All countries should strive to make accessible through the primary healt
reproductive health to all individuals of appropriate ages... Reproductive
the context of primary health care should, inter alia, include: family pla
ing, information, education, communication and services; education an
prenatal care, safe delivery and post natal care especially breast feed
and women's health care; prevention and appropriate treatment of infe
as specified in paragraph 8.25, including prevention of abortion and th
of the consequences of abortion, treatment of reproductive tract infec
transmitted diseases and other reproductive health conditions; and infor
tion and counseling, as appropriate, on human sexuality, reproducti
responsible parenthood.
Paragraph 7.6, Chapter VII., Programme of Action, International Conference on
Development, Cairo, 1994

Reproductive health care programmes should be designed to serve the ne
including adolescents, and must involve women in the leadership, plan
making, management, implementation, organization and evaluation of
Paragraph 7.7., Chapter VII., Programme of Action, International Conference on
Development, Cairo, 1994

Innovative programmes must be developed to make information, counse
ices for reproductive health accessible to adolescents and adult men.
Paragraph 7.8., Chapter VII., Programme of Action, International Conference on
Development, Cairo, 1994

Effective information, education, and communication are prerequisites
human development and power the way for attitudinal and behavioural ch
this begins with the recognition that decisions must be made freely, respo
an informal manner, on the number and spacing of children and in all a
daily life, including sexual and reproductive behaviour. Greater public k
commitment in a democratic setting create a climate conducive to re
informed decisions and behaviour.
Paragraph 11.12, Chapter XI., Programme of Action, International Conference
and Development, Cairo, 1994

Governments, assisted by the international community and donor agenci
sector, non-governmental organizations and the academic community, s
support for basic and applied biomedical, technological, clinical, epidem
social science research to strengthen reproductive health services.
Paragraph 12.12, Chapter XII., Programme of Action, International Conference on
Development, Cairo, 1994

Improved quality of services can be achieved only where quality has be
both users and providers of services and where women are actively inv
sion making and service delivery.
Paragraph 12.19., Chapter XII., Programme of Action, International Conference
and Development, Cairo, 1994

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Table of Contents

List of Acronyms

FP.....Family Planning
GOL.....Government of Lebanon
GP.....General Practitioners
GYN.....Gynecology
HIS.....Health Information System
IEC.....Information, Education and Communication
LFPA.....Lebanon Family Planning Association
MOPH.....Ministry of Public Health
MOSA.....Ministry of Social Affairs
NGO.....Non Governmental Organization
OB.....Obstetric
PHC.....Primary Health Care
RH.....Reproductive Health
STI.....Sexually Transmitted Infection
TV.....Television
UN.....United Nations
UNFPA.....United Nations Population Fund
UOB.....University of Balamand
VCR.....Video Recorder
WHO.....World Health Organization

Executive Summary

The first cycle of the Reproductive Health (RH) sub-programme 1997-2001 and supported by United Nations Population Fund (UNFPA) aimed to integrate comprehensive and sustainable quality RH services, including sexual health, within the framework of the Primary health Care (PHC) System. All through the cycle 1997-2001 of the sub-programme, RH services were variably integrated into an approximate number of 410 PHC health outlets. According to quarterly reports of the Ministry of Health (MOPH) during the year 2001, most of these outlets offer a non-specific range of health services, from simple contraceptive provision to a package of services including pregnancy care, family planning, and gynecological services. However, in some outlets especially those of the MOPH, RH services are not delivered due to shortage of specialized staff.

In this regard efforts have been carried to improve on the overall status of RH services from setting to human resources and equipment to target client. In trying to have more directed and efficient efforts, there has been a need to a have a mapping of the PHC centers.

To meet this need, a study on mapping of PHC centers was carried in an attempt to exactly describe and asses the status of RH services in terms of human resources, quality of services and their utilization and provision, management and finance of those services in addition to the setting within which RH services are delivered. The study also aimed at assessing the available equipment and their current utilization.

In meeting these objectives, this study is expected to provide RH project partners and policy makers with suitable basic and operational data on the general status of RH services. This data is expected to assist in the process of improving the quality of the existing RH services.

Although the original mapping involved 342 centers, but in this document only 50 representative centers were analyzed. Analysis revealed a need to assess the number, distribution, competencies and job assignments of the health care providers. In this respect, attention should be addressed to deal with shortages of paramedical staff and to carry on further training and workshops to update and improve the skills of various providers. In addition, re-considering the number of existing services and strengthening the operational ones coupled to adequate advocacy and promotion can contribute to improving RH services.

This survey despite the few limitations related to the design and field execution can represent a platform for the understanding of the status of RH services. It assists in preparing further studies for in-depth analysis of various RH components.

I. Introduction

The first cycle of the Reproductive Health (RH) sub-programme covering 1997-2001 and supported by United Nations Population Fund (UNFPA) aimed to integrate comprehensive and sustainable quality RH services, including sexual health, within the framework of the Primary Health Care (PHC) system. As the sub-programme came at a time when the public health sector in Lebanon was recovering from a long exhaustive civil strife, there were few operating health outlets at the beginning of the first cycle (1997-2002), and estimated to serve close to 15% of the population. Under the leadership of the Ministry of Public Health (MOPH), and in close cooperation and support of the United Nations (UN) agencies, mainly UNFPA, and in partnership with the Ministry of Social Affairs (MOSA) and local Non-Governmental Organizations (NGOs), a laborious endeavor to expand the RH service coverage was undertaken. This is in full accordance with the main objective of the RH sub-programme in ensuring accessible and quality RH, especially to underprivileged population (1).

Starting with a limited number of PHC centers and dispensaries at the launching of the sub-programme, there are currently a vast number of health outlets (410-430) belonging to the MOPH, MOSA, Lebanon Family Planning Association (LFPA), and other NGOs, and that are adequately distributed all over Lebanon. In this context, the MOPH is responsible for setting a National Health Policy that ensures integration of RH services within PHC.

All through the past cycle of the sub-programme, RH services were variably integrated into an approximate number of 410 PHC health outlets. According to quarterly reports of the MOPH, most of these outlets offer a non-specific range of health services, from simple contraceptive provision to a package of services including pregnancy care, FP, and gynecological services. However, in some outlets especially MOPH ones, RH services are not delivered due to shortage of specialized staff (2).

In further enhancing the process of integration of services, 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 and enhanced with Health Information System (HIS). It is hoped that these centers will be a model for best practices in PHC package including RH services. In addition, it is expected that various activities related to capacity building of human resources and strengthening of service setting will directly fortify PHC system and hence quality of RH services delivered. 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 that are 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, there is a lack of assessment tools to measure the status of these outlets in terms of their coverage, setting, equipment, human resources, and services. Moreover, the impact of RH services on all elements of PHC System makes it difficult to evaluate any expected results.

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 Government of Lebanon (GOL) attempted to re-build and improve its health services. Currently a total of 168 tertiary care centers and 850 PHC are widely spread across the country, making accessibility to health care relatively high (95%) (3).

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 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 (4), it is believed that the presence of these outlets had improved access to PHC. 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.

A health team consisting usually of a medical doctor, and/or a midwife, a nurse, provides these services 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 (2).

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.

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 had already started last year, and will continue through the current new cycle.

II. Objectives

Although the whole package of RH services are introduced within PHC setting, the main focus is still on "gynecological problems", pregnancy care, and family planning (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 (2). 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 (5). In some isolated islets, women are still totally lacking antenatal and gynecological care.

In this regard, a study on mapping of PHC centers was carried in an attempt to exactly describe and asses the status of RH services in terms of human resources, quality of services and their utilization and provision, management and finance of those services in addition to the setting within which RH services are delivered. The study also aimed at assessing the available equipment and their current utilization.

In meeting these objectives, this study is expected to provide RH project partners and policy makers with suitable basic and operational data on the general status of RH services. This data is expected to assist in the process of improving the quality of the existing RH services.

III. Methodology

A data collection tool (well-structured questionnaire) was constructed to collect information from the centers/dispensaries including employees profile, RH services, and Information, Education and Communication (IEC) activities.

questionnaire was finalized based on a consensus from the concerned parties including MOPH, UNFPA, the World Health Organization (WHO), and MOSA.

The questionnaire was administered to 342 centers/dispensaries by trained team from MOPH and University of Balamand (UOB). A direct interview with the managers of these outlets was carried to collect necessary information. Some of the data were collected from the records, especially employee information. In certain cases, information was not provided because of privacy and confidentiality as claimed.

In this report a sample of 50 centers chosen randomly from the different muhafaza in Lebanon were analyzed. Analysis of data was undertaken using SPSS software. Univariate and bivariate analysis were performed to identify and describe different characteristics of the status of these outlets.

IV. Results

A sample of 50 centers was studied and analyzed. These centers are distributed as follows: Bekaa 10, North 13, South 8, Mount Lebanon 12, and Nabatieh 7. These centers are affiliated to various public and private institutions: MOPH 9, MOSA 8, NGO 25, City Council 1, Red Cross 2, and Private 4. Some of these centers initiated their services as early as the 1970's, while others had started recently. Those centers cover a maximum population of about 300.000 people. Those individuals are within a distance range of up to 8 Kms from the nearest health center, which is within a distance range of 50m-24 Kms from the nearest hospital.

Results will be analyzed according to the following topics:

IV.1. Human Resources.

Most of RH services are provided by Obstetricians/Gynecologists assisted by a team of midwives, nurses, and social workers (Tables 1, 2, 3). In few situations, midwives also provide RH services. A total of 64 physicians provide RH services in the studied centers distributed as follows: 54% of the centers have one gynecologist, 16% have none, and the rest have between 2-4 gynecologists. In more than 60% of the centers, those physicians work 1-2 days/week and 14% work for 3-5 days. Other health workers include nurses whose total number is 41 distributed as follows: one nurse in 62% of the centers, 2 in 4%, and 3 in another 4% of the centers. The majority of them work between 5-7 days/week. There are also around 38 nurse assistants working in 54% of the centers with a work schedule of 5-7 days /week. As for other human resources, the majority of centers (80%) lack a medical lab technologist and a pharmacist.

Table 1. Number of RH Practitioners

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	0	8	16	16	16
	1	27	54	54	70
	2	9	18	18	88
	3	5	10	10	98
	4	1	2	2	100
	Total	50	100	100	

Table 2. Number of Nurses

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	0	14	28	28.6	28.6
	1	31	62	63.3	91.8
	2	2	4	4.1	95.9
	3	2	4	4.1	100
	Total	40	98	100	
Missing	System	1	2		
Total		50	100		

Table 3. Number of Assistant Nurses

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	0	22	44	44.9	44.9
	1	20	40	40.8	85.7
	2	3	6	6.1	91.8
	3	3	6	6.1	98
	4	1	2	2	100
	Total	49	98	100	
Missing	System	1	2		
Total		50	100		

Regarding the need for training for the health workers, there was a perceived need for training of physicians in 48% of the centers, and for midwives in 26%, and for nurses in 78% of the centers studied. The need for this training identifies topics in RH (70% of centers), ultrasound use (60%), quality services (54%), and Pap smear in 52% of the centers. At the same time, 94-96% of the centers are ready to participate in RH training and RH conferences and seminars.

IV.2. Reproductive Health Services

According to tables 4 and 5 the type of RH services provided in the surveyed centers includes: Safe motherhood, family planning, cancer surveillance, sexuality and youth, and Sexually Transmitted Infections (STIs) in respective order. Safe motherhood is provided mainly by Obstetricians/Gynecologists (Ob/Gyn) in 88% of the centers, followed by nurses in 32%, and midwives in 18% of the centers. As for family planning service, it is provided mostly by Obstetricians and Gynecologists in 74% of the centers, by nurses in 40%, and by midwives in 22% of them. Cancer surveillance is carried mainly by Obstetricians and Gynecologies (Ob/Gyn) in around 74% of centers, while sexuality and youth is provided by Ob/Gyn in 52%, and by nurse and midwives in about 10-16% of the centers. Other major RH services like STIs are also provided by Ob/Gyn in 54% of the centers, by midwives in 10%, and by nurses in 4% of the centers. Ob/Gyn, on the other hand, provides infertility services, in 70% of the centers, and by nurses and midwives in 6-10% of the centers.

Table 4. Safe Motherhood Providers

	Frequency	Percent
Ob/Gyn	44	88
Nurse	16	32
Midwife	9	18

Table 5. Family Planning Providers

	Frequency	Percent
Ob/Gyn	37	74
Nurse	20	40
Midwife	11	22

Breastfeeding counseling and recommendation is also provided by Ob/Gyn in 82% of the centers, by nurses in 38%, and by midwives in 20% of the centers.

As for the availability and use of ultrasound, it is absent in 82% of centers. In centers where ultrasound is available (18%), it is used by physicians working within them in 16% of the cases, and by an outside physician in 2% of the centers. Ultrasound maintenance is only done in 10% of the centers.

IV.3. Seminars and Research Activities

According to Tables 6 and,7 several activities related to RH are being done in the centers in terms of research, lectures, and seminars. The lectures are mostly addressed to the public and to the clients attending to the services of the center. The various RH topics are usually presented in addition to other health topics of general interest or to observe an international or national event (diabetes day, health day). Most of the educational activities are organized by and housed in the corresponding health center (44-32% of the centers respectively). Unfortunately, 92% of these centers have no libraries that could assist the health workers in updating their knowledge and in providing up-to-date information to clients.

Regarding the tools necessary to carry out such an activities (Table 8), it was found out that there is no photocopies in 74% of the centers, no flip charts, slide projector, and overhead in 90-92% of the surveyed centers. In 60-74% of the centers there is neither a Television (TV) nor a Video Recorder (VCR).

With respect to research (Table 7), few studies on breastfeeding, osteoporosis, birth, child health have been reported, yet there is no data on the way these studies have been conducted, their outcome, impact, and practical application. These studies were carried by 22% of the centers surveyed.

In relation to these activities, the managers of the centers expressed an urgent need for many RH educational means. These means include: medical books, pamphlets, brochures, in addition to more organized health awareness sessions on breast cancer, sexual health and Pap smear (Table 8).

Table 6. Cultural Activity

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	RH lecture	9	18	27.3	27.3
	Home accidents	2	4	6.1	33.3
	Health and hygiene	2	4	6.1	39.4
	Emergencies and how to protect children	1	2	3	42.4
	Vaccination	1	2	3	45.5
	Diarrhea management	2	4	6.1	51.5
	AIDS	2	4	6.1	57.6
	Prenatal care	1	2	3	60.6
	About women and girls	1	2	3	63.6
	Health Education	2	4	6.1	69.7
	Asthma and Allergy	1	2	3	72.7
	Breastfeeding	1	2	3	75.8
	Mines	1	2	3	78.8
	Mothers role in the family	1	2	3	81.8
	Children	1	2	3	84.8
	CVD	5	10	15.2	100
	Total	33	66	100	
Missing	System	17	34		
Total		50	100		

Table 7. Research Activities

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Study on west bekaa villages	1	2	9.1	9.1
	Study on breastfeeding	1	2	9.1	18.2
	Study on chronic diseases	2	4	18.2	36.4
	Study on diabetes	1	2	9.1	45.5
	Study on Migration Health and Medicine	1	2	9.1	54.5
	Study on osteoporosis	1	2	9.1	63.6
	Descriptive study on th elocal community	1	2	9.1	72.7
	Solid Waste Disposal	1	2	9.1	81.8
	RH and birth	1	2	9.1	90.9
	Children Health	2	2	9.1	69.7
	Total	11	22	100	
Missing	System	39	78		
Total		50	100		

Table 8. Activity or Service Needed

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Prenatal care	1	2	2.8	2.8
	Media equipment (books...)	1	2	2.8	5.6
	Brochures, leaflets	1	2	2.8	8.3
	x-ray	1	2	2.8	11.1
	Nursing training	1	2	2.8	13.9
	Health education	6	12	16.7	30.6
	Medication especially for children	10	20	27.8	58.3
	RH	3	6	8.3	66.7
	Ultrasound	8	16	22.2	88.9
	Physiotherapy	1	2	2.8	91.7
	Home care for elderly	1	2	2.8	94.4
	Training and educational equipment	1	2	2.8	97.2
	Psychotherapy	1	2	2.8	100
	Total	36	72	100	
Missing	System	14	28		
Total		50	100		

IV.4. Target Clients

These centers are located within residential areas, a situation that maximizes coverage, and is expected to ease access and increase utilization of RH services. The mean number of target beneficiaries is about 29500 among which there are a mean number of 11400 youth. The mean number of clients attending these centers is 428/month utilizing general health services, including RH. In specific, the mean number of RH visits carried per month is about 24 visits using mainly gynecological services, family planning and safe motherhood. Those clients are provided with a waiting room and a toilet facility in most of the centers.

IV.5. Management Information

All the centers surveyed have managers that constitute 9.7% of the whole staff, but make 9.3% of the staff as per the contract type. Those managers are either physicians or are holders of other degrees, like management for example in 1.9% of cases. Most of the managers are employed as full-timers in about 86% of the centers. Regarding the tools and process of management, those centers are inadequately provided with basic equipment. For example there is no computers in 62% of centers, no typing machines (78%), no photocopies (74%), and no printers in 66% of the centers surveyed. On the other hand, 92% of the centers lack a documentation center, and there are no meeting rooms in 32% of centers, though in 12% of those centers between 1-4 rooms are not used.

IV.5.1. Financial System

The majority of centers have financial records (92%), however, only 58% of centers have a defined yearly budget. Regarding the status of funding, only 50% of the centers are funded. Sources of funding include: MOPH-RH sub-programme (12% of the centers), MOSA 4%, while the majority of funding comes from NGOs, municipalities, Lebanese Red Cross, and private charity institutions (religious, and secular)(Table 9) .

Table 9. Sources of Funding

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	MOSA	2	4	13.3	13.3
	Lebanese Red Cross	1	2	6.7	20
	Imsa	1	2	6.7	26.7
	Karmadah Brotherhood	1	2	6.7	33.3
	YMCA	6	12	40	73.3
	Omar Karameh	1	2	6.7	80
	Mar Mansour Organization	1	2	6.7	86.7
	Local Municipality	1	2	6.7	93.3
	Local Organization	1	2	6.7	100
	Total	15	30	100	
Missing	System	35	70		
Total		50	100		

IV.5.2. Health Information System

The majority of the surveyed centers have an acceptable HIS. Around 88-96% of the centers have records for individuals, visits, and consultations. However, the family record is available only in 36% of the centers, and appointment records in 64%. RH records are present in 76% of centers only. Concerning drug supply and storage, medications related to RH services are available in 95% of the centers with a regular supply from the RH sub-programme in the MOPH in 84% of the centers. Fridges are available in most centers (96%), yet storage rooms are present in only 44.4%, closet and cooler in 47%, closet and shelves in 35% of the centers.

IV.5.3. Infection Control

The majority of centers have the adequate means and practices of infection control. In around 96-98% of the centers, medical gloves are available, the practice of immediate sterilization of equipment using electric sterilizer, and the presence of sterilization liquid. Usually equipment are clean-brushed in 72% of centers then washed in a running water sink, which is available in 74% of the surveyed centers. Hand soap is present in 94% of centers, and a trash bin in 98%.

IV.6. Service Setting

Around 66% of those centers are owned while 32% are rented. Half of the centers studied are provided with generators, and 78% with a sewage system. However, 34% of the centers had water leakage from walls and/or ceiling jeopardizing the beneficiaries and the equipment to humidity effects.

Regarding working schedule, 78% of the centers operate 6 days/week and the rest work between 2-7 days/week. Around 50% of the centers work 6 hours/day, 22% between 7 and 10 hours, and the rest work 2-6 hours/day.

Those centers have 1-2 examination rooms in 64% of the cases, and 3-5 in the rest of the centers. However, 52% of the centers have no consultation rooms, while 46% have 1 consultation room. As for the waiting room, 82% of the centers are accommodated with one waiting room, while 6% are not. The majority of the centers studied have conference rooms, kitchen, and toilets, while 92% of them have neither a library, nor a documentation center, although 12% of the centers have between 1-4 rooms that are not used.

Most of the centers have a suitable supply of chairs, closets, refrigerators, and ovens.

V. Discussion

This survey is intended to map PHC centers using a sub-sample 50 randomly selected centers. This discussion will address several elements of RH services including: service setting, RH services provided, human resources and capacity building, research and educational activities, and management aspects.

Generally speaking, these centers-being sponsored by several parties- are adequately distributed geographically and they either serve populated areas or/and are very close to residential areas, a situation that will ease access and help better utilization of RH services. In addition, these centers being also close to hospitals will ultimately facilitate the process of administrative networking and potential referrals of specific medical conditions. This complies accurately with the objectives of the national RH sub-programme regarding improving access with services, especially in under-privileged areas.

Regarding service setting, unfortunately not all centers are provided with the adequate basic and essential tools to deliver quality and acceptable service. Albeit the fact that most of centers have the basic settings, there is still maintenance problems in the building, and the remarkable lack of consultation rooms will both affect the overall impact of the RH services provided. It is expected that some clients will not be enthusiastic using the centers, and not comfortable to state the complaints in the absence of an enabling setting of privacy and confidentiality. In addition, lack of building maintenance will seriously damage existing equipment due to humidity, thus interfering with the quality of services delivered.

Most of the centers have a working schedule that is similar to the Government sector. Despite the fact that this schedule is very much related to the sponsoring parties of those centers, and to the financial and human resource restrictions, it renders the centers unable to receive clients presenting in the afternoon. In this case, the center might be missing a lot of clients, who in this case will use other facilities (probably private clinics), which is run by providers working in the PHC centers.

With respect to human resources, the results show that most of the providers responsible for RH services are Obstetricians/Gynecologists, with midwives in few other cases. Most of the physicians are not full-timers, so they cover 1-2 days/week, and attend to their clinic for other times. This schedule affects the continuous availability of RH services throughout the week, only to be covered by midwives when present, knowing that they are not trained to manage all cases in RH services. In other situations, there are few centers (16%) that have no gynecologists, and the results do not reveal clearly how RH services are delivered. It could be that midwives, or General Practitioners (GPs) provide some of the RH services, or even referred elsewhere.

Although it is shown that most of the centers have health teams where midwives, nurses, social assistants, and lab technologists work together, results indicate moderate to severe shortage of paramedical staff. This shortage in human resources is related to several factors including the employment policy, lack of incentives, and lack of budgetary allowances. Such a situation can affect quality of services in various ways, from client over-load, lack of certain services including laboratory ones, to inadequate provision of some other services.

Although the results cannot clearly identify the competencies of the physicians and other health care providers with respect to their background, training skills, standard of service delivered, managers of the centers surveyed expressed the need to train various RH providers

in many aspects in RH issues, specially in ultrasound application in RH, Pap smear procedure, and quality of services. All the centers are willing and ready to participate in any form of training and educational activity, which reflects their intentions to improve the overall quality of services. This urges various parties sponsoring these centers, namely the RH sub-programme within the MOPH in collaboration with MOSA, UNFPA, and leading NGOs to organize training workshops in the needed RH areas. In fact, several training activities have been conducted by the MOPH in cooperation with UNFPA on ultrasound application in RH and on clinical operating protocols and management guidelines. Nevertheless, a lot of work remains to be done regarding assessment of impact of training, profiling the provider competencies, and recruiting needed staff.

With regard to another aspect of PHC mapping which is the RH services, the results show that most of the elements of this service is being provided in most of the centers. The 3 main services are: gynecological exams, pregnancy care, and family planning. The rest of the RH services are also provided but to a lower extent. Comparing these findings with the quarterly reports of the RH sub-programme, it can be concluded that most of the RH services are provided in most of the centers.

It worth noting that some of the specialized services like infertility, are offered by midwives and nurses which represents a step-over their specialties, and which can imply inadequate service. At the same time, some of the services (breastfeeding) are mostly delivered by physicians while midwives and nurses can provide them in a better way. These findings could imply that there is an improper assignment of service provision, and that physicians may be mostly trusted to deliver services even in cases when the paramedical staff can do as good a job or even better.

The ultrasound machine, considered to be necessary in pregnancy are and gynecological examinations, is not available in most of the centers. This can drastically interfere with the degree of service utilization, adequacy of service, and satisfaction of the client. Ultrasounds have to be provided and training of their users should continue.

It looks that though most of RH services are there, however, the context and the content of these services remain to be examined and evaluated in depth based on the delivery of integrated type of services. It is beyond the scope of this mapping survey to draw conclusion on these issues.

With regard to para-clinical services, the results indicate the presence of several educational and research activities in most centers. The educational lectures and seminars reflect the willingness and readiness of the health care providers to promote awareness and knowledge to clients, despite the serious lack of audiovisual material in most of the centers. Although the findings did not reveal how the topics of health awareness were chosen, and to what extent they affected attitudes and behaviors of the targeted population, it appears that these educational activities need to be designed and arranged in close coordination with the main parties, namely the MOPH.

It is also encouraging to find out that some research work is taking place in these centers in various areas in health. It is compelling to understand the research questions, methodology, and the possible intervention and applications these studies have on the existing situation. Such activities need to be supported and disseminated to various stakeholders. In fact, ongoing research in these centers if reared properly, can add to the general understanding of service provision, client perception, community needs, and performance indicators.

With regard to management information, findings will be analyzed in relation to managers, financial aspect, HIS, and infection control. The managers of the surveyed centers are not always specialized, as physicians can be occupying fully or as a part-time this post. This can undoubtedly affect the performance and the efficiency of these centers, especially knowing that these centers are inadequately provided with basic equipment like computers and meeting rooms. Considering the restrictions on the RH sub-programme budget and

employment policy that are hindering better support of management of these centers, the existing situation remains acceptable. On the light of those findings, it worth considering the possibility of closing down certain centers that are suffering serious problems to strengthen other more efficient ones.

Regarding the management of financial issues, the findings suggest that the majority of centers have financial support from several parties that are recorded in financial records. This support manifests itself as free-of-charge drug supply, equipment, and other miscellaneous items. Nevertheless, close to half of the centers lack a defined yearly budget, a matter that deems attention as it interferes with capacity of these centers to maintain and acquire needed equipment.

As for the health information system in these centers, the findings indicate that the majority has an acceptable HIS manifested in the recording system during all the process of registry and service delivery. Concerning drug supply and storage, medications related to RH services are available and stored in most centers. Attention and assistance should go to centers that lack this vital information system as it affects proper follow up and management of RH cases.

The issue of infection control is well maintained and guarded in the majority of centers. This should be closely followed up to sustain a minimal risk of infection in these centers. The activities carried by the MOPH regarding on-the-job training in infection control have added remarkably to such a re-assuring findings of infection control, in addition to the availability of the necessary tools and equipment.

VI. Limitations

This is a mapping survey and it was intended to describe the various elements involved in PHC and within it RH care. The analysis in this document was based on a sub-sample of 50 centers, which could restrict and limit the scope of findings and recommendations. This study, due to its type, fails to provide many answers on performance of centers, operational aspects, and quality of services. Nonetheless, it describes to a greater extent the basic ingredients of RH services and supplies the stakeholders with a essential information on the status of PHC centers.

As reported by initial team who carried out the survey, there was inadequate coordination among all parties in preparation for the primary phase of the survey and also during data collection. In addition, contacts should have been made by the official partners with the managers of the centers prior to the implementation phase. At the time of implementation, the list of existing centers was not up-to-date. Another issue is that the original time allotted to this project was not sufficient according to the surveyors.

At the level of the design, the questionnaire does not contain questions that could have ultimately helped in analysis and discussion to give wider perspective on the PHC centers. This is probably related to the initial research question entertained and to the objectives of the study.

VII. Conclusion and Recommendations

The remarkable expansion of RH services under the mandate of the RH sub-programme had on one hand promoted an increased coverage and outreach of fragmented RH services, but had on the other hand raised several aspects about the various players involved in the delivery of those services, regarding quality, package services, providers, availability of health workers and services, and other technical aspects.

The results of this survey show explicitly that most of the existing services suffer from different types of problems related to the different components of quality service delivery of RH. Some of these problems can be remedied by training, advocacy, and monitoring, while others are more serious and even complicated, like the financial, employment, job description, and management.

The study shows that there is capacity and potential to deliver RH services, provided that a persistent and maintained up-grading and reformative actions to be taken at various service levels (human resources, financial, and service delivery). The study also represents an opportunity to sort out the performance of the many existing health care centers, a process that will feedback into the activities of the upcoming cycle of the RH sub-programme.

In this aspect, this survey is trying to look at all these aspects. Despite the few limitations related to the design and field execution, this survey represents a platform for the understanding of the status of RH services. It assists in preparing further studies for in-depth analysis of various RH components.

Several recommendations can be made based on the study results and analysis:

❒ There is a need to assess the number, distribution, competencies and job assignments of the health care providers. In this respect, attention should be addressed to deal with shortages of paramedical staff and to carry on further training and workshops to update and improve the skills of various providers. Most importantly, assessment of all the training should be carried to ensure the implementation of acquired skills and knowledge, as an indicator of attitude change on the side of the provider.

❒ Provision of centers with necessary tools and equipment for proper carrying of RH services and related managerial tasks. In this case, not all existing centers should be refurbished by similar equipment. On the contrary, a referral center for advanced equipment should be assigned depending on the load of clients, and on the skills of the providers. From a health economics point of view, some centers have very ineffective utilization of their ultrasound machine, while others are overloaded and need one or more of this equipment.

❒ Supervision and coordination of various educational and research activities, and that is again crucial as part of a plan to outreach the community, attract more clients, and evaluate the content and the messages of the educational activities. Regarding research, it should be part of a research agenda and in consultation with the RH sub-programme and research experts to ensure a valid and beneficial outcome.

❒ Re-looking the number and distribution of centers. This should be based on cost-effectiveness, community needs, and quality service delivery. Though the experience from the past RH cycle showed us that over-expanding the RH services is possible, but the issues of quality service, client load, dignity, were not met in all centers. It is important to invite the community to participate in the assessment and re-distribution of the existing RH services.

❒ Advocate for a wider sector of clients that includes men and youth, by intensifying efforts towards schools, labor sites (high-risk groups), families...and ensure a male-friendly services, through training on gender.

❒ Ensure the provision of various RH services in an integrated manner. This is a major task that requires a lot of RH sector reform that should address all aspects from the building to the provider to other aspects of financing and administration. It is expected that the upcoming RH cycle will seriously consider the process of service integration.

❒ Ensure prior use of space and utilization as per consultation and counseling rooms. This refers to dignity in RH care, which emphasizes the importance of confidentiality, privacy, and respect that should be part of any RH package of services.

The above mentioned recommendations fall within the wider frame of RH sector reform. In this regard, the mapping survey is expected to inform stakeholders about various aspects of RH services, the necessary reforms needed, as well as calling for further research studies on various aspects of RH status in Lebanon.

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