United Nations Population Fund
UNFPA

الجمهورية اللبنانية
مكتب وزير الدولة لشؤون التنمية الإدارية
مركز مشاريع ودراسات القطاع العام

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

Situation Analysis of the Reproductive Health in Lebanon

By Faysal El Kak
March-September 2001

Country Population Assessment
In Lebanon

I. Background

II. Objectives

III. Methodology

IV. Current RH Situation
- Policies/Strategies
- Ongoing Programmes
- RH within PHC
- Status of Population RH
- Quality of Care Issues

V. Services

1.Safe Motherhood
- Pre-conception Counseling
- Utilization of Antenatal Care
- Content of Antenatal Care
- High-Risk Pregnancies/Referral
- Postpartum Care
- Unplanned Pregnancy

2. Family Planning Services
- Trends in Knowledge and Use of Contraception.
- Method Mix
- Contraceptive Logistics

3. Gynecologic Services
4. Sexual Health and STI/HIV/AIDS
5. Infertility
6. Youth
7. Others

8. Management of RH Programs
- Providers/Managers
- Management

VI. Discussion Strategic Issues for Reproductive Health.

1. Organizational Issues for RH services
2. Partnership
3. Disparity/South Lebanon

4. Reproductive Health and Gender
5. Youth
6. Management of Services
7. Research Needs

VII. Limitations

VIII. Recommendations

IX. Conclusion

Abbreviation List

- GOL: Government of Lebanon
- SCOP: Standard Clinical Operating Protocols
- SDP: Standard Management Protocols
- SMP: Standard Management Protocols
- PHC: Primary health care
- CP: Country Programme
- PRSD: Program Review and Strategy Development
- IEC: Information, Education, and Communication
- CEAW
- MOSA: Ministry of Social Affairs
- MOPH: Ministry of Public Health
- NPPC: National Permanent Population Committee
- NAP: National AIDS Program
- STI: Sexually Transmitted Infections
- MICS2
- PAPCHILD
- MMR: Maternal Mortality Ratio
- IMR: Infant Mortality Rate
- CMR: Child Mortality Rate
- AUH: American University Hospital
- PID: Pelvic Inflammatory Disease
- HSRP: Health Sector Reform Project
- MSI: Marie Stopes International

Executive Summary

The Government of Lebanon is undertaking immense efforts to strengthen the Primary Health Care System and improve the quality of services delivered. These efforts are orchestrated with several UN and international agencies that provide technical and financial support to the Government. UNFPA, being one of those agencies, have been working with GOL over the past 10 years. A remarkable milestone of this collaboration is the launching of the RH sub-programme in its 5 years cycle (1997-2001). The achievements undertaken during that cycle were highly notable. There was a vast expansion of RH service coverage and improvement of quality through field visits, meeting with providers, and bettering the system of reporting (monthly and quarterly) with the assistance of a more activated role of the service coordinators. The provision of services was improved by achieving the standardization of SCOP, SDP, and SMP, with a corresponding pilot training of around 10% of the total number of providers and managers. In addition, an advanced draft of the national RH strategy with its plan of action was accomplished, as well as an assessment of RH status and its means of integration in the university curricula. Several studies were also achieved under this cycle including: RH research compilation, mapping of PHC outlets, client perception of RH services, and a socio-cultural study about RH utilization.

Despite these worthy achievements, several other tasks were not completed. These tasks include: Identification of interval RH indicators, capacity building, accurate bilateral monitoring, and optimal integration of services, in addition to enhancement of coordination and activation of supervision committees. These findings in addition to other issues identified during the CPA preparation suggest the following recommendations to be considered in the next cycle:

Political/administrative level: To strengthen the political commitment nationally through re-forming and/or re-activating the RH steering committee in terms of level of representation and demanded assignment, and in view of the participation of new partners. This might be achieved via the involvement of technical high-ranking officials or representatives of various parties coordinated by expert personnel. This personnel is supposed to closely ensure the engagement and the contribution of various stakeholders. This ought to be accompanied by a sub-ordinate joint coordination committee at the level of the projects to follow day-to-day planning and execution of activities. The MOPH remains the leader and the monitor of these functions.

Service level: The new directives undertaken for the next sub-programme cycle regarding the reduction of number of outlets and expanding the scope of RH services to include other elements (labor and delivery, youth) will necessitate ensuring the implementation of the set protocols in clinical services and management, and better utilization of services. It follows that close follow up of client files, monthly and quarterly reports, and field visits might be carried out.

Research level: One of the main limitations inherent in the process of evaluation of improvements of the previous cycle was the lack of indicators and performance surveys. This calls for emphasizing of research as an essential tool to provide quantitative and

performance indicators, as well as needs assessment that will ultimately help in evaluating achievements and monitor change.
The outputs achieved during the first cycle of the sub-programme were remarkable. The new cycle builds on that and emphasizes many issues related to ownership, service provision, and research. It remains very crucial to strengthen political commitment towards RH sub-programme by solidly placing it within the Ministerial structural bodies. This is expected to highlight major issues of concern that are related to RH (MMR, youth..), and will push forward research activities to address the existing situation, assess needs and achievements, and recommend strategic steps based on valid indicators. Efforts of various partners will be well orchestrated to ensure proper implementation of the outputs, in the light of understanding their specific roles and contributions.
Advancing the role of the public sector and increasing and sustaining cooperation with the private sector, remain tasks of paramount importance to ensure quality RH services and status.

I. Background

Lebanon belongs to the category of states undergoing epidemiological transition. This transition brought the government into face-to-face challenges that are directly related to health and environmental programmes, the new lifestyles, issues of 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 Government of Lebanon (GOL) to rebuild its technical capabilities in the area of population and reproductive health (RH). 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 seen as 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 RH, compromised access to RH 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.

Prior to the current CP (1993-1996), several UNFPA projects were conducted. In fact, and following The 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 multi-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.

The achievements undertaken during the first cycle of the RH sub-programme (1997-2001) were remarkable. There was a vast expansion of RH service coverage and

improvement of quality through field visits, meeting with providers, and bettering the system of reporting (monthly and quarterly) with the assistance of a more activated role of the service coordinators. The provision of services was improved by achieving the standardization of SCOP, SDP, and SMP, with a corresponding pilot training of around 10% of the total number of providers and managers. In addition, an advanced draft of the national RH strategy with its plan of action was accomplished, as well as an assessment of RH status and its means of integration in the university curricula. Several studies were also achieved under this cycle including: RH research compilation, mapping of PHC outlets, client perception of RH services, and a socio-cultural study about RH utilization.

Despite these worthy achievements, several other tasks were not completed. These tasks include: Identification of interval RH indicators, capacity building, accurate bilateral monitoring, and optimal integration of services, in addition to enhancement of coordination and activation of supervision committees.

II. Objectives

The main objective of the CP document is to address RH issues in consistence with national policies and recognized orientations. In this regard, this document builds upon the previous cycle and draw lessons from past achievements and unfinished tasks. It also considers the existing political atmosphere as manifested in the GPS and in accordance with the priorities of the concerned Ministries.

The document examines the current RH status, assesses the critical needs, and suggests recommendations for strategic actions. It also recommends possible means for resource mobilization and allocation.

Moreover, the CP document embodies the various views and future roles of all potential stakeholders, and sets its objectives accordingly. At the same time, the activities stated in the document will be undertaken in accordance with the principles and objectives of the Programme of Action of the ICPD. The document discourse is commitment to women's empowerment and gender equality, and to mainstreaming the gender issue into all its activities.

III. Methodology

In preparing for this document, several background meetings were held to lie down a strategy governing the steps that will be taken. During these preparatory meetings, a CPA team was formed of population, RH, and IEC consultants (see annex I), in addition to a CPA steering committee representing various stakeholders (see annex II), and the following tasks were carried:

- Literature review: The UNFPA office in Beirut provided the CPA team members with a pile of documents and relevant papers on topics like Youth, sexual health, gender, and other RH topics, national and international. These papers presented a sufficient background material for the CP document and were a helping tool for analysis and comparison undertaken during the course of the CPA document

preparation. CPA documents from other countries in the region were supplied for further assistance.

- Field visits: In an attempt to examine the actual situation in the field regarding status of health workers and RH services, several visits were carried to selected centers. During these site visits, delivery of services and their integration were examined, and the standpoint of RH providers as well as their perceptions regarding RH service provision, were documented.

- Meeting: At the same time, several meetings with the representatives of the potential stakeholders were held, including Director General of the Ministries of Public Health, Social Affairs, Education, Environment, and Youth, in addition to some NGOs (Family Planning, Scouts, Amel...). The meetings aimed to inform the CPA team about the stands and the modality of the future contribution of those parties. (see annex III)
- Focus groups: These activities targeted mainly youth category. Few schools were selected with the help of "Popular Security", where focus groups were held and documented. The outcome of these meetings was instrumental in feeding into the CPA document.
- CPA committee meetings: All through these activities, regular meetings for the CPA team were held to assess work done and to decide on future steps to be undertaken. Those meetings were held at UNFPA office and were coordinated by its representative.
- Steering committee: The steering committee was called to meet to assess work done and give comments, feedback, and instructions for the upcoming activities. The role of this committee was crucial in the finalization and directives of the CPA document.

Current RH Situation

- 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 expected to be promulgated by the Cabinet.

The national RH strategy preparation was commissioned last year to an ad-hoc committee of national experts. The strategy draft is being finalized, and will be approved early in the next cycle. The strategy vision is in coherence with the ICPD recommendations and in harmony with the socio/cultural setting of the country. It aims to provide and sustain quality integrated RH services in a non-discriminatory fashion, emphasizing the needs of deprived areas and marginalized groups.

- 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, clear division of labor and efficient communication.
Within the context of coordination, 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 dropouts.

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 at large 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 is helping to build 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 age 14-18 years through vocational training in full

cooperation with UNICEF. In Akkar, 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". It involves RH information provision to university students, prepared youth meetings, 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.

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.

- RH within PHC: 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.

- Status of Population RH. Since the inception of RH sub-programme in1997, RH services were 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, covering about 15-20%of the population.
Generally, it is believed that health of the population improved considerably over the past two decades. The Total Fertility Rate is around 3.4 (1). Infant Mortality Rate fell during this period from 65/1000 live birth to 26/1000 (2). A 30% decline in the Under-Five Mortality Rate is observed over the past decade, reaching 33/1000 (2). As a result, expectations of life at birth rose from 62-69 years for males and from 66-72 for females over around 30 years (1970-1996). The MMR is estimated to be 104/100.000, and CPR is around 63 (2) with more than half using traditional methods (17.1 IUD, 10%OCP)(3).

The relatively favorable indicators of maternal and child health at the national level conceal regional and social disparities. These are expressed in quantitative indicators (2) and observational reports (MMR and skilled attendance). Thus in the 1986-1996 period, infant mortality varied from a low of less than 20 per thousand in the mohafazat of Beirut to more than 48 per thousand in the Muhafazat of North Lebanon (3). According to MICS2 survey, the IMR and the CMR vary widely in between the Mohafazat (South). Regarding MMR, it is estimated to be 104/100000 live births (3).
A study of 35,058 deliveries between 1971 and 1982 was undertaken by the AUH indicated that 58% of maternal deaths were due to hemorrhage, abortion, sepsis, hypertension, disorders of pregnancy and ruptured uterus (4). According to the study, many deaths could have been averted if the women had sought treatment earlier or if they had rapid access to a hospital with surgical blood transfusion facilities.
Regional differences correlate well with the differences observed among regions with respect to accessibility and availability of adapted health services and preventive programmes as well as basic services, such as water supply, adequate sewage and waste disposal system.

The RH of special groups has been little explored so far, although some of which appear to have major influence on the overall development of health in Lebanon.
The elderly group carries the highest burden on the overall mortality and expenditures on health. This group needs to be developed in terms of the existing services and their costs, utilization of public services (which are not prepared?), and planning for home based care. There are no available data on the status of RH in this group, though it is believed that the existence of an array of problems, related to post menopausal period is not uncommon. Yet monthly reports of the MOPH indicate the very low utilization of RH services by the elderly, basically due to lack of sensitive and ready setting and also due to lack of proper advocacy.

Regarding HIV/AIDS, the cumulative number reported by NAP till December 2000 reached 609 cases among those 275 are HIV positive and 196 are AIDS cases. Out of those, 78.3% are males and 21% are females with the major mode of transmission being sexual contributing to about 70% of cases. The average age ranged between 31-40 years.

The NAP expects to have a new surge of imported cases either through Lebanese coming from abroad following the Israeli withdrawal from South, or through the influx of sex workers coming from Eastern Europe and Russia.

- 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.

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 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.*

V. 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 approximately 168 tertiary care centers and 850 PHC are widely spread across the country, making accessibility to health care relatively high (95%).

Regarding RH services, there is remarkable improvement in the coverage of these services manifested by vast expansion of health outlets delivering RH care in about 450 outlets all over the country. It is estimated that services offered through these outlets are utilized by a rough unofficial 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 indicators (3), it is believed that the presence of these outlets had improved access to PHC, in addition to other quantitative indicators. Unfortunately, the presence of a multitude of problems related to administration, infrastructure, socioeconomic factors, education, and disparity besides lack of periodic data 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 run by a team consisting usually of a medical doctor, 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.

To improve on the quality of RH services provided, standardization of clinical operating protocols and procedures, and management protocols have been achieved. Training of health care providers on these guidelines will be started soon.

Although the whole package of RH services are introduced within PHC setting, the main focus is still on "gynecological problems", pregnancy care, and FP, and minimal or absent attention is given to cervical and breast cancer screen, adolescent health, infertility work-up, menopause and post-menopause issues, and elderly health (5). Women are still having un-planned pregnancies due to lack of access or unmet needs, where many of these pregnancies end up in termination. Home deliveries are still taking place in sporadic cases in the under-served areas like Baalbeck-Hermel, Akkar, and South Lebanon. In some isolated islets, women are still totally lacking antenatal and gynecological care.

The degree of utilization of RH services is not up to the national set objectives. Some of the reasons insinuated are:
- Cost of service (in private) mainly
- Health reasons, like feeling no need to seek care, not having a complaint
- Access to service
- Lack of adequate advocacy in the community
- Inabilities, related to women empowerment
- Personal reasons related to lack of trust, compliance, and different health care providers.

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 those women having antenatal care, 98% are followed up in private facilities (87%), and some in public ones. Around 90% of deliveries were either performed or supervised by a physician or a midwife (3).

However, the estimated MMR is 104/100.000 deliveries (3), which may be related mainly to medical conditions during pregnancy, 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 (6), which is consistent with the minimum recommendations of WHO.

Antenatal care is practiced with no guiding principles, and many a times is not inclusive of all the required components, especially in case of high-risk cases. In fact there is no protocol available for special management and referral of the high-risk pregnancy cases. Maternal morbidity related to pregnancy and delivery is not documented, and an operational system for referral is lacking. Recently antenatal and postnatal care practice

is being standardized as part of clinical protocols in RH. It is expected to start implementing these protocols as of the late part of this cycle, and mainly at the onset of the new cycle.

- 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.

- 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 (3). 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.

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 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.

- 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 (3).

- 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, lacking 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. Developing clinical criteria for diagnosis and ensuring referral at the provider level in the two settings can address this.

- 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 (3).
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% (7). 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.

- 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 3.4(1). 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% (8). 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.

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.

- 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 (4). 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 (4). This is most likely to improve CPR with persistent disparity among geographic areas, reflected in part by increased total fertility rates. However, sometimes couples with undesired pregnancies are not able to meet their contraceptive needs.

According to the Unmet Needs Study (9), 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.

- 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.

- 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% (2). 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.

To secure client's choice of contraceptives, a range of modern contraceptives should be provided by the RH services, including emergency contraception information. This ought to be accompanied by competent providers who are able to give proper counseling regarding choice, side effects, and indications of each method. A priority issue here is to expand and sustain coverage, in addition to reaching those who are entertaining birth control and are hesitant about it.

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.

In order to meet these needs, the MOH has to secure a steady supply of easy available and affordable modern contraceptives for women, men, and youth, to all outlets with FP services (public or NGO). Suppliers of contraceptives should meet quality standards developed by the MOH in accordance with WHO guidelines on eligibility criteria for contraceptives. Clients have to be provided with an array of options that suit their needs and health conditions. This necessitates strengthening the counseling service and the IEC activities, in addition to implementing an advocacy strategy to outreach marginalized and needy groups.

3 Gynecological Services. The presence of gynecological services as part of selected RH services in PHC had led to improved utilization of these services (4). 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 (10). 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.

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 (4).

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 (11). 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 (12).

According to the NAP study on " Prevalence of Sexually Transmitted Diseases in Women Attending Ob/Gyn Clinics in Lebanon" (13), 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 symptomatic, 16 AIDS, with 11 of these cases being females). This raises the cumulative number of cases to 609 cases distributed as follows: 275 cases symptomatic, 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.

5. Infertility

Infertility service is scarcely addressed within primary health care setting. According to the MOH reports (4), 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 is 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.

6. OTHERS

Other important services like menopause and post-menopausal health, mental health, post-abortion services, 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:

1. Introducing gynecological services along with the family planning and antenatal services as it is the case here.
2. 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.
3. Establishing linkages to more specialized health facilities for consultation and referral.

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 (14). 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 (15). 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, 2001, (16) 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 legislations 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. Moreover, the government pledged to facilitate and support the sports sector through encouraging its activities and strengthening its various associations (16).

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 youth education, total enrollment had remarkable improvement over the past 30 years. Between 1970 and 1996, the total enrollment for those aged 15-24 years rose from around 13% to around 24%, with considerable increase in female enrollment. The gender differences in enrollment were virtually eliminated at the level of all Muhafazats. It is worth mentioning that despite issues of disparity between the Lebanese Muhafazats, the gender difference in enrollment in the rural areas of Beka and South.

This total improvement in enrollment has reflected in a rapid decline in illiteracy. The rate of illiteracy (15 years and above) declined from 36% in the 1970 to 11.6% in 2001 (MICS2). In specific, for age groups 15-24, rate dropped from 17.5% to around 4% in 1996. This decline in illiteracy was more pronounced for the younger female population. This is mainly related to the policy of universal primary education (16,17).

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 (18).

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 (19,20,21). These practices also include substance abuse, poor nutrition, and 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 (4). 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.

- Management of RH services

- Providers/Managers. Ideally, each PHC center entitled to provide RH care should have a working team composed of a medical doctor (Obstetricians/gynecologists, Family Medicine), 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 1999. 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.

- Management. 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 operationalization 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.

Several needs arise from the abovementioned situation analysis. There is a need to address the **providers** issue along different levels:
- 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

Regarding **management,** critical needs exist along the following:

- 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.
- Operationalization 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.

VI. Discussion

This document constitutes a situational analysis of the RH status in Lebanon since the onset of the national RH sub-programme. It does so by presenting RH aspects within the contextual framework of the primary health care system, and thus it is able to address most of the contributing factors to the process of the RH sub-programme execution and implementation. Many of the achievements are listed besides the several identified needs that are pressing on the thrust of the sub-programme. In this respect, this document might be able to raise some strategic issues in RH that builds on learned lessons, and that can be critical to the next cycle. These issues include:

1. Organizational Issues for RH services (Quality Enhancement). 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, STIs) 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 Director General of the MOH and the National RH Project director 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 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:

- Scope 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.

- Ensure 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 programs 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.

It is recommended that integration process demands 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:

1. Strengthening of the existing health infrastructure and operationalizing referral procedures.
2. Sustained maintenance of medical support, supplies, and logistics.
3. Ensuring provision of up-to-date service delivery guidelines.
4. Enacting the RHIS with close monitoring to guarantee providers commitment.
5. Ensure proper task delegation within the health outlets to avoid shortage of staff or work delays.
6. 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.

- 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.

2. 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 has 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) are 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 schools 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.
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 reporter, 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 can 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.

3. Disparity

The " Mapping of Living Conditions" survey (1998) highlighted disparity as a national and solemn issue. It crosscuts into all aspects of livings and seriously affecting various indicators including the health and RH indicators (refer to MICS2). This mainly exacerbated by poverty. 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, efforts will address a re-introduction of pregnancy care, family planning, and reproductive morbidity services 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.

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.

4. Reproductive Health and Gender

The ICPD Programme of Action recognizes the important relationship between gender and RH, which was also emphasized in ICPD+5. Under the first cycle of the RH sub-programme, the task of adopting a gender perspective in all the processes of policy formulation and implementation and in the delivery of services had been seriously considered. Gender and health cannot be distracted from the whole perspective of gender and society, in terms of inequalities, discrimination, and power relations between women and men. Addressing gender and health issue along with gender and the society should go hand in hand in order to achieve changes. In this respect, Lebanon has paid a great attention to improving women's conditions and expanding their role in building society, whether in the economic, cultural, social, or political life; and it worked towards removing the restrictions preventing their development and participation in the process of development. In fact, many laws were passed that guarantee women's rights and reduce gender gap, however, many obstacles still exist and are related to certain laws and policies (personal and family), access to resources, labor rules and regulations, social construction and gender stereotyping, in addition to dropping CEDAW reservations that shake women's RH rights.

In particular reference to RH, remarkable efforts have been undertook, mainly by MOSA, with strong support from UNFPA, through advocacy, training of RH service providers, re-assigning of jobs, and raising sensitization, to mainstream gender issues across the various constituents of the RH sub-programme. A gender focal point was assigned within concerned ministries and NGO's to help thrust the task of gender mainstreaming. There is still a lot of work and support to be done to raise more awareness and strike an attitude change in approach to RH issues and gender-based violence, at the level of policy makers, providers, and community.

Realizing the importance of the gender issue and the need for gender trainers, the UNFPA, Lebanon, arranged to send three experts in RH who are involved with the RH sub-programme, to a regional training workshop on gender, in Amman, Jordan, 2001. The workshop was highly professional and competent, in terms of theoretical and practical applications with a lot of skills and case studies. This comes as a major part of several activities to be carried during the upcoming RH sub-programme to emphasize and support efforts and outcomes in gender and RH. In addition, UNFPA, Lebanon, supported the coalition of several NGOs to launch an awareness campaign on gender-based violence including awareness seminars and training of RH care providers

It is expected that in the upcoming second RH cycle, a wider agenda of activities are planned in collaboration with wider sector of players, trying to understand the gender aspects of RH in terms of health-seeking behavior, RH indicators, access to service, and service provision is a critical task. Likewise, monitoring of RH services, and of outreach programs should be closely upheld.

5. Youth

Lebanese population is youthful, with those between 10-24 years of age amounting to around 31% of the total population (CAS, 97). For the sake of this document, youth aged 15-24 years of age make up 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 poet-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 developments 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 lawmakers, 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 outlet. A list of carefully selected outlets that satisfy an eligibility criterion can be utilized for this purpose.
At the education level, formal and informal sectors should be used to build the knowledge and information capacity of youth. In line with the ongoing Education Strategy, current school health programs can be reviewed and assessed as to their benefits for students. The school health services can also be an entry point for RH counseling and education. Effective programs should concentrate on reducing one or more high-risk behaviors that lead to a negative sequel. They also have to identify issues that could be changed by affording students with opportunities to practice communication and negotiation skills in a favorable environment.
In the informal sector, it is recommended that5 efforts join the ongoing UNICEF, UNDP efforts targeting youth mainly in south and try to design an "Information Provision" project with the help of local stakeholders and community leaders. In this regard, the adoption of youth-to-youth approach and peer counseling sessions may be considered.

6. 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.
The important role of IEC in RH service management must be supported and expanded to include reproductive rights and choices and gender sensitivity. This in turn requires skilled staff, privacy, adequate client-provider communication time, and continuous availability of service.

7. Research Needs

The area of socio-cultural research pertaining to RH is severely under-investigated. 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.
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.

VII. Limitations

In view of the limited period of time allotted for the preparation of the CPA document, and with respect to several limitations in the existing RH situation, some of the issues identified during the situation analysis were not properly addressed. Some of these limitations are:

- *Extensive meeting with service providers and beneficiaries*
- *Wide range meetings with multiple stakeholders and community leaders*
- *Lack of quantitative and performance indicators*
- *Lack of political commitment*
- *Lack of in-depth involvement of government players*

VIII. Recommendations

Based on the lessons learned from the first cycle of the sub-programme, and in accordance with the specific and more focused tasks identified during the CPA preparation, it appears crucial to emphasize certain recommendations at 3 levels:

- Political/administrative level: To strengthen the political commitment nationally through re-forming and/or re-activating the RH steering committee in terms of level of representation and demanded assignment, and in view of the participation of new partners. This might be achieved via the involvement of technical high-ranking officials or representatives of various parties coordinated by expert person (nel). This personnel is supposed to closely ensure the engagement and the contribution of various stakeholders. This ought to be accompanied by a sub-ordinate joint coordination committee at the level of the projects to follow day-to-day planning and

execution of activities. The MOPH remains the leader and the monitor of these functions.

- Service level: The new directives undertaken for the next sub-programme cycle regarding the reduction of number of outlets and expanding the scope of RH services to include other elements (labor and delivery, youth) will necessitate ensuring the implementation of the set protocols in clinical services and management, and better utilization of services. It follows that close follow up of client files, monthly and quarterly reports, and field visits might be carried out.

- Research level: One of the main limitations inherent in the process of evaluation of improvements of the previous cycle was the lack of indicators and performance surveys. This calls for emphasizing of research as an essential tool to provide quantitative and performance indicators, as well as needs assessment that will ultimately help in evaluating achievements and monitor change.

- Gender and RH: It is crucial to support and maintain all ongoing efforts in the issue of gender and RH and gender-based violence. This support must be provided to ensure access, counseling, dignity, and choice of high quality reproductive health services, and to outreach activities and initiatives particularly in target areas and for underserved groups and adolescents. Efforts will be exerted to address the issue of male participation particularly in relation to HIV risks and unwanted pregnancies among other high-risk behavior in light of the country's specificity in terms of high internal and external mobility. In addition, educational efforts are integral part of this process. They should begin within the family unit, in the community and in the schools at an appropriate age, but must also reach adults, in particular men, through non-formal education and a variety of community-based efforts.

IX. Conclusion

The outputs achieved during the first cycle of the sub-programme were remarkable. The new cycle builds on that and emphasizes many issues related to ownership, service provision, and research. It remains very crucial to strengthen political commitment towards RH sub-programme by solidly placing it within the Ministerial structural bodies. This is expected to highlight major issues of concern that are related to RH (MMR, youth.), and will push forward research activities to address the existing situation, assess needs and achievements, and recommend strategic steps based on valid indicators. Efforts of various partners will be well orchestrated to ensure proper implementation of the outputs, in the light of understanding their specific roles and contributions.
Advancing the role of the public sector and increasing and sustaining cooperation with the private sector, remain tasks of paramount importance to ensure quality RH services and status.

References

1. United Nations. Arab Woman: Trends, Statistics, and Indicators, 1995
2. Ministry of Health. Pan Arab Mother and Child Survey (PAPCHILD), 1996
3. Central Administration of Statistics.MICS2, 2000
4. Ministry of Public Health. Quarterly Reports of the RH Sub-programme on RH services, 2000-2001
5. AUB-Medical Center. Causes of Maternal Mortality, 1970-1982. Unpublished Report, 1982
6. Elkak, F., Chaaya, M., Kaddour, A., Campell, O. Responsiveness to Antenatal Care in Lebanon, In Press. East Mediterranean Journal, 2002.

7. Chaaya, M., ElKak, F., Campell, O. Prevalence of Postpartum Depression in Lebanon, In Press, 2002.
8. Mroueh, A. An Overview of RH Situation in Lebanon. An Unpublished Document prepared for the MOH, 1998
9. Tannouri, G. Unmet Needs in RH in Rural Women, LFPA Publications, 1997
10. Deeb,M. et al. Reproductive Morbidity in Bekaa, *unpublished study*, from the Faculty of Health Sciences, and Department of Family Medicine, AUB, 2001
11. Ministry of Health. EpiNews newsletter, June 1999.
12. Ministry of Health. National Study on Knowledge, Attitude, Behavior, and Practices of Young Males in Lebanon, Unpublished, National AIDS Programme, 1996.
13. Ministry of Health. Prevalence of Sexually Transmitted Diseases in Women Attending Ob/Gyn Clinics in Lebanon, Unpublished, NAP, 2001.
14. UNDP. The National Human Development Report, Lebanon, 1998
15. Central Administration of Statistics. Study on the Living Conditions IN 1997, 1998
16. Government Policy Statement, 2001.
17. Ministry of Social Affairs. Population and Housing Database Survey. 1996
18. Faour, M. The Silent Revolution in Lebanon: Changing Values of the Youth. Beirut, Lebanon, American University of Beirut, 1998.
19. Sibai, A. and Kanaan, N. Youth Health Risk Behavior Survey among Secondary School Students in Lebanon: Prevalence and Clustering of Risk Behavior, *unpublished study*, from the Faculty of Health Sciences, and Department of Family Medicine, AUB, 1997
20. El-kak, F., Afifi, R., Kanj, M., Telgeh, C., and Mona Shediac-Rizkallah, 1999, "High-School Students in Postwar Lebanon: their Attitudes and Information Sources Related to Sexual and Reproductive Health", *Journal of Adolescent Health*, Vol 29, 153-155, 2001
21. Shediac-Rizkallah MC, Afifi Soweid RA, Farhat TM, Yeretzian J, Nuwayhid I, Sibai AM, Kanj M, El-Kak F.H., Kassak KM, and Kanaan N. Adolescent health-related behaviors in postwar Lebanon: Findings among students at the American University of Beirut. *International Quarterly of Community Health Education*, Vol 20(2), 115-131, 2000-2001

الجمهورية اللبنانية
مكتب وزير الدولة لشؤون التنمية الإدارية
مركز مشاريع ودراسات القطاع العام

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

Annex I
CPA Team

- Dr Hala Nawfal, population
- Ms Najwa Kusaifi, IEC
- Dr Faysal ElKak, RH

Annex II

CPA Steering Committee

- Dr Mohammad Ali Kanaan
- Ms Joumana Kadi
- Mr George Nehme
- Ms Samira Souidan
- Ms
- Dr Marianne Sabbouri

Annex III

CPA Meetings

- Meeting with Dr Walid Ammar, Director General of MOPH
- Meeting with Ms Nimat Kanaan, Diector General of MOSA
- Meeting with Dr Mtanious Halabi, Director General of Ministry of Education
- Meeting with Mr Zayd Khiami, Director General of Ministry of Youth
- Meeting with Dr Burj Hadjitian, Director General of Ministry of ENVIRONMENT
- Meeting with Mr Emile Emile Lahhoud, Chairperson of the Parliamentarian Committee on Youth
- Meeting with Dr Atef Majdalani, Chairperson of the Parliamentarian Committee on Health