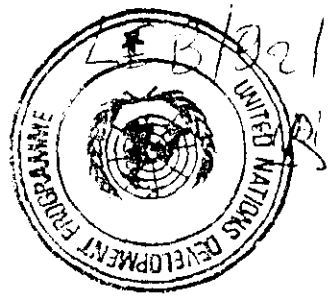

Republic of Lebanon
Office of the Minister of State for Administrative Reform
Center for Public Sector Projects and Studies
(C.P.S.P.S.)

ANNEX 4

HEALTH ASPECTS

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-I-INTRODUCTION

After the improvement of the security situation in Lebanon, the Government started to plan for reconstruction and development. Attention was to be focused at two main levels: first, the areas that was directly hit by the war and its aftermath, and second, the areas that did not receive adequate attention during the long years, namely, the remote rural areas situated at the periphery. The region of Baalbeck/Hermel in the Beka'a valley was among these areas. Attention was called by the Baalbeck/Hermel area for a number of reasons :

- Over the years, this area has been the main producer of illicit crops in Lebanon.
- The weak presence of governmental institutions in this area.
- The weak infrastructure present in the area whether related to health, education, transportation and water.

The area is characterized also by the high number of small villages dispersed over the area and the social organization along family and clan divisions.

Moreover, due to the absence of governmental NGO's have emerged and tried to provide social, health and educational services.

Previous projects have been implemented in this area in an attempt to find substitute plantations for the illicit crops. Most of these have failed however because the crops introduced did not compete with the illicit crops. Most importantly, these projects did not adopt an integrated and comprehensive approach to development.

Since 1992 a new plan started to be developed for this area, replying on an integrated rural development approach.

-II-OBJECTIVES

This report covers the findings of the assessment done for the health conditions and the facilities in the region of Baalbeck/Hermel and which took place in July 1993. This was a part of the assessment of the socio-economic characteristics', a preparatory step for the Integrated Rural Development Programme for the Baalbeck-Hermel region.

The specific objectives of the assessment that we undertook on the Health conditions and facilities were as follows:

1. Maternal health:
   a) Prenatal care
   b) Delivery

2. Child health:
   a) Immunization status for DPT OPV and measles
   b) Diarrheal diseases: incidence and management.
   c) Breastfeeding

3. Environmental conditions:
   a) Availability of domestic water and its status
   b) Refuse collection and disposal
   c) Pests and rodents
   d) Waste water

-III-MATERIAL AND METHODS

The methodology followed for collecting information about conditions and facilities has included three main methods:

1. Interviews done with mothers through the use of a structured questionnaire.
2. Direct field observations at household level.
3. Semi-structured interviews with key health personnel in the area.

A. Sampling:

The sample has included 125 mothers who have at least one child under five years of age to obtain information on diarrheal diseases and one child aged 12-23 months to obtain information on the immunization status and breastfeeding patterns. The villages were selected on the basis of criteria relevant to the study, namely:

a. Community or village used to growing or not illicit crops.
b. Big town or small size village.
c. Remote versus close proximity to major city.
d. Big gathering of small scale farmers.
e. Even religious distribution.
f. Representative geographical location.
g. Irrigated versus non-irrigated land.
h. Higher rainfall versus lower rainfall.

B. The survey instrument:

The survey instrument consisted of one questionnaire that included information reflecting the above objectives. It was built along guidelines specified in standard WHO questionnaires modified to fit the needs of this study.

C. Data Collection:

Data entry and data analysis were done at the department of Sociology of the American University of Beirut using D BASE and SPSS.

-IV-FINDINGS

The sample has included 125 mothers, 33.6 per cent of whom are from Hermel and 67,2 per cent from Baalbeck.

A. MATERNAL HEALTH

1) Prenatal care

72,8 per cent of mothers had prenatal care by visiting professionally trained health personnel (physicians and midwives), while 2,4 per cent had visited a TBA (Traditional Birth Attendant) and 24,8 percent did not have any prenatal care, as shown in table 1.

TABLE 1 : Percentage of Women with Prenatal Care.

Physician	63,2%
Midwife	9,6%
TBA	2,4%
No one	24,8%

54,1 per cent of women have visited a physician at least four times during their pregnancy.

The reasons for not visiting a health professional during pregnancy are revealed in the following table.

TABLE 2 : Reason for not have Prenatal care.

Financial reasons	31,6%
Distance	2,6%
No need	58%
Other reasons	2,6%
No answer	5,2%

2) Conditions at delivery.

94,3 per cent said that they did not receive a tetanus vaccine.

The attendants at delivery are shown in the following table.

TABLE 3 : Attendance at delivery

Physician	58,4%
Midwife	20%
TA	17,6%
Others	4, %

As for the place of delivery, hospitals seem to be the largest group as shown below.

TABLE 4 : Place of Delivery.

Hospital	54,4%
Home	23,2%
Small clinics	20,8%
Others	1,6%

B- CHILD HEALTH

1) Immunization.

The survey has revealed that 81,3 per cent of children aged 12-23 months had received DPT/OPV. Most of the information on immunization was obtained from history by the mother and not from the immunization cards as shown in the following table.

TABLE 5 : Immunization status of children 12-23 months

	DRT/OPV1	DPT/OPV2	DPT/OPV3
From Card	28,8%	27,2%	22,5%
From History	64,4%	62,1%	58,8%
T O T A L	93,2%	89,3%	81,3%

As for measles, 56,3 per cent of children were immunized while 43,7 per cent did not receive measles immunization.

The reasons for failure of immunization against measles are reported in the following table.

TABLE 6 : Reasons for failure of immunization against measles.

Lack of information	14%
Problem of accessibility	11,6%
Child sick, not brought	23,4%
Lack of belief	25,5%
Others	25,5%

TABLE 7 : Place of immunization

Immunization place:	DPT/ORV1	DPT/OPV2	DPT/OPV3
- Mobile team	11,5%	9,4%	6,2%
- Dispensary	72,5%	74,2%	76,3%
- Private clinic	16,0%	16,4%	17,5%

2) Diarrheal diseases.

35,3 per cent of mothers reported that their child had diarrhea during the past two weeks of the survey.

As for the management of diarrhea, results revealed that a large proportion of the mothers who were breastfeeding continued to do so (89 per cent) while 7,4 per cent of them stopped, a 39 per cent of mothers have increased fluid intake for their children during diarrhea, while 61 per cent did not.

As for the administration of anti-diarrheal drugs, half of mothers said that they gave their children drugs and half did not .

On the other hand, only 17,1 per cent of mothers have given children ORS (Oral Rehydration Salt) and 82,5 percent did not.

3) Breastfeeding.

80,8 per cent of mothers said that they have ever breastfed their last child.

C.Environment

1) Source of drinking water :

The sources of drinking water for households are shown in the following table.

TABLE 8 : Sources of drinking water

Tap Water	47,6%
Outside the house	4,0%
Cistern	8,1%
Well	17,7%
Bottled table water	4,8%
Spring	17,7%

As for the treatment of drinking water 74,2% of the respondents do not treat it at all while the others use the following methods

Boiling	12,9%
Chlorine	1,6%
Filtration	8,1%
Exposure to Sunlight	0,8%
Others	2,4%

Refuse collection at home is done through the following:
45,6 per cent said that they kept them in containers with lids
33,6 per cent in containers without lids
20,8 per cent kept them by other means

More than three fourths of mothers namely 87,1 per cent, complained from mosquitos and rodents within the Hermel dewellings. Half of them (48,3 per cent) complained also of open sewer lines.

-V-DISCUSSION AND RECOMMENDATIONS:

A) Prenatal care:

There is a high proportion of mothers who do not have prenatal care, or do not see professionally trained health personnel. The main reasons were financial (31,6%) and lack of awareness (58%).

This lack of awareness about the importance of prenatal care is coupled with the low proportion of women who have tetanus vaccination. Moreover, it is note worthy that only women who were coming from outside the country were those vaccinated for tetanus.

On the other hand, almost half of deliveries take place either at home or in small clinics (where they stay for one day). All these factors taken together imply that mothers are at risk for their health: problems related to nutrition during pregnancy might affect the weight of the baby at birth; lack of health care during pregnancy might affect the mother's health (anemia; closely pregnancies; etc...) unhygienic conditions at delivery might also lead to complications.

Recommendations:

1) An in-depth Study of the reasons for lack of prenatal care, through interviews with selected mothers.

2) Supervise and monitor, the quality of the health care provided by midwives, and especially by TBA's.

3) Training programmes of midwives and TBA's

4) Where necessary, supply of basic equipment to small clinics.

B) Immunization:

There seems to be an acceptable rate of child immunization. This apparently the result of the joint efforts exerted by the MOH NGOs, WHO and UNICEF. A remarkable result however is the high rate of drop-out between the first and the third dose for DPT/OPV. The reasons for this drop-out should be studied to put the appropriate strategies for dealing with them.

The level of immunization for measles is lower than of DPT/OPV as found in other studies. The lack of belief in the need of immunization against measles is the main reason behind

this phenomenon. People think that a child is going to get measles whether he is vaccinated or not, it is like a matter of fact.

There is an important role played by the public and NGO sector, while the private sector is weak. We were able to note this through our observations in health fields besides child immunization.

Recommendations:

1) Upgrade the knowledge and information of health staff in dispensaries so that they become able to give advice and raise awareness of parents about importance of immunization and clarify misconceptions.

2) Strengthen the fixed health infrastructure because this is the most important and most permanent health structure, while mobile teams may not continue to exist for a long time.

C) Diarrheal diseases

The prevalence rate of diarrheal diseases among children is close to the one obtained by MOH, and UNICEF in their national study in 1990. However, the management of diarrhea at home level should be more studied to see why mothers are not increasing fluids, and why they are still using anti-diarrheal drugs while these have been forbidden . More specifically, we need to see what types of drugs are used.

Recommendations:

1) Control the use of anti-diarrheal drugs prescribed by physicians.

2) Raise awareness of mothers about the need for proper infant and child nutrition during diarrhea.

D) Breast feeding

Most of the mothers seem to breastfeed as to contraceptive method.

Recommendations:

Promote proper breastfeeding among mothers and present them from moving into the bad practices of bottle feeding.

E) Environment

The environmental conditions in general seem to be very deteriorated in the region. This is reflected in terms of accessibility of water, its quality, and the practice related to refuse disposal.

More specifically, the infrastructure does not seem to offer any facilities to people. Most of them have to rely on getting water from outside their house. Moreover, people do not seem to have any ideas about treatment of drinking, water. As for refuse disposal, this is done on an individual, household level and not on a community level. The absence of governmental projects during the years of war and the focus of governmental activities on the cities and in areas affected by war had negative repercussions on the water and sanitation infrastructure.

Recommendations:

1) Improve the infrastructure in order to provide access to piped in potable water. This is an endeavour, that has to be done by the government with the help of the community.

2) Improve the government's capability to monitor the quality of water.

3) Raise awareness of the population about the importance of safe drinking water and give them information about simple techniques for disinfecting water since people are not aware at all about these matters.

4) Improve the system of waste water and refuse disposal since this directly affects health.

F) Health facilities

Through the meetings and visits that I was able to hold during my short stay in the area, I could rate the following with respect to the health facilities.

1) Lack of coordination among all health institutions, even those operating in a small village.

2) lack of statistics and informations about health conditions by people in health facilities.

3) Absence of preventive health services with a predominance of curative and therapeutic health services.

4) Lack of basic equipment in the health centers.

5) Low quality of care and absence of highly qualified health personnel in the health facilities.

-VI-GENERAL RECOMMENDATIONS

1) Work towards the improvement of the Socio-economic conditions of mothers, since financial reasons were revealed as an important obstacle for health care.

2) Raise awareness of mothers through both interpersonal communication and mass media.

3) Unify the strategy for the child immunization, management of diarrheal diseases, and all other factors related to primary health care among physicians, since they are coming from different schools.

4) Try to create income generating activities especially for women.

-VII-CONCLUSION

I have noted all throughout my work that many studies were done by different organizations with respect to health care and health conditions in the area of Baalbeck/Hermel. One thing should be done now is to coordinate and put together all these studies and all the strategies, plan of action that were put down in order to insure maximum efficiency and cost effectiveness.

Finally, a health plan for this area should be an integral component of the primary health care plan that is put for lebanon as a whole.

ANNEX

The following meetings were conducted with the concerned agencies who could be of use or have undertaken development work in the region of Baalbeck-Hermel:

- Ministry of Health:
  H.E Mr. Marwan Hamadé: Minister of Health
  Dr. Mohamed Ali Kanaan

- Ministry of Social Affairs:
  Mrs. Neemat Kanaan: Director General of Social Affairs

- Ministry of Public Works:
  H.E Mr. Mohamed Bassam Mourtada: Minister of Public Works
  Dr. Reem Kanso

- UNDP Lebanon:
  Mr. Hendrick van der Kloet: UNDP Resident Representative
  Mr. Philippe Poinsot
  Mr. Mounir Tabet

- UNICEF:
  Dr. Ali El-Zein: Programme Officer for Health
  Hatem Dimashki (Area field officer: Bekaa)

- WHO:
  Dr. Adel Hay Mechbal: WHO Representative

- Red Cross:
  General George Harrouk: President, Lebanese Red Cross
  Mona Mahfouz (Hermel)
  Mayada Ghosn: Medico-Social Assistant (Baalbeck)

- American University of Beirut (AUB):
  Mary Deeb- PhD: Assistant Professor, Epidemiology

- Middle East Council of Churches (MECC):
  Miss Lina Mukheibir

- Terre des Hommes:
  Miss Lina Chamas
  Soeur Anne Chantal (Hermel)

- Dispensary of Social Affairs:
  Mr. Nadia Tawtal (Bourj-Brajneh)
  Mrs Houda Souaid (Baalbeck)
  Gada Kenaan (Planning familial - Baalbeck)

- NGOs:
  . Young Men Christian Association (YMCA)
    Mr. Andre Karam
    Mr. Ghassan Sayah
  . Congregation des Petites Soeurs de Jesus
  . Order of Malte
  . Al Haya Sohiya Al Ilamiah

- Amal Movement
- High Shiite Islamic Council
- Hizballah
- Amel Association
- Al Mitha Association
- Tawjih Al Islam Association.