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# Medair Health Project in Bekaa Valley – Lebanon

## Health and Nutrition Knowledge, Practices and Coverage Household Survey Analysis 2019

### Part 1 – Analysis Report

Project and survey funded by EU-MADAD and the Government of Canada – IHA  
via Medair UK and Tearfund Canada



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**Medair Health Project in Bekaa Valley– Lebanon**  
**Health and Nutrition Knowledge, Practices and Coverage**  
**Household Survey 2019**  
**Part 1 – Analysis Report**

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# 1. Executive Summary

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Consultancy Name:	Health and Nutrition Knowledge, Practices and Coverage Household Survey 2019 Part 1 – Analysis Report
Location and country:	Bekaa Valley, Lebanon
Project titles and donors:	Improved access to essential health care services for Syrian refugees and vulnerable Lebanese host communities living in the Bekaa Valley (1 January 2017 – 31 December 2019), Government of Canada-IHA via Medair UK and Tearfund Canada. Planned number of beneficiaries: 156,000 Strengthening Protection Mechanisms for Syrian Refugees and Vulnerable Host Communities in Jordan and Lebanon (1 January 2018 – 31 December 2019), EU-MADAD. Planned number of beneficiaries: 105,000

## Introduction and Context<sup>1</sup>

In 2019 the Syria crisis entered its eighth year with almost 1 million registered and as many as 550,000 unregistered Syrian refugees continuing to reside in Lebanon, a third of whom live in the Bekaa Valley (UNHCR Data Portal, July 2019). The protracted nature of this conflict has seen the number of refugees residing in Lebanon remain relatively stable since 2014 and the number is not expected to decrease in the immediate future. Syrian refugees make up as much as a quarter of Lebanon's total population, with 80% of these refugees being women and children. The presence of refugees in such high numbers has strained the political, economic and social stability of the country, stretching basic services and systems that have weakened the host authorities' capacity to respond to the increased needs, especially in education, water supply and healthcare. Difficult living conditions exacerbated by the weather and poor sanitation and hygiene situation in refugee settlements have a strong impact on the public health situation of the refugees and has increased the risks of outbreaks of communicable diseases.

Since 2014 Medair has supported Ministry of Social Affairs (MOSA) Social Development Centers (SDC) implementing a project to improve refugees' and affected host communities' access to primary health care (PHC) and reproductive health (RH) services. Medair, in close collaboration with MOSA, currently supports six clinics in Central, West and North Bekaa, with a focus on mother and child health, in addition to mental health and psychosocial support. Medair supports clinics through the provision of human resources, medicines, equipment, capacity building and supportive supervision to each of the clinics.

Community Health Volunteers (CHVs) in the SDC catchment area deliver a community health promotion package and have been trained on relevant health topics including exclusive breastfeeding, family planning, essential maternal and newborn care, early marriage, lice and scabies treatment and referral systems. Community midwives provide antenatal care, postnatal care and family planning. CHVs and community midwives carry out household visits, community outreach in Informal Settlements within SDC catchment areas, as well as meeting refugees and vulnerable host communities in community shared places.

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<sup>1</sup> Extracted from TOR, P1

## **The survey<sup>2</sup>**

### ***Survey Purpose***

The Knowledge, Practice and Coverage (KPC) household survey will measure standardized health and nutrition indicators for Syrian refugees and vulnerable Lebanese, in the Medair-supported SDC project areas. The purpose of the survey is to provide robust data that will inform Medair, MOSA, Ministry of Public Health (MOPH) and other NGO programming and provide a strong evidence base to current and potential donors. The analysis will serve to compare key indicators across key target groups, as well as enable a comparison with the 2016, 2017 and 2018 KPC surveys.

### ***Survey Methodology***

The survey to be conducted will use a cluster design to enable the calculation of 95% confidence interval point estimates with acceptable degrees of precision. The sampling population will be distinct for both Syrian refugees (made up of those living in informal settlements) and vulnerable Lebanese; such that two cluster surveys will be conducted.

### ***Objectives of Survey***

The objective of the survey is to collect data on key health and nutrition related indicators at the household level, including the following thematic areas:

- Health seeking behavior
- Diarrhea and respiratory tract infection management for children
- Vaccination
- Reproductive health (including antenatal care, postnatal care and family planning)
- Breastfeeding practices
- Access to reproductive and psychosocial services

## **Results**

### ***Demographics***

1,529 Syrian refugees and 758 Vulnerable Lebanese women were interviewed. All were mothers of at least one child under-five years of age, and all were married at the time of the survey. A fifth (22.2%) of vulnerable Lebanese women and almost half (45.5%) of Syrian refugee women were married before turning 18 years old. Among vulnerable Lebanese women, 6.9% of respondents reported that they were unable to read and write. This rate was much higher among Syrian refugees (38.8%).

### ***Health seeking behavior***

Over 95% of both populations had been able to access health care sometimes or each time they needed care. Vulnerable Lebanese were significantly more likely to have been able to access care each time it was needed (67.1% versus 49.1%). Syrian refugees relied heavily on SDC health clinics (78.0%), while vulnerable Lebanese were approximately equally likely to have visited an SDC health clinic (49.6%) and a private clinic (48.6%).

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<sup>2</sup> Extracted from TOR, P4

Medair supported SDC health clinics (SDCs) continue to comprise a crucial health access point for both populations, particularly among Syrian refugees. However, awareness of these facilities was limited and the reputation of these facilities should be investigated and carefully managed in the community.

### ***Non-Communicable Diseases (NCDs)***

Just under a fifth of both populations reported that one or more household members had been diagnosed with hypertension and/or diabetes. Vulnerable Lebanese women were significantly more likely to report that one or more household member had been diagnosed with diabetes (11.7%, compared to 8.7% of Syrian refugees).

Knowledge about how to mitigate risks of NCDs was limited. Over half (53.7%) of vulnerable Lebanese women could correctly cite two or more behaviors that reduce the risk of NCDs, compared to under a third of Syrian refugees (30.4%). Syrian refugees were significantly less likely to identify each one of the risk factors accepted in the survey, with the exception of alcohol consumption. The top three strategies for NCD risk reduction identified by both groups were reducing sugar and sweets; reducing anger and stress and eating healthy foods. Given the high prevalence of smoking and overweight in these populations, it is concerning that these factors were mentioned by very few respondents.

### ***Vaccinations***

Vaccination rates in both populations were low and fell far short of the threshold for herd immunity, placing the project area population at risk of disease outbreak. Vaccination rates were particularly low among Syrian refugees. Less than one third of vulnerable Lebanese children and less than a quarter of Syrian children aged 12 months to five years had received the full complement of age-appropriate vaccines.

### ***Childhood illnesses: Acute respiratory illness (ARI)***

Syrian refugees were significantly more likely to have experienced fast or difficult breathing in the two weeks prior to the survey (17.9 %) than their vulnerable Lebanese counterparts (10.6%). Few children who had cough or fast breathing were taken to an appropriate health facility or provider for the symptoms of acute respiratory infection (ARI), defined as a doctor, a clinic or a hospital, excluding SDC health clinics (11.5% of Syrian refugees and 25.6% of vulnerable Lebanese children). More children were found to have accessed care but rates of treatment seeking remain low at less than half of each population sample. Appropriate treatment protocols for the treatment of ARIs, specifically the use of antibiotics, are not widely observed. Cough drops were the most common treatment for ARI among both populations, while antibiotics were used by approximately a third of each population.

### ***Childhood illnesses: Diarrhea***

Diarrhea remains highly prevalent, with over one third of Syrian refugees (36.5%) and one fifth of vulnerable Lebanese (21.6%) reporting that one or more of their children under-five years experienced diarrhea in the two weeks prior to the survey. Although treatment seeking is the norm and generally occurs within the first two days of illness, appropriate treatment protocols are rarely observed. Just 3.4% of Syrian refugees and 4.3% of vulnerable Lebanese received both ORS and zinc. Antibiotics, which are not indicated for the treatment of diarrhea except in specific circumstances were found to be over-prescribed for diarrhea and were the most common treatment for this illness.

### ***Reproductive health***

Both vulnerable Lebanese and Syrian refugee women demonstrated high rates of awareness of the reproductive health services available and where these services can be accessed. Almost nine in ten respondents were able to identify RH services available in their community; and a similar proportion identified where they could access RH services.

Over 80% of vulnerable Lebanese women and over 75% of Syrian refugees reported that they would be able and comfortable accessing such services. While rates of comfort in accessing these services was comparable between groups (95.5% among Syrian refugees and 96.2% among vulnerable Lebanese women), fewer Syrian women felt able to access these services (76.4% compared to 84.8%). Financial constraints appear to be the primary factor in the inability to access these services.

### ***Antenatal Counselling (ANC)***

Two-thirds of mothers of children under-two years of age had at least four antenatal visits when they were pregnant with their youngest child and the vast majority of women received ANC in the first trimester and last month of pregnancy. However, significant discrepancies between populations were observed: Syrian refugees were less likely than vulnerable Lebanese women to receive four ANC contacts (61.6% versus 78.6%), to receive ANC in the first trimester (84.6% versus 92.5%), and to receive ANC in the last month of pregnancy (87.8% versus 92.7%).

For those who participated in an ANC session, almost all were facilitated by a doctor. However, Syrian refugees were less likely than vulnerable Lebanese women to have received ANC from a doctor (95.7% versus 99.2%).

As with other health services, there was a clear reliance among Syrian refugees on SDC health clinics (54.8%), while vulnerable Lebanese demonstrated a preference for private clinics (83.4%).

### ***Delivery***

Despite generally favoring SDC health clinics and private clinics respectively, nine in ten vulnerable Lebanese (91.8%) and eight in ten Syrian refugees (81.4%) delivered their youngest child in hospital. This difference is significant and reflects a concern among Syrian refugees who did not deliver in hospital that the service would be too expensive or that they would be unable to reach the hospital due to transport limitations or a rapid labor.

Nine in ten women who delivered in hospital paid to do so, with Syrian refugees significantly more likely to have paid for their hospital stay. However, Syrian refugees generally paid a lower amount than vulnerable Lebanese.

Consistent with the high rates of hospital delivery, 97.5% of vulnerable Lebanese reported that a doctor assisted with the birth of their youngest child. Significantly fewer Syrian refugees reported assistance from a doctor. Midwives were the second most common provider of assistance during childbirth for both populations, while traditional birth attendants and relatives/ friends were less frequently relied upon.

The rate of Caesarian section delivery was very high in both populations (29.8% among Syrian refugees and twice as high (59.0%) among vulnerable Lebanese).

### ***Postnatal Care (PNC)***

The WHO recommended standard of postnatal care is not being met in either of the populations studied in this survey. Less than half of all mothers of children under-two years of age reported that they had received a post-partum visit from an appropriate trained health worker within two weeks after birth of their youngest child; and just 16% reported having received at least three postnatal contacts.

### ***Family Planning***

High rates of unplanned pregnancy in the study population (43.6% and 33.0% the last pregnancy of Syrian refugees and vulnerable Lebanese respectively) are coupled with low rates of modern contraceptive use (54.2% and 41.8%). Breastfeeding was inexplicably commonly reported as a reason for not using any method to delay pregnancy, requiring further investigation.

### ***Mortality in pregnancy***

5.9% of Syrian refugees and 6.7% of vulnerable Lebanese women who had a sister reported that one or more of their sisters had died just after delivering a baby in Lebanon. This rate suggests much higher maternal mortality than Unicef estimates for Syria or Lebanon, both of which are considered to have “very low” rates of maternal mortality.

Although awareness of the WHO recommendation that pregnancies should be spaced at least two years apart was low, particularly among Syrian refugees (42.1%), the majority of women were aware of at least one risk of getting pregnant within two years of the last delivery (76.0% of vulnerable Lebanese and 69.4% of Syrian refugees).

### ***Breastfeeding practices***

Breastfeeding rates in the study population are troublingly low. Although eight in ten vulnerable Lebanese mothers and nine in ten Syrian refugees reported that they had breastfed their youngest child, just two in three mothers in both samples reported breastfeeding within the first hour of birth; and just a quarter of vulnerable Lebanese and a third of Syrian refugees with children under six months reported that they were exclusively breastfeeding. The reasons given for not observing recommended breastfeeding practices (particularly a perceived lack of milk in the breasts) hint at a worrisome lack of support for women to initiate, establish and maintain appropriate breastfeeding practices.

Syrian refugees generally demonstrate more appropriate breastfeeding practices than vulnerable Lebanese: they are more likely to have breastfed their youngest child, to have initiated breastfeeding within the first hour of birth and to have continued breastfeeding for more than six months.

### ***Child registration***

6.1% of Syrian refugees reported that they did not receive a birth certificate for their youngest child. Over three quarters of mothers who had received birth certificates reported having received this document from the hospital.

### ***Psychosocial support (PSS) services***

The survey found high rates of psychological distress, with over three quarters (75.7%) of Syrian refugees and over two thirds (69.5%) of vulnerable Lebanese agreeing that in the past six months, they or someone they knew felt “sad, stressed, or under pressure.” Yet knowledge of available PSS services was limited, with less than a third of Syrian refugees and less than a quarter of vulnerable Lebanese able to identify PSS available in their communities ( $p = 0.03$ ).

Syrian refugees were significantly more likely to have talked to a trained service provider about PSS in the 12 months prior to the survey (17.1% of versus 6.1%;  $p < 0.01$ ). However, Syrian refugees were significantly less likely than vulnerable Lebanese to feel that they were able to access these services (49.4% versus 57.7%). Cost and a preference to keep psychosocial matters personal were commonly cited as reasons for not having engaged in discussions of PSS with a trained service provider, and a preference for dealing with sadness, stress or pressure by themselves or by reaching out to friends or family was evident in both populations.

## Conclusion

The 2019 KPC study provides important insight into the knowledge, attitudes and practices of Syrian refugees and vulnerable Lebanese in the Bekaa Valley. The findings demonstrate that both Syrian refugees and vulnerable Lebanese continue to face complex social, financial and logistical constraints in health care access, and that avoidable health risks persist for both populations. The need for improved access to basic health services and outreach programs persists.

## Recommendations

1. **Redouble efforts to reduce early marriage.** The high rates of early marriage observed in this KPC, particularly among Syrian refugees (45.5%), demand urgent action. With an understanding of cultural norms, sensitive communication to delay early marriage should be delivered across a range of delivery platforms, in addition to Medair's current commendable CHV outreach program. The delivery platforms may include (but should not be limited to) health centres, secondary schools, mass media and through religious and community leaders.
2. **Identify and target health decision makers and influencers within families and communities.** The high rates of early marriage observed in this KPC are indicative that gender inequity may be entrenched in these populations. This inequity may manifest in health care decision making, resulting in male family members having the primary say in matters related to finances, health care-seeking behavior and the use of family planning methods. Targeting women exclusively, even with regard to women's reproductive health, may therefore be inadequate. In addition to continuing to provide education on the risks of early marriage, Medair should consider investigating who in the family makes health decisions and who influences these decisions. Where possible, the proposed SBCC strategy should take a whole of family approach with a particular focus on identified decision makers and influencers.
3. **Raise the profile of SDC health clinics.** SDC health clinics continue to provide an important point of contact with the health system, particularly for Syrian refugees. Yet the survey indicated that 44.5% of Syrian refugees and 38.5% of vulnerable Lebanese respondents who did not visit a Medair SDC health clinic had not heard of these SDC health clinics. Consideration should therefore be given to raising the awareness of SDC health clinics through channels including (but not limited to) CHVs, religious leaders, community leaders and other community service providers.
4. **Reduce the cost of services.** Cost was a commonly cited barrier to health care access, preventing survey respondents from accessing health care generally; delivering in hospital and receiving PSS. Awareness of where and how health services can be affordably accessed should be raised; and consideration should be given to developing strategies and partnerships to reduce defray costs (for example, social insurance and other contextually appropriate forms of social protection).
5. **Ensure that all information, education and communication (IEC) materials rely on graphics.** In addition to being well focus tested and simple, the high rates of illiteracy, particularly among Syrian refugees (38.8%) requires that all IEC materials and tools developed rely on graphics and few words. The use of videos and other forms of verbal media may be useful mechanisms to convey important health messages.



6. **Scale up NCD education.** Just under 20% of respondents reported that one or more of their family members had been diagnosed with hypertension and/or diabetes and knowledge of NCD risk factors was found to be limited (particularly among Syrian refugees). National data for both Syria and Lebanon demonstrates high rates of smoking among these populations; yet just 8% of vulnerable Lebanese women and 2.5% of Syrian refugees identified smoking cessation as an NCD reduction strategy. Similarly, few respondents identified “reduce weight if overweight,” yet over two thirds of Lebanese adults and over six in ten Syrian adults have been found to be overweight. Targeted, context-specific IEC relevant to the prevention and control of NCDs should therefore be prioritized and provided during contacts with the health services and other community based delivery platforms
7. **Raise awareness of the importance of seeking advice and treatment for the symptoms of ARI.** Less than 50% of each population samples accessed health care when their child had symptoms of ARI. This result is much lower when SDC health clinics are not included in the list of appropriate health care facilities (1.5% of Syrian refugees and 25.6% of vulnerable Lebanese). As ARIs can lead to pneumonia, a potentially fatal condition and a leading global cause of child mortality, strategies to promote treatment seeking for these symptoms should be developed. These strategies should be based on a childhood illness-specific behavioral insights or KAP study, designed to elicit the underlying causes of the low rates of treatment seeking.
8. **Investigate the under-prescription of antibiotics for ARI.** WHO recommends the use of inexpensive, widely available and effective oral antibiotics for the treatment of ARI. However, only approximately one third of each population group with a child who had ARI symptoms accessed antibiotics. Cough drops and pain killers, which may treat the symptoms but do not treat the cause of ARI were more commonly used. While this is likely related to the low rates of health care access for ARI and it is possible that health workers conduct medical examinations and appropriately determine that antibiotics are not indicated, investigation of the potential under-prescription of antibiotics for ARI should be undertaken, starting with obtaining an in-depth understanding of the prescribing practices in the locations at which ARI treatment is generally sought (SDC health clinics, private clinics and pharmacies) .
9. **Identify and address the causes high rates of diarrhea.** Over one third of Syrian refugees (36.5%) and one fifth of vulnerable Lebanese (21.6%) reported that any of their children under-five years experienced diarrhea in the two weeks prior to the survey. These rates are alarmingly high. While the project currently seeks to improve the treatment of diarrhea, consideration should be given to diarrhea prevention activities, following a comprehensive investigation of the specific causes of this illness among these populations.
10. **Investigate the underuse of ORS and zinc and the over-prescription of antibiotics for diarrhea.** Contrary to WHO and UNICEF recommendations, just 3.6% of children with diarrhea received ORS and zinc per WHO guidelines, while antibiotics are the most common treatment for diarrhea in both populations. These sub-optimal treatment patterns persist despite high rates of treatment seeking. A study of the causes of the low rates of ORS and zinc use should be initiated, along with the over-prescription of antibiotics. The study should comprise an audit of health clinics, SDC health clinics and pharmacies to determine prescribing practices and preferences as well as interviews with parents and care givers to determine their treatment preferences and willingness to utilize ORS and zinc. An appropriate intervention should be developed based on the findings of this study.
11. **Review existing ANC services against recently updated global recommendations.** The KPC survey investigated whether mothers had received at least four antenatal visits when they were

pregnant with their youngest child, and found that just this standard of care had been met for just two thirds of respondents (78.6% of vulnerable Lebanese and 61.6% of Syrian refugees). It follows that far fewer received the recently updated WHO recommendations, which call for at least eight ANC contacts. Medair should therefore review existing services (including facilities, staffing and training) to ensure capacity to offer women at least eight antenatal contacts is available; sensitize communities to the pertinent recommendations outlined in WHO recommendations on antenatal care for a positive pregnancy experience (2016); and encourage and facilitate women to access at least eight ANC contacts.

12. **Investigate the high rates of caesarean sections.** The rates of caesarean section far exceed the WHO-recommended threshold of 15%, among both vulnerable Lebanese (59.0%) and Syrian refugees (29.8%). Given the risks associated with this procedure, investigation into the basis on which these surgeries are performed is warranted. This should include a behavioral insights methodology to identify community practices and preferences, as well as the attitudes and practices of health care providers.
13. **Investigate barriers to post-natal care.** Less than half of all mothers of children under-two years of age reported that they had received a post-partum visit from an appropriate trained health worker within two weeks after birth of their youngest child. Only 16.0% of mothers of children under-two years in the sample said that such a check had occurred at least three times. Syrian refugees had much lower rates of PNC access, but the reasons for low rates of PNC contacts were unclear. As PNC is among the most important interventions for both child and maternal health, further investigation is required to identify the reasons behind the failure to meet the recommended standard of PNC.
14. **Promote early initiation of breastfeeding.** WHO recommends that infants are breastfed within the first hour of birth. However, the KPC revealed that a third of infants were not breastfed within the first hour of birth. Also that a fifth of Syrian Refugees and an eighth of vulnerable Lebanese women who did not initiate breastfeeding in the first hour reported that medical providers had not given them their baby to breastfeed in the first hour; and a worrisome perception that there was no milk in the breasts (and therefore breastfeeding should not be initiated) was common. Medair's existing breastfeeding education programs should be reviewed in light of these findings, to ensure that medical staff and birth assistants serving these communities are trained to encourage, facilitate and support early initiation of breastfeeding wherever possible. Furthermore, that women and their families and communities are made aware of the global recommendations and the evidence to support this important practice.
15. **Restore the practice of exclusive breastfeeding for six months among Syrian refugees.** WHO recommends that infants should be exclusively breastfed for the first six months of life. However, rates of exclusive breastfeeding were found to be very low among both populations studied and World Bank estimates the prevalence of exclusive breastfeeding of infants under six months in Syria (2009) are much higher than those observed in the KPC. This raises concern that conflict and displacement has resulted in a loss of a previous cultural norm to exclusively breastfeed among Syrian refugees. This is consistent with global evidence that humanitarian emergencies and refugee situations result in disruption of breastfeeding practices, for example through the loss of support systems. In addition to supporting vulnerable Lebanese to increase the rate of exclusive breastfeeding, Medair should carry out in-depth behavioral insight research to confirm whether these practices have indeed been lost among Syrian refugees while tailoring breastfeeding support systems (such as mother support groups) to restore the globally recommended practice of exclusive breastfeeding for the first six months.

16. **Raise demand for family planning tools and services.** Although few women in the survey reported that they had sought family planning services and not been able to access them, there was a high rate of unplanned pregnancy among both Syrian refugees and vulnerable Lebanese (43.6% and 33.0%). This was reflected in low rates of use of modern contraceptives. “Breastfeeding” was commonly cited as a reason why women were not using modern contraception methods. This suggests an underlying incorrect belief that breastfeeding protects against pregnancy beyond the period of exclusive breastfeeding and/or a misapprehension that methods to delay pregnancy are incompatible with breastfeeding. A full analysis of why women do not use modern contraceptives, including their knowledge, attitudes and beliefs, as well as those of their husbands and other family members, should be undertaken. Steps should be taken to correct any misunderstandings, as well as educate about the dangers of early pregnancy and inadequate birth spacing, in order to raise demand for modern contraceptives and other family planning tools and services.
17. **Improve vaccination rates.** The vaccination coverage rate in the survey population falls short of herd immunity thresholds; less than a third of vulnerable Lebanese and less than a quarter of Syrian refugee children had received the full complement of age-appropriate vaccinations. While the reason behind the low rates of vaccination were not uncovered, it is clear that the Bekaa Valley is a potential flash point for disease outbreak. Vaccination campaigns should therefore be urgently scaled up to reach as many of the children of both nationalities as possible.
18. **Raise awareness of the importance of (and right to) a birth certificate among Syrian refugees.** Over 6% of Syrian refugees reported that they did not have a birth certificate for their youngest child. Birth certificates are particularly critical for refugees as they allow children to confirm or acquire nationality and protect them from statelessness. The reason birth certificates are not universal among this population should be investigated and if necessary, refugees should be given the knowledge and tools needed to assert their right to these documents. Concurrently, CHV, doctors, nurses, midwives, birth attendants, community leaders and religious leaders, as well as any other influential person who are in contact with pregnant women and their families, should be trained to advise and assist Syrian refugees to access birth certificates.

## Core impact indicators

Theme	Indicators	Vulnerable Lebanese	Syrian refugees
<b>Socio-demographic info</b>	% of mothers of children ages under-5 years who got married before the age of 18 years (early marriage).	22.2%	45.5%
	% of mothers of children ages under-5 years who do not know how to write and read.	6.9%	38.8%
	% of households (HH) with a crowdedness index above 1.5.	NA	NA
<b>Health care access general</b>	% of mothers of children aged under-5 years of age in project area who went to qualified health services when they needed medical services.	99.4%	95.2%
	% of mothers of children aged under-5 years of age in project who visited any Medair supported SDC during the 12 months prior to the survey.	41.4%	49.8%

Theme	Indicators	Vulnerable Lebanese	Syrian refugees
<b>Reproductive Health (RH) services</b>	% Women in the targeted communities who correctly identify available RH services.	89.8%	88.7%
	% WGMB in the targeted communities who correctly report where to access RH services.	89.2%	87.6%
	% Women in the targeted communities who report that they would be comfortable and able to access these (RH) services as needed.	84.8%	76.4%
	% of mothers of children under-5 years who report accessing RH services in the 6 months prior to the survey.	40.0%	41.6%
	% of mothers of children under-5 years receiving RH services who report satisfaction with support provided.	97.0%	97.3%
<b>ANC visits</b>	% of mothers of children under-two years of age who had at least 4 comprehensive antenatal visits when they were pregnant with their youngest child.	78.6%	61.6%
	% mothers of children aged 0-23 months who had their first ANC visit within the first 3 months of pregnancy.	92.5%	84.6%
	% mothers of children aged 0-23 months who had their last ANC visit less than 1 month before delivery.	92.7%	87.8%
<b>Delivery</b>	% of mothers of children under-5 years who delivered their youngest child at hospital.	91.8%	81.4%
	% of mothers of children under-5 years who delivered by caesarian section.	59.0%	29.8%
	% of mothers of children aged 0-23 months who received a health booklet during their stay at hospital.	NA	NA
	% of mothers of children aged 0-23 months who stayed at 24h in the hospital after delivery.	41.3%	16.8%
<b>Postnatal Care (PNC)</b>	% of mothers of children under-two years of age who received a post-partum visit from an appropriate trained health worker within two weeks after birth of their youngest child.	54.0%	38.3%
	% of children under-two years of age who were examined by an appropriately trained health worker 3 days after delivery.	3.9%	3.7%
	% of mothers of children under-two years of age who received at least 3 post-partum visits within 40 days after delivery.	20.4%	14.2%
<b>(Exclusive) breastfeeding</b>	% of infants 0-6 months who are exclusively breastfed (calculation method 1).	25.4%	32.8%
	% of infants 0-6 months who are exclusively breastfed (calculation method 2).	6.6%	11.1%
	% of mothers of children 7-23 months who breastfed their child within 1 hour after delivery.	66.5%	68.3%
<b>Family Planning (FP)</b>	% of mothers of children under-5 years who report discussing FP with a trained service provider in the 12 months preceding the survey.	22.0%	21.3%
	% of mothers of children 0-23 months who are using a modern contraceptive method.	41.8%	54.2%
	% of mothers of children 0-23 months who know at least one risk of	76.0%	69.4%

Theme	Indicators	Vulnerable Lebanese	Syrian refugees
	getting pregnant within 2 years of last delivery.		
	% of women of children 0-23 months who know what is the best birth spacing.	60.9%	42.1%
<b>Vaccinations</b>	% of children aged 12 months- 5 years who are vaccinated for measles in clinics' coverage area	57.5%	44.5%
	% of children aged 1- 5 years who are vaccinated for polio in clinics' coverage area	79.3%	72.1%
	% of children aged 1- 5 years who are vaccinated for Diphtheria and Pertussis and Tetanus (DPT) in clinics coverage area	78.6%	68.4%
	% of children age 12-23 months who received age appropriate vaccination at time of survey	32.5%	23.6%
<b>Treatment of sick child</b>	% of children under-5 years that had fast or difficult breathing in the last 2 weeks	10.6%	17.9%
	% of children under-5 years with fast or difficult breathing for whom advice or treatment was sought after more than 24h of fast or difficult breathing, in the last 2 weeks	15.0%	15.3
<b>Treatment of children with Acute Respiratory Infection (ARI)</b>	% of children under-5 years with fast or difficult breathing for whom advice or treatment was sought from an appropriate health facility or provider in the last 2 weeks	25.6%	11.5%
	% of children under-5 years with fast or difficult breathing or cough by type of treatment in the last 2 weeks (inclusive of antibiotics)	[See results]	[See results]
<b>Treatment of children with diarrhea</b>	% of children under-5 years with diarrhea receiving ORS and zinc supplementation	4.3%	3.4%
<b>Prevalence of diarrhea</b>	% of children under-5 years that experienced diarrhea in the last 2 weeks	21.6%	36.5%
<b>Non Communicable Diseases (NCD)</b>	% of mothers of children under-5 years who reported having at least one HH member with NCD	18.6%	18.8%
	% of women who know 2 or more ways to reduce the risk of NCDs	53.7%	30.4%
<b>Psycho Social Support (PSS) services</b>	% women in the targeted communities who correctly identify available PSS services	29.4%	35.9%
	% women in the targeted communities who correctly report where to access PSS services	48.9%	35.8%
	% of mothers of children under-5 years who report discussing PSS with a trained service provider in the 12 months preceding the survey	6.1%	17.1%
	% women in the targeted communities who report that they would be comfortable and able to access these (PSS) services as needed	53.7%	46.6%
	% of mothers of children under-5 years who report accessing PSS support services in the 6 months prior to the survey	2.8%	3.2%
	% of mothers of children under-5 years receiving PSS services who report satisfaction with support provided	95.0%	100%
<b>Child registration</b>	% of children under-5 years without birth certificate	NA	6.1%
<b>Mortality related to pregnancy</b>	% of women's sisters who died due to problems related to pregnancy	6.7%	5.9%

End of Executive Summary

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# Report Approval

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Data Collection 23 September to 4 October 2019  
Dates:

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Date Submitted: 3 December 2019

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## Disclaimer

The themes of this report have been developed around the parameters of the project's own design objectives, and the consultancy terms of reference. The findings and recommendations are based on the collection of monitoring documentation, survey responses of project beneficiaries and input from Medair staff. The consultant has attempted to triangulate data within the limits of the time and resources made available by the commissioning organisation. Nevertheless, the consultant shall not be liable for the accuracy of reporting data provided by the commissioning organisation or opinions expressed by stakeholders. The commissioning organisation is responsible for its own assessment and decisions about the applicability of conclusions and recommendations expressed in the report. The consultant will not be held responsible for decisions reached by the commissioning organisation's management, nor the manner in which recommendations are implemented.

## Ethics Declaration

All research was conducted in an ethical manner. This is to say that all participation in surveys, were voluntary. Voluntary involvement was assured by a scripted verbal delivery of a clear explanation of the survey being conducted.

Informants' anonymity and confidentiality has been ensured. While consent was sought to ask for the respondents' name and phone number for post-survey quality checks, these details have been removed from the full dataset following the successfully contacting of a sample of respondents.

No material inducement was offered to any interviewees.

## Declaration of Conflicts of Interest

The independent consultant data analysts are not and never have been employees of Medair and have no familial or financial relationships with any Medair staff other than the contractual relationship in relation to this consultancy. We declare no conflict of interest exists.

Medair staff designed the survey tool and conducted data collection.

# Glossary of Acronyms

The following acronyms and terms are used in this report.

AES	Australian Evaluation Society
ANC	Antenatal Counselling
ARI	Acute Respiratory Infection
CBO	Community Based Organization
CHVs	Community Health Volunteers
CMW	Community Midwife
DPT	Diphtheria and Pertussis and Tetanus
EBF	Exclusive Breastfeeding
EU-MADAD	European Union -
FP	Family Planning
Government of Canada-IHA	International Humanitarian Assistance
GP	General Practitioner
HFPH	Healthy family peaceful house
HH	Households
HHS	Household Survey
IAMP 56	Inter-Agency Mapping Project
IBM SPSS	A statistical analysis software package produced by IBM
IS	Informal Settlement
ITS	Informal Tented Settlement
KPC	Knowledge, practice, coverage
MMR	Measles, Mumps, Rubella
MoPH	Ministry of Public Health
MoSA	Ministry of Social Affairs
MS	Microsoft
MSF	Médecins Sans Frontiers/Doctors without borders
NCD	Non-Communicable Diseases
NGO	Non-Governmental Organization
ODK	Open Data Kit
PNC	Postnatal care
PSS	Psycho Social Support
PTSD	Post-traumatic stress disorder
RH	Reproductive Health
SDC	Social Development Centre
STI	Sexually Transmitted Infections
ToR	Terms of Reference
UNCEF	United Nations Children Fund
UNHCR	United Nations High Commission for Refugees
VaSyR	Vulnerability Assessment of Syrian Refugees in Lebanon
WHO	World Health Organization
WRC	World Relief Canada
SBCC	Social and behavior change communications

## 2. Project Background and Context<sup>3</sup>

---

### The Background

In 2019 the Syria crisis entered its eighth year with almost 1 million registered and as many as 550,000 unregistered Syrian refugees continuing to reside in Lebanon, a third of whom live in the Bekaa Valley (UNHCR Data Portal, July 2019). The protracted nature of this conflict has seen the number of refugees residing in Lebanon remain relatively stable since 2014 and the number is not expected to decrease in the immediate future. Syrian refugees make up as much as a quarter of Lebanon's total population, with 80% of these refugees being women and children. The presence of refugees in such high numbers has strained the political, economic and social stability of the country, stretching basic services and systems that have weakened the host authorities' capacity to respond to the increased needs, especially in education, water supply and healthcare. Difficult living conditions exacerbated by the weather and poor sanitation and hygiene situation in refugee settlements have a strong impact on the public health situation of the refugees and has increased the risks of outbreaks of communicable diseases.

### The Project

Since 2014 Medair has been supporting Ministry of Social Affairs (MOSA) Social Development Centers (SDC) implementing a project to improve refugees' and affected host communities' access to primary health care (PHC) services. Medair, in close collaboration with MOSA, currently supports six clinics in Central, West and North Bekaa, with a focus on mother and child health and reproductive health, in addition to mental health and psychosocial support. Medair supports clinics through the provision of human resources, medicines, equipment, capacity building and supportive supervision to each of the clinics.

Community Health Volunteers (CHVs) in the SDC catchment area deliver a community health promotion package and have been trained on relevant health topics including exclusive breastfeeding, family planning, essential maternal and newborn care, early marriage, lice and scabies treatment and referral systems. Community midwives provide antenatal care, postnatal care and family planning. CHVs and community midwives carry out household visits, community outreach in Informal Settlements within SDC catchment areas and as well as meeting refugees and vulnerable host communities in community shared places.

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<sup>3</sup> Adapted from Terms of Reference (TOR)

### 3. Purpose and Scope of the Consultancy<sup>4</sup>

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The Knowledge, Practice and Coverage (KPC) household survey measured standardized health and nutrition indicators for Syrian refugees and vulnerable Lebanese in the Medair-supported SDC project areas. Medair conducted its first KPC survey of the Syrian refugee and vulnerable Lebanese population residing in Lebanon in November 2015 and has repeated the survey each year since, with the purpose of providing *“robust data that will inform Medair, MOSA, Ministry of Social Affairs (MOPH) and other NGO programming and provide a strong evidence base to current and potential donors.”*

The purpose of the consultancy is two-fold:

1. **Part 1** is to analyze and report on the data collected from the household survey (see ‘Information on the survey’ section below) and make recommendations on current and future programming for Medair, MOSA, Ministry of Public Health (MoPH) and other Non-Governmental Organizations (NGOs). The analysis and reporting will be based on, but not restricted to, key health and nutrition related indicators, including the following thematic areas:

- Health seeking behavior
- Diarrhea and respiratory tract infection management for children
- Vaccinations
- Reproductive health (including antenatal care, postnatal care and family planning)
- Breastfeeding practices
- Access to reproductive and psychosocial services

The following report fulfils this purpose.

2. **Part 2** is to carry out a proxy comparative analysis of the 2019 dataset, with those of 2018, 2017 and 2016, to contextually identify and explore statistically significant trends between the four surveys and propose ways forward, including areas for qualitative research, for Medair, MOSA, MoPH and other NGOs.

This purpose is fulfilled in a separate report: *the 2016 to 2019 Comparison Report*.

### 4. Objective of the Report<sup>5</sup>

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This report provides analysis and synthesis of the data collected in the household survey and makes recommendations on current and future programming for Medair, MOSA, Ministry of Public Health (MoPH) and other Non-Governmental Organizations (NGOs). The analysis will serve to compare key indicators across key target groups.

### 5. Methodology

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<sup>4</sup> Adapted from consultancy ToR

<sup>5</sup> Adapted from consultancy ToR

## 5.1 Document Review

Desktop review was performed on:

- Medair's project design documents
- Previous survey reports
- The questionnaire used by Medair to collect the data under review in this report
- External reports and surveys related to Lebanon's health care system and the Syrian refugee response
- The global evidence on health promotion, health seeking and health behaviors
- International recommendations for the protection, promotion and support of health behaviors
- Global and national data from Syria and Lebanon

## 5.2 Household Survey<sup>6</sup>

The survey was conducted using a cluster design to enable the calculation of 95% confidence interval point estimates with acceptable degrees of precision. The sampling frames were distinct for both Syrian refugees (made up of those living in informal settlements) and vulnerable Lebanese, such that two cluster surveys were conducted.

Target population				Clusters x cluster respondents	Planned household respondents	Actual respondents
Syrian refugees (in Informal Settlements)				60 x 25	1,500	1,523
Vulnerable Lebanese				30 x 25	750	758
TOTAL					2,250	2,281

The sampling frames were **Syrian refugees** (made up of those living in informal settlements only) and **vulnerable Lebanese** in the catchment areas of the 6 Medair-supported SDCs (Talia, Brital, Marj, Kabelias, Jib Janine and Rafid). For further details on the clusters selected, see the Annex below. The respondents were women of child bearing age with children under the age of 5, or their care givers. The data was collected by approximately 70 enumerators, trained and supervised by Medair staff, using tablets and ODK (Open Data Kit) data collection software. A total of 2,250 questionnaires were planned to be completed. Data collection achieved 2,281 valid responses, exceeding the minimum required. Required responses were exceeded for both populations.

## Sampling approach<sup>7</sup>

General cluster selection procedure:

### 1. Syrian refugees:

- a. Using IAMP 63, the number of Syrian refugee households living in Informal Tented Settlements (ITS) within the coverage area of the 6 Medair-supported SDCs (23 Cadasters) was broken down by Cadaster and ITS and a cumulative population list was made.

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<sup>6</sup> Adapted from consultancy ToR

<sup>7</sup> Extracted from consultancy ToR

- b. Based on the total household population and the required sample size, an interval was calculated for 60 clusters, the starting point for which was selected by a random number.
- c. The cluster locations (ITS/Pcodes) were then selected using the interval through systematic random sampling.
- d. At the field level, the 25 household respondents were chosen firstly from within the selected ITS. Where there are not enough households with mothers (or care givers) with children under-5, the next nearest ITS were located in order to reach the required cluster sample size.

## **2. Vulnerable Lebanese:**

- a. In the same way that IAMP 63 was used for Syrian refugees in ITS, a cumulative population list of Lebanese was made by household per Cadaster. Starting with the 2018 KPC survey Municipality statistics on the number of Lebanese living in the Cadaster and the proportion of vulnerable Lebanese among them, additional sources were used to verify these numbers. These included a) updated Municipality data (through a phone survey), b) Wikipedia statistics, and c) staff local knowledge. The revised list was then used to conclude a final 2019 version of Cadaster populations of Lebanese and vulnerable Lebanese.
- b. Based on the total vulnerable Lebanese household population (from across the 23 Cadasters), an interval was calculated for 30 clusters, the starting point for which was selected by a random number.
- c. The cluster locations (Cadasters) were then selected using the interval through systematic random sampling.
- d. At the field level, where there is only one cluster in the Cadaster, the enumerator teams were directed either by the CBOs/Local NGOs that are partners of Medair, or by the Municipality, to a starting point in the Cadaster that contains high numbers of vulnerable Lebanese. After the first household has been identified, snowball sampling was used to reach the 25 required households per cluster.
- e. Where there is more than one cluster in the Cadaster, the same approach was used, but the Cadaster were delineated into the number of clusters through natural geographical boundaries, such as roads, rivers or urban areas.

## **5.3 Data analysis**

### **Data cleaning**

The data consultant analyst assumed that the same approach to data cleaning was taken as for the 2018 survey: Firstly, to ensure participants' anonymity, all identifying and contact details of respondents were removed by Medair staff overseeing data collection before sharing with the consultant. To remove invalid responses, surveys with short duration (less than 11 minutes) were removed as were any who reported a youngest child older than 5 years. These were picked up during the course of ongoing data cleaning while the survey was taking place so that the teams responsible had to replace these households by collecting additional data. All free text responses in Arabic were translated into English.

The consultant analysts also removed one entry from a respondent who was not the child's mother but a caregiver.

### **Analysis**

The data was analysed using IBM SPSS (Version 25) Complex Samples module, employing analysis plans that catered for the cluster sampling design. Since most of the data were categorical variables, the data was summarised using crosstabulations, summary statistics includes percentages of the

total falling into each category, unweighted count and 95% confidence intervals. The chi-square test for independence was used to determine statistical significance of the difference between the two groups: vulnerable Lebanese and Syrian refugees. All the working files have been supplied to Medair: datasets, analysis scripts, analysis plans and outputs.

Most data analyses outputs were exported to MS Excel to enable the generation of reader-friendly tables and graphs used throughout the report.

## 5.4 Limitations of the survey

**Separation of survey designers and analysts.** Medair monitoring and evaluation staff and health programme staff designed the survey questionnaire and oversaw data collection. Independent consultants were hired to analyse and interpret the data. This approach guarantees independence and objectivity of interpretation of the data. However, it opens potential for gaps in understanding of the intention of some questions and expected interpretation approach.

**Modification of some questions compared to previous years' surveys.** Some themes were surveyed this year using different question approaches to previous years. This reduced year-on-year comparability.

**Some responses had incomplete data.** Data/responses were missing for some questions. As a result, three respondents were excluded from the analysis, to avoid blank cells being misinterpreted as responses representing 'zero'.

**Population based survey** with no variable to allow for comparison between individuals benefiting from awareness raising sessions, thus not allowing to track Medair contribution in increasing knowledge to health related issues among project direct beneficiaries.

## 6. Results

Summary of core indicator targets: Socio-demographics

**% of mothers of children ages under-5 years who got married before the age of 18 years (early marriage)**

2019 result:	Vulnerable Lebanese	Syrian Refugees
<i>n</i> =	758	1529
<b>Estimate:</b>	<b>22.2%</b>	<b>45.5%</b>
95% CI Lower:	18.2%	42.4%
95% CI Upper:	26.7%	48.5%

**% of mothers of children ages under-5 years who do not know how to write and read**

2019 result:	Vulnerable Lebanese	Syrian Refugees
<i>n</i> =	758	1529
<b>Estimate:</b>	<b>6.9%</b>	<b>38.8%</b>
95% CI Lower:	4.5%	35.1%
95% CI Upper:	10.4%	42.7%

**% of households (HH) with a crowdedness index above 1.5**

Questions pertaining to this indicator were removed from the 2019 survey, so this indicator can not be addressed with the 2019 data.

### 6.1 Socio-demographics

The following tables and pie chart outline the demographic characteristics of the survey sample and their households. It shows that while the age of respondents was similar across populations, there were more children per household in the homes of Syrian refugees compared to the homes of vulnerable Lebanese.

**Table 1 - Demographic characteristics of sampled households**

Characteristic		Vulnerable Lebanese (within the SDC catchment areas)	Syrian Refugees (in informal settlements within the SDC catchment areas)
<b>Number of valid survey respondents</b>		758	1529
<b>Children per household</b>	Number of children under-5 in respondents' households	1,091	2,834
	Mean number of children under-5	1.4	1.9
<b>Percentage of respondents lived who in a household containing a child under-5 years old.</b>		100%	100%
<b>Gender of respondents</b>	Female	100%	100%
	Male	0%	0%
<b>Age of respondents</b>	Average age	29.7	28.9
	Median age	29	28
	Minimum age	15	15



	Maximum age	48	50
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Age of respondents by nationality (percentage)

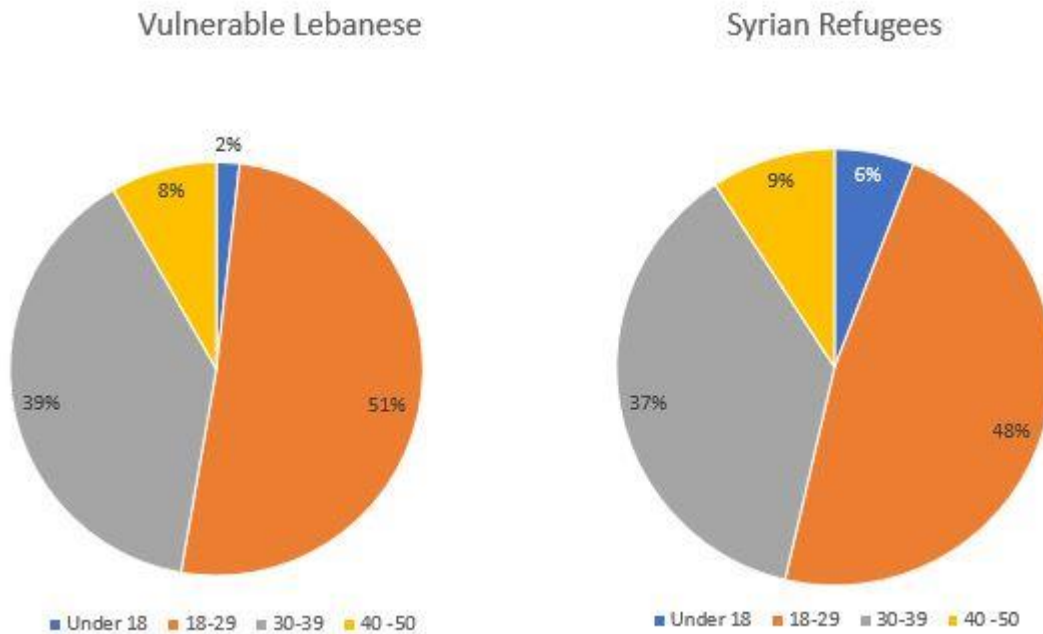


Figure 1 - Age of respondents by nationality (percentage)

## 6.2 Marital status of respondents

100% of respondents were married at the time of the survey. 22.2% of vulnerable Lebanese women (freq = 168/758, CI: 18.2% - 26.7%) and 45.5% of Syrian refugee women were married before they reached 18 years of age (freq = 695/1529, CI: 42.4% - 48.5). This difference is statistically significant ( $p < 0.01$ ) and suggests that Syrian refugees are approximately twice as likely as their vulnerable Lebanese counterparts to have experienced early marriage.

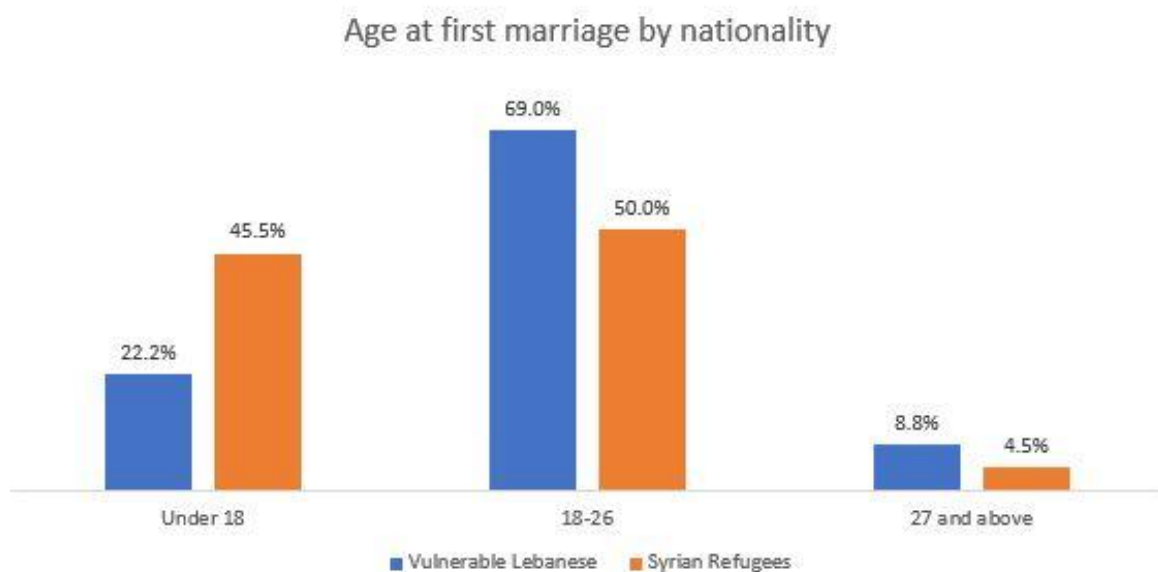


Figure 2 - Age at first marriage by nationality (percentage)

## Literacy rates

The survey found that while the proportion of respondents who are illiterate (cannot read or write) was quite high among both the vulnerable Lebanese population (6.9%; freq = 52/758, CI: 4.5% - 10.4%), it was five times as high Syrian refugees (38.8%, freq = 594/1529, CI: 35.1% - 42.7%;  $p < 0.01$ ).

## Habitation

Just three Syrian refugee respondents (0.2%) reported that they lived in a house, with the remaining women (99.8%) reporting that they lived in a tent. Conversely, just one vulnerable Lebanese woman reported living in a tent (0.1%), with the remaining 99.9% reporting living in a house.

## 6.3 Health seeking behavior

Summary of core indicator targets: General health access

**% of mothers of children aged under-5 years of age in project area who went to qualified health services when they needed medical services**

**2019 result:**                      **Vulnerable Lebanese**                      **Syrian Refugees**

*n =*                                      601                                      1374

<b>Estimate:</b>	<b>99.4%</b>	<b>95.2%</b>
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95% CI Lower:	98.3%	93.4%
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95% CI Upper:	99.7%	96.4%
---------------	-------	-------

**% of mothers of children aged under-5 years of age in project who visited any Medair supported SDC during the 12 months prior to the survey**

**2019 result:**                      **Vulnerable Lebanese**                      **Syrian Refugees**

*n =*                                      758                                      1506

<b>Estimate:</b>	<b>41.4%</b>	<b>49.8%</b>
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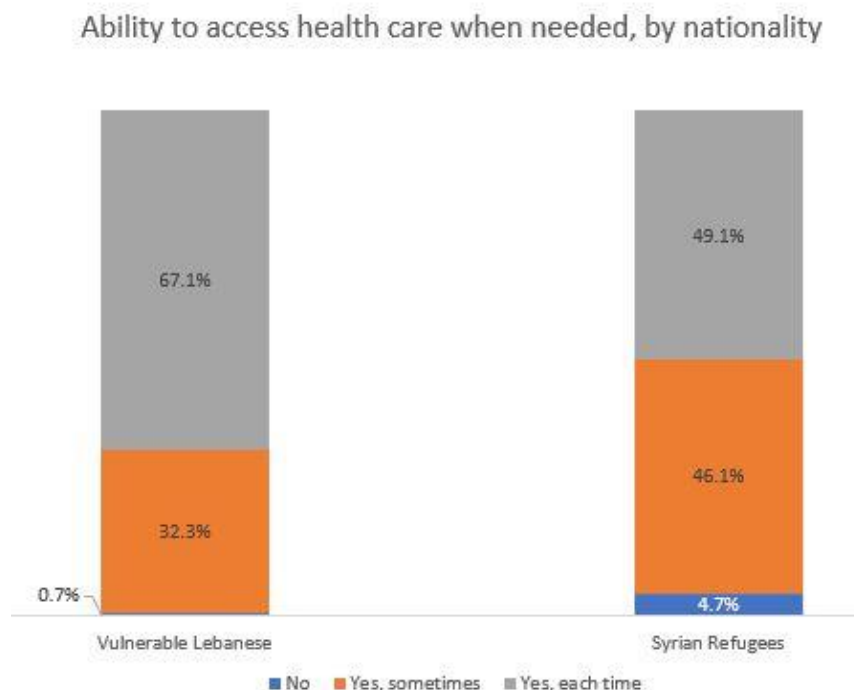
95% CI Lower:	42.7%	31.7%
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95% CI Upper:	57.0%	51.9%
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## General health care access

Almost nine in ten respondents answered “yes” to a question pertaining to whether they or their children had needed medical services in the year prior to the survey (86.4%; frequency = 1975/2287; CI: 84.4% - 88.1%). Syrian refugees were significantly more likely to report having needed medical services (89.9%, freq = 1374/1529, CI: 88.1%-91.4%) than vulnerable Lebanese (79.3%, freq: 601/758; CI: 75.2% - 82.9%).

Of the respondents who reported that they had needed medical services in the previous year, the majority reported that they had been able to access qualified health services (a doctor, a clinic, a hospital, community health programs by Medair involving FP, ANC and PNC, midwife, specialized clinic, doctor, MSF or Amil clinic) “sometimes” or “each time”. The chart below shows that vulnerable Lebanese were more likely to have accessed qualified health services each time they needed them (67.1%, freq = 403/601, CI: 62.2% – 71.6%) than Syrian refugees (49.1%, freq = 674/1374; 45.5% - 52.7%).



Syrian refugees who accessed health services generally did so through SDC health clinics (78.0%; freq = 1015/1301; CI: 74.3% – 81.3%). SDC health clinics are also heavily relied on by vulnerable Lebanese, although the proportion of vulnerable Lebanese who accessed SDC health clinics was significantly lower (49.6%, freq = 296/597; 44.7% - 54.5%). Private clinics closely followed SDC health clinics as the second most commonly accessed health service by vulnerable Lebanese (48.6%, freq = 290/597, CI: 43.5% - 53.6%); while Syrian refugees were much less likely to access services other than SDC health clinics.

Figure 3 - Ability to access health care when needed, by nationality

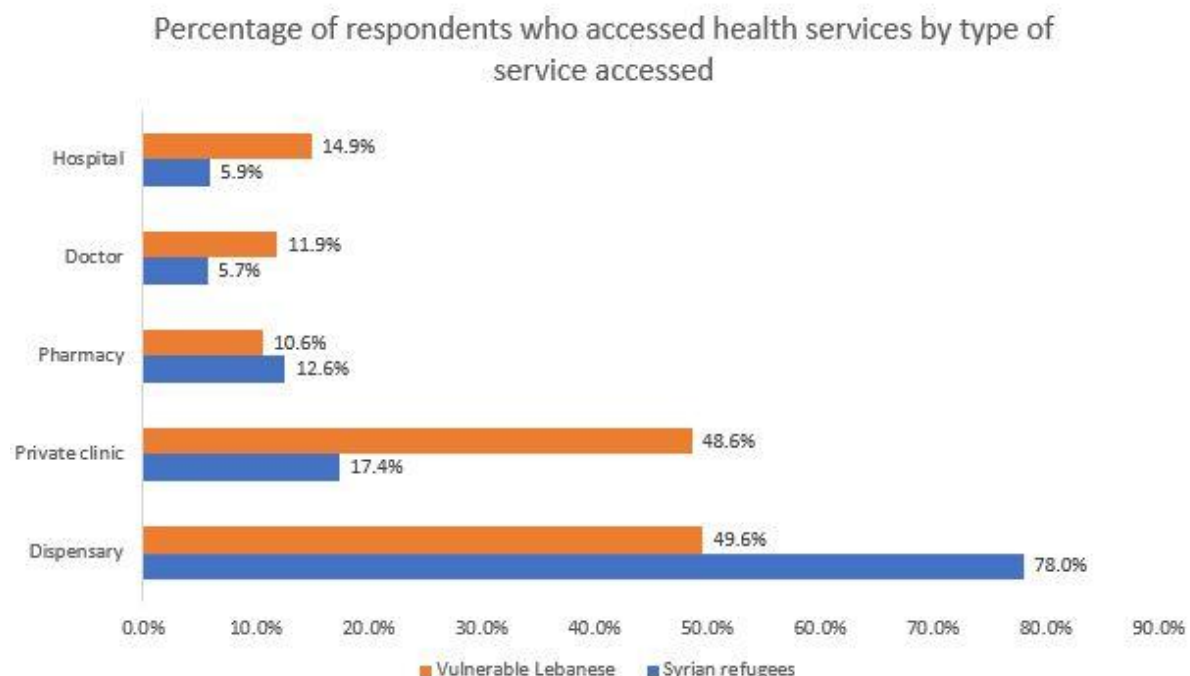


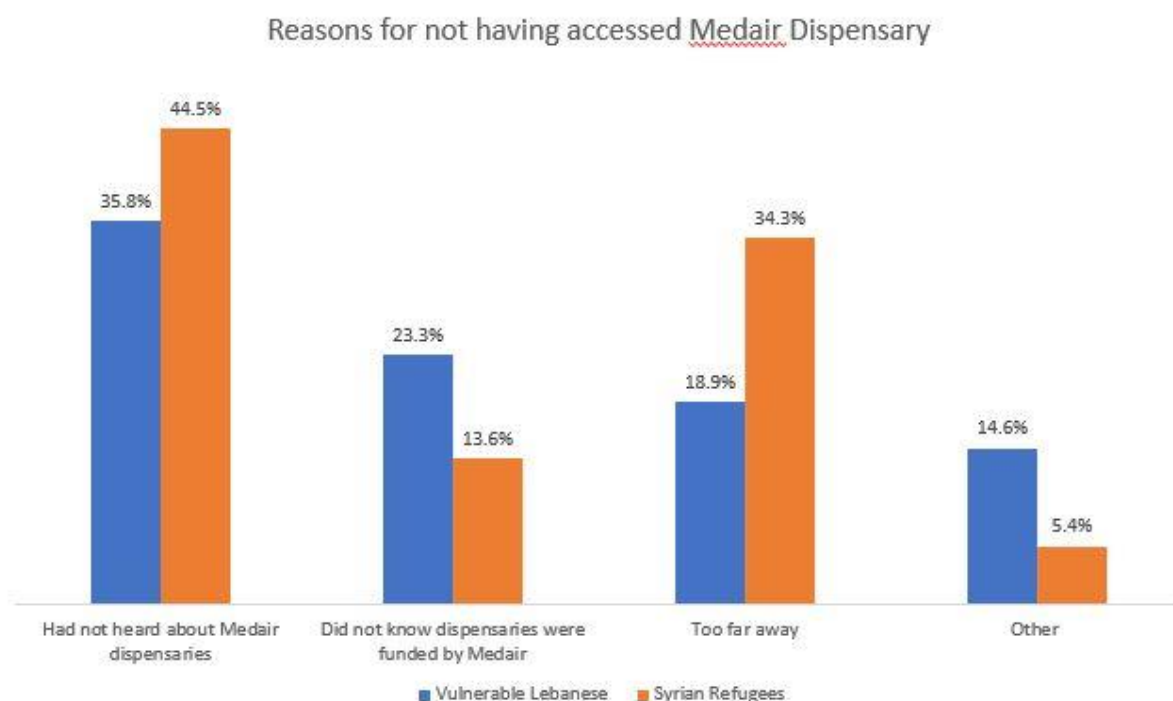
Figure 4 - Percentage of respondents who accessed health services by type of service accessed

Just four vulnerable Lebanese women reported that they or their children needed health care in the previous 12 months but did not access qualified services (0.7%, CI: 0.3% - 1.7%). Of the 64 Syrian refugees who needed but did not access qualified health care (4.7%; CI: 3.4% - 6.3%), the most commonly cited reason was cost. Almost a third (31.3%, freq = 20/64; CI: 21.0% – 43.7%) reported

that health services were too expensive and an additional 4.6% (freq = 3 / 64, CI: 3.2% - 28.9%) reported that having “no money” was the barrier they faced in accessing health care. A further 4 women (6.3%, CI: 2.4% - 15.1%) reported that they did not like the services available.

Medair supported SDC health clinics (SDCs) continue to comprise a crucial health access point for both populations. 47.0% of respondents reported that they visited a Medair supported SDC during the 12 months prior to the survey (freq =1211/ 2287; CI: 41.2% – 53.0%). This was higher among Syrian refugee women (49.8%; freq = 762/1529; CI: 42.7% - 57.0%) than vulnerable Lebanese women (41.4%, freq = 314/758; CI: 31.7% - 51.9%), but this difference was not significant (p = 0.189).

Not having heard of the Medair SDC health clinics was the most commonly cited reason for not visiting one of these facilities by respondents who had not accessed a Medair facility. 44.5% of Syrian refugees (freq = 341/ 767, CI: 39.8% - 49.2%) and 38.5% of vulnerable Lebanese respondents (freq = 171/444; CI: 32.6% - 44.7%) had not heard of these SDC health clinics. Distance to the facilities was reported to have been a barrier to access by over a third of Syrian refugees (34.3%, freq = 263/767, CI: 29.9% - 39.0%) and almost a fifth of vulnerable Lebanese (18.9%, freq = 99 / 444, CI: 14.1% - 24.9%). Notably, a lack of awareness that clinics were supported by Medair was also commonly cited by vulnerable Lebanese (23.3%, freq = 99/444, CI: 16.8 – 29.0), and to a lesser extent, Syrian refugees (13.6%, freq = 104/767; CI 10.7% – 17.1%).



**Figure 5 - Reasons for not having accessed Medair SDC health clinic (percentage)**

Eleven respondents (4 Syrian refugees and 7 vulnerable Lebanese) reported that the reason they had not visited a Medair SDC health clinic was “bad services” and a further 16 reported “mistreatment” in a Medair clinic (8 Syrian refugees and 8 vulnerable Lebanese).

## 6.4 Non-Communicable Diseases (NCD)

Summary of core indicator targets: NCDs

**% of mothers of children under-5 years who reported having at least one household member with NCD**

2019 result:	Vulnerable Lebanese	Syrian Refugees
<i>n</i> =	758	1529
<b>Estimate:</b>	18.6%	18.8%
95% CI Lower:	15.5%	16.7%
95% CI Upper:	22.2%	21.0%

**% of women who know 2 or more ways to reduce the risk of NCDs**

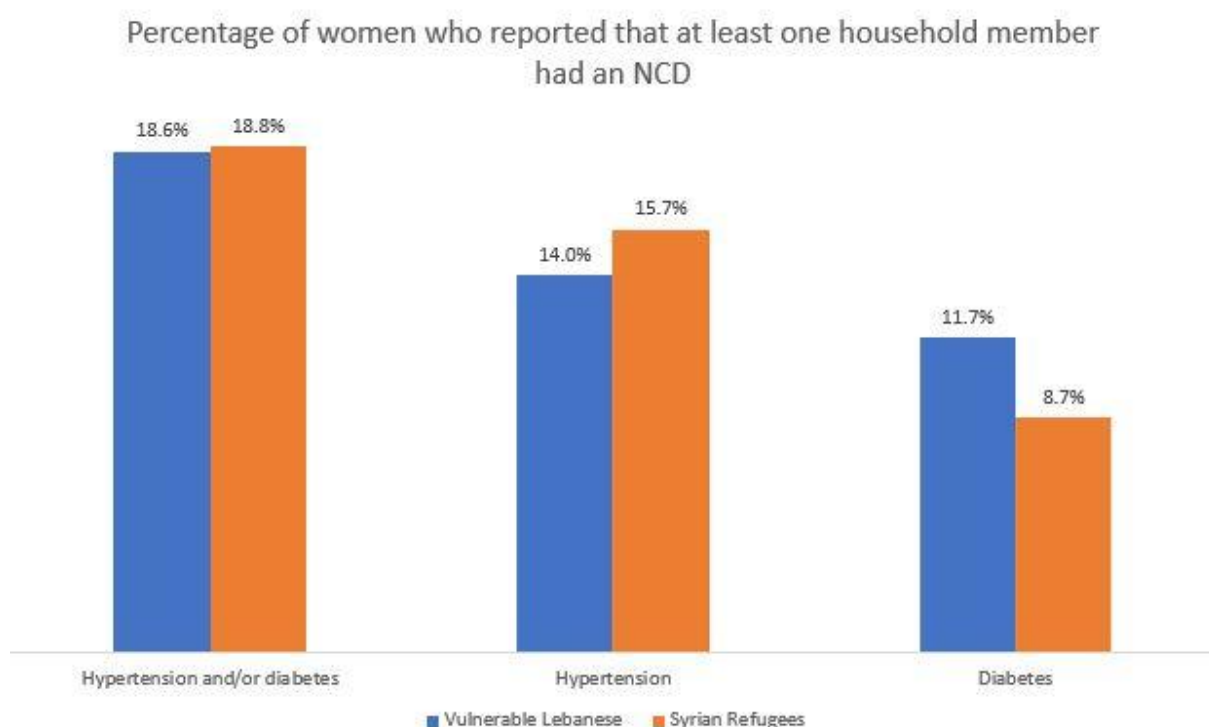
2019 result:	Vulnerable Lebanese	Syrian Refugees
<i>n</i> =	758	1529
<b>Estimate:</b>	53.7%	30.4%
95% CI Lower:	48.4%	27.8%
95% CI Upper:	58.9%	33.2%

NCDs are major causes of morbidity and mortality among both the Lebanese and Syrian populations. Nationally, the Lebanese diabetes prevalence is at 14.6%, approximately twice as high as the estimated rate in Syria (7.1%).<sup>8</sup> Similarly, rates of hypertension are high, with 23% of Lebanese adults (over 18 years) and 11% of Syrian adults experiencing raised blood pressure.<sup>9</sup> An understanding of the prevalence in refugee and vulnerable national populations, as well as their awareness of the issue is insightful to understand the gap in services.

The following chart demonstrates that Syrian refugees and vulnerable Lebanese respondents reported similar incidences of having at least one household member who had been diagnosed with an NCD (hypertension or diabetes) ( $p = 0.93$ ). While the difference in the proportion of women who responded that they had at least one household member who had been diagnosed with hypertension was not significant, significantly more vulnerable Lebanese women reported having at least one household member diagnosed with diabetes ( $p = 0.001$ ).

<sup>8</sup> International Diabetes Federation. *IDF Diabetes Atlas, 8th edn*. Brussels, Belgium: International Diabetes Federation, 2017. <http://www.diabetesatlas.org>

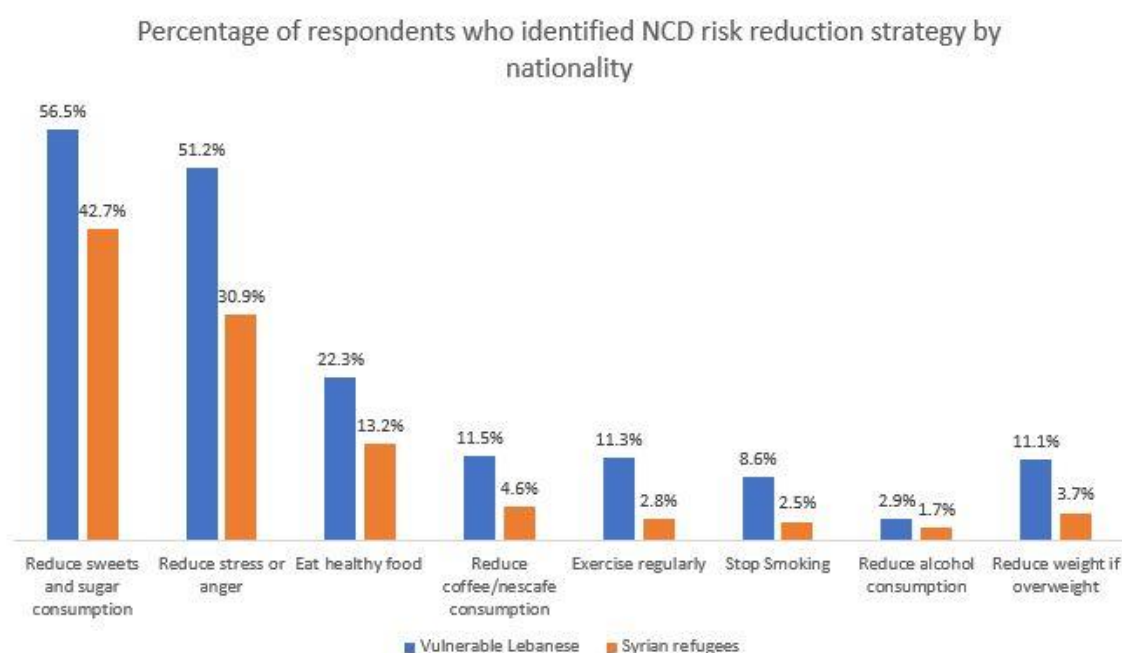
<sup>9</sup> WHO, Noncommunicable diseases country profiles, 2018, <https://www.who.int/nmh/countries/en/>



**Figure 6 – Percentage of women who reported that at least one household member had an NCD**

Survey respondents were asked to identify ways to reduce the risk of getting diabetes or hypertension. Vulnerable Lebanese women were significantly more likely than Syrian refugees to be able to identify two or more risk reduction strategies (vulnerable Lebanese: 53.7%, freq = 407/758; CI: 48.4% - 58.9%; Syrian refugees: 30.4%; freq = 465/1529, CI: 27.8% - 33.2%).

The following chart shows that reducing sweets and sugar consumption was the most frequently identified NCD risk reduction strategy by both vulnerable Lebanese and Syrian refugees; followed by reducing stress or anger, eating healthy foods and reducing coffee consumption. With the exception of reducing alcohol consumption, these differences were all highly significant.



**Figure 7 - Percentage of respondents who identified NCD risk reduction strategy by nationality**

#### Summary of core indicator targets: Vaccinations

##### **% of children aged 12 months - 5 years who are vaccinated for measles in clinics' coverage area**

<b>2019 result:</b>	<b>Vulnerable Lebanese</b>	<b>Syrian Refugees</b>
<i>n</i> =	365	742
<b>Estimate:</b>	<b>57.5%</b>	<b>44.5%</b>
95% CI Lower:	50.4%	38.6%
95% CI Upper:	64.4%	50.5%

##### **% of children aged 12 months - 5 years who are vaccinated for polio in clinics' coverage area**

<b>2019 result:</b>		
<i>n</i> =	295	535
<b>Estimate:</b>	<b>79.3%</b>	<b>72.1%</b>
95% CI Lower:	73.1%	67.5%
95% CI Upper:	84.4%	76.3%

##### **% of children aged 12 months - 5 years who are vaccinated for Diphtheria and Pertussis and Tetanus (DPT) in clinics coverage area**

<b>2019 result:</b>	<b>Vulnerable Lebanese</b>	<b>Syrian Refugees</b>
<i>n</i> =	295	535
<b>Estimate:</b>	<b>78.6%</b>	<b>68.4%</b>
95% CI Lower:	72.4%	62.9%
95% CI Upper:	83.8%	73.4%

##### **% of children age 12-23 months who received age appropriate vaccination at time of survey**

<b>2019 result:</b>	<b>Vulnerable Lebanese</b>	<b>Syrian Refugees</b>
<i>n</i> =	120	309
<b>Estimate:</b>	<b>32.5%</b>	<b>23.6%</b>
95% CI Lower:	24.2%	17.1%
95% CI Upper:	42.1%	31.7%

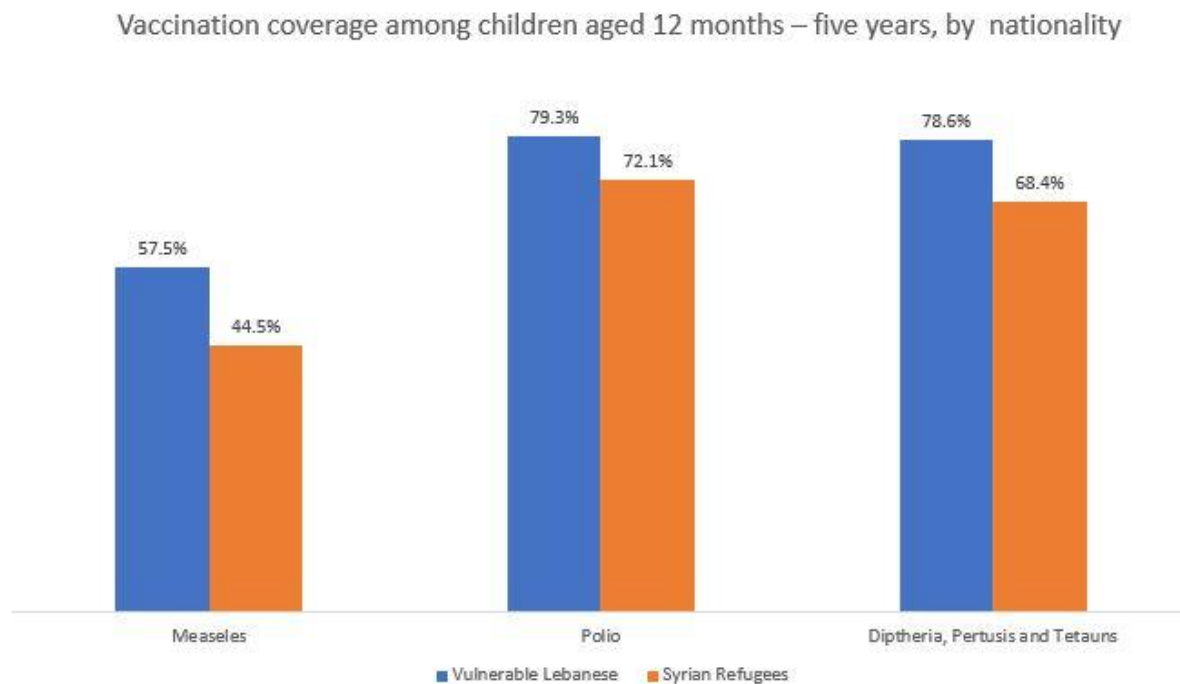
## 6.5 Vaccinations

The survey only collected vaccination data from mothers who presented a vaccination card for inspection. Syrian refugees were significantly less likely to have a vaccination card for their youngest child (70.1% compared to 82.7%;  $p < 0.01$ ). Of women who reported having a vaccination card, 857 Syrian refugees (88.3%) and 525 vulnerable Lebanese (73.7%) were able to produce a valid card.

As shown in the chart below, of children aged 12-59 months who had a valid health record, Syrian refugee children had a lower vaccination rates than vulnerable Lebanese children.

Syrian children were less likely to have received at least one dose of the measles vaccine (44.5%; freq = 330/742; CI: 38.6% - 50.5%) than their vulnerable Lebanese counterparts (57.5% freq = 210/365; CI: 50.4% - 64.4%). Similarly, the prevalence of full polio vaccination appears to be lower among Syrian refugees (72.1%; freq = 386/535; CI: 67.5% - 76.3%) than among vulnerable Lebanese (79.3%; freq = 234/295; CI: 73.1% - 84.4%). Just under three quarters (74.7%) of the total sample had received at least three doses of the DPT vaccine (79.3% of vulnerable Lebanese (freq = 234/295; CI: 73.1% - 84.4%) and 68.4% of Syrian refugees (freq = ; CI: 67.5% - 76.3%). The inferiority of the results for Syrian refugees was significant for DTP ( $p = 0.03$ ) and measles ( $p = 0.006$ ), but just shy of significance ( $p = 0.06$ ) for polio.





**Figure 8 - Vaccination coverage among children aged 12 months - five years, by nationality (percentage)**

Rates of age-appropriate vaccinations are low. Just a third of vulnerable Lebanese children aged 12-23 months (32.5%, freq = 39/120; CI: 24.2% - 42.1%) and a quarter of Syrian refugee children of the same age group (23.6%; freq = 73/309; CI: 17.1% - 31.7%) had received age-appropriate vaccinations at the time of the survey<sup>10</sup>. This difference did not reach significance ( $p = 0.131$ ). The chart below shows that children aged 12-17 months were less likely than those aged 18-23 months to have received age appropriate vaccinations in both populations.

<sup>10</sup> According to the Lebanese ministry of public health vaccination calendar, children of each age group should have received the following vaccinations:

*Children 12-17 months:* Polio 1, 2, 3 + penta 1,2,3 + HepB1 + PCV13 1, 2,3 + Measles + MMR1

*Children 18-23 months:* Above + Polio Booster 2 + Penta Booster 1 + MMR 2

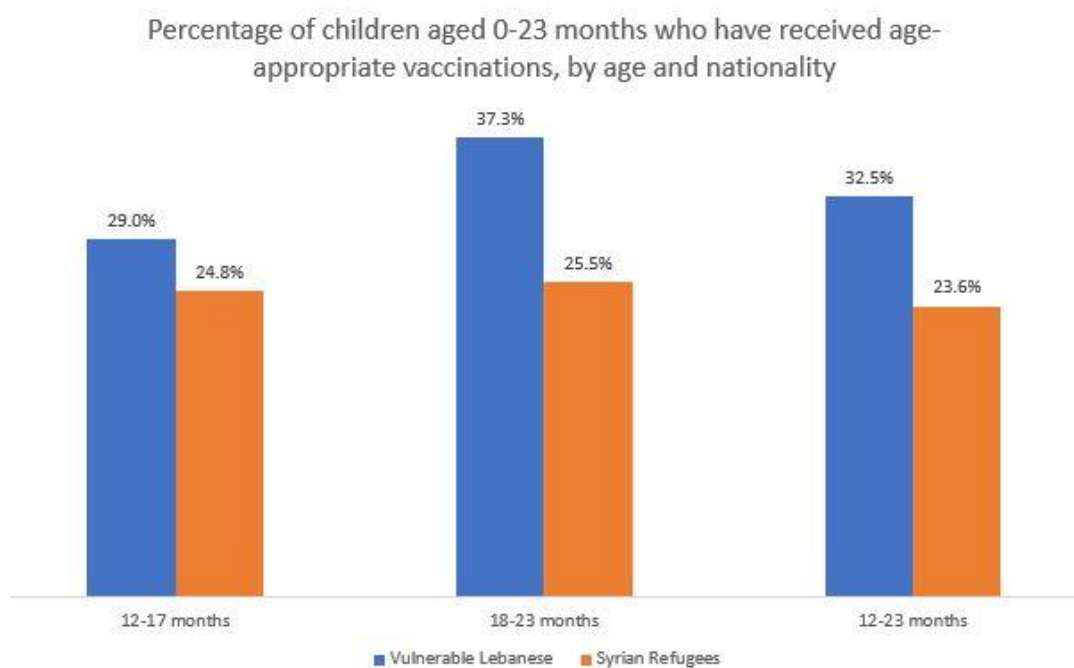


Figure 9 -

Percentage of children who have received age-appropriate vaccinations, by age and nationality

## 6.6 Childhood illnesses: Acute respiratory illness (ARI)

Summary of core indicator targets: ARI

**% of children under-5 years that had fast or difficult breathing in the last 2 weeks**

**2019 result:** **Vulnerable Lebanese** **Syrian Refugees**

**n =** 758 1529

<b>Estimate:</b>	<b>10.6%</b>	<b>17.9%</b>
	8.3%	15.9%
	13.3%	20.2%

**% of children under-5 years with fast or difficult breathing for whom advice or treatment was sought after more than 24h of fast or difficult breathing, in the last 2 weeks**

**2019 result:** **Vulnerable Lebanese** **Syrian Refugees**

**n =** 274 80

<b>Estimate:</b>	<b>15.0%</b>	<b>15.3%</b>
	8.4%	11.4%
	25.3%	20.4%

**% of children under-5 years with fast or difficult breathing for whom advice or treatment was sought from an appropriate health facility or provider in the last 2 weeks**

**2019 result:** **Vulnerable Lebanese** **Syrian Refugees**

**n =** 199 590

<b>Estimate:</b>	<b>25.6%</b>	<b>11.5%</b>
	19.0%	9.1%
	33.6%	14.5%

**% of children under-5 years with fast or difficult breathing or cough by type of treatment in the last 2 weeks (inclusive of antibiotics)**

**2019 result:** **Vulnerable Lebanese** **Syrian Refugees**

**n =** 152 438

<b>Antibiotics</b>		
<b>Estimate:</b>	<b>33.6%</b>	<b>37.0%</b>
	24.8%	32.4%
	43.7%	41.8%

<b>Cough drops</b>		
<b>Estimate:</b>	<b>63.8%</b>	<b>62.8%</b>
	55.0%	57.5%
	71.8%	67.8%

<b>Pain killers</b>		
<b>Estimate:</b>	<b>46.1%</b>	<b>40.0%</b>
	38.1%	34.9%
	54.2%	45.2%

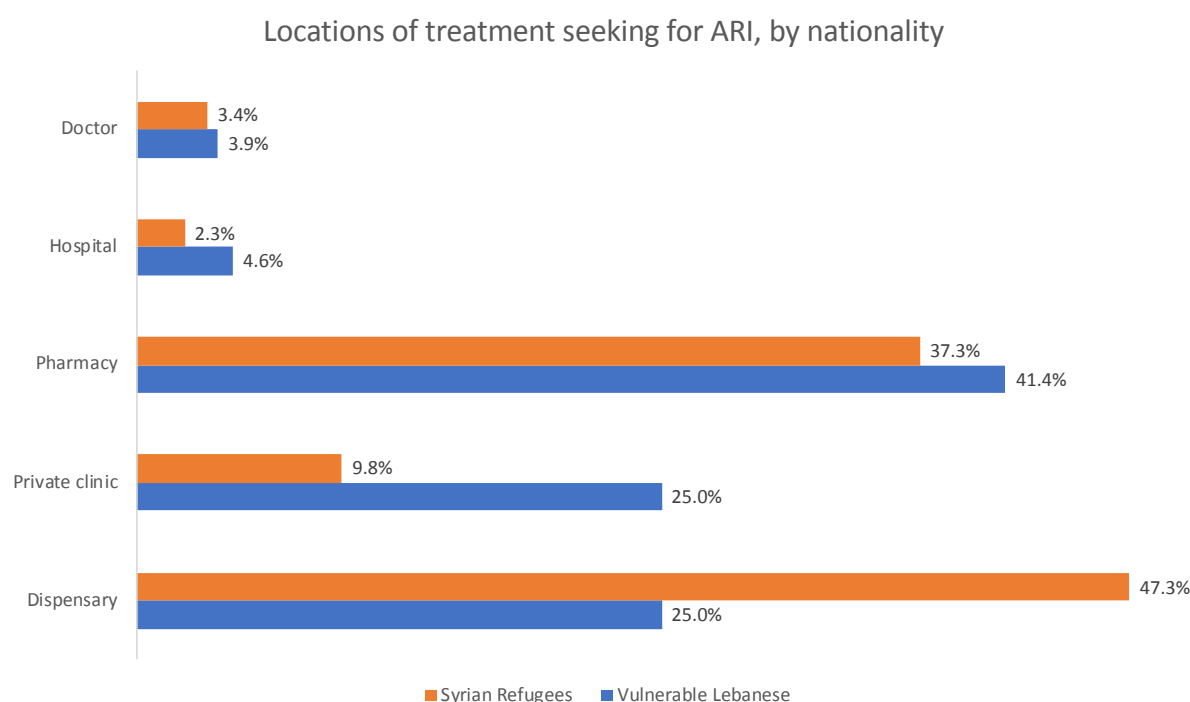
<b>Antihistamines</b>		
<b>Estimate:</b>	<b>18.4%</b>	<b>17.6%</b>
	13.6%	14.4%
	24.5%	21.3%

Syrian refugees were significantly more likely (17.9%, freq = 274; CI: 15.9% - 20.2%) than vulnerable Lebanese (10.6%; freq = 80; CI: 8.3% - 13.3%) to report that at least one of their children **had experienced** difficulty breathing, fast breathing or short, quick breaths in the two weeks prior to the survey ( $p < 0.001$ ).

Advice or treatment was sought after more than 24 hours of fast or difficult breathing in the last 2 weeks for 15.0% of vulnerable Lebanese children (freq = 12; CI: 8.4% – 25.3%) and 15.3% of Syrian refugee children (freq = 42; CI: 11.4% - 20.4%) with fast or difficult breathing.

Per the provided calculation methodology, an appropriate health facility or provider for the symptoms of ARI is defined as a doctor, a clinic or a hospital, excluding SDC health clinics. By this definition, 11.5% of Syrian refugees (freq = 68; CI: 9.1% - 14.5%) and 25.6% of vulnerable Lebanese children (freq = 51; CI: 19.0% – 33.6%) with cough<sup>11</sup> or fast or difficult breathing in the two weeks preceding the survey sought care from an appropriate health facility or provider. The inferiority of the result for Syrian children was highly statistically significant ( $p < 0.001$ ). However, when SDC health clinics are included health facilities at which care for these symptoms was sought, Syrian children are just as likely (46.8%; CI: 41.8% - 51.8%) as their vulnerable Lebanese counterparts (44.7%; CI: 38.1% - 51.6%) to have accessed care ( $p = 0.642$ ).

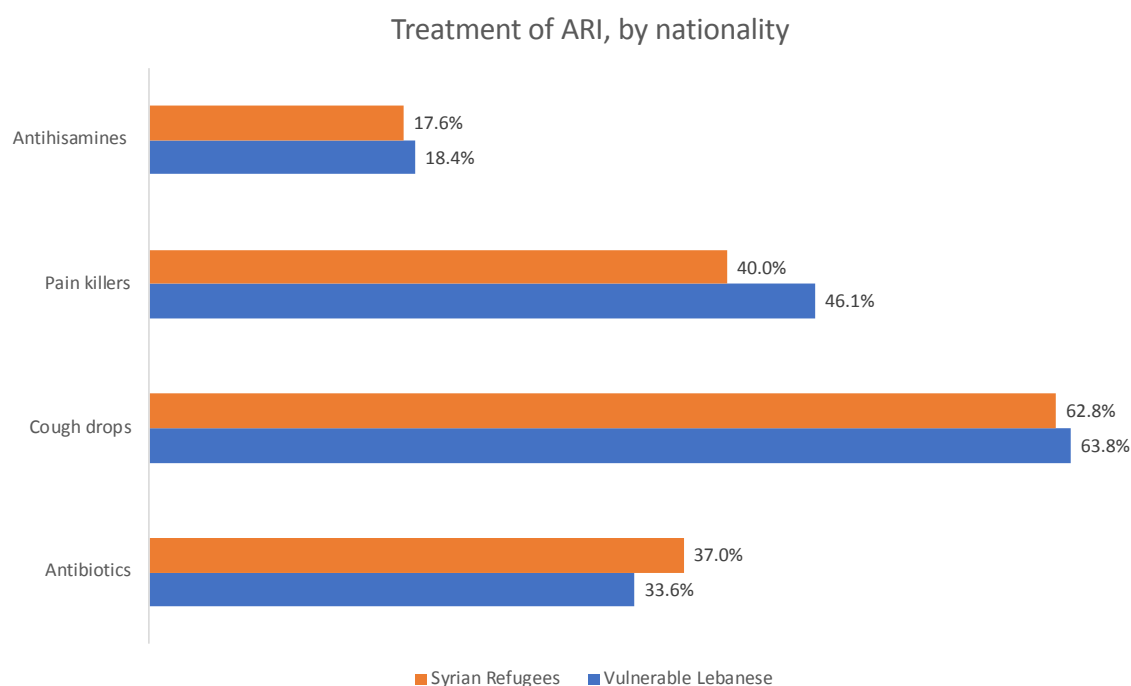
As shown in the chart below, Syrian refugees were most likely to seek advice or treatment for ARI at SDC health clinics (47.3%) or pharmacies (37.3%), while vulnerable Lebanese favoured pharmacies (41.4%), private clinics (25.0%) and SDC health clinics (25.0%).



**Figure 10 - Location of treatment seeking for ARI, by nationality**

Cough drops were the most common treatment for ARI among both populations, followed by pain killers. Antibiotics, which are recommended in the treatment of presumed pneumonia, were only used by approximately a third of each population (37.0% of Syrian refugees and 33.6% of vulnerable Lebanese). There were no statistically significant differences in the use of any treatment by nationality.

<sup>11</sup> Although cough is not included in the indicator definition, it is included in the provided calculation methodology and consistent with some international definitions of ARI. Consequently, we have included children with cough, as well as those with fast or difficult breathing, in our calculations and analysis here.



**Figure 11 - Treatment of ARI, by nationality**

Summary of core indicator targets: Diarrhea

**% of children under-5 years that experienced diarrhea in the last 2 weeks**

2019 result:	Vulnerable Lebanese	Syrian Refugees
<i>n</i> =	758	1529
<b>Estimate:</b>	<b>21.6%</b>	<b>36.5%</b>
	18.0%	33.5%
	25.8%	39.6%

**% of children under-5 years with diarrhea receiving ORS and zinc supplementation**

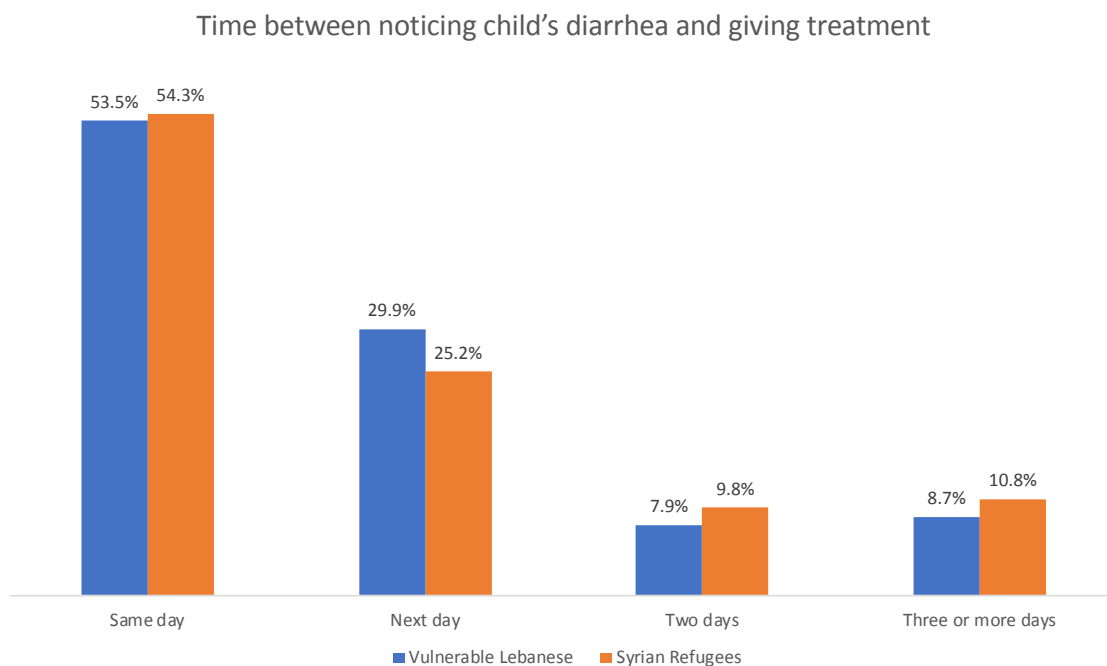
2019 result:	Vulnerable Lebanese	Syrian Refugees
<i>n</i> =	164	558
<b>Estimate:</b>	<b>4.3%</b>	<b>3.4%</b>
	2.1%	2.1%
	8.3%	5.5%

## 6.7 Childhood illnesses: Diarrhea

Diarrhea was found to be extremely common, with over one third of Syrian refugees (36.5%, freq = 558, CI: 33.5% - 39.6%) and one fifth of vulnerable Lebanese (21.6%, freq = 164, CI: 18.0% - 25.8%) reporting any of their children under-five years experienced three or more loose or liquid stools per day at some time over the two weeks prior to the survey. This difference was highly significant ( $p < 0.001$ ) and likely related to the inferior living conditions of informal settlements.

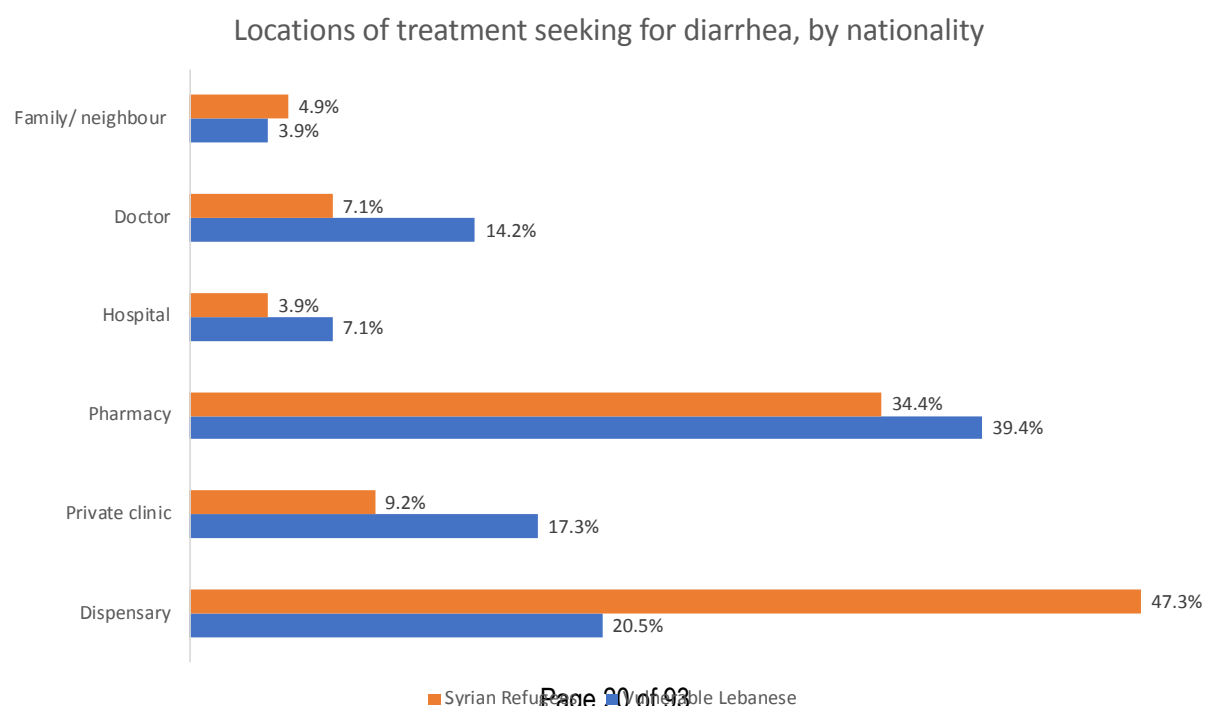
The majority of respondents who reported that they had at least one child with diarrhea had sought treatment (88.2% of Syrian refugees and 77.4% of vulnerable Lebanese;  $p < 0.001$ ). As shown in the

chart below, treatment was most commonly given on the same day as the diarrhea was noticed (53.5% of vulnerable Lebanese and 54.3% of Syrian refugees). However, a fifth of vulnerable Lebanese (20.5%) and a sixth of Syrian refugees (16.5%) reported waiting two or more days before



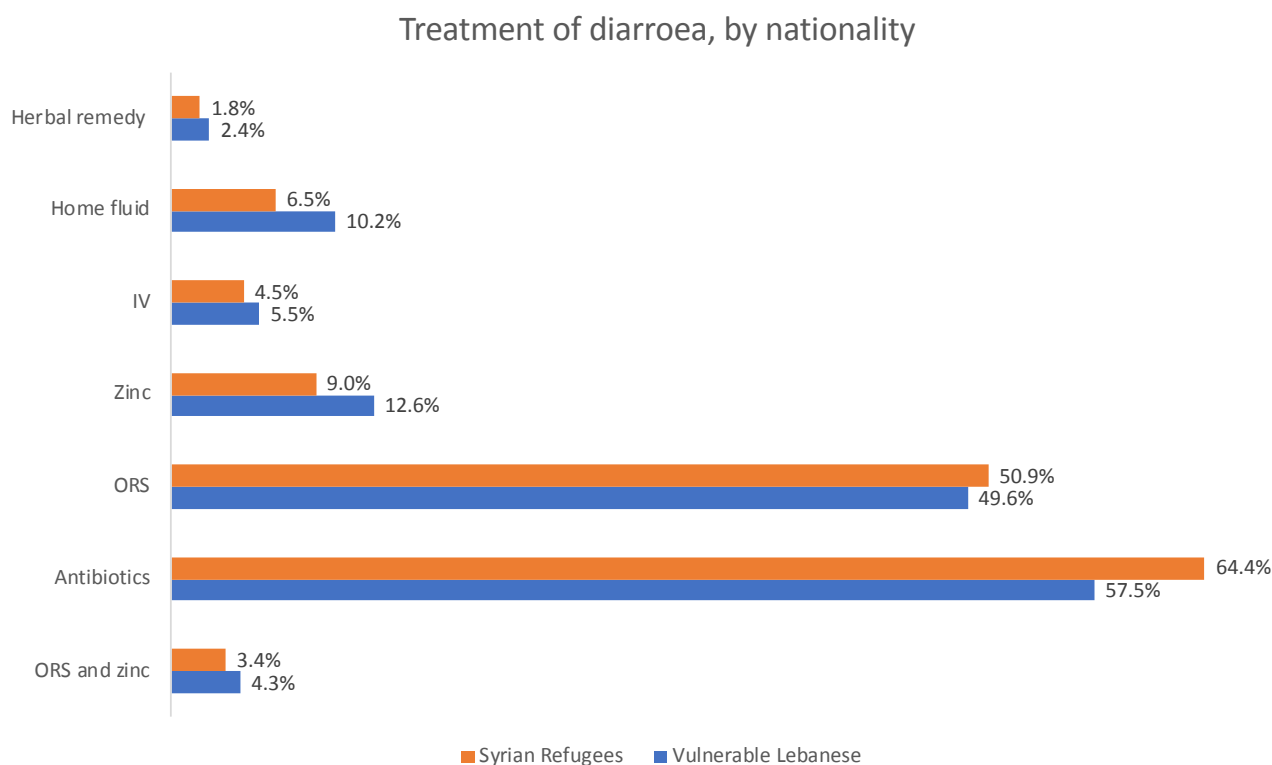
seeking treatment.

As shown in the chart below, Syrian refugees were most likely to report having sought treatment for diarrhea at a SDC health clinic (47.3%), followed by a pharmacy (34.4%). Private health clinics appear to be less commonly utilized by vulnerable Lebanese seeking treatment for diarrhea than they are for other types of health seeking with this population (17.3%), with pharmacies (39.4%) and SDC health clinics (20.5%) more commonly consulted. Comparing treatment seeking for diarrhea between the two populations reveals that Syrian refugees are significantly more likely to access services through SDC health clinics ( $p < 0.001$ ), while the reverse is true for private clinics ( $p = 0.015$ ) and doctors ( $p = 0.014$ ).



**Figure 12 - Locations of treatment seeking for diarrhea, by nationality**

Treatment of diarrhea with ORS and zinc, per WHO recommendations, was concerning uncommon. Just 3.4% of Syrian refugees (freq = 19; CI: 2.1% - 5.5%) and 4.3% of vulnerable Lebanese (freq = 7, CI: 2.1% - 8.3%) reported that their child had received both of these treatments ( $p = 0.59$ ). Approximately half of each population received ORS in the treatment of diarrhea. However, the most commonly used treatment was antibiotics (64.4% of Syrian refugees; 57.5% of vulnerable Lebanese;  $p = 0.165$ ), which is not a recommended standard treatment for diarrhea except when specifically indicated<sup>12</sup>.



**Figure 13 - Treatment of diarrhea, by nationality**

<sup>12</sup> WHO/UNICEF Joint Statement: Clinical management of acute diarrhoea, 2004, [https://www.unicef.org/publications/files/ENAcute\\_Diarrhoea\\_reprint.pdf](https://www.unicef.org/publications/files/ENAcute_Diarrhoea_reprint.pdf)

## 6.8 Reproductive health

Summary of core indicator targets: Reproductive health

### **% Women in the targeted communities who correctly identify available RH services**

**2019 result:**                      **Vulnerable Lebanese**                      **Syrian Refugees**

*n* =                                      785                                      1529

<b>Estimate:</b>	<b>89.8%</b>	<b>88.7%</b>
------------------	--------------	--------------

95% CI Lower:                      85.9%                                      85.6%

95% CI Upper:                      92.8%                                      91.2%

### **% women in the targeted communities who correctly report where to access RH services**

**2019 result:**                      **Vulnerable Lebanese**                      **Syrian Refugees**

*n* =                                      785                                      1529

<b>Estimate:</b>	<b>89.2%</b>	<b>87.6%</b>
------------------	--------------	--------------

95% CI Lower:                      85.3%                                      84.5%

95% CI Upper:                      92.1%                                      90.1%

### **% women in the targeted communities who report that they would be comfortable and able to access these (RH) services as needed**

**2019 result:**                      **Vulnerable Lebanese**                      **Syrian Refugees**

*n* =                                      758                                      1529

<b>Estimate:</b>	<b>84.8%</b>	<b>76.4%</b>
------------------	--------------	--------------

95% CI Lower:                      81.7%                                      73.4%

95% CI Upper:                      87.5%                                      79.1%

### **% of mothers of children under-5 years who report accessing RH services in the 6 months prior to the survey**

**2019 result:**                      **Vulnerable Lebanese**                      **Syrian Refugees**

*n* =                                      758                                      1529

<b>Estimate:</b>	<b>40.0%</b>	<b>41.6%</b>
------------------	--------------	--------------

95% CI Lower:                      36.1%                                      38.7%

95% CI Upper:                      44.0%                                      44.5%

### **% of mothers of children under-5 years receiving RH services who report satisfaction with support provided**

**2019 result:**                      **Vulnerable Lebanese**                      **Syrian Refugees**

*n* =                                      303                                      636

<b>Estimate:</b>	<b>97.0%</b>	<b>97.3%</b>
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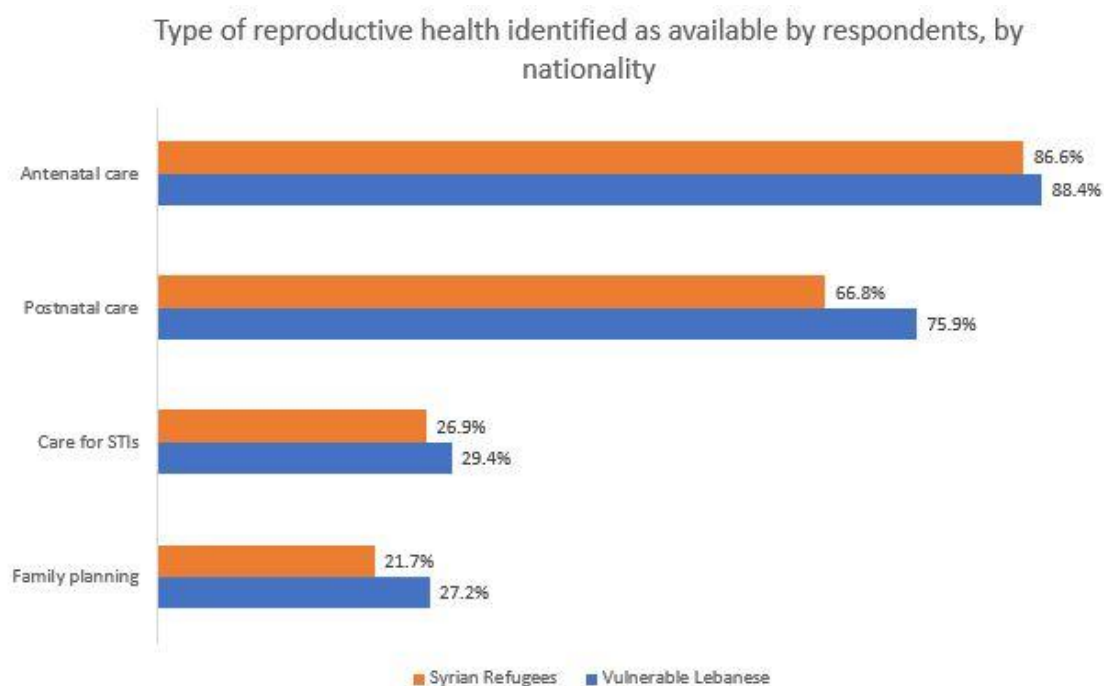
95% CI Lower:                      93.6%                                      95.4%

95% CI Upper:                      98.7%                                      98.5%

As shown in the data above, both vulnerable Lebanese and Syrian refugee women demonstrated high rates of awareness of the reproductive health services available and where these services can be accessed. Almost nine in ten respondents were able to identify RH services available in their community (ANC, PNC, family planning and/ or care for sexually transmitted diseases) (88.7% of Syrian refugees and 89.8% of vulnerable Lebanese); and a similar proportion identified where they could access RH services (SDC health clinics, private clinics, hospitals, doctors, nurses, Medair CMW, midwives or specialized clinics).

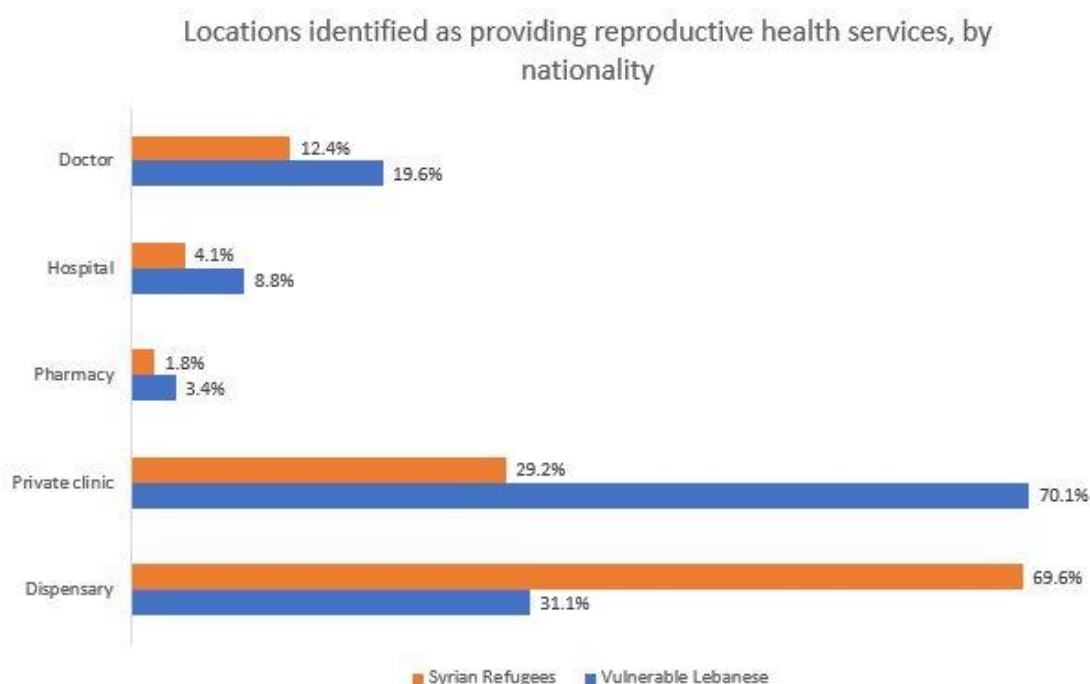
In regard to the specific services available, ANC was the most commonly identified by both populations (86.6% of Syrian refugees and 88.4% of vulnerable Lebanese), followed by postnatal care (66.8% of Syrian refugees and 75.9% of vulnerable Lebanese).





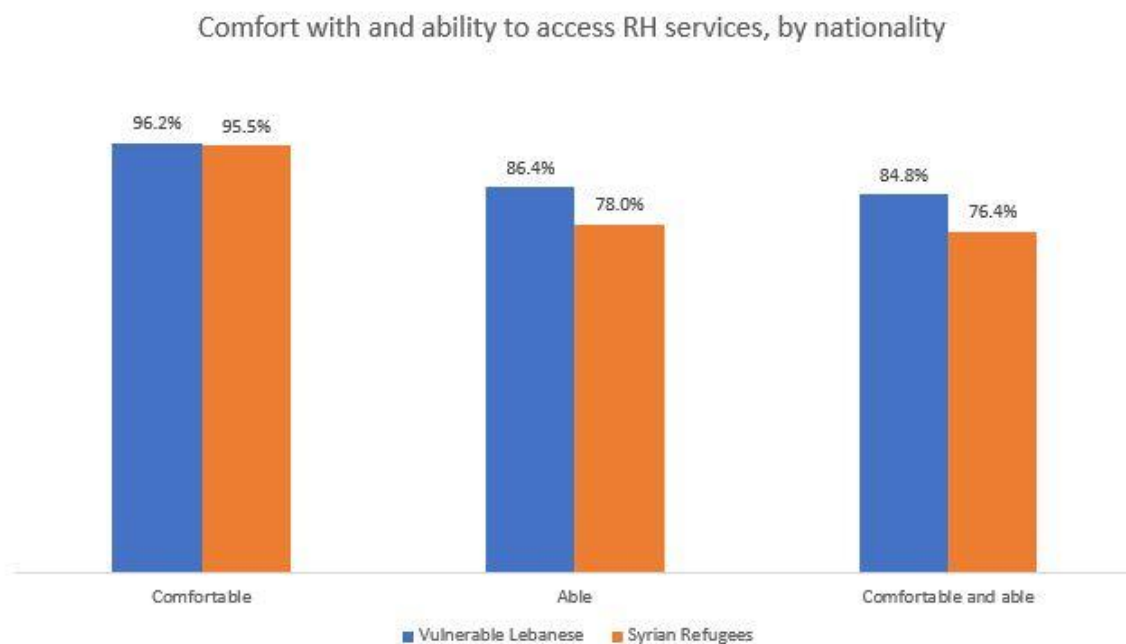
**Figure 14 - Type of reproductive health identified as available by respondents, by nationality (percentage)**

As shown in the chart below, when asked where RH services could be accessed, Syrian refugees most commonly identified SDC health clinics (69.6%). Less than half as many vulnerable Lebanese women identified SDC health clinics as providing RH services (31.1%). Conversely, 70.1% of vulnerable Lebanese women identified private clinics as providing RH services, compared to just 29.2% of Syrian refugees. Both of these differences were highly significant ( $p < 0.01$ ). Doctors were identified by a fifth of Lebanese respondents (19.6) and an eighth of Syrian refugees, while no other service provider type was identified by more than 10% of either population. Just 12 Syrian refugees (0.9%) and one vulnerable Lebanese woman (0.1%) identified Medair CMW as providing RH services.



**Figure 15 - Locations identified as providing reproductive health services, by nationality (percentage)**

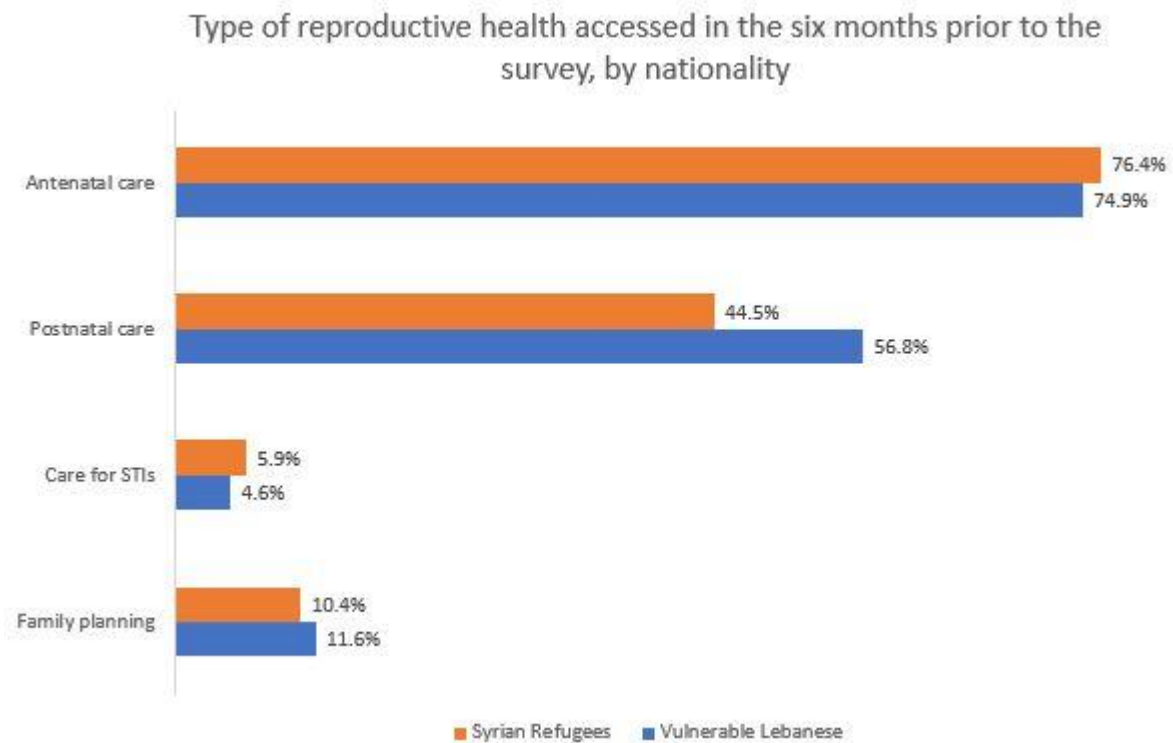
The reported level of comfort and ability to access these services was relatively high in both populations. However Syrian refugees were significantly less likely to report that they would be comfortable and able to access these services (76.4%; freq = 1168; CI: 73.4% - 79.1%) than vulnerable Lebanese women (84.8%; freq = 643/758; CI: 81.7% - 87.5%;  $p < 0.01$ ). As shown in the chart below, this difference is almost entirely explained by the proportion of women who reported that they would be able to access these services. Almost all women reported that they would be comfortable accessing reproductive health services ( $p = 0.718$ ), while Syrian refugees were significantly more likely to report that they would be unable to access these services (78.0%; freq = 1192; CI: 75.2% - 80.5%) than vulnerable Lebanese (86.4%; freq = 758; CI: 83.3% - 89.0%;  $p < 0.01$ ).



**Figure 16 - Comfort with and ability to access RH services, by nationality (percentage)**

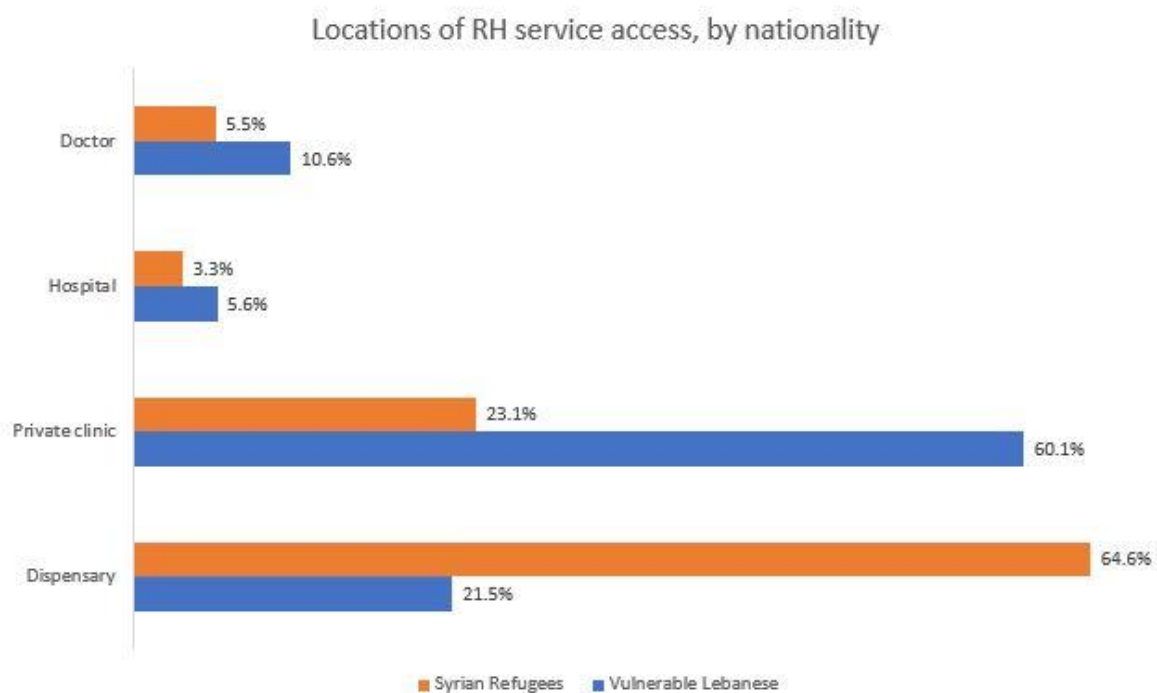
The data that is available in English on the reasons women do not feel comfortable or able to access these services indicates that a lack of money is a primary concern. 58.9% of Syrian refugees (freq = 209/355; CI: 51.1% - 66.2%) and 39.9% of vulnerable Lebanese (freq = 79/113; CI: 60.3% - 78.0%) reported “no money” as a reason they were unable to or did not feel comfortable accessing reproductive health services; while a further 55 Syrian refugees and 9 vulnerable Lebanese reported that these service are expensive. It is also notable that 20 Syrian refugees (5.6%) and 4 vulnerable Lebanese women (3.5%) reported “mistreatment” as a barrier to access.

When asked about accessing these services, similar proportion of vulnerable Lebanese and Syrian refugees reported that they had sought services related to RH in the six months prior to the survey (40.0% of vulnerable Lebanese (freq = 303/758; CI: 36.1% - 44.4%) and 41.6% of Syrian refugees (freq = 636/ 1529; CI: 38.7% - 44.5%)). Approximately three quarters of respondents reported having accessed antenatal care while approximately half of all respondents had accessed postnatal care. Just one in ten respondents reported having accessed family planning services.



**Figure 17 - Type of reproductive health accessed in the six months prior to the survey, by nationality**

In terms of where RH services were accessed, the chart below demonstrates a pattern observed throughout this survey: Syrian refugees depend heavily on SDC health clinics (64.6%; freq = 411/363; CI: 59.2% - 69.7%), while vulnerable Lebanese women favor private clinics (60.1%; freq = 182/303; CI: 54.1% - 65.7%). These differences are highly significant ( $p < 0.01$ ). Combined, these types of facilities account for over 80% of all RH services accessed by both populations.



**Figure 18 - Locations of RH service access, by nationality**

Satisfaction with RH services provided was high. Almost all (97.2%; freq = 913/939; CI: 95.7 – 98.2%) of those who received RH services reported that they were “satisfied” or “very satisfied” with the services they received. While there were no major differences in the total rates of satisfaction, vulnerable Lebanese were significantly more likely to have been “very satisfied” with the services received (46.2%, freq = 140/303; CI:39.7% - 52.8%) than Syrian refugees (29.4%; freq = 187/636; CI: 24.8% - 34.4%).

## Antenatal Care

Summary of core indicator targets: ANC visits

**% of mothers of children under-two years of age who had at least 4 comprehensive antenatal visits when they were pregnant with their youngest child**

**2019 result:** **Vulnerable Lebanese** **Syrian Refugees**

**n =** 412 1032

**Estimate:** **78.6%** **61.6%**

95% CI Lower: 74.6% 58.2%

95% CI Upper: 82.2% 65.0%

**% mothers of children aged 0-23 months who had their first ANC visit within the first 3 months of pregnancy**

**2019 result:** **Vulnerable Lebanese** **Syrian Refugees**

**n =** 412 1032

**Estimate:** **92.5%** **84.6%**

95% CI Lower: 89.5% 81.7%

95% CI Upper: 94.7% 87.1%

**% mothers of children aged 0-23 months who had their last ANC visit less than 1 month before delivery**

**2019 result:** **Vulnerable Lebanese** **Syrian Refugees**

**n =** 412 1032

**Estimate:** **92.7%** **87.8%**

95% CI Lower: 89.6% 85.4%

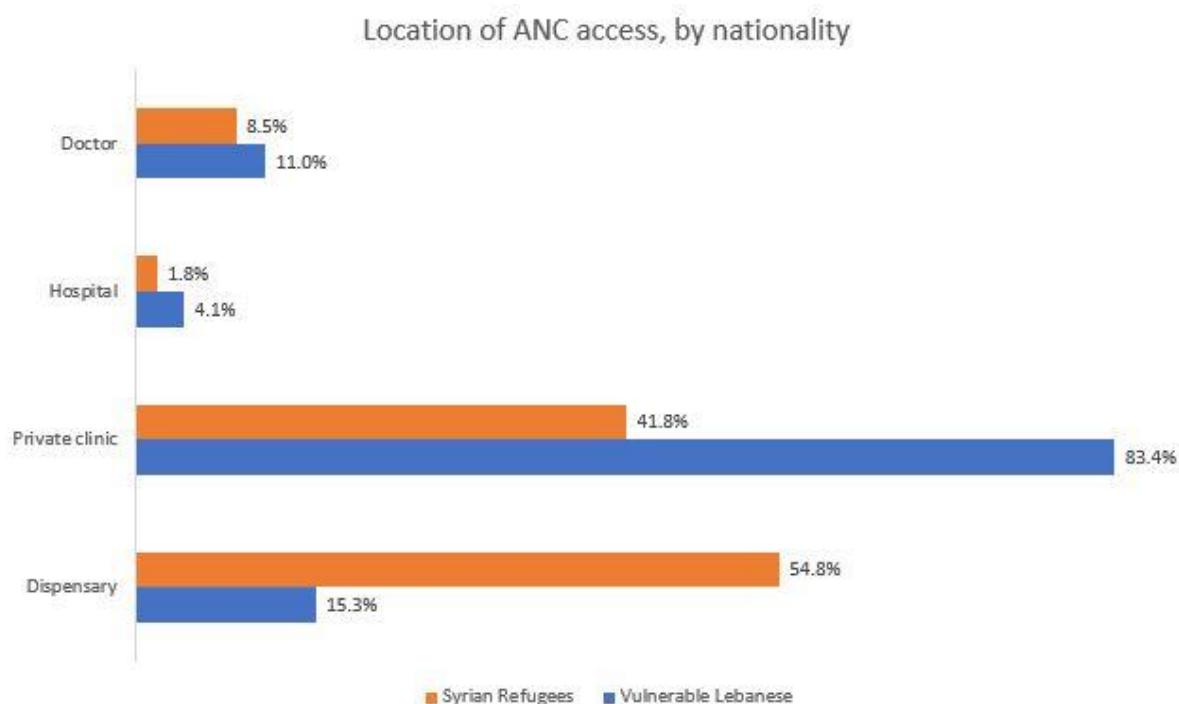
95% CI Upper: 95.0% 89.8%

Two thirds of mothers of children under-two years of age had at least four antenatal visits when they were pregnant with their youngest child (66.5%; freq = 690/1444; CI: 63.3%-69.5%). This was significantly lower among Syrian refugee women (61.6%; freq = 636/1032; CI: 58.2% - 65.0%) than vulnerable Lebanese women (78.6%; freq = 324/412; CI: 74.6% - 82.2%; p<0.01).

Almost nine in ten of mothers of children under-two years of age in the survey (86.8%) reported that they had received ANC within the first three months of pregnancy. Vulnerable Lebanese women were significantly more likely (p < 0.01) to have received ANC in the first trimester (92.5%; freq = 381/412; CI: 89.5% - 94.7%) than Syrian refugees (84.6%; freq = 873 / 1032; CI: 81.7% - 87.1%). Significantly fewer Syrian refugee mothers of children under-two years of age also reported having received ANC in the ninth month of pregnancy (87.8%; freq = 906/ 1032; CI: 85.4% - 89.8%) than vulnerable Lebanese women (92.7%; freq = 382/412; CI: 89.6% - 95.0%; p = 0.01).

Of mothers of children under-two years of age who received ANC, almost all reported receiving care from a doctor (96.9%). However, significantly fewer Syrian refugees (95.7%; freq = 1347/ 1408; CI: 93.9% - 97.0%) saw a doctor, compared of vulnerable Lebanese (99.2%; freq = 718/ 724; CI: 97.8% - 99.7%).

When asked where they accessed ANC, the chart below shows that the majority of vulnerable Lebanese women reported having accessed ANC through a private clinic (83.4%; freq = 604/724; CI: 79.1% - 87.0%); while a small majority of Syrian refugees reported visiting a SDC health clinic (54.8%; freq = 772/ 1408; CI: 50.2% - 59.4%). As noted above, this pattern is evident throughout the data, underscoring the importance of SDC health clinics for Syrian refugees.



**Figure 19 - Location of ANC access, by nationality**

## Delivery

Summary of core indicator targets: Delivery

### **% of mothers of children under-5 years who delivered at hospital**

**2019 result:**

	Vulnerable Lebanese	Syrian Refugees
<i>n</i> =	696	1244

<b>Estimate:</b>	<b>91.8%</b>	<b>81.4%</b>
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95% CI Lower:	77.5%	89.4%
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95% CI Upper:	84.7%	93.7%
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### **% of mothers of children under-5 years who delivered by caesarean section**

**2019 result:**

	Vulnerable Lebanese	Syrian Refugees
<i>n</i> =	756	1458

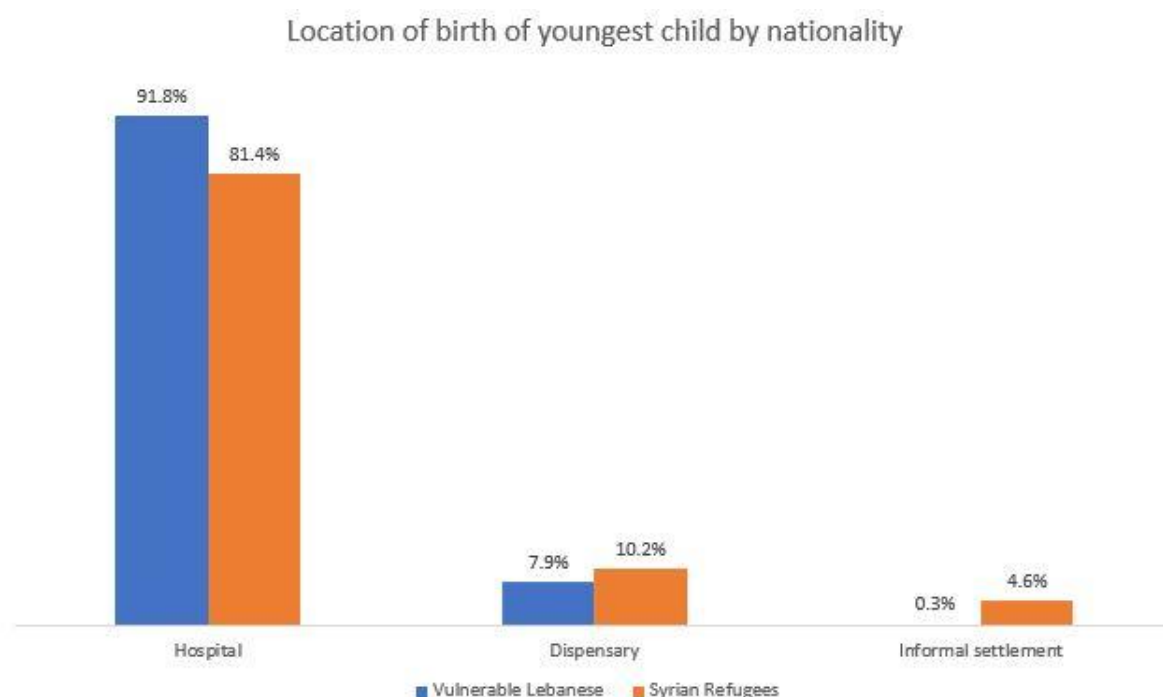
<b>Estimate:</b>	<b>59.0%</b>	<b>29.8%</b>
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95% CI Lower:	54.0%	27.1%
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95% CI Upper:	63.8%	32.6%
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Nine in ten vulnerable Lebanese women (91.8%; freq = 696 / 758; CI: 89.4% – 93.7%) and eight in ten Syrian refugees (81.4%; freq = 1244/ 1529; CI: 77.5% - 84.7%) reported that they had delivered their youngest child (under-five years) in a hospital. This is somewhat surprising, as just 14.8% of

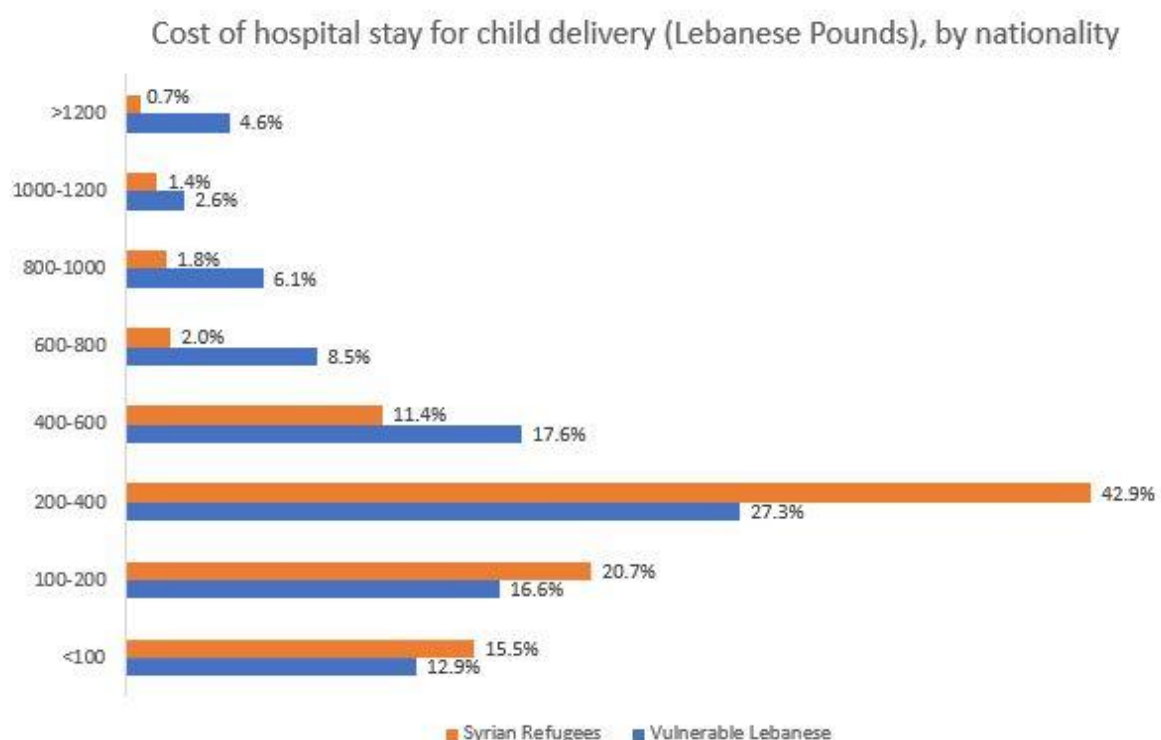
vulnerable Lebanese and 5.9% of Syrian refugees reported having sought health services at a hospital in the 12 months prior to the survey. The inferiority of the result for Syrian refugees is statistically significant ( $p < 0.01$ ). SDC health clinics were the second most commonly cited delivery location (10.2% of Syrian refugees and 7.9% of vulnerable Lebanese).



**Figure 20 - Location of birth of youngest child by nationality**

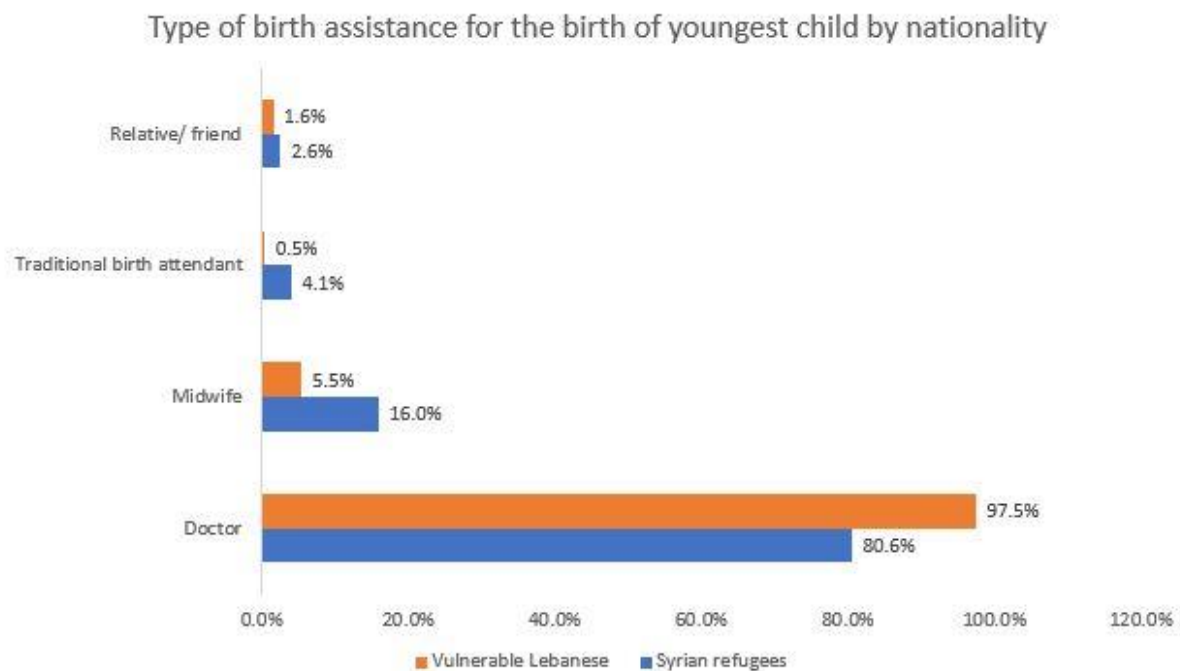
Of Syrian refugees who did not deliver in a hospital and gave a reason for this, the most commonly cited reason was the expense of hospital delivery (46.5%; freq = 60/129; CI: 36.6% - 56.7%), followed by rapid labour (24.0%; freq = 31/129; CI: 16.6% - 33.4%). Just two vulnerable Lebanese women gave a response to this question, both reporting that the expense had caused them not to deliver in hospital.

Indeed, delivering at a hospital does appear to involve a cost in the communities surveyed. Nine in ten respondents who did deliver in hospital paid to do so, with Syrian refugees significantly more likely to have paid for their hospital stay (91.7%; freq = 1337/1458; CI: 89.6%) than vulnerable Lebanese (86.6%; freq = 655/ 756; CI: 82.0% - 90.2%). The chart below shows that despite being asked to pay more frequently, Syrian refugees who delivered in hospital were more likely to pay amounts in the lower cost bands (less than 400,000 Lebanese pounds), vulnerable Lebanese women were more likely to have been charged amounts in the higher bands. The modal cost for both groups was 200,000-400,000 Lebanese pounds (USD132 – USD265). However, this chart does not account for the duration, quality or extent of services accessed.



**Figure 21 - Cost of hospital stay for child delivery (Lebanese Pounds), by nationality**

Consistent with the high rates of hospital delivery, 97.5% of vulnerable Lebanese (freq = 739/758; CI: 96.2% - 98.3%) reported that a doctor assisted with the birth of their youngest child. Significantly fewer Syrian refugees (80.6%, freq = 1227 / 1523; CI: 77.0% - 83.7%) reported assistance from a doctor. The chart below shows that midwives were the second most common provider of assistance during childbirth for both populations, while traditional birth attendants and relatives/ friends were less frequently relied upon.



**Figure 22 - Type of birth assistance for the birth of youngest child by nationality**

Almost four in ten (39.7 %) of mothers of children under-five years of age who reported how their youngest child was delivered reported that the child was delivered by caesarian section (CI: 36.1% – 43.5%). This was significantly lower among Syrian refugee women (29.8%; freq = 434/ 1458; CI: 27.1% - 32.6%) than vulnerable Lebanese women (59.0%; freq = 446/756; CI: 54.0% - 63.8%), possibly partially explaining the higher costs vulnerable Lebanese reported incurring for their hospital deliveries.



## Summary of core indicator targets: Postnatal Care (PNC)

*% of mothers of children aged 0-23 months who stayed at 24h in the hospital after delivery*

<b>2019 result:</b>	<b>Vulnerable Lebanese</b>	<b>Syrian Refugees</b>
<i>n =</i>	412	1032
<b>Estimate:</b>	<b>41.3%</b>	<b>16.8%</b>
95% CI Lower:	36.5%	14.6%
95% CI Upper:	46.2%	19.1%

*% of mothers of children under-two years of age who received a post-partum visit from an appropriate trained health worker within two weeks after birth of their youngest child*

<b>2019 result:</b>	<b>Vulnerable Lebanese</b>	<b>Syrian Refugees</b>
<i>n =</i>	409	1010
<b>Estimate:</b>	<b>54.0%</b>	<b>38.3%</b>
95% CI Lower:	48.1%	34.0%
95% CI Upper:	59.9%	42.8%

*% of children under-two years of age who were examined by an appropriately trained health worker 3 days after delivery*

<b>2019 result:</b>	<b>Vulnerable Lebanese</b>	<b>Syrian Refugees</b>
<i>n =</i>	412	1032
<b>Estimate:</b>	<b>3.9%</b>	<b>3.7%</b>
95% CI Lower:	2.2%	2.7%
95% CI Upper:	6.7%	5.0%

*% of mothers of children under-two years of age who received at least 3 post-partum visits within 40 days after delivery*

<b>2019 result:</b>	<b>Vulnerable Lebanese</b>	<b>Syrian Refugees</b>
<i>n =</i>	412	1032
<b>Estimate:</b>	<b>20.4%</b>	<b>14.2%</b>
95% CI Lower:	17.0%	11.9%
95% CI Upper:	24.2%	17.0%

## Postnatal Care (PNC)

Just 26.4% of mothers of children aged 0-23 months who delivered in hospital stayed in the hospital for over 24 hours after delivery (CI: 23.4% – 29.7%). Syrian refugee mothers of children under-two years who delivered in hospital were significantly less likely so have spent 24 hours in hospital after delivery (19.5%, CI: 16.9% - 22.3%) than vulnerable Lebanese women (42.1%, CI: 36.9% - 47.4%).

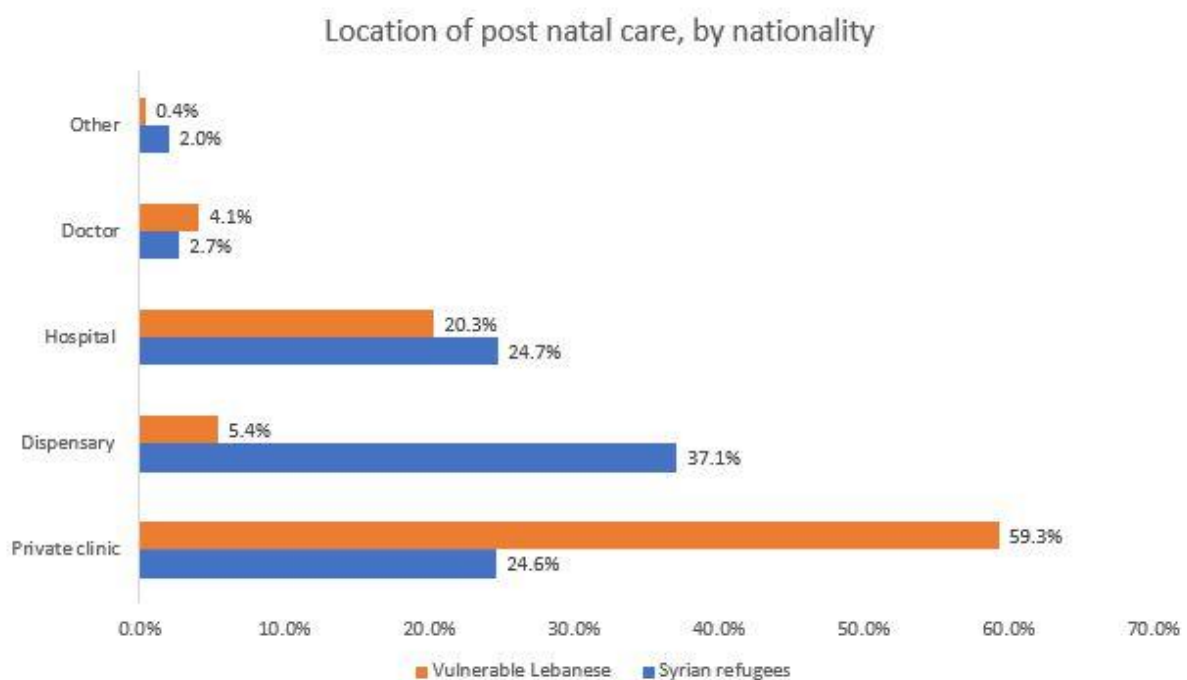
Less than half of all mothers of children under-two years of age reported that they had received a post-partum visit (“any check after being discharged”) from an appropriate trained health worker (doctor, nurse or midwife) within two weeks after birth of their youngest child (42.8%; freq = 608/1419; CI: 39.0% - 46.7%). This was significantly lower among Syrian refugee women (38.3%; freq: 387/1010; CI: 34.0% - 42.8%) than vulnerable Lebanese women (54.0%; freq = 221/409; CI: 48.1% - 59.9%;  $p < 0.001$ ).

Just 3.7% of Syrian mothers of children under-two years (freq = 38/1032; CI: 2.7%-5.0%) and 3.9% of vulnerable Lebanese mothers of children in this age group (freq = 16/412; CI: 2.2% -6.7%) recalled receiving a postnatal contact from an appropriate trained health worker (defined as a pediatrician or

a nurse but not a midwife) during this window. However, just under half of Syrian mothers of children under-two years (45.9%) and almost two thirds of vulnerable Lebanese (64.8%) received postnatal contact from an appropriate trained health worker *within* three days of delivery ( $p < 0.01$ ).

When asked whether someone had checked “on the health of the baby after the delivery, either at a health facility, home or other location,” 16.0% of mothers of children under-two years in the sample (freq = 231/1444) said that such a check had occurred at least three times. No time bounds were specified in the question, so it is unclear when these visits occurred. A greater proportion of vulnerable Lebanese women (20.4%; freq = 84/412; CI: 17.0%-24.2%) than Syrian refugees (14.2%; freq = 147/1032; 11.9% - 17.0%;  $p = 0.005$ ). Respondents who had received at least one of these checks almost universally identified a pediatrician as having conducted these checks: 99.4% of vulnerable Lebanese women (freq = 530 /533; CI: 98.3%- 99.8%) and 97.0% of Syrian refugees (freq = 764/788; CI 95.5% - 97.9%) who responded to this question reported that the child check had been conducted by a pediatrician.

In terms of where women access PNC, the pattern observed in general health care access, by which vulnerable Lebanese tend to access care through private clinics while Syrian refugees favor SDC health clinics, persists. The chart below shows that almost six in ten vulnerable Lebanese mothers of children under-two years accessed PNC through private clinics, compared to just a quarter of Syrian refugees. Conversely, while almost four in ten Syrian refugees (37.1%) accessed PNC through SDC health clinics, just one in 20 vulnerable Lebanese (5.4%) did so.



**Figure 23 - Location of post-natal care, by nationality**

## Family Planning (FP)

Summary of core indicator targets: Family Planning (FP) and child spacing

**% of mothers of children under-5 years who report discussing FP with a trained service provider in the 12 months preceding the survey**

<b>2019 result:</b>	<b>Vulnerable Lebanese</b>	<b>Syrian Refugees</b>
<i>n</i> =	236	483
<b>Estimate:</b>	<b>22.0%</b>	<b>21.3%</b>
95% CI Lower:	15.4%	15.9%
95% CI Upper:	30.5%	27.9%

**% of mothers of children 0-23 months who are using a modern contraceptive method**

<b>2019 result:</b>	<b>Vulnerable Lebanese</b>	<b>Syrian Refugees</b>
<i>n</i> =	220	347
<b>Estimate:</b>	<b>41.8%</b>	<b>54.2%</b>
95% CI Lower:	34.2%	46.8%
95% CI Upper:	49.9%	61.4%

**% of women of children 0-23 months who know what is the best birth spacing**

<b>2019 result:</b>	<b>Vulnerable Lebanese</b>	<b>Syrian Refugees</b>
<i>n</i> =	412	1032
<b>Estimate:</b>	<b>60.9%</b>	<b>42.1%</b>
95% CI Lower:	55.2%	38.9%
95% CI Upper:	66.4%	45.2%

**% of mothers of children 0-23 months who know at least one risk of getting pregnant within 2 years of last delivery**

<b>2019 result:</b>	<b>Vulnerable Lebanese</b>	<b>Syrian Refugees</b>
<i>n</i> =	412	1028
<b>Estimate:</b>	<b>76.0%</b>	<b>69.4%</b>
95% CI Lower:	68.9%	65.4%
95% CI Upper:	81.9%	73.0%

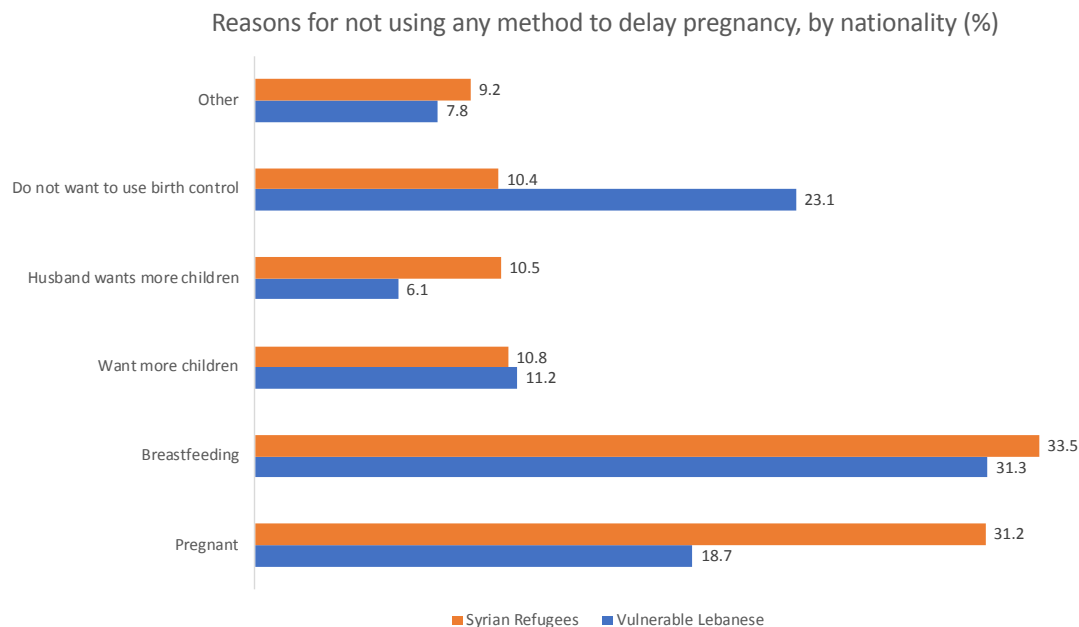
Survey respondents were asked whether their most recent pregnancy was planned. Four in ten pregnancies reported not to have been planned (40.1%; freq = 917 / 2287; CI: 37.2% - 43.1%). Syrian refugees' most recent pregnancy were significantly more likely to be unplanned (43.6%; freq = 667/1529; CI: 40.3% - 47.0%) than their Lebanese counterparts' (33.0%, freq = 250 /758; CI: 28.3% - 38.0%). This result indicates a high unmet need for family planning among both populations, especially among Syrian refugee women.

Less than one quarter of women in the sample who answered a question pertaining to family planning discussions had discussed family planning or family size with a trained health professional (doctor, nurse, midwife, clinic) in the 12 months prior to the survey. Results for this indicator were similar for Syrian refugees (21.3%; freq = 103/483; CI: 15.9% - 27.9%) and vulnerable Lebanese (22.0%; freq = 52/236; CI: 15.4% - 30.5%).

However, when asked whether they had sought family planning services and not been able to access them in the 12 months preceding the survey, just 1.6% of vulnerable Lebanese (freq = 12/758; CI: 0.9% - 2.9%) and 3.6% of Syrian refugees (freq = 55/1529; CI: 2.7% - 4.8%) reported that this had been their experience. Access to family planning services therefore does not seem to be the primary impediment to receiving family planning services.

Over half (53.9%) of the sample said they were not using any method to delay pregnancy. Syrian refugees were significantly more likely to report not using any method to delay pregnancy (61.4%;

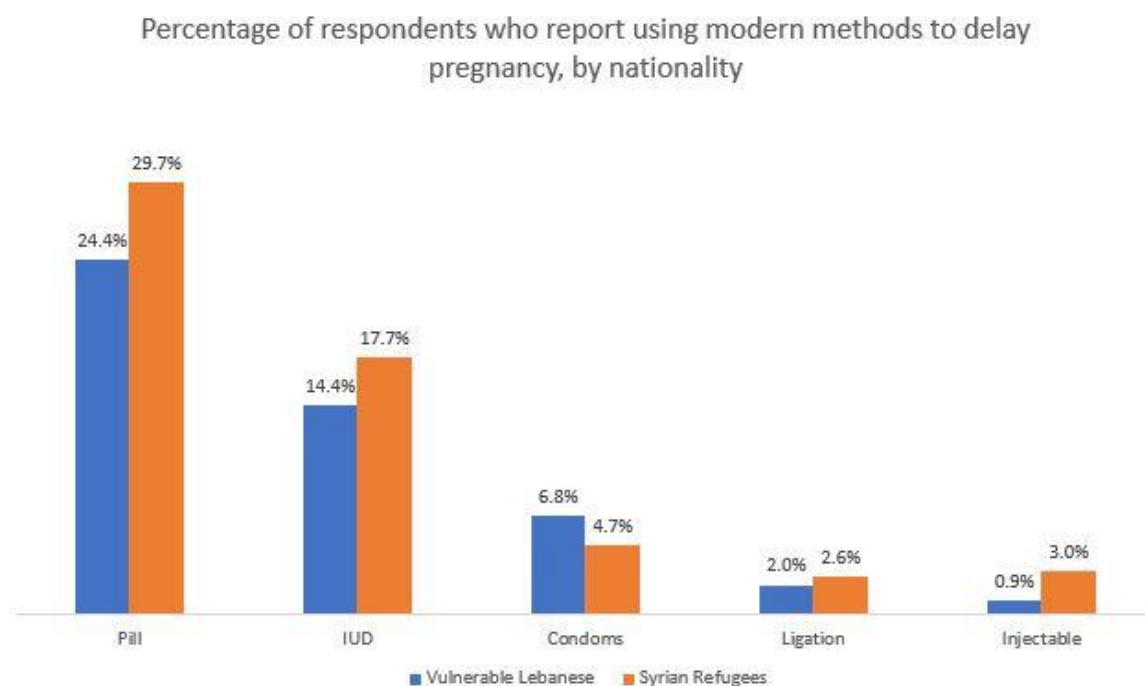
freq = 939/1529; CI: 48.1% - 64.6%) than vulnerable Lebanese women (38.8%; freq = 294 / 785). The chart below shows that the most commonly cited reasons for not using and form of birth control was that the respondent was breastfeeding for both populations. A third (31.2%) of Syrian refugees reported being pregnant as a reason for not using any method to delay pregnancy, compared to just under a fifth of Lebanese women in the sample (18.7%).



In relation to those who cited an 'other' response, most referred to the husband being away, deceased or incapacitated in some way; or a health problem or intolerance of contraceptive pills for the woman.

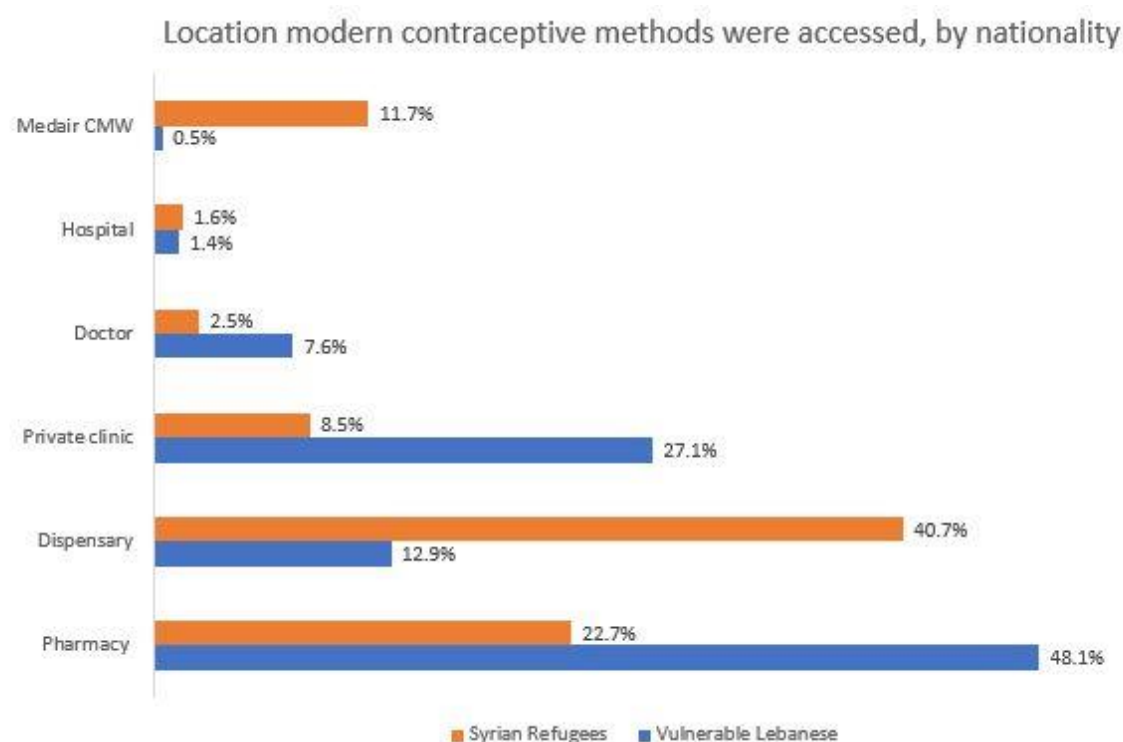
Of mothers of children under-two years of age who answered a question about birth control, 49.4% reported that they were using a modern method to delay pregnancy (pill, intrauterine device (IUD), condom, ligation, injectable or implant). Just over half of Syrian refugees (54.2%; freq = 188/347; CI: 46.8% - 61.4%) and just over four in ten vulnerable Lebanese women (41.8%; freq = 92/220; CI: 34.2% - 49.9%) reported using a modern contraceptive.

Withdrawal (a non-modern and unreliable method of birth spacing) was the most commonly cited method used to delay family planning. This method was used by 43.9% of Syrian refugees (freq = 253/576; CI: 37.8% - 50.2%) and 52.9% of vulnerable Lebanese women (freq = 243 / 459; CI: 46.0% - 59.7%). Of modern methods used, the chart below shows that contraceptive pills are the most commonly used modern method to delay pregnancy, followed by IUDs.



**Figure 24 - Percentage of respondents who report using modern methods to delay pregnancy, by nationality**

The chart below shows that pharmacies were the most common facility at which vulnerable Lebanese accessed modern contraceptive methods (48.1%; freq = 101/210; CI: 41.9% - 54.4%), while Syrian refugees were most likely to access these tools through SDC health clinics (40.7%; freq = 129/317; CI: 33.9% - 47.8%). It is notable that 11.7% of Syrian refugees (freq = 37/317; CI: 6.6%-19.7%) accessed family planning tools through a Medair CMW.



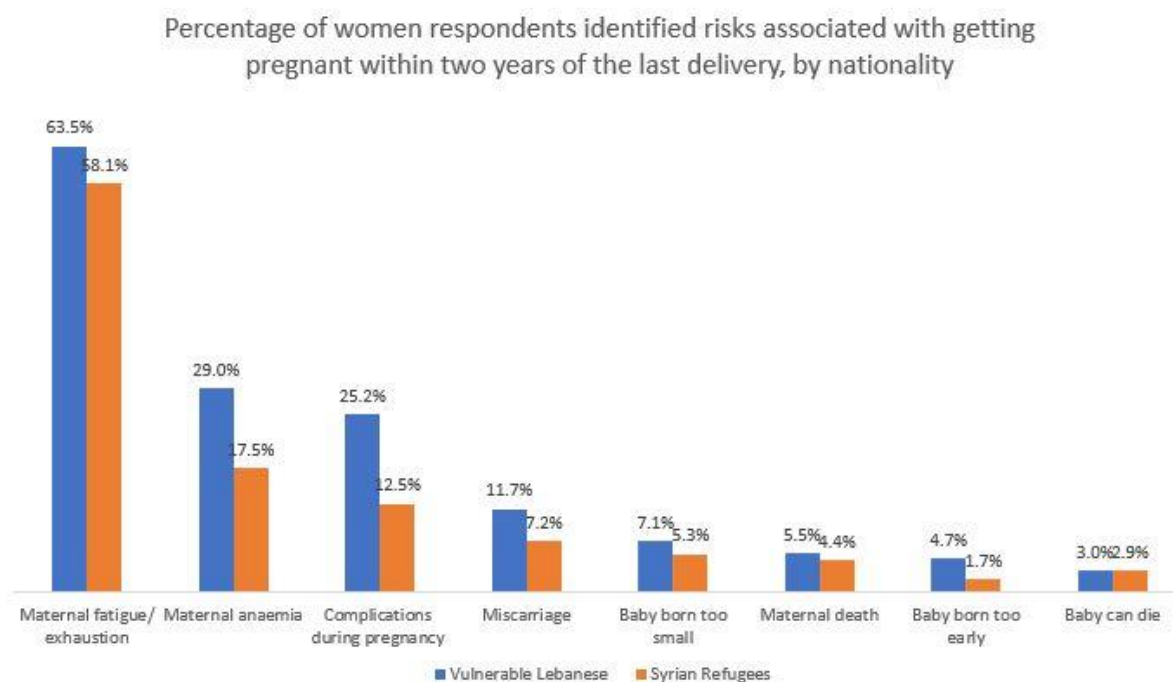
**Figure 25 - Location modern contraceptive methods were accessed by nationality**

## Birth Spacing

To identify whether the survey population was familiar with this recommendation, survey respondents were asked, “for you, what is the best time to get pregnant after delivery?.” Almost half of mothers of children 0-23 months (47.4%; freq = 685/1444; CI: 44.2% - 50.7%) knew that it is best to wait at least 24 months after last delivery before getting pregnant again (calculated as the percentage of women who answered that it is best to wait 2-5 years or more than 5 years after the last delivery). Syrian refugees were significantly less likely to correctly answer this question (42.1%, freq = 434/1032; CI: 38.9% - 45.2%) than vulnerable Lebanese women (60.9%; freq = 251/412; CI: 55.2% - 66.4%).

71.3% of mothers of children 0-23 months knew at least one risk of getting pregnant within two years of last delivery<sup>13</sup>. This was lower among Syrian refugee women (69.4%, CI: 65.5% - 73.0%) than vulnerable Lebanese women (76.0%, CI: 68.9% - 81.9%). The chart below shows that every accepted risk was identified by a higher proportion of vulnerable Lebanese women than Syrian refugees. Maternal fatigue/ exhaustion was the most commonly cited risk by both populations (63.5% of vulnerable Lebanese and 58.15% of Syrian refugees), followed by maternal anemia (29.0% and 17.5% respectively).

<sup>13</sup> Acceptable responses to this question included: baby born too small, baby born too early, baby can die, mother can die, mother can have miscarriage, mother can suffer from anemia, mother can suffer from fatigue or exhaustion, mother can have more complications during pregnancy like high blood pressure and bleeding, health issues (other), and baby not getting enough micronutrients (other).



**Figure 26 - Percentage of women respondents identified risks associated with getting pregnant within two years of the last delivery by nationality**

16.0% of Syrian refugees and 9.2% of vulnerable Lebanese admitted that they did not know any risks of getting pregnancy within two years of the previous delivery, while another 11.3% of vulnerable Lebanese women and 13.1% of Syrian refugees stated that there are no risks of getting pregnant within this timeframe.

Summary of indicator targets: Mortality in Pregnancy

**% of women's sisters who died due to problems related to pregnancy**

2019 result:	Vulnerable Lebanese	Syrian Refugees
<i>n</i> =	685	1443
<b>Estimate:</b>	<b>6.7%</b>	<b>5.9%</b>
95% CI Lower:	5.1%	4.8%
95% CI Upper:	8.7%	7.2%

## Mortality in Pregnancy

6.2% of women in the survey who had at least one sister, had at least one sister who “died just after delivering a child in Lebanon.” This was lower among Syrian refugees (5.9%, CI: 4.8% - 7.2%) than vulnerable Lebanese (6.7%, CI: 5.1% - 8.7%).

#### Summary of core indicator targets: Breastfeeding practices

##### **% of mothers of children 7-23 months who breastfed their child within 1 hour after delivery**

<b>2019 result:</b>	<b>Vulnerable Lebanese</b>	<b>Syrian Refugees</b>
<i>n</i> =	278	687
<b>Estimate:</b>	<b>66.5%</b>	<b>68.3%</b>
95% CI Lower:	60.4%	63.9%
95% CI Upper:	72.2%	72.3%

##### **% of infants 0-6 months who are exclusively breastfed (calculation method 1)**

<b>2019 result:</b>	<b>Vulnerable Lebanese</b>	<b>Syrian Refugees</b>
<i>n</i> =	134	345
<b>Estimate:</b>	<b>25.4%</b>	<b>32.8%</b>
95% CI Lower:	17.5%	27.5%
95% CI Upper:	35.2%	38.5%

##### **% of infants 0-6 months who are exclusively breastfed (calculation method 2)**

<b>2019 result:</b>	<b>Vulnerable Lebanese</b>	<b>Syrian Refugees</b>
<i>n</i> =	412	1025
<b>Estimate:</b>	<b>6.6%</b>	<b>11.1%</b>
95% CI Lower:	4.0%	9.2%
95% CI Upper:	10.6%	13.4%

## 6.9 Breastfeeding practices

Approximately nine in ten survey respondents reported that they ever breastfed their youngest child. Syrian refugees were significantly more likely (92.3%; freq = 953/1032; CI: 90.2% - 94.1%) than vulnerable Lebanese (83.7%; freq = 345/412; CI: 80.4% - 86.6%) to have breastfed their youngest child ( $p < 0.01$ ). When women who did not breastfeed their youngest child were asked why they did not breastfeed, the table below shows that a perception that they did not have enough milk was the most commonly cited reason.

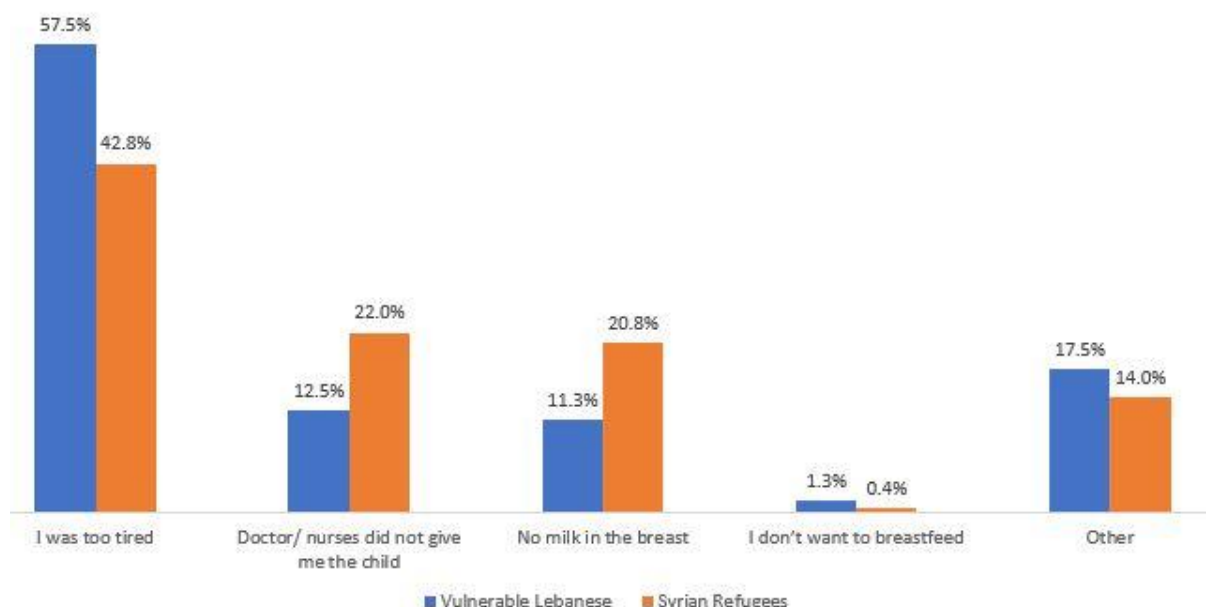


			Syrian refugees	Vulnerable Lebanese	Total
<b>No milk in breasts</b>	Estimate		67.1%	64.2%	65.8%
	95% Confidence Interval	Lower	55.8%	54.9%	58.5%
		Upper	76.7%	72.5%	72.3%
	Unweighted count		53	43	96
<b>Didn't have time/it wasn't convenient</b>	Estimate		5.1%	6.0%	5.5%
	95% Confidence Interval	Lower	1.9%	2.4%	2.8%
		Upper	13.0%	13.9%	10.4%
	Unweighted count		4	4	8
<b>I prefer to give my baby formula</b>	Estimate		6.3%	11.9%	8.9%
	95% Confidence Interval	Lower	2.4%	6.2%	5.1%
		Upper	15.9%	21.8%	15.0%
	Unweighted count		5	8	13
<b>Other</b>	Estimate		21.5%	17.9%	19.9%
	95% Confidence Interval	Lower	13.7%	10.5%	14.1%
		Upper	32.1%	28.9%	27.2%
	Unweighted count		17	12	29

Just two thirds of mothers of children aged 7-23 months in this sample (67.8%) reported that they had first “put [their] child to the breast within the first hour of birth. Rates were comparable between Syrian refugees (68.3%; freq = 469/687; CI: 63.9% - 72.3%) and vulnerable Lebanese (66.5%; freq = 185/278; CI: 60.4% - 72.2%; p = 0.64).

The chart below shows that when women who had not initiated breastfeeding within the first hour were asked for the reason for “not immediately putting [their] child to the breast”, the most common reason given among both populations was being too tired (57.5% of vulnerable Lebanese and 42.8% of Syrian refugees). This hints at a lack of available support; as does the concern raised that they did not have milk in their breasts (20.8% of Syrian refugees, 11.3% of vulnerable Lebanese). A fifth of Syrian Refugees and an eighth of vulnerable Lebanese women reported that medical providers had not given them their baby to breastfeed in the first hour.

### Reasons for not initiating breastfeeding within the first hour by nationality



**Figure 27 - Reasons for not initiating breastfeeding within the first hours by nationality**

Mothers of children under-five years who had delivered their youngest child by caesarian-section were less likely to have initiated breastfeeding in the first hour of birth (38.9% of Syrian refugees and 31.6% of vulnerable Lebanese). The high rates of caesarian-section, discussed above, may therefore contribute to the relatively low rate of initiation of breastfeeding within the first hour.

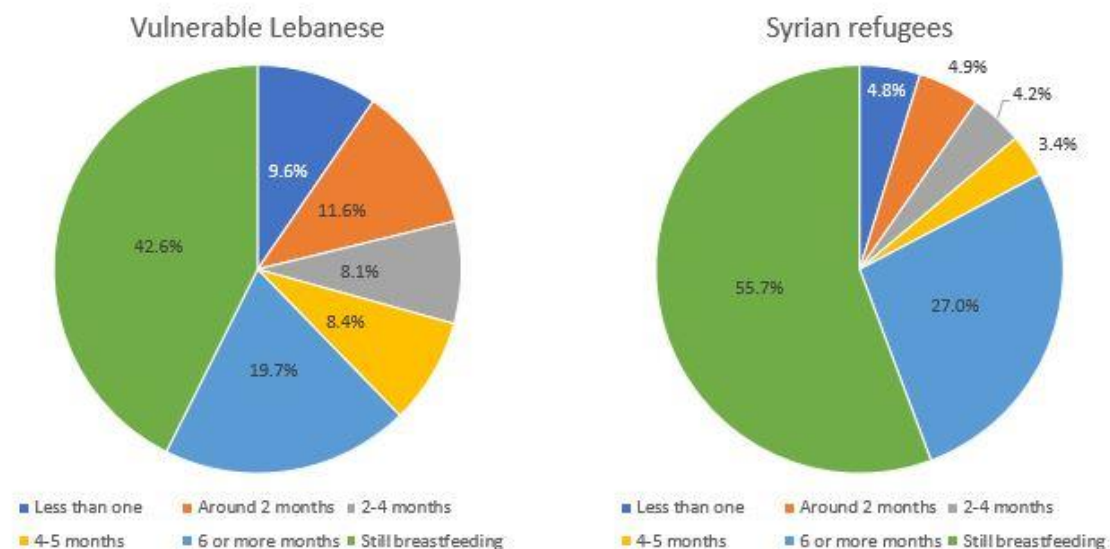
Less than a third of all mothers of infants under six months report that they are exclusively breastfeeding (30.7%). Syrian refugees with children in this age group appear to be slightly more likely to be exclusively breastfeeding (32.8%, freq = 113/345; CI: 27.5% - 38.5%) than their vulnerable Lebanese counterparts (30.7%, freq = 147/479; CI: 26.2% - 35.6%;  $p = 0.183$ ). The proportion of mothers of children under six months who reported that their child had not been fed any bottle/ powdered milk; water tea or alcohol; or “food from the house or from the market” (a proxy set of questions to triangulate the reported exclusive breastfeeding rate) was comparable, if slightly higher, than the reported breastfeeding rate. 40.7% of Syrian refugees and 33.3% of vulnerable Lebanese mothers of children under six months reported that they had not supplemented breastmilk with any of the foods or liquids mentioned.

However, a second calculation for the prevalence of exclusive breastfeeding for the first six months, using the responses of mothers of children aged 0-23 months to recall questions relating to whether children were fed water, tea or alcohol; food from the house or the market; or powdered milk during the first six months, triangulated with whether the child was still breastfeeding, points to an even lower rate of exclusive breastfeeding in these populations. Just 9.8% of the total sample met the criteria for exclusive breastfeeding for the first six months under this calculation (11.1% of Syrian refugees (freq= 114/1025; CI: 9.2% - 13.4%) and 6.6% of vulnerable Lebanese (freq = 27/415; CI: 4.0% - 10.6%);  $p = 0.04$ ).

Syrian refugees were more likely to breastfeed for over six months (27.0%; freq = 257/953; CI: 24.3%- 29.8%) than their Lebanese counterparts (19.7%; freq = 68/345; CI: 15.7% - 24.4%); or to still be breastfeeding their youngest child at the time of the survey (Syrian refugees: 55.7%; freq = 531/953;

CI: 52.4% - 59.0%; vulnerable Lebanese: 52.6%; freq =147/345; CI: 36.7% - 48.7%). This is shown in the chart below. While the survey did not provide information on the relative ages of respondents' youngest child, this data is suggestive that Syrian refugees breastfeed for longer than vulnerable Lebanese women.

Duration of breastfeeding of youngest child (of children who were ever breastfed), by nationality



**Figure 28 - Duration of breastfeeding of youngest child (of children who were ever breastfed), by nationality**

## 6.10 Child registration

Syrian refugees were asked whether they had received a birth certificate for their youngest child. The vast majority (93.9%; CI: 92.3% – 95.3%) responded that they had received this document. Almost eight in ten women (78.0%) reported that they had received the child's birth certificate from the hospital, with mokhtars (8.1%), doctors (6.2%), midwives (5.5%) also reported to have provided these documents.

## 6.11 Access to Psychosocial Services

Summary of core indicator targets: Psycho Social Support (PSS) services

### **% Women in the targeted communities who correctly identify available PSS services**

**2019 result:**                      **Vulnerable Lebanese**                      **Syrian Refugees**  
*n =*                                      758                                      1529

<b>Estimate:</b>	<b>29.4%</b>	<b>35.9%</b>
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95% CI Lower:	25.2%	32.2%
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95% CI Upper:	34.0%	39.7%
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### **% Women in the targeted communities who correctly report where to access PSS services**

**2019 result:**                      **Vulnerable Lebanese**                      **Syrian Refugees**  
*n =*                                      331                                      707

<b>Estimate:</b>	<b>48.9%</b>	<b>35.8%</b>
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95% CI Lower:	41.1%	32.1%
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95% CI Upper:	56.8%	39.7%
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### **% of mothers of children under-5 years who report discussing PSS with a trained service provider in the 12 months preceding the survey**

**2019 result:**                      **Vulnerable Lebanese**                      **Syrian Refugees**  
*n =*                                      758                                      1529

<b>Estimate:</b>	<b>6.1%</b>	<b>17.1%</b>
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95% CI Lower:	4.4%	14.5%
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95% CI Upper:	8.4%	17.1%
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### **% Women in the targeted communities who report that they would be comfortable and able to access these (PSS) services as needed**

**2019 result:**                      **Vulnerable Lebanese**                      **Syrian Refugees**  
*n =*                                      758                                      1529

<b>Estimate:</b>	<b>53.7%</b>	<b>46.6%</b>
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95% CI Lower:	49.0%	44.3%
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95% CI Upper:	58.3	49.0%
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### **% of mothers of children under-5 years who report accessing PSS support services in the 6 months prior to the survey**

**2019 result:**                      **Vulnerable Lebanese**                      **Syrian Refugees**  
*n =*                                      527                                      1153

<b>Estimate:</b>	<b>2.8%</b>	<b>3.2%</b>
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95% CI Lower:	1.7%	2.1%
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95% CI Upper:	4.7%	4.9%
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### **% of mothers of children under-5 years receiving PSS services who report satisfaction with support provided**

**2019 result:**                      **Vulnerable Lebanese**                      **Syrian Refugees**  
*n =*                                      20                                      48

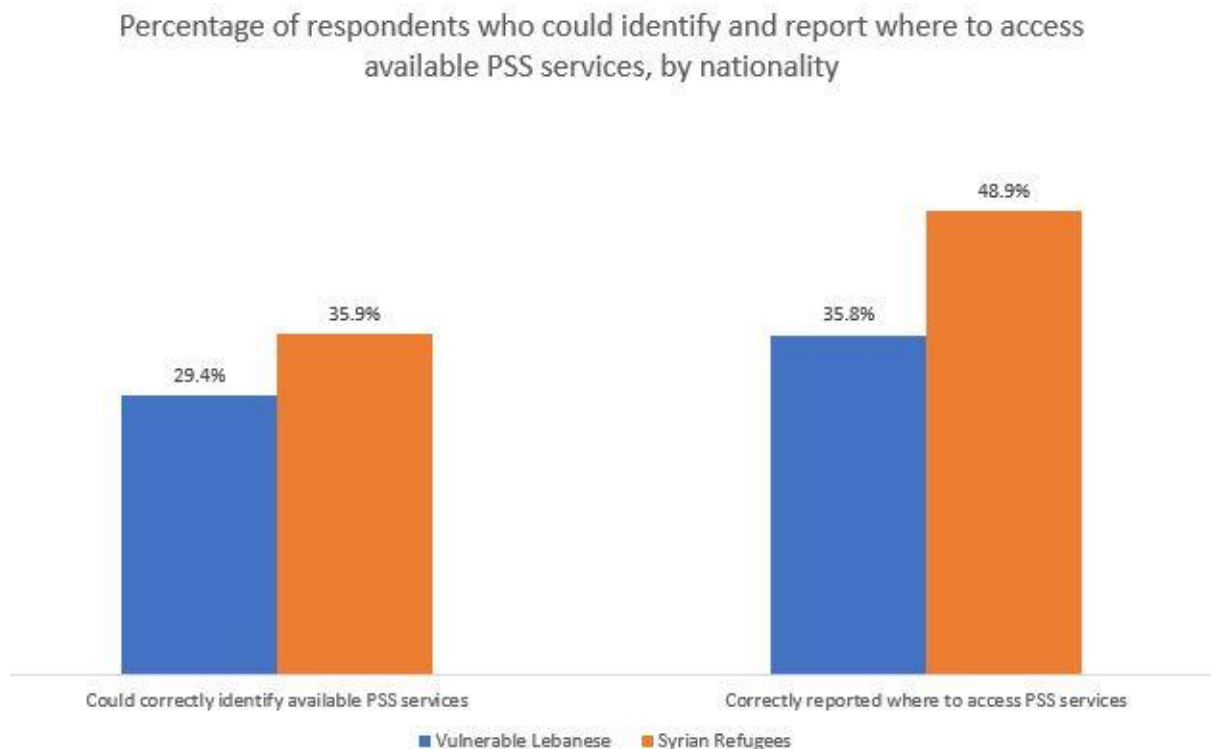
<b>Estimate:</b>	<b>95.0%</b>	<b>100%</b>
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95% CI Lower:	70.2%	100%
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95% CI Upper:	99.4%	100%
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The KPC survey found that over three quarters (75.7%) of Syrian refugees and over two thirds (69.5%) of vulnerable Lebanese agreed that in the past six months, they or someone they knew felt “sad, stressed, or under pressure.” However, as the chart below shows, just a third of women surveyed were able to identify available PSS services (acceptable responses included support groups, counselling, psychotherapy and psychotropic medicine) and four in ten women who responded to this question (*n* = 331 vulnerable Lebanese and 707 Syrian refugees) were able to report where to access these services (acceptable responses included SDC health clinics, clinics, NGOs and hospitals).

Syrian refugees were significantly more likely to be able to identify these services ( $p = 0.03$ ) and to correctly report where these services can be accessed ( $p = 0.03$ ).

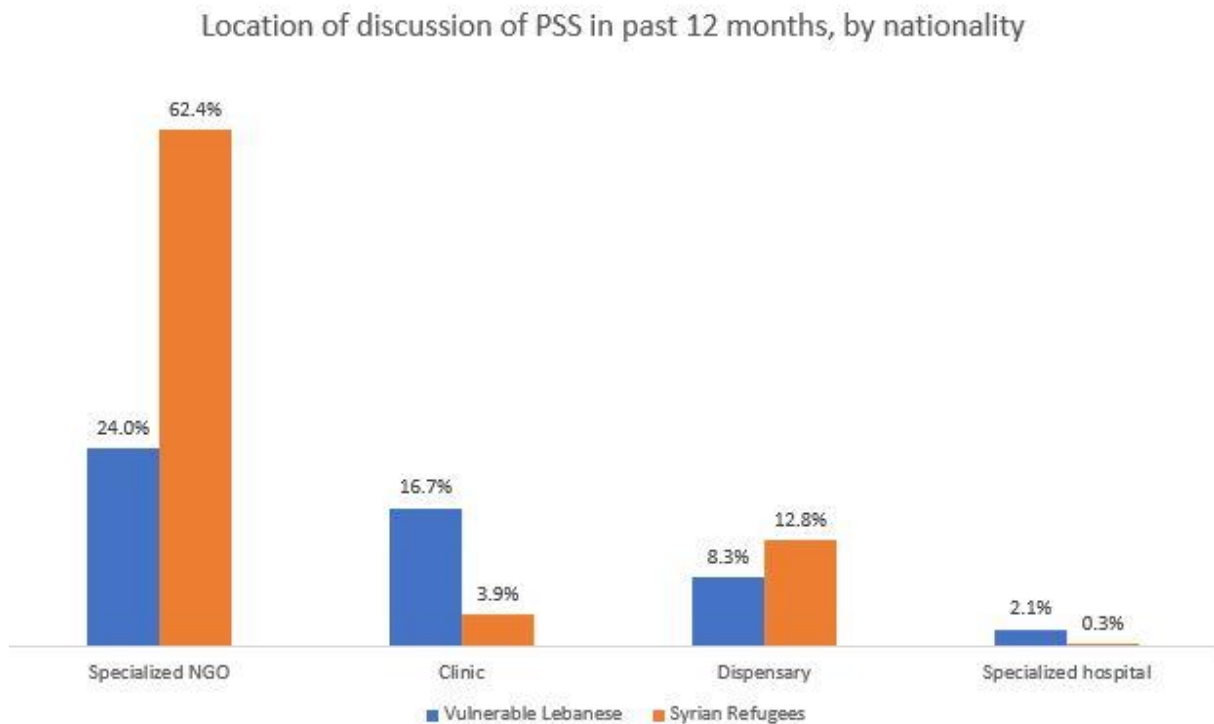


**Figure 29 - Percentage of respondents who could identify and report where to access available PSS services, by nationality**

The provision of mental health and psychosocial activities is understood by NGOs and UN agencies to be a critical component of supporting the well-being of individuals and communities in emergency situations. However, over four in ten vulnerable Lebanese respondents (41.6%; freq = 315/758, CI: 34.8% - 48.6%) reported the belief that there were no PSS available in their community, along with almost a quarter of Syrian refugees (24.2%; freq = 368/1523; CI: 20.2% - 28.6%;  $p < 0.01$ ).

13.4% of respondents reported that they had discussed “PSS with a trained service provider in the 12 months preceding the survey.” Syrian refugees were significantly more likely (17.1%; freq 261/1529; CI 14.5% - 20.0%) than vulnerable Lebanese women to have discussed PSS with a trained provider (6.1%; freq = 46/758; CI: 4.4% - 8.4%). As shown in the chart below, the most common response to a follow up question regarding where these discussions took place was “specialized NGO,” particularly among Syrian refugees (62.4%; freq = 209/335; CI: 54.9%-69.4%).

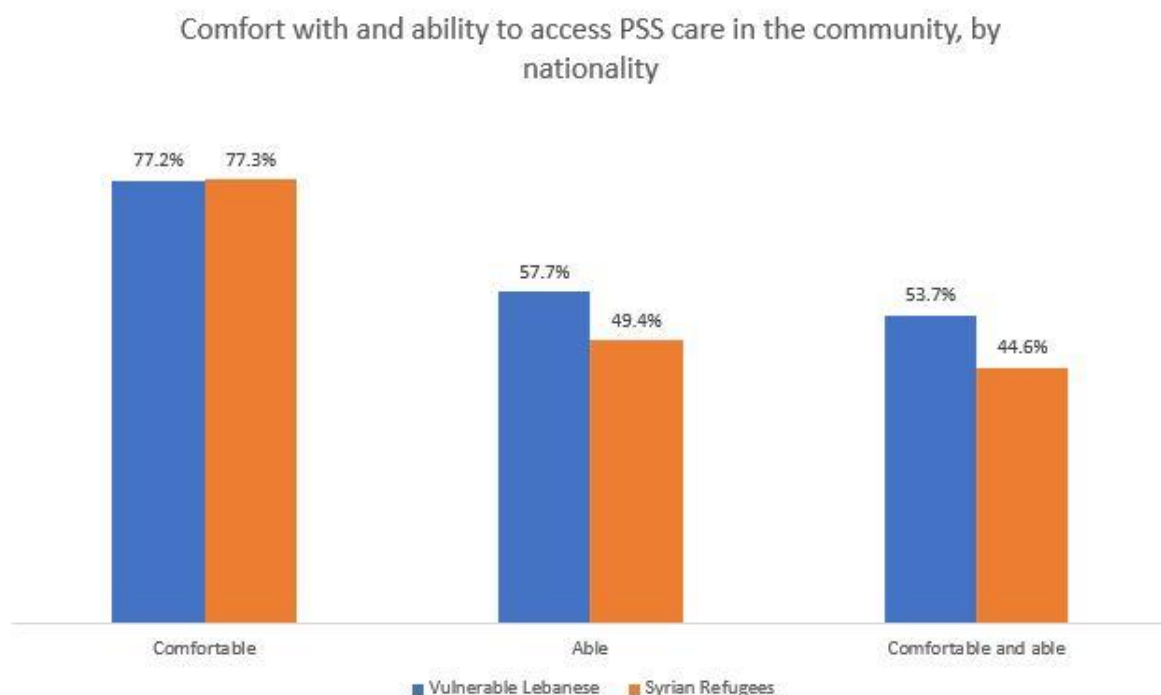
As shown in the table below, both Syrian refugees and vulnerable Lebanese were most likely to have accessed these services through a specialized NGO (24.0% of vulnerable Lebanese and 62.4% of Syrian refugees). Clinics were important PSS access points for vulnerable Lebanese (16.7%), while SDC health clinics were important for Syrian refugees (12.8%).



**Figure 30 - Location of discussion of PSS in past 12 months, by nationality**

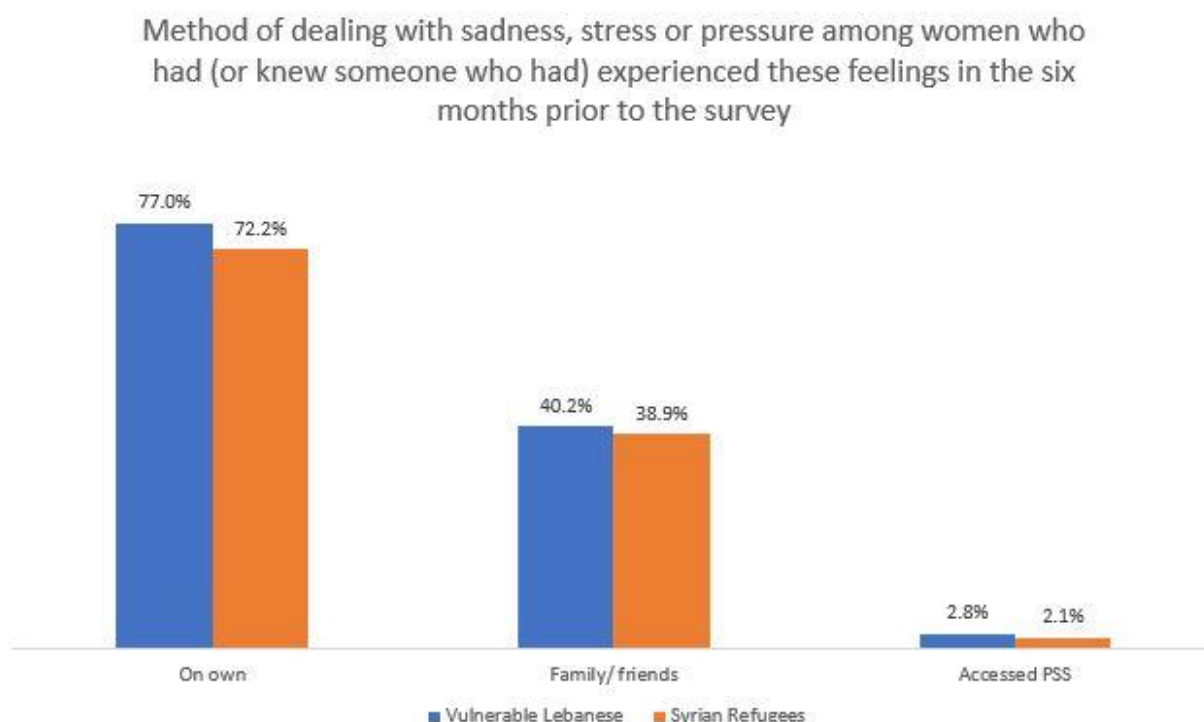
When asked why they did not access PSS, the expense was the most common reason cited by Syrian refugees (52.2%, compared to 39.8% of vulnerable Lebanese); while vulnerable Lebanese were most likely to report that they preferred to keep psychosocial matters personal (50.2%, compared to 37.7% of Syrian refugees).

Just under half of the survey respondents reported that they would be able to and comfortable accessing the support services in the community if they or someone they cared for needed psychological support (49%). Lebanese respondents were significantly more likely to report that they felt comfortable and able to access these services (53.7%; freq = 407/758; CI: 49.0% - 58.3%) than Syrian refugees (46.6%; freq = 713/1529; CI: 49.0% - 58.3%). The chart below shows that this difference is explained by the proportion of women who felt able to access PSS, which is higher among Syrian refugees than vulnerable Lebanese, while the proportion of women who reported that they would be comfortable accessing these services was almost identical between populations.



**Figure 31 - Comfort with and ability to access PSS care in the community, by nationality**

To calculate the percentage of mothers of children under-5 years who accessed PSS support services in the 6 months prior to the survey, women who responded that they or someone they know had felt sad, stressed, or under pressure in the six months prior to the survey were asked how they had dealt with this feeling. Those who answered that help was sought from a SDC clinic, health centre, NGO clinic, private clinic, specialized hospital, community based organization (CBO), CHVs or religious institutions were considered to have accessed PSS support services. As the indicator pertains to the percentage of mothers who accessed PSS, and not the percentage of mothers who accessed or know someone who accessed PSS, this is an imperfect calculation. However, the low results are revealing: just 3.2% of Syrian refugees (freq = 37/1153; CI: 2.1% - 4.9%) and 2.8% of vulnerable Lebanese (freq = 15/527; CI: 1.7% - 4.7%) who had themselves or knew someone who experienced sadness, stress or pressure in the past six months reported having accessed PSS care by this measure over this time period. As shown in the chart below, dealing with sadness, stress or pressure on their own or by reaching out to a friend or relative were much more common coping mechanisms that seeking PSS.



**Figure 32 - Method of dealing with sadness, stress or pressure among women who had (or know someone who had) experienced these feelings in the six months prior to the survey**

When women who had received PSS were asked whether they were satisfied with the PSS they received, there was near-universal agreement that the services had been satisfactory. 100% of the Syrian refugees who had access PSS reported that they were satisfied or very satisfied (freq = 48) and all but one of the vulnerable Lebanese women reported satisfaction (95.0%; freq = 19/20; CI: 70.2%-99.4%).

## 7. Discussion

### 7.1 Socio-demographics

Indicator	Medair KPC: Vulnerable Lebanese. Bekaa	Medair KPC: Syrian Refugees. Bekaa	VaSyR 2018: Syrian refugees nationally
<b>Marriage before 18</b>	22.2%	45.5%	29% of girls aged 15-19
<b>Illiteracy</b>	6.9%	38.8%	

Early marriage (formal or informal union where one or both parties are under 18 years of age) is a “fundamental violation of human rights” and prevention of early marriage is “now firmly on the development agenda.”<sup>14</sup> Early marriage often means the end to a girl’s formal education and the start of her child-bearing years – before she is emotionally or physically ready to be a mother. Child

<sup>14</sup> Unicef, *Child Marriage*, <https://data.unicef.org/topic/child-protection/child-marriage/>



brides face higher risks of death in childbirth and are particularly vulnerable to pregnancy-related illness and injury. Globally, complications in pregnancy and childbirth are the leading cause of death in girls aged 15-19 years.<sup>15</sup> The global Sustainable Development Goals (SDGs) therefore include target 5.3: Eliminate all harmful practices, such as child, early and forced marriage and female genital mutilation and Indicator 5.3.1: Proportion of women aged 20-24 years who were married or in a union before age 15 and before age 18.<sup>16</sup>

This KPC survey found that the prevalence of early marriage is very high among Syrian refugee women, with almost half (45.5%) having married before the age of 18, compared to just over one in five among vulnerable Lebanese. The rates observed in this KPC study are substantially higher than the most recent national estimates. While recent data is not available from either Syria or Lebanon, a 2006 MICS found that 13% of women in this age group were married by 18 years in Syria; while a 2009 MICS in Lebanon found that 6% of women in this age group had been married by 18.<sup>17</sup>

The 2018 *Vulnerability Assessment of Syrian Refugees in Lebanon (VASyR)* categorises early marriage as a “exploitation and abuse” and reports that 29% of female Syrian refugees in Lebanon aged 15 – 19 years were married (27% in Bekaa). The VASyR cautions that this has increased by 7% since 2017, and notes that just 2% of these married girls were enrolled in school or working<sup>18</sup>. Indeed, marriage was cited by 26% of females aged 15-18 who had dropped out of school as their reason for ceasing their education<sup>19</sup>.

The KPC survey found that the proportion of women who are illiterate was five times as high among Syrian refugees (38.8%) as vulnerable Lebanese (6.9%). The finding among vulnerable Lebanese is consistent with World Bank 2018 data, which reports literacy rates in Lebanon of 93% among females over 15 years (implying an illiteracy rate of 7%)<sup>20</sup>. However, World Bank 2004 data from Syria that shows a literacy rate of 74% among females over 15 years (and an implicit illiteracy rate of 26%) suggesting that literacy rates among this population may be in decline, consistent with global evidence that “conflict has a devastating impact on education and literacy<sup>21</sup>.”

In addition to the persistent conflict in their home country, high prevalence of illiteracy among Syrian refugee women may be related to the very high rates of early marriage among this population. There is a well-established link between early marriage and the end of a girls’ educational opportunities, which negatively impacts literacy. The World Bank reports “once a girl is married, it is very rare that she is also in school,” and demonstrates an intergenerational effect by which the children of girls who marry early receive less education than the children of women who do not experience early marriage<sup>22</sup>.

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<sup>15</sup> Girls Not Brides, <https://www.girlsnotbrides.org/themes/health/>

<sup>16</sup> United Nations, Sustainable Development Goal 5: Achieve gender equality and empower all women and girls, <https://sustainabledevelopment.un.org/sdg5>

<sup>17</sup> UNICEF global databases, 2019, based on Demographic and Health Surveys (DHS), Multiple Indicator Cluster Surveys (MICS) and other nationally representative surveys, [https://data.unicef.org/wp-content/uploads/2017/11/Child-marriage-database\\_Oct-2019.xlsx](https://data.unicef.org/wp-content/uploads/2017/11/Child-marriage-database_Oct-2019.xlsx)

<sup>18</sup> UNHCR, UNICEF & WFP, 2018, *Vulnerability Assessment of Syrian Refugees in Lebanon (VASyR 2018)*; pp 37

<sup>19</sup> UNHCR, UNICEF & WFP, 2018, *Vulnerability Assessment of Syrian Refugees in Lebanon (VASyR 2018)*; pp 150

<sup>20</sup> World Bank Data, Literacy rate, adult female (% of females ages 15 and above) <https://data.worldbank.org/indicator/SE.ADT.LITR.FE.ZS>

<sup>21</sup> Hanemann, U. (2005). *Literacy in conflict situations*. UNESCO Institute for Education, Hamburg, Germany.

<sup>22</sup> Wodon, Q., C. Male, A. Nayihouba, A. Onagoruwa, A. Savadogo, A. Yedan, J. Edmeades, A. Kes, N. John, L. Murithi, M. Steinhaus and S. Petroni (2017). *Economic Impacts of Child Marriage: Global Synthesis Report*, Washington, DC: The World Bank and International Center for Research on Women.

## 7.2 Health seeking behavior

Almost all respondents reported that they or their children had needed medical services in the year prior to the survey (89.9% of Syrian refugees and 79.3% of vulnerable Lebanese). While over 95% of both populations had been able to access health care sometimes or each time they needed care, Vulnerable Lebanese were significantly more likely to have been able to access care each time it was needed (67.1% versus 49.1%). Consistent with the Medair project design, Syrian refugees relied heavily on SDC health clinics (78.0%). Vulnerable Lebanese were approximately equally likely to have visited a SDC health clinic (49.6%) and a private clinic (48.6%).

Medair supported SDC health clinics (SDCs) continue to comprise a crucial health access point for both populations, particularly among Syrian refugees. **However, 44.5% of Syrian refugees and 38.5% of vulnerable Lebanese respondents who did not visit a Medair SDC had not heard of these SDC health clinics, highlighting a need to raise awareness of these services.** Investigation may also be warranted into the reputation of these clinics, as a small number of respondents (4 Syrian refugees and 7 vulnerable Lebanese) reported that the reason they had not visited a Medair SDC health clinic because of “bad services” and a further 16 reported “mistreatment” (8 Syrian refugees and 8 vulnerable Lebanese).

## 7.3 Non-Communicable Diseases (NCD)

*Project Target: 15% increase in % of women who know 2 or more ways to reduce the risk of NCDs<sup>23</sup>*

Indicator	Medair KPC: Vulnerable Lebanese. Bekaa	Medair KPC: Syrian Refugees. Bekaa	UNHCR 2018: Syrian refugees nationally
% HHs with at least one member with a chronic condition*	18.6%	18.8%	36%
% of women who know 2 or more ways to reduce the risk of NCDs	53.7%	30.4%	
*UNHCR's survey covered all chronic illnesses. Medair's covered only hypertension and diabetes. This contributes to the difference in results.			

Medair's Tearfund/Canadian government-funded project has objectives to use CHVs to provide NCD risk assessments and education at household level, and improve doctor and nurse NCD diagnosis, treatment and follow-up. The project also plans to assist SDC SDC health clinics to track each individual patient efficiently, and support the establishment of a pilot NCD clinic.

**The survey found very similar rates of women who reported having at least one household member who had been diagnosed with hypertension and/or diabetes between the study populations, at around 18% among Syrian refugees and vulnerable Lebanese.** While there was no statistical difference in the proportion of women who reported having at least one household member with hypertension (14.0% of vulnerable Lebanese and 15.7% of Syrian refugees), vulnerable Lebanese were significantly less likely to report having at least one household member with diabetes (11.7%) than their Syrian refugee counterparts (8.7%).

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<sup>23</sup> WRC Proposal multi-year funding -Lebanon, p35

Overall, **levels of knowledge about how to minimise risk of hypertension and diabetes was poor in both sampled groups.** This knowledge was particularly lacking among Syrian refugees, who were able to identify two or more ways of reducing the risk of NCDs at half the rate of their Lebanese counterparts. Syrian refugees were significantly less likely to identify every one of the risk factors included in this analysis, with the single exception of alcohol consumption.

It is notable that just 8% of vulnerable Lebanese women and 2.5% of Syrian refugees identified smoking cessation as an NCD reduction strategy. This is concerning as Lebanon ranks in the top 20 countries by smoking prevalence among adult females (27%, 2016)<sup>24</sup>, and the prevalence of smoking among adult men in Lebanon is even higher, at 41%. The global Tobacco Atlas reports that 21% of Syrian males over the age of 15 smoke, compared to 8.1% of women.<sup>25</sup> No data is available for the prevalence of smoking among Syrian women or men in Lebanon.

Similarly, the low numbers of respondents who identified “reduce weight if overweight” in both sampled population groups may be cause for a concern, as over two thirds of Lebanese adults (67.4%; 69.1% of females and 66.9% of males) and over six in ten (61.4%; 65.4% of females and 57.3% of males) of Syrian adults have been found to be overweight<sup>26</sup>.

Serious consideration should therefore be given to redoubling efforts to encourage smoking cessation and raising awareness about the risk of NCDs related to being overweight. However, the lack of difference in the total rates of diabetes and /or hypertension (and the higher rate of diabetes reported), despite the vastly superior knowledge of the Lebanese population with regard to the risk factors associated with NCDs, suggest that knowledge is not sufficient to reduce risky behaviors and suggests that efforts that go beyond awareness raising may be required.

## 7.4 Vaccinations

**Project target:** >90% of children aged 6 months to 5 years who are vaccinated for measles in clinics coverage area (WRC)

Indicator	Medair KPC: Vulnerable Lebanese. Bekaa	Medair KPC: Syrian Refugees. Bekaa	UNHCR 2018: Syrian refugees nationally	National estimates
Had received measles vaccination	57.5%	44.5%		Lebanon: 82% Syria: 63% (aged 12-23 months)
Had received polio vaccination	79.3%	72.1%	83%	Lebanon: 81% Syria: 53% <sup>27</sup>
Had received DPT vaccination	78.6%	68.4%		Lebanon: 83% Syria: 47% <sup>28</sup>
Received age-appropriate vaccines	32.5%	23.6%		

24 World Bank Data, Smoking prevalence, females (% of adults), <https://data.worldbank.org/indicator/SH.PR.V.SMOK.FE>

25 The Tobacco Atlas, Prevalence, <https://tobaccoatlas.org/topic/prevalence/>

26 World Bank, Data Bank, Health and Nutrition Population Statistics, Prevalence of overweight (% of adults), <https://databank.worldbank.org/reports.aspx?source=311&series=SH.STA.OWAD.ZS>

27 Unicef, Immunization, <https://data.unicef.org/topic/child-health/immunization/>

28 Unicef, Immunization, <https://data.unicef.org/topic/child-health/immunization/>

Through its Tearfund/Canadian government-funded project, Medair is providing immunisations through the SDC health clinics it supports in collaboration with MoSA and MoPH. CHVs are also trained and supervised to include promotion of vaccination in their community contacts. Approximately half of all respondents (49.7% of Syrian refugees and 51% of vulnerable Lebanese women) were able to produce a vaccination card. This may limit the applicability of the data generated by the survey to the population as a whole.

Vaccine coverage was higher among vulnerable Lebanese than Syrian refugees, particularly for measles and DPT. Rates of vaccine coverage among children aged 12 months to five years remain low, with just over half of vulnerable Lebanese (57.7%) and less than a half of Syrian refugees vaccinated against measles; under three quarters of both populations vaccinated against polio (79.3% of vulnerable Lebanese and 72.1% of Syrian refugees); and 78.6% of vulnerable Lebanese and 68.4% of Syrian refugees vaccinated against DTP.

Less than a third of vulnerable Lebanese had received the full complement of age-appropriate vaccinations set out in the Ministry of Public Health vaccination calendar (32.5%). This result was much lower among Syrian refugees (23.6%).

**As the table below shows, the vaccination coverage rate in the survey population falls short of herd immunity** (the cortical threshold of immunization coverage at which a population is protected from a disease) for all diseases considered. This population in the project area is therefore at risk of disease outbreaks. Indeed, Zahle in Central Bekaa: one of Medair's project locations, was cited as the center of a measles outbreak early in 2018. The call to intensify existing immunization campaigns cannot be over-emphasized<sup>29</sup>.

	Herd immunity level	KPC survey result
<b>Measles</b>	93-95% <sup>30</sup>	48.8%
<b>Polio</b>	80-85% <sup>31</sup>	70.7%
<b>Tetanus</b>	NA	72.0% (Pentavent)
<b>Diphtheria</b>	80-85% <sup>32</sup>	72.0% (Pentavent)
<b>Pertussis</b>	92-94%	72.0% (Pentavent)

Much more work is required by the health care community to raise coverage of the Lebanese and Syrian refugee communities to the level of herd immunity and to reach the project goal of >90% measles vaccination rates.

## 7.5 Childhood illnesses: Acute respiratory illness (ARI)

**Project target:** 15% increase in children under-5 with fast or difficult breathing for whom advice or treatment was sought from an appropriate health facility or provider (WRC)

<sup>29</sup> MoPH, 2018, MOPH Warns Against Measles Outbreak in Lebanon and Assures It will Secure Vaccines Free of Charge. 19/3/2018, MoPH press release. At URL: <https://www.moph.gov.lb/en/Pages/127/16118/moph-warns-against-measles-outbreak-in-lebanon>

<sup>30</sup> Funk, S. (2017). Critical immunity thresholds for measles elimination. Centre for the Mathematical Modelling of Infectious Diseases, London School of Hygiene & Tropical Medicine.

<sup>31</sup> Oxford Vaccine Group, (2016) Herd Immunity: How does it work?, <https://www.ovg.ox.ac.uk/news/herd-immunity-how-does-it-work>

<sup>32</sup> WHO, Diphtheria vaccine: review of evidence on vaccine effectiveness and immunogenicity to assess the duration of protection ≥10 years after the last booster dose.

[https://www.who.int/immunization/sage/meetings/2017/april/2\\_Review\\_Diphtheria\\_results\\_April2017\\_final\\_clean.pdf](https://www.who.int/immunization/sage/meetings/2017/april/2_Review_Diphtheria_results_April2017_final_clean.pdf)

Indicator	Vulnerable Lebanese	Syrian Refugees	VaSyR 2018: Syrian refugees nationally
% of children under-5 years that had fast or difficult breathing in the last 2 weeks	10.6%	17.9%	67% (cough, under-two years)

The most concerning and common complication of ARI is pneumonia, which accounts for 15% of all deaths of children under-five years old<sup>33</sup>. **The KPC found that Syrian refugees were significantly more likely to have experienced fast or difficult breathing in the two weeks prior to the survey (10.6%), consistent with ARI, than their vulnerable Lebanese counterparts (17.9%).**

**Few children (and significantly fewer Syrian refugee children) who had cough or fast breathing were taken to an appropriate health facility or provider for the symptoms of ARI**, defined as a doctor, a clinic or a hospital, excluding SDC health clinics (11.5% of Syrian refugees and 25.6% of vulnerable Lebanese children). It is unclear why SDC health clinics were not considered an appropriate health care contact for ARIs, as WHO specifically notes that trained community health workers can diagnose and treat ARIs effectively<sup>34</sup>. When SDC health clinics are included health facilities at which care for these symptoms was sought, Syrian children are just as likely (46.8%) as their vulnerable Lebanese counterparts (44.7%) to have accessed care ( $p = 0.642$ ). It is evident that SDC health clinics represent an important health contact point for both populations, as they are the most common health care access point for Syrian children with ARI (47.3%), and second most common (after private clinics) for vulnerable Lebanese children (25%). However, even with SDC health clinics included in the calculation, **rates of treatment seeking remain low at less than half of each population sample, indicating that further efforts to encourage parents and care givers to seek treatment for ARIs are required.**

Analysis of the types of treatment utilized reveals that there is a proclivity to treat the symptoms, rather than the underlying cause of the illness, and that appropriate treatment protocols are not widely observed. Cough drops were the most common treatment for ARI among both populations, followed by pain killers. **Antibiotics, which are recommended in the treatment of ARI<sup>35</sup>, were only used by approximately a third of each population** (37.0% of Syrian refugees and 33.6% of vulnerable Lebanese). These drugs are highly effective and inexpensive, so it is unclear why their appropriate use is not more widespread.

## 7.6 Childhood illnesses: Diarrhea

Indicator	Vulnerable Lebanese	Syrian Refugees	VaSyR 2018: Syrian refugees nationally
% of children under-5 years that experienced diarrhea in the last 2 weeks	36.5%	21.6%	53% (under-two years)

<sup>33</sup> WHO, Pneumonia Factsheet, <https://www.who.int/news-room/fact-sheets/detail/pneumonia>

<sup>34</sup> WHO, Pneumonia Factsheet, <https://www.who.int/news-room/fact-sheets/detail/pneumonia>

<sup>35</sup> WHO, Pneumonia Factsheet, <https://www.who.int/news-room/fact-sheets/detail/pneumonia>

Diarrhea is a leading killer of children, accounting for approximately 8 per cent of all deaths among children under age 5 worldwide in 2017.<sup>36</sup> This project therefore aims to provide behavior change communication for diarrhea treatment to mothers and other caretakers<sup>37</sup>. However, diarrhea remains highly prevalent, **with over one third of Syrian refugees (36.5%) and one fifth of vulnerable Lebanese (21.6%) reporting that any of their children under-five years experienced diarrhoea in the two weeks prior to the survey.**

It is encouraging to see that **the majority of respondents who reported that they had at least one child with diarrhea had sought treatment** (88.2% of Syrian refugees and 77.4% of vulnerable Lebanese); and that treatment was generally sought soon after the diarrhea was noticed.

However, despite high rates of treatment seeking, treatments given are not consistent with global recommendations. UNICEF and the World Health Organization (WHO) have long recommended treating childhood diarrhea by replacing lost fluids with continued feeding and ORS. More recent studies have shown that zinc supplementation has a significant and beneficial impact on the clinical course of acute diarrhea, reducing both its duration and severity. The recommended standard treatment for diarrhea therefore now includes both ORS and zinc<sup>38</sup>. **It is highly concerning that less than 5% of both populations reported that their child had received this protocol (3.4% of Syrian refugees and 4.3% of vulnerable Lebanese). This was due to both very low usage rate of zinc supplementation (9.0% among Syrian refugees and 12.6% among vulnerable Lebanese), and moderate use of ORS (approximately half of both groups).**

Furthermore, UNICEF and the World Health Organization (WHO) caution that antibiotics should be used “only when appropriate, i.e. in the presence of bloody diarrhea or shigellosis.”<sup>39</sup> However, **antibiotics were reported to be the most commonly utilized treatment for diarrhea (64.4% of Syrian refugees; 57.5% of vulnerable Lebanese).** It is possible that this is a recall error on the part of mothers, who assume that the medications their children have been given are antibiotics, that the prescribing practices of health workers are inappropriate and/or that parents request antibiotics under the misapprehension that they represent optimal treatment. Investigation into the apparent over-prescription of antibiotics is therefore warranted.

## 7.7 Reproductive health (including antenatal care, postnatal care and family planning)

Indicator	Medair KPC: Vulnerable Lebanese. Bekaa	Medair KPC: Syrian Refugees. Bekaa
Percentage of women able to and comfortable accessing RH services	84.8%	76.4%

<sup>36</sup> UNICEF, *Diarrheal Disease*, <https://data.unicef.org/topic/child-health/diarrhoeal-disease/>

<sup>37</sup> WRC Proposal multi-year funding -Lebanon, p8

<sup>38</sup> WHO/UNICEF Joint Statement: *Clinical management of acute diarrhoea*, 2004, [https://www.unicef.org/publications/files/ENAcute\\_Diarrhoea\\_reprint.pdf](https://www.unicef.org/publications/files/ENAcute_Diarrhoea_reprint.pdf)

<sup>39</sup> WHO/UNICEF Joint Statement: *Clinical management of acute diarrhoea*, 2004, [https://www.unicef.org/publications/files/ENAcute\\_Diarrhoea\\_reprint.pdf](https://www.unicef.org/publications/files/ENAcute_Diarrhoea_reprint.pdf)

<b>% of women who had accessed RH services in the six months prior to the survey</b>	40.0%	41.6%
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Reproductive health is defined as a “state of complete physical, mental and social well-being... in all matters relating to the reproductive system and to its functions and processes. Reproductive health implies that people .... have the capability to reproduce and the freedom to decide if, when and how often to do so”<sup>40</sup>. The United Nations High Commission for Refugees (UNHCR) acknowledges that “access to quality reproductive health services, including adequate emergency obstetric care, can drastically reduce the number of women who die during or after childbirth and ensure that mothers and their children enjoy a healthy life,” yet warns that in many cases, vulnerable populations are not able to access quality reproductive health services.

This KPC survey shows that just under nine in ten women in both populations were able to identify at least one RH service available in their community; and a similar proportion could identify where these services were available. ANC was the most service most commonly identified as available by both groups, followed by postnatal care. Given the inferiority of Syrian refugees access to PNC (discussed below), it is notable that the proportion of Syrian refugees who identified PNC (66.8%) is substantially lower than the proportion of Lebanese who identified this service (75.9%,  $p = 0.002$ ). It is also concerning that less than a third of respondents reported awareness that family planning services and care for STIs were available.

While a high and similar proportion of women in both sample groups reported that they would be comfortable and able to access RH services (over 95%), the proportion of Syrian refugees who reported that they would be able to access these services was significantly lower than the proportion of vulnerable Lebanese women who reported that they would be able to do so (76.4% versus 84.4%). **Monetary constraints were the primary barrier to accessing RH services, and a non-negligible number of women (24) reported “mistreatment” as a barrier to access.**

**Similar proportions of women in each sample group reported having accessed services related to RH in the six months prior to the survey (40.0% of vulnerable Lebanese and 41.6% of Syrian refugees).** Approximately three quarters of respondents who had accessed RH reported having accessed antenatal care while approximately half of all respondents had accessed postnatal care. Just one in ten respondents reported having accessed family planning services.

Again, we observe that Syrian refugees relied heavily on SDC health clinics for RH (64.6%), while far fewer vulnerable Lebanese women accessed RH through these services (21.5%). Vulnerable Lebanese were once again more likely to access services through private clinics (60.1%), while just 23.1% of Syrian refugees accessed RH through private clinics.

## Antenatal Counselling

**Project target:** >90% of mothers of children under-two years of age who had 4 comprehensive antenatal visits when they were pregnant with their youngest <sup>41</sup>

Indicator	Medair KPC: Vulnerable Lebanese. Bekaa	Medair KPC: Syrian Refugees. Bekaa	UNHCR 2018: Syrian refugees nationally <sup>42</sup>
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40 World Health Organization, Reproductive health, <https://www.who.int/westernpacific/health-topics/reproductive-health>

<sup>41</sup> WRC Proposal multi-year funding -Lebanon, p35



<b>Received at least 4 ANC contacts</b>	78.6%	61.6%	51%
<b>Where ANC was received:</b>	SDC health clinic: 15.3% Private clinic: 83.4%	54.8% 41.8%	SDC health clinic/PHC: 56% Private clinic: 43%

ANC is widely accepted to “reduce maternal and perinatal morbidity and mortality” both directly, through detection and treatment of pregnancy-related complications, and indirectly, through the identification of women and girls at increased risk of developing complications during labour and delivery.<sup>43</sup> Until recently, WHO recommended four-visit focused antenatal care. While this recommendation has now been withdrawn in favour of more comprehensive antenatal care models with a minimum of eight contacts to reduce perinatal mortality and improve women’s experience of care”,<sup>44</sup> the four-visit model used here provides a good comparison point.

In this KPC survey, just two thirds of mothers of children under-two years of age had at least four antenatal visits when they were pregnant with their youngest child, suggesting that the WHO ANC standard of care for the study populations is not met for the 4-visit model, let alone the more comprehensive 8-visit model. Syrian refugees were significantly less likely (61.6%) to have received at least four ANC contacts than vulnerable Lebanese (78.6%). Syrian refugees were also significantly less likely to access ANC in the first trimester (84.6% versus 92.5%) and to have accessed ANC in the final month of pregnancy (87.8% versus 92.7%).

As with other health services, this survey demonstrated that Syrian refugees rely heavily on SDC health clinics for ANC (54.8%), while vulnerable Lebanese strongly prefer private clinics (83.4%), once again highlighting the importance of these services for this highly vulnerable population.

## Delivery

Indicator	Medair KPC: Vulnerable Lebanese. Bekaa	Medair KPC: Syrian Refugees. Bekaa	UNHCR 2018: Syrian refugees in Lebanon <sup>45</sup>
<b>Delivered in hospital</b>	91.8%	81.4%	88%
<b>Why not in a hospital:</b>	Cost: 100% (n=2)	Cost: 46.5% Labour too fast: 24.0%	Cost: 50% Availability of a local midwife: 50%
<b>Assisted by a doctor</b>	97.5%	80.6%	
<b>% c-sections out of deliveries in health facilities</b>	59.0%	29.8%	31%

<sup>42</sup> UNHCR, 2018, *Health access and utilization survey among Syrian refugees in Lebanon*. At URL: <https://reliefweb.int/report/lebanon/health-access-and-utilization-survey-among-syrian-refugees-lebanon-december-2018>, p4

<sup>43</sup> World Health Organization. (2016). WHO recommendations on antenatal care for a positive pregnancy experience. World Health Organization.

<sup>44</sup> World Health Organization, 2018, *WHO recommendation on antenatal care contact schedules*, <https://extranet.who.int/rhl/topics/improving-health-system-performance/who-recommendation-antenatal-care-contact-schedules>

<sup>45</sup> UNHCR, 2018, *Health access and utilization survey among Syrian refugees in Lebanon*. At URL: <https://reliefweb.int/report/lebanon/health-access-and-utilization-survey-among-syrian-refugees-lebanon-december-2018>, p5



**Nine in ten vulnerable Lebanese women delivered their youngest child in hospital, significantly higher than the rate among Syrian refugees (eight in ten).** SDC health clinics account for almost all the remaining births among the vulnerable Lebanese population (7.9%), and 10.2% of Syrian refugees continue to rely on SDC health clinics for these services. Births in informal settlements are almost non-existent among vulnerable Lebanese women, but still account for 4.6% of births for Syrian refugee mothers.

**There are two clear reasons for the choice not to deliver in hospital among Syrian refugees: expense (46.5%) and rapid labour (24.0%).** Both of the two vulnerable Lebanese women who gave reasons for not delivering in hospital cited cost. Syrian refugees were more likely to have paid for their hospital stay when delivering their youngest child, although the data suggests that they tended to pay less than vulnerable Lebanese women who paid for these services.

Consistent with the rates of hospital deliveries, almost all vulnerable Lebanese women reported having been assisted in the birth of their youngest child by a doctor. While the rate of doctor-assisted delivery was reasonably high among Syrian refugees, it was significantly lower (80.6%). Midwives were the second most commonly cited birthing assistant, assisting in 16.0% of births among the Syrian refugee population and 5.5% of the vulnerable Lebanese population.

The rates of caesarean section are very high among both populations, and significantly higher among the vulnerable Lebanese (59.0%) than Syrian refugees (29.8%) possibly partially explaining the higher costs vulnerable Lebanese reported incurring for their hospital deliveries. **These rates are substantially higher than the WHO recommendation that a “caesarean delivery rate of 15% should be taken as a threshold that should not be exceeded,”<sup>46</sup>** suggesting that many of these deliveries may be unnecessary. Caesarean sections can increase the risk of maternal morbidity, neonatal death and neonatal admission to an intensive care unit and decrease the rate of early initiation and exclusive breastfeeding,<sup>47</sup> so should be undertaken only when medically necessary. Furthermore, the result for the Lebanese cohort is above the national rate of 47.1%.<sup>48</sup> While recent data is not available for Syria, 2004-2009 data is approximately consistent with the finding of this survey (26.0%)<sup>49</sup> and a 2018 UNHCR survey of Syrian refugees in Lebanon (31%)<sup>50</sup>. The high rates of caesarean sections, coupled with the dangers associated with unnecessary caesarean sections, warrants investigations into the basis on which these surgeries are performed.

## Postnatal care

It is widely acknowledged the postnatal period (the days and weeks following childbirth) is a critical phase in the lives of mothers and newborn babies and well-documented that most maternal and

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<sup>46</sup> *Monitoring emergency obstetric care: a handbook*. Geneva: World Health Organization; 2009. Available from: [http://www.unfpa.org/webdav/site/global/shared/documents/publications/2009/obstetric\\_monitoring.pdf](http://www.unfpa.org/webdav/site/global/shared/documents/publications/2009/obstetric_monitoring.pdf)

<sup>47</sup> Villar J, Carroli G, Zavaleta N, Donner A, Wojdyla D, Faundes A, et al., World Health Organization 2005 Global Survey on Maternal and Perinatal Health Research Group, et al. Maternal and neonatal individual risks and benefits associated with caesarean delivery: multicentre prospective study. *BMJ* 2007; 335:

<sup>48</sup> Ministry of Public Health [Lebanon]; 2017. Vital Data Observatory (VDO) statistics by Qada and nationality, 2016 [website]. Beirut: Ministry of Public Health [Lebanon]; 2017

<sup>49</sup> Global Health Observatory data repository, Births by caesarean section: Data by country, <https://apps.who.int/gho/data/node.main.BIRTHSBYCAESAREAN?lang=en>

<sup>50</sup> UNHCR, 2018, *Health access and utilization survey among Syrian refugees in Lebanon*. At URL: <https://reliefweb.int/report/lebanon/health-access-and-utilization-survey-among-syrian-refugees-lebanon-december-2018>, p5

infant deaths occur during this time. However, the *WHO recommendations on Postnatal care of the mother and newborn*<sup>51</sup> finds that this is the “most neglected period for the provision of quality care.”

WHO recommends that healthy mothers and newborns should receive care in the facility for at least 24 hours after birth after an uncomplicated vaginal birth. This stay should be extended for complicated births, caesarean sections and in instances where babies or mothers are not healthy. This standard of care was not met for the population in this sample: **just 19.5% of Syrian refugee mothers and 42.1% of vulnerable Lebanese mothers stayed in the hospital for over 24 hours after delivery** (p<0.01)

WHO also recommends that following a first prenatal contact within the first 24 hours, all mothers and newborns should receive PNC contacts on day 3 (48-72 hours), between days 7-14 and six weeks after birth. The results of this KPC study clearly demonstrate that this standard of care is not being met for either population studied. **Less than half of all mothers of children under-two years of age reported that they had received a post-partum visit from an appropriate trained health worker within two weeks after birth of their youngest child; and just 16.0% of mothers of children under-two years in the sample said that such a check had occurred at least three times** (14.2% of Syrian refugees and 20.4% of vulnerable Lebanese; p=0.005). In terms of where women access PNC, the pattern observed in general health care access, by which vulnerable Lebanese tend to access care through private clinics while Syrian refugees favor SDC health clinics, persists.

Access to PNC in the study populations is limited, particularly for Syrian refugees. The reasons more mothers did not access PNC should be urgently investigated and barriers to access addressed in order to protect mothers and newborns from the myriad serious risks posed by a lack of access to PNC.

## Family Planning

**Project target:** 20% increase in % of mothers of children ages 0-23 months who are using a modern contraceptive method (measured by survey)<sup>52</sup>

Indicator	Medair KPC: Vulnerable Lebanese. Bekaa	Medair KPC: Syrian Refugees. Bekaa	UNHCR 2018: Syrian refugees nationally
% reported use of modern contraceptive	41.8%	54.2%	57%
<b>NB: The Medair KPC excluded ‘counting days as a modern contraceptive. This contributes to the lower result than UNHCR</b>			

WHO has asserted that a “woman’s ability to choose if and when to become pregnant has a direct impact on her health and well-being” and that appropriate family planning prevents deaths of mothers and children<sup>53</sup>. Displaced women, including refugees, may be at a much greater risk of unintended pregnancy,<sup>54</sup> rendering an understanding of the ways in which family planning and contraceptive services are accessed critical to support the wellbeing of these vulnerable populations.

<sup>51</sup> World Health Organization, & WHO Guidelines Approved by the Guidelines Review Committee. (2013). WHO recommendations on postnatal care of the mother and newborn. Geneva: World Health Organization.

<sup>52</sup> WRC Proposal multi-year funding -Lebanon, p35

<sup>53</sup> WHO, *Factsheet: Family planning/ Contraception*, 2018 <https://www.who.int/news-room/fact-sheets/detail/family-planning-contraception>

<sup>54</sup> WHO, *Sexual and reproductive health*, 2018 Delivering contraceptive services in humanitarian settings, <https://www.who.int/reproductivehealth/publications/humanitarian-settings-contraception/en/>

The KPC study found that there was a high rate of unplanned pregnancies among both Syrian refugees and vulnerable Lebanese (43.6% and 33.0%;  $p < 0.01$ ). Consistent with this finding, just 41.8% of vulnerable Lebanese and 54.2% of mothers of children aged 0-23 months reported that they were using modern forms of contraceptives, with pills and IUDs the most commonly utilized modern method in both populations. Women who were not using any method to delay pregnancy most commonly reported that they were breastfeeding (33.5% of Syrian refugees and 31.3% of vulnerable Lebanese). While breastfeeding offers some protection against pregnancy (through lactational amenorrhea), this is temporary contraception for new mothers and requires exclusive breastfeeding of an infant less than six months of age.<sup>55</sup> As exclusive breastfeeding rates in these populations are low, it is unlikely that women who report breastfeeding as their reason for not using any contraceptive method are protected against pregnancy. Neither are any contraceptive methods considered unsafe for mother or baby beyond 30 days postpartum.<sup>56</sup> It is therefore unclear why respondents believed that breastfeeding was a reason not to utilize a pregnancy delaying method. This should be investigated, and steps taken to ensure that women are not under the misapprehension that methods to delay pregnancy are incompatible with breastfeeding.

Few respondents reported that they had sought family planning services and not been able to access them (1.6% of vulnerable Lebanese and 3.6% of Syrian refugees), suggesting that women who seek family planning services are able to access them and that the high rates of unplanned pregnancy are not related to a lack of accessibility to family planning services. Consequently, in order to reduce the high rates of unplanned pregnancy, consideration should be given to stoking demand for these services by raising awareness of the risks of short birth spacing (see below) and ensuring that women are aware of available family planning services.

## Birth spacing

It is recommended that the “minimum interval between a live birth and attempting next pregnancy should be 24 months” as shorter intervals are associated with elevated risk of infant, neonatal and perinatal mortality, low birth weight, small size for gestational age, and pre-term delivery.<sup>57</sup> **Just four in ten Syrian refugees were aware of this recommendation, compared to 60.9% of vulnerable Lebanese ( $p < 0.01$ ). However, over 69.4% of Syrian refugees and 76.0% of vulnerable Lebanese knew at least one risk of getting pregnant within two years of the last delivery.** Efforts should therefore be made to translate the understanding of the risks of short birth spacing to an awareness of the recommendation that births should be spaced at least two years apart, in addition to raising awareness of the risks of short birth spacing.

## Mortality in Pregnancy

Indicator	Medair KPC: Vulnerable Lebanese. Bekaa	Medair KPC: Syrian Refugees. Bekaa	Global estimates (deaths per 100,000 live births) <sup>58</sup>
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<sup>55</sup> WHO, Family planning/ Contraception, <https://www.who.int/news-room/fact-sheets/detail/family-planning-contraception>

<sup>56</sup> Centers for Disease Control and Prevention. Update to CDC's U.S. Medical Eligibility Criteria for Contraceptive Use, 2010: revised recommendations for the use of contraceptive methods during the postpartum period. *MMWR Morb Mortal Wkly Rep.* 2011;60(26):878–88

<sup>57</sup> World Health Organization. (2007). Report of a WHO technical consultation on birth spacing: Geneva, Switzerland 13-15 June 2005 (No. WHO/RHR/07.1). World Health Organization.

<sup>58</sup> Unicef: Maternal Mortality, <https://data.unicef.org/topic/maternal-health/maternal-mortality/>

% of women who had a sister, who had a sister who died just after delivery in Lebanon	6.7%	5.9%	Lebanon: 29 Syria: 31
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The survey used a truncated version of the “sisterhood method” to estimate maternal mortality. While several different versions of this method have been developed, respondents are generally asked for the number of sisters they ever had who reached the age of 15; the number of sisters who reached the age of 15 who are now deceased; and the number of sisters who died during a pregnancy or during childbirth, or during the six weeks after the end of a pregnancy. The KPC survey simply asked whether respondents have sisters, and whether any died just after childbirth in Lebanon.

**The KPC survey suggests very high rates of maternal mortality.** 6.2% of women in the survey who had at least one sister, had at least one sister who “died just after delivering a child in Lebanon” (CI: 5.2% – 7.2%). This was lower, but not significantly, among Syrian refugee women (5.9%, CI: 4.8% - 7.2%) than vulnerable Lebanese women (6.7%, CI: 5.1% - 8.7%). **However, no information was sought on the number of sisters each woman had ever had in Lebanon or the number of babies each sister had delivered in Lebanon.** As it is likely that the Lebanese sample had more sisters deliver more babies in Lebanon given that many Syrians arrived relatively recently this comparison provides limited insight.

While these results are extremely high, UNICEF categorized both Syria and Lebanon as having “very low” rates of maternal mortality<sup>59</sup>. **It is therefore possible that the questions asked was misleading, confusing or lead to inaccurate answers being provided.** However, report analysts have checked the data and calculations, which contain no errors and previous analyst checked the wording of the question was checked in English and Arabic, and we are confident its wording could not easily be misunderstood.

## 7.8 Breastfeeding practices

**Project target:** 20% increase in % of infants 0 to < 6 months who are exclusively breastfed<sup>60</sup>

Indicator	Medair KPC: Vulnerable Lebanese. Bekaa	Medair KPC: Syrian Refugees. Bekaa	VaSyR 2018: Syrian refugees nationally
% of children breastfed in the first hour of birth	66.5%	68.3%	
% of children breastfed	83.7%	92.3%	
% of children under 6 months exclusively breastfed	25.4%	32.8%	42%
% of children under 23 months who were exclusively breastfed for first six months	6.6%	11.1%	

<sup>59</sup> Unicef: Maternal Mortality, <https://data.unicef.org/topic/maternal-health/maternal-mortality/>

<sup>60</sup> WRC Proposal multi-year funding -Lebanon, p35

Breastfeeding is an “unequalled way of providing ideal food for the healthy growth and development of infants” and “an integral part of the reproductive process with important implications for the health of mothers”. It promotes sensory and cognitive development and protects the infant against infectious and chronic diseases; helps to space children, reduces the risk of ovarian cancer and breast cancer, increases family and national resources, is a secure way of feeding and is safe for the environment<sup>61</sup>. Breastfeeding becomes even more critical for survival in humanitarian emergencies, including refugee situations. Yet the challenges associated with breastfeeding are often compounded in these contexts. WHO reports that “uncontrolled distribution of breast-milk substitutes (including infant formula) is often a problem,” as donors send supplies of breast-milk substitutes “to feed starving children.” In addition, supportive networks of family and friends that help mothers who have difficulties breastfeeding are often not accessible in emergencies, and it may be difficult for mothers to find comfortable, private places to breastfeed<sup>62</sup>.

Through WRC-funded project and its EU-MADAD-funded project, Medair is providing education on breastfeeding practices to women who are pregnant, recently delivered or breastfeeding, and through the SDC health clinics they support, via material support and training for doctors and nurses. Training of trainers is provided to 108 CHVs, and social workers (81 under WRC and 27 under EU funding) connected to SDCs, and 10 CHVs connected to CBOs. The project also trains and supports midwives to conduct ANC and PNC visits, and refer emergency obstetric cases, based on WHO guidelines.

The KPC survey found that Syrian refugee mothers were more likely to have ever breastfed their youngest child than vulnerable Lebanese mothers (92.3% versus 83.7%). **Although the rate of breastfeeding is high, it is important to note that 7.7% of Syrian refugees and 16.3% of vulnerable Lebanese did not report that they breastfed their youngest child.** Given the importance of breastfeeding, noted above, there is reason to be concerned that this proportion of the population did not breastfeed. Primary reasons given for not breastfeeding included “no milk in breasts” (given by approximately two thirds of respondents) and a preference for formula. **As the evidence shows that “virtually all mothers can breastfeed, provided they have accurate information, and the support of their family, the health care system and society at large<sup>63</sup>,” the wide spread perception that women did not have any or enough breastmilk is concerning** and suggests that women are not being adequately supported to establish and maintain breastfeeding.

WHO and UNICEF recommend that breastfeeding is initiated within the first hour of birth. Referred to as “early initiation of breastfeeding,” this ensures that the infant receives the colostrum, or “first milk”, which is rich in protective factors<sup>64</sup>. Approximately two thirds of mothers in the sample breastfed their youngest child within the first hour of birth, with similar rates in both populations. Although no recent data is available for the Syrian population, comparison of the findings of this survey and UNICEF national estimates indicate that Syrian refugees in the study region are much more likely to initiate breastfeeding within the first hour than the Syrian population as a whole in 2009 (45.5%)<sup>65</sup>. Similarly, comparing the results of this survey with

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<sup>61</sup> WHO, *Breastfeeding*, [https://www.who.int/nutrition/topics/exclusive\\_breastfeeding/en/](https://www.who.int/nutrition/topics/exclusive_breastfeeding/en/)

<sup>62</sup> WHO, *Breastfeeding in emergencies: a question of survival*, <https://www.who.int/mediacentre/commentaries/breastfeeding-in-emergencies/en/>

<sup>63</sup> WHO, *Breastfeeding*, <https://www.who.int/topics/breastfeeding/en/>

<sup>64</sup> WHO, e-Library of Evidence for Nutrition Actions (eLENA); Early initiation of breastfeeding to promote exclusive breastfeeding, [https://www.who.int/elena/titles/early\\_breastfeeding/en/](https://www.who.int/elena/titles/early_breastfeeding/en/)

<sup>65</sup> Unicef, Early initiation rates by country, <https://www.unicef.org/breastfeeding/files/early-initiation-breastfeeding-rates-2018.pdf>

the 2004 Lebanon family health survey 2004 reveals that the survey population is more likely to initiate breastfeeding within the first hour than the Lebanese population as a whole in 2004 (41.3%)<sup>66</sup>.

**However, the fact that a third of infants were not breastfed within the first hour of birth should be addressed.** It is highly concerning that a fifth of Syrian refugees and an eighth of vulnerable Lebanese women who did not initiate breastfeeding in the first hour reported that medical providers had not given them their baby to breastfeed in the first hour. Similarly, the fact that the most common reasons for not breastfeeding in the first hour included being “too tired” and not having milk in the breasts hints at a lack of available support for women to initiate breastfeeding in a timely manner. Both of these factors should be addressed by supportive health providers immediately after birth. WHO recommends that “all mothers should be supported to initiate breastfeeding as soon as possible after birth, within the first hour after delivery”<sup>67</sup>. It is unclear why medical staff and birth assistants serving these communities did not encourage and support early initiation of breastfeeding wherever possible, and this should be urgently investigated and redressed.

Breast milk contains all the nutrients an infant needs in the first six months of life. WHO recommends that infants should be exclusively breastfed<sup>68</sup> for the first six months of life to achieve optimal growth, development and health<sup>69</sup>. However the KPC survey found that **less than a third of all mothers with children aged 0-6 months are exclusively breastfeeding their youngest child (25.4% of vulnerable Lebanese and 32.8% of Syrian refugees). A second calculation for exclusive breastfeeding yielded yet more alarming results: 11.1% of Syrian refugees and 6.6% of vulnerable Lebanese mothers of children aged 0-23 months reported that that they had not fed their child anything other than breastmilk for the first six months.** World Bank national estimates for Lebanon fall somewhere in between these calculations, at 15% (2009). However, World Bank estimates for Syria (2009) are much higher than the KPC data revealed by both indicators, at 43% - **suggesting a loss of a previous culture of exclusive breastfeeding among Syrian refugees**<sup>70</sup>.

Breastfeeding “continues to make an important nutritional contribution well beyond the first year of life as a significant energy source and by providing key nutrients to the growing infant”<sup>71</sup>. WHO therefore recommends that breastfeeding should continue for “up to two years or beyond”, along with nutritionally adequate complementary foods. While the KPC survey does not provide detailed information on the duration of breastfeeding, it does reveal that Syrian refugees were more likely to breastfeed for over six months (27%) than vulnerable Lebanese women (19.7%). These results are very low, and indicate that further work is needed to protect, promote and support women to breastfeed for longer durations.

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<sup>66</sup> Unicef, Early initiation rates by country, <https://www.unicef.org/breastfeeding/files/early-initiation-breastfeeding-rates-2018.pdf>

<sup>67</sup> WHO, e-Library of Evidence for Nutrition Actions (eLENA); Protecting, promoting and supporting breastfeeding in facilities providing maternity and newborn services, [https://www.who.int/elena/titles/full\\_recommendations/breastfeeding-support/en/](https://www.who.int/elena/titles/full_recommendations/breastfeeding-support/en/)

<sup>68</sup> Exclusive breastfeeding means that the infant receives only breast milk. No other liquids or solids are given – not even water – with the exception of oral rehydration solution, or drops/syrups of vitamins, minerals or medicines.

<sup>69</sup> WHO, e-Library of Evidence for Nutrition Actions (eLENA), Exclusive breastfeeding for optimal growth, development and health of infants, [https://www.who.int/elena/titles/exclusive\\_breastfeeding/en/](https://www.who.int/elena/titles/exclusive_breastfeeding/en/)

<sup>70</sup> World Bank Data, Exclusive Breastfeeding (% of children under six months) <https://data.worldbank.org/indicator/SH.STA.BFED.ZS>

<sup>71</sup> WHO, Continued breastfeeding for healthy growth and development of children, [https://www.who.int/elena/titles/continued\\_breastfeeding/en/](https://www.who.int/elena/titles/continued_breastfeeding/en/)

## 7.9 Child registration

The vast majority of Syrian refugees had received a birth certificate for their youngest child (93.9%), generally provided by the hospital (78.0%). It is not known why the remaining 6.1% of children did not have birth certificates. Birth certificates are critical for refugees as they allow children to confirm or acquire nationality, and protect children from statelessness<sup>72</sup>. **Consequently, the reasons 6.1% of mothers did not receive birth certificates should be investigated.**

## 7.10 Access to psychosocial services

UNHCR has reported that the psychological impact of being a refugee can be “complex and deleterious<sup>73</sup>”. This is consistent with studies of the mental health of Syrian refugees, including a 2018 study on post-traumatic stress disorder (PTSD) which found that 30% of Syrian refugees met the cut offs for PTSD<sup>74</sup>. Syrian refugee children and adolescents have been found to have even higher rates of trauma: a recent study found that 45.6% had developed PTSD with excessive risk of contributing to other illness and with emotional/behavioral dysfunction<sup>75</sup>. **The KPC survey also found high rates of psychological distress, with over three quarters (75.7%) of Syrian refugees and over two thirds (69.5%) of vulnerable Lebanese agreeing that in the past six months, they or someone they knew felt “sad, stressed, or under pressure.”**

Medair’s EU-MADAD-funded project seeks to mobilize 210 women’s and men’s support groups as well as community outreach events (across refugee settlements in the Bekaa Valley). Its objective is to promote healthy behaviors and psychological resilience through social relationships and fitness groups. The project is also mobilizing small counselling groups for survivors of trauma related to sexual or gender-based violence (SGBV) or conflict. It will also sensitize and train faith leaders to better understand and counsel men and women about social norms that promote or reduce SGBV. Training on all such programs will also be conducted for four CBOs in Lebanon to adopt the methods used by Medair, to extend the support through their own programs.

However, less than a third of Syrian refugees and less than a quarter of vulnerable Lebanese were able to identify PSS available in their communities ( $p = 0.03$ ) and less than half of Syrian refugees and just over a third of vulnerable Lebanese were able to identify where these services could be accessed ( $p = 0.03$ ). 41.6% of vulnerable Lebanese and 24.2% of Syrian refugees reported a belief that there are no PSS available in their community.

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<sup>72</sup> UNHCR, Ensuring birth registration for the prevention of Statelessness, <https://www.unhcr.org/ke/wp-content/uploads/sites/2/2017/11/Good-Practices-Paper-on-Ensuring-Birth-Registration-for-the-Prevention-of-Statelessness.pdf>

<sup>73</sup> UNHCR's mental health and psychosocial support for persons of concern. Geneva: United Nations High Commissioner for Refugees; 2013; <https://www.unhcr.org/en-us/research/evalreports/51bec3359/unhcrs-mental-health-psychosocial-support-persons-concern.html>

<sup>74</sup> Chung, M. C., Shakra, M., AlQarni, N., AlMazrouei, M., Al Mazrouei, S., & Al Hashimi, S. (2018). Posttraumatic stress among Syrian refugees: trauma exposure characteristics, trauma centrality, and emotional suppression. *Psychiatry*, 81(1), 54-70.

<sup>75</sup> Khamis V, 2019, Posttraumatic stress disorder and emotion dysregulation among Syrian refugee children and adolescents resettled in Lebanon and Jordan, *Child Abuse & Neglect*, Vol. 89. At URL: <https://www.sciencedirect.com/science/article/abs/pii/S0145213418304678>

Consistent with the demonstrated higher rates of awareness of available services, Syrian refugees were significantly more likely to have talked to a trained service provider about PSS in the 12 months prior to the survey (17.1% versus 6.1%;  $p < 0.01$ ). Cost and a preference to keep psychosocial matters personal were commonly cited by both populations as reasons for not having engaged in discussions of PSS with a trained service provider. A preference for dealing with sadness, stress or pressure by themselves or by reaching out to friends or family was evident in both populations.

Despite being more likely to have accessed PSS in the 12 months prior to the survey, Syrian refugees were significantly less likely than vulnerable Lebanese to feel comfortable and able to access PSS (44.6% versus 53.7%;  $p < 0.01$ ), explained by their lower rates of perceived ability of access these services (49.4% versus 57.7%).

These results demonstrate that much stands in the way of Lebanese and Syrian residents of the Bekaa Valley accessing trained service providers for mental health support. A lack of awareness of the services available, concern that the cost of accessing these services is too high, an apparent cultural preference for keeping psychosocial matters personal or between family and friends inhibit uptake of these services. **A need to continue to seek to community-based or informal approaches for creating perceived safe spaces for women and children to process their psychosocial difficulties therefore persists.**

## 8. Conclusion

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The 2019 KPC study provides important insight into the knowledge, attitudes and practices of Syrian refugees and vulnerable Lebanese in the Bekaa Valley. The findings demonstrate that both Syrian refugees and vulnerable Lebanese continue to face complex social, financial and logistical constraints in health care access, and that avoidable health risks persist for both populations.

Health seeking behaviors are sub-optimal and reflect a lack of awareness of the services available, perceived prohibitively high costs of services and a lack of accessibility. These gaps are compounded by inappropriate health behaviors, such as low rates of exclusive breastfeeding, early weaning, low coverage of vaccinations and low rates of family planning. Important gaps in awareness of appropriate health behaviors, including birth spacing and NCD prevention, exacerbate the precarious health situation of these populations and expose individuals and communities to heightened risk of poor health outcomes in both the short and long-term.

The gaps in health care access, knowledge and practices tend to be greater for Syrian refugees than vulnerable Lebanese. In combination with the heavy reliance of Syrian refugees on SDC health clinics, these findings justify the original design of the Medair projects which focus on health care at primary health care level, and outreach to women's homes and wider community outreach events.

The constraints for which the Medair projects were designed persist. Ongoing programming, adapted to reflect the lived experience of the survey populations studied, is required.

## 9. Recommendations

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The results of the KPC found significant differences between the two populations across a range of health seeking and health care behaviors. However, within a complex environment and based on the premise that influencing norms and creating demand for services can generate long-term positive



change, sensitive targeted changes to the way services are delivered and accessed may improve these behaviors and health outcomes for both populations.

A wholistic, context-specific and community driven approach to social and behavior communication change (SBCC) is required to support and change a range of health seeking behaviors and health promoting practices including (but not limited to) awareness of services, NCD prevention, vaccination, breastfeeding, family planning and reproductive health. Supported by other research, the results of the KPC survey provides an ideal opportunity to engage with the beneficiaries, to identify behavioral triggers and obstacles; develop smart and strategic messages; test new approaches; learn from failures and create a SBCC Strategy that is built on a dynamic two-way relationship between the program and the beneficiaries. Medair's long term engagement in this context uniquely positions the organization to start from people's lived experience and, through intense community engagement, identify the right people, language and tools at the right time to build a community-owned program that delivers targeted, evidence-based and actionable messages to address barriers to behavior change.

While flexibility will need to be built into the Strategy to allow adaption and response as the context evolves and lessons are learned, the results of this KPC survey suggest that the SBCC should focus on the following:

- 1. Redouble efforts to reduce early marriage.** The high rates of early marriage observed in this KPC, particularly among Syrian refugees (45.5%), demand urgent action. With an understanding of cultural norms, sensitive communication to delay early marriage should be delivered across a range of delivery platforms, in addition to Medair's current commendable CHV outreach program. The delivery platforms may include (but should not be limited to) health centres, secondary schools, mass media and through religious and community leaders.
- 2. Identify and target health decision makers and influencers within families and communities.** The high rates of early marriage observed in this KPC are indicative that gender inequity may be entrenched in these populations. This inequity may manifest in health care decision making, resulting in male family members having the primary say in matters related to finances, health care-seeking behavior and the use of family planning methods. Targeting women exclusively, even with regard to women's reproductive health, may therefore be inadequate. In addition to continuing to provide education on the risks of early marriage, Medair should consider investigating who in the family makes health decisions and who influences these decisions. Where possible, the proposed SBCC strategy should take a whole of family approach with a particular focus on identified decision makers and influencers.
- 3. Raise the profile of SDC health clinics.** SDC health clinics continue to provide an important point of contact with the health system, particularly for Syrian refugees. Yet the survey indicated that 44.5% of Syrian refugees and 38.5% of vulnerable Lebanese respondents who did not visit a Medair SDC health clinic had not heard of these SDC health clinics. Consideration should therefore be given to raising the awareness of SDC health clinics through channels including (but not limited to) CHVs, religious leaders, community leaders and other community service providers.
- 4. Reduce the cost of services.** Cost was a commonly cited barrier to health care access, preventing survey respondents from accessing health care generally; delivering in hospital and receiving PSS. Awareness of where and how health services can be affordably accessed should be raised; and consideration should be given to developing strategies and partnerships to reduce defray costs (for example, social insurance and other contextually appropriate forms of social protection).

5. **Ensure that all information, education and communication (IEC) materials rely on graphics.** In addition to being well focus tested and simple, the high rates of illiteracy, particularly among Syrian refugees (38.8%) requires that all IEC materials and tools developed rely on graphics and few words. The use of videos and other forms of verbal media may be useful mechanisms to convey important health messages.
6. **Scale up NCD education.** Just under 20% of respondents reported that one or more of their family members had been diagnosed with hypertension and/or diabetes, knowledge of NCD risk factors was found to be limited (particularly among Syrian refugees). National data for both Syrian and Lebanon demonstrates high rates of smoking among these populations; yet just 8% of vulnerable Lebanese women and 2.5% of Syrian refugees identified smoking cessation as an NCD reduction strategy. Similarly, few respondents identified “reduce weight if overweight,” yet over two thirds of Lebanese adults and over six in ten Syrian adults have been found to be overweight. Targeted, context-specific IEC relevant to the prevention and control of NCDs should therefore be prioritized and provided during contacts with the health services and other community-based delivery platforms.
7. **Raise awareness of the importance of seeking advice and treatment for the symptoms of ARI.** Less than 50% of each population samples accessed health care when their child had symptoms of ARI. This result is much lower when SDC health clinics are not included in the list of appropriate health care facilities (1.5% of Syrian refugees and 25.6% of vulnerable Lebanese). As ARIs can lead to pneumonia, a potentially fatal condition and a leading global cause of child mortality, strategies to promote treatment seeking for these symptoms should be developed. These strategies should be based on a childhood illness-specific behavioral insights or KAP study, designed to elicit the underlying causes of the low rates of treatment seeking.
8. **Investigate the under-prescription of antibiotics for ARI.** WHO recommends the use of inexpensive, widely available and effective oral antibiotics for the treatment of ARI. However, only approximately one third of each population group with a child who had ARI symptoms accessed antibiotics. Cough drops and pain killers, which may treat the symptoms but do not treat the cause of ARI were more commonly used. While this is likely related to the low rates of health care access for ARI and it is possible that health workers conduct medical examinations and appropriately determine that antibiotics are not indicated, investigation of the potential under-prescription of antibiotics for ARI should be undertaken, starting with obtaining an in-depth understanding of the prescribing practices in the locations at which ARI treatment is generally sought (SDC health clinics, private clinics and pharmacies) .
9. **Identify and address the causes high rates of diarrhea.** Over one third of Syrian refugees (36.5%) and one fifth of vulnerable Lebanese (21.6%) reported that any of their children under-five years experienced diarrhea in the two weeks prior to the survey. These rates are alarmingly high. While the project currently seeks to improve the treatment of diarrhea, consideration should be considered to diarrhea prevention activities, following a comprehensive investigation of the specific causes of this illness among these populations.
10. **Investigate the underuse of ORS and zinc and the over-prescription of antibiotics for diarrhea.** Contrary to WHO and UNICEF recommendations, just 3.6% of children with diarrhea received ORS and zinc per WHO guidelines, while antibiotics are the most common treatment for diarrhea in both populations. These sub-optimal treatment patterns persist despite high rates of treatment seeking. A study of the causes of the low rates of ORS and zinc use should be initiated, along with the over-prescription of antibiotics. The study should comprise an audit of health clinics, SDC health clinics and pharmacies to determine prescribing practices and preferences as well as interviews with parents and care givers to determine their treatment

preferences and willingness to utilize ORS and zinc. An appropriate intervention should be developed based on the findings of this study.

- 11. Review existing ANC services against recently updated global recommendations.** The KPC survey investigated whether mothers had received at least four antenatal visits when they were pregnant with their youngest child, and found that just this standard of care had been met for just two thirds of respondents (78.6% of vulnerable Lebanese and 61.6% of Syrian refugees). It follows that far fewer received the recently updated WHO recommendations, which call for at least eight ANC contacts. Medair should therefore review existing services (including facilities, staffing and training) to ensure capacity to offer women at least eight antenatal contacts is available; sensitize communities to the pertinent recommendations outlined in WHO recommendations on antenatal care for a positive pregnancy experience (2016); and encourage and facilitate women to access at least eight ANC contacts.
- 12. Investigate the high rates of caesarean sections.** The rates of caesarean section far exceed the WHO-recommended threshold of 15%, among both vulnerable Lebanese (59.0%) and Syrian refugees (29.8%). Given the risks associated with this procedure, investigation into the basis on which these surgeries are performed is warranted. This should include a behavioral insights methodology to identify community practices and preferences, as well as the attitudes and practices of health care providers.
- 13. Investigate barriers to post-natal care.** Less than half of all mothers of children under-two years of age reported that they had received a post-partum visit from an appropriate trained health worker within two weeks after birth of their youngest child and just 16.0% of mothers of children under-two years in the sample said that such a check had occurred at least three times. Syrian refugees had much lower rates of PNC access, but the reasons for low rates of PNC contacts were unclear. As PNC is among the most important interventions for both child and maternal health, further investigation is required to identify the reasons behind the failure to meet the recommended standard of PNC.
- 14. Promote early initiation of breastfeeding.** WHO recommends that infants are breastfed within the first hour of birth. However, the KPC revealed that a third of infants were not breastfed within the first hour of birth and that a fifth of Syrian Refugees and an eighth of vulnerable Lebanese women who did not initiate breastfeeding in the first hour reported that medical providers had not given them their baby to breastfeed in the first hour; and a worrisome perception that there was no milk in the breasts (and therefore breastfeeding should not be initiated) was common. Medair's existing breastfeeding education programs should be reviewed in light of these findings, to ensure that medical staff and birth assistants serving these communities are trained to encourage, facilitate and support early initiation of breastfeeding wherever possible, and women and their families and communities made aware of the global recommendations and the evidence to support this important practice.
- 15. Restore the practice of exclusive breastfeeding for six months among Syrian refugees.** WHO recommends that infants should be exclusively breastfed for the first six months of life. However, rates of exclusive breastfeeding were found to be very low among both populations studied and World Bank estimates for the prevalence of exclusive breastfeeding of infants under six months in Syria (2009) are much higher than those observed in the KPC. This raises concern that conflict and displacement has resulted in a loss of a previous cultural norm to exclusively breastfeed among Syrian refugees, consistent with global evidence that humanitarian emergencies and refugee situations result in disruption of breastfeeding practices, for example through the loss of support systems. In addition to supporting vulnerable Lebanese to increase the rate of exclusive breastfeeding, Medair should carry out in-depth behavioral insight research

to confirm whether these practices have indeed been lost among Syrian refugees and tailor breastfeeding support systems (such as mother support groups) to restore the globally recommended practice of exclusive breastfeeding for the first six months.

- 16. Raise demand for family planning tools and services.** Although few women in the survey reported that they had sought family planning services and not been able to access them, there was a high rate of unplanned pregnancy among both Syrian refugees and vulnerable Lebanese (43.6% and 33.0%). This was reflected in low rates of use of modern contraceptives. “Breastfeeding” was commonly cited as a reason women were not using modern contraception methods, suggesting an underlying incorrect belief that breastfeeding protects against pregnancy beyond the period of exclusive breastfeeding, and/or a misapprehension that methods to delay pregnancy are incompatible with breastfeeding. A full analysis of why women do not use modern contraceptives, including their knowledge, attitudes and beliefs, as well as those of their husbands and other family members, should be undertaken; and steps to correct any misunderstandings, as well as educate about the dangers of early pregnancy and inadequate birth spacing, taken in order to raise demand for modern contraceptives and other family planning tools and services.
- 17. Improve vaccination rates.** The vaccination coverage rate in the survey population falls short of herd immunity thresholds; and less than a third of vulnerable Lebanese and less than a quarter of Syrian refugee children had received the full complement of age-appropriate vaccinations. While the reason behind the low rates of vaccination were not uncovered, it is clear that the Bekaa Valley is a potential flash point for disease outbreak. Vaccination campaigns should therefore be urgently scaled up to reach as many of the children of both nationalities as possible.
- 18. Raise awareness of the importance of (and right to) a birth certificate among Syrian refugees.** Over 6% of Syrian refugees reported that they did not have a birth certificate for their youngest child. Birth certificates are particularly critical for refugees as they allow children to confirm or acquire nationality and protect them from statelessness. The reason birth certificates are not universal among this population should be investigated, and if necessary, refugees should be given the knowledge and tools needed to assert their right to these documents. Concurrently, CHV, doctors, nurses, midwives, birth attendants, community leaders and religious leaders, as well as any other influential person who are in contact with pregnant women and their families, should be trained to advise and assist Syrian refugees to access birth certificates.

## 10. Appendices

### Appendix A: KPC Report Terms of Reference



### Appendix B: Survey Tool

KPC Survey questions:

English	Arabic
Start	البداية
End	النهاية
Today	اليوم
Device id	معرف الجهاز
Enumerator number	رقم القائم بالإستبيان
Supervisor zone	منطقة المشرف
Cluster Number	رقم التجمع
Name of District	إسم القضاء
Name of Cadaster	إسم المنطقة بسجل المساحة
The house is:	المنزل هو
Pcode \${cadaster}-01-	رقم المخيم
Is there a female between the ages of 15-50 years old who lives in the residence and is considered the main caretaker of children present available to answer a survey?	هل يوجد امرأة بين عمر 15-50 سنة بتعيش بهيدا البيت وتعتبر المسؤولة الرئيسية عن الأولاد وموجودة للإجابة على هذه الدراسة لإستبيان؟
May I speak to her ?	هل ممكن ان اتكلم معها؟

Consent: I am (X) working with Medair which is a humanitarian organization. We are doing a health survey with the aim of understanding the knowledge, the practice and the access to service in order to design better health interventions. The survey usually takes about 40 minutes to complete. Any information that you provide will be kept strictly confidential. This is voluntary and you can choose to participate or not and if you participate, you can choose not to answer any of the questions. There will be no positive or negative consequences in participating or not in the survey and you will not receive any direct benefit from participating. If you don't have any questions, and you would like to participate, may I begin now?

( وهي منظمة إنسانية. Medair ) بشتغل مع مديير (X)مرحبا أنا ) عم منقوم بدراسة إستبيان حول الصحة بهدف فهم المعرفة والممارسة ومدى الوصول إلى الخدمات الصحية الحالية من أجل تحسينا وبشكل خاص الخدمات الصحية يللي بتتعلق بالطفل و المرأة الحامل. بتستغرق المشاركة بالدراسة إستبيان حوالي 40 دقيقة، ورح نحافظ على سرية المعلومات اللي بتقدميها ورح نحلها من دون ربطها باسمك. المشاركة بالدراسة إستبيان اختياري وبتقدري تختاري تشاركي أو ما تشاركي. وإذا قررت تشاركي، بتقدري تختاري عدم الإجابة عن أي من الأسئلة. ما رح يكون في أي نتائج إيجابية أو سلبية من المشاركة أو عدم المشاركة بالدراسة إستبيان، وما رح يكون في أي إفادة مباشرة من المشاركة. رح نستعمل الأجوبة بهدف تحسين الخدمات ( بتحبي تسألني أي سؤال Medair الصحية اللي بتقدميها مديير ) لتستوضحني عن الدراسة إستبيان؟ إذا ما كان عندك أي سؤال، هل بتحبي تشاركي بالدراسة إستبيان؟

Age of Respondent(in years):	ادي عمرك (عمر المجيبة بالسنوات)
Are you or were you married?	هل انت متزوجة حاليا او كنت متزوجة؟
Do you have a child under the age of 5 years old who currently lives with you?	عندك طفل عمرو تحت الخمس سنين عايش معك؟
How many children under the age of 5 do you have or are taking care of?	كم طفل لديك أو تحت رعايتك ما دون سن الخامسة؟
nationality	شو جنسيتك
KPC Start	بداية الدراسة
At what age did you get married(in years)?	في اي عمر تزوجتي؟
what is your level of education?	شو مستواكي العلمي؟
Sex of the youngest Child:	جنس أصغر طفل
Age of the youngest child:	عمر أصغر طفل
Relationship to Child:	العلاقة بالطفل
Health-Seeking Behavior	استخدام الخدمات الصحية
In the last year, have you or your child/children needed medical services?	خلال آخر سنة، احتجتي شي أنت أو طفلك/ أطفالك إلى خدمات صحية؟
Did you get the medical services when you needed them?	تلقيت الخدمات الصحية لما كنت بحاجة الى ؟
Why didn't you get when you needed the medical services?(except the birthgiving)	ليش ما قدرتي تاخدي الخدمات الصحية لما احتجتي الى (باستثناء الولادة)؟
What was the expensive service you needed?	شو كانت الخدمة الصحية المكلفة؟

How much expensive was the services(in L.L)?	ادي كانت تكلفة هيدي الخدمة الصحية (بالليرة اللبنانية)؟
if it's possible to mention some examples of how you were treated or what did you hear about the medical services	إذا ممكن، ذكرني بعض الأمثلة عن المعاملة أو عن شو سمعتي
Which health facility did you go to?	وين رحتي لتأخدي الخدمات الصحية؟
Which dispensary did you visit?	أي مستوصف زرتي؟
Where did you visit the doctor?	وين زرتي الدكتور؟
Which dispensary did you visit?	أي مستوصف زرتي؟
Did you visit one of medair's SDC? ( in Marj or Jib Janin or Qabelias or Talia or Brital or Rafid or Kfarzabad)	هل زرتي أحد مستوصفات وزارة الشؤون الإجتماعية المدعومة من مديبر السنة الماضية؟ (المرج، جب جنين، قب الياس، طاليا، بيريتيل، رفيد، كفر زبد)
Why didn't you visit one of these SDC?	لماذا لم تزوري أحد هذه المستوصفات المدعومة من مديبر Medair؟
Sick Child	نموذج طفل مريض (أقل من 5 سنوات)
Did any of your children under the age of 5 experience any of the following in the past two weeks?	باخر أسبوعين، هل عانى حدا من أطفالك يلي عمرن أقل من 5 سنوات أي من هذه العوارض الصحية؟
Diarrhea and 3 or more loose or liquid stool per day	إسهال
Cough	سعال
Difficulty breathing, fast breathing, short/quick breaths	صعوبة في التنفس، سرعة في التنفس، نفس قصير أو سريع
Diarrhea Module	نموذج الاسهال
How many children under-5 who had diarrhea in the last 2 weeks?	بأخر اسبوعين كم طفل تحت الخمس سنوات صار عندو اسهال؟
How old was the youngest child who had diarrhea?	ادي كان عمر اصغر طفل عانى من الاسهال؟
Did you give any treatment to your child ?	عطيتي شي علاج؟
How long after you noticed the child's diarrhea, did you give treatment?	بعد ادي من الوقت من بعد ما لاحظتني أنو طفلك عندو اسهال عطيتي العلاج؟
Where did you first seek for an advice or a treatment ?	وين رحتي بالأول لتأخدي النصيحة الطبية أو العلاج ؟
What was given to treat the diarrhea?	شو كان العلاج
Acute Respiratory Infection (ARI) Module	نموذج الاصابة بالالتهابات الرئوية
Did you seek advice or treatment for the cough or fast breathing?	طلبتي نصيحة طبية أو علاج للسعال أو للتنفس السريع؟
How long after you noticed the child's cough or fast breathing did you seek treatment?	بعد ادي من الوقت بعد ما لاحظتني سعال طفلك أو تنفسه السريع طلبتي نصيحة طبية أو علاج للسعال أو للتنفس السريع؟
Where did you first go for advice or treatment for your child's cough or fast breathing?	وين رحتي بالأول لتأخدي النصيحة الطبية أو العلاج للسعال أو للتنفس السريع؟
What was given to treat the child's cough or fast breathing?	شو كان العلاج للسعال او للتنفس السريع؟
Reproductive Health Services	نموذج خدمات الصحة الإنجابية

What types of services are available for reproductive health in your community?	خدمات الصحة الإنجابية هي الخدمات التي تتعلق بالمرأة الحامل خلال الحمل أو من بعد ما تولد وكمات تتعلق بمعالجة الالتهابات النسائية... شو هي أنواع الخدمات للصحة الإنجابية الموجودة في مجتمعك؟
Where can you access reproductive health services in your community?	وين فيكي تحسلي على خدمات الصحة الإنجابية بمجتمعك؟
For any type of reproductive healthcare needs, would you feel comfortable accessing one of these services?	إذا احتجتي لأي نوع من خدمات الصحة الإنجابية، هل بتشعري بالراحة للحصول على واحدة من هيدي الخدمات؟
If you needed reproductive health services for any reason, would you be able to access one of these services?	إذا كنت بحاجة لخدمات الصحة الإنجابية لأي سبب من الأسباب، بتحسي أنك بتقدري تحسلي على واحدة من هيدي الخدمات؟
Why would you not feel comfortable or be able to accessing one of these services?	لي ما بتحسي بالراحة أو مش قادرة انك تحسلي على واحدة من هذه الخدمات؟
In the past six months, did you seek any of the services related to RH?	بآخر 6 أشهر، هل رحتي لتحسلي على أي من الخدمات المتعلقة بالصحة الإنجابية؟
Which services did you access?	شو هي الخدمات لحصلتي عليها ؟
Where did you access those services?	وين حصلتي على هذه الخدمات ؟
Were you satisfied with the services you received?	كنتي راضية عن الخدمات يلي تلقيتها؟
Why not satisfied	لي ماكنتي راضية
Refugee Pregnancy	نموذج الحمل للمرأة السورية
Where did you receive antenatal care? In Lebanon or in Syria ?	بالنسبة لطفلك الأصغر، وين حصلتي على رعاية الحامل قبل الولادة؟ بلبنان أو بسوريا؟
Where did you give birth to your youngest child? In Lebanon or in Syria ?	وين ولدت طفلك الأصغر؟ بلبنان أو بسوريا؟
Why did you give birth in Syria?	لي ولدت طفلك بسوريا؟
Where did you receive post partum care?	وين حصلتي على الخدمات الصحية بعد ولادة طفلك الأصغر؟
Did you receive a birth certificate to your youngest child?	هل حصلت على شهادة ولادة لطفلك اصغر؟
From where did you receive a birth certificate ?	من وين حصلتي على شهادة الولادة؟
Ante-Natal Care	نموذج متابعة المرأة ما قبل الولادة
Did you plan your last pregnancy?	خططت لحملك الأخير؟
During your pregnancy with your youngest child, did you see anyone for antenatal care?	خلال حملك بطفلك الأصغر هل زرتي حدا لمتابعة الحمل قبل الولادة؟
Who did you see for antenatal care?	مين شفتي كرمال متابعة الحمل قبل الولادة؟
During your pregnancy with your youngest child, where did you receive antenatal care?	خلال حملك بطفلك الأصغر وين تلقيتي متابعة الحمل قبل الولادة؟
Which dipensary did you visit?	أي مستوصف زرتي؟
Where did you visit the doctor or the nurse ?	أين قمت بزيارة الدكتور أو الممرضة



During your pregnancy with your youngest child, how many months pregnant were you when you first received antenatal care?	خلال حملك بطفلك الأصغر في أي شهر من الحمل كنتي عندما تلقيت متابعة الحمل ما قبل الولادة لأول مرة؟
During your pregnancy with your youngest child, how many months pregnant were you when you last received antenatal care?	خلال حملك بطفلك الأصغر في أي شهر من الحمل كنت عندما تلقيت متابعة الحمل ما قبل الولادة لآخر مرة؟
During your pregnancy with your youngest child, how many times did you receive antenatal care?	خلال حملك بطفلك الأصغر كم مرة تلقيت متابعة للحمل ما قبل الولادة؟
Birth giving standard	نموذج الولادة
Where did you go when you gave birth to your youngest child?	وين ولدتي طفلك الأصغر؟ (بيت، عيادة، مستشفى...)
What was the reason that you did not deliver in a hospital or clinic?	شو السبب يلي ما خلاكي تولدي بمستشفى أو عيادة؟
If it's possible to mention some examples of how you were treated or what did you hear about the medical services	إذا ممكن، ذكرني بعض الأمثلة عن المعاملة أو عن شو سمعتني
Who assisted with the delivery of your youngest child?	من ساعدك لولادة طفلك الأصغر؟
Did you have a normal birth or a C-section?	كانت ولادتك طبيعية أو قيصرية (شق بطن)؟
How long did you stay in the health facility after delivery?	ادي بقيتي وقت بالمستشفى أو العيادة بعد الولادة؟
Did you pay for these services?	دفعتي مقابل هيدي الخدمات؟
How much did you pay for the services?	ادي دفعتي مقابل هيدي الخدمات؟
Did you receive health registry for the baby before discharge?	هل تلقيت السجل الصحي للطفل؟
Did you receive any documents that specify the health status of the baby	هل تلقيتي أي مستندات بتحدد الحالة الصحية للطفل؟
Post Partum Care	نموذج المعاينات ما بعد الولادة
After your youngest child, did you receive any checkat after being discharged?	بعد ولادة طفلك الأصغر، كم مرة تلقيتي معاينة صحية ما بعد الولادة؟
When did your first post partum medical check happen after delivery?	بعد ولادة طفلك الأصغر، متى تلقيت معاينة صحية ما بعد الولادة؟ أذكرني كل المرات
After giving birth with your youngest child, where did you receive post partum care?	بعد ولادة طفلك الأصغر، أين تلقيت المعاينة الصحية ما بعد الولادة؟
Which dipensary did you visit?	أي مستوصف زرتي؟
Where did you visit the doctor?	أين قمت بزيارة الدكتور أو الممرضة
Who did your PNC?	من قام بمعاينتك بعد الولادة؟
Did someone check on the health of the baby after the delivery, either at a health facility, home or other location? By check, I mean did anyone ask you questions about the baby health or examine him/her?	كم مرة تم معاينة طفلك بعد الولادة، سواء في مركز صحي أو منزل أو مكان آخر؟ اعني المعاينة اذا أي احد سألك أسئلة حول صحة الطفل أو فحصه؟
When did your newborn received a medical check? select all that applies	متى حصل طفلك الأصغر على الفحص الصحي؟

Who checked the baby health at that time?	مين فحص صحة الطفل ؟
Breastfeeding	نموذج الرضاعة الطبيعية
Did you ever breastfeed your youngest child?	هل سبق وقمت بإرضاع طفلك الأصغر من صدرك؟
For how many months, did you breastfeed your child?	كم شهر ارضعتي طفلكي الأصغر ؟
Why didn't you breastfeed?	لماذا لم ترضعيه؟
How long after birth did you first put your child to the breast?	بعد كم من الوقت بعد الولادة قمت بوضع طفلك على صدرك لإرضاعه لأول مرة؟
What is the reason for not immediately putting your child to the breast?	شو سبب عدم ارضاع طفلك فوراً بعد الولادة؟
When your baby was 0 to 6 months did you used to give him/her bottle(powder milk) at night or during the day?	لما كان طفلك بعمر 0 إلى 6 أشهر عطيتي قنينة ليلاً أم نهاراً؟
When your baby was 0 to 6 months did you used to give him/her with breastmilk some water, tea or alcohol ?	لما كان طفلك بعمر من 0 إلى 6 أشهر، عطيتي مع حليب صدرك بعض الماء أو الشاي أو غيره من السوائل؟
When your baby was 0 to 6 months did you used to give him/her with breastmilk some food from the house or from the market ?	لما كان طفلك بعمر من 0 إلى 6 أشهر، عطيتي مع حليب صدرك بعض الأكل سواء من البيت أو اشتريت من السوق؟
During the last 24 hours did you give him bottle(Powder Milk) at night or during the day?	خلال الـ 24 ساعة الماضية هل أعطيتي طفلك قنينة ليلاً أم نهاراً؟
During the last 24 hours did you give him with breastmilk some water, tea or alcohol ?	خلال الـ 24 ساعة الماضية هل أعطيتي طفلك مع حليب صدرك بعض الماء أو الشاي أو غيره من السوائل؟
During the last 24 hours did you give him with breastmilk some food from the house or from the market ?	خلال الـ 24 ساعة الماضية هل أعطيتي طفلك مع حليب صدرك بعض الأكل سواء من البيت أو اشتريت من السوق؟
Vaccinations	نموذج التلقيح
Did your child receive vaccine for hep. B within 2 days of delivery?	هل تلقى طفلك لقاح الصفيرة خلال يوم بعد الولادة؟
Vaccinations 1	التلقيح
Do you have a card or child health booklet where vaccinations are written down?	هل لديك بطاقة تلقيح للطفل أو سجل صحي حيث دونت اللقاحات؟
Why not?	لما لا ؟
May I see it please?	هل يمكنني الاطلاع عليه؟
May I copy the information from the card?	هل بإمكانني نسخ المعلومات عن بطاقة التلقيح أو السجل الصحي؟
Vaccination Card	بطاقة التلقيح
Polio 1	شلل الأطفال (بالعضل) جرعة أولى (عمر شهران)
Polio 2	شلل الأطفال (فموي) جرعة ثانية (عمر 4 اشهر)
Polio 3	شلل الأطفال (فموي) جرعة ثالثة (عمر 6 اشهر)
Polio booster 1	شلل الأطفال (فموي) تذكير اول (عمر 18 شهر)
Polio booster 2	شلل الأطفال (فموي) تذكير ثاني (عمر 4-5 سنوات)
Polio booster 3	شلل الأطفال (فموي) تذكير ثالث (عمر 10-12 سنوات)
Penta 1	الخماسي جرعة أولى (2 شهر)
Penta 2	الخماسي جرعة ثانية (4 اشهر)

Penta 3	الخماسي جرعة ثالثة (6 اشهر)
Penta booster 1 at 18 months	الخماسي تذكير اول (18 شهر)
HepB1 (at birth)	صفيرة (ب) جرعة 0 عند الولادة
PCV13 first dose 4 months	الاولى الجرعة الرئوية المكورات لقاح (اشهر 4 ال عمر )
PCV 13 2 <sup>nd</sup> dose 6 months	الثانية الجرعة الرئوية المكورات لقاح (اشهر 6 ال عمر )
PCV13 3 <sup>rd</sup> dose 12 months	الثالثة الجرعة الرئوية المكورات لقاح (شهر 12 ال عمر )
Measles (at about 9 months)	الحصبة جرعة اولى (9 اشهر)
MMR first dose (at about 12 months)	حصبة ، ابو كعب، حصبة المانية جرعة اولى (12 شهر)
MMR 2 <sup>nd</sup> dose (at about 18 months)	حصبة ، ابو كعب، حصبة المانية جرعة ثانية (18 شهر)
DPT boost 2 4-5 years	ثلاثي تذكير ثاني (عمر 4-5 سنوات)
DT boost 3 10-12 years	ثنائي تذكير ثالث (عمر 10-12 سنوات)
DT boost 4 16-18 years	ثنائي تذكير رابع (عمر 16-18 سنوات)
Image Of the card	
Please tell me if your child received any of the following vaccinations:	رجاء أعلميني إذا كان طفلك قد تلقى أي من اللقاحات التالية:
Did your child ever receive an injection in the arm to prevent measles?	هل سبق لطفلك أن تلقى تطعيم في الذراع للحماية من الحصبة؟
Was your child vaccinated against polio?	هل تم تلقيح ولدك لقاح ضد شلل الاطفال؟
DPT booster 2 at 4-5 year	لقاح ثلاثي تذكير ثاني على عمر 4-5 سنوات
Family Planning/Child Spacing	تنظيم الاسرة والمباعدة بين الولادات
For you what is the best time to get pregnant again after delivery?	بالنسبة إليك، بعد إدي وقت من الأفضل تحبلي مرة ثانية بعد الولادة؟
What are the risks of getting pregnant too soon after the birth of a child?	شو هي مخاطر الحمل الصحية إذا كان الحمل حصل بعد وقت كثير قصير من الولادة؟
Are you currently doing something or using any method to delay or avoid getting pregnant?	عم تعملي شي هلق او عم تستعملي شي وسيلة لتأخري او تمنعي الحمل؟
If you are not doing something or using any method to delay or avoid getting pregnant, why not?	إذا ما عم تعملي شي أو ما عم تستعملي أي وسيلة لتأجيل أو منع الحمل فشو السبب؟
If you are using a method, which method are you using to delay or avoid getting pregnant?	ما هي الوسيلة التي تستخدمينها من أجل تأجيل أو منع الحمل؟
If using modern family planning methods, where do you go to get this service?	إذا كنت عم تستخدمي وسائل لتنظيم الأسرة وين عم تروحي لتحصلي عليها؟
Which dispensary did you visit?	اي مستوصف زرتي
Where did you visit the doctor?	أين قمت بزيارة الدكتور أو الممرضة
In the past year have you sought family planning services and not been able to receive services?	بآخر سنة، هل حاولت تحصلي على خدمات تنظيم الأسرة وما قدرتي تحصلي على هيدي الخدمات؟
Why?	لماذا لا؟
Did you discuss family planning or family size with anyone in the past year?	بآخر سنة، هل ناقشتي مع حدا تنظيم الأسرة أو عدد الاشخاص بالاسرة؟
With whom did you discuss?	مع من ناقشت؟
Non-Communicable Diseases	الامراض غير المعدية

How many members in your household have been diagnosed of diabetes including yourself?	كم شخص ببيتك عندو سكري بما فيهين انت ؟
How many members in your household have been diagnosed high blood pressure, hypertension, including yourself?	كم شخص ببيتك عندو ارتفاع بضغط الدم بما فيهين انت ؟
How do you think people can reduce the risk of getting these diseases?	كيف برأيك يمكن للناس تتجنب الاصابة بالسكري أو الإرتفاع بضغط الدم؟
Is anybody in your household taking any medication for diabetes or hypertension?	في شي شخص ببيتك بياخذ أي دواء لمرض السكري أو ارتفاع ضغط الدم؟
How are they/you able to procure the medicine?	كيف عم بتجيبوا الدواء؟
Where are you getting those medication from?	من وين عم تحصلوا على هيدي الادوية ؟
Psychosocial Support Services	نموذج خدمات الدعم النفسي والاجتماعي
What types of psychosocial services are available in your community for someone who feels stressed or under pressure ?	شو هي أنواع خدمات الدعم النفسي الاجتماعي المتوفرة بمجتمعك لشخص يعاني بالتوتر او الضغط النفسي؟
In the past year did you discussed advices from anyone concerning psychosocial support ?	بالسنة الماضية هل استشرتني او اخذتي معلومات من حدا عن خدمات بتخص الدعم النفسي الاجتماعي
From where did you get the advice?	من مين اخذتي هل معلومات؟
If you or someone you care for needs psychosocial support service, where can you access this type of services?	إذا كنتي أنتي أو أي شخص بيعينيك بحاجة لخدمات الدعم النفسي الاجتماعي ، وين فيكي تحسلي على هيدا النوع من الخدمات؟
If you or someone you care for needs psychosocial support service, would you feel comfortable accessing one of the support services in your community?	إذا كنتي أنتي أو أي شخص بيعينيك بحاجة لخدمات الدعم النفسي الاجتماعي ، بتحسي بالراحة لتروحي تحسلي على واحدة من هيدي الخدمات؟
If you or someone you care for needs psychosocial support service, would you be able to access one of the support services in your community?	إذا كنتي أنتي أو أي شخص بيعينيك بحاجة لخدمات الدعم النفسي الاجتماعي ، هل بتحسي أنك قادرة تحسلي على واحدة من هيدي الخدمات؟
Why would you not feel comfortable or be able to accessing one of these services?	لي ما بتحسي بالراحة أو مش قادرة انك تحسلي على واحدة من هذه الخدمات؟
In the past six months, did you or someone you care for feel sad, stressed, or under pressure?	بآخر ستة أشهر ، هل شعرت أنت أو أي شخص بيعينيك بالحزن أو التوتر أو الضغط النفسي؟
How did you or the person you care for deal with that?	كيف تعاملت أنت أو الشخص يلي بيعينيك مع هيدا الشعور ؟
Were you satisfied with the services you received?	هل كنتم راضيين عن الخدمات التي تلقيتوها؟
Why Not Satisfied?	لماذا غير راضيين؟
Mortality standard	نموذج الوفيات
Do you have sisters?	عندك اخت أو أخوات؟
Did any of your sisters die just after delivering a child in Lebanon ?	هل عانت أحد أخواتك بصعوبات خلال الحمل أو الولادة أو ما بعد الولادة أدت إلى وفاتها؟

To make sure things went well it's possible that we call you from Medair to make sure that you felt comfortable giving the answers. Is it ok to take your name and your phone number or your husband's phone number ?

لنؤكد حسن سير جمع المعلومات من الممكن انو يتصلوا من قبل ليتأكدوا أنو كنتوا مرتحين بإعطاء الاجوبة في Medair جمعية اخذ اسمك و رقم تلفونك او تلفون جوزك؟

Full Name:

الاسم الكامل

Phone number

رقم الهاتف

With Whom the phone is?

الرقم يبقى مع :