COVID-19 EMERGENCY APPEAL

LEBANON

ISSUED 17 JULY 2020

About

Following consultations with the Government of Lebanon's COVID Inter-Ministerial Committee and international partners to chart collective, coordinated and decisive action in response to the unprecedented health emergency confronting Lebanon, the Resident and Humanitarian Coordinator ad interim (RC/HC a.i.) and humanitarian partners launched this in-country emergency funding appeal on 7 May, and are now updating it to cover the needs until the end of 2020. The Lebanon Emergency Appeal aims to highlight critical areas of humanitarian intervention to protect the lives of people in Lebanon who are most acutely at risk due to the COVID-19 outbreak in the country and its immediate socio-economic impact, taking into consideration the broader situation in Lebanon.

This document brings together activities planned for in the World Health Organization (WHO)-led COVID-19 Strategic Preparedness Response Plan (SPRP) for Lebanon, the 2020 Lebanon Crisis Response Plan (LCRP), as well as new relief activities aiming to mitigate the combined impact of the economic crisis and COVID-19 on population groups not previously receiving humanitarian assistance. The document also aims to align local efforts with regional and global fundraising efforts including: the UN Multi Partner Trust Fund launched on 11 April; the COVID-19 Global Humanitarian Response Plan launched on 25 March (updated on 7 May and 16 July); the regional 3RP for Syria; and, the UNRWA regional appeal launched on 17 March in response to the COVID-19 outbreak. The local Lebanon Emergency Appeal plan will continue to be adjusted as required in view of the evolving situation.

PHOTO ON COVER

UNICEF is distributing personal protective equipment (PPEs) to PHCs across all governorates to protect health workers from contracting the coronavirus while treating patients - Photo: UNICEF® Lebanon

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This document was prepared by the Office for the Coordination of Humanitarian Affairs, on behalf of the United Nations and its partners in Lebanon.

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Woman gathering weeds and roots in Tripoli (Abou Samra), December 2019
Photo: OCHA/ Sebastian Brandt

Context of the Crisis

The COVID-19 outbreak in Lebanon came as the country was already in the midst of a crippling socio-economic crisis, with total collapse looming on the horizon. Lockdown and other measures further exacerbated existing difficulties. The dual impact of pressure on the Lebanese Pound (LBP), as well as reduced imports (at increased prices), has led to inflation with prices skyrocketing at a time when many people are losing their jobs or being paid at reduced wages. The value of the LBP against the US Dollar has dropped by an estimated 350 per cent in the unofficial exchange as at end June.

Lebanon applied wide-reaching lockdown measures since the Cabinet announced a "general mobilization" on 15 March, now in place until 2 August, to curb the spread of the virus. After nearly four months of closure, Beirut Rafic Hariri International Airport re-opened on 1 July for commercial flights, with 10 per cent of air traffic capacity in comparison to a year ago (2,000 passengers per day). With a spike in the number of cases recorded early July, one-third of which are identified as individuals who newly returned to Lebanon, there is increasing concern among the population that the possible end of general mobilization and opening of airport might lead to further increase in the number of clusters of cases and an overwhelming of the existing health system capacity.

Like in other parts of the world, the disease outbreak has put extra pressure on an already overburdened and under-resourced national health system. Despite the available medical human resources, the health system in Lebanon was already facing structural challenges, including around the import of medicine and equipment. As importantly, a significant decrease in the number of patients' visits in primary health care centres was reported between February and April, and the number of children vaccinated in primary health care centres and dispensaries almost halved, despite primary health care centres having maintained activities.

Beyond the health impact of the disease outbreak, the non-health consequences will be deeper and longer lasting, requiring a collective and whole-of-system approach. In January 2020, and due to the on-going financial and economic crisis, poverty levels were already projected to reach 52 per cent, with a doubling of extreme (food) poverty from 10 percent to 20 percent in 2020. The price of the food component of the survival minimum expenditure basket (SMEB) has increased by 109 per cent between September 2019 and May 2020, with the highest increase recorded between April and May 2020.[1]

The pandemic has further underscored pre-existing poor housing conditions of a large majority of both refugee and host populations living predominantly in urban dense settings, some inadequate and characterized by poor building conditions, lack of tenure security, overcrowding, lack of access to basic urban services or water, sanitation and hygiene facilities. At least half of the population is living in informality:[2] UN-Habitat estimates that the 'slum' to urban population in Lebanon was around 50 per cent[3] in the year 2001. This situation has been exacerbated by internal and external migration and population movements, thus threats to housing tenure are more likely found in informal areas. In the face of this pandemic, the lack of adequate housing has repercussions on society as a whole and is a direct threat to everyone's health and safety. Ensuring secure housing for all and the provision of essential services are crucial components of national efforts to contain the spread of the pandemic and prevent the loss of life.

1 VAM Update on food price trends, WFP, June 2020

2 Informality in this context refers to both informal areas and the informal economy, as featured in the Lebanon Urban Profile by UN-Habitat

3 UN-Habitat (2011), Lebanon Urban Profile

Estimated poverty levels among Syrian refugees have risen; the number of refugees below the extreme poverty life increased from 55 per cent, pre-crisis, to an estimated three quarters of the refugee population in the country. Similarly, poverty figures among Palestine refugees are expected to have increased from 65 per cent among Palestine refugees in Lebanon and 90 per cent among Palestine refugees from Syria, as recorded in 2015. Further, migrants stranded in Lebanon are particularly facing increased levels of unemployment, abuse, violence, and exploitation. According to an assessment by IOM,[4] 79 per cent of migrants surveyed reported having lost their income after the economic crisis in 2019, 32 per cent of which was reported after the COVID-19 lockdown.

Limited domestic production is a major challenge. Lebanon is heavily dependent on imports through the airports and seaports for food and other items, including medical supplies. Restrictions of movement, as well as public administration and municipal measures, have consequently decreased access to essential services. Health centres may present a flashpoint for increased inter-communal tensions. With decreased access to health care, compromised livelihoods, and increasing food insecurity, there are concerns regarding child health and nutritional status, and sexual and reproductive health. The health of children under age 5 is also more at risk, as well as their nutritional status and immunization. Funding shortages also threaten Water Establishments' ability to pump water and maintain networks in the immediate future, risking nationwide water and sanitation services, and affecting water quality at hospitals and efforts to mitigate the COVID-19 outbreak.

Protection needs have increased for women and girls, refugees and migrants (including domestic workers), people with disabilities, older people and other vulnerable groups. Pyscho-social support needs have alarmingly increased for children, youth, women and men due to anxiety over the situation, limited livelihoods opportunities and overall desperation. There is significant documentation[5] from the UN and the Government on the impact of COVID-19 on increasing gender-based violence, unpaid care work for all – with a disproportionate impact on women and girls and on women's engagement in the labour market – with women leaving the labour market at higher rates than men. Further, according to the Inter-Agency SGBV Task Force assessment, 54 per cent of interviewed individuals reported observing an increase of harassment, violence or abuse against women and girls in the households and community.[6] The risk of Sexual Exploitation and Abuse (SEA) may also be exacerbated, as evidenced in other contexts. Overall, there are increased risks in times of crisis, particularly for the most vulnerable. Meeting our commitments to Accountability to Affected Populations (AAP) and Protection from Sexual Exploitation and Abuse (PSEA) is therefore especially important.

4 Situation of migrant workers in Lebanon in light of economic crisis and COVID-19, IOM, June 2020

5 Gender Alert on COVID-19 in Lebanon. April 2020. https://arabstates.unwomen.org/en/digital-library/publications/2020/04/gender-alert-on-covid-19-lebanon

6 Impact of COVID-19 on the SGBV Situation in Lebanon. Inter-Agency SGBV Task Force Lebanon, May 2020

Response Plan and Priorities

The plan recognizes the leadership role of the Government of Lebanon in the response and is premised on the principle of a single health response for all those residing in Lebanon, without distinction based on gender, nationality or status. In line with the national COVID-19 Response Plan, the UN and its partners have identified four key priority workstreams required to immediately respond to current humanitarian needs and prevent their aggravation in the medium and long-term.

The planning for activities under each of the workstreams is based on needs identified through available information and analysis, including existing monitoring of impact of the COVID-19 outbreak on known vulnerable groups, epidemiological modelling of the disease progress, pre-crisis work on social protection and recent rapid assessments and analysis. Planning assumptions have been discussed within existing coordination mechanisms (Lebanon SPRP pillar working groups for Priorities 1 and 2, and the sectors under the LCRP for Priority 3), as well as with the Government's Inter-Ministerial Social Safety Net Task Force for Priority 4. Specifically, estimated needs were calculated based on the outbreak progress and projections for cases, using mainly Oxford Model for outbreak projection. A cross-priority review has been undertaken to avoid duplication. Funding requirements have been calculated based on target populations and accounting for confirmed resources, while discussions on re-programming of existing projects have been ongoing.

Each of these workstreams is led by designated UN agencies, which are ensuring appropriate coordination and involvement of partners, to allow for an efficient and effective response. Detailed discussions with government counterparts in terms of needs and resources for Priorities 1 and 2 have taken place as required through existing mechanisms. Additional support is also being provided to the Government's Disaster Risk Management (DRM) unit, at the national and sub-national levels, to facilitate a coordinated whole-of-Government response and strengthen the engagement with national and international partners.

Recognizing the particular role of WHO in leading the COVID-19 response, the RC/HC a.i., with the support of the Office for the Coordination of Humanitarian Affairs (OCHA) and the RC's Office, will aim to ensure the overall coherence of the international community's efforts and strategic coordination with the Government of Lebanon. Internally, the Humanitarian Country Team will serve as the strategic coordination body for the COVID-19 response, in consultation within the broader UN system through the UN Country Team. This should ensure a collective approach and mutual accountability on issues of strategic relevance, as well as cross-cutting issues, such as conflict-prevention and a 'Do No Harm' approach, human rights protection, GBV, and PSEA and AAP.

Priorities 1 and 2 (WHO and UNICEF lead): 1) Supporting the preparedness and response capacity of the Lebanese health system in coping with the COVID-19 emergency; and, 2) Strengthening the engagement of and communication with communities, supporting good hygiene practices and ensuring COVID-19 specific support services

There are an estimated 6 million individuals living in Lebanon – citizens, refugees, migrant workers and stateless people – who need to have access to adequate health services. Based on the available epidemiological data, it is estimated that approximately 600,000 people (10 per cent of total population, including Lebanese, migrants and refugees) will contract the infection over a period of two to three months. Of these, 120,000 will require some form of health care. An estimated 20,400 will be asymptomatic or have mild symptoms but will require isolation at home or in isolation centres. About 12,600 people will be severe or critical cases requiring hospitalization, and 3,600 among them will require intensive care. About 70 per cent of those hospitalized will require free medical assistance to be covered by the Government of Lebanon, and by UN agencies for the refugees and other vulnerable groups, including migrant workers.

The health response needs to be coherent and unified under the oversight of the Government of Lebanon and offer the same level of services to all those in need of health care. The Appeal seeks to reinforce the national hospitalization and surveillance capacity, while making provision for the cost of testing and treating for the most vulnerable individuals, including refugees. The plan also includes specific interventions for patients under treatment or recovering, who are living in overcrowded areas and are unable to self-isolate at home. Based on patient care pathway, affected patients with severe symptoms will need to be admitted to hospitals, while patients with mild symptoms or asymptomatic who live in crowded areas or have special needs will be admitted to isolation sites. Further, people exposed to affected patients and tested negative will be quarantined at home or referred to isolation/quarantine sites if they live in crowded areas. The UN proposes to support these isolation/quarantine sites with health-related human resources (nurses and medical supervisors), WASH facilities and services, personal protective equipment (PPE) and waste management, starter kits (minimal equipment and minor rehabilitation), and additional logistics and operational support on a selective basis, in cooperation with NGOs. Critical water and sanitation services, including the distributing infection prevention and control (IPC) kits and cloth masks, are provided to vulnerable populations across the country as part of infection prevention.

As the first health facility accessible to the community, primary health care centres are being equipped with PPE and other IPC supplies to serve as triage and outpatient care for most suspected cases. Staff working in 900 primary health care centres and dispensaries have been trained accordingly (using e-health tools) on triage of patients and on proper use and disposal of PPEs.

For cases of COVID-19 with alarming signs of respiratory complications, the Rafik Hariri University Hospital (RHUH) is the main hospital, while 11 other hospitals – at least one per governorate – are being upgraded to establish so-called "flu clinics" for testing and inpatient care of moderate and severe cases, should the RHUH capacity be saturated, with adequate laboratory tests, as well as specific training of staff. The testing capacity is progressively expanding; the plan is to ensure that the country can test up to 5,000 tests per day, as a large influx of travellers is expected in the coming few months, especially after the airport opens on 1 July. The procurement of required material for IPC, PPEs, intensive care unit (ICU) equipment and personnel, and testing kits is being facilitated through a collective supply chain mechanism. Quality control is ensured through external quality assurance programme, which five labs have adhered to and 24 are in the pipeline.

Quarantine centres for suspected cases and isolation centres for confirmed asymptomatic cases or cases with mild symptoms are needed to assist all vulnerable people (Lebanese, displaced people, refugees, migrants and other marginalized groups living in overcrowded areas) in order to avoid overloading hospitals. Municipalities, as well as UNHCR and UNRWA for the Syrian and Palestine refugee populations, and UNICEF for mixed population groups particularly migrants, are establishing such centres in all governorates of the country. To date 38 centres have been assessed and approved by the Government; the official decrees for organizing management, support, and accountability frameworks have been issued.

Based on lessons learnt during the response to a cluster of cases among migrant communities in overcrowded settings, UNICEF, IOM, and ILO in partnership with the Ministries of Interior and Municipalities (MoIM), Ministry of Labour and the Office of the Prime Minister have initiated stronger outreach, through new communication channels, partners and awareness in the languages of migrants, to address the risk communication and referral information gaps among migrant workers. Further, the UN and partners are currently working on filling the gap of response and ensuring coordinated response to all populations by expanding the scope of and strengthening existing Rapid Reponse Teams (RRTs), initially established within the LCRP structure to respond to emergencies affecting Syrian refugees and vulnerable Lebanese in the context of COVID-19 national response.

In collaboration with the Ministry of Public Health (MoPH) and other Ministries, NGOs and civil society organizations such as the Lebanese Red Cross Society, a Risk Communication and Community Engagement (RCCE) Strategy and Action Plan has been developed. The strategy outlines interventions for the development of initiatives to establish integrated RCCE systems and processes and enhance partnership and build capacity. The plan also includes interventions to raise public awareness, cultivate community mobilization and engagement, change behaviours and assess impact for possible adjustments of on-going interventions.

As part of this strategy, work is ongoing with the Government and civil society to ensure all communities are provided, through adequate communication channels, with evidence-based guidance on prevention, mitigation and management of COVID-19 mild cases and referrals for severe cases. The adoption of specific activities to counter misinformation, fake news, scapegoating and stigmatization is a critical component of this workstream. Similarly, it is vital to ensure

that communication with and feedback from vulnerable communities, including refugees and migrants, are informing programming and advocacy. Given increased protection risks, specific attention is placed on informing vulnerable communities, including people with disabilities, about their rights, expected standard of conduct of actors providing services and assistance, PSEA and how to report misconduct, including SEA allegations.

The support to local communities, municipalities and governors involves the development and dissemination of technical guidance and the provision of support to ensure enhanced hygiene and handwashing practices by citizens, particularly in dense settings, and in public spaces and institutions at the country and local-level. It also foresees communication and awareness raising to the communities on how to protect themselves from virus transmission, and efforts to address stigma, social tension and psycho-social distress resulted from people's fears and effects of confinement.

Key messages are widely disseminated through different channels, including on the importance of report cases to the MoPH, and seeking treatment and medical support in public hospitals and primary health care centres. Affordability and accessibility to primary health care has become increasingly challenging for vulnerable population groups, with the main barriers being transport, fear of contagion, and financial constraints due to lack of income combined with inflation, further exacerbated by the ongoing economic crisis and during the lockdown. Misconceptions around the audience of primary health centres and the quality of the public health system are further obstacles.

COSTING Priority 1 and 2 (as reflected in the CPRP):

US$110,185,759

Priority 3 (UNHCR and UNDP co-lead): Ensure uninterrupted delivery of critical assistance and services to the most vulnerable communities affected by the Syria crisis, including refugees and host communities, in the context of the COVID-19 pandemic and severe economic crisis

The LCRP supports the COVID-19 preparedness and response through an integrated approach as many of the preparedness and response mechanisms cut across population cohorts and are multi-sectoral. Considering the tension landscape in Lebanon, it is crucial that all interventions are protection-centered and consider conflict sensitivity and do no harm approaches, due to the high risk of negative impact on communal relations. Equal access to services for all population cohorts is essential.

Through the LCRP structure, we aim to ensure that: 1) Critical LCRP interventions needed to ensure life-saving access to services and protection of the most vulnerable displaced persons from Syria and vulnerable Lebanese continue in line with the LCRP Business Continuity Plan; 2) prevention and response activities, particularly related to home isolation in overcrowded areas, are taking place according to SOPs; and, 3) support to communication and community engagement through trusted and credible channels using a risk communication and community engagement approach with harmonized messaging.

To mitigate the COVID-19 impact on LCRP operations, a Business Continuity Plan has been put in place. This plan aims to safeguard LCRP's critical operations and follows a risk mitigation approach. In June, the BCP was updated as the country started to ease the confinement measures which introduced new opportunities for LCRP partners to resume suspended activities. However, as the needs are growing, additional funding is required to ensure that critical assistance can continue. Considering the need to shift modalities and activities, donor flexibility is essential. The outbreak of COVID-19 is expected to substantially exacerbate the effects of the economic crisis on refugees and vulnerable Lebanese. To reduce the risks, additional support is needed, with priority to the most vulnerable non-refugee groups, especially women, girls, people with specific needs and elderly people.

There is an estimated 1.5 million displaced Syrians, around 51 per cent are women and 54 per cent children, and 1.5 million Lebanese whose vulnerabilities have been exacerbated by the Syrian crisis, the socio-economic situation and now COVID-19. The affected population also includes an estimated 27,700 Palestinian refugees from Syria and 180,000 Palestinian refugees from Lebanon. The additional funds being requested under Priority 3 will enable LCRP partners to continue to support these populations through protection and direct assistance, including emergency food and multi-purpose cash assistance, hygiene awareness and promotion, water supplies and sanitation services, child protection and support to GBV survivors – namely domestic or intimate partner violence. In addition, access to services will be better ensured by supporting public institutions, such as primary health care centres and hospitals by protecting health workers, providing routine immunization, making acute and chronic medication available and ensuring maternal and childcare. For example, preparations have begun to re-launch the second phase of the measles and polio vaccination campaign that was initially planned for January 2020 and will now start in September 2020. These types of initiatives are essential as they will help to reduce dependency on the health care system later on. For the Education sector, suspension of formal and non-formal education over the last couple of months disrupted learning for all Lebanese and non-Lebanese children. The enrolment trends for refugee children have decreased and drop-out rates from school are high (especially in cycle 3 between grade 7 and 9). The development and implementation of flexible distance/home-based or blended education programmes are required. Preparation for the resumption of formal and non-formal education in a safe learning environment is also needed.

Reports show that the pandemic has clearly exacerbated the economic and social problems many workers have long been facing in Lebanon and highlight the need to move quickly to provide the additional support these workers and the businesses employing them need, such as immediate short-term job creation and cash assistance. The current COVID-19 crisis is putting an additional burden on farmers as organizations reduced their field interventions and farmers are not able to sell their produce due to mobility restrictions. Emergency measures to continue agricultural activities for vulnerable Lebanese farmers are urgently needed.

COSTING Priority 3 (LCRP):

US$302,659,693

Priority 4 (WFP and UNRWA co-leads): Expand support to vulnerable population groups not included in the LCRP, in need of humanitarian assistance due to the combined socio-economic impact of the economic and banking crisis and COVID-19

Economic and social vulnerabilities have significantly increased since mid-2019, and food prices soared by 109 per cent between September 2019 and May 2020.[7] It was reported that a total of 430,000 people, equivalent to 32 per cent of the workforce, have lost their jobs [Infopro], and many are likely being pushed into the informal sector. In addition, access to basic services has been increasingly challenging, with a quarter of acute medications out of stock in December, salaries of frontline staff reduced or unpaid, and a dramatic drop in collection of utility fees [Inter-Agency, February 2020]. Economic growth had ground to a halt by the end of 2019 and will be further impacted by the default on debt repayment.

The outbreak of the COVID-19 substantially exacerbated the already severe effects of the economic and banking crisis in Lebanon, as the "lockdown" measures needed to contain the spread of the infection led to further businesses closures, reduction or suspension of salaries, and people staying at home without work. The recent survey[8] assessing the impact of the economic and COVID-19 crisis in Lebanon conducted from April to May 2020 revealed that 62 per cent of both Lebanese and Palestine refugees have suffered from income losses, compared to last year, and 52 per cent of Lebanese and 60 per cent of Palestine refugees have either lost their jobs or their salary was reduced. Further, 50 per cent of Lebanese and 63 per cent of Palestine refugees felt worried about not having enough food to eat in the last month.

Immediate social assistance to provide economic support is necessary, with priority to extremely poor Lebanese households and refugees previously not receiving relief assistance. This is coherent with the announced Government plans to provide emergency cash assistance to poor and vulnerable Lebanese households, including those with disabilities, the elderly and children. The cash and in-kind assistance envisaged in this Appeal will bridge the gap until the eventual scale-up of social protection measures foreseen by the Government in cooperation with the World Bank and complements the emergency cash support that the Government has started to provide. Targeting for in-kind food assistance under this workstream includes deduplication with the National Poverty Targeting Programme food e-card beneficiary lists which ensures there will be no duplication of assistance. Under this workstream, an estimated 257,000 Palestine refugees and other individuals eligible for UNRWA support will received cash assistance equivalent to half of the minimum food survival requirements. Further, provision is also being made for distance learning activities by UNRWA for 38,000 Palestine refugee children who cannot go to school in view of the situation.

Given the financial constrains exerted on Palestine refugee families living in Lebanon due to the tangible deterioration in the economic circumstances driven by the crisis and exacerbated by COVID-19, UNRWA expects a substantial increase of Palestine refugee children transferring from Lebanese private and governmental schools to UNRWA schools in the upcoming scholastic year 2020/2021. This could occur due to the unaffordable tuition fees of private schools and insufficient number of places in government schools where preference will be given to Lebanese students. This will lead to significant increase in the costs for the provision of new teachers' salaries, space within installations, textbooks, earning materials, stationary and other running costs.

Migrants stranded in Lebanon are facing increased levels of unemployment, abuse, violence and exploitation. According to the needs and vulnerability assessment conducted by IOM in May 2020, nearly 40 per cent of migrants surveyed are food insecure. Migrants in illegal or irregular status, or in sponsorship system (under the *Kafala* system) find it increasingly difficult to access much needed and life-saving humanitarian assistance. Given these circumstances, repatriation to their countries of origin should be considered for at least the most vulnerable, including people with significant medical conditions, pregnant women. In addition, a more detailed needs and vulnerability assessment of migrant workers will be conducted under this Priority 4, as the lack of existing information on the population, vulnerabilities, and protection risks faced by migrant community has been the challenge in establishing an effective and holistic response. Monthly cash transfers to identified vulnerable migrants to cover monthly basic needs, provision of other services such as psycho-social support, as well as assistance for voluntary returns to their countries of origin are also envisioned.

Finally, support will be provided in the form of cash-for-work to undertake the refurbishment of select venues identified as isolation centres to be managed by municipalities. This will boost the local economy in different regions and will ensure revenues to new vulnerable populations across beneficiary cohorts, including in urban poor neighbourhoods not previously targeted by the LCRP. COVID-19-related small businesses will also be promoted at the municipal-level to produce masks and other COVID-19 disinfection, materials and goods to be used by municipalities. This will involve a value chain impact as other businesses will be reactivated and will ensure revenues to vulnerable groups including women and youth.

COSTING Priority 4:

US$60,623,080

Total Lebanon Emergency Appeal requirement: US$473,468,532

7 Assessing the Impact of the Economic and COVID-19 Crisis in Lebanon. WFP, June 2020. Reference https://docs.wfp.org/api/documents/WFP-0000116784/download/

8 Assessing the Impact of the Economic and COVID-19 Crisis in Lebanon. WFP, June 2020. Reference https://docs.wfp.org/api/documents/WFP-0000116784/download/

#	PRIORITY	LEAD AGENCY	REQUIREMENTS (US$)
P01	Supporting the preparedness and response capacity of the Lebanese health system in coping with the COVID-19 emergency	WHO	
P02	Strengthening the engagement of and communication with communities, supporting good hygiene practices and ensuring COVID-19 specific support services	UNICEF	
	Costing Priority 1 and 2 (as reflected in the CPRP)		**$110.2 M**
P03	Ensure uninterrupted delivery of critical assistance and services to the most vulnerable communities affected by the Syria crisis, including refugees and host communities, in the context of the COVID-19 pandemic and severe economic crisis	UNHCR UNDP	**$302.7 M**
P04	Expand support to vulnerable population groups not included in the LCRP, in need of humanitarian assistance due to the combined socio-economic impact of the economic and banking crisis and COVID-19	WFP UNRWA	**$60.6 M**
	Total Lebanon Emergency Appeal requirement		**$473.5 M**

COSTING PRIORITIES

Critical WASH support to vulnerable populations
Photo: Norwegian Refugee Council

Annex I

Priority 1

Supporting the preparedness and response capacity of the Lebanese health system in coping with the COVID-19 emergency - WHO Lead

Priority 2

Strengthening the engagement of and communication with communities, supporting good hygiene practices and ensuring COVID-19 specific support services - UNICEF Lead

PILLAR	DESCRIPTION	TARGET	ESTIMATED FUNDING NEEDS (US$)	PARTNERS
COORDINATION, PLANNING AND MONITORING	• National Disaster Risk Management Unit supported to: (a) assist with national and regional level planning for the implementation of the COVID-19 response; and, (b) to promote business continuity of other key sectors and Ministries based on indicators agreed by relevant Government institutions. • Gender and protection considerations addressed and integrated throughout the response. • Protection from sexual exploitation and abuse (SEA) is strongly integrated in the response, including among health care actors, through trainings/awareness session on PSEA and increased capacity of frontline staff to safely and confidentially handle reports of SGBV and SEA to ensure survivors receive quick and appropriate assistance and support.	N/A	**$150,000**	WHO, UNWOMEN, UNDP, OCHA, UNICEF, UNHCR, UNRWA.

Mobile Medical Unit (MMU) performing PCR test- Photo: Humedica

PILLAR	DESCRIPTION	TARGET	ESTIMATED FUNDING NEEDS (US$)	PARTNERS
RISK COMMUNICATION AND COMMUNITY ENGAGEMENT	• In collaboration with the Government of Lebanon (GoL), communicate with communities through adapted mechanisms and provide evidence-based guidance about COVID-19 prevention, mitigation and case management through multiple communication channels including TV, social media channels, individual SMS and in dedicated communication with community channels. • Strengthen the Ministry of Public Health (MoPH) hotline. • In collaboration with MoPH, develop and implement a Risk Communication and Community Engagement (RCCE) strategy to fight against fake news, scapegoating and stigmatization, as well as to increase awareness of the patient flow between municipalities, primary health care centres, isolation centres and other support services such as social assistance, mental and psycho-social support, specific needs interventions, and infection prevention and control (IPC). • Support the development and dissemination of technical guidance and provide additional support to governors and municipalities to ensure enhanced hygiene practices in public spaces and institutions. • Support municipalities and local communities as relevant in coordinating and planning provision of various support services for mild COVID-19 cases and their families in collaboration with civil society and local private sector.	Communication: All population groups Community engagement: most vulnerable individuals through municipalities, CSOs, religious leaders, community initiatives and leaders as required for concerned most vulnerable groups and taking into account their specific needs (including gender, age, disability). Includes: **1,156,000 people** for direct outreach to most vulnerable communities through CSOs and public partners. **1,000,000 people** for establishment of feedback mechanisms and complaint mechanisms; monitoring of social media; tracking and respond to misinformation; hotlines; development and dissemination of awareness material.	**$6,232,000** UNDP: $250,000 UNICEF: $3,532,000 UNFPA: $350,000 UNHABITAT: $2,000,000 WHO: $100,000	UNICEF, UNDP, UNHCR, UNRWA, OHCHR, MSF, Mouvement Social, Balamand University, International Orthodox Christian Charities (IOCC), CRC, IMC, Lebanese Red Cross (LRC), Alef, CLDH, Relief International (RI)
SURVEILLANCE/RAPID RESPONSE TEAMS/ CASE INVESTIGATION	• Active case finding (6 million people - Lebanese, Syrian and Palestine refugees, as well as refugees of other nationalities, and migrants) through contact tracing in line with WHO guidelines (monitoring patients, and tracing all contacts in household, community, and healthcare workers' contacts). Positive COVID-19 cases for refugees either hospitalized or treated at home or in isolation centres. • Event-Based Surveillance: a call centre is already being supported to enhance event-based surveillance through community reporting for all communities including refugees. • Support the establishment of testing facilities in 11 hospitals (at least one per governorate) that will be upgraded as "flu clinics" for testing and inpatient care of moderate cases. • Enhancement and expansion of influenza-like illness (ILI) surveillance standards to include healthcare centres and public and private physicians (Lebanese and Syrians) to monitor possible community transmission.	**6 million people**	**$920,000** UNHCR: $50,000 WHO: $870,000 Costs include support staff to MoPH, training, logistics (drivers / transportation of specimen) and automation of the reporting system	WHO, UNHCR, Order of Physicians, Humedica, RI, ACF

PILLAR	DESCRIPTION	TARGET	ESTIMATED FUNDING NEEDS (US$)	PARTNERS
POINTS OF ENTRY	• Airport point of entry, as well five border points with Syria (including Masnaa and Arida) are being reinforced. • UNICEF, in collaboration with IOCC and MopH has: (i) increased the number of registered nurses serving at land borders and equipped each point with IPC and PPE supplies and training; and, (ii) with WHO, supported the replenishment of PPE materials at the airport, to cope with the repatriations. • Once borders re-open there will be a need to enhance the screening at the PoE, including additional staff, e- information system linked to the COVID-19 surveillance, awareness-raising campaign for travellers, and maintaining for every child crossing the border the systematic immunization against polio and measles.		**$433,000** IOM: $23,000 UNICEF: $210,000 WHO: $200,000	IOM, UNICEF, WHO, ICRC, Order of Nurses, IOCC, LRC, MSF
NATIONAL LABORATORIES	• In line with WHO advice, scaling up the testing programmes is the best response to slowing the advance of COVID-19. More testing kits are urgently needed. Rafiq Hariri University Hospital (RHUH) was initially performing 250-300 tests per day, with the private sector testing an additional 200 cases per day. There is a need to increase the number of tests per day to 2,000. • Support will be provided to the MoPH and Epidemiology and Surveillance Unit (ESU) team to expand the ILI to at least 25 additional sites. The support includes: capacity building, provision of information technology communication equipment, human resources support staff. This activity will be implemented directly by WHO, in coordination with the MoPH. • A selected number of peripheral public hospital labs will need to be upgraded in terms of testing capacity and biosafety measures. Intervention includes procurement of kits and reagents and supplies, and selected equipment.	6 million people	**$8,241,000** UNRWA: $500,000 WHO: $7,741,000	UNRWA, WHO, RI, MSF, PU-AMI

INFECTION PREVENTION AND CONTROL	• IPC practices in ambulances and health facilities (T1 reference hospitals with 27 ICU, laboratories, flu clinics in 11 hospitals at governorate level, 235 PHCs as triage points, and five land border point and one airport PoE quarantine shelters) should be enhanced to abide by IPC measures, during transport and treatment of patients with COVID-19, and prevent nosocomial contamination to staff, to non-case patients and further to other patients or visitors and the community. Personal protective equipment (PPE) with hygiene practices like hand-washing and social distancing are the main barriers against the spread of the disease. Procurement of PPEs is needed for healthcare workers working in laboratories, COVID-19 designated referral hospitals, flu clinics and UNRWA health facilities. • IPC and PPE equipment will be provided to primary health care centres which contribute to referral of mild individual cases while continuing routine services such as immunization, maternal new-born child and adolescent health. • IPC and PPE equipment, including for management of medical waste, are also foreseen for home isolation in vulnerable locations, public spaces, schools, Social Development Centres, and others. • Mobile handwashing stations and garbage containers specific for medical waste are supplied in the 30 most vulnerable urban localities along with awareness raising campaigns and technical support to municipalities.	Public institutions, including elderly homes, providing services to the most vulnerable population groups are supported with IPC packages, disinfection supplies, services and medical waste; Non-health front line humanitarian workers are provided with PPEs; Most vulnerable among the affected populations (estimated to 65 per cent of the total) are provided with IPC material; Medical waste garbage containers provided to 30 most vulnerable urban localities.	**$28,724,000** IOM: $168,000 UN-HABITAT: $1,500,000 UNFPA: $300,000 UNICEF: $21,539,000 WHO: $5,217,000 Other costs relate to assessment of IPC capacity at all levels, development and printing of materials and visual alerts, capacity building, awareness-raising and community engagement.	IOM, UNICEF, WHO, UNHCR, UNRWA, UNFPA, UNHABITAT, Order of Nurses, YMCA, LRC, AMEL, IMC, NRC, MDM, NCA, Intersos, Concern Worldwide, Relief International, Medical Teams International, Solidarites international, GVC, Welfare Association (Taawon), ACF, CARE, PU-AMI

UNICEF warehouse, where PPEs are stocked before distribution to partners and PHCs
Photo: UNICEF® Lebanon

PILLAR	DESCRIPTION	TARGET	ESTIMATED FUNDING NEEDS (US$)	PARTNERS
CASE MANAGEMENT AT PRIMARY HEALTHCARE LEVEL COMMUNITY LEVEL	Expand capacity of Community Case Management • The current PHC network at the MoPH is widely distributed across the country, with 235 PHC centres and some 800 dispensaries. It is estimated to serve around 1,000,000 vulnerable Lebanese and non-Lebanese, including Syrian refugees. In the event of community spread of COVID-19, the PHC centres will serve as first accessible point for triage and outpatient treatment for the vast majority of cases for these vulnerable groups that cannot afford private physician consultation. PHCs are to be used as "tier 1" level response, with additional community awareness and sensitization as most of the current centres do not have the necessary human resources to deal with COVID-19 cases. • All 235 PHCs will be provided with the testing kits, basic PPEs and IPC materials (hand sanitizer, etc.) for nurses and doctors, and will be trained on triage of suspected cases, providing medical care and advice. • For mild and moderate cases with alarm signs for respiratory complications, 11 hospitals – at least one per governorate – are upgraded to establish "flu clinics", with adequate laboratory testing (external safe spaces/kiosks, lab equipment, supplies), sufficient inpatient capacity and training of human resources. This is also an opportunity for increasing the testing capacity at the periphery (including with possible drive-through testing) and decongest the ERs, allowing identification of cases for self-isolation or quarantine in community shelter to avoid larger spread of contamination. • These 11 "flu clinics" in hospitals will be supported to account for the extra staff, with IPC and PPE supplies, equipment needed including waste management of these supplies, and the operationalization of the flu clinic to serve everyone in need across Lebanon.	1,000,000 vulnerable Lebanese and Syrian refugees through 235 PHC COVID-19 triage points; 10,000 patients among the most vulnerable groups seeking outpatient health care in flu-clinics;	**$1,400,000** WHO: $1,400,000 Costs include the procurement of selected supplies including PPEs for health workers, equipment (such as for drive through testing), and human resources and training.	WHO, UNICEF, LRC, AMEL, MSF, IMC, PU AMI, RI

PILLAR	DESCRIPTION	TARGET	ESTIMATED FUNDING NEEDS (US$)	PARTNERS
CASE MANAGEMENT AT SECONDARY HEALTHCARE LEVEL SEVERE CASES	Expand hospital case management capacity of Lebanon's health system. • Capacity of ICU services for COVID-19 severe and critical cases in public hospitals will be provided with minor rehabilitation, provision of equipment, capacity building and human resources reinforcement; rehabilitation works will be outsourced (national expert, bill of quantity, bidding according to WHO rules and regulations); procurement and capacity building activities will be done by WHO. Comprehensive medical, nutritional, and psycho-social care for those with COVID-19 will be ensured. • From 6 million people, a population of 600,000 (10 per cent) will be infected and 120,000 (20 per cent) will require care. Of those who seek care 3 per cent will need ICU services (3,600 over a period of 6 to 8 weeks). It is estimated that at the peak of the outbreak, around 700 ICU beds will be needed to be operating simultaneously. On average each patient will need seven days in ICU, at a cost of $700 per day. • UNHCR and UNRWA will cover the costs for ICU treatment of Syrian and Palestine refugees. Remuneration of care for vulnerable Lebanese is included. • Initially the public sector had only 140 ICU beds, while 300 beds will have to be availed by the private sector. Additional funds are needed to procure the needed equipment to ensure a capacity of 700 ICU beds.	For ICU and hospital improvements, support provided to eight public hospitals; For reimbursement of costs for vulnerable individuals, calculation is based on estimates of 65 per cent of patients being unable to afford needed care (30 per cent of whom are refugees).	**$30,904,159** UNHCR: $5,000,000 UNRWA: $10,093,659 WHO: $15,810,500 The estimated costs include the expansion of ICU capacity in terms of infrastructure and equipment to ensure access for everyone in need in Lebanon, as well as reimbursment of care for vulnerable populations.	WHO, UNHCR, UNRWA, RI
ISOLATION AND SELF-ISOLATION ASYMPTOMATIC OR MILD CASES	• If the virus spreads, people who test positive and are asymptomatic or with mild symptoms should recover without hospitalization in a contained space, away from their families and the general public. Isolation spaces are be needed for those unable to isolate at home. • The estimated cost for isolation centres includes support staff (at least two registered nurse per facility, and a medical doctor on call, rental subsidy, mental health and psycho-social support activities, and partial food support). • Municipalities are establishing isolation shelters, especially for those cases coming from overcrowded locations (including refugees), as well as mechanisms for self-isolation. These centres will require medical and security oversight as well as capacity to manage basic services including psycho-social support while catering to those with special needs in consideration of age, gender and disability. • UNHCR and UNRWA are also establishing dedicated isolation centres in areas with large proportion of refugees in informal settlements and refugee camps.	Patients who do not have the capacity to self-isolate and therefore should have access to dedicated isolation centres through a mix of Government and UN/partners-run locations	**$26,639,100** IOM: $700,000 UNDP: $1,900,000 UNICEF: $3,338,000 UNHCR: $10,300,000 UNRWA: $1,121,100 WHO & NGOs: $12,280,000	WHO, UNICEF, UNDP, UNHABITAT, UNHCR, UNRWA, RI, PUAMI, Medair

PILLAR	DESCRIPTION	TARGET	ESTIMATED FUNDING NEEDS (US$)	PARTNERS
COMPREHENSIVE PSYCHOSOCIAL CARE AND PROTECTION	• Avail remote mental health and psychosocial support for persons with COVID-19 and their families (including prevention of child separation). • Ensure equitable access to mental health services for children and adolescents. • Ensure comprehensive psycho-social care and protection-related case management procedures.	Estimated 4,200 most vulnerable patients with mental illness; 1,800 children in need of psycho-social support; 200 children requiring intense case management (e.g. separated children); 1,200 children indirectly supported with PSS kits in their home; 1,200 women supported through safe spaces (remotely); and, around 200 individuals to benefit from capacity-building on PSS.	**$3,117,500** UNFPA: $402,500 UNICEF: $715,000 WHO: $2,000,000	UNFPA. WHO, UNICEF, RI, MDM
EMERGENCY REFERRAL	• The Lebanese Red Cross, as the one referral service in the country, requires additional support in terms of advanced PPEs and refresher training on the management of severe acute respiratory infections, and COVID-19 specific protocols on case management and transportation measures.		**$200,000**	WHO
	• A national expert should be recruited to assess the burden on the local health system, and capacity to safely deliver primary healthcare services.		**$125,000**	WHO
	• Awareness-raising activities for the self-care of patients with mild COVID-19 symptoms, including guidance on when referral to healthcare facilities is required.		**$50,000**	WHO
RESEARCH IMPLEMENTATION OF CLINICAL TRIALS	• Lebanon has agreed to be enrolled in the randomized clinical trial on the use of therapeutic agents to COVID-19 patients. The cost includes provision of some medications for the clinical trial.		**$50,000**	WHO

Priority 3

Ensure uninterrupted delivery of critical assistance and services to the most vulnerable communities affected by the Syria crisis, including refugees and host communities, as foreseen in the LCRP Business Continuity Plan - UNHCR and UNDP co-lead

SECTOR	DESCRIPTION	ESTIMATED FUNDING NEEDS (US$)
PROTECTION	• Individual case management child protection and GBV interventions for cases which are prioritized in line with context dynamics (opening and/or closures of services and access to communities). • Communication costs support to 15,150 caregivers, individuals and case workers to ensure both child protection and GBV case management remote modalities. • Material support to GBV survivors and to children in need of psychosocial support through the provision of kits. • Safe shelters for 90 SGBV survivors. • Specialized services and case management for children at risk. • 8,900 PPEs to facilitate urgent follow-up for cases. • MHPSS - for the most vulnerable children and their caregivers through remote support sessions as well as support to national campaigns. • 50,000 dignity kits; and, • Top up of emergency cash assistance to address protection shocks, heightened protection threats and exacerbated vulnerabilities for persons at risk, child protection cases and GBV survivors.	**$3,935,000** Includes: $600,000 to assist families with children; $1,000,000 for dignity kits; $704,000 emergency cash for survivors.
FOOD SECURITY AND AGRICULTURE	• Emergency measures to continue agricultural activities for 25,000 vulnerable Lebanese farmers. • Food assistance to 93,650 vulnerable HHs (including Syrians, Lebanese and Palestine refugees) • Cash for food assistance to 420,000 vulnerable Syrians.	**$101,218,000** Includes: $18,675,000 support to Lebanese farmers; $82,543,000 in kind and cash assistance for food.
BASIC ASSISTANCE	• Emergency multi-purpose cash grant for vulnerable individuals not receiving cash assistance (100,793 SYR, 42,935 LEB and 9,160 PRS/PRL). • Distribution of multi-sectoral support packages.	**$61,021,793** Includes: $39,764,693 for temporary cash assistance $21,257,100 to provide support packages.
WASH	• Continued delivery of critical assistance and water, sanitation and hygiene services (633,290 SYR and 2,600 LEB). • The support would include trucking and desludging, latrine and hand washing facilities, IPC and disinfections kits for the affected families in informal settlements and collective shelters.	**$51,636,000**
LIVELIHOODS	• Vocational/skills training (through flexible, alternative modalities) for 5,500 individuals. • Emergency financial support to 47,500 micro small and medium enterprises. • Emergency support to 1,100 business (including cash-for-work) in response to COVID-19.	**$21,148,900** Includes: $3,562,500 emergency financial support to MSMEs $16,000,000 emergency support to businesses and cash for work

HEALTH	• Ensuring continued access to basic PHC services (medications for vulnerable host and refugee communities at PHC - 92,000 vulnerable Lebanese and Syrian refugees with chronic medical conditions and 350,000 patients (Lebanese and refugees) with acute medical condition), continuity of immunization services for vulnerable children, continuity of maternal newborn child and adolescent health, including mental health, provided with quality infection prevention and control to avoid any nosocomial infection. • Support to life saving non COVID-19 related hospitalization (60,000 refugees).	**$15,000,000** Includes: **$5,000,000** medications at PHCs; **$10,000,000** hospitalization for refugees.
SOCIAL STABILITY	• Support to municipalities on solid waste management. • Monitor and mitigate tensions, and address community disputes.	**$10,650,000** Includes: $8,000,000 support for solid waste management.
EDUCATION	• Support development and implementation of flexible education programmes to ensure continuity of learning for non-formal education (NFE) (target: 50,000 children) and targeted support to MEHE for children enrolled in formal education (target: 100,000 children); • Develop and carry out well-being activities targeting children and parents (target: 20,000 families) to support coping mechanisms and new home-based learning routines; • Parental engagement activities to support targeting parental/caregiver involvement in children's learning; • Promote health awareness on COVID-19 for parents and children in NFE (target: 50,000 children) and through targeted support to MEHE for children enrolled in formal education (target: 100,000 children); and, • Prepare for resumption of formal and NFE in safe learning environments.	**$33,050,000** Includes: **$22,000,000** flexible education programmes
ENERGY	• Ensure a stable and reliable electricity supply for public hospitals by sustainable energy solutions.	**$5,000,000** Includes: **$5,000,000** supporting the provision of electricity for critical health services.

UN Women and Care distributing hygiene kits for people affected by COVID-19
Photo: Care Int Lebanon

Priority 4

Expand support to vulnerable population groups not included in the LCRP, in need of humanitarian assistance due to the combined socio-economic impact of the economic and banking crisis and COVID-19 - WFP and UNRWA co-lead

PILLAR	DESCRIPTION	TARGET	ESTIMATED FUNDING NEEDS (US$)	PARTNERS
SUPPORT FOR NEW HUMANITARIAN CASELOAD	• Three-month bridging emergency social assistance programming by WFP and UNICEF for 50,000 most poor Lebanese households (food and cash), as well as al targeting of 39,000 households including those with disabilities, the elderly and households with many children; • Provision of cash assistance equivalent to half of the minimum food survival requirements for 257,000 Palestine refugees and other individuals eligible for UNRWA support (e.g. non-refugees married to Palestine refugee women and their children); • Education support for 38,000 Palestine refugee children prevented from accessing schools due to COVID-19 restrictions; • Cash-for-work programme including to refurbishment of 25 isolation centres; • Small business development across 40 municipalities through production of masks and COVID-19 related materials to benefit indirectly 40,000 households; • Provision of cash assistance to estimated 2,000 vulnerable migrant workers who lost their jobs but cannot go back to their home country to cover food needs; • Support to voluntary returns of 3,500 migrant workers to their countries of origin; and, • Provision of cash for rent, psycho-social support, and legal support to estimated 5,000 migrant workers.	50,000 most poor Lebanese households and 39,000 vulnerable Lebanese households, including those with disabilities, the elderly and households with many children. 257,000 Palestine refugees and other individuals eligible for UNRWA suppport. 38,000 Palestine refugee students enrolled in UNRWA schools in Lebanon Field during school year 2020/2021. Provision of communication assistance to 30% of students to support them actively participate in the blended approach (online Self-Learning / study during school year 2020/2021. 500 workers in vulnerable urban settings for refurbishment. 250 individuals in vulnerable urban settings engaged to service the isolation centres. 100 people directly benefitting from job opportunities (mainly women and youth). 2,000 migrant workers directly benefiting from cash transfers to cover food needs. 3,500 migrant workers supported for their return to their countries of origin. 5,000 migrant workers benefiting from NFI support.	**$60,623,080** Includes: WFP: **$20,000,000** social assistance; UNICEF: **$10,704,000** social assistance; UNRWA: **$19,281,280** cash assistance; UNRWA: **$2,160,000** remote education; UN-HABITAT: **$3,500,000** livelihood support; IOM: **$406,000** assessment, cash assistance, and monitoring IOM/AMEL: **$4,062,500** voluntary returns of migrant workers AMEL: **$509,300** provision of cash for rent and psycho-social and legal support	WFP, UNICEF, UNRWA, UN-HABITAT, AMEL, IOM

Annex II

This annex includes information related to the main achievements of the ongoing response since the beginning of the outbreak, gaps and challenges, as well as funding received as of 15 June.

Priorities 1 and 2 (WHO and UNICEF lead): 1) Supporting the preparedness and response capacity of the Lebanese health system in coping with the COVID-19 emergency; and, 2) Strengthening the engagement of and communication with communities, supporting good hygiene practices and ensuring COVID-19 specific support services

Main achievements:

• In addition to the laboratory at RHUH, all ten designated labs have been assessed, and procurement for required equipment launched.

• Ten designated public hospitals have been assessed for ICU-care capacity, and hospital isolation bed capacity. Individual support plan and procurement for equipment under preparation.

• Selected advanced equipment has been procured to RHUH and its laboratory, increasing its capacity to test 500 patients per day and to admit COVID-19 cases for ICU/ventilation.

• 19 ventilators were delivered to MoPH public hospitals.

• A total of 140,000 tests and corresponding supplies have been procured to the MoPH; **the testing capacity has been increased to an average of 1,500 tests per day, with sufficient COVID-19 testing supplies available in hospitals and primary health care centres for two months.** The plan is to ensure the country can conduct up to 5,000 tests per day, as a large influx of travellers is expected in the coming few months after opening of the airport on 1 July.

• **The total ICU bed capacity and ventilators have been increased** to 432 beds (the target is 600) and 428 (the target is 700) respectively.

• **The capacity of the airport and five border crossings has been upgraded** with expanded health team (nine nurses at airport and 25 nurses for border crossings), as well as distribution of awareness material and increased testing capacity for travellers. Further, training on IPC and provision of PPE to security forces have also been conducted.

• **Municipalities, as well as UNHCR and UNRWA for the Syrian and Palestine refugee populations and UNICEF for mixed population groups, particularly migrants, are establishing isolation centres in all governorates of the country.** So far, 51 isolation centres (for mild cases) have been assessed and approved by the Government, with six of these centres are ready to receive patients.-Mapping of isolation sites is ongoing, including on what sites are supported so far. Three additional isolation centres outside the approved list already supported with nursing staff and PPEs.

• All required and updated normative guidance for laboratory testing, patient care, surveillance and isolation/quarantine, lockdown/public health measures have been shared with concerned stakeholders.

• A national surveillance strategy for COVID-19 has been developed; accordingly, targeted testing, contact tracing and community testing, as well as preparation for a national sero-survey, are currently ongoing.

• **COVID-19 Rapid Response teams (CRRT) are being established in Beirut and Mount Lebanon,** expanding on existing RRT (established within the LCRP framework). The existing RRT in other *Mohafaza* will be reviewed, if needed, to expand partnerships and coordination to ensure consistent and coordinated response to COVID-19 to all populations, and report through the COVID-19 response platform.

• **Multi-channel information campaigns, including sign language, on hygiene practices and preventive behaviour to contain the spread of COVID-19 have reached over two thirds of the population** through TV and social media. Some thematic campaigns have been focused on mental health, social stigma, prevention at workplace, food safety and increase of domestic violence.

• **Information on precautionary hygiene measures, the MoPH's hotline for diagnosis and advice, and other information, has been broadly disseminated to Syrian and Palestine refugees** through SMS and dedicated community channels. This communication is complemented by the distribution of hygiene items in informal refugee settlements, where 22 per cent of the total Syrian refugee population is living in overcrowded conditions, as well as collective shelters and Palestine refugee camps.

• **Establishment of a National Technical Task Force on COVID-19 and pregnancy -** through a decree by the MoPH - entrusted to develop national inpatient and outpatient guidelines, mainstreaming the guidelines at primary and secondary care levels, training more than 1,700 frontliners, developing/disseminating related messages on social media and through health care outlets and availing a dedicated hotline number.

• **Leaflets on prevention of GBV, as well as SEA and referral pathways were widely disseminated** among partners and made available at all 236 primary health care centres. Hygiene kits (personal hygiene and household cleaning materials) were distributed to the most vulnerable families, including poor Lebanese, Syrian and Palestine refugees. This was accompanied by door to door awareness raising, with materials on appropriate use of hygiene materials and PSEA and SGBV.

• **Over 20 guidance documents and protocols were developed to standardize the response** in different sectors, including IPC in public institutions, protection and case management for children, GBV and PSEA procedures.

• UN-Habitat and UNDP, in collaboration with the DRM and the Ministry of Public Works drafted COVID-19 safety guidelines to be applied and adopted by workers on construction sites and by citizens and operators of public transport.

• Implementation of 22 public handwashing stations in vulnerable and dense settings in Beirut and Mount Lebanon, enhancing access to WASH, accompanied by appropriate communication and awareness raising measures on appropriate hygiene measures in the face of COVID-19.

• **Guidelines for the operationalization of the isolation and quarantine centres** across the country tackles different steps considered as part of the operationalization: UN joint field visits to assess the physical infrastructures of the centres, procurement of supplies such as PPE/IPC including the rationale behind the services allocated per centre and implementation of COVID-19 related activities in the centres.

• In collaboration with the MoIM, the MoPH and DRM, **UN agencies continue to support municipalities in facilitating the implementation of the local public health response**. Specifically, support will be given to municipalities to establish isolation shelters and defining a mechanism for self-isolation, including access for patients to support services such as IPC packages and medicines, social assistance, food, mental health and psycho-social support, and catering to people with special needs in consideration of age, gender and disability. The approach will build on and further strengthen the capacities of primary health care centres and Social Development Centres (SDCs).

Gaps and challenges:

• The clusters of COVID-19 cases among migrant workers revealed **the gap in response for some groups, especially migrant populations**, living in overcrowded places. The UN and partners are currently working on filling the gap and ensuring coordinated response to all populations by expanding the scope of and strengthening existing Rapid Reponses Teams (RRTs) to respond to new clusters of cases. Efforts to strengthen the integration of migrant workers in the response, as well as advocacy for more support continue to be required.

• **Gaps in terms of PPE and testing kits are anticipated**, especially if the epidemic progresses with a larger wave as projected in July-August 2020.

• **Additional funding is required for maintaining operations of isolation centres** over a longer period, particularly on food, management, and running costs, which is not planned under the UN support and needs to be secured by local communities/ municipalities or NGOs.

• **Lack of acceptance of some designated quarantine centres by the community** is contributing to delays in preparing and opening the centres, which requires substantial community engagement.

• **The capacity of the public sector to provide adequate care for severe cases remains so far limited**, both in terms of total bed / ICU capacity as well as in terms of qualified health personnel; the readiness of the public hospitals for these advanced services will necessitate additional 2-3 months.

• Social media listening reports show that the perceived health risk of COVID-19 as well as commitment to quarantine, confinement and preventive measures is decreasing. People who have lost their jobs and facing economic hardship, including food insecurity, are reluctant to stay at home.

• **Rapid spread of rumours and misinformation**, including the ones spread by people deemed to be credible including medical doctors, remains a challenge given their influence on the collective behaviour.

• **Continuously disseminating accurate information**, adapted to the situation at hand, as well as increase efforts to reach the most vulnerable, including people with disability, and migrant and domestic workers, will **remain critical.**

• Communication channels and means, including messages accessible to minority groups (e.g. non-Arabic speakers, disabled, other minorities), partners trusted by communities, need to be expanded.

• A main challenge remains **in urban dense neighbourhoods** where high density living and very poor hygiene conditions could contribute to an exponential increase of caseload, should there be an outbreak in such areas. The pandemic has further underlined the dire housing conditions of large proportions of both host and refugee populations, and the absence of any formal housing policy or targeting approach to slum-like conditions at the national level. This is a critical point of entry that needs to be funded in light of future pandemic resilience building.

• While the demand for RCCE is increasing, **the capacity for outreach is insufficient**. Existing humanitarian capacity in the country has been focused on Syrian refugee response and geographically concentrated in host localities or most vulnerable localities, while COVID-19 response requires a nation-wide intervention and hotspots are changing quickly.

• With people limiting their visits to urgent health care services, important routine services such as immunization, nutrition screening and antenatal and post-natal care are often being neglected, and the threat of communicable diseases such as measles or polio or malnutrition due to insufficient and inadequate food intake is rising among vulnerable communities.

COSTING Priority 1 and 2 (as reflected in the CPRP):

US$110,185,759

Funding received as of 15 June:

US$12,074,625

Priority 3 (UNHCR and UNDP co-lead): Ensure uninterrupted delivery of critical assistance and services to the most vulnerable communities affected by the Syria crisis, including refugees and host communities, in the context of the COVID-19 pandemic and severe economic crisis

Main achievements:

• Partners are working to maintain critical interventions needed to ensure life-saving access, while respecting the necessary precautionary measures to prevent spreading of the COVID-19 virus, in line with measures implemented by the government. To safeguard critical LCRP activities, a **Business Continuity Plan was prepared at the beginning of March and updated in June.** It outlines risks and critical interventions that are needed to ensure ongoing protection and access to life-saving services.

• The **Inter-Agency Service mapping has been strengthened to ensure consistent and up to date information on services available** under the LCRP (e.g identifies a partner that can provide food parcels, emergency cash). For health, it includes services related to primary health care centres (including mental health), mobile medical units and secondary health care services.

• **The Inter-Agency Guidance on Home isolation in Overcrowded Settings was finalised** in mid-March through a consultative process. SOPs are aligned with the *COVID-19 National Response Plan: Guidance note on selection and management of isolation facilities - Role of Governorates, Cazas, Union of Municipalities, Municipalities and Mukhtars*. It provides guidance on how quarantine and isolation can be achieved if there is a suspected or confirmed case in overcrowded settings, mainly informal settlements and collective shelters. This guidance is supported by operational plans at field level, taking into consideration specificities of each area and existing capacities and resources. The Inter-Agency is continuously updating the response plan as the situation evolves.

• The Inter-Agency has also **developed sector specific guidance notes to support the operationalization of the Home Isolation SOPs** and guide partners as needed to ensure a smooth and harmonized approach across all areas. All guidance is found on the COVID-19 Dropbox accessible **here** under the Plans & Guidelines. It includes guidance on for example, community engagement, recommendations for communication and engagement with older persons, persons with disabilities, persons with underlying medical conditions (and their caregivers), special considerations on the separation of children and of adults relying on a caregiver from their caregiver due to quarantine, isolation or hospital stay and composition of food parcels in emergency situations.

• A Dropbox folder has been created since the beginning of March, **for easy access to partners to all relevant COVID-19 materials**, such as information and communication materials, training materials, daily briefs from WHO Lebanon and DRM, plans and guidelines, governmental decrees, and service mappings.

• **LCRP Rapid Response Teams (RRT) are on standby ready to assist communities and families in overcrowded settings.** RRTs are comprised of humanitarian actors with different areas of expertise (e.g. health, shelter and WASH). They have been trained and are covering 1,254 cadastres (out of 1,612 cadastres in Lebanon) for COVID-19 prevention and response. These RRTs will ensure a quick response and proper use of referral pathways. Throughout April and May, specific ToRs were developed in the field for the RRTs, outlining their role and key responsibilities.

• The operationalization of the response is supported through **a tool that tracks prevention and response interventions** – mainly distribution of soaps, various kits and awareness raising sessions - to limit duplication, support a coordinated response and ensure coverage in all areas. This tool also supports the response through a multi-sectoral assessment and tracks cases and sites once they have been quarantined. All levels of isolation are currently being mapped, as well as identifying responsible actors for each site.

• The **Terms of Reference for the management of L3 facilities have been finalized** in mid-May in consultation with relevant stakeholders. This ToR outlines the administrative, management and service delivery accountabilities and responsibilities for Level 3 isolation facilities. This contributes to the *COVID-19 National Response Plan: Guidance note on selection and management of isolation facilities - Role of Governorates, Cazas, Union of Municipalities, Municipalities and Mukhtars*.

• A **multi-sectoral assistance package to address increased socio-economic needs**, has been agreed amongst LCRP partners that takes into consideration increased requests for assistance at individual and municipal level. The Food Security Sector, led by the Ministry of Agriculture, is mapping partners who are providing or planning to provide food assistance to expand coverage.

• **Community Health Volunteers have been identified and mobilized to raise awareness on COVID-19** amongst the community, identify at-risk or symptomatic persons, report community practices, issues and fears and help addressing them. They serve as a link between the refugee community and the RRTs. Site community groups were set up to promote safe practices, timely identifying symptoms and alerting community health volunteers.

• **Awareness SMS containing a variety of COVID-19 precautionary and awareness tips and messages were developed and sent out** on a regular basis to the entire refugee population in Lebanon. COVID-19 information material was printed and distributed. COVID-19 sensitization, precautionary and awareness messaging through WhatsApp communication tree reaching some 180,000 refugee families (some 900,000 individuals) were developed and sent. The same messaging material was spread through refugee Facebook pages reaching up to 260,000 followers.

• **A second round of distribution of hygiene kits together with hygiene promotion and awareness sessions was initiated** (first round was completed end of March) targeting 2,919 sites (mainly informal settlements and collective shelters) reached a total of 184,367 individuals / 36,873 households.

Gaps and challenges:

• **The LCRP funding overview for 2020 is bleak** with only US$422 million committed against the 2.67 appeal – this represent 16 per cent of the total appeal and includes a $136 million carry-over from 2019. Out of this, $4.6 million has been reprogrammed to support the COVID-19 response. The most underfunded sectors are Basic Assistance, Food Security & Agriculture, Shelter, Health and Livelihoods.

• **Partners report several operational constraints,** including increase in prices of material and equipment, devaluation of the Lebanese Pound, mobility constraints and delays in implementation. Partners report that it is getting increasingly difficult to deliver modalities remotely as many beneficiaries are not able to recharge their phone lines.

• Some partners have shifted funds that have been earmarked for medium/longer term assistance to address urgent gaps. **This may leave a gap to address medium/longer term issues** for the second part of the year.

• **The gaps in funding are coupled with increasing needs;** for example, an additional 51 per cent of Syrian refugees are estimated to now fall below the survival and minimum expenditure basket (SMEB) level due to the impacts of both inflation and loss of income shocks. This leaves an estimated gap of 503,000 vulnerable refugees who are currently unassisted under the LCRP. For vulnerable Lebanese, the planned target of 227,546 for cash supports remains unmet.

• **Refugees and host communities alike continue to raise concerns over how the socio-economic situation is leading to loss or inability to access livelihood opportunities.** The lack of cash and employment has a direct effect on abilities to pay rent and social services. With increased evictions, rising tensions and gaps in access to services, livelihoods has to be expanded and support to service provision. Although shorter-term cash injections are important, needs must be tackled from a medium-term perspective as well, also considering the perceptions of aid bias, especially from host community towards refugees.

• **Protection gaps are increasing.** There is a risk that certain types of SGBV will increase and reporting will decrease as a result of the challenging situation that survivors are facing during the COVID-19 outbreak. There is a high risk of increased incidents of violence against children in the home, and use of negative coping mechanisms, such as child labour or child marriage. Concerns and self-restricted movements among refugees are still being reported. Deadlines related to various types of applications and documents have been suspended until 30 June, and fines for expired permits have been waived by the GSO. However, a draft law to suspend all legal, judicial and administrative deadlines (including the late birth registration deadline) has not yet been adopted. One major concern is whether public institutions will be able to manage the backlog once services resume.

• **Decreased access to essential primary health care**, including medication and vaccinations, could negatively impact. Morbidity and mortality in the long term and will also increase the risk of preventable hospitalization. There is also a more general risk that people who require hospital care will delay seeking care for fear of infection coupled with the worsened economic situation, with potential negative health consequences in the medium- and long term.

• **There is risk of delayed education for many school-aged children.** Education interruptions could also lead to lower success rates on exams or for certification, including for those who were able to continue through distance learning. The lack of equitable access to quality education for all students in formal education is a concern as schools have different capacities to reach students through distance learning. This makes it more difficult to retain children in school and increases the risk of school dropout.

• **The quality of services at the municipal-level are deteriorating and further disruption will lead to decreased access to essential services** such as water trucking, wastewater and solid waste management. For Water Establishments, there is a risk of collapse as the decrease in fees collection reduced drastically the financial capacity of the establishments, some mitigation measures were taken by these establishments but not enough. The impact of collapse will affect the provision of service for the communities and health care system. For Solid Waste Management, although stopgap measures are in place, there is a risk that the lack of comprehensive solid waste management could lead to health as well as tensions.

• **Tensions has intensified in the past quarter, with increased pressure being put on LCRP partners to provide support** to municipalities and communities. Local authorities are increasingly requesting partners to expand coverage of service provision and increase inclusion of vulnerable Lebanese. Anti-refugee perceptions are growing and is resulting in stigmatization, targeted municipal measures and risks for delayed self-reporting.

COSTING Priority 3 (LCRP):

US$302,659,693

Update on the funding received to be made available shortly.

Priority 4 (WFP and UNRWA co-leads): Expand support to vulnerable population groups not included in the LCRP, in need of humanitarian assistance due to the combined socio-economic impact of the economic and banking crisis and COVID-19

Main achievements:

- **Preparations** such as procurement of food and targeting of vulnerable Lebanese **are on-going** in coordination with the Government of Lebanon and local authorities and local actors **to start distribution of in-kind food to 50,000 households by August 2020**.
- **Technical support being provided to the Government of Lebanon** to deliver their emergency cash assistance to vulnerable groups including those with disabilities, the elderly and households with many children under the National Social Solidarity Programme. **Around 130,000 households have so far received one cash grant**.
- The Inter-Ministerial Committee on Social Policy approved to develop a National Social Protection Response Strategy.
- **The first round of universal cash distribution for about 257,000 Palestine refugees and people eligible for UNRWA services currently residing in Lebanon were implemented**. The cash transfer is estimated to cover 40 per cent of minimum food requirements. The distribution is still ongoing and is welcomed by the refugees as it responded to an immediate need and mitigated a further deterioration in their humanitarian and socio-economic conditions.
- **The self-learning programme (SLP)** was launched, targeting 36,817 Palestine refugee students enrolled in grades from 1 to 12 during scholastic year 2019/2020 in its 65 schools all over Lebanon with a special focus on the most vulnerable students.

Gaps and challenges:

- **The primary constraint is related to funding**; all activities under this Priority have not been fully funded so far.
- There have been **delays related to the design and approval of the Emergency Social Safety Net (ESSN) Programme** formulated by the Government of Lebanon with support of the World Bank, which means additional funding for immediate social assistance for poor and vulnerable groups is even more urgent than before, and large numbers of poor and vulnerable households remain unsupported.
- **A major challenge faced for cash transfers is related to the registration data available on the Palestine refugees**, which does not reflect the actual situation of who is in the country and who is not because the registration with UNRWA is voluntary. This resulted in more people are turning up for the assistance than it was anticipated.
- **Non-compliance of precautionary measures among beneficiaries is an issue.** The coronavirus pandemic was a major constraint for the cash transfer operation for UNRWA particularly when refugees showed up in certain locations in big crowd in front of money transfer agent offices to cash the assistance without observing COVID-19 protection measures, such as social distancing and wearing masks.
- Through the Education Tracking System developed during the implementation of the SLP, an estimated 30 per cent of the students and parents/caregivers reported **difficulties in internet connection and hardware as the main challenge** which prevented their children from accessing the SLP.
- **Migrant workers are not being part of the targeted population in the LCRP,** which has created challenges for humanitarian partners working with migrants to provide essential services, including food, safe accommodation and protection.

COSTING Priority 4:

US$60,623,080

Funding received as of 15 June:

US$22,908,293

Total Lebanon Emergency Appeal requirement: US$473,468,532

Strengthening communication with communities - IEC posters distribution
Photo: Norwegian Refugee Council