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RIGHT TO HEALTH IN TIMES OF CRISIS

A review of barriers and challenges to achieving the right to health in Lebanon

Maysa Baroud

Senior Program and Research Officer, Arab NGO Network for Development

This report is published as part of the Arab NGO Network for Development's Arab Watch Report on Economic and Social Rights (AWR) series. The AWR is a periodic publication by the Network and each edition focuses on a specific right and on the national, regional and international policies and factors that lead to its violation. The AWR is developed through a participatory process which brings together relevant stakeholders, including civil society, experts in the field, academics, and representatives from the government in each of the countries represented in the report, as a means of increasing ownership among them and ensuring its localization and relevance to the context.

This 6th edition of the AWR focuses on the Right to Health. The AWR 2023 on the Right to Health is a collaboration between the Arab NGO Network for Development and the Faculty of Health Sciences at the American University of Beirut. Through this report we aim to provide a comprehensive and critical analysis of the status of the Right to Health in the region and prospects in a post COVID-19 era. It is hoped that the information and analysis presented in this report will serve as a platform to advocate for the realization of the right to health for all.

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Maysa Baroud is a Senior Program and Research Officer at the Arab NGO Network for Development, where she coordinates the Arab Watch Report on Economic and Social Rights. She has contributed to several research projects on refugee issues, with a focus on refugee livelihoods, and on healthcare issues in Lebanon.

CONTENTS

INTRODUCTION

Lebanon's current economic crisis, compounded by the COVID-19 pandemic and the August 4 Beirut Blast, has had a profound impact on all aspects of life and, in turn, on the living conditions for many. The currency has lost over 90% of its value, with consequences on the purchasing power of most of the population. Inflation is soaring—the overall consumer price index increased by 253.55% from June 2022 to June 2023, and food and non-alcoholic beverage prices increased by 279.54%, while the health prices (including services, medicines, and medical equipment) increased by 284.27% (Central Administration of Statistics [CAS] 2023). In addition, the government has lifted subsidies on basic commodities, including certain medicines, fuel, and infant formula. Import tariffs have also been raised, impacting the price of commodities and their affordability, noting that Lebanon relies heavily on imports for most goods, including food and medicine.

The crisis was years in the making and exposed a weak political and economic system upheld by a corrupt political class. Lebanon's liberal economic approach, adopted after the country's independence, has enriched a small proportion of the population while perpetuating inequities. Available welfare and social protection programs are fragmented, complex or non-functional and continue to promote reliance on the political class (Proudfoot 2021a, 2021b). Furthermore, what should be public services have often been provided by the private sector. Even before the crisis, the quality of public services in Lebanon was poor—with regard to health, the crisis exposed already existing structural problems in Lebanon's healthcare system. The quality of public services has continued to deteriorate since the onset of the compounded crisis at the end of 2019, while governorates other than the capital Beirut, and part of Mount Lebanon remain underdeveloped. Indeed, the greatest consequences of Lebanon's crisis have been especially felt by those most vulnerable (Bourhrous 2021).

Against this backdrop, this report seeks to shed light on the impact of Lebanon's ongoing economic crisis and weak public services on the health of individuals and the right to health for all in the country. The report provides a review of (select) cross-cutting issues that impact the attainment of the right to health, focusing on issues related to healthcare access

and management. The report also provides a brief overview of the development of Lebanon's health system. Based on the findings, it concludes with recommendations to facilitate the attainment of the right to health for all in Lebanon. The report relies primarily on a review of available literature and secondary data (the limitations of which are discussed in a later section of this report).

A BRIEF HISTORY OF LEBANON'S HEALTHCARE SYSTEM AND ITS DEVELOPMENT

The development of Lebanon's healthcare system, spanning from its pre-independence in 1943 to the onset of the civil war in 1975, highlights significant regional disparities in access to healthcare and medical education, growth of the private sector, and a focus on infectious diseases and related factors, in line with medical advancements of the time. Public-health related reforms and legislation introduced during this period resulted in a highly bureaucratic, centralized system characterized by duplication and inefficiency. The reforms also promoted increased dependence on the private sector for healthcare services, deepening disparities in the system and inequalities across communities, with repercussions on the right to health in Lebanon felt to this day. Given the limited availability of writings on the history of public health in Lebanon, this section relies heavily on a few key works (see Kronfol & Bashshur 1989; Kronfol 2006; Ammar 2003; Ammar 2009).

HEALTHCARE PRE-CIVIL WAR

The period from the French mandate to independence in 1943 set the foundations for the healthcare sector's privatization, thus contributing to inequitable access to healthcare services among the population. In 1918, Lebanon's first Department of Health was established as an entity within the Ministry of Interior (Kronfol & Bashshur 1989). The French invested very little in health during their mandate, instead promoting the provision of health through missionaries and the private sector (Abi-Rached & Diwan 2022). In line with the French state administration, Lebanon's healthcare system became highly bureaucratic and centralized. Two elite medical education institutions run by Western missionaries were established during this time, serving as "private voluntary organizations." The Syrian Protestant College (today, the American University of Beirut) and the Jesuit (St. Joseph) University, located in the capital Beirut, charged those who could pay and provided free care to the poor. In addition, several small for-profit private hospitals were established during this period, which catered to private patients from the middle and upper classes (Kronfol & Bashshur 1989).

In 1932, a health law was passed mandating that the Municipality of Beirut would be the only provider of public services within its jurisdiction, including health, greatly diminishing the role of the national ministry. The law focused on "protection of the public's health" and focused primarily on "environmental sanitation, quarantine and control of infectious diseases." Its introduction hindered national-level healthcare reform (Kronfol & Bashshur 1989, p. 379), facilitating development in some areas (such as the capital) over others. It was not until 1943, upon independence from France, that Lebanon's Ministry of Health and Public Relief was established, responsible for "the supervision, coordination, legislation and fostering of environmental sanitation and the control of communicable disease" (Kronfol & Bashshur 1989, p. 380).

Starting in the 1950s, and as a result of Lebanon's recession, the ministry started to provide public assistance and established a network of public hospitals exclusively for the poor, which by 1971 had reached 21 hospitals. Nevertheless, several regions in the country remained without a public hospital (Kronfol & Bashshur 1989). Besides generating regional disparities and furthering fragmentation, the creation of hospitals "exclusively for the poor" likely propagated class differences. Legislation pertaining to human resources for health and public health, including legislation related to licensing health workers' degrees, aiming to strengthen the public health sector, was also introduced in the 1950s (Kronfol & Bashshur 1989).

Instigated by nationwide protests in 1958, several health-related reforms were introduced up until the mid-1960s through a plan developed by the "Institut International de Recherche et de Formation en vue du développement intégral et harmonisé"[1] (IRFED). The reforms targeted health, among other sectors, to ensure the development of the "human potential" for all across the country, especially for those less economically privileged (Kronfol & Bashshur 1989, p. 382). Reforms were based on the findings of a socioeconomic study conducted by IRFED, which highlighted significant regional disparities in health standards, sanitation infrastructure, schooling conditions, and housing conditions across the country, and poor living conditions for a large proportion of the population, including in certain pockets within Beirut, with direct repercussions on public health (Merhej 2021), and on the attainment of the right to health, especially for poorer communities and those living outside the capital Beirut and some areas of Mount Lebanon. In 1959, the government

[1] International Center for Training and Harmonized Development

established the Office of Social Development, tasked with enhancing "health, education, social welfare and community development" toward social recovery and ensuring community participation, and acknowledging the "role of women in health and welfare" (p. 382); efforts were also made to build partnerships with the private sector (Kronfol & Bashshur 1989).

Other health-related reforms introduced during this period included the establishment of the National Social Security Fund (NSSF) in 1963 under the tutelage of the MoL. The NSSF is a contributory form of social insurance that provides end-of-service indemnity for Lebanese citizens who are formally employed in the private sector and also covers sickness (effective from 1971) and maternity and family compensation. The scheme was supposed to cover workplace accidents and occupational hazards, but the branch was never activated (Centre for Social Sciences Research & Action [CeSSRA] 2022; Osmat 2023). It was also in 1963 that social security coverage, including healthcare coverage, was introduced for public sector employees through the establishment of cooperatives for civil servants, security forces, and military personnel (CeSSRA 2022). In total, there are six publicly managed employment-based social insurance funds in Lebanon contributing to fragmentation in the system: the NSSF, the Cooperative for Civil Servants covering public sector employees, and four cooperatives covering the military, Internal Security Forces, Special Security Force and General Security Force (Ammar 2003; El-Jardali et al. 2023a).

This period also saw the promotion of primary healthcare through the establishment of a regional referral network facilitating access to primary, secondary, and tertiary care through both the public and private sectors (Kronfol & Bashshur 1989). The introduction of a fee-for-service reimbursement scheme by government entities (such as the NSSF and civil servant cooperatives) coupled with poor regulatory mechanisms resulted in the proliferation of privately owned hospitals and over-utilization of services. In parallel, the role of the Ministry of Health was to provide supervision, legislation, quality control, health planning, and care for the poor, as set forth by the 1961 Decree regarding the Organization of the Ministry of Public Health (MoPH). Still, the ministry continued to provide care through its facilities while simultaneously financing care for patients in private facilities (Kronfol & Bashshur 1989).

Attempts to regulate Lebanon's pharmaceutical sector toward the end of the 1960s (at the time, monopolized by four companies) were thwarted by pharmaceutical importers, who

halted the adoption of Resolution 361/1971 and Circular 411, proposed by the Minister of Health at the time, Emile Bitar. The resolution and circular aimed to control the prices of imported medicines by placing a cap on profit margins, diversify the medicines imported, ensure their quality, and support the growth of the local industry. At the time, pharmaceutical importers had inflated their prices and contributed to the introduction of high customs duties on the materials and equipment necessary for local pharmaceutical production, thus hindering the local industry (Merhej 2021; بطرس/Boutros 2021). The loss of this "battle" likely enabled today's pharmaceutical crisis by bolstering the industry's oligopoly and leading to uncontrolled medication prices, described further below. It also resulted in Emile Bitar's resignation (بطرس/Boutros 2021).

LEBANON'S CIVIL WAR AND POST-WAR RECONSTRUCTION

The attempts to improve Lebanon's public healthcare sector during the 1960s were lost during its civil war (1975-1990). The war resulted in significant destruction of infrastructure and public health facilities and impacted both the private and public sectors. Many healthcare providers left the country seeking better opportunities and safety abroad (Kronfol & Bashshur 1989'0. Due to the severe destruction of health facilities in the public sector, the MoPH and other government entities, such as the NSSF, increasingly depended on the private sector to provide care to the population, resulting in a depletion of reserves and savings (Ammar 2003; Kronfol 2006; Kronfol & Bashshur 1989). At the same time, the lack of regulation in the sector resulted in "price inflation for all types of health services" (Kronfol & Bashshur 1989, p. 386).

The private sector boomed during the war, with over 50 new private hospitals developed during the first few years since its onset, aiming to capture public funds (Kronfol & Bashshur 1989). Public spending on private healthcare for patients increased from 10% of the ministry's budget in 1970 to over 80% in the 1990s (Ammar 2003; Kronfol 2006). Outside of the capital Beirut, especially in poorer regions, healthcare deteriorated significantly, as the highly bureaucratic and centralized nature of the system (through the MoPH) halted the functioning of public institutions. Furthermore, the lack of healthcare providers created a space for political parties and armed militias to gain constituents by providing them with pharmaceuticals and minor or emergency healthcare (Kronfol & Bashshur 1989).

The war also destroyed other types of public infrastructure, including of telecommunications, energy, transportation, water, and education infrastructure (World Bank 1994)—all underlying determinants of health. It also left hundreds of thousands homeless or internally displaced persons and resulted in the migration of hundreds of thousands more, including of highly skilled individuals (Stewart 1996). Reconstruction after the civil war was primarily funded through private financing – mainly for real estate (Stewart 1996) and loans from international finance institutions, such as the World Bank for physical infrastructure reconstruction, such as of education and health facilities (Kronfol 2006; World Bank 1994). Most reconstruction efforts (and funding) were concentrated in the capital Beirut, and failed to address economic disparities (Stewart 1996). Development in the health and education sectors post-civil war was marred by unequal regional development and social inequity (Makdisi 2007), reinforcing historical regional disparities and widening health inequities.

THE HEALTHCARE SYSTEM TODAY

Van Lerberghe et al. (2018) recently described the "commodification" of Lebanon's healthcare sector, where care and services are influenced by supply and demand dynamics "ruled by lobbies and political clientelism" (p. 15). This vested interest by the political class, in addition to the uncontrolled growth of the private sector, prevents the shift toward a more just system. Today, Lebanon's healthcare system continues to be dominated by the private sector, while the public sector suffers from poor quality and continues to be underfunded (Ministry of Public Health [MoPH] & World Health Organization [WHO] 2022a; El-Jardali et al. 2023a). At the level of governance, institutions are weak, as are accountability mechanisms (El-Jardali et al. 2023a). Healthcare in Lebanon is mainly curative and aimed at hospitalization and secondary and tertiary care (Hemadeh et al. 2019a; Ammar 2009). There are 137 private hospitals in the country compared to 29 public hospitals (MoPH 2023). In addition, 86% of beds are in the private sector (Van Lerberghe et al. 2018).

Current health expenditure as a % of GDP was 7.95% in 2020, the highest in the Arab region and above the regional average of 5.32%. Still, only 3.27%[2] of the state's budget was allocated to the MoPH that same year (**Table 1**), down 10.10% from the previous year. In 2017, the bulk of the MoPH budget went to reimburse contracted hospitals and curative care (45.1%) and to cover pharmaceuticals (27.2%).[3] In addition, less than 10% of public health expenditure went to cover primary and preventive services (ESCWA 2021). Several other entities also finance health, including the Ministry of Social Affairs, the Ministry of Labor (MoL) in the case of the NSSF, and other ministries in the case of the army and civil cooperatives, contributing to fragmentation (MoPH & WHO 2022b; International Labour Organization [ILO] 2020).

The MoPH introduced several reforms throughout the 1990s and early 2000s to decrease out-of-pocket (OOP) spending. The MoPH focused its main efforts on decreasing OOP spending on ambulatory care and medicines. Other reforms included introducing flat rates for consultations and certain procedures, performance-based pricing, decreased unit prices, and financial ceilings for hospitals (Lerberghe et al. 2018). These reforms successfully decreased OOP spending from 57.79% in 2000 to

[2] In comparison, the state's budget on military spending for 2020 was 14.61%.
[3] Data based on the 2017 National Health Accounts, available at this link.

an estimated 38.28% in 2018 (World Bank 2023a). But by 2020, OOP spending had risen to 44.2% (World Health Organization 2023; see **Table 1**), likely a result of the devaluation of the Lebanese pound and decreased coverage by relevant social insurance funds, noting that all six funds are de facto bankrupt, and lifted subsidies on pharmaceuticals (Medecins sans Frontieres 2022; Isma'eel et al. 2020; Amnesty 2023). In 2022, Doctors Without Borders estimated that patients were covering as much as 90% of their hospital expenses out of their own pocket. Furthermore, private hospitals have begun to dollarize their fees. This has significant repercussions for those who are not able to afford healthcare. An indicative rapid assessment conducted by UNICEF in April 2023, found that 75% of the households participating in the study were reducing health spending as a means of coping with the crisis (UNICEF 2023).

Significant efforts were also made by the MoPH to enhance Lebanon's primary healthcare (PHC) network, in part aiming to ensure that care is more accessible and affordable to the poor (Van Lerberghe et al. 2018). In 2021, there were 258 PHC centers in the network, most of which were located in the Mount Lebanon (n=71) and North Lebanon (n=40) governorates. Almost 70% of PHCs in the network are run by the private sector and NGOs, which are reimbursed by the MoPH based on a performance and quality contracting scheme (MoPH 2023), while the MoSA and some association-run dispensaries, which are not directly connected with the MoPH. Recent research by Cammett (2019) on Lebanon's PHC network demonstrates how deeply embedded political and religious organizations are in Lebanon's welfare system, as in 2019, they operated around 25% of centers in the network. In the absence of high-quality, publicly run healthcare institutions, low-income individuals become dependent on political and religious organizations to meet their basic needs (including care) (Cammett 2019). This dependence on one's political or religious affiliation to secure basic needs is a major factor hindering the achievement of the right to health for all in Lebanon and can contribute to discrimination in access to care.

Syrian refugees and vulnerable Lebanese households are the main users of the national PHCs network (Hemadeh et al. 2019b). Still, the majority of Lebanese (who can afford it) opt for ambulatory care through the private sector (Kronfol 2006; Isma'eel 2020). The PHC network faces several challenges that impact the quality of care provided, including lack of funding, poor management, poor accountability, inadequate referral mechanisms, high staff turnover, difficulty in managing the drug

supply chain, and low resources, among others (Hamadeh et al. 2021; El-Jardali et al. 2023a). While identifying a shortage in family medicine physicians and nurses, a study by Hemadeh et al. (2020) assessing PHCs in the MoPH network (212 at the time) found that 89% were delivering all services required by national standards, and 89% of them had all basic equipment needed for care delivery. The study also found regional disparities regarding the availability of human resources for health between PHCs in urban and rural areas, with a shortage of human resources in rural PHCs (Hemadeh et al. 2020). The economic crisis has further limited the funding available for the MoPH, which has restricted the ministry's ability to import essential medicines, supplies, and equipment needed for the PHC network. Restricted funding also limits healthcare facilities' capacities to secure water and electricity, which are necessary for operation. As a result, efforts to minimize inequalities and facilitate access to basic services for the most vulnerable through the network have not been completely successful (Hamadeh et al. 2021).

Health institutions in the public sector continue to lack qualified human resources for health and other resources (MoPH & WHO 2022a; El-Jardali et al. 2023a). According to the MoPH, there were 33.3 physicians per 10,000 population and 38.6 nurses and midwives per 10,000 population in Lebanon prior to the crisis in 2019 (**Table 1**).[4] Since then, the World Health Organization has estimated that around 40% of physicians and 30% of nurses had emigrated by September 2021 (World Health Organization 2021). This mass emigration of healthcare workers can have negative repercussions on healthcare provision and access, and in some cases, has resulted in the closure of specialized departments or units at large healthcare centers in the country, including units for neonatal care (Ramadan 2022; WHO 2021; UNICEF 2022b). In 2022, a UNICEF Bed Capacity Assessment found that there had been a decrease in maternal and pediatric bed capacity, including pediatric and neonatal intensive care unit beds, affecting access to healthcare and capacity to treat mothers and children. The study also found that 58% of hospitals reported medicine shortages, while 39% reported medical consumables shortages (UNICEF 2022b). Reasons for the latter include hiring freezes and limitations on imports linked to the economic crisis, as described previously (UNICEF 2022b).

In the absence of a functioning public healthcare system due to the current crisis, numerous charitable health centers and associations are filling in gaps by expanding coverage and

[4] These numbers should be interpreted with care, considering that there are different estimates for the total population of Lebanon (including migrants and refugees).

providing affordable or free care and medicines to those in need, particularly among their constituents (the issues with this have been discussed previously). Nevertheless, the high number of non-governmental organizations, political and religious charitable organizations, the large private sector, the UNHCR, UNRWA, international organizations, and others, which all provide care and services in addition to public sector providers, all contribute to fragmentation in the system (Hamadeh et al. 2021; Kreichati 2020). At the systems level, fragmentation has contributed to inefficiency and ineffectiveness through the duplication of services (Hemadeh et al. 2019a; Hamadeh et al. 2021). At the population level, fragmentation hinders the attainment of the right to health through increasing disparities and inequities in access, with individuals accessing different (quality) services and benefits based on their ability to pay, coverage status, or political or religious affiliation. Fragmentation can also contribute to further marginalizing some individuals, such as the poor or informal workers, who are excluded from coverage schemes or have limited access to acceptable and quality health services nearby.

Table 1. Health system indicators

Current health expenditure, as a % of GDP, 2020[a]	7.95%
% MoPH budget out of state budget (including Directorate of Public Health, Public Hospitals, and Central Public Health Laboratory), 2020[b]	3.27%
Current health expenditure per capita, (US$), 2020[a]	994
Out-of-pocket expenditure on health (as a % of current health expenditure), 2020[a]	44.2%
Number of hospitals, private sector[c]	137 (82.5%)
Number of hospitals, public sector[c]	29 (17.5%)
Hospital beds (per 10,000 persons), 2017[d]	27.3
% of beds in private hospitals[e]	86%
Physicians (per 10,000 population), 2019[c]	33.3
Nurses and midwifes (per 10,000 population), 2019[c]	38.6
MRI machines, in the public and private sector, 2012[c]	41

a World Health Organization, Global Health Expenditure Database, Lebanon Country Profile: Link.

b Gherbal Initiative, State Budget: Link.

c Ministry of Public Health, Hospitals Directory: Private, Public; Health Indicators: Link.

d World Health Organization, The Global Health Observatory: Link.

e Van Lerberghe et al., 2018: Link.

INEQUITIES IN HEALTHCARE COVERAGE AND ACCESS

The absence of a universal social protection system or universal healthcare coverage is a significant barrier to attaining the right to health for all in Lebanon, as they contribute to unequal access to care and health outcomes among the population. In emergency situations, the cost of healthcare can be catastrophic for poorer households, especially considering that in 2022, 51%[5] of residents in Lebanon did not have any type of health insurance coverage (Central Administration of Statistics 2022). Indeed, several vulnerable groups, such as retirees, the unemployed, agricultural workers, migrants, refugees, and those working informally, are not covered by available formal social protection schemes.

Regional disparities regarding healthcare insurance coverage also exist, reflecting overall disparities in development across the country. For example, the percentage of uninsured in South Lebanon is 61.2% and 59.5% in Baalbeck-El Hermel, compared to 43.8% in Mount Lebanon and 47.8% in the capital Beirut (Central Administration of Statistics 2022). Lebanese without any type of insurance are eligible for health coverage through the MoPH, which acts as an "insurer of last resort," and to a lesser extent from the MoSA (Hemadeh et al. 2019a).[6] A limited number of extremely poor households are eligible for health coverage through social safety net programs, such as the National Poverty Targeting Program (NPTP) and the Emergency National Poverty Targeting Program (ENPTP), which provide a waiver of the 10-15% co-payment required by other coverage schemes. Lebanon's primary healthcare network, which provides a comprehensive package of essential services, is open to all residents of the country. Notably, the number of Lebanese visiting PHCs has increased since the onset of the crisis, as they are unable to afford care in the private sector (Sader 2021).

As for older persons, the stigma surrounding mental health, along with geographical distance and disability, all act as barriers to accessing healthcare. The majority have limited access to healthcare coverage after retirement, while only a small percentage benefit from a social pension (those who worked in the public sector or who worked formally in the private sector), but with the devaluation of the currency, their pension has lost its value; those who continue to work also face similar issues regarding the value of their salaries. Older persons are also often denied coverage through private insurance schemes, which cite their risky health status as a

[5] Data does not include domestic workers.
[6] From 2017-2019, just over 68% of social protection spending targeting the poor and vulnerable was from the MoPH, and 20% was from the MoSA.

reason (MoSA & UNFPA 2021). The situation has had a direct impact on the mental health situation of older persons in Lebanon. A study by Phenix Center and HelpAge International (2023) conducted among older Lebanese and Syrian refugees found that participants were feeling depressed and anxious and faced post-traumatic stress disorder related to their living situation. Older Lebanese worry about their health and access to medicines, while older Syrian refugees worry about being able to secure food, shelter, and medication (Phenix Center & HelpAge International 2023).

Regarding non-citizens, Palestine refugees can access healthcare services, partially covered through UNRWA and the Red Crescent Society (UNRWA 2023), and Syrian refugees, through the national PHC network and 33 contracted hospitals across the country, or the MoSA Social Development Centers (SDCs), subsidized by the UNHCR. At the primary-care level, refugees pay a consultation fee ranging from 3,000 LBP to 30,000 LBP, depending on the service received, while at the secondary and tertiary care level, the UNHCR only provides partial coverage for life-saving emergencies or limb-saving cases. Some urgent, life-threatening conditions (such as cancers treatable by surgery) are considered on a case-by-case basis. Coverage is only available at select hospitals, the majority of which are governmental hospitals (UNHCR 2023). Refugees and migrant workers can receive care through international organizations and NGOs, with a small co-payment or free of charge, depending on the service available through partnerships between these organizations and the MoPH. For example, refugees and migrant workers can access healthcare services through MSF and ICRC, including medical consultations, medicines, sexual and reproductive health services, mental health services, etc. The latter services are also available to Lebanese.

Migrant workers, and in particular women migrant domestic workers, face additional challenges that hinder their achievement of the right to health. Their status as documented, freelancer, or undocumented migrants dictates their access to healthcare (Fernandez 2018). In addition, migrant workers face various levels of discrimination, whether based on race, sex, or class, with an impact on their health (Fernandez 2018). Under the Kafala (or sponsorship) system, migrant domestic workers are at risk of exploitation and abuse. Their employers set their work contracts and conditions and can control their access to healthcare (Medecins sans Frontieres 2023). Live-in migrant domestic workers are often locked in the house, with their

passports withheld from them—their situation can block them from accessing protection or support services. Moreover, the standard insurance scheme that they are provided with does not cover outpatient care, dental care, sexual and reproductive health, or mental healthcare (Mezher et al. 2017; Fernandez 2018).

Similarly, members of the LGBTQ+ community also face significant barriers limiting their access to essential services, including healthcare, in Lebanon, with negative repercussions on their sexual and mental health (Naal et al. 2020; Abboud et al. 2023). Members of the community, particularly transgender persons, face discrimination at health centers and are sometimes denied care (Lebanese Union for the Physically Handicapped [LUPD] 2020). Members of the LGBTQ+ community, and particularly transgender persons, may avoid care due to the fear of discrimination and negative attitudes they face (Naal et al. 2020; Wright et al. 2017); although a more recent study found that physician attitudes toward LGBTQ+ individuals have changed, some physicians still hold discriminatory beliefs toward the community (Naal et al. 2020). Refugee members of the LGBTQ+ community face an added layer of discrimination due to their refugee status (Abboud et al. 2023; Moussawi 2023). Furthermore, available insurance or social security schemes do not cover gender-affirming surgeries or hormone replacement therapy for transgender persons, the cost of which is often prohibitive (Helem 2020).

Physical accessibility, that is, being able to safely reach and access healthcare services, is a core component of the right to health, as is financial accessibility. Nevertheless, cost remains a primary barrier to accessing care for refugees and migrant workers, including the costs of consultations, treatment, and medicines, and indirect costs related to transportation and distance to healthcare centers (UNHCR 2019; UNHCR, UNICEF, & WFP 2023; Norwegian Refugee Council 2020). In particular, UNICEF found that parents are no longer able to afford the costs of transportation to take their children to health centers to receive needed care or vaccines—this has contributed to the more than 30% reduction in vaccination rates among children, particularly among vulnerable groups (UNICEF 2022b). An additional challenge faced by Syrian refugees and migrant workers is limited freedom of movement, especially among those who do not have the proper paperwork (for example, residency permit), which, in turn, can limit their access to livelihoods, healthcare, and other necessities (International Commission of Jurists 2020).

Table 2. Select demographic and health indicators

Total population in millions, 2020[a]	4.8
Life expectancy at birth, years, 2023, male[b]	74
Life expectancy at birth, years, 2023, female[b]	78
Neonatal mortality rate, per 1,000 live births (nationals)[c]	4.37
Neonatal mortality rate, per 1,000 live births (non-nationals)[c]	8.11
Infant mortality rate, deaths per 1,000 live births[d]	7
Mortality rate of children younger than 5 years[d]	8
Maternal mortality rate (deaths per 100,000 live births), (nationals)[c]	6.1
Maternal mortality rate (deaths per 100,000 live births) (non-nationals)[c]	21.99
Maternal mortality rate (deaths per 100,000 live births) (total)[c]	15.76
Births attended by skilled health personnel, per cent, 2004-2020[b]	98%
Proportion of population using basic sanitation services[d]	74%
Proportion of population using safely managed drinking water services[d]	48%

a CAS & ILO, 2020: Link.
b UNFPA, 2023: Link.
c MoPH Vital Data Observatory and Health Indicators, data for 2022: Link.
d UNICEF: Link.

MORTALITY RATES

There has been a rapid rise in maternal and infant mortality rates since the onset of the crisis. The maternal mortality rate rose from 23.7 to 47 deaths per 100,000 live births between 2019 and 2021 and was higher among non-national (51.33) than Lebanese women (43.15) (MoPH 2023c; see **Table 2**). Increased maternal mortality rates in 2021 were in part due to COVID-19. In 2022, a decrease in maternal mortality rates was recorded among both Lebanese and non-Lebanese women, at 15.76 and 21.99 per 100,000 live births, respectively—still significantly higher among non-national women and still higher than the 2018 (pre-crisis) rates (MoPH 2023c; MoPH & WHO 2022b). Similarly, neonatal mortality rates increased from 5.3

to 5.5 per 1,000 live births between 2018 and 2020 and were higher among non-Lebanese than Lebanese. In 2022, the neonatal mortality rate per 1,000 live births for Lebanese was 4.37, compared to 8.11 for non-nationals, also significantly higher than for nationals (MoPH Vital Data Observatory). These differences in the mortality rates between Lebanese and non-nationals point to likely disparities in access to healthcare, whether due to socioeconomic status or locality. In a study assessing maternal mortality trends among Lebanese and Syrian refugee women from 2011-2018, El-Kak et al. (2019) suggest that slight increases in the maternal mortality rates in the North and Bekaa governorates, where Syrian refugees are concentrated, are likely due to a lack of referral centers. The authors also mention the low quality of maternity care as a potential cause of maternal mortality in Lebanon (El-Kak et al. 2019).

COVID-19 AND HEALTH SYSTEM DISPARITIES

COVID-19 and the response to the pandemic perpetuated health system disparities. With the private sector initially refusing to provide beds and care to COVID-19 patients, the burden of care fell on the public sector, which, by the time the pandemic hit in early 2020, was already reeling from the impact of the economic crisis. In April 2020, the MoPH provided a list of 15 hospitals[7] qualified to perform COVID-19 RT-PCR tests. Of these hospitals on the list, only the Rafic Hariri University Hospital (RHUH) was providing tests for free. The majority of hospitals on the list were located in the Beirut and Mount Lebanon areas, and none were located in rural areas, such as in the Bekaa region, South Lebanon (besides Saida), or Akkar. In addition, 129 laboratories were certified to provide testing, with prices as high as $100. Coverage of care was limited, whether by the MoPH and other public funds or insurance companies; as such, households had to pay for tests and care out-of-pocket (Kreichati 2020).

The RHUH (and the public sector in general) had limited capacity to receive COVID-19 patients. In turn, private hospitals set up units for COVID-19 patients, however, at a hefty price—unaffordable for the large majority of Lebanese who were not covered by any type of insurance scheme (Kreichati 2020). Vaccine rollout was also slow, and administration was inequitable. By the end of 2021, only 18% of vaccine doses had been administered to non-nationals, compared to 81% of Lebanese (MoPH 2023b).[8] A further breakdown of doses administered reveals that 10% of Syrians, 4% of

[5] See the list here.
[6] Nationality information was missing for 1% of vaccine-takers.

other nationalities, and only 2% of Palestinians had received the vaccine (MoPH 2023b). Possible explanations for low registration on the MoPH vaccine platform by non-nationals include fear of detention or deportation (for example, due to issues with residency paperwork), lack of trust in the Lebanese government, lack of information about the vaccine and registration, or inability to afford transportation fees (Kaloti & Fouad 2022; Human Rights Watch 2021). For migrant workers, cultural appropriateness and the language of information provided may also have played a role (Human Rights Watch 2021). There were also disparities in vaccine administration at the district level, with the vast majority of vaccine doses administered in Beirut and Mount Lebanon (MoPH 2023b). Whether based on nationality or district, disparities in vaccine administration reflect deeply entrenched inequities that hinder the right to health. Furthermore, data from the United Nations demonstrated that Syrian refugees and Palestinian refugees died from COVID-19 at rates well above the national average (Azhari 2021a, 2021b).

Regarding healthcare workers, limited personal protective equipment (due to lack of foreign funds and inability to import the needed quantities) placed them at increased risk of infection (El Jamal et al. 2021), while the increased workload (reflective of poor planning) caused high levels of burnout among physicians and nurses, particularly in the public sector, impacting their mental health. Several characteristics were associated with high burnout: being a woman, being a physician, being married, having a poor health status, having a dependent at home (such as a child, older person, or household member with comorbidity), and having a low income (Youssef et al. 2022). The impact of the pandemic on healthcare workers highlights the absence of laws and strategies to ensure a safe working environment for them (El Jamal et al. 2021). It also highlights inequalities between private sector and public sector employees, as well as potential discrimination among healthcare workers, as demonstrated by the study on burnout (Youssef et al. 2022).

MENTAL HEALTH

The COVID-19 pandemic also had an impact on the mental health of individuals, and in one study, fear of COVID-19 was found to increase stress and anxiety among participants (Salameh et al. 2020). Notably, Salameh et al. (2020, p.) found that stress and anxiety increased among participants also facing “financial hardship” during the pandemic, pointing to

the dual effect of Lebanon's multiple crises. Indeed, mental health was found to have deteriorated or to be poor among several communities across various studies conducted after the onset of Lebanon's multiple crises, but studies conducted before 2019 also point to poor mental health among residents, including refugee communities.[9] Yet, mental health services in the country continue to be inadequate and insufficient, despite the establishment of a National Mental Health Program in 2014, and the adoption of a mental health strategy in 2015, while individuals face significant barriers to accessing mental health services and medication.

About 50% of the MoPH budget allocated to mental health services is spent on hospitalization in the private sector, and mental health is not yet sufficiently integrated into Lebanon's primary healthcare network (El Khoury et al. 2020). Furthermore, services are concentrated in the capital (Farran 2021), and tend to focus on mental health as a clinical and medical condition and do not consider the structural and contextual factors (Noubani et al. 2021). Mental healthcare services and medicines are expensive and out of reach for many, but coverage remains limited. Regarding coverage, mental health services and psychotropic medicines are not covered or only partially covered by available insurance schemes (El Khoury et al. 2020). The latter all affect the accessibility of mental health services and medicines, especially among the vulnerable. The bulk of mental healthcare is provided through NGOs and international organizations that target specific communities, such as Syrian refugees, or provide short-term mental health services or psychosocial support programs (Farran 2021; Noubani et al. 2021).

PHARMACEUTICAL SECTOR

Issues with the pharmaceutical sector in Lebanon predate the current crisis (as described previously). The neoliberal policies that encourage privatization and profit in the health sector also apply to the pharmaceutical sector, which is also characterized by corruption and influenced by political clientelism. Ten importers dominate the market, four of which have over 50% of the market share, limiting competitiveness and increasing prices (Consultation & Research Institute 2020; Kreichati 2020). Close to 95% of medicines in Lebanon are imported as these companies hinder local production, and the market is dominated by brand-name medicines over cheaper generic alternatives (El-Harakeh & Haley 2022; Amnesty International 2021).

[9] See Farran, N. 2021. "Mental Health in Lebanon: Tomorrow's Silent Epidemic," for an overview of these studies.

The current crisis has further limited access to and affordability of medicines in Lebanon. Initially, the devaluation of the LBP, and a shortage of foreign currency, and limited bank credit lines affected medication imports and, in turn, medicines' availability. In November 2021, the government lifted subsidies off several essential medicines that it had introduced at the beginning of the crisis. This contributed to a significant increase in the price of medicines. It was estimated in 2021 that at least 70% of the population could not afford needed medicines (Amnesty International 2021; Amnesty International 2023). Shortages have also resulted in an informal market for medicines, facilitating the import of counterfeit or expired medicines (Amnesty 2023). Distributors and pharmacists have also been accused of hiding medicines, waiting for subsidies to be lifted to sell at a higher price, or smuggling the medicines out of the country (El-Harakeh & Haley 2022).

The unaffordability and inaccessibility of essential medicines can have a direct impact on the health of individuals. For example, the shortage in medicines has had tangible effects on the health of patients suffering from chronic or severe illnesses who are at risk of facing complications (Amnesty 2023). Those who can afford it have resorted to personally purchasing or importing necessary medicines from abroad, while NGOs have also been donating medicines to those in need. Still, the situation has contributed to inequitable access to essential medications among the population, thus hindering the attainment of the right to health for all.

LEGAL AND REGULATORY FRAMEWORK PERTAINING TO THE RIGHT TO HEALTH

The legislation and reforms introduced pre-civil war continue to dictate Lebanon's health policy-making, while the absence of health-related language in the Constitution continues to impact the right to health today. Across other sectors (determinants of health), laws, decrees, policies, and strategies fail to incorporate language on health. Despite a lack of right to health language in Lebanese legislation, the country is a party to several conventions and treaties that include provisions on the right to health, including the 1966 International Covenant on Economic, Social and Cultural Rights (Article 12), 1990 Convention on the Rights of the Child, 1979 Convention on the Elimination of All Forms of Discrimination against Women (CEDAW; with reservations to three articles), among others and is a signatory of the 2006 Convention on the Rights of Persons with Disabilities (Article 25). Notably, and despite hosting large refugee and migrant communities, Lebanon is not party to the relevant conventions aiming to protect refugees or migrant workers, such as the 1951 Refugee Convention.

The Lebanese Constitution was promulgated under the French mandate in 1926. The Constitution does not mention the right to health, nor is there a direct reference to health in the Constitution. Nevertheless, the preamble of the Constitution protects against discrimination between citizens, stating that "Lebanon is a democratic parliamentary republic…of social justice and equality in rights and duties among all citizens, without distinction or preference." Protected characteristics are not explicitly mentioned, except for freedom of belief and religious practice; as such, the Constitution does not necessarily protect against discrimination based on gender or sex. Further, the preamble dictates that the "even development among regions on the educational, social, and economic levels shall be a basic pillar of the unity of the state and the stability of the system." Equality is also referenced in Article 7 of the Constitution, which states that "All Lebanese are equal before the law. They equally enjoy civil and political rights…" (Lebanese Constitution 2004). Of note, the Constitution extends these rights and protection to citizens only with little reference to non-national residents of the country. This is of concern considering that just over 20% of the 4.8 million residents in the

country were non-nationals in mid-2018 (Central Administration of Statistics [CAS] & International Labour Organization [ILO] 2020).[10]

Public health in Lebanon today is governed by Decree No. 8377/1961, which, similarly to the Public Health Decree of 1932, focuses on the environment and sanitation and the control and prevention of infectious diseases and quarantine. Article 2 of the decree stipulates that the MoPH is responsible for "maintaining and improving public health through disease prevention, treatment of patients in need, and supervising private health institutions per the related provisions. The ministry is in charge of preparing proposals of regulation and amendments of existing laws and regulations relating to all fields of public health." The decree focuses more on the organization and operation of the ministry and does not mention the right to health for all, though it does extend free healthcare services to those in need (through the MoPH fund). Regarding Patient's Rights and Informed Consent, Law No. 574/2004 states that "The patient has the right, within the framework of a health system and social protection, to receive rational and appropriate medical care for his condition," focusing again on healthcare. More recently, in 2019, a draft law for universal healthcare coverage for Lebanese citizens was submitted to parliament but was repealed and has yet to be adopted (El-Jardali et al. 2023a).

In 2022, the MoPH, in partnership with the WHO, launched a National Health Strategy with a Vision 2030 for health (MoPH & WHO 2022a). The strategy acknowledges Lebanon's ongoing crises and the impact they have had on health and its determinants, and recognizes the importance of the determinants of health through its goal of "[Seeking an] intersectoral approach to address social determinants of health inequity, and promote the Health in All Policies concept." In line with this, the strategy highlights the need to "target regions with below average indicators" to promote population health, though the strategy mentions that this is not currently being done, nor is there a plan for achieving this goal yet. Building on the 2016-2020 strategy and previous MoPH efforts, this strategy also has as one of its main objectives the achievement of universal healthcare coverage. Though the strategy addresses fragmentation and the multiplicity of funding mechanisms as major challenges to the system, it does not aim to unify the six available social insurance funds as one of its objectives, rather proposing the development of a "unified essential benefits package." To this end, the strategy

[10] The Labour Force and Household Living Conditions Survey only covers residents and households living in residential dwellings. In the context of this survey, non-Lebanese residents refers to all those not holding Lebanese citizenship, irrespective of nationality.

aims to grant "all residents a basic common benefits package of essential primary healthcare and hospital services," to be financed by national sources (available funds) for Lebanese and by respective entities for non-Lebanese, namely, UNRWA for Palestinian refugees, UNHCR for Syrian refugees, and employers through a private insurance scheme for migrant workers (MoPH & WHO 2022a, p. 24). Implementation of this objective is likely to leave out groups such as the stateless and undocumented migrants and refugees and those who are working informally—groups that already face multiple layers of vulnerability. The strategy has several other limitations and requires a "feasible" action plan (El-Jardali et al. 2023b).

The extension of a basic package of essential healthcare services is also a key component of Lebanon's National Social Protection Strategy,[11] which has not been adopted and is pending amendments by the government. Among its objectives, the strategy aims to capitalize on existing SDCs to extend inclusive and quality social welfare services, including health, to the most marginalized and vulnerable groups and to introduce a social protection floor. The strategy uses rights-based language and aims to address some of the challenges that hinder attaining the right to health in Lebanon, including addressing fragmentation and current gaps in insurance coverage.

LEGISLATION RELATED TO VULNERABLE GROUPS – SOME EXAMPLES

Some legislation in Lebanon aims to extend 1) healthcare to vulnerable communities through extending the right to coverage, healthcare services and/or insurance, and/or 2) protection to them, but fails to comprehensively address the political, economic, social, and cultural determinants of health and the right to the highest attainable standard of health. Furthermore, current legislation is still discriminatory against Lebanese women and children, non-citizens residing in Lebanon, persons with disabilities, older persons, and the LGBTQ+ community, and contributes to their social exclusion. We present a few examples below.

For example, Decree No. 1692/1999 and Decree No. 4265/2000 ensure that children have medical care and mandate that hospitals and medical centers should include special sections for children. Children whose parents are registered with the NSSF or other public social funds are eligible for services under these funds, including health and education. However, this

[11] The National Social Protection Strategy was developed by Beyond Group in collaboration with UNICEF, the ILO, and the MoSA through a consultative process with national civil society and other relevant stakeholders. The final draft was completed in January 2022 but is still under discussion by the government.

right is not extended to children born to a Lebanese mother and a foreign father. Indeed, women in Lebanon face several levels of discrimination that hinder their right to the highest attainable standard of health and which also impact the health of their children. Lebanon has reservations against three articles of the CEDAW: Article 9 on nationality rights, Article 16 on personal status and the marriage of a child, and Article 29 on arbitration in case of related disputes. Firstly, Lebanese women married to a foreigner cannot extend their nationality to their spouse or their children, thus excluding their children from the rights they would otherwise be entitled to as citizens; as such, they face difficulties in accessing healthcare and education. Regarding early marriage, Lebanon has no legal minimum age for marriage, as this is left to the religious courts (Human Rights Watch 2017; Manara Network for Children's Rights 2011). Early marriage is still common in some pockets of Lebanon among Lebanese and non-citizen communities, with refugee and poorer communities most at risk. Early marriage is enabled by religious and cultural norms, and economic reasons, and has known negative effects on health outcomes, such as childbearing. It also increases the likelihood of dropping out of school and places girls at risk of marital rape and domestic violence (Abdulrahim et al. 2017; Human Rights Watch 2017; Moussawi 2023; El-Husseini Dean 2023).

Legislation pertinent to women and children in Lebanon is very much influenced by Lebanon's patriarchal religious establishment. This is most visible in the Lebanon Penal Code of 1943, which, among other issues, criminalizes abortion (Articles 539-546) and permits parents to discipline children within "general customs" (Article 186). With regard to abortion, in 1969, a presidential decree modified the Penal Code to allow abortion only in the case where a pregnant woman's life is in danger. In all other situations, abortion is illegal, and women face imprisonment. The majority of women participating in a research study by Fathallah (2019) were able to access a safe abortion; however, they faced judgment and blame by the physicians. Among study participants, socioeconomic background and financial constraints acted as a barrier to accessing a safe abortion. Along with a shortage of other medicines, the current crisis has resulted in a shortage of oral contraceptive pills (OCPs), with implications for the mental health and sexual and reproductive health of women. A study by Itani et al. (2023) found that among women who were not able to find their preferred OCP, 9.5% experienced an unplanned pregnancy, and the majority opted for an abortion. With no sexual and reproductive health rights under the Kafala

system, migrant domestic workers have little protection when they get pregnant; they risk being fired and can end up living in irregularity, or may be forced to have unsafe abortions (Mezher et al. 2021).

The influence of Lebanon's establishment is also visible in Law No. 205/2020 to criminalize sexual harassment and for the rehabilitation of its victims and Law No. 293/2014 on the protection of women and other family members from domestic violence, and their implementation (Moussawi 2023). Neither law protects non-citizens, including refugees and migrant workers. Furthermore, follow-through has been an issue with these laws, especially with regard to their implementation on the ground—particularly as women seek protection, but also due to additional legal obstacles, discriminatory practices, and economic, social, and cultural barriers, such as cultural and social biases from investigators and police officers, among other issues (International Commission of Jurists 2019; Moussawi 2023). This is alarming, as the prevalence of domestic violence has increased significantly in recent years among Lebanese and non-citizens, as a result of the financial crisis and especially during the COVID-19 pandemic (UN-Women et al. 2021; El-Husseini Dean 2023). Moreover, the Law No. 293/2014 does not criminalize marital rape, instead leaving decisions regarding this issue to the religious courts and one of 15 personal status laws (dependent on one's religious affiliation). Personal status laws are discriminatory and inequitable toward women with regard to divorce, child custody, and inheritance (Moussawi 2023). The latter has direct public health implications, as women may feel forced to stay in abusive relationships out of fear of losing their children at a young age due to child custody laws (Dabbous 2017). As for migrant domestic workers (99% of whom are women), they also face abuse, sexual harassment, rape, and violence at the hands of their employers, but in light of the Kafala system, have no legal recourse or protection (Mezher et al. 2021). Along with ongoing contextual factors, this systemic violence against women hinders them from attaining the right to health.

Similarly, systemic violence against members of the LGBTQ+[12] hinders them from attaining the right to health. For example, article No. 534 of the Penal Code criminalizes "sexual acts against nature." It has been used to penalize same-sex relations among members of the LGBTQ+ community, and gender expression among transgender persons, with a possibility of imprisonment of up to one year. Other articles of the Penal Code (209, 521, 526, 531, 532, and 533) have

[12] Lesbian, Gay, Bisexual, Transgender, Queer, and other categories.

also been used to arrest members of the LGBTQ+ community, with direct implications on their rights and freedoms. There have been reports of physical and other types of violence faced by members of the community by law enforcement or during arrest, with victims also facing degrading practices at police stations (Lebanese Union of the Physically Handicapped [LUPD] 2020; Helem 2020; Moussawi 2023). Transgender persons face several barriers to changing the gender markers on their identity cards, including high legal fees, a requirement to undergo sterilization, and prohibitive surgery fees (Helem 2020). Members of the community also face societal stigma perpetuated by Lebanon's overarching patriarchal structures (Moussawi 2023). Furthermore, increasing negative rhetoric in recent months by politicians, religious leaders, and civilian-led religious groups has resulted in increasing violence against community members, further marginalizing them and limiting the few safe spaces they can access. Lack of legal protection, a discriminatory environment, lack of availability of sexual health education, and fear of discrimination among members of the community when seeking healthcare, among other factors, can hinder their access to healthcare services and the attainment of the right to health, with a potential impact on their health outcomes (Assi et al. 2019; Abboud et al. 2023; Wright et al. 2017; LUPD 2020; Naas et al. 2020).

Regarding persons with disabilities (PwDs), Lebanon is a party to the Convention on the Rights of Persons with disabilities, which states that PwDs have "the enjoyment of the highest attainable standards of health without discrimination based on their disability." Health is referenced in Law No. 220/2000 on the Rights of People with Disabilities. Nevertheless, there is no implementation decree for Law No. 220/2000, nor are its provisions aligned with or reflected in other relevant laws. Specifically, Article 27 of the law states that "Any PwD has the right to fully benefit from the health, rehabilitation and support services, at the government expenses, represented by all administrations and bodies providing these services," and Article 28 states that "A PwD has the right to benefit from the full coverage provided by the Ministry of Public Health as a main provider…" In addition to its focus on the right to healthcare services rather than on the right to health, the law includes a limited definition of disability, focusing on an individual's medical condition, and does not take into consideration the physical, social, and legal barriers which stand in the way of PwDs leading a normal life. The provisions of this law are only extended to those who are holders of the Ministry of Social Affairs (MoSA) disability identification card

and who fit the limited definition of disability proposed by the law. Furthermore, although Law No. 220/2000 does not explicitly mention that only Lebanese are eligible to obtain a disability identification card, in practice, this is the case (Baroud & Mouheildine 2018; UNESCO 2013; Lebanese Civil Society's Coalition 2015). Although Law No. 220/2000 also calls for the right to an enabling environment, commute, housing, education, work and employment, and social benefits, these are not applied in practice. PwDs in Lebanon are not able to live an independent life with dignity—these factors are also important to ensuring that a PwDs' right to health is respected (Tayar & Etheredge 2020; Handicap International 2022; see also Abu Srour 2023 for the AWR2023).

Regarding older persons, the majority lose their health benefits upon retirement when they need them the most. For example, in 2018, 56% of older persons lived in households that did not benefit from any type of social protection benefits. This percentage increases to around 85% when considering older persons living in households in the lowest income quintile (HelpAge International & International Labour Organization 2022; International Labour Organization 2022). This is alarming considering that the estimated age dependency ratio in 2022 was 60% (World Bank 2023a).[13] Such a high dependency ratio has implications on households' healthcare burden, considering Lebanon's weak social security and public health systems. Several laws and decrees were introduced that extend coverage or healthcare services to older persons. For example, Law No. 248/2000 established an optional social insurance fund for older persons, which failed soon after its implementation due to structural issues (MoSA & UNFPA 2021). Another law, Law No. 27/2017, grants formal permanent private sector retirees with 20 years of service who had previously been enrolled in the sickness and maternity branches of the NSSF the right to benefit from this coverage after retirement. Retirees wishing to benefit from this coverage are expected to contribute to the fund to benefit from this coverage. While not addressing the right to health or the determinants that can lead to its achievement, these laws also fall short of providing older persons with fair and comprehensive social protection guarantees and do not address their specific vulnerabilities (HelpAge International & International Labour Organization 2022; Phenix Center & HelpAge International 2023).

[13] Compared to an estimated 55.4% as per Central Administration of Statistics Demographic Data in 2019, which is still considerably high.

DETERMINANTS OF HEALTH

INCREASING UNEMPLOYMENT AND POVERTY

Unemployment rates have increased significantly due to the crisis, rising from 11.4% in 2019 to 29.6% in 2022 (CAS & ILO 2022). Unemployment was recorded at 47.8% among youth, and stood at 32.7% among females. Informality is high—in 2021, 62.4% of the population worked informally, and 48.3% was employed in the informal sector (CAS & ILO 2022), thus falling outside available social protection schemes. Even for employees working in the private sector, non-compliance and lack of implementation of the law have resulted in low registration rates in the NSSF, with employers opting not to register their employees to avoid co-payment (Dara 2020). The majority of non-citizens, particularly Palestinian and Syrian refugees, also work informally since they face several barriers to obtaining a legal work permit (for example, prohibitive cost) or regarding the sectors in which they are allowed to work. Although a small number of Palestinian and Syrian refugees who have official work permits are expected to contribute to the NSSF, they do not benefit from its protections (including healthcare coverage) due to the principle of reciprocity,[14] among other barriers (International Labour Organization 2021; International Labour Organization 2020).

Another consequence of Lebanon's multi-faceted crisis has been a significant increase in the poverty rate, which, as mentioned previously, remains a significant challenge to achieving the right to health. Poverty is a significant determinant of health and the right to health and is likely to deepen health inequities, as it also affects (access to) other determinants of health, including food, water, sanitation services, adequate housing conditions, education, etc. In the first quarter of 2022, when the dollar exchange rate was close to 25 LBP to the dollar, the Central Administration of Statistics estimated that more than 80% of families lived on less than 430 USD. This is reiterated by multiple international and national bodies, which estimate that between 75% and 80% of families are considered in need of some form of assistance to enable them to meet their basic living needs. Among Palestinian refugees, the poverty rate was estimated at 93% as of September 2022 (UNRWA 2022). Among Syrian refugees,

[14] In the case of the NSSF, the principle of reciprocity has been interpreted to mean that only workers from countries with which Lebanon has a bilateral agreement on social security can benefit from NSSF provisions. To date, only nationals of Belgium, France, Italy, and the United Kingdom can benefit from NSSF provisions. .

67% were living below the Standard Minimum Expenditure Basket (SMEB) (UNHCR, UNICEF, & WFP 2023). As a result of such high poverty rates, households have had to prioritize basic necessities and have resorted to negative coping mechanisms to ensure survival, which has an impact on their health; for example, by reducing food portion sizes, discussed in the next section (UN Women et al. 2020; UNICEF 2023). Two programs aim to provide extremely poor Lebanese families (immediately following the COVID-19 period) with cash assistance and social services toward expanding social safety net coverage at the national level. The NPTP and Emergency Social Safety Net Program (ESSNP) programs cover nearly 160,000 families living in extreme poverty, but a significant proportion of the population remains without needed support (World Food Programme 2022; World Bank 2023b). Notably, a distribution monitoring survey found that families were spending their cash transfers primarily on food (43%), followed by healthcare (12%) (World Bank 2023b).

Women and girls have been especially hard hit by the crisis. For example, with subsidies lifted off menstrual hygiene products, these have become unaffordable for many, resulting in what has been termed period poverty (Moussawi 2023). Not able to afford these products, women may turn to unhealthy alternatives, which has an impact on their health (Moussawi 2023). Similarly, a study by Aouad & Abed (2021) for Oxfam found that members of the LGBTQ+ community, particularly trans- and non-binary individuals and queer refugees, reported difficulties in accessing employment and income, particularly post the August 4 Beirut Blast, which resulted in significant destruction of LGBTQ+ safe spaces. As discussed previously, issues such as discrimination against the LGBTQ+ community, lack of protection from the government, and legal restrictions, exacerbate the situation (Aouad & Abed 2021). With limited resources, members of the community participating in the study reported difficulties in securing basic services, such as housing and healthcare, including mental health and sexual and reproductive health services (Aouad & Abed 2021).

FOOD INSECURITY

The United Nations estimated that between September – December 2022, some 2 million residents (including Lebanese nationals and Syrian refugees) were struggling with food insecurity—partly due to the lifting of food subsidies and increasing cost of living (United Nations 2023). A national nutrition survey conducted in 2022 found that households

were resorting to negative food-related coping strategies, such as reducing portions of meals when not having enough food, particularly common among adults in favor of their children (FAO, FSC, UNICEF & WFP 2022). The survey also found that 70% of the children participating in the study are missing their best start in life-exclusive breast feeding, while 90% are missing at least one dimension of a quality and nutritious diet (FAO, FSC, UNICEF & WFP 2022). 30% of the Lebanese, Syrian, and Palestinian households participating in a rapid assessment conducted in April 2023 reported that at least one of their children was going to bed hungry, up from 23% the previous year (UNICEF 2023). Among Syrian refugees, 57% of households had inadequate food intake (UNHCR, UNICEF, & WFP 2023). Furthermore, over 80% of Syrian households living in non-permanent shelters reported not having consumed iron-rich foods in the week before the VASyR survey, while 19% reported not having consumed vitamin A-rich foods; percentages were equally poor for refugees living in non-residential shelters (UNHCR, UNICEF, & WFP 2023).

Inadequate nutrition can have dire consequences on a child's health and development, thus hindering the attainment of the right to health. Up until 2022, stunting levels were low to medium across all governorates, averaging 7% nationally, but were higher among Syrian children living in informal tented settlements, where the prevalence of stunting was 25.8% (FAO, FSC, UNICEF & WFP 2022; UNICEF 2022b). As for wasting, the national nutrition survey found that wasting among children was low to very low across the country (<5% across all strata) (FAO, FSC, UNICEF & WFP 2022). In addition, 41% of women and 43% of children participating in the national nutrition survey were found to suffer from some degree of anemia (FAO, FSC, UNICEF & WFP 2022), likely due to food insecurity and inadequate nutrition (UNICEF 2022b). Nevertheless, with food insecurity rising, children remain at risk of undernutrition and its consequences.

DETERIORATING PUBLIC SERVICES

With decreasing currency value and the ensuing fuel crisis, the government has been unable to maintain operations of public electricity and water infrastructure (Ferrando 2022). Poor or completely unavailable public utilities, including electricity, water, and sanitation services, have aggravated poverty and inequality. While access to private or commercially run generators is available for those who can afford it, a study by Human Rights Watch (2023) found that generator services

were unaffordable for almost 20% of low-income households. Low-income households were spending a much greater share of their monthly income on generator access, with an impact on their access to other basic needs. Increasing dependence on generators for power has also resulted in an increase in air pollution from diesel burning, especially in urban and overcrowded areas, impacting health, particularly of vulnerable groups, including children, older persons, and those with respiratory diseases (Human Rights Watch 2023). Lack of electricity also has an impact at the healthcare level itself; for example, electricity is necessary to maintain the cold chain needed for vaccines (UNICEF 2022), while some healthcare centers and hospitals limit their services to emergency care to ration power (Hamadeh et al. 2021).

The electricity crisis is directly linked to the water crisis, as electricity is necessary to power water pumps and wells. Since 2019, the daily water supply in Lebanon has dropped below the recommended 35 liters per capita (UNICEF 2021; UNICEF 2022a). Private water trucking businesses are also available to facilitate water access for households, albeit only for those who can afford it (Ferrando 2022; UNICEF 2022a). Furthermore, a large percentage of refugees (Palestinian=45%, Syrian=58%) live in overcrowded or poor shelter conditions (UNRWA 2020; UNHCR, UNICEF, & WFP 2023). Poor shelter conditions, water resources, and sanitation services can directly impact health, particularly of children, who are at risk of water- or sanitation-related diseases (UNHCR, UNICEF, & WFP 2023; UNICEF 2022a; UNICEF 2022b). For example, a significant indicator of Lebanon's deteriorating public health situation (and, more broadly, its infrastructure) is the recent cholera outbreak, the first such outbreak in almost three decades. Starting in the informal tented settlements of North Lebanon, the cholera outbreak quickly spread and was identified in cultures from potable water sources, irrigation, and sewage in the informal settlement, and later, in sewage water in two other regions of the country (World Health Organization 2022). As of June 2, 2023, there have been over 8,000 confirmed cholera cases in the country, with children among the most affected (MoPH 2023a).

THE ENVIRONMENT

In recent years, Lebanon has witnessed significant environmental deterioration with an impact on public health. Forest fires, polluted water resources and air pollution, poor waste management, an ongoing garbage crisis, and land

degradation, and uncontrolled quarry digging are only some of the environmental issues faced (UNDP, UNHCR, UNICEF, & MoE 2021). It is expected that climate-induced extreme weather events, such as floods, forest fires, and drought, will likely increase, impacting food security and disproportionately affecting lower-income households (Ferrando 2022). As mentioned previously, fuel consumption due to diesel generators, poor quality fuel from power plants, and land transportation (traffic jams) are significant contributors to air pollution in Lebanon (Baayoun et al. 2019; Human Rights Watch 2023), while ineffective wastewater treatment and untreated industrial waste and sewage are significant polluters of water resources in Lebanon. For example, pollution of the Litani River is among the largest contributors to food and well water contamination in the country, posing a threat to public health and agricultural production (Darwish et al. 2021). Also of note is Lebanon's ongoing solid waste crisis, which in the past has resulted in solid waste accumulation in cities across the country due to political deadlock and poor management (Human Rights Watch 2020). Both air pollution and improper waste management have a direct impact on health, particularly with regard to respiratory diseases such as chronic obstructive pulmonary disease and asthma, and skin conditions in the case of the latter.

DATA (UN)AVAILABILITY AND ITS IMPACT ON THE RIGHT TO HEALTH

At the national level, Lebanon's last census was conducted in 1932, and national-level data and indicators disaggregated by gender, age, ethnicity, rural or urban status, and socioeconomic group are generally unavailable to inform health policy and planning. A National Health Statistics Report published over a decade ago in 2012 provided some insight into the health status of Lebanese nationals and provided data on healthcare access and services available for refugees from the respective agencies, the UNRWA and UNHCR, but did not cover the health of migrant workers. Other national level or representative surveys are conducted, such as the Vulnerability Assessment of Syrian Refugees in Lebanon survey, and shed light on challenges and disparities faced by some vulnerable or non-citizen groups, including on health. Nevertheless, some vulnerable groups who face specific challenges, such as those who are unregistered or undocumented, are underrepresented in these surveys or excluded from them altogether. Available data lacks standardization (with, for example, different actors relying on different indicators and definitions), is outdated, and at times even contradictory, while relevant actors do not always share data (Badr & Asmar 2016).

Furthermore, the MoPH produces periodic statistical and epidemiological reports for several health indicators, including surveillance data for communicable and non-communicable diseases, as well as maternal and neonatal data (see the MoPH Vital Data Observatory and Health Indicators). Maternal and neonatal data is disaggregated by district and nationality, although non-nationals are grouped into a single group. The latter has implications for attaining the right to health for groups such as refugees and migrant workers, whose living conditions and determinants of health vary and whose access to healthcare is also limited. Moreover, the lack of standardized data collection methods and indicators does not allow for inter-group comparisons and can hinder policy and program development. In addition, there is no up-to-date official national data that researchers or advocates can access to assess the inequities in healthcare access or attainment of the right to health. This makes it difficult to hold the government accountable regarding its duty to ensure the right to health for all.

CONCLUSION AND RECOMMENDATIONS

Though the ongoing crisis has certainly exacerbated the situation, the foundations for Lebanon's inequitable health system predate the current crisis. Overall, progress (in health and other sectors) has been far from even across regions, as has development, and residents of Lebanon, to this day, do not enjoy equal rights, including the right to health. Instead, national policies and reforms have contributed to high levels of income inequality, engendered regional disparities across the determinants of health, and resulted in various left-behind groups. The main challenges and barriers hindering the attainment of the right to health in Lebanon can be summed up as follows:

- The promotion of a liberal economy—facilitated by the political class, corruption, and cronyism—has contributed to the proliferation of the private healthcare sector and hindered the development of the public healthcare sector. Similarly, it has hindered development in other sectors, affecting the underlying determinants of health, such as water and sanitation, energy, and the environment.
- Despite progress on certain fronts, weak governance, weak infrastructure, poor planning, underfunding, and poor quality of services have caused further deterioration of the public healthcare sector. The latter, along with fragmented financing and healthcare delivery, contribute to inequities in health access and provision among different segments of the population.
- Current health laws, decrees, policies, and strategies focus more on access to healthcare rather than on health as a right. Although Lebanon is a signatory to various conventions and treaties that provide for the right to health, these provisions are not implemented in practice. Furthermore, several laws and policies result in the social exclusion of certain groups, such as those related to the elderly, women, children, PwDs, and the LGBTQ+ community, hindering the attainment of the right to health.
- Health system development over the years has perpetuated a culture of curative care over preventative care.
- Lebanon lacks a comprehensive social protection strategy and universal healthcare coverage, and a functional primary

healthcare network able to provide a basic package of essential healthcare services to all.

- The situation has contributed to inequity and discrimination with regard to opportunity and access to health and healthcare based on what should be protected characteristics (such as gender, income level, political or religious affiliation, citizenship status, and nationality), especially for vulnerable and marginalized communities.

TOWARD THE RIGHT TO HEALTH FOR ALL IN LEBANON

Create a culture of health as a right: It is of utmost importance to constitutionalize or introduce the necessary national legislation that ensures the right to health for all, to raise awareness among residents about their rights, and to empower them to hold the government accountable to ensure this right is being fulfilled. In practice, efforts should be made to raise awareness about and promote the use of available complaints mechanisms in the public health sector, including the MoPH national complaint and inquiry hotline, website, and application, and the PHC network national grievance handling system.[15] The former must be made toll free, and its scope must be expanded to cover questions and complaints regarding a person's health rights. Individuals must be able to participate in decisions regarding their health (as laid out in Law No. 574/2004 on Patient's Rights and Informed Consent), but more broadly, civil society and the public must be engaged in public health programs and policy development, whether through national consultations, or local health committees. Efforts should be made to ensure that consultation and committees also engage the most vulnerable or marginalized members of our community and/or the CSOs that represent them. Health equity also requires reforms addressing the determinants of health, such as issues that hinder fair and equitable access to education and employment, clean water and proper sanitation, nutritionally adequate food, renewable energy resources, and a healthy environment. To this end, ensuring health is incorporated into all policies is important. The right to health also requires enhancing the acceptability of facilities and services in the public healthcare sector—which should be the primary provider of care in the country—and increasing awareness at the cultural and societal levels around the value of preventive services over curative services.

[15] Hammoud et al. (2021) provide an overview of the available complaints mechanisms, discuss the current gaps, and provide recommendations for improvement in the article, "Setting up a patient complaint system in the national primary healthcare network in Lebanon (2016–2020): Lessons for Low- and Middle Income Countries."

Strengthen Lebanon's primary healthcare network: Efforts should be made to strengthen Lebanon's public healthcare sector and its national primary healthcare network. The MoPH should improve the capacity, availability, and quality of services in its facilities, which requires ensuring that health staff have the proper qualifications. At the PHC level, services must include preventive care, sexual and reproductive care, and mental health services, which should be budgeted for adequately. Improving quality and ensuring patient safety are essential to building trust in the sector. To improve quality in the sector and enhance patient safety, the government must adopt a comprehensive policy for quality improvement and patient safety.[16] Furthermore, primary healthcare should be made accessible for all, both physically and financially. Practically, this means ensuring that centers are equitably distributed across governorates. It is also important to address issues with public transportation (for example, ensuring that it is accessible to PwDs, affordable, and safe for women and girls) to ensure that individuals are able to reach their nearest center. Centers must be equipped (for example, in terms of human resources for health, facilities, equipment, physical accessibility, etc.) to provide individuals with the care they need at an affordable price. It is also important to address the influence of political and religious institutions and corruption within the system.

Work toward a universal healthcare system: Adopting a universal healthcare law that extends basic healthcare services to all residents of Lebanon, and not just citizens, is a necessary step toward enhancing health equity and minimizing discrimination. Basic healthcare services and essential medicines should be available for all and affordable. Adoption of a universal healthcare law may minimize out-of-pocket spending, thus reducing the potential for catastrophic health expenditures on poorer households.[17] Furthermore, it is important to introduce legislation to control market prices and place a cap on profit margins in the healthcare sector, especially for medicines and specialized tests. Efforts should be made to minimize dependency on and further regulate the private sector. In parallel, it is of utmost importance to adopt the National Social Protection Strategy, as it provides coverage and a basic benefits package that includes essential healthcare services for all, including for vulnerable and marginalized groups. Financing for universal healthcare can be secured through introducing a progressive tax, among other financing mechanisms, but must be preceded by efforts to

[16] Jardali & Fadlallah (2017) describe how this can be achieved in practice in their study, "A Review of National Policies and Strategies to Improve Quality of Health Care and Patient Safety: A Case Study from Lebanon and Jordan."
[17] See this Evidence Summary by the Knowledge to Policy Center at the Faculty of Health Sciences at the American University of Beirut on accelerating progress toward universal healthcare coverage.

unify current financing mechanisms and enhance coordination among the various actors involved in the sector. This is crucial to minimizing fragmentation, duplication, inefficiency, and ineffectiveness, which significantly hinder the attainment of the right to health for all in the country.

Data availability and transparency: Making disaggregated data (based on gender, nationality, age, geographic location, urban/rural, type of shelter, etc.) available and possibly digitizing patient records through a national health information system can help to minimize discrimination and inequity, increase efficiency and decrease medical errors at the healthcare institute level, and improve the quality of care. Furthermore, data can facilitate national-level planning and budgeting to ensure that community and individual health needs are being met. Data is essential to developing an inclusive national public health strategy. Such a strategy must include health indicators and targets. In addition to epidemiological data, information on MoPH contracts, budgets, spending, etc., should be easily accessible to the public. This data can be used by the public and civil society to hold the government accountable through a national monitoring mechanism. In practice, efforts should be made to address the obstacles that hinder proper implementation of the Law No. 28/2017 on Right to Access Information, which obliges state institutions to share information regarding budgets, studies, reports, decisions, instructions, circulars, memos, etc., with the public, if requested (with few conditions). Obstacles include excuses from the relevant public institutions to not have to provide data and the absence of a national-level Anti-Corruption Commission. The former related to public institution resistance has been addressed, to a certain extent, through the introduction of amendments to law introduced in 2021 through Law No. 233/2021, but an Anti-Corruption Commission has not yet been established.[18]

Health equity cannot be achieved without addressing some of the endemic issues in our system, including corruption. Strengthening accountability and transparency mechanisms is key to minimizing corruption and regulating the healthcare sector, including public and private healthcare providers and the pharmaceutical sector. At the public healthcare level, transparency is important to ensure fair allocation of healthcare funds. Regarding the private sector, it is important to promote fair competition, ensure proper implementation of anti-corruption laws, and ensure transparency in the public procurement process.

[18] Merhej (2021) reviews the Access to Information Law in his article, "Lebanon's Access to Information Law Has Been Amended... What's New?"

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P.O.Box 11-0236 / Faculty of Health Sciences
Riad El-Solh / Beirut 1107 2020
Lebanon