Notre Dame University

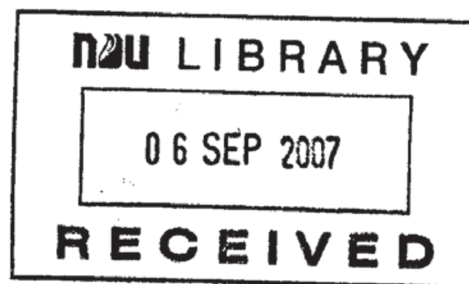
Faculty of Political Science, Public Administration & Diplomacy

Scopes of Cooperation between the World Health Organization and the Ministry of Health in Lebanon

M.A. Thesis

By

Nehman Sarkis Frangieh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Scopes of Cooperation between the World Health Organization and the Ministry of Health in Lebanon

By

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ABSTRACT

The first cooperative efforts toward international action were made in the twentieth century in order to prevent the spread of diseases from one region to another. The subsequent institutionalization of these efforts gave birth to the World Health Organization.

As the necessity for a single worldwide health system came to be recognized and felt as a pressing need to preserve the highest standards of health, WHO was seen as a way to satisfy this need. Also, the concept of "health for all", embodied by WHO, is fundamental to the attainment of peace, welfare and security of nations.

The assumption of the full burden in the field of health by WHO is not feasible; such a policy is beyond its available resources. This is why the collaboration of WHO's regional offices with the concerned governments is seen as a must.

In Lebanon, the civil war that took place weakened the role of the government in the field of health while the private sector and the non-governmental organizations assumed an active role. As the war ended, the Ministry of Health sought to strengthen its institutional capacities and to increase the degree of cooperation with health organizations and NGOs.

Joint programs between the Ministry of Health and WHO aim to control the spread of certain diseases, to treat illnesses, and to increase the awareness of the Lebanese population.

The study focuses on four major joint programs: The National AIDS Control Program, The Non-Communicable Diseases Program, The Expanded Program on Immunization, and The Tobacco Control Program. In addition, a series of recommendations is provided based on weaknesses and failures detected in the elaboration and implementation of these programs.

Finally it is crucial to note that the shortage of accurate information related to health constitutes a major limitation of the project.

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To the memory of my father

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Chapter I
Introduction

For centuries and even millennia, people on earth have exchanged diseases and remedies without generally thinking of ways to work together to promote measures that could go beyond national and local boundaries. The early attempts on international cooperation in health were limited to small groups of countries in the old and new worlds which addressed a few obviously contagious diseases such as cholera and small pox, and strategies such as quarantine to keep the contagious diseases at bay. In the twentieth century, governments, for the first time in history, began working together not only to protect their own people from imported diseases, but to work in favor of protection and promotion of positive health. These ideas were the pillar on which the World Health Organization (WHO) was founded in 1948.[1]

Epidemics do not respect physical boundaries but transcend national frontiers spreading persistent menace. The transmission of disease may spread over large areas especially when the existing ecological conditions are favorable and conductive. History witnesses numerous instances when pestilential diseases have spread from their original place to neighboring adjacent areas. This phenomenon enhanced the establishment of a cooperative endeavor on an international basis to combat and control the spread of disease. The necessity for an international health institute became obvious to all countries basically to restrict the spread of infection and contagious diseases and take the necessary medical precautions.

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[1] WHO, *World Health Organization What It is What It Does*, (Geneva: Division of Public Information and Education for Health Media Service, 1998), 1.

> "International organizations began to develop to meet two separate needs: First, a general desire for peace and the growth of powerful relations; Second, a series of precise and limited objectives to meet specific cases. The former requires one international organization universal in scope and objective, and the latter can be met through several different organizations roughly classified under the economic, technical, social, humanitarian, military and political."[2]

WHO is a specialized agency of the United Nations that was established in 1948 by 61 governments "for the purpose of cooperation among themselves and with others to promote the health of all people."[3] Seventeen specialized agencies operate today in affiliation with the United Nations. Among them is the World Health Organization.[4]

Lebanon is an active member of WHO since it became party to its constitution on 19 January 1949, only few months after WHO's constitution was adopted. The collaborative programs between WHO and its members are prepared in conformity with the WHO general program of work which fixes goals and targets for global health actions. In Lebanon, WHO is providing direct technical, administrative and financial support to the various programs under WHO/Ministry of Health (MOH) joint collaborative programs and others established by the MOH under cost sharing mechanism (trust fund) to improve the health status of the Lebanese population and strengthen the management and system of the health sector. Furthermore, extra budgetary resources from the World Bank, AGFund, the United Nations and others are also made available for the development and implementation of programs. WHO is also developing new programs to tackle

[2] Paul Reuter, *International Institutions* (London: Purnell and Sons Ltd., 1988), 205.

[3] WHO, *Introducing The World Health Organization Representation in Lebanon* (Lebanon: WHO Office, 2003), 3.

[4] A. LeRoy Benett and James K. Oliver, *International Organizational Principles and Issues*, 7th ed. (New Jersey: Pearson Education, Inc. Upper Saddle River, 2002), 308.

health related issues such as mental health, rehabilitation services, health of the elderly, women health and adolescent health.[5]

During the last few years international agencies, including WHO, have emphasized the role of health as the basis of sustainable development. Strengthening of national and global capacities to address the problems in developing countries is best advocated through close collaboration between various health institutions.[6] Perhaps the most important challenge for the new century is to share wealth, opportunities, and responsibilities between the rich and the poor - for a world where the chasm between rich and poor grows wider will be neither stable nor secure.[7]

Health is defined by the WHO constitution as: "A state of complete physical, mental and social well-being and not merely the absence of disease and infirmity". Health is seen as a shared responsibility calling for a high degree of self-reliance from the individual, the family, the community, and of course the nation as a whole.[8]

It goes without saying that no nation can hope to rebuild itself, or sustain itself, or improve itself without a healthy population. Health is the beginning for the effective social and economic development. And the beginning of good health is preventing bad health.

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[5] http://www.who.int/home-page/

[6] http://proquest.umi.com/pdqweb?index=2&sis=2&srchmode=1&vinst=PROD&fmt=4&... 18/02/2005

[7] Karen Kasmauski and Peter Jaret, *Impact From the Frontlines of Global Health*, with a foreword by Jimmy Carter (Washington: National Geography Society, 2003), 7.

[8] http://www.who.int/home-page/

In this first decade of the 21st century, immense advances in human well-being coexist with extreme deprivation. In global health we are witnessing the benefits of new medicines and technologies. But there are unprecedented reversals. Life expectancies have collapsed in some of the poorest countries to half the level of the richest – attributable to the ravages of HIV/AIDS in parts of Sub-Saharan Africa and to more than a dozen "failed states". These setbacks have been accompanied by growing fears, in rich and poor countries alike, of new infectious threats such as SARS and "hidden" behavioral conditions such as mental disorders and domestic violence. The world community has sufficient financial resources and technologies to tackle most of these challenges; yet today many national health systems are weak, unresponsive, inequitable – and even unsafe.[9]

According to Dr. Habib M. Latiri, WHO representative in Lebanon, the work of WHO Office in Lebanon enjoys double blessings, which increase the impact of its programs and activities. One of them is the strong partnership with the Ministry of Public Health and other Ministries, such as the Ministry of Education and the Ministry of Social Affairs. The WHO's Office in Lebanon is unique in managing national programs on behalf of the Government. The second blessing is the strong involvement and initiative of the civic community.[10]

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[9] WHO, *Working Together for Health,* (Geneva: The World Health Report, 2006), XV.

[10] WHO, *Introducing the World Health Organization Representation in Lebanon*, 1.

TOPICS AND ISSUES TO BE DISCUSSED

"The foundation of international organizations was built in ancient times, but the organizations themselves did not appear until the nineteenth century, when they were created by the dominant political units of world politics-- the nation-states."[11] An aftermath of the First World War was a universal desire to construct a mechanism to build a better world. It took the form of the League of Nations, one of the tasks of which was to attempt to take steps in matters of international concern for the prevention and control of disease. The United Nations plays an indispensable role in assisting many nations to escape from the intolerable conditions that condemn considerable portions of the world's population to a brutish existence. Although for each country self-help is the main key to improvement toward better social and economic standards, small states are dependent on the rest of the world for supportive conditions for their own efforts.

The remarkable progress attained by the WHO, one of the most specialized agencies of the United Nations, and its significant contributions to the welfare of mankind, make it worthwhile to examine the experience and the role of the World Health Organization.

This study attempts to expound on the manner in which WHO executes its programs by means of its unique regional arrangements on the Lebanese territory.

It will also address the role of, and the relationship between, MOH and WHO. To a lesser extent, MOH contributes enormously in the Lebanese health sector on different levels and so does WHO in Lebanon. As a matter of fact, MOH provides vaccines free-of-charge for most health centers and dispensaries in the

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[11] A. LeRoy Benett and James K. Oliver, *International Organizational Principles and Issues*, 1.

country. It also finances the procurement for chronic illnesses. For its part, the Government strives to cover the uninsured portion of the population, with the aim of providing universal access to health services.[12] Nevertheless, neither side can achieve a high level of success alone: collaboration between both parties is essential in order to increase the efficiency of all actions taken. The cooperation should not be exclusive to WHO and MOH, it should also include NGOs and the civic community in general. However, the international feature of the organization and the vastness of the field of competence in which the organization functions impose numerous limitations on the study. Only the relationship between WHO and MOH will be considered.

Further, to give the study a more practical aspect, four cases or "joint programs" between WHO and MOH are focused upon, namely: National AIDS Control Program (NAP), Non-Communicable Diseases Program (NCD), the Expanded Program on Immunization (EPI), and Tobacco Control Program.

Thesis statement: Stemming from the WHO vision that health is a human right and not a mere service or need, health must be seen as a responsibility of those involved in this domain, and above all the responsibility of the governmental authorities, mainly, the Ministry of Health. The relationship existing between WHO and MOH increases the chances to contain AIDS and its negative health and social impacts, to observe, control and prevent cancer, to contain the negative consequences of the tobacco problem, and to increase the degree of coverage of the immunization campaigns.

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[12] Walid Ammar, *Health System and Reform in Lebanon*, (Beirut: Entreprise Universitaire d'Etudes et de Publications, 2003), 16.

METHODOLOGY

The study intends to correlate data that has been gathered from many sources, such as government information (mainly from MOH), WHO bulletins and reports, the work of researchers, articles from specialized magazines and journals, as well as information collected from the Internet. This analysis moreover examines information from a variety of sources, relying mainly on secondary data. Secondary data, defined as "data collected for some purpose other than the problem at hand"[13], is collected from different sources. Internal secondary data from within WHO and MOH includes newsletters, pamphlets and reports. External secondary data comes from different sources such as: journals and other publications, and the Internet.

LITERATURE REVIEW

Regarding WHO, many reports, booklets, newsletters, pamphlets and websites are found. The same is true concerning, specifically, the work of this international organization in Lebanon. Although the list is quite long, the mostly used sources in this field are: *Introducing The World Health Organization Representation in Lebanon; World Health Organization: What It is, What It Does, 1998; Introducing WHO in Lebanon; Annual Report 2002, WHO Representative Office Beirut, Lebanon*, July 2003; and the website: http://www.who.int/home-page/

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[13] Naresh K. Malhotra, *Marketing Research An Applied Orientation*, 3rd ed., (USA: Bookwest Texbooks, 1998), 112.

When it comes to MOH, most of the books, reports, research, and pamphlets relate to the reforms of the health sector. An important book in this area is one that is written by MD, Ph.D. Walid Ammar, *Health System and Reform in Lebanon,* Entreprise Universitaire d'Etudes et de Publications, Beirut, 2003. As for sources other than books, the following can be mentioned: *Primary Health Care In Lebanon: Ten Years Later, A Review of Developments and Evaluation of Achievements in This Sector*, April 2004, by MD, Dr Nabil M Kronfol; and *The Lebanese Health Care System 2000: The Current Situation and Options for Reforms,* May 2000, by the same author, and the website: http://www.public-health.gov.lb/ was of great help. For discussion on the subject of health in general, the book of Karen Kasmauski and Peter Jaret, *Impact from the Frontlines of Global Health,* National Geographic Society, GlaxoSmithKline, was chosen.

Due to the fact that the topic of this thesis focuses on the relationship between WHO and MOH, a limited number of books in this field are published. Regarding the cases or joint programs between WHO and MOH chosen for this study, information collected in this field emanates largely from reports and research covering WHO's Eastern Mediterranean Regional Office (EMRO) in general, such as: *Preventing HIV/AIDS in the Middle East and North Africa: A Window of Opportunity to Act, A Synopsis of the World Bank Regional Strategy.*

Covering the Lebanese region and the HIV/AIDS in particular a few sources are found: *HIV Surveillance in Lebanon, Assignment Report,* by Dr Emile Fox, June-July 1993, and other articles from journals, newspapers and the Internet are used. Regarding the vaccination program, the following sources are selected:

Evaluation of the National Immunization programme and Disease Surveillance System in Lebanon, by Dr. Mohamed Taky Gaafar, Dr. Esmat Mansour, and Dr. Maureen Birmingham, 4-14 December 1994, and *Tentative Country Expected Results & Products and Services Related to the Epidemiological Surveillance Unit for the 11th Round of JOINT PROGRAMME REVIEW MISSION for the Biennium 2004-2005*, by Dr Nada Ghosn, August 2003.

Cancer in Lebanon: Situation, Response and Cost Analysis by Ghada El Karawi, Fall 2005-2006, covers an important part of the issue. It is completed by information found in a number of articles and brochures. The tobacco issue in Lebanon is treated extensively in different magazines, newspapers, and websites from the Internet.

Proposed Organization of the Thesis

Chapter I: Introduction

In this chapter the purpose of the study is delineated as well as the topics to be discussed and the approach and methodology used.

CHAPTER II: The Lebanese Health System

A presentation of the current situation of the Lebanese health system and of the Ministry of Public Health is provided, with an emphasis on the changing role of the Lebanese government from a provider role to a financing role, to a regulator role.

CHAPTER III: The World Health Organization (WHO) In Lebanon

The first part of this chapter is an introduction to WHO, including its identity, its functions and its structure. The second part describes the work of WHO in Lebanon and its programs.

CHAPTER IV: The National AIDS Control Program

The fourth chapter addresses one of the major "joint programs" between MOH and WHO: the National AIDS Control Program (NAP). Launched in 1989, this program seeks to increase the awareness of the general population about HIV/AIDS prevention and control.

CHAPTER V: The Non-Communicable Diseases Program (NCDP) – Cancer

The cancer unit (CU) is part of the Non-Communicable Diseases Program. It runs the National Cancer Registry (NCR) along with other activities of surveillance, control and prevention of cancer in Lebanon.

CHAPTER VI: The Expanded Program on Immunization (EPI)

In this chapter, we will address the efforts of MOH and WHO to achieve house to house immunization campaign.

CHAPTER VII: The Tobacco Control Program

In line with recommendations from WHO, MOH established the National Tobacco Control Program in 1997. The chapter addresses the collaboration between MOH and WHO in this field.

CHAPTER VIII: Conclusion and Recommendations

A summary of the findings on the collaboration between WHO and MOH is presented in this chapter. It is followed by a number of recommendations.

CHAPTER II
The Lebanese Health System

The Situation of the Lebanese Health System

The issues and difficulties facing the health care system in Lebanon are not new, and they precede the civil war 1975-1990. They emanate from an attitude of "laissez-faire" that had characterized most sectors since the country achieved its independence in 1943.

Lebanon's health sector until 1958 had followed international trends that had prevailed in the first half of the twentieth century. Initially, at the turn of that century, the State had focused primarily on promulgating legislation to protect Society against health ills that were predominately then infectious diseases. Thus, the quarantine system was established, laws governing water supply and sewage disposal were promulgated, and dispensaries for the poor and facilities to house the contagious patients and the mental patients were built and managed by the State. Medical care, that was not as sophisticated then, was entrusted to the charitable, religious and community groups, often with support from the Government. Private practice and facilities started in the twenties, patterned on the French model since Lebanon was under the mandate of France. Physicians who had trained and specialized primarily in Europe returned and opened small facilities to treat their patients, within their specialty. Medical education, and indeed the preparation of health manpower, was confined to the two prestigious foreign universities: the American University of Beirut (since 1866) and the Saint

Joseph University (since 1887). Both were and continue to be centers of excellence in professional education.

In the first fifteen years of independence, the State built a network of regional, district and rural hospitals, to provide care for essentially the under-privileged. Patients were then required to attest to their financial need to be admitted for care. This regulation stigmatized the users within their community as being in need. In 1958, the Government attempted reforms that were quite advanced even when compared with more advanced countries. Social development with community participation were encouraged and institutionalized. The National Security Fund was established in 1964, to insure several social programs. Before 1975 Lebanon boasted advanced health services and medical institutions that made Beirut a health care center for the entire Middle East region. The civil war that had started in 1975 had a negative impact on the public health care system, emergency medicine, and the treatment of traumatic injury overwhelmed the health care sector. The majority of state facilities were destroyed or deserted.

In fact, Lebanon's seventeen years of war (1974-1991) and upheaval resulted in an extensive destruction of its infrastructure which led to the weakening of the government institutional capacities. Government's institutional capacities were severely impaired and little opportunity was left for government involvement in the maintenance and development of basis public services. The huge gap in the availability of services, the increasing needs of the population, toped up with a civil war situation that requested rapid interventions, led to an

uncontrolled flow of initiatives. A very strong private sector went at full speed in the delivery of services without governmental control or supervision .Grass root organizations and NGOs played a major role in providing emergency relief and assistance during conflict situation, and in several areas such as health, vocational training, education, income generation etc... Also, due to continued political instability, public services severely affected and weakened by the war, were virtually non-existent for a period of 17 years. Most trained and capable people left the country, while those who stayed had to struggle to survive on inadequate salaries. Little opportunity was left for modernization of ideas, skills or style of work. Consequently, and among other things, public administration suffered from a lack of manpower, including managerial staff. With no exception to other similar governmental structures, the health services delivery system was fragmented in a multiplicity of uncoordinated public and private agencies. The public health programs that continued during the war period, e.g., vaccination or chronic medicine programs were donor-driven and channeled through NGOs of various denominations. As a result, most socio-medical services were provided by non-governmental organizations (NGOs) and the private sector. As such, the role which government related health institutions could have otherwise played in normal times progressively declined during the past two decades. The private sector and numerous NGOs provided extensive clinical, curative and to a lesser extent preventive services, but public health activities and the overall management of the health sector have been largely ignored. The most visible effect of the lack of sectoral planning was reflected in the rapid increase in the cost of health services associated with inequities in health coverage. Furthermore, the public

bills have been considerably inflated by the uncontrolled increasing acquisition and prescription of expensive heavy medical technology by the private sector. Along with the purchasing of hospital services in the private sector and the advanced technology practices, such as cancer chemotherapy, renal dialysis, cardiothoracic surgeries, funds in supporting preventive care and public health action were almost insignificant. [14]

The problems in health care continued into the 1980s. A World Health Organization (WHO) study conducted in 1983 found that the private sector dominated health care services and that public sector health organizations were in chaos. The weakened Ministry of Public Health maintained little coordination with other public sector health agencies, and over two-thirds of the ministry's budget (US$58.5 million in 1982) flowed to the private sector through inadequately monitored reimbursements for private hospital services. As of 1983 there were about 3.2 hospital beds (0.23 of them public) for every 1,000 persons, but control over the quality of hospital and medical services was minimal, and many public and private hospital beds were unoccupied. There was about one doctor for every 1,250 inhabitants, but nurses and middle-level technical personnel were scarce. Furthermore, health personnel were concentrated in Beirut, with minimum care available in many outlying areas. The Ministry of Public Health as well as other government and private agencies operated small clinics

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[14] Peggy Hanna, "Case Study on Government and Civil Society: The Case of the Ministry of Public Health" (Beirut, October 1996), 5-9.

and dispensaries, but few such centers existed in Beirut. Nowhere in Lebanon was there a health center which delivered a full range of primary health care services.[15]

"After the war ended in 1990, the Government started to refurbish its hospitals and to build new ones. In 1992, the Ministry decided to cover the treatments of patients undergoing complex surgeries and medical care such as cardiac surgery, cancer treatment, and renal dialysis".[16] "Most available health care is largely curative and privatized by 128 private or NGO hospitals, the 647 NGO health centers and dispensaries, and an abundance of highly qualified, specialized private physicians. The number of private clinics is unknown. There is a strong demand and willingness to pay for the highest quality health care. Approximately, 50% of the population is at last partially insured by one of several available private and public health insurance schemes. The MOH operates directly 42 health centers/dispensaries and 17 functioning hospitals." [17]

Over the last decade, the health sector has witnessed meaningful and sometimes paradoxical changes. Health authorities have recognized the importance of strengthening the institutional capabilities of the Ministry of Health in parallel with improving its image, and allowing it to build a consensus among stakeholders on a transparent and evidence-based reform plan. Such a plan constituting a blue-print for reform is still lacking, even though some components

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[15] http://www.country-data.com/cgi-bin/query/r-7994.html

[16] M.D. Nabil Kronfol, *The Lebanese Health Care System 2000 The Current Situation and Options for Reforms,* (Beirut, May 2000), 3-4.

[17] Dr. Gaafar Mohamed, Dr. Mansour Esmat and Dr. Birmingham Maureen, *Evaluation of the National Immunization programme and Disease Surveillance System in Lebanon,* (Beirut, 4-14 December 1994)

have already been drawn.[18] Indeed, the post-war period in Lebanon has witnessed an era of serious endeavors to reconstruct the devastated infrastructure. Since 1991, there have been continuous efforts to reconstruct the institutional capacities and health services of the MOH. MOH has started the reconstruction of hospitals and health centers in order to respond to the needs of the health sector which has been greatly affected during the war. Primary attention was paid to the extension and improvement of the primary health care network in order to cover the entire country with an effective system.[19]

In the last four years, the progress has slowed down enormously due to an increasing and geometrically high public deficit and the instability created by the Iraqi war as well as the Israeli-Palestinian conflict added to the recent instability at the Lebano-Israeli border. The recent events witnessed in Lebanon in 2005 after the assassination of the former primary minister Mr. Rafic Harriri, and the following weakening of the internal security has halted the internal development and has pushed international investors away. [20]

The private sector largely dominates in the provision of health care. This sector owns most of service delivery points and is spread over the whole country. It is estimated that the private sector provides up to around 94% of the hospital beds and around 90% of the ambulatory services. It is estimated that that most of

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[18] Walid Ammar, *Health System and Reform in Lebanon*, xiii.

[19] Peggy Hanna, "Case Study on Government and Civil Society", 7.

[20] WHO, *Report of the Joint Government/WHO Programme Review and Planning Mission*, (Lebanon July 2005), 1.

the ambulatory care is provided by private clinics (79% of outpatient care) and by NGO-owned health centers (10% of outpatient care).[21]

The physical resources for health are readily available in Lebanon, with a surplus of High Medical Technology, but show also large geographical discrepancies across the country. The total number of beds provided by 136 private hospitals and 16 partially operational public hospitals is highly sufficient, with a national ratio of 1 bed /255 persons comparable to the ratio observed in developed countries. However, there is a net discrepancy in the distribution of these hospital beds, with almost 4 times more hospital beds available in the area of Greater Beirut (1bed/166 persons), compared to a region like the North (1 bed/ 762 persons).[22]

With the efforts to develop the primary health care, and as a result of the active initiative of the NGO sector in the country, around 700 dispensaries and health centers are distributed across the region, providing a wide range of health services. On the other hand, there are around 1400 pharmacies distributed in the country, with more than 600 pharmacies in Mount Lebanon alone, reflecting again a geographical discrepancy. At the same time, there is more than 550 laboratory facilities, offering a range of services (including high tech radiology), but also unevenly distributed across the country.[23]

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[21] W. Van Lerberghe, *Reform Follows Failure: Pressure for Change in the Lebanese Health Sector*, (et al 1997), 11.

[22] R. Tabbarah, *The Health Sector in Lebanon*, (Beirut: MADMA, 2000), 36-37.

[23] Ibid

The Current Status of the Ministry of Public Health (MOH) in Lebanon

The MOH is headed by the Minister. He is assisted by the Director General who is directly responsible for planning and managing the different departments of the ministry; three directors responsible for disease prevention, medical care, and laboratories; and a cabinet responsible for accounting, pharmaceuticals, personnel and external affairs. At the Province level, there is a directorate of health services headed by the chief of Medical Authorities. At the Qada' level there is a physician who is responsible for the supervision of the preventive and curative services delivered in his respective Qada'. The Qada' physician is assisted in his work by one or more paramedical.

With the end of the war state and by 1992, the MOH was addressing policy changes in an attempt to focus more on health planning, Primary Health Care (PHC) and cost containment, as well as the improvement in the provision of the health care services provided in Lebanon. The concern in these activities was, therefore considered essential in fulfilling the need of MOH for the rehabilitation of its management, planning and programming capabilities. It is in the context of achieving these goals that MOH got into the preparations and negotiations for a loan agreement for health sector rehabilitation project with the World Bank. These led to the signature of a loan agreement between both sides accounting to US 35 millions.

Furthermore, a number of important steps have taken place in terms of the national health system:

• In 1991, and reflecting a high political commitment, the first National Health Conference recommended the adoption of PHC as the basis of the health system in Lebanon followed in 1993 by the allocation of a regular national budget for PHC.

• A workshop on PHC held in 1994 strongly affirmed and adopted the PHC strategies and policy as were outlined in the Ministry's documents. Also, number of actions have been undertaken to enhance PHC implementation: at the central level a PHC task force has been created charged with overseeing technical and administrative matters related to PHC. The system of information management at the health care center and corresponding software has been developed.

• Multiple efforts have been made towards the restructuring of the health information system in MOH. An epidemiological surveillance unit was established in 1995 at MOH with WHO support to collect, compile, analyze and report information about communicable diseases in Lebanon.

• A plan was implemented to provide health as well as social assistance to certain categories of the population previously deprived from such benefits, e.g., agricultural workers, fishermen, seasonal and daily workers.

• A National Drug Bureau was established whose main objective is to organize the drug market in Lebanon under the direction of the MOH and try to intervene in reducing the cost of medicines.

• A health sanitary map: "carte sanitaire" was prepared. It will serve in the first phase, as a data base of the numbers and levels and types of providers of health care in the country. It will also provide information and data on the

volume and quality of medical equipment available in the country. Furthermore, it will provide information on the numbers, types and quality of health human resources, both medical and Para-medical. Finally it will be used as a baseline for future planning within the health sector services, human resources and legislation.

- Computerization has been introduced into the planning unit as well as the administrative hospitalization unit. Suitable cadres were trained to familiarize with computer basic manipulations. The development of hospitals expenditures control software at the MOH has increased the control capacity as well as the provision of data base on hospitalized patients covered by MOH, cost of services and indicators on morbidity.

- MOH in collaboration with the relevant professionals' societies has developed the new nomenclatures of the medical acts and has succeeded in finalizing the nomenclature of laboratory and radiological acts. This can provide valuable information to analyze provided health care.[24]

However, a number of barriers are still affecting the smooth and efficient running of a significant number of projects within the MOH and delaying its role in policy formulation, planning, coordination and monitoring of health services and programs, the most important being the lack of qualified health manpower due to low salaries, lack of incentives and the administrative routine. [25]

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[24]Peggy Hanna, "Case Study on Government and Civil Society", 9.

[25] Ibid, 11.

The evolving role of the Lebanese Government

"The constant change in world relations affects individuals, states, businesses, and organizations--domestic or international, public or private. Better transportation and telecommunications link people, ideas, and commodities across national borders to a degree never before possible. These changes force states and international organizations to adjust their policies and operations in order to maintain their relevance in international relations."[26]

The World Bank reconsidered its position towards the role that governments should play in different sectors especially the social ones. A loan from the World Bank in the mid 1990s aimed at enhancing the role of the Lebanese government. The role of health authorities has been evolving, along with the occurrence of political and administrative changes. The only public role that has been maintained since the Ottoman Empire is the one related to the protection of the environment and public hygiene. This role has increasingly developed in parallel with scientific progress and rising public awareness. Regulatory tasks have been introduced progressively, whereas the financing role has been gaining more importance with the weakening of the government's direct provider role.[27]

Under the Ottoman Empire the public authority that was till then responsible of hygiene measures, food and water safety and waste disposal, started providing medical services to security forces members, the prisoners and the

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[26] LeRoy Benett and James K. Oliver, *International Organizational Principles and Issues*, 274.

[27] Walid Ammar, *Health System and Reform in Lebanon*, 96.

indigent through the establishment of three public hospitals. By 1920, under the French Mandate, a health directorate was established as part of the Ministry of Interior and five additional hospitals were built. The municipality had to bear the financial cost of the treatment of the indigent in public hospitals. Influenced by the European social policy development after World War II, the health system moved slowly from the paternalistic ethos to that of health as a human right. In 1943, the year of independence and in the context of decentralization, the government started building regional hospitals. In the 1960s a government budget was allocated for public hospitals and for covering services provided by private hospitals under contracts with MOH. The MOH has been taking part in financing health services in the private sector for the sole purpose of equity.

During the 1970s public hospitals reached their peak. But the civil strife (1975-1991) caused the public facilities to degrade, while the private sector was blossoming. Most MOH activities were geared towards contracting with private hospitals in order to face emergencies, but the nature of the contractual agreement was such that the Ministry had little control over access and virtually no control over standards and costs. This was in fact a continuation of the policy of contracting-out which had already existed before the war. In contrast the private sector remained very dynamic through the war. For example 56% of the present private hospital capacity was created during the war years[28].

In 1994, the government began rehabilitating public hospitals and building new ones in an attempt to face critics that accused the government of favoring the

[28] Peggy Hanna, "Case Study on Government and Civil Society", 5.

rehabilitation of the physical infrastructure while neglecting health and social affairs. However, the declared official strategy was to contain cost to enhance the bargaining power of public funds and to lessen their dependence on private providers. In other terms, the Government's strategy for the development of the health sector focused on rehabilitating the public health system to enable it to deliver the basic services needed to meet the health needs of the poor population.

From 1995 until 1998 there was a lack of political commitment on the part of MOH to address major sector issues, especially with regard to the excess capacity of hospital beds in the sector, civil servants reform, contracting with private hospitals and the need to have a clear national drug policy. From 1999 to 2000, in light of the political changes in the country, the new Government embarked on a series of reform attempts including in the Health Sector. This was reflected in the establishment of an inter-ministerial committee with technical support to identify the main areas of health reform. From 2001 to 2003, a new Minister of Health was appointed and fully supported the implementation of major project components with a far-reaching national impact. This was translated in the cabinet adopting several ministerial decrees that allowed the adoption and implementation of several projects and measures in the areas of: hospital accreditation, Interconnecting of Database of Beneficiaries from the Public funds, the review of drug pricing and import, the engagement of a private TPA to manage the contractual relationship between public funds and the private and autonomous hospitals. [29]

[29] Ministry of Public Health, *Health Sector Rehabilitation Project-Project Evaluation Report,* (Lebanon, April 2004), 29.

The Ministry of health is trying to make proper use of its power as a major financer for most hospitals, in order to strengthen its regulatory role. As privatization expanded the government intervention has become more imperative. Many economists believe that government ownership results in economic inefficiency due to the politicization of economic decision-making. According to Raymond Dutch, "There is a relationship between political control and the performance of the public enterprise; the greater the control by the government, the lower the performance of the state-owned enterprise"[30]. In fact, many international agencies, including the World Bank, have been encouraging the private sector including NGOs to intervene more in health care, while governments were being advised to minimize their intervention in providing health services.

Over the years, the MOH has introduced innovative strategies and objectives, which led to changes such as the introduction of the autonomy for public hospitals, changes in the payment mechanisms for hospital services, interest in leading and regulating the overall health system development, development of the health information system, and the development and implementation of a hospital accreditation program. Even though no clear and formal policy decision has been made on the delivery system run by MOH, the trend towards increasing autonomy or any other form of reducing the direct involvement in the delivery of care is putting the onset on the contracting role of MOH. The major responsibility of MOH, at this point in time, is the management

[30] M.D. Raymond Dutch, *Privatizing The Economy,* (Michigan: The University Of Michigan Press, 1991), 3&59.

of large funds allocated to buy hospital services from private and autonomous public hospitals. [31]

In addition, MOH has increasingly asserted its role as a regulatory body in the health sector. Within the current MOH operational functions, there is little doubt that most of the concerns are focused, at the moment around one major issue: how to improve the contracting position for the purchasing of hospital care, especially in the private sector. The question of providing direct care is not very important because of the size and resources allocated for the purchased services. Lebanon is oversupplied with hospital beds and sophisticated equipment; there exists disparity between provinces. Up-to now over-investment has been justified by damaged health facilities. The lack of regulating mechanisms has allowed the private sector to grow in a very chaotic manner.[32] As a matter of fact, the Ministry of Health is currently considering more "institution-light" options. Contracts between financer and provider present a potentially available effective mean for regulation. It has the advantage of being based on a common understanding of concerned parties, and of being more flexible than laws, and easier to modify and adapt to changing circumstances. It is generally said that the one who has the money can set the rules. This puts a financer such as the MOH in a privileged bargaining position when negotiating contracts. However, money ownership is not enough to monitor and implement regulation policies. For that, the provider who possesses the information has a greater advantage over MOH.[33]

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[31] Ministry of Public Health, *Health Sector Rehabilitation Project,* 6.

[32] Ibid, 11.

[33] Walid Ammar, *Health System and Reform in Lebanon*, 99-100.

Finally one can conclude that during the fifteen years of independence (1943-1958), the ethos of care by the Government was "paternalistic", a favor to the less privileged. After that period and before the civil disturbances that started in 1975, the Government was moving into the ethos of health care as a human right. During the period of civil disturbances, the Government relied on the private sector to provide care for the traumatized population. After the war ended in 1990, the Government was essentially another financing public agency, since close to 80% of its budget is spent on the hospitalization of patients on its account in private hospitals.[34] Moreover, from its original role to provide care for the poor, the Ministry has evolved to be the safety net, to cover, in principle, the medical care of all the non-insured, and to promote access and equity.[35] Lately, the regulating role of the Government is more likely to be seen through the contracts taking place between the Government and the providers as well as the licensure, the inspection and the control the Ministry has in this field. "The healthcare system will be based on a partnership between the public and private sectors, facilitating coordination and complementarity between all of the health groups and institutions, on a stable and long term partnership".[36] In this field, a national strategy for health reform was elaborated. In addition, a meaningful step was made by the creation of the "Inter-ministerial Committee for Health Reform" in 1999. This committee, chaired by the Prime Minister, reflects the high level of political commitment. It consists of all Ministers concerned with health financing and human development: Finance, Social Affairs, Economy, Labor, Higher

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[34] Peggy Hanna, "Case Study on Government and Civil Society", 5.

[35] M.D. Nabil Kronfol, *The Lebanese Health Care System,* 4.

[36] Minister Soleiman Frangieh, *National Health Policy,* (Lebanon, August 1997)

Education and Health. A meaningful progress has been achieved in modernizing the institutional machinery of the MOH, including: the introduction of information technology in many departments, the automation of MOH financing functions, the empowerment of health district officers, and the strengthening of the Primary Health Care.

CHAPTER III

The World Health Organization in Lebanon

The Emergence of Specialized Agencies

The need for international action to cope with the many social and economic hazards threatening the welfare of mankind acquired increasing recognition by the peoples of the world, in the last two decades. Consequently, efforts were geared to create a number of international institutions each responsible in its field of competence for the promotion of the economic and social advancement of all peoples. International organizations began to develop to meet two separate needs: first, a general desire for peace and the growth of relations; second, a series of precise and limited objectives to meet specific cases. The former requires one international organization universal in scope and objective, and the latter can be met through several different organizations roughly classified under the economic, technical, social, humanitarian, military and political.[37]

The Economic and Social Council of the United Nations appointed a standing committee on February 16, 1946 to negotiate agreements with the United Nations, subject to the approval of the Assembly, for the establishment of Specialized Agencies responsible and accountable to the Council and have harmonious relationships with the United Nations system. The Specialized Agencies possess special roles in the economic and social field devoted to social

[37] Paul Reuter, *International Institutions*, 205.

progress and welfare, and economic development and prosperity. However, each agency has its particular responsibility, unique problems, and definite procedures for the attainment of the goals.[38]

The Birth of the World Health Organization

The origin and immediate motivation of the World Health Organization predates the United Nations Organization. "The Geneva –based League of Nations, during its short history between World War I and World War II, had been the first to invoke international health cooperation to deal with many kinds of health problems; This was reflected through the "Health Organization" of the League of Nations. In the same period, the pan American Sanitary Organization, originally established in 1902, continued to work in its own geographic sphere, and became successively the Pan American Sanitary Bureau, and now the Pan American Health Organization (serving as WHO's Regional Office of the Americas)".[39]

The critical period in the evolution of International Public Health came at a time when the governments and peoples of the world were not only animated by the will to rebuild world peace on firm foundations, but also confident that science would provide them with the means to do so. In fact, "in 1945, when the war ended, a United Nations Conference on International Organization meeting in San Francisco unanimously approved a proposal by the delegations of Brazil and China that an international conference should be held to establish an international

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[38] WHO, *The First Ten Years of the World Health Organization,* (Geneva, 1988), 33.

[39] WHO, *WHO What It Is What it does,* 1.

health organization. That conference approved the Constitution of the World Health Organization in July 1946. Thus began the single, universal health organization that had been visualized almost 30 years before. However, the constitution did not come into force until 7 April 1948".[40]

In order to understand the full scope and nature of the World Health Organization, it is useful to examine it in detail to learn the nature of its functions, structure, and the range of its activities.

Scope of Activities, Aims and Functions of WHO

The World Health Organization is a public international organization and a specialized agency of the United Nations with headquarters in Geneva, Switzerland.[41] The World Health Organization (WHO) was established in 1948 by 61 governments or member states "for the purpose of cooperation among themselves and with others to promote the health of all peoples"[42]. The number of Member States has grown to 190. WHO achieves its activities through three principal bodies: the World Health Assembly, the Executive Board and the Secretariat. WHO maintains official relationships with more than 184 International Non-Governmental Organizations. WHO collaborates also with a network of national research centers and scientific institutions to pursue international goals and support WHO programs at all levels.[43] All countries which

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[40] WHO, *Introducing WHO,* (Geneva, 1996), 11.

[41] www.icann.org/tlds/health1/WHO-C-SO-Proposal.htm

[42] WHO, *Introducing WHO Lebanon,* (Lebanon: WHO Office, 2002), 1.

[43] Ibid

are Members of the United Nations may become Members of WHO by accepting its Constitution.

WHO's responsibilities are dictated by its constitution that sets "the attainment by all people of the highest possible level of health[44]" as the ultimate objective. "Health is defined by the WHO constitution as a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity. Health is seen as a shared responsibility, calling for a high degree of self-reliance from the individual, the family, the community, and of course the nation as a whole the efforts of the health sector must be supported and augmented by those of many other related sectors, including agriculture, water and sanitation, finance, planning, communication and education."[45] The constitution of WHO also specifies that WHO's role is to act as the directing and coordination authority in International Health. WHO's tasks range from eradication of diseases, improving aspects in environmental health, establishment of international norms and standards of biological vaccines and pharmaceutical products, and provision of support in health emergencies. WHO promotes and conducts research and works to foster cooperation among scientific and professional groups for advancement of health. In 1981, a new dimension was added by the adoption of the Global Strategy for Health for All and its implementation through Primary Health Care set forth by the Alma Ata Declaration of 1978. All governments were called upon to formulate national policies, strategies and plans of action to launch and sustain primary health care as

[44] WHO, *Introducing WHO,* 16.

[45] http://www.emro.who.int/lebanon/AboutWHO.htm#1

part of a comprehensive a national health system that will allow all citizens to attain a level of health permitting them to lead a socially and economically productive life. The challenge which WHO faces is: Achieving Health for All.[46]To conclude WHO has four main functions:

1. Give worldwide guidance in the field of health
2. Set global standards for health
3. Cooperate with governments in strengthening national health programs
4. Develop and transfer appropriate health technology, information and standards[47]

Structure of the World Health Organization

WHO has approximately 6000 staff worldwide, based at headquarters, the six regions, and in countries. A characteristic feature of WHO is its decentralization into six regions, each consisting of a Regional Committee and a Regional Office. A Regional Director heads the Regional Office. In the region of the Americas, The Regional Director is also the Director of the Pan American Health Organization (PAHO). The Regional Offices are responsible for formulating policies of a regional character and for monitoring regional activities. They are knowledgeable and acquainted with the technical cooperation programs, the management of the offices and the understanding of the political dimensions in the region. In most countries, there are resident WHO Representatives (WRs), who are responsible for WHO's Technical and Management activities in the

[46] Ibid
[47] WHO, *Introducing the World Health Organization Representation in Lebanon*, 3.

country, and who support the government in the planning and management of the national health programs. The WR is also acquainted with the governing process as well as the political system of the country. The Offices of the World Health Organization are:

- Headquarters (Geneva, Switzerland)
- WHO Regional Office for Africa (Harare, Zimbabwe)
- WHO Regional Office for the Americas/Pan American Sanitary Bureau (Washington D.C, USA)
- WHO Regional Office for the Eastern Mediterranean (Alexandria, Egypt)
- WHO Regional Office for Europe (Copenhagen, Denmark)
- WHO Regional Office for South East Asia (New Delhi, India)
- WHO Regional Office for the Western Pacific (Manila, Philippines)
- International Agency for Research on Cancer (Lyon, France).

The WHO Secretariat is staffed by some 3,800 health and other experts in both professional and general service categories, working at headquarters, in the six regional offices and in countries. The Secretariat is headed by the Director-General, who is appointed by the World Health Assembly on the nomination of the Executive Board. The constitution of WHO provides for the basic structure of

the agency which is composed of three organs designed to carry out the work of the organization[48]. These are:

1. The World Health Assembly: WHO's supreme decision-making body is the World Health Assembly. The Assembly is held, usually in Geneva, in May each year, and is attended by delegations from all Member States. Its main tasks are to approve the biennial program budget, and to decide on major policy matters. The Health Assembly also elects the Director General, supervises the financial policies of the Organization, approves the proposed program budget, and reviews the reports of the auditors. In addition, it considers reports of the Executive Board, requesting it to take further follow-up action on pertinent issues.

2. The Executive Board: It is composed of 32 individuals technically qualified in the field of health, each one designated by a Member State elected to do so by the World Health Assembly. The main functions of the Executive Board are to give effect to the decisions and policies of the Health Assembly, to advise it and generally to facilitate its work.

3. The Secretariat: It is headed by the Director-General who has the responsibility of preparing and submitting annually to the Board the financial statements and budget estimates of the organization. The Secretariat is staffed by around 3500 health experts, other experts and

[48] www.icann.org/tlds/health1/WHO-C-SO-Proposal.htm

support staff working on fixed-term appointments, at the headquarters, the six regional offices and country offices. The work of the Secretariat includes technical, advisory and administrative services.[49]

The Regional Office for the Eastern Mediterranean (EMRO) includes: Afghanistan, Bahrain, Cyprus, Djibouti, Egypt, Islamic Republic of Iran, Jordan, Kuwait, Lebanon, Libyan Arab Jamahiriya, Morocco, Oman, Pakistan, Qatar, Saudi Arabia, Somalia, Sudan, Syrian Arab Republic, Tunisia, United Arab Emirates, and Yemen.[50]

WHO in Lebanon

Lebanon is an active member of WHO since it became party to its constitution on 19 January 1949, only few months after WHO constitution was adopted. A resident WHO Representative, currently Dr. Habib M. Latiri, a Tunisian, heads the Lebanon WHO Country Office and works closely with the national authorities for formulation and implementation of adapted health policies and strategies and coordinates international health work. The collaborative programs are prepared in conformity with the WHO general program of work which fixes goals and targets for global health actions. Among WHO's contributions to advancement of health in Lebanon we can cite the eradication of malaria declared in 1964 as a major achievement. In addition, through collaborative efforts, remarkable progress has been made in immunization and polio eradication. WHO has played a major role in the dissemination of Primary

[49] Ibid

[50] WHO, *Introducing the World Health Organization Representation in Lebanon*, 6-7

Health Care concepts and in system establishment through development of the National Primary Health Care strategy and action plans, preparation of needed human resources for health through fellowships and training. WHO has been very active in raising public awareness on matters of health and has assisted in launching important and successful health promotion and disease control programs such as in HIV/AIDS, zoonoses, cancer, diabetes and other non-communicable disease control programs.[51]

For several years, the WHO Representative Office (WRO) has been active in Lebanon to serve the health and well-being of the Lebanese people, in support of the Lebanese health authorities, and in cooperation with the private sector as well as other UN agencies. In addition to its regular budget, the Lebanese government provides WHO-Lebanon with a trust fund to manage six national health programs which are: The National Non-Communicable Diseases Program, The National AIDS Program, National Tobacco Control Program, Primary Health Care, Injury Prevention, and Drug Management. The total amount of the trust fund is about USD 400,000 per year. However, it may vary based on the Ministry of Health (MOH) yearly budget. In recent years, public health in Lebanon continued to recover in several aspects from the sequels of the civil war. The infant mortality rate and life expectancy, which had been sliding during the 1980s, are improving again. At the same time however, evidence is emerging of inconsistent immunization coverage across all Lebanese areas. In 2002 unleaded

[51] http://www.emro.who.int/lebanon/AboutWHO.htm#1

gasoline became widely available and affordable in the country, thus contributing slightly to reducing the atmospheric pollution due to traffic exhaust fumes.[52]

A decision of the Lebanese government in the spring of 2002 to limit the use of diesel motor vehicles had a similar positive effect. Nevertheless, several reports from specialized agencies indicate that the levels of pollution and other environmental problems threatening the health of the Lebanese have reached alarming levels. Other unsettling news came from development agencies who have been reporting a decline in the proportion of children receiving school education for the first time in the modern history of Lebanon. Such a decline, if sustained, can affect the human development of Lebanon and will necessarily have adverse effects on health.[53]

In 2002, activities continued in all WHO-Lebanon's programs and departments. The main activities provided by WHO fall under the following categories:

1. Support of training, communication and education campaigns to promote health and prevent disease.

2. Setting up surveillance systems as needed, using various components such as running national surveys, establishing disease registries, building up a sentinel system to monitor changes in risk factors and disease incidence over time.

3. Provision of information and expertise as needed in situations of health emergencies.

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[52] WHO, *Annual Report 2002, WHO Representative Office*, (Lebanon: WHO Office, July 2003), 1-6.

[53] Ibid

4. Promotion and support of health research needed for needs assessment leading to evidence-based health decision-making and for the evaluation of policies and programs.

The following activities are being carried out in cooperation with the WHO Regional Office (EMRO) and through a number of national programs. Programs include:

1. The National AIDS Control Program (NAP).

2. The National Non-Communicable Diseases Program (NCDP) which plans and manages NCD surveillance, registries and training activities.

3. The Tobacco Control Program which had been focusing on activities leading to Lebanon's signing of the WHO-sponsored International Framework Convention on Tobacco Control.

4. A Basic Development Needs (BDN) was initiated primarily in Akkar.

5. The Drug Dispensing Center (DDC) where drugs for serious diseases such as cancer and multiple sclerosis are dispensed to uninsured needy citizens free of charge.

Other activities have included:

1. The launching of an accident and injuries prevention initiative.

2. Support for the Capacity Building Nursing Center in El- Khyam.

3. School health and environmental education activities.

4. Coordination and administration of large national survey/research programs.[54]

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[54] Ibid

Collaboration between WHO and MOH

In view of the current phase of global rehabilitation of the public health sector, WHO main lines of action were designed to respond to the pressing need for an immediate and sustained support in 3 major identified priority areas:

- Rebuilding of national capacities in health management, planning, supervision and situation assessment.
- Control of public expenditures in favor of budgetary reallocation for Primary Health Care (PHC), health prevention and promotion.
- Development of a national strategy for Primary Health Care in collaboration and coordination with different sectors, international organizations and NGOs.

Cluster programs were identified to support building up MOH infrastructure and the reestablishment of the different technical units at the Ministry with particular emphasis on strengthening the planning and management capabilities as well as epidemiological surveillance capacities, personnel management, costing of health care and the financing of the health system. During the past years, WHO provided technical and financial support to national activities such as meeting to draw up policies and strategies, the orientation of decisions-makers and health workers, and assistance in identifying research priorities and strategies. Various short term consultants were sponsored by WHO in the field of information system, epidemiological surveillance system, health financing, planning and coordination for strengthening the managerial capacities of MOH.

Training was provided through fellowships abroad, and national training and workshops for health workers from the public and the private sector.[55]

WHO is providing direct technical, administrative and financial support to the various programs under WHO/MOH joint collaborative programs (JPRM) and others established by the MOH under cost sharing mechanism (trust fund) to improve the health status of the Lebanese population and strengthen the management and system of the health sector. Furthermore, extra budgetary resources from the World Bank, AGFUND, UNAIDS and others are also made available for the development and implementation of programs. WHO is also developing new programs to tackle health related issues such as mental health, rehabilitation services, health of the elderly, women health and adolescent health. [56]

The most important achievement of MOH-WHO collaboration has been the preparation and elaboration of the Primary Health Care strategy in 1993 which calls for a multisectoral participation -- community, NGOs, and professional associations-- and ensures coordination of bilateral and international assistance. This strategy has been developed and referred to several times through this study as the basis of the national health system. WHO continued to promote and support health research and technology development in accordance with its policies and in response to the health problems in Lebanon. It has taken several initiatives in furthering research intended to solve health problems and contribute to the implementation of the MOH programs. These research projects were conducted

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[55] Peggy Hanna, "Case Study on Government and Civil Society", 29-30.

[56] http://www.emro.who.int/lebanon/AboutWHO.htm#1

by the public as well as the private sector. Furthermore, important technical support was given by WHO to various operation in computerization and survey through contracting a national computer programmer/statistical technician. This has proven to be a successful step as it ensured proper monitoring, adequate supervision and follow up, and coordination between WHO and MOH.[57] Last but not least, WHO has also been called upon as a technical advisor for most MOH independent and joint programs, and its role has been highlighted all through this document as a highly specialized and efficient partner in most MOH-NGO partnerships .

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[57] Peggy Hanna, "Case Study on Government and Civil Society", 29-30.

CHAPTER IV

The National AIDS Control Program

Symptoms of Change: HIV/AIDS Infection

No disclose, so far, has rivaled HIV/AIDS in destructive power. HIV/AIDS appeared at a time when many experts were confident that modern medicine was well on its way to defeating infectious diseases. One by one, disease agents were being identified and dissected, down to their genetic codes. Vaccines and antibiotics were steadily knocking-out these age-old enemies. When the first reports of a rare and deadly form of pneumonia appeared in a small medical journal in 1981, no one could have guessed the scope of the pandemic to come. As the pandemic exploded, researchers for the first time began to look seriously at the conditions that drive the emergence of new diseases. Their conclusions were deeply troubling. Despite the astonishing technological advances that medical science has made in the past half century, we may actually be more vulnerable to the emergence and spread of new diseases than ever before. In many ways, the modern world aids and abets disease agents, making it easier than ever before for them to evolve and spread with deadly speed.[58]

Far from being subdued, infectious agents remain major killers. Worldwide, six infectious illnesses (influenza, HIV/AIDS, diarrheal diseases, tuberculosis, malaria, and measles) account for almost half of all deaths between birth and age 44.[59]

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[58] Karen Kasmauski and Peter Jaret, *Impact From the Frontlines of Global Health*, 48.

[59] Ibid, 53.

HIV induces a disease of impoverishment of the immune system leading to major infections and malignancies, both pathologies that have always exacted heavy tolls on mankind and have been associated with a trail of fear and political decisions. The epidemics of HIV/AIDS have become linked to an alarming vicious circle. The major elements in this cycle include poverty and ignorance or poor education. It is striking to discover in the beginning of the third millennium, in the era of globalization and the supreme power of communication, in the era of worldwide networks of information, an increase in the numbers of the extremely poor and of the illiterates. These two scourges go along in the spread of diseases. Poverty leads to ignorance and vice versa. Poverty and want are associated with commercial sex work, with the replacement of unfulfilled dreams by the search for the artificial heaven of drugs. Ignorance is associated with poor understanding of modes of prevention and to the lack of access to adequate information. The consequences of commercial sex, substance abuse and HIV disease are more rejection from society, more rejection from the work place and therefore to more poverty and more ignorance.[60]

Over the past two decades, HIV/AIDS has emerged as one of the worst infectious diseases in modern history. The epidemic spread with devastating effects in Africa and is now threatening to spread with equal force in the Russian Federation, India, China, and many other transition economies around the world, including the countries in the Middle East and North Africa (MENA) region.[61]

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[60] WHO, "HIV/AIDS Statistics in Lebanon to Date," *Health for All,* Issue No.58, Oct-Nov-Dec 2005, 13.

[61] The World Bank, *Preventing HIV/AIDS in the Middle East and North Africa: A Window of Opportunity to Act, A Synopsis of the World Bank Regional Strategy 2005*

HIV/AIDS infection has a number of characteristics that make it a particularly devastating disease for the human population. It typically strikes people of working age, as well as those of child-bearing and child-rearing age. Consequently, the spread of disease leads to the loss of skilled and unskilled workers, the main breadwinners, and caretakers of the family. The high morbidity and mortality rates among these groups can seriously undermine the social and economical foundation of a nation.[62]

HIV/AIDS epidemic is also difficult to contain and control because the infection often remains invisible in a population for a long period. HIV (human immunodeficiency virus) infection typically stays hidden over an incubation period of five to eight years before the disease manifests itself in the form of acquired immune-deficiency syndrome (AIDS). Another for the difficulty in detecting this disease is that in the early stages of the epidemics, the HIV infection tends to be concentrated in a small number of high-risk groups who frequently face social stigma and are therefore difficult to identify and to provide with prevention, care, and treatment services. These high-risk groups include injecting drug users (IDUs), males who have sex with males (MSM), commercial sex workers and their clients, prisoners (who are often drug users), and patients with sexually transmitted diseases (STDs). In the absence of an effective surveillance system and prevention programs, HIV infection can spread silently from one group to another. Once the infection spreads to the general population, the

[62] Ibid

transmission rates will rise exponentially and an HIV/AIDS epidemic will be difficult to avoid. [63]

"HIV/AIDS, through its impact on mortality and morbidity and the resulting demographic changes, affects all levels of an economy and society, from individuals and households to small and large businesses to the different levels and activities of government."[64]

Lebanon and HIV/AIDS

The first patient with HIV/AIDS in Lebanon was diagnosed in 1984. He was a heterosexual male who had lived in a high prevalence area outside the country.[65]

Since then, the number of cases has been slowly but steadily increasing to reach, by December 2001 a total of 650 HIV/AIDS cases. Although a significant number of reported cases is linked to travel and migration to endemic areas, (around 48.3% of the cases) local spread has become a reality over the past few years (around 51.7% of the cases). The most frequent mode of transmission is sexual (69.8% of all cases, namely heterosexual: 52.8% of all cases) which is increasing, consequently, the vertical transmission (mother to child) of the disease (3.8% of all cases declared). Data on high risk groups (Intravenous Drug Users,

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[63] Ibid

[64] M. Haacker, *The Macroeconomics of HIV/AIDS*, (Washington, D.C: International Monetary Fund, 2004).

[65] Dr Emile Fox, *HIV Surveillance in Lebanon, Assignment Report,* (Beirut, June-July 1993).

Prostitutes, Prisoners), is incomplete, although the problem does exist. Blood Safety is relatively well controlled in the country.[66]

Since 1990, AIDS and HIV infections are notifiable to the Ministry of Health through its National AIDS Control Program (NAP). Confidentiality of infected individuals is assured. This reporting by physicians has been unsatisfactory so far. In fact, physicians often have lost a positive attitude towards disease reporting and their compliance to notifying AIDS cases remains very poor[67]. No new cases of HIV/AIDS infections through blood transfused in Lebanon have been reported since 1993. The vast majority of the blood transfusion borne infections (actually around 7.8% of all cases) was acquired in the early years of the spread of the epidemic, with most of the patients receiving multiple transfusions prepared or donated outside Lebanon. The higher number of cases is in the age group 30-44 years old, with a ratio of men/women close to 3.8/1. The increasing number of women infected is concordant with the mode of transmission (mainly heterosexual).[68]According to the World Health Organization's Selected Morbidity Indicators, 30 new HIV/AIDS cases were reported in 2002.[69]

As illustrated in table 1 below, the number of infected adults in Lebanon with ages varying from 15 to 49 years old has reached 2800 cases in 2003.

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[66] http://www.public-health.gov.lb/aidsprogram.shtml

[67] Dr Emile Fox, *HIV Surveillance in Lebanon.*

[68] http://www.public-health.gov.lb/aidsprogram.shtml

[69] http://www.emro.who.int/lebanon/Countryprofile.htm#morbidity

Table 1: HIV/AIDS in Lebanon

Adults age 15-49 with HIV/AIDS, 2003	**2,800**
New HIV infections, 2004	**nd**
Adult HIV prevalence (%), 2003	**0.1**
Women age 15-49 with HIV/AIDS, 2003	**<500**
Children with HIV/AIDS, 2003	**nd**
AIDS orphans (ages 0-17), 2003	**nd**
AIDS deaths, 2003	**<200**

nd = No data

Source: UNAIDS[70]

In 2005, new statistics were published regarding HIV/AIDS with the following data:

- Cumulative total number of reported HIV/AIDS cases: 903.
- Almost one fourth of cases are already AIDS cases when first reported.
- 81.72% are males and 17.82% are females.
- 52.15% are within the age group 31-50 years of age, compared to 57.7% in 2004.
- 51.38% had no travel history.
- Modes of transmission: sexual (76%), transfusion (6%), Intravenous Drug Users: IDVU (5%), and perinatal (2%).[71]

[70] http://www.unaids.org/bangkok2004/report.html
[71] WHO, "HIV/AIDS Statistics in Lebanon to Date," 7.

Statistics on Sexually Transmitted Diseases (STD) are unavailable. Also, no data exists on premarital and extramarital sexual relations as well as data on prostitute use. Prostitution is legal in Lebanon, but in recent years no new licenses for bars have been issued. Before the war, prostitutes were clustered in well-known areas of Beirut. However, all licensed bars in Beirut were destroyed during 1975-76. Since then, prostitutes and bars have become scattered all along the coastal region. The extent of male prostitution is not known. Homosexuality is illegal in Lebanon and this high risk behavior group lives underground. In conclusion, Lebanon presents some unique general features of interest to the HIV/AIDS epidemic. In particular, many Lebanese reside abroad in high HIV prevalence areas. The practice of transfusing untested blood was common during the 17 years of internal war. [72]

Lebanon is still one of the countries with low prevalence in HIV/AIDS. Most of the data on HIV/AIDS in Lebanon is based on active reporting. Infections among persons with no travel history are also on the rise, hence confirming an increase in local transmission. Infections among the vulnerable groups are at stable rates and the age distribution is shifting towards the younger age groups. There is no clear trend in terms of the socio-economic status of the infected or those living with the disease. Among those who reported their profession, HIV/AIDS has affected equally highly recognized professions (medical and paramedical, engineering, teachers) as well as skilled and unskilled laborers. One thing is certain, that the epidemic is mostly prevalent among the male population in Lebanon.[73]

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[72] Dr Emile Fox, *HIV Surveillance in Lebanon.*

[73] WHO, "HIV/AIDS Statistics in Lebanon to Date," 6.

The Collaboration between MOH and WHO: the National AIDS Program (NAP)

1-History

Dealing with HIV/AIDS is the most challenging public health problem that has ever been faced by humanity. Over the past 25 years, communities at large and particularly the medical community had to review many issues pertaining to human rights and patients' role in care related decision making. Although many a subject has evolved over the centuries, we have had to rediscover and to understand stigma and discrimination. Communities and leaders had to face up to their fears. Since the beginning, the World Health Organization has been the leader of the battle against HIV/AIDS. Along with its partner agencies in the UNAIDS theme groups, it helped developing prevention programs and educational activities. Its experts have also been spreading the messages of human rights and reduction of poverty and illiteracy. Many guidelines, workshops, and seminars helped in educating health care workers on proper infection control measures, treating and supporting infected individuals and encouraging clinical and scientific AIDS research. [74]

Support for AIDS awareness programs is also offered by various United Nations agencies, the World Health Organization, the Health Ministry and the Social Affairs Ministry. Joint efforts have helped to promote various activities,

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[74] Ibid, P.12-14

including community-based intervention, production of awareness material and organization of large youth meetings.[75]

As a national response to the slow but steady spread of the HIV epidemic, the MOH declared that HIV/AIDS is a serious public health danger. Accordingly, the National AIDS Control Program (NAP) was founded in 1989.[76] Since then, the Government of Lebanon has provided the NAP with the full political and financial support needed to carry out education and awareness activities among the general population and later on expanding into care and support including providing antiretroviral therapy to eligible patients. The Government of Lebanon being aware of the growth of the epidemic worldwide despite all the efforts made internationally to curb the epidemic is also acknowledging that HIV/AIDS could emerge as a primary threat to the growth and development of Lebanon in a few years based on the existence of risk factors for the disease in the country.[77]

It operates through a MOH trust fund at WHO. It is technically and administratively supported and supervised by WHO. Three advisory committees support the NAP on issues related to HIV, at the level of national policies and strategies, as well as at the level of technical assistance: the National AIDS committee, the Technical Committee, and the Information, Education, Communication Committee.[78]

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[75] http://www.dailystar.com.lb

[76] WHO, *Introducing the World Health Organization Representation in Lebanon*, 16.

[77] WHO, *Report of the Joint Government/WHO Programme Review and Planning Mission.*

[78] Peggy Hanna, "Case Study on Government and Civil Society", 55-56.

The Lebanese Government has been very supportive through representatives of various ministries in the National AIDS Committee, created in 1993 by a ministerial decree. The National AIDS committee advises on strategies and policies to adopt in the National response to the epidemic. So far sectors such as the Ministry of Education, Ministry of Interior , Ministry of Social Affairs, Ministry of Migrants, Ministry of Law, Ministry of Defense, Ministry of Labor... as well as the private sector and certain active NGOs have been represented in the National Committee and actively involved in NAP activities planning and implementation.[79]

2-Goals of NAP

- Promotion of prevention measures and safer sexual behavior to limit the spread of HIV epidemic and Sexually Transmitted Infections.
- Reduction of health and social impact of the HIV epidemic.
- Identification and mobilization of local and external resources to be used in the fight against the HIV epidemic.[80]

3-Objectives of the midterm work plan of NAP

- Prevention of HIV transmission
- Prevention of sexually transmitted diseases (STD)
- Encourage and support community participation in HIV prevention

4-Strategy

[79] Ibid

[80] WHO, *Introducing the World Health Organization Representation in Lebanon*, 16.

- Multisectoral approach to the AIDS epidemic, which necessitates the involvement of all concerned authorities in various sectors such as education sector, interior forces, and universities.
- Reinforcement of NGOs role through their representation in various committees and technical and financial support of their community based activities.
- Adoption of operational research as a basis for planning priority interventions.
- Adoption of the integrated approach in order to ensure sustained and continued activities on Prevention, Education, and Patient Support.[81]

4-Target Group

- Youth at schools and universities
- Women
- Migrants
- Foreign Workers
- Prisoners
- Armed Forces
- Sex Workers: Prostitutes, artists, dancers, bar girls
- Drug Users
- General population

5-Project implementation, execution and monitoring

In view of the diversity of the Lebanese communities and the privatization of most services including the health related services, and considering the poor

[81] Ibid

infrastructure of the governmental sector which is currently being reinforced, community participation has been a cornerstone in implementing NAP activities. A large network of NGOs has been mobilized, closely cooperating and operating with NAP. Special training and workshops for various NGOs representatives and field workers on health education have been conducted so far. The NAP is currently closely coordinating with around 35 NGOs, some are specialized like scouts for youth, SIDC (Soins Infirmiers et Developpement Comunautaire) for home based care, Dar el Amal for sex workers, Lebanese Aids Society for patient support; others have activities restricted to certain communities, all over the country[82].

The NAP is collaborating with the Ministry of Education to integrate HIV/AIDS in school curricula, a project that necessitates a lot of efforts and time. Meanwhile efforts are focused on the development of educational material to support the teaching of HIV in schools. A study conducted in 1994, revealed an important lack of awareness, inaccessibility of prevention means, and frequent unsafe practices. Efforts with specialized NGOs are focused on increasing awareness and behavior changes for a better protection, as well as accessibility of prevention means. As for paramedical professionals, the study revealed pitfalls in knowledge, attitudes and practices. Accordingly, several workshops have been implemented by NAP for health centers, private as well as public. Efforts are also focused on integrating HIV/AIDS into all paramedical schools curricula.[83]

A situation assessment was done in 1993 by a special WHO mission on blood transfusion safety. Efforts were also displaced by the International

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[82] http://www.public-health.gov.lb/aidsprogram.shtml

[83] Dr Emile Fox, *HIV Surveillance in Lebanon.*

Federation of Red Cross, in collaboration with the Lebanese Red Cross, NAP as well as the private sector for HIV screening of transfused blood and blood products. As for sexually transmitted diseases, little is known about the extent of the problem in the country. A consultancy mission was conducted by WHO on STD assessment in 1994. A project for clinical research to assess the prevalence of STD's as well as a project for a behavioral study concerning STD were proposed by the consultant in 1994, but not implemented due to lack of resources. Data are reported by treating physicians, laboratories, and blood banks. Analysis of the data is done through a special computer program adopted by WHO which ensure updated information about the prevalence of the disease in Lebanon.[84]

Training sessions have been conducted to improve health workers skills in HIV/AIDS management, targeting more than 600 persons from various sectors: nurses, lab technicians, health educators in NGOs, Qada doctors, head of public hospitals, laboratory doctors.35 conferences and workshops have been organized targeting about 35 institutions. Media campaigns have been launched including TV spots, radio and press ads. Educational material has been developed of in collaboration with NGOs (pamphlets, audiovisual material, posters...) addressed to targeted groups as well as general population. NAP intensively collaborates with a specialized home care NGO, which started home services for AIDS patients since 1991, the SIDC. Recently this group established a hot-line for giving support and information.[85]

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[84] Ibid

[85] Peggy Hanna, "Case Study on Government and Civil Society", 57-60

Technical and financial support has been given constantly by WHO. Consultancy missions were regularly conducted for planning, implementation and review of national programs and fellowships for external training was also continuously provided. Financial support was provided for priority activities, including health education, surveillance, blood safety, and STD control.[86]

6- Achievements

The NAP continues its efforts to prevent the spread of HIV/AIDS through implementing, monitoring, and evaluating the activities of its work plan on a yearly basis. In addition to awareness campaigns, NAP initiated a number of new activities: development of educational materials, implementation of AIDS/HIV workshops, and support for research projects. NAP continued building alliances with stakeholder, contributing to capacity building and resources mobilization, and fostering better support and care for people with HIV/AID, and their social networks. NAP shares experiences with local, regional and international organizations. Thus, NAP successfully participated in the Rapid Access to Drug Initiative, eventually finalizing deals with the different pharmaceutical companies to provide Anti-Retroviral Drugs at lower costs in Lebanon. The need to review the strategic plan for the NAP was sensed. Therefore, different steps were taken accordingly to ensure technical and financial support to realize a new updated strategic plan; thus permitting the NAP to tackle more effectively and efficiently this public health problem.[87]

The treatment for HIV/AIDS here averages $1,500 per month. Although the Health Ministry and the National Social Security Fund attempted to provide

[86] WHO, *Annual Report 2002, WHO Representative Office,* 7-10.
[87] Ibid

the funding, the financial resources they have are not always enough. In 2003, the Health Ministry signed a deal with a pharmaceutical company to save at least $1 million a year in prescription costs by providing AIDS treatment drugs at 15 percent of the market rate. The pharmaceutical company in question - Merck Sharp and Dohme (MSD) - included Lebanon in the company's "Facilitating Accelerated Access" initiative for HIV/AIDS patients. The initiative was a cooperative endeavor by the United Nations AIDS agency, the World Health Organization, the United Nations International Children's Fund (UNICEF) and the UN Population Fund (UNFPA). About 90% of the reported HIV/AIDS cases are covered by the Ministry of Health.[88]

Till now, the NAP has proven its leadership role in advocating national policies, defining strategies and planning for government and community response to the epidemic. It succeeded in ensuring partnership with UN agencies mainly WHO, bilateral organizations, community based groups, the private sector and the academic institutions. The NAP is actually considered as the source of technical assistance and information for planning, implementing monitoring as well as evaluating activities in relation to HIV/AIDS. The intensive and efficient collaboration of the NGO's has greatly contributed in the national efforts to limit the spread of the HIV epidemic. This collaboration has been very productive so far, and allows the NAP to use resources at grass root level and reach out for a large number of the population, mainly in peripheral areas, taking into account the particularities of the community addressed. The NAP program has gained important political support and HIV control figures on the list of priorities of the

[88] http://www.dailystar.com.lb

MOH. Important community and media participation has been demonstrated in all care and preventive strategies and action of the NAP.[89]

7- Failures and Limitations

Only a quarter of Lebanon's estimated 2,500 HIV sufferers are receiving treatment for the disease. According to Dr Jacques Mokhbat, head of the medical team that discovered the first case of AIDS here in 1984, only 697 HIV patients were in treatment programs. In other terms, only a quarter of Lebanon's estimated 2,500 HIV sufferers are receiving treatment for the disease. These are the people who actually came forward seeking medical attention, but the largest majority of the cases - 2,500 in all - remain unknown. Mokhabt believes Lebanese society still has a lot to understand about HIV/AIDS, its modes of transmission and its burden in relation to Lebanon and to the rest of the world. This is why awareness campaigns such as World AIDS Day (Dec. 1) are necessary to compensate for the lack of progress in Lebanon when it comes to the treatment and the prevention of the killer disease because HIV awareness is still rudimentary in this country.[90]

Another serious obstacle to the prevention against HIV/AIDS is a socio-cultural one: ethics and AIDS prevention do not go hand in hand in Lebanon although Lebanon was one of the first countries in the region to acknowledge the threat of AIDS and to formulate a national multi-factorial response based on strong cooperation between the public and private sectors. Because of the conservative nature of Lebanese society and the reluctant attitude on the sexual connotations of AIDS, posters promoting safer sex and the use of condoms here

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[89] Peggy Hanna, "Case Study on Government and Civil Society", 57-60.
[90] Jessy Chahine, "Majority of AIDS sufferers are not receiving treatment," *Daily Star,* 1 December 2004.

have been rarely produced. Furthermore, allegations that many - if not all - AIDS patients in the country are automatically dismissed from their jobs once diagnosed as HIV-positive are increasingly on the rise. There is no support for AIDS/HIV patients in the Arab World. Social Security is an example of this, as it does not cover any AIDS/HIV cases. Moreover, many people are too "embarrassed" to take an HIV test, despite the guidelines which guarantee professional secrecy and confidentiality for the individual, regardless of the test and its result. A standard HIV test can be performed in most medical laboratories. If the result is positive, it is advised to have the test repeated in a large hospital laboratory. [91]

[91] Ibid

CHAPTER V

The Non-Communicable Diseases Program: Cancer

Introduction

By convention, the term "non-communicable" diseases (NCDs) refer to major chronic diseases inclusive of cardiovascular diseases, diabetes, cancer and chronic respiratory diseases and their risk factors. The chronic conditions of musculoskeletal diseases have also been grouped alongside as country requirements.[92] Non-communicable, often preventable diseases are expected to become ever-increasing health problems in the decades to come, according to several studies. Risk factors such as high cholesterol, obesity, inactivity and smoking are all behaviors that can bring on non-communicable diseases, and they are all behaviors that can be changed with proper education and public health initiatives.[93]

Non-communicable diseases are increasing at serious alarming rates in the world nowadays. In particular, cancer is considered to be a life threatening disease: 10 million new cases occur each year with more than half of these taking places in the developing countries. From here rises the importance of discussing this disease not from a medical perspective but an analysis of the cycle of controlling cancer in our country.[94]

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[92] WHO, *Report of the Joint Government/WHO Programme Review and Planning Mission.*

[93] http://www.emro.who.int/lebanon/nationalprog-ncd-background.htm

[94] WHO, *Report of the Joint Government/WHO Programme Review and Planning Mission.*

Cancer is used to describe more than 100 different malignant tumors in different sites of the body.[95] By definition it is the "failure of the mechanisms that regulate normal cell growth, proliferation and cell death"[96] . Eventually the tumor progresses from mild to severe abnormality with the harm invading neighboring tissues and extending to reach other areas of the body. Cancer occurs as a result of the individual's exposure to carcinogenic substances. The environment in which we live, the tobacco-use and dietary styles, components of the life style we undertake as humans, are the major contributors to the development of cancer. In addition, Cancer occurrence is related to social and economic status. In fact, Cancer is highest among less educated and poorer groups.[97]

While a decade ago, fighting communicable diseases was the main target of ministries of health and health related organizations, nowadays non-communicable diseases are increasing at alarming rates. Each year, 10 million new cases occur around the world, with 5.5 million of these existing in the developing countries.[98]

Approaches in dealing with this disease in particular, and non-communicable diseases in general, are becoming of major importance nowadays, whether coming from public or non-governmental initiatives. And while National Cancer Control Programmes are being implemented in developed countries, developing countries are still lagging behind.

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[95] www.emro.who.int/Lebanon/ncd/cancer2002.pdf

[96] Ibid

[97] WHO, *Introducing WHO,* 29.

[98] www.emro.who.int

In Lebanon, few epidemiological studies have been done over the years[99], while no studies have assessed the implications and effect of cancer in Lebanon. On the other hand, while several actions took place in response to cancer's alarming rates[100], the impact on the awareness levels, prevention impact or cost effectiveness of these responses were not much evaluated.

Non-Communicable Diseases in the Middle East Region

Two million fatalities and 51 million Disability Adjusted Life Years (DALYs) are the yearly results of Non Communicable Diseases (NCD) on the population of the Eastern Mediterranean Regional Office (EMRO) region. NCD are considered to be the first reason behind the morbidity and mortality in the Middle East Region. These diseases such as cardiovascular diseases, diabetes, hypertension and cancer constitute nowadays 45% of the disease burden in the region and are expected to rise till 60% by 2002.[101]

The epidemic of Non Communicable diseases (NCD) is not a characteristic of the Middle East region. In the World Health Organization report of 2002, NCD was the main factor leading to death in the world.[102] While in the 1990s the volume of the diseases was concentrated around communicable diseases, maternal and prenatal conditions and nutritional deficiencies, Non Communicable Diseases are increasing at alarming rates in our region in the mean time.

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[99] K. Abou Daoud, "Morbidity from Cancer in Lebanon," *Cancer,* 19:1293, (Beirut, 1996).

[100] National Cancer Registry and Awareness Campaigns

[101] www.emro.who.int

[102] www.emro.who.int/Lebanon/ncd/cancer2002.pdf

In Lebanon, The leading causes of death among adults, also largely preventable, are attributed to cardiovascular diseases (29.2 percent) and cancer (9.8 percent). The rising incidence of chronic diseases affects the older categories in the population and those that lead unhealthy lifestyles, such as smokers. Around 4,000 new cases of cancer are registered each year. These diseases account for the bulk of public expenditures on health, mainly cancer chemotherapy, kidney dialysis and cardiac surgery.[103]

The main factors leading to this alarming increase are the lifestyle choices that are easily preventable. The increase in tobacco use, change in diets, reduction in physical activity and the increase in alcohol use are the major facets of the lifestyle changes in the world in general and in the region in particular. These risks explain about 75% of these conditions.[104]

Cancer and WHO

The main WHO activities in regard to cancer are concerned with its epidemiology, its pathology, and the improvement of measures for its prevention and control. The latter include early diagnosis, treatment, and after-care. WHO does not seek to duplicate the vast amount of research on the many problems of cancer that is being done throughout the world, but rather to provide the machinery for the international coordination of national efforts and international standardization of terminology and methods, and to provide to governments on request advice and assistance in the organization of national cancer control

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[103] http://www.undp.org.lb/programme/governance/advocacy/nhdr/nhdr97/chpt3g.pdf

[104] Ibid

services. A special program is the development of an international histological classification and nomenclature of tumors. As a matter of fact, classifications of different types of tumor are published by WHO with illustrations.[105]

In 1965 the Health Assembly decided to establish an International Agency for Research on Cancer (IARC), which now has its seat in Lyons, France. The activities of WHO and IARC are complementary, the latter being principally concerned with research into environmental factors involved in the etiology of cancer. In 1973 the Health Assembly, while recognizing that the main effort in cancer research would continue to be the responsibility of national institutions, decided that WHO should, in collaboration with IARC and the International Union against Cancer, intensify its cancer activities by sponsoring a broad international program that would cover, in addition to the coordination of basis and clinical research, the standardization of methods and terminology; epidemiological studies; the development of methods for early diagnosis and treatment; and preventive measures, including the identification of and removal of carcinogens from the environment.[106]

Cancer in Lebanon

1- The Current Situation

According to Dr. Adib Mufarrij, the director of the National Non-Communicable Diseases Program, the incidence rate in 2003 will be around 192 per 100,000, which makes the increase in 5 years about 22 cases per 100,000. This increase in the incidence rate of cancer in the country can be explained by several

[105] WHO, *Introducing WHO*, 27.

[106] Ibid, 29.

factors. Among these we have the aging process of the population. In addition, the increased unregulated tobacco consumption in all its forms plays a major role. Also, under reporting cancer cases in Lebanon contributed in this increase of cancer incidence rate. In fact, while in the 1960s cases of cancer of cancer were reported on a smaller scale, nowadays with the initiation of the National Cancer Registry, supposedly 80% of the cancer cases in Lebanon will be reported.[107]

Cancer incidence in Lebanon is similar to that of the neighboring countries in the Middle East Region, but still lower than that of Europe and the United States. The fact that Lebanon witnesses lower incidence rates than the developed countries can be explained by several factors. Among these, we have the youth of the Lebanese population in general. In fact, according to the WHO, the median age in Lebanon is 22 years old with 47% of the population being under 20 and 37% being under 15 years old. In addition, the problem of under reporting cancer in Lebanon plays a major role.[108]

According to the 2002 report of the National Cancer registry, the distribution of cancer patients based on the district in which they live is as follows:

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[107] Ghada El Karawi, "Cancer in Lebanon: Situation, Response and Cost Analysis", Practicum Project-HMPD, American University of Beirut (Beirut, Fall 2005-2006), 8-9.

[108] S. Adib, "Epidemiology of Cancer in Lebanon," *Sci-Quest,* 4:23-35, 1994.

Table 2. The distribution of cancer patients based on the district in which they live

Mohafaza	**Percentage**
Beirut	25.4%
Mount Lebanon	29.7%
South Lebanon	19.4%
North Lebanon	10.9%
Bekaa	5.9%
Nabatiyeh	8.6%
Elsewhere	0.1%

Source: MOH, 2003

For females, the most dominant cases of cancer have not changed much throughout the years. Breast cancer remained the most frequent type of cancer in the Lebanese female population. As it appears, lung cancer was less frequent in the earlier years while it ranked fourth in the 2002 report of the national Cancer registry. This could be explained by the increase in the habit of smoking among females as a result of the heavy non-banned marketing and advertising of cigarette smoking. Less medical explorations in the earlier years play an important role as well.

Consequently, a breast cancer awareness campaign "Early Detection Saves Lives," including seminars and distribution of brochures and posters was held in Lebanon during the international month of breast cancer in October 2002.[109]For the fourth consecutive year, The Ministry off Public Health, with the technical

[109] WHO, *Annual Report 2002, WHO Representative Office,* 13.

support of the World Health Organization in Lebanon, embarked on the annual Breast Cancer Awareness Campaign, which culminated during International Breast Cancer Awareness month in October, supported and financed by Hoffman La Roche. The campaign emphasized the importance of breast self-examination, clinical examination, as well as periodic mammography in early detection and prevention of breast cancer. Awareness about the risk of breast cancer was particularly focused among high risk and older women. The national campaign included many activities, namely: the provision of screening mammography in 183 hospitals and health centers across the country for a discounted price during the month of October; the distribution of educational materials about screening and early detection in hospitals, clinics, pharmacies, dispensaries, bakeries, shopping centers and malls, hairdressers and beauty saloons, fuel stations and the airport; the free SMS messages sent to all mobile through the contribution of the Ministry of Telecommunication, Alpha telecom and MTC touch; public conferences organized by local NGOs in different regions all around Lebanon; in addition to a wide-range advertising campaign and media support through interviews with relevant health professionals.[110]

On the other hand, the males' most frequent cancer cases changed a lot since 1953. While skin cancer ranked as the most dominant case in the period 1953 to 1960 and lung cancer ranked fourth, these figures tended to change later on. Throughout the period 1983-1994, 1998 and 2002, lung cancer became the most common cancer case among males. This is due to the increase in smoking among the Lebanese population. Additionally we notice a decrease in the rates of

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[110] WHO, "Breast Cancer Awareness Campaign 2005", *Health for All*, Issue No.58, Oct-Nov-Dec 2005, 15.

lymphomas and an increase in the incidence of bladder cancer. Finally prostate cancer hasn't been much prevalent except in 2002. This fact does not reveal much information about the increase in the incidence rate of prostate cancer. It is probably due to the recent use of Prostate Specific to discover prostate cancer.[111]

2- Responses to Cancer Situation

The Lebanese public response to cancer can be interpreted through the several actions initiated by the Ministry of health. Among these we have:

- Drug Dispensary Center (DCC)
- The National Cancer registry
- Prevention Campaigns

To begin with, Lebanese cancer patients who are not covered by any other type of public insurance (NSSF, Army, etc) and who need chemotherapy can obtain their medications for free from the Drug Dispensary Center. These patients should have their treating physician complete an information form from the Center. In addition, several documents are required such as a medical prescription, a detailed report of the condition of the patient and the pathology/blood tests. As soon as the form is completed, all the documents are presented to the medical committee of the Drug dispensary Center. Once the committee approves the request, the patient can take the treatment from the Karantina Center of the Ministry of Public Health. The form must be completed on a yearly basis.[112]

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[111] Ghada El Karawi, "Cancer in Lebanon: Situation, Response and Cost Analysis", 14.

[112] M.D. Nabil Kronfol, *The Lebanese Health Care System,* 21.

With the funding of the Italian cooperation, the Ministry of Public Health and the World Health Organization launched the Lebanese National Cancer Registry in 2002 with the collaboration of the National Non-Communicable Diseases Program as a response to cancer. The National Cancer Registry is considered as an information system that collects stores and analyses the data on cancer in the country.[113] More information on both the National Non-Communicable Diseases Program and the National Cancer Registry will be provided later on.

In addition to the Drug Dispensary Center and the National Cancer registry, the Ministry of Public Health is as well involved in prevention and screening campaigns. Among these, we have the breast cancer prevention campaign and the prostate screening campaign. These campaigns are important especially that the stages of diagnosis of cancer in Lebanon are at 50% of the times detected at the third and fourth stages of the disease. Thus it is very important to raise the awareness of the targeted population, here females, regarding Breast cancer and the importance of early detection. But despite the fact that this national campaign has major impacts on the rates of breast cancer's early detection, there are some pitfalls that need to be discussed.[114]

This National Breast Cancer Campaign is definitely very crucial in the primary prevention and early detection of Breast cancer cases in Lebanon. However, even though the campaign promoted mammography tests among females for early

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[113] Ghada El Karawi, "Cancer in Lebanon: Situation, Response and Cost Analysis", 17.

[114] WHO, "Breast Cancer Awareness Campaign 2005", 15.

detection through a 60% reduction, the problem was the initial price of the mammography test. The other problem in the two prevention campaigns launched by MOH is their funding. Both of these campaigns are funded by the private sector. This makes the continuous launching of the campaigns at risk if the private companies decide to stop the funding.[115]

Adding to the public response, the non-governmental agencies have done several efforts to deal with cancer, especially the United Nations agencies. In fact, the World Health Organization has put a good deal of efforts in collaboration with MOH in initiating the National Cancer Registry. Other non-profit organizations are highly involved in the prevention and screening of cancer: "Face it" Society, the Lebanese Cancer Society, the National Cancer Association, and the Islamic Health Society.[116]

In general the response to cancer in general, public or non-governmental, is not sufficient to deal with the alarming rates in the country. The focal point of prevention and screening campaigns is on Breast cancer. Despite the fact that high rates of lung, bladder and other types of cancer are emerging, minor efforts are done accordingly. Thus the response of the public sector in particular, must be more spread to deal with the most dominant cases of cancer according to the National Cancer Registry.

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[115] Ibid

[116] Ghada El Karawi, "Cancer in Lebanon: Situation, Response and Cost Analysis", 24-26.

3- The Non-Communicable Diseases Program in Lebanon and the National Cancer Registry in Lebanon

WHO is working with individual nations' health systems to develop greater capacity in preventive care programs that can encourage healthier lifestyles and stop the onset of disease. WHO is also advocating a regionally integrated approach to disease prevention and surveillance. The most important of these diseases are cardiovascular diseases, cancer, and diabetes. These diseases share several common, related risk factors: hypercholesterolemia, obesity and diabetes, which can be regarded both as disease and a risk factor for cardiovascular diseases; physical inactivity, smoking and high fat consumption.[117]To fight against these problems, the Program of Non-communicable Diseases is working to strengthen the capacity of the countries to formulate effective policies, strategies, and models to control non-communicable diseases, emphasizing cardiovascular diseases, diabetes and cancer.[118]

In Lebanon, cancer was first raised as a public issue by the Ministry of Public Health in 1995; the Non-Communicable Diseases Program (NCPD) was activated in 1997. The objectives of the program are:

- Health Education and increasing awareness among the population
- Support, coordination and training of Health workers, physicians and specialists from NGO's and private sector
- Celebration of National and International days
- Support and improvement of the reporting system on the epidemiology and statistics of NCPD

[117] http://www.emro.who.int/lebanon/nationalprog-ncd-background.htm

[118] Ibid

Following the political support from H.E. Mr. Suleiman Frangieh, minister of Health, and the technical support from WHO, NCDP was able to successfully launch and implement the National Cancer Registry in Lebanon. The launching ceremony took place on 19 February 2002 in the presence of the Minister of Health Mr. Suleiman Frangieh and Dr. Gezairy, Regional Director in addition to other officials from different governmental and non-governmental institutions. The Italian Cooperation supported the implementation of this registry. Following the publication of cancer data reports, the Programme was involved in several seminars and workshops and presented the national data.[119]

The Cancer Unit (CU) is part of the Non-Communicable Diseases Program. It runs the National Cancer Registry (NCR) along with other activities of surveillance, control and prevention of cancer in Lebanon. Its main aims are:

- Identification of all new cancer cases
- Description of trends in cancer load by types, demographic profiles, geographical location and historical changes.[120]

One of the major components of a National Cancer Control Program is prevention campaigns. This is the first crucial step in controlling cancer. Prevention means "eliminating or minimizing exposure to the causes of cancer and includes reducing individual susceptibility to the effects of such causes".[121]

Factors such as tobacco consumption, alcohol use and dietary style in addition to occupational and environmental exposure, are the major factors

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[119] WHO, *Annual Report 2002, WHO Representative Office,* 13.

[120] WHO, *Introducing The World Health Organization Representation in Lebanon*, 16.

[121] WHO, *Annual Report 2002, WHO Representative Office,* 14.

affecting the incidence of cancer. Thus promoting awareness about these factors and these factors and the risk of developing cancer upon exposure to these factors is vital in the attempt to control cancer. In addition to promoting awareness concerning risk factors, awareness concerning early diagnosis and screening is important as well.[122]

Early detection is the step that follows promoting awareness of risk factors, signs, and symptoms of cancer. Thus primary prevention contributes to the increase in rates of early detection rather than detecting the disease in advanced stages. Early detection increases the chances for effective and successful treatments especially for cancers of breast, mouth, larynx, colon, rectum, and skin. This raises the need to teach people the recognition of early warning signs "such as lumps, sores that fail to heal, abnormal bleeding, persistent indigestion, and chronic hoarseness, and the urge to seek prompt medical attention".[123]

Initiating a National Cancer Registry is very crucial in the control of cancer in any country. These registries must include data from treatment facilities, treating physicians, and death certificates. The cancer registry's main purpose is to analyze this data to provide information about mortality and morbidity of cancer in the country. In addition, the cancer registry is vital in the evaluation of national prevention and screening programs.[124]

Palliative and terminal care is as well an important facet of a National Cancer Control Program, since this is what adds quality to the life of cancer

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[122] Ibid

[123] Ibid, 16.

[124] www.emro.who.int/Lebanon/ncd/cancer2002.pdf

patients. National and regional guidelines for this type of care should be established, in addition to educational programs regarding pain relief that should be integrated within the health care system.[125]

In conclusion, many efforts have been done in both the public and the non-governmental sectors in dealing with the cancer incidence. These are considered as important steps in the path of controlling cancer. Credit is given to these steps especially that the country is going through a transitional period after the corruption of the civil war; yet major improvements need to be done for these programs to be more comprehensive in dealing with all types of cancer in more sophisticated ways and tools.

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[125] Ibid

Chapter VI
The Expanded Program on Immunization

Introduction

Globalization, increasing urbanization and poverty, civil strife and political instability, climate change and exploitation of new environments, all contribute to the global amplification and spread of new diseases and the resurgence of those once considered to be conquered. In addition, major outbreaks and epidemics continue to be caused by known pathogens. These outbreaks and epidemics repeatedly challenge national health services and disrupt routine control programs, diverting attention and funds. The increasing resistance of microorganisms to drugs further aggravates the problem by undermining available therapy, reducing opportunities for treatment and prevention and significantly increasing the costs of health care. In our closely interconnected world, adverse events in one country may easily cross borders and intrude on another and, thus, threatening the global health security.[126]

Louis Pasteur, father of the science of microbiology and a key figure in the development of vaccines in the 1880s, suggested that humans had the power "to make parasitic maladies disappear from the face of the globe." Yet, since then hundreds of millions of people have died of infectious diseases-tuberculosis, malaria, AIDS, dengue fever, smallpox, cholera, plague, and influenza. And after thirty years of discoveries in molecular biology--including DNA cloning, the sequencing of the human genome, and stunning new developments in techniques

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[126] Dr Nadia Teleb, *Briefing Notes for The 11th Round of Joint Programme Review Mission (JPRM) for the Biennium 2004-2005,* (Beirut, 2005).

of human stem cell research--we still face the daily tragedy of preventable human illnesses, some ancient and others new, unpredicted, and even more dangerous.[127] In fact, many of the infectious diseases prevalent in developing countries offer the most promising potential for the application of new knowledge gained by immunological research, but it is these countries that immunologists are very scarce.[128]

The proportion of children who were properly immunized against several common diseases rose worldwide from less than 5% in 1974 to 90% in 1990, though its slipped to some 70% overall during the 1990s. Most diseases can not be eradicated, of course, but many could be controlled much better. Global research and public health programs started to transform visions of what is possible and expected of public health professionals and organizations.[129]

The Eastern Mediterranean Region, being a centre of international travel related to trade, tourism, and religion in addition to the large continuously changing expatriate workforce, is exposed to high risk of introduction of emerging and other infectious diseases. The large population displacement due to wars, internal conflicts, droughts and floods in several countries, increases the opportunity of occurrence of outbreaks and hinders early detection and rapid response to these outbreaks.[130]

Although epidemiology is central to public health programs, a WHO delegation found that government health services in Lebanon lacked appropriate

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[127] Karen Kasmauski and Peter Jaret, *Impact From the Frontlines of Global Health*, 7.

[128] WHO, *Introducing WHO*, 37.

[129] Karen Kasmauski and Peter Jaret, *Impact From the Frontlines of Global Health*, 13.

[130] Dr Nadia Teleb, *Briefing Notes for The 11th Round of Joint Programme Review Mission.*

epidemiological techniques. At the local or community level, health personnel, especially doctors, rarely reported diseases to the health department, although they were legally obliged to do so for some diseases. A similar situation existed with respect to health establishments such as clinics, dispensaries, and hospitals. Consequently, not only was there a conspicuous absence of health records, but where available, they were often incomplete.[131]

WHO and Epidemiology

WHO has established a list of 200 essential drugs and vaccines that health services can use to deal with 80-90% of all cases of illness.[132]WHO has an unparalleled opportunity to guide the efforts of the biotechnological sciences and the pharmaceutical industries towards the diseases for which effective vaccines are most needed, and thus to bring the fruits of research within the reach of everyone.[133]

Also, WHO helped coordinate the international effort to eliminate smallpox, officially vanquished as of 1977. A WHO document uses clotted official prose to describe the group's role in the smallpox battle. WHO says its contribution was in "its energy and prestige as a trigger of global efforts bringing together scientists, governments, health workers, and ordinary citizens," and that "technical difficulties -- were overcome through prompt WHO-coordinated

[131] http://www.country-data.com/cgi-bin/query/r-7994.html

[132] WHO, *Introducing WHO*, 7.

[133] Ibid

research." The group also stressed the importance of "its neutrality and independence of national rivalries and suspicions."[134]

WHO also played a major coordinating role in controlling yaws in the late 1940s and onchocerciasis ("river blindness"), leprosy, and polio in the past three decades. A WHO-organized Malaria Eradication Program in the 60s made substantial progress in stemming that disease. As late as 1964, WHO publications expressed optimism that malaria would be wiped out. Alas, malaria resisted eradication and the disease still kills over 1 million people a year worldwide. WHO's main success story remains its role in eradicating smallpox. [135]

Situation Analysis in Lebanon

Since the establishment of the Epidemiological Surveillance Unit (ESU) in the Ministry of Health early 1995, many efforts have been made to develop a functional communicable disease surveillance system. However, this system still requires major improvements: The routine reporting of communicable diseases is not systematic. The involvement of the strong private sector in the surveillance system is insufficient. Viral hepatitis, meningitis, typhoid and epidemic diarrhea among other communicable diseases, continue to pose a real risk to the population. Further, the risk of introduction of emerging diseases is great. Efforts to prevent and control these diseases should seek pragmatic approaches.[136]

The National Expanded Immunization Program (EPI) was launched in

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[134] http://www.reason.com/0201/fe.bd.who.shtml

[135] Ibid

[136] Dr Nadia Teleb, *Briefing Notes for The 11th Round of Joint Programme Review Mission.*

1987 by MOH, NGOs, WHO and UNICEF. At that time no national program existed, immunization was provided solely by the private sector and sporadic campaigns were occasionally launched by MOH, in response to epidemics and some reported cases.[137]

The National Expanded Immunization Program (EPI) has been a main component of the Primary Health Care strategy, as it ought to be. Vaccines are distributed by the Department of Preventive Medicine through the qada' health department. The coverage rate in the country, as reported by the Department of Preventive Medicine is higher than 90% for most vaccines. Information is available on the DPT (Diphtheria-pertussis-tetanus), OPV (Oral poliovirus vaccine), Hepatitis B, and MMR (measles-mumps-rubella) vaccination rates for 2002.[138]

The absence of reported poliomyelitis cases for several years now leads to the obvious conclusion that preparations should be made to conclude the necessary steps leading to the eradication of poliomyelitis in Lebanon in the near future. However, although no major epidemics have been reported lately, the eradication of Poliomyelitis has received a setback with the identification of few cases in the country last year.[139]

There is a critical need for strengthening the national surveillance and response systems to generate information for action in a timely manner, to assist in understanding the epidemiology of epidemic-prone and emerging diseases; and to facilitate the timely implementation of effective prevention and control

[137] Peggy Hanna, "Case Study on Government and Civil Society", 50.

[138] M.D. Nabil Kronfol, *The Lebanese Health Care System.*

[139] Ibid

strategies. Such surveillance and response systems require trained staff, improved communications, provision of necessary supplies, strong public health laboratories, and links to international networks. Rules and regulations must be updated so that the mandatory reporting by the private sector is reinforced.[140]

The National Expanded Immunization Program (EPI)

1- History and Objectives

In the WHO immunology program, emphasis is placed not only on making the results of immunological research widely available and promoting the international standardization of immunological terminology, but also on the provision of facilities for immunologists to be trained in their own countries or regions. WHO supports, and where necessary assists in the establishment of immunological research and training centers in countries in which the major parasitic diseases are important causes of morbidity and mortality. An important aim of this program is to promote research into the development of measures for immunizing populations against these diseases. There is also a need for international orientation for both diagnosis and treatments.[141]

The epidemiological surveillance unit was born in 1995 on behalf of the World Bank health rehabilitation project. The unit is attached to the directorate of prevention at the ministry of public health.[142]The National Immunization Program in Lebanon began its activities in 1987. Despite the tremendous constraints of the

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[140] Dr Nadia Teleb, *Briefing Notes for The 11th Round of Joint Programme Review Mission.*

[141] WHO, *Introducing WHO*, 37.

[142] http://www.public-health.gov.lb/esu/esu.html

ongoing war, coverage steadily increased, and survey data indicate that a high percentage of children are immunized through routine immunization services and annual "acceleration campaigns". The national immunization schedule calls for a dose of DPT and OPV at three, four and five months of age with booster doses at 17 months and four years of age. Measles should be administered at 10 months of age. Before receiving immunizations, children are typically examined by a physician. NGOs and the private sector are using a multitude of different schedules, often giving measles shots for the first time at 15 months of age. Immunization services and coverage remain weakest in the regions of Akkar, Hermel and Baalbeck, and activities are currently targeted to strengthen these areas. The achievement of high immunization coverage has been the result of collaboration between the MOH, the multitude of NGOs, private physicians, UNICEF, and WHO.[143] The main goals of the program were (1) To immunize children against diphtheria, pertussis, tetanus (DPT), poliomyelitis and measles, (2) To reduce death from measles among children under 5 years old, (3) To eradicate polio and neonatal tetanus by 1996.[144]

Approximately 43 % of all immunizations are administered through the private sector. The remaining proportion is administered through the public sector and NGOs primarily at fixed sites, and a small proportion (3%) by mobile teams. UNICEF currently plays the principal role in terms of the operational aspects and monitoring of immunizations in the public and NGO sectors. The mass media, particularly television, has been used very effectively to mobilize

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[143] Dr. Gaafar Mohamed and others, *Evaluation of the National Immunization.*

[144] Peggy Hanna, "Case Study on Government and Civil Society", 51.

the population for immunizations.[145]

The main function of the surveillance unit is to strengthen communicable diseases surveillance according to the Law of 31 December 1957. The surveillance system is based upon the collaboration of the hospitals, health centers, dispensaries, laboratories, private clinics. Also surveillance is based upon the coordination with different health services related to different ministries: ministry of health, of social affairs, of interior, of defense...[146]

The last polio case was registered in Lebanon in July 1994. Since then, Lebanon has become member of the group of MENA countries that will form a polio free zone. Surveillance data from hospitals indicate that Lebanon has eliminated neonatal tetanus. In 2003, WHO actively participated in the fieldwork and was able to achieve House to House immunization campaign with more than 90% coverage rate in 4 underserved districts: Akkar, Baalbeck, Hermel, and Dennieh.[147]In fact, the total number of children immunized through the Personal Health Care network in 2003 has been reported to be a little more than 43,000, up from 22,500 in 2002. Although this is an improvement, it falls well short of the proportion of children needing immunization. The 2003 report of the Division does allude to a stern complaint from the Director-General of the MOH to the participating PHC centers and NGOs in the network. This has indeed prompted

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[145] Dr. Gaafar Mohamed and others, *Evaluation of the National Immunization.*

[146] http://www.public-health.gov.lb/esu/esu.html

[147] WHO, *Introducing The World Health Organization Representation in Lebanon,* 24.

the use of the young men undertaken military service to assist in the immunization campaign.[148]

2-Project implementation, execution and monitoring

The work was channeled through a network of 700 private and public dispensaries and health centers, as well as mobile teams covering the whole country. National days have been organized yearly since 1987 and have greatly contributed to achieving the Universal Child Immunization target for 1990. In addition 39 administrative units have been established to be in charge of the project in the 24 districts of Lebanon.[149]

UNICEF has been active in strengthening project management, support of a range of activities, national immunization days, health staff training and provision of vaccines and syringes. UNICEF supported also the administrative decentralization of the program, consolidation of the vaccine storage and cold chain systems and improving surveillance. On the other hand, since 1995, the government has started to assume responsibility for supply of vaccines and other projects supplies, through reimbursable procurement services provided by UNICEF Copenhagen.

At present the EPI program includes two components: Routine vaccination and national campaign days.[150]

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[148] M.D. Nabil Kronfol, *The Lebanese Health Care System.*

[149] Peggy Hanna, "Case Study on Government and Civil Society", 51-53.

[150] Ibid

Routine vaccination:

The project has succeeded in expanding immunization services to about 717 fixed health centers and dispensaries, in addition to dispatching mobile team to the areas that lacked a fixed health infrastructure and to areas that had very low immunization coverage. The centers, supplied also with reporting forms and immunization cards were requested to keep records of their activities. Immunization services are currently being provided according to the convenience of each center with no standardization of immunization policies and practices. Fees are being collected by some center for immunization services to allow partial recovery of operational costs.[151]The structure at the governorate and qada level usually consists of a medical officer assisted by one or more paramedical staff. Their role is the overall supervision of preventive and curative health services in their respective governorates or qadas including EPI and surveillance.[152]

National campaigns days:

The program adopts the policy of national campaigns days to assure immunization coverage against polio for the largest number possible of children between 0-5 years. The campaigns target around 350 000 children per year. Mobile teams are sent to remote area lacking health services. The campaign is organized by MOH, MOSA, NGOs, Private medical sector, Order of Physicians, Association of Pediatricians, WHO and UNICEF. To launch the campaign, each year a national central meeting is held to develop a general implementation plan of action under

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[151] Ibid

[152] Dr. Gaafar Mohamed and others, *Evaluation of the National Immunization programme.*

the chairmanship of the Minister of Health. Several mobilization meetings and activities are also carried out at various levels in preparation for the campaign. The meetings target the community leaders, community groups, representatives of local authorities, and participating health centers. Wide media coverage is also insured for the campaign. Additionally with the Ministry of Education, public and private schools are asked to cooperate in the campaign by having vaccination take place in the school.

In 1996, a revised national immunization schedule was adopted and implemented in 1997 in order to include all children from the age of 2 months up to 12 years.

3-Evaluation

In June 1996, the MOH in coordination with UNICEF conducted a national survey in order to assess immunization coverage of children and the level of coverage of the Polio National Immunization Days. The following results were achieved:

Table 3. Progress in immunization for DPT/OPV3 %

	1990	**1991**	**1992**	**1993**	**1994**	**1996**
Children under one year	77.8	81.6	85	87.4	91.6	94.2
Children 12-23 months	82.3	86.3	89.2		95.6	94.8

Source: Peggy Hanna, Case Study on Government and Civil Society, 1996 P.52

As we can see, the immunization rate for DPT/OPV3 has obviously increased.

In 2003, the indicators of coverage with primary health care show that 92% of the infants in Lebanon are fully immunized with both DPT and OPV3 vaccines, 96% of the infants are fully immunized with Measles vaccine and 88%

are fully immunized with Hepatitis B vaccine.[153] Consequently, we can conclude that the immunization rate in Lebanon is increasing or being sustained at a high rate. At the same time efforts will continue to improve coverage by the measles vaccine through improved organization and monitoring as well as an active health education and information program using the excellent opportunities for mass media cooperation. The EPI program is being continuously reviewed to include new vaccines as may be required.[154]

4-Major Achievements

The major achievement lies in the increase of level of immunization as mentioned above. Despite the tremendous constraints of the ongoing war, coverage steadily increased and survey data indicated that a high percentage of children were immunized through routine immunization and annual campaigns. The program has also successfully laid the ground for a solid and effective working relationship between the health centers of the public and NGOs sector, on the one hand, and scouts, youth and international organizations, on the other hand, thus strengthening the fixed health structure that provides vaccination services.[155]

Over the courses of the year, the program was able to reach a number of important milestones, notably the enhancements of the administrative decentralization of the program, consolidation of the vaccine storage and cold chain system, and establishment of an effective system for collection of information about child vaccination. Political commitment and support at the

[153] http://www.emro.who.int/lebanon/Countryprofile.htm#socioeconomic

[154] M.D. Nabil Kronfol, *The Lebanese Health Care System.*

[155] Ibid

highest level was activated and secured through the personal involvement of all the relevant authorities including the President, the Ministers, the Religious authorities.....This was very important for the generation and allocation of financial, material and human resources and ensured multisectorial input and coordination. The highest authorities were provided regularly with feedback and advocacy on the national targets, objectives, progress and constraints faced by the program in order to reactivate and sustain political commitment and support.[156]

EPI maintained outreach and mobile activities to ensure increasing accessibility in remote and isolated areas. This approach played a key role in the program success by providing immunization to areas unreached by fixed outlets. EPI created continuing consumer demand for immunization by maintaining social mobilization, public awareness and education, through various channel of communication, particularly the mass media.[157]

Moreover, the EPI helped reinforce the institutional capacities of many local grassroots NGOs, involving them directly in needs assessment, ordering of vaccines, shipment, storage, transportation, controlling, recording and staff training. As a matter of fact, in 1987, there were 762 vaccination point in all 29 districts with thousands of volunteers manning them during the 4-day campaign. Every major group of Lebanon was involved irrespective of its political or religious affiliation, the government authorities as well as the local authorities and even when there was a strike of the general federation of labor unions, the dispensaries and health facilities were exempted from that strike to enable this

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[156] Dr. Gaafar Mohamed and others, Evaluation of the National Immunization programme.

[157] M.D. Nabil Kronfol, *The Lebanese Health Care System.*

program to go ahead. Not only did the various fractions in the years of war refrain from fighting during the week of the campaign, but vehicles that normally carried weapons and armed men were used to convey mothers and children to vaccination posts and transport health equipment. This illustrate the successful joined venture experience of government, UN specialized agencies like WHO, and the NGO community in the health sector.[158]

5-Major constraints

Despite important achievements, some issues are still of concern, namely the limited role of MOH in the central management of EPI program, the lack of standardization of immunization policies and practices, and the poor training of health workers. In addition the surveillance system is incomplete.

Although the MOH has issued an immunization schedule, there are numerous schedules in use, some of which are inappropriate and not in accordance with WHO recommendations. This constitutes a major limitation to the EPI program.[159]

In villages located in the areas of low coverage, children are immunized against DPT and Measles by mobile teams only during Polio vaccination campaign days. No regular routine vaccination services are available the rest of the year. Local NGOs could be activated to address this issue. Also in this field, no assessment is done about the percentage of under-served population.[160]

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[158] Peggy Hanna, "Case Study on Government and Civil Society", 55.

[159] Dr. Gaafar Mohamed and others, *Evaluation of the National Immunization programme.*

[160] M.D. Nabil Kronfol, *The Lebanese Health Care System.*

CHAPTER VII
The Tobacco Control Program

Introduction

The growing use of tobacco around the world represents a health crisis of its own. More than a billion people use tobacco worldwide. An estimated four million people die annually as a result of tobacco-related illnesses. As tobacco companies intensify efforts to sell their deadly products to people in developing nations.[161] Cigarette smoking is a major avoidable cause of illness and premature death wherever the habit is widespread. It is responsible for about 90% of all cases of ischaemic heart disease as well as for lung cancer and a number of other types of cancer, pregnancy complications and respiratory diseases in children involuntarily exposed to smoking. Other dangers are involved in chewing tobacco. More evidence has accumulated that "passive" smoking may also have effects on the health of the non-smoker, particularly within closed circulation air conditioning systems, and that the smoke of a smoldering cigarette is more dangerous than that exhaled from the smoker's lungs.[162]

Today, tobacco is the single most preventable cause of death and disease in the world. In most of the developed countries around the world, governments passed legislation barring cigarette advertising on TV and radio, banning tobacco sales to minors, prohibiting smoking in public places, developing tobacco control policy activities, and increasing taxes on tobacco sales. However in an effort to

[161] Karen Kasmauski and Peter Jaret, *Impact From the Frontlines of Global Health*, 54.

[162] WHO, *WHO What It Is What it does*, 14.

retaliate against legislatures and policy makers, the tobacco industry is spending billions and billions of dollars on using creative patterns for advertising and promoting cigarette smoking targeting primarily young audiences not only in the Western Hemisphere but also in less technically developed countries as well.[163] Global companies are in the business of aggressively marketing their wares, which too often include tobacco products, high-calorie processed foods, and other fixtures of Western culture.[164]To that effect, the tobacco industry has somehow succeeded in steering its advertising in these countries chiefly that governments are not passing strict laws and ordinances restricting either the advertising or the use of tobacco in designated places although even if these laws were existent and legitimate, they are not being partially or fully enforced. That is certainly true because enforcement is almost a non-priority act to much more serious problems. In addition, the tobacco industry in this part of the world has been able to successfully influence its audience and attain its goals in targeting a large number of users due to the lack of public awareness and tobacco control activities by community leaders and anti-smoking lobbyists and coalitions (where they exist), not to undermine the social sanction of the smoking behavior among most segments of the population.[165]

Tobacco and Poverty: A Vicious Circle

There exists an inextricable link between tobacco and poverty, and how the use of tobacco, especially by poorer people who consume this product the

[163] http://www.emro.who.int/lebanon/NationalProg-tobacco-WHD2002.htm

[164] Karen Kasmauski and Peter Jaret, *Impact From the Frontlines of Global Health*, 66.

[165] http://www.emro.who.int/lebanon/NationalProg-tobacco-WHD2002.htm

most, can cause harmful consequences to their already precarious economies and income. Studies across all regions in the world show that the poorest people tend to smoke the most in both developing and developed countries, and who bear most of the disease burden. People with less education also tend to consume more tobacco. Many studies also show that poorer people spend a higher percentage of their household income on tobacco products, to the detriment of other basic needs such as food, healthcare or education.[166]

Tobacco can also have an adverse impact on countries economies. Studies trying to measure the economic costs of tobacco at a global level estimate that it results in an annual global net loss of 200 thousand million USD. The World Bank estimates that high-income countries spend currently between 6% and 15% of their total health-care costs to treat tobacco-related diseases. Also, an overwhelming majority of small tobacco farmers, especially in developing countries, live in poverty: precarious labor conditions, including the use of child labor and exposure to highly toxic products, and a highly negative impact on the environment.[167]

WHO and the Tobacco Issue

One WHO propaganda book lists five things that will be missed in "A World without WHO" -- presumably what it considers its most important achievements. It declares that in "a world without WHO -- national health officials would not be able to count on global moral support in their battle against

[166] WHO, "The World Health Organization Says That Tobacco Is Bad Economics All Around," *Press Release WHO/36*, 28 May 2004.

[167] Ibid

tobacco addiction," and "there would be no unifying moral and technical force to galvanize, guide and support countries in achieving health for all."[168]

Tobacco use increases risk of developing several cancers and diseases of the cardiovascular and respiratory systems. Therefore tobacco use is one of the main preventable causes of chronic disease and death in developed countries and is the second leading cause of death worldwide. Estimates of the future burden of tobacco-related disease are based on lung cancer deaths and calculation of the smoking impact ratio. Efforts to ameliorate the current and projected harm caused by tobacco use are needed.[169]

Since scientific facts about smoking are well established, WHO has concentrated its efforts on education and information of public and decision makers. A series of recommendations, that include proper legislation to guarantee the right to clean air for all, protection for youth and a proposal to end all forms of tobacco promotion and advertising, have been issued by various Expert Committees and the Executive Board of WHO.[170] Countries need to develop and implement comprehensive tobacco prevention and control programs. WHO is working with countries to prepare national tobacco action plans that include public education campaigns, cessation assistance programs, enforcement of

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[168] http://www.reason.com/0201/fe.bd.who.shtml

[169] C. Warren, N. Jones, M. Eriksen, and S. Asma, "Patterns of global tobacco use in young people and implications for future chronic disease burden in adults", *The Lancet,* March 4-10,2006

[170] WHO, *WHO What It Is What it does*, 14.

existing tobacco restrictions, and related policy efforts to support tobacco-control programs.[171]

The World Health Organization Framework Convention Tobacco Control (WHO FCTC) has become one of the most rapidly embraced United Nations' conventions, with 127 WHO Member States and the European Community (EC) signing and 23 countries ratifying, accepting, approving or acceding to the Convention, just one year after it opened for signature in Geneva. The rapid response to the WHO FCTC demonstrates the increasing commitment worldwide to control the tobacco epidemic, which continues to expand at alarming rates, especially among people in less-developed countries.[172]For many countries, the WHO Framework Convention on Tobacco Control provides a useful basis for implementation of such a comprehensive approach. This framework was unanimously adopted by the World Health Assembly in May 2003, was signed by 168 nations, and, at the time of writing, has been ratified by 123 nations. Full implementation of the principles should begin to limit tobacco use, initiation of smoking, exposure to secondhand smoke, and promote cessation.[173]

Current projections show a rise of 31% in tobacco-related deaths during the next twenty years, which will double the current death toll, bringing it to almost ten million a year. When the Treaty comes into force, national and local activities aimed at reversing these trends will be enormously strengthened. The result will be: improved public health and reduce poverty. The WHO FCTC,

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[171] C Warren et al., "Patterns of global tobacco use in young people."

[172] WHO, "The WHO Framework Convention on Tobacco Control on Track to Become Law by the End of the War", *Press Release WHO/47*, 2 July 2004.

[173] C Warren et al., "Patterns of global tobacco use in young people."

adopted unanimously by all WHO Member States, is the first public health treaty negotiated under the auspices of WHO. It was designed to become a toll to manage what has become the single biggest preventable cause of death. There are currently an estimated 1.3 billion smokers worldwide. Half of them, some 650 million people, are expected to prematurely die of a tobacco-related disease.[174]

Tobacco: The Actual Situation in Lebanon

1- Tobacco production, trade and industry

The arable land harvested for tobacco appears to have dropped from 3,400 hectares in 1985 to 1,954 hectares in 1990 (0.9% of arable land). Regarding production and trade, the annual cigarette production increased, from 900 million cigarettes in 1975, to around 4,200 million cigarettes in 1993. An additional 1,300 million cigarettes per year were imported into Lebanon during the early 1990s. From 1990-92, annual production of non-manufactured tobacco averaged 5,000 tons, of which 2,500 tons were exported each year. Import costs of tobacco in 1990 totaled 45million USD, while export earnings from tobacco were 6 million USD.[175]

2- Tobacco consumption

Annual adult per capita cigarette appears to have peaked in the mid 1980s, and declined somewhat in the early 1990s at around 2,900. These consumption figures may be rendered unreliable due to reported re-exports and smuggling

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174 WHO, "The WHO Framework Convention on Tobacco Control".

175 http://www.cdc.gov/tobacco/WHO/lebanon.htm

(hence, actual consumption may be lower). The smoking of moistened tobacco leaf in the arghila (a type of water pipe) is also common in Lebanon. [176]

Table 4. Consumption of Manufactured Cigarettes between 1970 and 1992

Consumption of Manufactured Cigarettes	
Year	Annual average per adult (15+)
1970-72	1,790
1980-82	3,230
1990-92	2,930

Source: http://www.cdc.gov/tobacco/WHO/lebanon.htm

Tobacco use and control in Lebanon is quite a complex issue. Tobacco use seems to be quite prevalent, as suggested by the various studies conducted over the past few years. In fact, according to a study done by AUB in the collaboration with UNICEF, WHO and the Ministries of Health and Education on students aged 15-18 years (1997), the distribution of smoking status is indicated by the following results:

- Median age of smoking = 14 years
- 65% of the smokers are males compared to 35% females. 6% of the males and 3.5% of the females do smoke regularly. In addition, 2% of the males and 0.1% of the females do smoke more than 20 cigarettes a day.[177]

[176] Ibid

[177] WHO, *Report of the Joint Government/WHO Programme Review and Planning Mission.*

According to EMRO, the socioeconomic indicators show that regular smokers reached a percentage of 40.6% in 1998 with a prevalence of the male smokers on female ones.[178]Other studies showed that Lebanon has one of the highest rates of smokers in the region: 53.6% of adults are smokers, with the proportion of male smokers at 60% while that of females at 40%.[179]

3- Tobacco control measures

Since tobacco dependence is considered by WHO a chronic condition, preventing the uptake of tobacco is one of the mostly recommended approaches. Legislative actions that increase the taxes on tobacco products, and limit the access and promotion of these products have shown an effective impact in several countries. Thus as a response to anti-smoking campaigns, the incidence of cancer will be monitored to some extent, especially the incidence of tobacco-related cancers.[180]

A 1983 law imposed a prohibition on the import, manufacture or sale of any form of manufactured tobacco product unless packets clearly bore the warning: "The Minister of Public Health warns you of the harmful effects of smoking". A health warning must also appear on all tobacco advertising. The warning must cover 15% of advertisements in newspapers, magazines, films and on television and billboards. For television ads, the warning must remain on the screen for the duration of the ad.[181]In the last few years, the Ministry of Health

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[178] http://www.emro.who.int/lebanon/Countryprofile.htm#socioeconomic

[179] Ibid

[180] WHO, *Report of the Joint Government/WHO Programme Review and Planning Mission.*

[181] http://www.cdc.gov/tobacco/WHO/lebanon.htm

passed several legislations such as: mandatory display of the health-warning message of tobacco advertising on the media outlets, i.e., TV, radio, and print media, prohibitions of smoking in hospitals.[182]

Regarding the anti-tobacco measures and legislation there is the ministerial decision number 1/213 issued on 11/3/93 and law number 394/95 issued on 12/1/95, which prohibits smoking in hospitals, infirmaries, pharmacies, theatres, public transport services, health clubs, and all schools, universities, and in elevators. As for law number 394/95, it is an amendment of the decree number 101/83 issued on 16/9/83, and consists of six items evolving around smoking hazards, stressing the necessity of label warning on all smoking packages including cigarettes and cigars and controlling the smoking advertisement through the media: "The ministry of health warns you that tobacco use leads to dangerous and deadly diseases". Moreover, the tobacco lobby in the country is very strong, spending, 100 Million USD per year on advertising. Smoking in the workplace is very common with more than 80% of smokers reporting that they smoke regularly while at work. The civil society, through active NGOs and some private institutions have attempted some actions that remained shy. Attempts at issuing a law prohibiting advertisement for tobacco use has failed, due to the enormous profit made by media companies.[183]

In view of the importance of the problem from a public health perspective, the MOH, in line with the recommendations of WHO, established a National

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[182] WHO, *Report of the Joint Government/WHO Programme Review and Planning Mission.*

[183] Ibid

Program for Control in 1998. Except for the sporadic media activities (concentrated mainly around the World Tobacco Day), no clear strategy had been developed; the Tobacco Control Program remained also without a defined plan of action. Moreover, there has been a major step in the legislation toward banning all tobacco advertisements in Lebanon. A law was circulated by the Minister of Health to the Council of Ministers to ban all types of Tobacco advertisements on a local TV stations, radios, and all print media. Unfortunately, the Council of Ministers disagreed with the legislation due to the economic laws that face this country.[184]

The National Tobacco Control Program

In Lebanon, a National Program for Tobacco control was established since 1997 as a joint program between the Ministry of Public Health and the World Health Organization. The main objectives of the program are:

- To determine the extent of the economical, sociocultural and behavioral settings to help us understand the factors that influence smoking in the population.
- To reduce the prevalence of smoking among all the categories in the Lebanese population, with more attention given to teenagers to prevent smoking among this risky group.[185]

The developed countries were able to implement policies to cut down on tobacco consumption with effective results; however, the problem is escalating in

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[184] Ibid

[185] http://www.emro.who.int/lebanon/NationalProg-tobacco-WHD2002.htm

the developing ones. Lebanon, a country with one of the highest rates of tobacco consumption, being the fourth largest consumer of American cigarettes as fraction of GDP, is no exception. In Lebanon, data on smoking are limited although the magnitude of the problem is obviously large. The medical community is poorly committed to smoking prevention and awareness policies; medical curricula do not include the community dimension of tobacco-related diseases.[186] With 50% of the population being smokers and 72USD million spent on cigarettes per year, specialists agree Lebanon is in trouble.[187]

In the last few years, the Parliament passed several legislations such as the mandatory display of the health-warning message of tobacco advertising on the media channels (i.e. TV, radio, and print media), label warning on all smoking packages including cigarettes and cigars, and the prohibition of smoking in public places. The civil society, through active NGOs and some private institutions, attempted some actions that remain shy. Efforts at issuing a law prohibiting advertisement for tobacco continue with the strong opposition from the lobby of the profit making media companies.[188]

During 2002, a two-day workshop was held focusing on how to search for tobacco documents on the Web. These documents allow researchers to learn what the tobacco companies knew all along about their product and how they planned to market this product in general and specifically to minors and to developing countries. The information gained has been used elsewhere in lawsuits, criminal

[186] WHO, *Annual Report 2002, WHO Representative Office*, 11.

[187] Jessy Chahine, "Anti-Smoking Campaign Fires Up", *The Daily Star*, 27 November 2004

[188] WHO, *Annual Report 2002, WHO Representative Office*, 12.

investigations, journalistic exposés, influencing politicians and policy makers, and informing the public. In the same year, The Program produced a documentary video "*Ana Wal Hayat*" on the health consequences of tobacco use during pregnancy. A training workshop for monitors and supervisors of the school clubs in thirty schools was also held on the 6th of April 2002. It aimed at training the monitors to work with students on tobacco related projects within the clubs activities, organizing activities for the "No Tobacco Day", and educating students about the tobacco consumption and its health effects. A *Global School Personnel Survey (GSPS),* was launched to document the prevalence of tobacco use, including cigarette smoking and current use of water pipes, cigars and others, among school personnel in Lebanon, to assess their knowledge and attitudes, and to document school policy and school curricula regarding tobacco.[189]

Every year the National Tobacco Control Program celebrates the World No Tobacco Day (WNTD) on May 31st. The program aims at raising awareness on the tobacco epidemic in general and the role of health professionals in tobacco control in particular. World No Tobacco Day 2005 focused on the fundamental role health professionals play in tobacco control. Since they give advice, guidance, and answers to questions related to the consequences of tobacco use they can serve as role models for non-smoking.[190]

On December 17, 2005, the Parliament had given the government its approval to be part of the International Anti-Smoking Convention starting December 7, 2005. However, the Parliament has not yet ratified the Anti-smoking

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[189] Ibid

[190] WHO, "World No Tobacco day 2005 Celebrations in Lebanon", 4.

Draft Law formulated by the Ministerial Health Committee, the World Health Organization Office and Consumers Lebanon Association, more than a year and a half ago. Thus, a delegation from the World Health Organization visited Lebanon on December 13, 2005 to stress the importance of sending experts in the fields of controlling smoking and especially supervising laws, health control, public awareness advertisements, smuggling limitation, tobacco taxes, etc...[191]

Marking the opening of what organizers called "the first national anti-smoking campaign," Dr. Habib Latiri, representing WHO in Lebanon, said: "Lebanon is one of the target consumer countries for most major tobacco companies". Latiri added that smoking was one of the "biggest problems of this era," and that the media should try to suppress the propaganda of tobacco companies. The head of the Lebanese Press Federation, Mohammed Baalbaki, described smoking as a "prominent social disaster". He also called for all media to stop advertising tobacco products in attempt to lessen the number of consumers. Also the chairman of the national anti-tobacco and anti-smoking campaign, Najib Ghosn, said smoking was both a social and an economic problem "whose consequences have a very negative effect on public health."[192] The campaign is directed against all those billboard cigarette advertisements, with the distribution anti-smoking flyers.

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[191] "World Health Organization and Fighting Smoking", *Al-Mustahlik*, Issue 16 Dec 2005

[192] Jessy Chahine, "Anti-Smoking Campaign Fires Up".

Chapter VIII
Conclusion and Recommendations

Conclusion

The Middle East is an area undergoing great transition. Behind the political conflicts that dominate the international headlines is a region whose demographics are changing dramatically. Some Middle Eastern countries, such as Yemen and Sudan, are predominantly rural, with relatively low educational levels, and high mortality due to infectious diseases. By contrast, countries such as Egypt, Jordan and Lebanon are experiencing increasing urbanization, raised educational levels, an increase in chronic diseases, and population shifts reflected in great numbers of adolescents and elderly people. Such changes have profound consequences for health policy and practice.[193]

In Lebanon, although accessibility to health services is high and the institutional and human potential is higher than most countries, the health system continues to suffer to some extent from serious structural problems. The current situation in the health sector provides mixed pictures of positive development trends, on the one hand, and emerging management issues, on the other. The Ministry of Health continues to face important management limitations, which has restrained its efficiency and leadership. The majority of public expenditures on health have been diverted into payment for hospitals services in an ever expanding and dominating private hospital sector. The burdens of acquisition of expensive medical technology added to a very expensive drug bill, among other items weighed on public bills. Important health challenges remain ahead related to the

[193] http://www.wellcome.ac.uk/doc_WTX024037.html

process of demographic and epidemiological transition that the country is undergoing, mainly the development of unhealthy lifestyles.

The World Health Organization was founded in the wake of World War II, in a wave of optimism over the ability of international bureaucracies to create and direct a safe and sane world. With its mission concentrated on managing or eradicating infectious diseases worldwide, the group had some notable successes and some near-successes. By the end of the 1970s, WHO's official rhetoric about its core purpose began to shift beyond simple disease eradication. In 1978, WHO adopted "World Health for All by 2000" as its goal. This assembly of international bureaucrats vowed that, by the close of the 20th century, "All governments will have assumed overall responsibility for the health of their people –through influencing lifestyles and controlling the physical and psychosocial environment." An "equitable distribution of health reserves, both among countries and within countries– is therefore fundamental to the strategy." This plan was "part of that fundamental reorganization of human relationships in the world through the search for a New International Economic Order."[194]

Among WHO's main functions we can mention: setting global standards for health, giving worldwide guidance in the field of health, cooperating with governments in strengthening national health programs and developing suitable health technology and information. WHO is composed of three organs: the WHO Assembly, the Executive Board, and the Secretariat. Worldwide, WHO has eight offices. Among them is: WHO Eastern Mediterranean Regional Office (EMRO), which include Lebanon. Lebanon has been an active member of WHO since 1949.

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[194] http://www.reason.com/0201/fe.bd.who.shtml

WHO is providing direct technical, administrative and financial support to the various programs under WHO/MOH (Ministry of Health) joint collaborative programs, including: The National AIDS Control Program, The National Non-Communicable Diseases Program, The Expanded Program on Immunization and The Tobacco Control Program.

The role of the Lebanese government has evolved over time. Limited to providing care for the poor and less privileged during the first fifteen years of independence, the Government changed its perception to health care to consider it as a "human right". Even though public health facilities were virtually destroyed during the war, the war had relatively limited effects on the overall health situation of the population, notwithstanding the diminished life expectancy resulting from war losses. This might be due to the importance of the education factor and to the strong tradition of self-reliance and private initiative, including non-governmental organizations which were very active during the war. Additional factors were the provision of external emergency and relief assistance, and involvement of international organizations, including UN organizations in delivery of disease control and health programs. Thus, during the civil war, the private sector provided care for the people. After that period, the Government intervention in regulating the health care market became more imperative as privatization expanded. Lebanon illustrates best how inefficient the private care sector would be in the absence of regulation, and the subsequent negative effects on both cost and quality. The health sector in Lebanon is characterized by high level of public expenditures, fragmented, inefficient resource allocation and

service delivery, excessive investment in hospital capacity and high technology, lack of quality assurance and consumer protection, and higher costs.

According to EMRO, the main risk factors of non-communicable diseases are related to lifestyle choices. In fact 75% of these cases are explained by the increase in tobacco use, change in diets, reduction of physical activities and the increase in alcohol use.[195] In response to these facts, MOH established, through a cost sharing mechanism and technical and administrative support of WHO, national joint programs for the control of non-communicable diseases (including cancer). Also, MOH-- in line with the recommendations from WHO-- established a National Program for Tobacco Control in 1997. Important WHO technical and financial support was given to improve knowledge of health trends, disease occurrence and health system operations. Along the efforts made to strengthen the public sector role, which was severely weakened by the war, the Government of Lebanon has sought to address problems of the public hospital system and strengthen their management capacity by enacting a new Law of Autonomy. This Law was updated in 1997 to become hospital based rather than Mohafaza based.

Regarding epidemiology, WHO assisted MOH in the immunization response and in monitoring the rate of immunization through the National Expanded Immunization Program (EPI). In addition, the National Cancer Control Program made it possible to set up a national cancer registry. A national AIDS Control Program is well established and focuses on Prevention and Promotion of safe Behavior.

[195] WHO, *Report of the Joint Government/WHO Programme Review and Planning Mission.*

The HIV epidemic was introduced to Lebanon in 1984, with the first diagnosed AIDS case. Since 1990, AIDS and HIV infections have been reported to the Ministry of Health through its National AIDS Control Program (NAP): the physicians report new cases to the MOH. In 2005, the cumulative total number of reported HIV/AIDS cases was 903 cases. Only one fifth of the cases are females. The main mode of transmission is sexual (with 76%of the cases), followed by transfusion (6%), then by Intravenous Drug Users: IDVU (5%), and finally by vertical transmission or mother to child (2%). Lebanon is still one of the countries with low prevalence in HIV/AIDS.

The National AIDS Program aims at preventing HIV transmission and sexually transmitted diseases (STD), and to encourage and support community participation in HIV prevention. The NAP implemented a number of activities intended to limit the spread of the HIV/AIDS epidemic in Lebanon. It includes community-based intervention, production of awareness material and organization of large youth meetings. A national strategy for AIDS has been endorsed through a consensus workshop that gathered experts, NGOs (mainly WHO) and officials in the sector of health. The strategy elaborated by the program seeks to involve all concerned authorities and NGOs to ensure sustained and continued activities on Prevention, Education, and Patient Support. It also stresses the importance of operational research.

To limit the spread of HIV/AIDS, NAP worked on HIV screening of transfused blood and blood products. To improve health workers skills in HIV/AIDS management, training sessions have been conducted. Deals with the different pharmaceutical companies to provide Anti-Retroviral Drugs at lower

costs in Lebanon were conducted through NAP. Also, media campaigns have been launched and educational material has been developed.

The NAP is the basis of technical assistance and information for planning, implementing, observing as well as evaluating activities related to HIV/AIDS. Although NAP has greatly contributed in the national efforts to limit the spread of the HIV epidemic, many limitations were registered. The largest majority of the cases in Lebanon remain unknown with only one fourth of the cases being reported. In addition, the social-cultural factors (mainly the conservative nature of Lebanese society and the reluctant attitude on the sexual connotations of AIDS) constitute important obstacles in the fight against the spread of the epidemic.

An epidemiological shift has been witnessed over the last decades with the changing disease pattern from communicable to non-communicable diseases. This paradigm shift is progressing very fast, with developing countries faced with double burden of diseases. Not only that the epidemiological pattern is changing but also the demographic and globalization factors are also contributing to rising aging population, sedentary lifestyles and changing nutritional patterns. Non-communicable diseases including cancer are increasing at serious alarming rates. Dealing with cancer in particular, and non-communicable diseases in general, is becoming a must whether coming from public or non-governmental initiatives.

The collaboration between WHO and MOH in regard to cancer gave birth to National Cancer Control Program as part of the Non-Communicable Diseases Program. The program is concerned with cancer: its pathology and the improvement of measures for its prevention and control including early diagnosis, treatment, and after-care.

Due to the fact that Breast cancer is the most common cancer case among females, breast cancer awareness campaigns are being conducted every year in October to highlight the importance of breast self-examination, clinical examination, as well as periodic mammography in early detection and prevention of breast cancer. On the other hand, the increase in smoking among the Lebanese population made Lung cancer the most frequent type of cancer in the Lebanese male population.

To face cancer, the Ministry of Health (in collaboration with WHO) decided to establish the Drug Dispensary Center and the National Cancer Registry. The first allows cancer patients in need for chemotherapy to obtain their medications in case they are not covered by the social security fund or any other type of insurance; whereas the Registry provides a useful source of information related to cancer in Lebanon (number of cancer cases, description of trends in cancer, etc.) . These actions are accompanied by awareness campaigns to help deal with or prevent or even detect Breast cancer or prostate at their early stages. However, the other types of cancers are not given great attention and little efforts are being engaged in those other fields, especially if we are to consider the fact that Lung cancer is the leading type of cancer in the male population. Also, the National Cancer Control Program seeks to add quality to the life of cancer patients through palliative and terminal care.

The power of vaccines is nothing short of miraculous. The world's first vaccine, against smallpox, ultimately eradicated the disease itself. Even when vaccines cannot eliminate afflictions, they can offer lifesaving protection. The bigger challenge will be bringing the miracle of vaccines to the people most in

need. A new push is under way today to extend the lifesaving reach of vaccinations which remain by far the most cost effective public health intervention available. Vaccination programs require concerted effort and staying power. History shows that when they slow down, preventable diseases surge back. But with a determined effort, millions upon millions of lives can be spared.

The Epidemiological Surveillance Unit was established by the Ministry of Health early 1995 in an effort to reinforce the surveillance and control of communicable diseases. Since then, efforts have been deployed to develop a functional communicable disease surveillance system.

Launched by MOH, NGOs, WHO and UNICEF in 1987, the National Expanded Immunization Program (EPI) aimed at providing immunization to children against several diseases (diphtheria, pertussis, tetanus or DPT, poliomyelitis and measles), and at eradicating polio and neonatal tetanus by 1996. Routine immunization services and annual "acceleration campaigns" contributed to an increase in coverage. National immunization days, health staff training and provision of vaccines and syringes were often provided by UNICEF, WHO and other NGOs. However, Akkar and other deprived regions (Hermel, Baalbeck) still suffer from a shortage in terms of immunization services.

Coordination with the central laboratory was strengthened. A hospital network for communicable disease reporting has been established in 717 fixed health centers and dispensaries in both the public and private sectors, where focal persons were designated in each hospital and are communicating regularly with MOH. Records of the health centers' activities are reported to MOH through

reporting forms and immunization cards. Unfortunately, there is no standardization of immunization policies and practices at present.

Recourse to publicity and mass media was often adopted to target and mobilize the Lebanese population. Each year a national central meeting is held to launch National campaign days to target as much children as possible against polio. Wide media coverage is also insured for the campaign and the cooperation of public and private schools is asked for.

As a result to the massive actions taken the indicators of coverage with primary health care show that immunization rate in Lebanon are increasing or being sustained at a high rate. The improvements of the administrative decentralization of the program and the establishment of an effective system for collection of information about child vaccination can be cited as major achievements of this program. The commitment and personal involvement of different authorities made the provision of needed resources for the program possible.

Too often, we are our own worst enemies. The growing use of tobacco around the world represents a health crisis of its own. More than a billion people use tobacco worldwide. As tobacco companies intensify efforts to sell their deadly products to people in developing nations, this number is almost certain to rise. By 2020s, according to WHO predictions, people dying as a result of tobacco related illnesses will number 10 million-70% of them in developing countries.[196] Today, tobacco is the single most preventable cause of death and disease in the world.

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[196] Karen Kasmauski and Peter Jaret, *Impact From the Frontlines of Global Health*, 54.

Due to many limitations that hinder the activities of the tobacco industry in developed countries, the tobacco companies shifted their efforts to target less developed countries where public awareness is lacking. Tobacco has very harmful consequences on the economies of less developed countries: tobacco consumption leads to poverty and vice versa.

The World Health Organization Framework Convention Tobacco Control works to limit tobacco use, initiation of smoking, exposure to secondhand smoke, and promote cessation. The Tobacco Control Office collaborated with the MOH to convince the Lebanese government to join the World Health Organization Framework Convention Tobacco Control. The collaboration succeeded and on December 17, 2005, the Parliament approved to be part of the International Anti-Smoking Convention.

Tobacco control efforts in recent years started with a ministerial decree from the ministries of Health and Interior in 1993. It prohibited smoking in hospitals, infirmaries, pharmacies, theatres, public transport services, health clubs, schools, universities, and elevators. In 1995, Parliament passed a law mandating warning labels on all smoking packages including cigarettes and cigars, and controlling smoking advertisement.

Studies showed that Lebanon has one of the highest rates of smokers in the region with a prevalence of the male smokers on female ones. This explains why lung cancer is the main type of cancer hitting the male population. The need for a program to control tobacco emerged.

The Tobacco Control Program aims at studying the factors that influence smoking and at reducing smoking prevalence in Lebanon. Although the program

has no clear strategy, it concentrates media activities (mainly: billboard cigarette advertisements and distribution of anti-smoking flyers) around the World Tobacco Day on May 31st. To increase public awareness against smoking, workshops have been held since 2002. Documentary videos showing the negative consequences of smoking are displayed and efforts to document school policy and school curricula regarding tobacco are being engaged.

Recommendations

The strength of the health care system rests on the quality and quantity of resources available such as hospital capacity, advanced technology and medical expertise. These resources have made possible the observed overall high level of accessibility to health care services. However, the health sector in Lebanon appears to have an inverted structure whereby resources are essentially concentrated in tertiary care rather than in secondary and primary health care levels. Primary health care is still fragmented with no linkages with the higher levels. As a matter of fact, the concept of health for all, to which Lebanon has subscribed, places equal access to quality health care at the center of health development. This goal can best be achieved through sustained services that provide better care, use resources more efficiently and facilitate regular access to basic care. For this purpose, there is no need to have high-cost advanced technology - intensive hospital care all over the country. Instead, basic health needs can be successfully met through adapted simple and affordable technologies, at first and secondary levels of care. Primary health care has thus become a global blueprint for health care delivery. A tier system should be

created, with links established between the various levels of health services; the first level units attending to the majority of cases and feeding district hospitals, which in turn can refer patients to more specialized centers if need be. It is also important that health structures provide health promotion and disease prevention and ensure rehabilitation services as integral parts of the services, rather than just concentrating on curative medicine.

Also, the impact of such resources on improving the health situation remains questionable in the absence of clear policies for the development of needed human resources, including those needed in support of sophisticated technology, and the absence of adapted regulatory mechanisms for control of costs and ensuring the quality of care.

MOH has the primary responsibility for the administration and development of the health sector, including policy formulation, planning and monitoring of public and private services and programs at the national and local levels. However, at present, MOH's organizational structure, management capabilities and administrative procedures are inadequate. The role of the Government needs to be redefined and the institutional capacity of the MOH has to be strengthened in order to fulfill this role.

At present the MOH is unable to properly discharge its responsibilities due to institutional weaknesses and the Government difficulty in enforcing regulations. Priorities should be focused on policy development, sector planning and sector regulation.

The concept of public health services is still unknown to many professionals in the medical field and the application of public health services is

very shy, since most of the attempts to conduct true public health projects have been implemented jointly by international NGOs or by main international health agencies such as WHO. The MOH major role would be monitoring and assessing the delivery of health services within certain norms agreed upon by both the private and public sector. Efforts should be coordinated to develop clear and effective channels of communication and lines of authority and to redefine the roles and responsibilities of the stakeholders. While each health provider keeps his own agenda, coordination needs to rest within MOH. It is important to clarify the relative roles of government and NGOs in service delivery and management, and the government's role in planning and regulation. Mutual trust and the willingness to coordinate are required for the development of the NGO sector towards national policy goals. To realize such potentials particularly in the area of primary health care, assistance is needed to be focused primarily on institutional-capacity development. The redefinition of the relative roles of the public and private sectors, complementarities and comparative advantage in addressing national priority issues is needed. MOH needs also to put rigid criteria and norms as well as develop quality monitoring procedures and tools before launching any new joint project in order to guarantee proper use of public funds.

National data for planning and monitoring are generally insufficient. Therefore, a major requirement is to develop cost effective national data collection and evaluation mechanisms for use by the Government, the private sector and NGOs. Extensive use has been made of estimates of indicators, and there are often conflicting sources of information on these indicators. In fact, the last national population census was conducted in 1932, and vital registration is

incomplete. Therefore, one would question the value of the estimates, based on which the calculations were made for Lebanon, such as Life tables, and Causes of Deaths.

MOH should aim at setting up a documentation center and personnel should be assigned to ensure regular updating of incoming documents as well as streamlining the available documentation. In fact, there is a widely-felt need for establishing and operating a modern and efficient comprehensive data base system of all health related NGOs in Lebanon. In this respect, the successful experiences in this area of other countries and lead agencies should be drawn upon. The growing body of knowledge, including advanced computer technology application must be tapped in setting up the desired data base system.

To ensure their long term sustainability, immunization services should be delivered within a comprehensive plan or a clear strategy to deliver immunization on a routine basis and through an extensive Expanded Immunization Program (EPI) infrastructure. Once standard and clear policies on immunizations are launched, it would become easier to convince the NGO and the private sector to adopt the national schedule. The collaboration schemes between MOH and MOE (Ministry of Education) to widen the scope of the program and enhance school health involvement in EPI must be encouraged. Also to address the question of technical capacities, training and/or refresher courses should be provided to upgrade and maintain the technical knowledge and skills of health workers at all level for sustaining high immunization coverage.

Regarding AIDS, a comprehensive review of National AIDS Control Program (NAP) activities should be carried out in order measure the program

performances, the community involvement and the training impact. Most of the NAP activities should be integrated within the Primary Health Care strategy. Greater commitment should be ensured to NAP sustainability, increased mobilization of national resources and active involvement of all relevant sectors, ministries, and NGOs in the planning, implementation, monitoring and evaluation of the program. Additional human and financial resources should be provided to enhance NAP effectively and efficiently. Efforts should continue to strengthen the network of NGOs and improve outreach activities particularly in peripheral areas and in some communities at particular risk for HIV/STD.

While several actions took place in response to cancer's alarming rates (National Cancer Registry and Awareness campaigns), more studies are needed to tackle the issue of policy making in controlling the disease. The implementation of a policy set by the Ministry of Public Health that obliges all hospitals to cooperate or even to report cancer cases they have is very vital to increase the effectiveness of the cancer registry as a cancer registry as a cancer incidence reporting system. Since the incompleteness of cancer-specific data is another limitation, the registries must include data such as the pathology of the cancer cases, information related to treatment facilities, and death certificates.

It is also recommended to follow up patients who had been diagnosed with cancer and to provide them with treatment. On the other hand, the funding of the campaigns by the private sector endangers their continuous launching in case the private companies refused to do the funding. Thus, to ensure the continuity of these promotional campaigns, and ensure increased benefits along the years, a budget should be set by the Ministry for these objectives.

The public sector in particular, must be more involved to deal with the most dominant cases of cancer. People must be taught to recognize the early warning signs of cancer. Although most of the awareness campaigns focused on breast cancer and some of them on prostate, similar campaigns must be launched for other types of cancer especially if we are to consider that lung cancer is the most predominant type of cancer in the male population.

In fact, tobacco consumption is behind most of the deaths from lung cancer, and other types of cancer (such as oral cavity, larynx, oesophagus...). This fact makes most of the cancer cases preventable if the individual is aware of the effects of actual life styles and exposure to environmental substances on health in general. This is why campaigns must be launched in order to show the bad consequences of tobacco consumption. The involvement of political and non-governmental parties must be sought to ensure the implementation of a policy to control smoking disregarding the fact that one of the largest revenue generating sectors of the country is tobacco industry. Also, in the field of controlling tobacco consumption, tobacco advertising must be banned to limit the targeting of young population and warning labels must be stated clearly. As for the tobacco consumption in public places, a clear law prohibiting smoking is not sufficient if it is not well applied. Thus, the right authorities must seek to make sure smokers abide by the law.

Finally, it is clear that the collaboration between MOH and WHO is a fact. However, a review is needed in many joint programs between the two entities to guarantee the highest level of efficiency in what serves the interest and safety of the Lebanese population. In other terms, it is suggested that the MOH regulates

the policies and activities related to Public Health to avoid duplication of efforts in some cases and neglect in others.

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