REPUBLIC OF LEBANON
MINISTRY OF PUBLIC HEALTH

Lebanon:
National Immunization Strategy (2026-2030)

Expanded Program on Immunization,
Primary Health Care Department,
Ministry of Public Health, Lebanon

Contents

List of Acronyms

AEFI	Adverse Event Following Immunization	cVDPV2	Circulating Vaccine-Derived Poliovirus type 2
AFP	Acute Flaccid Paralysis	LMIS	Logistics Management Information System
AI	Artificial Intelligence	LMS	Logistics and Management System (Central drugs warehouse information system)
CME	Continuing Medical Education	MCV	Measles-Containing Vaccine
NIS.COST	National Immunization Strategy Costing tool	MERA	MERA mobile immunization application (Mobile Electronic Reporting Application)
COVID-19	Coronavirus Disease 2019	MERA-PRO	MERA PRO – private-sector module
CRVS	Civil Registration and Vital Statistics	MOPH	Ministry of Public Health
DHIS2	District Health Information System 2	MR	Measles and Rubella vaccine
DO	District Office	MMR	Measles, Mumps and Rubella vaccine
DPT	Diphtheria–Pertussis–Tetanus vaccine	NCD	Non-Communicable Disease
DPT-HepB-Hib	Diphtheria–Pertussis–Tetanus–Hepatitis B–Haemophilus influenzae type b (pentavalent	NGO	Non-Governmental Organization
DQA	Data Quality Assessment	NIS	National Immunization Strategy
DTP	Diphtheria–Tetanus–Pertussis (containing vaccine)	NITAG	National Immunization Technical Advisory Group
DTP1	First dose of a DTP-containing vaccine	OPV	Oral Polio Vaccine
DTP3	Third dose of a DTP-containing vaccine	PCV	Pneumococcal Conjugate Vaccine
EMRO	WHO Eastern Mediterranean Regional Office	PCV13	13-valent Pneumococcal Conjugate Vaccine
ESCWA	United Nations Economic and Social Commission for Western Asia	PCV3	Third dose of Pneumococcal Conjugate Vaccine
ESU	Epidemiological Surveillance Unit	PHC	Primary Health Care
EPI	Expanded Programme on Immunization	PHCC	Primary Health Care Centre
EVM	Effective Vaccine Management	PHENICS	Primary Healthcare Network Information and Communication System
Gavi	Gavi, the Vaccine Alliance	RCCE	Risk Communication and Community Engagement
GDP	Gross Domestic Product	RRV	Rapid Response Vaccination (outbreak/response)
GIA	Global Immunization Agenda IA2030	SBC	Social and Behavior Change
GNI	Gross National Income	SDG	Sustainable Development Goal
HPV	Human Papillomavirus vaccine	SPO	Strategic Priority Objective (NIS strategic objectives)
HPV1	First dose of Human Papillomavirus vaccine	SOP	Standard Operating Procedure
HR	Human Resources	THE	Total Health Expenditure
HRD	Human Resource Development	TWG	Technical Working Group
HSS	Health System Strengthening	UHC	Universal Health Coverage
HSSP	Health Sector Strategic Plan	UN	United Nations
IA	Impact Area (IA 2030 framework)	UNHCR	United Nations High Commissioner for Refugees
IA2030	Immunization Agenda 2030	UNICEF	United Nations Children's Fund
ICC	Inter-agency Coordination Committee	UNRWA	United Nations Relief and Works Agency for Palestine Refugees in the Near East
IOM	International Organization for Migration	VPD	Vaccine-Preventable Disease
IPV	Inactivated Polio Vaccine	VISA	VISA hospital billing system (electronic hospital billing platform mentioned with PHENICS)
IPV1 IPV	First dose of Inactivated Polio Vaccine Inactivated Polio Vaccine	WHO	World Health Organization

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Foreword

The Expanded Programme on Immunization (EPI) is a key public health initiative in Lebanon, recognized as one of the most cost-effective preventive programs. It plays a crucial role in protecting children and communities from vaccine-preventable diseases. The National Immunization Strategy (NIS) has been introduced as the new guiding framework for the immunization programme for the next 5 years.

Developed through an extensive consultation process led by a team of experts from the ministry and health partners, the NIS provides future directions for EPI and is aligned with the Sustainable Development Goals (SDGs) and Universal Health Coverage (UHC) approach. This strategy adheres to the Immunization Agenda 2030 (IA2030) and the Regional Strategic Framework, emphasizing equity, resilience, and sustainability. The strategy highlights the need for strong governance, cross-sectoral collaboration, and innovative approaches to reach everyone, everywhere.

The Government of Lebanon remains fully committed to these objectives, ensuring that immunization services are accessible, equitable, high-quality, and sustainable. This strategy reflects our steadfast dedication to reducing child mortality, preventing disease outbreaks, and strengthening the healthcare system for better health of the people of Lebanon. Together, we strive for a healthier, more resilient future for our children and communities.

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Acknowledgments

The Ministry of Public Health extends its appreciation to all national and international partners who contributed to the development of this National Immunization Strategy. This strategy reflects the collective expertise, commitment, and collaboration of stakeholders dedicated to strengthening immunization services in Lebanon.

Sincere thanks are extended to all partners and collaborating agencies for their valuable technical guidance and continuous support. Special appreciation goes to the EPI teams, Regional Health Officers, PHC field coordinators and field workers whose insights and on-the-ground experience were instrumental in shaping the strategic directions of this document.

The Ministry also acknowledges the active participation of all stakeholders in consultations, workshops, bilateral meetings, and technical reviews. This engagement ensured that the strategy is evidence-based, aligned with national priorities, and responsive to the needs of all communities residing in Lebanon. Your dedication has been essential to the vision and development of this National Immunization Strategy.

Executive summary

Lebanon's National Immunization Strategy (NIS) 2026–2030 provides a unified roadmap to protect the population from vaccine-preventable diseases amid prolonged economic, social and humanitarian crises. Building on the Expanded Programme on Immunization (EPI), the NIS aligns with the national health sector vision, the Immunization Agenda 2030 (IA2030), the regional strategic framework, the Sustainable Development Goals (SDGs) and the Universal Health Coverage (UHC) agenda. It aims to sustain core gains—such as polio-free status and an expanded schedule—while urgently addressing declining coverage, widening inequities, and increasing numbers of zero-dose and under-immunized children.

The NIS, grounded in equitability and people-centeredness, sets the vision of ensuring equitable access of all individuals to vaccines, with public and private health care providers working together, communities trusting health authorities and demanding quality public immunization services. The overall objective is to reach and sustain at least 95% Penta3 coverage at the provincial level and a minimum of 85% at the district level by 2030, ultimately reducing morbidity and mortality from vaccine-preventable diseases. The strategy adopts a life-course approach, maintains childhood and school-age boosters, plans for HPV vaccine introduction, and strengthens immunization delivery in emergencies through micro-planning, outreach, a resilient cold chain, and rapid outbreak response.

Lebanon faces one of the world's most severe economic collapses, sharp contractions in gross domestic product (GDP), high poverty and heavy out-of-pocket (OOP) health spending, weakened insurance schemes and a heavy reliance on Ministry of Public Health (MoPH)-supported services. Immunization coverage has declined since 2019, with DTP3 and MCV2 coverage falling and dropout and zero-dose numbers increasing. A dual public–private system covers roughly 55–60% of children in the public sector and 40–45% in the private sector, but the absence of a unified routine immunization calendar, weak regulation of private providers and limited private-sector reporting lead to major information gaps and inequities.

Human resources are strained by emigration, under-staffing and wage erosion, particularly outside major cities, affecting different ministries relevant to health determinants. Service delivery is fragmented, with a dominant private sector, and an uneven network of public and NGO-supported primary health care centres and dispensaries. While health information systems have expanded through multiple digital platforms (DHIS2, PHENICS, MERA, MERA 2, VISA, LMS, etc…), data remains fragmented, incomplete and insufficiently used for decision-making. Bottlenecks are identified across program management and financing, human resources, supply and logistics, service delivery, coverage and AEFI monitoring, disease surveillance and demand generation. They include misalignment between EPI and national budget cycles; insufficient domestic and external financing; lack of a comprehensive HR strategy and recruitment constraints; under-resourced cold chain maintenance and vaccine transport; unknown denominators and limited outreach planning; fragmented digital systems with little to none private-sector reporting (limited to 126 private physicians within the MOPH network; under-performing disease surveillance; and weak social and behaviour change communication and community engagement in a context of mistrust and misinformation.

The NIS, grounded in a comprehensive situation analysis, was developed through a participatory process led by MoPH under the coordination of the EPI Manager, with technical and financial support from WHO and inputs from UNICEF, NGOs, consultants and partners. A national situation analysis workshop identified bottlenecks using the WHO "All-in-One" tool, followed by a multi-day workshop to define priority objectives, interventions, and activities. Costing was completed with the NIS.COST tool to support

multi-year planning and future budget dialogue with the Ministry of Finance, Parliament and development partners, recognizing the need to adjust priorities if full funding cannot be secured.
The strategy is organized around seven strategic areas with clear SPOs and interventions:

- **SP1. Programme Management and Financing:** Strengthening governance, adopting a consolidated EPI policy package—including a unified national calendar, private-sector reporting, HIS standards, reinforcing partner coordination mechanisms for improved accountability at national and subnational levels and aligning EPI planning with the national budget cycle.
- **SP2. Human Resources Management:** Addressing HR gaps through adopting an EPI HR strategy defining roles and responsibilities competency-based training, blended learning, and systematic supportive supervision.
- **SP3. Vaccine Supply, Quality and Logistics:** Reinforcing vaccine supply, quality and logistics through WHO-prequalified cold chain equipment with real-time temperature monitoring, improved forecasting for public and private sectors, dedicated vaccine managers, a funded national transport plan with appropriate refrigerated vehicles and cold boxes, and a national immunization waste management policy and operational protocols.
- **SP4. Service Delivery:** Improving service delivery through micro-planning, dropout tracking, outreach and catch-up activities for zero-dose and under-immunized children, flexible hours, and integration with quality PHC and MNCH services by mandating immunization card review and assigning data focal points in facilities.
- **SP5. Immunization Coverage and AEFI monitoring:** Enhancing coverage monitoring by unifying digital platforms governance and financing (PHENICS, MERA, MERA-PRO) and enforcing private-sector reporting, enabling automated reminders, and conducting regular data quality assessments. Coverage dashboards will guide targeted micro-plans and outreach at governmental and district levels. Strengthening AEFI surveillance by establishing a national committee, identifying focal points and standardizing risk-communication protocols.
- **SP6. Disease Surveillance:** Strengthening disease surveillance by improving staff and lab capacity, engaging private providers, and ensuring timely specimen referral and transport.
- **SP7. Demand Generation:** Boosting demand generation through a national SBC strategy, community engagement, interpersonal and community-centered communication, and structured feedback loops for service improvements.

Monitoring and evaluation will rely on a province-level scorecard aligned with IA2030 and a core indicator set covering disease prevention, equity, and programme performance (e.g., Penta3, PCV3, MCV2, IPV1, HPV). Additional indicators cover policy adoption, governance, planning, partner coordination, domestic financing, HR rules, regulations and training, cold chain and supply management, session quality, integration, private-sector reporting, data quality, AEFI monitoring, surveillance, and demand generation. Regular dashboards, supervision findings, and DQAs will support accountability and adaptive management.

Total financing needs for the five-year period amount to USD 106.3 million, driven primarily by vaccine procurement and supply chain operations, which account for 82% of overall costs. New investments—including HPV introduction, quality improvements, and expanded community engagement—represent 52% of total requirements, underscoring the shift toward a more resilient and efficient immunization system. Government financing remains the cornerstone of the program, contributing approximately USD 42 million, with the private sector expected to add USD 38 million, particularly through HPV vaccine uptake. Together, these domestic sources cover about 76% of total needs.

Development partners continue to provide technical assistance, targeted service delivery, and system-strengthening activities; however, projected external funding beyond 2026 remains limited. A financing gap of around USD 20 million is anticipated, concentrated in critical areas such as human resources, equipment upgrades, outreach, and campaigns. Addressing this gap will require strategic prioritization, enhanced public–private collaboration, and proactive resource mobilization.

Overall, Lebanon enters the 2026–2030 period with solid domestic commitment and a clear investment roadmap. Implementing the NIS will require coordinated action, agile budgeting, and sustained engagement with partners to ensure equitable coverage, improved performance, and long-term sustainability of the immunization programme.

1. Country Profile

1.1 Rationale for the development of a new NIS

Lebanon's last national immunization strategy (2016–2020) preceded a period of severe and overlapping crises — economic collapse, political instability, the protracted Syrian crisis, and post COVID-19 recovery- that heavily strained the health system. Although a new NIS (2023-2026) was initiated in 2022, it could not be finalized due to rapidly evolving conditions. A renewed strategy is now critical to realign national immunization priorities with Immunization Agenda 2030 and global guidance for 2026–2030[1].

1.2 Geopolitical, socioeconomic and security context

Lebanon, a Middle Eastern country of 10,452 km² divided into 8 governorates and 26 districts, is home to an estimated 5.5 million people as of mid-2025. This includes around 1.4 million Syrian and Palestinian refugees[2], with children and youth (0–24 years) representing nearly 54%[3] of the population. Over the past decade, Lebanon has faced overlapping shocks—the Syrian crisis, the 2019 financial collapse, the COVID-19 pandemic, the Beirut Blast, and the Israeli war—which have reversed earlier development gains and driven the country into a prolonged humanitarian and economic emergency.[4]

The security context remains fragile, marked by localized unrest and periodic cross-border tensions.

Around 30% of the population consists of refugees living in formal and informal settlements, alongside an estimated 250,000 migrant workers. These groups are among the most vulnerable and continue to face significant barriers to accessing essential services, including healthcare.[5]

Figure 1: Map of Lebanon

Economically, the World Bank characterizes the crisis as one of the most severe national collapses since the mid-19th century. Real GDP contracted by 2.1% in 2024, following cumulative losses of over 60% between 2019 and 2022, and dropped from USD 52 billion in 2019 to under USD 22 billion by 2024. Currency instability persists, with sharp and continuous fluctuations despite partial dollarization[6].

Poverty has risen dramatically: an estimated 80% of Lebanese households now live below the poverty line, with 40% in extreme poverty, compared to 20% and 8% in 2019. Among Syrian refugees, more than 90% live in extreme poverty. In 2022, Lebanon was reclassified as a **Lower Middle-Income Country** for the first time in nearly three decades—a classification that remains in place.[7].

Table 1: Socioeconomic Indicators Lebanon

Indicator	Statistic	Year
GDP per capita (USD)	$3,350	2024
Life expectancy at birth (years)	78.5	2023
Total health expenditure (THE) per capita (USD)	$574	2022
Government health expenditure (GHE) as % of THE	48%	2022
Other – Poverty rate (% population below national poverty line)	80%	2024

Sources: World Bank (2024); WHO (2022–2023); MoPH Lebanon (2023); UN ESCWA (2024).

[1] MoPH, 2025
[2] UNHCR, 2025
[3] MoPH, 2025
[4] World Bank, 2024
[5] UNHCR, 2025
[6] BdL, 2025
[7] World Bank, 2024

2. Organization of the health system

2.1 National Health Structure

Lebanon's healthcare system is a hybrid public-private model designed to cover diverse health needs, though it continues to face significant challenges amid ongoing socio-economic instability.

Table 2: Lebanon Health System Structure

Public Healthcare	Private Healthcare
• **Public healthcare** is a core pillar of service delivery in Lebanon, ensuring access for vulnerable and low-income populations. • **Public hospitals:** - 33 public hospitals operate nationwide, serving both urban and rural areas. - Partially government-funded, primarily serving low–middle income groups. - A few are well-equipped, while many face major financial and staff shortages, limiting service quality. • **Primary Healthcare Centers (PHCs):** - 335 PHCCs from the MOPH network, offer subsidized preventive, curative, and maternal/child health services. - 500+ additional centers and mobile clinics provide immunization services with vaccines supplied free by MOPH (475 dispensaries and 126 private clinics) - Most PHCCs and dispensaries are NGO-run and connected through the PHENICS digital system for data management.	• **Private hospitals and clinics:** - 120 private hospitals nationwide - Recognized for advanced technology and high-quality specialized care. - Attract local and regional patients, reinforcing Lebanon's role as a regional medical hub. • **Financing private healthcare:** - Primarily through employer-based insurance, private insurance plans, and out-of-pocket. - National social security schemes offer partial coverage for vulnerable groups. • **NGO–public sector partnership in EPI:** - NGOs contribute to the infrastructure, staffing, and community outreach. - MoPH ensures vaccine supply, cold chain support, and trainings. • **Digital information systems:** - The MERA/PHENICS platform links PHCCs, dispensaries, private providers, and caregivers (Sohatona) and enhances data sharing, monitoring, and reporting.

Table 3: Key Health Indicators

Indicator	Statistic	Year
Registered Live births	91,200	2023
Under-5 mortality rate (per 1000 live births)	11	2023
Infant mortality rate (per 1000 live births)	9.5	2023
Maternal mortality ratio (maternal deaths per 100 000 live births)	31	2023
Births attended by skilled health personnel (%)	98	2023
Neonatal Mortality Rate (per 1000 live births)	4.3	2023

(Source: MoPH, 2024; UNICEF, 2024). These figures represent either stagnation or slight deterioration compared to pre-crisis levels.

2.2 Expanded Programme on Immunization Structure (EPI)

The Expanded Programme on Immunization (EPI) is a cornerstone of Lebanon's public health system. Launched in 1987 and fully transitioned to Ministry of Public Health (MoPH) ownership by 2003, the EPI has sustained immunization services through prolonged crises by operating within a dual public–private delivery model. As of 2025, the MoPH supplies vaccines to about **55–60%** of children (including large refugee cohorts), while the private sector covers the remaining **40–45%**—a configuration that has helped preserve coverage but also contributed to persistent equity and access gaps. To this day, a range of national and international stakeholders support immunization in Lebanon.

a. Governance and technical advisory bodies

To strengthen governance and evidence-based decision-making, formal advisory structures are in place:

- **EPI Technical Committee (est. 2007)**, evolved into the **National Immunization Technical Advisory Group (NITAG, Aug 2022)** to review schedules, assess new vaccine introductions following PICO questions and ETR evidence-based methods, and inform preparedness and outbreak response.
- **National Polio Certification Committee (est. 2003)** continues to guide polio surveillance and maintenance of polio-free status.

Table 4: Key Milestones

Key Milestone	Year
Introduction of new vaccines (Rota, pneumococcal)	2024
Measles Elimination Initiation	2023
Gavi eligibility as a fragile state	2022
Establishment of the NITAG	2022
Introduction of MERA	2018

b. Operational Structure

The EPI is managed by the **MoPH Immunization Programme**, under the **Primary Healthcare Department** within the **Directorate of Preventive Medicine**, and functions through a decentralized delivery structure:

- **National Level:** Leads policy development, vaccine procurement and delivery planning, cold chain and logistics, SOPs development, capacity building, national campaigns, and partner coordination.
- **Governorate/District Level:** routine service, coverage monitoring, supervision and outreach.
- **NGOs and Private Providers:** supporting capacity-building, service delivery via PHCCs, dispensaries, private clinics and vaccine monitoring.
- **Digital Platforms:** Immunization data flow across **PHENICS (PHCCs)**, **MERA (dispensaries)**, **MERA-PRO (private sector)**, and **Sohatna (caregivers)**, enabling real-time tracking and reporting, identifying gaps and supporting decision-making in vaccine delivery and staff deployment.

c. Core objectives

EPI objectives align with WHO's Immunization Agenda 2030 and national health priorities to:

- Reduce morbidity and mortality from vaccine-preventable diseases and promote equity, resilience, and service continuity during emergencies, following a life-course approach.
- Sustain polio-free status and progress toward measles and rubella elimination.
- Ensure equitable access across regions and population groups, including refugees and migrants.
- Strengthen immunization information systems, data quality, and digital reporting.
- Build demand and community trust through engagement and communication.
- Support innovation, partnerships, and new vaccine introduction.

Table 5: Key National and International stakeholders supporting immunization

Key Stakeholders	Type of Support
European Union	Financial support at central level
World Bank	Financing partner (central level)
WHO	Technical assistance (central level)
UNICEF	Technical assistance and vaccine procurement support
Gavi	Support for vaccine procurement, cold chain, and technical assistance
UNHCR	Service delivery for refugee populations- stopped as of November 30, 2025
NGOs	Operational service delivery
Other ministries	Education, Social Affairs and Interior - Collaboration on campaigns
Lebanese General Security	Supports service delivery for non-citizen populations
PiVi	Technical assistance and support for procurement of Influenza Vaccine

d. Immunization schedule, adult vaccination and new antigens

The national schedule covers childhood, school-age boosters and adolescent vaccines (schedule revised 2023; see annex 1). Key recent actions include a COVID-19 vaccination campaign (2020–2023) that provided free vaccination across age groups through hospitals, PHCCs and mobile units. Vaccines administered included **Pfizer-BioNTech, AstraZeneca, Sputnik V, Sinopharm, Moderna**, and **Johnson & Johnson**[8].

Adult vaccination at the PHCCs is restricted to donations of Influenza vaccines through the global PIVI program, targeting mainly the front-line health care workers in the public sector, and elderly patients with chronic debilitating diseases, both in PHCCs and in elderly retirement homes. The private sector recommends Influenza and PCV vaccines to elderly people with chronic debilitating diseases as well. Selected vaccines will be expanded to adult populations, guided by the Terms of Reference developed by NITAG, this establishes a life-course immunization approach to bolster adult protection against VPDs.

The introduction of HPV vaccination has been approved, with ongoing discussions for funding and forecasting on the longer term, with the rollout expected starting mid-2026 and will depend on fiscal space and partner support (NITAG guidance, 2025).

e. Vaccine coverage & PHC vaccine utilization

Coverage has declined in recent years: WHO/UNICEF estimates show a **16.1% decline in DTP1** and a **27.6% decline in DTP3** between 2019 and 2023, with the DTP1→DTP3 dropout rate rising from **18.2% (2019)** to **29.5% (2023)**. These trends highlight gaps in service continuity and retention and reinforce the need to prioritize routine service recovery and targeted outreach.[9]

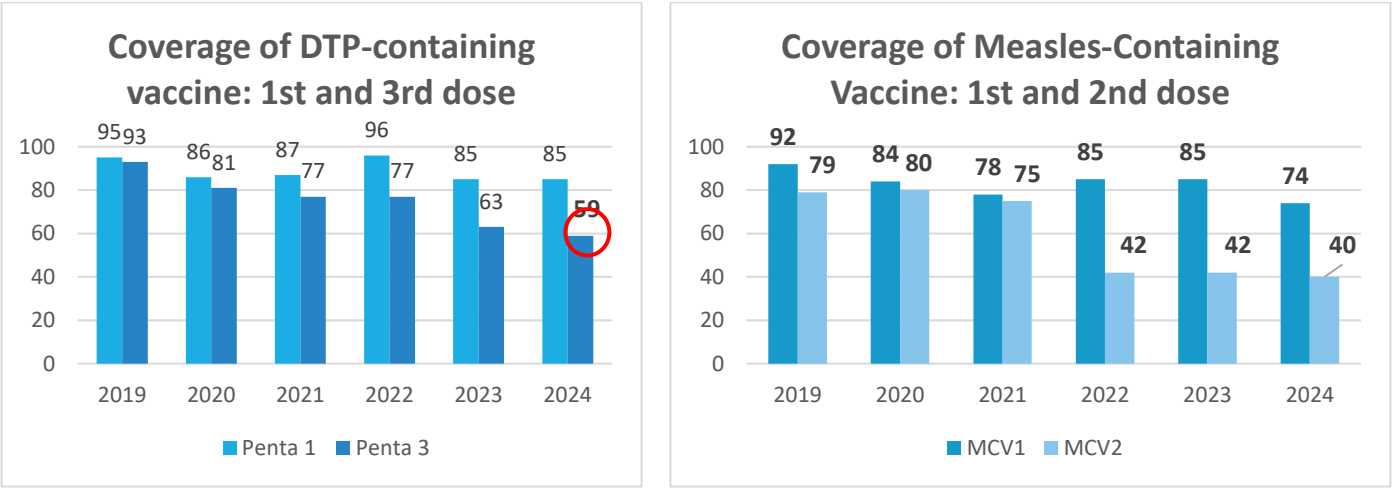


Figure 2: *Coverage of DTP and Measles containing vaccines (2019-2024)*

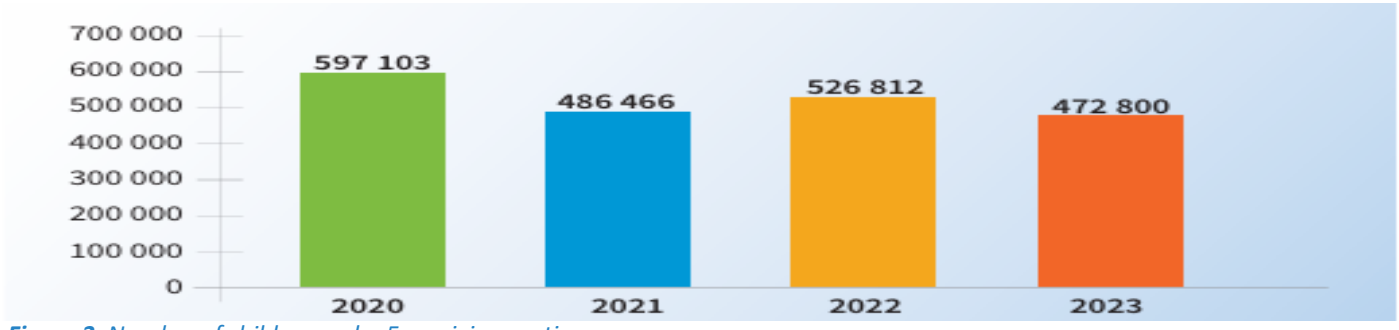


Figure 3: *Number of children under 5 receiving routine*

[8] MoPH, 2023
[9] Report on Immunization Coverage and trend analysis

f. Achievements

Despite the difficult context, Lebanon's EPI has maintained several critical achievements:

- **Sustained Polio-Free Status** and **effective outbreak response** (measles, Hepatitis A, cholera)[10].
- **Expanded Vaccine Portfolio**: RI now protects against **11 VPDs**. The private sector, however, offers additional vaccines such as HPV, Typhoid, influenza, varicella, meningitis, Hep A.
- **Digital Health Innovations**: PHENICS, MERA, MERA-PRO, Sohatna platforms improved data visibility and caregiver engagement[11].
- **Sustainable Cold Chain**: Solar energy is increasingly used for vaccine refrigeration in central and remote areas, improving reliability during power shortages (UNICEF, 2024). The central warehouse is fully renovated and rehabilitated, with a temperature monitoring system operational 24/7, with remote monitoring and a mitigation plan to be activated if the temperatures fall below requirements.
- **NGO Partnerships**: Ensuring service continuity for refugees and marginalized communities and supporting capacity building and training to maintain high-quality services, especially during crises.

g. Challenges

- Persistent inequities in access and coverage, especially in peripheral districts.
- Human resource shortages and uneven distribution of staff.
- Maintenance gaps in the cold chain at subnational levels.
- Timeliness and completeness of data feedback loops, limiting rapid programmatic adjustments.
- Fiscal constraints that complicate the introduction of new vaccines and scale-up plans.
- Vaccine hesitancy and misinformation affecting demand and coverage rates, particularly among the vulnerable

3. National Immunization Strategy Development

3.1 Development Process

The NIS was developed through a participatory process led by the MoPH under the coordination of the EPI Manager, with technical support from WHO. A core Technical Working Group—bringing together the MoPH, UN agencies, national and international partners, and other stakeholders—guided the process via series of consultative meetings and workshops, supported by technical consultants.

- **Situation Analysis Workshop:** A two-day workshop was organized to update the situation analysis. Technical working group (TWG) members were divided into seven groups, each assigned to review a specific EPI component. Participants reviewed the draft situation analysis, assessed the identified bottlenecks (removed or added new ones). Root cause analysis was done for all bottlenecks using the WHO "All-in-One" tool to facilitate the process.
- **Strategic Framework Workshop:** A three-day workshop followed with the same group of participants working on strategic framework development. This included formulating strategic priority objectives, key interventions, and activities (to each, highlighting the type, the priority and the level of administration).
- **Costing and Financing Methodology:** The strategic objectives and activities were costed using the NIS.Cost online tool, which supported budgeting, financial planning, and the generation of detailed reports. The costing process was informed by bilateral meetings and technical consultations with national counterparts, immunization partners, UN agencies, and experts, ensuring alignment with national priorities, validated assumptions, and consensus on resource needs for the NIS 2026–2030.

[10] WHO, 2024
[11] MoPH, 2025

4. National Health Sector Situation Analysis

The health sector continues to operate under the MoPH's National Health Strategy – Vision 2030 and its crisis-response addenda. Given ongoing intermittent conflict, both the Health Sector Strategic Plan and the NIS must incorporate risk assumptions, flexible implementations, and mechanisms for regular updates. The below is adapted from WHO EMRO "**Country Cooperation Strategy for Lebanon 2026–29"**.

4.1 Governance and leadership

The MoPH has strengthened its regulatory capacity in recent years through initiatives aimed at improving **transparency, accountability, and oversight of health stakeholders**.

- Updated contractual agreements with PHC centres, activation of the MoPH website, and automation of the central drug warehouse.
- "**Collaborative governance approach**," leveraging long-standing public–private partnerships, and everal national **consultative committees** were established.
- Delayed approval of major laws such as the UHC, tobacco taxation measures, International Health Regulations (IHR 2005) adoption, and the establishment of the National Drugs Authority.

4.2 Health workforce

- Despite significant emigration in recent years (40% of doctors (mainly specialists)), still around **8,000 medical doctors** remain, 70% specialists—equating to one physician per 680 people.
- The **nursing workforce remains chronically insufficient**, despite 208 nursing schools, and is heavily affected by outward migration and poor retention – emigration of 20% of nurses.
- **Human resources are unevenly distributed**, concentrated primarily in major cities.
- The **MoPH operates with less than one-third of its required workforce**.
- Severe **salary erosion due to currency devaluation** has further weakened retention of staff.
- The Order of Physicians reports **some recent returns of physicians** who had previously emigrated.
- Staffing shortages affecting other health-relevant ministries, limiting implementation of **One Health** and responses to broader health determinants.

4.3 Health service delivery

- Lebanon's health system is **predominantly private**, focusing on hospital and curative care.
- **Hospitals:** 153 in total (120 private, 33 public) ~13,000 beds; with 15% of beds in the public sector.
    - Most hospitals have <100 beds; only ~5% have >300 beds.
- **Non-profit health centres:**
    - 335 PHCs supported by MoPH (vaccines, NCD meds, acute care, training)
    - 250 dispensaries (vaccines, NCD meds) & 250 SDCs (MoSA-supported)
    - ~400 other health center's/dispensaries outside these networks, poorly monitored
    - Majority NGO-based, many affiliated with political/religious groups
- ~3,500 pharmacies, ~450 medical labs/radiology, ~1,000 physiotherapy/rehabilitation sites.
- ~8,000 private clinics or hospital outpatient departments, plus a network of non-profit centres.
- **Operational challenges:**
    - By mid-2024, hospitals operate at ~60% capacity due to economic crisis.
    - 2024 military escalations caused closure of 7 hospitals and 133 PHCs/dispensaries.
    - ~400 pharmacies in conflict-affected areas were partially or fully damaged.

4.4 Health Management Information System (HMIS)

- Transition to **E-government**, but the legislative framework is not yet fully developed.
- **Digitalization achievements in MoPH include:**
  - Expansion of **DHIS2** to Tuberculosis/HIV programs, CRVS, and Public Health Emergency Operation Center (PHEOC) casualty data
  - Automated **Logistics & Management System (LMS)** at central drug warehouse
  - **Meditrack** for 2D barcode pharmaceutical traceability
  - **VISA** system for hospital billing
  - **PHENICS** patient management system linked to **MERA** mobile vaccination app
  - Unique health identification number generation for patients
- **Health data management:**
  - Health sector partners report through the Lebanon Response Plan information system
  - MoPH hosts a **Health Data Observatory** collecting SDG indicators, birth and death data
  - Updated GIS database of hospitals, labs, pharmacies, PHCs, physiotherapy centres
- **Challenges:**
  - Health data is fragmented, inconsistent, and unreliable for policymaking
  - Population data, especially for Syrian and Palestinian refugees, is difficult to estimate
  - Introduction of **ICD-11** and a comprehensive electronic health record system is delayed
  - GIS updates remain irregular
- **Need:** Quality data assessment to ensure the reliability and validity of data collected and coordinated, integrated and monitored HIS to unify data and evidence-based decisions.

4.5 Health financing

- **UHC Service Coverage Index:** Estimated at 73/100 in 2021.
- **Public insurance challenges:**
  - Six publicly managed insurance funds are unable to pay for services since 2019.
  - Rising unemployment shifted **more** patients to **MoPH-supported services**.
  - About 80% of older adults (≈10% of population) lack health coverage.
- **Co-payments and service coverage:**
  - MoPH hospital co-payments increased: public hospitals 5% → 20% (2019–2024), private hospitals 15% → 35%
  - Implant coverage discontinued; selected PHC and emergency services partially covered.
  - Public funds vary in co-payment and benefits; economic crisis limited-service coverage.
  - Government ended medication subsidies, further restricting access.
- **Non-Lebanese residents:** Access PHCs for nominal fees; secondary/tertiary care coverage limited due to reduced UNHCR, UNRWA, and IOM support.
- **Out-of-pocket spending:**
  - ~85% of Lebanese pay for health care out-of-pocket.
  - Out-of-pocket expenditures now exceed 80% of total health costs, causing inequity and financial hardship for vulnerable populations.

Please refer to Annex 2 for further details on the National Health Accounts.

4.6 Detailed Situation Analysis

Bottleneck	Main Problem
1. PROGRAMME MANAGEMENT AND FINANCING	
1.1 Policy & guidance	
#NAME?	
- Multiple EPI calendar in use, with antigens added at the private sector. - Limited regulatory power on the private sector by the MoPH. - Absence of a formal policy on MOV. - Limited system enhancements and technical support have made the health information system (PHENICS/MERA) less user-friendly and less effective in supporting staff with monitoring and data-driven decision-making.	Lack of endorsed EPI policies and unified guidance, reflected in multiple calendars, weak regulation of private providers, and an unfriendly HIS for users, which prevents consistent implementation and data-driven oversight.
1.2 Governance & accountability	
- EPI committee is sole and only statutory multifunction committee. - Insufficient coordination within and between levels with no forum of performance sharing with all stakeholders (public and private) at district and governorate level. - Insufficient oversight of both public and private sector vaccination activities. - Limited performance monitoring with vaccination coverage tracking and data analysis needing further strengthening.	Over-centralized governance with weak multi-level coordination and oversight limits systematic performance monitoring across public and private providers.
1.3 Planning & procurement	
- Mismatch between planning cycle for the EPI and government financial. - Systematic routine outreach sessions not planned in district plans. - Government plan for vaccine procurement does not include vaccines for private sector. - Lack of a formal EPI staff development plan due to the absence of a capacity- building policy and limited funding. - Lack of sustainability in vaccine distribution plan from the central warehouse to districts, and from districts to vaccination points due to insufficient funds. - Insufficient funding to incorporate new vaccines, currently available in the private sector, into the national immunization calendar, limiting equitable access. - Lack of a sustainable plan for the procurement, preventive, and corrective maintenance of cold chain equipment and vaccination supplies, due to insufficient funding.	EPI planning is misaligned with government budget cycles and lacks funded plans for outreach, workforce development, vaccine distribution, and cold-chain maintenance; blocking equitable vaccine introduction and continuity.
1.4 Partner coordination	
- The National EPI Committee is merged with the NITAG committee, hence NITAG must perform additional functions. - Limited coordination between PHC coordinators and stakeholders at governorate level on EPI with irregular meetings. - Limited coordination at the district level with local partners to enhance vaccination demand.	Weak coordination at governorate/district levels leave NITAG/EPI committees overstretched and local partner engagement inconsistent.
1.5 Budgeting and financing	
- Limited funds from the government to finance the program. - Shortage of funds from donors and international communities with a health system depending on external funds. - Government Health system financing predominantly focused on secondary care. - Insufficient funds to procure vaccines for the entire population (as more and more children who used to be vaccinated in the private sector will be vaccinated in the public sector).	Limited funding from donors, insufficient government allocation, and inadequate resources at the PHCC level, combined with a health system predominantly focused on secondary care and insufficient funds to procure vaccines for the entire population, threaten the sustainability of the program and equitable immunization coverage.
2. HUMAN RESOURCES MANAGEMENT	
2.1 Human Resource planning	
- Priority is for curative and other services instead of preventive and EPI services. - Official decree preventing government employees' recruitment due to lack of funds. - No clear long-term policy on human resources.	Absence of a long-term EPI human resource strategy, compounded by hiring restrictions, lack of prioritization of preventive services, and unclear roles and reporting lines, leaving the program without sustainable staffing.
2.2 Capacity-building	
- No focused training on other EPI areas of interest except EVM due to a low score post assessment. - Not enough staff and transportation fees to conduct training on EPI programs and policies. - No dedicated governmental budget for staff development department (including training and orientation programs). - No comprehensive, competency-based training policy and systematic capacity-building framework. - Priority was first given to technical training before focusing on additionally competency-based skills.	Training is fragmented and underfunded, skewed to EVM with no policy on competency-based training, limited operational resources, and gaps in broader EPI skills.
2.3 Supervision & performance monitoring	
- Understaffed/Insufficient EPI technical staff at central and district level due to absence of recruitment ratio. - Lack of follow up on the quality assessment results of the facility following field visits.	Insufficient EPI staffing and weak follow-up on assessment findings undermine supportive supervision and accountability.
3. VACCINE SUPPLY, QUALITY & LOGISTICS	
3.1 Cold chain	
- Lack of accountability from the service point to report and others do not have the skills to fill electronic based reports; in addition, supervisors are overwhelmed. - Shortage of staff and high turnover at PHC level, does not permit government efforts to be sustained.	Cold-chain performance is constrained by staff shortages, weak

- Sub-optimal supervision and knowledge from staff at the Qada (district) level; also adding that there is shortage in EPI staff at Qada level and if available, they are usually not well trained and overwhelmed. - Partner dependence on cold chain maintenance due to lack of government budget.	accountability/reporting, limited supervisory capacity, and reliance on partners due to budget gaps.
3.2 Supply chain management	
- Inaccuracy in national forecast due to absence of denominators and covers only public sector. - Lack of capacity for lower levels to properly estimate needs and place orders. - Private sector procures routine immunization vaccines independent from the Ministry of Health. - Inequity in vaccine access with different procurement sources (private and public). - Shortage of staff at district and Central level for vaccine management. - There is no clear process of private sector forecasting.	Sub-optimal vaccine supply management due to insufficient data collection from Private sector and lack of denominator, and lack of skilled and sufficient number of staff at all EPI points.
3.3 Transport	
- Insufficient staff for vaccine delivery due to multitasking of few available staff. - Lack of specified vehicles for vaccine transportation (refrigerated trucks). - Insufficient funding for vaccine transportation from Central level to DO and from DOs to service delivery points is not allocated.	Insufficient staff and multitasking negatively affects vaccine delivery worsened, by the lack of specified vaccine transportation vehicles (refrigerated trucks) and insufficient budget.
3.4 Waste management	
- No sustainable solution by the government on the medical/vaccine waste management. - EPI training on waste management focuses on needles and vials.	Absence of a comprehensive medical waste management policy at national level (owned by government), with training narrowly focused on needles/vials and lacking broader application.
4. SERVICE DELIVERY	
4.1 HR & strategies	
- Zero-dose or missed communities difficult to identify given present strategies and non-mastery of a denominator at sub-national level. - Impact of Missed opportunities for vaccination is unknown. - Unknown denominator at district level hence no routine outreach activities planned. - Interest in financial gains, customer retention strategies, discrediting public sector vaccination and non-reporting of vaccinated children by some private facilities. - Most private facilities procure their vaccines, vaccinate, and do not share data with MoPH. - Payment of consultation before administration of routine vaccine in private sector may constitute a barrier to access and lead to inequity.	Unknown denominators, limited outreach planning, and weak private-sector reporting create blind spots, leaving zero- dose/missed children unidentified and equity gaps widening.
4.2 Session quality	
- No systematic monitoring of dropout rates at service delivery level with implementation of catch-up activities. - Vaccination hours are not flexible and does not necessary accommodate caregivers and children availability. - Zero dose children not identified due to a non-mastery of the denominator. - Outreach session not systematically planned by PHCs due to insufficient human and financial resources.	Sub-optimal quality of vaccination sessions due to short vaccination contacts sessions, inflexible vaccination hours and no community tracking of dropouts by facilities.
4.3 Integration	
- PHCC are not involved in estimating their coverage due to high workload and absence of a focal person to manage database. - Lack of implementation of pre-vaccination screening by nurses due to high workload. - Vaccination services not properly integrated into the overall medical services at PHCC hence vaccines are provided only to dose that present at the centre requesting for it (High probability of missed opportunities for vaccination). - Vaccination cards not reviewed in curative care due to insufficient integration and human resource. - Some private facilities do not fully collaborate with public sector and even go as far as advise against taking vaccines from public sector.	Insufficient integration between preventive (vaccination) and curative services to reduce missed opportunities of vaccination to minimum.
5. IMMUNIZATION COVERAGE & AEFI MONITORING	
5.1 HR & systems Immunization Coverage	
- Estimated vaccine coverage < 80% for all antigens. - Insufficient resources (human, funds, electricity, internet, computers etc) to properly manage the HIS and ensure continuous availability. Need for repeated training and retraining of staff to use the HIS due to turnover, migration etc... - Political and legal limitations inherent to the socio-cultural and political situation of the country leading to no unique identifier. - The present design does not permit the system to send notification to defaulters. - Multiple electronic platforms for EPI data management. - Most private physicians find MERA Plus less user friendly and would prefer spending time on consultation than reporting on vaccinated children. - The absence of a policy to regulate the private sector in Lebanon makes them not to feel any obligation to report to the MoPH hence a huge proportion of children vaccinated in the private sector are not captured by the system.	Fragmented and under-resourced HIS with multiple platforms, lack of unique identifier, limited coverage (<80%), user-unfriendly design, and poor private sector reporting, undermining coverage monitoring.
5.2 Recording & reporting	

- The private sector purchases their vaccines and do not report data on vaccinated individuals to public section. - Over 80% of private facilities still do not report to the EPI. - District Offices are not committed to the workflow and policy although trained. - Most health facilities do not have dedicated data clerks/retrospective data entry. - Private facilities fear tax returns from reporting on number of children vaccinated. - Absence of strict regulations and policy enforcing reporting by private facilities. - Limited opportunities to engage private facilities in advocacy and communication as they don't trust public sector. - Captured data in the HIS cannot be disaggregated by subnational level because information is not collected due to socio political reasons and absence of denominator for same level.	Very low immunization data completeness (<50%) due to non- reporting from private sector compounded by insufficient capacity building, multiple reporting, and multiple electronic platforms.
5.3 Data quality	
- Limited data audits and monitoring and evaluation skills at the Primary health care facilities level and dispensaries. - Poor data validation and quality assurance. - Lack of unique identifiers lead to double data entries or incomplete data entries. - Low data completeness with most of private sector not captured. - In some cases, there is incoherence between home-based records and electronic data.	Sub-optimal data quality issues linked to insufficient data audits, quality assurance reviews and absence of a unique identifier on an electronic platform.
5.4 Coverage monitoring & use	
- Non monitoring of coverage at sub-national level (governorates and districts). - Absence of monitoring for action. - Numerator problems – not all vaccinated children are captured by present system. Only those vaccinated in public sector are captured - Denominator problems – no denominator per district per governorate to permit monthly calculation of coverage. - Zero dose children and communities cannot be identified for action. - Proxy methods used to calculate coverage at the national level.	Limited EPI program monitoring for action with inability for the program to identify zero dose communities due to unknown sub- national (governorates and districts) coverage and proxy estimation of national coverage.
5.5 AEFI monitoring	
- Staff not trained on AEFI surveillance. - Insufficient resources to plan and address rumors on AEFIs.	Incomplete routine immunization AEFI monitoring cycle due to lack of capacity building on AEFI surveillance and mechanism for reporting at all levels.
6. DISEASE SURVEILLANCE	
6.1 HR & systems Disease Surveillance	
- Communicable diseases reporting is not included in the curriculum of medical studies. - Private physicians lack incentive to report. - Insufficient human resources for disease surveillance due to brain drain, migration, underpayment and non-replacement of retired staff.	Disease surveillance is weakened by a shortage of MoPH personnel, low reporting participation from private healthcare providers, and the absence of communicable disease reporting training in medical education.
6.2 Detection and response	
- Case reporting is at the discretion and willingness of physician. Active surveillance for AFP, measles/rubella and meningitis - Delays in sample transportation to reference labs due to limited transportation logistics at district level. - Delays in transportation of samples abroad due to frequent changes in in specific arrangements to ship polio samples to Syria polio lab withing 48 – 72 hours, caused by the security situation in both Syria and Lebanon.	Insufficient logistics and human resources for timely disease detection and response.
6.3 Performance	
- Measles surveillance indicators not met. - Limitations in healthcare affordability negatively affects health seeking behavior of suspected AFP and measles cases. - Poorly coordinated surveillance tasks, especially at peripheral regions.	Key indicators (e.g., measles) are not met due to affordability barriers to care and limited private-sector involvement in reporting.
7. DEMAND GENERATION	
7.1 Demand	
- Poor governance leads to lack of trust in the quality of vaccine in the public sector is sub-optimal. - Insufficient support from the government to existing or new feedback mechanisms. - Lack of clear national behavioral change strategy.	Absence of a social behavior change communication strategy, coupled with poor governance, socioeconomic crisis and spread of misinformation and rumors, which act as a barrier to generate increase in demand.
7.2 Advocacy & communication	
- Emphasis placed on delivery services rather than communication. - Use of conventional methods and lack of interpersonal communication skills.	Weak advocacy and communication systems, with over-reliance on conventional methods, content not addressing real barriers, lack of interpersonal communication skills combined with
7.3 Community engagement	
- Lack of human and financial resources in favor of community engagement. - Insufficient awareness and capacity building. - Private sectors are guided by profit with lack of social responsibility to protect public health.	Community engagement not embedded in the PHC structure due to lack of resources, timely and accurate information sharing, and profit-driven private sector practices, compound with lack of feedback mechanism.

5. NIS vision, goals, overall objective and special considerations

a. Country vision, goal and overall objective

Vision

- A country where everyone, everywhere, at every age fully benefits from vaccines through services delivered by an integrated, equitable and people-centred immunization program.

Goal

- To ensure equitable access for all individuals to benefit from existing and new vaccines: Communities, families and individuals live healthier lives and access quality vaccines.
- Strengthen public-private collaboration, positioning immunization as a key entry point to PHC and fostering strong demand for vaccines.
- Build and maintain public trust in health authorities, ensuring a commitment to public interest and leaving no one behind unvaccinated.

Overall objective

Attain and sustain 95% Penta 3 coverage provincial level and at least 85% coverage at the districts level by 2030 contributing towards reduction in morbidity and mortality due to VPDs.

Detailed Objectives

- Sustain strategic networks and partnerships between stakeholders around shared agendas serving public interest.
- Identify strategic priority objectives & interventions and mobilize required resources for a paradigm shift in governance, delivery of immunization services and the protection of health and well-being.
- Build the capacity to anticipate and responde to upcoming challenges and designing and implementing effective, efficient and equitable responses to the outbreaks due to VPDs.
- Respond to acute crisis to sustain the continuum of immunization services delivery.

b. Immunization throughout the life course

The following vaccines are administered beyond infancy: MMR 2nd dose at 18 months, DTP booster at 18 months and 4-5 years and dT booster doses at 10-12 years and 16-18 years. Further, during outbreak response appropriate vaccines are provided to all age groups who are epidemiologically susceptible.

c. New vaccine introduction and immunization programme coverage targets

The program intends to introduce HPV in stages: 10-year-old girls for two years, secured by Gavi, followed by protecting boys and girls aged 9 to 16 years in 2027, Influenza vaccine to the elderly, people with chronic diseases, frontline health workers, and children aged 6 months to 5 years and PCV 13 vaccine to the elderly with chronic conditions.

d. Immunization in conflict and emergency situations

The NIS will prioritize security-informed micro-planning for hard-to-reach and displaced populations; deploy outreach teams; maintain resilient cold-chain capacity through backup power, temperature monitoring, and last-mile carriers. Rapid response vaccination (RRV) will be triggered by event-based surveillance and EWARN/Integrated Disease Surveillance and Response (IDSR) alerts, with fast-track approvals and surge staffing. Zero-dose and under-immunized children will be mapped using GIS and partner data to target campaigns, while cross-border/line coordination ensures continuity for refugees and host communities. Risk communication and community engagement (RCCE) will address fear, misinformation, and access barriers. Lastly, flexible financing with pre-positioned supplies will safeguard service delivery when routine systems are disrupted.

6. NIS strategic priority objectives and main interventions

Level	Description	EPI Component	Priority
Objective	SP1: PROGRAMME MANAGEMENT AND FINANCING 1.1 Secure MoPH endorsement of an integrated EPI Policy & SOPs having one unified calendar, private-sector regulation & a userfriendly HIS standards and roll it out nationwide by 2030.	(SPO 1.5, GIA 7.2)	High
Main Intervention	1.1.1 Draft, consult, and approve unified EPI policy (calendar, private-sector duties, HIS/data standards).		
Activity	1.1.1.1. Develop a comprehensive policy document outlining the unified immunization calendar, the roles and responsibilities of private-sector providers in adhering to the national schedule, and standardized reporting to the MoPH through the HIS.	1.1 Policy & guidance	High
Activity	1.1.1.2 Conduct consultations with MoPH units, PHCCs, private providers, donors, and technical partners to gather feedback on the draft policy and related documents.	1.1 Policy & guidance	Medium
Activity	1.1.1.3. Incorporate stakeholder feedback and circulate the revised draft for internal review and validation by technical experts.	1.1 Policy & guidance	High
Activity	1.1.1.4. Submit the policy and the toolkits to the Ministry of Health or relevant authority for official endorsement. Issue ministerial decisions and rollout toolkit (SOPs, checklists, model contracts).	1.1 Policy & guidance	High
Activity	1.1.1.5. Share the approved policy and toolkits with all relevant stakeholders and conduct orientation sessions to ensure proper implementation and adherence.	1.1 Policy & guidance	High
Main Intervention	1.1.2 Monitoring the implementation of the ministerial decisions and the toolkit (SOPs, checklists, model contracts).		
Activity	1.1.2.1. Define indicators, tools, and reporting frequency to track adherence to ministerial decisions and toolkit use.	1.1 Policy & guidance	High
Main Intervention	1.1.3 Align all partner projects and MoPH directorates to the new policy (compliance clauses).		
Activity	1.1.3.1. Map all partner projects and directorates, Identify programs, NGOs, and MoPH units involved in immunization activities.	1.1 Policy & guidance	High
Activity	1.1.3.2. Map potential funding partners.	1.1 Policy & guidance	High
Activity	1.1.3.3 Map and engage local leaders, NGOs, and influencers for co-led outreach and awareness actions.	1.1 Policy & guidance	Medium
Activity	1.1.3.4 Engage partners in one workshop to explain policy requirements, expectations, and timelines for compliance.	1.1 Policy & guidance	High
Objective	1.2 Strengthen governance by creating more oversight committees, coordination, and accountability through quarterly EPI performance reviews in the EPI program to ensure effective oversight of vaccination activities and robust monitoring of coverage and service performance.	(SPO 1.1, GIA 7.1)	High
Main Intervention	1.2.1 Establish TORs, membership, and scorecards for national/governorate/district forums.		
Activity	1.2.1.1. Draft Terms of Reference (TORs), define the purpose, roles, responsibilities, decision-making processes, and meeting frequency for each forum level.	1.2 Governance & accountability	High
Activity	1.2.1.2. Select representatives from relevant MoPH units, PHCCs, partner organizations, and private sector stakeholders for national, governorate, and district forums.	1.2 Governance & accountability	Medium
Activity	1.2.1.3. Create standardized tracking sheets to monitor attendance, participation, decision-making, and follow-up on action items	1.2 Governance & accountability	High
Main Intervention	1.2.3 Develop a dashboard using electronic monitoring tools and plan corrective actions based on the results and findings.		
Activity	1.2.3.2. Analyze and interpret dashboard results, Review data outputs to identify strengths, weaknesses, and emerging issues at facility or district levels.	1.2 Governance & accountability	High
Activity	1.2.3.3. Generate summary monitoring reports, Produce regular reports highlighting findings, progress, and areas requiring improvement.	1.2 Governance & accountability	High
Activity	1.2.3.5. Develop and implement an agreement with the Order of Physicians for private physicians to formalize their commitment to immunization accountability and promote the use of a unified reporting platform for all providers once barriers are identified and enablers are suggested.	1.2 Governance & accountability	Medium
Main Intervention	1.2.4 Recruit EPI focal points, cold chain experts, and quality officers at national and subnational levels to strengthen immunization program management, ensure effective cold chain operations, and enhance quality assurance.		
Activity	1.2.4.1 Strengthen the planning, implementation, and monitoring of immunizationsprograms, ensuring effective service delivery and improved population health outcomes while collaborating with district teams and PHCCs to prepare targeted action plans addressing identified gaps and monitoring follow-up.	1.2 Governance & accountability	High
Activity	1.2.4.2 Develop a communication and coordination framework: Define objectives, roles, responsibilities, meeting frequency, and reporting lines for district-level coordination with local authorities, PHCCs, NGOs, and private providers and 26 outreach supervisors.	1.2 Governance & accountability	High
Activity	1.2.4.3 Provide technical assistance at the MoPH through an immunization and cold chain expert.	1.2 Governance & accountability	High
Activity	1.2.4.4. Recruit Quality Specialist.	1.2 Governance & accountability	High
Objective	1.3 Synchronize the EPI multiyear and annual plans with the national budget cycle and approve a protected line-item for outreach, human resource development (HRD), equitable distribution of vaccines, and O&M of cold chain.	(GIA 7.3)	High
Main Intervention	1.3.1. Co-develop a costed annual plan of action tied to MoPH calendar.		
Activity	1.3.1.1. Conduct up to 4 joint planning workshops, Engage MoF, and key partners to align planning timelines and priorities.	1.3 Planning & procurement	Medium
Activity	1.3.1.2. Identify and prioritize key EPI activities, Define annual targets, milestones, and resource requirements based on program needs (including laptops, tabs, printers, cars).	1.3 Planning & procurement	High
Activity	1.3.1.3. Develop detailed cost estimates and align plan submission with MoF budget cycle. Ensure timely integration of EPI financial requirements into the national budgeting process.	1.3 Planning & procurement	High
Main Intervention	1.3.2. Create protected budget lines (outreach, HRD, distribution, cold-chain O&M).		
Activity	1.3.2.1. Develop and implement an immunization financing framework, including defining budget codes for EPI components, establishing a co-financing strategy, developing financial guidelines, consolidating EPI expenditure data, and conducting advocacy with MoF and partners to secure sustainable funding.	1.3 Planning & procurement	High
Activity	1.3.2.2. Standardize financial goverment agreements between MOPH, donors and implementers.	1.3 Planning & procurement	High
Main Intervention	1.3.3. Introduce rolling forecasts for vaccines/supplies linked to procurement cycle (taking into consideration private sectors needs and newly introduced vaccines).		
Activity	1.3.3.1. Integrate private-sector demand and new vaccine introductions by including estimates of private-sector needs and adjust forecasts based on planned introduction of new antigens or program expansions, including adult vaccinations.	1.3 Planning & procurement	High
Activity	1.3.3.2. Monitor forecast accuracy and adjust planning parameters. Conduct quarterly reviews comparing forecasted vs. actual consumption and refine forecasting assumptions accordingly.	1.3 Planning & procurement	High
Objective	1.4 Strengthen capacity of governance/technical bodies for planning, coordination, and tracking progress at all levels by constituting a national ICC with TORs and meeting cadence, and formalize governorate/district partner coordination with quarterly workplans.	(GIA 7.1)	High
Main Intervention	1.4.1. Establish district coordination platforms with designated representatives and hold semi-annual meetings to address coverage, logistics, outreach, AEFI, and zero-dose reduction.		
Activity	1.4.1.1. Identify and appoint representatives from the District Health Office, PHCCs, local authorities, NGOs, and community partners.	1.4 Partner coordination	Medium
Activity	1.4.1.2. Establish and maintain a regular schedule of district-level coordination meetings to review immunization performance, coverage improvement, logistics, outreach activities, AEFI, zero-dose reduction, and agreed action points.	1.4 Partner coordination	High
Objective	1.5 Ensure sustainable financing for the EPI program by mobilizing adequate resources from government, PHCCs, and partners to maintain vaccine supply and achieve equitable immunization coverage.	(SPO 6.2, GIA 8.2)	High
Main Intervention	1.5.1. Prepare MTEF(medium term expenditures framework) for EPI with fiscal space analysis and co-financing plan.		
Activity	1.5.1.1. Mid-term review of the costed multi-year plan (MTEF), estimate resource requirements for 5 years based on program priorities, vaccine introductions, and coverage targets.	1.5 Budgeting and financing	High
Main Intervention	1.5.2. Introduce performance-based allocations tied to coverage/quality.		
Activity	1.5.2.2. Define performance indicators (e.g., vaccination coverage, data quality, cold chain functionality, and outreach activities) and establish and operationalize a performance-based funding system for PHCCs and districts, with regular data validation and annual review for effectiveness and sustainability.	1.5 Budgeting and financing	High
Main Intervention	1.5.3. Mobilize additional sources.		
Activity	1.5.3.2. Develop advocacy materials and investment briefs highlighting the public health and social impact of immunization.	1.5 Budgeting and financing	Medium
Main Intervention	1.5.4. Annual public expenditure review on EPI.		
Activity	1.5.4.1. Analyze spending patterns to assess efficiency, equity, and alignment with program priorities.	1.5 Budgeting and financing	High
Activity	1.5.4.2. Engage key stakeholders (MoF, donors, partners) in reviewing and validating expenditure findings.	1.5 Budgeting and financing	High
Activity	1.5.4.3. Publish and disseminate an annual expenditure report with recommendations to improve resource allocation and financial planning.	1.5 Budgeting and financing	High
Activity	1.5.4.4. Operational cost for office maintenance.	1.5 Budgeting and financing	High
Objective	SP2: HUMAN RESSOURCES 2.1 Ensure the availability of an adequate, effective, sustainable health workforce by a comprehensive EPI Human Resource Strategy, endorsed by the Ministry of Public Health, and implemented in at 100% of districts, defining staffing norms, competencies, and retention mechanisms.	(SPO 1.2)	High
Main Intervention	2.1.1 Develop EPI job descriptions as per organogramme and recruit/redeploy EPI staff to fill gaps in immunization staff at all levels.		
Activity	2.1.1.1 Conduct a comprehensive human resources assessment and planning exercise for the EPI program at all levels, including workforce profiling and distribution , workload analysis, and training needs assessment, to inform staffing plans, career pathways, updated TORs, and performance evaluation and reward systems that ensure continuity and quality of immunization services.	2.1 HR planning	High
Activity	2.1.1.2 Hold advocacy meetings with MoPH leadership and Ministry of Finance to endorse and fund the HR plan.	2.1 HR planning	High
Activity	2.1.1.3 Disseminate the approved HR plan and staffing guidelines to all districts.	2.1 HR planning	High
Activity	2.1.1.4 Advocate Official decree preventing recruitment due to lack of funds.	2.1 HR planning	High
Main Intervention	2.1.2 Strengthen workforce retention through non-financial incentives, career pathways, and supportive work environments.		
Activity	2.1.2.1 Recognize high-performing staff based on perfomance appraisal performed on system, through awards and public acknowledgment on yearly basis.(28 Nurse in each District , one/district or area and 2 EPI focal across all districts).	2.1 HR planning	Low
Activity	2.1.2.2 Pair experienced staff with juniors for guidance and skill building PHCC level.	2.1 HR planning	Low

Objective	**2.2 Improve technical and managerial capacity of health care workers by launching a national EPI competency framework and annual training plan with dedicated budget and cascade mentoring at all levels.**	**(SPO 1.2, GIA 1.1)**	High
Main Intervention	**2.2.1 Adapting innovative evidence-based, blended learning approaches for problem-solving and remote mentoring.**		
Activity	2.2.1.1 Annual training plan including mandatory (vaccine delivery, immunization supply chain and communication skills…) and focused trainings (Stress management, teamwork…).	2.2 Capacity-building	High
Main Intervention	**2.2.2 Developing comprehensive training packages aligned with national workforce development plans.**		
Activity	2.2.2.1 Establish an induction/standard EPI course for EPI staff.	2.2 Capacity-building	High
Activity	2.2.2.2 Elaborate a yearly calendar planned training (Refreshment trainings for all PHCs) for 50 trainers at national level.	2.2 Capacity-building	High
Objective	**2.3 Strengthen programme performance monitoring and management systems at all levels by implementing a supervision standard (frequency, tools, feedback loop) and require documented closure of findings within 30 days.**	**(GIA 7.2)**	High
Main Intervention	**2.3.1 Adapting innovative evidence-based, blended learning approaches for problem-solving and remote mentoring.**		
Activity	2.3.1.2 Establish a real-time digital supervision dashboard to track visits, performance gaps, and corrective actions and prepare annual evaluation report summarising all topics covered during the year.	2.3 Supervision & performance monitoring	High
Activity	2.3.1.3 Submit a report based on the review of the findings of supportive supervision during Qadaa quarterly review meeting, to propose corrective actions in addition to indicator data from the immunization dashboard.	2.3 Supervision & performance monitoring	Medium
Objective	**SP3: VACCINE SUPPLY, QUALITY & LOGISTICS** **3.1 By the end of 2030, ensure that 100% of Primary Health Care Centers (PHCCs) and vaccination points are equipped with WHO-prequalified cold chain equipment and that a real-time temperature monitoring and alert system is fully operational across all facilities; additionally, train and certify at least 90% of cold chain and immunization staff in equipment management, temperature monitoring, and data recording to maintain effective vaccine storage and reduce cold chain breaches by at least 50%.**	**(SPO 1.4, GIA 3.2, GIA 3.3)**	
Main Intervention	**3.1.1 Ensure timely and transparent procurement of WHO-prequalified vaccines through accurate forecasting and efficient supply processes.**		
Activity	3.1.1.1 Procurement of all vaccines including adult vaccines.	3.1 Cold chain	High
Main Intervention	**3.1.2 Establish and operationalize an integrated vaccine procurement and distribution mechanism to ensure timely, uninterrupted availability of all routine and newly introduced vaccines at national, regional, and service delivery levels.**		
Activity	3.1.2.1 Procure WHO-prequalified cold chain equipment (refrigerators and DULAS) for all health facilities providing vaccination services.	3.1 Cold chain	High
Activity	3.1.2.2 Procure WHO-prequalified vaccine carriers for all Primary Health Care Centers (PHCCs).	3.1 Cold chain	High
Activity	3.1.2.3 Procure WHO-prequalified freeze tags for all PHCCs.	3.1 Cold chain	High
Activity	3.1.2.4 Procure WHO-prequalified Real-Time Temperature Monitoring Devices (RTMDs) for all PHCCs.	3.1 Cold chain	High
Activity	3.1.2.5 Procure WHO-prequalified cold boxes for all PHCCs.	3.1 Cold chain	High
Activity	3.1.2.6 Procure WHO-prequalified data loggers for all PHCCs.	3.1 Cold chain	High
Activity	3.1.2.7 Record all cold chain equipment details in the national cold chain inventory system to ensure accurate tracking and asset management.	3.1 Cold chain	High
Activity	3.1.2.8 Prepare and regularly update the annual procurement plan for cold chain equipment and spare parts.	3.1 Cold chain	High
Activity	3.1.2.9 Develop and implement an annual maintenance subscription plan for Real-Time Temperature Monitoring Devices (RTMDs).	3.1 Cold chain	High
Activity	3.1.2.10 Oversee the distribution, installation, and maintenance of cold chain equipment (refrigerators, freezers, cold boxes) across all PHCCs by identifying and contracting qualified service providers for preventive maintenance through signed agreements.	3.1 Cold chain	High
Main Intervention	**3.1.3 Strengthen cold chain management capacity through updated training, digital performance monitoring, regular supervision, and periodic evaluation to ensure efficient and sustainable vaccine storage and delivery.**		
Activity	3.1.3.1 Update national training materials and guidelines on cold chain management in line with WHO standards and new technologies.	3.1 Cold chain	High
Activity	3.1.3.2 Conduct training sessions for EPI focal points, cold chain managers and logistics at all levels on system operation, data entry, troubleshooting, monitoring and response mechanisms.	3.1 Cold chain	Medium
Activity	3.1.3.4 Conduct quarterly supervision visits to verify maintenance activities and ensure compliance with standards.	3.1 Cold chain	High
Activity	3.1.3.5 Review and renew maintenance contracts based on performance indicators and service quality.	3.1 Cold chain	High
Activity	3.1.3.6 Conduct a comprehensive Effective Vaccine Management (EVM) assessment to evaluate cold chain efficiency and sustainability.	3.1 Cold chain	High
Objective	**3.2 By the end of 2026, strengthen immunization data management and digital logistics systems at all levels to ensure timely, accurate, and harmonized vaccine supply monitoring and reporting across the public and private sectors.**		High
Main Intervention	**3.2.1 Strengthen Data Collection and Reporting Systems.**		
Activity	3.2.1.2 Review and assess existing reporting tools and templates used at all levels (central, district, and PHC).	3.2 Supply chain management	Low
Activity	3.2.1.3 Conduct consultations with key stakeholders (MoPH, EPI, WHO, and partners) to identify data gaps and harmonization needs.	3.2 Supply chain management	High
Activity	3.2.1.4 Develop and standardize data collection, reporting, and forecasting templates aligned with national indicators.	3.2 Supply chain management	High
Activity	3.2.1.5 Finalize and secure MoPH/EPI approval for the standardized reporting tools.	3.2 Supply chain management	High
Main Intervention	**3.2.2 Enhance Digital Monitoring and Supply Chain Response.**		
Activity	3.2.2.1 Monitor and update the performance of the digital logistics management system (LMIS).	3.2 Supply chain management	Low
Activity	3.2.2.2 Establish ongoing technical support and maintenance protocols for system sustainability.	3.2 Supply chain management	Low
Activity	3.2.2.4 Define thresholds and indicators for vaccine stockout and overstock alerts.	3.2 Supply chain management	High
Activity	3.2.2.5 Integrate alert functions into existing LMIS or digital forecasting platforms at all levels.	3.2 Supply chain management	High
Activity	3.2.2.6 Update standard operating procedures (SOPs) for alert response at central and subnational levels.	3.2 Supply chain management	High
Objective	**3.3 By the end of 2026, optimize vaccine distribution and logistics management across all levels to ensure efficient, timely, and safe delivery of vaccines and supplies while maintaining cold chain integrity**	**(SPO 6.2, GIA 3.1)**	High
Main Intervention	**3.3.1 Strengthen Vaccine Distribution and Transport Systems.**		
Activity	3.3.1.1 Assess current transport routes and logistics systems for vaccine distribution at all levels.	3.3 Transport	High
Activity	3.3.1.2 Logistics planning and distribution routes from the central store to district and service delivery points.	3.3 Transport	High
Activity	3.3.1.3 Validate and approve the transport and distribution plan with EPI, MoPH, and partners.	3.3 Transport	High
Activity	3.3.1.4 Monitor and periodically review transport performance, updating routes and schedules based on operational data.	3.3 Transport	High
Activity	3.3.1.5 Distribute vaccines, cold chain equipment, and related supplies to all levels according to identified needs.	3.3 Transport	High
Activity	3.3.1.6 Establish maintenance and calibration schedules for transport vehicles and equipment.	3.3 Transport	High
Activity	3.3.1.7 Develop and implement tracking mechanisms for asset management, utilization, and reporting.	3.3 Transport	High
Main Intervention	**3.3.2 Enhance Capacity for Cold Chain and Logistics Management.**		
Activity	3.3.2.1 Develop and regularly update standardized training materials on vaccine handling, temperature monitoring, and emergency response.	3.3 Transport	High
Activity	3.3.2.2 Distribute standard operating procedures (SOPs) and quick reference guides for both routine operations and emergency scenarios.	3.3 Transport	High
Objective	**3.4 By the end of 2026, strengthen and standardize immunization waste management systems across all levels to ensure safe, compliant, and environmentally responsible disposal practices aligned with WHO standards.**	**(GIA 3.6)**	High
Main Intervention	**3.4.1 Strengthen Policy Framework and Oversight for Immunization Waste Management.**		
Activity	3.4.1.1 Conduct stakeholder consultations with MoH, EPI, environmental health, and partners to gather inputs on waste management priorities.	3.4 Waste management	High
Activity	3.4.1.2 Review and finalize the national immunization waste management policy and SOPs in line with WHO standards.	3.4 Waste management	High
Activity	3.4.1.3 Establish a monitoring and evaluation framework to ensure adherence to the approved SOPs at all levels.	3.4 Waste management	High

Main Intervention	**3.4.2 Build Capacity and Ensure Availability of Safe Waste Management Systems.**		
Activity	3.4.2.1 Identify and select national trainers from EPI, infection control, and environmental health departments.	3.4 Waste management	High
Activity	3.4.2.2 Conduct a national needs assessment to determine waste management material requirements at each facility and to find sustainability measures for the future in collecting, distributing and managing waste.	3.4 Waste management	High
Activity	3.4.2.3 Distribute required waste management supplies to PHCCs and service delivery points based on assessed needs.	3.4 Waste management	High
Activity	3.4.2.4 Monitor utilization, compliance, and safety practices through regular supervision and reporting.	3.4 Waste management	High
Objective	**SP4: SERVICE DELIVERY** **4.1 Extend immunization services to regularly unreached "zero-dose" and underimmunized children and communities by using micro-planning with defined denominators and private-sector reporting to target and serve zero-dose areas through routine outreach.**	**(SPO3.1)**	
Main Intervention	**4.1.1 Develop micro-plans with denominators and zero-dose children.**		
Activity	4.1.1.1 Identify target areas and estimated populations yearly.	4.1 HR & strategies	High
Activity	4.1.1.2 Elaborate microplanning training tools and templates.	4.1 HR & strategies	High
Activity	4.1.1.3.Conduct a microplanning TOT training for 20 PHC coordinators.	4.1 HR & strategies	High
Activity	4.1.1.4 Conduct one refresher training session on microplanning to all of the 26 districts at central level.	4.1 HR & strategies	Medium
Activity	4.1.1.5 Develop detailed micro-plans with estimated denominators (number of children to be vaccinated).	4.1 HR & strategies	High
Main Intervention	**4.1.2 Enhance outreach activities to underserved areas.**		
Activity	4.1.2.1 Update the electornic system to identify underserved areas and zero dose communities.	4.1 HR & strategies	Medium
Activity	4.1.2.2 Develop targeted outreach activities for PHCC to reach zero-dose children in remote and underserved areas.	4.1 HR & strategies	High
Activity	4.1.2.3 Asalemeh Project.	4.1 HR & strategies	Medium
Activity	4.1.2.4 Evaluation of Asalemeh project.	4.1 HR & strategies	High
Activity	4.1.2.5 Train outreach participants on vaccination services and communication (Asalemeh project expansion).	4.1 HR & strategies	Medium
Main Intervention	**4.1.3 Implement immunization campaigns to respond to outbreaks or to vaccinate dropout children, particularly following school health screenings.**		
Activity	4.1.3.1 Implement vaccination response campaigns whenever outbreaks occur.	4.1 HR & strategies	High
Activity	4.1.3.2 Medical school health screening.	4.1 HR & strategies	Medium
Activity	4.1.3.3 Conduct yearly simulation /drills for vaccine management and after-action reviews.	4.1 HR & strategies	High
Objective	**4.2 Strengthen immunization policies and service delivery where facilities track dropouts monthly, extend service hours where needed, and schedule catch-up/outreach accordingly.**	**(SPO4.1)**	
Main Intervention	**4.2.1 Enhance infrastructure, logistics, and healthcare worker capacity to support sustainable immunization services.**		
Activity	4.2.1.1 Recruiment of 14 vaccinators at the borders.	4.2 Session quality	High
Activity	4.2.1.2 Plan and implement the introduction of the HPV vaccine into the national immunization schedule: training of health workers on HPV introduction including training on microplans development.	4.4 Multiple Sub-Components of Service Delivery	High
Objective	**4.3 Establish integrated delivery points of contact between immunization and other public health interventions for different target age groups and institute an MoPH directive mandating card review/screening in all PHCC consultations and assigning a data focal point per PHCC.**	**(SPO4.2)**	
Main Intervention	**4.3.1 Monitor referral completion and immunization updates.**		
Activity	4.3.1.1 Monitor referral completion based on keyperformance indicators.	4.3 Integration	High
Objective	**SP5: IMMUNIZATION COVERAGE & AEFI MONITORING** **5.1 By 2030, establish a unified and interoperable national immunization information system that integrates all EPI-related digital platforms (PHENICS, MERA, MERA Pro) under a single governance , accountability structure and funding framework; enable defaulter notifications, and formalize private-sector reporting via policy and incentives.**	**(SPO 1.5, GIA 7.2)**	
Main Intervention	**5.1.1. Unify EPI digital platforms (PHENICS, MERA &MERA PRO,Sohatana), including interface with DHIS2.**		
Activity	5.1.1.1 Update the feasibility study with stakeholders(IT, EPI team, NITAG, UNICEF.....) by reviewing the system in-place while conducting consultations on technical assessment.	5.1 HR & systems Immunization Coverage	Low
Activity	5.1.1.2 Integrate a referral tracking module and a GIS-based geomapping system within the unified immunization platform to monitor children referred through outreach activities and visualize immunization facility coverage, enabling verification of service uptake, estimation of population by area, and targeted interventions for underserved communities.	5.1 HR & systems Immunization Coverage	Medium
Activity	5.1.1.3 Develop technical working group(EPI, IT, WHO, UNICEF, NITAG) to steer integration and oversee development (kick off meeting).	5.1 HR & systems Immunization Coverage	Medium
Activity	5.1.1.4 Pilot integrated systems and referral system.	5.1 HR & systems Immunization Coverage	Medium
Activity	5.1.1.5 Recruitment of 9 IT officers for the support of routine vaccination activities and campaigns (900 PHCCs and dispensaries and 30 vaccine distribution center + main warehouse) - development of MERA, PHENICS, Sohatouna - at all levels.	5.1 HR & systems Immunization Coverage	Medium
Activity	5.1.1.6 Update yearly Phenics through using "Telerik reporting tools dev craft ultimate" and "Telerik angular tools dev craft ultimate"	5.1 HR & systems Immunization Coverage	High
Activity	5.1.1.7 Establish and continuously update a digital reporting system for maintenance logs, repairs, and performance tracking using tools such as Power BI, iSpring, Telerik Angular, and Telerik Reporting.	5.1 HR & systems Immunization Coverage	High
Activity	5.1.1.8 Integrate AI functionalities within the PHENICS system to enhance vaccine management by detecting potential fraud in vaccine dispensing and enabling speech-to-text features for automated recording of medical notes, diagnoses, and prescriptions.	5.1 HR & systems Immunization Coverage	High
Activity	5.1.1.9 Develop Dashboard using DevExpress Universal Subscription on yearly basis.	5.1 HR & systems Immunization Coverage	High
Main Intervention	**5.1.2. Implement automated SMS/WhatsApp reminders for due/defaulter children and routine.**		
Activity	5.1.2.1 Present findings to the minister for buy in and connect with the ministry of communication for supporting message sent for free or for low cost without limits.	5.2 Recording & reporting	Medium
Activity	5.1.2.2 Integrate a defaulter tracing and tracking module within the HIS to monitor children missing scheduled vaccinations and include automated reminder functionality.	5.2 Recording & reporting	High
Activity	5.1.2.3 Develop multilingual (Arabic, English, French) reminder messages and conduct regular pilot testing to validate system functionality and user responsiveness.	5.2 Recording & reporting	Low
Main Intervention	**5.1.3 Develop and integrate the PHENICS Academy e-learning system to train all immunization providers, with course content developed through universities, modules designed by an e-learning specialist, and full linkage between PHENICS and the ELMS for automated user access, role-based course assignment, and progress tracking.**		
Activity	5.1.3.1 Course elaboration: Create interactive e-learning modules aligned with SOP content, covering key EPI components (cold chain, data reporting, AEFI, microplanning, etc.), receiving feedback and integrate changes as needed.	5.1 HR & systems Immunization Coverage	Medium
Activity	5.1.3.2 Elearning IT developer specialist for integration of courses.	5.1 HR & systems Immunization Coverage	Medium
Activity	5.1.3.3 Full integration between PHENICS and the elearning system (ELMS) by automatically creating accounts on ELMS (electronic learning Management System), assign courses accordingly to each users' role, and link the service delivery functions on PHENICS to the completeness of the elearing courses.	5.1 HR & systems Immunization Coverage	Medium
Activity	5.1.3.4 Make completion of specific modules mandatory for new and existing staff, with certification requirements.	1.3 Planning & procurement	Medium
Activity	5.1.3.5 Track participation, completion rates, and post-training performance improvements through a digital platform.	1.3 Planning & procurement	Medium
Main Intervention	**5.1.4 EPI focal point in District office generate monthly data quality and timeliness reviews.**		
Activity	5.1.4.1 Train EPI focal point and immunization staff on reporting by filling, interpeting the tools, detecting and investigating AEFI.	5.3 Data quality	Medium
Activity	5.1.4.2 Integrate EPI indicators into the PHC dashboard for performance monitoring and generate a monthly report by EPI focal point to MoPH.	5.3 Data quality	High
Activity	5.1.4.3 EPI team audit private doctors clinics using the EPI checklist developed by the IT team.	5.3 Data quality	Medium
Main Intervention	**5.1.5. Implement routine data quality assessments with standardized validation checks and provide corrective coaching at PHC level, while generating monthly HIS dashboards at governorate and district levels to identify coverage gaps and inform targeted micro-planning.**		
Activity	5.1.5.1 TRain EPI focal points on the WHO data quality tool.	5.4 Coverage monitoring & use	Medium
Activity	5.1.5.2 Integrate the M&E framework in the EPI system and share the DQA SOP with key stakeholders at central level to be refined based on feedback.	5.4 Coverage monitoring & use	High
Activity	5.1.5.3 Training on data quality for 50 nurses and 50 physicians (different every year).	5.4 Coverage monitoring & use	Low
Activity	5.1.5.4 Procure licenses for platform use (Power Bi) to provide credentials to authorized personnel (EPI focal point, district field coordinator and physicians).	5.4 Coverage monitoring & use	Medium
Activity	5.1.5.5 Integrate the material and upload the case investigation forms and lab results on PHENICS.	5.4 Coverage monitoring & use	High

Activity	5.1.5.6 Establish a digital interface between PHENICS platform and the AEFI system (vigiflow) system to enable automatic case sharing, and review status tracking, and outcome.	5.4 Coverage monitoring & use	High
Objective	**SP6: SURVEILLANCE** **6.1 By 2030 70% of eligible physicians are included in the regular reporting of VPDs through ESU reporting mechanism, fund surveillance positions and integrate communicable-disease reporting modules into medical education/CME with private-sector incentives.**	**(SPO 1.4, SPO 1.5)**	
Main Intervention	**6.1.1 Enhance VPD surveillance by supporting staff capacity, integrating reporting education into health professional licensing, engaging private clinics through training and directives, and providing easy-to-use electronic reporting tools.**		
Activity	6.1.1.1 Provide 26 VPD field surveillance kits	6.1 HR & systems Disease Surveillance	Medium
Activity	6.1.1.2 Conduct joint surveillance–lab coordination meetings at central level	6.1 HR & systems Disease Surveillance	Medium
Activity	6.1.1.3 Translate and digitize modules into Arabic and French	6.1 HR & systems Disease Surveillance	Low
Activity	6.1.1.4 Workshop for the professionals orders on LMS 1 day every year	6.1 HR & systems Disease Surveillance	High
Activity	6.1.1.5 Produce and disseminate guidance materials to syndicates	6.1 HR & systems Disease Surveillance	High
Activity	6.1.1.6 Draft and issue official directive memos mandating VPD reporting from private clinics using national case definitions	6.1 HR & systems Disease Surveillance	High
Activity	6.1.1.7 Disseminate guidance to approximately 2000 private clinics focusing on pediatric/vulnerable groups/ ones in remote areas via regional health offices and syndicates	6.1 HR & systems Disease Surveillance	Medium
Activity	6.1.1.8 Provide job aids, reporting forms, and posters with VPD case definitions and reporting flowcharts	6.1 HR & systems Disease Surveillance	Low
Activity	6.1.1.9 Establish/Maintain a call center / helpdesk for technical assistance on VPD case reporting (staffed at MOH)	6.1 HR & systems Disease Surveillance	Low
Activity	6.1.1.10 Establish feedback mechanisms (monthly DHIS2 summary, WhatsApp groups per governorate)	6.1 HR & systems Disease Surveillance	Low
Activity	6.1.1.11 Conduct annual review meetings between MoPH and private sector clinics to assess participation and data quality	6.1 HR & systems Disease Surveillance	Medium
Activity	6.1.1.12 Ensure critical VPD reagents for central public Health Laboratory (procurement)	6.1 HR & systems Disease Surveillance	High
Activity	6.1.1.13 Implement Laboratory Management System (LMS)	6.1 HR & systems Disease Surveillance	High
Main Intervention	**6.1.2 Secure reagent supply chains, renew transport capacity/insurance, and rapid shipment of samples (e.g., to Syria polio lab) to ensure that by 2030, 80% of samples will be referred and tested in the reference labs.**		
Activity	6.1.2.1 Link all public hospital labs to national inventory tracking	6.2 Detection and response	High
Activity	6.1.2.2 Develop & roll out digital transport coordination system	6.2 Detection and response	Low
Activity	6.1.2.3 Standardize packaging & labeling using barcodes	6.2 Detection and response	High
Activity	6.1.2.4 Train 100% of lab & field staff on biosafety & shipment	6.2 Detection and response	Medium
Activity	6.1.2.5 Renew cross-border sample shipment agreements (e.g., Syria polio lab)	6.2 Detection and response	Medium
Activity	6.1.2.6 Develop simplified customs clearance for biologicals	6.2 Detection and response	High
Activity	6.1.2.7 Integrate specimen referral indicators into national dashboards	6.2 Detection and response	High
Activity	6.1.2.8 Conduct bi-annual training on sample referral & biosafety	6.2 Detection and response	High
Activity	6.1.2.9 Monitor and report sample referral timeliness quarterly (≥80% compliance by 2030)	6.2 Detection and response	High
Objective	**SP7: DEMAND GENERATION** **7.1 By 2030, Lebanon will achieve equitable, community-driven, and resilient routine immunization coverage exceeding 95%, powered by a national culture of trust, transparency, and proactive health-seeking behavior — where every child is protected, every caregiver is informed, and every community is engaged.**	**(GIA 6.2, GIA 6.3)**	
Main Intervention	**7.1.1 Strengthen Governance, Coordination, and Accountability Mechanisms: Reinforce institutional leadership and intersectoral coordination to ensure transparent, efficient, and equitable immunization service delivery.**		
Activity	7.1.1.1 Revitalize RCCE (Risk Communication and Community Engagement) task force into a national-led SBCC (Social and Behavior Change Communication) task force with subworking groups (TORs, coordination among MoPH, municipalities, NGOs, sectors and partners).	7.2 Advocacy & communication	Medium
Activity	7.1.1.2 Recruit a Communication Officer at MoPH central level to lead Risk Communication and Community Engagement (RCCE), act as liaison and to coordinate among different stakeholders, and to manage the hotline for responding to misinformation and counterfeit alerts, collect and analyze community feedback from health facilities and social media, and ensure continuous hotline operation and maintenance.	7.2 Advocacy & communication	High
Activity	7.1.1.3 Roll-out of SBC (Social Behavioral Change)-CE (Community Engagement) strategy for routine immunization among PHCCs and other staekholders including private sectors.	7.3 Community engagement	High
Activity	7.1.1.4 Update the training modules and conduct capacity building on SBC-CE, interpersonal communication, rumor management, and vaccine confidence for health workers and social mobilizers and other stakeholders.	7.2 Advocacy & communication	Medium
Activity	7.1.1.5 Set a national plan for mass and social media including rumor monitoring and media engament plan.	7.2 Advocacy & communication	High
Activity	7.1.1.6 Develop unified, evidence-based messages and design culturally appropriate visuals and IEC materials (posters, flyers, infographics).	7.1 Demand	Low
Activity	7.1.1.7 Organize annual community review meetings to assess progress and co-create future actions.	7.1 Demand	Low
Activity	7.1.1.8 Develop and implement an M&E framework for demand generation activities, including indicators for communication reach, community engagement, and behavior change.	7.3 Community engagement	Medium
Activity	7.1.1.9 Prepare semi-annual and annual reports summarizing progress, lessons learned, and recommendations for improvement.	7.2 Advocacy & communication	High
Main Intervention	**7.1.2 Build Community Ownership and Resilience: Empower communities to co-create, monitor, and sustain immunization efforts through inclusive participation and local leadership.**		
Activity	7.1.2.1 Conduct supportive supervision and mentoring visits to evaluate training effectiveness and reinforce key messages including conducting regular feedback meetings and performance tracking for trained personnel.	7.3 Community engagement	High
Activity	7.1.2.2 Analyze and share findings with local authorities and communities to co-develop tailored interventions.	7.3 Community engagement	High
Activity	7.1.2.3 Broadcast awareness campaigns via TV, radio, and social media; collaborate with influencers and local radios.	7.3 Community engagement	High
Activity	7.1.2.4 Organize community interacting and engagement events with NGOs, youth groups, volunteers and other stakeholders.	7.3 Community engagement	High
Activity	7.1.2.5 Conduct training sessions and refresher courses for health workers, volunteers, and local leaders on communication and community engagement and engage trained social mobilizers to conduct household surveys, FGDs, and interviews with community leaders to identify barriers.	7.3 Community engagement	High

7. NIS monitoring and evaluation framework for action

7.1 Province Scorecard Indicators and Feedback Mechanisms

Scorecard is a list of key indicators that will be used to monitor progress towards meeting the country NIS goal/vision, and which will be shared with partners and stakeholders. Table 6 shows the PIS scorecard.

Table 6: Lebanon NIS 2026-2030 Scorecard by IA 2030 Impact Goals

Indicators	Source of Data	Baseline 2025	2026	2027	2028	2029	2030
1. Prevent disease							
Has the country achieved Polio (Wild Polio virus and cVDPV2) eradication?	MoPH	Yes	Yes	Yes	Yes	Yes	Yes
Has the country achieved hepatitis B elimination?		No					Yes
Has the country achieved Neonatal Tetanus elimination?		Yes	Yes	Yes	Yes	Yes	Yes
Measles incidence: Number of measles cases per 100,000 population		0.9	0.6	0.4	0.2	0.1	0
Number of large/disruptive measles outbreaks		0	0	0	0	0	0
2. Promote equity							
Number of new vaccines introduced?	MoPH	Nil	HPV				
Proportion (%) of zero dose children	Coverage trend analysis 2025	15	13	12	11	10	10
Proportion of governorate with Penta3 coverage >=80%		37.5%	50%	62.5%	75%	87.5%	100%
3. Build strong Immunization programs							
Penta3 coverage	Coverage trend analysis 2025	59%	65%	70%	75%	78%	80%
MVC2 coverage		40%	51%	56%	59%	62%	64%
PCV3 coverage		64%	70%	75%	77%	79%	80%
IPV1 Coverage		85%	87%	88%	89%	90%	92%
HPV coverage		NA	NA	50%	60%	65%	70%

Please refer to Annex 4 for the Monitoring and Evaluation Framework of the strategy.

Table 7: Key Indicators by Sub-components/Objectives *(**Core indicators aligned with IA2030/GIA)*

Sub-Component	Indicator	Source of data	Base-line	Target Value (by years)				
				2026	2027	2028	2029	2030
1. Programme Management and Financing								
1.1 Policy & guidance	Existence of a consolidated, signed MoPH package of EPI policy, SOPs and HIS standards.	MoPH decree, official circulars	No	Yes	Yes	Yes	Yes	Yes
1.2 Governance & Accountability	Proportion (%) of ICC/NITAG/subnational committees that met ≥75% of planned times with minutes and decisions.	Meeting minutes, attendance sheets	NA	70	80	90	95	100
1.3 Planning & procurement	Existence of a single costed annual EPI plan aligned to NIS and national health strategy/budget cycle.	Approved annual plan, budget	NA	Yes	Yes	Yes	Yes	Yes
1.4 Partners Coordination	Proportion (%) of planned national/subnational EPI partner meetings conducted with joint workplan updates.	Meeting minutes	NA	70	80	85	90	95
1.5 Budgeting & Financing	Proportion (%) of total routine immunization (vaccines + operations) financed from domestic public resources. **	MoPH/MoF financial reports**	20[12]**	30**	40**	50**	55**	60**
2. Human Resources Management								
2.1 Human Resource Planning	Proportion (%) of facilities providing RI that meet nationally defined EPI human resource strategy norms.	HRIS, facility assessments	NA	50	60	70	75	80
2.2 Capacity Building	Proportion (%) of EPI staff trained or refreshed with the approved curriculum in last 24 mo.	Training database	NA	60	70	80	90	95
2.3 Supervision &performance monitoring	Proportion (%) of RI facilities receiving at least one supportive supervision visit per quarter. **	Standard Compliance Checklist**	NA**	60**	70**	80**	90**	95**
3. Vaccine Supply, Quality and Logistics								
3.1 Cold Chain	Proportion (%) of vaccine storage points with functional, WHO-prequalified CCE **	CCE nventory, **	NA**	70**	80**	90**	95**	100**
	Proportion (%) of vaccine storage points with continuous temperature monitoring within 2–8°C. **	temp logs**	NA**	70**	80**	90**	95**	100**
3.2 Supply Management	Proportion (%) of PHCCs maintaining minimum stock levels for all scheduled RI vaccines**	LMIS, stock reports**	80**	85	90**	93**	95**	100**
3.3 Transport	Proportion (%) of vaccine shipments with complete and acceptable temperature records.	Cold chain transport records	80	85	90	93	95	100
3.4 Waste Management	Proportion (%) of facilities observed complying with national standards for segregation, storage and disposal. **	Supervision/ DQA tools**	NA**	70**	80**	90**	95**	100**
4. Service Delivery								
4.1 Human	Proportion (%) of surviving infants who did not	WUENIC,	15**	13**	12**	11**	10**	10**

[12] Definite data not available. This impression is based on World Bank and UNICF reports

Sub-Component	Indicator	Source of data	Base-line	Target Value (by years)				
				2026	2027	2028	2029	2030
Resource and Strategies	receive the first dose of a DTP-containing vaccine (zero-dose). **	surveys, HMIS**						
4.2 Session Quality	Proportion (%) of planned RI sessions (fixed + outreach) conducted as scheduled. **	Session registers, micro-plans**	NA**	70**	80**	90**	95**	100**
4.3 Integration	Proportion (%) of PHCCs where immunization status is checked and vaccination offered at all eligible PHC/MNCH service points (ANC, PNC, under-5 visits). **	Facility assessments **	80**	90**	90**	95**	95**	100**
5. Immunization Coverage and AEFI Monitoring								
5.1 Human resource and systems	Proportion (%) of targeted private facilities enrolled in the national RI reporting system.	HIS, registration lists	NA	50	60	70	75	80
5.2 Recording and reporting	Proportion (%) of registered private facilities submitting complete RI reports on time. **	Monthly reports**	NA	50	60	70	75	80
5.3 Data quality	Proportion (%) of targeted facilities where DQA was conducted as planned.	DQA reports	0	40	50	60	65	70
5.4 Coverage monitoring and use	Proportion (%) of months for which RI coverage dashboards are produced and disseminated on time. **	Dashboard files**	NA	40	50	60	65	70
5.5 AEFI Monitoring	Proportion (%) of districts with designated AEFI focal point or committee meeting at least annually.	AEFI records	NA	70	80	90	95	100
6. Disease Surveillance								
6.1 Disease surveillance	Proportion (%) of assigned sites submitting timely and complete VPD surveillance reports.**	Surveillance reports	NA	70**	80**	85**	90**	95**
6.2 Detection and response	Proportion (%) of VPD specimens arriving at reference labs within required time and in good condition.**	Lab registers, shipment logs	NA	70**	80**	85**	90**	95**
6.3 Performance	Proportion (%) of districts/governorates achieving agreed core VPD surveillance indicators (e.g. non-polio AFP rate, non-measles febrile rash illness (NMFRI) rate, completeness etc).**	Surveillance records	NA	50**	60**	65**	70**	75**
7. Demand Generation								
7.1 Demand	Proportion (%) of identified high-risk/zero-dose communities with implemented SBC plans linked to RI services. **	SBC plans, activity reports	NA	50**	60**	65**	70**	75**
7.2 Advocacy and communication	Proportion (%) of PHCCs with ≥1 staff trained in interpersonal communication for vaccination.	Training records	NA	50	70	80	85	90
7.3 Community Management	Proportion (%) of PHCCs with documented functional community committees/volunteers engaged in RI.	Standard Compliance checklist/add accreditation standards	NA	50	70	80	85	90

Detailed indicators are available as annexure

8. NIS Costing, Budgeting and Financing

8.1 Costing - needs resource allocation

The components of the strategy have been outlined in specific objectives, interventions and activities that have been costed using the "NIS.Cost" online tool, which facilitated budgeting and financing operations.

Comprehensive and detailed reports (data, assumptions, sources, and analyses) can be downloaded from the online tool NIS.Cost - Lebanon 2025

It is important to note that:

- The resource requirements for the EPI represent overall projections to inform future budget discussions, with more detailed estimates to be developed in each annual operational plan.
- Implementation timelines align with the NIS planning period for 2026–2030.
- Costs estimates are not fixed but preliminary projections, influenced by variable factors like demographics, market prices, and inflation; figures rely on weighted averages and approximations.
- Costing of NIS interventions was developed using inputs from the Ministry of Health's EPI team, stakeholder consultations, and prioritization criteria including impact, feasibility, cost-effectiveness, and alignment with national health goals.
- The costing includes both high-priority interventions and other essential activities needed to meet strategic objectives over the five-year period.
- Unit costs were derived from national procurement databases, UNICEF and WHO estimates, and other reliable sources. Vaccine costs are based on local market prices and UNICEF Supply Division rates, using target coverage projections and current UNICEF-negotiated procurement prices.
- Demographic projections used for vaccine forecasting costs reflect the most recent data available from national statistics and UN population estimates.

❖ Total Resource Needed for NIS Implementation (2026-2030)

Total resource needs have been estimated at around **106,262,160 USD**.

Resource costs are expected to fluctuate due to economic factors like inflation, exchange rates, supply chain processes, and others. Programmatic changes, such as scaling up services or introducing new vaccines, will influence costs. Additionally, workforce wages, population shifts, outbreaks, and political drive will add variability.

Table 8: National Immunization Strategy Program Costs by EPI Component and Year

Resource requirements of the EPI Programme Components projected over 5 years (USD)	YEAR 1 2026	YEAR 2 2027	YEAR 3 2028	YEAR 4 2029	YEAR 5 2030	TOTAL USD / COMPONENT
1. Programme Management and Financing 6.53M	1,315,150	1,124,710	1,487,870	1,124,710	1,482,040	**6,534,480**
2. Human Resources Management 0.19M	60,430	32,430	32,430	32,430	32,430	**190,150**
3. Vaccine Supply, Quality and Logistics 87.37M	14,117,124	18,353,836	17,849,190	18,074,626	18,979,949	**87,374,725**
4. Service Delivery 8.08M	3,687,785	1,169,150	1,071,020	1,086,750	1,068,365	**8,083,070**
5. Immunization Coverage and AEFI Monitoring 1.16M	311,092	244,627	212,347	197,347	197,347	**1,162,760**
6. Disease Surveillance 0.89M	196,030	171,030	176,030	171,030	176,030	**890,150**
7. Demand Generation 2.03M	409,365	404,365	404,365	404,365	404,365	**2,026,825**
TOTAL USD/YEAR	**20,096,976**	**21,500,148**	**21,233,252**	**21,091,258**	**22,340,526**	**106,262,160**

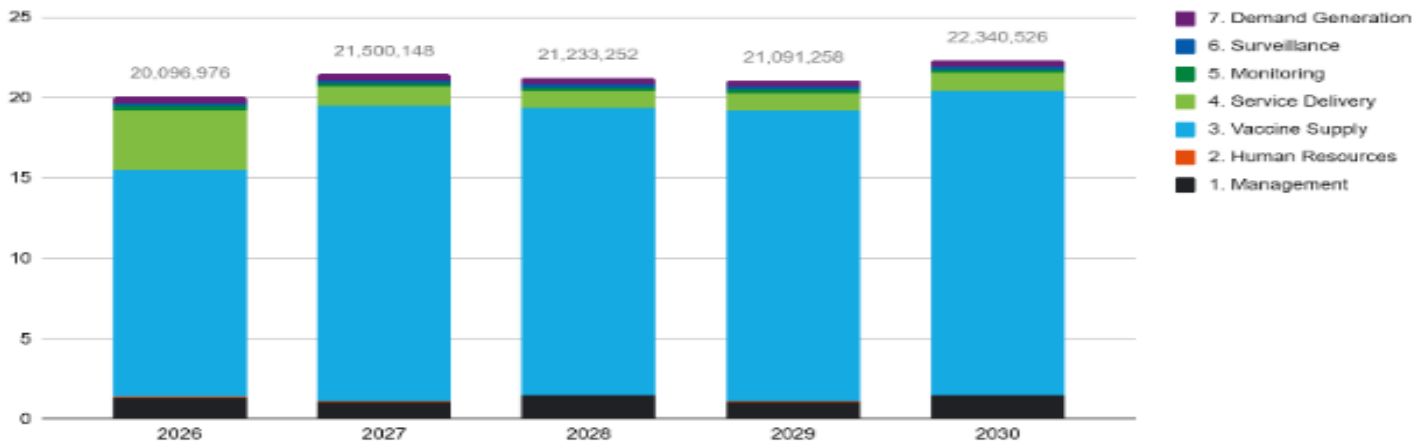


Figure 4: Costs by Component per Year

Overall, the resource needs analysis shows that for every year, the main cost driver is the "**Vaccine Supply, Quality, and Logistics**" component (due to vaccine procurement), accounting for around **82% of total costs**, while other components collectively represent around 18% of total resource needs.

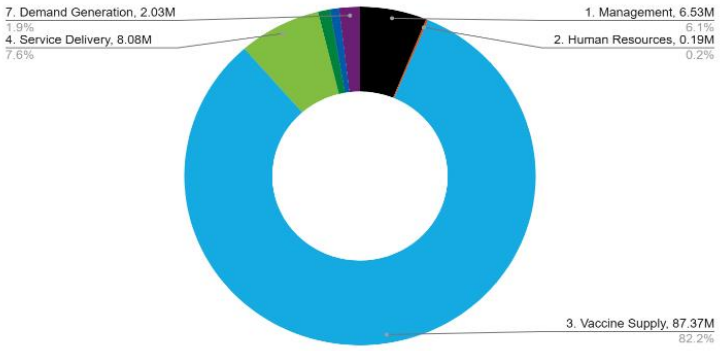


Figure 5: EPI Component Weight

❖ Resource Needed Split Between Activity Types

The resource needs analysis shows that 52% of total costs are attributed to new activities and 48% to routine operations. This distribution highlights a **transitional investment phase**, where significant resources are allocated to **system strengthening and scale-up efforts to bring the immunization program up to global benchmarks of quality, efficiency, and coverage —** consistent with WHO/UNICEF expectations for a high-performing EPI. The higher share allocated to f new activities reflects the need to **address programmatic and operational gaps** and support the transition toward an efficient and sustainable routine immunization **performance level**. Over time, as systems are strengthened, the cost structure is expected to **shift toward routine operations**, maintaining performance through sustained financing.

Table 9: Total Costs by Activity Type

Type	Total USD
Routine/Recurrent, 51.18M	51,178,824
New, 55.08M	55,083,336

Figure 6: Resource Needs based on Activity's Types

❖ Total Resource Needs by Expense Line Items

The largest expense is vaccine procurement (around 80 M USD) followed by the workforce wages costing around 6M USD. Equipment (CCE and office/furniture equipment), operational costs of campaigns, and outreach have almost the same share, each of approximately 4 M USD in total.

Table 10: Total Costs by Expense Line Items

LINE ITEMS OF COSTING	Total USD
Vaccines	79,625,350
Recruitment	6,016,000
Equipment	4,087,000
Campaigns	4,000,000
Outreach	3,990,000
Third Party	3,500,000
Workshop	1,901,445
Other	1,210,000
Technical assistance	528,800
Printing	440,000
Studies, Assessments, Evaluation	299,750
Meeting	272,830
Digitalization	179,585
Media	141,400
Supervision & Follow Up	70,000

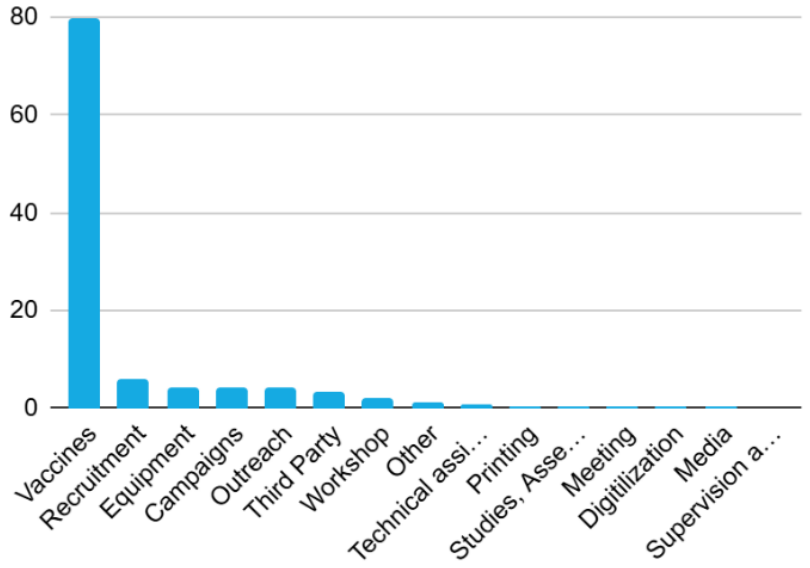


Figure 7: Costs of Expense Line items

❖ Vaccines: Cost Implications of Vaccines Procurement

Vaccine procurement costs were estimated using the National Immunization Schedule, the EPI-defined coverage objectives, the target population projections from the Department of Statistics, and antigen-specific unit prices provided by UNICEF Supply Division (SD). Calculations incorporate demographic stratification, target coverage assumptions, wastage rates, buffer stock requirements, and cold-chain–related logistics costs (handling, freight, insurance, and inspection fees (around 20%). Expenditures reflect the full cost of vaccines and associated injection supplies. All estimates follow standard UNICEF-SD forecasting and budgeting methodologies.

Cost variations across antigens are driven by differences in unit pricing and volume requirements. The introduction of new vaccine and schedule expansions particularly HPV significantly increase forecasted needs. Estimated wastage rates are 5% for PCV adults and Influenza adults, 10% for Rotavirus, Pentavalent, IPV, Hepatitis B, DPT, bOPV, MMR, HPV; 15% for PCV and dT, and 20% for measles vaccines.

The total resource needs estimate for vaccines, including consumables and logistics costs, is approximately **79,625,350 USD**, representing around **75% of the total strategy cost**.

Routine vaccine procurement accounts for USD 25,786,154 (32%), while new antigens represent USD 53,839,196 (68%), highlighting the significant investment needed to introduce and scale up new vaccines.

From 2026 to 2030, total vaccine costs increase steadily. The sharp rise from 2026 to 2027 reflects HPV introduction, after which costs grow more gradually due to demographic increases and higher coverage targets. This pattern aligns with a multi-year expansion strategy designed to sustain routine vaccination while integrating newer antigens.

For HPV introduction, unit prices vary by product: the bivalent vaccine is estimated at USD 2.9 per dose, compared to USD 4.5 per dose for the quadrivalent vaccine. The table below illustrates how these price differences translate into substantial budget implications when vaccinating the same cohort of girls and boys aged 9–16 years.

Table 11: Budget Implications of HPV antigen choice

Antigen Description	Y2	Y3	Y4	Y5	2027	2028	2029	2030	**Total USD**
HPV vaccine 2-valent, 1 dose, 2.90 USD	75%	95%	95%	98%	5,603,445	5,715,581	5,743,101	5,953,128	**23,015,255**
HPV vaccine 4-valent, 1 dose, 4.50 USD	75%	95%	95%	98%	8,672,838	8,840,798	8,883,365	9,208,233	**35,605,234**

The bivalent vaccine will cost around 23 M USD and the tetravalent will cost around 35 M USD over 4 years. It is important to mention that the private sector procures 50% of the HPV tetravalent vaccine. The introduction of new vaccines represents a long-term fiscal commitment that requires **sustained domestic financing**. Multi-year budgeting, scenario modelling, and annual recalibration of procurement forecasts are recommended, along with close coordination between MoPH, UNICEF-SD, and national financial authorities to ensure financial sustainability.

Adult vaccination accounts for approximately 30,823,941 USD representing around 29% of the total costs of the vaccines over 5 years. The influenza vaccine and the PCV for adults' vaccines are not yet introduced in the national immunization schedule however are available in the retail market by private agents.

❖ Recruitment: Cost Implications of Human Resources workforce

There is a substantial need for strengthening the human resource base. The proposed recruitment of additional staff amounts to around **USD 6 million, representing 22% of the total programme costs excluding vaccines.** These positions address key operational gaps in planning, supervision, cold chain management, data systems, and communication. Given the scale and long-term implications of this investment, a comprehensive workforce assessment is essential before finalizing recruitment to determine actual needs across all levels, identify functional gaps, assess task optimization opportunities, and validate the necessity and cost-effectiveness of each position.

❖ Equipment, campaigns, outreach - cost implications

The NIS estimates approximately USD 4 million in procurement needs for cold chain equipment, office furniture, and vehicles—representing a major share of operational investments. While these categories are essential for effective service delivery, a detailed needs assessment is required to ensure financial efficiency and long-term sustainability. Cold chain investments should be aligned with updated inventory data, storage capacity needs, maintenance strategies, and deployment feasibility. Office and facility equipment must be based on asset audits and staffing projections to avoid unnecessary purchases. Vehicle procurement—critical for supervision, outreach, and outbreak response—should consider fleet condition, coverage gaps, opportunities for shared use, and full operational costs. **Overall, procurement should be guided by evidence-based assessments to determine what must be replaced, repaired, redistributed, or phased, ensuring that resources are allocated strategically and cost-effectively**.

The USD 4 million estimate for vaccination campaigns reflects **preparedness needs** rather than routine expenditures, as campaigns are only triggered by outbreaks or low coverage. This amount likely represents an upper-bound projection, with actual costs depending on epidemiological trends, routine performance, surveillance sensitivity, and timely implementation of NIS strengthening measures. If routine services improve and immunity remains stable, nationwide campaigns may not be required, reducing financial needs. To ensure efficiency, campaign budgets should be regularly **updated using real-time data, adjusted annually during operational planning, and directed toward targeted, evidence-based responses** rather than large-scale mass campaigns.

Table 12: Budget Implications of Outreach

Activity Description	2026	2027	2028	2029	2030	Total USD
Grand Total	2,910,000	270,000	270,000	270,000	270,000	3,990,000
4.1.2.2 Develop targeted outreach activities for PHCC to reach zero-dose children in remote / underserved areas.	0	0	0	0	0	0
4.1.2.3 Asalemeh Project	2,640,000	0	0	0	0	2,640,000
7.1.1.3 Roll-out of SBC (Social Behavioral Change)-CE (Community Engagement) strategy for routine immunization among PHCCs and other stakeholders including private sectors.	150,000	150,000	150,000	150,000	150,000	750,000
7.1.2.4 Organize community interacting and engagement events with NGOs, volunteers and other stakeholders.	120,000	120,000	120,000	120,000	120,000	600,000

The ASalameh project that has been running since April 2024, represents a **major investment of over USD 2.5 million for 2026**. Given the magnitude of this investment and its substantial share within the overall strategy, a **comprehensive evaluation is essential** to determine whether the project is cost-effective and whether the outcomes justify the resources mobilized.

Only the first-year cost was included in the NIS analysis, as the project's **long-term vision, sustainability, and integration within routine health services remain unclear**. Without a multi-year cost projection or a clear institutionalization plan, it is difficult to assess the financial viability of continuing such a resource-intensive model. Moreover, given the current fiscal constraints in Lebanon, it is important to critically examine whether a large-scale community platform such as ASalameh remains the most efficient approach, or whether resources would be **better allocated to targeted outreach led by PHCCs**, focusing on zero-dose and underserved populations in remote areas. Such an approach may offer **higher cost-efficiency**, clearer accountability, and stronger alignment with the core objectives of the programme.

8.2 Financing and Financial Sustainability Strategies

The total estimated budget required for the implementation of the national immunization strategy over the coming five years amounts to approximately USD 106 million. Notably, the Government of Lebanon has committed USD 42 million, covering nearly 40% of the overall need. This substantial contribution reflects a **strong national commitment in ensuring the continuous availability of vaccines** across the country. In addition, the private sector funding mechanisms are expected to contribute approximately USD 38 million for vaccine procurement. The projected funding landscape indicates total expected contributions of **USD 80 million** from government and private sector sources, representing nearly **76% of all secured resources**. This reflects a strong national commitment to sustaining the program's long-term objectives.

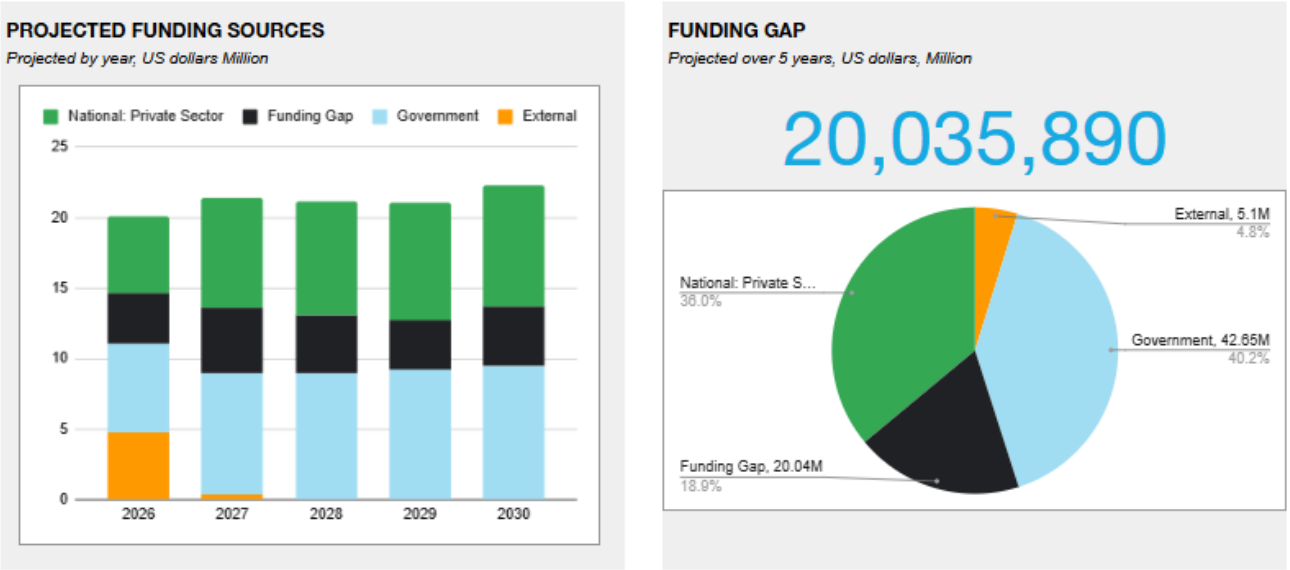
Private sector engagement emerges as a major pillar of financial sustainability. With projected contributions increasing from **USD 5.44 million in 2026** to **USD 8.59 million in 2030**, the private sector

represents a rapidly growing and reliable domestic partner. This trend underscores the importance of strengthening cross-sector alliances, formalizing corporate social responsibility partnerships, and developing structured engagement mechanisms to mobilize both financial and in-kind contributions.

External funding—amounting to **USD 5.1 million**, almost entirely concentrated in 2026 — plays an important catalytic role during the initial phase. However, the funding pipeline shows a sharp drop-in external support beyond the first year, underscoring the need for a deliberate, forward-looking resource mobilization effort. Sustaining the program's scale and quality in the outer years will require re-engaging development partners and expanding the donor base to mitigate the risks associated with this funding cliff. The existing resource envelope remains insufficient to fully meet programmatic needs.

Throughout the five-year period, a **funding gap of around USD 20 million** remains, representing an annual shortfall of approximately **18–20%**. The gap is highest in **2027 (USD 4.63 million)**, due to programmatic expansion.

Figure 8: *Projected Funding Sources per Year and Funding Gap projected over 5 years (USD)*



The funding gap for high-priority activities remains notably larger than that for lower-priority initiatives, reflecting a critical challenge in aligning available resources with the strategic priorities of the program. Bridging this gap will necessitate a collaborative approach, leveraging innovative financing mechanisms, fostering partnerships, and enhancing advocacy efforts to ensure that essential, high-impact interventions receive the financial support required.

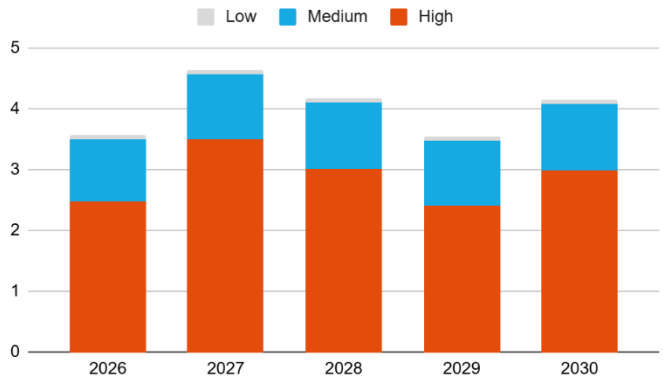


Figure 9: *Funding Gap per Type of Activity*

The chart below illustrates the amounts required to close the gap, based on the different spending lines (expense line items). Equipment and staffing (recruitment) require the highest amount, followed by expenses related to campaigns, third-party contractors, outreach and workshops activities.

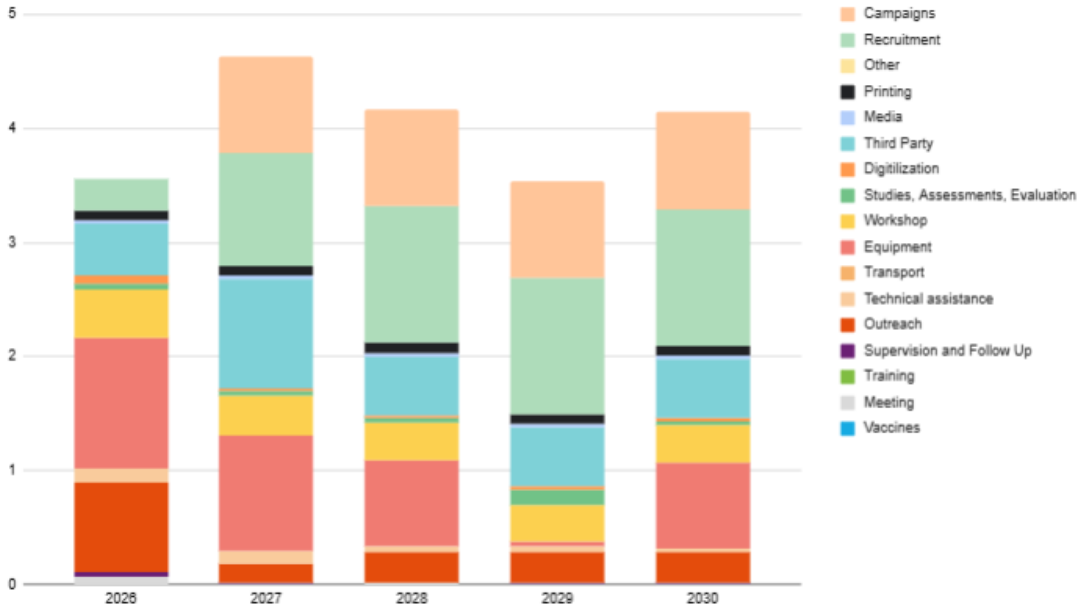


Figure 10: *Funding Gap based on Expense Line Items*

8.3 Development Partner Engagement and Prospects for Support

Lebanon's immunization strategy has benefited from the technical and financial engagement of several key development partners, each contributing in complementary ways to strengthen the national program. While ongoing support remains critical, all partners are facing funding constraints and are currently unable to confirm multi-year financial commitments beyond 2026. Despite these limitations, all partners have expressed their commitment to continue providing technical support, aligning with government priorities, and identifying opportunities for future collaboration.

Gavi has long supported Lebanon's immunization programme, including through MICS, and will fund 50% of HPV vaccines for 10-year-old girls in 2026, as well as technical assistance through UNICEF and WHO. However, it cannot yet confirm support beyond 2026. **WHO** continues to provide essential technical guidance in policy, surveillance, and system performance, but also faces funding limits affecting future financial commitments. **UNICEF** remains central to vaccine procurement, cold chain, training, social mobilization, and digital systems, while continuing to mobilize resources despite global constraints.

Premiere Urgence International (PUI) contributes by strengthening PHC centers, improving service delivery, and supporting outreach to vulnerable groups. The **International Medical Corps** (**IMC)** reinforces immunization within humanitarian health services, enhancing data quality, service delivery, and community outreach for displaced and underserved populations. The **Lebanese Red Cross (LRC)** is a key operational partner, supporting risk communication and community engagement (RCCE), digital systems, community surveillance, and mobile vaccination to reach hard-to-access areas.

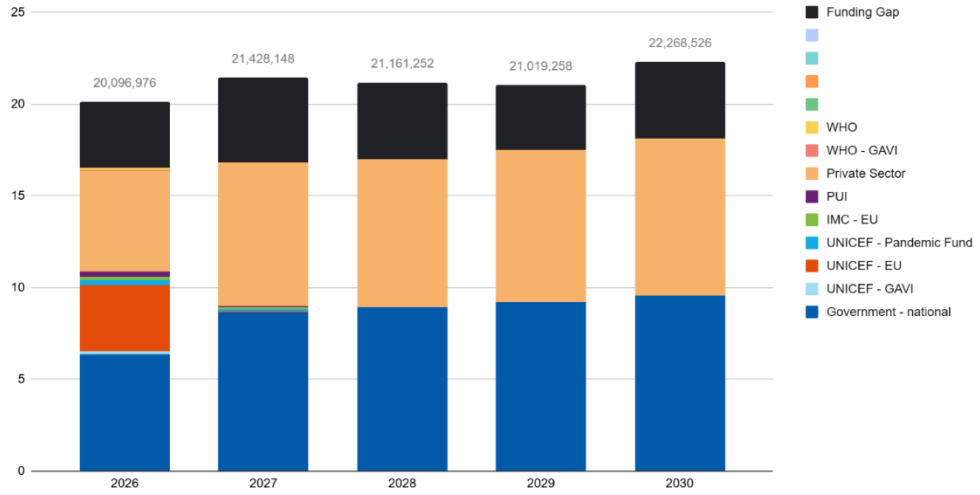


Figure 11: *Projected Funding Sources*

In light of the government's strong financial commitment, covering **nearly 40% of the total estimated immunization strategy budget**, these partnerships are vital to bridging the remaining funding gap. Continued collaboration, joint planning, and advocacy will be essential to ensure that Lebanon's immunization agenda remains on track and resilient in the face of fiscal challenges. Development partners are encouraged to consider increased and multi-year investments to close the remaining funding gap, strengthen system-wide capacity, and support the delivery of equitable and high-quality immunization services. Strategic support in areas such as **supply chain integration, data systems, health workforce, and outreach to underserved communities** will be key to maximizing the impact of existing resources and ensuring long-term immunization coverage and resilience.

The existing **positive collaboration** between the government and donors will be a key factor for the successful implementation of the strategy. This collaboration will help expand vaccination coverage, strengthen the health system's capacity, and ensure access to essential vaccines for all citizens. The close partnership will facilitate the mobilization of the additional resources required.

When allocating funds, it is crucial to prioritize closing the financial gap for **high-priority activities**, especially if the government has access to **flexible funding**. This ensures optimal resource allocation based on the most critical and strategic needs.

This approach will initiate in-depth **budgetary dialogue** among stakeholders, reflecting a **collective commitment** to vaccination and strengthening preparedness to achieve the defined objectives. The early mobilization of funds ensures the availability of the necessary financial resources to support the vaccination program, enabling more flexible fund management.

Annexes

Annexure 1: National Vaccination Calendar

Annexure 2: National Health Accounts

Annexure 3: Baseline and projected coverage rates for vaccines offered and planned

Annexure 4: M&E Framework NIS Lebanon

Annexure 5: Costing, budgeting and financing details

REPUBLIC OF LEBANON
MINISTRY OF PUBLIC HEALTH

National Calendar for vaccination

Child's Age	Vaccine	Doses
At Birth (During the first few hours in the hospital)	Hepatitis B	Zero Dose (Hospital)
2 months	IPV (Inactivated Polio Vaccine)	1st Dose
	Penta (DPT, Hib, Hep. B)	
	Rota vaccine	
4 months	IPV (Inactivated Polio Vaccine)	2nd Dose
	Penta (DPT, Hib, Hep. B)	
	Rota vaccine	
	Pneumococcal vaccine (PCV13)	1st Dose
6 months	OPV (Oral Polio Vaccine)	3rd Dose
	Penta (DPT, Hib, Hep. B)	
	Rota vaccine	
	Pneumococcal vaccine (PCV13)	2nd Dose
9 months	Measles	Zero Dose
12 months	MMR (Measles, Mumps, Rubella)	1st Dose
	Pneumococcal vaccine (PCV13)	Booster
18 months	OPV (Oral Polio Vaccine)	1st Booster
	Penta (DPT, Hib, Hep. B)	
	MMR (Measles, Mumps, Rubella)	2nd Dose
4 - 5 years	OPV (Oral Polio Vaccine)	2nd Booster
	DPT (Diphtheria, Pertussis, Tetanus)	
10 - 12 years	OPV (Oral Polio Vaccine)	3rd Booster
	dT	
16 - 18 years	OPV (Oral Polio Vaccine)	4th Booster
	dT	

Annex 2. National Health Accounts selected data[1]

NHA key indicators	2019	2020	2021
Total health expenditure as percentage of GDP	8.69	8.03	3.06*
General government expenditure on health as percentage of total health expenditure	27.31	25.10	14.80
Public expenditure on health as percentage of total health expenditure (includes social insurance)	49.29	40.56	23.56
Private expenditure on health as percentage of total health expenditure	50.71	59.44	76.44
Out-of-pocket expenditure as percentage of public expenditure on health	60.56	48.14	37.07
Out-of-pocket expenditure as percentage of total health expenditure	30.71	28.61	28.34
Total expenditure on health per capita	8.58	4.36	3.86
General government expenditure on health as percentage of GDP	2.37	2.01	0.45
Total expenditure on health (US$)	4 624 863 577	1 980 611 187	666 907 757
Total expenditure on health per capita (US$)	746.0	350.0	118.0
General government expenditure on health (per capita) (US$)	204.0	88.0	17.0
Private expenditure on health (per capita) (US$)	378.0	208.0	90.0
Private insurance (including private mutuals) (per capita) (US$)	124.0	50.0	25.0
Out-of-pocket expenditure (per capita) (US$)	229.0	100.0	33.0
Gross domestic product(US$)**	53 198 009 950	24 677 668 901	21 800 000 000

** Including an estimate of non-Lebanese; **GDP figures for 2019 and 2020 are official government figures while the 2021 figure was the World Bank estimate in US$ converted to Lebanese Pound because there is no official DP figure to date.*

[1] 34. NHA key indicators, 2019–2021. Beirut, Ministry of Public Health (https://www.moph.gov.lb/userfiles/images/Statistics/NHA%20Key%20Indicators%2C%202019-2020-2021.pdf).

Annex 3. Baseline and projected coverage rates for vaccines offered and planned

Indicator/antigen	Baseline	Future years				
Routine immunization	**2025***	**2026**	**2027**	**2028**	**2029**	**2030**
Hepatitis B (Hep B) – birth dose	92%	94%	95%	96%	97%	98%
Pentavalent (DPT-HepB-Hib) – 1	85%	87%	88%	89%	90%	90%
Oral polio vaccine (OPV) – 3	60%	70%	75%	80%	85%	90%
Pentavalent (DPT-HepB-Hib) – 3	59%	65%	70%	75%	78%	80%
Pneumococcal conjugate vaccine (PCV) – 1	92%	94%	95%	95%	95%	95%
Pneumococcal conjugate vaccine (PCV) – 3	64%	70%	75%	77%	79%	80%
Rotavirus vaccine – 1	88%	92%	94%	95%	95%	95%
Rotavirus vaccine – 2	53%	60%	65%	70%	73%	75%
Inactivated polio vaccine (IPV) – 1	85%	87%	88%	89%	90%	92%
Measles containing vaccine (MCV) – 1	74%	80%	83%	85%	87%	89%
Measles containing vaccine (MCV) – 2	40%	51%	56%	59%	62%	64%
Human papillomavirus vaccine 1 (HPV1)	NA	NA	75%	95%	95%	98%
DPT, Hep B, Hib 1-3 dropout rate	30%	25%	20%	16%	13%	11%
Measles dropout rate	46%	36%	33%	31%	29%	28%
Number of zero-dose children	13076	11332	10461	9589	8717	8717

**A report jointly prepared by WHO, UNICEF and MoPH in mid-2025 "Immunization coverage trend Analysis" is used as baseline and for target setting. It may change when survey results are available.*

Annex 4: Monitoring and Evaluation Framework NIS Lebanon

Key Indicators by Sub-components/Objectives

1. Programme management and financing							
1.1 Policy and guidance							
SPO	Secure MoPH endorsement of an integrated EPI Policy & SOPs and user-friendly HIS standards and roll it out nationwide by 2030.						
Indicator name	Integrated EPI Policy & SOPs endorsed						
Definition	Binary indicator confirming existence of a consolidated, signed MoPH package of EPI policy, SOPs and HIS standards.						
Numerator	Yes, if endorsed and in force; no if not						
Denominator	-						
Primary data source	MoPH decree, official circulars						
Frequency of data collection and measurement	Once (baseline, then on revision)						
Level of measurement	National						
Responsible office for measurement & action	MoPH/EPI, Legal Affairs						
Targets	Baseline	2026	2027	2028	2029	2030	
	No	Yes	Yes	Yes	Yes	Yes	
1.2 Governance and accountability							
SPO	Strengthen governance by creating more oversight committees with clear ToR at central and subnational levels, to coordinate vaccination activities and robust monitoring of coverage and service performance.						
Indicator name	Functional oversight committees						
Definition	Proportion (%) of ICC/NITAG/subnational committees that met ≥75% of planned times with minutes and decisions.						
Numerator	# oversight bodies meeting functionality criteria i.e. ≥75% of planned times with minutes and decisions						
Denominator	Total # oversight bodies established						
Primary data source	Meeting minutes, attendance sheets						
Frequency of data collection and measurement	Annual						
Level of measurement	National/ Governorate						
Responsible office for measurement & action	MoPH/EPI, ICC/NITAG Secretariats						
Targets	Baseline	2026	2027	2028	2029	2030	

		70	80	90	95	100	
1.3 Planning and procurement							
SPO	Synchronize the EPI multiyear and annual plans with the national health strategies and budgets, integrating HRD, equitable distribution of vaccines, and O&M of cold chain.						
Indicator name	Aligned, costed annual EPI plan						
Definition	Existence of a single costed annual EPI plan aligned to NIS and national health strategy/budget cycle.						
Numerator	Yes if aligned costed plan approved; No if not						
Denominator	-						
Primary data source	Approved annual plan, budget						
Frequency of data collection and measurement	Annual						
Level of measurement	National						
Responsible office for measurement & action	MoPH/EPI, Planning & Finance Depts						
Targets	Baseline	2026	2027	2028	2029	2030	
		Yes	Yes	Yes	Yes	Yes	
1.4 Partner coordination							
SPO	Strengthen capacity of governance/technical bodies for planning, coordination, and tracking progress at all levels by constituting a national ICC with TORs and meeting cadence, and formalize governorate/district partner coordination with quarterly workplans.						
Indicator name	Joint partner coordination meetings held						
Definition	Proportion (%) of planned national/subnational EPI partner meetings conducted with joint workplan updates.						
Numerator	# meetings held w/ documentation						
Denominator	# meetings planned						
Primary data source	Meeting minutes						
Frequency of data collection and measurement	Quarterly						
Level of measurement	National/ Governorate						
Responsible office for measurement & action	MoPH/EPI, partners						
Targets	Baseline	2026	2027	2028	2029	2030	
		70	80	85	90	95	
1.5 Budgeting and finance							

SPO	Ensure sustainable financing for the EPI program by mobilizing domestic and partner resources to maintain vaccine supply and achieve equitable immunization coverage.						
Indicator name	Government share of RI costs (IA2030/Gavi-aligned health financing)						
Definition	Proportion (%) of total routine immunization (vaccines + operations) financed from domestic public resources.						
Numerator	Govt RI expenditure						
Denominator	Total RI expenditure						
Primary data source	MoPH/MoF financial reports						
Frequency of data collection and measurement	Annual						
Level of measurement	National						
Responsible office for measurement & action	MoPH, MoF, EPI						
Targets	Baseline	2026	2027	2028	2029	2030	
	20	30	40	50	55	60	

2. Human resource management							
2.1 Human resource planning							
SPO	Ensure the availability of an adequate, effective, sustainable health workforce by a comprehensive EPI Human Resource Strategy, endorsed by the Ministry of Public Health, and implemented in at 100% of districts, defining staffing norms, competencies, and retention mechanisms.						
Indicator name	Facilities meeting EPI staffing human resource strategy norms						
Definition	Proportion (%) of facilities providing RI that meet nationally defined EPI human resource strategy norms.						
Numerator	# RI facilities meeting EPI human resource strategy norms						
Denominator	Total RI facilities						
Primary data source	HRIS, facility assessments						
Frequency of data collection and measurement	Annual						
Level of measurement	District/Facility						
Responsible office for measurement & action	MoPH HR, EPI						
Targets	Baseline	2026	2027	2028	2029	2030	
		50	60	70	75	80	

2.2 Capacity-building							
SPO	Improve technical and managerial capacity of health care workers by launching a national EPI competency framework and annual training plan with dedicated budget and cascade mentoring at all levels.						
Indicator name	Coverage of standardized EPI training						
Definition	Proportion (%) of EPI staff trained or refreshed with the approved curriculum in last 24 months.						
Numerator	# EPI staff trained/refreshed						
Denominator	Total # EPI staff						
Primary data source	Training database						
Frequency of data collection and measurement	Annual						
Level of measurement	National/District						
Responsible office for measurement & action	EPI, Training Dept						
Targets	Baseline	2026	2027	2028	2029	2030	
		60	70	80	90	95	

2.3 Supervision and performance monitoring							
SPO	Strengthen programme performance monitoring and management systems at all levels by implementing a supervision standard (frequency, tools, feedback loop) and require documented closure of findings within 30 days.						
Indicator name	Supervision coverage						
Definition	Proportion (%) of RI facilities receiving at least one supportive supervision visit per quarter.						
Numerator	# facilities visited ≥1/quarter						
Denominator	Total RI facilities						
Primary data source	Supervision reports						
Frequency of data collection and measurement	Quarterly						
Level of measurement	District/Facility						
Responsible office for measurement & action	DOs, EPI						
Targets	Baseline	2026	2027	2028	2029	2030	
		60	70	80	90	95	

3. Vaccine supply, quality and logistics							
3.1 Cold chain							
SPO	By 2030, increase capacity and quality of vaccine storage to achieve 100% functional WHO prequalified cold chain equipment across all PHCCs and vaccinaton points with real-time temperature monitoring and managed qualified staff, and preventive maintenance contracts with defined roles at Qada/PHC.						
Indicator name	Functional CCE rate (IA2030 supply-aligned)						
Definition	Proportion (%) of vaccine storage points with functional, WHO-prequalified CCE						
Numerator	# storage points meeting criteria						
Denominator	Total storage points						
Primary data source	CCE inventory						
Frequency of data collection and measurement	Quarterly						
Level of measurement	All levels						
Responsible office for measurement & action	EPI logistics						
Targets	Baseline	2026	2027	2028	2029	2030	
		70	80	90	95	100	
Indicator name	Functional CCE rate (IA2030 supply-aligned)						
Definition	Proportion (%) of vaccine storage points with continuous temperature monitoring within 2–8°C.						
Numerator	# storage points meeting criteria						
Denominator	Total storage points						
Primary data source	Temp logs						
Frequency of data collection and measurement	Quarterly						
Level of measurement	All levels						
Responsible office for measurement & action	EPI logistics						
Targets	Baseline	2026	2027	2028	2029	2030	
		70	80	90	95	100	
3.2 Supply management							
SPO	By 2030, secure high-quality supply chains for vaccines and related commodities and effective vaccine management, within the primary health care supply system by introducing unified forecasting that captures private sector,						

	establish denominators, and train designated vaccine managers at central/DO/PHC levels.						
Indicator name	Facilities without stock-out of any RI antigen in last 30 days (IA2030/Gavi core)						
Definition	Proportion (%) of PHCCs maintaining minimum stock levels for all scheduled RI vaccines						
Numerator	# facilities without stock-out						
Denominator	Total reporting facilities						
Primary data source	LMIS, stock reports						
Frequency of data collection and measurement	Monthly/Quarterly						
Level of measurement	District/Facility						
Responsible office for measurement & action	EPI logistics, DOs						
Targets	Baseline	2026	2027	2028	2029	2030	
		70	80	90	95	100	
3.3 Transport							
SPO	By 2030, fund and operationalize a dedicated vaccine transport plan (vehicles, cold boxes/refrigerated trucks, schedules, drivers, fuel) from central to DOs and DOs to service points with temperature log verification.						
Indicator name	Shipments with complete temperature documentation						
Definition	Proportion (%) of vaccine shipments with complete and acceptable temperature records.						
Numerator	# shipments with valid temp logs						
Denominator	Total shipments						
Primary data source	Cold chain transport records						
Frequency of data collection and measurement	Quarterly						
Level of measurement	National/District						
Responsible office for measurement & action	EPI logistics						
Targets	Baseline	2026	2027	2028	2029	2030	
		70	80	90	95	100	
3.4 Waste management							

SPO	By 2030, approve and implement a national immunization waste policy andstandard waste management protocols, extending training beyond needles/vials to end-to-end handling and disposal.						
Indicator name	Facilities complying with immunization waste SOPs						
Definition	Proportion (%) of facilities observed complying with national standards for segregation, storage and disposal.						
Numerator	# compliant facilities						
Denominator	Total facilities assessed						
Primary data source	Supervision/DQA tools						
Frequency of data collection and measurement	Annual						
Level of measurement	Facility						
Responsible office for measurement & action	MoPH EHS, EPI						
Targets	Baseline	2026	2027	2028	2029	2030	
		70	80	90	95	100	

4. Service delivery							
4.1 Human resources and strategies							
SPO	Extend immunization services to regularly unreached “zero-dose” and underimmunized children and communities by using micro-planning with defined denominators and private-sector reporting to target and serve zero-dose areas through routine outreach.						
Indicator name	Zero-dose DTP1 prevalence (IA2030 IG 2.1)						
Definition	Proportion (%) of surviving infants who did not receive the first dose of a DTP-containing vaccine (zero-dose).						
Numerator	# surviving infants 12–23m without DTP1						
Denominator	Total surviving infants 12–23m						
Primary data source	WUENIC, surveys, HMIS						
Frequency of data collection and measurement	Annual						
Level of measurement	National/Subnational						
Responsible office for measurement & action	EPI						
Targets	Baseline	2026	2027	2028	2029	2030	

	15	13	12	11	10	10	
4.2 Session quality							
SPO	Strengthen immunization policies and service delivery where facilities track dropouts monthly, extend service hours where needed, and schedule catch-up/outreach accordingly.						
Indicator name	Planned fixed & outreach sessions conducted						
Definition	Proportion (%) of planned RI sessions (fixed + outreach) conducted as scheduled.						
Numerator	# sessions conducted						
Denominator	# sessions planned						
Primary data source	Session registers, micro-plans						
Frequency of data collection and measurement	Monthly						
Level of measurement	Facility/District						
Responsible office for measurement & action	PHC facilities, DOs						
Targets	Baseline	2026	2027	2028	2029	2030	
		70	80	90	95	100	
4.3 Integration							
SPO	stablish integrated delivery points of contact between immunization and other public health interventions for different target age groups and institute an MoPH directive mandating card review/screening in all PHCC consultations and assigning a data focal point per PHCC						
Indicator name	PHCCs routinely offering RI at PHC/MNCH contacts						
Definition	Proportion (%) of PHCCs where immunization status is checked and vaccination offered at all eligible PHC/MNCH service points (ANC, PNC, under-5 visits)						
Numerator	# PHCCs meeting integration criteria						
Denominator	Total PHCCs						
Primary data source	Facility assessments						
Frequency of data collection and measurement	Annual						
Level of measurement	Facility						
Responsible office for measurement & action	PHC Dept, EPI						

Targets	Baseline	2026	2027	2028	2029	2030	
		70	80	90	95	100	

5. Immunization coverage and AEFI monitoring							
5.1 Human resources and system							
SPO	By 2027, strengthen immunization information within a robust health information system by establishing a unified and interoperable national immunization information system that integrates all EPI-related digital platforms (PHENICS, MERA, MERA Pro) under a single governance , accountability structure and funding framework; enable defaulter notifications, and formalize private-sector reporting via policy and incentives.						
Indicator name	Private facilities enrolled in national RI reporting						
Definition	Proportion (%) of targeted private facilities enrolled in the national RI reporting system.						
Numerator	# private facilities enrolled						
Denominator	Total targeted private facilities						
Primary data source	HIS, registration lists						
Frequency of data collection and measurement	Quarterly						
Level of measurement	National						
Responsible office for measurement & action	MoPH/EPI						
Targets	Baseline	2026	2027	2028	2029	2030	
	NA	50	60	70	75	80	
5.2 Recording and reporting							
SPO	Enforce private-sector reporting through regulation plus simplified workflows and periodic DO-led data quality reviews.						
Indicator name	Reporting completeness among private facilities						
Definition	Proportion (%) of registered private facilities submitting complete RI reports on time.						
Numerator	# private facilities w/ timely, complete reports						
Denominator	Total registered private facilities						
Primary data source	Monthly reports						
Frequency of data collection and measurement	Monthly						

Level of measurement	District/National						
Responsible office for measurement & action	MoPH/EPI, DOs						
Targets	Baseline	2026	2027	2028	2029	2030	
	NA	50	60	70	75	80	
5.3 Data quality							
SPO	Implement quarterly data quality assessment (DQAs) with standard validation checks (including unique identifier <UID>/proxy rules) and corrective coaching at PHC level.						
Indicator name	Targeted facilities with completed DQA						
Definition	Proportion (%) of targeted facilities where DQA was conducted as planned.						
Numerator	# facilities with DQA done						
Denominator	# facilities targeted						
Primary data source	DQA reports						
Frequency of data collection and measurement	Quarterly/Annual						
Level of measurement	District						
Responsible office for measurement & action	EPI, DOs						
Targets	Baseline	2026	2027	2028	2029	2030	
	0	40	50	60	65	70	
5.4 Coverage monitoring and use							
SPO	Produce monthly governorate/district coverage dashboards on HIS using improved denominators and trigger targeted micro-plans for gaps to strengthen programme performance monitoring and management systems at all levels .						
Indicator name	Timely production of dashboards						
Definition	Proportion (%) of months for which RI coverage dashboards are produced and disseminated on time.						
Numerator	# months with timely dashboards						
Denominator	12						
Primary data source	Dashboard files						
Frequency of data collection and measurement	Monthly						
Level of measurement	National/Subnational						

Responsible office for measurement & action	EPI						
Targets	Baseline	2026	2027	2028	2029	2030	
	NA	40	50	60	65	70	
5.5 AEFI monitoring							
SPO	Train focal points at all levels, activate a national AEFI committee workflow, and deploy a standard rapid response & risk-communication protocol.						
Indicator name	Districts with functional AEFI focal point/committee						
Definition	Proportion (%) of districts with designated AEFI focal point or committee meeting at least annually.						
Numerator	# districts with functional AEFI structure						
Denominator	Total districts						
Primary data source	AEFI records						
Frequency of data collection and measurement	Annual						
Level of measurement	District						
Responsible office for measurement & action	EPI, NRA/Pharmacovigilance						
Targets	Baseline	2026	2027	2028	2029	2030	
	NA	70	80	90	95	100	

6. Disease surveillance	
6.1 Disease surveillance	
SPO	Build and strengthen comprehensive vaccine-preventable disease surveillance through ESU reporting mechanism, to ensure that by 2030 70% of eligible physicians are included in the regular reporting of VPDs , fund surveillance positions and integrate communicable-disease reporting modules into medical education/CME with private-sector incentives.
Indicator name	Timely & complete VPD reporting sites
Definition	Proportion (%) of sentinel/assigned sites submitting timely and complete VPD surveillance reports.
Numerator	# sites w/ timely, complete reports
Denominator	Total surveillance sites
Primary data source	Surveillance reports

Frequency of data collection and measurement	Monthly						
Level of measurement	District/National						
Responsible office for measurement & action	MoPH Surveillance, EPI						
Targets	Baseline	2026	2027	2028	2029	2030	
	NA	70	80	85	90	95	
6.2 Reporting and response							
SPO	Secure reagent supply chains, renew transport capacity/insurance, and formalize rapid shipment agreements (e.g., to Syria polio lab) to ensure that by 2030, at least 80% of samples will be referred and tested in the reference labs.						
Indicator name	Specimens meeting timeliness & quality standards						
Definition	Proportion (%) of VPD specimens arriving at reference labs within required time and in good condition.						
Numerator	# specimens meeting standards						
Denominator	Total specimens received						
Primary data source	Lab registers, shipment logs						
Frequency of data collection and measurement	Quarterly						
Level of measurement	District/National						
Responsible office for measurement & action	Lab & Surveillance units						
Targets	Baseline	2026	2027	2028	2029	2030	
	NA	70	80	85	90	95	
6.3 Performance							
SPO	Enhance surveillance performance based on proper organization of ESU team, and on private sector cooperation..						
Indicator name	Districts/governorates meeting core VPD performance indicators						
Definition	Proportion (%) of districts/governorates achieving agreed core VPD surveillance indicators (e.g. non-polio AFP rate, non-measles febrile rash illness (NMFRI) rate, completeness etc).						
Numerator	# districts meeting benchmarks						
Denominator	Total districts						
Primary data source	Surveillance scorecards						

Frequency of data collection and measurement	Annual						
Level of measurement	District/National						
Responsible office for measurement & action	MoPH Surveillance						
Targets	Baseline	2026	2027	2028	2029	2030	
	NA	50	60	65	70	75	

7. Demand generation							
7.1 Demand							
SPO	Design and implement social and behaviour change interventions by launching a national SBCC strategy with trust-building narratives, rumor tracking, and feedback loops linked to service improvements.						
Indicator name	Priority communities with SBC plans implemented						
Definition	Proportionn (%) of identified high-risk/zero-dose communities with implemented SBC plans linked to RI services.						
Numerator	# communities with SBC implemented						
Denominator	# identified priority communities						
Primary data source	SBC plans, activity reports						
Frequency of data collection and measurement	Annual						
Level of measurement	District/Community						
Responsible office for measurement & action	MoPH/EPI, partners						
Targets	Baseline	2026	2027	2028	2029	2030	
	NA	50	60	65	70	75	
7.2 Advocacy and communication							
SPO	Re-tool communication from broadcast to interpersonal/community-centric approaches; train PHC teams in IPC and deploy targeted content.						
Indicator name	PHCCs with staff trained in IPC for immunization						
Definition	Proportion (%) of PHCCs with ≥1 staff trained in interpersonal communication for vaccination.						
Numerator	# PHCs with trained IPC staff						
Denominator	Total PHCCs						

Primary data source	Training records						
Frequency of data collection and measurement	Annual						
Level of measurement	Facility						
Responsible office for measurement & action	PHC Dept, EPI						
Targets	Baseline	2026	2027	2028	2029	2030	
	NA	50	70	80	85	90	
7.3 Community engagement							
SPO	Embed community engagement roles; establish two-way feedback channels and private-sector commitments to public health goals.						
Indicator name	PHCCs with active community engagement mechanisms						
Definition	Proportion (%) of PHCCs with documented functional community committees/volunteers engaged in RI.						
Numerator	# PHCs with active mechanism						
Denominator	Total PHCCs						
Primary data source	Standard Compliance checklist						
Frequency of data collection and measurement	Annual						
Level of measurement	Facility						
Responsible office for measurement & action	PHC Dept, EPI						
Targets	Baseline	2026	2027	2028	2029	2030	
	NA	50	70	80	85	90	

Lebanon

BUDGET OF NATIONAL IMMUNIZATION STRATEGY BUDGET

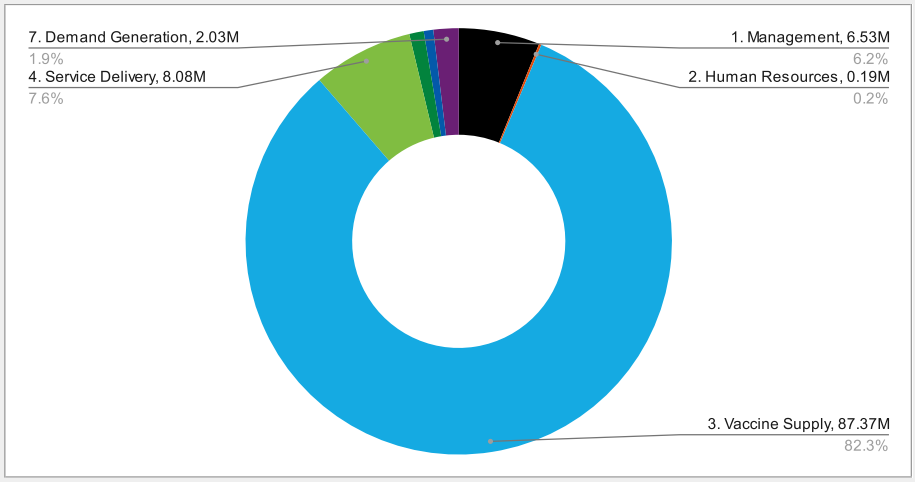
Resource requirements projected over 5 years, US dollars

106,142,160

An investment of USD 17.9 per capita

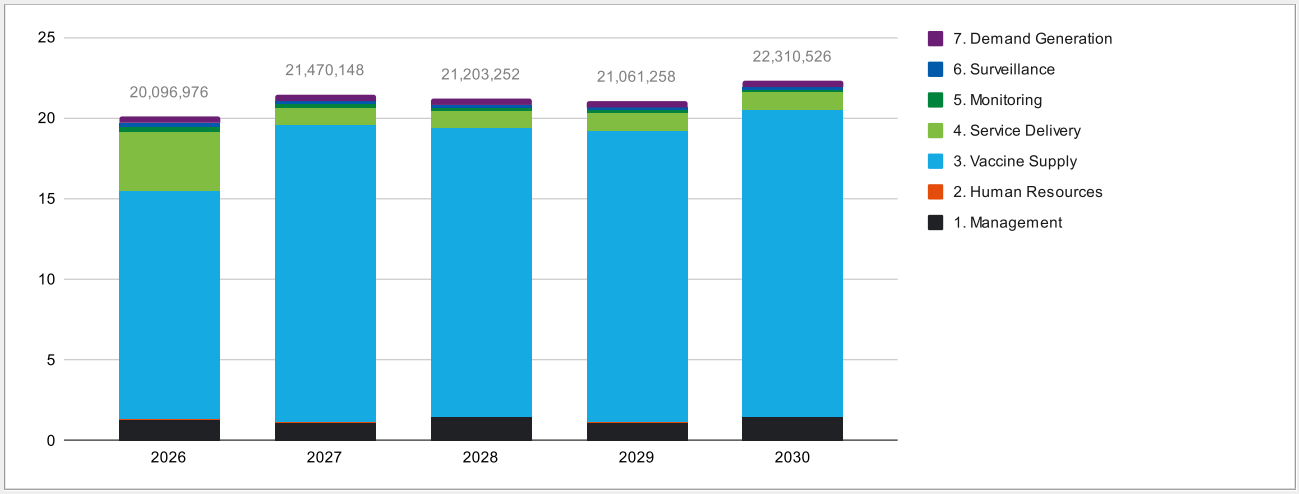
EPI PROGRAMME COMPONENTS

Projected over 5 years, US dollars, Million



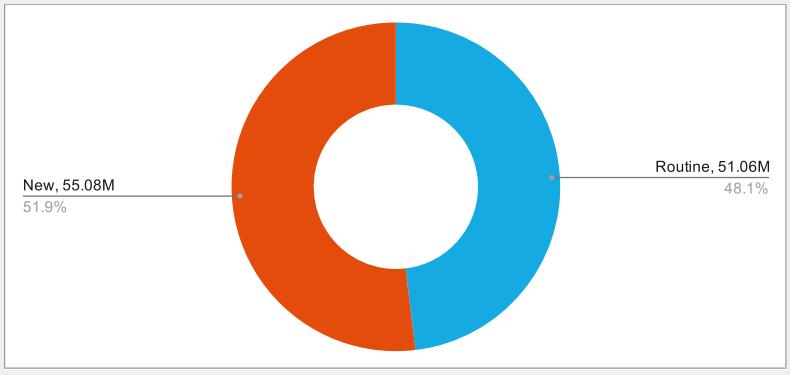
EPI PROGRAMME COMPONENTS

Projected by year, US dollars, Million



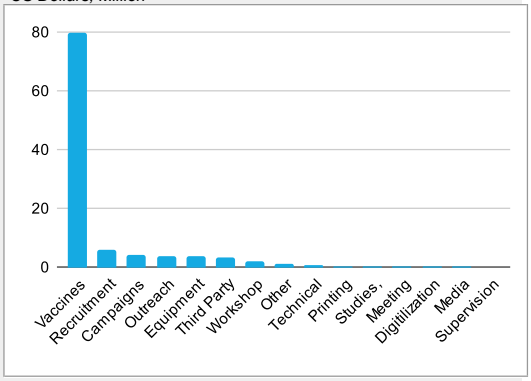
STRATEGIC INNOVATIONS

New strategies planned



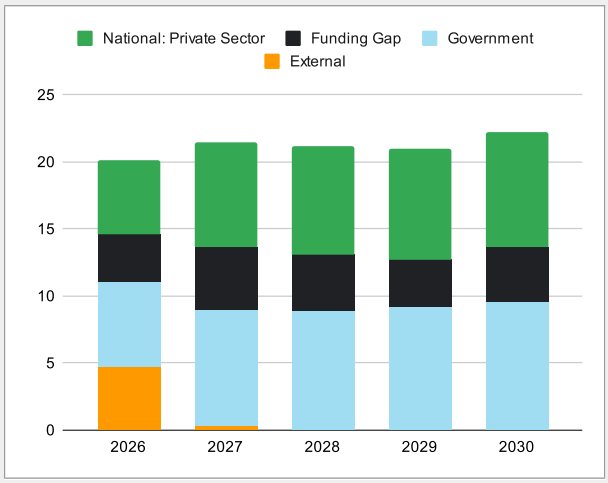
LINE ITEMS OF COSTING

US Dollars, Million



PROJECTED FUNDING SOURCES

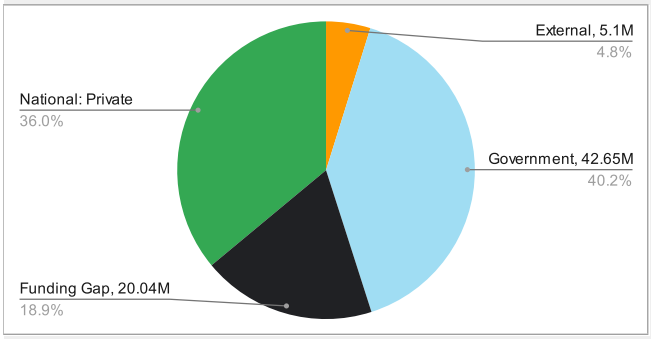
Projected by year, US dollars Million



FUNDING GAP

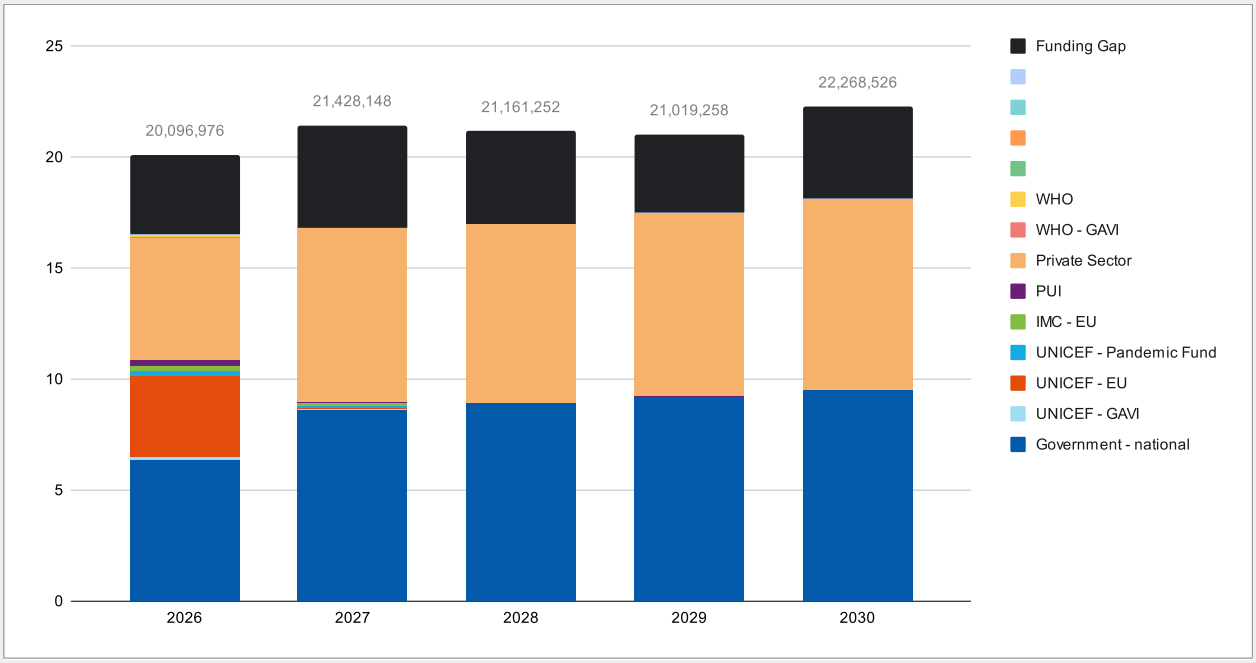
Projected over 5 years, US dollars, Million

20,035,890



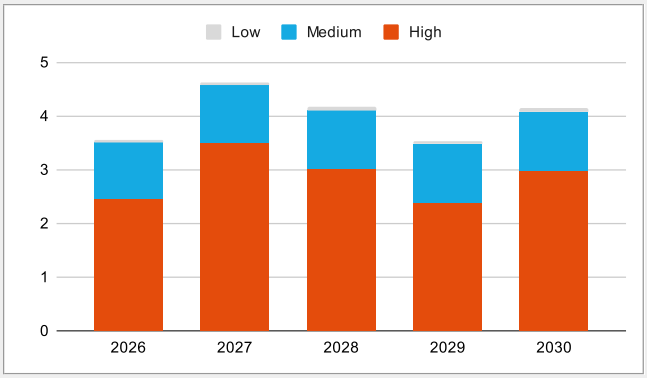
PROJECTED FUNDING SOURCES

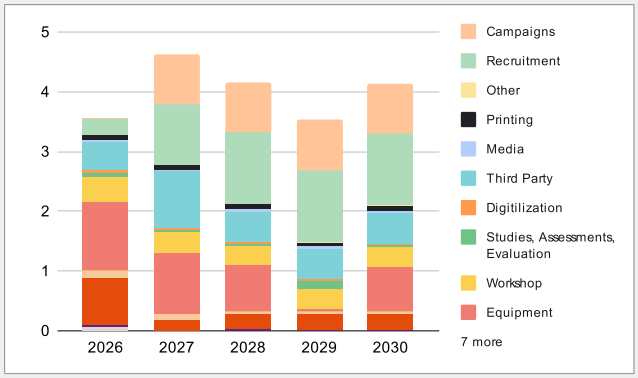
Projected over 5 years, US dollars, Million



FUNDING GAP

Detailed Funding Gap View By Priority and Costing Line Items, US Dollars, Million





VACCINATION SCHEDULE

National immuniation schedule

Activity	Cost Parameters	Type	2026	2027	2028	2029	2030
Rotavirus vaccine, liq., oral, 2 ds vial	RV1-2 ~ Surviving infants < 11 months old, USD 0.8	Routine	196,318	165,892	166,956	166,604	166,429
DTwP-HepB-Hib vac., lqd., 1 ds vial	DTP-HepB-Hib-1 (lqd) ~ Surviving infants < 11 months old, USD 1.27	Routine	447,953	375,711	378,394	381,836	381,436
Inactivated polio vaccine,sgl dose vial	IPV-1 ~ Surviving infants < 11 months old, USD 2.79	Routine	650,021	544,200	548,086	553,074	564,771
Pneumococcal conj.vacc,10-val.,5 ds vial	PCV10-5 ~ Surviving infants < 11 months old, USD 2.4	Routine	960,258	803,373	800,014	798,327	797,490
HepB vaccine, pediatric, vial of 1 dose	HepB-1 ~ Number of Newborns, USD 0.55	Routine	72,584	61,309	61,956	62,754	63,631
dT vaccine for 10-12 and 16-18,vial of 10 doses	Td-10 ~ Cohort 10-12 and 16-18 years old, USD 0.17	Routine	176,605	151,069	151,792	152,523	153,261
DPT vaccine,adsorbed,vial of 10 doses	DTP-10 ~ Surviving infants < 11 months old, USD 0.22	Routine	27,950	23,786	23,955	24,174	24,149
bOPV,bivalent type 1+3,vial of 10 doses	BOPV-10 ~ Children < 5 years old, USD 0.27	Routine	662,599	590,887	629,254	667,355	705,245
Measles vaccine, vial of 5 doses	MR-5 ~ Surviving infants < 11 months old, USD 0.57	Routine	71,369	61,589	62,811	64,153	65,559
MMR vaccine,vial of single dose	MMR-1 ~ Children < 5 years old, USD 3.73	Routine	2,258,337	2,066,316	2,173,465	2,279,792	2,348,782
HPV vaccine 2-valent, 1 dose vial	HPV2-1 ~ Cohort 9-16 years old (girls and boys) HPV, USD 2.9	New	0	5,603,445	5,715,581	5,743,101	5,953,128
HPV vaccine 4-valent, 1 dose	HPV4-1 ~ Cohort 9-16 years old (girls and boys) HPV, USD 4.5	New	0	0	0	0	0
Influenza vaccine for adults	Influvac Tetra ~ Cohort Influenza, USD 10.9	New	3,163,992	3,021,005	3,172,058	3,330,643	3,497,166
PCV for adults	PCV10-1 ~ Cohort PCV adults, USD 38	New	2,862,263	2,732,379	2,868,993	3,012,415	3,163,027

BACK

C. BUDGET BY EPI COMPONENTS

EPI Comoponents	Year 1	Year 2	Year 3	Year 4	Year 5	Total
Grand Total	20,096,976	21,470,148	21,203,252	21,061,258	22,310,526	106,142,160
1. PROGRAMME MANAGEMENT & FINANCING	1,315,150	1,124,710	1,487,870	1,124,710	1,482,040	6,534,480
1.1 Policy & guidance	148,440	0	5,830	0	5,830	160,100
1.2 Governance & accountability	835,200	835,200	835,200	835,200	835,200	4,176,000
1.3 Planning & procurement	42,260	14,260	365,760	14,260	365,760	802,300
1.4 Partner coordination	8,250	8,250	8,250	8,250	8,250	41,250
1.5 Budgeting and financing	281,000	267,000	272,830	267,000	267,000	1,354,830
1.6 Multiple Sub-Components of Program Management & Financing	0	0	0	0	0	0
2. HUMAN RESOURCES MANAGEMENT	60,430	32,430	32,430	32,430	32,430	190,150
2.1 HR planning	31,280	3,280	3,280	3,280	3,280	44,400
2.2 Capacity-building	29,150	29,150	29,150	29,150	29,150	145,750
2.3 Supervision & performance monitoring	0	0	0	0	0	0
2.4 Multiple Sub-Components of Human Resources Management	0	0	0	0	0	0
3. VACCINE SUPPLY, QUALITY & LOGISTICS	14,117,124	18,353,836	17,849,190	18,074,626	18,979,949	87,374,725
3.1 Cold chain	13,566,124	17,823,836	17,759,190	17,984,626	18,889,949	86,023,725
3.2 Supply chain management	0	0	0	0	0	0
3.3 Transport	90,000	90,000	90,000	90,000	90,000	450,000
3.4 Waste management	461,000	440,000	0	0	0	901,000
3.5 Multiple Sub-Components of Vaccine Supply, Quality & Logistics	0	0	0	0	0	0
4. SERVICE DELIVERY	3,687,785	1,169,150	1,071,020	1,086,750	1,068,365	8,083,070
4.1 HR & strategies	3,357,395	906,750	891,020	906,750	888,365	6,950,280
4.2 Session quality	180,000	180,000	180,000	180,000	180,000	900,000
4.3 Integration	82,400	82,400	0	0	0	164,800
4.4 Multiple Sub-Components of Service Delivery	67,990	0	0	0	0	67,990
5. IMMUNIZATION COVERAGE & AEFI MONITORING	311,092	244,627	212,347	197,347	197,347	1,162,760
5.1 HR & systems Immunization Coverage	285,294	176,549	186,549	171,549	171,549	991,490
5.2 Recording & reporting	8,000	8,000	8,000	8,000	8,000	40,000
5.3 Data quality	0	29,150	0	0	0	29,150
5.4 Coverage monitoring & use	17,798	30,928	17,798	17,798	17,798	102,120
5.5 AEFI monitoring	0	0	0	0	0	0
5.6 Multiple Sub-Components of Immunization Coverage & AEFI Mon	0	0	0	0	0	0
6. DISEASE SURVEILLANCE	196,030	141,030	146,030	141,030	146,030	770,150
6.1 HR & systems Disease Surveillance	117,465	72,465	77,465	72,465	77,465	417,325
6.2 Detection and response	78,565	68,565	68,565	68,565	68,565	352,825
6.3 Preformance	0	0	0	0	0	0
6.4 Multiple Sub-Components of Disease Surveillance	0	0	0	0	0	0

BACK

C. BUDGET BY EPI COMPONENTS

EPI Comoponents	Year 1	Year 2	Year 3	Year 4	Year 5	Total
7. DEMAND GENERATION	409,365	404,365	404,365	404,365	404,365	2,026,825
7.1 Demand	15,000	15,000	15,000	15,000	15,000	75,000
7.2 Advocacy & communication	38,000	38,000	38,000	38,000	38,000	190,000
7.3 Community engagement	356,365	351,365	351,365	351,365	351,365	1,761,825
7.4 Multiple Sub-Components of Demand Generation	0	0	0	0	0	0

5. REPORT

Priority | Type | Level | LINE ITEMS OF COSTING | INVESTMENT | Clear Filters

A. BUDGET BY ROADMAP

Level	Description	Year 1	Year 2	Year 3	Year 4	Year 5	Total
Level	Description	Year 1	Year 2	Year 3	Year 4	Year 5	Total
	Grand Total	20,096,976	21,470,148	21,203,252	21,061,258	22,310,526	106,142,160
Objective	1.0. - SP1: PROGRAMME MANAGEMENT AND FINANCING 1.1 Secure MoPH endorsement of an integrated EPI Policy & SOPs having one unified calendar, private-sector regulation & a userfriendly HIS standards and roll it out nationwide by 2030.	148,440	0	5,830	0	5,830	160,100
Main Intervention	1.1. - 1.1.1 Draft, consult, and approve unified EPI policy (calendar, private-sector duties, HIS/data standards).	143,440	0	5,830	0	5,830	155,100
Main Intervention	1.2. - 1.1.2 Monitoring the implementation of the ministerial decisions and the toolkit (SOPs, checklists, model contracts)	0	0	0	0	0	0
Main Intervention	1.3. - 1.1.3 Align all partner projects and MoPH directorates to the new policy (compliance clauses).	5,000	0	0	0	0	5,000
Objective	2.0. - 1.2 Strengthen governance by creating more oversight committees, coordination, and accountability through quarterly EPI performance reviews in the EPI program to ensure effective oversight of vaccination activities and robust monitoring of coverage and service performance	835,200	835,200	835,200	835,200	835,200	4,176,000
Main Intervention	2.1. - 1.2.1 Establish TORs, membership, and scorecards for national/governorate/district forums.	0	0	0	0	0	0
Main Intervention	2.2. - 1.2.3 Develop a dashboard using electronic monitoring tools and plan corrective actions based on the results and findings.	0	0	0	0	0	0
Main intervention	2.3. - 1.2.4 Recruit EPI focal points, cold chain experts, and quality officers at national and subnational levels to strengthen immunization program management, ensure effective cold chain operations, and enhance quality assurance	835,200	835,200	835,200	835,200	835,200	4,176,000
Objective	3.0. - 1.3 Synchronize the EPI multiyear and annual plans with the national budget cycle and approve a protected line-item for outreach, human resource development (HRD), equitable distribution of vaccines, and O&M of cold chain.	42,260	14,260	365,760	14,260	365,760	802,300
Main Intervention	3.1. - 1.3.1. Co-develop a costed annual plan of action tied to MoPH calendar.	14,260	14,260	365,760	14,260	365,760	774,300
Main Intervention	3.2. - 1.3.2. Create protected budget lines (outreach, HRD, distribution, cold-chain O&M).	28,000	0	0	0	0	28,000
Main Intervention	3.3. - 1.3.3. Introduce rolling forecasts for vaccines/supplies linked to procurement cycle (taking into consideration private sectors needs and newly introduced vaccines).	0	0	0	0	0	0

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Priority | Type | Level | LINE ITEMS OF COSTING | INVESTMENT | Clear Filters

A. BUDGET BY ROADMAP

Level	Description	Year 1	Year 2	Year 3	Year 4	Year 5	Total
Objective	4.0. - 1.4 Strengthen capacity of governance/technical bodies for planning, coordination, and tracking progress at all levels by constituting a national ICC with TORs and meeting cadence, and formalize governorate/district partner coordination with quarterly workplans.	8,250	8,250	8,250	8,250	8,250	41,250
Main Intervention	4.1. - 1.4.1. Establish district coordination platforms with designated representatives and hold semi-annual meetings to address coverage, logistics, outreach, AEFI, and zero-dose reduction.	8,250	8,250	8,250	8,250	8,250	41,250
Objective	5.0. - 1.5 Ensure sustainable financing for the EPI program by mobilizing adequate resources from government, PHCCs, and partners to maintain vaccine supply and achieve equitable immunization coverage	281,000	267,000	272,830	267,000	267,000	1,354,830
Main Intervention	5.1. - 1.5.1. Prepare MTEF(medium term expenditures framework) for EPI with fiscal space analysis and co-financing plan.	0	0	5,830	0	0	5,830
Main Intervention	5.2. - 1.5.2. Introduce performance-based allocations tied to coverage/quality.	0	0	0	0	0	0
Main Intervention	5.3. - 1.5.3. Mobilize additional sources	25,000	25,000	25,000	25,000	25,000	125,000
Main Intervention	5.4. - 1.5.4. Annual public expenditure review on EPI.	256,000	242,000	242,000	242,000	242,000	1,224,000
Objective	6.0. - SP2: HUMAN RESSOURCES 2.1 Ensure the availability of an adequate, effective, sustainable health workforce by a comprehensive EPI Human Resource Strategy, endorsed by the Ministry of Public Health, and implemented in at 100% of districts, defining staffing norms, competencies, and retention mechanisms.	31,280	3,280	3,280	3,280	3,280	44,400
Main Intervention	6.1. - 2.1.1 Develop EPI job descriptions as per organogramme and recruit/redeploy EPI staff to fill gaps in immunization staff at all levels	28,000	0	0	0	0	28,000
Main Intervention	6.2. - 2.1.2 Strengthen workforce retention through non-financial incentives, career pathways, and supportive work environments.	3,280	3,280	3,280	3,280	3,280	16,400
Objective	7.0. - 2.2 Improve technical and managerial capacity of health care workers by launching a national EPI competency framework and annual training plan with dedicated budget and cascade mentoring at all levels.	29,150	29,150	29,150	29,150	29,150	145,750
Main Intervention	7.1. - 2.2.1 Adapting innovative evidence-based, blended learning approaches for problem-solving and remote mentoring	0	0	0	0	0	0

5. REPORT

Priority | Type | Level | LINE ITEMS OF COSTING | INVESTMENT | Clear Filters

A. BUDGET BY ROADMAP

Level	Description	Year 1	Year 2	Year 3	Year 4	Year 5	Total
Main Intervention	7.2. - 2.2.2 Developing comprehensive training packages aligned with national workforce development plans	29,150	29,150	29,150	29,150	29,150	145,750
Objective	8.0. - 2.3 Strengthen programme performance monitoring and management systems at all levels by implementing a supervision standard (frequency, tools, feedback loop) and require documented closure of findings within 30 days.	0	0	0	0	0	0
Main Intervention	8.1. - 2.3.1 Adapting innovative evidence-based, blended learning approaches for problem-solving and remote mentoring	0	0	0	0	0	0
Objective	9.0. - SP3: VACCINE SUPPLY, QUALITY & LOGISTICS 3.1 By the end of 2030, ensure that 100% of Primary Health Care Centers (PHCCs) and vaccination points are equipped with WHO-prequalified cold chain equipment and that a real-time temperature monitoring and alert system is fully operational across all facilities; additionally, train and certify at least 90% of cold chain and immunization staff in equipment management, temperature monitoring, and data recording to maintain effective vaccine storage and reduce cold chain breaches by at least 50%.	13,566,124	17,823,836	17,759,190	17,984,626	18,889,949	86,023,725
Main intervention	9.1. - 3.1.1 Ensure timely and transparent procurement of WHO-prequalified vaccines through accurate forecasting and efficient supply processes.	11,550,249	16,200,961	16,753,315	17,236,751	17,884,074	79,625,350
Main intervention	9.2. - 3.1.2 Establish and operationalize an integrated vaccine procurement and distribution mechanism to ensure timely, uninterrupted availability of all routine and newly introduced vaccines at national, regional, and service delivery levels.	1,791,000	1,433,000	816,000	458,000	816,000	5,314,000
Main intervention	9.3. - 3.1.3 Strengthen cold chain management capacity through updated training, digital performance monitoring, regular supervision, and periodic evaluation to ensure efficient and sustainable vaccine storage and delivery	224,875	189,875	189,875	289,875	189,875	1,084,375
Objective	10.0. - 3.2 By the end of 2026, strengthen immunization data management and digital logistics systems at all levels to ensure timely, accurate, and harmonized vaccine supply monitoring and reporting across the public and private sectors.	0	0	0	0	0	0
Main intervention	10.1. - 3.2.1 Strengthen Data Collection and Reporting Systems	0	0	0	0	0	0
Main intervention	10.2. - 3.2.2 Enhance Digital Monitoring and Supply Chain Response	0	0	0	0	0	0

5. REPORT

Priority | Type | Level | LINE ITEMS OF COSTING | INVESTMENT | Clear Filters

A. BUDGET BY ROADMAP

Level	Description	Year 1	Year 2	Year 3	Year 4	Year 5	Total
Objective	11.0. - 3.3 By the end of 2026, optimize vaccine distribution and logistics management across all levels to ensure efficient, timely, and safe delivery of vaccines and supplies while maintaining cold chain integrity	90,000	90,000	90,000	90,000	90,000	450,000
Main intervention	11.1. - 3.3.1 Strengthen Vaccine Distribution and Transport Systems	60,000	60,000	60,000	60,000	60,000	300,000
Main intervention	11.2. - 3.3.2 Enhance Capacity for Cold Chain and Logistics Management	30,000	30,000	30,000	30,000	30,000	150,000
Objective	12.0. - 3.4 By the end of 2026, strengthen and standardize immunization waste management systems across all levels to ensure safe, compliant, and environmentally responsible disposal practices aligned with WHO standards.	461,000	440,000	0	0	0	901,000
Main intervention	12.1. - 3.4.1 Strengthen Policy Framework and Oversight for Immunization Waste Management	0	0	0	0	0	0
Main intervention	12.2. - 3.4.2 Build Capacity and Ensure Availability of Safe Waste Management Systems	461,000	440,000	0	0	0	901,000
Objective	13.0. - SP4: SERVICE DELIVERY 4.1 Extend immunization services to regularly unreached “zero-dose” and underimmunized children and communities by using micro-planning with defined denominators and private-sector reporting to target and serve zero-dose areas through routine outreach.	3,357,395	906,750	891,020	906,750	888,365	6,950,280
Main intervention	13.1. - 4.1.1 Develop micro-plans with denominators and zero-dose children.	50,750	35,750	41,020	35,750	38,365	201,635
Main intervention	13.2. - 4.1.2 Enhance outreach activities to underserved areas.	2,706,645	0	0	0	0	2,706,645
Main intervention	13.3. - 4.1.3 Implement immunization campaigns to respond to outbreaks or to vaccinate dropout children , particularly following school health screenings.	600,000	871,000	850,000	871,000	850,000	4,042,000
Objective	14.0. - 4.2 Strengthen immunization policies and service delivery where facilities track dropouts monthly, extend service hours where needed, and schedule catch-up/outreach accordingly.	247,990	180,000	180,000	180,000	180,000	967,990
Main intervention	14.1. - 4.2.1 Enhance infrastructure, logistics, and healthcare worker capacity to support sustainable immunization services..	247,990	180,000	180,000	180,000	180,000	967,990

5. REPORT

Priority | Type | Level | LINE ITEMS OF COSTING | INVESTMENT | Clear Filters

A. BUDGET BY ROADMAP

Level	Description	Year 1	Year 2	Year 3	Year 4	Year 5	Total
Objective	15.0. - 4.3 Establish integrated delivery points of contact between immunization and other public health interventions for different target age groups and institute an MoPH directive mandating card review/screening in all PHCC consultations and assigning a data focal point per PHCC.	82,400	82,400	0	0	0	164,800
Main intervention	15.1. - 4.3.1 Monitor referral completion and immunization updates.	82,400	82,400	0	0	0	164,800
Objective	16.0. - SP5: IMMUNIZATION COVERAGE & AEFI MONITORING 5.1 By 2030, establish a unified and interoperable national immunization information system that integrates all EPI-related digital platforms (PHENICS, MERA, MERA Pro) under a single governance , accountability structure and funding framework; enable defaulter notifications, and formalize private-sector reporting via policy and incentives.	311,092	244,627	212,347	197,347	197,347	1,162,760
Main intervention	16.1. - 5.1.1. Unify EPI digital platforms (PHENICS, MERA &MERA PRO,Sohatana), including interface with DHIS2	238,294	171,549	186,549	171,549	171,549	939,490
Main intervention	16.2. - 5.1.2. Implement automated SMS/WhatsApp reminders for due/defaulter children and routine.	8,000	8,000	8,000	8,000	8,000	40,000
Main intervention	16.3. - 5.1.3 Develop and integrate the PHENICS Academy e-learning system to train all immunization providers, with course content developed through universities, modules designed by an e-learning specialist, and full linkage between PHENICS and the ELMS for automated user access, role-based course assignment, and progress tracking.	47,000	5,000	0	0	0	52,000
Main intervention	16.4. - 5.1.4 EPI focal point in District office generate monthly data quality and timeliness reviews.	0	29,150	0	0	0	29,150
Main intervention	16.5. - 5.1.5. Implement routine data quality assessments with standardized validation checks and provide corrective coaching at PHC level, while generating monthly HIS dashboards at governorate and district levels to identify coverage gaps and inform targeted micro-planning.	17,798	30,928	17,798	17,798	17,798	102,120
Objective	17.0. - SP6: SURVEILLANCE 6.1 By 2030 70% of eligible physicians are included in the regular reporting of VPDs through ESU reporting mechanism, fund surveillance positions and integrate communicable-disease reporting modules into medical education/CME with private-sector incentives.	196,030	141,030	146,030	141,030	146,030	770,150

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Priority | Type | Level | LINE ITEMS OF COSTING | INVESTMENT | Clear Filters

A. BUDGET BY ROADMAP

Level	Description	Year 1	Year 2	Year 3	Year 4	Year 5	Total
Main intervention	17.1. - 6.1.1 Enhance VPD surveillance by supporting staff capacity, integrating reporting education into health professional licensing, engaging private clinics through training and directives, and providing easy-to-use electronic reporting tools.	117,465	72,465	77,465	72,465	77,465	417,325
Main intervention	17.2. - 6.1.2 Secure reagent supply chains, renew transport capacity/insurance, and rapid shipment of samples (e.g., to Syria polio lab) to ensure that by 2030, 80% of samples wiil be referred and tested in the reference labs .	78,565	68,565	68,565	68,565	68,565	352,825
Objective	18.0. - SP7: DEMAND GENERATION 7.1 By 2030, Lebanon will achieve equitable, community-driven, and resilient routine immunization coverage exceeding 95%, powered by a national culture of trust, transparency, and proactive health-seeking behavior — where every child is protected, every caregiver is informed, and every community is engaged	409,365	404,365	404,365	404,365	404,365	2,026,825
Main intervention	18.1. - 7.1.1 Strengthen Governance, Coordination, and Accountability Mechanisms: Reinforce institutional leadership and intersectoral coordination to ensure transparent, efficient, and equitable immunization service delivery	213,000	208,000	208,000	208,000	208,000	1,045,000
Main intervention	18.2. - 7.1.2 Build Community Ownership and Resilience: Empower communities to co-create, monitor, and sustain immunization efforts through inclusive participation and local leadership.	196,365	196,365	196,365	196,365	196,365	981,825

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Priority | Type | Level | LINE ITEMS OF COSTING | INVESTMENT | Clear Filters

D. BUDGET BY GOVERNMENT BUDGET / EXPENSE HEADS

Government Budget / Expense Heads	Year 1	Year 2	Year 3	Year 4	Year 5	Total
Government Budget / Expense Heads	Year 1	Year 2	Year 3	Year 4	Year 5	Total
Grand Total	20,096,976	21,470,148	21,203,252	21,061,258	22,310,526	106,142,160
Vaccines Supplies	11,550,249	16,200,961	16,753,315	17,236,751	17,884,074	79,625,350
16-734 نفقات شتى متنوعة / برنامج الرعاية الصحية الاولية	8,350,697	5,128,157	4,303,907	3,683,477	4,280,422	25,746,660
16-742 نفقات شتى متنوعة / برنامج الترصد الوبائي	196,030	141,030	146,030	141,030	146,030	770,150

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BACK

E. FINANCING

Objective	Main intervention	Total Budget	Total Funding	Total Funding Gap	Government - national	UNICEF - GAVI	UNICEF - EU	UNICEF - Pandemic Fund	IMC - EU	PUI	Private Sector	WHO - GAVI	WHO				
	Grand Total	106,142,160	85,938,270	20,203,890	42,650,345	196,500	3,659,600	356,500	340,430	341,900	38,185,005	67,990	140,000	0	0	0	0
1.0. - SP1: PROGRAMME MANAGEMENT AND FINANCING 1.1 Secure MoPH endorsement of an integrated EPI Policy & SOPs having one unified calendar, private-sector regulation & a userfriendly HIS standards and roll it out nationwide by 2030.		160,100	0	160,100	0	0	0	0	0	0	0	0	0	0	0	0	0
	1.1. - 1.1.1 Draft, consult, and approve unified EPI policy (calendar, private-sector duties, HIS/data standards).	155,100	0	155,100	0	0	0	0	0	0	0	0	0	0	0	0	0
	1.2. - 1.1.2 Monitoring the implementation of the ministerial decisions and the toolkit (SOPs, checklists, model contracts)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	1.3. - 1.1.3 Align all partner projects and MoPH directorates to the new policy (compliance clauses).	5,000	0	5,000	0	0	0	0	0	0	0	0	0	0	0	0	0
10.0. - 3.2 By the end of 2026, strengthen immunization data management and digital logistics systems at all levels to ensure timely, accurate, and harmonized vaccine supply monitoring and reporting across the public and private sectors.		0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	10.1. - 3.2.1 Strengthen Data Collection and Reporting Systems	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	10.2. - 3.2.2 Enhance Digital Monitoring and Supply Chain Response	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
11.0. - 3.3 By the end of 2026, optimize vaccine distribution and logistics management across all levels to ensure efficient, timely, and safe delivery of vaccines and supplies while maintaining cold chain integrity		450,000	10,000	440,000	0	10,000	0	0	0	0	0	0	0	0	0	0	0
	11.1. - 3.3.1 Strengthen Vaccine Distribution and Transport Systems	300,000	10,000	290,000	0	10,000	0	0	0	0	0	0	0	0	0	0	0
	11.2. - 3.3.2 Enhance Capacity for Cold Chain and Logistics Management	150,000	0	150,000	0	0	0	0	0	0	0	0	0	0	0	0	0
12.0. - 3.4 By the end of 2026, strengthen and standardize immunization waste management systems across all levels to ensure safe, compliant, and environmentally responsible disposal practices aligned with WHO standards.		901,000	100,000	801,000	0	100,000	0	0	0	0	0	0	0	0	0	0	0
	12.1. - 3.4.1 Strengthen Policy Framework and Oversight for Immunization Waste Management	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	12.2. - 3.4.2 Build Capacity and Ensure Availability of Safe Waste Management Systems	901,000	100,000	801,000	0	100,000	0	0	0	0	0	0	0	0	0	0	0
13.0. - SP4: SERVICE DELIVERY 4.1 Extend immunization services to regularly unreached "zero-dose" and underimmunized children and communities by using micro-planning with defined denominators and private-sector reporting to target and serve zero-dose areas through routine outreach.		6,950,280	2,615,000	4,335,280	0	15,000	2,600,000	0	0	0	0	0	0	0	0	0	0
	13.1. - 4.1.1 Develop micro-plans with denominators and zero-dose children.	201,635	15,000	186,635	0	15,000	0	0	0	0	0	0	0	0	0	0	0
	13.2. - 4.1.2 Enhance outreach activities to underserved areas.	2,706,645	2,000,000	706,645	0	0	2,000,000	0	0	0	0	0	0	0	0	0	0
	13.3. - 4.1.3 Implement immunization campaigns to respond to outbreaks or to vaccinate dropout children , particularly following school health screenings.	4,042,000	600,000	3,442,000	0	0	600,000	0	0	0	0	0	0	0	0	0	0
14.0. - 4.2 Strengthen immunization policies and service delivery where facilities track dropouts monthly, extend service hours where needed, and schedule catch-up/outreach accordingly.		967,990	292,990	675,000	0	0	0	225,000	0	0	0	67,990	0	0	0	0	0
	14.1. - 4.2.1 Enhance infrastructure, logistics, and healthcare worker capacity to support sustainable immunization services..	967,990	292,990	675,000	0	0	0	225,000	0	0	0	67,990	0	0	0	0	0
15.0. - 4.3 Establish integrated delivery points of contact between immunization and other public health interventions for different target age groups and institute an MoPH directive mandating card review/screening in all PHCC consultations and assigning a data focal point per PHCC.		164,800	107,400	57,400	0	0	0	0	75,000	32,400	0	0	0	0	0	0	0
	15.1. - 4.3.1 Monitor referral completion and immunization updates.	164,800	107,400	57,400	0	0	0	0	75,000	32,400	0	0	0	0	0	0	0
16.0. - SP5: IMMUNIZATION COVERAGE & AEFI MONITORING 5.1 By 2030, establish a unified and interoperable national immunization information system that integrates all EPI-related digital platforms (PHENICS, MERA, MERA Pro) under a single governance , accountability structure and funding framework; enable defaulter notifications, and formalize private-sector reporting via policy and incentives.		1,162,760	233,430	929,330	0	28,000	72,000	0	115,430	18,000	0	0	0	0	0	0	0
	16.1. - 5.1.1. Unify EPI digital platforms (PHENICS, MERA &MERA PRO,Sohatana), including interface with DHIS2	939,490	216,000	723,490	0	18,000	72,000	0	108,000	18,000	0	0	0	0	0	0	0
	16.2. - 5.1.2. Implement automated SMS/WhatsApp reminders for due/defaulter children and routine.	40,000	0	40,000	0	0	0	0	0	0	0	0	0	0	0	0	0
	16.3. - 5.1.3 Develop and integrate the PHENICS Academy e-learning system to train all immunization providers, with course content developed through universities, modules designed by an e-learning specialist, and full linkage between PHENICS and the ELMS for automated user access, role-based course assignment, and progress tracking.	52,000	10,000	42,000	0	10,000	0	0	0	0	0	0	0	0	0	0	0
	16.4. - 5.1.4 EPI focal point in District office generate monthly data quality and timeliness reviews.	29,150	0	29,150	0	0	0	0	0	0	0	0	0	0	0	0	0
	16.5. - 5.1.5. Implement routine data quality assessments with standardized validation checks and provide corrective coaching at PHC level, while generating monthly HIS dashboards at governorate and district levels to identify coverage gaps and inform targeted micro-planning.	102,120	7,430	94,690	0	0	0	0	7,430	0	0	0	0	0	0	0	0
17.0. - SP6: SURVEILLANCE 6.1 By 2030 70% of eligible physicians are included in the regular reporting of VPDs through ESU reporting mechanism, fund surveillance positions and integrate communicable-disease reporting modules into medical education/CME with private-sector incentives.		770,150	95,000	675,150	0	0	0	0	5,000	0	0	0	90,000	0	0	0	0
	17.1. - 6.1.1 Enhance VPD surveillance by supporting staff capacity, integrating reporting education into health professional licensing, engaging private clinics through training and directives, and providing easy-to-use electronic reporting tools.	417,325	65,000	352,325	0	0	0	0	5,000	0	0	0	60,000	0	0	0	0

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E. FINANCING

Objective	Main intervention	Total Budget	Total Funding	Total Funding Gap	Government - national	UNICEF - GAVI	UNICEF - EU	UNICEF - Pandemic Fund	IMC - EU	PUI	Private Sector	WHO - GAVI	WHO				
	Grand Total	106,142,160	85,938,270	20,203,890	42,650,345	196,500	3,659,600	356,500	340,430	341,900	38,185,005	67,990	140,000	0	0	0	0
	17.2. - 6.1.2 Secure reagent supply chains, renew transport capacity/insurance, and rapid shipment of samples (e.g., to Syria polio lab) to ensure that by 2030, 80% of samples will be referred and tested in the reference labs .	352,825	30,000	322,825	0	0	0	0	0	0	0	0	30,000	0	0	0	0
18.0. - SP7: DEMAND GENERATION 7.1 By 2030, Lebanon will achieve equitable, community-driven, and resilient routine immunization coverage exceeding 95%, powered by a national culture of trust, transparency, and proactive health-seeking behavior — where every child is protected, every caregiver is informed, and every community is engaged		2,026,825	337,500	1,689,325	0	0	170,000	131,500	36,000	0	0	0	0	0	0	0	0
	18.1. - 7.1.1 Strengthen Governance, Coordination, and Accountability Mechanisms: Reinforce institutional leadership and intersectoral coordination to ensure transparent, efficient, and equitable immunization service delivery	1,045,000	57,500	987,500	0	0	0	21,500	36,000	0	0	0	0	0	0	0	0
	18.2. - 7.1.2 Build Community Ownership and Resilience: Empower communities to co-create, monitor, and sustain immunization efforts through inclusive participation and local leadership.	981,825	280,000	701,825	0	0	170,000	110,000	0	0	0	0	0	0	0	0	0
2.0. - 1.2 Strengthen governance by creating more oversight committees, coordination, and accountability through quarterly EPI performance reviews in the EPI program to ensure effective oversight of vaccination activities and robust monitoring of coverage and service performance		4,176,000	690,600	3,485,400	0	43,500	201,600	0	104,000	291,500	0	0	50,000	0	0	0	0
	2.1. - 1.2.1 Establish TORs, membership, and scorecards for national/governorate/district forums.	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	2.2. - 1.2.3 Develop a dashboard using electronic monitoring tools and plan corrective actions based on the results and findings.	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	2.3. - 1.2.4 Recruit EPI focal points, cold chain experts, and quality officers at national and subnational levels to strengthen immunization program management, ensure effective cold chain operations, and enhance quality assurance	4,176,000	690,600	3,485,400	0	43,500	201,600	0	104,000	291,500	0	0	50,000	0	0	0	0
3.0. - 1.3 Synchronize the EPI multiyear and annual plans with the national budget cycle and approve a protected line-item for outreach, human resource development (HRD), equitable distribution of vaccines, and O&M of cold chain.		802,300	0	802,300	0	0	0	0	0	0	0	0	0	0	0	0	0
	3.1. - 1.3.1. Co-develop a costed annual plan of action tied to MoPH calendar.	774,300	0	774,300	0	0	0	0	0	0	0	0	0	0	0	0	0
	3.2. - 1.3.2. Create protected budget lines (outreach, HRD, distribution, cold-chain O&M).	28,000	0	28,000	0	0	0	0	0	0	0	0	0	0	0	0	0
	3.3. - 1.3.3. Introduce rolling forecasts for vaccines/supplies linked to procurement cycle (taking into consideration private sectors needs and newly introduced vaccines).	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
4.0. - 1.4 Strengthen capacity of governance/technical bodies for planning, coordination, and tracking progress at all levels by constituting a national ICC with TORs and meeting cadence, and formalize governorate/district partner coordination with quarterly workplans.		41,250	0	41,250	0	0	0	0	0	0	0	0	0	0	0	0	0
	4.1. - 1.4.1. Establish district coordination platforms with designated representatives and hold semi-annual meetings to address coverage, logistics, outreach, AEFI, and zero-dose reduction.	41,250	0	41,250	0	0	0	0	0	0	0	0	0	0	0	0	0
5.0. - 1.5 Ensure sustainable financing for the EPI program by mobilizing adequate resources from government, PHCCs, and partners to maintain vaccine supply and achieve equitable immunization coverage		1,354,830	1,210,000	144,830	1,210,000	0	0	0	0	0	0	0	0	0	0	0	0
	5.1. - 1.5.1. Prepare MTEF(medium term expenditures framework) for EPI with fiscal space analysis and co-financing plan.	5,830	0	5,830	0	0	0	0	0	0	0	0	0	0	0	0	0
	5.2. - 1.5.2. Introduce performance-based allocations tied to coverage/quality.	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	5.3. - 1.5.3. Mobilize additional sources	125,000	0	125,000	0	0	0	0	0	0	0	0	0	0	0	0	0
	5.4. - 1.5.4. Annual public expenditure review on EPI.	1,224,000	1,210,000	14,000	1,210,000	0	0	0	0	0	0	0	0	0	0	0	0
6.0. - SP2: HUMAN RESSOURCES 2.1 Ensure the availability of an adequate, effective, sustainable health workforce by a comprehensive EPI Human Resource Strategy, endorsed by the Ministry of Public Health, and implemented in at 100% of districts, defining staffing norms, competencies, and retention mechanisms.		44,400	0	44,400	0	0	0	0	0	0	0	0	0	0	0	0	0
	6.1. - 2.1.1 Develop EPI job descriptions as per organogramme and recruit/redeploy EPI staff to fill gaps in immunization staff at all levels	28,000	0	28,000	0	0	0	0	0	0	0	0	0	0	0	0	0
	6.2. - 2.1.2 Strengthen workforce retention through non-financial incentives, career pathways, and supportive work environments.	16,400	0	16,400	0	0	0	0	0	0	0	0	0	0	0	0	0
7.0. - 2.2 Improve technical and managerial capacity of health care workers by launching a national EPI competency framework and annual training plan with dedicated budget and cascade mentoring at all levels.		145,750	0	145,750	0	0	0	0	0	0	0	0	0	0	0	0	0
	7.1. - 2.2.1 Adapting innovative evidence-based, blended learning approaches for problem-solving and remote mentoring	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	7.2. - 2.2.2 Developing comprehensive training packages aligned with national workforce development plans	145,750	0	145,750	0	0	0	0	0	0	0	0	0	0	0	0	0
8.0. - 2.3 Strengthen programme performance monitoring and management systems at all levels by implementing a supervision standard (frequency, tools, feedback loop) and require documented closure of findings within 30 days.		0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	8.1. - 2.3.1 Adapting innovative evidence-based, blended learning approaches for problem-solving and remote mentoring	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0

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5. REPORT

VIEW | YEAR | Priority | Type | Level | LINE ITEMS OF COSTING | INVESTMENT | Clear Filters

BACK

E. FINANCING

Objective	Main intervention	Total Budget	Total Funding	Total Funding Gap	Government - national	UNICEF - GAVI	UNICEF - EU	UNICEF - Pandemic Fund	IMC - EU	PUI	Private Sector	WHO - GAVI	WHO				
	Grand Total	106,142,160	85,938,270	20,203,890	42,650,345	196,500	3,659,600	356,500	340,430	341,900	38,185,005	67,990	140,000	0	0	0	0
9.0. - SP3: VACCINE SUPPLY, QUALITY & LOGISTICS 3.1 By the end of 2030, ensure that 100% of Primary Health Care Centers (PHCCs) and vaccination points are equipped with WHO-prequalified cold chain equipment and that a real-time temperature monitoring and alert system is fully operational across all facilities; additionally, train and certify at least 90% of cold chain and immunization staff in equipment management, temperature monitoring, and data recording to maintain effective vaccine storage and reduce cold chain breaches by at least 50%.		86,023,725	80,246,350	5,777,375	41,440,345	0	616,000	0	5,000	0	38,185,005	0	0	0	0	0	0
	9.1. - 3.1.1 Ensure timely and transparent procurement of WHO-prequalified vaccines through accurate forecasting and efficient supply processes.	79,625,350	79,625,350	0	41,440,345	0	0	0	0	0	38,185,005	0	0	0	0	0	0
	9.2. - 3.1.2 Establish and operationalize an integrated vaccine procurement and distribution mechanism to ensure timely, uninterrupted availability of all routine and newly introduced vaccines at national, regional, and service delivery levels.	5,314,000	616,000	4,698,000	0	0	616,000	0	0	0	0	0	0	0	0	0	0
	9.3. - 3.1.3 Strengthen cold chain management capacity through updated training, digital performance monitoring, regular supervision, and periodic evaluation to ensure efficient and sustainable vaccine storage and delivery	1,084,375	5,000	1,079,375	0	0	0	0	5,000	0	0	0	0	0	0	0	0