUI paying the salary of a new member of staff) in some PHCCs which is particularly an issue with the growth in consultation numbers seen with the implementation of the FFM	8.In the setting of PHCCs with a high patient load increase the staff support provided so PHCCs can benefit from both data entry support and a key clinical role such as midwife

Findings	Recommendations
Health Workforce	
There is a need to ensure sustainable change in practice from PHCC staff	9.Conduct a training needs assessment and expand on the current capacity building plan including both MoPH external training and in house training to ensure the sustainability of REBAHS governance and quality activities
Some respondents reported issues with the physicians rota both in terms of accuracy and balance between male and female doctors	10.Health teams to work with PHCCs to ensure there is an up-to-date physicians schedule available and that recruitment takes into account the need for gender sensitive care
Health Financing	
There was a perception voiced by some CHWs that subsidized consultations fees was only available if beneficiaries had a referral slip	11.PUI to clarify the position of referral slips with CHWs and PUI to continue to conduct regular field monitoring visits to ensure that consultations that are covered by the FFM are always available at the flat fee of 3,000 LBP without exception.
Governance and Leadership / Quality Improvement Programme	
Quality standards are felt to be in line with those required by MOPH	12.PUI to look at potential solutions for the recruitment challenges faced in Akkar with regards to the Quality Assurance Advisor
Provision of incentives via the performance-based financing program is felt to motivate clinic staff to improve their performance	
Some felt that there was a need to recruit additional quality assurance personnel to oversee some PHCC (there was a gap in recruitment at the time)	
Access to essential medicines	
PHCC patients are reported to be provided with free medications when available	13.Re-evaluating the processes of ordering and delivering medications with IMC UK
PHCC pharmacists feel that they have acquired skills in forecasting the centre's medication requirements.	14.Conduct an audit of the medications prescribed at selected PHCCs and review against the MoPH Essential Medications list based on these findings work with PHCCs to prescribe within formulary unless clear clinical indications to prescribe off formulary
Participants were concerned that sometimes medicines were prescribed that are not on the MOPH essential drug list. Therefore, patients are not able to get them in the PHCC pharmacy	
Health Information Systems	
There are some inaccuracies in Phenics data that are reviewed and corrected by PHCCs with the support of PUI on a regular basis	1.Continue to provide support to PHCCs on Phenics data entry and data cleaning to ensure the optimal accuracy in health surveillance

Findings	Recommendations
Community Health	
The project is felt to build the capacity of CHWs through a series of trainings	15.Community Health Zonal Supervisor to support increased visibility of CHWs in the community
CHWs are reported to be delivering health awareness campaigns based on community needs assessments	16.As the expenses are fixed by the UNHCR, PUI shouldreview what can be done to ensure that there is not undue expenditure on the part of the CHW and support with transport when needed
CHW interventions in the community are perceived positively in that they increases awareness of PHCC services and connect beneficiaries to those services. However, CHWs feld more needed to be done to ensure visibility at community level	17.Develop a joint PHCC and Community health plan to enhance awareness and access to ANC and PNC. To include continuing to provide NFI kits. PUI has also added the quality assurance indicator to cover presence of updated and contacted contact list of patients due for PNC to incentivize follow up for women who have delivered in the PHCC and this needs to be monitored with additional attention to ensuring vulnerable Lebanese women are reached
CHWs find the current expenses paid to them does not cover their field expenses and there can be delays in their distribution	
There is a perceived lack of importance placed on referral slips by PHCCs; thus it is difficult to report on referred cases.	18.Due to the nature of the intervention it is not possible to commence prior to the PHCC being confirmed; however, organisation and planning should ensure that the community health element starts as soon as possible after the PHCC is contracted.
Continuing educational efforts are required around ANC & PNC packages	
There can be delays in the implementation of the community health intervention at new PHCCs	19.Review of CHW training schedule with consideration of location and duration
The location and duration of CHWs training sessions are seen by some as being inconvenient for participants.	20.PUI to finalise development of a safety and security protocol specifically for CHWs
Logistical/HR support	
There can be a paucity of materials available for the community health elements and equipment and some felt they could be better planned	21.PUI to improve planning for awareness sessions and make sure all IEC materials are available and have a strong visual element for those with lower levels of literacy
On a HR level, a high turnover of staff is reported at the mission. It is a challenge for HR, to identify qualified candidates for positions on this project. Delays in the recruitment process have also been reported	22.PUI to review of the HR process to streamline the recruitment process and reduce any unnecessary delays
Transportation	23.PUI to review logistics requirements at mission level to ensure there is enough cars and drivers to deliver the project.

Introduction and Background

Context

The situation in Lebanon is a protracted crisis attributable to the devastation caused by more than eight years of conflict in Syria. With around 4.5 million Lebanese hosting one million registered Syrian refugees, Lebanon hosts the second-largest population of Syrian refugees in the region, after Turkey[1]. The refugee influx has strained Lebanon's already fragile health system and posed health service access challenges for vulnerable Lebanese. Nearly half of those affected by the crisis are children, with at least 1.4 million Lebanese, Syrian and Palestinian children considered vulnerable[2]. The World Bank estimates that Lebanon has incurred a loss of $13.1 billion USD in government revenues since 2012 and demand for basic services such as health far exceeds infrastructure and capacity. Quality of available primary care services is a concern and out-of-pocket costs are the primary barriers to care seeking among refugees and vulnerable Lebanese. [2,3,4]

REBAHS Project

In order to further reduce the financial burden of health services and the barriers that refugees face in accessing care, Première Urgence Internationale (PUI), after a successful pilot in 2015, introduced a flat-fee model (FFM) at scale within an IMC led consortium funded by the with support from the EU Regional Trust Fund in Response to the Syrian Crisis. The FFM is an innovative pricing and reimbursement model that provides Syrian refugees and poor Lebanese nationals' access to primary healthcare services. Under the FFM, an initial consultation, follow up, and essential laboratory, imaging, diagnostic tests and procedures, which have been chosen to accurately represent the population's disease burden, are provided to care seekers for a set price of 3000 Lebanese Pounds (LBP) per visit; this is equal to about US $2 and is typically affordable to these populations. The project then reimburses PHCCs at the end of each month for the remaining cost of the consultation (7000 LBP) and the cost of the laboratory and imaging tests provided to care seekers. Also included in the FFM are performance-based incentives for PHCCs in order to support the achievement of key quality care standards that are required for the PHCC to be accredited by the Ministry of Public Health (MoPH).

The FFM also includes measures to support the health system as a whole in the form of PHCC running costs and an additional staff member (nurse, midwife, or data entry clerk) per clinic based on identified needs. Access to essential medicines is supported by the provision of top up essential medicines and medical equipment to PHCCs (Via Consortium lead IMC) and the Health Information System (HIS) support is provided as technical assistance and guidance to PHCCs transitioning to using the MoPH PHENICS health information system software (if not already in use).

Evaluation Questions

This process evaluation aims to answer the following questions:

- Was the REBAHS intervention implemented as intended?
- Did the intervention reach the targeted population?

Overarching question

- Is what is stated in the proposal being implemented on the ground?

[1] UN Office for Coordination of Humanitarian Affairs (OCHA). Lebanon Humanitarian Fund – Annual Report 2017. URL: https://reliefweb.int/report/lebanon/lebanon-humanitarian-fund-annual-report-2017.

[2] Government of Lebanon, UN Resident Humanitarian Coordinator for Lebanon. Lebanon Crisis Response Plan 2017-2020. Part II Operational Response Plans – Health. URL: https://data2.unhcr.org/en/documents/download/62328.

[3] Lyles E, Hanquart B, Chela L, Woodman M, the LHAS Study Team, Fouad F, Sibai A and Doocy S. Health service access and utilization among Syrian refugees and affected host communities in Lebanon. J Refugee Studies 2017 May 24.

[4] World Health Organization. Beyond the barriers: framing evidence on health system strengthening to improve the health of migrants experiencing poverty and social exclusion. Geneva: World Health Organization; 2017

Methodology

This process evaluation takes the form of a mixed method study which aims to understand the functioning of an intervention. For this Process Evaluation IMC and PUI developed the following framework for analysis designed to answer the evaluation questions above. The Framework consists of four pillars:

1. Appropriateness/Quality:

Measures the appropriateness of the process and answers whether it is replicable.
Was the service delivered appropriately?
Was the service provided?
Is PUI reaching our target population?

2. Fidelity:

Is PUI mplementing the intervention by following exactly the core elements outlined in the logic model – protocols – processes? Is PUI in line with the design?
It is important to highlight that there are 3 main scenarios or threats to fidelity:

1. No project is being provided
2. A different project then intended is being provided
3. An inconsistent project is being provided

3. Satisfaction:

Understanding beneficiary satisfaction and basically answering the following questions from the beneficiaries perspective:
1. What is being received
2. What was expected
3. How are our beneficiaries treated?

Challenges to measuring Satisfaction:
1. It is essential to understand whether satisfaction is being biased by the ceiling effect?
2. Are there any discrepancies between different sources?
3. Does the measure include an exploration of expectations and experiences or are they just focusing on perception?

4. Project Logistics:

Basically the workflow that is in place. What are the order of tasks? What is the amount of work done by staff? What was produced (Material)? And is it of a sufficient quantity?
These was considered within the logic model that was used to design the project and is used as a basis for the process evaluation using the four pilars of appropriateness/quality, fidelity, satisfaction and logistics as detailed below.

The Logic Model Framework for the Process Evaluation

Objective	Indicator	Logic of the intervention	Evaluation Questions	Sources of information
Provision of quality primary health care s ervices through supported primary health care centres	Number of PHC consultations provided for Syrian and other vulnerable populations at the supported PHCCs	Syrian and vulnerable populations who received health services at the contracted PHCCs (excluding vaccinations)	1) What type of services were provided? (disaggregated by Age-Gender-Nationality) (A) 2) Are the assumptions of the FFM matching with the current implementation? (A) 3) What are the demographics of the beneficiaries (characteristics of targeted population: Age-Gender-Nationality) (A) 4) Are at least 50% of beneficiaries Syrian refugees? (F) 5) Are PUI selecting and targeting the most needed PHCCs? (A) 6) Are the services PUI are supposed to be supporting available at the supported PHCC? (F) 7) Is the physician's schedule available and accurate ? (A) 8) Are the PHCCs following the protocol for waived consultations in terms of assessing vulnerability? (A) 9) Are the services provided following the FFM? (F) 10) Is the waiting time for consultations acceptable? (A) 11) Is confidentiality of files ensured? (A) 12) Is privacy ensured in the PHCCs? (A) 13) What are the main challenges in initiating support for a PHCC? (L) 14) Is the population in the catchment area aware of the s ervice provision? (A) 15) Is Phenics data accurate and complete? (A) 16) Are patients satisfied with the services provided? (S)	FFM Analysis PHCC prioritization selection criteria PHCCs assessment reports HFO observation and report DHIS2 reports Staff JDs REBAHS SOPs Coordination meeting minutes / Field visits report FGD reports KII Interviews Baseline report Quality Performance Report Medical Records Assessments Database extraction and medical records Patient Satisfaction Reports

Objective	Indicator	Logic of the intervention	Evaluation Questions	Sources of information
	Number of antenatal consultations provided at the supported PHCCs	Count total number of ANC consultations provided by IMC & PU-AMI out of all provided consultations at PHCC.	1) Has the target for ANC consultations been reached? Disaggregated by nationality and age (F) 2) Are the OB/GYN services provided by gynaecologist or midwife? (L) 3) Is the ANC MoPH/FFM protocol being followed by the PHCC staff? (A) 4) Are patients satisfied with the services provided? (S) 5) Are the ANC kits distributed at PHCC? (F) 6) Are beneficiaries satisfied with the contents of the kit? (S) 7) Are the kits delivered on a timely manner? (L)	Phenics data FFM Review by Pascale Le Roy in October 2018 PHCC prioritization selection criteria PHCCs assessment reports HFO observation and report DHIS2 reports REBAHS SOPs Coordination meeting minutes / Field visits report Key Informant Interviews Focus Groups Discussions Baseline report Quality Improvement Report Medical Records Assessments Patient Satisfaction Survey REBAHS Reporting data
	Number of staff supported at PHCCs	Number of staff that are recruited by IMC/PUI or paid incentives to provide better quality services.	1) Are staff selected as per the needs? (A) 2) What are the main challenges faced in supporting staff? (L) 3) Is the number of supported staff aligned with the target? (F) 4) Is the salary paid by PU aligned with the average salaries? (L)	Key Informant Interviews HFO observation and report REBAHS Reporting Data Quality Improvement Reports

Objective	Indicator	Logic of the intervention	Evaluation Questions	Sources of information
	Number of women attending at least one postnatal care visit at the supported health facilities	Women receiving at least one PNC visit (within 6 weeks of delivery)	1) Did PUI reach the target forPNC? Disaggregated by nationality and age (F) 2) Are the awareness sessions conducted in PHCCs and in the community targeting pregnant women? (A) 3) Is the PNC MoPH/FFM protocol followed by the PHCCs staff? (A) 4) Are patients satisfied with the services provided? (S) 5) Are the PNC kits distributed at PHCC? (F) 6) Are women satisfied with the contents of the kit? (S) 7) Are the kits delivered on a timely manner? (L)	Phenics REBAHS Reporting data Quality Improvement reports PSS reports Field visits reports
	Number of vaccination visits for children under 5 years at the supported facilities.	Count number of visits for children under 5 receiving vaccination provided by IMC & PU-AMI out of all consultations at PHCC.	1) Are vaccinations provided for free at the PHCCs? (A) 2) Are we reaching the target # of vaccination visits so far? (F) 3) Is the community aware about free vaccination services at the PHCC? (A) 4) Are vaccines and consumables available all the time at the PHCCs? (L) 5) Are the vaccines stored properly? (A) 6) Is the logbook/inventory filled in correctly and completely? (A) 7) Are immunization cards filled in an accurately and completelyy? (A) 8) Are the staff dedicated to vaccinations trained? (A)	Phenics and Vaccination Logbooks Vaccination Cards Temperature Logsheet Medical Records assessments

Objective	Indicator	Logic of the intervention	Evaluation Questions	Sources of information
	Number of patients receiving diagnostic tests disaggregated by children under 5, acute, pregnant women, and chronic patients	Count number of patient receiving diagnostic tests by type provided by IMC & PU-AMI	1) Is PUI reaching the targets? Disaggregated by category (F) 2) Are the package of Laboratory, Imagine and Diagnostic Tests delivered according to the MoPH and FFM protocols? (A) 3) Are PUI staff following the pre-approval procedure? (A) 4) Is the protocol relevant to the health conditions observed in the PHCC? (A) 5) What are the gaps in provision of diagnostic tests? (A) 6) Are the PHCCs capable of providing diagnostic tests? Do all PHCC have either contracted or their own services (L) 7) How is the quality of Laboratory Tests ensuredt? (A) 8) Are Point of Care (POC) tests available in supported PHCC? (L) 9) Is the Pre-Approval process efficient? (L) 10) Is the Laboratory Test Request correctly recorded on the DHIS2? (A) 11) Are physicians aware of the available services (as per protocol)? (A) 12) Is there a control mechanism in place to promote rational use? (A)	DHIS 2 Key Informant Interviews Focus Groups Discussions PSS Report Review of SOPs
	Number of beneficiaries receiving acute illness medications at the supported PHCCs on monthly basis	Count number of beneficiaries receiving acute illness medication	1) Are essential medications available all the time at the PHCC? (L) 2) Is PUI meeting the 50% of the target? (F) 3) Are patients receiving the appropriate treatment based on the diagnosis? (A) 4) Are patients satisfied with the medications provided? (S) 5) Is any gap the MoPH essential medication supply filled? (F) 6) Is pharmacy management consistent with SOPs (stock control, management, data recording, inventory/documentation, cold chain etc.)? (L)	Phenics PSS Report Feedback from MoPH Pharmacy Assessment Reports REBAHS reporting data

Objective	Indicator	Logic of the intervention	Evaluation Questions	Sources of information
	Number of PHCCS achieving 50% of the unmet standards identified in the baseline assessment	Count number of PHCCs achieving 50% of unmet standards identified in the baseline assessment	1) What are the challenges in recruiting Quality Assurance staff? (L) 2) Are there Quality Improvement Plan developed and in place for each PHCC? (F) 3) Is there a monthly monitoring in place? (A)	Quality Improvement Report
Provision of community health services focusing on health promotion, disease prevention, and health seeking behaviour	Number of Community Health Workers trained on key health topics each year	Count number of community health workers attending trainings	1) Have the targets been met to date? (F) 2) Did we manage to find and train 2 CHW per catchment area? (F) 3) Has a balance in nationality and gender been achieved? (F) 4) What are the reasons for drop-outs? (L) 5) Is there a security and safety SOP in place ? (L) 6) Is the security and safety SOP followed? (L) 7) Are the CHWs' able to perform the required tasks? (A) - able to deliver key messages etc. 8) Are CHWs satisfied with the remuneration vs. working hours? (S) 9) What are the challenges in recruiting and retaining CHWs? (L)	Qualitative and Quantitative Community Outreach reports Key Informant Interviews Focus Groups Discussions

For the Key Informant Interviews and Focus Group discussion the following Qualitative Data Analysis was conducted by an external consultant

All focus groups and in-depth interviews with key informants (KIIs) were transcribed and then translated into English. A thematic approach was used to conduct an in-depth analysis of the data. As an initial step, each transcript was read and re-read to familiarize the researcher with the information. The codes were then generated based on the six main aspects of the project activities (clinic level analysis, PHCC consultation, diagnostic tests, acute illness medications, quality assurance, and community health), where each indicator was sub-categorized into four main pillars of process evaluation (appropriateness, fidelity, satisfaction, and logistics). Findings were provided in a narrative format with quotes from the interviewees to support the theme or sub-themes.

Key Findings

I. Clinic level analysis

In terms of clinic level analysis, findings were categorized into the following main pillars of process evaluation: (a) appropriateness and fidelity (including data pertinent to the overall project and its community health services, PHCCs' selection and introduction to the project, PHCCs' services, and human resources); (b) satisfaction (including data pertinent to the overall project, capacity building, and incentives); and (c) logistics (including data pertinent to cars, drivers, and road safety; and logistical and finance departments).

Appropriateness and Fidelity

Overall project and its community health services

When asked about the overall success of the REBAHS project, 62,920 were conducted in PUI supported PHCCs in 2018. 51% of these consultations were with children under 18. 66% of consultation were with Syrian refugees, 35% vulnerable Lebanese and the rest other nationalities. Females made up 64% of all patients benefiting from consultations. Most participants highlighted its importance in 'providing access to health services' at discounted fees, which is believed to 'encourage people to follow up on their health issues'. This has been echoed by the reported 'increase in number of visitors [patients] in the PHCs particularly after receiving awareness sessions'. This is supported by quantitative data for the project that shows an increase in consultation numbers across the board after the implementation of the FFM. Furthermore, several participants reported overall satisfaction with the FFM and indicated the importance of the project in decreasing hospitalization. Moreover, other participants described the 'innovative' strategy of the project in which the essential needs of patients are being covered at PHCCs, in a country where the healthcare system has been dominated by expensive private health care providers. CHWs added that 'people are very vulnerable, and [before the project] they had to visit private clinics and pay around 50,000 LBP, which is a huge amount for them'. More specifically, one KI highlighted the success of the project in reaching various target populations including 'children, adolescent, women, and men', as well as 'any vulnerable person who shows up at the PHCC'. Another KI voiced that 'services are provided equally to people of different nationalities'.

In addition to the project's success at patient level, achievements at the level of PHCCs and the community were also highlighted. For instance, the project was reported to 'help the PHCC directors put an action plan targeting what is not working at the PHCC and which guidelines to use to improve the services'. It was also indicated that the project 'helps support the development of a link between the community and the PHCCs'. Another KI added that the project contributed to the 'empowerment of the community through the recruitment, training and implanting awareness session/campaigns by the CHWs'.

Some of the project's successes may be attributed to the 'high level of coordination' reported by some participants, who 'work by rotation so each team member is aware of all the PHCCs' work; thus, each one would be able to cover for another in case of absences'. Moreover, one KI reported that 'all PHCCs have [been provided with] the essential equipment needed to operate', which may have also contributed to the successful provision of health services.

At the financial level, although one KI associated the project's success with the 'strong financial programming and control of expenses', others reported 'delays in payments to the PHCCs' due to the 'strict financial procedures required and the heavy administrative revision to follow before issuing payments' in compliance with MADAD requirements.

However, the number of consultations that were associated with LIDTs was lower than anticipated in the initial assumptions. During the planned review of the FFM consultant Pascale Le Roy carried out a review of the FFM and made some key recommendations that address a considerable number of the points raised in the process evaluation particularly the expansion in the breadth and depth of the package of services covered by the FFM. Within this initial period where the FFM is implementing in new PHCCs the strong controls are required as part of PUIs accountability. PUI's utilisation of Health Field Officers in each PHCC also allows for greater control as well as resulting in a closer relationship with the PHCC and this fact was raised in the FFM review as being beneficial for implementation.

Primary Health Care Centres (PHCCs) selection and introduction to the project

When asked about the selection of the PHCCs, diverse opinions were communicated. In terms of PHCC locations, although one KI stated that 'the location of the PHCCs is in line with what is indicated in the proposal', another KI reported that the 'selection of the PHCCs is not always following the assessment and reviewing the contract'. On review there is a clear PHCC prioritisation criteria and certain documents are required to proceed to contracting so not all PHCCs that are assessed will proceed to contracting/

Other participants echoed difficulties due to 'distant geographical location of the areas of intervention (PHCCs vs Community)', which was perceived to negatively affect transportation and departures of teams to those areas. Another KI also agreed that the 'identification of new PHCCs [is a main challenge] due

to different reasons such as distances from other supported PHCCs'. Furthermore, additional challenges pertinent to the selection of new PHCCs were indicated, including the 'number of consultations per day and the different criteria between MoPH and UNHCR'. Moreover, 'weak bridges with the community' as well as 'no community intervention [strategies]' were identified at the level of some newly supported PHCCs, which was believed to cause 'delays in spreading news [reaching out] to the population'.

With regards to the process in which PUI initiated the FFM in PHCCs, one KI stated that 'clinics are being introduced though health PM meetings, then PHCC team manager, pharmacist and medical advisor meet with the concerned staff to further explain [processes]'. Another KI pointed out that '[what was provided was a] small briefing during the assessment and then full description during the contract review meeting'. Additionally, when asked about the trainings run for PHCC staff, some KIs highlighted the 'need for regular PHCC staff trainings, meetings, and collaboration/cooperation', indicating that 'it is only the in-house [activities] and running interventions that can really help the staff visualize the project's components'. Moreover, the need for additional on the job training was communicated stating that 'the staff may not acquire the information and know the services from the first meeting, especially ANC/PNC; thus, practice is needed'.

Primary Health Care Centres (PHCCs) services

a)The Flat Fee Model

When asked about the services provided by the PHCCs, although many were appropriately delivering the services as per the agreement, some other PHCCs were not fully implementing them at the level of consultation fees and referral slips. For instance, regarding consultation fees, some CHWs reported that beneficiaries 'who lose their file number are being asked [by some PHCCs] to pay more than 3,000 LBP', elaborating that since 'there is no computer [at the PHCC] to look up the file number, this requires the PHCC to do additional work to locate the patient file. Therefore, those PHCCs are requesting more money'. This is definitely not in accordance with the Annex A of the PHCC contract but what is difficult to establish is whether these consultations were included in the FFM has subsequently undergone a planned review and in response to feedback generated through this process evaluation expanded to include more types of consultations.

The importance placed on referral slips has been raised as an issue with some CHWs explaining that 'some patients are being denied service if they don't have a referral slip, despite it not being a requirement for service'. One of the CHWs added that 'having a referral slip seems to influence PHCCs to ensure that they adhere to the subsidized consultation fees, as they know that deviations will be reported to the CHW who in turn will report back to PUI staff'. In other areas, CHWs stated that 'some PHCC staff are not giving enough importance to the referral slip. Thus, some beneficiaries stopped giving importance to it, despite it being needed to measure the effectiveness of the referrals'.

highlighted the 'need for regular PHCC staff trainings, meetings, and collaboration/cooperation', indicating that 'it is only the in-house [activities] and running interventions that can really help the staff visualize the project's components'. Moreover, the need for additional on the job training was communicated stating that 'the staff may not acquire the information and know the services from the first meeting, especially ANC/PNC; thus, practice is needed'.

b) Physicians' Schedules and Waiting times

Availability of some physicians at PHCC level was an issue raised with a range of explanations given such as they 'might be on leave or are busy due to their private clinics' or that 'specialists are often having urgent cases and cannot attend to the PHCC' but clarified that 'in most cases, a replacement is found, as well as the GP is always present in the PHCC'. CHWs elaborated that, in such cases, 'patients might do multiple visits while also incurring transportation costs to be able to see the doctor'. Furthermore, CHWs suggested the recruitment of more female doctors, as well as additional specialists to be covered under the PUI package, including orthopaedic surgeons and neurologists. With reference to the package physicians are not support within the REBAHS project specifically in terms of staff salary. However, teams work with PHCCs to ensure that the rota is filled and there is no specific reference to ensuring gender sensitive rotas. In parallel, one KI indicated that 'under the flat fee model, some services -such as specialist consultations- were not covered, but now they will be added'. This is verified with the SOP at the time a fact that has been changed in light of feedback from the 2019 FFM review. However, not all PHCCs cover all specialties; however, the core specialities of general practice, paediatrics, obstetrics and gynaecology, endocrinology and cardiology are covered by most PHCCs with the exception of a few PHCC who do not have an endocrinology in which case services are covered by either a Family Medical Doctor if available or another speciality.

As for changes in the physicians' schedules, one KI indicated that 'when a patient arrives at the PHCC, it is communicated whether the doctor is available. As for the specialists, the schedule change is communicated [to patients] by SMS or phone call'. Conversely, many CHWs reported challenges faced due to inaccurate doctors' schedules that are posted at the PHCCs, in terms of the timing as well as the names of the attending doctors. CHWs explained that 'some patients are interested in seeing a particular doctor who had previously diagnosed them, but when they go, they are surprised to find a different doctor at the clinic'. . The Patient Satisfaction Survey shows that Syrian respondents are more likely to be satisfied from PHCC service than Lebanese respondents with a percentage of satisfied Syrian respondents rising to 94% in each region. Although 78% of respondents in Akkar reported waiting for more than 15 min to see the doctors, 61% of total respondents were satisfied with waiting time to see a doctor. However, in Akkar waiting areas were seen as uncomfortable. In Saida 50% of respondents were satisfied with the waiting time to see a doctor. It is noted that waiting times can exceed one hour and this is the case for 37% of respondents in Saida and 19% in Akkar. This is particularly the case in PHCCs with no appointment system.

c) Management of vulnerable cases

Regarding vulnerable cases, some CHWs stated that 'people with special needs [vulnerable cases] are having to pay for consultations'. One KI added that 'not all PHCCs are implementing the assessment of vulnerable cases. Some PHCCs are not reporting any, although some have a lot'. Thus, it was suggested that more awareness and additional refresher trainings pertinent

to the identification of such cases should be raised. Moreover, one KI described the process by stating that 'in terms of medical cases, the vulnerability assessment form is proved by medical records/reports/diagnostic tests which is signed and stamped by the physician. As for the socio-economic part of the vulnerability assessment form, the director is the one highlighting that the patient is in need to be covered as waived. In turn, PUI FOs will be present and validating on spot'.

d) Health Information System

All PHCCs have been supported in implementing Phenics the MoPH HIS if they are not already doing so. In addition to this PHCC are provided with a package of support to improve the accuracy of data recording ultimately leading to improved health surveillance at a national level. With data cleaning being supported at each PHCC there has been an improvement over the implementation period in data accuracy and completeness but teams are still continuing to work in this area.

e) PHCC behaviour towards beneficiaries

Although 90% of patients in Saida and 88% of patient in Akkar spent less than 10min with the doctor. The majority of patients reported receiving a clear description of their diagnosis and 81% of respondents in Saida and Akkar received an explanation about the administration of prescribed medication. The mistreatment of some beneficiaries was another challenge reported. To elaborate, some CHWs indicated that 'some beneficiaries are being treated harshly by some PHCC staff, which discourages them [beneficiaries] from doing future visits to the PHCCs'. However, in the PSS 100% of respondents in South/BML and 98% in Akkar reporting being treated with respect is 100% in Saida and 98% in Akkar. CHWs explained that in such cases, the incidents are reported to the CHWs who communicate with the PUI staff to intervene. However, not all approaches lead to improvement in behaviour. One KI added that this treatment affects the community's perception of the PHCCs with 'the level of service at the PHCC can affect how the CHWs are perceived by the community. [As such], negative experience by patients at the PHCCs will create negative feedback towards the CHWs in the community'.

f) Human Resources

i) PUI Staff

In terms of the sufficiency of the current human resources, various opinions were raised. Some KIs reported that, in general, 'the current human resource in place are sufficient'. Others indicated the need for additional human resources if more PHCCs are added. To elaborate, one KI explained that 'the number of PHCCs is being increased to meet the targets set in the proposal. As a result of this increase, the staff recruitment's needs also increased. Thus, some staff were initially part-time workers but were then changed to full-time employees given the increased work load'.

Moreover, regarding the availability of health care specialists, some difficulties were described. For instance, few KIs indicated some challenges associated with the 'high turnover and difficulties in recruitment of [some] specialists'. Therefore, 'some delays in recruitment occurred due to difficulties in finding the right candidates'. In general it was felt that 'the recruited staff are doing their jobs according to their job description' and one KI added that the performance of the recruited staff is being monitored on a monthly basis.

ii) PHCC Support Staff

Ate the end of December 2018 12 PHCC staff were being supported by PUI. This is less than the target of 17 due to a combination of challenges in recruitment for specific staff such as midwives in some PHCCs and staff in newly supported PHCCs note being recruited yet. Staff to be recruited are negotiated at the start of implementation with a new PHCC. Salaries for supported staff are a fixed salary grid agreed with IMC UK. When asked about the process of staff recruitment at clinic level, there was a diverse range of views. One KI indicated that the 'staff were completely recruited by the PHCC director in agreement with PUI after one month of the implementation to ensure the proper estimation of the workload'. Another KI added that 'the supported staff were chosen from the existing PHCC staff, after consulting with the PHCC manager'. Triangulating this with key project documents the staff support is given to new additional staff not existing staff. However, one participant stated that, in theory, the 'staff are recruited based on the needs and gaps of the PHCCs, but when it comes to practice, this cannot be reflected in the perfect way'. To elaborate, the KI added that in one PHCC, a midwife was recruited because this position was not present; however, what the PHCC needed was a data entry clerk. This is consistent with other feedback that in general the allowance of support for one member of staff per protocol is limiting especially for big PHCCs that may have multiple needs. The need for data entry clerks, was specifically raised but the perception of whether that need was met was variable with on respondent say that given that 'data entry is taking the biggest part of work and time' this is a gap for some PHCCs; whilst one KI had the impression that data entry clerks had been recruited at each clinic. This latter statement is not consistent with the supported staff database which at the end of December 2018 showed that PUI was supporting 2 midwives, 5 data entry clerks and 5 registered nurses.

Satisfaction

Overall project

When asked about the level of satisfaction with the project, most participants reported 'overall satisfaction', though KIs added that 'improvements and adaptations are always possible as population's needs might change'. This is consistent with data from the PSS that found 77% of patients were satisfied with the care they received. When breaking down the aspects of satisfaction, there were clear notable differences. There were very high levels of satisfaction for ease of access (84%), Quality and comprehensiveness of information provided regarding the services (95%) but clear areas of less satisfaction was around the availability of medication with a rate of 40% satisfaction. The challenges with availability of medication due to shortage in MoPH and YMCA supply and delays in medical procurement by the Consortium lead IMC has definitely impacted on implementation of the REBAHS project and is an issue that is raised across multiple data sources.

Capacity building

In terms of capacity building, there were differing opinions. For instance, many CHWs appreciated the 'increased personal knowledge' provided to them. Whereas other participants hoped for 'a better capacity building process, so that the project leaves a future impact not just a temporary outcome'. This is in keeping with the projects emphasis on making sustainable changes to the health system in Lebanon. However, at the same time the

MoPH's role in training and general leadership and governance has been promoted by PUI and it is felt important that this be done in partnership with the MoPH.

Incentives

Regarding incentives at the clinic level, dissatisfaction was indicated by one KI who felt that physicians should also be offered incentives as means of 'encouraging them to work' and currently they are not incentivised.

Staff Salaries

As for PUI staff salaries, a few KIs suggested that there should be 'a salary scale upgrade since the salaries are lower than those of other employees at other NGOs'.

Logistics

Cars, drivers, and road safety

Regarding drivers, a few KIs reported the difficulties faced 'regarding the disponibility of drivers as well as cars for the movements'. Such difficulties have been attributed to the 'distant geographical location of the areas of intervention'. Moreover, it was reported that 'there is no [proper] coordination [on cars' movement], and things don't always go smoothly'. In addition, a few KIs were concerned with the road safety of some staff members, who sometimes 'have to drive and work at the same time, which can create difficulties in concentrating while driving and thus increase the risk of traffic accidents'. Many participants faced challenges with the logistical department in terms of availability of cars and drivers. One KI explained the possibility of this department being overworked, given that it 'might have many requests from various projects at the same time, thus reducing the availability of staff to respond to requests with ease'.

Finance department requirements

The requirements of the finance department were raise, with some participants reporting that the 'finance department is always asking for documents that are difficult to collect from the PHCCs on time, or even at all'. Thus, it was suggested that 'They [the finance department] should show more understanding in their future requests'.

II. PHCC Consultations provided for Syrian and other vulnerable populations at the supported PHCCs

In terms of the PHCC consultations provided, findings were categorized into 'appropriateness and fidelity' as the main pillars of process evaluation. These pillars were sub-categorized into: vaccination, ANC/PNC, and chronic disease.

Appropriateness and Fidelity

Vaccination

PUI has achieved 135% of its target with 12,602 vaccination consultations; this high level of achievement is due to a combination of external factors and REBAHS factors. The REBAHS related factors are ensuring support at PHCC level for MoPH's policies and strategy to widen vaccine coverage in Lebanon, this is both through PUI's Medical Advisers and Health Field Officers placed in the PHCCs. In accordance with the MoPH guidelines, PUI has been promoting task shifting from the Paediatricians to registered nurses creating more windows of opportunity for vaccination. This has been reinforced by either supporting a registered nurse or arranging MoPH training or by utilizing a performance-based financing mechanism for existing staff. The quality management activities also contribute to maintenance of the cold chain and appropriate documentation around vaccination.

In addition to this, the need and availability of vaccines at PHCCs is a key message within community health awareness raising. External factors include the policy of ensuring all children are vaccinated before being able to attend school and the MoPH's Accelerated Immunization Activities, which has increased the number of people presenting to the PHCC for vaccination.

When asked about the vaccination services, participants' opinions varied. Many CHWs reported an 'increased number of vaccine provision'. Whereas others identified challenges with 'some referred individuals being turned down when they request child vaccinations, even though the PHCC schedules enlist vaccination for those particular days'.

ANC/PNC

PUI has provided 6,240 antenatal consultations representing an achievement of 117% of the Year 1 target. Syrian Refugees make up 84% of beneficiaries. However, for PNC services PUI is under target with 198 consultations (24% of the target) with again Syrian Refugees making up the majority of beneficiaries at 80%. Barriers identified to attending postnatal consultations in the clinic including transportation costs and general sleep deprivation associated with having a young infant so it has been difficult to increase uptake of PNC in a setting when both them and their child are not ill . So this has been a key area that both the community health team and the BCIP have been working on to raise awareness of key preventative actions such as breastfeeding that can be taken in the postnatal period. Both ANC/PNC services are being provided by Obstetricians and Midwives with the support of task shifting aspects of ANC and PNC care to the midwife increasing access to ANC and PNC. Regarding respondent's views on ANC/PNC services, some KIs reported overall satisfaction with the follow up on ANC and PNC packages. Moreover, many CHWs indicated an 'increased prevalence of breastfeeding after awareness [sessions were given]'. Conversely, one participant from the same region was concerned with the low number of covered ANC/PNC visits, stating that 'the number of visits assigned for ANC is somehow small. Some OB/GYN request a visit each month throughout the pregnancy, but ANC/PNC packages are only covering 4 out of 9'. Another KI indicated that 'only 2 echographies are covered under the protocol and a third when needed', and added that 'sometimes a visit is made before the due date, which is not covered'. One participant mentioned that because of this if a pregnant women wants an additional visit beyond the protocol 'for the mother, only consultation is covered. X-rays and lab tests are not covered'. In the FFM review it was noted that PUI medical advisors were supporting access to comprehensive ANC by prompting physicians to add additional tests if they only requested part of the preventative package.

Furthermore, some challenges were encountered with the beneficiaries themselves where, for example, pregnant women were reported to 'fail in visiting the PHCC on the due time [..] because of their lack of awareness'. Moreover, one KI was concerned with the 'worldwide challenge faced in terms of follow-ups on ANC and PNC packages'. Thus, the need for 'continued efforts in education at the level of households, communities, schools and clinic care settings for both women and men' was requested.

Chronic disease

Some KIs reported an overall satisfaction with the follow up packages related to patients with chronic diseases, which attribute to decreased complications among those populations.

III. Diagnostic tests provided for Syrian and other vulnerable populations at the supported PHCCs

In terms of the diagnostic tests provided, findings were categorized into 'appropriateness and fidelity' as the main pillars of process evaluation. These pillars were sub-categorized into: overall process; acute cases, pregnant women, NCD patients; and additional diagnostic tests.

Appropriateness and Fidelity

Overall process

In 2018, PUI ensured that 13,311 beneficiaries had access to free diagnostic tests (65% of whom were Syrian Refugees. This accounted for 1,893 acute/general diagnostic tests for children under 5 (880 males and 1,013 females), 7,868 acute/general diagnostic tests for patients over 5 (2,001 males and 5,867 females). Diagnostic tests for 2,750 pregnant women and 2,994 chronic disease patients (1,076 males and 1,918 females).

When asked about the efficiency of diagnostic test processes, there were a diverse array of opinions shared between and within regions. A few KIs reported overall satisfaction with diagnostic test processes, whereas others indicated inefficiencies. For instance, it was stated that 'the process takes time to fill all the parts of the Claim Form, adds more work for the doctors, the Medical Advisor cannot be available in all the PHCCs at the same time, and the HFO sends the Claim forms by Telegram which takes time'. This is balanced with the continuing need for a robust pre-approval process that was highlighted in the FFM review especially at the initial stages of support to ensure rational use and the cost effectiveness of the intervention.

Moreover, despite that 'over 90% of tests are approved' and that 'upon signing the contract, the physicians and PHCC staff involved in the prescription and diagnostic tests are trained on the processes', suggestions were made to simplify processes. The need to 'keep what is most relevant and effective at the primary health care level', and the need for more flexibility were also suggested. Health Field Officers record all Laboratory, Imaging and diagnostic tests supported by PUI on the DHIS2 and the financial report generated from the DHIS2 is used to verify PHCC invoices along with phenics data, payslips, the "Service agreement contract between service provider and staff (e.g. nurse, midwife, pharmacist, data entry clerk), Staff ID + signature, timesheets, incentives scoring sheets, letter of appreciate and claim forms as per protocol.

There is a variation in what is available at PHCC level in terms of point of care tests but all PHCC have contracts with Laboratories and radiology centres to be able to supply the laboratory, imaging and diagnostic tests that are supported under the FFM. The Laboratories are visited by PUI Medical Advisors for quality assurance as per MoPH guidelines.

Acute cases, pregnant women, and NCD patients

Opinions regarding diagnostic test processes also varied depending on the patient's case. For instance, although 'diagnostic tests for acute conditions were shown to be a challenge, given the very heavy battery of tests and combinations' making pre-approval difficult at times, some KIs indicated satisfaction with 'the diagnostic tests pertinent to NCDs and pregnant women'. To elaborate, one KI explained that 'for complicated pregnancy, it is flexible to add more lab tests and to do more ultrasounds. For uncontrolled NCD patients, it is flexible with the follow-up visits'.

Additional diagnostic tests

Additional diagnostic tests were suggested by some participants and in the PSS when asked about medical gaps in the services 30% of respondent reported that some medical tests are not covered by PUI. 31% of respondents in Akkar had to pay extra fees at the PHCC for services not cover by PUI; such, imaging and lab tests.

For example, some CHWs were concerned that 'some needed lab tests are not being covered'. This was also voiced by few KIs who stated that 'only a couple of cases are covered under the NCD and acute causes list'. Other KIs highlighted the need for new diagnostic tests. For instance, it was indicated that 'for unknown fever, CRP is not available. For abdominal pain, no echographies for abdomen or urinary track is available. No breast ultra sound is available for women. Cardiologist ECG is covered only for hypertension, even when not needed, whereas it is not covered for other needed cases'.

IV. Medications provided for Syrian and other vulnerable populations at the supported PHCCs

In terms of medication provision, findings were categorized into 'appropriateness and fidelity' as well as 'fidelity' as the main pillars of process evaluation. These pillars were sub-categorized into the following: (a) appropriateness and fidelity (including data pertinent to gaps in medication provision as well as enhancing the efficiency of processes; and (b) satisfaction (including data pertinent to supplements and additional medications).

Appropriateness and Fidelity

Gaps in medication provision

13,803 beneficiaries received acute illness medications at PUI supported clinics in 2018. Representing 33% of the target for year 1. The target for year one was not achieved for this indicator due to the delay in dispending medications to the PHCC, with the initial batch being delivered mid-Q2and for PUI in only 11 PHCCs. For the second batch of medications, delivery was

planned mid-November 2018, but this was not received until mid-January 2019. Respondents have further elaborated about the challenges at early stages of the project's implementation. One KI associated these difficulties with the inflexible budget allocated for medications as well as the MoPH gaps, indicating that 'at the beginning of the project, each PHCC was allocated 1700$ only, with no possibility to increase the amount. Now the MoPH doesn't have any drugs to offer, and MADAD project will cover the gaps for the acute medication since the chronic drugs are the responsibility of the YMCA'. However, it was clarified that as the project progressed, processes pertinent to the provision of medications became more efficient. To elaborate, one KI explained that, at the launching stages of the project, PHCCs were not provided with the required medication as the need needed to be assessed. Another KI explained that the gap in medication provision at PHCCs may be attributed to the limited availability of different medication dosages. This consequence of which would be that 'a big number of packets is given to the patient in order to meet the required dosage, which [in turn] leads to shortages in medications'. This shortage was also associated with an inefficient estimation process at initial delivery stages, where for instance, in one area, 'the drug order was made based on the existing patient number, which then peaked after PUI intervention'. Shortages in medications may have also resulted from the 'delays in delivery due dates which are causing gaps in supply' as well as the inefficient 'reception of drug orders from Karantina [MOPH Dispensing Center]' . As such, one KI (pharmacist) suggested that 'the delivery is first made to a PUI warehouse, where accurate count can be made, and then the order gets distributed to the PHCCs'.

Similar challenges were shared by other participants; for instance, some CHWs reported the lack of availability of medications, including those for chronic diseases. Thus, CHWs suggested that 'more medications should be in stock to cover the needs' given that 'some beneficiaries have to pay 20,000 LBP [as a monthly average] for medication that they purchase outside the PHCC'. In the PSS an average of 44,000 to 50,000 LBP was being spent on medication. Additional examples were shared whereby 'some injured beneficiaries had to take tetanus injections that are not covered and are costly for some'. In such case, beneficiaries revert to the CHW complaining that they could not get their medication from the PHCC, which discourages them from making future PHCC visits. The dissatisfaction around the availability of medication is substantiated by the PSS report that found that only 40% of respondents were satisfied with the availability of medication. However, for those that did they report getting a clear explanation on administration.

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Enhancing the efficiency of processes

Despite the challenges presented, same KIs clarified that as the project progressed, processes pertinent to medication provision and ordering became more efficient and pharmacists became more experienced in 'predict[ing] the load of each PHCC and request[ing] the needed drug earlier to avoid shortage'. Thus, few KIs indicated that things are usually going smoothly' and that 'patients are receiving the drugs for free', 'the list of medication is covering most of the diseases', . Furthermore, even with the difficulties faced, the project was still able to achieve a reduction in expenses at PHCCs where 'the latter are offered consumables that they had to buy before the project started, which reduced expenses at the PHCCs and is contributing in better service provision'. Moreover, 'the stock rooms are now organized, PHCCs are better equipped, and PHCCs' staff are building capacity' with the support of PUI pharmacis.

Satisfaction

Supplements and additional medications

Few KI were concerned with the lack of provision of supplements and with the prescription of medications that are not on the MoPH Essential Drug list, stating that 'some prescriptions are not on the essential list, and are thus not available. Vulnerable population are less likely to purchase these medications from outside the PHCC, which leaves them at risk'. In the PSS, in the South/BML 20% got all their medication from PHCC whilst in Akkar 30% got all their medication from the PHCC. In general, 25% of respondents did not find their prescribed medication at PHCC and reported not intending to buy it elsewhere.

V. Quality Program

In terms of the quality program, findings were categorized into 'appropriateness and fidelity' as the main pillars of process evaluation. These pillars were sub-categorized into: overall quality program, performance-based financing, human resources, and training.

Appropriateness and Fidelity

Overall quality program

Throughout year one of the project, 9 PUI supported PHCCs out of a potential 11 PHCCs (6 have not been supported for long enough to be able to demonstrate improvement) showed improvements in terms of meeting quality standards more than the target for year 1. Exceptions include 2 PHCCs in the Akkar area which have not achieved the target yet, but have only been operational from Q3. Further improvements are expected especially with quality improvement plans being in place for all PHCCs and tailored support being provided by PUI dedicated quality assurance advisors alongside monthly monitoring. When asked about the quality program, an overall satisfaction was reported by several KIs. Some explained that 'the quality [standards] follow the modality implemented by the MoPH' and 'the Canadian accreditation standards', and are 'in line with the quality needs

of PHCCs'. Both confidentiality and privacy feature as Quality Assurance Standards that are monitoring at each PHCC and if there are any concerns a Quality Improvement Plan is made with the PHCC to address concerns.

One KI elaborated on the appropriateness of the scoring indicators, stating that 'indicators are clearly defined and address most of the existing quality needs of the PHCCs, and the calculation method is objective'. Another KI indicated that 'the set of standard indicators need continuous observation and are very basic, and the inclusion of other indicators will require extra budget to be implemented where not all PHCCs can afford to pay for this'.

Performance-based financing

When asked about the appropriateness of the quality incentive program, one KI indicated that 'the incentives are based on individual performance, and the incentives modality is appropriate'. Moreover, one KI highlighted the importance of the quality incentive program in 'creating a motive for the employees' but reported the 'lack of the directors' commitment toward the improvement process'.

Human resources

Regarding the human resources of the quality program, despite being described as 'homogenous teams', one KI reported insufficient human resources particularly quality officers.

Training

In terms of training PUI and PHCC staff's view of the quality program, some KIs indicated that 'no [official] training was conducted before [implementation]; [however], PUI is continuously coordinating with MoPH to deliver in-house training for the staff in need on different topics including Phenix, vaccination, etc'. One KI stated that 'as far as a formal inception of the program, it was not done. However, when needed, trainings are provided to PHCC staff to help them achieve the quality standard'.

VI. Provision of community health services

In terms of the provision of community health services, the results of the FGDs and KIIs were categorized into the following main pillars of process evaluation: (a) appropriateness and fidelity (including the tasks undertaken, human resources and number of beneficiaries, training of CHWs, and perception of the community); (b) satisfaction (including data pertinent to the tasks undertaken, training of CHWs, and expenses); and (c) logistics (including data pertinent to transportation, equipment and materials/tools, and personal matters).

Appropriateness and Fidelity

Tasks undertaken

Overall, PUI trained 36 CHWs achieving the target for the projects 34 of which were female. A total of 12,294 beneficiaries participated in awareness raising activities achieving 96% of the target for year 1. 84% of who were Syrian refugees and 69% females.

When asked about the tasks undertaken, almost all CHWs described their success in 'passing the messages from the NGO to the community; benefitting large numbers of beneficiaries; providing beneficiaries with awareness sessions; introducing the health services covered in the PHCCs to the community; and making referrals'. For instance, in one area, one CHW said that 'the PHCC is new and people are not aware that it exists. Through our visits, people have become aware of it and of the services provided'. CHWs added that they refer pregnant women to the PHCC and inform them about the processes to follow up on their medical wellbeing. CHWs believed that 'through the awareness sessions, people are now being more careful and seeking medical care'. Other participants were pleased with the success that was accomplished in such a short period, stating that although 'it's very difficult to introduce a team that has almost nothing to offer but information, patients now know how to deal with their illness and are more aware of health habits'. For instance, 'the concept of contraception was very negative among people. They were against contraception, but when they get proper information about family planning, they accept it'. Thus, 'awareness sessions are leaving an impact on people. People now find sharing heath information interesting. You can see neighbours talking about hypertension or vaccination and encouraging each other to take precautions'. Moreover, CHWs are also the link between beneficiaries and PUI, if there are any incidents reported to the CHWs, they forward the complaints to PUI staff for follow up. CHWs has also 'improved the relation between patients and PHCCs'

In terms of security difficulties, some CHWs were concerned with some areas. For example, one CHW stated that she 'does not know anyone in the village and does not feel secure to do households visits alone over there', thus requesting to have a partner to work with her in that village.

This had been fed back previously and it was noted that there is a Safety and Security SOP in decelopment.

Human resources and number of beneficiaries

At the level of human resources, challenges were faced in terms of recruitment of personnel and workload of some team members. For instance, at the launching phase of the project, some participants reported having delayed recruitments, thus team members 'had to work harder to cover the gap created by the late recruitment'. In terms of workload, these areas reported that although 'workload is fair once the team works for the current months rather than compensating for previous months'. For the Behavioural Change Intervention Programme 'the number of visits that was pre-set in the project's proposal is almost impossible to cover in the limited time we [they] have'.

As for the number of recruited CHWs (36), opinions varied between areas. On one hand, one KI indicated that 'the number of CHWs is enough, but the main issue is with transportation to remote areas'. This KI also stated that 'the ratio of CHWs to beneficiaries is appropriate, but sometime CHWs need to look for beneficiaries'. On the other hand, another participant reported that 'the number of CHWs should be bigger to cover a larger geographical area and to finish the workload within the limited time, or the number of hours and incentives should be increased'.

Training of CHWs

Regarding the training sessions provided to CHWs, opinions varied between areas. Some CHWs and one KI indicated that 'the

topics were very much needed and in line with the community needs', whereas other CHWs highlighted some gaps in terms of needed training sessions. For instance, it was reported that not all CHWs covered all basic topics such as diabetes and hypertension. Moreover, some CHWs suggested being trained on new topics that are requested by some beneficiaries such as "bone diseases". Other participants added that 'CHWs should be enabled to deliver the information; hence, additional trainings are required. Four days are not enough for them to receive all the needed information'.

Perception of the community

In terms of perception of the community, some CHWs and other participants reported challenges faced due to the lack of credibility of CHWs in some areas and misunderstanding of the CHWs' services, as well as mistreatment by some beneficiaries. For instance, some community health members faced difficulties with municipalities and beneficiaries, when there was no visibility of who they really are and what their job entails. This is consistent with the PSS for which respondents generally reported being referred by family or friends to PHCCs supported by PUI. 94% and 81% for Saida/BML and Akkar respectively. The analysis shows that CHWs are not main source of referral to PHCC services; however, this is likely because CHWs are members of the community and considered as relatives or friends. Especially given that 60% of patients coming to the selected PHCCs in South and Mount Lebanon are staying in areas where CHWs are delivering awareness sessions and this is 45% in Akkar. Some participants elaborated that some 'people believe that CHWs collect data for the purpose of sending back refugees to Syria. They [beneficiaries] sometimes refuse to let the CHWs in, and they kicked them [CHWs] out once'. It was also reported that 'one CHW was verbally insulted, and this incident was reported to PUI who dealt with it'. Moreover, few CHWs reported facing challenges with Lebanese households, stating that 'there are few Syrians in my village, and it is not as easy to visit Lebanese households (despite me being Lebanese)'. Moreover, one KI agreed that, in some cases, the 'acceptance of the CHWs is a challenge, especially due to nationality difference (i.e. Lebanese can show less acceptance to Syrian CHWs)'. As such, CHWs suggested increasing their visibility by 'accompanying the PUI staff so that they [CHWs] are known in the community, and thus gain more trust'.

Satisfaction

Tasks undertaken

Almost all CHWs value their tasks and had positive perceptions of their duties towards the community. CHWs confirmed that the awareness sessions they provide 'have a positive impact on the communities'. For instance, 'skin diseases incidences decreased a lot. Child vaccination was not taken seriously by parents. Some misconceptions on child vaccination has been changed. Parents often thought that vaccination induces child illness and would rather wait till the child is 2 years old to consider vaccination'. Moreover, some CHWs stated that refugees who are of lower educational levels have shown great interest in learning about health issues.

Training of CHWs

When asked about their training sessions, almost all CHWs were satisfied, especially with the soft skills training conducted during household visits. CHWs appreciated 'learning new information' and considered their training sessions provided by PUI staff to be 'clear and enough'. For instance, one CHW who was already trained on early child education said that she 'learned a lot and corrected some views on child upbringing as the result of the training'. CHWs also valued the protection training. As for the duration and periods of trainings sessions, opinions varied. Some CHWs stated that 'the duration of training is sufficient' and 'appropriate'; while others reported that 'the training period is long' and that 'one day training per month is enough'. As for the location of the training sessions, many CHWs were complaining about the inconvenient location of trainings sessions being 'too far from our [their] houses'; others indicated that 'the location at PUI office was good'. One KI also stated that 'CHWs are satisfied with the duration, content, and location' of the training sessions.

Expenses

When asked about their expenses, all CHWs reported that 'the financial incentives are not enough' and suggested 'an increase to 300$', especially given the high cost incurred on phone recharge costs as well as transportation expenses. To elaborate, additional costs are often being met by CHWs when it comes to things such as phone calls to follow up on referrals or to call back beneficiaries who had called them. Moreover, since some areas are remote with no transportation available, CHWs 'have to hire a taxi that charges hefty amounts, as no other option is available'. Other participants added that '200$ is not enough. CHWs can see that other NGOs are paying more and giving phone cards and transportation for their CHWs'. Furthermore, one KI added that the 'low incentive provision may affect the referral rates of beneficiaries given the CHWs' inability to use their phones to call. Despite the relatively low incentive, the CHWs are dedicated, and it is not effecting the turnover rate'. Financial complains were also raised in terms 'incentive delays'. The amount of expenses given was verified but is consistent with IMC UK and the guidelines given by UNHCR.

Logistics

Transportation

Regarding transportation, some participants reported 'facing problems with cars and drivers that are not always available'. The importance of 'the presence of drivers in making the female employees feel safer and helping them reach remote places' was also highlighted.

Equipment and materials/tools

Regarding the equipment, some delays in the receipt of some medical equipment were reported. As for the material/tools required for the awareness sessions, some CHWs reported shortage in IEC materials for the awareness sessions, whereas one KI indicated that 'the IEC materials was designed with inputs from the CHWs' and that 'they are being used effectively'. Moreover, some CHWs highlighted the 'need for posters that help deliver the message in an easier manner to the beneficiaries' and reported the 'lack of flyers'. Others suggested the 'need for LCD projectors when big awareness sessions are given'. The MEAL team conducting the PSS reported that respondents were more likely to be neutral to health materials if they had a lower level of literacy, something that materials did not routinely take into account.

Some CHWs proposed enhancing the credibility of CHWs among the communities by suggesting the provision of badges or handbags with PUI logo. These CHWs explained that 'this helps building trust [with beneficiaries] that CHWs are indeed volunteering with the organization', given that 'many fraudulent organizations are working' and CHWs' credibility was questioned 'how can we know that you are not one?'. Some participants added that 'the team needs more resources and more equipment because the more you have to give to people, the better reputation/credibility you have'.

Work Environment

In terms of the CHWs' privacy matters, 'mobile phones were requested for the CHWs, so they don't use their personal phones due to privacy issue. However, the request was declined'.

Some participants stated that the office is not equipped for them to store their personal belongings and complained about the the quality of the desks

Other implementation challenges

In addition to some financial challenges, some participants indicated challenges faced due to changes in 'surveys, registration forms, and DHIS2 [which] have new rules and SOPs every now and then', particularly at the launching phase of the project.

VII.Limitations

There are some key limitations to consider when interpreting the insights provided by the evaluation. Firstly, though efforts were made to seek out the opinions of a wide range of stakeholders. It is likely that there are key stakeholders whose views are not represented here. Secondly, the combination of interview, survey, desk review and quantitative data has helped enrich the evidence base. Thus, some of the perceptions shared during interviews have been challenging to triangulate. Finally, while the key messages of the evaluation there are regional variations that needed to be considered in carrying forward recommendations.

VIII. Conclusion and Recommendations

Overall the REBAHS project was seen as a positive force for providing immediate access to health care for Syrian Refugees and vulnerable Lebanese as well as providing a core health system strengthening functions across the six building blocks[5] (Service Delivery, health workforce, health financing, health information systems, governance and leadership and access to essential medications). The limitations of the project was mostly concentrated around the implementation of the support for availability of essential medications and the breadth and depth of the service package.

This process evaluation has highlighted key areas that at the time of writing this report have already been addressed such as the depth and breadth of the package offered which was more specifically outlined within the FFM review. It has also highlighted key areas for monitoring and further actions such as the prescription audit and the process evaluation as a whole adds to the monitoring evaluation process that are continually informing implementation and holding PUI accountable to communities, humanitarian actors, authorities and donors as per PUI accountability field guide.

[5] World Health Organization. (2010). Monitoring the building blocks of health systems: a handbook of indicators and their measurement strategies. World Health Organization. http://www.who.int/iris/handle/10665/258734

The below table (Table 1) presents the key findings and recommendations of this process evaluation.

Findings	Recommendations
Service Delivery	
The FFM is a useful, relevant, efficient, and needed model for providing health care to Syrian Refugees and Vulnerable Lebanese. With the incorporation of the recommendations included in this report there will likely be even greater access to healthcare through it	1.Continue current intervention increasing breadth and depth of coverage to encompass more types of consultation and diagnostic tests 2.PUI MEAL teams to continue to conduct regular field monitoring visits to observe staff and collect patient feedback 3.PUI staff and Community health team to raise awareness of PUI's Complain Response Mechanism to ensure that any disrespectful encounters are reported and appropriately managed 4.A review of current vaccination practice at PHCC level should be conducted by PUI medical advisors and the team manager to liaise with the MoPH coordinator to ensure appropriate training. 5.A review of current vaccination practice at PHCC level should be conducted by PUI medical advisors and the team manager to liaise with the MoPH coordinator to ensure appropriate training. 6.Review Pre-Approval Process to ensure maximal efficiency on implementation. 7.Quality Assurance Advisors and Health Field Officers to support PHCCs to introduce an appointment system in PHCCs to reduce waiting time 8.
Vulnerable populations are felt to have access to affordable quality health services	
PUI's activities are seen as enhancing PHCC services in a country dominated by expensive private health care providers	
PHCC services are seen as reaching the target population both in terms of ensuring access to healthcare for Syrian Refugees and ensuring that specific groups i.e. pregnant women and people with NCD's receive preventative and curative health services	
Pregnant women are felt to have very good access to affordable ANC and PNC services including free antenatal laboratory tests and ultrasounds.	
Beneficiaries have access to free diagnostic /laboratory tests at supported PHCCs	
There have been incidences when beneficiaries felt that PHCC staff were disrespectful in their approach towards them	
Concerns have been raised that vaccinations are not being given as per MoPH guidance	
Some delays were reported within the pre-approval process but SOPs ensure there is needed control over diagnostic test utilisation	
Waiting times are reported as being reduced in PHCCs which have an appointment system	
Health Workforce	
There are challenges at PHCC level in the identification of vulnerable cases	9.Providing refresher trainings, including awareness/ training on assessment of vulnerable cases
There is insufficient staff support (PUI paying the salary of a new member of staff) in some PHCCs which is particularly an issue with the growth in consultation numbers seen with the implementation of the FFM	10.In the setting of PHCCs with a high patient load increase the staff support provided so PHCCs can benefit from both data entry support and a key clinical role such as a midwife

Findings	Recommendations
There is a need to ensure sustainable change in practice from PHCC staff	11.Conduct a training needs assessment and expand on the current capacity building plan including both MoPH external training and in house training to ensure the sustainability of REBAHS governance and quality activities
Some respondents reported issues with the physicians rota both in terms of accuracy and balance between male and female doctors	12.Health teams to work with PHCCs to ensure there is an up-to-date physicians schedule available and that recruitment takes into account the need for female doctors.
Health Financing	
There was a perception voiced by some CHWs that subsidized consultations fees was only available if beneficiaries had a referral slip	1.PUI to clarify the position of referral slips with CHWs and PUI to continue to conduct regular field monitoring visits to ensure that consultations that are covered by the FFM are always available at the flat fee of 3,000 LBP without exception.
Governance and Leadership / Quality Improvement Programme	
Quality standards are felt to be in line with those required by MOPH	13.PUI to look at potential solutions for the recruitment challenge faced in Akkar with regards to the Quality Assurance Advisor
Provision of incentives via the performance-based financing program is felt to motivate clinic staff to improve their performance	
Some felt that there was a need to recruit additional quality assurance personnel to oversee some PHCC (there was a gap in recruitment at the time)	
Access to essential medicines	
PHCC patients are reported to be provided with free medications when available	14.Re-evaluating the processes of ordering and delivering medications with IMC UK
PHCC pharmacists feel that they have acquired skills in forecasting the centre's medication requirements.	15.Conduct an audit of the medication prescribed at selected PHCCs and review against the MoPH Essential Medications list based on these findings work with PHCCs to prescribe within formulary unless clear clinical indications to prescribe off formulary
Participants were concerned that sometimes medicines were prescribed that are not on the MOPH essential drug list. Therefore, patients are not able to get them in the PHCC pharmacy	
Health Information Systems	
There are some inaccuracies in Phenics data that are reviewed and corrected by PHCCs with the support of PUI on a regular basis	16.Continue to provide support to PHCCs on Phenics data entry and data cleaning to ensure the optimal accuracy in health surveillance

Findings	Recommendations
Community Health	
The project is felt to build the capacity of CHWs through a series of trainings	17.As the expenses are fixed by the UNHCR review what can be done to ensure that there is not undue expenditure on the part of the CHW and support with transport when needed
CHWs are reported to be delivering health awareness campaigns based on community needs assessments	18.evelop a joint PHCC and Community health plan to enhance awareness and access to ANC and PNC. To include continuing to provide NFI kits. PUI has also added the quality assurance indicator to cover presence of updated and contacted contact list of patients due for PNC to incentivize follow up for women who have delivered in the PHCC and this needs to be monitored with additional attention to ensuring vulnerable Lebanese women are reached
CHW interventions in the community is perceived positively in that it increases awareness of PHCC services and connects beneficiaries to those services	
CHWs find the current expenses paid to them does not cover their field expenses and there can be delays in their distribution	19.Due to the nature of the intervention it is not possible to commence prior to the PHCC being confirmed; however, organisation and planning should ensure that the community health element starts as soon as possible after the PHCC is contracted.
There is a perceived lack of importance placed on referral slips by PHCCs; thus it is difficult to report on referred cases.	
Continuing educational efforts are required around ANC & PNC packages	20.Review of CHW training schedule with consideration of location and duration
There can be delays in the implementation of the community health intervention at new PHCCs	21.Community Health Zonal Supervisor to support increased visibility of CHWs in the community
The location and duration of CHWs training sessions are seen by some as being inconvenient for participants.	22.PUI to finalise development of a safety and security protocol specifically for CHWs
Logistical/HR support	
There can be a paucity of materials available for the community health elements and equipment and some felt they could be better planned	23.PUI to improve planning for awareness sessions and make sure all IEC materials are available and have a strong visual element for those with lower levels of literacy
On a HR level, a high turnover of staff is reported at the mission. It is a challenge for HR, to identify qualified candidates for positions on this project. Delays in the recruitment process have also been reported	24.PUI to review of the HR process to streamline the recruitment process and reduce any unnecessary delays 25.PUI to review logistics requirements at mission level to ensure there is enough cars and drivers to deliver the project.
Transportation	

Section 2
Mental Health Program

International Medical Corps and Fundación Promoción Social – Lebanon

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List of Abbreviations

CHW: Community Health Worker

CM: Case Manager

CSG: Community Support Group

FGD: Focus Group Discussion

FPS: Fundación Promoción Social

FS: Functioning Scale

GBV: Gender Based Violence

IMC: International Medical Corps

ITS: Informal Tent Settlement

KII: Key Informant Interview

M&E: Monitoring and Evaluation

MDM: Médecins du Monde

MEAL: Monitoring, Evaluation, Accountability and Learning

MH: Mental Health

MHPSS CM: Mental Health and Psychosocial Support Case Management

MoPH: Ministry of Public Health

MoSA: Ministry of Social Affairs

NFI: Non-Food Items

NGO: Non-Governmental Organisation

NMHP: National Mental Health Program

PFA: Psychological First Aid

PHCC: Primary HealthCare Centre

PHQ: Patient Health Questionnaire

PSS: Psychosocial Support

RSW: Roving Social Worker

SDC: Social Development Center

SOP: Standard Operating Procedure

UNHCR: United Nations High Commissioner for Refugees

Executive Summary

The purpose of this report is to assess the current processes of International Medical Corps (IMC) and Fundación Promoción Social (FPS), through which the different Mental Health and Psychosocial Support (MHPSS) services and activities are delivered to beneficiaries. The report also aims to assess whether these processes are taking place according to verbal or written program guidelines, as well as beneficiary satisfaction with the process of receiving MHPSS case management (CM) services at the centers.

The report aims to provide insight on existing processes through quantitative analysis of secondary data and of satisfaction surveys conducted with beneficiaries at the IMC and FPS centers funded by the European Union under the project titled "Reducing Economic Barriers to Accessing Health Services in Lebanon (REBAHS)". Qualitative data was also collected through Key Informant Interviews and Focus Group Discussions with IMC and FPS program and field staff. Findings from both quantitative and qualitative data were analysed, reported, and compared to existing program guidelines. Moreover, monitoring checklists were developed for some of the activities and the results were incorporated to provide further input into the current process. Secondary data was also analysed and incorporated when relevant to provide further input and statistics.

Findings from the satisfaction surveys conducted showed that 92% of IMC and FPS beneficiaries expressed satisfaction with the services provided. Itemized satisfaction shows that beneficiaries were the most satisfied (at above 98% of responses) with the personal conduct of the MHPSS CM team staff, the privacy during consultations, and waiting time. On the other hand, beneficiaries were the least satisfied with accessibility to the centers and with the availability of psychotropic medications (at 64% and 87% of beneficiaries reporting satisfaction, respectively).

Findings from qualitative data highlighted the need for updating or developing standard guidelines for the different activities delivered by the program teams, such as awareness sessions and community support groups. Findings also highlighted that both IMC and FPS programs should extend the reach of their awareness activities to a wider target group. Moreover, guideline development is highly needed for different processes required to deliver quality MHPSS CM services to beneficiaries. Examples of such guidelines include those for the proper implementation of assessment tools to determine beneficiary improvement in daily functioning, as well as guidelines detailing the order in which tasks should occur on a center level, starting from when the beneficiary first attends the center, up until discharge.

Introduction

Under a project titled “Reducing Economic Barriers to Accessing Health Services in Lebanon”, International Medical Corps (IMC) has been providing affordable quality primary healthcare services in supported health facilities funded by the Madad-European Union grant.

Over 24 months, International Medical Corps UK (IMC) is working with consortium partners, Première Urgence-Aide Médicale Internationale (PU-AMI) and Fundación Promoción Social (FPS), on improving access to quality primary health care, community health, and mental health services for Syrian refugees and other vulnerable populations in Beirut and Mount Lebanon, Akkar, Tripoli, Beqaa, and the South. The overall objective of this intervention is to reduce the vulnerability of crisis affected populations through the provision of health and mental health services across Lebanon, with a focus on Syrian refugees.

Under the project, IMC supports four centers, three PHCCs in Akkar, BML, and the South, as well as one community mental health center in the Beqaa – Baalbeck. Consortium partner FPS also supports a community based mental health center in the Beqaa – Zahle. All mental health case management services and medication provided to beneficiaries attending the aforementioned centers are provided free of charge. These services include consultations with the case managers, psychotherapists (adult or child), and psychiatrists. Additionally, FPS also provides nurse consultations for beneficiaries seeing the psychiatrist and taking psychotropic medications.

Moreover, both IMC and FPS provide mental health awareness raising sessions, community support groups, and trainings to front-line workers. The report aims to assess the current processes through which the different services and activities are delivered to beneficiaries, whether these processes are taking place according to program guidelines, whether written or verbal, as well as beneficiary satisfaction with the process of receiving MHPSS CM services at the centers.

Methodology

Study Design

The process evaluation was conducted with the aim of better understanding how MHPSS CM services are being provided in IMC and FPS centers, as well as any other activities, and whether the same process is followed across the different IMC supported centers. The aforementioned was also compared with any pre-existing guidelines when applicable, or with informal program guidelines and procedures in both IMC and FPS supported centers.

In the planning phase of the process evaluation, a workshop was organized by IMC MEAL Team for a round table discussion on the project implementation, and central staff from both IMC and FPS were invited to participate. The attendees included the main central staff; Deputy Country Director, MHPSS Program Coordinator, Deputy MHPSS Program Coordinator, and MH and GBV Information and Reporting Officer, in addition to FPS's MH Project Coordinator, Program Manager, and MHPSS Technical Advisor.

Moreover, the workshop also included the MEAL manager, M&E Regional advisor, and M&E Officers from both FPS and IMC. Attendees were able to identify several questions related to the process of implementation of the REBAHS project that were transcribed under the four process evaluation pillars: Appropriateness, Fidelity, Satisfaction and Logistics. The questions were logged under the respective pillars and following an additional workshop, were eventually used to create the Mental Health Evaluation Matrix. The Matrix was used to design and or modify primary data collection sources (quantitative and qualitative), as well as secondary data collection sources (desk reviews of available documents and datasets).

Quantitative data results provided in the following report were mainly obtained from primary or secondary data sources. A Client Satisfaction Survey was conducted with beneficiaries attending the centers for the purpose of the process evaluation, and other statistics were calculated through existing datasets, evaluations, existing activity satisfaction surveys, or from indicator tracking tables measuring the progress of program activities to date.

The client satisfaction survey design was a cross sectional one and was administered in the five Madad supported centers in the Beqaa, Beirut and Mount Lebanon, Akkar and South during the months of October and November 2018. Four of the aforementioned center are supported by IMC, with one center in each of the area, and one center is supported by FPS on the Beqaa. Survey questions were adapted from an existing IMC regional guidelines document for conducting satisfaction surveys for health services. The data collection was mainly led by the IMC M&E Assistant, FPS's M&E Officer, with the support of four enumerators who were trained by the M&E departments on the project and the data collection tool. In parallel with the quantitative data, Key Informant Interviews and Focus Groups Discussions with program team staff were also conducted, including CMs, RSWs, psychiatrists, and nurses, who are the front-line service providers of MHPSS CM services and awareness sessions. A desk review of relevant program documents was also conducted for the purpose of the report.

Additional workshops were also conducted by the IMC MEAL team, with more in depth round table discussions among FPS and IMC program staff, where questions developed from the first workshop were reviewed and narrowed, and respective data collection tools were determined. As mentioned earlier, results of these discussions were used to generate a program specific matrix with all the important issues and questions in need of clarification. The evaluation matrix was used as a blueprint for the design of the quantitative tool and the various qualitative data collection tools such as KIIs and FGDs. The qualitative data collection was led by the M&E Officer with the support of the M&E Assistant or MEAL team staff.

Ethical Considerations

For the quantitative and qualitative data collection, beneficiaries and program team staff were asked for their consent to conduct the client satisfaction survey, KII or FGD. All participants were given a full explanation about the objectives of the study and were informed that participation is optional. Participants were also informed that the purpose of the data collected would be to improve the quality of care provided and received at the centers, and that all responses will be kept confidential, and only aim to better understand and improve on current activities and the provision of services if and when possible. After acquiring participant consent, both quantitative and qualitative data collection began.

Because of IMC and FPS's continuous efforts to ensure beneficiary and data confidentiality, the following measures were adopted by the MEAL team pre and post data collection. For the satisfaction surveys conducted, all surveys were anonymous, without any beneficiary details being collected that could allow for the identification of the respondents. For the qualitative data collection, an informed consent was provided to all participants, and during all the interviews and group discussions, detailed notes were taken and voice recording of the FGDs were made (following participant approval). The recordings were only accessible to the M&E Officer, and M&E assistant, and all such notes were protected following transcription, and all recordings and notes were deleted after the finalization of the qualitative report.

Sampling Method

For the client satisfaction survey conducted with beneficiaries, quantitative data was collected from all four IMC supported centers, and one FPS supported center under the REBAHS project. In order to calculate a representative sample size, the population visiting the IMC MHPSS centers was determined as the total number of beneficiaries who utilized the facilities during the previous quarter. The overall sample of 203 was calculated using an online sample size calculator[1] with a population size of 431 (average number of beneficiaries visiting all REBAHS supported clinics during June, July, and August), 95% confidence level and 5% confidence interval or margin of error. The list of centers in which beneficiaries were approached can be viewed in Table 1 below.

Table 1: Supported Centers under the REBAHS Project

Area	Center Name	Average Number of beneficiaries during the last quarter	Number of surveys to be collected
Akkar	Iman Medical Association-Bebnine	63	30
Beqaa	Dari Community Based Mental Health Center (CMHC) – Baalbeck	66	31
	Zahle Community Mental Health Center (CMHC) – FPS supported	201	94
Beirut - Mount Lebanon	Lebanese Association for Early Childhood Development (January 2018 – November 2018)	62	29
South	Al Kayan Association - Nabatiyyeh	39	19
	Total	**431**	**203**

For the KIIs and FGDs, qualitative data was collected from various program team staff, including but not limited to, the MHPSS Program Coordinator, Area Managers, and Case Managers, among others. Table 2 below shows a breakdown of program team staff who participated in the KIIs or FGDs, their respective positions, and the qualitative tool used to collect the needed information.

Table 2: Qualitative Data Participants and Means of Data Collection

<table>
<tr><th>Organization</th><th>Position</th><th>Tool Used</th></tr>
<tr><td rowspan="6">IMC</td><td>MHPSS Program Coordinator</td><td rowspan="4">KII</td></tr>
<tr><td>Pharmacist</td></tr>
<tr><td>MHPSS Trainer</td></tr>
<tr><td>Area Managers x 3</td></tr>
<tr><td>Case Managers</td><td rowspan="2">FGD</td></tr>
<tr><td>Roving Social Workers</td></tr>
<tr><td rowspan="5">FPS</td><td>Team Leader</td><td rowspan="5">KII</td></tr>
<tr><td>Case Managers x 3</td></tr>
<tr><td>Senior Case Manager</td></tr>
<tr><td>Nurses x 2</td></tr>
<tr><td>Psychiatrist</td></tr>
</table>

[1] http://www.raosoft.com/samplesize.html

Tool Design

For the quantitative data collection, the MH M&E Officer adapted the satisfaction survey from the IMC regional guideline document for satisfaction surveys, and added certain questions relevant to the context. Upon finalizing the first draft of questions to be included in the survey, the draft was shared with consortium partner FPS's M&E Officer and MHPSS Technical Advisor, who provided their input on existing questions, and added a few questions relevant only to their context, such as questions related to the nurse. The design of the tool mainly focused on the satisfaction of beneficiaries with different dimensions of the services provided. Such dimensions included but were not limited to: accessibility, operational hours, and availability of medication, as well as certain factors such as waiting time to see MHPSS CM staff, session duration, among other questions included in the MH Matrix developed in the workshops conducted.

Prior to beginning data collection, a pilot test of the survey was conducted in October 2018 with five beneficiaries to ensure that the questions were easy to understand, and that there were no errors in the skip logic conditions included in the survey. Any findings from the pilot phase were addressed accordingly.

For the qualitative data collection, the M&E Officer reviewed existing SOPs, guidelines, and documents, on which certain questions were based to be able to compare current processes with written and standard ones. The MH matrix was also referred to when developing the KIIs and FGDs to ensure that certain questions were also reflected in the tools. A set of standard questions detailing tasks and responsibilities, as well as the sequence of tasks on a center level related to the provision of services to beneficiaries, along with a few other questions were also added to all qualitative tools developed.

A couple of monitoring checklists were also developed for the purpose of the evaluation, which allowed for the monitoring of awareness activities and case file audits. Both tools were developed by the M&E officer, in collaboration with FPS's M&E Officer and the program teams. Items included in the checklists were based on informal program guidelines and other requirements for each of the awareness sessions and case file documentation. The checklists differed slightly for IMC and FPS activities based on some differences in activity implementation, further explained in the remainder of the report.

Data Collection

A data collection plan was set in the planning phase of the evaluation, which more or less went as initially expected, except for a few delays in the collection of the quantitative data. The fact that a busy day at IMC supported centers, where one of the specialists is usually attending, only allows for surveying between eight and 11 beneficiaries lead to the data collection process taking a slightly longer time than anticipated. On some days, enumerators were only able to conduct between four and seven surveys. Also, since beneficiaries receiving MHPSS CM services usually receive more than one consultation per month, and see more than one member of the MHPSS CM team, there were several beneficiaries that had been previously surveyed that were present on other days of data collection, which decreased the number of beneficiaries that could be surveyed per day even further. Nonetheless, data collection was still completed within approximately four weeks, as originally planned.

Data Analysis

All focus group discussions and in-depth interviews were translated and transcribed into English, and a thematic approach was used to conduct the qualitative data analysis. As an initial step, each transcript was read and re-read to ensure familiarization with the information. Codes were then generated based on the five main aspects of the project activities (MHPSS CM consultations, psychotropic medications, community support groups, awareness sessions, and trainings), where each activity or indicator was sub-categorized into four main pillars of process evaluation (appropriateness, fidelity, satisfaction, and logistics). Moreover, successes, challenges, and recommendations were also identified. Findings are presented in the narrative with several quotes from KI and FGD participants supporting the aforementioned themes.

Results

Provision of MHPSS CM Consultations

Table 3: Log frame MHPSS CM Consultation Indicator, Targets and Achievements for Year 1.

Indicator	Organization	Y1 Target	Y1 Achieved
Number of MHPSS consultations provided, disaggregated by consultation type			
	IMC	12,900	13,177
	FPS	4,222	13,177

In year one of the project, both IMC and FPS overachieved the consultation target, reaching 13,177 and 6,335 consultations respectively.

To provide a clear overview of the process through which beneficiaries receive MHPSS CM services, several aspects were considered in the following section such as the process of referrals to specialists, the duration and frequency of sessions, as well as any other factors that could affect the quality of the services delivered to beneficiaries. The IMC MHPSS CM team is comprised of case managers, adult psychotherapists, child psychotherapists, and psychiatrists. The FPS MHPSS CM team is comprised of case managers, adult psychotherapists, psychiatrists, and nurses.

Case Management Process

To better understand the process through which consultations are provided to beneficiaries at the IMC and FPS supported centers, several KIs were asked about the sequence of tasks at the center that are related to the provision of MHPSS CM services. All IMC area managers described a similar sequence of tasks, shown in the template below. The sequence of tasks represented below provides a general overview of the process followed at IMC supported centers, from when the beneficiary first attends the center, until s/he is referred to a specialist. Following referral to specialized services, there are further processes to be followed that will not be depicted in the figure, but will be referred to in the remainder of the report.

CMs reported a similar sequence as the one shown below with one exception. The majority of CMs mentioned that the consent form is usually filled following opening a file for the beneficiary, unless the beneficiary was referred to the center. In that case, the consent form is filled prior to opening the beneficiary file. However, as per IMC's informal program[2] guidelines and as mentioned by the area managers, the consent form should be filled prior to opening the beneficiary file. As a result, the program is highly recommended to develop written standard guidelines and SOPs detailing the order in which tasks should occur, starting from when the beneficiary first attends the center, up until discharge.

Findings from FPS KIIs with CMs showed that a similar process to the one above is followed, with a few exceptions. As mentioned earlier, FPS also supports nurses as part of their MHPSS CM team. Once a beneficiary is referred to a psychiatrist, the beneficiary is also directly followed up with by the nurse.

It is important to note that IMC and FPS use different forms, but the forms used serve the same function. First, instead of filling a consultation form with individuals first attending the center, the intake form (equivalent to the social assessment form) is filled with beneficiaries. Based on the CMs assessment, a file is opened or the individual is referred to other services. If a need for MHPSS CM services is found, the consent form is filled, and the same process as above is then followed. Second, all beneficiaries referred to the psychiatrist are directly seen by the nurse as well. Additionally, any cases referred from other NGOs to receive specialized services do not meet with the CM, but meet with the nurse instead. More details regarding this process are elaborated in following sections of the report. The process explained matched FPS's informal guidelines, nonetheless, the program is highly advised to develop standard written guidelines explaining the process above. In addition, the program should consider introducing a consultation form similar to the one used by IMC teams to avoid the collection of detailed information for individuals who do not show the need to receive MHPSS CM services.

IMC CMs were also asked when beneficiaries are usually referred to each of the psychotherapist or psychiatrist. The different levels addressed were based on the five levels of MHPSS CM services identified by IMC and documented in the "Guidelines for Providing Technical Support and Guidance for MHPSS Staff". The below table summarizes the five levels, the respective referrals to be provided, and whether responses were in line with the guidelines.

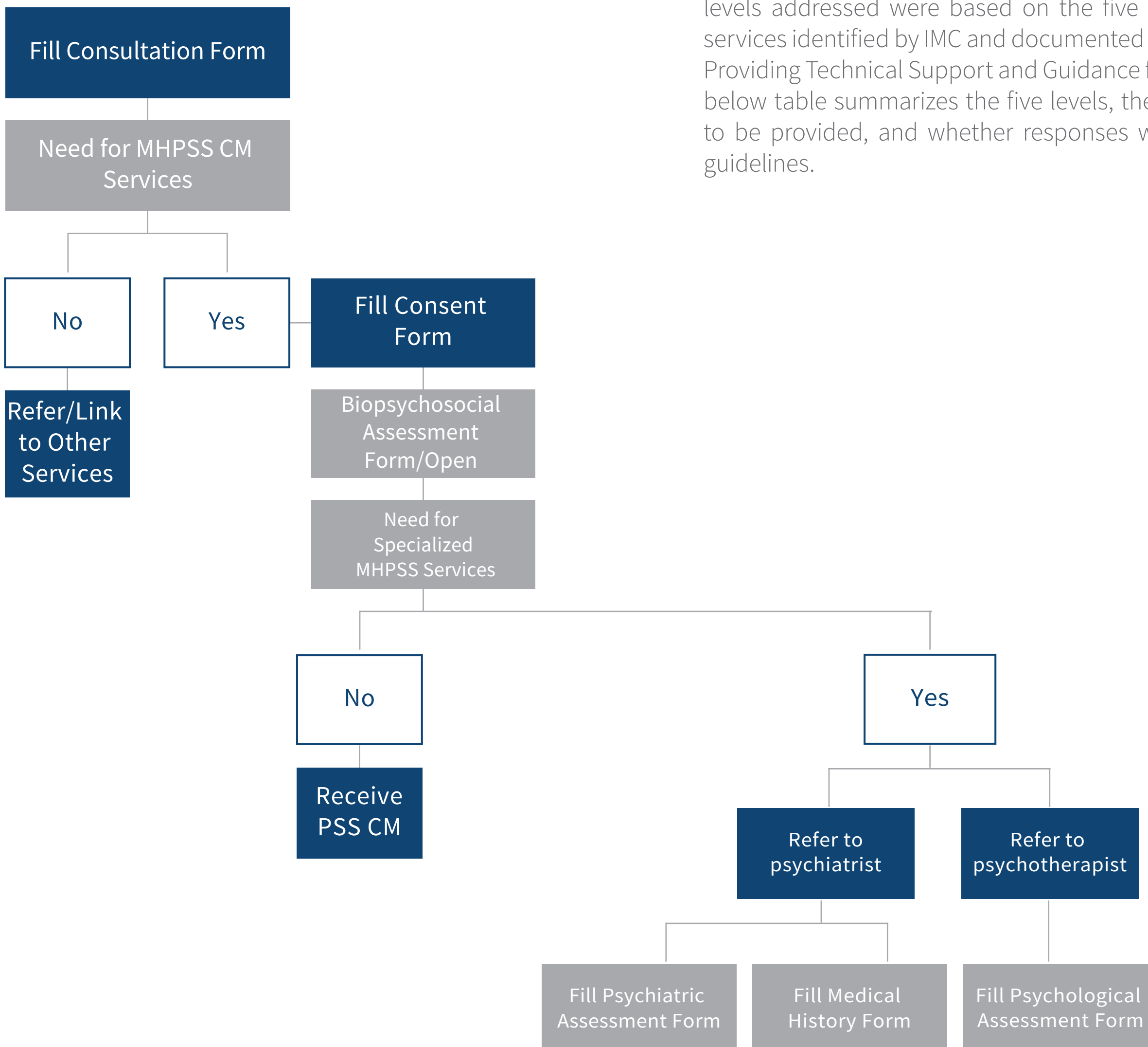

Figure 1: Case Management Level Process

[2] Informal guidelines refer to a general verbal and common understanding among the program team of the proper way of activity implementation or delivery of services.

Table 4: Five Levels of IMC MHPSS CM Services

Beneficiary is:	Referral	Referral to	Guidelines Met
1. Dealing with Psychosocial stressors	No	N/A - PSS services provided	Met
2. Showing signs of distress, but their day-to-day functioning is not affected, their symptoms are not very clear and may disappear	Depends	Psychotherapist – Following second consultation	Partially Met
3. Showing clear symptoms of mental health symptoms or distress	Yes	Psychotherapist Psychiatrist (if case presents with psychosis)	Met
4. Already taking psychotropic medications	Yes	Psychiatrist	Met
5. Showing clear signs of potential risk/harm to themselves or those around them	Yes	Psychiatrist	Met

As shown in Table 4, CMs are properly referring beneficiaries to specialists based on the case they are presented with. To elaborate on the second level above, beneficiaries are not directly referred to a psychotherapist from the first visit, where a second consultation (or more) is needed to better assess the beneficiary's condition prior to the referral. This level was rated as partially met due to the fact that the guidelines specify that the beneficiary be referred following one month of receiving CM services, and it was not clear from the CMs whether that is the duration spent prior to referral. Nonetheless, and for all the above mentioned levels, it is important to note that such minor variations within the guidelines should not be a cause of concern, since every case differs, and it is difficult to follow all set guidelines exactly as stated, especially in the context of mental health. Nonetheless, certain minimum guidelines and criteria can and should still be set and followed, as in the cases above, with a basic acceptance of some form of fluidity.

When discussing level five of MHPSS service provision, all CMs agreed that in such cases, beneficiaries are directly regarded as high priority cases, and the process of referring high priority cases is followed as detailed in the following section of the report.

Although FPS does not have guidelines similar to the ones above, key informants were also asked about the above five levels and how referrals are made based on the presenting case. Results from qualitative data were similar to IMC's, where the process for all levels was met, except for the second level. In those cases, the duration spent before the beneficiary is referred to a psychotherapist is not very clear, similarly to what was stated by key informants from IMC, mentioned above.

FPS staff were asked about the process of proper case referrals to the needed specialist, and all KIs agreed that the case managers do the initial assessment, through which referrals are determined. However, referrals to specialists differ based on the presenting cases, where some referral assessments are based on mhGAP symptoms list, whereas others are based on the PHQ9 (Patient Health Questionnaire) scale. The PHQ9 scale is used to screen for and assess the level of severity of depression. Some of the referrals to the psychotherapist are based on the psychiatrist's recommendation as she sees that therapy is needed. Sometimes, further explanation and discussion with the psychiatrist is needed in order to analyze the symptoms and suggest the right referrals. According to the psychiatrist '70% are accurate referrals for individuals diagnosed with mental illness, or patients [beneficiaries] already taking medications, or [showing] symptoms of severe mental disorders, [whereas] 30% of the referrals are beneficiaries that only need psychotherapy or case management support [for] mild depression, or [beneficiaries with] intellectual disability and do not need medication nor psychiatrist consultations'. The psychiatrist highlighted the need for a training to be provided to the case managers regarding the referral system to the specialists for best referral outcome. The psychiatrist also suggested the possibility of delivering such trainings herself. There are currently no specific guidelines that are set regarding proper referrals to the specialists. As a result, the program is advised to develop guidelines detailing the different scenarios under which beneficiaries should be referred to each of the specialists.

Due to the high number of beneficiaries only receiving specialized services at Zahle CMHC, the nurses and the psychiatrist were asked about the coordination and communication with other NGOs. In these cases, beneficiaries receive case management from other NGOs, and follow up with the psychiatrist and nurse at Zahle CMHC. When asked about the process of referrals (shows in the below template), all KIs agreed that referring NGOs should send an interagency form to FPS for the referral to be accepted.

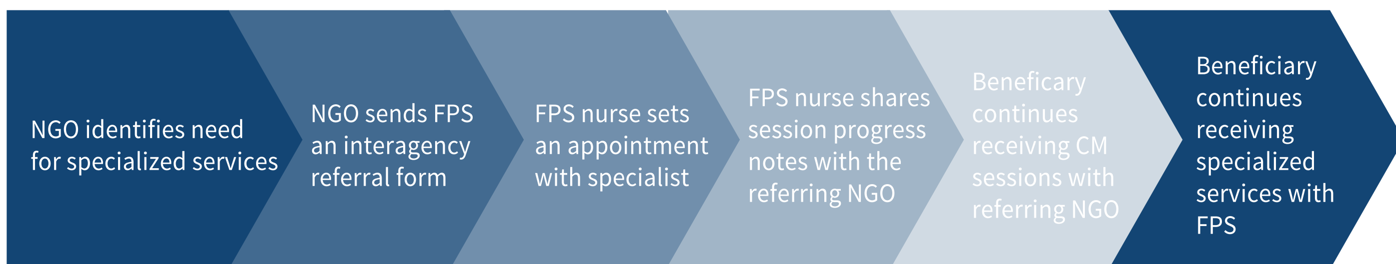

Figure 2: FPS Referral Process from Other NGOs

Results from the satisfaction survey conducted showed that 13 of the 93 FPS beneficiaries mentioned receiving case management services from other NGOs, all of whom are receiving specialized services from Zahle CMHC (14% of FPS beneficiaries).

Beneficiaries were asked about how long the referral process took (from when they were first referred to Zahle CMHC until they received their first appointment), and 8 respondents stated that it took between one and two weeks, and the remaining 5 respondents stated that it took under one week.

Following referrals, the nurse sets an appointment with the specialist needed, and after each consultation, the nurse sends the progress notes of the session to the CM following up with the case. These notes are shared via WhatsApp or by e-mail, and sometimes communication takes place over the phone. The main reason for such referrals is the unavailability of specialized psychological and psychiatric services, as well as the unavailability of psychotropic medications at the NGOs providing case management services. The psychiatrist suggested that NGOs should also be sharing progress notes of the case management sessions with FPS, in order to be aware of the development of these beneficiaries, since sometimes, psychiatric consultations could be three months apart. The psychiatrist also clarified that there are currently no regular meetings happening with other NGOs, except with MDM, which takes place once each month. The program team is advised to call for more consistent meetings between the FPS specialists and CM from other NGOs, to ensure a more effective collaborative treatment plan and regular communication and coordination.

If a need for inpatient psychiatric admission is recommended by the psychiatrist, other steps are taken by the area managers such as contacting UNHCR to provide a claim form and medical report for admission, as well as to cover 90% of admission costs. Also following their approval, the availability of a bed is communicated to area managers, after which area managers proceed with finding an NGO that can cover the remaining 10%, in case the caregivers are unable to do so. Furthermore, area manager follow up with the beneficiary's caregivers to confirm the availability of proper documentation, among others, to ensure that all necessary steps from their side have been taken to allow for admission. While the beneficiaries are waiting to be admitted, case managers follow up with them on a regular basis and provide case management. Case managers also follow up with beneficiaries following their discharge from the psychiatric hospital.

Overall, findings from the interview show that all team members involved with high priority cases are following the same process, which in general terms matches the guidelines set by IMC, as well FPS's informal guidelines. This is very crucial due to the importance and sensitivity of such cases, and managing these situations according to the set protocols helps to ensure that all the correct actions are taken to stabilize the beneficiary. FPS does not have any written guidelines for high priority cases; the program is therefore advised to develop written guidelines for the steps to be taken in such sensitive cases.

High priority cases

All IMC and FPS staff who were asked about the process of identifying and supporting high priority cases mentioned following a very similar process when managing such cases. In general, the main steps mentioned following the CMs identification of a high risk case are shown in the template below.

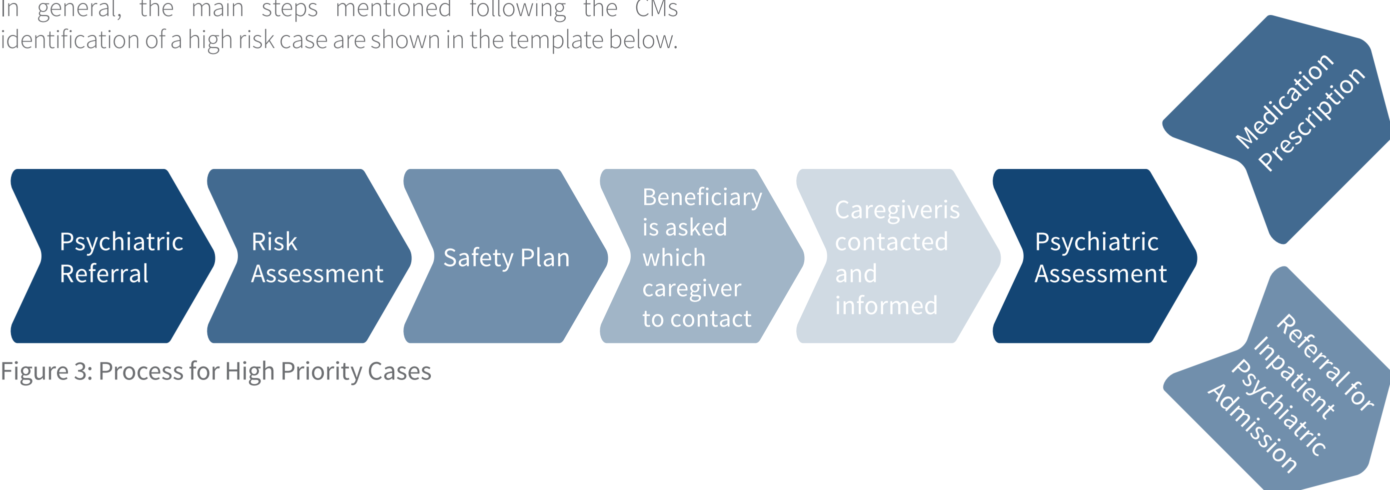

Figure 3: Process for High Priority Cases

Client Functioning Scale Tool

As part of measuring beneficiary progress during the treatment plan, IMC and FPS CMs fill a couple of tools, including the Client Functioning Scale. The Client FS is a treatment plan tool that should be filled by beneficiaries above the age of 18. The tool should first be administered within the first few sessions to assess beneficiary daily functioning at the beginning of the treatment plan. The Client FS should then be administered every two to three months, to assess any progress made and better focus on certain aspects that need further improvement. However, in some cases at IMC, the tool is being filled with the support of the CMs, especially in the cases of illiteracy, but in FPS, the tool is always filled with the CM. Findings from both IMC and FPS secondary data also showed that the tool is not being filled properly with all beneficiaries every two to three months. The main reasons mentioned in secondary data sources were time restrictions within the session, beneficiaries not attending the center in a given month, and beneficiaries being unstable to fill the tool. As per the program's decision in 2019 however, in case the beneficiary is not stable to fill the tool, it should be filled with his/her caregiver.

Treatment Plan Development

When asked about when specialists start thinking about and developing the treatment plan, all interviewed IMC staff mentioned that this usually occurs within the first few sessions after a beneficiary starts seeing the specialists, which is in line with the program guidelines. One of the area managers provided some additional details, where 'psychiatrists develop the treatment plan in the first session, and psychotherapists usually develop it during the first session but there could be exceptions and the treatment plan could be developed in the 2nd or 3rd visit due to the different roles they [the psychotherapist and psychiatrist] have'. This flexibility is usually found since not all beneficiaries present with the same case, and sometimes 'the psychotherapist may need more time to assess the case'. One of the area managers added that for the psychiatrist, 'the treatment plan is developed once the need is completely identified, and is usually developed to ensure beneficiary stabilization'. Findings from the interview with one of FPS's KIs showed similar results, where similar differences were also highlighted. Psychiatrists start developing a treatment plan from the first visit; however, psychotherapists usually need more time to assess the case, and it could sometimes take up to three sessions for an assessment and for objectives to be set.

Table 5: Client FS Tool Challenges, Successes, and Recommendations

Challenges	Successes	Recommendations
CM involvement in filling the Client FS tool, where it should be filled by the beneficiary or caregiver themselves	Provides measurable scores to define beneficiary situation	Develop guidelines on the proper use of the Client FS tool, when and with who it should be filled depending on the beneficiary state
Tool not being administered every two to three months, due to time restrictions or beneficiaries not attending the center in a given month	Opens up further questions to ask and discuss with beneficiaries	
Questions in the tool are too general, not reflecting the general situation the beneficiary is living in		

Most CMs agreed that they feel that the Client FS tool is 'not that reflective of the situation the beneficiary is living in because the questions are too general'. However, several CMs also mentioned some positive feedback regarding the tool, where it 'gives scores and defines the real situation of the beneficiary and opens up for further questions', and helps the proceed with their work. Results from year one show that 77% of IMC beneficiaries and 83% of FPS beneficiaries who filled the Client FS throughout 2018 showed improvement in their daily functioning.

Both IMC and FPS programs are strongly advised to develop guidelines on the proper use of the Client FS tool, in terms of how often the tool needs to be filled, and the different beneficiaries it can be filled with. For example, the guidelines should specify whether the Client FS is filled with unstable beneficiaries, in which cases the tool should be filled with the assistance of the CM, etc.

All IMC area managers agreed that when it comes to the termination of treatment with the specialists, the process is usually in line with the exit strategy. 'Once a beneficiary starts becoming stable and has achieved the treatment objectives, they [psychotherapists] start mentioning to the beneficiary that their case is becoming better, and they inform them of the remaining required sessions before discharge'.

Findings from FPS showed that the intervention should be terminated based on the stability of the beneficiary and the number of sessions received. The team leader explained that cases 'that are characterized between mild and moderate' and only follow up with the CM and psychotherapists, and 'that show quick improvement' during their treatment plan are usually discharged following a maximum of 14 to 16 sessions with the psychotherapist. However, if a beneficiary is receiving medications and becomes stable, it may be more difficult to discharge due to the unavailability of mhGAP trained general practitioners in the PHCCs or nearby PHCCs, and the availability of psychotropic medications at those centers.

Session Duration

According to IMC formal or informal program guidelines, beneficiaries should spend a minimum amount of time with each of the MHPSS CM Team staff (a minimum of 15 minutes with the CM, 30 minutes with the psychotherapists, and 20 minutes with the psychiatrist, for follow-up beneficiaries); FPS does not have similar guidelines and the program is advised to develop SOPs detailing minimum session requirements. In addition, key informants were also asked about their knowledge of the minimum session requirements with different staff. Findings from the qualitative data were compared to guidelines when applicable, as well as results from the satisfaction survey conducted, shown in Table 6 below. for detailing all information related to CM sessions, including the expected duration of sessions.

Results from the satisfaction survey showed that 65% of IMC beneficiaries seeing the case manager spent less than 15 minutes in the session. This could be interpreted by the fact that surveys were conducted on the days the specialists were attending the center. When specialists are present in the centers, between eight to 11 beneficiaries usually have appointments, which means that case managers are quite busy on those days, and do not spend as much time with the same beneficiaries as they do on days where specialists are not present, unless the beneficiary requires more time.

Table 6: Session Requirement across different MHPSS team staff vs. actual session duration

Challenges	Implementing Organization	Informal/Formal Guidelines of Session Duration	Session Duration According to Key Informants	Actual Session Duration
Case Managers	IMC	New: 30 minutes or more Follow-up: 15 minutes or more	New: 30 minutes or more Follow-up: 15 minutes or more	65% of beneficiaries spent less than 15 minutes in a given session
	FPS	No guidelines	N/A	63% of beneficiaries spent less than 15 minutes in a given session
Psychotherapists	IMC	Between 30 to 45 minutes	Between 30 to 45 minutes	64% reported receiving a session longer than 30 minutes in duration
	FPS	No guidelines	Between 45 and 50 minutes	55% reported receiving a session between 30 to 45 minutes, 36% reported spending more than 45 minutes in a session
Case Managers	IMC	New: 30 minutes or more Follow-up: 20 minutes or more	New: 30 minutes or more Follow-up: 20 minutes or more	39% of beneficiaries reported spending the minimum requirement in the sessions
	FPS	N/A	New: 40 minutes or more Follow-up: 20 minutes or more	33% reported spending between 15 to 40 minutes in a session
Nurses	FPS	No guidelines	N/A	64% reported spending less than 10 minutes in the session

According to IMC informal program guidelines/procedures regarding the expected session duration with CMs, beneficiaries should spend at least 15 minutes with the CM if it is a follow-up visit, and at least 30 minutes if it is a first visit. All respondents agreed that a follow-up session with a CM should last at between at least 15 and 20 minutes. There was a minor discrepancy regarding the session duration for new beneficiaries, where one of the area manager stated that the minimum duration of the first session should be 45 minutes. However, this is still in line with the informal guidelines, where the minimum duration of the sessions is still at least 30 minutes. It is highly recommended that the program develops formal and written SOPs that allow

IMC Case Manager Session Duration

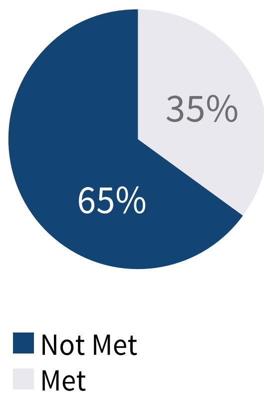

Figure 4: IMC Case Manager Session Duration

Findings from the satisfaction survey also showed that 63 % of FPS beneficiaries who saw the case manager spent less than 15 minutes in the session; these consultations were all follow-up sessions. FPS does not have any guidelines to compare the above findings to, and as a result, the program team is therefore advised to develop guidelines for session duration with the CMs, and to make a distinction between follow-up and first visit durations.

FPS Case Manager Session Duration

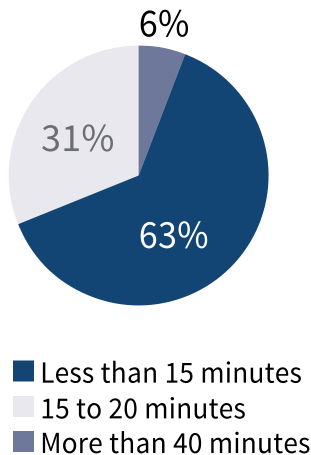

Figure 5: FPS Case Manager Session Duration

When asked about the duration of sessions with the specialists, area managers made a distinction between first and follow-up visits when applicable, and their responses were in line with the guidelines set. All key informants mentioned that a regular consultation with a psychotherapist should take between 30 and 45 minutes, whether it is the beneficiary's first or follow-up visits

Regarding session duration with specialists at the FPS supported center, the team leader also made a distinction between first and follow-up visits when applicable, where a regular consultation with a psychotherapist should take between 45 and 50 minutes, whether it is the beneficiary's first or follow-up visit. Although the minimum session requirements differ between IMC and FPS for psychotherapists, for both organizations, a session duration with a psychotherapist should and does not differ for first or follow-up visits.

Results from the satisfaction survey showed that out of 45 beneficiaries seeing the adult or child psychotherapist at IMC supported centers, 64% reported receiving a session longer than 30 minutes in duration. For the remaining 36% of sessions, the program is advised to look into potential reasons the sessions did not meet the minimum requirement. Further analysis showed that sessions with the child psychotherapists were more in line with the guidelines, where 79% of beneficiaries reported spending a minimum of 30 minutes in a given session, as opposed to 58% of beneficiaries seeing the adult psychotherapist.

IMC Child Psychotherapist Session Duration

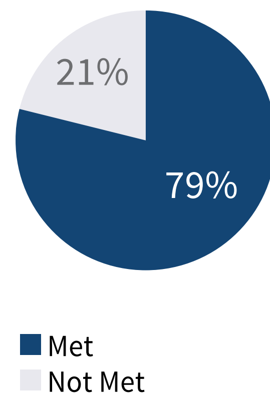

Figure 6: IMC Child Psychotherapist Session Duration

IMC Adult Psychotherapist Session Duration

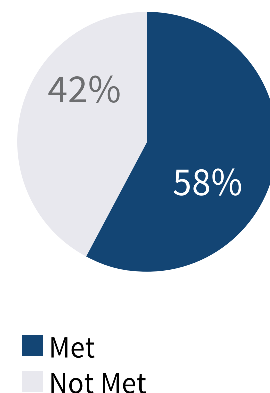

Figure 7: IMC Adult Psychotherapist Session Duration

At Zahle CMHC, of the 11 beneficiaries who saw the psychotherapist, 55% reported receiving a session between 30 to 45 minutes, 36% reported spending more than 45 minutes in a session, and 9% reported spending less than 30 minutes in a given session. FPS does not have any guidelines concerning the session duration, and the program is advised to develop such guidelines.

FPS Psychotherapist Session Duration

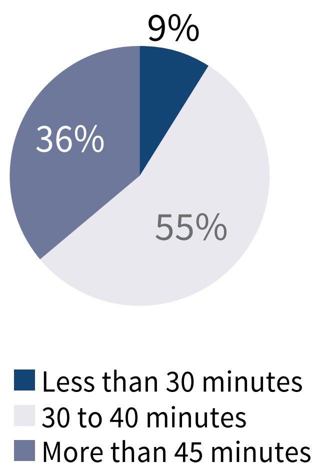

Figure 8: FPS Psychotherapist Session Duration

Findings from IMC KIs revealed that the consultation length differs for the psychiatrist, where the first consultation is generally more elaborate than a follow-up consultation. The session durations mentioned for both scenarios, although slightly different, were in line with the minimum duration of consultations (20 minutes for follow-up and 30 minutes for new) set in the guidelines. Similarly, consultation length at FPS differs for the psychiatrist, where according to the team leader, the first consultation is generally more elaborate (40 minutes) than a follow-up consultation (20 minutes). FPS does not have any guidelines regarding the average session duration with the specialist, and the program is therefore advised to develop guidelines for each of the specialists.

Satisfaction survey results showed that out of 33 beneficiaries seeing the IMC psychiatrists, 61% of beneficiaries reported spending less than the minimum requirement in the sessions (whether new or follow-up). The program is also advised to look into potential reasons for sessions not meeting the guideline requirements. As mentioned in the satisfaction report, the options provided in the satisfaction survey for psychiatrist duration were not reflective of the minimum duration for follow-up beneficiaries (with 20 minutes as a minimum duration). As a result, for the remaining 36% who reported seeing the psychiatrist between 15 and 40 minutes, it cannot be known for certain whether the session lasted for longer or less than 20 minutes. This will be addressed in future surveys conducted by IMC and FPS to ensure the collection and analysis of more accurate data.

IMC Psychiatrist Session Duration

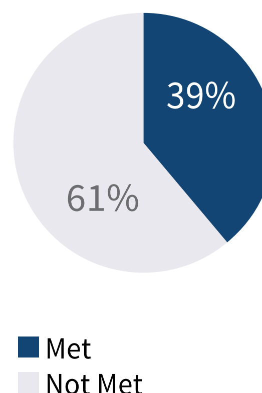

Figure 9: IMC Psychiatrist Session Duration

At the FPS supported center, out of 40 beneficiaries who reported seeing the psychiatrist, 68% reported receiving a session less than 15 minutes (2 respondents were new, 25 respondents were follow-up), 33% reported spending between 15 to 40 minutes in a session (2 respondents were new, 11 respondents were follow-up).

FPS Psychiatrist Session Duration

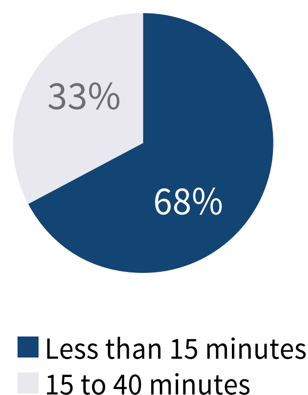

Figure 10: FPS Psychiatrist Session Duration

Additionally, FPS also provides nurse consultations for beneficiaries seeing the psychiatrist and taking psychotropic medications. The nurse is responsible for providing educational messages to beneficiaries in regards to medication use and side-effects. The nurse is also responsible for ensuring compliance to the medical treatment, for acting as a resource for beneficiaries on all medication related issues and questions, as well as for providing appropriate psychosocial support to beneficiaries in need. Satisfaction survey results showed that out of 59 beneficiaries who saw the nurse, 64% reported spending less than 10 minutes in the session. This is due to the fact that for follow-up beneficiaries (which constituted 95% of respondents), an explanation on how medications should be taken and any side effects would have been already discussed in previous sessions. 32% of beneficiaries reported spending 10 to 20 minutes in the session, and only 3% reported spending more than 20 minutes. FPS does not have any guidelines on the average session duration with the nurse and with the psychiatrist to compare the above findings to.

FPS Nurse Session Duration

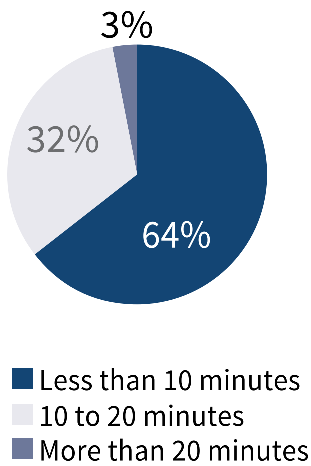

Figure 11: FPS Nurse Session Duration

Session Frequency

When IMC CMs were asked about how often beneficiaries are seen by each of the psychotherapist and psychiatrist, all CMs had similar responses regarding the frequency of visits with the psychotherapist. In general, when beneficiaries are in the beginning of their treatment plan, the psychotherapist should be seen twice a month. Following the psychotherapist's assessment, the number of consultations will either be increased or reduced. As mentioned by one of the CMs, 'we start with two sessions per month, but if we see the beneficiaries are in need we then provide three sessions per month. We have a long waiting list so we do so if we have the capacity to'. The above findings seem to be in line with the written guidelines, where it is stated that, "the beneficiary/patient can be seen weekly or bi-weekly or even monthly as deemed appropriate by the psychologist/ psychotherapists" (pg. 4).

In relation to the frequency of sessions with the psychiatrist, IMC CMs had differing answers, where CMs from two of the areas mentioned that following the first consultation, 'the follow up will occur after three weeks'. One of the CMs elaborated that the purpose of the first follow-up visit is to 'track medications and if there are any side effects'. If the beneficiary calls the CM and mentions any side effects, 'the follow up will be given the following week directly'. CMs from the remaining two areas stated that the first follow-up session should be 'provided after two weeks', and not three. According to psychiatrist guidelines, the frequency of visits is set by the psychiatrist in coordination with the MHPSS CM team, making sure "to lower this frequency as much as possible without exceeding the total of 6 sessions during a three month period" (pg.4). It is not clear however whether the sessions within the first three months of treatment should not go below six sessions, or should not exceed six sessions. As a result, the program is advised to review the wording of the aforementioned section.

When FPS KIs were asked about how often the beneficiaries are seen by each specialist, all KIs mentioned that the frequency of visits depends on each case, and whether the beneficiary is new or follow-up. In general, KIs mentioned following processes shown in the below template.

Frequency of Consultaions

Psychotherapist

Once per week for the first two months

Once every two weeks in the third month

Once a month until a total of 14-16 sessions is reached

Psychiatrist

First consultation provided

Follow-up consultation two weeks later

Once a month until beneficiary is stable

Once every three months when beneficiary is stable

Figure 12: Frequency of Specialist Visits - FPS

For the psychotherapist, the same number of follow-up consultations are received, where for the first two months of the treatment plan, beneficiaries should see the psychotherapist once per week. During the third month, the beneficiaries should receive two consultations, after which they should start receiving one consultation per month, to reach a total of 14 or 16 sessions. For the psychiatrist, the beneficiary should receive the first follow up consultation two weeks following the first consultation, after which a monthly consultation should be provided. After the case is stable, consultations should be provided once every three months. However, in urgent cases, the beneficiary may need to be seeing the specialists more frequently. Since frequency of visits to specialists is currently based on informal guidelines, the program team is highly advised to develop written guidelines on session frequency with specialists.

Technical Meetings

Throughout the course of the treatment, IMC CMs are constantly involved in discussions with the specialists regarding beneficiary cases and their progress following sessions. Also, if the specialists identify a need to refer a beneficiary to outside services, '[they] provide recommendations for referrals, but the case manager is the one that actually refers and follows-up on all referrals'. A similar process is followed by FPS's MHPSS case management team.

Since it is crucial for all members of the IMC MHPSS case management team to meet to discuss common cases, technical meetings should be occurring between all members of the interdisciplinary team, including the area manager, twice a month. One of the area managers explained that the point of these meetings is that 'care plans are reviewed for common cases, all medication related topics are discussed (e.g.: side effects, dosage, etc.), and the treatment plan is discussed, and any progress or relapse is [also] discussed'. One limitation of the meetings mentioned was 'that there are currently no proper guidelines to technical meetings'. These guidelines have however been finalized in the beginning of 2019. Table 7 below presents some of the main challenges for conducting technical meetings and respective recommendations.

Findings from the qualitative data highlighted that '[IMC MHPSS case management staff] are finding some difficulty for all the team to meet at once', and technical meetings are not taking place. This finding was consistent across all areas, and the main reason mentioned by all those asked was that 'the psychotherapists and psychiatrists do not attend the centers on the same day', and the 'specialist dates don't overlap so they are not found at the center on the same day. To be able to attend the meeting, there will be additional hours that are not compensated. Also, if they are both present at the same day by any chance, and if we didn't want to exceed the hours allocated [to specialists, the] time will be taken away from the consultations'.

One of the IMC respondents also mentioned that '[Specialists] are not available to attend [the center on] a different day [for these meetings] since the days already allocated as per the contract are being attended for consultations. For the days not contracted with IMC, the specialist may have other obligations or work that does not allow them to attend'. Also, and as pointed out by another respondent, 'previously, specialists were paid for the time spent on the meeting but currently that is not the case'.

Due to the importance of these meetings for the success of the treatment plan of beneficiaries, all IMC respondents mentioned an alternative solution they are implementing until they are able to hold the technical meetings as required. 'What is happening is that a meeting is being done with the CMs and the psychotherapist at the end of the day attended, same [is happening with] the psychiatrist'. One respondent also mentioned that 'whenever there is a high risk case and a meeting is not possible, all coordination and discussion happens over the phone between the case manager and the psychiatrist'. If there is an important discussion around a common case seeing both specialists, the case manager makes sure that the messages are shared with both of them, but in any case 'the [consultation] progress notes are usually used by the case managers and specialists to be aware of progress happening [with the beneficiary]'.

The MHPSS CM team at Zahle CMHC is also facing some difficulties in conducting technical meetings regularly. Table 8 below presents some of the main challenges for conducting technical meetings and respective recommendations.

Table 7: Technical Meetings Challenges and Recommendations – IMC

Challenges	Alternative solutions currently implemented	Recommendations from the program team
Difficulty for all the MHPSS CM team to meet at once	CMs meet with each of the psychiatrist and psychotherapist at the end of each day attended	Technical meetings to take place over the phone, through WhatsApp calls
Specialist days do not overlap, and in order to attend these meetings, additional non-compensated hours will be needed	CMs share main issues discussed in end of day meetings with the other specialist	Factoring in technical meeting into the contracts of specialists
Some appointments would have to be cancelled for the meetings to take place, but the priority is beneficiary need		Ensuring two rooms are available incontracted centers, therefore allowing both specialists to attend the center on the same day

Table 8: Technical Meetings Challenges and Recommendations – FPS

Challenges	Alternative solutions currently implemented	Recommendations
Difficulty for all the MHPSS CM team to meet at once	MHPSS CM staff are coordinating among each other on a daily basis following each consultation	Set a schedule in order to try to meet at least once a week as a team; better time management
Center has a high load of beneficiaries, and the schedule of specialists is fully booked	Progress of the cases is discussed on a weekly basis with the respective specialist	Update the guidelines for these meeting to occur on a monthly rather than a weekly basis, since the SOPs were first developed when Zahle CMHC had a smaller team and lower load of beneficiaries
Some appointments would have to be cancelled for the meetings to take place, but the priority is beneficiary need		

For FPS, and from a communication and coordination perspective, all FPS MHPSS CM staff are coordinating among each other on a daily basis following each consultation, and the progress of the cases is discussed on a weekly basis. Depending on the severity of the cases, these discussions could occur on a daily basis. However, a mandatory and fixed weekly multidisciplinary meeting is not being set, as specified in the program's SOPs. FPS's team leader also mentioned that 'when the psychiatrist is present, 'a 30 minute' time frame is being set with CMs at the end of the day to discuss all common cases. However, this has proven to be difficult to maintain due to the fact that during that time, most case managers are usually in the field conducting outreach activities'. The team leader explained that these meetings are not always taking place due to the fact that 'the clinic is always overwhelmed with [a high load] of beneficiaries, and the schedule of specialists is always fully booked'. Therefore, setting a weekly multidisciplinary meeting is 'difficult because we would have to cancel some appointments to meet, but our priority is the beneficiary need'. To ensure that these meetings occur as specified in the SOPs, the program is recommended to set a schedule in order to try to meet at least once a week as a team, which could be managed ahead of time; it is a time management issue that should be resolved at the field level. The program is highly recommended to update the guidelines for these meeting to occur on a monthly basis since the SOPs were first written when Zahle CMHC had a smaller team and load of beneficiaries.

Since there is no direct communication between the specialists, one of the IMC respondents noted that 'the effect of this could be negative due to the miscommunication of messages and the risk of the message being communicated differently than intended'. The respondent also suggested that to overcome this, it should be 'ensured [that] technical meetings take place, maximum through a group WhatsApp call, although not as effective as a face to face meeting, but it is better than not meeting at all'. The respondent also mentioned not preferring this means since it is 'not an official means of communication by IMC', but is currently one of the options to be considered since these meetings affect the quality of the services provided.

A few solutions provided by IMC KIs moving forwards were 'factoring [in] the technical meetings into the contracts of specialists' and 'trying to ensure that two rooms are available in the PHCCs which will allow us to have both specialists in one day, after confirming a fixed schedule [with them] throughout the year'.

Roving Social Worker Consultations

The role of RSWs was added by IMC under the Madad project in the aim of increasing MHPSS service utilization and awareness of mental health services. RSWs attend a set number of selected centers that are not supported by IMC MHPSS CM services, and allocate their time in these different centers, where they provide awareness sessions and consultations to participants that approach them following these sessions. Based on these consultations, individuals are then referred or linked to other services depending on their need, or to IMC supported centers providing mental health services. Findings from secondary data showed that RSWs provided 4,182 consultations in year one of the project, and referred or linked 1,507 individuals from July 2018 until December 2018. Of those individuals, 459 were linked or referred to IMC MHPSS CM services, 268 were linked or referred to IMC health services, and 30 were linked or referred to IMC GBV services. The remaining 692 individuals were referred or linked to other services, mainly to other NGOs.

It is important to note that the consultations provided by the RSW are not equivalent to those provided by CMs due to the nature of the consultations. RSW consultations are usually more focused on referring or linking beneficiaries to the required services, whereas CM consultations should focus on the provision of comprehensive MHPSS case management services and the beneficiary treatment plan. As stated by one of the RSWs, 'I prefer doing links and referrals because this is my role as a RSW. I think this is the right procedure, the role of the case manager is to work on case management cases. 99% of the beneficiaries that I refer to do not mind starting case management with the CM.' Due to the above, and since the indicator is worded as 'number of MHPSS consultations provided, disaggregated by consultation type', the program may want to consider separating the target and indicator for consultations provided by the RSWs from those provided by the MHPSS CM team. Although RSWs provide MHPSS consultations and support, the above is recommended due to the difference in the nature of the consultations provided, where those provided by the CM team are more focused and in-depth, as opposed to those provided by RSWs.

As secondary data showed however, in some cases, RSWs are having to provide several consultations to beneficiaries who are in need of MHPSS services but cannot attend the center for reasons such as stigma on MH, cultural beliefs, or distance to the nearest MHPSS CM supported center. As a result, and as is currently the case, the program should ensure that all RSWs recruited should either have the background that allows them to provide MHPSS support, or should receive a training in providing brief MHPSS support.

Beneficiary File Documentation

Consultations provided by the MHPSS CM team at IMC and FPS supported centers are documented and stored confidentially at the center with unique beneficiary file numbers. A case file audit was conducted by the Mental Health Case Management Support Manager, to ensure that all necessary forms and documents are properly stored. A random sample of 54 beneficiary files from all four IMC supported centers, and 50 FPS beneficiary files, was selected for case file auditing. The sample was determined by taking 20% of active beneficiaries from the month being audited. Tables 9 and 10 below represent case file audit findings from IMC and FPS respectively.

Table 9: IMC Case File Audit Results

Forms	IMC Proper Documentation
CM Consultation Form	20%
Consent Form	48%
Social Assessment Form	100%
Progress Notes	94%
Psychological Assessment Form	13%
Psychiatric Assessment Form	62%
Functioning Scale	61%

Table 10: FPS Case File Audit Results

Forms	FPS Proper Documentation
Consent Form	22%
Intake Form	96%
Progress Notes	96%
Nurse Form	98%
PHQ9 Scale	73%
Functioning Scale	92%

Consultation forms were found in all files audited at the newly supported center under Madad year two, but were only found in two of the previously existing centers' files. This could be attributed to the fact that as a newly opened center, there are no pre-existing ways of working that could affect what the CMs were trained on. Results of psychological assessment form documents were really low at only 13% of the files including the form. This calculation was based on beneficiary files (24 files) where the presence of the document was applicable (for beneficiaries receiving services from the psychotherapist). The program is strongly advised to look into this low figure and ensure proper documentation moving forwards of all forms mentioned in the above table. The program should also ensure that the Mental Health Case Management Support Manager and area managers complete case file audits more systematically moving forward, and that MHPSS CM team staff systematically fill and document all required forms. Also, all CMs that have been working at the centers since before 2018 should be given a refresher training on the process that should be followed with beneficiaries to ensure a consistent approach in all supported centers.

The intake form used by FPS also includes the Psychological and Psychiatric assessment forms, which means that in 96% of the files, both assessment forms were documented. CMs at FPS started filling the consent form starting November 12th for all new and existing beneficiaries. Prior to that, CMs were taking verbal consent from beneficiaries. The implementation of the PHQ9 Scale started in October 2018, and the audit was for beneficiary files who attended in November. This could explain the missing 27% PHQ9 scales, especially since the scale cannot always be filled from the first visit. Both IMC and FPS intend on conducting case file audits more regularly in year two as part of their monitoring plans.

Reporting of Consultations

IMC CMs were asked about when they consider the service provided to beneficiaries as a consultation, and some discrepancies were found across the different centers on what is reported as a consultation. Similar responses were provided across all centers, with the exception of one center that was the most in line with informal guideline requirements.

Almost all CMs agreed that the service is considered a consultation based on the topic discussed, as opposed to the duration of the service provided. In addition, if any information is revealed during the interaction with the beneficiary that should be included in the progress notes, the interaction is considered as a consultation. One of the CMs disagreed with the above and stated that in case of a telephone conversation, if the discussion 'took more than 10 to 15 minutes with the case, we consider it as a pure PSS consultation'. The same CM also added that for an in-person interaction 'it depends on the case and the time consumed, if it takes 15-20 minutes then I consider it as a consultation. I need at least 15 to 20 minutes to consider it as a consultation, and sometimes even more, because I think that the beneficiary needs approximately this timeframe for a proper PSS impact'. The other CMs all agreed that the topics discussed during the interaction affect whether or not it is considered to be a consultations, where one of the CMs elaborated saying that 'I can talk to a beneficiary for 5-10 minutes and not consider it as a consultation because s/he is repeating the same topic that was previously discussed and I can talk to a beneficiary for only one minute and consider it a consultation, in case the beneficiary was trying to commit

suicide for example'. Due to the nature of MHPSS CM services, it is relatively more difficult to standardize what is or is not considered a consultation. Nonetheless, and due to some differences across CMs, it is important that the program sets minimum requirements that should be met for an interaction with a beneficiary to be considered as a PSS consultation. Although requirements for session duration with the CMs was clear to the area managers and program coordinator, it does not seem to be as clear to the CMs. As mentioned above, the minimum duration of a consultation varies between the areas, especially with what is reported. This could be affecting what is reported as a consultation, which points to a lack of clear guidelines provided to the CMs. As a result, what is reported could cause certain limitations to the M&E department in terms of proper monitoring of consultations provided.

When FPS staff were asked about what counts as a consultation, all KIs mentioned that home visits and follow-up telephone conversations are considered as consultations. Moreover, all clinic consultations lasting for 15 minutes, such as psychoeducational interventions, psychosocial interventions, and family intervention, are also being considered as consultations. In regards to what is considered as a consultation with the nurses, KIs stated that an interaction with the nurse is not considered as a consultation 'if someone came to take medications while their medications haven't finished yet and an appointment is scheduled for a later time. Also, if someone has an appointment with the psychiatrist and isn't prescribed medication during that session', the interaction will not be considered a consultation.

Procurement and Provision of Psychotropic medications

As mentioned in the proposal, and as part of the services provided by the MH program, IMC will continue with the procurement of psychotropic medication (for both IMC and FPS supported centers) in order to support the provision of MHPSS CM services at the supported centers. The mental health pharmacist explained the procurement process of psychotropic medications, and that medications procured are based mainly on the essential list of medication provided by the Ministry of Public Health (MoPH) and that follows the World Health Organization's (WHO) guidelines. Since FPS does not have a pharmacist, psychotropic medications are received from both IMC and MoPH, which are therefore also based on the aforementioned essential list of medication.

Also in line with the proposal, all psychotropic medications were provided free of charge to IMC beneficiaries receiving psychiatric services at the supported centers. Results from the satisfaction survey showed that out of 31 beneficiaries who reported receiving medications from IMC supported centers, 97% did not pay for the medications received. The remaining 3% (1 respondent) who reported paying for medications received was from a beneficiary who reported receiving medications from Dari CMHC, although no medications are provided through that center (see Satisfaction Survey Report for more details). In addition, 77% of IMC beneficiaries reported satisfaction with the availability of medications at the centers.

All FPS medications provided through IMC are provided free of charge. However, FPS beneficiaries were previously paying a 7,000 LBP fee as the cost of the pharmacy consultation fee at Zahle CMHC for medication provided by MoPH. Satisfaction survey results showed that 37% of beneficiaries (28 respondents out of 75 who received medications) reported paying for medications received. Certain steps were taken to waive the 7,000 LBP fee, where long negotiations surpassing a year were held with the Director General of MoSA. The fee was finally waived for Zahle CMHC, which is the only SDC in the country in which the fee has been fully waived. As of the 12th of November 2018, beneficiaries have been receiving all psychotropic medications provided through MoPH free of charge.

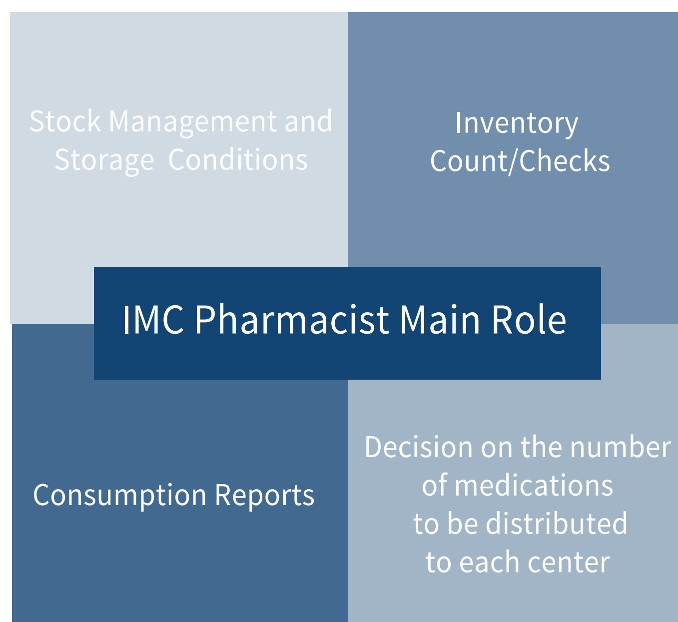

Figure 13: IMC Pharmacist's Main Roles and Responsibilities

As mentioned in the proposal, the IMC pharmacist is responsible for stock management and storage conditions, as well as consumption reports. Consumption reports of every month are collected during the first week of the following month as hard copies from the centers to ensure that over-consumption of medications is not taking place. As mentioned by the pharmacist in the KII, certain steps are taken to ensure that beneficiaries are not receiving medications from two different IMC supported centers, since 'the beneficiary could be consuming medication more than the recommended therapeutic dose, and will also be taking medications that could be used by another beneficiary'. Quality checks, inventory count, and verifying the expiration date of medications were among the tasks the pharmacists is responsible for.

Although the whole process was clearly explained by the IMC pharmacist, from the procurement phase to stock management and quality checks and audits, and although there were not any challenges mentioned regarding the process, there are no SOPs to which this information can be compared. As a result, we highly recommend that the program develops SOPs for the proper procurement and management of psychotropic medications.

At Zahle CMHC, psychotropic medications are stored in the center's pharmacy, where the MH nurses, with the supervision of the team leader, are responsible for stock management. Both

nurses and the team leader count the stock on a weekly basis and check the expiry date of medications. Also, monthly consumption reports referred to above are completed and shared with the IMC pharmacist. The pharmacist then coordinates with the team leader regarding consumption and evaluates the needs of the center in relation to the different psychotropic medications consumed. The team leader also communicates with IMC's pharmacist regarding any medications needed when necessary.

Although IMC bases its procurement of medication on WHO's Essential Drug List and the list of National Medications approved by the MoPH, and as mentioned by the program coordinator, 'IMC [also] procures medication outside the list, which is already communicated with MoPH. However, the first medications to be prescribed should usually be from the initial list provided by WHO and MoPH. The reason is that these medications on the list are very generic and can be used for several disorders. These medications are also sustainable since they are not very expensive, and in the case funding diminishes, these medications will still be affordable ([whether] out of pocket for beneficiaries or for MoPH to procure)'.

If medications are prescribed that are not on the MoPH or IMC list, this should be pointed out to the program management, who in turn informs the mental health technical advisor. 'Here, there is more focus on the medication being prescribed to find out why a medication has been prescribed where the beneficiary would have to buy the medication out of pocket. There should be a valid reason for prescribing medication outside the list provided by MoPH or IMC'. The fact that medications should be from within the existing list is found in the psychiatrist guidelines developed by IMC that mention that "For exceptional cases, when in need of medications that are not included in the list, a written report explaining the necessity for the medication should be provided by the treating psychiatrist" (pg.2). Whether this written report is being provided however was not clear from the information collected, however, it was mentioned by the program coordinator that 'coordination is required by the technical advisor and the psychiatrist to decide on whether the medications [prescribed] outside the list is the best way to go'. When IMC beneficiaries were asked about their satisfaction with the availability of prescribed psychotropic medications at the centers, 77% of beneficiaries who had received medications reported being satisfied.

It is not very clear whether the process of prescribing medication outside the list matches the guidelines written. Some information suggests that the medication outside the list is first prescribed and then shared with the technical advisor for follow-up, and other information suggests that 'coordination is required by the technical advisor and the psychiatrist' to make a decision on whether the prescribed medication is the most suitable choice. As a result, we suggest that this section be reviewed and updated if need be.

Regarding the prescription of psychotropic medications at FPS, the psychiatrist is following the essential list of medications provided by MoPH. However, the psychiatrist mentioned a few challenges concerning the list, where 'in some cases, beneficiaries aren't showing improvement using a certain medication from the list and this has to change as to prescribe new types of medications from outside the list, but as psychiatrists, we don't have multiple choices to choose from. In addition, some medications have less side effects and aren't in the list'. If and when medications not on the MoPH or IMC list are prescribed, beneficiaries would have to purchase these medications from outside the facility. Results from the satisfaction survey showed that 91% of FPS respondents reported being satisfied with the availability of psychotropic medications, and 7% reported being dissatisfied as they couldn't afford to pay for medications from external pharmacies.

At Zahle CMHC, the nurses are responsible for providing the medications to beneficiaries following psychiatric consultations, unlike at IMC centers, where the medications are usually provided through the center pharmacies, or in the exceptional case of LAECD, through the CMs. IMC beneficiaries usually receive their medication from the center pharmacy, after which they pass by the CM and sign the consumption report. In LAECD, the CM was responsible for providing the medications due to the unavailability of center staff, and lack of cooperation from the center.

When the nurses were asked about the provision of medications to beneficiaries, both nurses mentioned that they provide the required dosage in one of two ways, either by tablet, or through the original package. This usually depends on the number of tablets the beneficiaries need and are prescribed. '[The nurses] check if the beneficiary is taking his medication properly by counting how many pills are still remaining, or if his medication runs out before due time". Nurses are also providing psychoeducational sessions about the medication by explaining the side effects, the proper dosage and use of the medication, and the importance of taking the medications regularly and storing them in appropriate conditions. The beneficiaries are expected to sign a nurse consultation form when they receive their medications, which also matches the SOPs set by FPS. When asked, the psychiatrist expressed satisfaction regarding the process of medication provision, where 'both the psychiatrist and nurses are explaining the possible side effects and the [proper] use of the medications'. The psychiatrist also expressed a concern, '[the nurses] should provide the medications by tablet and not in their original package to avoid the possibility of medications provided being sold by beneficiaries'. FPS does not have any guidelines regarding the medications delivery by tablet or by original package.

Community Support Groups

As described in the proposal, community support groups are designed to bring together and support community members who share a common stressor. The groups focus on a collective and community based approach where participants (five participants per group) are given the opportunity to better cope with their stressors by sharing their experiences over eight sessions. As mentioned by the IMC MHPSS Trainer in charge of the activity design and curriculum 'all participants should be facing or dealing with a common stressor to ensure a homogeneous group'. These sessions focus on topics related to psychosocial support, where participants are provided with targeted messages on coping with the stressors, practicing self-care, and maintaining their over-all wellbeing. CMs are responsible for delivering the community support groups, and all IMC and FPS CMs were trained by the IMC MHPSS Trainer on facilitating the sessions.

During year one of the project, eleven community support groups were completed by IMC, with 52 participants completing the activity. Participants are considered to have completed an activity if more than 70% of the sessions are attended (at least six sessions). The main target groups of the majority of CSGs conducted with individuals were individuals with depression, and individuals with a common psychosocial stressor. The target groups of the three CSGs conducted with caregivers were caregivers of individuals with epilepsy, schizophrenia, and cerebral palsy.

FPS conducted four CSGs in 2018, with 20 participants completing the activity. The subject of each CSG was decided by the MH CM facilitating the group and based on the community's need. The main topics of the groups were: caregivers of people diagnosed with a psychotic disorder, persons with depression, caregivers of children with a disability and persons facing grief.

The effect of these groups on participants is measured through pre and post-tests. Participants in both IMC and FPS groups fill two validated scales, the Rosenberg Self Esteem Scale, and the Warwick-Edinburgh Mental Wellbeing Scale (WEMWBS) in the first and the last session. In 2018, 52 participants completed the groups conducted by IMC and filled the pre and post-tests. Results showed that 71% of IMC participants and 75% of FPS participants showed an improvement in their overall wellbeing, which is considered an acceptable percentage of participants showing improvement following the activity.

CSG Number of Sessions and Duration

When IMC case managers, who facilitate the sessions, were asked whether they believe that eight sessions are enough, all agreed that the sessions should be increased to nine sessions since previously, community support groups consisted of 10 sessions, but were reduced to eight sessions. The 10th session was cancelled, and content from the ninth session added to the eighth session. As a result, all case managers facilitating these sessions agreed that 'we should change it back to nine sessions especially that the last two sessions [eighth and ninth] are [currently] combined together'.

Three of FPS case managers mentioned that 'the number of sessions is enough, [and there is] no need for more sessions', mainly to in a way allow 'the participants to create an independent life and to apply what we gave them [throughout the sessions]'. One of the key informants suggested adding two more sessions because the participants were in need to further express themselves and their experiences. Moreover, analysis of existing CSG satisfaction surveys showed that 10% of the participants suggested more sessions and if possible, longer session durations.

In relation to the above, the MHPSS Trainer stated that 'the number of sessions is enough but I don't believe that the duration is' and suggested to 'increase the duration of the sessions from two hours to three hours to allow more time for beneficiaries to discuss challenges or experiences regarding the topics being discussed'. In addition to the above, secondary data analysis of participant satisfaction with the activity revealed that three out of 47 participants (6%), although satisfied with the duration of the session, suggested that more time is needed if possible. Also, 19% of participants suggested that the number of sessions be increased, however this cannot be directly attributed to whether participants felt that eight sessions were too little in achieving their intended purpose, or to the fact that they enjoyed the sessions and would prefer attending more than eight sessions. Given that satisfaction survey results were positive, the latter explanation may be more accurate.

In either case, the program is advised to study the possibility of altering the activity design, whether through increasing the number of sessions or increasing the duration of each session, while taking into consideration any factors that may favour one option over the other.

CSG Participant Selection

In regards to participant selection, the IMC MHPSS Trainer and case managers mentioned a few methods for selecting a homogeneous group of participants, such as the identification of beneficiaries already receiving MHPSS CM services, and the identification of participants through awareness sessions. One of the case manager mentioned that usually, '[beneficiaries] that have the same stressor and are excited to take part in the community support group, and are ready to be fully committed to attend [the sessions]' are selected to participate. In addition, case managers from two of the areas mentioned that in some cases, participants are selected through 'referral[s] from specialist[s], especially psychotherapist[s]'. Participants are also selected through awareness sessions conducted on mental health services and topics, where some individuals show their interest in participating in the sessions, or 'sometimes, following awareness sessions, some individuals talk to the case manager who identifies the need for participation' and contacts them before a new community support group is conducted.

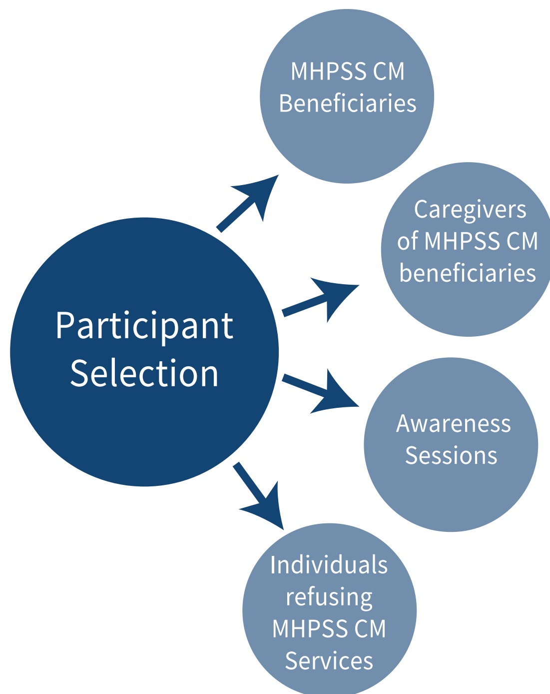

Figure 14: Participant Selection for CSGs from different activities

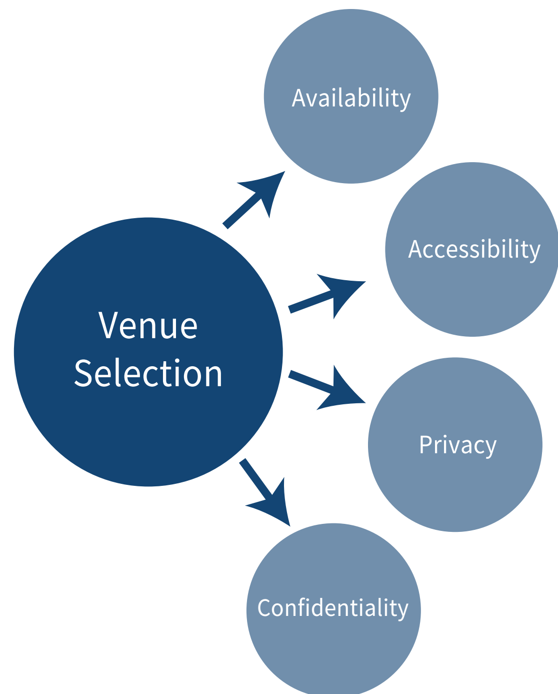

Figure 15: Venue Selection for CSG Group Sessions

Since community support groups also target caregivers of beneficiaries or individuals, some IMC case managers mentioned that participants for these groups are selected 'based on the caregivers of our beneficiaries, such as the parents [or wives] of a beneficiary with schizophrenia, because sometimes we see that they are facing depression due to their family members' situation'.

Finally, and as mentioned by the MHPSS Trainer, some participants are 'chosen from individuals that have attended the center and were in need of psychosocial support but refused to receive it due to stigma [surrounding mental health'.. The different aforementioned methods of participant selection ensure that the activity is 'branching out to beneficiaries from different locations and with different stressors'.

All FPS key informants agreed that the selection of the participants should be based on a common problem faced by participants, since the community support groups target a specific topic. Participants selected should also have the ability to commit for the duration of the eight sessions. The participants were either selected through beneficiaries receiving MHPSS CM services at the center, or through identification from outreach awareness sessions.

CSG Venue Selection

As for the venue selection for IMC activities conducted outside the supported centers, the place is selected based on its 'availability, accessibility, privacy and confidentiality'. Results from satisfaction surveys showed that IMC beneficiaries were 100% satisfied with all the above mentioned aspects, except for accessibility, detailed in the below sections.

For CSGs conducted by FPS, the sessions are usually held in the center. All FPS CMs mentioned that the group venue was accessible to all participants, and that all participants are receiving transportation allowance. One of the KIs mentioned that there were some issues with the transportation to the activity due to the unavailability of public transportation at times. Similarly to IMC results, participants were the least satisfied with accessibility to the activity, with 35% stating that it was not easy to get to the activity location, and 5% stating that the transportation allowance provided was not enough to cover transportation costs to the activity location.

CSG Participant Satisfaction

The satisfaction surveys conducted were divided into five sections: Accessibility, Logistics/Center, Facilitator, Activity, and Overall Satisfaction. Each section included several questions to allow for a better understanding of each section, detailed in the below figure. Analysis of the satisfaction surveys with 47 beneficiaries showed that participants were fully satisfied with all aspects of the activity, except accessibility. Participants were the least satisfied with accessibility to the activity, with 79% stating that it was easy to get to the activity location, and 87% stating that the transportation allowance provided was sufficient. Average satisfaction with overall accessibility was 83%. Table 11 below presents the different questions asked to assess satisfaction under each of the sections, in addition to results from the satisfaction surveys conducted.

Analysis of 20 FPS satisfaction surveys showed that all participants were fully satisfied with the facilitator and with the overall activity. Satisfaction with other factors is presented below:

- Accessibility: Participants were the least satisfied with accessibility to the activity, with 65% stating that it was easy to get to the activity location and 95% stating that the transportation allowance provided was sufficient. Average satisfaction with overall accessibility was 80%.
- Logistics: 95% of participants stated that the activity started on time. Average satisfaction with overall logistics was 98%.
- Activity: 90% of participants stated that the duration of the sessions was appropriate, and 95% stated that the topics were presented in a fun and interactive way. Average satisfaction with the overall activity was 97%

Table 11: CSG Satisfaction Survey Questions and Results of IMC Participants

Main Sections	Questions	Percentage Satisfied
Accessibility	It was easy for me to get to the activity location	79%
	The per diem I received was enough to cover transportation costs to the activity location	87%
Logistics	The set-up of the activity room was comfortable (the chairs were comfortable, the room was well lit)	100%
	The activity usually started on time	100%
	The activity room was private and I did not worry about being overheard	100%
Facilitator	The facilitator was polite and treated me with respect	100%
	The facilitator gave me enough time and attention in our sessions	100%
	It was easy to communicate with the facilitator	100%
	I trust that the facilitator respects my privacy and will not share any of my personal or case details with others	100%
	I feel that the facilitator showed concern and cared about my questions and worries	100%
Activity	I learned new skills/information by attending this activity	100%
	The topics covered were interesting and/or relevant to my needs	100%
	The duration of the sessions was appropriate	100%
	The topics were presented in an easy and simple way	100%
	The topics were presented in a fun and interactive way	100%
Overall	I would recommend this activity to other individuals	100%
	Overall, I am satisfied with the activity	100%

IMC CMs more or less agreed that the content of the sessions was relevant and appropriate to beneficiary needs. The majority of CMs also mentioned that 'some terminologies should be more simplified so they can be [more] easily understood.' However, one of the CMs believes that 'participants are enjoying new terminologies and activities. They feel they are maximizing their knowledge'. All FPS CMs also believed that the content of the sessions was relevant, but that the main challenge usually faced is to follow the curriculum, since the content isn't applicable to their real life. FPS CMs therefore suggested being given some flexibility in adding their input to some of the activities and better adapting them to participants' lives/context.

Detection and Referral Trainings

Detection and referral trainings take place over a period of two days, and target front-line workers who spend a lot of their time on the field or being in direct contact with beneficiaries. The main purpose of the training is to improve participants' understanding on mental health disorder and symptoms, and to allow them to be able to detect and refer beneficiaries they think may be in need of mental health services.

The training aims to have as many interactive modes of presentation as possible, to ensure participant involvement and improved learning, and increased knowledge is measured through pre and post-tests. Secondary data analysis for 2018 trainings showed that out of the 88 participants who filled the pre and post-tests, 94% showed an increase in their knowledge on the topic discussed. Secondary data analysis of training evaluations also showed that different modes of presentation were used. According to participants, the most preferred modes of presentation used in the training were role playing (27% of responses), case studies (22%), and group exercises (11%). Other modes mentioned by participants included videos, discussions, and lectures.

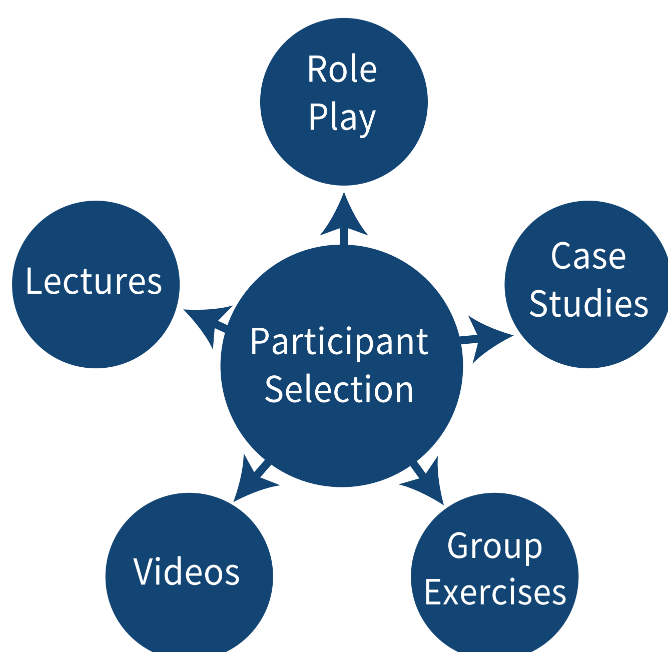

Figure 16: Modes of Presentation in Detection and Referral Trainings

Invitations for these trainings are usually sent out in each area, where an email is sent out 'to local and international NGOs informing them of the activity, with certain criteria, most importantly the participants being field level staff and in direct contact with beneficiaries'. In the e-mail, and as mentioned by a couple of key informants (area managers), NGOs are requested to only nominate two of their front-line staff that may benefit from the training. One of the area managers mentioned that additionally, 'we also mention that participants nominated cannot have an elaborate knowledge on MH or have received similar training in the past such as mhGAP'. Participants are then selected on a first come first serve basis.

In the training evaluation, participants were asked whether they had received enough information about the training before attending it, and 87% participants (74 out of 85) reported that they had.

The program does not currently have any formal guidelines or SOPs for the training, but have a PowerPoint presentation based on WHO mhGAP guidelines that is being followed. As a result, the program is advised to develop guidelines/SOPs for Detection and Referral trainings. However, and as per the training design and curriculum, the training should include 15 participants. All key informants mentioned that they are sometimes having to exceed the maximum number of participants either due to the high need for the trainings, or 'out of experience that in some areas, participants do not attend the full two days of the training'.

'We are sometimes exceeding the maximum number to take into account that some participants may not attend. During other times, some staff from NGOs contact us and show a very high interest in the training, which is when we also sometimes exceed the number of participants per training'. Although a higher number of participants is recruited for these training, one of the key informants mentioned that 'we are also having to reject a high number of the participants because we do not have the capacity to train all those interested. We are able to add two participants for example, but we cannot add more than two. There is a high need for these trainings in the area, which is another reason we are having to exceed the number [of participants]'.

The trainings are usually delivered and divided across different areas in Lebanon, and as one respondent stated, 'we are facing a high demand, and due to the limited number of trainings being delivered per area, we have to allow for a higher number of participants'.

Since all key informants agreed that there is a high need for these trainings, the program may want to look into increasing the number of trainings to be able to accommodate for the high need for such trainings in the areas.

The program may also want to consider increasing the duration of the training, or adding a refresher training, since participant feedback on the trainings showed that for trainings attended in 2018, 21% of participants believed that the quantity of the information given in one of the training days was a lot (of 87 responses). In the comments section, four participants suggested that the training should be longer, and one participant stated that 'the quantity of information was too much compared to the duration of the training'. Based on the MHPSS Trainer delivering detection and referral trainings, 'ideally, a three-day training would be better but the main concern is that participants may not be as committed to a three day training'. Instead, she

suggests that 'a refresher training two to three months following the training could also help in consolidating the information learned, and [allow for] discussing challenges faced on the field'.

Psychological First Aid Trainings

FPS organized six psychological first aid trainings for front-line workers in four different areas (Zahle, Tyre, Beirut and Tripoli). The main purpose of the training is to help providers to deal with physical, social and psychological aspects of distressing events. As per the training design, the trainings usually consist of 15 participants overall.

Secondary data analysis for 2018 trainings showed that out of the 86 participants who filled the pre and post-tests, 93% showed an increase in their knowledge on the topics discussed. Secondary data analysis of training evaluations also showed that all trainees described the training to be very informative because they were exposed to the PFA principles of 'Look, Listen, and Link', as well as being provided with new methods on how to approach and build rapport with traumatized individuals. The trainees emphasized that the usage of case studies, role-playing, videos, and concrete examples were effective presentation styles that helped crystallize the concepts of PFA more clearly. The majority of the front-line workers said that the material covered during the training was very satisfactory. Moreover, participants considered the presentation topic to be very useful in their daily work and with dealing with individuals who have experienced trauma. Participants requested the training to be longer than a one-day training, to avoid all the content being condensed within the same day. As a result, the program is advised to consider discussing with NMHP the possibility of extending the training over two days instead of one, since the curriculum is provided through them.

Invitations for these trainings are usually sent out in each area, where an email is sent 'to local and international NGOs, and to the NMHP informing them about the activity, with certain [selection] criteria, [where] most importantly, the participants should be field level staff and in direct contact with beneficiaries'. In some cases, the maximum number of participants (15 per training) is being exceeded, to account for the possibility of some participants not attending the training.

Crisis Management trainings

FPS organized five Crisis Management trainings instead of the six initially planned, and increased the number of participants from 15 to 18 participants in each training in order to meet the target in 2018. The training was delivered to front-line workers in four different regions (Beirut, Tripoli, Saida, Zahle) for front-line workers. The main purpose of the training is to understand the importance of planning for crises and potential dangers and to learn how to involve stakeholders in the event of a crisis.

In terms of sending invitations to the trainings, FPS is following the same process as the one followed for sending out PFA training invitations.

Secondary data analysis for 2018 trainings showed that out of the 72 participants who filled the pre and post-tests, 81% showed an increase in their knowledge on the topics discussed.

Secondary data analysis of training evaluations also showed that all the trainees recommend this training to others. All trainees described the training to be very useful not only in their work, but also in their lives. The trainees emphasized that the interaction between participants, role play and examples given during the training were effective. In addition, the participants requested that the duration of the training be longer, and to have a two day trainings as opposed to one. Some participants commented on the need for more training days, to avoid the material being condensed within one day and to allow going into more details. Moreover, 93% of participants would recommend the training to others.

Awareness Raising Sessions

Table 12: Log frame Awareness Indicator, Targets and Achievements for Year 1

Indicator	Organization	Y1 Target	Y1 Achieved
Number of participants in MHPSS outreach and awareness raising sessions			
	IMC	6,000	8895
	FPS	3,600	4041

In order to increase MHPSS service utilization and awareness of mental health services, case managers conduct awareness sessions in the waiting rooms of the centers they attend, as well as through outreach visits. The IMC position of Roving Social Workers was added under the Madad project in the aim of further increasing awareness on mental health topics and accessibility to mental health services, as well as further integrating MH into PHC services. In some cases, awareness raising sessions are also conducted outside these centers, which is usually based on requests from other NGOs or the health department at IMC. In such cases, 'we [RSWs] don't identify or choose the catchment area; even the topic is chosen for us'.

In year one, RSWs provided awareness raising sessions to 7,467 participants. Based on RSWs findings on the field, the need for mental health awareness raising appeared to be significantly high, where RSWs provided awareness raising sessions to an average of 750 participants per month. As a result, CMs in the centers were requested to focus less on awareness raising sessions and allocate their time on providing consultations or conducting community support groups.

At FPS, the CMs are responsible for conducting awareness raising sessions for Syrian refugees and vulnerable Lebanese throughout the Bekaa governorate through outreach visits to ITS camps. These sessions are usually conducted within closed/isolated private rooms within the camps.

FPS CMs started providing awareness raising session in late May 2018, as FPS was initially short on staff, with only one CM being available to provide MHPSS services at the beginning of the project. Once the full team was recruited, the program team conducted a training on the different awareness raising topics and provided the team with all relevant materials. Due to late start date of the awareness raising sessions, and due to the need to attain the set target, CMs faced some challenges in meeting the year one target.

Nonetheless, FPS met the target for year one of the project, and reached a total of 4,041 participants through 296 awareness raising sessions. During the sessions, different topics were addressed and delivered, such as depression, mental health, post-traumatic stress disorder (PTSD), loss and grief, postpartum depression, anxiety and stress, children with aggressive behaviour, epilepsy, and enuresis.

As part of the process evaluation, eight awareness raising sessions were attended by the MH M&E Assistant (two in each area), to better assess whether the sessions are meeting certain requirements. A checklist was developed and filled in each session, and analysis of these checklists showed that in each session, the facilitator discussed MH services at the beginning or the end of the session, was polite and respectful towards participants, encouraged participants to ask questions and participate, and answered questions in a polite, clear, and prompt manner (when applicable). Results from FPS awareness raising checklists showed similar results. In year two of the project, IMC and FPS intend to conduct these observational sessions on a more regular basis, as part of their monitoring plans.

Awareness Raising Session Setting

Awareness raising sessions are usually provided by RSWs in the waiting room of the centers visited, or provided by CMs in the waiting room of the IMC MHPSS supported centers, or through outreach visits. Certain challenges were highlighted by both RSWs and CMs regarding the setting the awareness raising sessions are conducted in, where the majority of CMs agreed that they face the following challenges:

• Beneficiaries leaving or entering the waiting room in the middle of the awareness session

• Beneficiaries' primary focus during the sessions is receiving their appointment.

• Waiting room noise and crowdedness

• Interruption during the sessions by others

According to the MH M&E assistant who attended the sessions, the setting of five out of eight sessions was noisy, as well as caused interruption to the awareness raising session being conducted. As per observational findings, settings of the sessions are noisy only when they occur in PHCCs, where there is a load of beneficiaries and when the waiting rooms are open, as well as when children accompany their parents to the center. On the other hand, the setting is not considered to be noisy when it occurs in a private waiting room, or towards the afternoon when less health specialists are attending the centers, and there is therefore a lower load of beneficiaries. In regards to the interruptions caused, observation also revealed the most common interruptions to be from: staff in the PHCCs calling patients for their appointments, beneficiaries entering and leaving the waiting rooms, or other people passing by the waiting rooms causing participants to get distracted.

Due to the above mentioned challenges, one of the RSWs mentioned an alternative approach to conducting some of the awareness raising sessions, where s/he stated that due to the continuous noise in the waiting rooms, a day is selected when an empty room is available at the PHCC, and a group of five participants is invited to attend a more focused awareness raising session. RSWs in the different areas mentioned their inability to follow a similar approach due various limitations such as the unavailability of empty room at the centers they are attending.

Awareness Raising Session Attendance

In order to report on the number of participants reached through awareness raising sessions, CMs and RSWs are requested to fill an attendance sheet with participants at the end of each session. The information collected on these sheets includes but is not limited to, beneficiary names, contact numbers, and signatures. However, the majority of IMC and FPS CMs, as well as IMC RSWs reported a challenge in collecting the above information following the sessions, where some beneficiaries do not want to provide their personal details and signatures following awareness

sessions. In these cases, the information is not collected. FPS CMs also reported challenges in collecting such information following the sessions due to the illiteracy of some participants and their inability to sign, as well as the fact that some beneficiaries prefer to not provide their phone numbers since the session duration is between 30 and 45 minutes.

The above mentioned challenge is understandable given that the duration of the awareness sessions, as reported by all RSWs and one of the CMs last between either 15 to 20 minutes for regular sessions. Participants may therefore not feel comfortable sharing their personal information and signatures for having attended an awareness raising session while waiting for their appointments. For focused awareness sessions provided by RSWs, and lasting 'between 30 to 45 minutes', and for CM outreach visits (as mentioned by only one CM) lasting 'approximately 45 minutes', the collection of this data may be more feasible. Other CMs mentioned that awareness sessions usually last 30 minutes.

Although not all participants are opposed to sharing their personal details, the program is still advised to update their attendance sheets to only include demographic information that allows for the analysis of the target groups and number of participants reached, to unify the type of data collected in focused and non-focused awareness sessions. Since the duration between focused and non-focused sessions varies a considerable amount, the program may also decide to consider the possibility of separating the reporting of focused and non-focused sessions, and potentially the attendance sheets used for each type of session.

Results for the awareness raising checklists showed that out of the eight sessions attended, only six sessions involved an attendance sheet. According to the staff that did not use an attendance sheet, this is due to the fact that, as mentioned above, participants prefer to not share their personal information. Out of the six awareness sessions that involved an attendance sheet, facilitators took the attendance at the end of the session, and only from participants who attended the full session, as per informal program guidelines. In sessions where it was applicable, participants who left or joined in the middle of the session were not included in the attendance sheet. However, analysis of these checklists showed that in only three out of the six sessions, all required information on the attendance sheets were collected. Due to the same reason of participant hesitance to provide certain details, information not collected in these three sessions included names, signatures, and phone numbers.

According to observations made by the M&E Assistant, participants preferred to not provide their names, signatures, and phone numbers. Based on several field visits, some of the participants asked the RSW/CM why the attendance sheet was being used. As a result, all RSWs/CMs were making sure to reassure participants about the administrative function of the attendance sheet and that the choice to include their names and details on the attendance sheet was optional.

Awareness Raising Sessions Target Groups

During the FGD conducted, all RSWs agreed that the main target group for awareness raising sessions is females, which they attributed to several reasons. One of the reasons mentioned by some of the RSWs was that 'most of the time, we work with the health sector that already have cases, and most of their services target females and not males'. Another reason focused on the waiting time to receive an appointment in the centers attended by RSWs, where female beneficiaries are more likely to wait longer hours for their appointments compared to males.

Secondary data analysis confirmed the above findings, where out of all participants attending awareness raising sessions provided by RSWs, 77% were female, whereas only 23% were male. Nonetheless, and if possible, the program is strongly advised to design activities that allow for targeting and appealing to a higher number of males. Such activities can be done in collaboration with community health workers for example, where following the awareness raising topics to be discussed by the community health team, RSWs can also discuss mental health topics. Since one of the RSWs mentioned that males usually 'come for the incentives (kits)', and if the aforementioned is accurate, a suggestion could be for RSWs to be present following or preceding distributions of NFI kits, and to provide a small introduction to mental health services and most common disorders.

According to secondary data from FPS, the main target group for awareness raising sessions conducted in 2018 was Syrians and females, where 85% of participants were female whereas only 15% were male. In addition, the majority of the target group was Syrian, at 99% of participants, whereas only 1% was Lebanese. The main reason mentioned by the CMs to explain the target group consisting mainly of females was that the activity is conducted during working hours, when most males are usually in their jobs or working. As for the target group consisting mainly of Syrian beneficiaries, the main reason was that these sessions were provided through outreach activities in ITSs, where there is no Lebanese population present. The program is advised to design activities targeting a higher number of Lebanese and male participants.

In relation to mainly providing awareness raising sessions to females, the majority of RSWs agreed that 'it is easier to work with females than with males'. According to their experience on the field, some RSWs have come to realize that 'females show a lot of interest and interaction. Males resist this [awareness sessions] because they feel their basic needs need to be addressed before we can speak of depression for example' and are therefore 'more connected to their work [jobs]'. Also, 'females accept the topics related to mental health more than males', and that some males do not 'accept to talk about depression' for example.

On the other hand, and to explain the fact that awareness sessions mainly target females, one of the RSWs suggested that in his/her opinion 'the only reason we are seeing acceptance from females more than males is that we simply have a higher female ratio compared to males attending the PHCCs'.

Due to the above findings, it is important to try and involve males and increase their willingness to discuss mental health topics or participate in mental health related activities (such as awareness raising sessions).

Awareness Raising Session Topics

According to informal program guidelines/procedures of awareness raising sessions, participants should be presented with a set of topics to choose from, to be discussed during the sessions. However, as some of the qualitative findings suggest, this is not always possible.

Findings from the FGD conducted show that only some of the CMs present individuals with a choice of topics, whereas others

sometimes either discuss mental health in general, or choose the topics themselves according to their 'observation, targets, and participants present in the awareness session. For example, if most of the beneficiaries have their children with them, [they] discuss Enuresis'.

When a general topic is presented, this is due to the fact that participants 'usually have their kids with them', and due to the nature and crowdedness of the waiting rooms mentioned earlier. However, specific topics are also sometimes discussed as deemed necessary by the CM, and in some cases, CMs 'choose to go further with specific topics according to participant feedback and to the topics that we [CMs] suggest; they tend to choose a topic from the ones suggested'.

Findings from qualitative data showed that RSWs faced some challenges regarding the provision of mental health topics when they first started. All RSWs agreed that they could not always start with certain mental health topics, especially since 'people still have a general stigma around mental health'. One of the RSWs mentioned that when s/he first started providing awareness raising sessions, s/he started discussing mental health in general, and would not discuss topics 'such as depression or enuresis', because when introducing him/herself as a RSW working with the mental health department at IMC, participants 'used to get scared and some participants reacted to this with surprise [and would say], 'Do you think we are crazy?''. However, after talking about mental health several times, 'people became somehow aware about what mental health is in general'.

Awareness raising sessions conducted usually cover one or two of 15 mental health topics, and most RSWs agreed that they first need to 'approach people with things they can relate to more and accept, for example depression', or with 'topics that are more common to them', as opposed to less mild topics such as torture, for example. According to some RSWs, topics such as depression are easier to approach 'because depression is accepted by people and because its symptoms are more common to them', and because 'while talking about depression in the session you can hear beneficiaries saying 'yes, I think this also happens with me''. Some RSWs pointed out that individuals were 'more attracted to topics such as depressions, psychosocial stressors, postpartum depression, and enuresis', whereas 'reacted to other topics with negativity (such as torture, schizophrenia, and torture)'. One of the RSWs noted that when the topic of torture was approached, 'one of the participants rejected talking about it and told [the RSW], 'you want to talk to me about murder and torture?''. Some participants also reacted to some of the topics with disbelief, asking one of the RSWs whether the topics they are talking about are even real.

The above mentioned findings point to the need for awareness raising sessions, where there is still a relatively high resistance to mental health disorders and their symptoms, where even when a participant informs the RSW of their children having some of the symptoms, and the RSW 'refer[s] them to mental health services, they get scared'. However, with time, and as mentioned by RSWs, participants are becoming more aware and accepting of some mental health topics.

When asked whether participants are given a choice of topics to be discussed in the sessions, the majority of RSWs mentioned that there are certain limitations in doing so, and that they rarely present options. Similarly to one of the CMs' approach mentioned earlier, one of the RSWs stated that sometimes, even if participants do not suggest a certain topic, it is still presented because the RSW assesses that 'the environment requires it [the topic]'. On the other hand, one of the RSWs noted that providing participants with the option of selecting from the list of topics is unlikely because it is difficult to have the booklets of the 15 topics at the same time 'because they are heavy, especially that we distribute booklets to each beneficiary'. However, to address the limitations of giving participants a choice in the topic presented, one of the RSWs collects the contact information of those interested, and schedules another awareness session 'to address a topic that enticed participants' interest' and one that they requested.

Results from the awareness raising checklists showed that a choice of topic was presented in only two out of the eight IMC sessions attended. One of the reasons mentioned by the M&E assistant for not providing a choice of topic in two of the session was that the topics were chosen based on the assessment of the facilitator, where the choice was influenced by the fact that the waiting rooms included children. Checklist results are in line with the above findings, where choices of topics are not always presented to participants.

Findings from the awareness raising checklists showed that FPS CMs did not provide topic options before beginning the session. CMs first discuss mental health in general, then choose the topics themselves according to participant need. Findings from secondary data showed that 44 % of topics presented in 2018 were on general mental health, and 37% were on depression.

Awareness Raising Session Booklets

As per informal program guidelines/procedure for awareness raising sessions, participants should be provided with a booklet of the topic being presented, since CMs and RSWs should be reading the stories included in the booklet when explaining a specific mental health disorder or topic. Findings showed that all CMs are distributing IMC MH awareness raising booklets during the sessions conducted, whereas not all RSWs are able to do so due to a shortage in the availability of booklets.

In regards to the booklets, all RSWs agreed that although 'according to our training, we are requested to read them [the stories] out loud', however, they do not refer to the story in the booklet exactly as it is written since all RSWs believe that the booklets are not very effective if used that way. Instead, some RSWs 'focus on key messages', whereas others 'provide the information in a way that suits them [participants]' and that they can relate to, or 'customize the information' in their own way, that allows them to 'focus primarily on the symptoms' and other important aspects.

The main reason mentioned by all RSWs as to why the stories cannot be followed exactly as mentioned in the booklets was the setting of the waiting room, 'where people come in and go out frequently'. However, and in line with the above limitation, one of the RSWs noted that stories in the booklets are read out to beneficiaries when a quiet setting is available.

As a result, when developing the guidelines for conducting awareness sessions, the program is advised to take the above mentioned limitations into consideration, and assess the importance of reading the stories as written in the booklet, especially given the experiences of RSWs on the field.

According to one of the RSWs, the 'booklets include a lot of female characters and not males', where in one of the sessions on psychosocial stressors, one of the male participant said that the RSW is 'always talking about females and not males'.

However, printed booklets include an almost equal number of females and males. The aforementioned observation made by one of the RSWs could be a result of the most common topics being presented to participants coincidentally including female characters instead of males.

Due to the shortage of booklets in several areas, some RSWs are being unable to distribute them during the sessions, and others are collecting the booklets at the end of the sessions. One RSW mentioned that the decision to keep the booklet or return it is given to the beneficiary, but that in many cases, booklets are not being distributed due to a shortage. Results from awareness checklists showed that booklets were distributed in only three out of the eight sessions attended, which was mainly due to a shortage of booklets, as informed by the RSW/CM conducting the session, or due to the fact that the session conducted was a general one since participants had little to no awareness on mental health. All booklets distributed remained with the participants following the session.

Based on the above finding regarding booklet shortage, RSWs were asked to rank the topics most accepted by and presented to beneficiaries, in order to better assess the number of booklets to be printed depending on the most recurring topics, and the current shortage in booklets. All RSWs agreed on the below ranking of the most discussed topics and shortage in booklets:

1- Depression

2- Post-partum Depression

3- Attention Deficit Hyperactivity Disorder

4- Enuresis

5- Psychosocial Stressors

6- Loss and Grief

7- Post-traumatic Stress Disorder

The program is advised to take the above ranking into consideration when printing awareness session booklets in the future, therefore increasing the number of copies printed for the above topics as proven necessary. Alternatively however, focusing on the most common disorders that participants may have some familiarity with could also play a role in decreasing the possibility of raising awareness on other equally important topics. The program may therefore consider providing the other topics more frequently and as the context allows. In 2019, IMC's program team has a "topic of the month" planned to ensure that all topics are being provided. FPS has developed their own awareness raising materials to be used during the sessions, which did not include booklets. The program team at FPS is therefore advised to consider developing booklets for 2019 awareness sessions based on their assessment of such a need.

Recommendations and Conclusion

The findings of the report suggest that overall, services and activities are more or less being provided according to program guidelines, with a few exceptions and discrepancies between staff in different areas. Main findings revolved around a high need for developing SOPs for several processes and some activities, for both IMC and FPS, such as the case management process, the implementation of the Client FS Tool, and Detection and Referral Trainings, among others. Some other recommendations focus on refresher trainers to be conducted with some CMs, and expanding the reach of awareness raising sessions to males, to name a few.

In conclusion, the process evaluation revealed that targets for all indicators discussed in the report have been reached for both IMC and FPS, and in general, processes for different activities are mostly consistent across the different areas. Also, results show that participants in trainings and activities are overall satisfied with the design and content of activities. Also, the target groups for different MHPSS activities have been reached for both IMC and FPS, with the exception of males not being reached in awareness raising sessions. All recommendations for the different MHPSS activities being provided can be found in Table 14 below.

Table 13: Summary of Challenges - IMC and FPS

Case Management Process	
Consent form is not always filled prior to opening a beneficiary file	IMC
Progress notes of CM sessions provided through the referring NGO are not shared with Zahle CMHC MHPSS CM team	FPS
No regular meetings taking place between MHPSS CM staff at Zahle CMHC and CMs from referring NGOs	
Client Functioning Scale Tool	
Tool is not being filled consistently with all beneficiaries every two to three months	FPS/IMC
Questions in the tool are too general, not reflecting the general situation the beneficiary is living in	IMC
CM involvement in filling the Client FS tool, where it should be filled by the beneficiary or caregiver themselves	
MHPSS CM Session Duration	
In the majority of consultations provided, the minimum session duration with the CM is not meeting informal program guidelines	IMC
In the majority of consultations provided, the minimum session duration with the psychiatrist is not meeting formal program guidelines	
Technical Meetings	
Difficulty for all the MHPSS CM team to meet at once	IMC
Specialist days do not overlap, and in order to attend these meetings, additional non-compensated hours will be needed	
Specialists may have other obligations on days where they are not attending IMC supported centers	
Difficulty for all the MHPSS CM team to meet at once	FPS
Center has a high load of beneficiaries, and the schedule of specialists is fully booked	
Some appointments would have to be cancelled for the meetings to take place, but the priority is beneficiary need	

Beneficiary File Documentation	
No proper documentation of different forms, especially CM consultation forms and psychological assessment forms	IMC
No proper documentation of consent forms since they were introduced towards the end of 2018	FPS
CMs that have been working at the centers since before 2018 should be given a refresher training on the process that should be followed with beneficiaries	
Consultation Reporting	
No consistency across CMs in what is considered and reported as a consultation	IMC
Detection and Referral Trainings	
Maximum number of participants is being exceeded due to a high need for the training	IMC
Quantity of information provided in the training was rated as ‘a lot’ by 21% of participants	
Crisis Management Trainings	
Participants requested the training duration to be longer to avoid the material being condensed into one day, and to allow going into more details	FPS
Awareness Raising Session Setting	
Beneficiaries leaving or entering the waiting room in the middle of the awareness session	IMC
Beneficiaries’ primary focus during the sessions is receiving their appointment	
Waiting room noise and crowdedness	
Interruption during the sessions by others	
Awareness Raising Session Attendance	
Collecting participant information following the sessions (such as names and phone numbers)	IMC/FPS
Awareness Raising Session Target Groups	
Majority of participants in awareness raising sessions are female, low number of male participants	IMC/FPS

Booklets	
Shortage of booklets in the field	IMC
No proper documentation of consent forms since they were introduced towards the end of 2018	

Table 14: Summary of Recommendations – IMC and FPS

Indicator	Case Management Process	
Number of MHPSS consultations provided, disaggregated by consultation type	Develop SOPs detailing case management process, starting from when the beneficiary first attends the center, up until discharge.	IMC
	Consider introducing the filling of consultation forms during first visits	FPS
	Develop guidelines detailing the different scenarios under which beneficiaries should be referred to each of the specialists.	
	Call for more consistent meetings between FPS specialists and CMs from other NGOs	
	High Priority Cases	
	Develop written guidelines for the steps to be taken in high risk cases.	FPS/IMC
	MHPSS CM Session Duration	
	Develop SOPs that allow for detailing all information related to CM sessions, including the expected duration of sessions	IMC
	Look into potential reasons the sessions duration of MHPSS CM team staff did not meet the minimum session requirement.	
	Develop guidelines for session duration with the CMs, distinguishing between follow-up and first visit durations.	FPS
	Develop guidelines for psychotherapists	
	Develop guidelines for psychiatrists	
	Technical Meetings	
	Update technical meeting guidelines to account for current staffing and load of beneficiaries	FPS

Indicator	RSW Consultations	
Number of MHPSS consultations provided, disaggregated by consultation type	Recruit RSWs with backgrounds allowing the provision of MHPSS support	IMC
	Provide RSWs with a training on brief MHPSS support.	
	Develop guidelines detailing the different scenarios under which beneficiaries should be referred to each of the specialists.	
	Separate consultations provided by RSWs from those provided by the MHPSS CM Team	
	Beneficiary File Documentation	
	Look into the low figure of psychological assessment form documentation in beneficiary files	IMC
	Ensure proper documentation of all forms	
	Ensure that the Mental Health Case Management Support Manager and area managers complete case file audits more systematically moving forward	
	Ensure that MHPSS CM team staff systematically fill and document all required forms	
	CMs that have been working at the centers since before 2018 should be given a refresher training on the process that should be followed with beneficiaries	
	Consultation Reporting	
	Set minimum requirements that should be met for an interaction with a beneficiary to be considered as a PSS consultation.	IMC
	Psychotropic Medications	
No Specific Indicator	Update technical meeting guidelines to account for current staffing and load of beneficiaries	IMC
	Community Support Groups	
Number of participants in community support groups	Increase number of sessions or duration of each session	IMC

Indicator	RSW Consultations	
Number of front-line staff and PHCC providers participating in mental health trainings, disaggregated by training type (detection and referral training, Crisis Management Protocol for Frontline Humanitarians, and Psychological First Aid trainings).	Develop guidelines for Detection and Referral trainings.	IMC
	Increase number of trainings provided to accommodate for the high need for such trainings in the areas	
	Increase training duration	
	Add a refresher Detection and Referral training	
	PFA Trainings	
	Discuss with NMHP the possibility of extending the PFA training to two days	FPS
	Awareness Sessions	
Number of participants in MHPSS outreach and awareness raising sessions	Update attendance sheets to only include general demographic information	IMC
	Separate the reporting of focused and non-focused awareness sessions, and respective attendance sheets	
	Awareness Target Group	
	Design awareness activities that allow for targeting and appealing to a higher number of males.	IMC
	Design awareness activities that allow for targeting a higher number of Lebanese and male participants.	FPS
	Booklets	
	Consider the importance of referring to booklets during awareness sessions	IMC
	Consider increasing number of booklets printed based on most discussed awareness topics, or alternatively consider providing the other topics more frequently and as the context allows	
	Consider developing booklets based on program assessment of such a need	FPS