Chapter Seven

YOUTH AND HEALTH

I. INTRODUCTION

Health, defined as "a state of complete physical, mental and social wellbeing and not merely the absence of disease and infirmity", is a particularly important aspect and an integral part of human development. Its proxy, the expectation of life at birth, is one of the three variables that constitute the Human Development Index. According to the human development approach, health, like education and economic participation, plays the dual role of a necessary input in development and a necessary output of the development effort. A healthy population is a necessary condition for high productivity, as economic growth is based on a productive workforce. It is also one of the principal and direct goals of development. Youth constitutes a sizeable population group with behavioural patterns that may have serious risks and implications on health. From that perspective, youth are an important target of developmental action.

The purpose of this Chapter is to analyze the health situation, particularly as it relates to the youth population, to examine the trends in mortality and to discuss the major morbidity issues of particular concern to youth (reproductive health, disability, addiction, AIDS, etc.). Some policy conclusions are drawn as outcome of this analysis.

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II. THE NATIONAL HEALTH SITUATION

The information below provides the backdrop for the review and analysis of the health situation of youth. In this connection, it is important to note that the health situation of specific population groups, including youth as well as the elderly, women and handicapped, has hardly been explored. The youth population being a target group for investment for development has recently been the subject of studies concerning health risk behaviour, and of specific prevention activities aimed at modification of lifestyle and risk reduction. Although most of the studies on youth have been limited in scope and coverage, significant data can be retained.

At present, the country is in a state of epidemiological transition. There are still important health problems related to infectious diseases, such as acute respiratory infections, typhoid fever, brucellosis and other zoonoses, tuberculosis and parasitic infections. Efforts have been made to improve control, but a sharper focus is required towards strengthening the national capacity for integrated action, mainly with respect to zoonoses and waterborne diseases in remote areas where incidence remains important.

Chronic and degenerative diseases have become more prevalent, such as diabetes (prevalence 13 percent), hypertension (prevalence 26 percent), and cancer (4,000 new cases per year) as well as other degenerative and cardiovascular diseases. They have become the main

cause of death, as a result of the ageing of the population, changing dietary habits, and lifestyles. The rapid development of non-communicable diseases has not yet triggered adequate preventive action against risk factors, such as smoking and alcohol consumption. Some regulations have been elaborated, but their application is not enforced. A national non-communicable diseases programme and a national tobacco control programme with focus on prevention and behaviour modification were recently initiated by the government in collaboration with WHO and reflect the commitment of the government to address these issues.

As indicated earlier in the report, efforts are being deployed to address the main environmental issues, including water resources pollution and drinking water supply, wastewater and solid waste, coastal pollution, air pollution, forest degradation and soil degradation. It is emphasized that youth are much concerned about environmental problems, but more information is required about the perception of their role and support warranted in this respect.

Accidents and injuries also represent a significant burden with important implications on death and disability and on household and public health budgets. Although data in this respect are incomplete, traffic and road accidents, reported by the Internal Security Forces, caused 337 deaths and 3,222 wounded in 1996. The main cause of accidents was excessive speed (78 percent of all accidents) in addition to not using safety measures.

Even though public health facilities were virtually destroyed during the war, there were relatively limited effects on the overall health situation of the population. This might have been due to the importance of the education factor and the strong tradition of self-reliance and private initiative, including non-governmental organizations, which were very active during the war. Additional factors were the provision of humanitarian assistance and the involvement of the UN System and other international organizations in the delivery of disease control and health programmes.

Indeed, notwithstanding the effects of the war, the health of the population improved considerably in the past two or three decades. The crude death rate fell from around 9 per thousand population in 1970 to 7 per thousand in 1996. More important, the infant mortality rate fell during this period from 65 per thousand live births to 28 per thousand. As a result, the expectation of life at birth rose from 64 years in 1970 (62 years for males and 66 years for females) to 71 years in 1996 (69 years for males and 72 years for females). This places the country within the range of the developed countries with respect to mortality levels[1].

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The relatively favourable indicators of maternal and child health at the national level conceal important regional and social disparities. Thus in the1986-1996 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 Mohafazat of North Lebanon (Lebanon: PAPCHILD, 1996).

[1] 1970 rates from Courbage and Fargues, 1974; rates for 1996 calculated from adjusted data of Lebanon: Ministry of Social Affairs and UNFPA, 1996.

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.

While health system coverage is almost universal, insurance coverage is rather limited. Insurance coverage is ensured by a number of public institutions (National Social Security Fund, Civil Servants Cooperative, and four public insurance schemes for the military and security forces) and the private sector including the special funds of a number of syndicates and private insurance companies. The former covers just under 50 percent of the population and the latter 8 percent. The remaining part of the population, 43 percent, is left to the charge of the Ministry of Public Health, which spends more than 80 percent of its budget on curative health care. It does so through public and private hospitals and its own public health centers and dispensaries as well as the centers of the Ministry of Social Affairs.

The present health care system, which relies heavily on private hospitals and on curative rather than preventive medical care, results in high cost of care per individual. It is noteworthy that in 1997 total health system expenditures amounted to US$ 1,470 million or 9.7 percent of GDP, which is far higher than in other countries at the same income level as Lebanon (Ammar et al., 1998). Out-of-pocket expenditures represented 53 percent and disbursements by the public sector 47 percent. The heavy burden on the government budget has prompted the public authorities concerned to devise a national strategy for primary health care and to initiate a programme of rehabilitation and strengthening of the capacity of the public health institutions, as discussed in Chapter Human Development in Lebanon above.

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III. YOUTH AND REPRODUCTIVE HEALTH

There is international consensus that couples have the right to determine freely and responsibly the number of children they desire and that governments have the obligation to provide them with the knowledge and means to do so. This right was elaborated in the Plan of Action adopted at the World Population Conference in Bucharest, Romania, in 1974, and reiterated and further elaborated in subsequent international population conferences. It was also reaffirmed in the World Youth Forum held in August 1998 in Portugal. This right involves provision of information to couples as well as access to safe, effective and acceptable methods of family planning of their choice. It also includes the right for women to access appropriate health care services that will enable them to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant. The government provides these services through medical clinics and social development centers overseen, respectively, by the Ministry of Public Health and the Ministry of Social Affairs. A number of non-governmental organizations are also active in this domain, most important among which is the Lebanese Family Planning Association.

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The Lebanon Maternal and Child Health Survey (Lebanon: PAPCHILD 1996) indicated wide knowledge of means of family planning methods, particularly among young mothers. Indeed, 99 percent of married women 15-24 years of age indicated that they knew about at least one method of contraception and 98 percent indicated knowledge of a modern method. This was accompanied by a high rate of utilization of these methods. Of the ever-married women 20-24 years of age in the sample, 67 percent indicated they actually had utilized at least one method of contraception. As expected, the degree of utilization was lower among the least educated women than among the rest (Table 7.1)[2]. This is probably due more to the fact that women with higher education have a desire for smaller families than to the greater knowledge of contraceptive methods among them.

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The major reason for using contraception among married women aged 15-24 years is spacing of children (82 percent) and delaying pregnancies. This is as expected since this age group of married women (under 25 years) is generally in the process of building a family. Only 17 percent used contraception because they had reached the desired number of children.

Table 7.1: Married women under 25 years of age having used birth control, 1996
(Percent of total)

Education Level	Any Method	Modern Method
Illiterate	--	--
Read and Write	52.2	28.7
Elementary	59.2	36.7
Intermediate	75.4	46.8
Secondary or Higher	67.6	44.8
Total	64.9	41.7

Source: Lebanon: PAPCHILD (1996).

Pre-natal care is widespread among pregnant women less than 30 years of age. 89 percent of those who had a child in the five-year period preceding the survey indicated that during their pregnancy they had at least one pregnancy-related consultation. This ratio varies only slightly by Mohafazat, except for the Mohafazat of North Lebanon. It reached 99 percent in the Mohafazat of Beirut and 72 percent in the Mohafazat of North Lebanon. It also rises with the education level of the woman (Table 7.2).

The quality of *natal care* depends largely on the health care provider attending to the birth (doctor, midwife, etc.) and on the environment in which the birth takes place in terms of sanitation, appropriate equipment and supplies and the like. Births take place mainly in medical institutions such as hospitals or medical clinics. In 1996, 93 percent of births to young females took place in such institutions and only 7 percent at home. Only 19 percent of births took place in public institutions against 74 percent in private institutions. With regard to the attending person at delivery, a large majority of births (76 percent) that occurred during the five

[2] The highest rate is observed in relation to women with intermediate education but this may be due to statistical error caused by the smallness of the sample.

previous years were attended by medical doctors as against 17 percent attended by a legal midwife or a nurse. (Lebanon: PAPCHILD, 1996)

Post-natal care for the mother is an important factor in the reproductive cycle and can reduce birth-related morbidity and mortality. This seems to be the weakest link in the reproductive chain. Among young mothers 15-24 years of age, only 34 percent indicated that they had received post-natal care (Lebanon: PAPCHILD, 1996). The highest proportion of post-natal care was provided in Beirut followed by Mount Lebanon; the lowest proportion was in Nabatieh. The proportion receiving such care increased with the level of education of the mother. Furthermore, only 34 percent of all births were followed by health care and 68 percent that did receive such care did so by consulting a physician, the remaining 32 percent consulted paramedical personnel (e.g., a midwife or nurse).

Table 7.2: Proportion of women who gave birth in the 1991-1996 period and received professional attention during pregnancy, distributed by Mohafat and education status
(Percent of total)

Mohafazat	Proportion with at least one checkup	Purpose of checkup		
		Regular	Health problem	Total
Beirut	99	74.4	25.6	100
Mount Lebanon	97.6	69.4	30.6	100
North Lebanon	71.7	69.1	30.9	100
Bekaa	95.2	62.5	37.5	100
South Lebanon	96.5	81.8	18.2	100
Nabatiyeh	92.1	48.6	51.4	100
Education status				
No degrees	73.9	57.5	42.5	100
Elementary	89.8	67.5	32.5	100
Secondary and higher	97.7	71.9	28.1	100
Total	90.6	68.2	31.8	100

Source: Lebanon: PAPCHILD (1996).

IV. HEALTH RISKS AND MOST FREQUENT HEALTH PROBLEMS OF YOUTH

1. Youth and disability

Statistics on disability worldwide are known to suffer from definitional problems. The same is obviously true in Lebanon. Estimates of disabled persons vary from 30,000 to 150,000 depending on definition and the accuracy of data. Caritas, an international non-governmental organization working in the country, estimated this number in 1981 - less than halfway through the war - at 106,400. The Population and Housing Survey (Lebanon: Ministry of Social Affairs and UNFPA, 1996) gave the figure of 30,000 and the Survey on Living Conditions (Lebanon: Central Administration of Statistics, 1998) put the number at 60,000. These wide differences reflect differences in definition and an inherent difficulty in collecting disability statistics.

In spite of the difficulty to determine the overall size of disability in the country, a number of its characteristics are nevertheless apparent from the data. For this purpose and because of the details that the data afford, there is heavy reliance in this section on the data

obtained from the Population and Housing Survey of 1996 (that give an unduly low rate of disability).

The first characteristic relates to age and gender differences in disability. As seen from Table 7.3, the disability rate of males is 62 percent higher that of females (12.3 percent compared to 7.6 percent). This gender difference is most pronounced in relation to the age group 25-44 years (and to somewhat lesser extent the age group 45-64 years) where the male rate is twice the female rate. This is likely to be partly due to the effect of the war since this age group constituted the majority of the militia members who were predominantly male.

Table 7.3: Disability rates of children, youth and total population by sex, 1996
(Number per thousand population)

Age group (years)	Males	Females	Total
0-14	5.5	4.1	4.8
15-24	10.1	6.2	8.2
Total population	12.3	7.6	10.0

Source: Lebanon: Ministry of Social Affairs and UNFPA (1996).
Note: As indicated in the text, these rates represent the lowest estimates of disability. They could in reality be up to five times higher, according to the highest estimates.

As for the types of disability, physical disability accounts for 41 percent of total (Table 7.4). This high proportion may be partly explained by the war. Physical disability is also the result of accidents and injuries, intentional and non-intentional. Data from the Youth Health Risk Behaviour Survey (Sibai-Kanaan, 1997) reveal that youth rarely or never use safety belts (72 percent), motorcycle helmets (88 percent), and bicycle helmets (97 percent). Moreover, 11 percent of traffic accidents require hospitalization. 24 percent of those hospitalized were between 0 and 18 years of age (Gerbaka, 1998). The proportion of physical disability may also be due to the relative ease to collect the data (compared to those on mental disability) and, thus, greater coverage in data collection.

The largest proportion of disabled youth is in the category of mental disability (38 percent), which is the second most common type of disability overall. The effect of the war on physical disability of youth is not greatly felt, since in 1996 the age group 15-24 years was mostly not yet born when the war began in 1975 and was only 9 to 18 years when the war ended.

"…the major type of disability overall is physical disability… For the youth age group,… the largest proportion of disabled … is in the category of mental disability, which is the second most common type of disability overall."

Table 7.4: Relative distribution of disability by type for children, youth and total population, 1996
(Percent of total)

Disability/Age Group	<15	15-24	Total
Sight	3.1	4.3	7.4
Hearing	8.7	9.4	9.7
Physical*	27.7	30.7	41.0
Mental	33.2	38.0	24.2
Multiple	10.3	5.6	6.0
Other	17.2	12.0	11.7
Total	14.2	16.4	100

Source: Lebanon: Ministry of Social Affairs and UNFPA (1996).
*Includes paralysis, limb loss and retarded limbs.

The main reason for the relatively high incidence of mental disability could be the marriages among close relatives (in addition to other less important causes such as genetically transmitted, birth accidents and the like). In 1996, some 20 percent of ever-married women were married to a close relative, usually a first cousin. This type of marriage occurs more with women of lower education. Thus, 24 percent of illiterate women were married to a relative as against 12 percent for those with at least a secondary school degree (Lebanon: PAPCHILD, 1996). Suicide and depression could also add to disability. Data on mental health of youth reveal that 15 percent of students had thought of suicide, 6 percent had a plan for suicide, and 4.7 percent had actually attempted suicide (Sibai-Kanaan, 1997). These data point to a significant problem for the youth age group.

The distribution of disability by type does not differ greatly between males and females, except for the higher occurence of disability of the physical type among males, reflecting perhaps greater male direct participation in the fighting.

A large proportion (90 percent) of the disabled appear to be in families where the head of the household works in a lower-scale occupation (such as unskilled, agricultural and street sales), (Lebanon: Ministry of Social Affairs and UNFPA, 1996). However, this very high proportion may in large part be due to the greater willingness of those in need to declare disability occurrence in their households.

2. Youth and HIV/AIDS

The first case of AIDS was recorded in the country in 1984. The government formed the National Council for Combating AIDS in 1988 and reconstituted it in 1993. It oversees a number of technical and educational committees. A National Programme for Combating AIDS was put in place. The National Programme emphasizes prevention through awareness and undertakes wide information campaigns using the written, spoken and visual media. Recognizing the importance of data in this respect, the Council began data collection in 1990 from various sources including doctors and in particular five specialists in the disease, laboratories including those dealing with prisoners, reports from medical officers at the district level and others.

According to the statistics gathered, the cumulative number of persons infected by the AIDS virus in June 1997 was 450, including 94 persons sick with the disease, and in June 1998

530 reported cases of HIV/AIDS, of which 8 percent were between 10 and 20 years of age. Many of those sick with the disease were return emigrants from Africa. The Council estimates the real number to be higher than reported and that the number of infected persons may reach 5,000 by the year 2000. Data also revealed that only 3 percent of sexually active males age 15-24 reported symptoms indicative of sexually transmitted diseases.

"…it was found that the degree of awareness [of AIDS among youth in school] is very high, almost universal, including awareness of the ways that the disease is communicated. … Nevertheless, 71 percent of the students indicated that they wanted to know more about the disease."

Recent data from the National AIDS Programme and other studies show that first intercourse occurs at a relatively early age for a sizeable proportion of youth and only two-thirds use effective protection.

The National AIDS Programme undertook two studies to determine the extent of knowledge of the disease and the ways it is communicated. The study targeted secondary school and university students (14-21 years) and young persons outside school (13-21 years). For secondary school students, it was found that the main source of knowledge of reproductive health/sexual transmitted diseases was television, and some knowledge was received from the written media and radio and conferences. The degree of awareness is very high (99.6 percent), almost universal, including awareness of the ways that the disease is communicated. 86 percent of the respondents knew what condoms were and that they are the principal means of prevention of AIDS. Many indicated that part of their knowledge comes from courses taken in school, particularly those dealing with natural sciences. Nevertheless, 71 percent of the students indicated that they wanted to know more about the disease (Lebanon: National Aids Control Programme, 1993). For youth outside school, knowledge of the disease was still widespread but less so than among the students. False knowledge about the ways the disease is communicated was also more widespread among this group (Lebanon: National Aids Control Programme, 1994).

3. Youth and addiction

Data on addictive practices in relation to cigarette smoking, alcohol and drugs are scanty and largely unreliable. Statistical dependence in this section will be mainly on two studies undertaken at the American University of Beirut covering the Beirut area in the years 1983 and 1993 (Zurayk and Armenian, 1985, and Deeb, 1997). These two studies, although limited to the Beirut area, permit some conclusions regarding trends in cigarette smoking and alcohol intake. Table 7.5 summarizes the findings of these studies in this respect. Reference is also made to a few other studies.

With regard to cigarette smoking, it is clear that in both years smoking among males was much higher than among females. This was also true for the youth age groups. There was a slight increase in the smoking habit among males between 1983-84 and 1992-93; and a strong increase among the young male population (nearly 150 percent for 18-19 years of age and more than 20 percent for 20-29 years of age). On the contrary, there was a noticeable decrease in smoking among females (very pronounced among young females). Thus, 31 percent of the young females interviewed smoked in 1983-84 and only 22 percent in 1992-93. For the entire

sample, the decrease was from 31 percent to 27 percent. Since the total includes young females, the decline in smoking among the older female age group was negligible.

A study by Baddoura (1997) revealed that, in the 15-19 year age group, 16 percent were current cigarette smokers, 21 percent had smoked before, and 34 percent had never smoked, with a male/female ratio of 1.8. The study result confirmed that, in this age group, the prevalence of smoking increases rapidly with age, to reach 6 percent at 19 years. The average onset of smoking is just under 16 years, mostly encouraged by peers. Nearly two-thirds of young smokers also reported intake of alcohol.

Table 7.5: Distribution of smokers and alcohol consumers by sex and youth age groups, 1983-84 and 1992-93

(Percent of total)

	1983-84		1992-93	
	Male	**Female**	**Male**	**Female**
Smoking				
18-19 years	11	10	27	4
20-29 years	36	31	43	22
Total Sample	43	31	46	27
Drinking				
18-19 years	10	5	18	8
20-29 years	18	13	29	13
Total Sample	27	16	34	15

Sources: Zurayk and Armenian (1984) and Deeb (1997).

"…there was a slight increase in the smoking habit among males … and a strong increase among the young male population…between 1983 and 1993… There was a noticeable decrease in smoking among females (which was very pronounced among young females)."

The proportion of males who consume alcohol increased from 27 percent to 34 percent between 1983-84 and 1992-93. For the male age group 20-29 years, the increase was considerable, from 18 percent to 29 percent. However, most striking was the rise in the proportion of the 18-19 year old males who consume alcohol (as was the case for tobacco), from 10 percent to 18 percent. It rose only from 5 percent to 8 percent among 18-19 year old females. This is undoubtedly due to the new lifestyle that is gradually being introduced among university students. But while this trend may be true, alcoholism does not seem a problem so far and at least is not so widespread among young persons to be noticeable in daily life.

Reliable statistics on drug addiction are even scantier and less reliable where they exist. A national sample survey (Hatab, 1997) covering 943 persons aged 10-24 years shows that 21 percent of those in the sample knew persons whom they considered as drug addicted persons. This seems to indicate that the problem exists although its extent remains to be determined (according to another study, illicit drug use among youth appears to be marginal, 0.3 percent admitting to being current users). The same above-referred to study showed that 39 percent knew persons who were addicted to barbiturates. This problem seems to be more acute since these types of drugs can be obtained in the country without prescription.

4. Youth and obesity

Data on obesity are limited, but prevalence appears to be quite high among the population. Using the body mass index and the percentage of body fat, 47 percent and 36 percent, respectively, of the population is considered obese (Baba, 1998). However, for the age group 11-18 years, the mean body mass index and the percentage of body fat were below the cut-off point. Data from the Health Risk Behaviour Survey among secondary school students (Sibai-Kanaan, 1997) reveal that 22 percent of the students consider themselves moderately overweighed – only 0.6 percent had a body mass index above the cut-off point. The same study also revealed that youth increasingly eat junk food, 88 percent admitted eating junk food regularly. Comforting this negative development is the fact that students still regularly eat fruits (80 percent) and salads (65 percent).

5. Youth and physical activity

Again, data on this subject are scarce. Study results indicate that the majority of adolescents live a relatively sedentary life, reporting only little regular exercise (less than three times a week, twenty minutes exercise). Most schools provide physical exercise facilities, but only 25 percent of students are member of a school team. This is of particular importance in the absence of outdoor recreational space. Moreover, the existence of expensive private clubs does not help to make sports and exercising accessible to youth. Overall, boys are less sedentary than girls. (Sibai-Kanaan, 1997). There are indications though that there is an increased interest of youth for regular practice of sports, which should be strongly encouraged by the national authorities, school directors and parents.

V. CONCLUSION

There has been a growing concern in the past decade about health issues in the country. The national health data and averages conceal important regional differences. The cost of health care is a major problem and related to it health insurance, which is far from universal, and health financing. Considerable efforts have been deployed to reinforce and modernize the health system through structuring, organization and capacity building.

In the current epidemiological transition, more attention is given to health risk behaviour, especially with the growing concern about non-communicable diseases, addiction and tobacco smoking, reproductive health and sexually transmitted diseases (including HIV).

The youth population seems to be at risk for such problems. Indeed, inadequate dietary habits and significant incidence of tobacco smoking together with rather sedentary life increase the potential threat of non-communicable diseases for the youth population in the future.

Other behaviours, such as sexual activity with relatively low utilization of modern contraceptive and preventive methods, may put the youth population at an increased risk for reproductive health problems including sexually transmitted diseases and HIV.

A positive fact is that youth (and the population in general) are generally well aware and informed about health risks and problems faced and seek assistance in a generally satisfactory manner. The large majority of women, including young married women, know about at least one method of birth control. The use of contraception is also widespread both for spacing and

limiting births. More efforts should be deployed to ensure a wider range of modern contraceptive choices. Knowledge of AIDS and the means of transmitting it are almost universal among youth and a large proportion of them wishes to know more. This has undoubtedly been a factor in limiting the spread of the disease.

Efforts geared towards health information, promotion and education, specifically targeting the youth population, have already started through various health programmes, and need to be continued and intensified. Mention is made of the information and advocacy campaigns, particularly in the areas of AIDS and AIDS prevention, smoking cessation, drug addiction and accident prevention, which have had initial salutary effects. Health education as part of the new school curriculum is being introduced in all schools.

Data on disability do not allow making firm conclusions about its extent among the population and in particular among youth, but allow deriving certain characteristics. Mental disability and physical disability are the most prevalent types. There are problems with respect to consanguineous marriages in particular and with respect to depression and suicide, on the one hand, and with respect to road accidents and injuries, on the other. Disability increases with age, hence low prevalence among children and youth compared to midlife adults. Disability is more prevalent among males than females.

Finally, additional efforts have to be made to produce reliable data on behavioural risks for related health problems, both for the youth population and the population in general. Field surveys and related analysis have to be given high priority.