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REVIEW OF REPRODUCTIVE HEALTH RESEARCH IN LEBANON

by:
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A. INTRODUCTION

Reproductive health issues are deeply rooted in the biomedical dimensions, yet their origins often lie in human behavior that is at the heart of sociocultural dimensions. Sociocultural research has a major contribution to make to our understanding of consequences of reproductive ill-health. It brings a wide array of qualitative and quantitative tools that can be used to gain insight into reproductive health issues. It also brings a perspective that stems partly from the consideration that technology, interventions and services should be modified to suit people, rather than the other way around. The reproductive health sub-programme for Lebanon clearly emphasizes and stresses the need for sociocultural and operations research. This research should aim at improving quality of RH services and their utilization. As such, the mission document calls to select priority areas for improvement and to conduct studies to asses efficiency, examine utilization patterns of current services as well as determine satisfaction levels of service users. The mission also recommends that the government should conduct sociocultural research on attitudes of men, women, youth and adolescents toward Reproductive Health and Family Planning (RH/FP) issues to compliment the existing research in this area.

In its attempt to improve the quality of care that should accompany the transition from family planning services to the full provision of RH care, the mission also recommends conducting socio-cultural research aimed at improving quality and ensuring safety of RH/FP services, taking into account women's needs and perspective when organizing the services. Research should also focus on measuring programme impact especially for the new initiatives. As such, select priority areas for improvement and conduct studies to assess efficiency, examine utilization patterns of current services as well as determine satisfaction levels of service users. At the time the mission document was being prepared, research activities in reproductive health were scarce and scattered. The recommendations inherent in the document had set grounds for launching research in certain priority areas in reproductive health matters. Though most likely these recommendations were not followed, other RH sub-programme constraints had contributed to lack of research agenda that will direct and guide the efforts and interests of RH researchers in various arenas. Fortune enough, the establishment of the national RH sub-programme had prepared and contributed to the foundation of few research groups and initiatives that will later on produce most of the available RH research. Some of these groups are concerned with different RH topics like safe motherhood, reproductive morbidity, and men's role in RH.

In this endeavor, and with this prevailing situation in the background, the review will attempt to compile all the available completed and ongoing research work that tackles RH

issues as defined by the ICPD, and will try to reflect on this work and on future areas of research.

B. Methodology

This review comes in two parts. The first part is a compilation of all the available research on RH, completed and ongoing. Each work will be compiled under a relevant RH heading, and will be summarized in a way to show its purpose, methodology, results, and conclusion or recommendation. It will be made clear if the work is published, unpublished, or ongoing. The compilation will include all the possible topics that touch directly or indirectly on RH matters in order to expose all the efforts done in this regard. Special note will be made on the compiled work of students and graduates in various disciplines of reproductive health.

The second part of the review reflects on the compiled work in terms of its practical relevance and novelty, and will try to come up with certain remarks and recommendations for future research. Research restrictions will be reviewed along with possible areas of duplication in research if any. This review does not in any mean pretend to judge the quality of contents of these works, but it attempts to provide different researchers and other interested groups a kind of data base on RH research in the context of the national RH sub-programme.

C. Compiled Research by RH Topic

The research topics are compiled under five headings: STD/HIV/AIDS, Reproductive Morbidity, Safe Motherhood, Family Planning and Fertility, Youth, Gender and IEC, Combined RH Topics, and Others.

1. STD's and AIDS

The WHO being an executing partner of the RH sub-programme, is responsible for executing the operations of the research component. It has supported and sponsored several research activities, while other institutions carried out their own research on reproductive health issues, some of which were also assisted by WHO.

Starting 1992, the National AIDS Control Program (NAP) in collaboration with the WHO sponsored a series of Knowledge, Attitude, Behavior, and Practice (KABP) surveys related to HIV/AIDS in Lebanon. The main aim of these surveys is to describe and examine the knowledge, attitudes, behavior, and practices of different populations in the Lebanese community, to be able to devise proper intervention models, and thus minimize spread of HIV/AIDS. This series was designed, implemented and reported by Dr Abdo Jurjis. The surveys will be presented by the title of the studied group.

The refugee camps (1992)

The methodology of this survey involved interviewing around 1500 persons from 500 randomly selected families in 7 large refugee camps. It was analyzed with respect to knowledge, attitudes, and practices related to HIV/AIDS according to age group, sex, occupation, marital status, and level of education.

Results show that in assessing the level of knowledge , generally the refugees were still confused about the true nature of AIDS disease with males being better knowledgeable than females (less so in widows and divorced), and the younger better than the older. However, there was good level of knowledge regarding modes of transmission and high risk behavior, despite low level of knowledge about degree of infectivity. Just above one third of the sample realized that there is no cure . A proportion ranging from 1/3 to 1/2 of the sample are not clear about modes of non-transmission like kissing, toilet seats, hand shaking etc.

The author concludes that the majority of the interviewed believe that AIDS is a serious problem in camps, but little will sympathize, and they are willing to take all the necessary measures and practices to prevent its transmission. Nevertheless, the use of condoms for protection was disregarded due to possibility of breakage. A good percentage mentioned abstinence and advised health education. Mass media was the main source of information. The author recommends special awareness and counseling programs for this community to help them deal better with this problem.

The laboratory technicians (1993)

This survey aims for an initial assessment of the KAP of laboratory technicians concerning HIV/AIDS biosafety precautions during testing. The methodology involved using 59 observation lists and 115 questionnaires for technicians covering most of the labs in Lebanon testing for HIV.

Results reveal that regarding HIV/AIDS knowledge, technicians got their information from medical journals, books and physicians. Regarding the knowledge of safety measures and precautions, about 15% of technicians were aware of the presence of a universal precaution list, and about 1/3 did not know about modes of HIV transmission. Worrying enough, a proportion of the sample between 20-50% of technicians is not practicing proper measures regarding disposal of infected material, wearing gloves, and use of special boxes. The majority requested training courses and workshops. The author recommends that NAP responds to the needs of those technicians by providing them with skills and training needed.

Nurses (1993)

This study aims at assessing KAP of nurses in relation to patient care and infection in the various health settings. Methodology involved surveying a total of 314 nurses with a

questionnaire answered by an interview. The sample is randomly selected, and representative of all the Muhafazats. Results imply that most of the nurses were overloaded with patient's care, and around 18% had a university level affected gravely their learning and continuous education as well as educating patients and their families. Although nurses seemed to know very well the different modes of transmission of the HIV/AIDS and the risk of asymptomatic carriers, they still have misconceptions about the possible transmission by casual contacts. This is affecting negatively their attitude towards strict application of universal precautions to all patients. In fact , nurses practice universal precautions only on HIV positive patients. They falsely agree (97.5%) that the success of universal precautions depends on the health personnel knowledge of HIV status of the patient. It seems that they miss the basic philosophy of universal precautions. Regarding their perception of AIDS, the majority of nurses expressed certain thoughts, feelings, and opinions that are not consistent with international health standards and instructions; nevertheless they would report AIDS cases to health registry officials which is cooperative in this case. The study also revealed that nurses were not clear about the path physiology of the disease, its various stages and its complications.

The author concluded that the attitudes of nurses towards AIDS patient reflected a lot of discrimination at the basis of HIV status and affected seriously the approach and the performance of procedure and care. This might be related to the need of nurses for more appropriate information on the AIDS disease, as their current sources of information are audio-visual mass media, and journals and workshops for those in university settings. A lot of efforts should be done to assert to nurses the basic preaching and education concerning AIDS disease and patients It remains an essential matter to act to raise awareness and improve infection control in clinical settings.

Secondary School Students (1993)

This survey is looking into the KABP of secondary school students, stressing the need for adequate formulation of health education programs on AIDS at schools. Methodology included 2235 students randomly selected from private and public secondary school, representing all grades.

Results revealed the need for proper AIDS information provision for students. Certain variables identified some suitable means that are culturally and socially widespread to help launch an effective AIDS program. It was concluded that school teachers (biology) must receive adequate capacity building on AIDS, as they represent a good source of information for students. TV could be properly used to channel scientific information and suitable guidance to students nation-wide. Future campaings for students in curricular and extra-curricular activities should stress issues related to HIV testing, transmission, and their effect on reproductive health. The need to decently deal with AIDS victims should be emphasized.

Out-of-school Youth (1994)

This study aimed to assess the educational needs of the out-of-school youth using the Focus Group Discussion sessions. Results show that the level of knowledge of this "hi risk" group was not satisfactory, as their knowledge of causes, stages and modes of transmission, in addition to preventive measures of AIDS was confused. This insufficient and confusing knowledge had seriously affected the sexual practices of the sample studied, where the majority engaged in unsafe sexual and physical (skin piercing) practices. These findings entitled the investigators to adopt an educational campaign (brochure, educational sessions, and condom distribution) that was found to impact remarkably the knowledge, attitudes, and behaviors of the out-of-school youth.

The investigators recommend that out-of-school youth needs particular attention concerning clear information provision, easy access to condoms, information, and counseling, and available job opportunities.

Students-Officers (1995)

This study tried to look into the KABP of students-officers, and consequently to intervene by providing educational materials and sessions, and assess outcome. Methodology involved Focus Group Discussions revealed a group at hi risk regarding insufficient knowledge and indulgence in unsafe sex practices. After an intervention in th form of a booklet containing an educational material followed by a group discussion (30-40 persons), the response was positive and the sample studied expressed they know better and are willing to know more and to adopt safer behaviors. The author calls upon making educational sessions more regular and sustained by reinforcing booklets and group discussions and relevant illustrations.

General Population (1996)

This national study assessed the prevention efforts aimed at reducing the rate of HIV transmission through sexual intercourse using selected indicators. The methodology included a representative sample of 1504 respondents, age 15-64 surveyed in relation to KABP. The sample was characterized by the presence of high-risk indicators regarding non-regular multiple partners, early sexual activities, and unsafe sexual practices.

Data show that this study reflected remarkable improvement in awareness and knowledge concerning the various aspects of the disease and its prevention. In addition, the overall rates of misconceptions decreased, yet many still believe that HIV/AIDS carriers always show symptoms. Despite more availability and easier access to condoms their rate of use is still relatively low. This lack of condom use in the face of relatively high percentage of non-regular partners could present a risky window for potential HIV transmission. The perception of risk, attitudes and behaviors of people towards HIV/AIDS patients although progressed from 1991, more work is needed to introduce positive changes in lifestyles, and adoption of safer sexual behavior.

The researchers recommend that the future work in the prevention of HIV transmission in Lebanon should stress upon: repeat essential prevention messages, address misconception, issue of asymptomatic HIV positive, promote safer sexual practices, and focus on the peripheral zones.

Jihan Tawileh (1993), Females and HIV infection in Lebanon 1988-1993 (from the National AIDS Control Programme).

From 1988 to 1993 around 205 individuals were reported to be infected with HIV. Out of these, 16% are females. They seem to have contacted the disease primarily from heterosexual contact; intravenous drug abuse was responsible for less than 10% of the cases. The author recommends immediate interventions as there are no available data on safe sex in Lebanon, and the number of unwed mothers is almost unheard of in addition to expected rise of prostitution.

Elie Karam (1993), Women and AIDS (in an Expert Report on Substance Abuse in Lebanon, presented to WHO)

This report contains a special reference to women and AIDS. It notes that of the 205 individuals HIV infected individuals reported in Lebanon from 1988-1993, 16% are females. They seem to have contacted the disease primarily from heterosexual contact; intravenous drug abuse was responsible for less than 10% of the cases.
The author recommends immediate interventions as there are no available data on safe sex in Lebanon, and the number of unwed mothers is almost unheard of in addition to expected rise of prostitution.

Ghada A. Nuwayhed (1997), AIDS and Unprotected Sex: Knowledge, Attitudes, Beliefs and Behaviors of Students at the American University of Beirut (thesis dissertation for a Master of Science in Population Studies)

The purpose of this study is to investigate AIDS-related knowledge, attitudes, beliefs and behaviors of students at the American University of Beirut. It also aims to identify the relationship between condom use, as a protective measure against AIDS, and elements of the Health Belief Model, and with individual, parental, and general characteristics.

The method of investigation was an 8-page questionnaire distributed through campus mail. Four hundred and sixty seven subjects were drawn from a stratified student population enrolled in the 1995/1996 fall semester on a simple random basis. A total of two hundred and eighty-eight questionnaires were received. In general, the respondents were single, Lebanese, heterosexual, and almost evenly distributed between males and females belonging to middle and high class. The average age was 20.91 years. Almost 50% of respondents claimed to be sexually active with 68.1% of who are condom users.

The respondents were knowledgeable about AIDS and expressed positive attitude towards AIDS and condoms. The levels of perceived severity of and susceptibility to AIDS were moderate. Although they perceived condom use as an effective method against AIDS, several barriers to their use were reported mainly: unpleasant to use, reduce sexual pleasure, prone to tear, and partner disagreement to its use. On the other hand, reading or hearing about AIDS, or discussing AIDS with family members, physicians, or friends motivated students towards condom use. Students also expressed their willingness to change risky practices related to AIDS by selecting and limiting partners, condom use, and avoiding sex with high risk groups. Compared to other variables, determined perceived severity of and susceptibility to AIDS have stronger predictive power of condom use. The study recommends educational campaigns on proper condom use and adequate sex education and its role in minimizing vulnerability of youg adults to AIDS.

Ongoing Research:

National AIDS Program (1999). STD Sentinelle Surveillance in Lebanon

The aim of this study is to determine the prevalence of STD's among women attending obstetrics and gynecology clinics. It is hoped that this will help determine the etiology and pattern of STD's among clinic attenders and of the antimicrobial susceptibility pattern of some STD pathogens.

A total of 700 cases from 4 centers will be interviewed and examined. The age range is 15-55 years and pregnants are excluded. Collection of different laboratory specimen is done in the clinic. At the laboratory, tests for candida, trichomonads, N. gonorrhea, chlamydia, H. ducreyi, and syphillis will be carried out. All patients with STD related syndromes will be treated syndromically according to national guidelines.

Adnan Mroueh and Muheiddine Seoud (2000), Prevalence of Human Papilloma Virus in Lebanon (from the Department of Obstetrics and Gynecology, Faculty of Medicine, American University of Beirut)

This study aims to look at the prevalence of Human Papilloma Virus in Lebanon by examining registers and charts.

2. Reproductive Morbidity

Muheiddine Seoud, Ali Khalil, John Jamal, and Faysal El-Kak (1994), Pap Smear at the American University of Beirut - Medical Center, 1994: How Good is our Screening? (from the Department of Obstetrics and Gynecology, Faculty of Medicine, American University of Beirut).

This study aims to look at the correctness of the technique used in collecting Pap smears and to assess their reports. The methodology involved reviewing all 3000 Pap smears done

over a period of one year (1993-1994) and examined the means of reporting and the results. Results show that the percentage of positive findings is very low and some means of reporting are not satisfactory. The authors urge specialists to adopt to standard guidelines in performing and reporting Pap smears.

Mary Deeb and Francoise Ghorayeb (1994), Who Goes for a Pap Test? Preventive behavior among women in Beirut, Lebanon (from the Faculty of Health Sciences, American University of Beirut).

This study aims to assess the preventive behavior among women in Beirut, Lebanon. In order to assess the reason for non-utilization, a questionnaire was designed that looks at the knowledge, attitudes, beliefs and behavior of women concerning the Pap smear test. In addition, hospital-based data collection on cervical cancer was carried out in order to evaluate the seriousness of the problem in Lebanon. Results showed a low rate of preventive health services utilization, including Pap smear screening. The authors recommend encouraging women to use preventive services by working with health care providers and women themselves.

Mary Deeb, Francoise Ghorayeb, Tamar Kabakian and Naji Aswad (1995), Reproductive Morbidity Database (from the Faculty of Health Sciences and Faculty of Medicine, American University of Beirut).

The aim of this project is to attempt to strengthen the population laboratory database on reproductive health. For this purpose, the group launched two surveys in 1995 that addressed gynecological morbidities: a clinic based study and a hospital based one. Gynecological morbidity data from 779 ever-married women aged 15-49 who reported visiting a gynecologist in a population-based health interview in Beirut, Lebanon, were compared with data collected from 808 ever-married woman aged 15-49 years visiting private gynecologists clinics. These surveys aim to provide a more comprehensive picture of gynecological morbidities in Beirut in terms of women's perception of their symptoms, their health seeking behavior and their medically diagnosed conditions. This will enable researchers to identify the conditions that need to be targeted in prevention programs, specifically through the hospital based data, as well as the conditions that women need to be aware of.

Results of neither of data sources represent the actual prevalence of gynecological conditions among ever-married women aged 15-49 years in Beirut. Nevertheless, in the absence of any other source of information in the country, both data sources shed some light on the importance of certain reproductive health problems like, menstrual disturbances, lower reproductive tract infections, and infertility-related problems, from women's perspective as well as from clinic perspective.

The authors recommend the use of health service data provided a representative sample of providers can be identified, and health service use is high. They also recommend using this study indirectly to analyze medical procedures and assess the quality of reproductive health care.

Mary Deeb (ed.) 1997, Beirut: A Health Profile 1984-1994, Beirut, American University of Beirut.

This study population is based on two population household surveys that were undertaken by the Faculty of Health Sciences, AUB in the city of Beirut in 1983-1984 and 1992-1993. These two surveys provide a unique longitudinal perspective in describing change overtime in health issues. In each household the respondent provided information on all permanent residents of the household,, the survey cohort data covered 1641 comprising a total of 6327 individuals. Morbidity information covered specific current ailments and chronic conditions ever experienced by members of the household. A good section in this study includes issues in reproductive and child health. The method used was based on the perceived morbidity reported by the respondent.

Regarding reproductive and child health section, this section addressed reproductive health through a three-dimensional framework including gynecological diseases and risks, successful childbearing, and reproductive choice. This is the first attempt in Lebanon trying to include reproductive gynecological morbidity indicators in a population-based survey. Use of health services and health indicators are analyzed in relation to selected socio-demographic indicators.

The findings point to a relatively high use of gynecological health services, albeit most of it non-preventive. Women's most frequently reported gynecological complaints were inflammations (part of lower reproductive tract infections) and menstrual irregularities. The most commonly reported medical diagnosis resulting from visits to a gynecologist were conditions of the lower reproductive tract.

Concerning successful childbearing, it was found that among women who delivered in the past 3 years, 94.8% had antenatal care and 92.4% had had hospital deliveries. However, the proportion having postnatal care was lower (59%). Concerning reproductive choice, overall contraceptive prevalence was around 61%, with women interviewed reporting 86% ever using. This represents higher rates of utilization compared to other countries Egypt and Tunisia. A comparison of maternal health care in Morocco and Tunisia which used data from DHS (Obermeyer 93) revealed an effect of socio-economic factors, especially education and women's status, on the use of family planning methods. IUD was the most commonly used, followed by rhythm method and oral contraceptives. However, close to 40% are still using the traditional methods. It worth mentioning that the use of oral contraceptives dropped and the IUD rose in comparison to 83-84 and due to the fact that the population of 93-94 is older. Factors like desire for more children, undesirable side effects of contraceptives, inconvenience, irregularity of the menstrual cycle and others were behind not using the methods. This again warrants additional studies and interventions to cope with the unmet needs.

The findings of this study could have future implications for planning of health promotion activities and utilization of medical services.

Naji El-Saghir, Ziad Salem, Salim Adib, Kamal Bikhazi, and Phillip Issa (1997), Breast Cancer Screening: Recommendations and Controversies with Reference to Screening in Lebanon (from the Departments of Internal Medicine, Surgery, and Radiology, Faculty of Medicine, and Faculty of Health Sciences, AUB). In the *Lebanese Medical Journal*, 45, 206-211.

This is a review article attempting to provide a set of recommendations in breast cancer screening for the case of Lebanon, that are adopted from international and standard guidelines. In Lebanon there is no vital statistics available, and the authors report launching a major campaign to establish a national tumor registry. This includes the Lebanese Cancer Societies, Ministry of Health, Order of Physicians, and the main hospitals. The authors stress the importance of continuing medical education of our practicing physicians, as well as nurses to properly explain and perform breast examinations and recommend mammography screening guidelines.

Nagi El-Saghir, Salim Adib, Amjad Mufarrij, Spiridon Kahwaji, Ali Taher, Phillip Issa, and Ali Shamseddine (1998), Cancer in Lebanon: Analysis of 10220 Cases from the American University Medical Center (from the Faculty of Medicine, Faculty of Health Sciences, AUB). In *Lebanese Medical Journal*, 46(1): 4-11.

This study reviews and analyzes cancer cases in Lebanon. A total of 10220 cancer cases seen and recorded 1983-1995 in the American Hospital Tumor Registry were retrospectively reviewed. There were 5086 cancer cases in males with the 5 most common being: lung cancer, bladder, larynx, lymphoma, and leukemia. As for females, there were 5134 cases with the 5 most common being: breast, cervical, colo-rectal, lymphoma, and brain cancers. The average of age of females was relatively lower as compared to males

Francoise Ghorayeb, Mary Deeb, and Tamar Kabakian-Kasholian (1998), Differentials of Women's Perception and Medical Diagnosis of Reproductive Morbidity in Beirut (from the Faculty of Health Sciences, American University of Beirut).

The aim of this study is to examine the educational differentials between women's reports of signs and symptoms and physicians' diagnosis of gynecological morbidity. A total of 789 women visiting 27 private gynecological clinics in Beirut were interviewed. Unlike women's reports of symptoms of menstrual problems and infertility, reports of discharge, burning sensation, itching, and irritation were found to be in perfect agreement with the clinical diagnosis of Lower Reproductive Tract Infections. Moreover, the specificity level was lower among the low education group as compared to the high education group. These findings highlight the contribution of cultural variations in women's understandings of the nature of the condition, their endurance and health expectations.

Mary Deeb, Johnny Awwad, and Hanna Kaspar (1998). Bekaa Reproductive Health Study (from the Faculty of Health Sciences and Faculty of Medicine, American University of Beirut).

This study is similar to "Giza Morbidity Study" and aims at investigating the prevalence of gynecological conditions and their risk factors, as well as understand women's perceptions of these morbidity conditions of health and ill-health as related to reproduction. A random sample of a total of 557 women aged 15-60, and residing in the village of Nabi Sheet were selected to participate in a variety of methods that included a detailed questionnaire, medical examination, and laboratory tests. The study was undertaken by a multi-disciplinary team of researchers based at the Faculty of Health Sciences and American University of Beirut-Medical Center.

Preliminary analysis of results suggests surprisingly low levels of reproductive morbidity, outside genital prolapse, and despite high fertility (contrary to Giza). However, half the women studied were found to be suffering from any type of genital prolapse. Although contraceptive use was quiet high, yet there still are women who do not use any of the most common methods (IUD and pills) due to side effects. It looks like there is a lack of appropriate contraceptive methods for elderly. There was a frequent mentioning of *ta'sib* and related problems, a concept which is culture specific. It is expected that further analysis will shed light on several questions related to women's perception of health conditions and its matching with the diagnosis and patterns of health care utilization.

Carla Makhlouf Obermeyer, Francoise Ghorayeb, Robert Reynolds (1999), Symptom Reporting around the Menopause in Beirut-Lebanon (from the Department of Population and International Health, Harvard University, 665 Avenue of the Arts, Boston, Monde Arabe 02115, USA and UNFPA, Amman, Jordan). In *Maturitas* 33, 249-258.

The aim of this study is to assess the extent to which women in Beirut suffer from symptoms in the course of the menopause transition, and to measure the medical management of menopause. A representative sample of 298 women were asked about their sociodemographic characteristics, life circumstances, general health, and reproductive health; questions about symptom management and lifestyle were also asked.

The study documents the frequencies of various symptoms associated with aging and menopause. The number of symptoms reported by respondents is negatively associated with employment, but other associations with sociodemographic variables are not significant. Smoking is found to be high in the study population and is associated with the occurrence of hot flashes, but its association with other menopausal symptoms is not significant. Over a third of the women seek help in dealing with the symptoms they experience, 15% use HRT, and 20% calcium supplements.

Ghada El-Hajj Fuleihan, Mary Deeb (1999), Hypovitaminosis D in a Sunny Country (from Epidemiology and Biostatistics Department, Faculty of Health Sciences, and Internal Medicine Department, Faculty of Medicine, American University of Beirut). Letter to the editor in *The New England Journal of Medicine*, vol.340, no.23, 1840-1841.

The paper aims to measure vitamin D level in a group of rural women in Lebanon. Serum 25-hydroxyvitamin D and parathyroid hormone were measured in the serum of 465 women. Results demonstrate that a substantial number of healthy young women in central Lebanon had vitamin D insufficiency in the summer. This might be explained by the lack of government program to supplement food, and by the cultural habits of women. Results underscore that it can also be endemic even in young women in sunny countries.

Abla M. Sibai (1998), The Elderly in Lebanon: their Demographic, Socioeconomic, Social and Health Aspects (from the Department of Epidemiology and Biostatistics, Faculty of Health Sciences, AUB).

The aim of this study is to provide a sound and scientific basis for governmental and non-governmental organizations to take appropriate actions and mobilize resources for the elderly in the right direction. The methodology utilizes data from different sources. It relied heavily on secondary in-depth analysis of the data of the "Population and Housing Survey" (PHS). The sample of this study is a national probability sample covering governates and cazas and consisted of around 70,000 households (10% of total population) covering demographic and socioeconomic characteristics, health status and social support of the elderly.

Results show an increase in the proportion of the elderly population in Lebanon, with females outnumbering males. Their socioeconomic profile showed increased self-sufficiency with age and engagement in labor with the advantages of living in an independent residence. However, there are striking gender gaps in widowhood affecting mostly elderly females who represent the most disadvantaged family profile. Regarding health profile and despite the limitations of the PHS data, elderly population suffers from serious morbid conditions and disabilities.

The authors recommend examining the current policies and services for the elderly and update them. They also recommend future research to evaluate the environmental and socioeconomic conditions of the elderly including clinical assessments and measurements.

Abla M. Sibai and May Baydoun (1999), Elderly Lebanese Women in an Aging World (from the Department of Epidemiology and Biostatistics, Faculty of Health Sciences, AUB). In *Al-Raida* Special Issue, 16 (85), 11-21.

The aim of this study is to examine the socioeconomic and health characteristics of the elderly women in Lebanon. The methodology uses the Population and Housing Survey (PHS), to estimate the number of elderly and study their characteristics. The results show that the number of elderly women is increasing in Lebanon, unequally distributed among regions. They had greater life expectancy than elderly males (4 years). The wider the gender gap the more elderly women are expected to suffer from the consequences of widowhood, loneliness, major restructuring of family relationships and social roles, loss in socio-economic resources and decline in social support. As for health status and needs, the

leading causes of morbidity remain chronic in nature and are usually associated with disabilities.

The authors recommend two types of investigative efforts: firstly, a thorough assessment of present resources including services and activities provided by the government, voluntary organizations and families; secondly, a thorough assessment of present and projected needs of the elderly in the community and in organizations. Such data will provide valuable information for health and social policy makers to plan interventions

Ongoing Research:

Muheiddine Seoud, Ali Khalil, Hanna Kaspar, Ghassan Azar, Ramiz Azoury, and Munir Nasr (2000), Vulvar Cancer in Lebanon (from the Department of Obstetrics and Gynecology, Faculty of Medicine, American University of Beirut).

This study is about examining the prevalence of vulvar cancer in Lebanon.

Hanna Kaspar, Mary Deeb, Johnny Awwad, and M. Schulein (2000), Prevalence of Reproductive Health Conditions in a Rural Area of the Bekaa Valley in Lebanon (from the Faculty of Health Sciences and the Faculty of Medicine, American University of Beirut).

This study aims at looking for the first time at the prevalence of gynecological morbidity in a main town in Bekaa Valley in Lebanon.

Mary Deeb, Johnny Awwad, and Hanna Kaspar (2000), Utilization of Reproductive Health Services in Bekaa Valley, Lebanon (from the Faculty of Health Sciences and the Faculty of Medicine, American University of Beirut).

This study attempts to examine the degree of utilization of reproductive health services according to the women perception of the complaint.

Mary Deeb, Johnny Awwad, Hanna Kaspar, Tilda Farhat, and L. Kobeissi (2000), Comparing Women's Perceptions and Medically Diagnosed Morbidity Conditions in Rural Bekaa, Lebanon (from the Faculty of Health Sciences and the Faculty of Medicine, American University of Beirut).

This study attempts to examine and compare what women perceive as complaint and what is really diagnosed.

Mary Deeb (2000), Reproductive Morbidity Conditions and Family Planning (from the Faculty of Health Sciences, American University of Beirut).

Ghada El-Hajj Fuleihan (2000), Prevalence of Osteoporosis and Determinants of Bone Loss in Patients Referred for Bone Density Measurement at AUB-MC (from the Department of Internal Medicine, Faculty of Medicine, American University of Beirut).

Ghada El-Hajj Fuleihan (2000), Nutritional and Lifestyle Risk Factors for Bone Loss in Elderly Patients at Dar El-Ajaza (from the Department of Internal Medicine, Faculty of Medicine, American University of Beirut).

3. Safe Motherhood

Nabil Mounla and Adele Khudr (1989), Pediatric Mortality: an Avoidable Tragedy (from the Department of Pediatrics, Faculty of Medicine, American University of Beirut). In the *Lebanese Medical Journal*; 38(1): 25-8.

The aim of this study is to focus attention on the problem of infant mortality in Lebanon. The methodology included data compilation on infant mortality from 1978-1986 at AUB-MC, where causes of death were analyzed for 602 males and 398 females.

Results show that around 40% of all neonatal deaths were due to neonatal disease like hyaline membrane disease that can be prevented by better prenatal care. Infections cause around one quarter of deaths and many are preventable through adequate public health measures and good personal hygiene. Congenital diseases were around 22%. In utero diagnosis and treatment can reduce these problems. Other mortalities are related to tumors and other miscellaneous diseases. The authors recommend steps to reduce infant mortality: prenatal care, diagnosis and screening, intrauterine surgery; resuscitation and intensive care centers with modern equipment and trained personnel; national vaccination and screening programs and parental education.

Iman Nuweyhed, Bassem Yammout, Ghassan Azar, and Mona Al Kouatly Kambris (1998), Narghille (Hubble-Bubble) Smoking, Low Birth Weight, and Other Pregnancy Outcomes (from Department of Environmental Health, Faculty of Health Sciences, Departments of Obstetrics and Gynecology, and Internal Medicine, Faculty of Medicine, American University of Beirut). In *American Journal of Epidemiology*, Vol.148, No. 4, 375-383.

The aim of this study is to identify the effect of smoking narghiles during pregnancy on the weight of the newborn and other pregnancy outcomes. The methodology involved interviewing three groups of women in several hospitals in Lebanon between 1993 and 1995: 106 who smoked narghiles during pregnancy, 227 who smoked cigarettes, and 512 who did not smoke.

Results show that the adjusted mean birht weight of babies born to women who smoked one or more narghiles a day during pregnancy and to women who started smoking in the first trimester was more than 100 g less than that of babies born to nonsmokers ($p<0.1$).

The adjusted odds ratio of having babies with low birth weight (<2500g) among the narghile smokers was 1.89 (95% confidence interval (CI). The risk increased to 2.62 (95% CI 0.90-7.66) among those who started smoking narghiles in the first trimester. A stronger association and a dose-response relation were found among cigarette smokers. The association between narghile smoking and other pregnancy outcomes, especially Apgar score and respiratory distress, was also noticeable. The authors recommend further research and a policy action to fight the misperception that narghile smoking is safe.

Pan Arab Project for Child Development (1998), Lebanon Maternal and Child Health Survey.

This survey aims to build a database on various aspests that affect Maternal and Child Health in Lebanon. The methodology involved a survey conducted during January-March 1996. The sample included 5431 households from 291 clusters of all governorates, of which 3314 of 3443 by ever married women aged under 55 years were completed. Data was collected on households, housing, maternal and child health, and community characteristics.

Results indicate that infant mortality declined to 28/1000 live births. Under-age-5 child mortality declined to 32/1000 live births during the 5 years preceding the survey. Almost 74% of infant mortality occurred neonatally; it was higher among males. Infant and child mortality were lower in Nabatieh and Beirut governorates. Among the 1767 children aged under 5 years, 12% were moderately/severely stunted. The highest levels were among children aged 48-59 months. Under 3% were wasted. During the 2 weeks before the survey,23% of children aged 6-11 months had diarrhea, especially boys. 57% suffered from coughs, of whom 19% also had difficulty breathing. Cough prevalence was highest among children aged 6-11 months. 8% ever had measles. Measles were higher among children of illiterate mothers. 31% suffered from fever. 86% of children aged 12-23 months were fully immunized. Although most mothers knew about oral rehydration, only 33% treated diarrhea with it. 88% of infants were ever breast-fed. Maternal mortality had been 104/100,000 live births since 1984. 39% of mothers received postnatal care. The fertility rate was 2.5 in the preceding 5 years. Women desired 4 children.

The recommendations focus on health education programs, improving the environmental conditions that affect mother and child health, and support policies for population and reproductive health.

Helen Chacar Rabay, M Sokhn, and M Azar (1997), Breast Feeding Practices in an Area of Beirut. In Lebanese Medical Journal, June, 45(2): 84-9.

The aim of this study is to examine breast-feeding practices in a group of Lebanese women. The methodology included surveying 170 breast-feeding mothers in pediatric clinics in Beirut and its suburbs. Results show that the average age of mothers was 27.8 years with average duration of marriage being 4.6 years. One third of mothers were primiparas breast-feeding for the first time. Only 11% of newborns were fed within the

first hour of life, and the majority fed between first and sixth hour. Close to 50% of the newborns were exclusively breast fed in the first 4 months. Around 50% of breast feeding mothers changed their eating habits. Most of the mothers consumed inadequate quantities of milk, fruits, and vegetables. The percentage consuming tobacco, coffee, tea, and alcohol were similar during pregnancy and breast-feeding and somewhat lower than before pregnancy. The authors conclude that women were inadequately informed about breast-feeding and its benefits.

Mary Deeb (1998), Breast Feeding and Weaning Practices. In Lebanon Maternal and Child Health Survey 1996, 95-110, Ministry of Social Affairs.

This report focuses on breast feeding issue in PAPCHILD. It reflects the increased incidence of breast-feeding, with a trend of shorter periods and complementary feeding at younger ages of children. The average breast feeding period was 9 months, and was done according to baby's needs and not according to a certain time schedule. There was a correlation between shorter breast feeding periods, early weaning and higher education.

Jinan Usta (1997), Midwifery and Small Maternity Clinics in Lebanon (from the Department of Family Medicine, AUB).

This study attempts to describe the complications associated with deliveries in small maternity clinics run by midwives. The methodology consists of collecting cases referred from maternity clinics to large hospitals within Lebanon for the year 1996. Results show that the most common complication was postpartum hemorrhage followed by endometritis and postpartum infection. In the newborn, the most reported complication was jaundice followed by prematurity, hypothermia and sepsis. The study recommends further training for midwives regarding skills to assure antiseptic deliveries and adequate newborn care, in addition to providing adequate transport facilities for the high risk newborns.

Muheiddine Seoud, Iman Dabbousi, and Khalida Bitar (1993), Maternal and Perinatal Outcome of Elderly Gravidas over the Age of 40 years (from the Department of Obstetrics and Gynecology, AUB).

This study aims to look at the outcome of pregnancy of advanced maternal age at the AUB-MC. The method involved reviewing the outcome of 400 pregnant women above the age of 40 years, and comparing them to 400 well-matched and randomly chosen control group aged 20-30 years. Results show a significant increase in maternal and perinatal mortality and morbidity. The authors recommend close follow up and monitoring of those pregnancies. In addition, they emphasize counseling for those women before getting pregnant and assure their unmet needs in family planning.

Muheiddine Seoud, Ali Khalil, Ghassan Azar, Naji Aswad, Abdel-Rahman Bizri, Madlene Akel, and Mona Nabulsi-Khalil (1992), Screening for Tuberculosis in

Pregnancy: is it Cost Effective? (from the Departments of Obstetrics and Gynecology, Medicine, Family Medicine, and Pediatrics, AUB).

This study attempts to asses the cost-effectiveness of tuberculosis (TB) screening in pregnancy at AUB. The methodology involved studying 850 pregnant women with PPD and those who tested positive had Chest X Ray, sputum culture and HIV. There were over 35 women with positive PPD 4 of them with active TB. Epidemiologic survey of the place of living was done and will be used for formulating universal screening.

Mona Nabulsi, Ali Khalil, A.Farah, and George Araj (1997). Prevalence of Hepatitis B surface Antigen in Pregnant Lebanese Women (from the Departments of Pediatrics, Obstetrics and Gynecology, and Laboratory Medicine, Faculty of Medicine, American University of Beirut) In *International Journal of Gynecology and Obstetrics*, August, 58(2): 243-4.

This study aims to look at the prevalence of hepatits B antigen in pregnant Lebanese women. The methodology included a cross sectional study of 558 pregnant Lebanese women attending the antenatal clinics at the American University of Beirut Medical Center. Results show that 16 women were positive for HBs Ag and, of those, only 1 was positive for Hbe Ag. There were no significant differences between Hbs Ag-positive and negative women in terms of age, education, socioeconomic status, or HBV risk factors (e.g. blood transfusion, intravenous drug use, alcohol intake, history of jaundice, marriage to a man with multiple sexual partners).

Authors conclude that the 2.9% prevalence detected in this study places Lebanon among countries with moderate endemicity for HBV. Since known risk factors for HBV were not associated with Hasbro positively, routine antenatal screening as well as universal newborn vaccination against HBV is recommended to prevent prenatal infection and horizontal transmission in the community.

Zuheir Bittar (1998), Rates of Prenatal Mortality and Low Birth Weight Among 3367 Consecutive Births in South of Beirut (from the Department of Pediatrics, Lebanese University). In *Lebanese Medical Journal*, 46(3): 126-130.

A total of 3367 consecutive births were reviewed prospectively from a population with relatively underprivileged living conditions. Prenatal mortality was found at a rate of 22.4/1000 births, early neonatal mortality formed 6.66/1000 births, and stillbirth formed 15.83/1000 birth. Low birth weight rate was 5.43% of live birth. Analysis of our findings suggests the need to improve follow-up and care in the immediate period before and during delivery, in the immediate postpartum and neonatal care periods.

The aim is to prevent and treat intrauterine asphyxia, fetal distress, obstetric complications, and resuscitate the newborn and improve the Intensive Care Nursery (ICN) procedures. These measures are expected to reduce fresh stillbirth and early neonatal mortality. Lowering the rate of low birth weight is of less urgent nature in this population

as it is relatively not high. The author recommends recruiting more neonatologists and to subject ICN units in Lebanon to standardized requirements. Centralization of care given to severely sick neonates and to women with high risk pregnancy in optimal conditions is mostly needed.

Zuheir Bittar (1998), Major Congenital Malformation Presenting in the First 24 Hours of Life in 3865 Consecutive Births in South of Beirut: Incidence and Pattern (from the Department of Pediatrics, Lebanese University). In *Lebanese Medical Journal*, 46(5): 256-260.

The aim of this study is to look into the incidence and pattern of congenital anomalies in the area of southern Beirut. A total of 3865 consecutive newborns delivered between 1991 and 1993 were prospectively studied. All neonates had received a physical examination during the first 24 hours of life. The most common congenital anomalies was skeletal, followed by genitourinary and neural tube defect. The malformed infants formed around 25% of all prenatal death suggesting that improved care given to these patients will reduce prenatal mortality.

Incidence of neural tube defect, 3.1/1000 births, was higher than in many western and Middle Eastern countries reports suggesting the need for further testing for incidence and etiology. Among the malformed infants, the rate of low birth weight and the rate of parental first cousin consanguinity were significantly higher than corresponding rates among normal infants in a control group.

Joseph Suidan and Georges H. Abitayeh (1999), Obstetrical Outcome Following Epidural Analgesia in 506 Consecutive Deliveries (from the Department of Obstetrics and Gynecology, Hotel-Dieu de France Hospital and St Joseph University Faculty of Medicine). In *Lebanese Medical Journal*, 47(6): 329-332.

This study examines the effect of epidural analgesia on delivery outcome. A total of 506 consecutive deliveries in Hotel-Dieu Hospital, under epidural, and delivered by the same obstetrician were studied. Around 336 delivered without epidural at the same period. The epidural group had around 20% normal vaginal deliveries, and around 7% by cesarean sections, while the rest had operative deliveries. There was one case of dural puncture that was managed by blood patch. The degree of pain relief obtained by th eepidural was deemed satisfactory in 456 patients (90%). The primary cesarean section rate in patients who received an epidural was not higher than that in patients who did not. The authors conclude that epidural analgesia is a safe and highly effective method of pain relief during labor.

Toufic Ossiran (1998). Phasing Out TBA's in Lebanon (from the Family Planning Association-Lebanon). In *Planned Parenthood Challenges*, (1):22.

The aim of this study is to identify the remaining traditional birth attendants and determine their level of education and the quality of services they offer. The methodology included a survey interviewing TBA's on demographic and practice profiles. Results show that the majority of TBA's in Lebanon are over 50 years of age, illiterate, and completely untrained. Only 26% of them ever observed or assisted ia trained midwife or physician in a delivery. The majority used traditional instruments or outdated methods employing powerful medications. It is estimated that 12% of all deliveries in Lebanon are attended by TBA's, more on rural than in urban areas. It was impossible to determine what percentage of maternal mortality rate was attributable to them. The majority of TBA's stated that they are not interested in training.

The author recommends that the government must regulate the practice of the TBA's and must urge them to have training. The author also recommends phasing out TBA's practice within 10 years, finding alternatives for the remaining ones.

Nazek El-Khoury, Elie G. Karam and Nadine M. Melhem (1999). Depression in Pregnancy (from the Departments of Psychiatry and Psychology/Saint-George Hospital - Beirut, Psychotherapy/Sacré-Coeur Hospital - Baabda, Faculty of Medicine/Saint-Joseph University - Beirut, Departments of Psychology/Lebanese University, Psychology/ American University of Beirut, Institut de développement de la recherche appliquée à la clinique (IDRAC) - Beirut, and Faculty of Health Sciences/American University of Beirut). In *Lebanese Medical Journal*; 47(3): 169-174.

This study aims to examine the prevalence of depression in pregnant women. It is one of the pilot studies on depression on Lebanon. The methodology included 150 women admitted consecutively during the months of May and April 1987 during the "Lebanon Wars" to the delivery suite at Saint-George Hospital, Beirut. They were interviewed using a structured questionnaire (DIS). The study was conducted in two phases: the first on the second post-delivery day, and the second, one year later. Results reveal that the prevalence of major depression in these women was found to be 31.3% lifetime, 10% during pregnancy and 10.9% during one-year follow-up. The authors conclude that lifetime depression increased with the number of children in the household. Depression during pregnancy was found to be inversely related to economic and educational levels.

Mary Deeb, Oona M.R.Campbell, and Tamar Kabakian-Kasholian (1997), Safe Motherhood in Lebanon: New Population-Based Results from the Beirut 1994 Survey (from the Epidemiology and Biostatistics Department, Faculty of Health Sciences, American University of Beirut, and Maternal and Child Epidemiology Unit, Department of Epidemiology and Population Sciences, London School of Hygiene and Tropical Medicine, London, UK). In *International Journal of Gynecology&Obstetrics*, 56 (1997), 181-182.

This paper attempts to present new data on safe motherhood in Lebanon to argue the estimates presented by WHO and UNICEF of maternal mortality which gave Lebanon a high implausible figure. A multipurpose, population-based, health interview survey of

2017 households was conducted in Beirut, in 1992-93. Other methods and supplementary data from national samples were also used. The data presented prove that medical services around pregnancy and childbirth continued to be provided in all times-even war times- in addition to data collection and research.

Rita Khayat and Oona M.R. Campbell (2000), Hospital Practices in Maternity Wards in Lebanon (from the Faculty of Health Sciences, American University of Beirut, and London School of Hygiene and Tropical Medicine, London, UK). In *Health Policy and Planning*; 15(3); 270-278.

The main objectives of this study were to acquire baseline data on policies and routines applied in the obstetrics ward service for women having normal delivery, estimate the prevalence of certain practices, assess whether women are given choice and look into the degree of agreement between process of care at hospitals and women's reporting of preferences and care received. A sample of 39 hospitals was selected and the director, head midwife, or head nurse of the Obstetrics Department was interviewed.

Results show that the majority of hospitals have no written policies or standard birth procedures and lack mechanisms for evaluation although records were available. This is well stressed in the national sub-programme towards improving quality of services and having a committee for guidelines procedures and protocols. Women received minimal prenatal care education and minimal family planning counseling in the postpartum period. The authors recommends further work assessing health outcomes of maternity care, and need for intervention-related research to implement changes in provider practice.

Tamar Kabakian-Khasholian, Oona Campbell, Mona Shediac-Rizkallah, Francoise Ghorayeb (2000), Women's Experience of Maternity Care: Satisfaction or Passivity? (from the Faculty of Health Sciences, American University of Beirut, Beirut, Lebanon and Maternal and Child Epidemiology Unit, Department of Epidemiology and Population Sciences, London School of Hygiene and Tropical Medicine, London, UK and UNFPA, Amman, Jordan). In *Social Science and Medicine* 51, 103-113.

This study aims at describing Lebanese women's responses to the management of their pregnancy and delivery as part of safe motherhood. Semi-structured interviews were conducted with women from three areas in Lebanon. A total of 117 interviews were completed using a qualitative approach, and focus group discussions.

Results show that selection of health care provider was highly influenced by the opinion of other women, with more comfort in female HCP, and more trust in male HCP competence. There was lack of information provision (antenatal and intrapartum) and women did not complain as they trust their health care provider. Women rated the level of communication between the health care provider and themselves as being of primary importance in determining their level of satisfaction with care. The extent of passivity and feeling of discontent women have varies according to their social class and the amount of psychosocial support they receive throughout the process of childbirth.

Important study implications to consider for policy formulation include: issues pertaining to patient-doctor interaction and increased mother-baby contact after childbirth, improving women's awareness of availability of alternative choices and their perceived need for preventive care, encouraging HCP to supply information about childbirth and to respect women's right for alternative choices.

Monique Chaaya, Oona M.R. Campbell, Faysal El-Kak, and Hilda Harb (1999), Psychosocial and Obstetrical Risk Factors for Postpartum Depression (from the Faculty of Health Sciences, American University of Beirut, and Department of Epidemiology and Population Sciences, London School of Hygiene and Tropical Medicine, London, UK). In press.

The aim of this study is to assess the prevalence and risk factors of postpartum depression in Lebanese women. The study is a prospective investigation of 538 women delivering in hospitals in Lebanon over a period of two months. The first phase involved collecting information within 24 hours of delivery using a structured questionnaire, on predictors of postpartum depression. The women were asked to agree to a home visit for interview 2 to 3 months after delivery. In the second phase, data on postpartum depression were collected using Edinburgh Postnatal Depression Scale (EPDS) and other information on the health of the mother and the baby.

One in five women (21%) were found to have postpartum depression according to the EPDS. In the bivariate analyses postpartum depression was significantly related to depression during pregnancy, social support, type of delivery, fetal monitoring, episiotomy, education and health of the mother, and stressful life events. In the multivariate analysis, depression during pregnancy and chronic illness predicted significantly postpartum depression.

Findings from this study are consistent with other studies. Obstetrical procedures and care during pregnancy are not adequately targeting the issues of post-partum depression. Implications for research and action concerning antenatal package, labor and delivery practices are raised.

Faysal El-Kak, Monique Chaaya, Oona M.R. Campbell, and Afamia Kaddur (1999), Patterns of Antenatal Care in Lebanon (from the Faculty of Health Sciences, American University of Beirut, and Department of Epidemiology and Population Sciences, London School of Hygiene and Tropical Medicine, London, UK). In progress.

The aim of this study is to describe the antenatal and labor package offered by different providers, asses its impact on pregnant women, and compare it to international updated patterns of care. A total of 538 women were interviewed within 24 hours of delivery using a structured questionnaire, where the questions were arranged in reverse chronological order (backward recall). They addressed different aspects respectively relating to the

newborn, postpartum symptoms, delivery care practices, course of the current pregnancy, the package of prenatal care received, and the type of health care provider.

Results were analyzed in terms of two independent variables: the provider and the number of antenatal visits. In case of the provider, the only significant finding was related to more oxytocin use in women who visited obstetricians as compared to midwives. There were more compliance with antenatal recommendations in women who visited obstetricians, but that was not significant. When taking the number of visits as independent variable, it was found that reduced number of visits (0-4) is significantly related to problematic outcome for the baby. Number of visits was also significantly correlated with epidural anesthesia and more compliance with diet advice and regular check-up.

It appears that the traditional package of antenatal care visits practiced in Lebanon could be re-evaluated putting more weight on the content of these visits without affecting perinatal outcomes. Antenatal care provided by midwives appears to be as satisfactory as that of obstetrician.

Ongoing Research:

Muheiddine Seoud, R. Sultaneh, and A. Itani (1993), Nutritional Survey of Lebanese Pregnant Patients (from the Department of Obstetrics and Gynecology, Faculty of Medicine, American University of Beirut).

This study is a national survey trying to assess the nutritional profile of the Lebanese pregnant women in terms of diet content, health care provider recommendations, and eating habit.

Monique Chaaya and Johnny Awwad (2000), Smoking and Pregnancy (from the Department of Epidemiology and Biostatistics at the Faculty of Health Sciences, and the Department of Obstetrics and Gynecology at the Faculty of Medicine, American University of Beirut).

This study aims at identifying the profile of women who continue to smoke during pregnancy.

Khaled Younis (1999), Hospital Network on a Data-Base on Maternal and Neonatal Mortality.

Tamar Kabakian-Kosholian and Oona M.R. Campbell (2000), Postpartum Health Needs of Women (from the Faculty of Health Sciences, American University of Beirut and London School of Hygiene and Tropical Medicine, London, UK).

This work aims at identifying health needs of postpartum women and attempt to develop a

health education tool.

Ministry of Health (2000), National survey of Perinatal and Maternal Mortality and Morbidity. ushered by Norma Rizk.

4. Youth

Abdo Jurjus, Jihan Tawilah, and Fadi Gerges (1991), A School Health Programme for Lebanon. In *World Health Forum*; 12 (4):452-3.(letter)

This study aims to assess health needs in Lebanon at school level. The methodology involved 882 students aged 5-19 years from 8 schools whose health needs were assessed by a health team including a physician, a medical intern, a dentist, a nurse, and a health worker. Parents completed a questionnaire on health and demographic concerns, while students were physically examined. Results indicate that 16.8% of students needed follow up care with a specialist for congenital and developmental ailments or communicable diseases. Health education was nnot included in school curriculum.

The authors recommend that health education begin in the primary grades and within community. Comprehensive health programs including health services, health education, and a healthy environment need to be instituted. Home, community, and school need encouragement to build a strong liaison.

Basem Saab, Nabil Shararah, Malek Makarem, Elias Saaru, Jinan Usta, and Mustapha Khogali (1996), Data from a School Health Project in Beirut (from the Department of Family Medicine, Faculty of Medicine, American University of Beirut). In *Lebanese Medical Journal*, 44, 63-67.

This study evaluates the health status of elementary school students in Lebanon. A total of 2778 elementary students enrolled in 25 government schools in Beirut were surveyed. Parents completed special forms relating to demographic and socio-economic information and to the students medical and vaccination history. Each student had a complete physical examination. Results show that the most common medical problems were poor dentition, followed by incomplete immunization, enuriosis, pediculosis and defective vision. It was also noticed that 72% of the students have at least one member in the family who smokes. The authors recommend need for floridation of public water, provision of accessible and affordable medical and dental care, carrying vaccination campaigns and introducing health education in elementary schools in Lebanon.

Abla Sibai and Nabil Kanaan (1997), Youth Health Risk Behavior Survey among Secondary School Students in Lebanon: Prevalence and Clustering of Risk Behavior (from the Faculty of Health Sciences, and Department of Family Medicine, American University of Beirut).

The aims of this study are to evaluate the prevalence of high-risk behavior among high school students in Lebanon, and to determine the age of first knowing about these behaviors. A cross-sectional survey on public and private secondary school students was conducted. It included 1086 students from 14 schools within Beirut and suberbs answering unanimously a close-ended questionnaire. Part of the questionnaire covered issues related to sexual health.

Results clearly shows that sexual activity starts as early as the age of 15 years and it is more common among males as compared to females (30% vs 2.5%), with relatively high percentage of them (10.5%) having multiple partners. The use of condom was the most prevalent contraceptive. It was noticed that sexual behavior was clustered with other high-risk behaviors like substance abuse and risky driving, issues that will put adolescents at higher risks of morbidity. It remains to be tested the level of reproductive health knowledge among adolescents.

The investigators recommend integrating a school health programme in the curricula to address pre-adolescent to secondary school stage. This is intended to encourage positive and healthy life-styles and to create a healthy school environment. They also recommend a holistic approach to health issues to affect health behavior in all aspects of adolescent life accompanied by legislation and adequate media campaign.

Mona Shediac-Rizkallah, Rima Afifi, Tilda Farhat, Joumana Yeretzian, Faysal El-Kak, Iman Nuwayhed, Abla Sibai, Kassem Kassak, and Nabil Kanann (2000), A Glance at Adolescent Health in Post-War Lebanon: Findings among Students at the American University of Beirut (from the Faculty of Health Sciences, American University of Beirut).

The aim of this comprehensive study was to assess the prevalence of health behaviors among students at the American University of Beirut, both overall, and in subgroups varying by gender and age. In addition, the distribution in the total number of health risk behaviors in the study population was examined, also looking at the effect of gender and age. The methodology involved the vast majority of students newly entering the University (1065 students) who were asked to complete a self-administered questionnaire covering 15 behavioral and lifestyle risk factor areas, including sexual behavior and gender.

Results covered a final sample of 954 students and they show that large numbers of the university students are engaging in behaviors which place them at increased risk for negative health outcomes. For example, 24% of students ever had sexual intercourse, with significantly higher proportion among males. Gender appeared to be a key influencing factor on many health behaviors. The authors point to the need for health-promoting interventions, particularly in the policy area. They also recommend additional research on a national representative sample with emphasis on gender and cultural factors.

Faysal El-Kak, Rima Afifi, Mayada Kanj, Carol Telgeh. and Mona Shediac-Rizkallah (1999), High-School Students in Postwar Lebanon: their Attitudes and Information Sources Related to Sexual and Reproductive Health (from the Department of Health Behavior Education, Faculty of Health Sciences, American University of Beirut). In Press, *Journal of Adolescent Health.*

This study aims to propose school programs in sex education and adolescent counseling. It addresses attitudes of high-school students in Lebanon towards sexual and reproductive health issues and services, in a context where school health education programs and adolescent health services are almost absent at all levels of government, school and society

High school students (n=466) attending a career orientation fair in December 1997 were asked to answer a one-to-one sexual health inventory in the presence of health educators. The questionnaire covered topics about counseling, reproductive health issues, sexual education tools and services. The sample includes 54.5% females and 45.5% males; mean age is 17.5 years old and age range is 15-20 years old. Overall, 93% of the students were extremely willing to know more about family planning and contraception, pregnancy and childbirth issues. Our students showed a perceived need for education, guidance and health services. The majority of them (90.8%) supported sex education in schools. As for the sources of sexual and reproductive health information, friends were cited as the leading source (60.5%), followed by media (51.6%). Parents were reported as the next more frequent source (32.2%). Also, friends ranked first in the list of persons with whom sexual health issues were discussed, followed distantly by parents.

Results show unequivocally that students want to know more about SRH issues. Yet, a majority believes that sexual health services and counseling are not readily available to young people.

Mohammed Faour (1998), The Silent Revolution in Lebanon: Changing Values of Youth, Beirut, Lebanon (from the American University of Beirut)..

The aim of this study is to investigate the prevalence of a set of social values and norms among Lebanese college students, and compare, where feasible, the results with relevant pre-war data. The set includes individual values, societal values, family norms, and political norms. Also the impact of gender, social class, and educational level will be examined.

The methodology is based on four surveys of Lebanese students aged 17-24 years. These surveys include a stratified random sample of AUB students in 1993; two quota-samples of AUB students in 1994 and 1996; and a purposive sample of LU students in 1996. The total sample size was 2893 students.

Results, especially those related to gender and family, show that there is a notable rise in democratic practices within the Lebanese nuclear family. The nuclear family form is

rapidly gaining grounds at the expense of the traditional extended form. Results also show that the number of Lebanese women in higher education is rising along with their participation in the labor force. The authors calls upon the government to respond to the growing social change permeating young people and capitalize on it. He also advises men and all concerned to yield to women's demands.

Family Planning Association-Lebanon (1997), Youth in Lebanon and Issues of Reproductive Health, AIDS, and Addiction.

This survey aims to assess the KAB of youth of Lebanon in relation to high risk issues and to provide guidelines for policy makers. The methodology involved a random national sample of around 1000 individuals, age 10-24 years, selected from the national survey (95-96), where they were asked to respond to a questionnaire about their attitudes concerning issues of RH, AIDS, and substance abuse or addiction.

Regarding RH issues, young people defined RH as the ability of people to enjoy a well balanced family life as far as emotional, sexual, and social dimensions are concerned. This reveals a deeper and wider understanding of the RH concept away from the classical definition of family planning. This brought them closer to the international standard definition, especially the educated sectors. The study shows that socio-economic and educational changes had affected the youth (more females than males) regarding delaying the age of marriage with a clear trend among females to marry between ages 25-29. Both expressed their willingness to know about RH issues more so in older age groups (20-24). Amazingly enough, 6% find no need for RH knowledge and 12.5% had no answers.

Willingness to know more was remarkable with higher education and age. The need for sexual knowledge and awareness was clearly expressed where the need is most for AIDS, followed by sexual diseases, followed by birth control. The issue of abortion is still taboo for a good number of young peoples, in addition to disinterest of those guys in contraceptives. There was a gender issue studied in terms of roles of boys and girls within marriage. Regarding information source; doctors were the best source of RH information followed by books, and lastly the biology teachers. This response reflects youth need for scientifically sound information, where they insisted that it should be given to them in an interesting and interactive way (audiovisual, debates), and it should contain all components of RH. In specific, youth expressed their will to know about anatomy and physiology topics as well as safe sexual practices, STDs, risks of homosexuality, and genetic diseases.

Regarding AIDS component in this study, it was shown that the vast majority of youth has heard of the disease and is aware or conscious of its seriousness. However, this was not commensurate with the belief that AIDS is a threat to the Lebanese community. This could in a way reflect insufficient amount of information and inefficient health media addressing youth who are supposed to be provided with accurate and sound information. On the other hand, the youth were knowledgeable about modes of AIDS transmission, despite some mentioning toilet seats, swimming pools and shaking hands as possible means of communicating the disease. With respect to preventive measures, only 23% of

youth had scientifically solid knowledge, and the majority demanded proper dissemination of correct information on prevention to be carried by the concerned institutions (ministries, national program) in addition to awareness sessions in universities, support and counseling to the victims and their families. Regarding their attitudes, around one third responded that AIDS patients should stay away from healthy people, while the rest advised AIDS patients to continue treatment, avoid sexual activities, keep a normal life, isolate themselves, and tell people about it so they can learn from the experience. These same attitudes did not change in case of HIV positive cases. These attitudes embodying a lot of hostility, blame and criminal implication led the youth to include general security forces to play a role in prevention. There appears to be an ethical dilemma at the level of the approach to AIDS and sero-positive cases that need to be re –defined and clarified by all concerned parties. The youth were extremely willing to take part in all voluntary activities aimed to reduce AIDS.

The study concludes by stressing the importance of youth role. The authors recommend launching of well-prepared campaigns of awareness and skills at different levels in different settings to address needs of youth.

5. Family Planning and Fertility

Mohammed Faour (1990). Family Planning in Lebanon: Constraints and Performance (from the Department of Sociology, AUB). In *Al-Abhath*, Vol.38, 75-88.

This descriptive article aims at identifying the major societal constraints to family planning in Lebanon and at assessing the demographic performance of the programme in rural areas. The methodology relies on the analysis of data and statistics made available from the Family Planning Association records. Results indicate that the basic constraints to effective functioning of the family planning programme in Lebanon are: legal, political, and social. The author calls for an indirect approach where family planning issues are introduced within a the broad strategy of social and economic development. This can be much more effective than the traditional direct approach.

Marianne Khlat, Mary Deeb, and Yousef Courbage (1997), Fertility Levels and Differentials in Beirut during Wartime: an Indirect Estimation based on Maternity Registers (from the Department of Epidemiology and Biostatistics, American University of Beirut, and Institut d'Etudes Démographiques, Paris). In *Population Studies,* 51(1), 85-92.

This paper attempts to assess fertility changes in the two main religious communities in Lebanon's capital during the war period. The methodology is based on information relating to all births recorded in the maternity registers of hospitals in Greater Beirut (city and inner suburbs) in 1984 and 1991. Demographic variables (mother's age and parity) were used in an indirect estimation of fertility and information on socio-demographic variables (religion and hospital class) was recorded, with the latter variables being used as a proxy for social class. Total fertility (TF) in Greater Beirut was estimated from these

data for Christians and Muslims separately. The technique was based on the distribution of births by mother's age and parity. A statistical analysis of the joint distributions of mothers by age, parity, religion, hospital class, and study year was also undertaken to investigate fertility differences by religion within social class.

Indirect estimates of TF indicates a decline of fertility that was higher in M uslims as compared to Christians (4.8% vs 3.6%) but that was not significant as results indicate absence of any substantial drop in fertility during the Lebanese civil war. This was related to factors of internal migration and previous fertility decline. The authors recommending using this data to establish local monitoring system for fertility, which could be used by policy makers for health and family planning purposes.

H.N. Rizkallah and A.A. Moneim (1997), Fertility Decline in Lebanon. In *Population,* September-October; 52(5): 1224-33.

The aim of this study is to examine fertility trends in Lebanon. The methodology involved interviewing 3000 ever-married under the age of 50 years in 4600 households for the Lebanese Survey of Maternal and Child Health. Results indicate that in the periods 10-14 years and 0-4 years prior to the survey, the total fertility rates dropped from 3.8 to 2.5 respectively. The decline affected all age groups, especially women aged 20-35 years. The majority of non-single women had ever used a contraceptive method. IUD was the most commonly used method followed by withdrawal, oral contraceptives, and condoms. Pharmacies were the single most important source of contraceptives. The authors conclude that contraception and later marriage have been the principal determinants of fertility decline.

Prem C. Saxena and Habbouba Y. Aoun (1997), Women's Education, Economic Activity and Fertility: Relationship Re-Examined (from the Population Studies Program, Faculty of Health Sciences, American University of Beirut, and Faculty of Health Sciences, University of Balamand, Lebanon). In *Al-Abhath*, 45: 25-39.

The aim of this study is to investigate how women's education and work status affect fertility of Lebanese women. The study also attempts to assess the extent of maternal role incompatibility experienced by Lebanese women engaged in higher and lower prestigious occupations and its effect on their fertility. The methodology included a sample of women working in a Lebanese private school. The list included 596 names of married men and women classified according to level of education. Non-working wives of males working at school were included in the sample. The sample was drawn through a systematic random sampling procedure, and data was collected through personal interview method.

Results show that women working in lower prestigious occupations had borne on average 1.7 children as compared to 2.1 children born to women working in higher prestigious occupations. Non-working women had borne on average 3.2 children. Maternal role incompatibility, experienced more in lower educated category, had a significant effect on the number of children borne (fertility). The authors concluded that although the study is

based on data collected from one private school only, results have clearly demonstrated a greater impact of maternal role incompatibility as compare to education in the reduction of fertility of working women.

Andrzej Kulczycki and Prem C. Saxena (1999), New Evidence on Fertility Transition through Wartime in Lebanon (from the Population Graduate Program). *Genus*, Vol. LV, n. 3-4, 131-152.

The aim of this article is to briefly review the design of the Population and Housing Survey (PHS) and to derive estimates of both current and cohort fertility. The article then shows how fertility rates and trends differ spatially across Lebanon and attempts to provide a partial account for some of this variation. The methods made use of the PHS household survey implemented between November 1995 and June 1996 by the Ministry of Social Affairs with assistance from UNFPA. The survey consisted of a stratified cluster sample of 64,472 households. A number of indirect techniques can be used to derive fertility estimates. In this paper, the authors used the Brass P/F ratio, cohort parity progression ratios (CPPRs), and cohort fertility rates (CFRs) methods.

Results show that fertility levels have been falling steadily in Lebanon over the course of several decades. However, the regional differentials in fertility are very large for such a small population. The authors conclude that war had no significant depressing effect on the quantum of fertility. This raises the question if an increase in fertility could yet occur, perhaps due to improving economic conditions and the new climate of optimism within Lebanon where pronatalist norms remain intact.

Prem C. Saxena and Andrzej Kulczycki (1996), A Comparative Study of the Demographic and Health Situation in Selected Arab Countries, (from Population Studies Program, AUB).

This study derives national and sub-national estimates of fertility and draws conclusions about the levels and trends of fertility over the past five decades for Lebanon. It uses the 1996 Population and Housing Survey (PHS) to reflect on the fertility rate ranges over years and per Muhafaza. It was noted that the major reductions in family size came from decline in parities four, five and six. The disparities in fertility are even more striking at the district level and have widened over time. The researchers concluded that fertility decline does not appear to have been significantly interrupted by the hostilities of the civil war.

Ongoing Research:

Andrzej Kulczycki and Prem C. Saxena (1997), Marriage, Consanguinity and Family Planning in Southern Lebanon, (from Population Studies Program, AUB)

This project investigates current and recent marriage and family planning practice in southern Lebanon. It examines the determinants, preferences and trends associated with marriage and consanguinity, as well as their relation to family planning. It is a systemic random sample of currently married women of childbearing age from households from 4 villages in southern Lebanon.

Andrzej Kulczycki and Prem C. Saxena (1997), Contraceptive Use Dynamics in Southern Lebanon, (from Population Studies Program, AUB)

This study examines a number of features of fertility and family planning, including specific problems related to contraceptive use and other aspects of reproductive health in southern Lebanon. It includes 600 currently married women aged 15-49 randomly selected from 6 villages, in addition to focus group discussions with married women and men. The work is still ongoing and no data was made available.

Cynthia Myntti, Abir Ballan, Omar Dawache, Faysal El-Kak, and Mary Deeb (2000), Men's Role in Reproductive Health (from the Faculty of Health Sciences, American University of Beirut).

This work attempts to look into the profile of both women and men who practice withdrawal contraception.

6. General or Combined RH Issues

Mohammed Faour (1996), Knowledge, Attitudes, and Practices of Women about Pregnancy and Childbirth, Family Planning, and Quality of Services (from the Family Planning Association-Lebanon).

The aim of this study is to look at the attitudes, knowledge, and practices of women residing in the southern suburb of Beirut, in relation to experiences in pregnancy and childbirth, family planning, and quality services. Systematic random sampling of 1200 household was performed. With respect to educational and economic levels of interviewed females, it was found that despite the in-existence of illiteracy among females below 30 years of age, it still increases with advancement of age. More than 17% of females aged 10 years and more are in the labor force. Regarding pregnancy and childbirth, the mean age at first marriage is 19.4 years, with the average number of pregnancies being 4.6 reaching 7.4 in women aged 45-49 years of age. Besides, the incidence of induced and spontaneous abortions increases with age (0.5 per woman for induced abortion and 1.9 for spontaneous). This means that 38% of pregnancies do not reach term. This implies that a lot of pregnancies are still unplanned and not followed up properly. Results clearly show there is a remarkable drop in cumulative fertility as compared to 1971 survey (5.9 to 3.65), and a drop in total fertility rate.

Despite the elevated number of hospitals and supervised deliveries, the percentages of home deliveries was found to be close to 10% and of unattended deliveries was close to 7%. These findings indicate that pregnant women are still facing the risk of unsafe deliveries and postpartum problems. Regarding knowledge, attitudes and practices related to contraception, results reveal that close to 98% of women know about two methods (OCP and IUD) at least. However, this was not reflective of equivalent contraceptive use. In fact, the current Contraceptive Prevalent Rate (CPR) was again high (70%), and the majority (54%) uses modern methods with One Year Continuation Rate of 82%. Women using methods prefer the IUD followed by OCP with no major complaints reported. The two main sources for the methods were the physician and the pharmacy, followed by dispensaries, nurses, and mid-wives. The majority of women were satisfied with the services offered but asked to have more information and counseling.

The author recommends that family planning clinics should posses more advanced audiovisual aids, and should hold more IEC activities and training sessions in order to meet the demand of their clients for quality services.

Georgette Tannouri (1998), Unmet Reproductive Health Needs of Rural Women in Bekaa Area (from the Family Planning Association-Lebanon).

This study aims at identifying, defining, and addressing unmet reproductive and sexual health needs of rural women in Bekaa area. The study methodology involved 500 women selected randomly from households in 10 villages (2 villages per Caza), and it included 4 components: demographic, pregnancy and childbirth, family planning, and reproductive and sexual health knowledge, in addition to a focus group discussion.

Results have shown that the fertility is still high; total fertility rate was 4.49 and marital fertility rate was 6.64-7.15, which might be responsible for cases of unplanned pregnancy leading to induced abortions. Cases of spontaneous abortions, stillbirth, and neonatal mortality are still happening reflecting poor antenatal care. The differences between average number of pregnancies and average number of live birth (4.47 vs 3.64) indicates an average loss of one baby? per mother.

With respect to family planning, the CPR is still low (52%), with prevalence of use of traditional methods (30%). The preferred sources for the methods are the "doctor" and the "pharmacy", due to lack of trust in other health care providers including the social worker. The use of contraceptive methods is accompanied by several problems (79%) and no counseling was given. Knowledge about the content of family planning services was low and these services was not sufficient and of quality, according to women. The study revealed an ample need for "information" related to SRH, especially the young category showing a greater need for knowledge related to STD and safe sexual life. A need was expressed for SRH services in all th evillages with and without FP services, especially services related to "adequate medical tests" and STD. Along that women expressed their demand in having job offers and opportunities. Social workers need to be more remunerated to do a better job.

Mariana Khayyat Sabbouri (1996), Educational and Cultural Obstacles to Reproductive Health in Sidon-Lebanon.

This paper aims at defining the cultural obstacles affecting the reproductive health behavior, related to religious statements, popular beliefs, and common practices happening especially among low socioeconomic groups surveyed. The method used included: observation and guided interviews, in addition to field trials, whereby the research team looked at the degree of response of women to the PHC services, and the problems facing them in this regard. In addition, the team looked into the women's reproductive behavior starting from marriage till after delivery in the light of the present traditions, and to what extent they are attached and affected by theoretical and practical religious principles.

In this study, the author showed how prominent is the effect of tradition and popular stories on the reproductive behavior and understanding of this group of people. Besides, an overwhelming belief in destiny and control by superpowers was clearly observed mainly to justify people's inability to access health services and indicate their ignorance (high levels of illiteracy). The author recommends intense and well-designed reproductive health education programs (group discussions including men) coupled with free or near free access to services, and proper training of health care workers.

7. Gender and IEC

Zouheir Hatab (1989), Man and Family Planning in Lebanon (from the Family Planning Association-Lebanon).

This study identifies men's attitude and behaviors related to contraception. The methodology included a stratified national random sample that involved 1400 interviews of men aged 19-50 years. The results reveal that in general Lebanese men are willing to widely accept the idea of family planning and give women more role in selecting contraceptive methods. Family planning methods are firstly used for birth spacing, and secondly for preventing future pregnancies. Results indicate that there is no proper understanding of the family planning concept and its practices within a comprehensive vision to family well-being. All contraceptive practices are mainly related to socioeconomic factors. The author recommends addressing men in specific activities to encourage them to play more definite and responsible role in family planning.

Azzam, I., Lebanese Women in Television: Status and Role. A Quantitative and Qualitative Assessment of the Position of Lebanese Women in the Currently Functioning TV Stations since 1997, (from the Department of Social and Behavioral Sciences, AUB).

The study investigates the extent to which Lebanese women are consciously challenging or reinforcing oppressive cultural symbols.

Ali Faour (1995), Lebanese Women Facing War and Violence (1975-1990) (from the Family Planning Association, Lebanon).

The aim of this study is to examine the social and economic conditions of the Lebanese women and families during the civil unrest (1975-1990) that lead to remarkable change in the socioeconomic and demographic structures. The methodology included 3 descriptive field surveys carried out in areas in Lebanon in different times. The surveys covered several hundreds of houses and thousands of individuals in 4 components: housing conditions, demographic changes, educational level, and economic activity.

Results revealed dramatic effects of destruction caused by war leading to displacement and as a result formation of miserable over-populated quarters. Regarding demographic changes, results reveal a decline in total fertility rate and an increase in the percentage of female singles, in addition to noticeable spread of cases of widowship, divorce, migration, violence against women, sexual assault, and more involvement of women in economical support of their families. The author recommends and urges the government and the private sector to issue legislations and create opportunities towards women empowerment, protection, and justice.

Michèle Obeid (1998), Gender and Division of Labor in a Changing Rural Area: Irsal, a Case Study (thesis towards a Master of Arts in Anthropology).

The aim of this work is to explore social change in the remote village of Irsal in Northern Bekaa, Lebanon and the means of coping with this change. It also aims to look into gender relations and the extent to which the gender system has been affected. The method employed was the participant observation, with in-depth interviews and focus groups.

M. Arevian, S. Noureddine, Tamar Kabakian (1997), A Survey of Knowledge, Attitude, and Practice of Cervical Screening among Lebanese/Armenian Women (from the School of Nursing, American University of Beirut), in *Nursing Outlook*, 45(1), 16-22.

This study aims to examine the impact of an intervention on the knowledge, attitude and practice of cervical screening in the population of Lebanese/Armenian women. A cross sectional survey of 176 women was carried using a self-administered questionnaire, following a one-year long intervention. The intervention included activities educational classes, media messages and free screening. Results show that higher knowledge was noted in women who received the intervention compared to those who did not ($p<0.05$). No difference in attitude or practice was noted between the intervention and comparison groups. The authors recommend that further research is needed to explore the attitudes that hinder the practice of cervical screening so that appropriate interventions can be developed.

Nada I. Sleem (1998), Women's Perception of Power and Health: Evidence from a Village in Lebanon (thesis towards Master of Sciences in Population Studies, Faculty of Health Sciences, AUB).

This purpose of this study is to examine the decision-making power structure between husband and wife in a rural area in Lebanon. It also aims at investigating the possible resources that may affect these marital power relations. A further attempt was to examine the relationship between dominance and wives' mental health and the family members' acute and chronic physical health. The survey included 153 currently married women interviewed using a structured questionnaire. Several dimensions of power were considered including taking decisions related to reproduction, children, buying food and household items, social relations as well as macro and women related issues.

Results reflected sociocultural characteristics of the study area and the importance of socioeconomic attributes in affecting wives' relative decision-making power. Using the Multinomial Logit Regression analysis, findings noted that women who win in case of conflict were more likely to perceive relationships to be egalitarian or dominated by themselves rather than by their husbands. This related to several factors that women have like: belonging to the same village as husband, work, not religious, literate father-in-law, husband working in urban areas, lower number of children, higher number of boys, higher age at marriage, and unarranged marriage. In terms of dominance and health, results showed that women who have literate fathers–in-law are more likely to perceive themselves dominant than their husbands in matters of reproduction as compared to women who have illiterate ones. It was also found that controlling decision-making areas that are not in accordance with the community defined roles is related to depression among women and to chronic physical problems among men. The study recommends additional research involving men, urban areas, and bigger samples of study. It also calls for policy implications towards increasing women's education and social empowerment.

Zeinab M. Mawla (1993), The Roots of Gender Discrimination in Family Upbringing (from Institute of Social Sciences, Lebanese University).

This study aims to look at factors and reasons behind gender discrimination in Lebanese families, and its effects on the individual and the society. The researcher reviews some of the literature that examines the domains and the manifestations of discrimination in human relations, family values, social contexts, education, and others. The study warns from negative consequences to this discrimination on family members and societal relations by quoting certain literature.

T. Papazian (1993), Should Women's Health be a Medical Specialty? In *Al-Raida*, Vol.10, No.61, 10-12.

The aim of this survey is to examine the attitudes of medical doctors regarding totality of women's health. The methodology involved a simple interview of 7 Lebanese physicians of different specialty. Results show that none of the physicians interviewed were aware of

the idea of a women's health specialty, and they refused it categorically. They agreed that a family physician is the best person to provide comprehensive care and to refer the patient. The author was intrigued by the similarity of responses of male and female physicians and related this to the same background of the physicians and to the absence of an aggressive women's liberation movement in Lebanon.

Randa Abul-Husn (1994), Health Awareness among Lebanese Women. In *Al-Raida*, Vol. XI, No.67, 20-23..

This small study attempts to look into the health awareness among Lebanese women. A random sample of 201 women were surveyed, the majority are in the age bracket 20-30 years and of university education engaged in remunerated work or employment. Results reveal that Lebanese women possess some degree of general awareness about health matters and issues, and are eager to know more. However, they seem to lack initiative in proper health practices and behaviors, such as exercising and regular medical check ups. Generalizations from this survey imply that Lebanese women seem to lack discipline and attitude needed for being health conscious person.

Institute for Women's Studies in the Arab World (1998), Female Labor Force in Lebanon. In *Al-Raida*, Volume XV, No.82, 12-23.

The goal of this study is to provide the data base needed to formulate prioritized strategy related to the supply of and demand for women in the Lebanese labor market and to design adequate plans of action and policies to implement such a strategy. The specific objectives of the study are: t provide a profile of working women, to highlight women working conditions, to examine sociocultural problems facing women at work, and to detect employer preferences. The results on gender issue in the study showed that as the educational level of parents improves, female workers tend to disregard the effect of gender on their access to employment opportunities. Higher female education and professional levels and more years of experience decrease the impact of gender on access to employment opportunities. Also, gender bias in access to employment declines as the size of enterprise increases. The importance of gender as a criterion in the selection of work is confirmed by 43% of working women. The degree to which gender forms a primary consideration within this context varies according to educational levels of the female and family and status at work. The study concludes with general recommendations that can be used to improve the quality of female labor force supply and make it more responsive to labor demand.

Mary Deeb and J. Hatem (1998). Review of Legal Aspects of Women's Health in Lebanon, (from Faculty of Health Sciences, AUB).

This is a review article of certain legal issues and laws that are directly affecting women's health in relation to rights and quality.

Ezzat Charara (1998). Psychological Health of Woman between Science and Religion, Beirut, Dar al-Jadeed.

This book is about a study examining woman and psychological health in Lebanon, emphasizing the surrounding situations concerned with her psychological and counseling cure. For this purpose, all those involved with psychological health of woman were interviewed.

Leila Ahamed (1992), Women and Gender in Islam, New Haven, Yale University Press.

This book looks and examines the historical roots of practices taking shape in early Islam and the discourse of these practices and its relation to social change in the modern era. It also traces the impact of socioeconomic changes to the appearance and evolution of feminist discourses.

Sherifa Zuhur (1992), Revealing Reveiling: Islamist Gender Ideology in Cotemporary Egypt, Albany-NY, SUNY Press.

This book is originally a thesis reflecting on the opinions and ideals of fifty Egyptian women, veiled and unveiled, and compares their views to the gender ideology of the contemporary Islamists. Women social backgrounds are examined in the context of the Egyptian state and its social policies. It also explores the history of Muslim women and the debates over gender that have developed since the golden age of Islam.

Ongoing Research:

Ghada El-Hajj Fuleihan (2000), Gender Differences in Nutritional and Lifestyle Risk Factors for Bone Loss in Children in Lebanon, (from the Department of Internal Medicine, Faculty of Medicine, AUB).

Ghada El-Hajj Fuleihan (2000), Education as a Strategy to Improve Patient's Adherence to Raloxifene Therapy, (from the Department of Internal Medicine, Faculty of Medicine, AUB).

8. Others

Leila Farhood, Huda Zurayk, Monique Chaya, Fadia Saadeh, Garbis Meshefedjian, and Thuraya Sidani (1993). The Impact of War on the Physical and Mental Health of

the Family: The Lebanese Experience. In *Social Science and Medicine*, vol. 36 (12), 1555-1567.

The aim of this study is to address the impact of war-related stressful life events on the health of families living through the war conditions prevailing in Lebanon for the past 12 years. Health outcome is represented by indicators of somatization, depression, psychological symptoms, interpersonal relations and marital relations. Associations are described between elements of war stress and health outcome variables for mothers, fathers and adolescents in a sample of Beirut families. The role of the mediating factors of social support and social class is discussed.

Saint-Joseph University, Mid-wifery School.

Several small research projects done by students and supervised by the faculty of this school had been provided for this review from year 1991-2000. These projects include:
- Evaluation of the health conditions of mother and infant in the region of Karm El Zeitoun, Beirut.
- Prevalence of breast cancer in women presenting to Hotel-Dieu Hospital during the year 2000.
- Complications of induced labor.
- Evaluation of the efficacy of prevention tools of cervical cancer in women presenting to a community dispensary in Nabaa, Beirut, during 1992-1993.
- Urinary incontinence.
- Examining the indication of cesarean sections in women delivering at Hotel-Dieu in 1998.

Other student projects are being done in various universities that address issues related to RH and are mainly about attitudes and prevalence.

D. About the National RH Research

1. Current and Ongoing Research: Background and Status.

The first pre-requisite of good research is that its general aim and specific objectives be clearly defined. The compiled available research in this document embodies several components of RH as per ICPD definition. Obviously, academic institutions, concerned NGOs, and research groups are attempting to convoy the introduction and the evolution of RH concept since its inception. These efforts were charged and intensified with the establishment of the national sub-programme on reproductive health and the NAP. Those programmes had vehemently emphasized the needfulness of sociocultural research in respective RH areas. Though this research albeit its happening, should be fostered by certain guidelines in order for it to be contributing to action and change.

In Lebanon, RH research was started by some public health and social scientists who were exposed and trained in the emanating RH issues. The crux of the research questions

remained within these circles and to a large extent stayed away from academicians and physicians. Research groups like Reproductive Health Working Group (RHWG), Bettering Women's conditions in Labor and delivery in Lebanon (BWELL), and Surveillance and Intervention for Behavioral Risk factors in adolescents (SIBER), all housed in the Faculty of Health Sciences at the American University of Beirut, and are conducting high quality research in the area of reproductive health and adolescent health.
The fact that physicians are not closely involved in RH research is a matter-of-factly related to the formation of doctors as leaders of technical and biomedical models of health care. Despite the emphasis of the RH sub-programme document on the component of research, this emphasis was not paralleled in implementation. So, research remained fluctuating and muddled depending on the initiative of the corresponding institutions or organization. In fact, the majority of compiled research work came from institutions of Health and Social Sciences and minimal studies came from medical schools. Even then, medical doctors had a public health specialist or a social scientist co-investigating the work. In this respect, researchers did not attempt to come together to set an agenda for research guidelines and topics.

Despite all the apparent and inherent constraints delaying the adequate continuation of research activities, the compiled research had addressed several topics and subjects which open doors for various additional works. The compiled research has many characteristics that make it practically relevant. These characteristics are:

- The research done appears to answer clear research questions.
- The research is conducted mainly by a multidisciplinary team of social scientists and medical doctors that adds to the value and quality of research.
- The compiled work –undoubtedly- adds to the national capacity building of researchers and other team members in relation to expertise and information exchange.
- The research done contributes to the international debate on questions related to evolving RH issues like reproductive morbidity, youth, and dignity in health care.
- The research does also contribute to national problems especially those raised by the national RH sub-programme.
- The research done is culturally sensitive, relevant, and timely.

The compiled research will be addressed along these characteristics:

STD/AIDS Research
The National AIDS Program (NAP) in Lebanon supported by the WHO had initially carried out a series of baseline studies attempting to identify the sociocultural status of AIDS. These studies addressed in the first place random samples of high risk groups and culminated in a national sample. Knowledge, attitudes, behaviors, and practices of those groups were carefully examined and recommendations were issued in a way to orient the NAP to the most appropriate tools in the most demanding population. This is an essential endeavor that was shown later and after lucid feedback and reinforcement, to be the leading measure in dissemination and prevention efforts.

Other studies from AUB and the Family Planning Association-Lebanon had again revealed respondents' awareness of AIDS, but this was not commensurate with crucial

knowledge regarding transmission, HIV sero-positive prevalence, and life-style changes like safe sex practice. The high degree of awareness might be related to the immensity of the programme launching in the media that made everyone aware about the term AIDS. Studies show a need for intense in-depth intervention. In addition, many of the findings revealed in the aforementioned studies call for more focused research that shall investigate determinants of these findings and their corresponding correlation.

Reproductive Morbidity

Reproductive morbidity is essentially a basic component of reproductive health which came to the interest of researchers in the early nineties and more so from 1994 and on. The work done at AUB is novel in studying for the first time in Lebanon, reproductive health issues. In fact, the study " Beirut: A Health Profile 84-94", AUB, was the first to include reproductive gynecological morbidity indicators in a population-based survey. These indicators were analyzed in relation to selected socio-demographic indicators. This and other studies tried to describe and understand the nature, magnitude, and determinants of reproductive behavior. This included assessment and perception of risk, biomedically defined versus self-provided and reported reproductive morbidity, and socioeconomic and demographic characteristics of those affected by ill-health, towards having a morbidity data base. This will call for further studying the prevalence of other reproductive ailments that will help later on to concentrate efforts at the levels of policy and services in a way that suits and impacts women well-being.

Safe Motherhood

Accumulated studies carried out by several institutions attempted to examine the basic indicators of safe motherhood, by looking into the pregnant perception of service delivery, the health care provider and the type of care provided, and the hospital policies implemented for maternity wards. Some other studies examined risk factors in pregnancy like maternal age, depression, smoking, and nutrition. All these findings will assist in interventions that are evidence-based, at the level of the service and of the health care provider, in addition to educating women about pregnancy and childbirth. It is hoped that these efforts will congeal towards a national network that will make pregnancy safer.

Youth

Youth is considered to be one of the under-served groups that deserve attention. The accumulated national work concerning youth is exiguous as it carries certain limitations attributed to country and community specificities. In addition, these studies –except the one of family planning- are sample-specific (schools, universities) and so not representative nationally. The family planning study on youth albeit national, is so general and descriptive of a certain level of knowledge and attitudes, delivered through a closed response self-answered questionnaire. Nonetheless, the available studies had definite research questions addressing knowledge, attitudes, behaviors, and practices of youth in issues related to reproductive health including sexual health. Besides, few studies addressed reproductive and sexual issues along with other life style ailments like drug abuse and injuries. This is important because it tries to look into cluster behaviors-common in youth- and thus examine determinants of behavior in their true perspective. This undoubtedly fills a research gap about a marginalized sector that needs vast investigation. These studies have a practical relevance as they can contribute-albeit

minutely to date- to formation of guidelines and frameworks to help design the most effective research and intervention for youth.

Family Planning and Fertility
Studies performed in this domain addressed two main themes: fertility trends and contraceptive prevalence. The work on fertility trends reflects or includes wartime effects and one of them is national, while the rest are community-based. The other studies focusing on the contraceptive prevalence aim to examine unmet need in family planning. They are mainly community-based KAP studies. Although this research adds a lot of information about contraceptive prevalence, it came short of in-depth analysis relating this prevalence to other conditions like morbidity, services, and other socio-cultural factors. Nonetheless, the research had enlightened programme managers and services to the size of the needs in family planning.

Gender and IEC
The majority of the compiled data are gender-sensitive in that analysis examines prevalence and perception by gender. This in addition to studies examining gender as a research question. However other studies did not include male component or contribution to the formation of results. The studies examine the sociocultural background dictating gender discrimination at the levels of policy, legal aspects, delivery service and health care provider, and consumer level.

2. Research Constraints

The mission document for the national RH sub-programme recommends that the government should conduct sociocultural research on attitudes of men, women, youth and adolescents toward RH/FP issues to compliment the existing research in this area. The mission also recommends conducting sociocultural research aimed at improving quality and ensuring safety of RH/FP services. Research should also focus on measuring programme impact by selecting priority areas for study to assess efficiency, examine utilization patterns of current services as well as determine satisfaction levels of service users.

This clearly indicates that the sub-programme highlighted and marked areas of research priority. However, the delays that thwarted the start and the pace of the sub-programme had definitely affected the research component. Under these circumstances, no efforts have been made to identify research groups and sensitize them to RH research, or even to coordinate between existing groups and teams. This has left researchers without a research agenda that would include relevant and needed topics and areas of research for the sub-programme.

As a matter of fact, the areas of research in RH are vast and demand several levels of study and assessment. These areas are also continuously evolving and so breed more research. All this makes it difficult and time demanding to researchers to keep up with it, especially to make the desired impact. This again requires several research teams that will

coordinate to exchange expertise to complement each other; a case that is believed to be totally missing.

3. Areas of Duplication

The fact that reproductive health research in Lebanon is still burgeoning minimizes the likelihood of duplication of research. At the same time, this budding research in trying to address national issues that are rooted in RH definitions could lend itself to duplication with respect to research questions, community-specificity, or practical relevance. For example, in certain situations the AIDS KABP surveys done by the NAP and the Family Planning ask similar questions to similar samples. Likewise, studies related to antenatal and childbirth care. Some times several studies have the same type and would not have an additive answers to some national problems. One might argue that some of the similar studies done may have a clearer research questions and more representative sample. Even few studies are particularly done as situation analysis to assess a service or to implement one.

It worth mentioning that the almost absent dynamic interaction between national RH research groups and the feckless dissemination of their results could lead to duplication. In general, the available compiled research indicates that the majority of studies – done or ongoing – are original and unique.

4. Areas of Future Research

The National Sub-Programme on RH starting in 1997 together with the National AIDS Program had fueled sociocultural RH research in Lebanon. Unfortunately, this research is not utterly coordinated and guided to cope with existing research gaps. Besides and as aforementioned, research teams in different institutions failed to have a joint agenda or common perspectives for prioritizing and complimenting research topics. This has dictated that completed and ongoing research are planned based on several factors related to researchers interests, funder preference, and academic considerations with no reference to the sub-programme needs.

One of the mainstays of sociocultural research is humanization of health care. This stems partly from the consideration that technology, interventions and services should be modified to suit people, rather than the other way around. The fact that sociocultural research have both a biological and a social/cultural component demands providing insights into an array of research questions. These considerations necessitate conducting many research activities that would permeate all the echelons of reproductive health from epidemiology of reproductive conditions to reproductive and sexual behavior to services to national policy-makers.

Future research needs to be identified in the context of specific activities that should meet RH sub-programme demands. It should also abide by certain guidelines. Some of these guidelines aim at:

- Identifying and defining reproductive health problems by measuring the magnitude and nature of reproductive/sexual behavior and reproductive ill-health.
- Investigating its determinants and consequences.
- Improving and supporting intervention programmes which attempt to prevent or treat reproductive health problems through health, family planning, educational and other services.
- Understanding, informing and influencing the policy, legal or social arena in which reproductive health concerns arise.

Despite the practical relevance of the outcome of the compiled completed and ongoing research, this review calls for the following suggested areas of future research:

a. Epidemiology

It essential for the implementation of the RH sub-programme to conduct research that will quantify the prevalence of various reproductive morbidities and their determinants. This has been started and shall continue through community-based surveys that will help design and implement interventions to meet needs of local women and men.

b. Reproductive and Sexual Behavior and Reproductive Morbidity
Sociocultural research into the determinants and consequences of reproductive behavior and morbidity is essential. In this regard, adolescents should receive special attention. This may address the following:

-Sexual behavior and negotiation in relation to gender issues and sexual practices stressing women's vulnerability to unwanted outcomes;
-Individuals' experience of reproductive health problems and their desired solution;
-Burden of reproductive health problems in terms of physical, psychological, cultural, social, and economic terms;
-Socioeconomic and demographic characteristics of under-served groups affected by unwanted reproductive outcomes, emphasizing adolescents.

c. Service-Based Approaches
Future sociocultural research should examine service-based approaches in both the preventive and curative aspects. It may look into:

- The degree of accessibility and acceptability of services
- Estimation of the magnitude of various costs of services in terms of economic, social, and labor considerations
- Dynamics of services regarding compliance and continuation;
- Prioritizing content of services regarding seriousness of the complaint in terms of prevalence or consequence. This will clarify priority problems in each service and for each geographical area
- Culturally appropriate methods for promoting behavior change, including communication strategies for achieving them
- Technical and managerial quality of care

- Risk perception and motivation for utilization of preventive services.

d. Policy and Legal Aspects

Good reproductive outcome implies working to impact policy and legal arenas that impinge on the determinants and consequences of RH problems. Future research might consider the following:

- Effectiveness of different types of services and providers
- Identifying best systems for service delivery
- Assessing the value of integrated services
- Policy barriers to reproductive change and to examination of sexual behaviors and practices, especially of adolescents
- Identifying agents of social change
- Mechanism for creating demand for services.

e. Evaluation of Sub-programme Impact

An essential mechanism of examining the sub-programme achievements and identify future needs is to conduct research that will look into the impact of the sub-programme outputs. This includes the components of service utilization, quality of care, capacity building, and IEC activities. Throughout all these tasks, the gender issue should be cross-cutting in a way to sensitize all the involved elements in the sub-programme to gender, and to contribute to a comprehensive understanding of the role of gender in all the details of implementation.

5. Concluding Remarks

This review has attempted to compile all the available research work on RH issues. This work covers most of RH topics and it sets grounds for different types of investigation and analysis. The evolving nature of RH concept generates areas of research that deserve prompt consideration and demand lots of efforts. This puts sub-programme managers and stakeholders and RH researches face-to-face with several challenges that constrain the national sub-programme. A lot of these challenges had been mentioned several times in the bearing of this review, and serious actions and measures must be taken to deal with them. Some of these actions and measures have to do with the following:

- Initiate a research committee from all involved sectors to work with the sub-programme responsibles on identifying and prioritizing areas of research.
- Advocate for RH matters among researchers dealing with RH-related topics.
- Encourage formation of research teams with different RH interests in a way to compliment other ongoing research work.
- Ensure coordination between existing research groups that will help sharing expertise, exchange information, and exposing data for additional treatment.
- Create a mechanism for impact assessment through research.

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REPRODUCTIVE HEALTH

Lebanon belongs to the category of states undergoing epidemiological transition. This transition brought the government into a face-to-face challenges that are directly related to health and environmental programmes, the new lifestyles, issues related to children's and women's health, and pressing reforms in the health sector. The government in an attempt to cope with the emerging situation was willing to get international support. In line with this government stand, a five-year Population Programme of Assistance (1997-2001) was approved to support the GOL to rebuild its technical capabilities in the area of population and reproductive health. This has materialized into a Country Programme (CP) that was based on the findings of a Program Review and Strategy Development (PRSD) mission to Lebanon that took place in August/September, 1996. The CP was developed in close collaboration and consultation with a wide panel of stakeholders including the Government representatives, NGOs, policy makers, and academic bodies.

The formulation and inception of the CP happened in phase with the overwhelming engagement of the GOL in the post-war reconstruction process. A process that seen tedious and costly and giving less immediate attention to the public health sector. Consequently, this sector suffered of limited resources, in-coordinated activities, and lack of adequate policies and strategies, besides a competent and growing private sector. The health sector was rankled by serious problems like, absent of a national population policy and RH strategy, absent social agenda, lack of technical expertise in population and reproductive health, compromised access to reproductive health services, lack of proper reproductive and sexual health counseling and information. As such, the CP was a timely endeavor to respond to the country's urgent needs in RH and population.

The main focus of the CP document is mainly RH in consistence with national policies and acknowledged orientations. At the same time, the document states that its activities would be undertaken in accordance with the principles and objectives of the Programme of Action of the ICPD. The document indicates a commitment to women's empowerment and gender equality, and to mainstreaming the gender issue into all its activities.

Prior to the current CP (1993-1996), several UNFPA projects were conducted. In fact, and following Second Amman Declaration on Population and Development in the Arab World issued during Arab Population Conference held in Amman, Jordan in April 1993, the UNFPA, upon the Government request, had supported several projects in the field of population and housing data collection, training of nurses and midwives, population related IEC and provision of MCH/FP services, especially to the internally displaced population and returnees. The UNFPA support extended also towards the National Committee to formulate and implement a national muti-sectoral population policy with quantifiable goals that can be integrated into the country's development and reconstruction plans and programmes.

Actually, the previous UNFPA activities were especially instrumental in the inclusion of FP and STDs in PHC in 1995, and in the timely completion of the much-recognized large-scale population and housing survey of 1996 (under the leadership of the MOSA). The

current UNFPA cycle of assistance for Lebanon was intended to build on the successes of such ventures.

3.4 Current RH Situation

3.4.1 Policies/Strategies

A strategic vision that defines national priorities, outlines a strategy and determines policy directions is critical to overcome national development challenges and to bring about improved coordination and stronger programming, including monitoring and evaluation.

The participation of Lebanon in the UN global conferences was at the highest ranking official level, yet the outcomes of the conferences were not legally binding in several areas. The participation of Lebanon in these conferences and its adoption of their plans of action is expected to implicitly commit the government to take action towards the achievement of the stated goals and targets. Despite the unsatisfactory processes of planning, and coordination on the side of the GOL, international conventions and global conferences have been instrumental in bringing about certain change in many areas, mainly of concern here is RH and Population.

In this regard, Lebanon ratified five of the six human rights conventions, although important reservations were put on two, notably CEDAW. An important achievement was the adoption of the law on free and compulsory education. Other laws adopted included the law amended on child labor, the law on pre-marital health certificate, the law on the disabled, and most recently the law on the elderly.

The NPPC under with the guidance and support of MOSA finalized the NPP document which is expected to be promulgated by the Cabinet in the near future.

The national RH strategy preparation was commissioned last year to an ad-hoc committee of national experts. The strategy draft is being finalized, and it is expected to be approved end of this cycle. The strategy vision in coherence with the ICPD recommendations and in harmony with the socio/cultural setting, is befitting the laborious process of development undertaken by the GOL. It aims to provide and sustain quality integrated RH services in a non-discriminatory fashion, emphasizing the need of deprived areas and marginalized groups for services like safe motherhood, family planning, RTIs, and youth RH. The strategy will embark, whenever possible, on tasks carried on by other programmes for development.

3.4.2 Ongoing Programmes

It is apparent that the ongoing coordination among the implementing agencies (MOPH, MOSA) as well as the executing ones (UNFPA, WHO, MSI) has contributed to improved implementation of outcomes and consequently to the endeavor of enhancing human and regional development.

Within this context, there is continued collaboration with the regional development programme of Baalbeck-Hermel, and expectantly the upcoming regional programme for South Lebanon, mainly in relation to PHC services. Though equally important, collaboration with National AIDS Programme is not apparent, despite its active role in STIs/HIV/AIDS monitoring and prevention. There was also no direct collaboration with UNICEF programmes that deals with vocational nurse aid training to school drop-outs.

A minimal and limited collaboration was started also with the regional socio-economic development programme for South Lebanon. In this respect, several health outlets in different areas in the South were enrolled in the RH project where they benefit from free procurement of contraceptives and basic gynecological drugs, in addition to certain equipment. In fact, some of these outlets were provided ultrasound machines.

The inter-linkage between health and development is one of the main goals of the next cycle. It necessitates an organized and effective collaboration and coordination with the various ongoing programmes lead by UN agencies. There is a need for UN assistance in the RH sub-programme to promote human resources and management systems, in addition to complementing and benefiting from existing activities, especially those pertaining to South Lebanon.

Currently, there are two main programmes pertaining to youth issues and led by UNDP and UNICEF in various areas in Lebanon, with focus on South Lebanon. The UNICEF programme attempts to identify youth dropouts for enrollment in vocational training. In fact, UNICEF has instigated the building of vocational schools for this sake, particularly in the South, in line with the UNDAF recommendations.

UNDP programme is also focusing on youth in 3 different areas in Lebanon. In the South, efforts address the problem of youth re-integration into the local community after a long period of occupation. So, the programme with the assistance of local and community leaders and workers had identified different groups of youth from different towns and villages. These groups will have regular and thematic meetings in the form of workshops that stress youth re-integration in their areas, through introduction to their communities, participation in local activities, debates and educational meetings.
In Mount Lebanon, similar activities are held, but are more developed due to the assistance of already existing clubs and NGOs. In the Bekaa area, the programme is addressing school dropouts ages 14-18 years through vocational training in full cooperation with UNICEF. In Akkar area, the programme is mainly focusing on capacity building of local NGOs.
On the other hand, the LFPA is actively involved in activities related to RH issues. There is the ongoing project "RH for University Students" which involves RH information provision to university students, preparation of meetings for youth, 24 hours "hotline service", and yearly camps or retreats for youth where RH issues are discussed in the presence of specialists and educators.

The Lebanese Scout Union has been participating in a regional workshop on RH, under the patronage of the Arab Scout Federation. Last May 01, a training workshop was held in Lebanon aiming to train scout leaders on IEC skills related to RH.

In the academic arena, the Lebanese Medical Students Society, being part of the IMSF, had also formed a student committee on RH and AIDS. This committee is responsible for information provision in various schools in Lebanon. Last year they held, in collaboration with UNFPA and the RHWG at AUB, an international summer school on RH issues. At AUB, the RHWG is heavily involved with RH research and material production and the SIBER group is leading research on youth and activities on peer education training.

It appears that a lot of work is addressing youth in different aspects of their life. In that continuum, the next programme cycle must collaborate with these ongoing efforts to compliment and contribute to a better RH status for youth.

3.4.3 Reproductive Health within Primary Health Care

One of the main purposes of the RH sub-programme is to integrate comprehensive and sustainable quality RH, including sexual health, within the framework of the PHC System. Currently, the sub-programme operates through a vast number of health outlets belonging to the MOPH, MOSA, LFPA, and other NGOs. Under this purpose, the MOPH is responsible for setting a National Health Policy that ensures integration of RH services within PHC. All through this cycle of the sub-programme, RH services were variably integrated into a total of 430 PHC health outlets to date. Most of these outlets offer a non-specific range of health services, from simple contraceptive provision to a package of services (pregnancy care, FP, and gynecological services). However, in some outlets especially MOPH ones, RH services are not delivered due to shortage of specialized staff.

At the same time, the MOPH supported by the World Bank, is "piloting" a full range of PHC services in around 42 model centers. These centers belong to different stakeholders (MOPH, MOSA, NGOs) and are highly equipped with computers and other tools, with an enhanced HIS. It is hoped that these centers will be a model for best practices in PHC package including RH services. These centers are spread all over the country and, depending on the success of the trial will be incrementally increased to better quality of care.

Regarding the expected benefits of integrating RH within PHC, it is hoped that activities related to capacity building of human resources and strengthening of service setting will directly fortify PHC system. Unfortunately, unavoidable delays in training activities and guidelines implementation had undoubtedly severed this process.

In specific, the capacity building benefit is true at the level of managers, nurses, and medico/social assistants because they are involved in all the spectrum of PHC. However in case of primary providers of RH services (gynecologists and midwives), their capacities improvement is restricted to RH skills which is also part of PHC. This is because, although services are "horizontally integrated", they are provided by different providers. In other situations where services are present side by side, usually are delivered by the same providers responsible for other general health services.
In all cases, the lack of assessment tools to measure impact of RH services on all elements of PHC System makes it difficult to evaluate any expected results.

As there is a compelling need to strengthen PHC System, the need is as critical to appraise the status of RH services within PHC in terms of improved coverage, bettering utilization, and ensure relevant integration. In this regard, assessment of these indicators is necessary for evaluation of RH place within PHC. There also a need to know the effect of RH introduction on the other components of PHC System (staff, setting,..). In this respect, it is crucially important to ensure success for the trial of the aforementioned 42 centers.

3.4.4 Status of Population Reproductive Health

Since the inception of RH sub-programme in1997, RH services-within PHC- are extended to cover all districts of Lebanon through 430 health outlets to date. These outlets are offering a varied range of RH services being mainly, pregnancy care, family planning, and non-specific gynecologic services, a situation that has added to the relative improvement of population RH as mentioned previously in this section (refer to pop section)

3.4.5 Quality of Care Issues

Provision and assurance of quality RH services remain the corner stone of the current and future RH sub-programme. Quality of care is strongly correlated with all the components of RH service and its measurement depends mainly on specific set of indicators. In the absence of a defined set of quality indicators and the lack of quantitative measurement of interval progress, it was quite difficult to assess the performance of RH service provision. Nonetheless, analysis of the current situation can shed light on the issue of quality.

Although the RH sub-programme is built around outputs that will ultimately ensure quality, the unprecedented delays and limitations that struck the sub-programme had impeded this task. At the service level, integration of all RH issues is incompletely implemented; most of the times FP, pregnancy care, and some non-specific gynecological services constituted the bulk of utilized services.
The delivery of services is not guided by any standardized protocols in the absence of SCOP, SDP, SMP, RHIS and MIS. All are fundamental issues for QOC. Fortunately, and except for the MIS, all these guidelines will be made effective towards the last half of this cycle. Necessary training of providers and managers will take place soon. This training is not expected to reach all active health workers due to time limitations.
Currently, a survey on client perception of RH care -should be out soon- is anticipated also to contribute to QOC assessment.
As efforts in this cycle are focused mainly around tasks related to expansion of service coverage, improving quality of service provision, setting RH strategic vision and framework, assessment of quality of care was short of being addressed. There was no identified set of indicators to be utilized.
Nevertheless, service expansion has led to an impressive-yet-vast increase in the number of health outlets, which increased utilization. This step was not accompanied by a satisfactory mechanism for monitoring performance, in addition to existing difficulties in ensuring adequate and sufficient providers within a convenient service setting.
Another drawback adding to lack of quality measurement is the ineffective role of the National Steering Committee for RH. This Committee is supposed to meet 2x/yr and to supervise performance and assist in eliminating obstacles of implementation. Regrettably, the Committee met once during cycle one and as one could expect, it did not contribute to the progress of the RH sub-programme.

With the onset of the next cycle, and in the light of the progress made, there is a gripping need to identify and adopt a set of quality indicators. These presumed indicators are expected to reflect on issues of disparity, integration of services, management, and youth coverage.

3.5 Services

Amidst the civil turmoil, the public health services were drained and nearly stupefied, while the private ones were mushrooming to meet the pressing needs of that period. This has led to a well-developed private sector. In the aftermath of the conflict, the GOL attempted to re-build and improve its health services. Currently a total of about 168 tertiary care centers and 850 PHC are widely spread across the country, making accessibility to health care relatively high (95%).
Despite this high accessibility, utilization of services -whether public or private- is in part related to cost. In this respect, the health sector in Lebanon, due to poorly coherent national health strategy and policy, is characterized by a chaotic financing of services rendering cooperation and coordination between various service funders (army, NSSF, COOP, private insurance, MOPH) very poor . As a result, there is high level of 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 out-of-pocket costs (50% of the population lacks formal health insurance). The MOPH minimally provides, but does not finance (as a third party payer) outpatient health services, except for RH services. Under this existing situation, inequity among different social strata and geographic regions in seeking health care may arise.
Studies also show that a large percentage of the household expenditures go to purchasing medications and paying private physicians fees. It is expected that the pending release of data of the "Mapping Survey" and the "Health Utilization and Expenditure" will provide more insights on these issues.

Regarding RH services, It is estimated that they are offered through 430 PHC outlets and are utilized by a rough estimates of 15% of the population. These outlets belong to the MOPH, MOSA, and the NGOs, and are supported by the RH project in the sense that they freely receive contraceptives and essential gynecological drugs, equipment, and necessary kits. This was accompanied by several measures leading to strengthening of human resources and technical facilities. Although Lebanon enjoys acceptable RH quantitative indicators (PAP), it is believed that the presence of these outlets had further improved access to and utilization of PHC services. Unfortunately, the presence of a multitude of problems related to administration, infrastructure, socioeconomic factors, education, and disparity besides lack of registries and inconsistent data sources, is seriously affecting the process of monitoring progress and identifying priorities. Needless to mention that particular attention should be given to indicators capturing regional disparities and disparities within specific groups. Also particular attention needs to be paid to the quality of the mechanism of data collection and to setting of certain process indicators for quality of service assessment.

These services are provided by a team which consists usually of a medical doctor and/or a midwife, a nurse, and a social assistant working as a team coordinated by a manager in certain times. Those health workers were rarely involved in an organized training or continuous medical education programs. Most of them, if not all, come from the private sector and are involved in private practice; a matter that might create conflict of interest not in favor of the public sector service utilization. Recently, and in this last part of the cycle, 25 Obstetrician/Gynecologists from different outlets will be trained in ultrasonography applications in RH.

In the private sector, which holds an estimate of around 85% of the clients, offers a full range of obstetrical and gynecologic service without a RH perspective, and with no standardized protocols and no well-defined terms of cooperation or exchange of expertise. Again, the cost of these services is sliding.

In view of the abovementioned situation, the degree of utilization of RH services in its full range is not up to the national set objectives. Many of the screening tests are not done as well as other components of services may be under-utilized. At the same time, other procedures is estimated to be over-utilized. Reasons insinuated for this varied utilization are:

- Cost of certain services and screening tests or procedures (in private) mainly
- Health reasons, like feeling no need to seek care, not having a complaint
- Access to service
- Lack of adequate IEC in the community for some services
- Inabilities, related to women empowerment
- Personal reasons related to lack of trust, compliance, and attitudes of different health care providers. In this aspect, the up-coming data of the "Client Perception of RH Care" will provide more information to this issue.

3.5.1 Safe motherhood

Currently most of the safe motherhood services are being offered at the PHC centers. It is estimated that around 80% of pregnant women had at least one antenatal visit and this varies from an average of 94% in Beirut and Mount Lebanon areas to 54% in the North. Of women having antenatal care, around 98% are followed up by private facilities (87%) and some by public ones (PAP). Around 90% of deliveries were either performed or supervised by a physician or a midwife. (PAP)

However, the estimated MMR is 104/100.000 deliveries (PAP), which may be related partly to medical conditions during pregnancy and to events happening during and after delivery, especially that around 12% of deliveries occur at home (25% in the North), according to PAPCHILD. The majority of pregnancy care is done by the private sector, while the public sector is estimated to cover around 15-20% with an average of 3.1visits per pregnancy (PAP). In another study, the majority of pregnant women had a minimum of 4 antenatal visits (El-Kak et al), which is consistent with the minimum recommendations of WHO.

(a) Pre-conception Counseling. The concept is relatively new to the package of RH services. Since it has to be addressed primarily to those who are planning pregnancy, it looks uneasy to implement as the current services are not attracting this category of beneficiaries. This is due to the lack of optimal awareness on the importance of this issue. Some of those centers have counselors that might be practicing preconception counseling within family planning or birth spacing measures. So far, there is no indication to its practice in the available reports, a component if well addressed could improve quality of services and consequently increase antenatal coverage. This service could be more efficiently introduced whenever advocacy ensues and counseling is made available.

(b) Utilization of Antenatal Care. Antenatal care is one of the mainstays of RH services offered in PHC centers. About 80% of pregnant women utilize antenatal care mainly provided by a physician in 92,3% of cases and by a midwife in 5.5%. This varies with regional disparity from 75% in Bekaa to 95% in Beirut (PAP). The content and provision of this service vary by centers, providers, and regions. The various components of antenatal package are not adequately emphasized, and some are often neglected (proper screening tests, nutrition and exercise recommendations, and counseling), or improperly practiced (prescription of drugs, sonography, lab tests). As mentioned previously, there is no available protocol for high-risk pregnancy management, a matter that affects quality and service utilization. It is expected that with the finalized guidelines, antenatal care service provision can be improved in quality and equity.

Despite being low compared to the private sector, this estimated figure shows interval marked increase reflecting progress made in improving utilization, due to RH service expansion, low cost, and free medicine.

It is apparent that antenatal service can be better utilized especially in the public services. This insufficient utilization could be related to several reasons like lack of IEC activities showing the need for regular pregnancy care, sub-optimal quality of care, lack of antenatal care continuum, incompetent provider skills, with obvious inconsistencies nationally due to disparities between and within districts, all being serious limitations that need to be investigated. The fact that deliveries are happening outside the supervision of the PHC services, is seriously affecting the safe motherhood service within RH.

Despite the noted increase of antenatal coverage, efforts should address improving its utilization by re-looking into the whole package of antenatal care and its determinants. There is need to emphasize a basic elements to be offered in antenatal care, a matter which will be addressed in the clinical guidelines, in addition to ensure provider friendly attitude and communication. Depending on the up-coming RH services institution, need might arise for assigned sessions of pregnancy care adjacent to other services.

It worth noting that, pregnant women prefer to be cared for and delivered by the same provider in an already known setting. In the current PHC setting each pregnant woman is followed up by same provider, however delivery might happen by another provider. This necessitates assessing the possibility of including public and other collaborating maternity services within PHC, provided a protocol will be developed for inclusion criterion, referral system, and technical supervision.

This calls for a focused awareness and information provision to women and families concerning the importance of antenatal care and to encourage utilize government services. At the same time, RH services should strengthen pregnancy care components including soliciting arrangements with secondary and tertiary level facilities, to secure timely and safe delivery of the pregnant women.

(c) Content of Antenatal Care. The content of antenatal care may vary with the provider. Generally, the antenatal package includes routine blood pressure

measurement, bodyweight, fetal heart rate, and checking hemoglobin and urine at least once during the course of pregnancy, with no clear evidence of accompanying counseling. Several times, certain measures or procedures are taken with no satisfactory rationale.

Another aspect of antenatal care is that women are not screened for chronic or high-risk conditions, in the absence of a screening and referral protocols. There is no emphasis on issues related to diet, behavioral changes, exercise, counseling, and delivery preparation. Despite improvement in antenatal care utilization, reports indicate a drop in tetanus vaccination percentage. This could be related to several factors like availability of long term vaccines, newly vaccinated pregnant, or disinterest of the providers in view of absence of new cases of tetanus in pregnancy (PAP).

(d) *High-Risk Pregnancies and Referral*. Currently, the existing RH services do not cover high-risk pregnancies. This is due to the absence of an assessment criterion for these cases, lack of a referral system or a networking mechanism with secondary or tertiary level centers. Usually these cases are managed in the private sector.
Foreseeing the intricacy of building a referral system in the immediate future, the up-coming sub-programme services should address the issue of identification of high-risk cases and their optimal referral. This can be done by developing clinical criteria for diagnosis and ensuring referral at the provider level between the primary and the higher level settings.

(e) *Postpartum Care*. Despite the excellent utilization of antenatal care only around39% of delivered women present for postpartum care, being highest in Beirut (64%) and reaching as low as 23% in the South (PAP).
Although this might be a common practice in this region, there is need to urge providers to emphasize postpartum care during antenatal visits, as 2/3 of maternal problems occur in this period.
Postpartum period should be emphasized as it includes prevention or early detection of maternal or newborn complications, as well as contraceptive advice to permit adequate maternal recuperation before the next pregnancy. It is also the period for psychosocial support, as there is no mention or estimation of postpartum depression. A recent study conducted by the Faculty of Health Sciences at AUB about the prevalence of postpartum depression in Lebanon revealed an incidence of 20% (Chaaya, Elkak, Campbell). The low prevalence of postpartum care could be one of the main reasons for unplanned pregnancies.

Investigation of this period regarding improving utilization and avoiding expected complications is highly demanded. Again, inclusion of labor and delivery within PHC services can emphasize proper attention by providers to postpartum care.

(f) *Unplanned Pregnancy*. Another related matter that should be addressed is the unplanned pregnancy. This issue is closely related to the issue of reproductive rights as part of the ICPD recommendations. Unplanned pregnancy is a reflection of the couple's ability in general, and woman in particular to control reproductive destiny. This issue permeates several echelons at the political, family/society, and service levels.

Over the past 3 decades, there was a remarkable improvement in reproductive behavior in Lebanon dropping TFR from 6 to 2.9?(s). This fast transition from high fertility in 1970's to a low one, though positively affected the health situation and the process of development, it did contribute to the load of unplanned pregnancies amounting to 40% (Mroueh paper to RH strategy). This is due to several factors among which are the pros and cons of the use of FP method (health hazards, side effects, cost, access, husbands will), women's education, professional status, and other socio-cultural factors.

Evidence of increased incidence of unplanned pregnancy exists among sexually active youth (unofficial observations) having difficulties accessing proper information and suitable services. This issue has to be addressed mainly through information provision and special counseling.

Efforts should address all the contributing factors by increasing the availability of FP methods, counseling and information provision to couples, and improving the socio/economic and educational status of women. The later 2 factors require the collaboration of other sectors and stakeholders.

The MOH is attempting to drop the MMR. In addition to all the above-mentioned efforts, other measures have also to be considered. These include improving women's access to RH care (which requires eliminating all legal, social, and economic obstacles), enhancing partnership with NGOs, local authorities, and private sector, in addition to involving women's groups and men in planning and decisions. Moreover, all necessary technical and human support should be provided to reduce complications of pregnancy care and delivery.

3.5.2 Family Planning Services

The procurement of modern FP methods is one of the main deliverables of the national RH sub-programme. Currently all the health outlets operating within the sub-programme receive free-of-charge supplies of family planning methods mainly OCPs, IUDs, progesterone injectables, condoms, spermicides, and vaginal foams. This contraceptive supply is totally endorsed by the UNFPA. Usually, RH care beneficiaries in the PHC System -excluding the MOH centers- are minimally charged for each single method, and the collected funds are supposed to sustain those outlets. In addition, family planning services are offered through private gynecology and midwifery clinics, other NGOs, and pharmacies.

There is no documentation to reflect the degree of increase in the use of modern methods. The MOH aims to attain an objective of 55% by 2006 for modern contraceptive use by increasing coverage and encouraging utilization. In the absence of interim or periodic reports about current CPR, it remains difficult to assess exact improvement or utilization, except for the noted increase in clients due to outlet number increase.

(a) Trends in Knowledge and Use of Contraception. According to the results of PAPCHILD, more than 99% of women know about a FP method, yet only about 61% of married women are using a method of contraception (modern or traditional). About 37.2% of those couples are using modern methods, and 39% are not using any method.

Regarding the most common modern methods used by married couples, first ranks the IUD, followed by OCP and condom, whereas in the primary health care outlets, OCP comes first then IUDs (MOH reports). The most likely explanation for this finding is related to the providers in PHC setting who might encourage clients to have IUD inserted in their clinics instead.
Although contraceptives are supplied by many sources all over the country, the use of contraceptives still vary among districts, being the lowest in the North (53.2% vs 66.4% in Bekaa), which is also the district with the highest percentage of non-users of contraceptives (46.8%) followed by South (42.3%) as compared to Bekaa (33.3%) and Mount Lebanon (35.6%).

The ongoing expansion of PHC outlets has directly improved contraceptive coverage and as a result, increased the number of clients utilizing FP methods (MOH quarterly reports). This is most likely to improve CPR with **persistent disparity among geographic** areas, reflected in part by increased total fertility rates. However, reports indicate that couples with undesired pregnancies are not able to meet their contraceptive needs (source).

According to the Unmet Needs Study (LFPA,97), the wide knowledge of contraceptives and the high percentage of those unwilling to have pregnancy, did not necessarily lead to a proportionate increase in contraceptive use. Some of the cited reasons for non-use are mainly related to socio-cultural and traditional constructions (personal reasons, fear of complications, religious, and family opposition) that could negatively affect reproductive decisions.

(b) *The Method Mix*. There is wide range of contraceptive choices accessible to clients. This includes OCP, IUDs, condoms, injectables, and vaginal foams. This is in addition to Norplant and female condom that are serviceable in the private sector.

In the absence of a contraceptive logistics to date, it is expected that with increased coverage of RH services, modern contraceptive use will increase with the IUD method being more demanded. Consequently, the percentage of women using traditional method among total users will decline in favor of IUD.

Regarding cases of non-compliance with or quitting of the contraceptive method, or even changing to other methods, they are in part related to lack of optimal counseling and adequate information provision about contraceptive methods and their side effects, contributing to this client attitude.

(c) *Contraceptive Logistics*. The MOH is the sole official supplier of contraceptives. PHC centers provide FP methods for around 13% of married women, while the private sector provides for about 28.3% (PAP). The share of the PHC outlets is expected to have increased as they have expanded over the past 5 years. In most outlets, with the exception of the private clinics, very little profit if any is made on the provision of contraceptives to clients. This may be an incentive to increase utilization of RH services in this regard.

Logistics and supply of contraceptives and their effective use rely upon a system of proper storage and continued supply of the desired method. The **warehousing** and distribution system of the RH programme was found to be well adapted to its needs. Contraceptive methods and essential RH drugs are adequately stored in a central warehouse in Quarantina Hospital under the supervision of the MOH. Contraceptives are even located separately in different compartment. All commodities are reliably checked for quantity, content, expiry date, and eventual damage.

Monthly supplies are provided to health outlets by service coordinators based on requests of needs, past consumption rates, and availability. In the outlets, supplies are stored in regular closets at room temperature. Monthly records of contraceptive use are kept and evaluated.

Contraceptive supply is a main deliverable of the national RH sub-programme. As the current cycle is closing, it is of paramount importance to keep adequate and sustained supply of contraceptives during the transitional period from the current cycle to the next one. This issue should be meticulously addressed by the MOH and the UNFPA as it represents an essential part of a contraceptive strategy for the coming cycle. This calls for the establishment of a "Contraceptive Requirement and Logistics Management Needs" assessment for the Period 2001-2010.
Also, there is need to encourage social marketing of quality, affordable condoms by NGO, NAP, and private sector to secure easy availability throughout the country as well as information of their correct use, particularly where youth are concerned. Need also extends to peripheral areas where there is high percentage of non-users to inform about and encourage use of contraception.

3.5.3 Gynecological Services.

The presence of gynecological services as part of selected RH services in PHC had led to improved utilization of these services (MOH reports). It had also contributed to the needed expansion from pregnancy care and FP alone to a package of wider-scope services. In a study about the prevalence of reproductive morbidity conditions conducted by the RH Group at the FHS, AUB, in the Bekaa area, it was found that the prevalence of morbid conditions like vault prolapse reached 60%, and that of RTIs reached 20% due to erratic use of antibiotics (DEEB et al, 00). Most of these conditions were not brought to medical attention, as they were not perceived as serious problems.
Although MOH records are not accurate regarding the various components of the gynecologic service available, this service remains the most commonly utilized compared to pregnancy care and FP.

Unfortunately this marked utilization is not congruent with a similar utilization of screening tests (Pap, breast), specific reproductive conditions, or menopause service. An observation that raises a compelling question about the "gynecological exam" services, and demands discerning the exact types of the services delivered. Recently, a dissection of those gynecological services was conducted in selected outlets and it was found that many reproductive morbidity conditions were registered. However, it remains that these services have to be strengthened to provide quality assessment, and be emphasized and well promoted. This again leads to the need to assess the status of services in terms of their degree of integration within the PHC System.

In this respect, providers and managers need to promote the importance of screening tests and should try to elicit other complaints or possible morbid conditions that are not voiced by the client. In other wards, gynecological morbidity services need to be well integrated and made available to clients, while at the same time making clients aware of their existence.

3.5.4 Sexual Health and STI/HIV/AIDS.

Although sexual health is part of the ICPD recommendations, it is not properly included within the RH services, and is rarely addressed as a delicate issue. The existing health outlets are not provided with necessary tools and equipment to diagnose various types of sexually transmitted infections, yet quarterly reports document very few cases that are registered and not definitely reflecting the true incidence of those infections. For example, around 208 cases of protozoal infections are reported only in the area of South Lebanon out of a total of 11477 cases seen, while the total number of cases of "gonorrhea" are 9 cases all over Lebanon out of a total of 46870 visits (MOH report, 01).

According to the Epidemiology Surveillance Unit in the MOH, there are 35 cases of syphilis and 1 case of gonorrhea, and around 200 cases of hepatitis B reported in the first half of 1998 (EpiNews, June 99). This reflects the under-reporting of cases thus making low the actual prevalence of such conditions. Underreporting may be related to several reasons (social, cultural, HIS, mechanism of reporting and collection, physician's commitment).

In the current PHC System, there are no specialized STD clinics. Besides the suggested reasons for under-reporting, key informants (physicians of different specialties) believe that it is either a low prevalence country or STD cases are usually self-treated. Some gynecologists admit treating infertility cases secondary to STD infections (PID, chlamydia). However, no laboratory or precise statistical data is available.

Data on HIV cases reveal that around 15% of the most declared cases report a history of previous or concomitant STD infection (most commonly non-specific urethritis). A national KABP study completed in May 1996 revealed that 5.6% of the sexually active males report at least one episode of STD infection over past year prior to the interview.

According to the NAP study on " Prevalence of Sexually Transmitted Diseases in Women Attending Ob/Gyn Clinics in Lebanon" (March, 2001), where a sample of 462 women aged 15-55 years was reached in 4 clinics, chlamydia (14.3%) and candida (13.6%) diagnosis was the most prevalent, and gonorrhea, syphillis, and HIV had zero prevalence. Chlamydia and candida are more likely to be prevalent among younger age groups and divorced females. Chlamydia was also more prevalent among working women.

There is need for gender-sensitive large studies of clients presenting to different specialty clinics to further clarify the STD status. Besides, KABP studies on STDs will help primary prevention interventions.
Since there is no population-based studies or statistics on the prevalence of STDs, there is a real need to improve service statistics on STDs in order to expand coverage and

improve reliability. The health personnel must also be trained –through NAP collaboration- to observe universal precautions. Improving conditions of confidentiality in testing and sensitizing the community to its importance could help in identifying cases for control of transmission as well as proper implementation of counseling services (revive the hotline project).

The prevalence of HIV/AIDS. By December 2000, the total number HIV/AIDS reported by NAP is 27cases (11 asymptomatic, 16 AIDS, with 11 of these cases being females). This raises the cumulative number of cases to 609 cases distributed as follows: 275 cases asymptomatic, 196 AIDS, with 21% being females. The probable way of transmission remains sexual in about 70% of the cases and perinatal in 4.1% of cases. The age distribution of the reported cases is 31-40 years.
The NAP being the official authority within the MOH on HIV/AIDS information and education is involved in the provision of condoms especially to high-risk groups, training of health care providers, and holding of awareness campaigns. These condoms are supplied by UNFPA.
Unfortunately, the cooperation between the RH sub-programme and NAP is very limited. With the onset of the new cycle, there is need to involve NAP in up-coming activities related to advocacy, youth and capacity building of RH health care providers.

3.5.5 Infertility

Infertility service is scarcely addressed within primary health care setting. According to the MOH reports, infertility cases make up around 0.4% of all the new cases presenting over a 3 month period. The majority of the infertility cases usually seek care in private clinics as it is considered a secondary and tertiary level of care. Although many of the infertility work-up steps can be achieved at the PHC, there need to be proper advocacy for this service coupled with sufficient training of providers. Providers have to be urged to promote this service and to investigate within the PHC setting. It is hoped that with the upcoming cycle, and as the RH services are going to be better strengthened and integrated, infertility work up can better be delivered.

3.5.6 OTHERS

Other important services like menopause and post-menopausal health, mental health, **ABORTION**??and violence against women are totally lacking at the PHC level. The MOH is urged, with the collaboration of NGO's and other women's groups in the community, to address these issues. The role of the IEC and advocacy is vital to fully launch those services within the RH package.

Women should be capable to seek and get medical advice and care for their reproductive complaints including menopausal and post menopausal periods. It is hoped that this service is introduced through the expansion process undertaken by the MOH regarding RH services.
A strategy for the improvement of the reproductive morbidity services is based on a 3-pronged approach that includes:

- Introducing gynecological services along with the family planning and antenatal services as it is the case here.
- Building outreach linkages to women by complementing the clinical services with the social services in the community that would allow to take into account the social

conditions in women's lives, to offer them health education, and to encourage them to use health services.
- Establishing linkages to more specialized health facilities for consultation and referral.

3.5.7 Youth

Today's global youth population, ranging in age from 15-24 years, is estimated at 1.03 billion, representing 18% of the people inhabiting the earth (UNDP, 1997b). Eighty four percent of those young men and women live in developing countries, and their numbers are expected to increase well into the 21st century. They are considered to be a special group that faces particular problems and uncertainties regarding the future, problems that have to do in part with limited opportunities for employment.
Youth are also affected by a growing incidence of substance abuse and juvenile delinquency. In addition, unprecedented numbers of young people in many developing countries are migrating from rural areas to urban centers.

The World Programme of Action for Youth to the year 2000 and Beyond which was formulated and adopted by the General Assembly (GA Resolution 50/81), identifies ten priority areas for action aimed at improving the situation and well-being of youth. These areas include: education, employment, hunger and poverty, health, environment, drug abuse, juvenile delinquency, leisure-time activities, girls and young women, and the full and effective participation of youth in the life of society and in decision-making.
Regarding health, youth are at risk of unsafe environment, infectious, parasitic and water-borne diseases, substance abuse and destructive activity. In many countries, there is lack of information and services available to youth to help them understand their sexuality.

Lebanon, being a developing country, is demographically a young country. Youth account for about 19% of the total population, distributed as 19.4% males and 18.4% females (MOSA, UNFPA, 1996). The relative importance of youth is projected to gradually decrease to around17% by the year 2011.

The geographic distribution of youth among the different areas of the country is more or less even, varying from 19% in Beirut to 21% in Bekaa. It looks that higher rural fertility is compensating partly for rural-to-urban migration

Lebanon in this regard is fully aware of the importance of youth issues. The firm conviction of the government in the role of youth has led to the introduction of a special portfolio. According to the **government policy statement, 2000**, the government will strive to firmly support the newly found Ministry of Youth so it can house all categories of youth by undertaking all necessary initiatives and measures. It is hoped that a favorable environment for youth will be created to enhance their participation in decision-making processes. The government promised to endorse the legislation needed to achieve this task.
In view of the stifling socioeconomic crisis seriously affecting youth, the government has promised to invigorate the economical cycle to generate job opportunities for them. Moreover, the government pledged to facilitate and support the sports sector through

encouraging its activities and strengthening its various associations (Government Policy Statement, 2000).

On the other hand, the drafted national RH strategy strongly emphasizes the importance of youth and their role. It calls for programmes that ensure adequate counseling, education, and information provision in service setting, formal and informal educational sectors.

Regarding health, youth is considered to be a healthy category, yet they are more exposed to high-risk behaviors that lead to a lot of preventable morbidity. The current youth of Lebanon belongs to a generation that grew up amidst a sad civil war (1975-1991), where every aspect of life suffered immensely. Nonetheless, the adolescent years of those students coincide with an unprecedented period of reconstruction and development. This has been accompanied by large-scale societal change brought about by a multitude of factors. Some of these probably include: new ideas and attitudes brought by Lebanese citizens who had migrated during the war and are now returning to the country; the influx of migrants from other countries seeking work in Lebanon; and, the dizzying speed of the worldwide waves of modernization and globalization. All this may have led to a rapid shift in norms and values of adolescents towards a more liberal orientation within a fairly conservative society.

Supportive evidence for these observations comes from a recent survey of Lebanese university students which found that students exhibit, in their values, characteristics of modern, or postmodern, rather than traditional society (Faour M. *The Silent Revolution in Lebanon: Changing Values of the Youth.* Beirut, Lebanon: American University of Beirut, 1998).

Evidence from several studies on youth health and in specific RH, reveal that Lebanese youth are exposed to high-risk cluster practices like unsafe sexual practices that expose them to consequences like, unplanned pregnancy, STIs, and abortion, in the face of almost total absent of any kind of national plans for information provision and counseling and a pressing need for RSH information (Sibai&Kanan 97, SIBER 01, El-Kak et al 01, and LFPA 97). These practices also include substance abuse, poor nutrition, lack of exercise, peer pressure, and lack of social support.

In 1998, the ministry of education had implemented in public schools a new curriculum including health education. Despite many defects appearing at the level of teaching and provision of this material, this curriculum represented the sole source of health education to students. A process of evaluation and amendments is being undertaken. Many NGOs-especially LFPA- is carrying many activities related to RH information provision for youth through 2 main projects: one assigned for the youth doing their military service, and the other one addresses university students.

Although current selected services are supposed to serve all age groups concerned, there are no specific considerations meeting youth needs, especially reproductive health needs. Nonetheless, regular reports from the MOH indicate that beneficiaries in the 15-24 years of age constitute 20% of the total clients (quarterly, 01). This represents a marked improvement in attracting youth to utilize available services, as compared to

previous reports.Unfortunately, there is no substantial information on the health-seeking behavior of youth. Besides, official MOH reports do not reveal the type of services utilized by youth, although it is believed that pregnancy care, menstrual disorders and non-specific vulvo-vaginal discomfort are the most common services.

In exceptional situations, youth may be provided OCP and condoms from certain outlets, and in an unofficial manner, or sometimes through the activities of the National AIDS Programme in case of condoms. At times, youth can still and do have an access to private clinics for services related to sexual health and its outcomes. Again, this is done in a very discrete way.

Despite evidence from the above mentioned surveys showing prevalence of premarital sexual activity and need for sexual health information, full comprehensive services for adolescents remains absent, and the need for them is not acknowledged.

In view of the current youth situation, and in line with the GPS, there is a critical need to prioritize youth issue. This need calls for proper integration of certain youth services (RTIs, reproductive dysfunction, counseling, information provision, pubertal problems) accompanied by adequate sensitization of providers to youth issues and skills of communication. There is also need to ensure that all components of youth services in terms of privacy, confidentiality, and understanding are well secured. Advocacy for these services should be carried in the most appropriate way possible.

Youth need to be provided with apt and opportune RH information in both formal and informal sectors using modern means of communication like peer-peer counseling.
Need compels undertaking national surveys and qualitative studies that concern youth health behaviors and attitudes. These studies must be segregated by gender and region.

There is need to provide information that are optimal and culturally-sensitive in all tracks of youth life (ongoing UN projects) Attention should be given to youth at high risk, and also those living in deprived and marginalized areas, especially South Lebanon where tremendous efforts to re-integrate the youth are undertaken.

3.6. Human Resources in Reproductive Health

3.6.1 Providers/Managers of Reproductive Health

Ideally, each PHC center entitled to provide RH care should have a working team composed of a medical doctor (Ob/G, FM), a midwife, a nurse, and a social worker, in addition to a counselor. Although this might be the case in some of the PHC "model" centers, the majority of the existing outlets have teams of an average of 3 health providers (Physician/midwife, nurse, and a social worker). Providers of clinical RH services are either physicians or midwives, in addition to nurses that help in service provision. Most of those providers have different educational and training backgrounds, reflected as differences in competence and quality of service provision. During their work with the RH sub-programme, they received minimal training in RH concepts, issues, and selected service delivery through a block seminar during the current cycle (1997), yet they are not fully comprehensive of RH dimensions and applications. The

MOSA also carried 2 training seminars on counseling and communication for ? providers in 199?. No other seminars or refreshing courses were conducted.
So RH services may not be well promoted for by the providers, which affects its utilization and delivery in an integrated manner. Another activity is being conducted by the MOSA to train 100 providers on counseling and communication in RH issues.
Most providers have part-time contracts, and they are in private practice, an issue that creates a conflict of interest interfering with optimal RH service utilization. Over and above, those providers have low or absent professional remunerations, with no subsistent incentives to encourage them and to strengthen their commitment to the PHC System. In this regard, monthly meetings, educational material, regional scientific conferences are some forms of incentives.
Currently, the practice of RH care is not based on standard protocols for clinical operations, an issue that -when implemented- can enable providers to ensure better quality of care.

3.6.2 Management of Reproductive Health.

The RH services are managed at 2 different levels: the central level and the field level.
Centrally, since RH management operates within PHC, it is worth noting that in 1993 the MOPH undertook a major review of the PHC System, supported by the World Bank. As a result, a National Strategy for PHC was developed with the participation of a number of stakeholders. Since 1996, the MOPH initiated the implementation of this strategy through a network of 20 public and 21 NGOs centers.

As for health management in the districts, a decentralized system exists in Lebanon in the form of 5 Health Authorities in the 5 Muhafaza, and the Caza Health Offices. However in practice, the system is seriously weakened by the years of civil turmoil and the District Health Offices are currently understaffed, ill-equipped, short of funds, and lack a clear job description. Hence, they are unapt to carry the expected heavy load related to PHC services.

Recent efforts exerted by MOPH, WHO, and HSRP attempt to remedy District-level administration. Activities so far have included identifying problems and needs, and carrying out a number of individual and group meetings and workshops with Caza Physicians to discuss best options and alternatives. The WHO supported a project aiming to strengthen management capacities at the district level, which was launched end of 1999. This project is facing some delays in view of the weak administrative situation in view of the government stand to freeze all new appointments.

Regarding RH Project, the management is responsible for execution and sustainability of all the outputs of the project. Necessary meeting are conducted with all partners (UNFPA, WHO, MOH, MOSA) to ensure close coordination and supervision of ongoing activities. Periodic reports are issued monthly, quarterly, and yearly on the progress of various activities. Although the national director of the project is a MOPH staff and is fully responsible for the project, and represents the project in all national, regional, and international meetings, unfortunately, the project is not institutionalized within the infrastructure of the MOPH. As a result, sustainability for the managing staff is not ensured and so is that of the project. Most of the project staff is on project funds. This could affect in many ways the launching and the progress of the project. In this regard,

and following the MTR recommendation (July, 00), the project staff was strengthened by the recruitment of a NPPP to help in the execution of the remaining outputs. It is expected that interval progress will improve.

The central management also has 4 service coordinators working at the level of the districts (Beirut&Mount Lebanon, Bekaa, North, and South). The coordinators are supposed to follow up closely the progress and the quality of work at the outlets, as fart as health workers, managers, drug supply, and health information are concerned. They are expected to ensure adequacy of service delivery in a timely and friendly fashion. The service coordinators must also be able to identify limitations and restrictions affecting RH service elements.
In all these endeavors, the service coordinators are in continuous contact with the central administration, and they have regular meeting to follow up on various issues of relevance. These meetings include evaluation and submission of monthly reports, and issues related to monitoring the progress of the outlets.

At the field level, the managers of the outlets are not specialized in management and usually work on a part-time basis schedule. In many situations, the outlets are managed by a physician, a midwife, or a nurse, and not necessarily by non-medical personnel. Although they exert lot of efforts to ensure adequate coordination of work, a lot remains to be done regarding capacity building, technical support, and data management.
The managers are in direct and regular contact with the service coordinators, who ensure provision of needed contraceptives and essential drugs and monitor the work in the respective outlets. This allows for mutual suggestions and recommendations, a kind of dialogue between the center and the field. Although coordinators point to a lot of defects in the management like lack of team work, proper client registration and follow up, and medical records, lack of proper and clear mechanism for monitoring and follow up, and absent standardized MIS, staff commitment, mechanization, makes achieving good management a hard job. Besides, no role is given to the caza physicians or district health departments in this project.

The opertionalization of RH services is compromised in view of the existing management in some of the outlets.
As part of the outputs of this project, SCOP, SMP, SDP, RHIS guidelines are ready to be implemented in various outlets, after proper training of the staff. This is expected to improve remarkably the performance of the management, and ensure better quality.

3.7. Critical needs in Reproductive

3.7.1 At the level of providers:

- Need for programmed training and capacity building to ensure induction of RH concepts, sensitization to clients needs specially youth, and to advocate for services.
- Need to ensure incentives for providers like material resources, or incentives related to capacity building (books, regular meeting, conferences, participation in assessment of care and getting them more involved.
- Need to ensure proper documentation of health information
- Need to redefine job description and specific role within team. This implies team spirit and teamwork approach.

- Need to re-look in the contract system

3.7.2 At the level of management:

- Integrate RH project in the MOPH structural cadre
- Ensure consistent client registration and health information documentation.
- Specialized staff that delivers quality services accompanied with capacity building activities
- Mechanization of the management processes and operations
- Mechanism for monitoring and surveillance of various aspects of RH services.
- Team coordination that clearly defines job assignments and terms of coordination.
- Opertionalization of RH service setting.
- Local community involvement in the activity and plans of the outlet.
- Ensure proper adherence to the operational guidelines.

An important and imperious need that stands at the whole management level is the re-consideration of the existing number and scope of the health outlets. The current 430 outlets, though serving more clients, are compromising timely monitoring and follow up, thus seriously affecting quality of care.

3.8 Information, Education and Communication

Despite the absence of a ratified national IEC strategy in population and RH, dozens of groups have been active in promoting IEC concepts and strategies in these areas, including UNFPA supported PDS and RH strategies (not yet ratified) and a national strategy for women. However, a concept of IEC as a comprehensive programming intervention and an integral part of a country development program still needs to be developed by parties active in IEC activities in Lebanon.

From the experiences of groups working in IEC/ RH in Lebanon, the following trends have been identified: 1) the need to address IEC activities to multiple audiences; 2) the need to enhance the skills of service providers; 3) the potential for coordinating and pooling stakeholder resources; 4) the need to identify and address critical issues and constraints; 5) the potential for collaborative and complementary work among groups.

Numerous RH/IEC programmes have been implemented by the UN system, including the UNFPA, UNIFEM and UNICEF; government ministries, especially MOSA (RH/IEC sub-programme Leb98/PO1), MOPH (RH sub-programme Leb/97/PO2), the National AIDS Control Program (NAP), the Lebanese Family Planning Association (LFPA), and dozens of other NGOs. Universities and research groups have also been involved in IEC activities, as has the media, though to a limited extent.

Governmental IEC Units and coordinating committees are eligible to establish effective IEC programmes that can provide an umbrella to secure the coordination and sustainability of IEC. However, IEC units seem to suffer generally from inadequately trained technical staff in addition to insufficient resources. This situation has also been noted in the PRSD and MTR. These government units/committees include the health education department of the MOPH, the Population IEC Unit and the Social Training

Center of MOSA, the IEC unit at the Ministry of Environment, and the National Permanent Population Committee.

The channels / approaches used in IEC for gender, population and RH are diverse. They include: media resources, counseling, hotlines, websites, campaigns, and community-based health workers etc. Minimal assessment has occurred in Lebanon regarding the use of the different modalities/ approaches in IEC and the concomitant changes in attitude and behavior. However, it is apparent that thus far, IEC activities in the informal sector have not been based on adequate strategy and research, while those in the formal sector--namely regarding efforts to introduce population and RH education into school curricula—have not been well-studied or thought-out.

Despite progress in IEC programming, several of the constraints referred to in the PRSD document (1996) are still valid. Based on the CPA exercise and workshops described in the methodology, a number of constraints were identified. This wide-range of areas that need improvement includes: concepts, partnerships and coalitions, evaluation and monitoring, supervision within projects, data and research availability and accessibility, socio-cultural sensitivity, participatory needs assessment, gender awareness, human resource development, counseling skills, coordination of IEC contents with the media, audio-visual resource development, and advocacy enhancement.

Geographically, Lebanon has wide regional disparity with regards to RH indicators, and it is necessary to focus on areas that are underserved in RH services. This is of particular importance when working under limited resources while aiming at quality assurance. Identified areas of need are in Hermel, Akkar, the Beqaa, and the southern suburbs of Beirut. South Lebanon is also targeted given the political situation, the socio-economic situation and the UN initiative in the South.

Given their needs and limited resources, youth/adolescents were endorsed as a key target group. Additionally, it is necessary to continue targeting women, as was the case with the 1996-2001 cycle. Targeting men is also to be encouraged, especially as men were not a target group during 1996-2001 cycle.

Additionally, there are several key target groups within the youth/adolescent category, including boys and girls during puberty and between ages 15 -24, youth/adolescents living in underserved areas and heavily populated neighborhoods, school and university students, orphans and youth /adolescents from broken families, members of school and community youth clubs, youth/adolescent participants in summer camps, conscripts ("tajneed") and scouts, youth in vocational / technical schools, youth in reform schools and prisons, young married couples, and youth preparing for marriage or who are engaged.

With regards to youth in particular, a national IEC strategy for RH addressed to youth /adolescents is not only dependent on PDS and RH strategy, but on the presence of youth policy and strategy as well. A national youth conference that is to address youth priorities in several sectors including health is forthcoming and will be the continuation of the March 01 conference in which 50 people from 40 NGOs participated in examining Lebanon's youth policy.

Based on the MTR (2000) that recognized the need to exert effort to involve youth in existing RH activities, the national RH programme introduced youth into its ongoing IEC activities. A national youth media awareness campaign is being planned for summer 01, in order to educate youth about their RH rights and responsible behavior and provide youth with accurate RH information.

Several stakeholders working in Lebanon have identified youth/ adolescent needs in population, gender, and RH as a priority. Examples include: NAP, LFPA, SIDC, AUB, A'mel, Armenian Rescue Cross, Secours Populaire, Dar Al-Amal, LRC, Popular Solidarity Group/Saida, The Imam Al-Sadr Foundation, Movemente Sociale, Makassed, etc). In addition, many UN programs are engaged in youth activities and interested in cooperative and coordinated efforts. These include UNDP, UNICEF, ILO, UNIFEM, WHO, ESCWA and UNESCO.

The activities of the population education committee have been suspended. Formed in 1987, the population education committee was responsible for introducing population education into the curriculum. The committee was composed of the LFPA, the Center for Educational Research and Development (CERD) and university experts. The level of integration of population education and reproductive health in the curriculum still needs to be assessed and upgraded. An evaluation report was produce by the WHO in 2001, but has not yet been published.

In 2000, and under the pressure from religious groups, the reproductive health chapter (which includes sexuality) was eliminated by presidential decree from the 7^{th} grade curriculum. However, many private schools as well as some religious ones have disregarded this curricular decree and are teaching the eliminated chapters as well as supplementary lectures on sex education (Beydoun 2000).

During the CPA exercise, the need to re-address the topic of sexual health was voiced by service providers, decision makers and youth themselves. Youth frequently stated that sexual health should be introduced through schools, as it is a topic they cannot discuss with their parents.

Research addressing IEC /youth is minimal in Lebanon. However, research in the area of RH and adolescent health is being and has been conducted by several research groups including the Reproductive Health Working Group and SIBER, both at PHD/ AUB. Additionally, NAP has undertaken several studies to determine youth knowledge about HIV/AIDS and how it is transmitted.

Stakeholders who are active in youth RH in Lebanon use different channels /approaches in IEC. Both participatory approaches and entertainment education are gaining popularity as effective means of working with youth/adolescents. A comprehensive approach has also proven valuable for addressing broader issues of youth/adolescent lifestyle. During the CPA, several groups voiced the need to address youth/adolescent with an integrated approach that takes into consideration relationships with parents, schools and communities.

Successful activities targeting youth that have been undertaken by NGOs in Lebanon include the use of peer educators, participatory workshops, hotlines, summer camps, health fairs, and various publications and media activities.

Youth programmes face particular constraints in addition to those faced by IEC more generally. These include the lack of an integrated national youth policy, inadequate political will to treat the problems and potentials of youth, insufficient training for personnel from youth-related ministries, low-budget support for delivery of youth policies, problems in defining youth versus child, conservative societal attitudes that restrict the movement of youth/adolescents, the belief within Lebanon that "our" youth do not need sex education, inadequacy of the current health system in addressing the youth RH needs, lack of access to quality and non-judgmental services and RH counseling, lack of access to reliable and clear information, lack of programs /projects that help youth/adolescents attain a level of maturity required to make responsible decisions, and the persistence of early marriage and parenthood in some communities in Lebanon.

In sum, the situation of adolescents/youth is aggravated by their lack of resources, poor knowledge, uneasy communications with parents and guardians, lack of access to reliable information and professional and ethical counseling, a negative attitude on the part of health professionals, unavailability of youth friendly services and lack of understanding and support.

3.9 Advocacy:

Since RH and population problems are deeply rooted in the social, cultural, economic, legal and political environment, they can only be addressed and resolved by a combination of long term solutions as well as short term ones. It is here that advocacy, in support of both specific programmes and longer-term policy and legislative change, is crucial.

Advocacy should focus on building constituencies, effecting legal reform and enforcing laws regarding population issues, including reproductive health issues, gender rights and empowerment. This thematic area has not yet been well developed in Lebanon. However, there have been some independent initiatives, listed here. In the coming cycle, advocacy is to be heavily emphasized.

Although some advocacy activities in support of population issues have been launched by the UNFPA in conjunction with the NCW, the LFPA, and NAP, these activities have not been sufficient to mobilize support for integrating the recent UN programme of actions (ICPD, FWCW, WSSD and Habitat) into the action plans of national institutions. Furthermore, other issues have yet to be addressed by advocacy activities, including increased coverage by private media of population issues and enhanced of coordination among the government, NGOs and the donor community.

The National Permanent Population Committee has coordinated the production of a National Population Policy which was submitted to the Lebanese government but has not

yet been endorsed. Once endorsed, it will be possible to begin implementing a Population Policy Programme in compliance with the content of the Policy.

In 2000, and under the pressure from religious groups, the reproductive health chapter (which includes sexuality) was eliminated by presidential decree from the 7th grade curriculum. Advocacy events targeting decision-makers should be organized in order to advocate for the re-integration of sexual health into school curricula. In addition, efforts should be made to negotiate with vocal opposition leaders to bring them to an understanding of the importance of RH and SH education for youth.

The National Council of Women (NCW) conducts advocacy activities in support of the ratification by the government of the International Convention on the Elimination of all Forms of Discrimination against women. To this effect, the NCW conducted and published studies on legislation discriminating against women and on women's images in school textbooks and produced information programs on women's roles. The NCW has succeeded in abrogating laws, which have prohibited women from travel, and practicing commerce without their husbands' prior consent.

However, women still do not have full reproductive rights, freedom, and choices in Lebanon. In addition, many women do not understand the rights that they do have, and thus are not in a position to claim them. Hence, more and better coordinated advocacy is needed to ensure the legislative changes necessary to guarantee women equality and equity in their reproductive and other rights. Among the basic long-term solutions that require advocacy are promoting education for girls, promoting laws that empower women to make RH decisions, abolishing laws that hinder women's development, and eliminating social and cultural discrimination against women. In addition, advocacy efforts are needed to reform the penal code, which as it stands today, reinforces injustice and discrimination especially in dealing with adultery and its consequences, minimizing penalties or providing loopholes for men who commit "honor crimes."

3.10 Gender, Population and Development

Women's status in Lebanon is characterized by great diversity and disparity. As such, the study of women's status in Lebanon relates to many factors, which can affect her empowerment, place in society, relationships with men in the private and public arenas, and participation in sustainable development. The factors are culturally specific and include the physical and psychological aspects of men and women; the social, cultural and traditional environment; the values, concepts and trends within communities; and individual decision-making practices and behavioral criteria.

Since the civil war, Lebanon has worked to improve the quality of life for all by linking population changes to social and economic development, taking part in many regional and international conferences for ICPD +5 and in the Fourth Women's Conference in Beijing in 1995, ratifying a series of international conventions including CEDAW, establishing women's groups, and making concrete improvements such as education availability, free health services, and steps for the adoption of a national population policy and strategy.

3.11 Critical needs in gender, population and development

(a) *Poverty and participation in development:* There are deep socio-economic disparities among women belonging to different sociocultural groups and regions in Lebanon. The poverty of women intensifies gender-based inequalities particularly with regards to the distribution of the benefits and sacrifices of development. The situation is particularly intensified when it comes to women headed families (estimated at 14%). Attempts at integrating women in mainstream development and improving their status have followed a sectoral rather than a multi-sectoral approach with small income generating projects. Indeed, the absence of a concerted effort coupled with an overall strategy effectively addressing the root causes of women's poverty resulted in scattered projects with dilute impact.

(b) *Displacement and internal migration:* Although suffering is shared by men and women among the displaced, women often experience additional hardship. There is a need to improve and expand existing programs to provide outreach services tailored to women's specific needs.

(c) *Economic activity and employment:* Participation of women in positions of responsibility on a local or international scale, as well as in the state and political and trade –union organizations remains very weak. As in other countries, women compared to men are less "present" in the labor market, and are concentrated in sectors of low productivity, low earnings and low status. Women earn less than men even in otherwise comparable situations and stand a higher chance of being unemployed (i.e., able and willing to work, but unable to find employment). In addition to occupational discrimination, women face the dual responsibility of being a career woman, a mother and a housewife.

(d) *Legal status and gender (in)equality:* The Lebanese constitution provides for equality among all citizens in rights and duties. However, there are still a lot of obstacles to achieve the goal of gender equality. They include discriminatory stereotyping, traditional social attitudes, policies, laws, institutional arrangements and lack of resources. More over, women are often unaware of their rights and there is often a large gap between existing laws and their application in practice. Decision-makers seem to ignore the need to use legislation positively to improve women's status. There is also a lack of legal services and no support system to enable disadvantaged groups and particularly women to obtain their rights in practice. The most crucial of the legal problems is that of the family codes and individual status law's which regulate issues related to marriage, divorce, inheritance and custody over children, and which are maintained separately by the religious leaders of each confession. These laws still put women under pressures like polygamy, unilateral divorce, or the impossibility of divorcee even in cases of serious conflicts. Finally, the penal code reinforces injustice and discrimination especially in dealing with adultery and its consequences, minimizing penalties or providing loopholes for men who commit "honor crimes."

(e) *Participation in the public sphere:* Currently only three women sit in the parliament and few more hold positions at a high level of decision-making power. The political arena is still almost exclusively male. This may be due partially to women's reluctance to assume formal leadership positions but also to the existence of various barriers to their full participation.

(f) *Education:* Despite compulsory education for both sexes of Lebanese nationality, gender disparity is apparent at different stages of education and is concordant with regional disparities and differences between urban and rural zones, and private and public sectors. In addition, illiteracy remains a critical problem among women.

(g) *Reproductive Health:* While there is no indication of discrimination against girls in health related issues, there is a need to improve the quality of health services. Although many health services target women, the user's perspective is weak and the prevailing tendency among physicians is patronizing in nature when it comes to women's needs for information. There is also a lack of a comprehensive approach to women's health including menopause, infertility problems, violence and sexual abuses. Early marriage and childbearing, often due to pressures from the husband's family, is another key factor impinging upon RH in many communities. Efforts need to be made to enhance the decision-making power of women in the field of sexuality and contraception. Furthermore, HIV/AIDS need to be addressed from a gender perspective.

(h) *Violence against women:* Numerous forms of violence against women exist, including domestic violence, harassment in the public spaces, early and forced marriages, forced divorce and repudiation, desertion of spouse, sexual harassment and honor killings. While violence against women is recognized as important, both qualitatively and quantitatively, there is no national program nor national strategy for approaching the problem. Furthermore, existing laws minimize penalties for crimes of honor committed by males against female family members. As such, there exists a strong need to raise awareness and to protect and empower women, particularly the vulnerable.

(i) *Gender institutionalization at the governmental and non-governmental levels:* Gender mainstreaming needs to occur in the planning and programming processes of programmes.

(j) *Gender and youth:* Lebanon faces a strong problem of migration, particularly with regards to youth. This migration impacts the growth of the number of non-married young women, an issue that has been emphasized in the south in particular.

CHAPTER 4
Mobilization of financial resources for population and reproductive health programmes

CHAPTER 5
Recommendations for strategic actions

POPULATION AND DEVELOPMENT STRATEGIES

We have previously highlighted Lebanon's progress towards achieving balance between population dynamics and socioeconomic development in light of the ICPD and ICPD+5 recommendations. However, as was revealed in Chapter 3, the government is facing challenges in its implementation of plans and strategies.The basic challenge is to integrate population and gender issues within sectoral strategies and national plans.

This challenge necessitates efforts by all policy makers, planners and partners at all levels. The government's commitment is needed in order to finalize the formulation of the NPP, to endorse it, to integrate its objectives in sectoral plans and to monitor and evaluate it while ensuring the necessary financial, technical and legal means. To achieve this, there is a need to undertake the following strategic actions:

5.1 Enhancing Institutional and Technical Capacity to Formulate and Implement the Population Policy.

Strengthening the institutional and technical capacity to formulate and implement the population policy is an essential prerequisite for integrating the objectives of the NPP into national and sectoral plans. Such integration cannot be achieved in isolation from the NPP/POA, which in turn is related to the endorsement of the NPP by the Council of Ministers. In this context, there is a need to widen the scope of dialogue, to reach consensus on the importance of the NPP as well as gender issues and reproductive health, to reinforce knowledge about the repercussions of globalization, privatization and structural adjustment programmes on population issues including poverty, women's work, youth, education and health.

The integration of the NPP objectives into national and sectoral plans also requires strengthening the human and technical skills of the NPPC/TS and activating its communication channels with the NPP focal points and other agencies represented in the committee. There is also a need for an active role of the parliamentarians and lawmakers in widening the political speech to include the issues of population, gender, reproductive health and the achievement of a balance between population growth and available resources.

5.2 Strengthening Databases, Research and the Drawing of Indicators.

The enablement and strengthening of the national capacity in providing information and indicators on population and gender are basic guidelines for the formulation, implementation, monitoring and evaluation of the NPP. The issue of data collection, analysis and dissemination is crucial for planning in the domains of population, gender and reproductive health. There is also a need to support Policy and Operations' Oriented Research on issues of priority such as internal migration, emigration, ageing, reproductive health for youth and teenagers, gender equity, equality and the empowerment of women, unmet needs in family planning and cultural determinants of

gender disparities. Thus, the role of CAS should be reinforced. Its coordination with other research centers and universities is crucial. In addition, there is a need to strengthen and motivate statistical and research units in ministries and public institutions.

REPRODUCTIVE HEALTH

5.3 Organizational Issues for RH services, (Enhance Quality).

Quality of Care remains the corner stone of RH service provision. It permeates all the echelons of RH sub-programme components. Effective RH programs requires a re-orientation of existing services (MCH, FP, STD) toward the health needs of women, newborns, and men in terms of service quality standards. The failure to identify and operationalize a set of agreed upon quality indicators had severely deterred the capacity of measuring quality and assessing progress.

Central to any considerations of quality issues in RH care, is the critical assessment of the number of the existing health outlets. Despite the many advantages resulting from the expansion of the current RH services within 430 outlets, the issue of quality is hard to attain and maintain. Consultative meetings with the DG of the MOH and the NPD pointed to the possibility of selecting 50 centers for the next cycle. These centers may be selected from the PHC "model" centers accounting for the issue of adequate regional distribution. A target of 100 centers can be aimed for during the next cycle. Adopting these 50 centers can allow for possible implementation of recommended quality measures and should not -in any way- affect maintenance of services in the rest of the outlets.

In this regard, it is of preeminent importance to maintain delivery of RH services in the transition towards the next cycle. Although it is foreseen that ultimate service provision, including procurement of essential drugs and contraceptives, will be the MOH responsibility and not UNFPA, an exit strategy has to be figured out and adopted over the coming 2-3 years.

Enhancing QOC demands the following recommendations:

5.3.1 Breadth of Services.

In order to strengthen and increase coverage of RH services within PHC, it is strongly recommended to broaden and deepen the extent of the existing and to-be-added services. The breadth and scope of services to be delivered presents a formidable challenge in design, execution, administration, and evaluation. These services can be re-introduced in clusters that are relevant to RH components. Clustering depends on the degree of need of the RH service during the client lifetime. The simultaneous delivery of different clusters of services at different levels of health care system imposes major demands on clinical and non-clinical training, sustainable acquisition and distribution of essential drugs and contraceptives, equipment supplements, adequate worker supervision, and client record-keeping. Program managers must achieve an operational compatibility among service clusters, availing themselves of possible arrangement for linkage, coordination, or integration. The implementation of the upcoming standardized protocols can facilitate this approach and assist workers in providing in-depth services. In the face of a potential difficulty in ensuring orchestrated interventions among levels of the Health Care System, it might be possible to rely on local and higher level referral

at least in technical part, especially regarding high-risk pregnancy identification and referral.

5.3.2 Integration of Services

The ICPD recommendations emphasize the holistic approach to RH. The vast expansion of health outlets though had improved coverage and service utilization, it came short of achieving RH delivery of integrated services. The focus continues on a minimal package of services, a matter that defeats the whole purpose of holistic RH. The extent of services integration has always been a central issue in RH care. In our case, it is expected that RH care will integrated within PHC. The 2 projects are administered and implemented harmoniously at the central level. At field level, RH services have to maintain some separate identity near other PHC services and should be delivered by different providers (physicians and midwives), but share the other health workers (nurses, counselors, assistants). It seems that this pattern of integration is a combination of vertical and horizontal types of model. This model demands a greater degree of political and administrative support, where some services may benefit from vertical programs (adolescents, men). Services for adolescents and for men may include some that benefit and others that do not benefit from linkage to services reaching married women.

The integration process will demand full consideration of the perceived needs of clients, their convenience and concerns for privacy, and not just the operational efficiency and administrative suitability. Other services that complement neglected health problems to population already in contact with existing FP or health services, would be good candidates for integration into existing services. An example about this would be reproductive tract infections management.

It should be kept in mind that integration and broadening of services requires up-graded facilities, equipment, and trained personnel that may not be available in the existing health outlets. But implementation of certain services (EOC) is likely to require efforts to stimulate community awareness of complications and of where to seek treatment. In many of the outlets, integration usually occurs by necessity, if not choice.
Integration process raises certain issues that the next cycle has to deal with. These are related to the following:

- Strengthening of the existing health infrastructure and opertionalizing referral procedures.
- Sustained maintenance of medical support, supplies, and logistics.
- Ensuring provision of up-to-date service delivery guidelines.
- Enacting the RHIS with close monitoring to guarantee providers commitment.
- Ensure proper task delegation within the health outlets to avoid shortage of staff or work delays.
- Adequate monitoring of service personnel. Important gender differences exist and sensitization clinic and outreach staff is necessary.

A key issue concerning integration relates to whether services to youth, men, women, and married couple should be separate. In this case there is no simple generalization, because both (integration and separation) have advantages and disadvantages that are closely connected with the cultural, social, provider, and logistic considerations. It is

recommended that in case of Lebanon, where some RH services like (sexual health matters for youth and unmarried couples) are socially sensitive, the health rationale warrants integrating those services within other health services, preferably in NGO outlets. This necessitates addressing other aspects of the service such as working hours, waiting spaces, consultation room, provider sensitivity, and staff confidentiality. This will greatly help to reduce concerns of social stigmatization and embarrassment.

5.3.3 Decentralization

The current management of the RH project exercises some degree of decentralization through the field level coordinators in the districts. In this sense, those coordinators provide monthly drug supplies, and do frequent field visits for monitoring and follow up. However, all arising and upcoming issues have to be resolved and dealt with at the central level.

The issue of monitoring and management of service delivery remain a major challenge. It is recommended that enacting a possible role for the health authorities in the districts can bring about a synergistic effect to the overall quality measures. Authorities at the district level may contribute to the process of identifying priorities, designing interventions, and implementing centrally defined health interventions. A potential for coordination among district health departments, Caza physicians, and service coordinators exists and it can be initiated to assist in monitoring and follow up. This can be achieved through regular and timely meetings and field visits, especially that the number of outlets is vast. It also can assist in acting like the first level of control and re-enforcement. This approach demands considerable management capabilities and efficient structures linking the different levels within the system. Though it is believed that greater flexibility and efficiency might accrue from decentralization, global evidence indicates that the success of decentralization efforts is still mixed.

5.4 Partnership

The upcoming cycle encroaches on specific issues that have multidisciplinary characteristics, a matter that requires a wider scope of potential stakeholders for cooperation and coordination strategies. At the government level, ministries like MOPH. MOSA, MOEd, and MOY are leading ministers that can deal with the different facets of every issue.

At the level of the NGOs, situation analysis have identified many organizations that are already involved in ongoing projects on Youth (information, peer education, counseling services). These organizations include: LFPA, Scouts, Amel.....in addition to potential ones that might also participate in the implementation of the activities of the upcoming cycle. It is of utmost important that upcoming projects build and benefit from existing plans and achievements, and probably contribute to needed technical support. Issues of advocacy, outreach, and community sensitization can best be achieved within NGOs strategies due to the flexibility they enjoy in addressing culturally-sensitive and embarrassing topics.

At the level of the academic institutions, universities like AUB, Balamand, and LU have established courses and research activities that are directly related to RH issues and health education and promotion. Moreover, these and other universities are involved in

the endeavor of integrating RH in the curricula. So, cooperation with potential universities on strategies related to Youth education and providers training (pre-service and in-service) is essential, and it can also lead to capacity building in these universities.

At the level of the private sector, it definitely holds the biggest stake in health services. It is of paramount importance to identify possible means of cooperation and alliance. As it is known that the private sector is a liberal sector which is not subjected to any rigorous or tight restrictions. There is no unified practice guidelines or abiding regulations in terms of practice. Also the private practitioners come from 70 different medical school and training program which makes it difficult to enforce any unified regulations. This leaves cooperation confined to areas of RH information provision, counseling, client-provider communication and sensitization. This can be accomplished through training workshops, material supply, and seminars. Additional issue worth considering is the possibility of designing a "benefit package" that is not provided by the public RH services and delivering it to the clients whenever needed and upon referral. Moreover, private sector support can be solicited in establishing registries for issues like: STIs, breast and cervical cancers and others to help design interventions.

Nonetheless, the formulation of a mechanism that governs and coordinates the various roles and contributions of each and every stakeholder is a major challenge and a key to the next cycle success. Current experience with the national steering committee is unfortunately botched. Several reasons were cited for its failure like high political caliber, lack of a full-time coordinator, and lack of commitment. Project outcomes and corresponding activities have to be thoroughly inspected as where be best implemented. The MOPH had adequately executed and implemented RH services and its related activities like training, RH strategy, and RH integration in the academic programs. On the other hand, the MOSA is successfully implementing the IEC component. In the upcoming cycle, the situation is more sophisticated and inter-related. Different stakeholders might be implementing different aspects of the same output that necessitates close coordination. It must be made clear how capacious stakeholders can be to carry on specific assignments. Thorough negotiations among all relevant partners are deemed essential to address this issue. It may be recommended to form a technical level committee with an enabled secretariat to ensure proper progress of activities. The technical committee might include members in charge of individual projects or other effective focal points with a rigorous mechanism of work. Another committee, a high-ranking political committee might be formed to cinch needed support and commitment. This calls for a need to professional personnel.

5.5 Disparity and South Lebanon

The " Mapping of Living Conditions" survey (1998) highlighted disparity as a national and solemn issue. It crosscuts into all aspects of living and seriously affects various indicators including health and RH indicators (refer to MICS2). This is mainly exacerbated by poverty which partly explains that most of the public expenditure goes to rural areas as compared to Beirut (Lebanese Studies, 98). Though health outlets are evenly distributed in different districts, the caliber and scope of services vary widely in disfavor of rural areas. Based on previous recommendation of broadening and integrating RH services, it would be more effective to emphasize an essential RH package in selected outlets in rural areas. In view of unfavorable indicators in MMR,

IMR, CMR, CPR, and morbidity prevalence (NC), efforts will address a re-introduction of PC, FP, and RM within RH scope in a way to contain all the ramifications leading to a negative outcome. This demands laboriously working with the community to promote for such services and their importance in bettering health conditions. It also demands cooperation with the private sector to assist in covering certain elements of the package that cannot be offered at the PHC level.

As this "trial" proceeds, an incremental provision of additional services can be undertaken. This can concentrate efforts of providers towards addressing basic needs of this underserved community. Special attention should be given the liberated area of South Lebanon as it was not covered by the activities of the current cycle. It is strongly recommended that efforts add to the already ongoing or planned projects proposed by UN agencies (UNFPA, UNICEF) on improving PHC services and Youth re-integration and capacity building.

An approach like this can be a part of a total revision of the location and number of health outlets. It allows for a proper management and allocation of human resources ultimately leading to more optimal service delivery. In this regard, a full range of multi-level arrangement that accommodates specific needs and ensures referral when needed has to exist. This will improve service utilization and increase coverage and client satisfaction

Encouraging the initiation of organizations to work in the underserved areas and to advocate for balancing the use of health system resources in an equitable manner stressing more the preventive side. This might be hard to attain as the curative component of the health care is consuming most of the resources.

5.6 Youth

Lebanese population is youthful, with those between 10-24 years of age amounting to around 31% of the total population (CAS,97). The up-coming cycle emphasizes youth aged 15-24 years of age who constitute 20% of the population. Lebanon, being engaged in a strenuous process of reconstruction, has the youth shouldering a good part of this burden. However, this process albeit ongoing, is not contributing to the reduction of youth problems like unemployment, migration, and low participation on public and political life. In addition, various studies have demonstrated that youth in Lebanon are involved in post-modern life style behaviors and are subjected to risky and high-risk practices that put them in jeopardy. This pattern could affect their immediate or future life in relation to violence, smoking, substance abuse, and STDs. In view of this, there is absence of opportunities for basic life skill development among young people, especially those who are out-of-school, save the projects of the UN agencies mentioned above.

The issue of Youth remains multi-dimensional and diverse. There are main challenges rooted in regional disparity, social marginalization, and dwindling economic situation. This is seriously affecting-among other aspects- the health status of youth and its respective indicators. Youth health and specifically RH, including sexual health, need a sectoral approach, involving services, information provision, and counseling in different settings (health outlet, school, workplace). It is recommended first to clearly understand

that RH in youth is part of a cluster of high-risk behaviors that are interactive and dynamic, and is directly affected by different surrounding circumstances.

Young people need places and environments that offer them nurturing, guidance, rules, clear expectations, and consistent limits. They need opportunities to explore, excel, contribute, earn, lead, and join. More important, they need people with high expectations who are committed to their wellbeing. Although youth in Lebanon are the primary group of the interventions, they are diverse group and such diversity needs to be understood and taken into account. So, adults who constantly interact with youth (parents, teachers, youth leaders, religious leaders) are an important secondary group for interventions. At a wider circle, groups like law-makers, politicians, media, and other national figures can also be considered. It is necessary to consider the specific situation of each group of the youth population to ensure relevant interventions. The type of interventions, activities and approaches used can vary according to gender, age, state of health, and family and social situations. These considerations albeit important, can imply availability of major interventions at the level of health services, building skills, and information provision.

At the service level, it is recommended that providers should promote healthy development, prevent health problems, and respond to health issues as they arise. It is expected that part of service widening and "special integration" plans, and in the light of socio-cultural limitations and GOL views, it is strongly recommended to strengthen and emphasize youth gender-sensitive services in the outlets that relates to certain services and to information provision and counseling. Confidentiality, sensitivity, and privacy have to be ensured. This entails special arrangements (waiting space, schedule,..) towards a youth-friendly outlets. A list of carefully selected outlets that satisfy an eligibility criterion can be utilized for this purpose.

5.7 Management of Services

Mechanisms should be institutionalized to promote client-friendly services and a bottom-up approach to management to increase service use and accountability of health providers and to ensure community participation. Some possible strategies include: involving the community in planning and service delivery, including monitoring and evaluation of programs, and supporting health workers (midwives and nurses) to assess community needs and satisfaction with services, provide adequate incentives to health care workers to encourage them and to ensure delivery of quality RH care. Health care workers need to be supported, respected, and given opportunities for advancement professionally and socially. This will raise their motivation and improve interaction with clients.

Also to improve management, a team approach to service provision should be promoted. Members of the team will be assigned roles and duties according to their capacities, where they all can participate in planning and in management of health center. This demands identification of gaps at team level and working to minimize them by meeting training needs. Specific issues are counseling skills, monitoring and supervision, and community outreach.

In managing services, priority will go to the most cost-effective one. Newly introduced services like breast and cervical cancer screening must be strengthened and well maintained. An incremental approach regarding expansion to other RH services may be considered to keep proper monitoring and to deliver quality service.

Regarding inclusion of adolescent service in the range of RH services, caution must be applied. Innovative and novel approaches should be created to provide this service. The management might consider not integrating this service into RH ones.

Adequate management also entails improving the already acceptable infrastructure and maintenance of RH services to facilitate quality of care. It also demands building capacity for logistic management and unified health information system. This requires working up a package of basic RH indicators as per ICPD, and standardizing clinical operating protocols, procedures, and client records.

5.8 Research Needs

The existing RH research in Lebanon has been compiled by WHO. It represents a reference document to pursue further additional socio-cultural research pertaining to improvement of quality RH services. There is a need to design operational research plans and proposals to assess the quality and impact of RH services. Urgent research is needed on the various components of maternal mortality and morbidity, as well as prevalence of various gynecological conditions, and the optimal package of routine RH services.

There is also need to explore the local reactions to issues of youth, men's role, client satisfaction, and gynecological morbidity. This requires in-depth qualitative research, which demands training young researchers on this kind of research. At any case, building capacity in doing research and in linking it to concrete needs and interventions is needed.

5.9 Effectiveness of IEC programmes

In order to improve the effectiveness of IEC programmes, it is first imperative to ensure that concepts of RH and population are understood clearly. Also critical is the need to ratify the national IEC strategy and PDS and RH strategies.

Partnerships/ networks/ coordination/ cooperation are to be enhanced among NGOs, the UN and the government. In addition, programme planners are to maintain awareness of the importance of synchronization when IEC works in parallel with services.

Research is an area that needs work. Behavior and attitude changes are to be measured, and needs assessment undertaken. An accessible databank is to be developed that may include a registry of all groups involved in IEC projects and activities in RH, publications, films, research studies, and other resources. Relevant research and studies are to be developed.

It is crucial to utilize the most appropriate approaches in IEC to ensure effectiveness. To this end, audio-visuals, resources, and technical support are all to be developed.

Efforts should be made to maintain a high level of sensitivity to the values and traditions of all local communities. Multiple audiences should be targeted, and the media included in all phases, including the planning phase.

Within projects, it is necessary to enhance supervision mechanisms, evaluation, and monitoring. Gender awareness should be incorporated, and human resources developed.

5.9.1 Target key groups and underserved areas

In order to target key groups and underserved areas, creative approaches for IEC outreach should be used. In addition, coordination among groups working in IEC is necessary. Youth are a key target group for the next cycle. Men should also be targeted, while continuing to target women.

5.9.2 Target youth/ adolescents in IEC programmes

First and foremost, it is necessary to formulate and implement an integrated national youth health strategy. Youth should be targeted within a comprehensive framework that includes their families, schools, and environment. IEC for youth should focus on empowering youth with skills, including life skills, RH skills, and a knowledge and understanding of their reproductive rights. It is also important to actively involve youth in the design, development and evaluation of programs to ensure that the programs meet their RH needs and present information in language they understand. To this end, it is important to undertake studies in order to accurately assess youth needs and knowledge.

Learning approaches should be diverse and should build upon the principles of trust-building, active learning, and respect for privacy and confidentiality.
Youth-to-youth interaction should be encouraged, including peer education and peer counselors. Service providers need to be trained in counseling skills and hotlines should be improved and linked to service networks.

The development of educational materials and practices with youth should be gender-balanced, as should the educational setting, in order to ensure equal access for girls and young women.

Service providers should be trained in counseling skills, including the ability to listen in a non-judgmental manner and to maintain confidence. A better approach to counseling, though more costly, is to encourage the appointment in health and social centers of a counselor whose sole role is that of counseling youth (i.e., a person who does not otherwise interact with youth or their families). In order to ensure the confidentiality of counseling and the confidence of youth in the counselor, it is imperative to provide a safe and private place where counseling can be sought by youth.

5.9.3 Population and sexual health education

It is first necessary to assess the level of population education and sexual health currently in the school curriculum in order to design an action plan accordingly. Efforts to address sexual health for youth using diverse channels and coordinating with NAP

should be encouraged. Another means for making information and counseling on sexual health available to youth without the support of the school system is through organized peer counseling and the use of peer educators.

Advocacy events targeting decision-makers should be organized in order to advocate for the re-integration of sexual health into school curricula despite religious opposition and the integration of population materials. In addition, efforts should be made to negotiate with vocal opposition leaders to bring them to an understanding of the importance of population, RH and SH education for youth. Social marketing and individual contacts should be used to build networks and mobilize other stakeholders in school population and sex education, including community leaders, NGOs, professional chapters, academic institutions, men, women's groups, business and industry groups, and the banking sector.

5.10 Advocacy

Advocacy should focus on building constituencies, effecting legal reform, and enforcing laws regarding population issues, including RH issues, gender and empowerment. The formulation and enactment of these laws will help Lebanon reach gender equality and promote women's participation in public life. Moreover, advocacy in the area of population and development strategies will constitute a starting point for supporting the work toward addressing the RH needs of the public. It will ensure the partnership and mobilization of a wide range of constituencies such as policy-makers, women's advocacy groups, grass-roots organizations, service providers and community representatives, among others.

Advocacy efforts are necessary in support of the endorsement of the National Population Policy and the design and implementation of a subsequent National Population Programme must be undertaken. Advocacy is also a critical tool with regards to the National Reproductive Health Programme. Furthermore, advocacy efforts should concentrate on establishing or strengthening National or Parliamentary Committees such as the National Lebanese Women's Committee, the Population Education Committee, and a National Committee for Youth. In addition, advocacy activities must occur in support of the integration of the recent UN programmes of action (ICPD, FWCW, WSSD and Habitat) into the plans of national institutions.

Furthermore, other issues have yet to be addressed by advocacy activities, including insufficient coverage by private media of population issues and lack of coordination among the government, NGOs and the donor community.

Efforts should be made to build national institutions and capacities, for example, a population and RH communication unit, a national center for health information and education, or in-country training on key issues. It is important to carry out intensive meetings with selective decision-makers with the intent of sensitizing them to population issues and the population policy, as well as issues surrounding gender and youth. These efforts should include a focus on the re-activation or strengthening of the existing National Population Committee and National Women's Committee, and the establishment of a Parliamentary Youth Committee. Efforts should be made to build

consensus around key issues, by holding consensus building workshops at the national and governmental levels.

Social mobilization is a critical approach in advocacy, that can be accomplished through major events focused around key issues. Creating bottom-up support in this manner will raise public expectations for better services that may lead to pressure on decision-makers.

Advocacy programs should be grounded in ongoing research. This research should be used to define audiences and formulate messages, and will also allow for midcourse modifications as needed. Advocacy messages should also be pre-tested with key opinion leaders in order to avoid objections from key gatekeepers. In addition, more emphasis should be placed on conducting relevant research that supports advocacy interventions; remembering that research results themselves are a powerful advocacy tool.

Coalitions and partnerships should be cultivated, bringing together gatekeepers, stakeholders, the media, human rights organizations, academic institutions and private sector businesses around key issues. Relationships should be cultivated with religious leaders who support RH, PDS, and gender issues, and advocacy activities should be undertaken that strengthen support while neutralizing opposition.

A short-term advocacy plan that targets the Ministry of Information, the Faculty of Communication at the Lebanese University, as well as other university departments in Lebanon, should be developed.

Advocacy with the objectives of promoting awareness of women's changing roles in society, and encouraging more egalitarian relations between males and females are to be carried out for policy and opinion makers, community and religious leaders, educators and youth groups.

In order to ensure youth RH rights, it is necessary to formulate and implement an integrated national youth health strategy that addresses major health issues and includes RH and sexual health, HIV/AIDS and STIs, and sexual abuse and exploitation, among other issues.

Media and communication professionals are to be trained on how to better develop and conduct systematic and results-based advocacy campaigns that are grounded in research, in support of PDS, RH, and gender issues. In addition, communication specialists and academics are to be trained on how to conduct gender analysis of media content.

A group of young professionals at the municipality level are to be selected and trained to effectively advocacy locally for PDS, RH, and gender. These advocates will then act as facilitators to mobilize local communities, and will improve the reach of advocacy and IEC programs into underserved and more remote areas of the country.

Finally, potential sources for the financial resources needed in order to pursue advocacy activities are to be situated. Advocacy must also be undertaken for resource mobilization.

5.11 Reproductive Health rights for women

A key step in ensuring RH rights for women is by educating women and girls about their reproductive rights as a key component of IEC programming and contents planning. In addition, coalitions should be built with NGOs and local women's groups in order to advocate effectively for legislation ensuring women's reproductive rights and the elimination of legislation that restricts women's reproductive freedom and choices. Efforts should be made to ensure women's control of their own fertility. This involves educating both women and men about reproductive rights and choices and FP. It also necessitate empowering women to make and implement their own FP decisions.

5.12 Gender equity, equality and empowerment of women

It is important to enhance the concept of gender for both women and men and carry out outreach regarding gender roles and the roles of both men and women in building future generations. In addition, gender should be systematically mainstreamed as a planning methodology in all areas and levels of programmes. It is particularly important to make efforts to involve men and youth of both sexes in both the planning and implementation of activities organized regarding women's rights.

A gender diagnosis of society should be conducted and more research encourages, particularly dealing with women's productive activities and their health. Additionally, studies should be done to understand the reasons behind women's truancy, with the objective of ascertaining the necessary means to provide women with the greatest possible share of education, especially technical education.

Compulsory education should be enforced and continuing adult education programs developed.

A national strategy for a plan of action to eliminate all forms of violence against women should be designed. It is critical to provide adequate and sufficient safe places for women and their children who suffer from violence and who have no other refuge.

Efforts should be made to work out possibilities and means for improving and operationalizing the national strategy for women, and integrating other interested institutions and organizations from the government or civil society as both stakeholders and full partners. A women's component and gender methodology, tools and objectives should be introduced into planning processes and national plans. Decision-makers should be lobbied in order to gain political commitment and create a task force that includes stakeholders and beneficiaries. This task force should then create a legislative agenda. In addition, in each ministry, a unit should be created which would have the mandate to set objectives for GEEEW, develop plans of actions, monitor progress and suggest corrective measure to remove

existing barriers and enable women particularly among the disadvantaged groups, to derive greater benefit from development.

National partners should be trained, including those within the UNDAF process, with the objective of developing their capacities in gender mainstreaming. In addition, the NCLW should be reinforced and their contribution to the achievement of the gender, population and development program including RH/RR as well as with youth and adolescent supported.

It is imperative not only that men's involvement in RH be recognized, but that it be advocated for. A national strategy for the participation of men in RH areas should be designed and implemented.

The search for job opportunities for men and women should be expanded. In addition the establishment of businesses and skills adapted to the environment should be encouraged, in an effort to limit the impact of poverty on women. In addition, the laws that put mothers as workers and/or housewives under great injustice should be studied and remedied. Public opinion regarding the necessity of amending these laws should be cultivated through advocacy. Efforts should also be made to standardize employment practices, including the development of job descriptions, the provision of ongoing training, flexible hours, evaluation, and task enrichment. Furthermore, credit programs for women entrepreneurs should be supported and the development of a comprehensive programs encouraged. These should include training in managerial skills and follow up support through counseling.

Efforts should be made to raise the awareness of women with regards to their participation in public decision-making processes. This involves developing women's capacities for self-empowerment at the grassroots level and in rural areas. Efforts should also be made to involve women who are experienced in community and organizational work in national committees in order to ensure that the interests of women from the disadvantaged groups are taken well into account. In addition, efforts should be made to support the capacity building of existing women NGOs at the community level and Social development Services Centers (SDSC) to avoid duplication and maximize limited resources.