World Health Organization

Lebanon

WHO-EM/PME/009/E

COUNTRY COOPERATION STRATEGY

2019-2023

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SIGNATURE PAGE

The signing of the CCS 2019-2023 reaffirms the strength of the relationship between the World Health Organization (WHO) as part of the wider United Nations system and the Government of Lebanon.

It underscores the commitment to work together toward agreed priorities for the greater impact and relevance to the people of Lebanon as envisioned with the national targets set for the achievement of the Sustainable Development Goals.

The strategy further advances WHO's long history of support to, and alignment with, the national development priorities and adds a stronger emphasis on coherence and coordination from all levels of the organization with Lebanon.

Government (President, MoH, or other)

WHO Director-General / Regional Director

UN Resident Coordinator

CONTENTS

LIST OF ACRONYMS

CAS	Central Administration of Statistics
CCS	Country Cooperation Strategy
CHE	Current Health Expenditure
EPI	Expanded Program on Immunization
EU	European Union
EWARS	Early Warning and Response System
GDP	Gross Domestic Product
GPW	General Programme of Work
HCT	Humanitarian Country Team
IHR	International Health Regulations
INGO	International Non-governmental organization
JEE	Joint External Evaluation
LCRP	Lebanon Crisis Response Plan
MCH	Mother and Child Health
MDG	Millennium Development Goal
MoPH	Ministry of Public Health
MoSA	Ministry of Social Affairs
NCD	Non-communicable diseases
NGO	Non-governmental organization
OOP	Out-of-pocket
PHC	Primary Health Care
SDGs	Sustainable Development Goals
TB	Tuberculosis
UHC	Universal Health Coverage
UN	United Nations
UNCT	United Nations Country Team
UNSF	United Nations Strategic Framework
WFP	World Food Programme
WHO	World Health Organization

EXECUTIVE SUMMARY

The Lebanon–WHO Country Cooperation Strategy (CCS) 2019-2023 signals a strong commitment from WHO and the Government of Lebanon to work together with partners to achieve the following ambitious country goals by 2023:

The **entire population** (6.09 million people) better **protected** from health emergencies

+300,000 of the most vulnerable people (150,000 Lebanese and 150,000 refugees) have **access** to **affordable** essential health services

Improved **health and well-being** for **2 million people** whose health is negatively impacted by social, behavioural, and environmental risk factors

This CCS is developed at a time where Lebanon's political stability is fragile, affected by political and confessional cleavages, and the protracted civil war in Syria has severely impacted by the country's stability, economy and social fabric. The presence of an estimated 1.5 million Syrian refugees/displaced and more than 0.3 million Palestinian refugees puts huge pressure on Lebanon's resources and its social and health services. Major economic drawbacks occurred simultaneously with an unprecedented and sudden increase of demand and strain on the health care system.

Despite all this, the Lebanese health system has been showing considerable resilience. The continuous focus on targeted reforms in the health sector shows that progress in achieving strategic goals has been possible against all the odds. Improvements have been in health outcomes, in health care productivity and performance, and in health sector governance. Increasing access to the primary health care system, increasing the efficiency of hospital care and reducing out of pocket payments have been major objectives for the Ministry of Public Health (MoPH). In fact, between 2011 and 2017, access to services expanded in terms of both coverage and distribution of health facilities, as well as in types of services.

The health profile of Lebanon remains dominated by non-communicable diseases (NCDs) in an ageing society. However, the influx of refugees with their triple burden of communicable diseases, NCDs and the social, economic and psychological effects of their displacement adds considerable complexity. Lebanon has in the past performed poorly in controlling determinants and risk factors of NCDs: two thirds of the population suffer from overweight/obesity, half lack regular physical activity and one-third smokes.

The disruption of immunization activities in Syria coupled with poor living conditions of the displaced in Lebanon has heightened risks of disease outbreaks. There has been a major threat that polio outbreaks in Syria would spillover to Lebanon. Massive immunization efforts ensured that Lebanon remained polio free.

Health authorities are confronted with a triple challenge: ensuring access to care for the refugees; ensuring resilience and coping capacity of the health care delivery system confronted with the strain of increased demand; and managing the health risks associated with the refugee influx.

This country cooperation strategy matches the uniqueness of Lebanon by defining a strategic agenda that addresses country-specific bottlenecks to health and development, leveraging the multiple resources for health in Lebanon. A series of discussions with the MoPH, other Government departments, development partners, civil society, academia and professional organizations shaped the strategy. The agreed focus of WHO's engagement and support will be on several areas of intervention, namely: strengthening health governance and evidence-based policy making; improving quality of care at primary health care (people-centeredness); further developing financing mechanisms to ensure access to an essential Universal Health Coverage (UHC) service package; strengthening emergency preparedness and response capacities within the health security framework; and promoting multi-sectoral programs to tackle NCD risk factors.

WHO support to Lebanon will leverage the resources and expertise of the three levels of the Organization: the Office of WHO Representative in Lebanon (country office), the WHO Regional Office for the Eastern Mediterranean in Cairo, and WHO headquarters in Geneva. In doing so, WHO seeks to harness global knowledge for the betterment of the health of the Lebanese people and provide a platform for Lebanon to engage in regional and global health initiatives. WHO will adapt the way it works in Lebanon to maximize its contribution – as a place of meeting and dialogue where public health stakeholders come together to consider challenges and develop innovative solutions. WHO will use its influence and convening power to assist MoPH in collaborating with government bodies, legislators, and UN partners to support the adoption and implementation of health-related taxation laws and regulations and to promote multi-sectoral collaboration for achieving the Lebanon's Sustainable Development Goals (SDGs) health targets including for tobacco, mental health, road traffic injuries, environmental health and food safety, and healthy lifestyles.

1 INTRODUCTION

The Country Cooperation Strategy Lebanon (CCS) 2019-2023 aims to guide the application of the WHO's comparative advantage and global strategic priorities as set out in the 13th General Programme of Work (GPW 13)[1], according to development priorities determined by the Government of Lebanon.

The current CCS aims at ensuring that WHO's work at country level responds to national health priorities, including national targets for achieving the Sustainable Development Goals (SDGs) targets, as well as supporting national capacities in health emergency preparedness and emergency risk management. The CCS is aligned with the GPW13 that focuses on health coverage improvement, health emergencies preparedness and response, and improvement of health and well-being of populations.

This CCS builds on the United Nations Strategic Framework (UNSF) for Lebanon (2017-2020) that places health at the heart of the social-economic development pillar (ref Lebanon UNSF 2017-2020[2]); and on the Lebanon Crisis Response Plan (LCRP)[3] 2017-2020 whereby WHO's focus is on addressing gaps related to access to health services and to leverage the emergency and humanitarian support to strengthen the Lebanese health system's resilience and health security. This CCS is also harmonized with the national health strategic plan[4] 2016-2020 which was nationally developed to promote the country's progress towards Universal Health Coverage (UHC). The national health strategy has four main pillars: modernize and strengthen sector governance; improve collective health and promotion across the life-cycle; continue progress to UHC; develop and maintain emergency preparedness and health security.

[1] General Programme of Work (GPW13) accessible via the following link: http://www.who.int/about/what-we-do/gpw-thirteen-consultation/en/
[2] United Nations Strategic Framework (UNSF) for Lebanon (2017-2020) accessible via the following link: https://reliefweb.int/report/lebanon/united-nations-strategic-framework-unsf-lebanon-2017-2020
[3] Lebanon Crisis Response Plan (LCRP) 2017-2020 accessible via the following link: http://www.un.org.lb/lcrp2017-2020
[4] MoPH national health strategic plan 2016-2020 accessible via the following link: https://www.moph.gov.lb/en/Pages/9/1269/strategic-plans#/en/view/11666/strategic-plan-2016-2020

The CCS also embeds the SDGs and the current Minister of Health's Strategy 2025. The Ministry also established in collaboration with WHO and the American University of Beirut a health policy observatory to strengthen evidence-based policymaking. WHO's technical inputs to the expansion of the World Bank supported MoPH "Emergency Primary Health Care Restoration Project" will continue as well as support to expanding the MoPH- Primary Health Care (PHC) network throughout the country to improve access to quality health services.

The 'light' and concise country strategy is designed to clearly identify WHO's cooperation and planned contribution to agreed outcomes under three broad strategic priority areas: Universal Health Coverage; health security; and improved health and well-being. As the strategic basis for all of WHO's work with the country and results-based planning and programming processes, the CCS includes a high-level overview of the role of WHO at all levels as well as budget envelope required for the implementation of each of the strategic priorities.

Central to the implementation of the CCS will be a coherent One-WHO approach interacting with a horizontal and vertical whole-of-government approach. Underpinning all of WHO's work is a focus on policy, advocacy and national capacity development for long-term sustainability.

Illustrating WHO's commitment to impact in every country, a clear results framework for monitoring and evaluation has been articulated within. Recognizing the joint responsibility and accountability of WHO and the Government to improving the health and well-being of Lebanon's population, monitoring and evaluation of the CCS will be conducted jointly, and with partners.

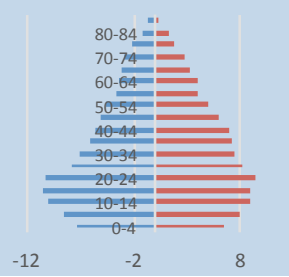
Finally, the CCS as the main strategic instrument represents the main areas where WHO will focus efforts and resources over the next 5 years. It does not cover all of what WHO does and WHO remains committed to responding to and adapting to changing needs as they arise.

2 HEALTH AND DEVELOPMENT SITUATION

A country analysis conducted by WHO in 2018 articulates Lebanon's health and development challenges and potential vulnerabilities along with implications for the work of WHO and other development partners.

2.1 POLITICAL, SOCIAL, AND ECONOMIC CONTEXT

DEMOGRAPHIC



In 2018 the population living in Lebanon is estimated at 6,093,509 including approx. 4.4 million Lebanese, and 1.7 million displaced people, refugees and migrants. The population growth rate is at 0.18. A national census has not been conducted since 1932. The total fertility rate is 1.7 per woman. Around 25% of the Lebanese population is under 15 years of age, and 10% is older than 65 years.

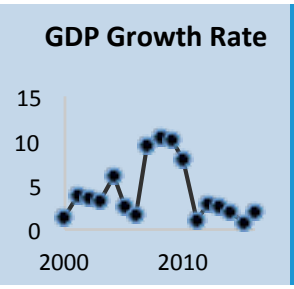
POLITICAL

Lebanon is a parliamentary representative democratic republic, where the President Minister is the head of government. Executive power is exercised by the government, while legislative power is vested in both the government and parliament. In addition to the Ministry of Public Health, the Ministry of Social Affairs and municipalities carry responsibility for primary health care activities.

SOCIAL

Lebanon's society is multicultural and dynamic and civil society plays a major role in social service delivery. From 2012 onwards a mass displacement of an estimated 1.5 million people from Syria to Lebanon took place. Lebanese poverty rates are rising: 28.5% of the Lebanese population (1.07 million individuals) are estimated to be poor as well as 76% of displaced Syrians.

ECONOMIC



Lebanon is an upper-middle income country with gross national income of $14,690 per capita in purchasing power parity in (2017). Lebanon's Gross Domestic Product (GDP) growth has been decimated, from a 9.2% average between 2007-2010 to just 2.0% in 2017 - due to the impact of the civil war in Syria on Lebanon's economy. In 2018 all government sectors experienced budget cuts of 20%.

Sources:
- MoPH. 2016. Statistical bulletin. Available from http://moph.gov.lb/en/Pages/8/14902/statistical-bulletin-2016#/en/view/14930/b-population-data
- World Bank (2017). GNI per capita, purchasing power parity. Available from https://data.worldbank.org/indicator/NY.GNP.PCAP.PP.CD?locations=LB
- World Bank (2017). GDP growth, annual. Available from https://data.worldbank.org/indicator/NY.GDP.MKTP.KD.ZG?locations=LB

Lebanon is currently the country hosting the largest number of refugees per capita. It is estimated that 30% of the population are refugees and displaced from neighbouring countries. The majority of persons displaced from Syria (87%) are concentrated in the same areas where the most deprived Lebanese (67%) are living (i.e. the country's 251 most vulnerable cadastres, out of a total of 1,653 cadastres)[5].

Despite the resilience shown by both Lebanese society and the refugee population, the complex nature of the crisis poses an unprecedented challenge for the state, the society, and its people. The Syrian crisis had repercussions on the demography, the entire social fabric, the economy, and the national security. Lebanon's Gross Domestic Product (GDP) growth has been decimated, from a 9.2% average between 2007-2010 to just 2% in 2017. An estimated $13.1 billion has been drained from the economy since 2012, with a third of those losses (11% of GDP) in 2015 alone. Lebanese poverty rates are rising. The 2016 figures show that around 1.5 million Lebanese are considered vulnerable, 28.5% of the Lebanese population are estimated to be poor (living on less than $4 per day), and about 300,000 individuals are considered extremely poor (living on less than $2.4 per day) and unable to meet their most basic food needs[6]. Among displaced Syrians, poverty is rising very fast such that in 2017, 76% had slipped under the poverty line. The local host communities are strained by limited infrastructural capacity and increased competition for services and resources.

[5] Lebanon Crisis Response Plan (LCRP) 2017-2020 accessible via the following link: http://www.un.org.lb/lcrp2017-2020.

[6] UNDP. 2016. Rapid Poverty Assessment in Lebanon for 2016. Available from: http://www.lb.undp.org/content/lebanon/en/home/Response_to_the_Syrian_Crisis/successstories/Rapid-Poverty-Assessment-in-Lebanon-for-2016.html [Accessed 2016]

While Lebanon has broadly managed to preserve macroeconomic stability and market confidence, public financing has struggled to keep pace with the tremendous efforts government institutions have made to extend services to an increasingly poor society. Servicing Lebanon's growing debt has constrained the amount of money available for operating budgets, capital investments, and social spending.

Those major economic drawbacks occurred simultaneously with an unprecedented increase in demand and strain on the health care system. Despite of all this, the Lebanese health system has been showing considerable resilience. The continuous focus on targeted reforms in the health sector shows that progress in achieving strategic goals has been possible against all the odds. Thus, improvements have been in health outcomes, in health care productivity and performance, and in health sector governance.

2.2 HEALTH STATUS

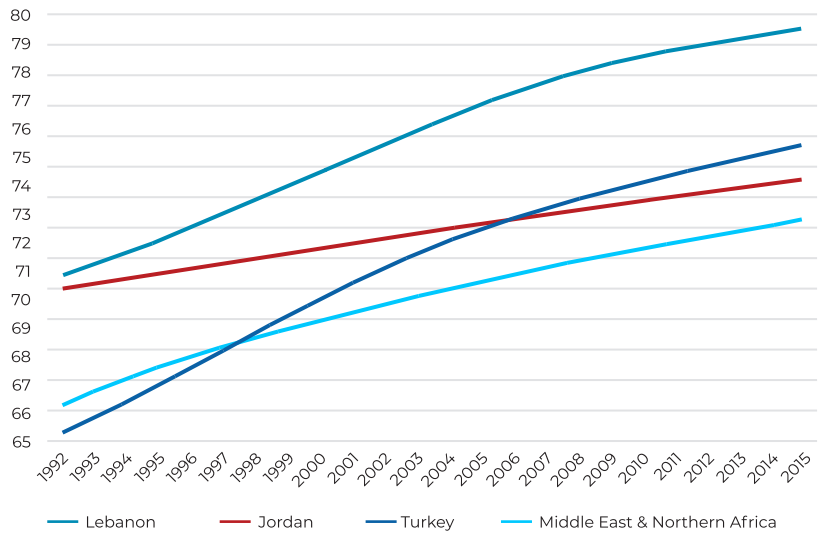


Figure 1. Life expectancy at birth of Lebanon population compared to Jordan, Turkey and the Middle East & Northern Africa region from 1992 to 2016.

Investments in strengthening health systems and programs to prevent and control outbreaks, to increase equity in access to essential care, to decrease out-of-pocket (OOP) expenditures, and to lower maternal and child mortality rates have paid dividends. Key indicators of health outcomes have improved considerably until 2016. In 2016, infant mortality rates have been one-fourth of what they were in 1990. Child mortality stood at 8.3‰ and neonatal mortality at 4.8‰[7]. Lebanon is one of only 16 countries to have achieved the maternal mortality Millennium Development Goal (MDG) 5, with an annualized rate of decrease of 6.7% in the 1990-2003 period, and 8.6% during the period 2003-2013. This is among the fastest reductions recorded worldwide. These reductions resulted in the addition of 5.1 years to life expectancy at birth between 2000 and 2015 (Figure 1).

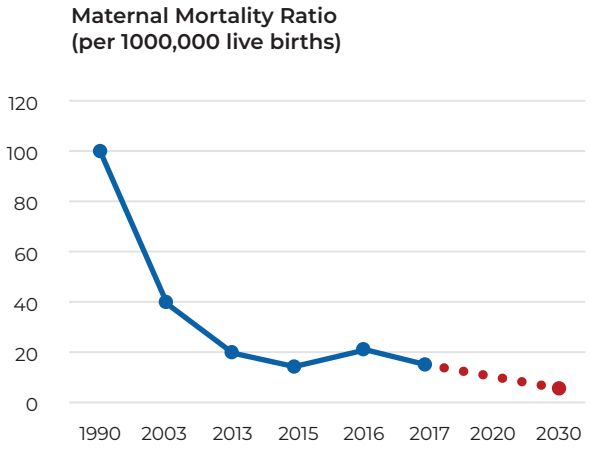
Meanwhile, the health profile of Lebanon remains one dominated by NCDs in an ageing society, but where the influx of refugees with their triple burden of communicable diseases, NCDs and the social, economic and psychological effects of their displacement adds considerable complexity.

[7] Global Health Observatory. 2018. Available from: http://apps.who.int/gho/data/?theme=country&vid=12100

NCDs, including cancer, are the top causes of mortality and morbidity among adults in the country. Lebanon has in the past performed poorly in controlling determinants and risk factors of NCDs. Two-thirds of the population suffer from overweight/obesity, half lack low physical activity and one-third smokes[8]. Road traffic injuries are on the rise, particularly among youth. Water, soil and air pollution are on the rise due to the failure of national waste and energy management, which is aggravated by the inappropriate water and sanitation infrastructure in the informal refugee settlements.

Five key health indicators – Progress made and distance to go to meet 2030 targets

Maternal mortality



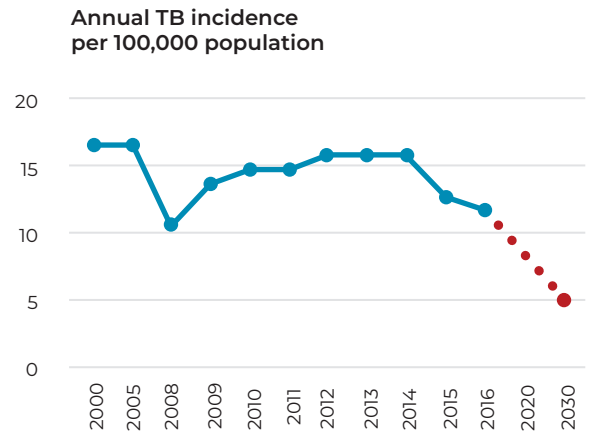
Underlying factors:

- Improved coverage of quality antenatal care and obstetric care; decline in fertility rates has led to a reduction in maternal mortality until 2014.
- Lower utilization of antenatal care and obstetric care by vulnerable refugees and Lebanese populations have resulted in an increase after 2014.

Implications for WHO and partners:

- Close monitoring of maternal deaths through MoPH.
- Community-based interventions to improve maternal care seeking behaviour.
- Promoting accessibility, quality and financial sustainability of mother and child health care.

Reduce tuberculosis deaths



Underlying factors:

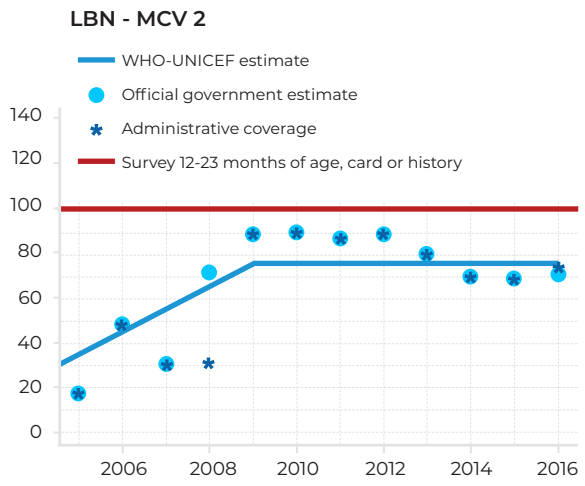
- Improved free access to tuberculosis (TB) treatment (DOTS) and screening before the advent of the Syria crisis.
- Increased incidence after 2013, due to refugee suboptimal living conditions and limited access to care.

Implications for WHO and partners:

- Operationalize *End TB Strategy* and monitor implementation.
- Improve access to MDR treatment.

[8] WHO. STEPwise approach to chronic disease risk factor surveillance. Available from: http://www.who.int/ncds/surveillance/steps/lebanon/en/

Vaccination coverage



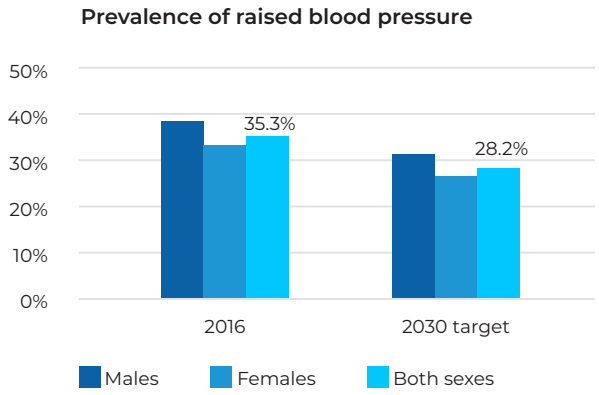
Underlying factors:

- Limited PHC capacity for outreach.
- Hard to reach areas.
- Affordability of vaccines.

Implications for WHO and partners:

- Invest in strong and sustained routine vaccination system.
- Fill gaps in coverage through targeted campaigns.
- Engage UN partners, civil society and academic institutions.

Raised blood pressure



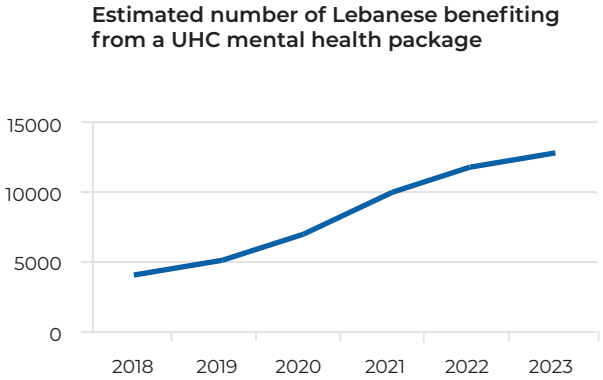
Underlying factors:

- High prevalence of risk factors such as smoking, lack of physical activity, high salt intake.
- Suboptimal access to screening and early detection and preventative interventions.

Implications for WHO and partners:

- Support the implementation of the national multisectoral NCD plan of action.

Service coverage for mental health



Underlying factors:

- National Mental Health Programme established in 2014.
- Financial coverage of mental health hospital admissions by MoPH; In future, financial coverage of ambulatory mental health care under poverty targeting program.

Implications for WHO and partners:

- Continued support to mental health reform process.
- Capacity development of mental health service providers.

2.3 HEALTH SYSTEM STATUS AND UNIVERSAL HEALTH COVERAGE

Currently 50% of the population benefits from some form of health insurance, while around 50% is uninsured and benefits from health services subsidized by the MoPH limited in scope.

Lebanon is exploring mechanisms to improve health services coverage and financial protection to its population, with a commitment to achieving UHC by 2030, targeting in particular the most vulnerable uninsured population groups. Approaches to addressing key health care access challenges, including equity and citizen engagement are evolving, such as: integrating new services in primary health care (mental health, NCD early detection), new payments mechanisms (performance-based reimbursement of pre-paid set of packages, capitation, fee for service), and targeting specific populations (poorest and less poor as per the National Poverty Targeting Program). However, the country faces multiple challenges in improving efficiency and quality across health – limited government regulatory capacity in a private-for-profit dominated health sector and low expenditure on public sector human resources are a key bottleneck atall levels.

Health system characteristics (ref MoPH statistical bulletin 2016)	
Total Government expenditure on health as a percentage of general government expenditure (estimated without Government debt)(2014)	10.03%
Spending on health as a share of household spending (2012)	7.8%
Physicians density (per 1000 population) (2017)	3.1
Nursing and midwifery personnel density (per 1000 population) (2017)	3.4

Despite a remarkable increase in the moral and technical authority of the MoPH, the regulatory arsenal of public authority over the health sector remains limited. In a context where command and control approaches could not even be envisaged, it has adopted a collaborative networking approach to steer-and-negotiate governance of the sector. In Lebanon's political context this remains vulnerable to political instability, changing power constellations and vested commercial interests with important stakes. It also limits the leverage of MoPH in addressing systemic gaps: human resource for health imbalances and unregulated practice, the imbalance between technology-centred curative care and public health prevention and promotion, the large variations in quality of care with private care providers over whom MoPH has no authority.

Lebanon spent 10.7% of its GDP on health in 2000. This was reduced to a more sustainable 7.3% in 2015 [9]. In GDP terms, government, social security, and voluntary health insurance expenditures increased from 7.6 to 8.6%. Total health expenditure was also reduced by 22%. The most important feature of this reduction was that OOP payments dropped from 627,000 LBP per capita (US$ 416) down to 273,000 LBP (US$ 181); government spending and voluntary health insurance remained virtually the same, while social health insurance contributions doubled.

[9] World Bank Data. 2018. Current health expenditures (% of GDP). Available from: https://data.worldbank.org/indicator/SH.XPD.CHEX.GD.ZS?locations=LB

The share of OOP in total spending thus dropped from 54% in 2000 to 36.4% in 2017. This made a substantial difference to household budgets. As a share of household spending, OOP payments halved from 12.0% to 7.8% in 2012. The key interventions to reduce OOP payment have been the rationalization of the pharmaceutical sector and the renegotiation of medicine pricing. The subsidized supply of medicines for chronic diseases through the PHC network could have played a key role in reducing OOP payments among low-income population groups.

Out-of-pocket spending in total spending dropped from 54% in 2000 to 36.4% in 2017

A law for autonomy of public hospitals has been developed and enacted, and a health financing model is being piloted based on a prepaid primary health care package and referral system to public hospitals when needed. Access to primary health care and hospital beds is high; however, the country suffers from a severe imbalance in human resources for health, with a surplus of medical doctors and a severe shortage of nurses, paramedical staff and health managerial staff. The resources are unequally distributed, favouring larger cities. As noted, a new system of contracting with the private sector is on its way to implementation, based on performance and quality standards.

The MoPH has updated the national guidelines on good manufacturing practices and reinforced its inspection capacity. Also, a review of pricing has been implemented, along with updating the list of essential and chronic medicines. A standardized system for eligibility criteria for support in terms of catastrophic illness medications (cancer, haemophilia, renal failure, rare diseases) has also been established. In addition, the MoPH has developed a national strategy for medical devices, with a short-term plan of action whereby regulations and standards are elaborated. Vaccines are provided free of charge in more than 500 primary health care centres and dispensaries. Reinforcing the regulatory role of the MoPH and ensuring financial sustainability for chronic disease medications, especially in light of the influx of Syrian refugees, are some of the challenges faced by the country.

There is wealth of information on health coverage and outcomes that are being collected within the system by the Central Administration of Statistics (CAS), the MoPH and other sector ministries, academic institutions, the private sector and NGOs. Much however is fragmented, unsystematic and lacking coherence; what exists focuses to a large extent on health care products that are being purchased by MoPH, from NGO health centres or private hospitals. However, even that is markedly incomplete, duplicated and of low quality. There is an urgent need for a master plan for health information system that engages all relevant institutions, strategizes and harmonizes data collection and analysis to prevent future waste of resources.

FACT BOX.

Where does Lebanon stand with regard to UHC dimensions?

a. Service coverage

The health system in Lebanon is characterized by a longstanding public-private partnership, a dynamic civil society, a flourishing private sector, and a public sector that is progressively regaining its leadership and regulatory role. The MoPH covers hospital stays and expensive medicines for Lebanese who are not insured through the program of catastrophic illnesses. The National Social Security Fund and the Government Employee Funds cover around 40% of the population; private insurance covers around 8%. For the 52% of the population that is not covered by health insurance, health services are purchased by the MoPH from the private and public sectors. The health system is also characterized by a surplus of medical doctors and a severe shortage in nurses and paramedical staff.

The MoPH developed options for provider payment reforms in ambulatory care, and initiated a system of accreditation for PHC including standard setting guidelines, requirements for physical facilities, and manpower, equipment and operational systems. It also established a national network of PHC centres that has been progressively expanding over years to cover most geographical areas in the country, with more focus on areas with vulnerable populations. This national network of PHC centres provides essential drugs and essential health services such as pediatrics, family medicine, oral health, reproductive health, cardiology, and vaccination. The mechanism for coordination between MoPH and NGOs is well established and there are attempts at improving quality audit and reviews.

As dual private and public practice is allowed in the country, all the physicians working in the PHC network and/or in the dispensaries have private practices. Services in the private sector are based on fee for service, and in the PHC/dispensaries on hours of work. It is rare to encounter a PHC or dispensary with a full time general practitioner (GP) or family physician, except in the UN Relief Works Assistance for Palestinian refugees in Lebanon (UNRWA)-run clinics. Over the past decade, the political commitment of the MoPH to family practice was expressed by the adoption of the people-centred approach to PHC.

b. Financial protection

Private health expenditure as share of Current Health Expenditure (CHE) was 48% in 2015; and OOP spending represented 32% of CHE. The high share of OOP spending increases the risk of financial hardship and impoverishment.

c. Population coverage

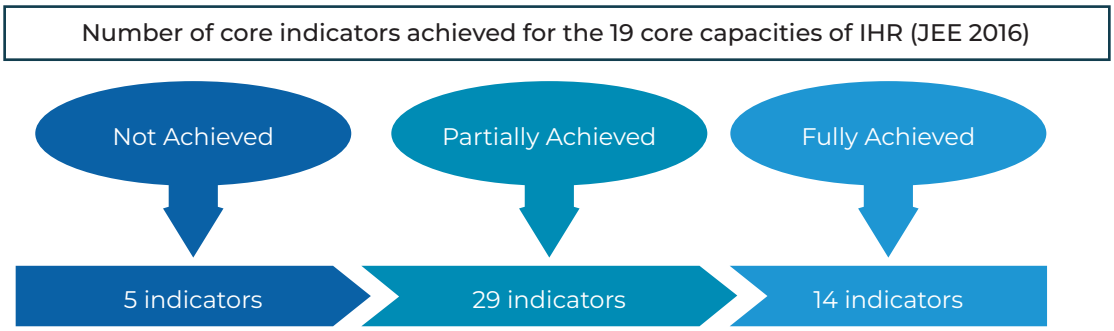
Around 50% of the population do not benefit from any form of formal health insurance, and for whom, the MoPH acts as the insurer of last resort. The other 50% are covered through: (a) the Lebanese National Social Security Fund [20%]; Armed Forces [10-12%]; private insurance schemes [6-8%]; and by the government as civil servants [12%].

2.4 EMERGENCY PREPAREDNESS AND VULNERABILITY

With three main emergencies in neighbouring countries, large displacement of population and repeated vaccine-preventable and waterborne outbreaks in the region, Lebanon is at increased threat of communicable diseases outbreaks. The disruption of immunization activities in Syria coupled with poor living conditions of the displaced in Lebanon has heightened risks of disease outbreaks, including measles, mumps and polio, and the introduction of new diseases such as cutaneous leishmaniosis with a high risk of transmission to the host community. There has been a major threat that Polio outbreaks in Syria would spill over to Lebanon. Massive immunization efforts ensured that Lebanon remained polio-free. However, the risk for an outbreak of vaccine-preventable diseases remains high despite the aggressive vaccination campaigns and the relentless efforts to accelerate routine vaccination. Poor hygiene and sanitation conditions have led to outbreaks of waterborne diseases such as Hepatitis A and other diarrheal diseases. There is evidence that access to safe drinking water is poor[10]. However, the interventions remain fragmented and poorly coordinated. One main limitation is the absence of a dedicated team/unit at the MoPH for emergency risk and crisis management. Secondly, as emergency situations, particularly those related to refugees endure, it becomes increasingly necessary to develop transition management strategies to avoid unintended consequences and impacts on the regular health systems of the country. Moreover, with the porous border with Syria, the risk of chemical and other weapons hazards is real. This raises the threat of Chemical, Biological, Radiological, and Nuclear events and warrants vigilance in preparedness, monitoring and early warning and response.

The Joint External Evaluation (JEE) mission for International Health Regulations (IHR) was implemented in 2016. The JEE mission's main observations included: 1) there is a need to put in place systems/structures to ensure adequate coordination of information sharing and rapid response as well as full multi-sectoral engagement; 2) the private sector in Lebanon has an important role in providing services related to the national IHR capacity, and needs to be adequately engaged and represented; and 3) there is an insufficient IHR–related human resources capacity at different levels of administration.

IHR core capacities implementation status, 2016



[10] WHO and UNICEF. 2016. Joint Monitoring Program for Water Supply, Sanitation and Hygiene.

2.5 ENVIRONMENTAL HEALTH

Lebanon is suffering from progressive environmental degradation, aggravated by a large number of informal refugees settlements, an accelerated deforestation, lower precipitates and poor water resources management. Air pollution presents a serious health hazard, made worse with the poorly managed solid waste disposal topped by chaotic uncontrolled use of small local electricity generators. The MoPH has mainly a consultative role, and the Ministry of Environment has no executive role. This dissolves responsibility and accountability. However, the MoPH, with WHO support, has developed a national environmental health strategy in 2016, that could not go into a plan of action due to Government laxity and poorly defined mandates. The civil society (NGOs and academic institutions and private sector) has been very active in proposing alternative clean and sustainable environmental solutions however, the buy-in of the government officials has not been secured. Intensive advocacy and generation of evidence is highly needed to address the environmental health challenges.

3 DEVELOPMENT PARTNERS

3.1 MAIN HEALTH AND DEVELOPMENT PARTNERS IN LEBANON

Lebanon is rich in terms of partners in health. Since the civil war, local non-governmental organizations (NGOs) have been playing a major role in health service provision. The MoPH relies on a public-private partnership with a network of NGOs to provide primary care services to the most vulnerable Lebanese population. WHO has been supporting capacity development of NGO service providers. WHO also collaborates with the MoPH and NGOs to increase access to NCD prevention, early detection, treatment, palliative care and home care. Professional health associations are partners in improving quality of care through standard setting and capacity building of health professions. Lebanon has a tradition of strong medical / health science faculties among its academic institutions, which are partners in researching to provide scientific evidence for policy development.

In the context of the crisis in Syria, the international humanitarian community is well represented in Lebanon to support the government of Lebanon to cope with the impact of the massive displacement of Syrians to Lebanon. WHO is assuming a technical leadership role for the humanitarian health sector response, while UNHCR is managing the subsidies for the health care of refugees and UNICEF supports access to vaccination, water and sanitation.

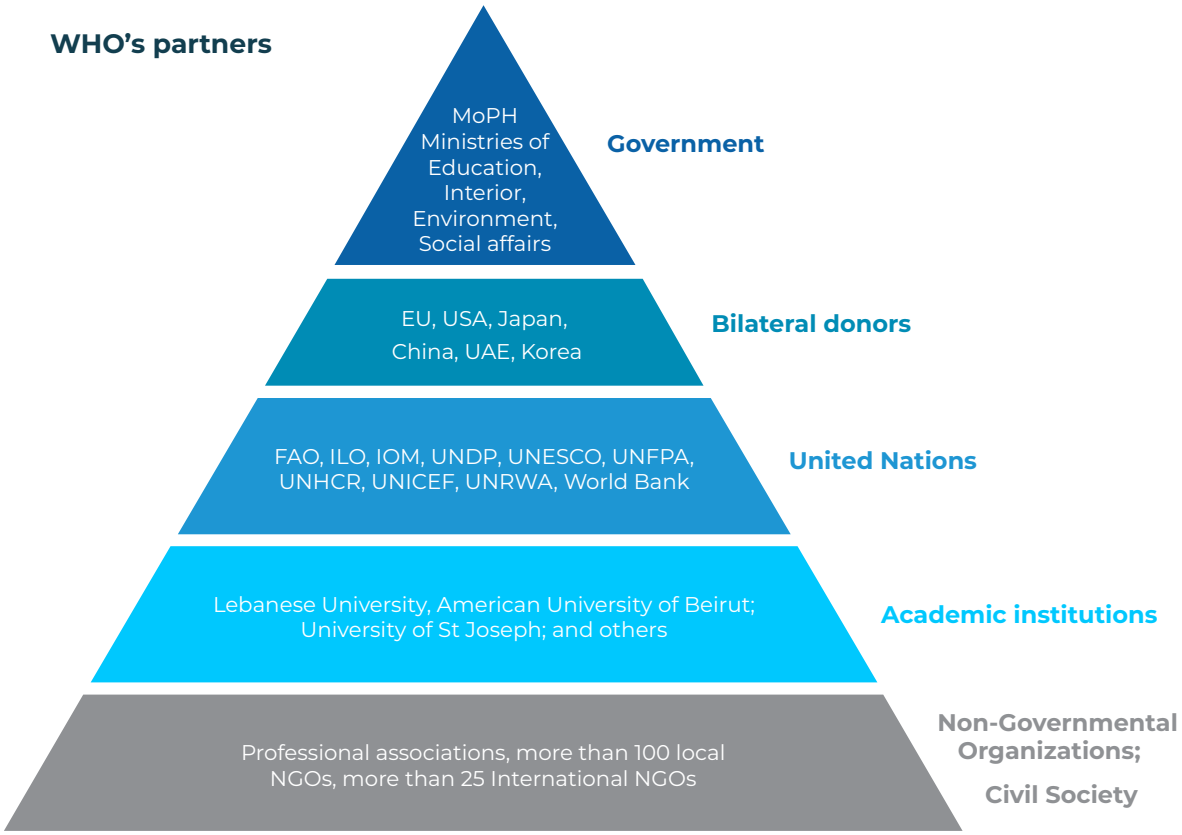
3.2 COLLABORATION WITH THE UNITED NATIONS SYSTEM AT COUNTRY LEVEL

WHO is a member of the UN country team and has been instrumental in the development of the health sector component of the United Nations Strategic Framework (UNSF) 2017-2020. The framework sets out three main priorities for collaboration among the UN family of agencies:

- Core Priority 1: All people in Lebanon have peace and security.
- Core Priority 2: Lebanon enjoys domestic stability and practices effective governance.
- Core Priority 3: Lebanon reduces poverty and promotes sustainable development while addressing immediate needs in a human rights/gender-sensitive manner.

UN development and humanitarian support to the health sector are included under core priorities 1 (health security) and 3 (UHC). Collaboration is maintained between WHO and UNFPA on strengthening Reproductive Health services, as well as strengthening the National Civil Registration and Vital Statistics system. Joint efforts are deployed between WHO, UNICEF and UNFPA to strengthen the PHC quality and service delivery capacity. Moreover, institutional capacity building for the national Expanded Program on Immunization (EPI) and the National Mental Health Programme is coordinated with UNICEF. Technical cooperation is jointly provided with the World Bank, and financial support is provided by the European Union (EU) to strengthen the service delivery system at PHC, and to establish new payment mechanisms. Cooperation between WHO and several national and International NGOs, as well as selected academic institutions is maintained to design and pilot service delivery models.

Since 2012, as a member of the Humanitarian Country Team (HCT), WHO has been co-leading with UNHCR the humanitarian health sector response to the Syrian refugee crisis. Humanitarian actors all work together guided by the Lebanon Crisis Response Plan 2017-2020 (LCRP). The LCRP aims to address national objectives and priorities for responding to the impact of the Syrian crisis in Lebanon through an overarching four-year strategic planning framework developed and implemented under the leadership of the Ministry of Social Affairs (MoSA) in collaboration with the UN, national and international NGOs, other civil society actors and the donor community.



4 WHO IN LEBANON: HISTORY OF COLLABORATION

4.1 WHO'S WORK IN LEBANON

TECHNICAL FOCUS

- Communicable diseases
- Non-communicable diseases
- Health throughout the life course
- Health governance, information systems, financing, service delivery
- International Health Regulations core capacities
- Humanitarian response to refugee crisis

COUNTRY PRESENCE

- Began in 1953
- Key functions
  - Policy formulation – implementing norms and standards
  - Health system development
  - Emergency preparedness and response
  - Monitoring country health situation

KEY ACHIEVEMENTS OVER PAST 5 YEARS

- National health strategic plan
- PHC network strengthened to serve vulnerable people (including refugees)
- Improved health data for decision making
- Emergency preparedness plans and response teams in place
- NCD early detection and free treatment

LESSONS LEARNED & OPPORTUNITIES

Since sector governance remains vulnerable to Lebanon's human and political geography in a context of clientelism and politicization, the collaborative governance approach developed and nurtured by the MoPH leadership, must be consolidated and expanded. WHO's strong engagement and support to the newly established Policy Support Observatory and the organization of National Health Fora will be a timely and strategic investment.

Existing public-private partnerships, in particular the MoPH-NGO PHC network is a unique characteristic of the Lebanese health system. WHO's support should be directed towards MoPH's plans for establishing a systematic quality monitoring system, expanding the scope of services included in the financial coverage by the MoPH and investing in capacity to provide people-centred care is likely to enhance access and utilization. Scenarios for engaging private-for-profit health providers in the network so to further increase coverage of a UHC benefit package should be explored. A national dialogue on sustainable health financing mechanisms for the future is needed in order to respond to the growing population needs, especially in terms of preventive services and catastrophic illnesses.

The MoPH and partners should optimize the availability of well-trained human resources for health through a national strategy for attracting and retaining qualified personnel in the public sector.

The health sector was able to improve monitoring and control of diseases as well as maintaining relatively good population health; however, maintaining such achievements and reaching the SDG targets warrants an intensive multi-sectoral cooperation, particularly in terms of addressing social and environmental risks and other determinants of health.

5 SETTING THE STRATEGIC PRIORITIES

5.1 PRIORITIZATION PROCESS AND ALIGNMENT TO THE GENERAL PROGRAMME OF WORK, NATIONAL HEALTH STRATEGY AND THE UNITED NATIONS STRATEGIC FRAMEWORK

SUSTAINABLE DEVELOPMENT AGENDA

New CCS Health Situation Analysis

+

National Health Strategy 2016-2020 + WHO's 13th GPW 3 strategic priorities + UNSF 2017-2020 3 main priorities

=

10 (total) health related priorities, indicators, targets

↓

Joint WHO-Country Priorities Identified 2019-2023

↓

1. Comparative analysis across elements undertaken
2. Review of alignment
3. Partner & stakeholder role & capacity analysis
4. Gaps in capacity and leadership identified
5. Definition of WHO's comparative advantage in country, capacity and resources
6. Review of good practices and lessons learned
7. Extensive cross-sectoral dialogue, consultation and negotiation

CCS 2019-2023 PRIORITIES IDENTIFIED – AND KEY ALIGNMENT

	Health Coverage	Health Emergencies	Population Health
	System Development for UHC	**Develop and maintain emergency preparedness and health security**	**Improve health and well-being**
National Health Strategic Plan 2016-2020	· Continue progress to UHC · Modernize and strengthen health sector governance	Develop and maintain emergency preparedness and health security	Improve collective Public Health and Promotion
GPW13 Strategic Priorities	Strategic priority 1 on UHC	Strategic priority 2 on health emergencies	Strategic priority 3 on health determinants
UNSF 2017-2020	Improved equitable access to and delivery of quality social services	Territorial integrity and security strengthened in accordance with human rights principles	· Improved equitable access to and delivery of quality social services, social protection and direct assistance · Improved environmental governance

5.2 COUNTRY RESULTS FRAMEWORK

WHO will jointly monitor and measure progress in these areas with the Government of Lebanon and the UNCT as part of the UNSF evaluation process.

Indicators	Baseline (year)	Target (2023)	Disaggregation Factors*	Indicator alignment
Health Coverage				
Priority 1 – Health Coverage: Improve access to affordable essential health services				
No. Lebanese (vulnerable[$]) population accessing PHC UHC benefit package	150,000 (2018)	300,000	Age/sex /geo Nationality	GPW
No. of PHC services participating in MoPH network	207 (2017)	250 (2023)	Geo	LCRP
% people suffering financial hardship in accessing health care (10% or more household income)	1.2% *(estimate when OOPE is 30-40%)*	0.8% *(estimate when OOPE is 20-30%)*	Age/sex /geo	GPW, UNDAF, NHP
Health Emergencies				
Priority 2 – Protect health: Develop and maintain emergency preparedness and health security				
No. IHR core capacities fully implemented (IHR core capacities index)	14 indicators (2016)	48	N/A	GPW
No. of operational surveillance sites (i.e. health facilities reporting epidemic-prone diseases in a timely and complete manner)	50	500	N/A	LCRP (# functional EWARS centres).
% population affected by displacement accessing PHC (refugees)	86% (2017)	95%	Age/sex/geo	GPW; LCRP
Population Health				
Priority 3 – Health priorities: Improve health and well-being				
% children vaccinated (DTP3 coverage)	82.6% (2016)	95%	Geo / SE, Age/ sex (EPI cluster survey)	GPW; SDG (UHC tracer); LCRP
TB death rate (per 100,000)	1.6 (2016)	1	Age/sex	SDG; national TB strategy
Sepsis deaths due to AMR	TBD	TBD	TBD	TBD
Prevalence raised blood pressure	35.3% (2016)	<30%	Age/sex	NCD strategy; SDG
% of vulnerable[$] people with mental health conditions accessing mental health care	TBD	TBD	TBD	TBD

* Disaggregation factors – where specified, data to be collected and analysed based on:
Age – Age | Gen – Gender | Geo – Geographical / Urban-rural | SE – Socio-economic
[$] Vulnerable = targeted by national poverty targeting program

6 IMPLEMENTATION: CONTRIBUTION FROM WHO & PARTNERS

6.1 KEY CONTRIBUTIONS TO THE 3 STRATEGIC PRIORITIES

Priority 1 – Health coverage: Develop the health system towards UHC

WHO's Contribution		
Country Office	**Regional Office**	**Headquarters**
Strengthen health system governance, national health policies and regulatory frameworks (health policy support observatory; national health fora; human resource strategy; Health information system master plan; Electronic health record). Establish instruments for modernised sector management (electronic surveillance system; e-health record; e-supplies management; pharma barcode system). Engage in an open and broad-ranging review of financing options. Build systems and capacity for the provision of quality people-centred primary care. Improve capacity for optimizing choice of medicines and health technologies for UHC (Health Technology Assessment).	Strengthen country office capacity in supporting the adaptation and strengthening of health information systems to collect disaggregated data to track disease mortality, morbidity, risk factors and health inequities to inform future policy-making. Adapt global tools to the regional context to improve health system governance, including institutional, legal, regulatory and societal frameworks, and coordinate with regional partners to accelerate UHC.	Develop guidance and support for improving equitable access to essential noncommunicable disease medicines, including generics, and basic technologies. Generate international best practices and develop guidance to support Member States in leading multisectoral policy dialogue and capacity-building for effective development and implementation of intersectoral action and "Health in All Policies" towards UHC.

Collective outcomes / outputs
• Developing and piloting an integrated people-centred health care approach. • Developing a DCP-3 based benefit package of essential services. • Technical support and capacity building for the planning and roll-out a sustainable Mental Health Reform with the aim to reduce unnecessary hospitalization and increase access to mental health care at community level. • Tobacco Control Law Implementation. Push for implementation of the tobacco law. • Health information system strengthened to collect high quality disaggregated data for health inequality monitoring. • Vision 2030 and comprehensive national health strategy and implementation plan in place to support universal health coverage. • Sustainable health financing model established to ensure financial risk protection.

Key implementation partners
Ministry of Public Health – health system development and monitoring UHC. EU and Government of Japan - health governance; regulatory capacity; PHC service delivery system development. World Bank – Health System Financing for UHC. Humanitarian Country Team partners – supporting services for vulnerable refugee and Lebanese populations.

Priority 2 - Protect health: Develop and maintain emergency preparedness and health security

WHO's Contribution		
Country Office	**Regional Office**	**Headquarters**
Support consolidation and expansion of surveillance and prevention programs for high-threat infectious hazards (EWARS). Support the evaluation and strengthening of IHR core capacities (decentralized emergency preparedness plans; HAZMAT teams; simulation exercises; point-of-entry facilities). Provide technical leadership for the health response to the Syrian refugee crisis and contribute to maintaining essential health services for Syrians refugees.	Support country office to run simulation exercises and after-action reviews as part of country IHR evaluation. Provide backstopping and coordination support in emergencies, including in the maintenance of essential health services for affected populations.	Develop and disseminate a guideline on integrated disease prevention and health care in crises and emergencies. Establish and coordinate expert networks at the global level for forecasting and modelling, pathogen identification and virulence assessment, risk communication and response.

Collective outcomes/outputs
• Multi-sectoral national action plan for strengthening IHR core capacities monitored and funded. • Emergency preparedness, early warning and surveillance system in place with sufficient laboratory capacity. • Response to emergencies is effective with access to essential health services to affected population; Health care coverage for Syrian refugees maintained.

Key implementation partners
IHR capacity development / Preparedness: Ministries of Public Health, Defense, Agriculture, Red Cross; Delivering essential food, health services and vaccinations in emergencies: UNHCR, UNICEF, WFP, national and INGOs.

Priority 3 - Health priorities: Improve health and well-being across different life stages

WHO's Contribution		
Country Office	**Regional Office**	**Headquarters**
Work with government institutions, legislators, civil society and UN partner agencies to support the adoption and implementation of health-promoting policies, laws and regulations (focus: tobacco, salt). Support the monitoring of main risk factors and the modelling of the health, social and economic benefits of addressing them. Promote health and rights literacy and people's participation and engagement in health to reduce risk factors. Strengthen preventive programs to reach the underserved populations at different life stages (focus: EPI; MCH; NCD). Strengthen policies and systems for tackling AMR.	Strengthen and complement country office capacity to provide in developing, implementing and evaluating national NCD prevention and control plan (2016-2020) targets and indicators and multisectoral coordination mechanisms for the prevention and control of NCDs.	Develop technical guidance and tools for developing, prioritizing, costing, implementing and valuating multisectoral NCD plans, including guidance on a national multisectoral mechanism.

Collective outcomes/outputs
• National NCD action plan funded and implemented. • NCD risk factors monitored. • Multi-sectoral NCD task force.

Key implementation partners
Ministries of Public Health, Finance, Education, Social Affairs, Industry, Environment; UN partners; Professional associations: Order of physicians; Order of nurses; Academic institutions; NGOs

6.2 FINANCING THE STRATEGIC PRIORITIES

5-Year Budget Estimate (2019-2023)			
Strategic Priority	**Estimated Budget Required (A)**[11]	**Anticipated Funding (B)**[12]	**Anticipated Funding Gap (C)**[13]
System Development for UHC	US$ 23,340,000	US$ 18,672,000	US$ 4,668,000
Develop and maintain emergency preparedness and health security	US$ 7,212,500	US$ 5,770,000	US$ 1,442,500
Improve health and well-being	US$ 14,785,500	US$ 11,828,400	US$ 2,957,100
TOTAL	**US$ 45,338,000**	**US$ 36,270,400**	**US$ 9,067,600**

Investment Case and Country Resource Mobilization Plan
WHO will prepare a Health advocacy kit, based on evidence and health situation updated annually, and would seek fund raising through development of targeted proposals, both to fill gaps in access to health services, as well as to provide the required institutional and development support. The national Health Fora, supported by WHO through the Policy Support Observatory, will constitute a leverage for advocacy and policy elaboration for health system support.

[11] (A) Planning and Technical Networks devise and use consistent methodology to define budget which may include main planned activities across 3 levels, scale of the problem and historical costs.

[12] (B) Based on historical funding and anticipated funding from donors in priority areas.

[13] (C) A minus B. Funding gap forms the basis for country resource mobilization plan.

7 MONITORING & EVALUATION

KEY MILESTONES, APPROACH & ACTIVITIES

2018 — CCS Launched

Main health outcomes, baselines and targets established for each strategic priority.
Ensure country-level data available or capacity strengthened where required.

2019-20 — Monitoring of implementation

Country Work Plan 2020-21 developed
Defines:
- Country office budget
- Activities and detailed activities at all 3 levels to priorities
- Outcomes / outputs
- Resource mobilization targets

2021 — CCS mid-term evaluation

Country Office-led evaluation of:
- Progress toward health outcomes
- Implementation of Country Work Plan 2020-21

Qualitative impact – County Success Stories (backed up by evidence)

CCS progress report with recommendations Shared with Government, within WHO and partners

2022 — Monitoring of implementation

Country Work Plan 2022-23 developed
Defines:
- Country office budget
- Activities and detailed activities at all 3 levels to priorities
- Outcomes / outputs
- Resource mobilization targets

2023 — CCS final evaluation

Joint evaluation with Member States and partners

Independently validated

Includes:

Health outcomes

Implementation of Work Plans

Qualitative success stories

Lessons learned

CCS Final Evaluation Published

ANNEXES

ANNEX 1: MATRIX OF HEALTH-RELATED PRIORITIES IN NATIONAL HEALTH POLICIES, STRATEGIES AND PLANS, GPW, UNSF

GPW 13	CCS	National Health Strategy 2017-2020	UNSF
Promote health			
1 billion more people with UHC	Health coverage: Develop the health system towards UHC	1) Continue progress to UHC 2) Modernize and strengthen health sector governance	Improved equitable access to and delivery of quality social services, social protection and direct assistance.
	300,000 more most vulnerable people (150,000 Lebanese and 150,000 refugees) have access to affordable essential health services		% increase of population without formal health insurance coverage, who access primary, secondary and tertiary health care at affordable cost with support from UN
Keep the world safe			
1 billion more people protected from health emergencies	Protect health: develop and maintain emergency preparedness and health security	Develop and maintain emergency preparedness and health security	
	The entire population (6.09 million people) better protected from health emergencies		
Serve the vulnerable			
1 billion more people enjoying better health and well-being	Health priorities: Improve health and well-being across different life stages	Improve collective Public Health and Promotion	
	Improved health and well-being for 2 million people whose health is negatively impacted by social, behavioural and environmental risk factors		

ANNEX 2: METHODOLOGY FOR BUDGET ESTIMATION FOR IMPLEMENTING PRIORITIES

The budget needed to implement priorities was calculated based on the anticipated funding across 2019-2023 as shown in the table below (segregated by year and donor). Taking into consideration the historical costs, the estimated budget was calculated by adding 25% to the anticipated funding.

5-Year Budget Estimate (2019-2013)

Strategic priority	Estimated Budget Required (A)	Anticipated Funding (B)						Anticipated Funding Gap (C)
		Fund/ donor	2019	2020	2021	2022	2023	
1. System Development for UHC		EU MADAD	$2,000,000	$2,000,000	$2,000,000			
		EU LUX	$500,000	$500,000	$500,000	$500,000	$500,000	
		Japan	$500,000					
		AFD	$700,000	$700,000	$700,000	$700,000	$700,000	
		Trust fund (IHR & Gov)	$300,000	$300,000	$300,000	$300,000	$300,000	
		Trust fund (PHC)	$150,000	$150,000	$150,000	$150,000	$150,000	
		Operational	$770,000	$770,000	$770,000	$770,000	$770,000	
		Flexible fund	$72,000					
		TOTAL	$4,992,000	$4,420,000	$4,420,000	$2,420,000	$2,420,000	
Total Strategic Priority 1	**$ 23,340,000**	**$ 18,672,000**						**$ 4,668,000**
2. Develop and maintain emergency preparedness and health security		Trust fund (IHR & Gov)	$360,000	$360,000	$360,000	$360,000	$360,000	
		Operational	$770,000	$770,000	$770,000	$770,000	$770,000	
		Flexible fund	$120,000					
		TOTAL	$1,250,000	$1,130,000	$1,130,000	$1,130,000	$1,130,000	
Total Strategic Priority 2	**$ 7,212,500**	**$ 5,770,000**						**$ 1,442,500**
3. Improve health and well-being		EU MADAD	$800,000	$800,000	$800,000			
		AFD	$300,000	$300,000	$300,000	$300,000	$300,000	
		BPRM	$1,000,000	$1,000,000				
		Trust fund (PHC)	$180,000	$180,000	$180,000	$180,000	$180,000	
		Trust fund (AIDS)	$130,000	$130,000	$130,000	$130,000	$130,000	
		PIP	$390,000					
		Operational	$770,000	$770,000	$770,000	$770,000	$770,000	
		Flexible fund	$138,400					
		TOTAL	$3,708,400	$3,180,000	$2,180,000	$1,380,000	$1,380,000	
Total Strategic Priority 3	**$ 14,785,500**	**$ 11,828,400**						**$ 2,957,100**
Grand Total	**$ 45,338,000**	**$ 36,270,400**						**$ 9,067,600**

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