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Lebanon

Country Cooperation Strategy for WHO and Lebanon

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Signature page

The signing of the revised CCS 2019–2023 reaffirms the strength of the relationship between the WHO as part of the wider UN System and the Government of Lebanon.

The revised CCS incorporates the emerging health needs and support identified through a thorough situation assessment, building on the gains achieved, while adopting the Humanitarian-Development Peace Nexus approach.

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.

This revised 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.

MINISTER OF PUBLIC HEALTH

Government (President, MoH, or other)

WHO Director-General / Regional Director

UN Resident Coordinator

Contents

Acronyms and abbreviations

AMR	Antimicrobial resistance
CCS	Country Cooperation Strategy
CPHL	Central public health laboratory
CRVS	Civil registration and vital statistics
EPI	Expanded Programme on Immunization
ERP	Lebanon Emergency Response Plan
ESU	Epidemiological Surveillance Unit
EWARS	Early Warning, Alert and Response System
GDP	Gross domestic product
GPW13	WHO's Thirteenth General Programme of Work, 2019–2023
ICU	Intensive care unit
IHR	International Health Regulations (2005)
LCRP	Lebanon Crisis Response Plan
LPSP	Long-term primary care subsidized protocol
MDG	Millennium Development Goal
NCDs	Noncommunicable diseases
NDA	National Drug Authority
PHC	Primary health care
SDGs	Sustainable Development Goals
TB	Tuberculosis
UHC	Universal health coverage
UN	United Nations
UNHCR	United Nations High Commissioner For Refugees
UNRWA	United Nations Relief And Works Agency For Palestine Refugees in the Near East
UNSDCF	United Nations Sustainable Development Cooperation Framework
UNSF	United Nations Strategic Framework
WHO	World Health Organization

Preface

This mid-term update to Lebanon's Country Cooperation Strategy (CCS) 2019–2023 responds to emerging developments and the impact of the multifaceted crisis that the country has been experiencing since 2019.

The revision of the CCS was conducted virtually by the WHO Country Office in Lebanon, with colleagues from the WHO Regional Office for the Eastern Mediterranean and WHO headquarters, and in close consultation with the Ministry of Public Health, concerned national authorities, United Nations agencies and other development partners.

The decision to use rapid, concise revision methodology was dictated by the intensity and urgency of the present situation. As the needs in terms of continuity of health care are becoming increasingly pressing, bridging humanitarian interventions to critical development interventions is clearly the best approach to optimize the scarce resources.

The proposed revised areas of work and approaches are in line with WHO's Thirteenth General Programme of Work 2019–2023 (GPW13), the 2030 Agenda for Sustainable Development, the SDG 3+ GAP road map developed for Lebanon in 2019, and the new United Nations Sustainable Development Cooperation Framework (UNSDCF) for 2023 and beyond. The CCS priorities and critical areas of work take into account the health crisis in particular, which is heavily impacted by and interlinked with concomitant economic, political and social crises.

While the country is going through a severely unstable period, the CCS update aims at supporting the health system to withstand the severity of the shocks, to initiate seed interventions for the recovery and further development phase, and to sustain the gains in population health of the past three decades.

Executive summary

Lebanon is experiencing an unprecedented and complex crisis which is heavily impacting the development of the health system as well as the health of the population.

Access to medications and hospital care is progressively and increasingly limited, hospitals are cutting down on their operational bed capacity and an accelerated exodus of human resources for health is being observed. With the severe devaluation of the Lebanese pound against the US dollar, health financing is increasingly difficult and out-of-pocket expenditures on health are rising sharply, putting the most vulnerable populations at high risk of financial hardship. Health system resilience and the coping strategies of the population are challenged, threatening health gains over the past few decades and the sustainability of even basic health services such as primary health care (PHC) and life-saving treatments.

Available data indicate a deterioration in health indicators, with higher excess mortality already observed and increased maternal and child mortality rates reported over the past three years among vulnerable Lebanese, refugee populations and migrant workers. The prevalence of noncommunicable diseases (NCDs) and mental health conditions is on the rise, while the risk of communicable disease outbreaks, especially vaccine-preventable diseases and waterborne diseases, is increasing due to lower vaccination coverage and the deterioration of water and sanitation quality and environmental degradation.

The principles of WHO support will be based mainly on the Humanitarian-Development-Peace Nexus approach, bridging humanitarian interventions to development interventions within the overall goals of the 2030 Agenda for Sustainable Development and in line with the strategic priorities of WHO's Thirteenth General Programme of Work 2019–2023 (GPW13).

The main areas of work are outlined below:

Promote health: strengthen health system resilience and development towards universal health coverage (UHC)

1. Support to PHC – with emphasis on service integration and provision of essential services.
2. Support to the hospital sector – with emphasis on improving quality and safety of care.
3. Strategy development – with emphasis on finalizing the national health sector strategy and plan of action and selected programmes' strategic plans, including the Expanded Programme on Immunization (EPI), mental health and HIV/AIDS.
4. Support to the pharmaceutical sector – with emphasis on digitalization.
5. Evidence for policy-making – with emphasis on generation of selected data for public health decision-making in the areas of disease control and prevention, risk behaviours and health financing.

Keep the world safe: protect from health emergencies

1. Surveillance – with emphasis on strategic planning, and the Early Warning, Alert and Response System (EWARS) expansion and digitalization.
2. International Health Regulations (IHR 2005) and emergency preparedness – with emphasis on a One Health approach, a national health emergency operations centre, roll out of the antimicrobial resistance (AMR) plan and re-establishment of the central public health laboratory (CPHL).
3. COVID-19 response – with emphasis on leadership and supporting response.

Serve the vulnerable: better health and well-being

1. School health environment – with emphasis on the school health strategy.
2. Environmental health – with emphasis on medical waste management and tobacco control.

WHO Country Office and leadership – with emphasis on communication, coordination and team maintenance

1. Political, social and economic context

Lebanon is enduring an unprecedented and multifaceted crisis, with financial, fiscal, economic, social, health, security and political downturns now threatening the country's survival.

Just when Lebanon was stabilizing after a long period of civil war, the advent of the Syrian crisis in 2011 impacted its demography, economy, infrastructure and, subsequently, the health system. **Lebanon hosts the largest number of refugees per capita in the world**; it is estimated that 30% of the population are refugees who have been displaced from neighbouring countries (occupied Palestinian territory and Syrian Arab Republic). The majority of displaced persons from the Syrian Arab Republic (87%) were initially concentrated in the same areas as the most-deprived sections of the Lebanese population (67%).

Over the last decade, the country has experienced high levels of political instability, with prolonged periods of political deadlock and numerous security events (such as suicide bombs and assassination of political figures), creating social tensions that have recently manifested in outbursts of street violence.

Since 2019, the country has been experiencing a severe financial and fiscal crisis whereby the Lebanese pound has been devalued by around 13 times against the US dollar. **Inflation averaged 145% in 2021**, ranking third globally after Venezuela and Sudan, and the minimum wage has decreased from the equivalent of US$ 450 per month to less than US$ 30 per month. The gross domestic product (GDP) has seen the highest contraction in a list of 193 countries. Real GDP is estimated to have declined by 10.5% in 2021, on the back of a 21.4% contraction in 2020. In fact, Lebanon's GDP plummeted from close to US$ 52 billion in 2019 to a projected US$ 21.8 billion in 2021, marking a **58.1% contraction**.[1]

Financial restrictions on the use of foreign currency have severely constrained operational budgets, capital investments and social spending. **Poverty rates are rapidly rising and it is estimated that more than 70% of Lebanese people and more than 90% of Syrian refugees are living below the poverty line**.[2] Unemployment is steadily increasing, reaching more than 50% among young people. The population is being heavily strained by the removal of subsidies (food, fuel, medications), limited infrastructural capacity namely water, electricity and transportation (due to fuel shortages and increased prices), and increased competition over services and resources. The profound financial freefall in parallel with high political instability, the impact of the COVID-19 pandemic, and the aftermath of the August 2020 Beirut port explosion has had a toll on the resilience of the country and its people. In 2022, the war between the Russian Federation and Ukraine is diverting attention to urgent needs in Europe, hence there is a threat of reduced support from the main international donor organizations.

[1] Lebanon economic monitor, fall 2021: the great denial [website]. Washington, DC: The World Bank Group; 2022 (*https://www.worldbank.org/en/country/lebanon/publication/lebanon-economic-monitor-fall-2021-the-great-denial*, accessed 21 July 2022).

[2] Multidimensional poverty in Lebanon: painful reality and uncertain prospects. Beirut: UN Economic and Social Commission for Western Asia; 2021 (*https://reliefweb.int/report/lebanon/multidimensional-poverty-lebanon-2019-2021-painful-reality-and-uncertain-prospects*, accessed 21 July 2022).

2. Impact on the health sector

Until 2019, the Lebanese health system was showing considerable resilience. A flourishing private health sector was able to respond to the sudden increase in demand on health services imposed by a large refugee presence. The refugee crisis created momentum and an opportunity to develop the public health system, with an emphasis on PHC.

However, since the crisis intensified in 2019, the health sector has been heavily hit.

Most hospitals are working at around 50% capacity due to fiscal and financial restrictions. Shortages in medical supplies and medications are frequently observed, especially after the Government decided to lift financial subsidies along with imposing restrictions on foreign currency. A massive exodus of well-trained health care workers is creating a significant void in health care, whereby around 20% of the nursing force and close to 40% of specialized medical doctors have left the country (as reported by the Lebanese Order of Physicians and the Order of Nurses). The country has also witnessed the closure of hundreds of private pharmacies (as reported by the Order of Pharmacists of Lebanon). This is negatively affecting the timeliness, quality and safety of health care.

The COVID-19 pandemic revealed the suboptimal readiness and preparedness of the public health system in responding to emergencies, as well as the unwillingness of the private sector to be frontliners in responding to pandemics. This necessitated immediate and significant support to cope with COVID-19 care needs and sustain the public health response. The Beirut port explosion put around 500 hospital beds and 17 PHC centres, serving a population of around 300 000 in the 5-kilometre radius around the explosion, out of order for over a year and created sudden additional health needs, including mental health needs. The health surveillance system has been severely strained and overwhelmed by the COVID-19 pandemic. As a result, health system productivity and performance, as well as health sector governance, have been severely and negatively impacted.

Box 1. Frameworks and plans for health sector support

The health sector is operating without a national health sector strategy, but rather a Ministry of Public Health response strategy (2016–2020) developed in the context of the Syrian crisis.[3] The country has not developed an SDG 2030 plan. In 2018, WHO supported the development of an SDG3+ GAP, that was not further implemented in view of the rapid crisis development at country level. UN support through the overarching United Nations Strategic Framework (UNSF) 2017–2020 has been extended to the end of 2022. The Lebanon Crisis Response Plan (LCRP), which addresses national objectives and priorities for responding to the impact of the Syrian crisis, has been extended to 2023. In 2021, preparations were initiated for the Common Country Assessment and United Nations Sustainable Development Cooperation Framework (UNSDCF), to be effective in 2023. Beirut port explosion support is channelled under the Reform, Recovery and Reconstruction Framework (3RF), and humanitarian crisis support is channelled under the Emergency Response Plan (ERP) (2021–2022).

[3] Health Strategic Plan for the medium term (2016 to 2020). Beirut: Ministry of Public Health; 2016. (*https://www.moph.gov.lb/en/view/11666/strategic-plan-2016-2020-*, accessed 21 July 2022).

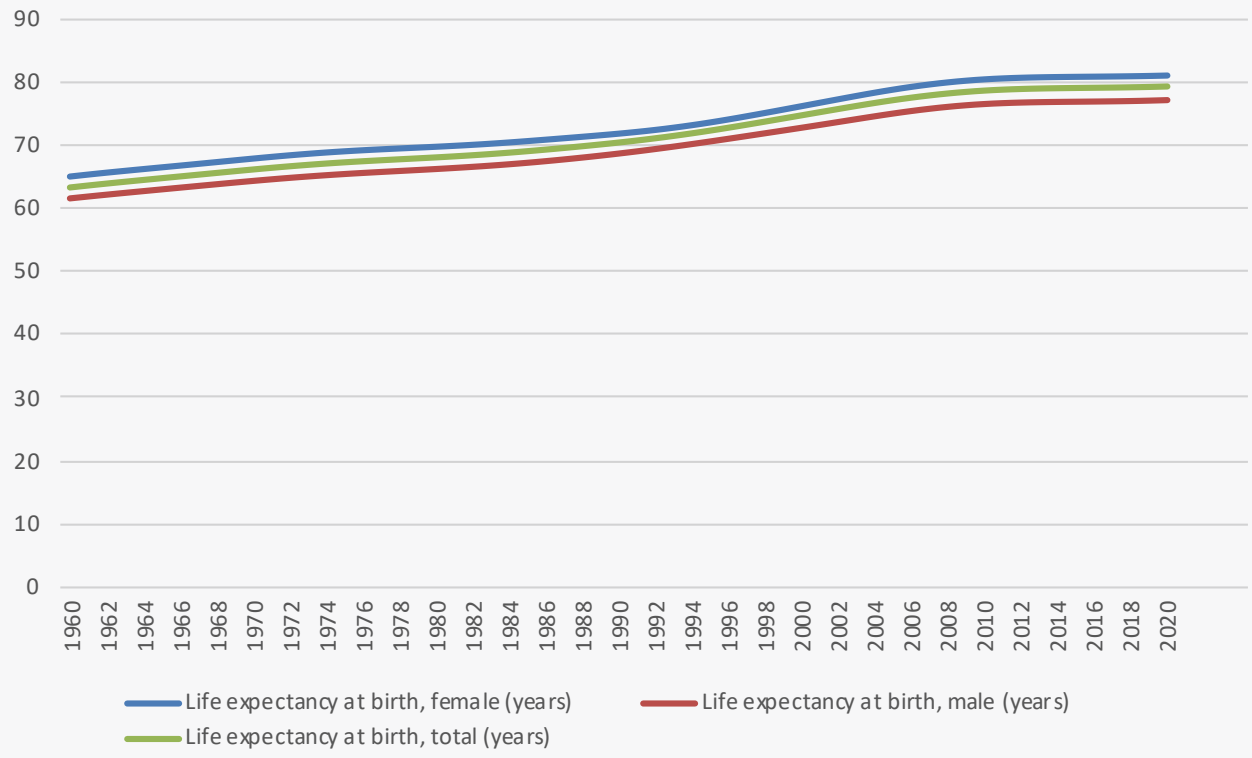
2.1. Changes in population health needs

Estimates show that by the end of 2021 around 54% of the population of Lebanon is in health need (approximately 1.95 million Lebanese people and migrant workers), of which around 15% are people with disabilities – an increase of 43% of people in need for supported health services and care since August 2021. In addition, around 1 365 000 Syrian refugees (of which around 850 000 are registered with the United Nations High Commissioner for Refugees (UNHCR)) and nearly 248 000 Palestinian refugees (registered at the United Nations Relief and Works Agency for Palestine Refugees in the Near East (UNRWA)) depend on humanitarian support for health care. An assessment of people in need and severity revealed that most of the districts of Lebanon have a severity scale of 4 out of 5 for health need (4 = severe, 5 = extreme). While some areas of the country have traditionally been underserved and include a large number of people in need of health support (such as Akkar), new areas of the country are now hosting large pockets of poverty and people in need (such as El Metn and Baabda),[4] reflecting a progressive vanishing of the middle class.

2.2. Population health

Key health indicators improved considerably in Lebanon up until 2016. Lebanon was one of only 16 countries to achieve Millennium Development Goal (MDG) target 5A on the reduction in maternal mortality ratio (MMR), with MMR dropping to 21 maternal deaths per 100 000 live births in 2016. Trends show that life expectancy at birth increased by 5.1 years between 2000 and 2015 (Fig. 1).

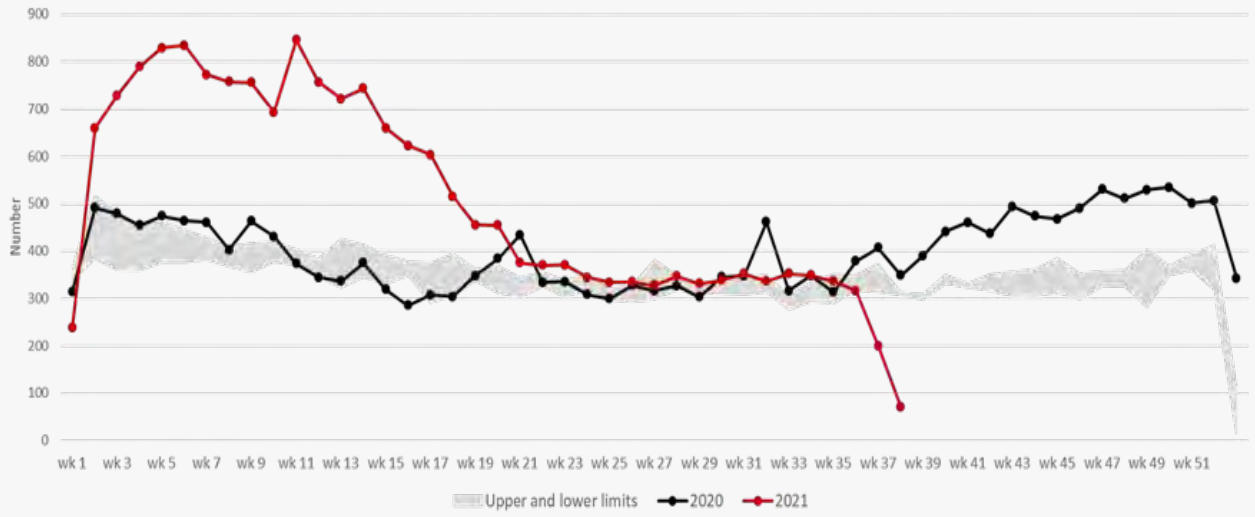
Fig. 1. Trends in life expectancy in Lebanon



However, indicators over the past three years show a decline in the gains in population health. The under-5 mortality rate increased from 9.4 deaths per 1000 live births in 2018 to 14.5 in 2020. Maternal deaths increased from 18 deaths per 100 000 live births in 2019 to 47 in 2021, more than 50% of which are attributed to COVID-19 (as per initial investigations). Excess mortality was estimated at around 15.4% in 2020 and 34.4% in 2021. Excess mortality attributed to non-COVID-19 was 3.4% in 2020 (Fig. 2).

[4] Lebanon 2021 Multi-Sector Needs Assessment 2021. Geneva: REACH Initiative; 2022 (*https://www.impact-repository.org/document/reach/be948f1b/REACH-MSNA_2021_Report_Leb_Mig_PRL_April-2022-2.pdf*, accessed 28 July 2022).

Fig. 2. Excess mortality data in 2020 and 2021, compared to historical average

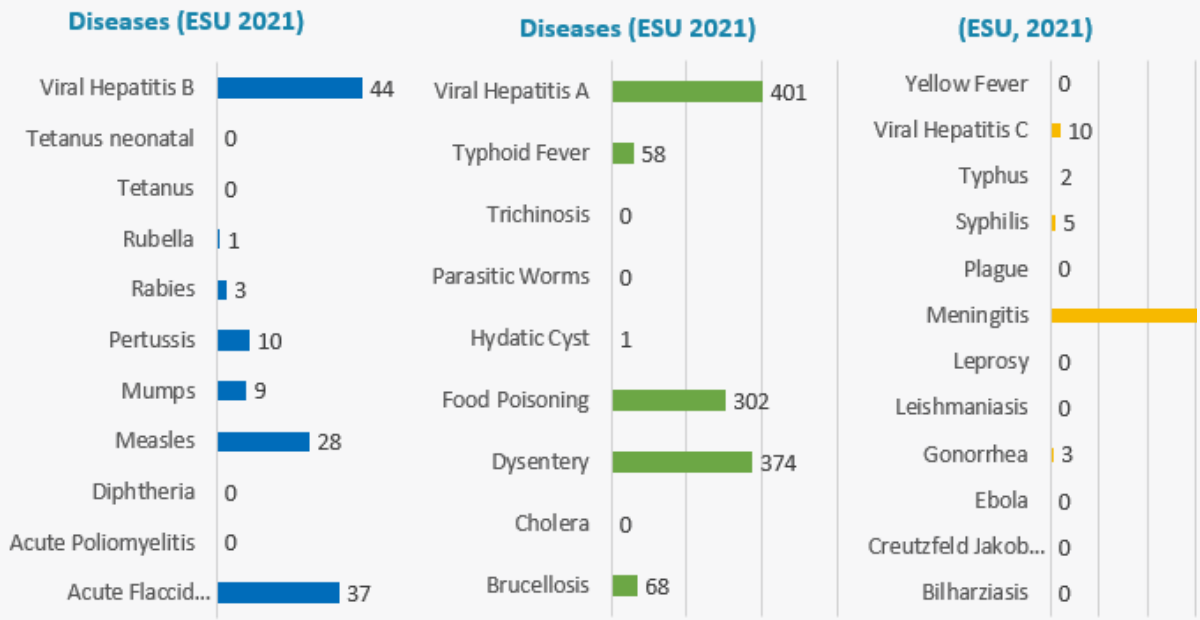


Source: Ministry of Public Health database, 2021.

Communicable diseases

Lebanon is in epidemiological transition from communicable to noncommunicable diseases. However, communicable diseases remain prevalent and the risk of outbreaks of vaccine-preventable and waterborne diseases is increasing. Although the focus of the Epidemiological Surveillance Unit at the Ministry of Public Health has been on COVID-19 over the past two years, outbreaks of hepatitis A, salmonella and food poisoning have been reported. Sporadic cases of brucellosis are still observed. Among tuberculosis (TB) patients, 658 were treated for active TB in 2020 compared to 479 in 2021; the drop is mainly attributed to a decrease in the number of migrant workers, who constitute more than 30% of all cases. Reported cases of HIV have remained stable at around 200 new cases per year, with persistent high prevalence among men who have sex with men. Zoonotic diseases have also been reported over the past two years.

Fig. 3. Number of reported communicable diseases, 2021



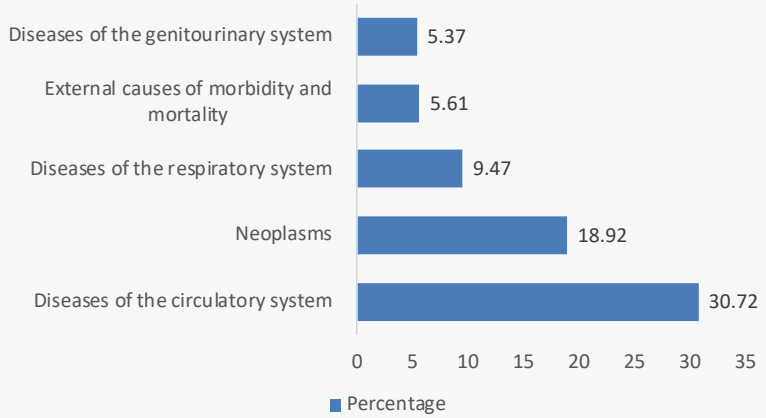
Source: Epidemiological Surveillance Unit, Ministry of Public Health, 2021.

The risk of disease outbreaks has increased as food and water safety are poorly monitored, mainly due to overlapping functions, poor coordination, lack of accountability and poor functional inspection programmes. Recent data estimate that vaccination coverage has dropped by 40%, an alarming decrease that could potentiate outbreaks of vaccine-preventable diseases and may further increase child mortality and morbidity rates.

NCDs

NCDs are the leading cause of mortality and morbidity among adults in Lebanon; cardiovascular diseases and cancer are the two main underlying causes of death (Fig. 4).

Fig. 4. Leading causes of death, Lebanon



Lebanon has performed poorly in terms of reducing the risk factors for NCDs. Around 55% of the adult population suffer from overweight/obesity, more than 60% have insufficient physical activity, and around 40% smoke.[5] Hypertension is observed in around 35% of the population aged above 18 years, and around 14.5% have high blood sugar (diabetic or pre-diabetic). Childhood obesity, one of the predictors of adult obesity and NCDs, is poorly monitored. Wasting and stunting prevalence is low nationally, although it is relatively high in Syrian camps (25.8%). Road traffic injuries are on the rise, particularly among young people, with around a 3% increase in car accidents over the past decade.

Estimates show that around 8000–10 000 new cases of cancer are reported yearly. Colorectal, thyroid and lung cancers, known to be affected by environmental hazards exposure, increased by 60%, 97% and 41%, respectively, between 2005 and 2015.[6] Five diseases account for 73% of the total Ministry of Public Health spending on cancer medicines: breast cancer, chronic myelogenous leukaemia, colorectal cancer, lung cancer and non-Hodgkin's lymphoma.

Mental health professionals are observing a rapid increase in cases of post-traumatic stress disorder, and many refer to "collective depression". According to the Lebanon 2021 Multi-Sector Needs Assessment, high levels of psychological distress are reported in adults, among both Lebanese and Palestinian refugee households – 45% and 50%, respectively[7].

[5] WHO STEPwise approach to NCD risk factor surveillance (STEPS) survey, Lebanon 2016–2017. Geneva: World Health Organization; 2017 (*https://www.who.int/teams/noncommunicable-diseases/surveillance/data/lebanon*, accessed 27 July 2022).

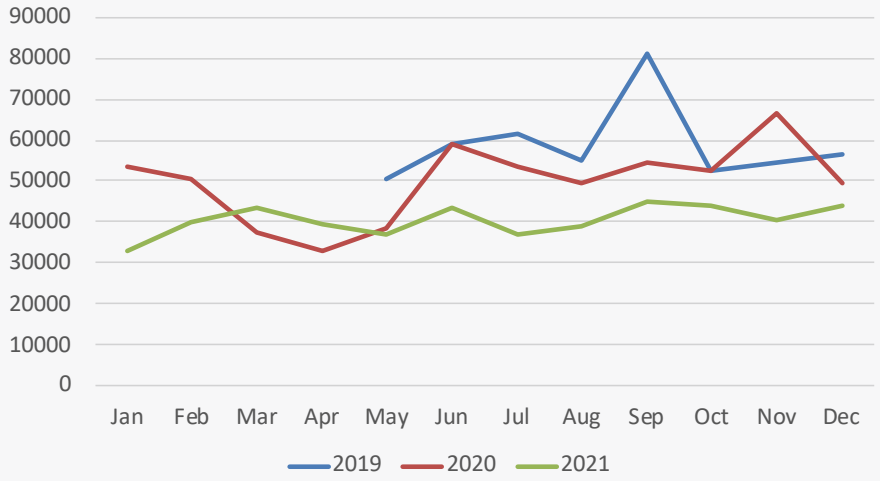
[6] National Cancer Registry, 2019. Beirut: Ministry of Public Health; 2019 (*https://moph.gov.lb/en/Pages/8/19526/national-cancer-registry*, accessed 15 May 2022).

[7] Lebanon 2021 Multi-Sector Needs Assessment, available at: *https://www.impact-repository.org/document/reach/be948f1b/REACH-MSNA_2021_Report_Leb_Mig_PRL_April-2022-2.pdf*.

2.3. Access to and utilization of health care

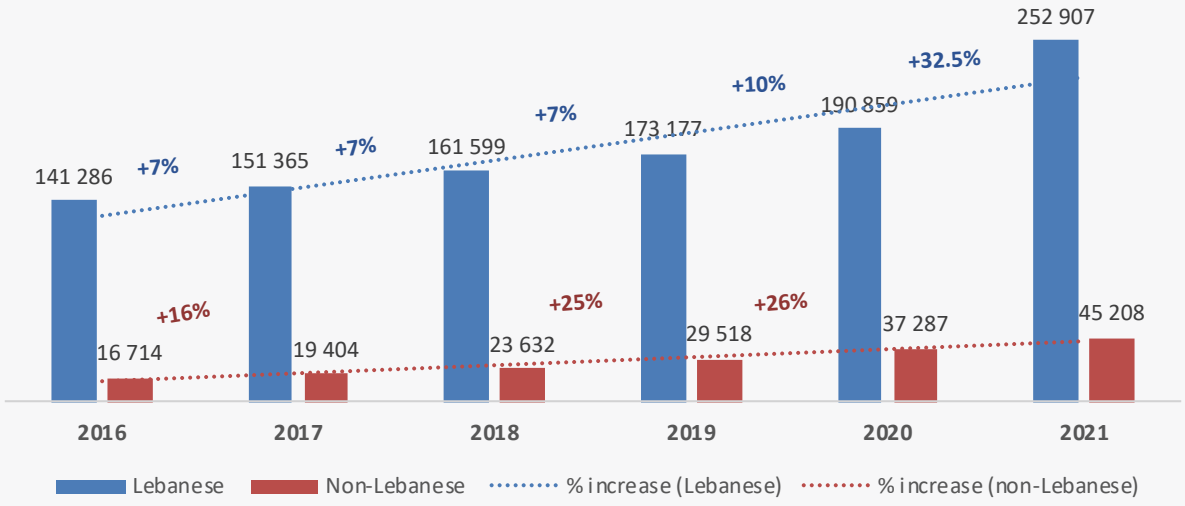
Health service utilization indicators show a decrease in overall access to health care, mainly in the private sector partially due to increasing poverty and decreasing purchasing power of the population in general, and partially due to COVID-19 lock downs in 2020 and 2021. Severe limitations in transportation, as well as limited operational capacity of health facilities, both in private and public sector, have hampered access to care. Vaccination coverage has dropped by at least 30% in the public sector and by more than 40% in the private sector (Fig. 5), jeopardizing the MDG gains in child health and survival and increasing the risk of vaccine-preventable disease outbreaks.

Fig. 5. Number of children aged under 5 years receiving routing vaccination at PHC centres, 2019–2021



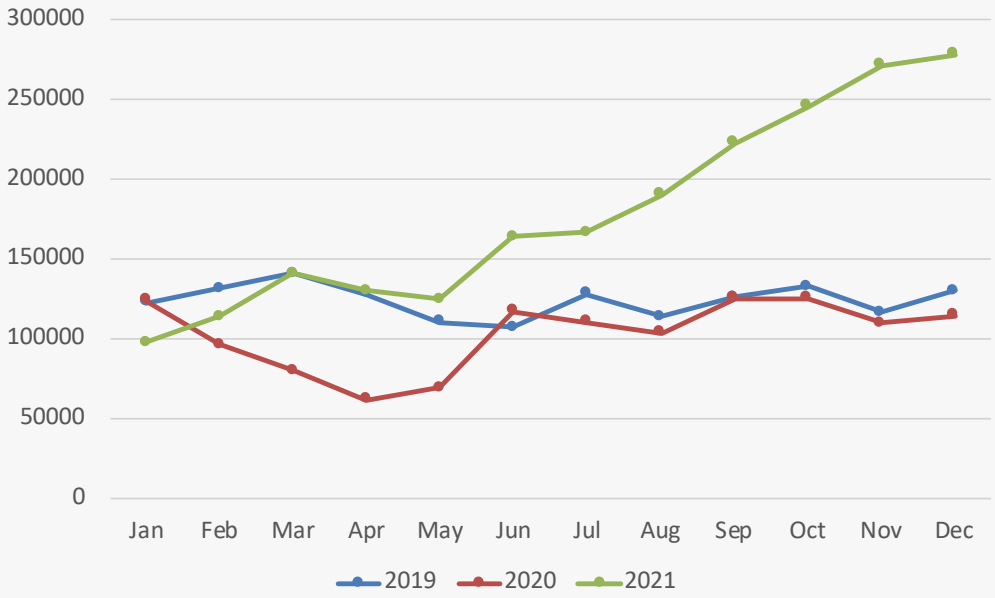
Paradoxically, high demand is observed for NCD medications at the PHC level, with the number of beneficiaries reaching more than 270 000 in 2021 from a baseline of 78 000 in 2016 (Fig. 6). This is mainly attributed to the severe shortages observed in private pharmacies, directing a significant proportion of the population to the PHCs. Similarly, Ministry of Public Health data show utilization of basic services at the PHC level has doubled since 2019, with particularly high increases over the last quarter of 2021 (Fig. 7).

Fig. 6. Number of beneficiaries of NCD medications programme, 2016–2021



Source: YMCA, December 2021.

Fig. 7. Number of beneficiaries of basic PHC services, 2019–2021



Source: Ministry of Public Health, 2021.

In terms of mental health services, unmet need is evident in the high increase in demand on the national mental health hotline, especially among young people. The number of callers seeking support for suicidal ideation/suicide attempt has more than quadrupled between 2019 and 2021, and referral to specialized mental health services has increased by around 50%.[8] However, the 2021 MSNA revealed that the large majority of people with mental health conditions are not seeking care.[9]

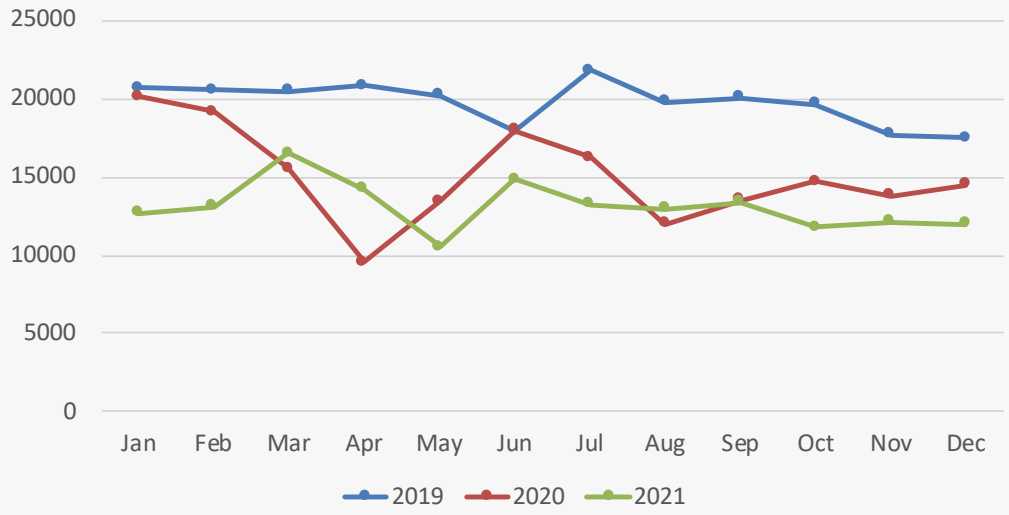
Regarding HIV treatment and antiretroviral therapy (ART), all medications are readily available at the National AIDS Control Programme ART dispensing centre, with adequate quantity supported by the Global Fund to Fight AIDS, Tuberculosis and Malaria. Similarly, the national TB programme is still able to provide medications and follow-up to around 700 patients annually.

In parallel, a drop in hospitalization rates is observed of around 30% in 2021 compared to previous years, especially for surgical procedures (Fig. 8).

[8] Embrace national hotline, 2019–2020 data.

[9] Lebanon 2021 Multi-Sector Needs Assessment, available at: https://www.impact-repository.org/document/reach/be948f1b/REACH-MSNA_2021_Report_Leb_Mig_PRL_April-2022-2.pdf.

Fig. 8. Number of hospital admissions for Lebanese patients supported by Ministry of Public Health, 2019–2021



Source: Ministry of Public Health, retrieved on 31 January 2022.

Changes in health-seeking behaviours

The changes in health-seeking behaviours and health service utilization could be due to several factors, including increased poverty and decreased purchasing power, as well as shortages of medications in the private market due to the financial crisis and restrictions. A trend towards a delay in seeking health care services has also been observed, which can result in irreversible complications and in some cases death;[10] in addition, more people are seeking alternative care such as traditional medicines (as reported by the 2021 MSNA).

The 2021 MSNA revealed that up to 25% of households are exhausting their coping mechanisms for accessing health care, stating that inflated health care cost due to devaluation of the currency and the lifting of the government subsidy on the medications are the most important reasons for coping. Around 87% of Lebanese, 86% of Palestinian refugees, 50% of migrant households and around 20% of Syrian refugees[11] reported having experienced barriers that prevented them from accessing medications when needed during the last quarter of 2021.

2.4. Determinants of health

In addition to individual behaviours that increase the risk of NCDs, environmental determinants are negatively impacting on population health. Water, soil and air pollution are on the rise due to the failure of national waste and energy management services. It is estimated that the tap water of more than 50% of households across the country is contaminated.[12]

Data reported from four major cities in Lebanon indicate that annual mean particulate matter 2.5 ($PM_{2.5}$) levels were above the WHO guideline value of 10 µg/m^3. Exposure to pollution is amplified by heavy traffic and numerous construction sites, as well as diesel generators spread throughout neighbourhoods to provide electricity during daily power outages. The association between short-term variations in ambient air concentrations of particulate matter (PM_{10} and $PM_{2.5}$) and emergency hospital admissions in the city of Beirut (for asthma, or exacerbation of chronic obstructive pulmonary disease and coronary artery disease) has been well documented in recent years. The repercussions of environment degradation is already seen in terms of frequent outbreaks of waterborne diseases and

[10] Syndicate of Hospitals in Lebanon report, 2021.

[11] UNHCR, UNICEF and WFP. VASyR 2021: Vulnerability assessment of Syrian refugees in Lebanon. Rome: World Food Programme; 2022 (*https://reliefweb.int/report/lebanon/vasyr-2021-vulnerability-assessment-syrian-refugees-lebanon-0*, accessed 28 July 2022).

[12] WHO/UNICEF Joint Monitoring Programme (JMP) 2017 update. *https://washdata.org/report/jmp-2017-annual-report*

increased incidence of certain cancers known to be correlated with environmental hazards exposure such as thyroid cancer, colon cancer, lung cancer and some types of leukaemia.[13]

Climate change hazards are expected to worsen. By the end of the century, a mean annual temperature rise of up to 4.3°C is expected and total annual precipitation could decrease by about 25%. Drought events and wildfires are projected to increase under a high emissions scenario. This would have a severe impact on food security and subsequently worsen malnutrition among the most vulnerable groups.

The Ministry of Public Health, with WHO support, updated the national environmental health strategy in 2020, However, the plan of action to enact this strategy was not developed, due to the acceleration of the crisis and emerging critical health priorities. In fact, the Ministry of Public Health has mainly a consultative role and the Ministry of Environment has no executive role. This dissolves responsibility and accountability. Civil society (nongovernmental organizations, civil society organizations, academic institutions) and the private sector have been very active in proposing alternative clean and sustainable environmental solutions; however, the buy-in of government officials has not been secured. Intensive advocacy and evidence generation are needed to address the environmental health challenges in Lebanon.

2.5. Health system status and UHC coverage

Even before the advent of the current complex crisis, Lebanon was exploring mechanisms to improve health service coverage and financial protection, with a commitment to achieving UHC by 2030 and targeting the most vulnerable, uninsured population groups. Approaches for addressing key challenges to access to health care – including improving equity and community engagement – are evolving, for example: integrating new services in PHC (mental health, early detection of NCDs); new payment mechanisms (performance-based reimbursement of prepaid packages, capitation, fee-for-service); and targeting specific populations (the poorest and most vulnerable, as per the National Poverty Targeting Program). However, the country faces multiple challenges in improving efficiency and quality across health care: limited government regulatory capacity in a private for-profit dominated health sector and low expenditure on public sector human resources are key bottlenecks at all levels.

In terms of health sector **governance**, and despite a remarkable increase in the moral and technical authority of the Ministry of Public Health, the regulatory capacity of public authorities over the health sector remains limited. The Ministry of Public Health has adopted a collaborative networking approach to steer and negotiate governance of the health sector. Given Lebanon's political context, this approach remains vulnerable due to political instability, changing power dynamics and vested commercial interests that hold important stakes. It also limits the leverage of the Ministry to address systemic gaps, including: imbalances in human resources and unregulated practice; the imbalance between technology-centred curative care and public health prevention and promotion; and the wide variations in quality of care of private providers, over whom the Ministry of Public Health has no authority.

In terms of health **financing and expenditure**, based on the latest National Health Accounts report[14] issued in 2019 (covering 2016–2017), health expenditure was 6238 billion Lebanese pounds (US$ 4.14 billion),[15] representing a 2.2% increase from 2016. Health expenditure per capita was 1 411 000 Lebanese pounds (US$ 936). Health expenditure constituted 7.8% of GDP. In 2017, around 47.6% of health expenditure was financed through government and compulsory contributory schemes, while 52.4% was financed through private voluntary schemes and household out-of-pocket payments. Social health insurance represented 23.4% of total health expenditure and 49% of government and compulsory contributory schemes. It was estimated that 33.0% of total health expenditure was financed from direct out-of-pocket payments. Around 52.5% of total current health expenditure was spent on curative and

[13] National Cancer Registry 2019. Beirut: Ministry of Public Health; 2019 (*https://moph.gov.lb/en/Pages/8/19526/national-cancer-registry*, accessed 21 July 2022).

[14] National Health Accounts 2019 report. *https://moph.gov.lb/userfiles/files/Statistics2019.pdf*.

[15] 1 US$ = 1507.5 Lebanese pound in 2017; National Accounts, Central Administration of Statistics.

rehabilitative care, 27.2% on medical goods, 4.6% on ancillary services, 8.7% on health administration, and 7.1% on all other services (including preventive care). In light of the severe and complex crisis, especially the financial and fiscal crisis where the Lebanese pound has been devalued by 13 times against the US dollar, most of these health financing and expenditure figures and estimates need to be revised.

In terms of **service delivery**, Lebanon benefits from a large number of PHC centres and dispensaries (around 1000 across the country) that offer various types of services, from simple dispensing of essential medications to more comprehensive packages of services. Most of these PHC centres and dispensaries are owned and operated by nongovernmental organizations. The Ministry of Public Health has established a National PHC Network, which benefits from medications (acute, chronic and vaccines) and capacity-building, as well as support to selected packages of care. In 2021, the Ministry of Public Health redesigned its PHC package of services, now called the long-term primary health care subsidized protocol (LPSP), which entirely depends on donor funding. The LPSP offers the most vulnerable population groups a package of services for general wellness and prevention, antenatal care, NCD and mental health care, disability care, and communicable disease care. A referral network of selected PHC centres, supported by specialized nongovernmental organizations, has been established for victims of gender-based violence and clinical management of rape. In the context of the current crisis, many of these local nongovernmental organizations are supported by international organizations and donor funds.

The **hospital sector** offers a total capacity around 13 000 beds, of which only 2000 are available in the 27 operational public hospitals. However, because of the current crisis (both financial and COVID-19-related) more than 30% of private hospital beds are closed, average monthly inpatient admissions have dropped by at least 15% and the average monthly inpatient days have dropped by 25%.[16] The yearly market size of the hospital sector (private and public) is estimated at around US$ 800–1000 million per year, serving around 12% of the population, with an average 800 000 admissions per year.[17] However, because of the crisis, reimbursement to hospitals by third parties (government and private insurances) has dropped by 90%, threatening the financial and operational viability of both the private and public hospital sector.

In terms of **human resources for health**, Lebanon has historically suffered from severe imbalance in resources, with a surplus of medical doctors and a significant shortage of nurses, paramedical staff and health managerial staff. However, the current crisis has accelerated the exodus of health care workers. The professional orders estimate that around 40% of medical doctors have permanently or partially emigrated, and some 20% of the nursing workforce have left the country. This is clearly jeopardizing the timeliness and quality of health care in the country. Moreover, a similar exodus is observed at the Ministry of Public Health, whereby it is currently operating with less than 30% of its initial staff capacity, both centrally and at peripheral areas. This is jeopardizing the continuity of critical programmes, as well as the regulatory capacity of the Ministry of Public Health.

Before the crisis, the **pharmaceutical sector** was one of the main pillars of the health system, with an estimated market size of around US$ 1.2 billion per year. More than 90% of pharmaceutical products and 100% of medical supplies, devices and equipment are imported. The 2020 lifting of the government subsidy for medications and medical supplies, coupled with restrictions on foreign currency, has severely impacted the pharmaceutical sector. Repeated shortages of medications and medical supplies have been observed, and local pharmaceutical manufacturers do not have capacity to fill the gap, at least in essential medications. Over the last five years, WHO has supported the pharmaceutical sector through critical interventions such as: filling the gap in acute/chronic disease medications (at PHC level) and selected life-saving medications (for the most vulnerable and uninsured); capacity-building; evaluation of Good Manufacturing Practices and Good Governance of Medicines; updating the list of essential and chronic medicines; the 2D barcode traceability system for medicines; and an automated logistics and management system at the central drug warehouse. The latter has been fully reconstructed after the Beirut port explosion and was expanded by around five-fold in terms of storage capacity, with a backup sustainable energy source (solar panels).

[16] Data from the Syndicate of Hospitals in Lebanon, June 2021.

[17] Data from the Syndicate of Hospitals in Lebanon, 2021.

Reinforcing the regulatory role of the Ministry of Public Health and ensuring financial sustainability for chronic disease medications, while increasing local production of medicines and rationalizing government support to medicines supply, especially in light of the current complex crisis, are the challenges faced by the pharmaceutical sector.

In December 2021, the Lebanese Parliament issued a law to establish an independent National Drug Authority (NDA). For this law to be implemented, it will require a detailed implementation plan, including a transition plan between the Ministry of Public Health and the newly established NDA, and the necessary premises, staffing and funding. The central public health laboratory (CPHL) for medicines, medical devices and food supplements would be under the control of the NDA. Meanwhile, CPHL functions will need to be urgently restored within an accountability and quality standard framework.

There is a wealth of **health information** on service coverage and health outcomes being collected within the health system by the Central Administration of Statistics, the Ministry of Public Health and other related ministries, academic institutions, the private sector and nongovernmental organizations. However, much of the data are fragmented, unsystematic and lacking in coherence; most available data are incomplete, duplicated and of low quality. There is an urgent need for a master plan for a health information system that engages all relevant institutions and strategizes and harmonizes data collection and analysis to prevent future waste of resources.

2.6. Emergency preparedness and response

The current complex crisis has demonstrated the weaknesses and vulnerabilities in health emergency preparedness and response, in line with the main observations of the joint external evaluation mission in 2016 on IHR (2005) core capacities.

The COVID-19 pandemic revealed the poor readiness of public hospitals to address national health emergencies, and the heavy reliance on the private sector. On the other hand, the private sector hesitated to engage at the beginning of the pandemic, essentially because of the severity of the financial crisis. WHO and donors had to rapidly expand the capacity of public hospitals in terms of human resources, equipment for laboratories and intensive care units (ICU), and provision of personal protective equipment and laboratory reagents to be able to manage cases of COVID-19.

In the absence of an adapted national health emergency preparedness and response plan, most of the responses to COVID-19 and other concurrent emergencies were improvised. However, and because of previous WHO support in improving IHR (2005) implementation, the national public referral hospital (Rafik Hariri University Hospital) was able to accommodate the first wave of COVID-19 cases. The Hospital had benefited from WHO support in terms of training of health care workers, establishment of isolation beds, and upgrading of laboratory and diagnostics capacity and quality.

Lebanon started the deployment of COVID-19 vaccines in February 2021 and reached around 40% of the population fully vaccinated by February 2022. Greater efforts are needed to reach the 70% target set by WHO and to overcome vaccine hesitancy and vaccination centre fatigue.

Support is continuously provided to the **Early Warning, Alert and Response System** (EWARS) in terms of expansion, automation and human resources at the Ministry of Public Health. Initiation for EWARS establishment at the Ministry of Agriculture and potentially at the Ministry of Environment has started, but significant support will be required to develop a One Health approach.

Risk of outbreaks

The risk of outbreaks has increased in Lebanon over the past two years:

- low vaccination coverage due to COVID-19 lockdowns, decreased capacity of PHC centres in terms of operational capacity, shortage of vaccines in the private market and decreased purchasing power of the middle class – factors which are increasing the risk of vaccine-preventable diseases;
- limited capacity of the Epidemiological Surveillance Unit at the Ministry of Public Health – routine surveillance was severely hampered as resources were redirected to COVID-19 monitoring;
- points of entry have been relatively well-monitored, with vaccination provided at land borders for children aged under 5 years – however, this intervention is totally dependent on UN support;
- vaccine-derived poliovirus cases have been reported in the Gaza Strip, the West Bank and Yemen, and wild poliovirus cases in Malawi, and an outbreak of measles in the northern Syrian Arab Republic was observed in February 2022 – increasing the risk of cross-border transmission;
- heavily contaminated water sources and poorly monitored water piping systems – increasing the risk of waterborne diseases.

Main limitations of the emergency preparedness and response system

The main observations of the joint external evaluation mission to Lebanon in 2016 for IHR core capacities included: 1) the need to put in place systems/structures to ensure adequate coordination of information sharing and rapid response, as well as full multisectoral engagement; 2) recognizing the importance of the private sector's role in Lebanon in providing services related to national IHR capacity, and for needs to be adequately engaged and represented; and 3) acknowledgement of insufficient IHR-related human resources capacity at different levels of administration.

A main limitation is the absence of a dedicated team/unit at the Ministry of Public Health for emergency risk and crisis management. Although a national inter-ministerial committee and a national multidisciplinary task force were established for the COVID-19 response, they remain ad hoc and temporary, with poorly delineated terms of reference and mandates and a lack of incentives/reimbursement, which has an impact on accountability.

Another important limitation is the absence of a national public health laboratory to allow early and timely confirmation of outbreaks and other potential hazards. Instead, the functions of the CPHL have been reassigned to various institutions on an ad hoc basis. The National Influenza Centre, fully supported by WHO, is located at the research laboratory of the Rafik Hariri University Hospital, while the national measles reference laboratory is located at the Hospital's medical laboratory. Agreement has been made with Rodolphe Mérieux Laboratory of Beirut, at Saint-Joseph University, for TB culture and antimicrobial resistance (AMR) monitoring. Radionuclear and chemical hazards monitoring and testing are assigned to the National Center for Research and Development. A private toxicology laboratory is used for confirmation of poisoning or atypical cases. The need remains for better structured national CPHL functions, with an accountability framework and relative autonomy.

An additional limitation is the late and limited engagement of the private sector in COVID-19 pandemic response, and heavy reliance on a public system that has very limited capacity.

3. Partnerships

The UN Country Team began to develop the Common Country Assessment in 2021 and has recently finalized the draft United Nations Sustainable Development Cooperation Framework (UNSDCF). Taking an agenda aimed at resetting the pace towards development, the UNSDCF contains a "preventive approach, aiming at reducing risk and building resilience" with an acknowledgment of the need to accelerate efforts and deliver differently to cover humanitarian needs, in parallel with addressing risks and vulnerabilities that could derail peace.

Given the multiple crises faced by Lebanon, the UN understands the need of delivering at a faster speed to address root causes: "An 'emergency development' approach will promote development differently".

The UNSDCF is built around four goals, as given below.

1. Improved lives and well-being for all people in Lebanon.
2. Improved, resilient and competitive productive sectors for enhanced and inclusive income-generating and livelihood opportunities.
3. Sustained peaceful and inclusive societies for participatory and equitable development.
4. Restored rich nature and ecosystem of Lebanon for inclusive green recovery.

It is planned that the UN will ensure technical capacities and expertise, as well as provide space for policy-making and resources to support coherent, integrated and multidimensional responses including in joint analyses, planning and programming. There is a focus to "address data gaps and strengthen national data ecosystem, improving evidence-based policy, programme design, learning and monitoring and evaluation, using innovative inter-disciplinary approaches, data and research."

The Lebanon CCS objectives will align to the four UNSDCF goals and WHO will collaborate in the various programmes with relevant government entities, the UN, development partners, academia, civil society and nongovernmental organizations. Complementarity in programming and delivery will be sought with the key UN agencies working on health for all in Lebanon.

4. WHO Country Office performance reviews

4.1. Biennium performance evaluation

As part of the review of the Programme Budget 2020–2021, the WHO Country Office in Lebanon's performance evaluation was more than satisfactory across all scorecard dimensions. The Country Office has spearheaded coordination across the health sector and across various response plans including the COVID-19 response plan, the Lebanon Emergency Response Plan (ERP) and the Lebanon Crisis Response Plan (LCRP) for refugees. WHO led the COVID-19 response and was able to pioneer joint coordination between all health sector actors. After the Beirut port explosion in August 2020, WHO also assumed co-leadership of health-related interventions and the working group of the UN's Reform, Recovery and Reconstruction Framework (3RF).

Despite the complex crisis situation and the disruptions caused by the COVID-19 pandemic, the Country Office was able to maintain delivery of technical support, including direct support for the development of the national health sector strategy and for several critical public health programmes, such as: the 2D barcode pharmaceuticals traceability project; digitalization of the central warehouse logistics and management system; maintenance of the CRVS programme; and automation of National Health Accounts. To ensure people with disabilities were not left behind, WHO and partners engaged in strong and sustained advocacy efforts to ensure they were prioritized for COVID-19 vaccination due to their vulnerable status. People with disabilities were subsequently prioritized at the PHC level.

Gender issues were integrated within all activities and plans, and gender-specific activities (such as assessing vaccination hesitancy among women) were completed. Value for money was evident through the standardized processes for procurement as well as the return on investment for selected interventions, such as equipment and human resources for ICUs. This increased access to health care for COVID-19 patients and provided cost-effective results.

In summary, Lebanon Country office performance in terms of technical support, leadership, global goods, gender equity human rights and disability scoring the highest, as illustrated in Fig. 9 below.

4.2. Country functional review (CFR) update and WHO Country Office staff

In view of the severity of the current crisis, the need to review the scope of operations in Lebanon and provide support to the WHO Country Office triggered a modular CFR approach to review/update the recommendations of the 2019 CFR.

The Country Office has in fact expanded its operations, despite very limited current staffing, as the budget has grown from US$ 20 million at the start of Programme Budget 2020–2021 to US$ 80 million by the end of 2021 (with expectations of additional funding), which has implications for oversight, monitoring and reporting. In addition, the Office has relied more on direct implementation modalities, with a progressively increasing role in procurement, logistics and supply management. Hence, the virtual CFR update for Lebanon aimed to:

- identify priority areas for immediate attention based on the current and emerging socio-political context and its implications vis-a-vis health challenges in the country;
- analyse the implications on the capacity of the Country Office to respond and expand its scope of operations, and propose options for ensuring that the Office remains "fit for purpose", including on technical and operational aspects, and has adequate financial resources;
- identify support required from the WHO Regional Office for the Eastern Mediterranean and WHO headquarters.

The CFR update adopted a principled approach towards supporting national institutions and avoiding complete substitution, and engaged national authorities especially the Ministry of Public Health and key stakeholders in an ongoing dialogue. Based on the CFR, readjustments in the organogram were made to become more fit-for-purpose to respond to the context change and new needs.

5. WHO Country Office main achievements

5.1. COVID-19 response

The WHO Country Office led the UN's COVID-19 response in Lebanon and provided direct support to the Ministry of Public Health and other government institutions, national response structures and task forces to reinforce the national pandemic response. WHO support focused on case management, laboratory diagnostics and surveillance, as well as risk communication and community engagement. Subsequently, 45% of public hospitals doubled their bed capacity through direct support to nursing, ICUs and laboratory equipment. This has resulted in the hospital system being able to accommodate the increase in demand caused by COVID-19, even though hospitals were working with reduced capacity.

5.2. Beirut port explosion

Within 24 hours of the explosion, WHO had deployed medical and surgical kits to address the immediate PHC and surgical needs for around 6000 injured and more than 300 000 affected people. Within 24 hours, the medications at the central drug warehouse were relocated to an alternative warehouse. The central warehouse was totally reconstructed within a year of the explosion, with five times its initial capacity.

5.3. National health sector strategy

The Country Office focused on supporting the development of the national health sector strategy, and has so far completed the situation assessment. This is being followed in 2022 with key informant interviews, consensus-building and finalization of the strategy.

5.4. EWARS and surveillance

WHO has ensured that surveillance is strengthened and reporting is comprehensive and covers all the country. Support included: staffing (68 additional staff); full automation of EWARS; provision of kits for COVID-19 surveillance; upgrading the capacity of the National Influenza Centre; and conducting external quality assurance exercises for laboratories performing PCR analysis.

5.5. PHC

WHO supported the finalization of PHC packages of services, including integration of NCDs and mental health care services.

5.6. Civil registration and vital statistics

Lebanon has made significant progress in improving the civil registration and vital statistics (CRVS) system, with direct support from WHO. Since 2017, the country has been able to report on causes of death through the CRVS system, which is operational in 143 hospitals. During the COVID-19 pandemic, investments in the cause-of-death registration system were highly effective and timely to facilitate and support the surveillance system for COVID-19-related deaths. The system has contributed to better understanding and monitoring of the pandemic situation in Lebanon.

5.7. Innovative projects

The WHO-led twinning project optimized a private–public partnership model for the transfer of knowledge and expertise for COVID-19 care from private university hospitals to public hospitals. The prisons health project focused on improving access to PHC for prisoners and detainees, developing an automated medical record system and supporting COVID-19 prevention through isolation and referral.

5.8. WHO leadership

WHO's role in the UN was reaffirmed through its coordination and leadership of the COVID-19 response and ERP, co-leadership of the 3RF after the Beirut port explosion, and co-leadership of the LCRP for refugees. WHO is actively contributing to revision of the UNSF, as well as to development of the CCA and finalization of the UNSDCF for 2023.

5.9. Resource mobilization

The Country Office succeeded in increasing mobilization of resources by five-fold, from US$ 20 million to US$ 100 million. The procurement of goods, medications and information and communication technology equipments was done strictly under the standards for Global Public Health Goods. The technical support provided by the three levels of WHO was instrumental in shaping the health response to the complex emergency situation at the country level.

Public health impact

- More than 600 000 vulnerable patients benefited from zero interruption of stocks of essential medicines (acute, chronic and mental health medications).
- A total of 948 COVID-19 patients were supported with ICU services.
- A total of 705 nurses were deployed for a total of 38 288 nursing days for COVID-19 care.
- The pharmacovigilance centre became fully operational and linked to monitoring of COVID-19 vaccination.
- Around 700 000 children received measles, mumps and rubella vaccination and oral poliovirus vaccines through immunization campaigns in 2019–2020.
- Digitalization of health was accelerated through: 2D barcode traceability system for pharmaceuticals; full automation of the logistics and supply system at the central drugs warehouse; automation of National Health Accounts; and expansion and upgrading of CRVS.


TABLE

6. WHO main areas of work

The Ministry of Public Health is focused on priorities of an emergency nature that require immediate response. WHO support is needed to reinforce the Ministry's monitoring and regulatory capacity,

WHO will advocate through its strong connections with international donors and partners as a catalyst, convener and accelerator of change, with the moral, legitimate and neutral status required for donor support as well as for Government buy-in of critical interventions.

- WHO will intensify its efforts for continued resource mobilization and coordination of health sector support.
- WHO will intensify its efforts to advance and reshape health care and health financing in Lebanon, taking into account the differences in opinion and the trust issues of stakeholders.
- Moreover, WHO will maintain its role as the hub for technical advice and building of capacities and institutional capabilities, providing thinktank functions to lay the strategic groundwork in key priority areas.

CCS main objectives

The principle of WHO support will be mainly based on the Humanitarian-Development-Peace Nexus, bridging humanitarian interventions to development interventions within the overall goals of the 2030 Agenda for Sustainable Development and in line with the strategic priorities of GPW13.

The main focus of WHO's work will be:

- ensuring access to health services and the continuum of care, especially for the most vulnerable populations;
- supporting development of the health information management system;
- strengthening emergency preparedness, response and recovery, as well as IHR core capacities.

Promote health: strengthen health system resilience and development towards UHC

1. Support to PHC

- Improving service integration and monitoring at the PHC level: NCDs, mental health, disability, nutrition, and maternal, newborn, child and adolescent health.
- Filling gaps in acute and chronic medications.
- Acceleration of the routine immunization programme.
- Expansion of the people-centred primary care approach.
- Sustaining support to the National AIDS Control Programme.

2. Support to the hospital sector

- Improving quality and safety of care: maintaining the twinning project; training on management of near-miss cases, infection prevention and control, advanced life support, respirators and oxygen use; upgrading of public hospital emergency room capacities (equipment, training); support in filling gaps in nursing at selected public hospital ICUs.
- Supporting reimbursement of hospital care for the most vulnerable patients.

3. Strategy development

- Finalization of the national health sector strategy and plan of action.
- Finalization of selected programmes' strategic plans: EPI, mental health and HIV/AIDS.

4. Support to the pharmaceutical sector

- Expansion of the 2D barcode system.
- Finalization and implementation of the implantable medical devices traceability system.
- Roll-out of the logistics and supply system, from the central warehouse to end-users at PHC level.
- Supporting expansion of the national pharmacovigilance centre.

5. Evidence for policy-making

- Conducting the WHO STEPwise approach to NCD risk factor surveillance (STEPS).
- Conducting the health-seeking behaviours study.
- Conducting the Global School-based Student Health Survey.
- Supporting National Health Accounts automation and report generation.
- Supporting the CRVS hospital-based cause-of-death reporting system and annual report generation.

Keep the world safe: protect from health emergencies

1. Surveillance

- Supporting the routine surveillance system and EWARS: technical missions, Epidemiological Surveillance Unit strategic plan, filing human resources gaps, training on DHIS2 and advanced tools.
- Supporting integration of the influenza-like illness (ILI)/COVID-19-like illness (CLI) surveillance systems.
- Supporting the National Influenza Centre.

2. IHR and emergency preparedness

- Development of a two-year plan for initiating the One Health approach.
- Finalization of the pandemic preparedness plan.
- Updating the AMR national plan and establishing a hospital-based AMR surveillance system.
- Supporting establishment of a national health emergency operations centre.
- Supporting re-establishment of the CPHL, including an accountable and sustainable framework of action.

3. COVID-19 response

- Maintaining leadership of the COVID-19 response among UN entities.
- Supporting hospital-based COVID-19 units.
- Supporting COVID-19 vaccination: operational cost contributions, risk communication and community engagement.
- Monitoring COVID-19 through targeted research: serosurveys, genomic sequencing.

Serve the vulnerable: better health and well-being

1. School health environment

- Supporting the update of the school health strategy.

2. Environmental health

- Supporting update and roll out of the medical waste management guidelines.
- Finalization of the economic case for tobacco taxation.

WHO Country Office and leadership

- Develop a WHO Country Office communication and visibility plan.
- Reaffirm WHO's presence in UN coordination mechanisms, including Data and Statistics Working Group (DSWG), Sustainable Development Goals (SDGs), Common Country Analysis/United Nations Strategic Development Cooperation Framework (CCA/UNSDCF), UN Humanitarian Country Team, UN Communication Group (UNCG).
- Maintain adequate staffing of the WHO Country Office.

7. Assumptions and risks

The revised CCS makes the following assumptions:

- sufficient funding will be secured to maintain and retain the WHO Country Office team;
- WHO support will be maintained and reinforced at the three levels of the Organization;
- funding for critical projects will be made available;
- the crisis situation will stabilize without further deterioration.

Risks	Mitigation
Security deterioration	Working from home modalities established
Political instability	Most projects and interventions already approved and agreed upon
Donor fatigue	Funding for selected large projects secured for at least one year

Annex 1. Matrix of health-related priorities in national health policies, strategies and plans, GPW13 and UNSF

GPW13	CCS	Health strategic plan 2016–2020	UNSF
Promote health			
	Health coverage: develop the health system towards UHC	1) Continue progress to UHC 2) Modernize and strengthen health sector governance	Improve equitable access to and delivery of quality social services, social protection and direct assistance
1 billion more people benefiting from UHC	300 000 more most vulnerable people (150 000 Lebanese and 150 000 refugees) have access to affordable essential health services		Increase percentage 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			
	Protect health: develop and maintain emergency preparedness and health security	Develop and maintain emergency preparedness and health security	
1 billion more people protected from health emergencies	Entire population (6.09 million people) better protected from health emergencies		
Serve the vulnerable			
	Health priorities: improve health and well-being across different life stages	Improve collective public health and promotion	
1 billion more people enjoying better health and well-being	Improve health and well-being for 2 million people whose health is negatively impacted by social, behavioural and environmental risk factors		

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