Final Report
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ACKNOWLEDGEMENT

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The evaluation team also acknowledges the information and data generously provided by the Ministry of Public Health, international development partners, health professionals and parents during interviews, focus groups and site visits, which were used as part of the analysis.

The evaluation acknowledges the continuous support provided by UNICEF to the Ministry of Public Health in the Expanded Immunisation Programme. The evaluation does not assess the overall work of the Ministry of Public Health, but only focuses on UNICEF’s involvement.
### ACRONYMS

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<thead>
<tr>
<th>Acronym</th>
<th>Full Form</th>
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<tr>
<td>AWP</td>
<td>Annual Work Plans</td>
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<td>EPI</td>
<td>Expanded Programme on Immunisation</td>
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<td>EVM</td>
<td>Effective Management on Vaccination</td>
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<td>IOCC</td>
<td>International Orthodox Christian Charities</td>
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<td>IP</td>
<td>Implementing Partner</td>
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<td>IR</td>
<td>Inception Report</td>
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<td>LAECD</td>
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<td>RBM</td>
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<td>ToC</td>
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<td>Training of Trainers</td>
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<td>Terms of Reference</td>
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<td>United Nations High Commission for Refugees</td>
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<td>WHO</td>
<td>World Health Organisation</td>
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<td>UNRWA</td>
<td>United Nations Relief and Works Agency for Palestinian</td>
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EXECUTIVE SUMMARY

Background

This evaluation report presents findings from a six-month assessment of the Expanded Immunisation Programme (EPI) component within the UNICEF Country Programme in Lebanon (2013-2017). EPI in Lebanon aims to elevate routine vaccination coverage per region of Lebanon to 95%, preserve Lebanon as a polio-free country, keeping in consideration the influx of Syrian refugees, and finally, eradicate measles and rubella by the end of 2018.

Evaluation objectives and intended audience

The evaluation, which was commissioned by UNICEF Lebanon, sought to better understand the relevance, effectiveness, efficiency and sustainability of the Immunisation Programme component of UNICEF's Health and Nutrition Country Programme from 2013 to 2017, as highlighted in Annual Work Plans (AWPs). The formative evaluation is intended to allow UNICEF to learn from the outcomes of their collaboration with the MoPH on supporting their Expanded Programme on Immunisation (EPI) and provide nuanced recommendations to strengthen the national immunisation system and future collaboration between the MoPH and UNICEF.

The evaluation captured results across three main pillars in the UNICEF Annual Work Plans. As previously highlighted, the time period of the evaluation covered the work plans from 2013 until 2017 across the following thematic pillars of the intervention:

- Increase the routine vaccination coverage for children under five years through the provision of vaccines (including vaccination campaigns for routine immunisation as well as campaigns in prevention of a polio outbreak),
- The capacity building of staff of MoPH and implementing partners
- The provision of vaccines and cold chain supplies to MoPH and subsequently various primary health care centres and dispensaries. In addition to the technical training relevant to use these supplies/equipment and cold chain procedures.

Methodology

The evaluation took a qualitative approach and aimed to assess UNICEF’s support to EPI across Lebanon with no geographical exceptions. Subsequently findings were intended to provide narrative insight at national and localised levels. With exception to the use of an observational check list, which can be considered quantitative, the evaluation team was primarily concerned with exploring performance using qualitative methods. The evaluation team, therefore used the following methods to address evaluation questions: Desk Review, 21 Key Informant Interviews, 14 Focus Group Discussions, 39 In-depth Interviews (exit interviews) and 32 Structured Observations of Vaccination sites.

Main findings and conclusions

The evaluation team was focused on exploring four areas of interest, as prescribed by UNICEF Lebanon; including relevance, effectiveness, efficiency and sustainability. Throughout this period, UNICEF provided ongoing financial and technical support to the Ministry of Public Health (MoPH) and Implementing Partners to increase the effectiveness and quality of EPI in Lebanon, and ensure interventions reached the most vulnerable and marginalised. Given the significant increase in population in Lebanon in 2013-2015 as a result of the conflict in neighbouring Syria, UNICEF became a prime stakeholder ensuring the Lebanese government was capable of meeting vaccination needs of all children under the age of 5, regardless of nationality. Support
to EPI has continued until the present time, with the MoPH recognising UNICEF as a priority partner ensuring the health of children across Lebanon. Nevertheless, as this reported has demonstrated, results concerning the effectiveness, efficiency and sustainability of support provided to MoPH were mixed. While UNICEF has undoubtedly provided significant support to the populations of Lebanon, the exact extent of their successes was challenging to measure. This was largely a result of limited reporting and monitoring from 2013 to 2017.

Relevance

The evaluation team found that the adopted strategies and points of intervention in the area of immunisation were relevant to achieving the expected results in UNICEF Annual Work Plans and were generally relevant to the needs of the populations of Lebanon given the rapid influx of population and overall MoPH objectives and goals between 2013-2017. The AWPs also reflected the need to address gaps in capacity and technical skills to appropriately manage and maintain EPI at national, casa and local levels.

Nevertheless, while the support provided by UNICEF, as highlighted in the AWPs, does address the immediate needs of the population, specific strategies to ensure the most marginalized and remote had access to vaccines, were limited. Additional interventions focused predominately on Palestinians communities who were already being support by UNRWA. There was little mention of specific strategies to address families from lower socio-economic backgrounds or disabled families (with MoPH suggesting that disabled children were not within their immediate scope of work). Furthermore, reviews highlighted immediate gaps in the overall incorporation of gender into EPI activities and strategies; whereby ignoring the nuances of gender relations and inter-household dynamics that can impact on the opportunity for female care givers to ensure their children are vaccinated under EPI.

Effectiveness

The overall effectiveness of UNICEF support to MoPH was mixed. This was primarily a result of limited data which was able to demonstrate overall improvements or benefits of UNICEF interventions at local levels and longitudinal learnings within the MoPH since 2013. Nevertheless, since 2013, evidence does demonstrate that UNICEF has made considerable strides to address the immediate immunisation needs of the population. From 2013, the primary type of support provided by UNICEF was through emergency aid in the provision of vaccines and technical support to MoPH. UNICEF provided invaluable support ensuring that not only the Lebanese populations had access to vaccines under the EPI, but also that migrants and refugees from neighbouring countries were not excluded. Additional support was provided to local NGOs and other UN agencies such as UNRWA, to cover gaps in MoPH coverage and financial capacity. As such, UNICEF has been able to assist in maintaining high coverage rates across the country from 2013 – 2017, with estimates suggesting that coverage was around 85 – 90%. Furthermore, UNICEF successfully supported the overall impact of EPI through the provision of immunisation materials, such as cold chain equipment including fridges. PHCs and dispensaries across the country received various types of fridges, including solar and electric fridges to ensure vaccines were stored at optimal levels and the quality of vaccines was maintained.

Additional efforts to build on the successes of EPI were noted in relationships formed with local NGOs and International NGOs; providing funding, technical support and monitoring activities to track performance and increase overall awareness of the benefits of vaccinating children.

Nevertheless, a notable gap in efforts was the extent to which lessons learned across projects and monitoring activities were incorporated into UNICEF AWP and future interventions. Gaps were also noted in the extent to which UNICEF played a role in ensuring the effectiveness of EPI at local levels. Findings from this evaluation highlighted that UNICEF support was provided at national / central levels, and at local levels little intervention was seen.
The evaluation also found barriers and challenges which influenced the effectiveness of EPI interventions across the country such as wastage, availability of quality vaccines, minority Groups not being directly supported through EPI, misconceptions about the safety of vaccines, geographic barriers, residual costs and perceived inequalities across populations.

**Efficiency**

From 2013 – 2017 UNICEF has spent considerable time and funding supporting immunisation activities under EPI, including the provision of vaccines, cold chain equipment and the facilitation of capacity building sessions. The extent to which financial contributions to EPI can be considered efficient and cost effective however, was mixed. This was primarily because no documentation was recorded concerning budget predictions compared with actual spending. UNICEF teams were unable to provide considerable insight on costs associated with EPI activities in the AWP, apart from budgets noted within AWPs.

Nevertheless, following UNICEF reports that they are responsible for vaccine funding, there was little evidence to suggest that efforts had been made to track and determine the cost effectiveness of these provisions.

**Sustainability**

The evaluation team found that the overall sustainability of UNCIEF efforts to support EPI was limited, and that considerable efforts do not appear to have been made on behalf of MoPH or UNICEF to ensure necessary strategies or practices were being considered to manage EPI in the absence of UNICEF financial support. Data highlighted that MoPH currently have no alternative practices or strategies in place to cover the full cost of vaccines for the Lebanese, Syrian and Palestinian populations. Furthermore, the high turnover of staffing across the MoPH saw significant limitations in the extent to staff had necessary institutional knowledge. As a result, UNICEF continue to spend resources to retrain MoPH staff on management and vaccine storage practices.

**Main recommendations**

- The AWP should mention specific strategies to address families from lower-socio economic backgrounds. Although UNICEF staff acknowledged that residual costs were a constant barrier for accessing vaccines, the activities detailed in the AWPs from 2013 to 2017 do not incorporate any specific strategy for overcoming those challenges at a programmatic level. In that regard, UNICEF could support the MoPH in the analysis of out of pocket expenditures related to immunisation and the drafting of a National policy on free access to vaccine and to vaccination till full immunisation of the child.

- Furthermore, there was little mention of specific strategies to address families with disabled children. In line with UNICEF global efforts, more should be done in Lebanon to work with the MoPH to ensure health professionals do not consider disability alone as a contraindication for immunization.

- Capacity building activities should be more closely documented, and should be focused on providing Training of Trainer (ToT) activities rather than simply training. Hence, ToT should support greater sustainability across MoPH, at the central, district and local level, and provide MoPH with the knowledge and skills to run their own training as new staff are contracted, rather than UNICEF needing to repeat training sessions.

- Additionally, UNICEF can support PHCs through the introduction of practices and policies which promote equality across nationalities, providing greater support to hamper any misconceptions about biased among Syrians or Lebanese.
In order to target residual costs that hinder access to vaccination services, UNICEF could further support the MoPH in tackling the cost of vaccines through PHCs and other health facilities. UNICEF should encourage the MoPH to collaborate with all actors (including the private sector) involved in making sure that they are a still and clear strategy that effectively ensure that vaccination is free for all children under five. Furthermore, the evaluation team suggests that UNICEF conducts research into wastage to better understand the extent to which it impacts on effectiveness and efficiency.

Wastage of vaccines remains an ongoing concern that prohibits effective vaccine management at the national level. Health professionals at the local and district levels shared initiatives to reduce wastage. One option worth exploring further is the redistribution of non-used unexpired vaccines through the MoPH.

No evidence was shared proving that efforts are made to verify reported vaccination needs and consider cost effectiveness when procuring vaccines and equipment. The first step to achieve some progress in that direction is to be made on the accuracy and transparency of MoPH data records. UNICEF shall work with the Ministry to support their efforts, drawing on the lessons learnt from the successful experience of other countries in the region that have put forth such reforms.

One major issue regarding the efficiency of the procurement of vaccines remains on the choice between single and multi-doses. Further investigation, both with the MoPH and UNICEF Supply Division, is required to better understand the procurement choices despite the awareness that wastage is an ongoing concern. Efforts needs to be made by UNICEF to collect and review spending, such as budgets allocated for vaccine procurement. UNICEF shall conduct a thorough needs-cost analysis to support their choices of procurement.

Building on UNICEF’s global experience, UNICEF Lebanon could work more closely with MoPH to develop lessons learned approaches to their practices, with the introduction of workshops or seminars, encouraging shared dialogue. Examples of topics to be discussed may include the following – best practices in other countries, data record keeping practices at national and local levels, monitoring tools and activities. The objective of such workshops is to ensure that the MoPH is aware and has the tools to introduce policies and practices that have been deemed successful to overcome challenges in other countries.

Given the role played by the private sector in achieving the objectives of the EPI, UNICEF could encourage the MoPH and support it in better understanding the provision of immunisation services by the private sector, including vaccine safety issues (e.g., integrity of the cold chain), whom the sector serves, how services are paid for, its contribution to coverage, and its integration with monitoring and surveillance.
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SECTION A: BACKGROUND

A.1 Context of the Evaluation

This evaluation report presents findings from a six-month assessment of the Expanded Immunisation Programme (EPI) component within the UNICEF Country Programme in Lebanon (2013-2017). The EPI in Lebanon is foundational to ensuring children from all socio-economic, gender and ethnic backgrounds, especially the most marginalized and vulnerable, have access to routine immunisations preventing childhood diseases. The EPI, originally established in 1987, aims to guarantee the right of every child in Lebanon, regardless of social status or parents’ education level, to be immunized and protected from diseases with ‘available, quality and safe vaccines.’ The programme is further focused on providing special attention to children residing in remote and underprivileged areas, through quality outreach activities. EPI in Lebanon is a model which has been replicated globally to ensure universal access to all relevant vaccines for children at risk.\(^1\) The global policies for immunisation and establishment of the goal of providing universal immunisation for children by 1999 was originally established in 1977 and considered an essential element of WHO strategy to achieve health for all by 2000. In Lebanon specifically, EPI aims to elevate routine vaccination coverage per region of Lebanon to 95%, preserve Lebanon as a polio-free country, keeping in consideration the influx of Syrian refugees, and finally, eradicate measles and rubella by the end of 2018.

A.2 National Context

Despite its status as a middle-income country, from 2013-2017 Lebanon continuously faced socio-economic and political challenges. This was both a result of internal challenges and the neighbouring Syrian conflict. These continued to impact the quality of lives of families and children across the country. A stagnant economy, coupled with minor threats of insecurity, demands on public services and limited job opportunities have increased the likelihood that children and their families struggle to meet their basic needs.\(^3\) These challenges whereby, have had a significant impact on access to affordable healthcare services, particularly immunisations (despite MoPH attempts at making vaccination free to children across the country). In addition to the widespread barriers, findings from the 2017 Vulnerability Assessment for Syrian Refugees in Lebanon, highlighted that female headed households were further marginalised. Female-headed households were identified as being far less food secure, had worse diets and higher poverty rates. Data found that on average 56% of female headed households had no working member, compared to 32% of households headed by males. Subsequently, results from this report suggested that children from female-headed households had less access to services, such as health care and vaccination than other households.

A.3 Health Care Context

Looking in particular at health care services in Lebanon, they are largely privatized or private with limited official government-run health clinics which creates greater burdens on families. UNICEF highlighted that there was a distinct difference between privatized and private medical centres. Private health care centres work outside of the MoPH network, they are profit-based and generally run independently of MoPH. Privatized health care centres work within the MoPH network and in general, are run or funded by NGOs. In both centres, there are notable costs involved for provision of immunisation services. In particular, in ‘privatised’ centres, there are indirect costs (residual) often coming from pre-vaccine consultation fees. The majority of health centres section

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2 Ibid, 2017
are owned and managed by NGOs (67%), by the municipality (20%). The remaining 13% are operated by the MoPH.

Currently, EPI exists and functions within this network of PHCs. Ensuring there is appropriate access to such facilities, and that facilities can provide adequate quality care for all populations is foundational to the success of EPI in Lebanon. To that end, EPI relies on a variety of stakeholders from the MoPH, UNICEF, WHO, UNWRA, international and local NGOs. Furthermore, a specific focus on creating and maintaining a stable and successful EPI system is paramount, given the outbreaks of vaccine-preventable illnesses over the past decade.

According to UNICEF, during 2013 and 2014 there was an outbreak of measles and mumps in different areas across the country, in addition to the detection of the polio virus in Syria in 2013. While Lebanon declared that the country was polio-free in 2002 and was able to prevent a potential outbreak of polio among nationals and refugees, high levels of displacement had the potential to influence immunity levels across the country and reverse the absence of the polio virus. The recurrence of formerly eradicated diseases suggests that there are limitations in current vaccination coverage, particularly among vulnerable populations, such as refugees and the poor Lebanese population. Measles, mumps, and polio epidemics were also focus points for the MoPH and UNICEF through appropriate vaccination practices. The Ministry of Public Health (MoPH) launched, in 2016 the Health Response Strategy Maintaining Health Security, Preserving Population Health & Saving Children and Women Lives, where MoPH reiterated its commitment to provide free vaccines. In collaboration with the MoPH, UNICEF is supporting the implementation of EPI.

A.4 Barriers to Understanding Vaccination Rates and Coverage

While MoPH and collaborating, agencies such as UNICEF and the World Health Organisation (WHO) are supporting the implementation of EPI across the country, there are still significant challenges in accurately measuring coverage and understanding barriers to increased coverage. Available data on the scope of vaccination is not fully accurate and the limited monitoring activities which have been conducted, are unable to effectively capture and address the complexities of tracking vaccinations across PHCs and refugee camps. For example, using current practices, medical professionals are struggling to track accurate rates of vaccination and those who are receiving full dosages as there is no centralised system on which health professional can record a vaccination. As a result, if one child receives a vaccination at one location and then goes to a second location, the health centre will be unable to effectively track their vaccination schedule.

At the hospital, women receive health cards for their new-borns; it includes the vaccination schedule and growth monitoring information. This approach however, does not account for at home births. At the PHC level, caregivers can be provided with a vaccination card that only has the vaccination schedule. There are no apparent activities which seek to ensure all women with new-borns are accessing the necessary information about vaccination schedules. Secondary research highlighted that this is particularly relevant in low socio-economic and marginalized areas, where families may not have the same access to health services as those of higher socio-economic standards.

A.5 UNICEF Intervention and Support to EPI

According to UNICEF, approximately 50% of vaccination services are provided by the public health sector, and UNICEF and the MoPH have made extensive efforts to ensure that all children in crisis have access to services. Nevertheless, a significant proportion of these needs remain unmet. In response to this growing crisis across Lebanon, UNICEF has developed, in collaboration with MoPH, Annual Workplans following a result

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5 The evaluation team was only provided with monitoring reports completed in 2017, previous reports were not made available.
chain structure based on a Results Based Management (RBM) strategy. The EPI is a component of this structure and highlights the support being provided to MoPH and more specifically EPI from 2013 to 2017.

Based on aforementioned challenges to immunisation in Lebanon, UNICEF work plans – which are approved by MoPH (Annual Work Plan 2013, 2014-2015; Annual Work Plan 2015-2016; Annual Work Plan 2017) focus predominately on the following:

- Increase of routine vaccination coverage for children under five years
- Increase of capacity building of MoPH staff and implementing partners to manage EPI systems
- Sustainable provisions of vaccines, supplies/equipment and cold chain
- Communication activities such as national or local awareness and vaccination campaigns

Examples of specific activities involved in these work plans included providing a series of trainings on Effective Vaccine Management to all vaccinators and a regional expert training on vaccine supply management to ministerial immunisation officers (Annual Work Plan 2017). Furthermore, UNICEF, recruited registered nurses, public health officers and information technology officers to work in central and regional MoPH offices to strengthen the monitoring and reporting of the national EPI programme. Finally, UNICEF further supported MoPH with cold rooms, solar fridges and sibir fridges to ensure appropriate medical cooling of vaccinations, and the provision of all vaccines under the EPI schedule.
### A.6 Key Stakeholders and Beneficiaries

Identified key stakeholders and beneficiaries for UNICEF support to EPI included the following:

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<tr>
<th>Stakeholder</th>
<th>Beneficiary</th>
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<td>Ministry of Public Health</td>
<td>All children in Lebanon under the age of 5</td>
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<td>UNICEF</td>
<td>MoPH national level staff</td>
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<td>World Health Organisation (WHO)</td>
<td>Public Health Professionals at PHCs</td>
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<td>United Nations Relief and Work Agency for</td>
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SECTION B: EVALUATION PURPOSE, OBJECTIVE AND SCOPE

This report presents the findings of an independent country programme evaluation of UNICEF’s support to Lebanon’s EPI between 2013 and 2017. The summative evaluation was commissioned by UNICEF Lebanon and conducted between March and October 2018. The evaluation report contains methodology of evaluation, evaluation findings, conclusion and recommendations.

B.1 Ethical considerations

Sayara Research has ensured the safety, integrity, dignity and confidentiality of all participants in this evaluation, and in line with UNEG Norms and Standards, as well as UNEG’s Ethical guidelines. Important to note however, specific ethical approval was not a requirement of this evaluation.

The evaluation team has ensured the following principles were also incorporated:
- The evaluation team operated in impartial and an unbiased manner; ensuring that all strengths and weaknesses as balanced and take into account potential diverse views of stakeholder,
- All findings presented were reported based on reliable and credible data. The report highlights the consistency and dependability of data, findings and judgements, highlighting any challenges or limitations in data collection or analysis.

B.2 Theory of Change

The overall framework of this evaluation is based on the below Theory of Change (ToC) and UNICEF evaluation questions. The overall approach for this evaluation were designed in line with OECD DAC criteria, which are relevance, effectiveness, efficiency, impact (outside of the scope of this evaluation) and sustainability.

Since 2013, UNICEF has been providing ongoing support to the MoPH to assist in fulfilling technical and financial gaps concerning national EPI. While the status of EPI continues past the scope of this evaluation (from 2017 to present day), this theory of change reflects technical and financial support provided between 2013 and 2017.

The evaluation team conducted comprehensive reviews of a body of documentation which provided insight into some activities and intended outputs, however, the causal linkages of UNICEF support to EPI had not been formally articulated in the form of a Theory of Change (ToC). In this sense, a ToC should highlight the intended outcomes and impacts generated by support provided by UNICEF. As such, following a desk review and discussions with the UNICEF team, the starting point of this evaluation was to derive a proposed ToC in collaboration with the UNICEF team. It is important to note however, that UNICEF Lebanon did have a working ToC for their overall nutrition and health programming, this ToC however, was unable to accurately reflect individual points of intervention and overall outcomes and objectives of support provided to EPI.

Based on the aforementioned gap, the evaluation team worked collaboratively with UNICEF to design and test a tailored ToC for UNICEF support provided to EPI.

As such the following problem statement was derived:

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6 Guidance Norms and Standards UNEG Foundation Documents
7 Organisation for Economic Cooperation and Development Assistance Committee
8 Based on the terms of the contract.
The most disadvantaged and vulnerable populations in Lebanon continue to have limited access to routine vaccinations for children under the age of five. Due to the increase in population and economic demands placed on Lebanon, as a result of the conflict in Syria, the subsequent increase in vaccination demand has put a strain on both the economy and health system, whereby inhibiting the MoPH to ensure the health rights of all children through the provision of quality vaccines.

As a result of the highlighted problem, UNICEF has provided specialised support from 2013 to the MoPH, to ensure they are both financially and technically capable of meeting the vaccination needs of all children, and in particular the most disadvantaged and vulnerable. This support is provided to assist all populations in Lebanon, including Syrian, Palestinian and Lebanese families.

Following the identification of the root problem that UNICEF aimed to address between 2013-2017, the evaluation team identified a series of barriers and bottlenecks that continue to inhibit the ultimate goal of ensuring quality health care for all children. These barriers and bottlenecks have been categorized based on the four pillars of (1) financial accessibility, (2) availability of vaccines and immunisation material, (3) geographic accessibility and (4) acceptability.

Financial Accessibility

During design and analysis phases, the evaluation team identified that financial costs associated with immunisation were an ongoing barrier to increased coverage. The long-term effects of the Syrian crisis and economic downturn of Lebanon have seen the residual costs associated with vaccination and health services continue - both privatized and private (including costs associated with vaccination). These residual costs reportedly prevent families from accessing free vaccination services, which in accordance with the MoPH should be accessible and free of charge to the most vulnerable population in Lebanon (for Syrians, Palestinians and Lebanese). UNHCR highlighted that a total of 11% of Syrians reported being unable to access vaccinations due to associated financial burdens and 7.4% could not cover the cost of transportation. International research on immunisation practices highlight that cost and resource allocation is often a primary barrier to accessing vaccines. Almost all formal health systems (which is the most common form of health service available across the country) entail indirect costs which are predominately related to transportation, costs to access a physician etc.

Availability

In the case of availability, if a local PHC does not have the necessary and quality vaccines available, stored in a quality fridge and managed across appropriate cold chain practices, then a family cannot fulfil their immunisation needs. Furthermore, if a centre does not have the demand for vaccines, the availability of vaccines is also sure to be limited. UNICEF highlighted that a total of 10.2% of Syrians reported that their local health care centre did not have available vaccines when visited. In addition, availability also refers to the availability of appropriate staff and capacity to maintain vaccine systems.

Geographical Accessibility

Limited availability of vaccines is also likely to increase the barriers of geographical accessibility. Families may be required to travel greater distances to access vaccines, which would include greater indirect costs and potentially introduce socio-cultural barriers, such as women being unable to travel without a male counterpart, or fear of discrimination when care givers are refugees or Lebanese from a low socio-economic background.

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Acceptability

Finally, the last pillar of accessibility, suggests that there may be sub groups of the population which are not as accepting of vaccinations. While it is generally understood that vaccinations are in high demand across the country, we cannot automatically discount the fact that there may be sub groups of the population who disapprove. This may be a result, again, of socio-cultural barriers pervasive in conservative communities, especially refugee communities coming from Syria. This barrier however, was noted by the UNICEF team, not to be a considerable one, as in their experience, they found little evidence that families were unaccepting of vaccinations.

Following a review of the all relevant programmatic documents and secondary literature, the evaluation team designed a working theory of Change (ToC) to represent the efforts being made by UNICEF to support national EPI activities. The ToC was designed in collaboration with UNICEF and based on activities highlighted across the 2016 and 2017 Annual Work plans. The result of these discussions is illustrated in the infographic ToC below:
PROBLEM:
The most disadvantaged and vulnerable populations of Lebanon continue to have limited access to routine vaccinations for children under five. Due to the conflict in Syria, the increase in vaccination demand has put a strain on both the economy and health system, thereby inhibiting the MoPH to ensure the health rights of all children.

ASSUMPTIONS:
- That the population of Lebanon wants to vaccinate their children
- The MoPH does not have sustainable funding to meet vaccination demands of the population
- The population of Lebanon recognises the benefits of vaccination
- MoPH is committed to ensuring all children have equal rights to free vaccinations
- Community-based vision of health to reach all vulnerable and disadvantaged populations
- Public health system can cover every clinic
**Purpose, Objectives and Scope**

The evaluation, which was commissioned by UNICEF Lebanon, sought to better understand the relevance, effectiveness, efficiency and sustainability of the *Immunisation Programme* component of UNICEF’s Health and Nutrition Country Programme from 2013 to 2017, as highlighted in Annual Work Plans (AWPs). The *formative evaluation* is intended to allow UNICEF to learn from the outcomes of their collaboration with the MoPH on supporting their Expanded Programme on Immunisation (EPI) and provide nuanced recommendations to strengthen the national immunisation system and future collaboration between the MoPH and UNICEF.

**B.4 Utility**

The ToR highlights that UNICEF will be the primary user of the evaluation, followed by secondary users including the MoPH and implementing partners. The evaluation is also foreseen to be an informative document for health stakeholders in Lebanon and advisory agencies such as the United Nations High Commissioner for Refugees (UNHCR) and the World Health Organisation (WHO).

The results of this evaluation provide relevant and timely contributions to organizational learning, informed decision making and accountability. UNICEF and identified relevant stakeholders should be able to gain accurate and contextual insight into the effectiveness and relevance of the immunisations programme component of UNICEF’s country programme. The evaluation highlights the *strengths and weaknesses* associated with support provided by UNICEF, and ultimately highlights *gaps and challenges* in EPI systems in collaborations among all participating parties. While the evaluation team understood they were not assessing the performance of collaborating partners, findings were still able to highlight their strengths and weaknesses, contributing to an already existing body of evidence and research on EPI in Lebanon. Relevant stakeholders ideally will utilise these findings to inform future programme work plans and rectify any existing gaps in approach to reach the most marginalised populations. Furthermore, findings and recommendations act as an evidence base to which both UNICEF and MoPH can refer, to understand the overall relevance, effectiveness, efficiency and sustainability of their collaboration.

Finally, evaluation findings from community members and caregivers will contribute to a set of knowledge beyond UNICEF and MoPH’s collaboration. Findings have been able to generate a body of knowledge on experiences and perceptions of EPI across the country and highlighting existing barriers preventing full vaccination coverage; all which will contribute to a greater set of primary research on challenges pertaining to vaccine coverage.

**B.5 Evaluation Objectives**

The overarching objective of this evaluation is to conduct a formative assessment to allow UNICEF to learn from the outcomes of collaboration between UNICEF and the Ministry of Public Health (MoPH) concerning the Expanded Immunisation Programme (EPI), providing robust and contextual recommendations which can assist in strengthening future collaboration between both parties and relevant implementing partners.

UNICEF was interested in understanding how better to position themselves, to ensure they are instrumental and effective in providing support to MoPH, in a way which is both economically and technically sustainable. While the provision of vaccinations to MoPH, technical support through capacity building as well as

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12 These implementing partners include above highlighted stakeholders including UN agencies, MoPH, and implementing partners for who will be involved in future intervention. Exact implementing partners for future intervention was unknown to the evaluation team.
immunisation campaigns have been a particular focus, the evaluation highlights how UNICEF can best support future activities to ensure the most vulnerable and marginalized among both Lebanese and Syrian populations were accessing immunisations.

UNICEF’s goal of working with MoPH in the EPI is to ensure that health continues to be the primary right of a child, through routine immunisation coverage to the most vulnerable. The objective of the evaluation supports the generation of robust and accurate evidence on immunisation for both programming and policy purposes. Objectives as stated in the TOR were as such:

- Learn from previous experience of the annual work plans signed between MoPH and UNICEF in matter of immunisation component
- Provide concrete recommendations to improve planning and implementation for achieving better results and reaching most children, in the matter of immunisation
- Use evaluation findings and recommendations to be considered in mid-term review of the Country Programme Document (CPD) 2017-2020

These were UNICEF’s objectives as to how the evaluation will assist their strategy and programming in the future. Nevertheless, the evaluation team did note that these were objectives that could not be obtained by the evaluation team. The evaluation team specifically, was unable to address the aforementioned objectives as they did not have the responsibility or ability to make programmatic revisions in future activities. In saying that, the evaluation team, to ensure their approach in evaluation design, implementation and analysis looked at the following two objectives which were derived from the aforementioned UNICEF objectives. These objectives were adjusted at inception phases and did not require any further adjustment throughout the evaluation period.

- Provide learnings from previous experience of the annual work plans signed between MoPH and UNICEF in the matter of the immunisation component
- Provide concrete recommendations to improve planning and implementation in order to achieve better results and ensure greater covered, in the matter of immunisation

B.6 Scope of Evaluation

The evaluation captured results across three main pillars in the UNICEF Annual Work Plans. As previously highlighted, the time period of the evaluation covered the work plans from 2013 until 2017 across the following thematic pillars of the intervention:

- Increase the routine vaccination coverage for children under five years through the provision of vaccines (including vaccination campaigns for routine immunisation as well as campaigns in prevention of a polio outbreak),
- The capacity building of staff of MoPH and implementing partners
- The provision of vaccines and cold chain supplies to MoPH and subsequently various primary health care centres and dispensaries. In addition to the technical training relevant to use these supplies/equipment and cold chain procedures.

The evaluation took a qualitative approach and aimed to assess UNICEF’s support to EPI across Lebanon with no geographical exceptions. Subsequently findings were intended to provide narrative insight at national and localised levels. Areas of specific interest were concretely decided on an iterative basis throughout the course of the evaluation. Evaluation findings acted as a source of information with which to identify specific areas to visit and assess. Evaluation teams, in collaboration with UNICEF, then decided whether any of these regional areas should be incorporated into the sampling approach. For example, it was noted in early stages of field work that additional data should be collected from Palestinian communities in camps as MoPH were not mandated to support vaccine needs to such population. The evaluation team therefore, focused specifically on

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13 The extent to which narrative insight and recommendations could be made based on evidence collected at local levels was limited, given the overall limited amount of activity UNICEF had at local levels.
the direct support provided by UNICEF to UNRWA to ensure gaps in target populations were being met. Furthermore, additional gaps noted throughout the evaluation period was the lack of understanding among pregnant and expecting mothers regarding their awareness and experience with childhood vaccinations. As such, additional interviews were conducted with expecting mothers.

There were no areas across the country which were considered to be outside the scope of assessment, and as such efforts were made to ensure that data was able to accurately reflect all geographic areas, socio-economic levels, nationalities, gender and disabilities – including border crossings and refugee camps for both Syrians and Palestinians. Nevertheless, as previously highlighted, the direct support and impact of UNICEF interventions were challenging to identify at local levels due to limited grass root activities or support. Therefore, data reflecting attitudes and practices from across the country were noted in interviews with local health care providers and community members in FGDs and IDIs.

Furthermore, the evaluation included the following relevant stakeholders:

Identified local communities, male and female caregivers and children to the extent possible represented marginalised and vulnerable populations, as this was the primary target group of UNICEF in their support for EPI. These included communities which had significant socio-economic challenges or geographic remoteness. All target participants were sourced from areas identified as ‘vulnerable and under-sourced’ by UNICEF’s relevant teams and relevant MoPH staff.

Furthermore, while mothers are generally identified as the primary care givers of children, the evaluation team recognise the importance in including male as relevant stakeholders. While mothers may be the one who generally take children to PHCs, fathers more often than not play an important role in the decision to immunize a child from a socio-cultural and economic stand point, which was highlighted in UNICEF’s KAP study. By ensuring the evaluation included males into the scope of work, the evaluation team were better able to measure

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14 UNICEF, 2017, ‘Cross Sectional Formative Research: Knowledge Attitudes and Practice Study,’
the dynamics of household decision making and the extent to which UNICEF was providing sufficient support in their campaigns to identify and target these stakeholders, as well as accounting for gender sensitivity in their programming.

**B.7 Cross Cutting Themes: Gender, Human Rights and Socio-cultural Family dynamics**

The promotion of gender equality, equity and human rights is central to UNICEF programming internationally, and all programming is required to address underlying causes of human rights violations, including discrimination against women and girls and utilizing processes that are in line with the human rights principles. Human rights in the context of this evaluation will refer to ‘the civil, cultural, economic, political and social rights inherent to all humans, regardless of nationality, gender or ethnicity’. Gender equality refers to the equal rights and opportunities of men, women, girls and boys.

The evaluation team explored and assessed the extent to which control over household resources and decision may have been a gender barrier for female care givers, and if so, whether this had been addressed or acknowledged in UNICEF’s annual work plans. This was particularly relevant to adolescent mothers, who may have far greater limitations in their households.

Immunisation programming that fails to recognise the constraints that women and mothers face in accessing and utilizing services may inadvertently contribute to greater gender inequality, in addition to creating greater barriers to increasing coverage. The Swiss Tropical and Public Health Institute suggests that provider attitudes, public exposure to criticism and missed opportunities can reinforce gender stereotypes and divisions, maintaining the perception that child health is the woman’s responsibility. This argument suggests that immunisation services are gendered in how they are understood, presented and managed. Most immunisation services target mothers as the primary caretakers, and as a result these processes are feminised or gendered, reinforcing the premise that health care is the responsibility of mothers; and ignoring the realities of decision making within a household.

For example, a literature review on global experiences of gender and immunisation found that the health status of a child, in developing contexts, is linked to the mother’s capacity to care and nurture a child. Findings suggested that despite the father and often extended family’s say in how the mother can and should care for the child, it is ultimately her responsibility. These findings however, suggested that a mother’s ability to care for her child was often jeopardised by her lower status in society and within the family. Limited autonomy and ability to mobilise resources inside and outside the house can impact a mother’s ability to follow health-related recommendations.

Moreover, as fathers and men are rarely implicated in vaccination processes, information does not reach them to the same extent it does women. This also may neglect the critical influence men have over women’s decision-making power.

The evaluation team assessed the extent to which the interests, needs and priorities of both male and female caregivers, from all marginalised and disadvantaged groups were taken into consideration in the annual work plans and addressed through UNICEF’s support to EPI. The evaluation team looked at the extent to which the work plan has incorporated or recognised any gender-based, equity and human rights-based obstacles which may be prevalent among target beneficiaries and ultimately impacting on the ability for UNICEF to ensure full vaccination coverage among the most vulnerable and marginalized in Lebanon.

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15 Swiss Tropical and Public Health Institute, 2010, ‘Gender and Immunisation: Summary report for SAGE,’
16 Ibid, 2010
17 Ibid. 2010
SECTION C: EVALUATION METHODOLOGY

The evaluation team took a predominately qualitative approach to this evaluation based on the terms of reference (ToR) stated by UNICEF. This approach followed the original methodology requested by UNICEF and based on the OECD DAC criteria (relevance, effectiveness, efficiency and sustainability). A qualitative approach allowed the evaluation team to capture narrative insight into the realities of the collaboration between UNICEF and MoPH. With exception to the use of an observational check list, which can be considered quantitative, the evaluation team was primarily concerned with exploring performance using qualitative methods.

The evaluation chose not to take a quantitative or mixed methods approach as the potential for capturing representative quantitative information would have been far larger than the scope of this evaluation. The evaluation team was not interested in capturing the KAP of beneficiaries or assessing the performance of MoPH, therefore a qualitative approach was the most effective and efficient means of measuring the performance of the UNICEF and their collaboration. Furthermore, in order to capture a more in-depth understanding about the strengths and weaknesses of the support being provided to MoPH, a qualitative approach allowed participants a greater space with which to share their opinions and experiences and explore areas of interest – a quantitative approach did not allow for the evaluation team to explore the ‘unknown.’ Furthermore, given the large time frame of the evaluation (2013-2017), the use of quantitative methods would not have been able to provide relevant and accurate findings which could represent the entire period of assessment. Quantitative approaches, in this instance, would have only been appropriate if the evaluation team needed to capture a single set of data which was relevant from one given time frame.

All data collection methods have been selected based on the evaluation questions and indicators as highlighted in the table below. Based on the original evaluation questions set in the ToR, the following methods have been identified by both UNICEF and the evaluation team as being the most appropriate for capturing narrative insight into the realities of the collaboration between UNICEF and MoPH. Furthermore, the evaluation team used a sequencing approach.

C.1 Guiding Principles

The overall approach to this evaluation has been developed in accordance with UNEG Norms and Standards and the UNEG Ethical guidelines for review. The presentation of the evaluation framework which was designed and approved in collaboration with UNICEF Lebanon can be found as a reference in Annex 1: Evaluation Matrix. The framework highlights the evaluation questions which were part of the original ToR, including sub questions, indicators, sources of data, and data collection methods – all which were designed by the evaluation team.
The principal evaluation questions included the following:

C.2 Methods and Stakeholders

The evaluation team, therefore used the following methods to address evaluation questions:

- Desk Review
- Key Informant Interviews
- Focus Group Discussions
- In-depth Interviews (exit interviews)
- Structured Observations of Vaccination sites

Key stakeholders who have benefited from and have interest in and influence on EPI in Lebanon included:
<table>
<thead>
<tr>
<th>Stakeholders</th>
<th>Representative</th>
<th>Type of Interview</th>
</tr>
</thead>
<tbody>
<tr>
<td>UNICEF Staff</td>
<td>UNICEF Health and Nutrition Senior Programme Team</td>
<td>Key Informant Interviews</td>
</tr>
<tr>
<td></td>
<td>UNICEF Communications Team</td>
<td></td>
</tr>
<tr>
<td></td>
<td>UNICEF PPL Team</td>
<td></td>
</tr>
<tr>
<td>MoPH at central office</td>
<td>MoPH Warehouse supply team</td>
<td>Key Informant Interviews</td>
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<tr>
<td></td>
<td>MoPH Senior EPI officers</td>
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<tr>
<td>MoPH at governorate / Regional office</td>
<td>MoPH PHC Coordinators</td>
<td>Key Informant Interviews</td>
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<tr>
<td></td>
<td>MoPH Public Health Officers</td>
<td></td>
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<td></td>
<td>PHC Directors</td>
<td></td>
</tr>
<tr>
<td>Other UN Agencies</td>
<td>Representatives from UNHCR</td>
<td>Key Informant Interviews</td>
</tr>
<tr>
<td></td>
<td>Representatives from WHO</td>
<td></td>
</tr>
<tr>
<td>Partners / Strategic Partners</td>
<td>Beyond Programme Staff</td>
<td>Key Informant Interviews</td>
</tr>
<tr>
<td></td>
<td>International Orthodox Christian Charities (IOCC) Programme Staff</td>
<td></td>
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<tr>
<td></td>
<td>Makhzoumi Foundation Programme Staff</td>
<td></td>
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<tr>
<td></td>
<td>Lebanese Association for Early Childhood Development (LAEC) Programme Staff</td>
<td></td>
</tr>
<tr>
<td>Care Givers</td>
<td>Male caregivers (Syrian, Lebanese and Palestinian)</td>
<td>Focus Group Discussions</td>
</tr>
<tr>
<td></td>
<td>Female caregivers (Syrian and Lebanese)</td>
<td>In-depth (Exit) Interviews</td>
</tr>
<tr>
<td>Medical Professionals and Community Health Professionals</td>
<td>Public Health Officers at PHCs in targeted regions</td>
<td>Key Informant Interviews</td>
</tr>
<tr>
<td></td>
<td>Public Health workers</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Vaccinators</td>
<td>Structured Observations</td>
</tr>
<tr>
<td></td>
<td>Nurses at PHCs and relevant public health facilities</td>
<td></td>
</tr>
</tbody>
</table>

**Desk Review**

The primary step in the evaluation process was a thorough review of all programmatic documentation and associated literature on immunisation in Lebanon. This included reviews of the documentation detailed in the bibliography attached.

The desk review was conducted during the inception phase of the project. This initial period provided the evaluation team with contextual foundation from which to design evaluation instruments, approach analysis and implement efficient and robust data collection. A list of documentation reviewed for this evaluation can be found in the bibliography attached in Annex 3.

**Key Informant Interviews (KII): 21 in total**

Key informant interviews focused on capturing key programmatic information about the support provided to MoPH from UNICEF concerning immunisations. Interviews with key informants provided in-depth insight into specific programmatic areas concerning capacity building, provision of supplies and communication campaigning. Interviews were conducted a national, regional and municipal levels, ensuring the voices of stakeholders at all levels are incorporated into the evaluation findings. Furthermore, interviews assisted in contextualizing the impact of outcomes, and analysed the enablers and barriers to support and capacity of MoPH concerning EPI.

Key informant interviews were mapped and identified in collaboration with UNICEF and the MoPH. The rationale behind the selection of key informants was because of their experience and expert knowledge of components within the EPI Programme and UNICEF and MoPH's collaboration. Each of the stakeholders
mentioned were able to provide the evaluation team varied insights into the strengths and weaknesses of UNICEF’s support to EPI, in addition to highlighting some of the existing gaps and barriers which may not be addressed in previous and existing workplans. They were also able to assist in triangulating findings across various key informant stakeholders.

- Staff from the MoPH at national, governorate and district level
- Health workers at relevant vaccination sites, including vaccinators at borders
- Partner staff from organisations such as ‘Beyond Association’ the International Orthodox Christian Charities (IOCC), the Makhzoumi Foundation and the Lebanese Association for Early Childhood Development (LAECED).
- UNICEF staff
- UNHCR staff – those working in health and nutrition with Palestinian and Syrian refugees
- World Health Organisation (WHO) staff
- UNRWA and UNICEF PPL colleagues

Interviews were semi-structured, with a focus on directing interviewees thematically and encouraging them to share their experiences and attitudes. Interviews were participatory, to the greatest extent possible, allowing the interviewee to direct the content of the interview and identifying experiences and concepts which they considered to be the most important to the success or failure of interventions. By allowing interviewees to lead the interviews, the evaluation team provided the opportunity to take ownership over the details being shared and share details which the evaluation team may not initially consider important. All interviews were recorded and translated into English for analysis.

The total number of KIIs conducted was 21: 6 with MOPH staff, another 3 with UNICEF staff and 5 with implementing partners as well as others detailed below. The exact location of each interview was decided on an iterative basis and in collaboration with UNICEF and MoPH.

<table>
<thead>
<tr>
<th>Key Informant</th>
<th>Number of Interviews</th>
</tr>
</thead>
<tbody>
<tr>
<td>MoPH Staff</td>
<td>6</td>
</tr>
<tr>
<td>UNICEF staff</td>
<td>3</td>
</tr>
<tr>
<td>Implementing partners</td>
<td>5</td>
</tr>
<tr>
<td>UN staff (UNRWA, WHO, UNHCR)</td>
<td>4</td>
</tr>
<tr>
<td>Health Workers</td>
<td>3</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>21</strong></td>
</tr>
</tbody>
</table>

Focus Group Discussions (FGDs): 14 in total

Focus Group Discussions were conducted with community members (female and male care givers) to identify existing perceptions and experiences of vaccination programming in Lebanon. These were focused primarily on the most vulnerable and marginalized beneficiary families, as these were the primary target of UNICEF. Furthermore, it was primarily focused on understanding public perceptions about the quality of vaccination services. This included the availability of routine vaccinations, costs associated with vaccinations, any biased or discrimination felt as a result of facility staff etc.

Findings from FGDs contributed beyond the support being provided by UNICEF by generating knowledge on existing experiences and barriers preventing families from vaccinating their children. Important to note however, that data collected from community members can only accurately represent experiences and opinions from 2016. Participants were selected based on the criteria that they had children under the age of 5. In this instance, many participants would be unable to report or comment on their opinions from 2013-2015.
The evaluation team conducted FGDs in all 8 governorates. All governorates in Lebanon were covered in this evaluation to ensure UNICEF and MoPH understood any differences or nuanced experiences in various areas of the country. By interviewing families in all governorates, the evaluation team was able to capture any differences which may be a result of geographic location.

FGDs were completed with the following stakeholders:

- Mothers / Female care givers (from Lebanese, Palestinian and Syrian communities)
- Fathers / Male care givers (from Lebanese, Palestinian and Syrian communities)
- Non-beneficiary families (families who access vaccinations through the private system)

Additionally, not enough pregnant women care givers could be found to conduct FGDs in the different governorates. Therefore, 2 Key Informant Interviews were conducted with pregnant women one with a Syrian woman in Akkar and one with a Lebanese woman in the North, in order to still gather their feedback and understand their perceptions about the quality of vaccination services.

By conducting FGDs with families from Lebanese, Palestinian and Syrian communities, the evaluation team was able to capture the varying experiences of the different nationalities and social and religious groups across the country. This provided valuable insight into how effectively UNICEF's support and MoPH has understood
the specific nuances of each group, and how effectively UNICEF and MoPH have address their individual challenges and needs. The rationale for selecting a broad range of members of the population was to measure the extent to which sub groups of the population benefited more from the distribution of vaccines, given vaccines are available to all socio-economic levels in the population. Furthermore, by separating males and females, the evaluation team was able to more deeply explore gendered nuances, assessing the extent to which gender mainstreaming has been incorporated into interventions and the diverse experiences of both genders.

**Gender Mainstreaming Checklist**
In order to ensure that gender is adequately addressed across FGDs, the evaluation team ensured the following:

- **Appropriate group composition** The evaluation team ensured that the composition of the groups was age, gender and culturally appropriate. Such that males and females were not interviewed together, and to the extent possible holding homogenous FGDs. Furthermore, the team ensured that marginalised and at risks groups were incorporated into sessions
- **Group Setting** FGD took place in a secure setting, where all participants were comfortable with discussions
- **Appropriate facilitators** Only female facilitators were assigned to female groups and male to male groups. Facilitators were trained on GBV concepts and referral pathways if necessary.

Important to note that children as evaluation participants were not targeted in this evaluation. This was because the evaluation team found that there was no specific need to introduce a child’s experiences into this particular evaluation, and the potential for harm outweighed the evaluation needs.

**In-depth (Exit) Interviews with caregivers who attend clinics: 39 in total**

The services provided to families represent a significant part of UNICEF support and MoPH work with clinics. By conducting exit interviews with care-givers who attended clinics, the evaluation team could capture very specific information about the experiences and expectations of families when they went to clinics for immunisations. While FGDs focused on attitudes and practices of vaccinations, exit interviews provided much more specific information about the support and process of receiving a vaccination. Interviews were conducted with a random selection of male or female caregivers who accessed health care centres for vaccinations. The evaluation team had not agreed on any specific sampling approach, as there was no way to determine what families would come to clinics for vaccination services. Nevertheless, to the extent possible, the evaluation’s field team attempted to ensure that families from all hierarchies and socio-cultural backgrounds were met. This included Syrian refugees, Lebanese (of all socio-economic levels), male and female care givers and any influential family members.

Discussions focused on some of the following thematic areas:

- Ease of accessing the clinic and booking an appointment
- Attitudes towards the staff and process of immunisation
- Reasons for immunising their children (were families told to immunise their children?)
- Financial costs involved in immunising children
- Overall perceptions of the clinic

Interviews followed a structured format, ensuring that all specific technical questions were asked. Interviews were also recorded and translated for analysis. For the purpose of anonymity and confidentiality, exact locations of the public health centres are not discussed in this report, however, are available to UNICEF’s Lebanon team.

<table>
<thead>
<tr>
<th>Location</th>
<th>Total per Governorate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Akkar</td>
<td>4</td>
</tr>
<tr>
<td>Beirut</td>
<td>5</td>
</tr>
<tr>
<td>Beqaa</td>
<td>5</td>
</tr>
<tr>
<td>Baalbeck/Hermel</td>
<td>5</td>
</tr>
</tbody>
</table>
Structured Observations of Immunisation Activities: 32 in total

A series of structured observation of immunisation activities were conducted by field staff to assess performance of staff in real time. The most effective way of collecting such information was through the use of quantitative check lists. These check lists assessed the extent to which staff were completing necessary outputs, and the extent to which they were fulfilling their necessary responsibilities. Furthermore, observations were also assessing the appropriateness of the environment in which immunisation activities took place. Site observations were able to assess the extent to which learnings from capacity building activities have been translated into practice in the field. Observations also captured the environment of clinics. The instrument for the structure observation was based on an existing instrument that regional UNICEF staff used when conducting site visits. Furthermore, the templates were a practical tool which has been developed by the team who work in the field and understand the daily expectations of vaccinators.

Interviewees were selected randomly and based on availability at centres during days of observations. The selection of sites were finalised in collaboration with UNICEF based on initial site visits to MoPH warehouse.

C.3 Limitations

Throughout the evaluation period, including the design, implementation and analysis period, the evaluation team came across a series of limitations which impacted on the team’s ability to accurately capture and discuss elements of the evaluation. The following section highlights these limitations.

C.3.1 Design and Sampling

During the design phase of the evaluation, the evaluation team met limitations in the extent to which they could accurately design observational tools which were relevant to UNICEF’s support. The observation tool was intended to capture insight into the quality of facilities and operationality of public health centres which were to be indirectly supported by UNICEF. The evaluation team requested UNICEF to provide a template or list of criteria that should be observed and was relevant to UNICEF support. The evaluation team referred to any monitoring templates that are used by UNICEF M&E teams as a point of reference. These templates however,
were either not available or not made available to the evaluation team. As such, the evaluation team had to draw on their own experience and understanding of Annual Work Plans to design instruments. Subsequently, the team was unable to specifically tailor an observation to match the exact intervention points which may have been influenced by UNICEF work. Nevertheless, it was later noted during the analysis phase of the evaluation that UNICEF played an extremely limited role in activities or quality of PHCs at local levels, and as such it became apparent that the observation method was not going to be able to accurately capture relevant data on UNICEF support. The tool therefore, was used predominately, to comment on overall operationality of PHCs and the extent to which vaccines and cold chain equipment was available and in use.

The overall approach to sampling of key informant interviews was done through snowballing, with UNICEF remaining the primary point of reference. Throughout the evaluation process, the evaluation team relied on UNICEF to provide the names and contact details of individuals who were determined – by UNICEF – to be of interest to the evaluation. While this approach was decided to increase the efficiency of data collection, potential biases do need to be considered. In such instances, the evaluation team relied on UNICEF to highlight key sources of information, sources which may or may not have been more favourable to UNICEF activities. Furthermore, key informants were generally individuals who were familiar and well known to the UNICEF team, leaving the potential for other key informants to be missed. While the evaluation team, to the extent possible, attempted to identify additional key informants through communication with the MoPH and NGOs, there was considerable reluctance to share such information.

The evaluation team also had considerable challenges accessing key members of the EPI team at the MoPH. Despite considerable support from the UNICEF team, many members of MoPH were either unwilling or did not respond to requests for interviews about UNICEF support to EPI. As a result, the evaluation team were unable to gather as much data from the MoPH as the team would have liked. As a result there were various gaps in specific areas of the evaluation, such as the extent to which the MoPH was satisfied with UNICEF support, or the various types of training that had been provided to MoPH teams. As a result, the evaluation team had to rely on discussions from UNICEF staff about the type and quality of training provided. This limitation was noted throughout the evaluation when relevant.

Furthermore, the evaluation team sought to incorporate the opinions of single headed female households and pregnant women into community related components of the evaluation. The evaluation team experienced considerable challenges identifying willing participants. As such, the evaluation team shifted from having FGDs with pregnant women to IDIs. Women were identified in various areas of the country and as such, the evaluation team was unable to put together an FGD. IDIs were used in their place.

Finally, upon reflection of the overall evaluation approach, the evaluation team noted that some of the evaluation questions put forth in the original ToR may not have accurately identified necessary areas of interest. For example, in terms of efficiency the evaluation questions provided were concerned predominately with changes over time, rather than the documentation of best practices. While the evaluation team attempted to document best practices, in most cases lessons learned and best practices had not been documented by the UNICEF team over time, as such gaps in information and the ability to accurately comment on best practices was limited.

C.3.2 Field Work and Data Collection

During the field work and data collection phase of the evaluation, there were several limitations that impacted the team’s ability to accurately capture the relevant qualitative data needed for the evaluation. Such limitations included the following:

- Limited institutional knowledge across UNICEF and MoPH
- Limited data available to demonstrate and account for activities completed as part of EPI support
- Availability and willingness of key informants to participate in evaluation activities
Limited recall across community members and families about their experiences with vaccination practices prior to 2017

Limited Institutional Knowledge and Gaps in Access to Information Across UNICEF and MoPH

As this evaluation relied heavily on the knowledge and experiences of UNICEF and MoPH staff, it was critical that the evaluation team had access to accurate data and recall from 2013 to 2017. Capturing this scope of information however, proved to be a significant challenge in that no particular systems had been put in place within UNICEF or MoPH to maintain institutional knowledge across their years of work. It was highlighted in various occasions that the rapid turnover of both MoPH staff and UNICEF caused significant issues maintaining institutional knowledge. As such only a small pool of people who could both be contacted for interviews and have the necessary institutional knowledge and experience to accurately comment on UNICEF’s support from 2013. In fact, the evaluation team was not able to draw on any individual staff who were involved in EPI activities in 2013 and 2014, therefore, any data findings from these years could only be sources through UNICEF reports, and could not be accurately verified through primary data collection. Therefore, some consideration needs to be had on the extent to which internal and external documents on UNICEF’s EPI support could be considered biased and may not have accurately represented the scope of work during the early years of this evaluation.

Furthermore, the extent to which the evaluation team could assess the effectiveness of training provided was limited. training agendas and reported learning from training sessions were not readily available, and therefore the primary source of information to assess effectiveness was the feedback provided by those who participated in training.

Limited Data Available to Demonstrate and Account for Activities Completed as Part of UNICEF’s EPI Support

Another common barrier during the field work phases of this evaluation was the extent to which documentation and data concerning EPI activities were available. For example, the evaluation team had no access to data on forecasting of immunisation needs prior to 2017, and monitoring reports from 2013 to 2016. In addition, no documents on budgets were provided to the team, and therefore, trend analysis of the cost effectiveness of immunisation supplies provided by UNICEF over the years, could not be completed. This has created a considerable gap in findings concerning the efficiency of support being provided to MoPH.

Similarly, not having access to monitoring reports or annual programme reports prevented the evaluation team from understanding the extent to which lessons learned or field observations were incorporated into annual work plans over the year, and the extent to which overall EPI strategies were revised to better address any gaps in programming.

Availability and Willingness of Key Informants to Participate in Evaluation Activities

During the field work phase, the evaluation team faced delays in data collection due to the unavailability or limited willingness of key informants to participate in requested interviews. While the UNICEF team provided as much supports as possible to the evaluation team, including personally calling highlighted key informants, many were still unwilling to participate or did not respond to requests for interviews. This was predominately an issue with MoPH staff. As a result, the evaluation team had little access to information of the experiences and work of MoPH staff and their collaboration with UNICEF. Furthermore, among those who were willing to support the evaluation team, their institutional knowledge was often limited and they were unable to accurately comment on collaborations with UNICEF. Gaps in information have been noted throughout the evaluation.

Limited Recall Across Community Members and Families about Their Experiences with Vaccination Practices prior to 2017
As part of the ToR for this evaluation, it was necessary to ensure the voices of communities and families from Syrian, Lebanese and Palestinian population were included. While families provided valuable feedback about their experiences, many were only able to comment on their most recent experiences with health centres and vaccination. Many of the families did not have younger children in 2013 or 2014, and therefore could not comment on vaccinations at that time. Of those who did have children who were vaccinated in those years, many were unable to recall specific experiences or any differences they may have come across over the years. Therefore, all data from communities and families can only be considered accurate about experiences in 2016-2017.

C.3.3 Analysis

Overall, there were no considerable limitations met during the analysis phase, apart from the gap in data made available during field work. One valuable observation however, which was only highlighted during the analysis phase, was the extent to which the observational and exit interview tools could not provide valuable insight into UNICEF support. The tools, as highlighted in the methodology section, were intended to measure the extent to which PHCs were fully operational and functional. According to UNICEF, this was a requirement that needed to be measured in the evaluation. Findings however, demonstrated that there was little to no evidence to suggest that UNICEF played any active role in the functionality of PHCs at local levels, and therefore, any observations could not be contributed to UNICEF work. For example, the availability of vaccines at clinics was the responsibility of MoPH and not UNICEF. Furthermore, UNICEF played no role in training staff or conducting regularly monitoring to ensure immunisation equipment such as fridges were operational. Nevertheless, results from these tools have been included in the findings, and their limitations noted.

C.3.4 Gaps in Data Concerning MoPH

Further limitations were noted in the extent to which the evaluation team could comment on the capacity of MoPH throughout the time period assessed in this evaluation. In order to comment accurately on the sustainability and effectiveness of EPI with relation to MoPH activities, a tailored assessment of MoPH performance would have been required. This however, was out of the scope of this evaluation. Nevertheless, not including this particular aspect also created gaps in terms of how accurately the evaluation team could comment on how well MoPH staff are functioning and the extent to which existing staffing meets EPI needs.

Furthermore, interviews were also conducted with MoPH staff about their experience of training with UNICEF. Overall, limited information was provided from interviewees, with many simply stating that training was ‘useful.’ The evaluation team requested information specifically on the training provided to MoPH but outlines and agendas of training were generally not available. Furthermore, training conducted in 2013-2015 was not accurately documented, and given the turnover of staff across the UNICEF office, there was limited institutional knowledge to comment on early training. UNICEF appeared to be consulted on the content of the training and provided on certain occasion trainers – only one occasion during the AIA campaign in 2017 could be cited by UNICEF staff. The extent to which UNICEF directly contributes to the health care workers training being useful and effective appears to be limited.
SECTION D: FINDINGS

In line with the evaluation questions, the report highlights findings covering the three key pillars in matter of immunisation in the Annual Work Plans between 2013 and 2017. First, the relevance of UNICEF’s support to EPI will be assessed, followed by the effectiveness, and the efficiency and then by the sustainability.

D.1 RELEVANCE

The following section will cover the relevance of UNICEF’s support to EPI and associated strategies to meet the needs of the most marginalized children in Lebanon. The evaluation examined the extent to which UNICEF Lebanon’s Health and Nutrition programme was able to provide the necessary technical and resource support to the MoPH and adjust to the significant external and internal changes in Lebanon since 2013. Relevance was predominately measured through a review of UNICEF’s Annual Work Plans, as requested by UNICEF’s M&E team. Additional aspects of relevance that were examined included relevance of intervention and support provided based on the priorities and objectives of the Government of Lebanon and relevance to emergency needs of the population.

EVALUATION QUESTIONS

To what extent did the planning of immunisation component in annual work plans identify the needs to achieve results, in terms of:

- Capacity building
- Provision of supplies / equipment and cold chain
- Communication, taking into consideration Lebanon context in the time of the Syrian context

To what extent did the annual work plan address the needs of the following

- Capacity building
- Provision of supplies / equipment and cold chain
- Communication, taking into consideration Lebanon context in the time of the Syrian context

To what extent was gender, equity and human rights considered and addressed in the annual work plan?

D.1.1 Capacity building, Vaccine Provisioning, and Communication in AWPs

The Health and Nutrition component of UNICEF’s work since 2013 has been focused on ensuring families have access to quality health care and that the nutritional needs of children are being met, irrespective of nationality. More specifically, one component of the Health and Nutrition team’s work has been supporting existing structures in Lebanon to ensure health professionals and relevant stakeholders have the necessary capacity and provisions to maximise the impact of the Expanded Programme of Immunisation (EPI). This support has been extensively highlighted and detailed in UNICEF’s Annual Work Plans since 2013.

UNICEF’s annual work plan for Health and Nutrition is a mandatory component of UNICEF work and guides UNICEF’s health interventions throughout Lebanon. According to joint agreements and Memorandums of Understanding between UNICEF and MoPH, the annual work plan highlights the national priorities of UNICEF and their support to MoPH – such that UNICEF provides technical and resource support to MoPH for a coordinated and government-led health and nutrition response to the vulnerable in Lebanon, regardless of nationality. UNICEF efforts, as highlighted in the annual work plans (Annual Work Plan 2014-2015; Annual Work Plan 2015-2016; Annual Work Plan 2017), align closely with MoPH aims to satisfy individual needs for
health care, while also alleviating the financial burden of health-related costs on households, particularly among the marginalized and poor.

While annual work plans are drawn up to cover UNICEF’s entire Health and Nutrition programming, the Expanded Programme on Immunisation (EPI) is one component of the annual work plan. The EPI related components of AWPs from 2013 to 2017 are the point of interest in this evaluation. The AWPs, designed in collaboration with MoPH, are broken down into four influential pillars of support led by UNICEF. These included: capacity building support to health professionals and MoPH, provision of supplies such as vaccinations, cold chain equipment and strategic communications.

AWPs are designed on an annual basis in collaboration with the MoPH. According to UNICEF senior staff, discussions are informally held with MoPH staff – “during discussions with MoPH, we identify needs, we do informal needs assessments and MoPH identify people who should participate in different training sessions.” Additional scoping and mapping exercises are not completed as part of annual planning activities, rather decisions are based on the experience and knowledge of MoPH and UNICEF staff.

The following section of this evaluation will explore each component of EPI related activities (capacity building, procurement and supply, strategic communication) as highlighted in the AWPs from 2013 to 2017, and assess the overall relevance of UNICEF approaches to EPI.

"The main prevention programme is the EPI because it prevents children from all diseases prevented by immunisation. Our goal is to reach every child and to reach the coverage rate above 95% at the district level, to eliminate measles and keep the country polio-free." (Chief Central Coordinator for EPI in MoPH)

D.1.1.1 Capacity Building

Since 2013, UNICEF has worked with the MoPH to increase the capacity of health systems and health providers. Based on the AWPs, the predominate goals of capacity building support provided by UNICEF was to ensure that MoPH and relevant stakeholders and health professionals had the capacity to manage vaccination distribution and storage at national and local levels. Capacity building activities were reported to take place from national / central levels with the MoPH to governorate and caza levels.

Overall, given the context and capacity of MoPH since 2013, the need for capacity building and technical learning was highly relevant. Interviews with both MoPH and UNICEF staff highlighted that prior to the influx of refugees, MoPH did not need to manage such a large programme. As such population needs were not as high. Nevertheless, given the influx of refugees from 2013, MoPH were required to manage a much larger programme and also manage different nationalities, including existing Palestinians and Syrians. To do such, required far greater capacity, more systematic approaches to immunisation and structured vaccine forecasting and procurement. As a result, the capacity building support provided to MoPH was an attempt to meet these needs, and therefore can be considered relevant. The following paragraphs highlight this support in more detail:

In 2013 and 2014, capacity building support in AWPs was orientated towards emergency response as a result of the conflict in Syria and influx of refugees and migrants. During this time, a particular focus was given on training and equipping health workers with the skills and knowledge to manage vaccines through effective cold chain management. In 2014-2015 further capacity building support was provided through ‘Training of Trainers (ToT)’ for MoPH focal points to upscale the number of staff who had vaccine management knowledge. According to UNICEF’s 2015 Annual Report, a total of 891 EPI staff were trained on effective vaccine management through the provision of ‘Tools needed to monitor and assess vaccine supply chains, vaccine management and reduce adverse events following immunisation’. In 2016, a shift away from emergency response support was taken, and a greater focus was given towards upscaling the number of health staff across
MoPH who were capable of maintaining vaccines and subsequent cold chain practices. As such, a further 985 EPI specific staff were trained on effective vaccine management. Additional trainings were also then provided to MoPH staff on micro-planning and effective vaccine management training. Further details on each of these training sessions were not available to the vaccination team, and as such comments on the relevance of content was not included in this evaluation.

The focus of capacity building in 2017 appeared to be on ensuring lessons learned from previous AWPs were revised and relayed to the MoPH, especially on better tracking and registering children for vaccination. UNICEF managed to scale up its capacity building efforts and diversify the scope of its training to reach staff involved in detecting non-vaccinated children, vaccine management at the level of the PHC or other health dispensaries as well as data management to ensure the monitoring of the vaccination process. As such, with the support of other implementing partners such as WHO, UNICEF planned to provide capacity building / refresher of EPI staff on vaccination services, including on-the-job training / coaching in its capacity building efforts for MOPH staff.

D.1.1.2 Procurement and Provision of Quality Vaccinations

The role of vaccine supply chains and procurement to ensure the quality and protection of vaccinations was another component of support being provided by UNICEF for EPI. With the influx of populations into Lebanon following the conflict in Syria, considerable pressures have been put on vaccine supply chains, requiring them to perform at levels for which they were not designed. As a result of this influx, UNICEF took a leading role in providing emergency response support to the MoPH through the provision of EPI related vaccines to cover the needs of the increased population, given the limited financial capacity of the MoPH. Since 2013, the procurement and supply of quality vaccines to MoPH for distribution to PHCs has been continuously managed by UNICEF and their supply team.

History of Vaccine Procurement and Supply 2013-2017

A thorough review of UNICEF’s AWPs from 2013 to 2017, in addition to reviews of annual assessments, highlighted the extent to which UNICEF considered interventions which addressed gaps in vaccination practices, supply and the influx of increased populations from neighbouring countries. The AWPs from 2013-2017 reflected the needs of a rapidly changing environment across Lebanon as a result of the conflict in Syria. AWPs in most cases accurately identified existing gaps in vaccination needs and aimed to provide emergency support to the Government of Lebanon and the MoPH to manage and meet the needs of the increase influx of children under the age of 5 requiring vaccinations under the EPI. Examples of support provided in terms of procurement and supply are highlighted below.

Response to the Polio Outbreak in Syria and Iraq in 2013

In response to the polio outbreak in Syria and Iraq in 2013, UNICEF supported the MoPH in preventing cases in Lebanon, especially among the refugee population. Hence, EPI activities through UNICEF that year were heavily focused on providing preventative support through the supply of 1.5 million doses of polio vaccines to the Ministry of Public Health. Feedback in annual work reviews highlighted that with short notice a total of 829,037 children (628,274 Lebanese – 76%) were vaccinated against polio, 580,770 of whom were reached in nationwide polio campaigns in November and December 2013, achieving a 98.4 per cent coverage rate.

With the success of the MoPH in avert the spread of polio cases in Lebanon, the national strategy, and thus UNICEF’s support, shifted from crisis-response to a more preventive and long-term approach to polio coverage.

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18 UNICEF 2016 Annual Report
19 MoPH data
Response to Overall EPI Requirements 2013-2017

As highlighted in AWPs since 2013, UNICEF’s supply team has procured and dispensed vaccines to the MoPH warehouse in Karentina (Beirut), where the MoPH has been responsible for distributing them to health facilities for vaccinations across the country. Secondary data highlighted that, in 2014 alone, more than 79,000 children under 5 were immunized, nearly reaching the 2014 target of 80,000.\textsuperscript{20} They all received vaccines provided by UNICEF to the national MoPH. The following year’s target (2015) of 150,000 children under five with routine vaccination was surpassed, with 226,311 children immunised.\textsuperscript{21} In total UNICEF stated in its 2015 Annual Report that four million vaccine doses were delivered to children. In particular, given the threat of the polio outbreak in 2015, UNICEF was able to deliver 1.5 million doses of the polio vaccine through the accelerated immunisation campaign in partnership with the MoPH. Further specific details on these campaigns were not available to the evaluation team, so an in-depth analysis on the content and geographic distribution of information was unknown.

UNICEF, in accordance with their international mandate to support all children under the age of 5, also procured vaccines to support UNRWA and the Palestinian minorities living in camps across the country. Vaccines for these Palestinian communities were not supplied or managed by MoPH, but directly provided to UNRWA Lebanon Field Office according to UNRWA immunisation calendar. In 2014, UNICEF supported UNRWA in the implementation of the emergency measles vaccination campaign in the Shatila, Sabra and Burj Barjneh camps at UNRWA health clinics, kindergartens and schools. A total of 23,028 Palestine refugees (21,445 PRL\textsuperscript{22} and 1,583 PRS\textsuperscript{23}) benefitted from this round of vaccination. In 2015, UNICEF provided EPI vaccination requirements to all 27 UNRWA health clinics, benefitting a total of 27,000 under five children (23,500 Palestinian refugee children in Lebanon and 3,500 Palestinian refugee children from Syria) and 11,000 school students (TD vaccine). According to the 2016 UNICEF Annual report, “the vaccines were provided in-kind to UNRWA, and were distributed to UNRWA primary health care centres and administered by UNRWA medical staff.”


In addition to the supply of vaccines, the AWPs from 2013 – 2017 highlight that UNICEF provided support on the management of the MoPH warehouse for vaccines, the cold chain and effective management of vaccination stock. Additionally, UNICEF supported UNRWA through Expanded Programme of Immunization (EPI) requirements (vaccines, syringes, needles, cold chain supplies, needle destroyers, refrigerators, ORS). This was outside the scope of MoPH, as MoPH did not consider the vaccination of children in camps within the immediate responsibility of the ministry. Since the middle of 2017, UNICEF reported that they had been working more closely with the central warehouse to align stock keeping records, tracking consumption throughout the PHC and dispensary network and forecast needs for replenishment.

Based on the number of supplies provided to stakeholders from 2014, the 2017 AWP reflected a more sustainable approach to the provisions already provided to health centres. There was a specific focus on the need to follow up on the functionality of cold chain equipment, its maintenance, repair and the necessary purchase of any new items. An additional focus on the Border Vaccination Centres, such as the UNHCR reception centres, in hard to reach areas and where the maintenance challenges were reported as being among the highest were targeted for additional infrastructure support.

\textsuperscript{20} UNICEF Lebanon Annual Report 2014  
\textsuperscript{21} UNICEF Lebanon Annual Report 2015  
\textsuperscript{22} Palestinian Refugees from Lebanon  
\textsuperscript{23} Palestinian Refugees from Syria
In terms of the extent to which the provision and procurement of vaccines and relevant equipment was needed to achieve results in increasing the EPI, findings and analysis of the Lebanese context from 2013-2017 suggest that it was a necessary component due to the limitations of the MoPH in terms of finances and capacity. The conflict in neighbouring Syria and subsequent economic crisis in Lebanon demonstrated that the MoPH, alone, was unable to adequately address the increase in demand for vaccines and health vulnerabilities which come about as a result of the rapid influx of migrants and refugees. Demand for health services, especially among populations of children in lower-socioeconomic levels increased dramatically. As the MoPH highlighted to the evaluation team, it was unable to adjust appropriately in response to the immediate changes in the country and the needs of the most vulnerable populations, notably on financing the procurement of vaccines for all children in Lebanon irrespective of their nationality. As a result, UNICEF in collaboration with the MoPH have attempted to address the relevant needs of the country to reduce gaps in capacity and provisions to manage EPI. As such, the evaluation team conclude that indeed, the procurement of immunisation equipment and vaccines was highly relevant considering MoPH shortcomings.

D.1.1.3 Strategic Communications

The following section looks specifically at the relevance of strategic communications as a pillar of support provided by UNICEF. The AWPs from 2013 – 2017 highlighted that UNICEF intended to provide support to EPI through communication activities such as awareness campaigns to meet the information needs of the populations – Syrian, Palestinian and Lebanese. While these activities were generally conducted through implementing partners, they attempted to address - at both a national and local levels – the need to increase awareness and knowledge of the types of vaccinations required under the EPI vaccination schedule. Reported activities included puppet theatre, children’s games, focus group discussions, house to house mobilisation and awareness sessions.

Following the emergency response-based activities in 2013-2014, AWPs reflected the need for UNICEF to develop a more preventative focused and long-standing communication strategy to support MoPH in increasing the overall awareness of populations about EPI scheduling and the benefits of vaccinating children under the age of 5. This is not to say however, that emergency response-based communication activities ceased during that time. In 2015 and 2016 two sub-national polio immunisation campaigns were held in localities which were identified as the most vulnerable and at risk. This was done in partnership with the World Health Organisation (WHO) and the NGO partner BEYOND. In January and February 2016, a “Mop-Up Polio Campaign” was launched. The campaign consisted of door-to-door immunisations, in specific areas where the threat of polio was considered the highest.

The extent however, to which strategic communication was a necessary and relevant component of the AWPs was still unclear to the evaluation team. There was no specific evidence available to highlight the gaps in information among families and communities, and even the most appropriate platforms of communication given literacy levels, education levels and even socio-cultural mobility. Therefore, without documented evidence to prove the need for strategic communications, the evaluation team can not directly conclude the relevance in the various approaches. (Approaches are discussed in detail in the effectiveness section of this report).

D.1.1.4 Financial Support of Health Practitioners

UNICEF, in addition to the aforementioned activities, also provide the salaries to Public Health Officers at central and peripheral levels since 2016, they are in charge of improving the local governance at the PHCs. Although immunisation is not the core of their activities, UNICEF still ensure that appropriate staffing and structures are in place to provide children with access to vaccinations. According to UNICEF, one of the

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25 UNICEF Annual Report 2015
biggest barriers facing vaccination coverage is the residual costs associated with private health care. Public support positions are intended to ensure public health staff are answerable to the MoPH and not part of the private profit-making system which is prevalent across the country.

A major question resides in financing mechanism for EPI, and the analysis of out of pocket expenditures related to immunisation, will be essential to analyse and document to further influence national policy on free access to vaccine and to vaccination till full immunisation of the child.

**D.1.1.5 Relevance to priorities and objectives of the Government of Lebanon and MoPH**

Another key point of this evaluation, was to better understand the extent to which UNICEF support and interventions were relevant and in line with the priorities and objectives of the Government of Lebanon and the MoPH. Overall, UNICEF’s support – highlighted through the current and past AWPs – were relevant to the Government of Lebanon’s priorities and more specifically the Ministry of Public Health’s (MoPH) priorities and the needs of children across all nationalities from 2013 to 2017, as detailed below. UNICEF’s work was broadly aligned with and supportive of government-led interventions and strategies.

Rates of immunisation are key public health indicators and reported among the specific objectives of the MoPH with regards to “increasing the efficacy and efficiency of population based (vertical) public health and communicable disease programs.” EPI was mentioned in the 2017 Operational plan annexed to the MoPH Strategic Plan for 2016 to 2020.

Furthermore, the three aims of the EPI at the MoPH from 2013 to 2017 were to:

- Elevate routine vaccination coverage per district to above 95%
- Preserve Lebanon as polio-free, considering the continuous influx of Syrian refugees and in preparation to the eradication of polio in the region and worldwide.
- Eradicate Measles and Rubella by the end of year 2018.

As highlighted above, UNICEF has played a contributing role in attempting to achieve the above-mentioned aims and goals of the MoPH. The following three areas were also focus points for the MoPH since 2013, all point with which UNICEF intervention and support aligned.

**Elevate Routine Vaccination Coverage to Above 95%**

The AWPs repeatedly highlighted targeted numbers of beneficiaries of routine immunisation services, for all vaccines provided in the national calendar for children under 5. The AWP 2014-2015 clearly had for outcome to improve access, coverage and quality of PHC services through direct support, including the provision of Routine vaccination (EPI). In 2017, the AWP still stated that one of its outcomes was for children to have increased access to routine immunisation.

**Preserve Lebanon as polio-free (2013-2017)**

In April 2017, the MoPH announced that Inactivated Polio Vaccine (IPV) provision to all children under 5 in Lebanon would be free of charge for all children, regardless of nationality at PHCs across Lebanon, in addition to border points and UNHCR reception centres.

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26 MoPH Health Strategic Plan (2016-2020)
The MoPH managed, with the support of UNICEF and other partners to prevent a polio outbreak in the country. As such, the previously highlighted focus of UNICEF activities from 2013-2017 on supporting the MoPH in preventing polio was in line with the second aim of the MoPH.

Eradicate Measles and Rubella by the end of year 2018

In its strategic plan for 2016 to 2020, hence covering the end of the scope of the present evaluation (2013-2017), the MoPH highlighted that rates of immunisation increased between 2009 and 2015 in three key areas: polio (93 – 99.85%), measles (93 – 99%) and pentavalent vaccines (93 – 98%). Yet, there was a significant outbreak of measles in 2013 and 2014. As detailed previously, UNICEF supported the MoPH in dealing with the outbreak through, among other activities, the implementation of the emergency measles vaccination campaign targeted at Palestinian children and mothers as well as vulnerable Palestinian children living in the camps and conducted through UNRWA health clinics, kindergartens and schools. Furthermore, the support provided to the National Measles Laboratory of Lebanon in 2015 has been done in the aim of scaling up the country’s ability to prevent and alert on future measles outbreaks.

Finally, a request by UNICEF’s team was to look closely at how effectively they were able to overcome challenges to keep up with changes in the National EPI calendar – including the provision of 2OPV, IPV and PCV. To the extent possible, the evaluation team attempt to collect data on such challenges, however, interviewees were unable to provide any specific insight and no documentation was available which discussed such concerns.

D.1.2 Gender, equity and human rights in AWPs

While the AWPs reflected national mandate and objectives for EPI and provided relevant emergency response support to address the influx neighbouring populations, the extent to which specific strategies and support considered gender, equity and human rights was mixed.

D.1.2.1 Gender

Across all AWPs there were no reference to potential gender barriers or gender-based interventions / support which need to be considered during vaccination activities. Gender in this evaluation refers to the equal rights and opportunities of men, women, girls and boys. One component of this is the role of female care givers and the gendered role they play in ensuring the health of their children. A gender sensitive approach to programming should account for the needs of these women and recognise potential gaps in existing programming which cannot address these needs. For example, research has widely demonstrated that female care givers often face more barriers accessing health facilities and ensuring the vaccinations of their children. Nevertheless, and given the status of Lebanon as a middle-income country specific effort to ensure women were able to access health facilities, make decisions concerning the need to vaccinate their children and household power dynamics were not seen in the AWPs. Furthermore, household decisions are often conditions by unequal distributions of resources, both financial and time. In the case of conservative Muslim families, intra-family power relations also influence resource management and decision making – all which are generally triggered by socio-cultural norms. This often translates to women having little ability to access resources and make autonomous decisions about how to use resources. In the case of immunisation, the opportunity for a mother to bring her child to a fixed facility providing immunisation services may be dependent on the decisions on other household members and in some cases funding for transportation.

Furthermore, as briefly mentioned before, secondary research on global experiences of gender and immunisation found that the health status of a child, in developing contexts, is linked to the mother’s capacity.

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27 Swiss Centre for International Health, 2010, ‘Gender and Immunisation,’ Swiss Tropical and Public Health Institute
to care and nurture a child\textsuperscript{28}. Findings suggested that despite the father and often extended family’s say in how the mother can and should care for the child, it is ultimately her responsibility. These findings however, suggested that a mother’s ability to care for her child was often jeopardised by her lower status in society and within the family. Limited autonomy and ability to mobilise resources inside and outside the house can impact on a mother’s ability to follow health related recommendations. Moreover, as fathers and men are rarely included in vaccination processes, information does not reach them to the same extent it does women. This also may neglect the critical influence men have over women’s decision-making power. As such, lesson learned from work to date should include the extent to which male care givers and male household influencers may determine whether a child is able to be vaccinated and how this can be better incorporated into programming. While women are predominately considered to be responsible for the health of a child, efforts are not being made to ensure that male counterparts are also supporting mothers to ensure they are able to vaccinate their children.

Interviews with UNICEF nutrition staff highlighted that there was an awareness of gender barriers facing women when accessing vaccination services for their children. They commented that they had previously attempted to identify gender equity barriers in EPI activities through the disaggregation of gender as a cross tabulation across project indicators (the exact indicators and methods of disaggregation were not shared with the evaluation team). It was noted however, that no notable differences came up concerning gender. Despite this single report of incorporating gender equality into planning and implementation, there was no further evidence that gender mainstreaming or gender sensitive activities had been considered and introduced. Moving forward, the evaluation team recommends reviewing the overall gender approach to EPI programming, and ensuring gender was a common and consistent cross cutting theme across all project activities and research studies.

\textbf{D.1.2.2 Human Rights and Equity}

To a certain extent, evidence of equity and human rights focusing on ensuring minorities had access to vaccines was visible. Human rights in the context of this evaluation refer to the civil, cultural, economic, political and social rights inherent to all humans, regardless of nationality, gender or ethnicity.

Looking at the international human rights commitments, UNICEF’s support is in line with Lebanon’s obligations under the Convention on the Rights of the Child (CRC). Indeed, the article 24 of the aforementioned Convention stipulates that “States Parties recognize the right of the child to the enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health. States Parties shall strive to ensure that no child is deprived of his or her right of access to such health care services.”\textsuperscript{29} In its Concluding Observations (May 2017), the Committee on the Rights of the Child recognized the financial repercussions of the Syrian crisis for Lebanon and the resources allocated to the key sector of health. Hence, making UNICEF’s support decisive for meeting the obligations of the CRC for all children, irrespective of their nationality.

AWPs and UNICEF interventions assisted in filling gaps that the MoPH did not complete – such as the provision of vaccinations for Palestinian populations living in camps. Support was provided through the provision of vaccines and necessary vaccine equipment such as fridges to UNRWA. In this case, UNICEF took advances to ensure vulnerable populations, which were outside the scope of MoPH had access to vaccinations. Furthermore, efforts were made to ensure that vulnerable populations were able to access vaccinations at border crossings. UNICEF provided additional supplies of vaccines – especially the polio vaccine – to health workers at border crossings. Nevertheless, closer analysis highlighted that there still appeared to be gaps in ensuring equal access to vaccinations among disabled populations. For example, the AWPs and relevant activities did not highlight that efforts were made to ensure disabled children, either physically or mentally, were tracked and vaccinated in instances where they could not reach a health centre. According to the MoPH, disabled children

\textsuperscript{28} Ibid, 2010

\textsuperscript{29} Lebanon ratified the Convention on the Rights of the Child (CRC) in 1991.
were outside of the scope of their work, and they were not in a position to provide individual support to families with disabled children, ensuring they had access to vaccines. Overall, a review of documentation pertaining to this evaluation did not mention the disabled in any instances, and therefore the evaluation team concluded that no specific efforts were being made in this area.

Conclusion

In summary, the adopted strategies and points of intervention in the area of vaccination were relevant to achieving the expected results in UNICEF Annual Work Plans and were generally relevant to the needs of the populations of Lebanon given the rapid influx of population and overall MoPH objectives and goals between 2013-2017. While the support provided by UNICEF, as highlighted in the AWPs, does address the immediate needs of the population, specific strategies to ensure the most marginalized and remote are accessing have access to EPI was limited and additional interventions focused predominately on Palestinians communities who were already being support by UNRWA. There was little mention of specific strategies to address families from lower-socio economic backgrounds, apart from the recognition that residual costs were a constant barrier. These areas specifically, have not been readily addressed in the AWPs, and therefore not adopted in UNICEF or MoPH EPI strategies. Furthermore, reviews highlighted immediate gaps in the overall incorporation of gender into EPI activities and strategies; whereby ignoring the nuances of gender relations and inter-household dynamics.
**D.2 EFFECTIVENESS**

The following section will cover the effectiveness of UNICEF’s support to EPI and associated strategies to meet the needs of the most marginalized children in Lebanon. The evaluation examined the extent to which UNICEF helped to ensure that primary health care centres and dispensaries of MoPH network in all Lebanon were fully equipped and operational so that all children benefited from the Immunisation Programme. Furthermore, the extent to which trainings provided to health workers effective and useful was also looked at and measured through observations and interviews with both families that had their children vaccinated and health workers at the health centres.

Additionally, the evaluation explored to what level the stock, distribution and cold chain properly were managed and implemented. Effectiveness was also covered by reporting the satisfaction of MoPH in its collaboration with UNICEF and more specifically on the different areas of the collaboration that are capacity building, communications and provision of supplies.

Finally, and based on the extensive interviews and focus group discussions conducted at the local, district and national levels, the evaluation team reported the opportunities and barriers that facilitated or hindered the implementation of the Expanded programme of Immunisation.

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**EVALUATION QUESTION**

To what extent did UNICEF help to ensure that primary health care centres and dispensaries of MoPH network in all Lebanon were fully equipped and operational, so that all children benefited from the Immunisation Programme?

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**Sub Questions**

- What activities did UNICEF do to monitor the quality and quantity of EPI supported health facilities in Lebanon?
- What did UNICEF supply to PHCs and dispensaries in the MoPH network to ensure fully equipped and operational centres?
- What was the perception of quality of vaccinations?

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**EVALUATION QUESTION**

To what extent were trainings provided to health workers effective and useful?

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**Sub Questions**

- Health care workers report training to be useful and effective
- To what extent did health workers in EPI supported health facilities report that training was useful and effective?
- What was done to ensure the learnings from training were carried out in practice?

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**EVALUATION QUESTION**

To what level were the stock, distribution and cold chain properly managed and implemented?

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**Sub Questions**

- How were stock, distribution and cold chain managed?
- How were stock, distribution and cold chain implemented?
- What was the level of stock during observations? Did this match reported needs?

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**EVALUATION QUESTION**

To what extent is MoPH satisfied about the collaboration with UNICEF?

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**Sub Questions**

- To what extent did MoPH report satisfaction with the support of UNICEF?
- Was any additional support request from UNICEF?
What improvements could be made in the collaboration between UNICEF and MoPH?
To what extent is their commitment to work in partnership to strengthen EPI programming across the country?

EVALUATION QUESTIONS

What were the opportunities and barriers that facilitated or hindered the implementation of the Expanded programme of Immunisation?
What were the barriers of the Immunisation Programme to be gender equitable?

Sub Questions
Were there any opportunities which facilitated EPI?
Were there any barriers which inhibited the facilitation of EPI?
To what extent did implementation activities consider the needs of women?

D.2.1 Operational capacity of EPI supported PHCs and dispensaries

D.2.1.1 UNICEF monitoring of EPI supported PHCs

The extent to which UNICEF was involved in monitoring and ensuring the quality of vaccines in primary health care centres and dispensaries was limited. While UNICEF's AWPs highlighted that the primary responsibility of UNICEF teams was the provision of vaccinations and cold chain equipment, they played little role in managing or monitoring vaccinations once they were provided to MoPH warehouse and distributed to targeted PHCs and dispensaries. Discussions with UNICEF staff suggested that on an ad hoc basis, field officers visited PHCs across the country, but they predominately monitored the quality of the facility and health care staff, rather than a specific focus on the quality of vaccinations and their maintenance. The only difference to this was when specifically designed TPM activities were introduced, such as the monitoring of polio campaign. One MoPH staff (PHC Coordinator) stressed that although they have daily contacts with some UNICEF zonal coordinators their face to face support was limited. They stated: “The (UNICEF) coordinator is coming but not as often as before.” Field visits were suggested from UNICEF to be inconsistent and infrequent. UNICEF senior staff highlighted that across the UNICEF office in Lebanon, there were only 5 Health and Nutrition officers in the zonal offices allocated to conduct monitoring visits, and that was across the entire programme of UNICEF, and not specific to EPI. This brings into question the considerable amount of work required for 5 staff and may highlight the need to re-consider existing human resources. This also creates a space for UNICEF to potentially support implementing partners (IP) to conduct their own monitoring visits with technical support from UNICEF.

On occasion between 2013 – 2017, desk reviews highlighted that some commissioned TPM work was conducted in health facilities. In 2014 – 2015 InfoPro (research company) was commissioned by UNICEF to monitor the vaccination process of the 2014 national polio immunisation campaign. The TPM consisted of visiting 73 informal settlements where Syrian refugees were living. They assessed the performance of the vaccinators and conducted observations of teams working on the ground such as workers involved in door-to-door activities and mobile teams. At the request of UNICEF, InfoPro also conducted an intra-campaign monitoring by checking the vaccination status of children and evaluating the reasons why children were missed or non-vaccinated.

Additionally, the same partner (InfoPro) conducted a total of 112 ad hoc visits to monitor the vaccination process and the performance of BEYOND (local implementer) in the Abboudieh, Béqaâa, Aarida border centers located in Akkar and the Masnaa center located in the West Bèqaa. Field monitors evaluated the numbers of children receiving vaccines, did an inventory status of vaccines temperature, the availability of polio and measles vaccines. The teams also assessed the registration process of vaccinated children in BEYOND's records. This TPM approach however, appeared to only be limited to 2014-2015.

Moreover, a total of 160 reports of monitoring visits conducted in 2017 by UNICEF staff across the different health centres were shared with the evaluation team. Nevertheless, because no report from 2013 to 2016 were provided, no specific feedback on the value of monitoring could be included in this evaluation. However, during the interviews, UNICEF admitted that
more visits were required, and that field officers with UNICEF should be completing them on a more regular basis. Furthermore, senior UNICEF staff suggested that they were available to do more visits.

Furthermore, interviews with UNICEF and a review of programmatic documentation suggested that no specific monitoring of MoPH immunisation warehouse in Beirut was conducted, despite UNICEF’s ongoing support to improve overall management practices across the warehouse. This was also the same for all cold chain activities, no specific monitoring of cold chain processes, such as the appropriate distribution of vaccines to PHCs or caza offices, were noted.

A further gap in programming was the extent to which lessons learned from any monitoring activities from 2013 – 2017 appeared to be documented and integrated into future programming. Discussions with senior UNICEF staff suggested that little was done to document lessons learned, or even discuss lessons from monitoring visits – “There is no lessons learnt from the monitoring nor discussion on how to solve the frequent issues.” Senior UNICEF staff. The turnover of staff in UNICEF prevented the evaluation team from capturing further in-depth details on the results of TPM activities. There was no evidence or comments from UNICEF teams during the evaluation that monitoring of campaigns and PHCs was part of their scope of work, nor an immediate priority.

**D.2.1.2 UNICEF provisioning to EPI supported PHCs and dispensaries**

As highlighted, UNICEF has consistently provided MoPH with vaccines and necessary cold chain equipment – such as vaccine fridges. Apart from the vaccination centres monitored at the border, there was no evidence however, that UNICEF provided direct support or supplies to PHCs and dispensaries within the MoPH network, to independently ensure they were fully equipped and operational. Generally, support provided by UNICEF was given directly to the MoPH, and UNICEF’s involvement in the distribution of vaccines and maintenance of relevant cold chain equipment at a local level was not conducted. It was unclear to the evaluation team however, whether direct support to PHCs was within UNICEF’s existing scope of work. There were mixed responses across MoPH and UNICEF staff.

Nevertheless, the evaluation team conducted a series of observation of PHCs across Lebanon, to assess the extent to which PHCs and dispensaries were fully equipped and operational with regards to vaccine administration. The observation checklist helped to determine whether there was a cold fridge in the facility, if the vaccines were administrated in a specific room, if the vaccines were stored in the fridge, if any alternatives were in place to ensure vaccines are kept at the right temperature in case of a power cut as well as whether qualified personnel were present to provide vaccination on the day of observation.

The following facilities (25% of the total of facilities visited) did not fulfil all the requirements detailed above. The lack of staff available to administer vaccines was the most predominant reason for a facility not to be declared as operational based on the observation check list. Nevertheless, two health centres in the Beqaa did not have any cold fridge to store the vaccines at the right temperature, hence failing to be operational.

<table>
<thead>
<tr>
<th>Governorate</th>
<th>Number of health facilities not operational</th>
<th>Reason for not being operational – based on the observation checklist</th>
</tr>
</thead>
<tbody>
<tr>
<td>South</td>
<td>1</td>
<td>no staff available</td>
</tr>
<tr>
<td>Beqaa</td>
<td>2</td>
<td>no cold fridge</td>
</tr>
<tr>
<td>Akkar</td>
<td>4</td>
<td>no staff available</td>
</tr>
<tr>
<td>Nabatieh</td>
<td>1</td>
<td>no staff available</td>
</tr>
</tbody>
</table>

Nevertheless, apart from those 8 facilities, most prerequisite conditions were met. In the health facilities visited, all staff reported administrating the vaccines in an allocated room, as well as storing the vaccines in a cold fridge. In Mount Lebanon, North and South governorates, the fridge was generally stored in the doctor’s office, whereas in Beirut it was in the pharmacy at the health facility. Other PHCs stated that the fridge was in their cold storage room. Moreover, those who did not have a generator in case of a power cut mentioned that either vaccines were moved to another location or they had some solar energy system to maintain the vaccines at the right temperature. As such, the evaluation team could conclude that among the PHCs
and dispensaries observed, almost all (75%) where fully equipped and operational. They also followed necessary cold chain protocols to ensure the quality of vaccines.

Nevertheless, the extent to which this can be considered as part of UNICEF support or work was unclear. Discussions with UNICEF and interviews with public health professionals suggested that there was very limited direct support to PHCs and dispensaries to ensure effective practices in EPI. UNICEF suggested that most of the monitoring and support to ensure facilities were fully equipped was the responsibility of MoPH.

Some support to ensure EPI was operational across the country, however, can be contributed to UNICEF. A key component of UNICEF’s work from 2013 – 2017 was the establishment of valuable partnerships with local and international NGOs which provided additional support in terms of outreach and mobile vaccinations and awareness campaigning at local levels. Such local partners appeared to benefit from MoPH and UNICEF support in directing their EPI related interventions. As of 2017, UNICEF has eight local implementing partners – among which three were interviewed namely the International Orthodox Christian Charities (IOCC), the Makhzoumi Foundation and the Lebanese Association for Early Childhood Development (LAEC). From 2013 to 2016, the main actors through which UNICEF led in those activities was the NGO BEYOND. This local implementing partner entered in partnership with UNICEF and the MoPH to provide vaccination for Syrians displaced in hard to reach areas, such as Akkar, Minieh, Beqaa and South Lebanon.

In the course of their activities, BEYOND provided – among other activities – immunisation for under 5 Syrian children and 15-49 years old women in the informal settlements and collective shelters, as well as at the UNHCR Registration Centres and border check points through their medical mobile units (MMUs) and immunisation teams.

In Mount Lebanon, the NGO IOCC sent outreach workers to conduct household visits and check vaccination cards of children under 15, before referring the children with missing vaccines to the specifics PHCs. The staff at the IOCC has declared that in this partnership, they focused on MMR, measles and polio vaccination. Additionally, some vaccines were provided through MMUs in areas where there were no PHCs or dispensaries to which they could refer children. Nevertheless, the IOCC denoted that there were not enough instructions or support given by UNICEF in the implementation process of the AIA and that they often received last minute changes and requests about the work they were to complete.

Overall, local implementers – whether current or former – praised the collaboration between UNICEF and the MoPH. The IP staff interviewed regretted their lack of involvement in determining appropriate outreach strategies in remote areas, support to ensure mobile units were fully equipped and overall reliance as a source of information.

Reviews of UNICEF’s work since 2013 highlighted that support and intervention was predominately provided to MoPH at a central / national level. UNICEF had little oversight or management of the quality of vaccines and cold chains outside of the national tiers of MoPH. While this approach does promote a sense of ownership over EPI across the country, it does little to ensure that any support or provisions provided at a national level are effective at the cada and PHC level – which are of most concern. The quality and effectiveness of EPI activities at local levels and their actual impact on increasing overall EPI coverage cannot be assessed by UNICEF or this evaluation team. As such, UNICEF appears to currently run on the assumption that as long as provisions and capacity building is provided at a national / central level, the MoPH has the capacity, resources and commitment to ensure that learnings and materials trickle down to local levels.

D.2.1.3 Effectiveness of UNICEF EPI trainings to health care professionals

As highlighted earlier in the report, based on the AWPs, since 2013, UNICEF has spent considerable funding and time conducting capacity building sessions with health care professionals and MoPH central staff to improve their overall knowledge and capacity to manage vaccines and immunisation related systems. The following section, to the extent possible, looks at whether these capacity building sessions were reported to be useful and beneficial to participants, and the extent to which lessons learned were monitored and integrated into national and local EPI practices and systems.

30 Interview with BEYOND staff.
D.2.1.4 Health care workers who reported trainings to be useful and effective

The extent to which UNICEF provided in-depth and regular training to local level health professionals in areas concerning EPI appeared to be limited. Feedback from interviews with MoPH and public health workers highlighted that most training appeared to be provided to MoPH officials. From the interviews with MoPH and UNICEF staff, both mentioned that UNICEF was organising regional workshops and training for MoPH officials, mainly at the national level for managerial staff.

At the district and local level, MoPH staff were unsure of the direct involvement of UNICEF in training, apart from funding the sessions. Such information was confirmed by UNICEF: ‘we do not provide trainings, WHO does.’ It was reported that the EVM training was contracted to be run by an external company. Nevertheless, MoPH officials in Akkar commented that they had previously taken part in those training sessions on EVM. They reported it to be particularly beneficial to their existing roles and requested that additional training be provided so they can continue to increase their capacity to manage EPI more effectively.

MoPH officials also highlighted that they received regular training through the MoPH. For example, in 2017, an official in Akkar commented that he had participated in at least 7 sessions facilitated by the Ministry. Only 4 out of the 30 health workers interviewed at health facilities across the country reported that they received trainings. All the health workers that stated receiving such technical support, were in Akkar.

D.2.1.5 Assimilation of learning from training

Overall, there was no documented evidence to suggest that learnings from trainings were carried out in practice. Reports of lessons learned were those reported by participants and UNICEF staff. For example, UNICEF staff regularly suggested that as a result of training on vaccine management, they noticed considerable improvements in the systems MoPH used to manage immunisation practices.

D.2.1.6 Management and implementation of stock, distribution and cold chain

Overall responsibility for the management of cold chain and stock is done by individual PHCs. Nevertheless, interviews highlighted that UNICEF has played a contributing role to ensuring the quality of vaccines through the provision of cold chains and supported the delivery of vaccines to the MoPH warehouse. NGOs, MoPH officials and UNICEF staff all highlighted that the distribution of vaccines was closely monitored according to cold chain procedures. One UN staff member from UNRWA commented “the cold chain is fully monitored and supervised by UNICEF and MoPH...the first step of the cold chain starts from the airport, to the supplier, the MoPH warehouse and then during transportation to allocated health centres.”

According to UNICEF, they are responsible for ensuring that anything related to immunisation is brought into the country is cleared by MoPH or requested by the MoPH. Furthermore, in order to ensure appropriate number of vaccines are made available to MoPH, both UNICEF and MoPH conduct individual forecasts – “Forecasts are done in the MoPH but at the same time UNICEF monitors the forecasts and assesses if it is adequate and fits with our predicted needs.” According to UNICEF the required vaccine stock is determined in three-month intervals, providing enough time for producers and distributors to make the necessary number of vaccines. Nevertheless, according to UNICEF, since mid-2017, UNICEF has started to monitor the stock of vaccines in the central warehouse to better estimate procurement needs and replenishment of stock in collaboration with MoPH. Evidence and documentation were not provided during this evaluation.

MoPH staff highlighted that vaccine distribution was done through the central warehouse in Beirut – Karentina. Distribution to the caza was then done on a monthly basis, following requests for vaccines from PHCs and dispensaries. During shipping, temperatures of vaccines were apparently maintained through the use of ice packs and tags. Once they arrived at PHCs, nurses were responsible for maintaining vaccines and putting them in allocated fridges. According to MoPH, ‘we have a very good cold chain. It is monitored by a central team at the caza level but also by each dispensary and PHC.’ They suggested that
UNICEF supported EPI at a local level through the procurement and supply of refrigerators to all dispensaries and PHCs, in addition to caza dispensaries and offices. These all helped to improve cold chain processes and ensure the quality of vaccines.

One common complaint among MoPH staff at facilities was the limited awareness of who was responsible for the provision and maintenance of fridges for vaccines. In Akkar, one health professional highlighted “we sent a request for the company to check the fridge but they did not respond. So, we had to buy another fridge. UNICEF gave us the fridge, but it also stopped working, and they did not accept the request for maintenance.” Moving forward, efforts should be made to provide feedback as to who is responsible for the overall maintenance of cold chain related material. Moreover, UNICEF reported having contracted, since 2016, a maintenance company to check on a yearly basis the status of equipment in the health facilities. There was no evidence provided to support any monitoring or supervision activities by UNICEF of the maintenance work done by the contractor.

According to senior health staff at UNICEF, the distribution network for MoPH is extensively elaborate. UNICEF highlighted however, that since 2017, they have been establishing a Health Information System to track the services provided to beneficiaries, including the number and type of vaccines given. Furthermore, a new platform intends to register children and record their vaccination history and vaccination status is in the process. UNICEF hopes that this platform would provide the MoPH with a more accurate population dimension to coverage data. This new information system, however, had not been completed by the end of 2017, and therefore is not within the scope of discussion for this evaluation.

**D.2.1.7 Level of vaccine stock during observations**

In an attempt to better identify the extent to which immunisation related stock and materials provided by UNICEF were adequate for PHC needs, the evaluation team conducted on site observations of PHCs across the country. The evaluation team observed whether the following vaccines were available on the day of observation: BCG, DTP1, DTP3, Pol3, MCV1, HEP B3, Hib3, RotaC, PeV3. These are the vaccines included in the current EPI schedule and the evaluation team was required to assess the extent to which PHCs were able to meet the vaccination needs of children under the EPI.

Overall, it was difficult for the evaluation team to determine the extent to which levels of stock were appropriate for the local population. Health care centres did not keep readily accessible records on vaccine figures and the number of children registered with the clinic who required vaccines under EPI. As such, the team focused on the extent to which certain vaccines were available on the day of observation. In general, enumerators reported that all cold fridges contained vaccines. Yet, not all the vaccines were available in the different facilities. Only 2 facilities – one in Akkar and one in the North – reported having RotaC doses (these vaccines are not currently in the immunisation calendar and therefore cannot be attributed to UNICEF or MoPH. The team reviewed the extent to which vaccines and vaccine doses were available. Overall, most facilities did not have any BCG, HEP B3 and Hib3 doses – except in Akkar and in the North around 60% of the health facilities had PeV3, DTP3 and Pol3 doses. Most had DTP1 doses except 2 in Baalbeck and 2 in the South. Only 6 did not have any MCV doses – 2 in Baalbeck, 2 in Beirut and 2 in the Beqaa.

Further discussions on overall stock flow and stock needs with UNICEF highlighted that existing figures may not be completely accurate. UNICEF senior health staff highlighted that “inaccuracy in figures come from the fact that health centres sometime inflate their needs to receive more vaccines. In other instances, they don’t have time to do the reporting.” This highlighted challenges in accurately gauging the needs to PHCs, and the need to improve the accuracy and regularity of data reporting. Inaccurate registration of vaccine needs influences the likelihood that wastage is increased, and appropriate sets of vaccines are not being sent to targeted areas.

**D.2.2 MoPH satisfaction with UNICEF collaboration and support**

In general, relations between MoPH and UNICEF concerning EPI appeared to be relatively good. No immediate concerns were noted from either party. Satisfactory collaboration appeared to also be consistent since 2013, with MoPH staff highlighting the ongoing support being provided in terms of vaccination provisions, fridges, cold chain activities and previous support in communication and vaccination awareness campaigns. MoPH staff, at the national, local and district level, acknowledged that ‘nothing could be done without the support of UNICEF’.
According to the Chief Coordinator for EPI in the MoPH, UNICEF has been supporting the procurement of vaccines, as ‘they are capable of getting cheaper vaccines.’ They further highlighted that UNICEF was able to support the administrative systems surrounding EPI programming at a national level, through assistance in vaccine management and storage. Additional assistance has also been provided in the funding of MoPH positions related to EPI at caza and national levels. The number of staff and exact positions were not provided to the vaccination team.

UNICEF senior staff reported that they thought their collaboration and communication with MoPH was strong. For example, UNICEF staff highlighted that since 2013, they had spent considerable time and effort improving relations with the MoPH – “we changed a lot of things, and we started to talk about the problems and barriers in EPI much more. We are now able to talk about residual fees, when before we were unable to even bring up the topic. Now the Ministry talks to us about how to improve the situation concerning residual fees and participates in the AIA.”

D.2.2.1 Potential improvements to the collaboration between UNICEF and MoPH

Several notes were made by district MoPH staff, suggesting that UNICEF could provide greater support at the municipal level rather than providing support through INGOs – which were reported to have little impact at a grassroots level. One MoPH official in Akaar noted - “I understand it is easier to work with INGOs, but in the field UNICEF should work more with the municipality, they are the ones who know their needs better. It is a much better approach than working with NGOs which come from the outside.” Furthermore, it was regularly noted among MoPH that greater support in awareness building campaigns and activities could be provided to assist in increasing general coverage, especially among marginalized and rural communities.

D.2.3 Opportunities and barriers to the implementation of EPI

In the following section, the evaluation team was concerned with identifying any opportunities or barriers which either facilitated improvements in EPI or hindered intervention activities. In this case, opportunities referred to any additional activities or knowledge uptake opportunities – such as commissioned research – which provided greater insight and recommendations about how to improve or build on the reported successes of EPI to date. Furthermore, this also included any changes in the political, social or economic environment that may have contributed to more positive results / greater coverage among children. Barriers on the other hand, refer to existing challenges or socio-economic or political changes that may have negatively impacted on EPI activities.

D.2.3.1 Opportunities

Feedback from UNICEF and MoPH staff highlighted that there were few significant opportunities over the past years which facilitated improvements in EPI. Nevertheless, the commission of several research studies did assist in the uptake of information which can be used to create more tailored approaches to EPI related activities. For example, InfroPro (local partner) has been commissioned to hold focus group discussions with Syrian refugee women with vaccinated children under five years of age to report on the quality of medical services for routine immunisations. The results of the 2016 MoPH survey were used to plan activities in areas identified as low coverage according to UNICEF staff. In November 2017, UNICEF commissioned a cross-sectoral formative research – Knowledge, Attitude and Practice study including some immunisation components, conducted by researchers from Malmö University, Sweden, to establish a baseline for UNICEF Lebanon’s Country Programme Document for the period 2017 to 2020 and recommend C4D interventions.

In review discussions with the evaluation team, UNICEF suggested that additional opportunities to highlight EPI across the country included the outbreak of measles in 2013-2014, introduction of IPV in 2016, introduction of MMR and introduction of PCV. Documented evidence and discussions of these opportunities were not provided to the evaluation team or discussed during interviews, therefore, the evaluation team is reluctant to comment on the effectiveness of these opportunities to increase opportunities to the implementation and coverage of EPI.

31 In collaboration with WHO.
Strategic Communication

Strategic communications were identified by UNICEF and the MoPH as a relevant and necessary component of EPI. Considerable effort has been made by various parties across Lebanon to fill information gaps of the various populations and encourage families to vaccinate their children. The extent however, to which this work can be contributed to UNICEF is limited. For example, at a national level, UNICEF’s AWPs and interviews with the Communications team highlighted that they occasionally supported the MoPH with national EPI related campaigns. Secondary resources highlighted that in 2013, communication activities focused on two major disease outbreaks: measles in February and polio in October. After cases of measles was reported in Lebanon, at the request of the MoPH, UNICEF developed Information Education Communication (IEC) materials for a nationwide vaccination campaign such as 5,000 brochures for health workers, 10,000 posters for health centres, TV spots and radio spots which broadcast on seven local TV stations. Such materials were also provided to implementing partners to support their existing work in health-related activities. The names of implementing partners were not available to the vaccination team and not noted in secondary resources.

A second national polio vaccination campaign was led in 2013 after polio cases were confirmed in Syria with 1,150,000 brochures for parents, 6,000 brochures for health workers, 10,000 posters, and TV spot and radio spot produced and broadcast nationally. Furthermore, UNICEF recognized the needs to implement a community-based tailored approach. In 2013, bakawete (traditional Syrian storytellers) were recruited to speak to Syrian refugee children and families in informal settlements about polio, promoting community knowledge and positive behaviour. Based on the needs identified by the MoPH regarding polio, efforts were intensified in 2014 to raise awareness on the importance of immunising children against polio. UNICEF mentioned in its 2014 Annual Report having conducted “a comprehensive and multi-channel communication strategy” by “tailoring messages, building high visibility, bolstering socio-political commitment, engaging the health private sector, and targeting high risk areas with social mobilisation interventions”. One of the most notable media used was a 15-minute segment on LBCI’s prime show ‘Hki Jelis’ to cover the polio campaign, with featured spokespeople from UNICEF and the MoPH. Among others, 25 videos were produced and published, 35 photo missions were commissioned or conducted by Communications staff, press events were held and supported, and 8 human interest stories were published. The success of the campaign was measured by an awareness rate of 86 percent, recorded in the most vulnerable areas, as well as by the 305 local, regional and global media mentions of UNICEF Lebanon and the issues the most vulnerable children were facing.

Furthermore, at a more local level, field teams assessed the presence of communication material at public health centres. All families that were present at the health facilities for the vaccination of their child reported that they saw information about vaccines at the health centre, and furthermore that such information was useful and informative about vaccinations for children. Furthermore, the presence of education material on EPI on the walls of the facilities was confirmed through the site observations. Moreover, in Akkar, in the North and in the South, information specifically referring to UNICEF was reported. Among the types of information present in all locations were the types of vaccines provided and in some facilities the vaccine schedule. Yet, the majority of health centres did not display any information on the benefits of vaccines or on how to administer vaccines. Furthermore, all facilities had pamphlets or brochures available to families about EPI. Further reference was made by UNICEF to the use of a ‘song’ created by the communication team, and strategic communication work surrounding the measles campaigns in 2013-2017. Documentation and discussions on these areas however, (despite requests for information) were not found during the evaluation period and therefore has not been included as part of the performance of UNICEF.

The extent however, to which most communication activities are attributable to the direct work of UNICEF, may be limited. Implementing partners highlighted that much of the communication strategies and activities were designed and implemented by partners themselves, without direct collaboration with UNICEF’s

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32 UNICEF Annual Report 2014
33 UNICEF Annual Report 2014
communication team. Therefore, while communication was regularly noted as a key area of intervention for EPI, apart from secondary material provided by UNICEF and highlighted in UNCIEF reports, there was no primary data for the evaluation team to draw off, and whereby directly crediting communication activities to UNICEF.

National Context

Furthermore, UNICEF has highlighted that the decrease in the influx of refugees from Syria in 2016 and 2017, created more ‘breathing room’ for the MoPH and UNICEF to coordinate and consider more long term and sustainable approaches to EPI. In this case, UNICEF shifted from providing emergency response support and were able to focus on providing MoPH with the technical support to better manage stock flows and track coverage across the country. During this time UNICEF and MoPH have been able to have more in-depth discussions on barriers and challenges to EPI, such as issues of wastage, residual fees and the introduction of new vaccines into EPI. Moreover, UNICEF and MoPH staff reported working on a new Health Information system to overcome the registration and follow-up challenges given the lack of accurate data available.

Most notable throughout the course of this evaluation is the number of barriers that continue to inhibit or impinge on the potential to increase coverage rates across the country.

D.2.3.2 Barriers and Challenges

Considerable barriers and challenges were identified and noted during the data collection phase of this evaluation. These barriers and challenges, as reported by UNICEF and the MoPH continue to impinge on the potential to improve EPI coverage and improve the overall efficiency and effectiveness of existing interventions. These challenges and barriers included the following:

- Wastage
- Availability and Quality of Vaccines
- Minority groups and Gender Sensitivity Not being Directly Supported through EPI
- Misconceptions about the Safety and Quality of Vaccines
- Geographical Barriers
- Residual Costs
- Perceived Inequalities Among Populations

Availability of Quality Vaccines

Community members and families regularly noted that the limited availability of vaccinations in some PHCs created additional burdens and often deterred families from getting vaccinations per the vaccination schedule. One female from Tripoli highlighted the following “Sometimes in the clinics there are no vaccines, they tell us to come back tomorrow or the day after that, and sometimes they tell us to just wait until another time.”

Nevertheless, the overall perceptions of vaccinations among respondents was generally quite high. Qualitative interviews highlighted that most respondents recognized the importance of vaccinations for their children. Among male and female respondents, they all highlighted that childhood illnesses could be prevented through the use of vaccinations. One female in Tripoli commented “When the child has a vaccination you feel a lot safer, because any illness that the child seems to have is only mild…” A male in Beirut reported “Vaccinations are good for children, even if, God forbid, they get a little sick, vaccinations will protect them in the long run.” Apart from the minority of respondents who reported that they did not support vaccinations in general, no community members suggested that they had any concerns with the quality of vaccines being administered to their children. This was noted across Lebanese, Syrian and Palestinian populations. In fact, Syrians on occasion commented that, despite differences in the quality of health care, they had no concerns about the quality of
vaccinations compared to those that were available in Syria. Health professionals further noted that they had little issue with patients commenting on the quality of vaccines.

All families that were interviewed at the health facilities after their child had received a vaccine reported being happy with the vaccination provided. They all stated that they would be happy to return to the PHCs to receive another vaccine in the future. Nevertheless, one issue that was present in all governorates was the waiting time before getting the vaccine. In Baalbeck, Beirut and Mount Lebanon, families mentioned that they waited 20 to 40 minutes. In the South, more than half of the respondents waited from 30 minutes to one hour at the facility. However, the waiting time in the Beqaa during the field visit was only 5 to 10 minutes. Hence, the waiting time at the vaccination points challenges the provision on quality vaccines for patients.

On average, the number of vaccines provided on a weekly basis, was between 10 to 200 in the health facilities visited. PHCs in Akkar reported an average of 100 per week while the numbers mentioned were much lower in the South and in Beirut and Mount Lebanon. In Akkar, the staff interviewed mentioned that they would need to have more nurses to administrate the vaccines. Hence, reducing the waiting time at the facility. Indeed, on average, on the day of observation, 1 to 3 qualified persons to administer a vaccine were present in the facility. Yet, in Akkar there was only 1 was available compared to 4 in the Beqaa. Furthermore, families that vaccinated their child reported that they were using different health facilities in their governorate for vaccination. This was especially true in Akkar and in the North, but less frequent in the South. Hence, this suggested that families appear to be content to use PHC services irrespective of the health care centre they use.

**Vulnerable Populations Not being Directly Supported through EPI**

Since the influx of Syrians into Lebanon, considerable pressure has been put on the MoPH to account for the increased number of children requiring vaccinations. While UNICEF has been able to source vaccinations on behalf of the MoPH, the availability of PHCs, vaccination centres and mobile clinics was also constrained. As such, interviews highlighted that there were still various pockets of the population who did not have access to vaccinations which were supported by MoPH. For example, although the immunisation coverage among Palestinian is high, some of the Palestinian children living in camps throughout the country were noted by UNICEF to be among the most vulnerable populations. While UNICEF currently provides vaccinations to UNRWA, the MoPH has little involvement in their provision, distribution, storage or administration. In this instance, UNICEF is fulfilling a considerable gap which is not currently being met by MoPH led EPI. UNRWA representatives highlighted that in agreement with the MoPH and UNICEF, UNICEF would work directly to ensure adequate numbers of vaccines are accessible to Palestinian communities through UNRWA facilities. These vaccines however, are managed, stored and administered independently through UNRWA. The concern with this current approach is the limited potential for sustainable vaccination practices. The reliance on UNICEF to ensure the provision of vaccinations may create considerable concerns in the coming years, especially considering the limited funding being provided to Palestinian agencies.

Furthermore, there was no evidence to suggest that the MoPH or UNICEF were addressing the needs of disabled, and acting in such a way which ensured that they also had the necessary access to vaccines. This was also valid for gender barriers which were highlighted as affecting women. These included access and mobility – a result of socio-cultural practices among conservative Muslim families, and access to necessary funds to travel or pay for vaccinations (considered as residual costs, despite vaccines being free of charge). As previously highlight, additional gender focused research should be conducted to better understand the extent to which gender concerns are impacting on the overall quality and effectiveness of EPI.

**Misconceptions Concerning the Safety of Vaccines**

While vaccination rates across Lebanon continue to be relatively high, even among the various nationalities, data highlighted that there are still pockets of the population which hold considerable misconceptions about the safety and legitimacy of vaccines. FGD responses from Syrian males demonstrated that there was limited trust associated with organisations – such as NGOs and INGOs – providing vaccinations through mobile clinics. One Syrian refugee commented “I won’t vaccinate any of my children. I’m afraid, it is all lies and deception. You have people in vans who say they are from organisations who come here and say they want to vaccinate our children. We don’t know who they are or where they come from. They say they are UN, but I don’t believe them…” Another commented that they felt there were many illegitimate people posing as
vaccinators across the country. “People from the UN usually have cards, but the people who come to our camp to do vaccinations don’t have cards… one of them made one of the children bleed very badly and there is no way to report them…”

Another highlighted that he previously had his daughter vaccinated in Lebanon and a week later she was sick. In this instance, the father contributed the vaccination to the illness of his daughter. He further suggested that he had returned to the clinic to see a doctor and was told that the vaccine was ‘bad’.

Data therefore, highlights that for some pockets of the community, especially among refugee populations, considerable efforts in strategic communication are still needed. While promoting vaccination and the benefits of vaccination are necessary, additional efforts should also consider demonstrating families how to identify legitimate vaccinators and vaccines. As this data highlighted, families do not necessarily disapprove of vaccinations, but rather are more concerned with illegitimate and ‘bad’ vaccines being used in their place by unidentified parties. The most prominent fear therefore, is not with vaccinations overall, but the risk associated with being vaccinated with poor quality vaccines or being abused by unidentifiable vaccinators.

**Geographic Barriers and Accessing PHCs**

Given the mountainous terrain of Lebanon, pockets of the population continue to live in areas in which public services, such as PHCs are inaccessible. One of the most commonly noted reasons for being unable to vaccinations was the limited accessibility of health facilities. This was noted across the country, but generally among respondents who lived in remote areas of the country in which PHCs were not set up. Most importantly however, PHCs were identified as the primary location to obtain vaccinations. In such cases where a PHC was not available, interviews highlighted that sometimes mobile vaccination units are used. These units, managed by the MoPH, are not however, widely available to all remote communities across the country during campaign periods.

**Residual Costs Associated with Vaccinations**

Residual costs associated with vaccinations were noted as one of the biggest barriers to increased vaccination coverage. In this case, residual costs generally referred to additional fees health facilities required in order to provide a child with a vaccine. Vaccines in the majority of cases were noted as being ‘free of charge’ but consultation costs were generally also required, especially in dispensaries. This was also most commonly cited among private health centres and on occasion within PHCs. In these instances, interviewees highlighted that health clinics would state that a doctor needed to provide the vaccine, and as such a consultation cost was required. The issue of residual costs was widely known across the staff in the MoPH and UNICEF, and identified as an ongoing issue which both parties are attempting to rectify. As it currently stands, MoPH mandate holds that all vaccinations under EPI are to be provided free of charge to any member of the population (Syrian, Lebanese or Palestinian). The ability to monitor and manage this mandate however, has proved to be more difficult, as UNICEF and MoPH officials all reported that at local levels they were unable to ensure vaccinations were being provided free of charge, as most health facilities function independently and often are not directly accountable to MoPH for their finances. Respondents who reported that they had previously paid for the cost of vaccines suggested that a consultation could vary anywhere between 5,000 LBP to 15,000 LBP, depending on the doctor and the facility.

One female care giver from Tripoli commented “the MoPH give us the vaccines for free, but they also receive 5,000 LBP as a doctor’s fee.” This was noted to be a significant barrier for many families, especially those who had more than one child who required vaccinations. This was most commonly cited among Syrian families – “I have four children and every time I need to vaccine them, I pay 2,000 LBP. This all adds up and I cannot afford such payments.” (Female care giver from Nabatieh). A staff member from UNHCR highlighted “the MoPH states that vaccinations are for free. Some NGOs however, are running health centres, and they require patients to pay minimal fees like 2,000-3,000 LBP. This has been common practice for many years now.” As a reminder, 67% of the PHCs are run by NGOs in Lebanon.

Responses however, were mixed. In some various occasions care givers reported that they paid no residual costs for vaccines. There did not appear to be any particular patterns related to geography or nationality, but rather reports of residual costs were noted across the country and across the myriad of respondents – Syrian, Palestinian and Lebanese. While residual costs were not consistent across all health centres, it continued to be a persistent barrier for many families – especially those with larger
numbers of children. While the cost of vaccines through PHCs is outside the scope of UNICEF’s current workplans, it does present a gap for future support and an additional area of collaboration with MoPH.

Perceived Inequalities Among Populations

Discussions of inequality among predominately Syrian and Lebanese populations were regularly noted throughout field work. While perceived inequalities did not appear to directly impact on the decision to vaccine a child or not, it did appear to create some tension among communities, and grievances which were most notable in PHCs. As a result of tensions noted in PHCs, health professionals noted that Lebanese families often had vaccines administered in private clinics, clinics which required additional payments. In this instance, Lebanese families from lower socio-economic levels faced greater barriers to ensure their children were vaccinated. It was a common perception among Lebanese that Syrians were prioritized by the public health system. They were noted as receiving more financial aid and were able to access a greater range of various health services than local Lebanese populations.

On the other hand, when Syrians were asked about their experiences with Lebanese in PHCs, they regularly commented that they believed Lebanese received preferential treatment. One Syrian male care giver in Nabatieh suggested “we (Syrians) always feel like there is a difference in how we are treated compared to the Lebanese. I would be waiting my turn in the clinic, but when a Lebanese family arrived, they were admitted immediately.” Another male from Nabatieh commented “Once I came with my wife and daughter, we waited for an hour to see a doctor. A Lebanese mother came in and 5 minutes later she was with a doctor.”

Conclusion

The overall effectiveness of UNICEF support to MoPH was mixed. This was primarily a result of limited data which was able to demonstrate overall improvements or benefits of UNICEF interventions at local levels and longitudinal learnings within the MoPH that were provided by UNICEF since 2013. As such, the previous section relied heavily on feedback from UNICEF staff, MoPH officials, implementing partners and community members – including male and female care givers, and local communities which detailed successes and challenges.

Nevertheless, since 2013, evidence does demonstrate that UNICEF has made considerable strides to address the immediate immunisation needs of the population. From 2013, the primary type of support provided by UNICEF was through emergency aid in the provision of vaccines and technical support to MoPH. UNICEF provided invaluable support ensuring that not only the Lebanese populations had access to vaccines under the EPI, but also that migrants and refugees from neighbouring countries were not excluded. Additional support was provided to local NGOs and other UN agencies such as UNRWA, to cover gaps in MoPH coverage and financial capacity. As such, UNICEF has been able to assist in maintaining high coverage rates across the country from 2013 – 2017, with estimates suggesting that coverage was around 85 – 90%. Furthermore, UNICEF successfully supported the overall impact of EPI through the provision of immunisation materials, such as cold chain equipment including fridges. PHCs and dispensaries across the country received various types of fridges, including solar and electric fridges to ensure vaccines were stored at optimal levels and the quality of vaccines was maintained.

Additional efforts to build on the successes of EPI were noted in partnerships formed with local NGOs and International NGOS, providing funding, technical support and monitoring activities to track performance and increase overall awareness of the benefits of vaccinating children.

Nevertheless, a notable gap in efforts was the extent to which lessons learned across projects and monitoring activities were incorporated into UNICEF AWP and future interventions. UNICEF staff reported that no significant changes has been made in their overall strategies which incorporated ‘lessons learned’. Furthermore, the evaluation team was provided with no evidence to suggest that ‘lessons learned’ across monitoring efforts
or annual reports had considered challenges or gaps in activities, and subsequently incorporated them into activities for the following year.

Gaps were also noted in the extent to which UNICEF played a role in ensuring the effectiveness of EPI at local levels. Findings from this evaluation highlighted that UNICEF support was provided at national / central levels, and at local levels little intervention was seen. While UNICEF maintain a staffing of 5 monitoring officers, these officers were responsible for monitoring all UNICEF work and rarely conducted any on-site visits to PHCs to ensure they were effective and operational, and appropriately using resources provided by UNICEF. While UNICEF highlighted that the MoPH was predominately responsible for conducting monitoring visits and assessing the performance of PHCs at local levels, UNICEF seems to be conducting some monitoring visits at local levels. However, the extent to which those visits assess the EPI performance and the follow-ups when challenges are raised are unclear.

As a result of limited engagement at local levels and reliance on MoPH to provide appropriate support, UNICEF was unable to accurately measure the effectiveness of their support at local levels. While there is considerable value creating ownership of EPI through the MoPH, the evaluation team was unable to determine the extent to which UNICEF support specifically, was notable at local levels (as this was under the scope of MoPH work). The evaluation team does not necessarily suggest that UNICEF play a more active role in implementing activities at a local level, but rather potentially review and assess the performance of their efforts at local levels to verify relevance and overall effectiveness of their technical and financial support.

To the extent possible, the evaluation team did conduct a series of interviews and data collection activities at local levels to better understand the experiences, opinions and knowledge of families accessing vaccines through PHCs. This component of the data collection highlighted that there are still significant barriers and challenges influencing the effectiveness of EPI interventions across the country. These were identified in the following areas:

- Wastage
  - Health professionals noted considerable concerns with vaccine wastage; suggesting that often the provision of multi dose vaccines created significant waste. From 2013 to 2017, there was no evidence that efforts have been made by UNICEF or MoPH to measure the extent of wastage facing PHCs and the economic impact this had on UNICEF
- Availability of quality vaccines
  - Limited availability of vaccines in some clinics were reported to deter families from travelling to PHCs, as they were never sure if the required vaccines were available on the date of their visit
- Minority Groups not Being Directly Supported through EPI
  - Considerable pressure was put on MoPH to manage the immunisation needs of the PRS and PRL. Currently however, national EPI activities did not directly incorporate some pockets of minority populations, such as Palestinians living in camps. Responsibility was given to UNRWA and UNICEF; whereby creating divisions between populations concerning access to vaccines
- Misconceptions about the Safety of Vaccines
  - Pockets of the population were concerned with the safety of some vaccines when they were administered in mobile units. Some community members suggested that they did not necessarily trust the motives of vaccinators, and were often unsure if they were legitimate vaccinators
- Geographic Barriers
  - Geographical remoteness was commonly cited; with families highlighting that they were unable to access PHCs for vaccinations because their homes were too far and terrain was not suitable for regular travel.
- Residual Costs
Residual costs, such as consultation fees, continued to be an influential determinant as to whether families vaccinated their children – especially among Syrian populations. Families reported that despite vaccinations being ‘free of charge’ they were often required to pay additional fees to have the vaccine administered by a doctor.

- Perceived inequalities across Populations
  - Perceived inequality between Syrian and Lebanese populations appeared to be a regular barrier influencing attitudes of Syrian and Lebanese families. While Lebanese reported that Syrians received greater benefits and support, Syrians suggested that Lebanese families were prioritised and treated better in PHCs.
**D.3 EFFICIENCY**

The following section will cover the extent to which support provided to EPI by UNICEF was cost effective from 2013 to 2017. Overall, the evaluation team found it particularly challenging to accurately comment on the efficiency of support provided to MoPH, due to a lack of documentation highlighting budgets compared with spending. What was most noticeable for the evaluation team however, was the extent to which contradictions on spending were found across stakeholders, which will be highlighted in the following section.

<table>
<thead>
<tr>
<th>EVALUATION QUESTION</th>
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<td>To what extent the Immunisation Programme has improved in matter of cost efficiency along the years from 2013 to 2017?</td>
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**Sub Questions**

- What were costs provided from UNICEF for 2013, 2014, 2015, 2016, 2017?
- What are the reasons for any differences in costs?
- To what extent to UNICEF staff identify the programme as cost effective?
- How could costs be improved to be more efficient?

**D.3.1 Cost efficiency from 2013 to 2017**

According to key informant interviews with UNICEF and MoPH staff, UNICEF’s has played a key role in ensuring immunisation financing under the EPI since 2013. In the case of Lebanon, immunisation financing is broader than just financing vaccines. Financing needs to include support for cold chain and logistics, health workers, monitoring and surveillance and supervision. A thorough review of immunisation financing for Lebanon is not within the scope of this evaluation and should be considered as part of MoPH responsibilities.

A review of secondary literature from UNICEF on immunisation in the MENA suggested that currently, Lebanon is not eligible for GAVI supported funding through UNICEF, meaning they are not eligible to have the cost of vaccines covered by UNICEF. Lebanon, however, is, according to regional MENA UNICEF office, eligible to receive external aid for immunisation to cover the cost for refugees. Interviews with MoPH officials reflected this reality, suggesting that the MoPH budget remains the mainstay of immunisation financing in Lebanon with additional financial support from donors such as the EU, US, Japan, Korea and Russia due to the influx in refugee populations. Interestingly however, discussions with UNICEF senior staff provided contradictory details. According to senior staff, UNICEF covered from 2013 to 2017 the cost of all EPI related vaccines in Lebanon, with exception to PCV (introduced in 2016) which is covered by MoPH for the Lebanese population, but covered by UNICEF for the Syrian and Palestinian populations.

Nevertheless, despite the inconsistency with the origins of funding, MoPH highlighted that UNICEF’s expertise as the largest procurement agent of vaccines for developing markets was decisive in ensuring that immunisation procurement was cost effective. As interviews highlighted, UNICEF has taken considerable strides to make the costs of vaccines affordable to governments and donors, while covering manufacturers minimum requirements. Without such support, it is likely that the MoPH would be forced to negotiate directly with manufacturers, resulting in a likely much higher unit cost of vaccines procured.

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34 Immunisation Financing in MENA Middle-Income Countries, UNICEF May 2018
**D.3.1.1 Procurement and Forecasting of Vaccines**

Based on the suggestion that UNICEF covered the cost of vaccines for EPI, the evaluation team was interested in exploring the extent to which UNICEF was involved in tracking the number of vaccines being used, and comparing figures with predicted forecasts. Vaccines as part of EPI include booster vaccines for all children until the age of 18, and therefore there was an expectation that booster vaccines would be considered in all forecasting calculations. According to UNICEF however, forecasting was the responsibility of the MoPH, based on their own records – which had no mention of booster vaccines. While UNICEF suggested that they provide some support on annual administrative coverage data by advising on calculations, ‘in the end, MoPH does what it likes.’ As such, MoPH provided forecasting results to UNICEF which included their ‘perceived’ vaccine needs for the year. Interestingly however, no follow up or additional calculations appeared to be conducted by UNICEF to confirm figures. Based on this practice, UNICEF therefore, had little opportunity to verify the reported number of vaccines versus actual vaccine needs. Should figures that are provided by MoPH prove to be inaccurate or inflated, this would impact considerably on the cost effectiveness of providing vaccines and immunisation support to the MoPH. UNICEF also, would be unable to accurately report on cost effectiveness concerning their immunisation procurement practices. Furthermore, UNICEF staff highlighted that cost effectiveness was not necessarily considered in their daily work, and they put more focus on ensuring the affordability of vaccine for the population. Senior staff commented that cost effectiveness was not directly taken into consideration during procurement phases or in the design of EPI related interventions. Nevertheless, the M&E team highlighted in response, that all activities and targets are decided based on budget availability and that EPI activities are therefore planned with a series of high-performance indicators. Comments however, were reported during key informant interviews with the evaluation team and as such have been incorporated into findings.

Finally, it was highlighted on numerous occasions during field work that UNICEF was not particularly confident in the accuracy of MoPH data records because of the lack of a centralized data base, and a standardized reporting system.

**D.3.1.2 Costs provided from UNICEF for 2013, 2014, 2015, 2016, 2017**

Despite the limited availability of budget related documents, the evaluation team did explore the spending allocated to EPI related activities from 2013 to 2017. Costs of the activities assessed in this evaluation were estimated based on figures provided in the AWPS 2014-2015, AWP 2015-2016 and AWP 2017. However, those can only serve as estimation of the cost of the planned activities and should not account for the spent budget. No documents from UNICEF were communicated for a more detailed analysis of the cost of the EPI.

The total budgeted amount in 2014-2015 was equal to USD 16,135,000. The following work plan reduced its estimated needs for a total yearly budget of USD 5,22,300. In the AWP 2017, the annual budget required, increased somewhat to USD 8,620,000. According to the AWP 2014-2015, only 15% of the estimated budget was funded in 2014-2015. The difficulty to find funds for the planned activities could partially explained why the revised budget were more than half lower.

In the AWP 2014-2015, the provision of vaccines accounted for 88% of the total estimated budget for all the EPI activities. A total of 4% of the budget was allocated to the development of a communication strategy, an additional 5% was supposed to cover the provision of materials and cold chain systems as well as the training of trainers to manage and repair the new materials while the remaining 3% were set for the conduct of trainings of MoPH focal points.

In the following AWP (2015-2016), the provision of vaccines for children made up 59% of the EPI budget, followed by 29% on the provision of vaccine supplies and equipment. The increased support on the cold chain systems through the delivery of fridges weighted significantly of the budgetary repartition. 9% of the remaining funds needed were reserved to campaigns and technical community-based awareness sessions, and 3% towards capacity building of frontline workers, notably for the training on effective vaccine management (EVM).
A total of 73% of the required funds in the final AWP 2017 were set for the provision of vaccines. A total of 18% of the 2017 provisional budget was reserved for outreach and communication activities, while 4% was allocated towards capacity building. A further 3% was set to follow up on functionality of the cold chain equipment and provide infrastructure support for Border Vaccination Centres.

Based on this review, the cost of vaccines made up the largest percentage of spending for UNICEF. As highlighted previously, efforts should therefore be made to ensure that UNICEF is accurately able to confirm figures presented by MoPH to ensure AWP and allocated budgets reflect the direct needs of the Lebanese population. The cost of vaccines was reported to be decided by UNICEF’s supply division in Copenhagen. WHO were also suggested to make decisions as to whether vaccines would be procured in single or multi-dose packages. According to UNICEF, multidose vaccines were the most commonly procured vaccine packaging, despite being identified as inappropriate and cost inefficient given the Lebanese context. Further investigation is required to better understand why multidose vaccines continue to be procured, despite the awareness that wastage is an ongoing concern. This should assist in better measuring the cost effectiveness of vaccination procurement.

D.3.1.3 Wastage

The issue of ‘wastage’ was commonly noted across most key informants; suggesting that considerable efforts needed to be made in the future to account for the high levels of wastage in vaccinations. Effective vaccine management involves accurately estimating the number of vaccine doses, diluents and injection equipment needed for the targeted population over a stated supply period.

According to UNRWA health professionals, wastage is one of the most common issues facing vaccination practices in Lebanon. It was highlighted ‘if procurement took place in terms of single dosage, then wastage was considerably lower. If procurement however was done in multi-doses then the wastage rate increased.’ Staff commented as an example “if BCG vaccines come in packs of 20, and if you don’t use the 20 doses in one day then the remaining are wasted.” This was noted as being a similar case for polio vaccines. While this was not an immediate concern for large health centres, it was noted as being a significant concern for small health facilities. For example, BCG (despite not being part of the Lebanese EPI schedule but part of UNRWA immunisation calendar) had a wastage rate of 70-80%, and DPT was at 40%. According to staff, the Penta vaccine is now available in single dose, so the wastage rate has decreased significantly.

When asked what the health facility did with the expired vaccines that could no longer be used, most of the staff mentioned that they would give them to the MoPH. In the North and in Akkar, the PHCs seemed to rely on one organisation taking care of medical waste (NGO ARC EN CIEL). Nevertheless, all reported that less than 2% of vaccines were wasted. The PHCs also mentioned that some activities were introduced to limit the rate of vaccination wastage such as giving appointments for 10 children to come together, or directly going to school to administrate the vaccines.

In the Beqaa and in some facilities in the Akkar and North, the PHC staff further reported that there was a process to redistribute non-used unexpired vaccines, through the MoPH. Further details however, were not provided.

Further discussions with UNICEF suggested that they regularly observed a disconnect between the central warehouse of stock management / dispatch and monitoring and the MoPH information system on consumption, which appeared to affect rates of wastage. Further details on this however, were not provided and as such the evaluation team could not comment further.
The most commonly cited barriers hindering the implementation of EPI were highlighted among the general public and in particular families with children of vaccination age.

D.3.1.4 UNICEF staff and cost effectiveness

UNICEF staff interviewed rarely commented on the cost effectiveness of the activities. Regarding the procurement of vaccines, MoPH senior staff were questioned on why, despite having the cold room capabilities, vaccines were not all procured in single doses rather than multiple doses, to avoid extra waste. The reason stated by all respondents was that there was a lower cost for procuring multiple rather than single doses. As previously highlighted, specific efforts were not necessarily taken from 2013 to 2017, within UNICEF, to calculate the efficiency of their spending, and ensure practices are cost effective.

D.3.1.5 Potential improvements to cost effectiveness

Given the lack of available documentation on budgeting and spending, the evaluation team is unable to comment on how costs could be improved to be more efficient. Efforts needs to be made by UNICEF to collect and review spending, such as budgets allocated for vaccine procurement. According to UNICEF such efforts on forecast and costing are being monitored since mid-2017. Nevertheless, from 2013, there appeared to be a heavy reliance on MoPH to provide accurate data; highlighting vaccine requirements.

**D.3.1.6 Gender and Human Rights Based Approaches for Sustainability**

As highlighted previously in this report, the extent to which gender and equal access was incorporated into all activities and planning was considerably limited. This gap in programming will also impact on the overall sustainability of EPI. The fact that little has been done by either UNICEF or MoPH in terms of ensuring EPI practices are flexible and adaptable to meet the needs of marginalised and vulnerable populations will likely influence the extent to which high coverage can be maintained. Ongoing efforts need to be made to ensure that in all activities moving forward, the barriers facing women and vulnerable populations – such as the disabled – are addressed and are consistently being addressed moving forward.

**Conclusion**

As highlighted, from 2013 – 2017 UNICEF has spent considerable time and funding supporting immunisation activities under EPI, including the provision of vaccines, cold chain equipment and the facilitation of capacity building sessions. The extent to which financial contributions to EPI can be considered efficient and cost effective however, was mixed. This was primarily because no documentation was recorded concerning budget predictions compared with actual spending. UNICEF teams were unable to provide considerable insight on costs associated with EPI activities in the AWP, apart from budgets noted within AWPs.

Furthermore, as highlighted, the cost of vaccine procurement appeared to make up the majority of financial costs associated with UNICEF support. The evaluation team, however, was unable to clearly determine the origin of vaccine funding, with both MoPH and UNICEF reporting that they were responsible for financing the majority of vaccines. Furthermore, UNICEF funding contradicts existing regional MENA documentation which stated that Lebanon was eligible for GAVI funding, and only received additional financial support to cover vaccine costs for the refugee population.

Nevertheless, following UNICEF reports that they are responsible for vaccine funding, there was little evidence to suggest that efforts had been made to track and determine the cost effectiveness of these provisions. As highlighted, MoPH was responsible for reporting vaccination needs for the country, and forecast the number of vaccinations which UNICEF needed to acquire. UNICEF highlighted that they played little role in verifying these figures, and conducted no additional activities to assess the accuracy of figures. Overall, while UNICEF may not be directly responsible for tracking the number of vaccines required in EPI, efforts should be made to assess the cost effectiveness of current support, and identify the extent to which MoPH figures may be inaccurate or inflated.
**D.4 SUSTAINABILITY**

The following section will cover the sustainability of UNICEF’s support to EPI and associated strategies to meet the needs of the most marginalized children in Lebanon. The evaluation examined the extent to which the collaboration between UNICEF and the MoPH, enables the MoPH to have the self-sufficient capacity to take on the tasks planning, capacity building, implementation, monitoring and securing optimal coverage without continued support of UNICEF. The evaluation explored whether the efforts taken by the MoPH could be maintained, if UNICEF financial and technical support was to stop. Evaluators also looked at the demand for vaccinations among beneficiaries, and the extent to which this demand could influence sustainability for vaccine procurement and immunisation related activities.

**EVALUATION QUESTION**

To what extent did the collaboration between UNICEF and MoPH, enable MoPH to have the self-sufficient capacity to take on the tasks planning, capacity building, implementation, monitoring and securing optimal coverage without continued support of UNICEF?

**Sub Questions**

- Can we consider the MoPH to be self-sustainable?
- Are MoPH taking on the tasks of planning, capacity building, implementation, monitoring and securing coverage?
- Can MoPH continue these efforts without the support of UNICEF?

**D.4.1 MoPH self-sufficiency in tasks planning, capacity building, implementation, monitoring and securing optimal coverage without continued support of UNICEF**

Based on evidence collected throughout this evaluation, there is little evidence to suggest that MoPH could sustain the EPI programme without the financial and technical support of UNICEF. Interviews with MoPH officials and health professionals in PHCs all reported that the MoPH did not have the financial capital or technical expertise to meet vaccination needs, despite the decrease in the number of refugees and migrants from neighbouring countries. It is important to note however, that the reports of limited finance are subjectively reported by MoPH, and accurate data on their existing budgets and capacity to cover the cost of required vaccines is unknown and not within the scope of this evaluation.

Interviews with MoPH highlighted that sustainability of EPI was a considerable concern for the Ministry. Across all interviews conducted with MoPH there was little awareness of potential options which could ensure the sustainability of EPI without support of UNICEF and local NGOs. “The PHCs do not have the resources to complete activities without somebody supporting them. We need to think of a more sustainable activities that are being implemented by PHCs.” MoPH staff were unable to highlight to the evaluation team any specific plans or actions that had been taken to ensure the sustainability of EPI without the support of UNICEF and partnering NGOs.

A notable challenge highlighted by UNICEF was the high turnover of staff at the MoPH. Sufficient systems appear not to be in place to ensure institutional knowledge is shared with new staff. “It happens that when people leave the MoPH we need to train other people again to replace them.” This leads to an extensive overlap in activities provided by UNICEF.
**D.4.1.1 Planning, Implementation and Monitoring**

Senior MoPH officials mentioned that the MoPH has started tackling the issue of registration and follow-up to ensure their children remain on track to receive all required vaccines and vaccine boosters under the EPI schedule. UNICEF staff has also reported supporting the MoPH on the planning and implementation of the future health monitoring system. Although some informal discussions have started at the end of 2017, the project remains to be implemented and is not in the scope of this evaluation.

It is nevertheless worth mentioning the difficulties highlighted during the field work conducted for this evaluation. Broad regional differences on follow-ups and the methods used to communicate with parents were witnessed across the country. Based on the interviews conducted at the health facilities with staff member, not all children received all the doses required per the national vaccination calendar. The reported average rate of patients that completed the full EPI schedule during the site observations conducted by the evaluation team was 70 to 80%. Only one PHC worker in Baalbeck declared that 100% of the children were administered the full list of vaccines. Consequently, staff interviewed at the district level added that, although the EPI was working successfully, there should be some improvements on follow-up. Nevertheless, according to the staff, there is a system to remind parents of the next vaccination appointment – except in Mount Lebanon. Most recalled that it was a phone call process rather than a SMS system.

In addition, the issue of registration was mentioned by many of the staff and families interviewed at the PHCs. The majority of the families that were interviewed at the health facility after their child was vaccinated had a vaccination card for their child prior to this visit. All reported that this card was updated by the health worker with the dates for future vaccines and vaccine booster. Only one in the South mentioned that no information was given about the dates for future vaccines and vaccine booster. According to the PHC workers, there was a system at the health facility for registering children that have received vaccines. In all governorates, except in the Beqaa and in Baalbeck governorates, the registration was done through an online Software. In parallel, there seemed to be a written system. Yet, in PHCs in Akkar, North and Beirut, the paper system has been replaced by an online tool.

According to the staff interviewed at the MoPH, this new health information system will not replace the current monitoring system - Phoenix software - implemented in the PHCs to track the services provided to beneficiaries, including the number and type of vaccines given.

More broadly, the issue of poor data available for decision making is a decisive concern for the sustainability of MoPH activities in Lebanon. Such challenge is predominant in all the countries in the region, where limited data are available about household health expenditures, actual use of and access to public and private facilities, and the cost of health services and programmes, particularly since 2011.41

**D.4.1.2 Securing the procurement of vaccines**

From 2013 until 2017, the MoPH has been relying on UNICEF Supply Division for the procurement of all vaccines distributed to children under five. Despite the cost and logistical benefits of relying on UNICEF to cover these activities, the sustainability of the partnership is questionable. As an example, other countries in the region rely on UNICEF Supply Division only for the more expensive new vaccines and could share on how they have successfully worked within UNICEF SD services or adapted government procurement regulations. The opportunity for the MoPH to use the Vaccine Independence Initiative (VII) or commercial financing instruments to meet its prepayment requirement for the procurement of vaccines are worth being explored. Furthermore, findings suggested that equipment associated with immunisations currently appeared to be unsustainable. Interviews with MoPH and UNICEF staff highlights that there was not process for the provisions of maintenance of equipment such as fridges and no evidence that replacements were available. This, in collaboration with UNICEF, moving forward, needs to be immediately addressed. Sustainability without immediate support of UNICEF will be reliant on MoPH having clear practices in place to help maintain the necessary equipment to store and administer vaccines.

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41 Immunisation Financing in MENA Middle-Income Countries, UNICEF May 2018
D.4.1.3 Securing national coverage by understanding the practices of the private sector

Although the private sector’s role in EPI is outside of the scope of this evaluation, a good portion of the population in Lebanon – especially the Lebanese – receives vaccination in private clinics. With the objective of reaching national coverage rates, understanding the practices of the private sector in providing immunisation services is outmost. Especially since it has been noted that such services are growing in the region. Notably, among the 20 countries of the region, private health insurance is the highest in Lebanon, reaching 17 per cent of current health expenditure in 2015. Among the reasons mentioned for the growth of private services are public dissatisfaction with the availability, quality and convenience of government-provided services as well as the increasing number of health professionals and the difficulty governments have to recruit and keep them in the public sector by offering salaries and working conditions with incentives\(^42\). Consequently, there is an opportunity for UNICEF to support the MoPH in better understanding the provision of immunisation services by the private sector, including vaccine safety issues (e.g., integrity of the cold chain), whom the sector serves, how services are paid for, its contribution to coverage, and its integration with monitoring and surveillance.

D.4.1.4 Beneficiary Demand and influence on Sustainability

As this paper has highlighted, beneficiaries in general appear to demonstrate a clear commitment to the use of vaccines and need to protect their children against childhood diseases. While this evaluation did not look at overall coverage levels, and was not concerned with tracking and verifying the accuracy of existing records, qualitative findings did highlight that irrespective of nationality, education level or socio-economic level, families and in particular care givers, recognised the importance of having vaccines administered to their children. While existing barriers continue to impede some families – as highlighted throughout this evaluation – the commitment and knowledge of caregivers does contribute to the sustainability of EPI related activities. The demand for vaccines and improved access to vaccines will likely continue to hold the MoPH accountable for the health of children, irrespective of UNICEF support.

D.4.1.5 MoPH Skill level and its influence on Sustainability

The overall skill set and knowledge of MoPH staff is vital to the sustainability of EPI related activities. Ensuring staff are equipped with the necessary health related and technical knowledge to appropriate manage immunisation activities, is foundational to high coverage rates. To the extent possible, the evaluation team attempted to assess the skill set of MoPH staff, – although it was outside the scope of the evaluation – limited communication from MoPH however, prevented the evaluation team from capturing an accurate understanding of current skill sets and capacity. While training has been provided to MoPH, as highlighted in this report, the extent to which this training has been implemented into general MoPH practices is unknown. The fact however, that UNICEF report the continued need to provide repeated training due to changes in staffing, suggests that there may be considerable gaps in the extent to which MoPH is ensuring staff have the necessary skills sets to manage and implement EPI without the support of UNICEF. The overall goal for MoPH, in terms of staffing, and to ensure effective and sustainable practices in EPI activities, is to hold make sure all knowledge transferred through trainings are shared and institutionalised across EPI related teams. Furthermore, as this evaluation has demonstrated, significant efforts need to be made to ensure staff have the appropriate skills to conduct accurate forecasting and have the technical skills to either ensure the maintenance of EPI equipment – or at least have processes in place to outsource such services. A future recommendation would be to conduct performance assessments of MoPH staff to assess the extent to which they are capable and committed to continuing EPI activities without the technical support of UNICEF.

Conclusion

The evaluation team found that the overall sustainability of UNICEF efforts to support EPI was limited, and that considerable efforts do not appear to have been made on behalf of MoPH or UNICEF to ensure necessary strategies or practices were being considered to manage EPI in the absence of UNICEF financial support. Data highlighted that MoPH currently have

\(^{42}\) Immunisation Financing in MENA Middle-Income Countries, UNICEF May 2018
no alternative practices or strategies in place to cover the full cost of vaccines for the Lebanese, Syrian and Palestinian populations. Furthermore, the high turnover of staffing across the MoPH saw significant limitations in the extent to which staff had necessary institutional knowledge. As a result, UNICEF continue to spend resources to retrain MoPH staff on management and vaccine storage practices.

While alternatives for UNICEF funding may be outside of the scope of UNICEF, additional efforts could be made to ensure that MoPH is appropriately and accurately recording lessons learned, especially those learned through training, so that institutional knowledge can be maintained at central and local levels. Furthermore, UNICEF also has the potential to open discussions on sustainability, and potentially support MoPH understand vaccine procurement practices and attempt to be more ‘cost effective’ through accurate data collection and reporting and systematic reviews of vaccine forecasting. Finally, efforts need to be made to support the MoPH to incorporate gender and human rights-based approaches into their strategies.

To date, as highlighted throughout this report, there was little evidence that UNICEF or MoPH strongly considered gender needs and issues of minorities were generally left in the hand of UNICEF (such as Palestinian refugees who were supported by UNRWA). These are considerable gaps in programming and strategies which need to be addressed to ensure that, not only vaccinations reach the most marginalised, but are also accessible and delivered in such a way that they can account for gender and rights-based barriers.
SECTION E: CONCLUSION

This evaluation team was commissioned by UNICEF Lebanon to conduct an in-depth qualitative evaluation of UNICEF’s support and intervention in the Expanded Programme for Immunisation (EPI). From March 2018 – September 2018, the evaluation team conducted a series of key informant interviews, focus group discussions, exit interviews and observations, with UNICEF health and nutrition staff, MoPH EPI staff, health professionals in targeted PHCs and members of the general population, including caregivers about their overall opinions and experience of UNICEF support to EPI in Lebanon.

The evaluation team was focused on exploring four areas of interest, as prescribed by UNICEF Lebanon; including relevance, effectiveness, efficiency and sustainability. Each area has been individually addressed and discussed with reference to primary data collected from the evaluation team and thorough reviews of secondary and programmatic material which was either independently sources or provided by UNICEF Lebanon.

The evaluation was focused on providing findings about the overall relevance, effectiveness, efficiency and sustainability of UNICEF support to EPI from 2013 to 2017. Throughout this period, UNICEF provided ongoing financial and technical support to the Ministry of Public Health (MoPH) and Implementing Partners to increase the effectiveness and quality of EPI in Lebanon, and ensure interventions reached the most vulnerable and marginalised. Given the significant increase in population in Lebanon in 2013-2015 as a result of the conflict in neighbouring Syria, UNICEF became a prime stakeholder ensuring the Lebanese government was capable of meeting vaccination needs of all children under the age of 5, regardless of nationality. Support to EPI has continued until the present time, with the MoPH recognising UNICEF as a priority partner ensuring the health of children across Lebanon. Nevertheless, as this reported has demonstrated, results concerning the effectiveness, efficiency and sustainability of support provided to MoPH were mixed. While UNICEF has undoubtably provided significant support to the populations of Lebanon, the exact extent of their successes was challenging to measure. This was largely a result of limited reporting and monitoring from 2013 to 2017.

Relevance

The evaluation team found that the adopted strategies and points of intervention in the area of immunisation were relevant to achieving the expected results in UNICEF Annual Work Plans and were generally relevant to the needs of the populations of Lebanon given the rapid influx of population and overall MoPH objectives and goals between 2013-2017. The AWPs also reflected the need to address gaps in capacity and technical skills to appropriately manage and maintain EPI at national, casa and local levels.

Nevertheless, while the support provided by UNICEF, as highlighted in the AWPs, does address the immediate needs of the population, specific strategies to ensure the most marginalized and remote had access to vaccines, were limited. Additional interventions focused predominately on Palestinians communities who were already being support by UNRWA. There was little mention of specific strategies to address families from lower socioeconomic backgrounds or disabled families (with MoPH suggesting that disabled children were not within their immediate scope of work). Furthermore, reviews highlighted immediate gaps in the overall incorporation of gender into EPI activities and strategies; whereby ignoring the nuances of gender relations and inter-household dynamics that can impact on the opportunity for female care givers to ensure their children are vaccinated under EPI.

Continual efforts need to be made, and revisions discussed, to ensure that considerations are being made to ensure EPI activities are continuing to address national EPI needs, but also reaching the most marginalised while accounting for potential barriers which are a result of gender dynamics in a household and disabilities.
**Effectiveness**

The overall effectiveness of UNICEF support to MoPH was mixed. This was primarily a result of limited data which was able to demonstrate overall improvements or benefits of UNICEF interventions at local levels and longitudinal learnings within the MoPH since 2013.

Nevertheless, since 2013, evidence does demonstrate that UNICEF has made considerable strides to address the immediate immunisation needs of the population. From 2013, the primary type of support provided by UNICEF was through emergency aid in the provision of vaccines and technical support to MoPH. UNICEF provided invaluable support ensuring that not only the Lebanese populations had access to vaccines under the EPI, but also that migrants and refugees from neighbouring countries were not excluded. Additional support was provided to local NGOs and other UN agencies such as UNRWA, to cover gaps in MoPH coverage and financial capacity. As such, UNICEF has been able to assist in maintaining high coverage rates across the country from 2013 – 2017, with estimates suggesting that coverage was around 85 – 90%. Furthermore, UNICEF successfully supported the overall impact of EPI through the provision of immunisation materials, such as cold chain equipment including fridges. PHCs and dispensaries across the country received various types of fridges, including solar and electric fridges to ensure vaccines were stored at optimal levels and the quality of vaccines was maintained.

Additional efforts to build on the successes of EPI were noted in relationships formed with local NGOs and International NGOs; providing funding, technical support and monitoring activities to track performance and increase overall awareness of the benefits of vaccinating children.

Nevertheless, a notable gap in efforts was the extent to which lessons learned across projects and monitoring activities were incorporated into UNICEF AWP and future interventions. UNICEF staff reported that no significant changes has been made in their overall strategies which incorporated ‘lessons learned’ Furthermore, the evaluation team was provided with no evidence to suggest that ‘lessons learned’ across monitoring efforts or annual reports had considered challenges or gaps in activities, and subsequently incorporated them into activities for the following year.

Gaps were also noted in the extent to which UNICEF played a role in ensuring the effectiveness of EPI at local levels. Findings from this evaluation highlighted that UNICEF support was provided at national / central levels, and at local levels little intervention was seen. While UNICEF maintain a staffing of 5 monitoring officers, these officers were responsible for monitoring all UNICEF work and rarely conducted any on-site visits to PHCs to ensure they were effective and operational, and appropriately using resources provided by UNICEF. While UNICEF highlighted that the MoPH was predominately responsible for conducting monitoring visits and assessing the performance of PHCs at local levels, UNICEF did not appear to review data on overall EPI performance at local levels, and instead relied on informal discussions with MoPH when necessary.

As a result of limited engagement at local levels and reliance on MoPH to provide appropriate support, UNICEF was unable to accurately measure the effectiveness of their support at local levels. While there is considerable value creating ownership of EPI through the MoPH, the evaluation team was unable to determine the extent to which UNICEF support specifically, was notable at local levels (as this was under the scope of MoPH work). The evaluation team does not necessarily suggest that UNICEF play a more active role in implementing activities at a local level, but rather potentially review and assess the performance of their efforts at local levels to verify relevance and overall effectiveness of their technical and financial support.

The evaluation also found barriers and challenges which influenced the effectiveness of EPI interventions across the country. These were identified in the following areas:

- Wastage
Health professionals noted considerable concerns with vaccine wastage; suggesting that often the provision of multi dose vaccines created significant waste. From 2013 to 2017, there was no evidence that efforts have been made by UNICEF or MoPH to measure the extent of wastage facing PHCs and the economic impact this had on UNICEF.

- Availability of quality vaccines
  - Limited availability of vaccines in some clinics were reported to deter families from travelling to PHCs, as they were never sure if the required vaccines were available on the date of their visit.

- Minority Groups not Being Directly Supported through EPI
  - Considerable pressure was put on MoPH to manage the immunisation needs of the PRS and PRL. Currently however, national EPI activities did not directly incorporate some pockets of minority populations, such as Palestinians living in camps. Responsibility was given to UNRWA and UNICEF; whereby creating divisions between populations concerning access to vaccines.

- Misconceptions about the Safety of Vaccines
  - Pockets of the population were concerned with the safety of some vaccines when they were administered in mobile units. Some community members suggested that they did not necessarily trust the motives of vaccinators, and were often unsure if they were legitimate vaccinators.

- Geographic Barriers
  - Geographical remoteness was commonly cited; with families highlighting that they were unable to access PHCs for vaccinations because their homes were too far and terrain was not suitable for regular travel.

- Residual Costs
  - Residual costs, such as consultation fees, continued to be an influential determinant as to whether families vaccinated their children – especially among Syrian populations. Families reported that despite vaccinations being ‘free of charge’ they were often required to pay additional fees to have the vaccine administered by a doctor.

- Perceived inequalities across Populations
  - Perceived inequality between Syrian and Lebanese populations appeared to be a regular barrier influencing attitudes of Syrian and Lebanese families. While Lebanese reported that Syrians received greater benefits and support, Syrians suggested that Lebanese families were prioritised and treated better in PHCs.

**Efficiency**

From 2013 – 2017 UNICEF has spent considerable time and funding supporting immunisation activities under EPI, including the provision of vaccines, cold chain equipment and the facilitation of capacity building sessions. The extent to which financial contributions to EPI can be considered efficient and cost effective however, was mixed. This was primarily because no documentation was recorded concerning budget predictions compared with actual spending. UNICEF teams were unable to provide considerable insight on costs associated with EPI activities in the AWP, apart from budgets noted within AWPs.

Furthermore, as highlighted, the cost of vaccine procurement appeared to make up the majority of financial costs associated with UNICEF support. The evaluation team, however, was unable to clearly determine the origin of vaccine funding, with both MoPH and UNICEF reporting that they were responsible for financing the majority of vaccines. Furthermore, UNICEF full funding contradicts existing regional MENA documentation which stated that Lebanon was eligible for GAVI funding, and only received some additional financial support to cover vaccine costs for the refugee population.

Nevertheless, following UNICEF reports that they are responsible for vaccine funding, there was little evidence to suggest that efforts had been made to track and determine the cost effectiveness of these provisions. As highlighted, MoPH was...
responsible for reporting vaccination needs for the country, and forecast the number of vaccinations which UNICEF needed to acquire. UNICEF highlighted that they played little role in verifying these figures, and conducted no additional activities to assess the accuracy of figures. Overall, while UNICEF may not be directly responsible for tracking the number of vaccines required in EPI, efforts should be made to assess the cost effectiveness of current support, and identify the extent to which MoPH figures may be inaccurate or inflated.

**Sustainability**

The evaluation team found that the overall sustainability of UNICEF efforts to support EPI was limited, and that considerable efforts do not appear to have been made on behalf of MoPH or UNICEF to ensure necessary strategies or practices were being considered to manage EPI in the absence of UNICEF financial support. Data highlighted that MoPH currently have no alternative practices or strategies in place to cover the full cost of vaccines for the Lebanese, Syrian and Palestinian populations. Furthermore, the high turnover of staffing across the MoPH saw significant limitations in the extent to which staff had necessary institutional knowledge. As a result, UNICEF continue to spend resources to retrain MoPH staff on management and vaccine storage practices.

While alternatives for UNICEF funding may be outside of the scope of UNICEF, additional efforts could be made to ensure that MoPH is appropriately and accurately recording lessons learned, especially those learned through training, so that institutional knowledge can be maintained at central and local levels. Furthermore, UNICEF also has the potential to open discussions on sustainability, and potentially support MoPH understand vaccine procurement practices and attempt to be more ‘cost effective’ through accurate data collection and reporting and systematic reviews of vaccine forecasting. Finally, efforts need to be made to support the MoPH to incorporate gender and human rights-based approaches into their strategies. To date, as highlighted throughout this report, there was little evidence that UNICEF or MoPH strongly considered gender needs and issues of minorities were generally left in the hand of UNICEF (such as Palestinian refugees who were supported by UNRWA). These are considerable gaps in programming and strategies which need to be addressed to ensure that, not only vaccinations reach the most marginalised, but are also accessible and delivered in such a way that they can account for gender and rights-based barriers.
SECTION F: RECOMMENDATIONS and LESSONS LEARNED

Relevance

AWPs are designed on an annual basis in collaboration with the MoPH. Currently the AWPs provide little specific information concerning EPI, as the work plan is all encompassing for Health and Nutrition activities. Approaches to designing the AWP each year could benefit from a more detailed and nuanced design. While UNICEF produces one AWP per year, individual and tailored work plans could also be designed for each area of intervention within the Health and Nutrition programme – such as EPI, maternal health care etc. This would allow UNICEF to demonstrate a more holistic and comprehensive strategy to their work. For example, the continuity of activities from one year to the other could be made clearer in the work plan, drawing on lessons learned and highlighting forecasting for the upcoming year. This would help UNICEF and external stakeholders more accurately understand reasons for revisions in activities or why certain activities are being continued from year to year. Furthermore, the AWP could better highlight which activities are ‘ad hoc’ campaigns or activities which are designed to respond to a specific crisis in that year, such as the potential for a polio outbreak.

The AWP should mention and seek to more closely reflect the support needed for families from lower socio-economic backgrounds. Gaps in holistic human rights-based approaches to EPI demonstrated that specific efforts to ensure populations from lower socio-economic families were not being incorporated into current approach. Although UNICEF staff acknowledged that residual costs were a constant barrier for accessing vaccines, the activities detailed in the AWPs from 2013 to 2017 do not incorporate any specific strategy for overcoming those challenges at a programmatic or strategic level. In that regard, UNICEF could support the MoPH in the analysis of out of pocket expenditures related to immunisation and the drafting of a National policy on free access to vaccine and to vaccination till full immunisation of the child. This should focus heavily on Lebanese populations, in addition to Syrian and Palestinians – as findings also highlighted significant financial barriers among Lebanese families. This should also be incorporated into any upcoming campaigns, whereby informing families of their rights to free vaccines free from consultation costs.

A gender approach to EPI programming has been lacking from 2013 to 2017. Activities directly integrating potential gender challenges should be a consistent cross cutting theme across all project activities and research studies. UNICEF in collaboration with MoPH should attempt to identify gender constraints that may be preventing some women from accessing health care services for their children. Currently the only gender analysis completed, was the extent to which both male and female children were being vaccinated. This however, does not account for gender barriers which may affect overall coverage. Efforts need to be made to better understand potential barriers, such as socio-cultural or religious practices which may limit the mobility of women. This could be done through formal research, or informal discussions with local communities. The perspectives of both men and women however, need to be incorporated to better understand the differences in experience and perspective. In this case, males may be able to provide valuable insight into reasons why women’s mobility may be limited or highlight any nuanced barriers which women may not easily identify.

In general, there was little mention of specific strategies to address families with disabled children and ensure they were able to access vaccines. In line with UNICEF global efforts and international mandate to incorporate human rights into all interventions, considerable effort needs to be taken to work closely with the MoPH, local NGOs and health professionals to ensure needs of the disabled will be addressed. In the case of contraindications, clear guidelines should be published. Immunization efforts, including strategic communications, should be disability-friendly in order to not further stigmatize and to reach the parents and caregivers, as well as the children with disabilities. Furthermore, efforts should be made to scope the extent to which disabled are currently able to easily access vaccination services to better identify potential points of intervention; ensuring a more holistic approach to increased coverage. Again, this can be done formally through research or through informal discussions with local communities and health professionals.
Effectiveness

Capacity building activities should be more closely documented, and should be focused on providing Training of Trainer (ToT) activities rather than simply training. As highlighted throughout the evaluation, the turnover of staff prevents the effectiveness of UNICEF capacity building activities. Hence, ToT should support greater sustainability across MoPH, at the central, district and local level, and provide MoPH with the knowledge and skills to run their own training as new staff are contracted, rather than UNICEF needing to repeat training sessions. Furthermore, the evaluation team was unable to determine the effectiveness or relevance of training sessions, as agendas and material used in the training were not documented and available for review. In future, efforts should be made to also document all aspects of training including presentations, handouts from training sessions.

In line with the previous recommendation, UNICEF should further document institutional knowledge, ensuring that information can be passed across staff and departments throughout the future, thus preventing gaps in knowledge. During the evaluation, very few interviewees were able to recall events and lesson learnt from 2013 to 2017. More transparent and regular monitoring activities through UNICEF would also contribute to this recommendation in order to address and follow up on the challenges witnessed during the monitoring visits in the PHCs. Furthermore, this should be encouraged within MoPH practices too. Not only will this assist UNICEF and MoPH to document their work, but it will also allow them to more effectively measure changes in their approaches and interventions over the years.

In order to target residual costs that hinder access to vaccination services, UNICEF could further support the MoPH in tackling the cost of vaccines through PHCs and other health facilities. The governance structure of the health centres is complex in Lebanon and depends on a variety of actors beyond the MoPH (municipalities, NGOs, MoSA, private sector etc.) whose approach to immunisation participate in increasing – or decreasing – barriers for accessing vaccination services. Therefore, UNICEF should encourage the MoPH to collaborate with all actors involved in making sure that they are a still and clear strategy that effectively ensure that vaccination is free for all children under five. The evaluation team recommends that UNICEF conducts an additional research across populations to better understand the burden or residual costs.

As identified through the evaluation, families are sceptical about the vaccination administered through local partners or anyone outside of the health centres. Since UNICEF relies heavily on such partners, via their mobile clinics or door-to-door campaigns, it is decisive to expand the scope of vaccination messages to highlight how to recognize legitimate vaccines and vaccinators. Additional efforts should consider demonstrating families how to identify legitimate vaccinators and vaccines. Considerations should also be made to communicate such messages at both national and local levels.

Despite the provision of health services to Palestinian refugees being outside of the scope of the MoPH’s attribution, the Ministry should open discussions on how to ensure the provision of immunisation services targeted at vulnerable populations in the coming years. The funding shortage that UNRWA faces – which are likely to continue - and the heavy reliance on UNICEF to provide funding to the Palestinian Refugees Agency are threatening the continuous provision of immunisation of services if UNICEF support were to put to a halt.

Additionally, UNICEF can support PHCs through the introduction of practices and policies which promote equality across nationalities, providing greater support to hamper any misconceptions about biased among Syrians or Lebanese.

Wastage of vaccines remains an ongoing concern that prohibits effective vaccine management at the national level. Health professionals at the local and district levels shared initiatives to reduce wastage. One option worth exploring further is the redistribution of non-used unexpired vaccines through the MoPH. UNICEF could work with the MoPH on ensuring the redistribution of those non-used unexpired vaccines in line with cold chain requirements. Furthermore, the evaluation team suggests that UNICEF conducts research into wastage to better understand the extent to which it impacts on effectiveness and efficiency.
Furthermore, clarification of responsibility needs to be made in terms of who will take care of the provision and maintenance of equipment, such as fridges. Currently neither UNICEF or the MoPH have taken official responsibility, and therefore PHCs are unaware of who to contact or what to do in instances where equipment breaks down, or issues appear.

Another key area to be addressed is the appropriateness and longevity of training provided by UNICEF. While the evaluation team were unable to determine the effectiveness of training individually, it was clear that efforts need to be made to more appropriately document training sessions, issues discussed in training and conducting pre and post knowledge tests of participants. Pre and post testing in training will help to highlight the extent to which participants have increased in their knowledge of a given issue and how they think it can be implemented into their work. Follow up should also be done to ensure lessons are being used during periodical reviews. This is relevant for all staff working within EPI.

As highlighted throughout the report, the current strategy of UNICEF is to provide national level support to EPI. While overall objectives are aimed at improving EPI from top to local levels, there is limited evidence to correlated UNICEF’s efforts and outcomes at local levels. Current practices allow MoPH to manage the EPI, which is a positive step. Nevertheless, for the purpose of efficiency and effectiveness, MoPH needs to remain accountable for their work. Therefore, UNICEF should take more steps to more closely monitor and support MoPH interventions at local levels. For example, engaging with dispatch teams – those who distribute vaccines to health centres, working with randomly selected PHCs to review stock levels and vaccine management practices, and overall capacity of health workers across PHCs. Greater monitoring and observations should allow UNICEF to more accurately measure and track their support through MoPH and identify additional areas for intervention.

Efficiency

No evidence was shared proving that efforts are made to verify reported vaccination needs and consider cost effectiveness when procuring vaccines and equipment. The first step to achieve some progress in that direction is to be made on the accuracy and transparency of MoPH data records. UNICEF should work with the Ministry to support their efforts, drawing on the lessons learnt from the successful experience of other countries in the region that have put forth such reforms.

One major issue regarding the efficiency of the procurement of vaccines remains on the choice between single and multi-doses. Further investigation, both with the MoPH and UNICEF Supply Division, is required to better understand the procurement choices despite the awareness that wastage is an ongoing concern. Efforts needs to be made by UNICEF to collect and review spending, such as budgets allocated for vaccine procurement. UNICEF shall conduct a thorough needs-cost analysis to support their choices of procurement.

Sustainability

Building on the recommendation above, UNICEF could explore alternative options for the procurement of all vaccines distributed to children under five. Indeed, the sustainability of the MoPH full reliance on UNICEF is questionable. As an example, other countries in the region rely on UNICEF Supply Division only for the more expensive new vaccines and could share on how they have successfully worked within UNICEF SD services or adapted government procurement regulations.

As detailed previously, dialogue on the cost effectiveness of vaccines and equipment procurement as well as efforts on forecasting and data management are currently lacking. Building on UNICEF’s global experience, UNICEF Lebanon could work more closely with MoPH to develop lessons learned approaches to their practices, with the introduction of workshops or seminars, encouraging shared dialogue. Examples of topics to be discussed may include the following—best practices in other countries, data record keeping practices at national and local levels, monitoring tools and activities. The objective of such workshops is to ensure that the MoPH is aware and has the tools to introduce policies and practices that have been deemed successful to overcome challenges in other countries.
Given the role played by the private sector in achieving the objectives of the EPI, UNICEF could encourage the MoPH and support it in better understanding the provision of immunisation services by the private sector, including vaccine safety issues (e.g., integrity of the cold chain), whom the sector serves, how services are paid for, its contribution to coverage, and its integration with monitoring and surveillance.

Finally, the findings of this evaluation and other lessons learned among UNICEF and MoPH need to be discussed and communicated to all relevant stakeholders. Interviews highlighted that many key stakeholders lack key information on the processes and practices of EPI. Efforts should be made to highlight and discuss all gaps, weaknesses and strengths of previous approaches and use these findings as lessons learned to create a more tailored and flexible approach to future AWPs.

Additional Research

As highlighted throughout the report, there were significant gaps in information from which the evaluation team could draw from for conclusions. This was most pertinent in areas of public knowledge, awareness and attitudes of EPI, capacity and processes of MoPH and inclusion of marginalised populations into work plans. Many of these areas were outside the scope of this evaluation and therefore were not thoroughly investigated. Nevertheless, based on results and gaps from this evaluation, the following areas of research should be considered to ensure programming is appropriately tailored and meeting the needs of both stakeholders and beneficiaries.

1. A KAP study on of the population to better understand why pockets of the population continue not to vaccinate or are unable to fully vaccinate their children. This will also help to identify structural and non-structural barriers such as socio-cultural practices, religion, government support, infrastructure and materials available (such as vaccines or fridges). This study could also support the development of appropriate communication campaigns which are evidence based and accurately addressing gaps in existing knowledge

2. A gender study which looks specifically at potential barriers related to gender, such as household dynamics, social hierarchy, roles and responsibilities of female care givers and male care givers. This type of study could provide valuable insight into the dynamics of decision making and how to increase coverage levels by addressing gender roles.

3. A clear monitoring framework should be designed and implementing in collaboration with MoPH. Currently there was no evidence that performance of staffing was being monitored, or that vaccines and immunisation equipment was being sent and used appropriately by PHCs. A monitoring framework which is designed collaboratively between MoPH and UNICEF can help to maintain relations and allow each party to hold one another accountable for their individual performances. Such monitoring will also be an important reference point for future studies and evaluations.

4. An extensive study on the current impact wastage has on efficiency is pertinent. To date, UNICEF and MoPH are unable to estimate the extent to which wastage is impacting on the quality of EPI and overall funding. Such a study can not only identify the extent of wastage but also identify areas for improvement and create an evidence base with which to adjust or revise current practices and improve rates of wastage.
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<th>Evaluation Question</th>
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<td>1</td>
<td>To what extent did the planning of immunisation component in annual work plans identify the needs to achieve results, in terms of:</td>
<td>How did UNICEF understand what support was required in terms of? 1. Capacity building 2. Provision of Supplies etc. 3. Communications</td>
<td>UNICEF H&amp;N staff (individuals associated with EPI component of Annual Work Plan) Relevant MoPH staff at national, regional and municipal levels Desk review of annual work plans from 2013 – 2017</td>
<td>Desk Review Key Informant Interviews Site visit to Warehouse</td>
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<td>- A) Capacity building</td>
<td>What did UNICEF’s annual work plans identify needed to be done in terms of? 1. Capacity building 2. Provision of Supplies etc. 3. Communications</td>
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<td>- B) Provision of supplies / equipment and cold chain</td>
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<td>- C) Communication, taking into consideration Lebanon context in the time of the Syrian context</td>
<td>How did UNICEF address the identified needs of the following? 1. Capacity building 2. Provision of Supplies etc. 3. Communications</td>
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<td>To what extent was gender, equity and human rights considered and addressed in the annual work plan</td>
<td>Extent to which annual work plan incorporated the following thematic areas into EPI annual work plan: o Capacity building o Provision of supplies o Communication activities</td>
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<td>Extent to UNICEF and MoPH teams report that the following thematic areas were addressing existing EPI needs and introduced into the annual work plan? o Capacity building o Provisions of supplies o Communication activities</td>
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<td>The number of supplies and provisions provided to MoPH compared to the needs of the national population</td>
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<td>Extent to which communication activities are reaching the most marginalised and vulnerable population in Lebanon</td>
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<td>Effectiveness</td>
<td>To what extent did UNICEF help to ensure that primary health care centres and dispensaries of MoPH network in all Lebanon were fully equipped and operational, so that all children benefited from the Immunisation Programme?</td>
<td>What activities did UNICEF do to monitor the quality and quantity of EPI supported health facilities in Lebanon?</td>
<td>UNICEF H&amp;N staff (individuals associated with EPI component of Annual Work Plan) Relevant MoPH staff at national, regional and municipal levels</td>
<td>Key Informant Interviews Focus Group Discussions Site observations</td>
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<td>Percentage of EPI supported health facilities which are fully equipped and operational</td>
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<td>Extent to which EPI supported health facilities staff report fully operational and equipped</td>
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| 3 | To what extent were trainings provided to health workers effective and useful? | • To what extent did health workers in EPI supported health facilities report that training was useful and effective?  
• What was done to ensure the learnings from training were carried out in practice? | • Health care workers report training to be useful and effective  
• Health care workers are implementing learnings shared in trainings  
• Community members report that health care workers appeared to be capable and were sharing lessons about children’s health | Health care workers through the ministry of public health  
UNICEF EPI programme related staff  
Site observations | Key Informant Interviews  
Focus Group Discussions  
Site Observations  
Trends in EPI coverage (monthly administrative routine from MoPH) |
|---|---|---|---|---|---|
| 4 | To what level were the stock, distribution and cold chain properly managed and implemented  
(vaccines and vaccination commodities (syringes/ diluent/ gloves etc. but also Waste management on vaccination supplies) | • How were stock, distribution and cold chain managed?  
• How were stock, distribution and cold chain implemented?  
• What was the level of stock during observations? Did this match reported needs | • UNICEF and MoPH report that stock, distribution and cold chain is being appropriately managed  
• PHCs and vaccine related centres report appropriate distribution and stock flow for vaccination needs  
• Extent to which processes and management are functional in warehouse and distribution systems of vaccines | UNICEF H&N staff (individuals associated with EPI component of Annual Work Plan)  
Relevant MoPH staff at national, regional and municipal levels  
Reviews of stock at selected target sites | Key Informant Interviews  
Site Observations  
Warehouse site visit |
| 5 | To what extent is MoPH satisfied about the collaboration with UNICEF | • To what extent did MoPH report satisfaction with the support of UNICEF?  
• Was any additional support request from UNICEF?  
• What improvements could be made in the collaboration between UNICEF and MoPH? | MoPH staff at national, regional and municipal levels report satisfaction with collaboration with UNICEF in the following areas:  
• Capacity building  
• Communications  
• Provision of supplies | UNICEF H&N staff (individuals associated with EPI component of Annual Work Plan)  
Relevant MoPH staff at national, regional and municipal levels | Key Informant Interviews |
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<th></th>
<th>To what extent is their commitment to work in partnership to strengthen EPI programming across the country?</th>
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</table>
| 6 | What were the opportunities and barriers that facilitated or hindered the implementation of the Expanded programme of Immunisation?  
What were the barriers of the Immunisation Programme to be gender equitable?  
Were there any opportunities which facilitated EPI?  
Were there any barriers which inhibited the facilitation of EPI?  
To what extent did implementation activities consider the needs of women?  
- Ensuring accessibility  
- Ensuring culturally appropriate staffing in health facilities?  
- Ensuring cultural barriers affecting women (especially Syrian refugees)  
Ensuring information / comms is equitably addressed at the needs of both male and female care givers  
The types and number of barriers reported by EPI stakeholders (including MoPH, UNICEF, IPs)  
Extent to which stakeholders report gaps in support for men and women, based on identified gender differences  
Extent to which targeted community members are reporting that programming is reaching them  
Extent to which gender dissipates among marginalised groups are considered and incorporated in annual work plans in collaborations with MoPH |
|   | UNICEF H&N staff (individuals associated with EPI component of Annual Work Plan)  
Relevant MoPH staff at national, regional and municipal levels  
Implementing Partners (Beyond, Relief International, UNHCR)  
Community members  
- Female care givers  
- Male care givers  
- Local community  
- Those with disabilities |

**Efficiency**

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<th>To what extent the Immunisation Programme has improved in matter of cost efficiency along the years from 2013 to 2017?</th>
</tr>
</thead>
</table>
| 7 | What were costs provided from UNICEF for 2013, 2014, 2015, 2016, 2017?  
What are the reasons for any differences in costs?  
To what extent to UNICEF staff identify the programme as cost effective?  
How could costs be improved to be more efficient?  
Extent to which costs for EPI programming in UNICFE’s annual work plan have improved since 2013 – 2017 |
|   | Desk Review of Funding through UNICEF  
UNICEF H&N staff (individuals associated with EPI component of Annual Work Plan)  
Relevant MoPH staff at national, regional and municipal levels |

**Sustainability**

<table>
<thead>
<tr>
<th></th>
<th>To what extent did the collaboration between UNICEF and MoPH, enable MoPH to have the self-sufficient capacity to take on the tasks planning, capacity building, implementation, monitoring and</th>
</tr>
</thead>
</table>
| 8 | Can we consider the MoPH to be self-sustainable?  
Are MoPH taking on the tasks of planning, capacity building,  
Extent to which MoPH has taken on the following:  
- Task planning  
- Capacity building |
|   | UNICEF H&N staff (individuals associated with EPI component of Annual Work Plan)  
Key Informant Interviews |
| Securing optimal coverage without continued support of UNICEF? | Implementation, monitoring and securing coverage  
- Can MoPH continue these efforts without the support of UNICEF? | Implementation  
- Monitoring  
- Securing optimal coverage | Relevant MoPH staff at national, regional and municipal levels |
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<td></td>
<td>UNICEF report extent to which MoPH can effectively function without UNICEF support</td>
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</table>
ANNEX 2: BIBLIOGRAPHY

Documents provided by UNICEF:
- UNICEF Lebanon Annual Reports 2013 to 2017
- HHRP 2015/2016
- Post Campaign Monitoring 2015 and 2016
- Immunisation Focus Group Discussion Reports, 2015
- Coverage data: EPI cluster Survey, 2016 and MoPH Coverage Routine Data
- MoPH Health Strategic Plan (2016-2020)
- Feedback from EVM Training, 2016
- BEYOND Programme Document, 2016
- Coverage data: EPI cluster Survey, 2016 and MoPH Coverage Routine Data
- WHO and UNICEF estimates of immunisation coverage, 2017
- Health and Nutrition Monitoring Reports 2017
- MoPH recruited staff 2017
- Surveillance of vaccine preventable diseases MOPH online website (Measles, Mumps, Pertussis, Polio)
- Routine Immunisation Reports
- 2017/2018 PCV use and forecast
- Forecast Health and Nutrition 2017-2018 and 2018-2019
- Surveillance of vaccine preventable diseases MOPH online website (Measles, Mumps, Pertussis, Polio)
- Routine Immunisation Reports
- Border Centres Vaccination Checklist


Guidance Norms and Standards UNEG Foundation Documents Organisation for Economic Cooperation and Development Assistance Committee


Immunisation Financing in MENA Middle-Income Countries, UNICEF May 2018


Swiss Centre for International Health, 2010, ‘Gender and Immunisation,’ Swiss Tropical and Public Health Institute

Swiss Tropical and Public Health Institute, 2010, ‘Gender and Immunisation: Summary report for SAGE,’


ANNEX 3: INSTRUMENTS

FOCUS GROUP DISCUSSIONS
1. UNICEF- Qualitative Focus Group Discussion – Mothers / Female Care Giver
2. UNICEF- Qualitative Focus Group Discussion – Fathers / Male Care Givers
3. UNICEF- Qualitative Focus Group Discussion – Non-Beneficiary Families (Females)
4. UNICEF- Qualitative Focus Group Discussion – Non-beneficiary Families (Males)

KIs
5. UNICEF- Key Informant Interviews – MoPH EPI team
6. UNICEF- Key Informant Interviews – MoPH Warehouse Team
7. UNICEF- Key Informant Interviews – Public Health Officers / Medical Professionals / Vaccinators / Nurses / Public Health Workers
8. UNICEF- Key Informant Interviews – UNICEF Communications team
9. UNICEF- Key Informant Interviews – UNICEF Project Team
10. UNICEF- Key Informant Interviews – UNICEF Regional team
11. UNICEF- Key Informant Interviews – UNICEF Supply team

IDIs / EXIT INTERVIEWS

STRUCTURED OBSERVATIONS
Interviewer guidance: The participants of these focus groups should be female care givers from the local communities. We would like you to sample a maximum of 10 female caregivers. It is important that you take a random sample of 10 female caregivers from the larger group of female caregivers, as we would like to make sure that female caregivers from different socio-economic, ethnic and language groups are included. We would also like to include female caregivers who are of Lebanese and Syrian origin.

Thank you very much for taking the time to participate in this focus group. My name is _______________, and this is my colleague _______________. We are working for Sayara Research, a research company that was asked to assist UNICEF and the Ministry of Public Health to better understand how effective the immunisation system works in Lebanon. UNICEF is supporting the Ministry of Public Health across the country to ensure vaccinations are available to all children. To better inform their activities in medical centres, we would like to know a little more about your opinion and experience with vaccinations.

The issues discussed here will be completely anonymous and your name or other personal details will not be used or mentioned in any report. If you feel uncomfortable at any point, you can say that you do not want to answer the question.

For further information please contact: (name and number to be given)

1. Can you please tell me, what do you think are the most prominent health risks facing children under the age of 2 in your family?
   a. Why do you think this is?
   b. Do you think any of these illnesses are preventable? (if so, how can you prevent them?)

2. What is your opinion of vaccinations?
   a. Do you agree or disagree with vaccinating your children?
   b. Why do you agree or disagree?
3. For those of you who agree to vaccinating your children, how easy or difficult do you think it is to get your children vaccinated?
   a. What kind of barriers might prevent you from vaccinating your child?
      i. Location of vaccination clinic
      ii. Cost of vaccinations
      iii. Quality of staff doing vaccinations
      iv. Limited availability of vaccinations
   b. Do you think these barriers are the same for all groups of people? (if yes, why)
      i. Men
      ii. Women
      iii. Elderly
      iv. Young
      v. Refugees

4. For those of you who have been to a health centre to receive vaccines, can you tell me about your overall experience?
   a. To what extent were the staff capable and helpful?
   b. Did the centres appear to be fully operational and equipped with all necessary supplies?

5. Do you perceive there to be any safety or security concerns with accessing and using health facilities in your community or local area?
   a. If so, why so and which concerns?

6. How well trained do you think the health care workers were in the health centre?
   a. Did they provide you with any advice or knowledge about future vaccinations or the health of your children?

7. For any previous vaccinations, did you need to pay any fees to get the vaccination?
   a. Which costs did you need to pay?
      i. Transpiration
      ii. Consultation
      iii. Cost of medicine

8. Do you think there are any differences in accessing vaccinations for Syrians and Lebanese?
   a. If yes, why do you think this?

9. Where have you heard information about vaccinations?
   a. In your community
   b. TV
   c. Radio
   d. Brouchers / billboards

10. What sources of information do you most trust when you want to find out information about your children’s health and in particular vaccinations?
    a. Why do you trust / not trust this source?

11. In your household, who generally makes decisions concerning a child’s health, and whether they can be vaccinated?
    a. Do you think there are any barriers within your household which may prevent you from vaccinating your children?
       i. Do you have opportunities to make financial decisions in your household?
       ii. Do you have opportunities to move freely outside of your home with your child, or are you required to have a male family member accompany you?
UNICEF- Qualitative Focus Group Discussion – Fathers / Male Care Givers

Name of Translator
Name of Interviewer
Governorate
District
Community
Location of Focus group
Date
Time FG Started
Time FG Ended

Focus group Participants
No/Code | Nationality | Name | Age | Profession/job | Education level (grade of school completed)
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Interviewer guidance: The participants of these focus groups should be male care givers from the local communities. We would like you to sample a maximum of 10 male caregivers. It is important that you take a random sample of 10 male caregivers from the larger group of male caregivers, as we would like to make sure that male caregivers from different socio-economic, ethnic and language groups are included. We would also like to include male caregivers who are of Lebanese and Syrian origin.

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Thank you very much for taking the time to participate in this focus group. My name is _______________, and this is my colleague _______________. We are working for Sayara Research, a research company that was asked to assist UNICEF and the Ministry of Public Health to better understand how effective the immunisation system works in Lebanon. UNICEF is supporting the Ministry of Public Health across the country to ensure vaccinations are available to all children. To better inform their activities in medical centres, we would like to know a little more about your opinion and experience with vaccinations.

The issues discussed here will be completely anonymous and your name or other personal details will not be used or mentioned in any report. If you feel uncomfortable at any point, you can say that you do not want to answer the question.

For further information please contact: (name and number to be given)

1. Can you please tell me, what do you think are the most prominent health risks facing children under the age of 2 in your family?
   a. Why do you think this is?
   b. Do you think any of these illnesses are preventable? (if so, how can you prevent them?)

2. What is your opinion of vaccinations?
   a. Do you agree or disagree with vaccinating your children?
b. Why do you agree or disagree?

3. For those of you who agree to vaccinating your children, how easy or difficult do you think it is to get your children vaccinated?
   a. What kind of barriers might prevent you from vaccinating your child?
      i. Location of vaccination clinic
      ii. Cost of vaccinations
      iii. Quality of staff doing vaccinations
      iv. Limited availability of vaccinations

4. For those of you who have been to a health centre to receive vaccines, can you tell me about your overall experience?
   a. To what extent were the staff capable and helpful?
   b. Did the centres appear to be fully operational and equipped with all necessary supplies?

5. How well trained do you think the health care workers were in the health centre?
   a. Did they provide you with any advice or knowledge about future vaccinations or the health of your children?

6. For any previous vaccinations, did you need to pay any fees to get the vaccination?
   a. Which costs did you need to pay?
      i. Transpiration
      ii. Consultation
      iii. Cost of medicine

7. Do you think there are any differences in accessing vaccinations for Syrians and Lebanese?
   a. If yes, why do you think this?

8. Where have you heard information about vaccinations?
   a. In your community
   b. TV
   c. Radio
   d. Bouchers / billboards

9. What sources of information do you most trust when you want to find out information about your children’s health and in particular vaccinations?
   a. Why do you trust / not trust this source?

10. Who is the person in your household who makes decisions about whether a child is vaccinated?
    a. Why is this the case?

Thank you kindly for taking the time to speak with us today. Do any of you have any final comments you would like to share about your opinions or experiences of vaccination in Lebanon?
**UNICEF- Qualitative Focus Group Discussion – Non-Beneficiary Families (Females)**

<table>
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<tr>
<th>Focus group Participants</th>
<th>No/Code</th>
<th>Nationality</th>
<th>Name</th>
<th>Age</th>
<th>Profession/job</th>
<th>Education level (grade of school completed)</th>
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**Interviewer guidance:** The participants of these focus groups should be female care givers from the local communities. We would like you to sample a maximum of 10 female caregivers. It is important that you take a random sample of 10 female caregivers from the larger group of female caregivers, as we would like to make sure that female caregivers from different socio-economic, ethnic and language groups are included. We would also like to include female caregivers who are of Lebanese and Syrian origin.

Thank you very much for taking the time to participate in this focus group. My name is _______________, and this is my colleague ________________. We are working for Sayara Research, a research company that was asked to assist UNICEF and the Ministry of Public Health to better understand how effective the immunisation system works in Lebanon. UNICEF is supporting the Ministry of Public Health across the country to ensure vaccinations are available to all children. To better inform their activities in medical centres, we would like to know a little more about your opinion and experience with vaccinations.

The issues discussed here will be completely anonymous and your name or other personal details will not be used or mentioned in any report. If you feel uncomfortable at any point, you can say that you do not want to answer the question.

For further information please contact: (name and number to be given)

1. Can you please tell me, what do you think are the most prominent health risks facing children under the age of 2 in your family?
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      ii. Cost of vaccinations
      iii. Quality of staff doing vaccinations
      iv. Limited availability of vaccinations
   b. Do you think these barriers are the same for all groups of people? (if yes, why)
      i. Men
      ii. Women
      iii. Elderly
      iv. Young
      v. Refugees

4. For those of you who have been to a health centre to receive vaccines, can you tell me about your overall experience?
   a. To what extent were the staff capable and helpful?
   b. Did the centres appear to be fully operational and equipped with all necessary supplies?

5. Do you perceive there to be any safety or security concerns with accessing and using health facilities in your community or local area?
   a. If so, why so and which concerns?

6. How well trained do you think the health care workers were in the health centre?
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       i. Do you have opportunities to make financial decisions in your household?
       ii. Do you have opportunities to move freely outside of your home with your child, or are you required to have a male family member accompany you?

12. Why do you prefer to use a private clinic rather than used public health facilities when getting your children vaccinated?
### Interviewer guidance:
The participants of these focus groups should be male care givers from the local communities. We would like you to sample a maximum of 10 male caregivers. It is important that you take a random sample of 10 male caregivers from the larger group of male caregivers, as we would like to make sure that male caregivers from different socio-economic, ethnic and language groups are included. We would also like to include male caregivers who are of Lebanese and Syrian origin.

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The issues discussed here will be completely anonymous and your name or other personal details will not be used or mentioned in any report. If you feel uncomfortable at any point, you can say that you do not want to answer the question.

For further information please contact: (name and number to be given)

---

1. Can you please tell me, what do you think are the most prominent health risks facing children under the age of 2 in your family?
   a. Why do you think this is?
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8. Where have you heard information about vaccinations?
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9. What sources of information do you most trust when you want to find out information about your children’s health and in particular vaccinations?
   a. Why do you trust / not trust this source?

10. Who is the person in your household who makes decisions about whether a child is vaccinated?
    a. Why is this the case?

11. Why do you prefer to use a private clinic rather than used public health facilities when getting your children vaccinated?

Thank you kindly for taking the time to speak with us today. Do any of you have any final comments you would like to share about your opinions or experiences of vaccination in Lebanon?
**UNICEF- Key Informant Interviews – MoPH EPI team**

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<th>Name of Translator</th>
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<td>Key Informant name</td>
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<tr>
<td>Key Informant Position</td>
<td>MoPH EPI staff</td>
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<tr>
<td>Key Informant Contact Information</td>
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**Interviewer guidance:** The interviewees for this KII should have been selected and approved by UNICEF and Sayara’s senior research team. The key informant is likely to be one of the following:

1. UNICEF staff
2. MoPH staff
3. Other UN Agencies
4. Strategic Partners
5. Medical professionals / Community Health Professionals

Thank you very much for taking the time to participate in this focus group. My name is _______________, and this is my colleague _______________. We are working for Sayara Research, a research company that was asked to assist UNICEF and the Ministry of Public Health to better understand how effective the immunisation system works in Lebanon. UNICEF is supporting the Ministry of Public Health across the country to ensure vaccinations are available to all children. To better inform their activities in medical centres, we would like to know a little more about your opinion and experience with vaccinations.

You have been selected to participate in our evaluation because of your specialised understanding of health and immunisation in Lebanon.

The issues discussed here will be completely anonymous and your name or other personal details will not be used or mentioned in any report. The interview will be recorded for quality assurance and translation for analysis. If you feel uncomfortable at any point, you can say that you do not want to answer the question.

1. Can you please explain your role in MoPH and EPI activities?

2. What is MoPH’s role in EPI?

3. This evaluation is looking at effects of the collaboration between MoPH and UNICEF concerning EPI in Lebanon. We are looking at the period of collaboration between 2013 and 2017. Can you please tell me what support UNICEF provides to MoPH and EPI?
   a. Why is this support being provided?
   b. Has this support changed since 2013?

4. How did UNICEF or MoPH identify the type of support needed to EPI?

5. As far as you know, has UNICEF provided any capacity building support or training to any MoPH staff?
   a. What type of training / support was provided?

6. What are different reasons you think that populations in Lebanon may not be vaccinating their children?
   a. What barriers or risks?
b. Does this differ between the Lebanese and Syrian populations?
   i. If so, what are the differences for Lebanese and Syrian populations?

7. To what extent does MoPH activities incorporate specific activities or approaches to ensure the most marginalised and disadvantaged have access to vaccinations?
   a. Women / female headed households / young mothers
   b. Syrian refugees
   c. Disabled and geographically remote

8. Can you explain how stock, distribution and cold chain is managed either through UNICEF or MoPH?
   a. Have management processes changed since 2013?
      i. If so, how have they changed and why did they change?

9. What is the process of distributing vaccinations across the country?
   a. How do you determine which centres / vaccination sites require which vaccinations?

10. To what extent does MoPH monitor the use and management of vaccines in PHCs and relevant vaccination sites?
    a. Ensuring cold chain
    b. Ensuring quality of vaccines
    c. Ensuring staff are capable of administering vaccines

11. Does MoPH conduct any monitoring of facilities across the country?
    a. If yes, what is the process of monitoring?
    b. What is monitored?
    c. How regularly are sites monitored?

12. I would now like to know a little more about your experience working with UNICEF. To what extent has MoPH been satisfied with the support being provided by UNICEF?
    a. Why / why not?

13. Has MoPH requested any further support from UNICEF since 2013?
    a. Has UNICEF provided any of this support?
       i. Why / why not?

14. Do you think any improvements could be made concerning the collaboration between UNICEF and MoPH?
    a. How do you think these improvements could take place?

15. To what extent do you think MoPH is committed to working closely with UNICEF to improve access to vaccinations?
    a. To what extent do you think UNICEF is committed to working closely with MoPH?

16. Are there any existing barriers which inhibit the facilitation of EPI?

17. Have there been any opportunities which improve the facilitation of EPI?

18. Can you tell me if MoPH is taking on any tasks in the following areas without the support of UNICEF?
    a. Planning
    b. Capacity building
    c. Monitoring of EPI activities
    d. Securing coverage in the most disadvantaged and vulnerable areas
    e. Securing provision of supplies

19. Would you consider EPI to have improved over the past 5 years due to the support of UNICEF?
    a. Why / Why not?

20. Moving into 2018, what approach and priorities has MoPH identified in terms of improving the coverage of vaccinations in Lebanon?
UNICEF- Key Informant Interviews – MoPH Warehouse Team

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**Interviewer guidance:** The interviewees for this KII should have been selected and approved by UNICEF and Sayara’s senior research team. The key informant is likely to be one of the following:

6. UNICEF staff
7. MoPH staff
8. Other UN Agencies
9. Strategic Partners
10. Medical professionals / Community Health Professionals

---

Thank you very much for taking the time to participate in this focus group. My name is _______________, and this is my colleague _______________. We are working for Sayara Research, a research company that was asked to assist UNICEF and the Ministry of Public Health to better understand how effective the immunisation system works in Lebanon. UNICEF is supporting the Ministry of Public Health across the country to ensure vaccinations are available to all children. To better inform their activities in medical centres, we would like to know a little more about your opinion and experience with vaccinations.

You have been selected to participate in our evaluation because of your specialised understanding of health and immunisation in Lebanon.

The issues discussed here will be completely anonymous and your name or other personal details will not be used or mentioned in any report. The interview will be recorded for quality assurance and translation for analysis. If you feel uncomfortable at any point, you can say that you do not want to answer the question.

For further information please contact: (name and number to be given)

1. Can you please tell me your role and responsibilities in the MoPH warehouse?
   a. What is your role specifically with vaccinations and managing EPI supplies?

2. Can you please tell me the role of UNICEF in providing support to MoPH for EPI supplies?

3. What are current management processes in place to ensure the following:
   a. Tracking received and distributed vaccines and products
   b. Stock management within the warehouse
c. Ensuring quality of vaccines

4. What role does MoPH play in terms of supporting management of the warehouse?

5. How does MoPH determine the number of vaccines required to meet the needs of the population?
   a. What is the process of acquiring vaccinations when more are required?

6. What is the process of distributing vaccines across the country?
   a. Who determines where vaccines are sent and why?
   b. How does MoPH ensure that the most marginalised and vulnerable are accessing vaccines?

7. Can you explain how the management of vaccines may have changed since 2013?
   a. What new or revised processes have been introduced?
   b. Why were these introduced?
   c. Who was responsible for introducing these revised processes?

8. Do you foresee any further changes being made in terms of warehouse management in the coming year?
   a. Why do these changes need to be made?

9. Do you think MoPH could effectively procure and manage EPI vaccines without the financial or technical support of UNICEF?
   a. Please explain why or why not
### UNICEF- Key Informant Interviews – Public Health Officers / Medical Professionals / Vaccinators / Nurses / Public Health Workers

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<td>Key Informant Position (circle appropriate response)</td>
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<td>Key Informant Contact Information</td>
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**Interviewer guidance:** The interviewees for this KII should have been selected and approved by UNICEF and Sayara’s senior research team. The key informant is likely to be one of the following:

1. UNICEF staff
2. MoPH staff
3. Other UN Agencies
4. Strategic Partners
5. Medical professionals / Community Health Professionals

---

Thank you very much for taking the time to participate in this focus group. My name is _______________, and this is my colleague _______________. We are working for Sayara Research, a research company that was asked to assist UNICEF and the Ministry of Public Health to better understand how effective the immunisation system works in Lebanon. UNICEF is supporting the Ministry of Public Health across the country to ensure vaccinations are available to all children. To better inform their activities in medical centres, we would like to know a little more about your opinion and experience with vaccinations.

You have been selected to participate in our evaluation because of your specialised understanding of health and immunisation in Lebanon.

The issues discussed here will be completely anonymous and your name or other personal details will not be used or mentioned in any report. The interview will be recorded for quality assurance and translation for analysis. If you feel uncomfortable at any point, you can say that you do not want to answer the question.

For further information please contact: (name and number to be given)

1. Can you please tell me a bit about your position and your involvement with EPI?
2. In your opinion what are the biggest health risks facing children in your area?
3. In your experience, to what extent do you think families are vaccinating their children?
   a. If they are not vaccinating their children, can you explain why, based on your experience?
4. What types of barriers have you seen that may prevent families from vaccinating their children?
   a. Finances
   b. Geographic access
   c. Socio-cultural barriers
   d. Attitudes towards vaccines

5. Do you notice any differences between Syrians or Lebanese accessing vaccinations?
   a. If so, what are the differences and why?

6. Where do you currently source your vaccines?
   a. How do you manage and store the vaccines?

7. What is the process of registering a child for vaccination and maintaining their vaccination details?
   a. Are the rates of registered children and vaccination shared with any other parties for information purposes?

8. What is the process for a family to receive a vaccine?
   a. Do they need to make a consultation time?
   b. Can they come to the clinic at any point?

9. What is the average cost involved in having a child vaccinated?

10. Currently MoPH is managing EPI, but with the support of UNICEF. Have you, to date, received any support from UNICEF in terms of supplies, capacity building, technical support?

11. Has a UNICEF staff member ever visited you to monitor vaccination processes or the quality of the centre?
   a. If not, has anyone ever come to monitor the quality of work in this centre?

12. Have you received any direct support from the MoPH?
   a. If yes, what support have you received?

13. In your experience, have you noticed any other gaps or barriers which may be preventing nationwide coverage of immunisation for children?

Thank you kindly for taking the time to speak with us today. Your assistance was greatly appreciated, and we may be in contact again should any further questions come up.
Interviewer guidance: The interviewees for this KII should have been selected and approved by UNICEF and Sayara’s senior research team. The key informant is likely to be one of the following:

16. UNICEF staff
17. MoPH staff
18. Other UN Agencies
19. Strategic Partners
20. Medical professionals / Community Health Professionals

Thank you very much for taking the time to participate in this focus group. My name is _______________, and this is my colleague ________________. We are working for Sayara Research, a research company that was asked to assist UNICEF and the Ministry of Public Health to better understand how effective the immunisation system works in Lebanon. UNICEF is supporting the Ministry of Public Health across the country to ensure vaccinations are available to all children. To better inform their activities in medical centres, we would like to know a little more about your opinion and experience with vaccinations.

You have been selected to participate in our evaluation because of your specialised understanding of health and immunisation in Lebanon.

The issues discussed here will be completely anonymous and your name or other personal details will not be used or mentioned in any report. The interview will be recorded for quality assurance and translation for analysis. If you feel uncomfortable at any point, you can say that you do not want to answer the question.

For further information please contact: (name and number to be given)

1. According to the annual work plan of UNICEF’s Health and Nutrition department, effective communication strategies play an important role in UNICEF’s support to EPI programming. Can you please tell me what activities, specifically, that UNICEF does to increase awareness and knowledge of vaccination services across the country?
   a. Which platforms are you currently using?
   b. How did you decide to use these platforms?
2. As far as you understand, how did UNICEF identify that strategic communications had to be an important part of EPI support and the annual work plan?

3. Based on your understanding and experience, what specifically did UNICEF identify that needed to be communicated with the populations in Lebanon?
   a. From what information was this sourced?

4. Who are the primary targets of your communication campaigns?
   a. To what extent has your team kept in mind the most marginalised and vulnerable groups among Lebanese and Syrians?
      i. Including gender
      ii. Disability
      iii. Socio-cultural norms

5. As far as we understand, much of the communication work is designed by UNICEF but implemented by strategic partners. Can you please explain to me a bit more about the relationship between strategic partners and UNICEF?
   a. Which activities are they responsible for implementing and which are UNICEF responsible for implementing?
   b. Why do you choose strategic partners rather than implementing them yourself?
   c. How successful do you think relationships with these partners have been? (over the past 5 years)
      i. Which are the most successful and which are not and why?

6. What locations of the country are currently not being addressed through communication campaigns?
   a. Why is this the case?
   b. Have these locations ever been addressed in previous years?
   c. Do you foresee conducting any activities in these areas in coming future?

7. How does UNICEF monitor and assess the quality of performance of their communication campaigns?
   a. Evaluations?
   b. Micro Assessments?
   c. Qualitative groups?

8. To what extent has UNICEF worked collaboratively with MoPH in terms of their communication work?
   a. Does the MoPH have say in any of the themes or platforms being used through communication activities?

9. Are there any other areas that you think UNICEF and MoPH could improve on, in terms of communication activities concerning EPI programming?
### Interviewer guidance:
The interviewees for this KII should have been selected and approved by UNICEF and Sayara's senior research team. The key informant is likely to be one of the following:

- 21. UNICEF staff
- 22. MoPH staff
- 23. Other UN Agencies
- 24. Strategic Partners
- 25. Medical professionals / Community Health Professionals

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**Thank you very much for taking the time to participate in this focus group. My name is _______________, and this is my colleague _______________. We are working for Sayara Research, a research company that was asked to assist UNICEF and the Ministry of Public Health to better understand how effective the immunisation system works in Lebanon. UNICEF is supporting the Ministry of Public Health across the country to ensure vaccinations are available to all children. To better inform their activities in medical centres, we would like to know a little more about your opinion and experience with vaccinations.**

You have been selected to participate in our evaluation because of your specialised understanding of health and immunisation in Lebanon.

The issues discussed here will be completely anonymous and your name or other personal details will not be used or mentioned in any report. The interview will be recorded for quality assurance and translation for analysis. If you feel uncomfortable at any point, you can say that you do not want to answer the question.

For further information please contact: (name and number to be given)

1. Can you please explain your role in UNICEF and EPI activities?

2. This evaluation is looking at the extent to which UNICEF’s annual work plan, since 2013, has effectively addressed EPI needs across the country. The most recent annual work plans have highlighted that there were three major pillars – capacity building, communications and provision of supplies.

   Can you please tell me why these three areas of interest were selected as support being provided by UNICEF?
3. How did UNICEF identify the specific support needs of the following:
   a. Capacity building (ie. How did UNICEF identify who specifically needed capacity building and in what areas)
   b. Communications
   c. Provision of Supply

4. Were these activities always considered in the annual work plans, or have changes been made in strategic approaches since 2013?

5. What specific training has been provided to health care professionals through UNICEF?
   a. How regularly has this training been provided and what follow ups have been done to ensure lessons learned are being implemented in the field?

6. UNICEF currently provides vaccinations to the MoPH to ensure the available quantities for the population. What activities or monitoring does UNICEF do to ensure the following?
   a. Quality of vaccinations
   b. Appropriate quantity of vaccinations
   c. Overall management of stock flow
   d. Where vaccinations are distributed (ensuring marginalised and disadvantaged areas are included)
   e. How vaccines are stored in the MoPH warehouse – duration of storage
   f. Duration of storage in Public Health clinics

7. What data is kept on stock levels of vaccines and other necessary supplies?
   a. How accurate would you consider this data to be?

8. How does UNICEF ensure that PHCs and dispensaries are fully equipped and operational?
   a. What are the differences in responsibilities of MoPH and UNICEF?
   b. To what extent does UNICEF do site visits to PHCs and dispensaries to check the quality and quantity of vaccinations, and overall quality of the vicinity

9. For those who agree to vaccinating their children, how easy or difficult do you think it is to get your children vaccinated?
   a. What kind of barriers might prevent you from vaccinating your child?
      i. Location of vaccination clinic
      ii. Cost of vaccinations
      iii. Quality of staff doing vaccinations
      iv. Limited availability of vaccinations
   b. Do you think these barriers are the same for all groups of people?
      i. Men
      ii. Women
      iii. Elderly
      iv. Young
      v. Refugees

10. To what extent do you understand gender to be a concern when designing the annual work plan?
    a. What specific gender issues or gender mainstreaming activities have been incorporated into the annual work plans from 2013 – 2017
    b. What specific gender barriers have been identified in EPI related activities?
11. Based on your experience, what are the most marginalised and disadvantaged groups requiring assistance to access health and vaccines?
   a. Why do you think this is the case?

12. How satisfied have you been with the overall collaboration between UNICEF and MoPH?
   a. Do you think this collaboration could be improved? (if yes, how so)
   b. Do you think there are any conflicts or gaps in collaboration with MoPH?

13. To what extent do you think that the partnership between UNICEF and MoPH has strengthened EPI across the country?
   a. Why do you think this?

14. Are there any existing barriers which inhibit the facilitation of EPI?

15. Have there been any opportunities which improve the facilitation of EPI?

16. What are the overall costs associated with providing MoPH the support required?
   a. Cost of vaccines
   b. Cost of capacity building
   c. Cost of communication activities
   d. Cost of additional staff supported by UNICEF

17. Have these costs been consistent across the annual work plans from 2013-2017? Or have prices and costs fluctuated?

18. To what extent would you say that current support provided to MoPH by UNICEF is cost effective or ineffective?

19. Do you think costs could be improved to be more efficient?
   a. If so, how could this be done?
   b. Is this considered in upcoming work plans?

20. To what extent do you think the MoPH could sustain EPI without the financial and technical support of UNICEF?
   a. Why / why not?

21. Have you seen any evidence that MoPH is taking on any tasks in the following areas?
   a. Planning
   b. Capacity building
   c. Monitoring of EPI activities
   d. Securing coverage in the most disadvantaged and vulnerable areas
   e. Securing provision of supplies

22. Do you consider there to be any limitations in MoPH’s management and understanding of EPI?
   a. Concerning the Syrian population
   b. Poor and marginalised Lebanese populations
   c. Females / single headed households / young mothers
   d. Disabled

23. Would you consider EPI to have improved over the past 5 years due to the support of UNICEF?
   a. Why / Why not?

24. Moving into 2018, what approach and priorities has UNICEF identified in terms of improving the coverage of vaccinations in Lebanon?
Interviewer guidance: The interviewees for this KII should have been selected and approved by UNICEF and Sayara’s senior research team. The key informant is likely to be one of the following:

- UNICEF staff
- MoPH staff
- Other UN Agencies
- Strategic Partners
- Medical professionals / Community Health Professionals

Thank you very much for taking the time to participate in this focus group. My name is _______________, and this is my colleague ________________. We are working for Sayara Research, a research company that was asked to assist UNICEF and the Ministry of Public Health to better understand how effective the immunisation system works in Lebanon. UNICEF is supporting the Ministry of Public Health across the country to ensure vaccinations are available to all children. To better inform their activities in medical centres, we would like to know a little more about your opinion and experience with vaccinations.

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For further information please contact: (name and number to be given)

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2. This evaluation is looking at the extent to which UNICEF’s annual work plan, since 2013, has effectively addressed EPI needs across the country. The most recent annual work plans have highlighted that there were three major pillars – capacity building, communications and provision of supplies.

   Can you please tell me why these three areas of interest were selected as support being provided by UNICEF in your allocated regions?
a. Capacity Building
b. Communications
c. Provision of Supplies

3. How did UNICEF identify the specific support needs of the following:
   a. Capacity building (ie. How did UNICEF identify who specifically needed capacity building and in what areas)
   b. Communications
   c. Provision of Supply

4. Were these specific to your allocated region, or were these practices allocated nationwide?

5. UNICEF currently provides vaccinations to the MoPH to ensure the available quantities for the population. What activities or monitoring does UNICEF do to ensure the following?
   a. Quality of vaccinations
   b. Appropriate quantity of vaccinations
   c. Overall management of stock flow
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   a. How accurate would you consider this data to be?

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   a. What are the differences in responsibilities of MoPH and UNICEF?
   b. To what extent does UNICEF do site visits to PHCs and dispensaries to check the quality and quantity of vaccinations, and overall quality of the vicinity

13. For those of you who agree to vaccinating your children, how easy or difficult do you think it is to get your children vaccinated?
   a. What kind of barriers might prevent you from vaccinating your child?
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8. To what extent do you understand gender to be a concern when designing the annual work plan?
   a. What specific gender issues or gender mainstreaming activities have been incorporated into the annual work plans from 2013 – 2017
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   a. Why do you think this is the case?

10. How satisfied have you been with the overall collaboration between UNICEF and MoPH?
    a. Do you think this collaboration could be improved? (if yes, how so)
    b. Do you think there are any conflicts or gaps in collaboration with MoPH?
11. To what extent do you think that the partnership between UNICEF and MoPH has strengthened EPI across the country?  
   a. Why do you think this?

12. Are there any existing barriers which inhibit the facilitation of EPI?

13. Have there been any opportunities which improve the facilitation of EPI?

14. To what extent would you say that current support provided to MoPH by UNICEF is cost effective or ineffective?

15. Do you think costs could be improved to be more efficient?  
   a. If so, how could this be done?  
   b. Is this considered in upcoming work plans?

16. To what extent do you think the MoPH could sustain EPI without the financial and technical support of UNICEF?  
   a. Why / why not?

17. Have you seen any evidence that MoPH is taking on any tasks in the following areas:  
   a. Planning  
   b. Capacity building  
   c. Monitoring of EPI activities  
   d. Securing coverage in the most disadvantaged and vulnerable areas
### UNICEF Key Informant Interviews – UNICEF Supply team

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<td>Supply Team</td>
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26. UNICEF staff  
27. MoPH staff  
28. Other UN Agencies  
29. Strategic Partners  
30. Medical professionals / Community Health Professionals

Thank you very much for taking the time to participate in this focus group. My name is _______________, and this is my colleague _______________. We are working for Sayara Research, a research company that was asked to assist UNICEF and the Ministry of Public Health to better understand how effective the immunisation system works in Lebanon. UNICEF is supporting the Ministry of Public Health across the country to ensure vaccinations are available to all children. To better inform their activities in medical centres, we would like to know a little more about your opinion and experience with vaccinations.

You have been selected to participate in our evaluation because of your specialised understanding of health and immunisation in Lebanon.

The issues discussed here will be completely anonymous and your name or other personal details will not be used or mentioned in any report. The interview will be recorded for quality assurance and translation for analysis. If you feel uncomfortable at any point, you can say that you do not want to answer the question.

For further information please contact: (name and number to be given)

1. Can you please tell me about the supply team’s involvement in the EPI programme within UNICEF and MoPH?  
   a. What specific activities does the supply team do?  
   b. Do they have allocated staff for EPI related activities?  
   c. What specifically does the supply team provide MoPH (vaccines, cold chain fridges etc.)

2. Why is UNICEF procuring vaccinations and supplies for MoPH?
3. Can you tell me a bit about the process of procuring vaccinations and how they are passed to the MoPH?
   a. Does UNICEF play any role in how vaccinations are stored and distributed?

4. What is the quantity of vaccinations and supplies being procured by UNICEF for MoPH?
   a. How is this figure calculated?
   b. Which vaccinations are procured by UNICEF?

5. How is UNICEF informed that vaccination stocks / supplies are required and need to be procured?
   a. What are the processes of verifying these reports and figures?

6. To what extent is UNICEF involved in the management of vaccinations once they are given to the MoPH warehouse facilities?
   a. To what extent do you think it would be beneficial / unbeneificial to have UNICEF play a more hands on role in terms of stock management

7. What are the current monitoring and quality control procedures in place to ensure the following:
   a. Quality of vaccinations
   b. Quantity of vaccinations
   c. How effectively stock is being managed
   d. How stock is being distributed

8. To what extent does UNICEF ensure that vaccinations are being distributed to the most marginalised and vulnerable areas of the country?
### Exit Interview: Families of Vaccination Recipients at Health Facilities

This interview is only to be conducted in the instance that a family has received a vaccination on the day of observation.

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|                  | 2. Hospital  
|                  | 3. Private Clinic  
|                  | 4. Dispensary  |

**Enumerator to read:**

“Hello, my name is [enumerator name] and I am working with a local research company called Sayara International. We are conducting research in collaboration with the Ministry of Public Health and UNICEF. We would like to better understand how your experience was with health provider today and receiving the vaccination.

This interview will take approximately 15 minutes but will help us to better understand the strengths and weaknesses of the vaccination programme.

I would like to assure you that your participation in this survey is completely voluntary and no personal information will be shared with any party outside of this study. The answers from this study will be compiled with the results of other interviewees. Should at any point you wish not to continue the interview, please let me know.

Are you willing to participate in this short survey?  

[ ] Yes  
[ ] No

1. How old is your child? [Months]  
2. Which vaccine did your child receive today?  

[ ] 1. BCG  
[ ] 2. DTP1  
[ ] 3. DTP3  
[ ] 4. Pol3  
[ ] 5. MCV1  
[ ] 6. HEP B3
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<tr>
<th>Question</th>
<th>Options</th>
</tr>
</thead>
<tbody>
<tr>
<td>3. How long did you wait to receive your vaccine today? (minutes)</td>
<td>1. ________________</td>
</tr>
<tr>
<td>4. How many vaccines has your child already received?</td>
<td>1. ________________</td>
</tr>
<tr>
<td>5. Are you happy for your child to receive vaccines?</td>
<td>1. ________________</td>
</tr>
<tr>
<td>6. Do you only receive vaccines at this facility?</td>
<td>1. Yes</td>
</tr>
<tr>
<td></td>
<td>2. No</td>
</tr>
<tr>
<td>7. How did you hear about the need to vaccinate your child?</td>
<td>1. Knowledge from previous child</td>
</tr>
<tr>
<td></td>
<td>2. Family and community</td>
</tr>
<tr>
<td></td>
<td>3. Health worker at your house</td>
</tr>
<tr>
<td></td>
<td>4. Health worker at the health facility</td>
</tr>
<tr>
<td></td>
<td>5. Other</td>
</tr>
<tr>
<td>8. Has a health worker ever come to your house to inform you about vaccinations at this health centre?</td>
<td>1. Yes</td>
</tr>
<tr>
<td></td>
<td>2. No</td>
</tr>
<tr>
<td>9. Is this your first time getting your child vaccinated at this health facility?</td>
<td>1. Yes (Skip to 11)</td>
</tr>
<tr>
<td></td>
<td>2. No, but for another child (Skip to 11)</td>
</tr>
<tr>
<td></td>
<td>3. No</td>
</tr>
<tr>
<td>10. Have you received (phone or SMS) a reminder to come get this vaccination for your child?</td>
<td>1. Yes</td>
</tr>
<tr>
<td></td>
<td>2. No</td>
</tr>
<tr>
<td>11. Do you pay any fees to have this vaccine?</td>
<td>1. Yes</td>
</tr>
<tr>
<td></td>
<td>2. No</td>
</tr>
<tr>
<td>12. How much did you pay? (in LBP)</td>
<td>1. ________________</td>
</tr>
<tr>
<td>13. Who administered your vaccine today?</td>
<td>1. Doctor</td>
</tr>
<tr>
<td></td>
<td>2. Nurse</td>
</tr>
<tr>
<td></td>
<td>3. Other</td>
</tr>
<tr>
<td>14. Were you satisfied with how the vaccine was administered?</td>
<td>1. Yes</td>
</tr>
<tr>
<td></td>
<td>2. No</td>
</tr>
<tr>
<td>15. Did you feel the vaccinator was appropriately informed about the vaccination?</td>
<td>1. Yes</td>
</tr>
<tr>
<td></td>
<td>2. No</td>
</tr>
<tr>
<td>16. Do you feel the vaccinator was knowledgeable about vaccinations for children?</td>
<td>1. Yes</td>
</tr>
<tr>
<td></td>
<td>2. No</td>
</tr>
<tr>
<td>17. How comfortable do you think your child felt receiving the vaccine?</td>
<td>1. Very comfortable</td>
</tr>
<tr>
<td></td>
<td>2. Somewhat comfortable</td>
</tr>
<tr>
<td></td>
<td>3. Somewhat uncomfortable</td>
</tr>
<tr>
<td></td>
<td>4. Very uncomfortable</td>
</tr>
<tr>
<td>18. Would you be happy to return to receive another vaccine in the future?</td>
<td>1. Yes (skip to Q20)</td>
</tr>
<tr>
<td></td>
<td>2. No</td>
</tr>
<tr>
<td>19. Why not?</td>
<td>1. ________________</td>
</tr>
<tr>
<td>20. Does your child have a vaccination card?</td>
<td>1. Yes, prior to this vaccination</td>
</tr>
<tr>
<td></td>
<td>2. Yes, given today at the health centre</td>
</tr>
<tr>
<td></td>
<td>3. No (Skip to Q22)</td>
</tr>
<tr>
<td>21. Was this card updated by the health worker with the dates for future vaccines and vaccines booster?</td>
<td>1. Yes</td>
</tr>
<tr>
<td></td>
<td>2. No</td>
</tr>
<tr>
<td>22. Was any information given to you about the dates for future vaccines and vaccines booster?</td>
<td>1. Yes</td>
</tr>
<tr>
<td></td>
<td>2. No</td>
</tr>
<tr>
<td>23. Did you notice any information about vaccinations in this facility?</td>
<td>1. Yes</td>
</tr>
<tr>
<td></td>
<td>2. No (Skip to Q27)</td>
</tr>
<tr>
<td>24. Did you think this information was useful and informative about vaccinations for children?</td>
<td>1. Yes</td>
</tr>
<tr>
<td></td>
<td>2. No (skip to Q26)</td>
</tr>
<tr>
<td>Question</td>
<td>1.</td>
</tr>
<tr>
<td>-------------------------------------------------------------------------</td>
<td>-------------------------</td>
</tr>
<tr>
<td>25. Why was it useful?</td>
<td></td>
</tr>
<tr>
<td>26. Why was it not useful?</td>
<td></td>
</tr>
<tr>
<td>27. Do you think more or less information should be provided about</td>
<td>[ ] 1. More</td>
</tr>
<tr>
<td>vaccines in facilities?</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>28. Do you feel you are appropriately informed about vaccination</td>
<td>[ ] 1. Yes (Skip to 30)</td>
</tr>
<tr>
<td>practices for children?</td>
<td></td>
</tr>
<tr>
<td>29. Why not?</td>
<td></td>
</tr>
<tr>
<td>30. Do you think there is anything this facility could do to make it</td>
<td>[ ] 1. Yes</td>
</tr>
<tr>
<td>easy for you to vaccinate your children?</td>
<td></td>
</tr>
<tr>
<td>31. What could the facility do?</td>
<td></td>
</tr>
</tbody>
</table>

Thank you kindly for your time today, and your support is much appreciated in conducting this study.
<table>
<thead>
<tr>
<th><strong>Observational Check List: Medical Health Facilities</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Questionnaire ID</td>
</tr>
<tr>
<td>Coder Code</td>
</tr>
<tr>
<td>Enumerator Code:</td>
</tr>
<tr>
<td>Enumerator ID:</td>
</tr>
<tr>
<td>Supervisor Name:</td>
</tr>
<tr>
<td>Supervisor ID:</td>
</tr>
<tr>
<td>Date of Interview</td>
</tr>
<tr>
<td>Observation Start Time (24 hour format)</td>
</tr>
<tr>
<td>Observation End time: 24-hour format</td>
</tr>
<tr>
<td>Name of PHCC</td>
</tr>
<tr>
<td>Name of Point of contact at PHCC</td>
</tr>
<tr>
<td>Contact number of PHCC</td>
</tr>
</tbody>
</table>

| Governorate | 1. |
| District | 1. |
| Village | 1. |
| Locality | 3. Urban |
| | 4. Rural |

| Facility Name | 1. |
| Facility Type | 5. PHCC |
| | 6. Hospital |
| | 7. Private Clinic |
| | 8. Dispensary |

1. Is this facility currently supported by NGOs?  
   1. [ ] Yes  
   2. [ ] No

2. What is the name of NGOs which are supporting these facilities?  
   1. ________________________________

3. What support does the NGO provide?  
   [ ] 1. Financial subsidies  
   [ ] 2. Equipment or medical material  
   [ ] 3. Building  
   [ ] 4. Medical staffing  
   [ ] 5. Training for medical staff  
   [ ] 6. Provision of medicines or vaccines  
   [ ] 7. Other ____________________

4. Does this facility provide vaccinations as part of the EPI programme?  
   [ ] 1. Yes  
   [ ] 2. No [Finish interview and thank them for their time]

5. Which of the following vaccinations are available on the day of observation?  
   [ ] 1. BCG  
   [ ] 2. DTP1  
   [ ] 3. DTP3  
   [ ] 4. Pol3  
   [ ] 5. MCV1  
   [ ] 6. HEP B3  
   [ ] 7. Hib3  
   [ ] 8. RotaC  
   [ ] 9. PcV3

6. How many in the facility on day of observation are qualified to provide vaccinations to children?  
   1. ________________

7. Are vaccines administrated in a specific room?  
   [ ] 1. Yes
<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>8. Do the health workers have access to toilets at the health facility?</td>
<td></td>
<td>2. No</td>
</tr>
<tr>
<td>9. Is there a cold fridge in the facility?</td>
<td></td>
<td>2. No [Skip to Q15]</td>
</tr>
<tr>
<td>10. Who provided the cold fridge to the facility?</td>
<td></td>
<td>1. UNICEF</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2. MoPH</td>
</tr>
<tr>
<td></td>
<td></td>
<td>3. Other NGOs</td>
</tr>
<tr>
<td></td>
<td></td>
<td>4. Private donor</td>
</tr>
<tr>
<td>11. Are there currently vaccines being stored in the cold fridge?</td>
<td></td>
<td>1. Yes</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2. No</td>
</tr>
<tr>
<td>12. Why are there no vaccines stored in the cold fridge currently?</td>
<td></td>
<td>1. ____________________________________</td>
</tr>
<tr>
<td>13. Where is the cold fridge stored?</td>
<td></td>
<td>1. Within a doctor’s office</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2. Within the pharmacy in the facility</td>
</tr>
<tr>
<td></td>
<td></td>
<td>3. In a nurses’ office</td>
</tr>
<tr>
<td></td>
<td></td>
<td>4. In a storage room</td>
</tr>
<tr>
<td></td>
<td></td>
<td>5. Other ____________________</td>
</tr>
<tr>
<td>14. Should there be a power cut in the facility, what alternatives are in place to ensure vaccines are kept cool?</td>
<td></td>
<td>1. Generator</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2. Vaccines are moved to an alternative location</td>
</tr>
<tr>
<td></td>
<td></td>
<td>3. There are no alternatives</td>
</tr>
<tr>
<td></td>
<td></td>
<td>4. Other ____________________</td>
</tr>
<tr>
<td>15. Are there Education material on EPI available on the walls of the facility?</td>
<td></td>
<td>1. Yes</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2. No [Skip to Q 19]</td>
</tr>
<tr>
<td>16. Where do they Education materials come from?</td>
<td></td>
<td>1. UNICEF</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2. WHO</td>
</tr>
<tr>
<td></td>
<td></td>
<td>3. MoPH</td>
</tr>
<tr>
<td></td>
<td></td>
<td>4. Other NGOs</td>
</tr>
<tr>
<td></td>
<td></td>
<td>5. Facility provided them personally</td>
</tr>
<tr>
<td>17. What type of information on EPI is available for patients to view</td>
<td></td>
<td>1. The types of vaccines needed</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2. Vaccine schedules</td>
</tr>
<tr>
<td></td>
<td></td>
<td>3. Benefits of Vaccines</td>
</tr>
<tr>
<td></td>
<td></td>
<td>4. Information about individual vaccines</td>
</tr>
<tr>
<td></td>
<td></td>
<td>5. How to administer vaccines</td>
</tr>
<tr>
<td></td>
<td></td>
<td>6. Other ____________________</td>
</tr>
<tr>
<td>18. How long have these materials been on the wall? (assessing relevance)</td>
<td></td>
<td>1. Less than 6 months</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2. More than 6 months but less than a year</td>
</tr>
<tr>
<td></td>
<td></td>
<td>3. More than one year but less than 18 months</td>
</tr>
<tr>
<td></td>
<td></td>
<td>4. More than 18 months</td>
</tr>
<tr>
<td></td>
<td></td>
<td>5. 2 years +</td>
</tr>
<tr>
<td>19. Are pamphlets or brochures available to families about EPI?</td>
<td></td>
<td>1. Yes</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2. No</td>
</tr>
<tr>
<td>20. How many vaccines does the facility generally provide in a week?</td>
<td></td>
<td>1. ________________</td>
</tr>
<tr>
<td>21. What does the facility do with vaccines that are expired and can no longer be used?</td>
<td></td>
<td>1. ________________</td>
</tr>
<tr>
<td>22. What percentage of vaccines would the facility say are wasted?</td>
<td></td>
<td>1. ________________</td>
</tr>
<tr>
<td>Question</td>
<td>Answer Options</td>
<td></td>
</tr>
<tr>
<td>-------------------------------------------------------------------------</td>
<td>----------------</td>
<td></td>
</tr>
<tr>
<td>23. Are any anti–waste activities introduced to limit the rate of vaccination wastage?</td>
<td>1. Yes, 2. No [Skip to Q 25]</td>
<td></td>
</tr>
<tr>
<td>24. What are these activities?</td>
<td>1. ____________________________</td>
<td></td>
</tr>
<tr>
<td>25. Is there a process to redistribute non-expired unused vaccines?</td>
<td>1. Yes, 2. No [Skip to Q 27]</td>
<td></td>
</tr>
<tr>
<td>27. How regularly does the facility receive new vaccinations?</td>
<td>1. ____________________________</td>
<td></td>
</tr>
<tr>
<td>28. Does the facility consider this to be done within a considerable time frame?</td>
<td>1. Yes, 2. No</td>
<td></td>
</tr>
<tr>
<td>29. What percentage of patients would you suggest complete the full EPI schedule?</td>
<td>1. ____________________________</td>
<td></td>
</tr>
<tr>
<td>30. Is there a system at the Health Facility for registering children that have received vaccines?</td>
<td>1. Yes, online, 2. Yes, written [Skip to Q 28], 3. No [Skip to Q 28], 4. Other ____________________________ [Skip to Q 28]</td>
<td></td>
</tr>
<tr>
<td>31. Does the computer has an internet connection or software used to update the online registry?</td>
<td>1. Yes, 2. No</td>
<td></td>
</tr>
<tr>
<td>32. Is there a system to remind parents of their next vaccination appointment?</td>
<td>1. Yes, 2. No [Skip to Q 30]</td>
<td></td>
</tr>
<tr>
<td>33. How are parents reminded of the next vaccination appointment?</td>
<td>1. SMS, 2. Phone Call, 3. Other</td>
<td></td>
</tr>
<tr>
<td>34. Are there any costs involved in providing a child with a vaccine?</td>
<td>1. Yes, 2. No [Skip to Q 32]</td>
<td></td>
</tr>
<tr>
<td>35. What is the cost of providing a child a vaccine in LBP?</td>
<td>1. ____________________________</td>
<td></td>
</tr>
<tr>
<td>36. Who provides the vaccines to the facility?</td>
<td>1. ____________________________</td>
<td></td>
</tr>
<tr>
<td>37. What is the process of requesting more stock of vaccines?</td>
<td>1. ____________________________</td>
<td></td>
</tr>
<tr>
<td>38. Are there any vaccines which families are less likely to have administered?</td>
<td>1. BCG, 2. DTP1, 3. DTP3, 4. Pol3, 5. MCV1, 6. HEP B3, 7. Hib3, 8. RotaC, 9. PcV3, 10. No [ Skip to Q 36]</td>
<td></td>
</tr>
<tr>
<td>39. Why do some families prefer not to use these / this vaccine?</td>
<td>1. ____________________________</td>
<td></td>
</tr>
<tr>
<td>40. Would you say the EPI is working successfully in this facility?</td>
<td>1. Yes, 2. No</td>
<td></td>
</tr>
<tr>
<td>41. If no, what should be improved? If yes, what is the reason of considering it successful?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>--------------------------------------------------------------------------------------------</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Enumerator: Are there any additional observations you have about the clinic which may impact on the ability to administer vaccinations?</td>
<td>1.</td>
<td></td>
</tr>
</tbody>
</table>
ANNEX 4: TERMS OF REFERENCE

<table>
<thead>
<tr>
<th>Item</th>
<th>Service Description</th>
<th>Quantity</th>
<th>Unit</th>
<th>Unit Price</th>
<th>Price</th>
</tr>
</thead>
<tbody>
<tr>
<td>10</td>
<td>Evaluation of the immunization programme</td>
<td></td>
<td></td>
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</tbody>
</table>

PROJECT/ASSIGNMENT TITLE:
Evaluation of the immunization Programme Component within the UNICEF Country Programme in Lebanon (2013-2016)

Background:
Lebanon, the country of 10,452 km\(^2\) with approximately four million citizens struggle to withstand the social, economic and political impact of the Syrian conflict that started in March 2011. In March 2011, the number of registered displaced Syrians was 791 and increased to 274,227 in March 2013 and 1,011,366 in December 2016 based on UNHCR registration figures. While registration has been suspended; the official figure used in the Lebanon Crisis Response Plan for Displaced Syrians is 1,500,000, and 277,985 for the Palestinian Refugees in Lebanon. The percentage of children under five years within the displaced Syrian community is 17.6%; while the percentage for the same cohort for Lebanese is 5.49% and 9.33% for the Palestinian Refugees in Lebanon.

A stagnant economy, coupled with the threat of minor insecurity issues in some areas increase fears that children and families living in poverty will sink further into deprivation (nearly half of those affected by the Syrian crisis are children and adolescents).

As consequence of the on-going Syrian crisis, population augmentation of both host and displaced communities has resulted in gradually shrinking spaces for livelihood and income-generation which significantly impacts the ability for vulnerable children and their families to secure their basic needs.

During 2013 and 2014, isolated outbreaks of measles (1781 cases in 2013 and 235 cases in 2014) and mumps (736 cases in 2014) have been reported from different parts of the country. The occurrence of three epidemics of vaccine preventable childhood infections within two years period suggests that immunization coverage against these diseases is suboptimal. In addition, in 2013 and 2014, there were polio outbreaks in two neighboring countries which ultimately put Lebanon at risk of reintroduction of the wild polio virus owing to huge and frequent population movements to and from those countries.

To boost the EPI and vaccination coverage, the Ministry of Public Health (MoPH) provides free vaccines for healthcare facilities within the public sector. With the beginning of the refugee crisis, the nominal fees charged by some of those centers as consultation fees were identified as a potential barrier to the refugee families and to impoverished Lebanese families to have their children vaccinated. In 2015, the Ministry of Public Health (MoPH) addressed this obstacle by issuing a circular forbidding the centers to charge vaccination services even if the child needs medical consultation prior to vaccine and is constantly following-up on its implementation via multiple channels especially the beneficiary grievance system available.

In Lebanon, about 50% of the vaccination services is being provided by the public health sector. Because of the poor financial situation of most of the people-in-crisis to afford vaccination from the private sector, MoPH is paying intensive efforts to reach them around the country through multiple ways in collaboration with partners; though a significant proportion of these needs may remain unmet. As a result, it is likely that a certain number of children will have dropped out at a certain point of their vaccination schedule. A National EPI Coverage Cluster Survey has been implemented in 2016 and could be used for further action once finalized and approved.

Work quality in the dispensaries could be further enhanced. Despite the efforts made in monitoring the work in the health centers, the monitoring process is yet in need of further support because of the huge work load over the Primary Healthcare Department comprising the EPI and the shortage of monitoring personnel and lack of tools to monitor quality. In addition, the monitoring role of the Ministry of Public Health is limited to the health centers and dispensaries to which MoPH provides vaccines, while there is almost complete absence of any monitoring and supervision of the cold chain and supply quality of the vaccination services provided by the private sector. Moreover, the target population is calculated based on estimates and projection (in the absence of a national
Census since 1938), and therefore the denominator used to estimate coverage is not very accurate, while data on vaccination services taking place in the private sector is not retrievable which hinders the utilization of administrative reports to assess coverage, and the only means to calculate coverage is through EPI cluster surveys, that do not happen regularly.

The on-going Syrian conflict has posed challenges to the access, coverage and provision of quality immunization service in the country. The impact of the crisis has not only led to 1.3 million children vulnerable, including most Syrian refugee children along with poor and marginalized children from the Lebanese and Palestinian communities, but has also increased their needs and demand for routine immunization services across the country.

As part of UNICEF commitment to children right to enjoy of the highest attainable standard of health, Since the end of the civil war in Lebanon in 1991, UNICEF takes in charge the procurement procedures and quality assurance of all the vaccines imported in the country to be distributed by the MoPH.

Workplans between UNICEF and MoPH
In response to the Syrian crisis, UNICEF has developed with MoPH annual workplans following a result chain structure based on the Result Based Management (RBM) strategy. These workplans covered the health and nutrition, which immunization is a component of.

The workplans with MoPH focus mainly on the following results:
- The increase of routine vaccination coverage for children under five years.
- The increase of capacity building of MoPH staff and implementing partners.
- The sustainable provision of vaccines, supplies/equipments and cold chain;

In practical example of implementations that refers to the above results, since 2013 UNICEF took in charge to procure all the vaccines and drugs to the MoPH except for the PCV (Pneumococcal Conjugated Vaccine) destined to the Lebanese which is being financed by the Lebanese government as the rest of the vaccines. Grants fund the PCV13 vaccine to non-Lebanese provided by the MoPH. Those vaccines are provided by MoPH free of charge for all the health centres in the country: 220 PHC centres affiliated with the Ministry of Public Health, 220 Social Development Centres (SDC) affiliated with the Ministry of Social Affairs, and some 500 dispensaries. Vaccination campaigns were conducted on national level between 2013 and 2018.

UNICEF and partners supported the MOPH in delivering two series of training on Effective Vaccine Management to all vaccinators, and Regional expert training on vaccine supply management to Ministerial Immunization Officers. UNICEF assisted in funding newly recruited registered nurses and Information technology officers to work in central and zonal (district) MoPH health Offices and strengthen the monitoring and reporting of the national EPI program.

UNICEF continues to support MoSA with additional nurses to cover extra opening hours of social development centres that deliver immunization services.

UNICEF supported with strong cold chain equipment, namely 26 cold rooms (one in each district), 250 solar fridges and 500 Sibir Fridges distributed in all vaccination centres of the country. Those fridges are maintained and fixed when needed by a company hired by UNICEF.

Objectives, Purpose & Expected results:
The purpose of this formative evaluation is to allow UNICEF to learn from the outcome of the collaboration of UNICEF and Ministry of Public Health (MoPH) on the immunization programme, and provide recommendations to strengthen future plans.

UNICEF will be the primary user of the evaluation. The Ministry of Public Health (MoPH) and the implementing partners will be the secondary users. The evaluation will be an informative document to health stakeholders and to advisory agencies such as UNHCR, WHO, etc.

UNICEF will follow the findings and recommendations of the evaluation with a management response that will include actions points to be implemented in a defined time-period.

The main objectives of the evaluation are:
<table>
<thead>
<tr>
<th>Item</th>
<th>Service Description</th>
<th>Quantity</th>
<th>Unit</th>
<th>Unit Price</th>
<th>Price</th>
</tr>
</thead>
</table>

(i) Learn from previous experience of the annual work plans signed between Ministry of Public Health (MoPH) and UNICEF in matter of the immunization component.
(ii) Provide concrete recommendation to improve planning and implementation for achieving better results and reaching the most children in need, in matter of immunization.
(iii) Use the evaluation findings and recommendations to be considered in mid-review of the Country Program Document (CPD) 2017-2020 and in the planning of the 2018 Annual Work Plan with MoPH.

Scope of work:
a. The evaluation will cover the three key pillars in matter of immunization in the Annual Work Plans between UNICEF and MoPH. These pillars are covered within the Annual Work Plans between UNICEF and MoPH and they annexed to this TOR.

The three pillars are:
Pillar 1: the increase of routine vaccination coverage for children under five years. This also includes the vaccination campaigns.
Pillar 2: the capacity building of staff of MoPH and implementing partners.
Pillar 3: the provision of vaccines, supplies/equipment#s and cold chain to MoPH primary health care centers and dispensaries. And the technical training relevant to the use of these supplies/equipment and cold chain procedures.
b. Time-period covered by evaluation:
   The period from 2013 to 2018 will be considered as the time frame for the evaluation.

c. Timing of the evaluation
As previously mentioned, the evaluation findings and recommendations will be used in mid-review of the Country Program Document (CPD) 2017-2020 and in the planning of the 2018 Annual Work Plan with MoPH.

Evaluation questions:
The following are the key questions of the evaluation that are in line with OECD-DAC criteria (Organization for Economic Cooperation and Development Assistance Committee):

Relevance:
To what extent did the planning of immunization component in the annual work plans considered the needs to achieve results, in terms of capacity building, provision of supplies/equipment and cold chain and communication; taking into consideration Lebanon context in the time of the Syrian crisis?

Effectiveness:
To what extent was UNICEF support to the Ministry of Public Health (MoPH) appropriate and effective in supporting the national EPI program:
a. To what extent did UNICEF help to ensure that primary health care centers and dispensaries of MoPH network in all Lebanon were fully equipped and operational, so that all children benefited from the immunization programme?
b. To what extent were the training provided to health workers effective and useful? To what extent did they increase the capacity of health workers?
c. To what level were the stock, distribution and cold chain properly managed and implemented (cold chain maintenance, vaccine storage, temperature monitoring practices and assessment of vaccine and supplies wastage, etc.).
d. To what extent is MoPH satisfied about the collaboration with UNICEF?
e. What were the opportunities and barriers that facilitated or hindered the implementation of the immunization
programme? What were the opportunities and barriers of the immunization programme to be gender equitable?

Efficiency:
To what extent the immunization programme has improved in matter of cost efficiency along the years from 2013 to 2016?

Sustainability:
To what extent did the collaboration between UNICEF and MOPH enable MOPH to have the self-sufficient capacity to take on the tasks of planning, capacity building, implementing, monitoring and securing optimal coverage without the continued support of UNICEF?

Stakeholders:
A preliminary mapping of relevant stakeholders of the Immunization programme by the committee of the evaluation has identified the below list of stakeholders. In addition, these stakeholders are divided into four sub-categories depending on their relative level of interest and relative influence. This is intended to be a preliminary guide to assist in mapping out the key stakeholders who the team will engage with and tailor the products accordingly:

Low Influence and Low Interest:
- Local Communities
- Women
- Children (girls and boys)

Low Influence and high Interest:
- International/national NGOS
- Municipalities (Mayors)

High Influence and high Interest:
- MoPH
- MoSA
- WHO
- Beyond (implementing partner)
- Donors
- UNICEF
- UNHCR

Ethical considerations:
The evaluation research should undergo an institutional review. In line with the Standards for Evaluations in the UN System (developed by the UN Evaluation Group), all those engaged in designing, conducting and managing evaluation activities will aspire to conduct high quality and ethical work guided by professional standards and ethical and moral principles and should sit for an Internal Review Board (IRB) certification. The proposal must identify actual or potential ethical issues, as well as measures and methods adopted to mitigate against these issues. All interviewees will be informed with the purpose of the evaluation and their role and what information is required specifically from them. Confidentiality of their views is ensured. If interviewees will include minors, a written consent should be taken from the persons in charge of their care. All the documents, including data and fieldwork instruments, developed during this consultancy are the intellectual property of UNICEF.

Management of the evaluation and stakeholder roles
The evaluation will be managed by the Planning, Monitoring and Evaluation Specialist in coordination of the focal point from the Health and Nutrition section and MoPH team. UNICEF team will oversee the timely implementation of the evaluation work plan and provide overall guidance in the management of the evaluation process and will be the
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<th>Item</th>
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main contact point for the evaluation team within UNICEF.

The Planning, Monitoring and Evaluation team as evaluation manager will also be responsible for approving the inception report and pre-approve the final report. The final evaluation report will be approved by UNICEF Representative. The Planning, Monitoring and Evaluation team will manage and coordinate the management response in consultation with the Representative.

In addition, UNICEF team will support the coordination of the evaluation, by facilitating the evaluation team and providing necessary assistance, information to effectively support the Health and Nutrition Programme Evaluation. The Regional Office (RO) will also be involved in commenting on the draft deliverables. The Planning, Monitoring and Evaluation team with the Representative and in consultation with Chief of Health and Nutrition will give final approval for all the deliverables prior to final payment.

UNICEF team will be responsible in the evaluation of bids and act as the selection panel following the rules and regulations of UNICEF, which will be the contacting party.

The final evaluation report will be reviewed by the Planning Monitoring and Evaluation team, and by the health section team, then approved by the UNICEF representative.

The final evaluation report will be followed within 60-day period by the management response where action points will be taken based on the findings and recommendations.

The final report will also be translated to Arabic and communicated with the Ministry of Public Health in Lebanon.

Deliverables:
*Work progress should not occur during the review period. It is a non-working period for the consultant firm. Each submission will be made available electronically and will be addressed to the manager of the evaluation.

Phase 1:
- Task: Review background documentation, including reports on Immunization programme interventions, policies, guidelines, other Immunization evaluations in Lebanon and other countries that have similar context as Lebanon.
- Deliverables: Conceptual framework of the evaluation research.
- Timeline (Calendar Days): 10 days

Phase 2:
- Task 1: Develop an inception report on evaluation design and detailed methodology/tools, work plan for data collection, and data analysis outline/framework.
- Deliverables: Inception Report submitted to UNICEF Lebanon country office.
- Timeline (Calendar Days): 10 days

- Task 2: Review by MOPH, UNICEF Country Office and UNICEF Regional office
- Deliverables: Feedback and clearance of inception report.
- Timeline (Calendar Days): 15 days.

- Task 3: Provide final inception report.
- Deliverables: Submission of finalized inception report with incorporation of comments.
- Timeline (Calendar Days): 7 days.

Phase 3:
- Task: Data collection: Meet/interview/group discussion with relevant key stakeholders and beneficiaries.
- Deliverables: Interviews and group discussion with key stakeholders conducted in due time.
- Timeline (Calendar Days): 20 days.

Phase 4:
- Task 1: Perform analysis and produce draft preliminary findings and produce a draft evaluation report.
- Deliverables: Preliminary findings and draft evaluation report available and shared with UNICEF Lebanon
country office, regional office and other key stakeholders.
- Timeline (Calendar Days): 25 days

- Deliverables: Feedback.
- Timeline (Calendar Days): 15 days

- Task 3: Provide final evaluation report.
- Deliverables: Final evaluation report with an executive summary and a summary presentation to be submitted to
UNICEF Lebanon country office. The final report should be between 40 and 60 pages (excluding annexes).
- Timeline (Calendar Days): 7 days

*Work progress should not occur during the review period. It is a non-working period for the consultant firm.

Payment schedule:

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<tr>
<td>30% of total cost</td>
<td>Upon delivery of phase 1 &amp; 2 deliverables</td>
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<tr>
<td>30% of total cost</td>
<td>Upon finalization of phase 3</td>
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<tr>
<td>40% of total cost</td>
<td>Upon delivery of phase 4 deliverables</td>
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Methodology:
The methodology for this evaluation will mainly be qualitative in gaining insights from range of stakeholders and
analyzing available quantitative data and other relevant documents. The overall methodology should be
participatory and should ensure that the various social groups including the most marginalized will be reached and
their voices elicited.
It is expected that the evaluation will consider the geographical disparities and the gender when possible.
Triangulation of data through different tools and sources is considered fundamental.
It is expected that the evaluation will use the following methods at a minimum:

- Desk Review of key programme documents including UNICEF’s reports, relevant national documents,
researches, baseline surveys, studies and administrative data from MOPH.
- Key informant interviews with MOPH staff, partner staff, UNICEF staff.
- Focus group discussions with communities (mothers, fathers, caregivers having children under 5) in Beirut,
Mount Lebanon, Bekaa, Baalbeck Hermel, South, Nabatieh, Akkar, North.
- Exit interview with parents/caregivers who attend clinics.
- Structured observation of the immunization activities.

Existing information sources:
The following are some of the key information sources for the evaluation: additional documents could be provided
during the evaluation process if needed and available.
The consultant will be able to base his findings on the below documents; which many of them are official and
endorsed by UNICEF and MoPH. Knowing that some surveys/assessment were not subject to a peer review for
quality assurance.
- UNICEF and MoPH work plans
- HHRP 2015/2016
- LCRP strategy and progress reports
- Work plan and reports from Beyond
- Vulnerability Assessment for Syrian (VASyr; 2013 to 2016)
- Community Assessment: OCHA/UNICEF/REACH
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<td>- Baseline survey 2016 (when approved by MoPH)</td>
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<td>- Post Campaign Monitoring (PCM): WHO/MOPH</td>
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<td>- Feedback from EVM trainings</td>
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<td>- Rapid Poverty Assessment for Lebanese (UNDP 2016)</td>
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<td>- MOPH coverage data, review missions done in Lebanon</td>
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<tr>
<td>EPI cluster survey 2016 (if available)</td>
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Limitations:
The consultant might be confronted with some limitations in matter of:
- Limited availability of validated data related to immunization coverage. Non-validated data by MoPH cannot be used within the evaluation report.
- Previous implementing partner in matter of Health Program is no longer partner to UNICEF; which might limit access to some information for the years 2013-2016.
- Turn-over in UNICEF team. They key staff relevant to the immunization programme are not in Beirut office. The new staff might not have the same flow of information for the previous years of the programme.
- The population fatigue of assessment; that sometimes is translated in challenging recruitment for focus group discussion.

Responsibilities:
The consultant is responsible to produce the following by the stated deadlines:
- Desk review and submission of the inception report: 20 days
- Submission of finalized inception report after review: 7 days
- Data collection: 20 days
- Evaluation report draft submission: 25 days
- Final report finalized and summary of findings after review: 7 days

Reporting requirements:
- The consultant needs to meet UNICEF#s Quality Assurance requirements to an evaluation. Guidance and tools relevant to these requirements at any stage of work and respective deliverable: Inception report and Full evaluation report, as well as Ethical review requirements, will be shared with the selected service provider. (Annex: Evaluation quality assurance/ Ethical review).
- The report structure will be as per UNEG required standard, (Annexed: UNICEF-Adapted UNEG Evaluation Reports Standards)
- The Consultant will report to the Planning, Monitoring and Evaluation Specialist.
- The reports will be electronically submitted to the Planning, Monitoring and Evaluation Specialist.

Qualification Requirements:
- Team of Consultants: Work Experience and academic qualification.
- Team Leader(International):
  - Advanced University degree with at least 8 years of work experience (both international and national) in public health programming in both humanitarian and long term solutions;
  - A solid experience in conducting evaluations; quantitative and qualitative assessment expertise.
  - Excellent report writing and analytical skills in English;
  - Knowledge of Arabic language will be an asset;
  - Familiarity with UNICEF’s programming strategies and organizational culture
  - Previous experience in undertaking evaluations for health and nutrition programmes or similar work experience in the Region specifically in Lebanon will be an asset; experience in a humanitarian health emergency is a primary asset;
Previous experience in immunization programming
   Strong inter-personal, teamwork and organizational skills
   Familiarity with information technology, including proficiency in word processing, spreadsheets, and presentation software.

- Overall Consultant team requirements:
   University degree in one of the disciplines relevant to the following areas: Public Health a field relevant to international immunization related development assistance;
   Experience in both quantitative and qualitative methods
   Previous experience in undertaking evaluations especially for health and nutrition programmes is considered an advantage;
   Experience in application of quantitative and qualitative methods.
   Familiarity with UNICEF’s programming strategies and organizational culture;
   Familiarity with information technology, including proficiency in word processing, spreadsheets, and presentation software;
   Fluent in both English and Arabic languages.
   Consideration of gender parity within the team.

Timing/Duration of Contract:

UNICEF to receive the final evaluation report within calendar 109 days from the date of contract signature.

Duty Station:

Beirut

Administrative issues:

   Overall, management oversight will be provided by UNICEF; in coordination with MoPH
   The evaluation team is to be based in Lebanon for the entire period of the consultancy.
   The evaluation team will present the inception report and the findings of the evaluation prior to the submission of the report and the official review by UNICEF Lebanon Country Office and the Regional Office.
   Data collection cannot start before the reception of clearance from the Regional Office.

Project management:

The project will be managed by the Planning, Monitoring and Evaluation team in coordination with the Health and Nutrition section and MoPH team.

Annexes as separate files (attached in the e-mail with the LRPS): AWP with MOPH - 2014-2015/ AWP with MOPH # 2015/ AWP with MOPH # 2016/ UNEG_UNICEF_Eval_Report_Standards.

Evaluation of the immunization programme 1 PU