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Medair Health Project in Bekaa Valley - Lebanon

+ Health and Nutrition Knowledge, Practices and Coverage
2022 Household Survey Report.

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Acronyms

ANC	Ante-Natal Care
ARI	Acute Respiratory Infection
CHV	Community Health Volunteer
CMW	Community Midwife
C-Section	Caesarean Section
DG ECHO	Directorate-General for European Civil Protection and Humanitarian Aid Operations
DPT	Diphtheria, Pertussis and Tetanus
EBF	Exclusive Breastfeeding
FDFA	Federal Department of Foreign Affairs
FP	Family Planning
GIS	Geographic information System
HH	Households
ITS	Informal Tented Settlement
KPC	Knowledge, Practice, and Coverage
MCH	Maternal and Child Health
MDD	Minimum Dietary Diversity
MHPSS	Mental health and Psychosocial Support
MMR	Measles Mumps Rubella
MoSA	Ministry of Social Affairs
MoPH	Ministry of Public Health
NGO	Non-Governmental Organizations
ODK	Open Data Kit
ORS	Oral Rehydration Solution
PHC	Primary Health Care
PNC	Post-Natal Care
PPC	Post-Partum Care
PPT	Percentage Point
PSS	Psycho-Social Support
RH	Reproductive Health
SDC	Social Development Centre
STI	Sexually Transmitted Infections
TOR	Terms of Reference
UNICEF	United Nations Children Fund
UNHCR	United Nations High Commissioner for Refugees
WASH	Water Sanitation and Hygiene
WHO	World Health Organization

Introduction

Since 2014, Medair has supported accessible primary healthcare services to affected communities through the provision of human resources, medicines, equipment, capacity building and community outreach activities. Medair has supported throughout the years various different Social Development Centers (SDCs).

As of quarter three in 2022, Medair continues to support two SDCs and two primary health care centres (PHC) in Bekaa. These centres benefit from a complete package of services including subsidized consultations, child vaccination, sexual and reproductive health (SRH).

Further, Medair has been supporting PHCs in the south for only child vaccination whilst providing COVID-19 vaccination and community engagement services across different geographical areas through one static vaccination center in Saida and mobile busses covering Bekaa, South and the North to promote COVID-19 vaccination and other key health messages. Funding to support the Medair health projects comes from an array of donors, including DG ECHO, UNICEF, Chaine du Bonheur and the Swiss Agency for Development and Cooperation of the Federal Department of Foreign Affairs (FDFA).

The current health project activities focus on four main objectives:

1. Improving access of the households to primary health care and vaccination services focusing on those having children under 5 years of age.
2. Improve the quality of health care services provided by supported healthcare facilities.
3. Increase the health, nutrition, and hygiene awareness and practice among mothers with children under five.
4. Establish mental health and psychosocial support (MHPSS) awareness channels and supportive groups in the targeted communities

Key thematic areas under these objectives include:

1. Health seeking behaviour
2. Diarrhoea and respiratory tract infection management for children
3. Vaccinations
4. Reproductive health managements
5. Breastfeeding practices
6. Access to sexual and reproductive services
7. Access to mental health and psychosocial services.

To measure health project indicators in the coverage area, Medair planned an annual Knowledge, Practice, and Coverage (KPC) household survey with a random sample of Households – both Syrian and Lebanese – in the Medair coverage areas.

Medair conducted its first KPC survey in November 2015 and has repeated the survey each year. This year the targeted areas were expanded to include the South and the North whilst previously it was only covering Bekaa. The survey data tracks project indicator progress and provides evidence-based data for Medair, donors and official bodies (MOSA and MoPH) regarding the health gaps in the targeted areas which will further inform future decision-making, advocacy, and programming.

This report represents the key findings generated to profile the contemporary annual state of the 50 indicators according to the developed ToR for this purpose (Annex 1) and based on the findings provide suggestions for adaptations or new programming approaches.

Data collection methodology and sampling

The KPC household survey was conducted with Syrian refugees and vulnerable Lebanese populations living in three location Bekaa, South and the North. It targeted both male and female caregivers aged 18+ years and above. A two-stage cluster random sampling to achieve 95% confidence interval and 5% margin of error at governorate level was employed. For further details on the clusters selected, see Annex 2 at the end of the document.

A total of 985 responses were originally planned. The surveyed population included both persons who participated in Medair activities as well as the general population.

Data collection in 2022 was done during the month of August. Verbal informed consent was sought from respondents at the starting of the KPC survey.

In the field 976 responses were collected with 99.1% response rate. The following table summarizes the sample size and margin of error per nationality. The margin of error is for the entire population, but because the survey analysis included disaggregation by Lebanese and Syrian respondents, the table also includes the margin of error for each of these two populations.

Table 1: Sample Size and Margin of Error for total populations by Nationality

Sample Size			Margin of Error ¹		
Total	Syrian	Lebanese	Total	Syrian	Lebanese
965	256	709	3.1	6.1	3.7

The sampling approach is based on the most updated GIS data. Households living within 5 km of the coverage area of the Medair-supported clinics were sampled per cluster to generate a cumulative population list. Syrian refugees lived almost exclusively in the Informal Tented Settlements while the Lebanese usually lived within the neighbouring communities – with both within the clinic’s coverage areas.

To ensure consistency in the data collection, enumerators were contracted and supervised by Medair field staff. A 1-day training was conducted per area to cover an orientation to the KPC survey, project activities and areas of intervention. Data was collected on tablets using Open Data Kit (ODK) technology.

Data Cleaning and Analysis

The survey data was exported as excel files from the ODK platform. Data cleaning for 2022 and the other data sets was conducted using the same criteria described in earlier project

reports: HHs with no children under 5 were not counted, all HH who refused to give informed consent were not included in the analysis, data was checked for ambiguity and consistency across all the survey questions.

Analysis of the variables was done using descriptive statistics and presented in Microsoft excel 365 using pivot tables. Categorical variables were presented by count and percentage while numerical variables by mean and standard deviation. Project indicators were presented using percentage and 95% confidence interval. The Analysis framework with indicator definitions and calculations is found in Annex 3.

Disaggregation of the indicators: For 2022 dataset analysis, the survey results for each indicator were reported disaggregated by nationality – differentiating between the Syrian refugee and the vulnerable Lebanese host community selected for participation.

Limitations to the study

Limitations to a study can be classified into one of three categories: data collection, methodology, and logframe. Overall, the data collection process went smoothly, and the standard application of long-standing tools and approaches provided high-quality insights into the project activities. Nevertheless, potential limitations should be recognized:

1. The data generated are representative of the general population surveyed with an error of 3.1%, however per governorate the data is generalizable mainly for Baalbek while being indicative or exploratory for other areas (Bekaa, South, Nabatieh and North).
2. The sampling of respondents didn't exclude any nationality in the coverage area. However, data analysis was presented for Lebanese and Syrian since Palestinian numbers were low.
3. Some questions were only partially reflecting the indicator, consequently the indicators definition and the calculation method was clarified accordingly.
4. Child vaccination indicator results reflect coverage of vaccines as verified by a vaccine booklet, rather than recall. Therefore, actual vaccination coverage may be under reported.
5. The fluid nature of households and their ability to make choices both among which health clinic to attend or whether to attend other options, creates challenges for tracking whether specific clinics or health options are the ones that are most influencing reported health behaviour.
6. Relying on respondent self-report for knowledge is dependable but relying on respondent self-report for behaviour, while necessary, comes with the limitation that respondents may not always be truthful about their behaviour – especially when it comes to factors that may be affected by social desirability bias (such as breastfeeding or accessing STI services).
7. The length of the questionnaire is extensive to measure all the required variables which can lead to respondent fatigue and unreliable reporting – especially for questions in the latter half of the survey.

2022 Log frame Indicator Summary

Dimension	Indicators	Total (% , CI*)	Syrian Refugees (%)	Vulnerable Lebanese (%)
Socio-demographic info	1. % Mothers of children ages under 5 years who got married before the age of 18 years (early marriage)	15.6 (10.3-21.0)	37.1	8.3
General Health				
Health seeking Behaviour	2. % Respondents of children aged under 5 years of age in project area who went to qualified health services when they needed medical services	80.0 (75.0-85.0)	76.1	81.4
	3. % Respondents of children aged under 5 years of age in project who visited any PHC or SDC during the 12 months prior to the survey	91.6 (88.1-95.1)	92.8	91.0
COVID-19 vaccination	4. % Respondents who reported being vaccinated during the last year	50.6 (44.3-56.9)	40.6	54.3
	5. % Respondents who reported knowing how to register on IMPACT platform	67.6 (61.7-73.5)	51.8	73.3
	6. % Respondents who agree on the importance of COVID-19 vaccination	63.8 (57.8-69.9)	60.6	65.0%
	7. % Respondents that received COVID-19 related services	15.3 (10.8-19.9)	17.1	14.9
	8. % Respondents who received service that agree that the service was helpful in reducing stress and fear from COVID-19	97.3 (92.1-100.0)	97.7	97.1
	9. % Respondents that are hesitant towards COVID-19 vaccination	17.2(12.4-22.0)	18.7	16.9
Maternal Health				
Reproductive Health (RH) services	10. % Respondents in the targeted communities who correctly identify available RH services	74.6 (69.1-80.1)	63.3	79.1
	11. % WGMB in the targeted communities who correctly report where to access RH services	94.8 (92.0-97.6)	94.4	96.0
	12. % Respondents in the targeted communities who report that they would be: - comfortable to access - able to access these (RH) services as needed	89.2 (85.3-93.1) 84.2 (79.7-88.8)	89.2 82.5	89.2 84.9

	13. % Mothers of children under 5 years who report accessing RH services in the 6 months prior to the survey	72.4 (65.8-79.1)	76.5	71.3
	14. % Mothers of children under 5 years receiving RH services who report satisfaction with support provided	100.0	100.0	100.0
ANC visits	15. % Mothers of children under two years of age who had at least 4 comprehensive antenatal visits when they were pregnant with their youngest child	82.6 (74.2-91.1)	70.9	86.8
	16. % mothers of children aged 0-23 months who had their first ANC visit within the first 3 months of pregnancy	93.2 (87.7-98.8)	86.0	95.9
	17. % mothers of children aged 0-23 months who had their last ANC visit less than 1 month before delivery	77.5 (68.2-86.8)	73.3	79.5
Delivery	18. % of mothers of children under 5 years who delivered their youngest child at hospital	94.1 (90.6-97.6)	90.0	95.3
	19. % of mothers of children under 2 years who delivered their youngest child at hospital	93.7 (88.5-98.9)	88.5	95.7
	20. % of mothers of children under 5 years who delivered by caesarean section	52.8 (45.3-60.2)	37.7	57.4
	21. % of mothers of children under 2 years who delivered by caesarean section	49.2 (38.5-60.0)	35.5	54.3
	22. % of birth attended by skilled health professional	99.3 (98.2-100.0)	98.8	99.4
Postnatal Care (PNC)	23. % of mothers of children under two years of age who received a post-partum visit within two weeks after birth of their youngest child	76.4 (65.8-87.1)	77.2	76.2
	24. % of mothers of children under two years of age who received at least 3 post-partum visits within 40 days after delivery	9.1 (1.8-16.3)	3.5	16.0
	25. % of children under two years of age who were examined within 3 days after delivery	96.5 (92.5-100)	96.4	96.4
Family Planning (FP)	26. % of respondents of children under 5 years who report discussing FP with a trained service provider in the 12 months preceding the survey	8.7 (5.1-12.3)	4.8	10.1

	27. % of respondents of children 0-23 months who are using modern contraceptive methods	60.8 (51.6-70.1)	65.7	58.2
	% of Females of children 0-23 months who are using a modern contraceptive method	61.0 (50.4-71.6)	63.9	58.7
	% of males of children 0-23 months who are using a modern contraceptive method	60.4 (41.3-79.5)	70.4	56.8
	28. % of respondents who are willing to use contraceptive in the future	40.9 (31.7-50.2)	40.2	41.2
	29. % of respondents who know at least one risk of getting pregnant within 2 years of last delivery	73.9 (68.3-79.4)	59.4	78.9
Child Health				
Child Illness	30. % of children under 5 years that had fast or difficult breathing in the last 2 weeks	8.7 (5.1-12.3)	7.5	11.6
	31. % 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	56.4 (43.5-69.4)	56.3	57.7
	32. % 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	100.0	100.0	100.0
	33. % of children under 5 years that experienced diarrhoea in the last 2 weeks	26.4 (20.9-32.0)	28.7	25.0
	34. % of children under 5 years with diarrhoea receiving ORS and zinc supplementation	2.7 (0-6.8)	0.0	4.0
Breastfeeding	35. Percent of children 0-5 months of age who are exclusively breastfed (Exclusive breastfeeding under 6 months)	62.1 (46.3-77.9)	69.0	58.8
	36. % of children 0-24 months who were put to breastfeeding within 1 hour after of birth(Early initiation of breast feeding)	88.5 (82.3-94.7)	91.7	88.3
Child Vaccinations	37. % of children aged 12 months- 5 years who are vaccinated for measles in clinic coverage area	22.6 (16.4-28.8)	23.2	21.1
	38. % of children aged 1- 5 years who are vaccinated for polio in clinic coverage area	24.0 (17.7-30.3)	23.2	23.6

	39. % of children aged 1- 5 years who are vaccinated for Diphtheria and Pertussis and Tetanus (DPT) in clinic coverage area	22.4 (16.3-28.6)	20.8	22.2
	40. % of children aged 0-24 months who received age-appropriate vaccination at time of survey	11.0 (5.4-16.6)	9.8	10.5
Mental Health				
Psycho Social Support (PSS) services	41. % respondents in the targeted communities who correctly identify available PSS services	39.7 (33.5-45.9)	29.5	43.0
	42. % respondents in the targeted communities who correctly report where to access PSS services	55.7 (46.4-64.9)	47.8	59.8
	43. % respondents of children under 5 years who report discussing PSS with a trained service provider in the 12 months preceding the survey	10.6 (6.7-14.4)	9.2	11.1
	44. % respondents in the targeted communities who report that they would be comfortable to access these (PSS) services as needed	68.9 (63.1-74.8)	66.5	70.0
	45. % respondents of children under 5 years who report able to access PSS support services in the last 6 months prior to the survey	54.3 (48-60.6)	50.2	56.0
	46. % respondents of children under 5 years receiving PSS services who report satisfaction with support provided	92.6 (78.6-100.0)	88.9	92.9
Child Nutrition	47. % Breastfed and non-breastfed children 6–23 months who received at least 4 meals in the past 24 hr	30.4(19.4-41.3)	23.7	33.3
	48. Minimum Dietary Diversity: % of children 6–23 months of age who receive foods from 5 or more food groups (including breast feeding)	13.0(4.9-21.0)	3.9	16.4
	49. % of children 6-23 months with severe child food poverty)	54.1(45.2-62.9)	76.3	46.6
	50. % Children 24-59 months eating at least 3 meals in past 24hr	85.6(79.3-91.8)	75.2	88.4

*CI: 95% confidence Interval for the estimate

Findings

Socio-demographic Characteristics

The following table summarizes the common demographic variables in the 2022 sample.

Table 2: 2022 Dataset Demographic Summaries

Demographic	Syrian Refugees	Vulnerable Lebanese
Number	256	709
Females	68.4%	72.9%
Cannot read or write (Total)	26.3%	2.3%
Cannot read or write (females only)	28.2%	2.3%
Women Married under 18 years	37.1%	8.3%
Participated in Medair activities	15.5%	14.5%
Mean Age of Respondent	30.0	32.3
Mean Age when married	18.3	21.3
Mean number of children under 5	1.6	1.3
Mean age of youngest child (months)	23.8	26.7
Coverage Area		
<i>Baalbek Hermel</i>	38.2%	37.9%
<i>Bekaa</i>	22.0%	18.8%
<i>North</i>	16.2%	18.0%
<i>South</i>	11.6%	12.5%
<i>Nabatieh</i>	7.8%	9.0%
<i>Akkar</i>	4.2%	3.9%

A total of 976 Households (HH) participated in survey. The participants were from various areas: Baalbek El Hermel (37.7%), Bekaa (20.9%), North (16.5%), South (12.8%), Nabatieh (8%) and Akkar (4%). Most of the participants were Lebanese (72.6%) followed by Syrian (26.2%) and minority were Palestinian (1.1%). 72% of the participants were Females (Syrian 68.4%, Lebanese 72.9%). The majority were married (97.3%) with average age of 23 years. 87.2% of them were above 18 when they were married with an average of 1.4 child under 5 years in each household. Literacy was high with only 8.5% reporting being illiterate, although varying significantly by population, with 2.3% of Lebanese women and 28.2% of Syrian women being illiterate. People with special needs (PwSn) presence in the household was high (approximately 0.09 per HH) with prevalence in Syrian double (11.7%) that of Lebanese (5.6%).

Indicator 1: Percent of Women who got married before the age of 18 years (early marriage)

Percent of Syrian mothers marrying before the age of 18 is still high. 15.6% of the women participating in the survey married before the age of 18. Syrian refugees' mothers tended to be married at an earlier age with 37.1% marrying below the age of 18 versus 8.3% for the Lebanese.

Syrian mothers also tend to be younger, have more children under five in the household (average Syrian children in HH is 1.6 versus 1.3 for Lebanese nationality) and had younger children overall. Syrian refugees were also more likely to not be able to read or write, and to have participated in Medair activities.

As for differences per governorate, the south region had the higher percentage of females married before the age of 18 (20.8%) followed by Baalbek Hermel (17.9%), Bekaa (14.4%) then North, Akkar and Nabatiyeh (around 10% each).

Health Seeking Behavior

The two indicators related to health seeking behaviour are whether beneficiaries sought qualified medical services when needed and whether beneficiaries visited any health clinic during the past 12 months. Supplementary questions included exploring reasons for why not accessing services.

Indicator 2: Percent beneficiaries of children under 5 years in the project area who went to qualified health services when they needed medical services.

A high percent of respondents went to qualified health services in the past year.

In the survey, respondents were first asked if they or their children had needed medical services in the year prior. Then, for those that said yes, a follow up question was asked regarding whether they had sought medical services and from which source. The percentage of respondents who answered that they needed services was 80%, with Syrian reporting this need being 76.1 % and Lebanese 81.4%

Lebanese were slightly more likely to seek services each time compared to Syrians, but only by a small margin (4 ppt).

66.6% of beneficiaries reported that reaching health clinics required transportation. The cost of transportation exceeded 50,000 LBP for 64% of the respondents, who needed transportation with an average of 82,000 LBP. North, South and Nabatiyeh were more likely to pay more for transportation than other governorates.

Indicator 3: Percent of beneficiaries in the project area who visited any PHC or SDC during 12 months prior the survey.

PHC and SDC in the coverage areas are accessible to the surrounding communities but not fulfilling all beneficiaries needs.

During the past year, 91.6% of the respondents visited a PHC or SDC in the coverage area, with similar percentages between Syrian and Lebanese. This indicates high accessibility to the surrounding clinics, however 17.1% reported not getting the services that they wanted (Syrian 22% and Lebanese 15.4%). The areas reporting a higher proportion of not getting their needs met from the health facilities were the South (34.7%), North (30.8%) and Nabatiyeh (18.2%).

COVID-19 vaccination

Because of the pandemic, a series of questions were added to the survey specifically exploring vaccine coverage, knowledge of how to be registered, perceptions and hesitation towards vaccination and the impact of the vaccination on reducing stress. These are summarized below:

Table 3: 2022 COVID-19 perception and practices

Indicator #	Question	Syrian	Lebanese
Indicator 4	Percent of respondents who reported being vaccinated during the last year	40.6	54.3
Indicator 5	Percent of respondents hesitant towards COVID-19 vaccination	18.7	16.9
Indicator 6	Percent of respondents who reported knowing how to register for COVID vaccine on IMPACT	51.8	73.1
Indicator 7	Percent of respondents they agree on importance of COVID-19 Vaccination	60.6	64.9
Indicator 8	Percent of respondents that received COVID related services	17.1	14.9
Indicator 9	Percent of respondents that agree that the service was helpful in reducing stress and fear from COVID-19	97.7	97.1

Indicator 4: Percent of respondents who reported being vaccinated during the last year

Vaccine coverage is within the national average for Lebanese while below the average for Syrian. Overall vaccine coverage is average. Lebanese respondents are more likely to have been fully vaccinated than Syrians (54.3% Lebanese versus 40.6% Syrian). The South Baalbek-Hermel and Bekaa had a similar average of around 45% and above being vaccinated while North and Akkar had a higher proportion exceeding 62%.

Indicator 5: Percent of respondents hesitant towards COVID-19 vaccination

Vaccine hesitancy apparently decreased in 2022 and is driven by fear of the vaccines side effects rather than dismissing COVID itself. Previous KPC data in 2021 measured hesitancy in terms of respondents who are afraid of side effects or not vaccinating because

vaccine is relatively new. The proportion of respondents who reported this reached around 34%.

In 2022, a proportion of the respondents are still hesitant towards vaccination (17.2%). Similarly, the main reasons for this hesitation are concerns related to safety of the vaccine as well as fear from side effect. Some also prefer that more people experience the vaccine before they do it themselves. Around 20% of those who are not willing to vaccinate in the sample (similar across both nationalities) reported not believing in vaccines. The proportion of those who didn't believe in vaccines was highest in the south (28.6%) and Nabatiyeh (25%) followed by the other regions. In addition, respondents expressed mistrust in MoPH (11.9% Syrian, 17.2% Lebanese).

Most people do not have challenges in getting the vaccine except for concerns about the side effects. About half of the respondents reported that there were no challenges to getting the vaccines (even if they didn't get vaccinated). About a third were concerned about the side effects of the vaccines. However, more than 90% of the respondents knew where to go, had no transportation barriers, and knew how to register.

Table 4: COVID- most frequently cited reasons not vaccinated

Question	Syrian	Lebanese
Not safe to take vaccine as still new	37.8	34.2
Fear of side effects	20.7	15.4
Do not believe in vaccines	20.7	19.4
Will wait until others take it	9.6	10.7
Do not trust Ministry of Public Health	11.9	17.2
Health concerns about the vaccine	12.6	11.0
COVID not an issue	4.4	5.3
Already had COVID	0.7	3.4

Table 5: COVID - Challenges for getting the vaccine

Question	Syrian	Lebanese
Side effects	35.1	32.0
Do not know where to go	9.2	5.1
Transportation	10.4	7.4
Do not know how to register	5.2	2.8
No challenges	45.4	56.0

Indicator 6: Percent of respondents who reported knowing how to register for COVID vaccine on IMPACT

Knowing how to register on IMPACT platform increased tremendously over the past year. More than 67% knew how to register on the IMPACT platform with Lebanese more likely to know than Syrian (73.1% versus 51.8%). Effectively 53% register themselves indicating an increased knowledge versus previous data. In the 2021 KPC, the average was around 37% who were able to register themselves.

Indicator 7: Percent of respondents they agree on importance of COVID-19 Vaccination

Majority of respondent reported that COVID-19 vaccine is important. More than 60% of the respondents agreed on the importance of COVID-19 vaccination. Lebanese reporting slightly higher numbers than Syrian (about 4 ppt difference). Per governorate, Akkar,,North and south presented high proportion of respondents reporting that the vaccine is important while this proportion decreased in Bekaa and more significantly in Baalbek Hermel were 46% reported that the vaccine is not important.

Indicator 8: Percent of respondents that received COVID related services

COVID-19 related services received by communities are considered low and varied by location.

Technical Note: COVID-19 related service definition: This includes vaccination, Covid-19 awareness and education sessions, personal protective equipment and antiseptics.

15.3% of the HH reported receiving COVID-19 related services by Medair or other entities in the community. Syrian reported higher numbers (17.1%). Per governorate, North reported highest proportion (20.1%) followed Baalbak Hermel (17%), Nabatiyeh (14.3%), Bekaa (14.2%) and South (9.1%). However, this indicator contradicts the fact than more than 50% of the respondents are vaccinated so they definitely received a service, Therefore, this indicator might not have been reflected fully by the question and respondents understood it as service beyond vaccination – results should therefore be interpreted with caution.

Indicator 9: Percent of respondents that agree that the service was helpful in reducing stress and fear from COVID-19

The vast majority of the respondents who took the COVID-19 related service agree that the service is helpful in reducing stress and fear from COVID-19.

97.3% said the service was helpful with no difference across nationality or governorates. Those few who said it wasn't helpful was because they only received antiseptics with no other services.

Reproductive Health Services

This section assesses the degree to which respondents can access and are satisfied with reproductive health (RH) services – Ante-natal care (ANC), post-natal care (PNC), family planning (FP) and sexually transmitted illness (STI) treatment. Five indicators operationalize this dimension: Whether respondents are aware of what types of RH services are available and where they can access them; whether respondents would feel comfortable and able to access these services and finally, whether respondents did access these services in the last six months and how satisfied they were with the services provided.

Indicator 10: Percent of respondents who correctly identify available RH services.

There is good knowledge of ANC and PNC services but very little awareness of FP and STI services. 74.6% of the respondents can cite at least one RH service – usually ANC and PNC services with percentage higher among Lebanese (79.1%) versus Syrian (63.3%). 34.1% of them could cite FP services and only around 13.9% could cite STI services with the latter being particularly lower in Syrian (8.2%). Nabatiyeh, North and the South had a lower proportion of respondents (around 50%) who were able to cite available RH services than other governorates.

Indicator 11: Percent of WGMB who correctly identify where to access RH services.

Syrians and Lebanese respondents know where to go for RH services. Most of the respondents (94.8%) could cite at least one location for RH services. The main location cited was either a dispensary (50.2%) or a private clinic (42.4%). Few respondents cited hospitals, pharmacies, doctors and very few cited nurses or midwives.

Syrians are more likely to access a dispensary over private clinics than Lebanese. Around 66% of the Syrian reported that they would access a dispensary for RH services and 20% a private clinic. While Lebanese tend more to access private clinics (51%) versus dispensaries (44.2%). South and the North were among the governorates whose respondents were more likely to access dispensary over private clinic (47.5% and 42.6% respectively)

Indicator 12: Percent of respondents who report that they would be comfortable and able to access RH services.

Beneficiaries feel comfortable and able to access RH services but are likely only thinking of ANC and PNC activities. 89.2% of the respondents stated that they were comfortable and able to access RH services. There is a small difference between respondents who said they would be comfortable and who said that they would be able (Syrian about 6.7 ppt difference and Lebanese 4.3 ppt difference). It suggests that for a few specific individuals, there would be some level of difficulty accessing RH services even if they felt comfortable doing so but this is not a systemic issue.

The main barriers for access were high cost and living conditions (57.7%) and unshared reasons (21.5%). This is likely since ANC and PNC services were cited by most of the respondents less controversy or stigma associated with those services. However, if respondents were asked specifically about their comfort level for FP consultations or STI services, it is possible that for those services, a greater percentage would not feel either comfortable or able to access the services. It is recommended that in future surveys these elements are separated out and measured separately.

Indicator 13: Percent of mothers of children under 5 years who report accessing RH services in 12 months prior to the survey.

The most frequently sought services are ANC and PNC; few mothers seek out FP or STI services. In both Syrians and Lebanese, 72.4% sought at least one RH service in the past 12 months. The most frequently sought services were ANC and PNC services. Low numbers reported accessing FP (17.6%) or STI services (5.9%). Nationality had a small influence in seeking services (5.2 ppt difference were Syrian had higher access than Lebanese to these services).

Syrians access services mainly through dispensaries while Lebanese were more equally distributed between dispensaries and private clinics. Majority of respondents were choosing between either dispensaries or clinics to access their RH service. Most Syrians (66.1%) used the dispensaries. In contrast, Lebanese tended to use more of a mixture of different options a slightly higher percentage accessing the private clinics over dispensaries. A good percentage did report using hospitals (17%) – more so among Lebanese. Almost negligible numbers reported using nurses, midwives, or other options given in the survey.

Respondents accessing RH services differs per governorate. Respondents' accessibility was highest in Bekaa (81.9%), followed by Baalbek Hermel (79.2%), Akkar (71.8%), south (65.3%), North (59.1%) and Nabatiyeh (44.2%).

Indicator 14: Percent of mothers with children under 5 years who report satisfaction with RH services provided.

Mothers are satisfied with the quality of service. In general, this reflects that sexual and reproductive health services are delivered with a quality that is acceptable to the recipients. Note that this does not necessarily align with technical quality standards agreed at international levels.

Ante-Natal Care (ANC) Visits

Ante-natal care (ANC) is measured through three indicators all of which focus on those mothers with children under two. These are whether a mother had attended at least four comprehensive ANC visits while pregnant with their youngest child, whether the first ANC visit occurred during the first trimester and whether the last ANC visit occurred during the final month of pregnancy.

Indicator 15: Percent of mothers of children under two years of age who had at least four ANC visits when they were pregnant with their youngest child

Most of women attend four ANC visits (82.6%), but less frequently among Syrians. The differences in nationality were substantive: 70.9% of Syrian mothers reported receiving at least four ANC visits, whilst 86.8% of Lebanese women were likely to have four ANC visits.

Syrians rely more on dispensaries for ANC visits while Lebanese more often use private clinics. Although there were a variety of options presented for where one might go for ANC visits, the two main sources were either dispensaries or private clinics followed by doctors. 59.5% of Syrian attend dispensaries and 30.6% attend private clinics while 63.4% of Lebanese attend private clinics and 21% attend dispensaries. In the survey, there were also options asking who did the mothers see for ANC care and they could choose among doctors, nurses, or the community midwives. The vast majority reported seeing a doctor. Nurses and midwives together comprised less than 2% of the responses.

Indicator 16: Percent of mothers of children aged 0-23 months who had their first ANC visit within the first 3 months of pregnancy.

A high percentage of women (93.2%) have an ANC visit within the first trimester, even the Syrian mothers who do not complete all four ANC visits. Lebanese were more likely to conduct a first trimester visit (95.9%) than Syrian (86%).

Indicator 17: Percent of mothers of children aged 0-23 months who had their last ANC visit within the last month.

Most of the women had an ANC visit within the last month of their pregnancy. Syrian mothers were a little less likely (73.3%) than Lebanese mothers (79.5%) to have a final ANC visit in the last month of pregnancy.

Delivery

This dimension focusing on healthy birthing behaviours is operationalized through different indicators: whether they delivered in hospital; whether the birth was by Caesarean section; and whether the birth was attended by skilled health professional. These indicators were gathered for mothers of children under 5 and under 2 years of age.

These indicators are considered important for good maternal and child health as per MoPH recommendations

Indicator 18: Percent of mothers under 5 who delivered their child at hospital.

Indicator 19: Percent of mothers under 2 who delivered their child at hospital.

There are very few births that happen outside of the formal medical system. The vast majority of mothers in the survey reported giving birth in either a hospital (94.5%) or clinic/dispensary (4.5%). Lebanese mothers were almost unanimous in giving birth in either a hospital or clinic while about 4% of Syrian mothers did *not* give birth in one of these two options rather than informal birth situations within the informal settlement. There was very small difference when reported this indicator for children under 5 years and under 2 years (94.1 and 93.7 respectively). No difference existed across governorate as well.

This suggests the vast majority have good access to the formal health care system.

Among the reasons cited for not using the formal system was the cost of the delivery in the hospitals (50%) and other reasons (birth was fast, COVID-19 situation, not liking the formal system).

Indicator 20: Percent of mothers of children under 5 years who delivered their child by C-section.

Indicator 21: Percent of mothers of children under 2 years who delivered their child by C-section.

The percentage of mothers in 2022 who had C-sections is surprisingly high in the sample compared to global targets and national patterns. Globally, natural birth is promoted among health guidelines and there is concern regarding the casual use of C-sections as a convenience for doctors or mothers with the World Health Organization (WHO) suggesting an ideal 10-15% C-section rate.² As awareness raising activities increase, one should see a decline across the length of a project cycle in terms of the mothers using C-sections. The national average in Lebanon for C-sections hovers around 45%.³ This survey found that Lebanese women with children under 5 years are much more likely to have a C-section (57.4%) compared to Syrian women (37.7%). Given that Lebanese women are in general less vulnerable than the Syrian mothers, this suggests that the percentages of C-sections are not related to pre-natal care or difficult births. This is triangulated from the fact that was suggested from previous years multi-comparison analysis that there are other factors that are correlated with this action such as literacy levels and age of marriage. Women who are literate and who married over the age of 18 were *more* likely to have C-sections.

When reporting this indicator for mothers of children under 2 years of age, the percentage of c-sections decreased slightly (49.2%) with same trends across nationality. Most governorates showed similar percentages to the total with the exception of the south which was higher than the average (65.4%).

The high C-section rate is reported to be related to medical decision making rather than personal preference: 75.3% of respondents who had a C-section reported that it was performed due to a medical problem and 18.4% said it was a personal choice. Among Lebanese women, 20.1% reported choosing to have a C-section compared with 11.1% Syrian women. Although not explored in this survey, the high C-section rate highlights the need for engagement with the MOH, referral facilities and community to understand and address the contributory factors.

Indicator 22: Percent of birth attended by skilled health professional

Almost all respondents reported that the birth of their youngest child was attended by skilled health professional. The main health professionals attending the birth for both Lebanese and Syrian were doctors (95.6%). Few numbers attended birth from midwives and traditional birth attendant with Syrian more likely to utilise this service than their Lebanese counterparts.

² <http://www.emro.who.int/emhj-volume-27-2021/volume-27-issue-2/trends-in-caesarean-section-deliveries-in-jordan-from-1982-to-2017-retrospective-analyses-of-annual-hospital-reports.html>

³ Ibid

Post-Natal Care (PNC)

Post-Natal care is important in terms of both timeliness and frequency. The most crucial factor is how early the first postnatal check occurs. Because of this, this dimension is measured through four questions. First, whether *the child* was examined by a health worker after delivery, then whether the mother received a Post-Partum Care (PPC) visit within three days and within two weeks from delivery; finally, whether the mother received at least three post-partum visits within 40 days of delivery.

Indicator 23: Percent of mothers with children under two who received a post-partum visit within two weeks after birth of their youngest child

The percentage of mothers who reported a PPC visit within two weeks for both Syrians and Lebanese was 76.4%. In 2022, most mothers went to private clinics followed by hospitals and dispensaries for their PPC care. This year observation is that Syrian mothers are utilizing more private (28.1%) and hospital channels (28.1%) compared to previous historical data that Medair collected, where at least 63% of Syrian attended dispensaries for PPC.

Indicator 24: Percent of mothers with children under two who received at least three post-partum check-ups (PPC) within 40 days.

Mothers generally receive one PPC visit, but do not receive the full complement of three visits. Among both Syrian and Lebanese mothers, only 9% of respondents reported receiving three PPC visits within 40 days. Syrian women were more than four times less likely as Lebanese women to receive 3 PNC visits (Syrian 3.5%, Lebanese 16%).

The COVID-19 pandemic appears to have negative impact for utilization of the services as reported by the mothers. Around 37% reported that COVID-19 pandemic affected PNC access due fear of transmission (45.5%), restriction in movement (36.1%) and sickness (24.9%).

Indicator 25: Percent of children under two years of age who were examined within 3 days after delivery.

Most children have post-delivery medical check-up within 3 days of birth. 96.5% of respondents reported that their children received a medical check-up within 3 days post-delivery, 91.7% occurred in the same day of delivery. Results were similar for both Syrian and Lebanese children.

Family Planning

The Family Planning (FP) dimension is measured by four indicators – two of which measure actions (FP discussions with service providers and contraception use) and two which measure knowledge (appropriate birth spacing and risks of rapid pregnancies) as well as willing to use contraceptive in the future.

Indicator 26: Percent of respondents of children under 5 who report discussing FP with trained service provider in the last 12 month preceding the survey

Very few women have FP discussions with trained service providers. About one third of both Syrian and Lebanese mothers reported having FP discussions, but the majority of these were with non-trained providers: 9% reported talking with a trained service provider (doctor, nurse, or midwife). Syrians (5.2%) were twice less likely than Lebanese (10.1%) to have these FP discussions with trained service provider.

Indicator 27: Percent of respondents with children under 2 years who report using a modern contraceptive method.

Respondents with children under two are using modern contraception methods. 58% of Lebanese respondents with children under two reported using a modern contraceptive method, whilst Syrian respondents reported a higher percentage (65.7%).

Mothers with children over two years of age were more likely to be using modern contraception methods than mothers with children under two. This may be due to mothers of children under two continuing to breastfeed and expecting that will reduce likelihood of pregnancy or reliance on other methods such as counting or withdrawal. Mothers with older young children are using modern methods more frequently.

Cost of modern contraception is a challenge for both Syrian and Lebanese. When asked why they may not be using a contraceptive method, the most common reason cited was high cost (50%). Modern contraception was mainly accessed through pharmacies (68.8%) and doctors (26.8%). **Women are not avoiding contraception because they want more children.** None of the respondents said that they wanted more children and only 5% said that their husbands wanted more children. Barrier analysis would be beneficial to understand factors, other than cost, which inhibit uptake of modern contraception methods. Continued awareness raising, and health education can increase knowledge of benefits of birth spacing.

Awareness raising activities should focus on misperceptions. These factors suggest that awareness raising, and health education are necessary to increase understanding of how contraception measures work. Awareness of the benefits of child spacing seems to be widespread despite low uptake of modern contraceptive methods.

Indicator 28: Percent of respondents with children under 5 who are willing to use contraceptive in the future

Approximately 41% of the respondents with children under 5 (who are not currently using contraception) expressed willingness to use contraceptive methods in the near future. No major difference occurred across nationality with similar patterns between Lebanese and

Syrian. The willingness to use contraceptive methods were higher for respondents having children under 2 years of age (47%) versus those having older children (33%).). Among governorates, an above-average willingness was reported in Akkar (55.6%) and Baalbeck-Hermel (51.3%).

Indicator 29: Percent of respondents who know at least one risk of getting pregnant within 2 years of last delivery.

A substantive percentage of mothers were aware of the risks of pregnancy within two years of last delivery. About 59% of Syrian respondents and 78.9% of Lebanese respondents could cite at least one risk. This percentage held stable when comparing between those women with children under two years and those women with children over two. Some differences across locations were noted; 18.6% of respondents in Bekaa were not aware of risks related to short intervals between pregnancies, followed by 15.6% in Nabatiyeh and 10.4% in Baalbek –Hermel. The rest of the governorates were lower than 6%.

Child Illnesses

This section combines three dimensions related to behaviour of the head of the household regarding treatment of sick children with an emphasis on the treatment of acute respiratory infections (ARI) and diarrhoea. The indicators track cases of ARI and diarrhoea, whether treatment was sought, and type of treatment obtained for each condition.

Acute Respiratory Infection (ARI)

Indicator 30: Percent of children under 5 years that had fast or difficult breathing in last two weeks

There is low incidence of severe ARI. 8.7% of the respondents reporting having ARI in under five children.

Syrian children were more likely to have ARI (11.6%) compared to Lebanese children (7.5%). Coughing was more prevalent occurring in 20.5% of the total children under 5, occurring in 18.9% of the Lebanese and reaching 24% for Syrian respondents.

Syrian families are still more vulnerable to ARI incidents compared to Lebanese families. Even with the improvements, there are still substantive differences between the two groups in terms of reported ARI. This implies that Syrian families may not be able to access such a good environment as the Lebanese families, and likely highlights the health impact of living in an ITS versus a settled community. ARI and coughing were highly prevalent in the south with 19.8% and 43.8% respectively which is much higher than the average reported for the whole group.

Indicator 31: Percent of children under 5 years with fast or difficult breathing in last two weeks who sought advice or treatment after more than 24 hours.

The intent of the indicator was to measure if and where families sought treatment for a sick child. Seeking treatment after 24 hours reflects sub-optimal response to health seeking for illness. 42.2% of respondents reported seeking treatment for a sick child with fast or difficult breathing within 24 hours, while 56.4% of the respondent's sought treatment after 24 hours. A small percentage (1.4%) did not seek treatment. **The percentage of respondents seeking treatment was similar for both nationalities:**56.3% Syrian and 57.7% Lebanese sought treatment after 24 hours. Of those who did not seek treatment, 2.8% were Syrian and 0.7% were Lebanese.

Indicator 32: Percent of respondents with children under 5 years with fast or difficult breathing in last two weeks whom advice or treatment was sought from an appropriate health facility.

Almost all households sought treatment for children with fast or difficult breathing, but Syrians use dispensaries more than any other option (98.7%). All respondents who reported seeking treatment did so in an appropriate health facility. The pattern in the responses mirrors the general health seeking behaviour options profiled in earlier sections. Syrians are using dispensaries with Pharmacies a distant second while Lebanese are more likely to have an equal distribution of accessing dispensaries, Clinics, and Pharmacies.

Diarrhea

This section tracks the prevalence and treatment of Diarrhoea, especially the use of Oral Rehydration Solution (ORS). It is important to note that when discussing the percentage of children by treatment, this is referring only to those who had a diarrhoea incident.

Indicator 33: Percent of households with children under 5 years that experienced diarrhea

High diarrhoea prevalence is noted, higher among Syrians than Lebanese. Across the total sample, 26.4 % (95% CI, 20.9-32.0) of children were reported to have diarrhoea in the previous two weeks, higher among Syrian children (28.7%) compared to Lebanese (25%). This represents an increase in diarrhoea prevalence compared to 2021 KPC data (17.1% in Syrian and 9.5% in Lebanese) and may indicate a deterioration in living conditions, lack access to adequate safe water and poor hygiene practices. A possible hypothesis is that electricity shortages have affected safe food storage in the home, and reduced access to adequate quantities of safe water, due to limited supply and cost, has led to people to buying water from unsafe sources.

Diarrhoea incidence differs by location. Respondents in the North reported a high prevalence of diarrhoea (48.7%) followed by the South (37.5%) and Akkar (31%).

Indicator 34: Percent of children under 5 experiencing diarrhoea and receiving ORS and zinc supplementation.

Extremely low coverage of provision of both ORS and zinc in treatment of diarrhoea is indicated 2.7% (95%CI 0-6.8). In the sample, 96% of the respondents reported sought treatment. 42% of the respondents reported receiving ORS and 11.4% reported receiving zinc supplements. 2.7% reported receiving both ORS and Zinc.

As with the other health seeking options, Syrians were more likely to use dispensaries or pharmacies for treatment while for Lebanese the options were more equally distributed among clinics, pharmacies, and dispensaries

The primary treatment reported for diarrhoea is antibiotics and/or ORS. In terms of treatment type, the percentage of HH reporting receiving antibiotics is very close in both nationalities (44.9% for Lebanese and 50% for Syrian) with Lebanese using ORS slightly higher than the Syrian(47.2% Lebanese and 31.9% Syrian).

Breastfeeding

This dimension assessed three indicators which explore the degree that exclusive breastfeeding is practiced and the degree to which mothers' practice "early initiation breastfeeding" within the first hour after delivery. These questions focus on mothers of infants of under 6 months of age. The percentage of infants exclusively breastfed is based on infants who received only breast milk during the previous 24 hours.

Indicator 35: Percent of children 0-5 months of age who are exclusively breastfed(Exclusive breastfeeding under 6 months)

More than half of the women (62%) who breastfeeding children under 6 months practiced exclusively breastfeeding in the 24 hours prior to the survey. The percentage of mothers who reported exclusive breastfeeding over the past 24 hours is higher than those that reported continuing exclusive breastfeeding of infants until they were 6 months.

Women reported feeling tired and not having enough milk were the most common reasons given for *not* breastfeeding. Within the sample, 11.9% did not breastfeed. Among those giving a reason for not breastfeeding, feeling tired was reported by 44%, not having milk in the breast by 22% and doctors and nurses didn't give the baby early enough to the mother (16%). This highlights the need for breastfeeding counselling and support for new mothers as well as health staff.

Indicator 36: Percent of Children 0-24 month who were put to breastfeeding within 1 hour of birth.

Most mothers reported breastfeeding their child within the first hour. 88.5% of the respondents reported early initiation of breastfeeding within one hour of birth. Syrian tend to earlier initiate breastfeeding than Lebanese (91.7% versus 88.3% respectively). Around 59.8% stated they breastfed their infants for at least 6 months.

Vaccinations

There are four indicators tracking vaccination coverage. Three of the indicators track individual vaccinations: Measles, Polio, Diphtheria, Pertussis and Tetanus (DPT). The other indicator is a synthesis asking the percentage of children who have received age-appropriate vaccinations. The survey, based on the MoPH calendar guidelines, tracks 15 vaccinations to measure age-appropriateness.

Technical Note I – Under-reporting coverage: The way the data is collected makes it seem that there are less vaccinations happening than is the case. One important consideration when interpreting this data is that the survey only records the percentage of vaccinations among those mothers who can produce a vaccination booklet for their child and who give permission for Medair enumerators to copy the data. This is a technically correct approach and a standard practice to mitigate the unreliability of memory recall of 15 different vaccinations. However, this likely leads to under-reporting of vaccination coverage as very few mothers were able to show their children's health booklets despite recalling that their child had received vaccines. Only 53.2% of the respondents could show the enumerator a vaccination booklet, although 81% stated that they had one.

Indicator 37: Percent of children aged 1-5 years vaccinated for measles (as verified by vaccine booklet).

Children are significantly under-vaccinated for measles. 22.6% CI (16.4-28.8) of children are vaccinated for measles in the coverage areas as verified with vaccine booklets.

56.4% of caregivers of children aged 1-5 years could show a child vaccination booklet. Of those children with a booklet, 22.6% of children 1-5 years had received measles vaccine with 23.2% of Syrian children had the measles vaccine and 21.1% of Lebanese children.

On another note, self-reporting had much higher figures for measles vaccination. 79.7% of the HHs reported that their children under 5 were vaccinated for measles (73% Syrian and 81.5% Lebanese). This was further disaggregated by literacy and data revealed that 81.4% of the literate tend to vaccinate their children for measles while this proportion reduced to 65.1% if caregivers were illiterate. Amongst the areas presenting self-report vaccination, South was the only one below average (67.9%).

Indicator 38: Percent of children aged 1-5 years vaccinated for polio

Children appear low vaccination coverage against polio with similar pattern as that of measles. 24% had received the polio vaccines with 23.2% of vaccination among the Syrian versus 23.6% among the Lebanese as verified by vaccine booklet. Polio vaccination occurred in 81.4% of respondents based on self-reporting which shows a high discrepancy with

vaccination booklet method. Again, the South region was lowest in proportion versus other areas (63.6%).

Indicator 39: Percent of children aged 1-5 years vaccinated for DPT

DPT vaccination is lower than previously reported. Respondents reported 22.4% children aged 1-5 years were vaccinated for DPT. Vaccination was observed to be lower among Syrian children (20.8%) than Lebanese (22.2%). This represents a drop in vaccine coverage rates compared with previous Medair KPC surveys, although targeted areas vary. It may also be indicative of increased need to support immunisation services with vaccine shortages and increased prices of vaccines in the private sector after the recent currency inflation that occurred in 2022.

Patterns of responses are mirroring polio and measles vaccination coverage. This implies that whatever factors are influencing general vaccination coverage are influencing all vaccinations and measures taken to address one will have positive results on the other as well.

Indicator 40: Percent of children 0-24 months who received age-appropriate vaccinations

Among children with vaccine booklets, 11% have received all age-appropriate vaccinations. Similar percentages were shown between nationalities with around 9.8% of the Lebanese children received age-appropriate vaccinations while 10.5% of Syrian children have all vaccines done. This low coverage of routine immunisations among those who have received a vaccine booklet shows health system issues, raises concern over availability and access to services and highlights the need for defaulter tracking, vaccine catch up and EPI outreach activities.

Psycho-Social Support (PSS)

This section assesses the degree to which respondents can access and are satisfied with mental health and psycho-social support services (MHPSS). The MHPSS services profiled include focused non-specialized support by trained health staff and community-based psychosocial activities such as peer support groups, (lay) counselling and psychoeducation. Six indicators are contained in this dimension: Whether respondents are aware of what types of PSS services are available and where they can access them; whether respondents would feel comfortable and able to access these services; whether respondents have had a discussion on PSS with a trained service provider and finally, whether respondents did access these services in the last six months and how satisfied they were with the services provided.

Indicator 41: Percent of respondents who correctly identify available PSS services.

Awareness of PSS services is low among both Syrians and Lebanese and usually understood as support groups. About 40% of the respondents could cite at least one PSS service available. The most cited service is for support groups (about 25%) while the other

services were cited by less than 15% of the respondents. **Awareness of PSS services is lower in Syrian versus the Lebanese (29.5% and 38.1% respectively)**

Indicator 42: Percent of respondents who correctly identify where to access PSS services.

There is low awareness of where PSS services can be resourced. When asked about locations for PSS services, about half of the respondents cited PSS locations for trained service provision (such as dispensaries, MH clinics or hospitals). Moreover, a good number cited informal options such as friends, family, religious figures and so forth. Among the different governorates, Akkar respondents cited dispensaries as the main provider of services while other locations cited both dispensaries and MH clinics as the main service providers except for Nabatiyeh where 60.8% of the respondents reported MH clinics.

Indicator 43: Percent of respondents who discussed PSS with a trained provider in the 12 months preceding the survey.

Majority of respondents are seeking help from their social circles very few respondents are having PSS discussions with trained service providers. When asked if they had had discussed PSS advice with someone, around 10% of respondents in 2022 said they had the discussion with a trained service provider – the remainder being informal discussions with family and friends. In terms of where they go to seek the advice, for Syrians, dispensaries are slightly more likely than other options, but not substantively different. For Lebanese, they tended to go to MH clinics, dispensaries, relatives, and friends. However, for both populations, having PSS discussions with a trained service provider is not common, even amid the social and economic stress the country is passing through.

Indicator 44: Percent of respondents who report that they would be comfortable and able to access PSS services.

Most respondents say that they are able and comfortable to access PSS services. The percentages of respondents who said that they would be comfortable and able to access PSS services is high. About 69% of the sample (both Syrian and Lebanese) said that they would be comfortable accessing these services and about 54.3% of the sample said that they would be able to access the services. A slight difference existed between Syrians who can access the service (50.2%) and Lebanese (56%). A substantial difference occurred between those who are comfortable to access and able to access in Akkar (84.6% comfortable and 56.4% able to access) and the North (73% comfortable and 47.2% able to access).

Vulnerable households face more barriers to accessing PSS services. For those respondents who would not feel comfortable or able to access, more than half of these said that it would be because it was too expensive while 35% stated that it would be because they would prefer no one knew they were accessing it and the others reported various barriers (transportation cost, services not available etc).

Indicator 45: Percent of respondents who report accessing PSS services in past six months.

Most of the respondents reported feeling sad or stressed but a very low number seek formal PSS support – relying on themselves or friends and family. In 2022, 77% of the respondents reported feeling sad, stressed or under pressure. 67% report dealing with this by themselves, and 48.3% through family, friends and neighbors. However, the percentage of respondents who accessed PSS services is very low - less than 4% of those with a need. Less than half of the respondents reported having discussions with family or friends, with religious figures or other forms of informal support. If PSS services are narrowed to the provision of specialized and non-specialised services from SDCs, clinics or other trained service providers, the responses who sought professional help are quite small. What can be inferred from these patterns is that respondents do value the support from informal sources for addressing PSS need but have not yet become accustomed to using dedicated services for PSS support. This is an interesting finding that invites Medair to further assess if support by trained MHPSS providers is not needed or if the uptake of focused MHPSS services is limited because beneficiaries do not know what services are available.

Indicator 46: Percent of women who report accessing PSS services in past six months who are satisfied with the support.

Almost majority who accesses PSS services report being satisfied with the service (92.6%). The percentage of respondents in the 2022 sample who actually accessed services from trained providers is too low and the unanimity of satisfaction with services is too high to provide useful analysis of satisfaction with services. Because of the wide consistency in the patterns of response, it is not possible to differentiate relative satisfaction with services provided.

Nutrition of children under five years

In this section, the nutrition status of the children under five was investigated based on the age group. The indicators varied between measuring the food quantity, frequency and diversity based on the critical age of children between 6-23 months.

Minimum dietary diversity (MDD) is defined as the percentage of children consuming foods and beverages from at least five out of eight defined food groups during the previous day. Child food poverty was measured using the UNICEF-WHO children's dietary diversity score in early childhood.

Severe child food poverty refers to the percentage of young children under 6-23months consuming foods and beverages from zero, one or two out of eight defined food groups during the previous day. **Moderate child food poverty** refers to consumption of foods and beverages from three or four out of eight defined food groups during the previous day.

Age group between 6-23 months:

Indicator 47: Percent of breastfed and non-breastfed children 6-23 months who received at least 4 meals in past 24 hrs.

The frequency of meals in children aged 6-23 months who were breastfed or non-breastfed reaching four times or more was 30.4% . The frequency was lower in Syrian (23.7%) versus Lebanese (33.3%).

Indicator 48: Percent of children 6-23 months who receive foods from 5 or more food groups (including breastfeeding)

Minimum Dietary Diversity (MDD): low proportion (13%) of children aged 6-23 receive foods from 5 or more food groups, indicating inadequate diet diversity. MDD was much lower among Syrian (3.9% versus 16.4% of the Lebanese)

Most of the caregivers reported giving meals to children aged 6-23 months with or without breastfeeding. 6.7% of the total group said they gave none or only one meal in the last 24 hours; the percentage was higher amongst Syrian (11.8%) versus 4.8% in Lebanese. Additionally, various food options are given to children in this age.

Syrians were more likely to include dairy products and milk followed by grains, roots, tuber, and eggs. Lebanese food groups were predominantly grains, roots, tuber and dairy products followed by fruits and vegetables. Meat and fish were provided by only 3.9% of the Syrian and 30.7% of the Lebanese.

Indicator 49: Percent of children 6-23months with severe child food poverty

54.1 % of this age group presented with severe child food poverty, 33 % with moderate and only 13% met the minimum food diversity adequate for their age. Severity differed by nationality with Syrian having a much higher score (76.3%) versus Lebanese (46.6%). Those who met minimum food diversity requirement were only 3.9% in Syrian versus 16.4% in Lebanese.

Indicator 50: % Children 24-59 months eating at least 3 meals in past 24hr

Age group between 24-59 months:

For this age group, the respondents were asked if their children are having enough meals (at least 3 meals every 24 hours). 85.6% of the whole sample agreed, with a lower proportion of Syrian respondents (75.2%) compared to Lebanese (88.4%).

Various food options were available for this age on the top being grains, roots, tuber and dairy products. Flesh food remained low especially among Syrian (11%).

Additional sections in the survey in 2022:

These are the additional sections in the survey that had no official indicators but rather provided some context information that would be helpful to plan for future programs.

The objective of this part is to understand some needs and gaps related to general health needs, sexual and gender-based violence. The presence of conflict and tensions in the health clinics in the coverage areas of the survey was also explored.

SGBV

A new section was added to the survey about sexual and gender-based violence. The objective to understand the community’s knowledge level about SGBV and if they are aware of the existing channels for accessing SGBV related service.

Respondents’ awareness of what is SGBV is limited. More than 75% of the sample reported knowing what SGBV is. When they were asked to give example around 66% said beating your spouse, 21% reported psychological abuse and 12.6% verbal abuse.

Respondents’ awareness of where to access SGBV is general and not specific. More than third of the respondents named KAFA as one of the organisations they can access it for SGBV protection. Another third reported ‘an NGO’ without naming a specific one. Other channels reported were police, dispensaries and psychologists.

Conflict and Tensions

A series of new questions were added to get an assessment regarding how Syrians and Lebanese perceive themselves to be treated at the health facilities.

Table 6: 2022 Perceptions on Conflict and Tensions

Question	Syrian	Lebanese
Percent reporting that health facilities prioritize Syrians	4.5	13.8
Percent reporting that health facilities prioritize Lebanese	9.1	5.0
Percent reporting having faced tensions in the health facilities	14.3	9.4

Few respondents report facing tensions. The overall percentages show small percentages of respondents facing tensions. About 11% of the respondents perceived that the health facilities prioritize Syrians and around 5.5% perceive that health facilities prioritizing Lebanese. Syrians were slightly more likely to perceive that facilities are prioritizing Lebanese and Lebanese were slightly more likely to perceive facilities prioritizing Syrians.

Tensions are equally distributed between staff and patients and tensions among patients. About half of the respondents who reported tensions identified the tensions as being between health facilities staff and patients and the other half related to patients sparring with each other.

Needs assessment

Highest priorities for respondents are medications followed by subsidization of health services.When asked about the highest priorities, more than 60% of the respondents said it was medications followed by subsidization of services (11.8%), cash for health (8.5%) and other minor priorities.

The best two ways stated to receive health was through subsidization (56.1%) or non-conditional cash (15.5%).

Medications are mainly outsourced from private market. 68.8% of the respondents get their medications from pharmacies while 24% get it from dispensaries, in addition to other minor resources such as hospitals and black market. For Lebanese respondents, medications are mainly received from pharmacies (78.2%) followed by dispensaries (16.7%) However, for Syrian respondents' dispensaries play an equally essential role (45.1%) as the pharmacies (49.6%) in provision of medicines.

Access to medication is problematic: 85% overall had troubles accessing medications, with more than 50% having trouble accessing their medications all time or frequently and 32.3% sometimes - only 15% reported rarely or never. There was a negligible difference between nationality, (85.9% Syrian versus 85% Lebanese). Akkar respondents reported the highest accessibility problems, reaching up to 95%, followed by the north governorate (92.5%). The main barriers were high costs (44.8%) and no availability (51.1%). Medications that are hardest to obtain were antibiotics (46%), NCD medication (45.6%), cough medications (30.2%), Allergy (26.1%) as well as cancer (16.6%) and others (6.7%).

Diagnostic procedures are inaccessible mainly because of unavailability then cost: For diagnostic procedures, 42.9% had trouble accessing it all the time or frequently, with 29.5% sometimes and 27.7% had never or rarely encountered troubles accessing. The main barriers were services not being available (76.7%) and high costs (20.8%). These procedures were slightly less likely to be accessible for Syrian (79.3%) versus Lebanese (70.2%).

Accessing Secondary and Tertiary care is hard. 44.8% of the whole sample had issues accessing secondary or tertiary care mainly due to high cost (61.7%), or no room (18.2%), in addition to not having insurance and the need for a high deposit before accessing the hospitals. Syrians again had slightly more issues than Lebanese in accessing these services (49.2% versus 42.5%).

Conclusions

The 2022 KPC survey have been revised to include additional dimensions and to target new areas of interest. 50 indicators were collected and presented with disaggregation based on nationality (Syrian and Lebanese).

Demographic data shows that the coverage area of the targeted facilities has relatively literate population except for Syrian women with high prevalence of PwSn especially among the Syrian refugees.

Health seeking behaviour is acceptable with a good proportion attending qualified health services. Even though that PHCs and SDCs in target areas were accessible, however not all the health needs were fulfilled as reported by the respondents. Cost of transportation presented a barrier especially for population living in the North, South and Nabatiyeh.

Covid-19 vaccination is within the national average for Lebanese and below average for Syrian refugees. Vaccine hesitancy still an issue but decreased over the past year and is driven by the fear of vaccine side effects. Respondents perceived the vaccine as important tool in managing the disease. Additionally, majority of respondents who received COVID-19 services found it helpful in reducing stress and fear from COVID-19.

Reproductive health knowledge is adequate, but this is largely focused on ANC and PNC. Most respondents do not consider FP or STI and most know of only one place to access RH services. Most women comply with minimum number of ANC and PPC visits recommended. C-section proportion was reported high especially with Lebanese women.

Family planning is practiced but still there are gaps in terms of seeking qualified service provider consultations. Also, the cost of modern contraception presented the main challenge for those who are not using FP methods or relying on natural methods.

SGBV awareness was proved to be limited. Respondents as well are not aware of specific channels that they can access in case they needed help.

As for **child health**, most childbirth occurred within the formal system and attended by skilled health professional. Breastfeeding was widely practiced but exclusive breastfeeding under 6 months was less common. For child diseases, ARI was less common among the respondents who mainly reported high occurrence of cough. Diarrhoea prevalence reported was alarming and need further investigation for the reasons behind that especially in Syrian population. Routine immunization or vaccination of children presented a challenge of a fundamental inaccuracy in reporting of vaccine coverage due to the low levels of vaccine booklet management. The decline in measles, polio and DPT coverage and low percentages of age-appropriate vaccines are huge gaps to address further. Data also showed that children under 5 are at risk of chronic malnutrition with very low number meeting minimum dietary diversity standards for their age in the age group 6-23 months.

In terms of percent of respondents using services, the biggest shortfall is for accessing **PSS support**. PSS knowledge about services or locations are not well known and many respondents can't access PSS services from trained service providers even if they are in need.

Finally, respondents shared that the top **health needs** are medications and subsidization of services. Cost of services presented the main barrier to accessibility.

Recommendation and Future Programming Considerations

Based on the patterns in the findings, there are future programming considerations that were identified for consideration in any future health activities in the camps:

1. **Strengthen Health Centre capacity** to meet beneficiaries PHC needs, provide quality services, provision of essential PHC medicines and appropriate diagnostic procedures
2. **Reduce transportation barriers**, either by supporting transportation costs to vulnerable families or by increasing services available in the community.

3. **Integrate more FP and STI focused activities.** There is widespread knowledge of ANC and PNC services, but little awareness of FP and STI. More could be done to strengthen those areas in project activities including re-examining barriers to changing FP and STI behaviour.
4. **Focusing natural birth awareness activities towards doctors and health professionals in hospitals and private clinics.** Most of the C-section decisions are made by the doctor, not according to patient preference.
5. Monitor incidence of **Diarrhoea** in targeted areas and investigate the root causes for this high occurrence.
6. **Focus on improving IYCF practices, including exclusive breastfeeding for children <6months.**
7. **Investigate low vaccine coverage:** review of vaccine services, defaulter tracking, EPI cover and outreach and advocate for mobile vaccination services in communities with limited access to facility based PHC.
8. **Strengthening PSS awareness and opportunities.** In future programming it may be helpful to place more emphasis in PSS awareness raising on both what is meant by PSS support and where it can be accessed.
9. **Include SGBV** awareness sessions and where to access these services within the health planned activities
10. **COVID-19 vaccine hesitancy.** Focus vaccination awareness on mitigating fears around the vaccine (rather than on awareness raising, logistics, or about COVID-19 itself).

Annexes

Annex 1: Terms of Reference



KPC-TOR-2022-final
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Annex 2: KPC 2022 selected Clusters



KPC 2022 Selected
clusters.pdf

Annex 3: KPC 2022 indicator definition



KPC 2022 indicators
definitions.pdf