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Medair Health Project in Bekaa Valley— Lebanon

Health and Nutrition Knowledge, Practices and Coverage
Household Survey 2018
Part 1 – Analysis Report

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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 2018
Part 1 – Analysis Report**

18 April 2019

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1. Executive Summary

Consultancy Name:	Health and Nutrition Knowledge, Practices and Coverage Household Survey 2018 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

In 2018 the Syria crisis entered its seventh year with almost 1 million registered, and many more unregistered Syrian refugees continuing to reside in Lebanon, a third of whom reside in the Bekaa Valley (UNHCR Data Portal, November 2018). 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. Difficult living conditions exacerbated by the weather and poor sanitation and hygiene situations in refugee settlements. These, in turn, have a strong impact on the public health situation of the refugees and increase the risks of outbreaks of communicable diseases.

Since 2014 Medair has been supporting the Ministry of Social Affairs (MoSA) **Social Development Centres (SDC)** by implementing a project to improve refugees' and affected host communities' access to primary health care (PHC) services. In 2018, Medair supported seven clinics in Central, West and North Bekaa with **a focus on mother and child health** in addition to mental health and psychosocial support. Medair provides these SDCs with human resources, medicines, equipment, capacity building and supportive supervision to each of the clinics.

At the community level, Medair's **Community health volunteers (CHVs)** have been trained on relevant health topics and referral systems. These CHVs in the SDC catchment areas deliver to households the developed messages mainly related to reproductive health, newborn and child health, mental health and well-being and gender. These messages address the specific barriers Syrian refugees and vulnerable Lebanese face and reinforce the benefits to of adopting healthy norms. **Community midwives (CMWs)** provide antenatal care, postnatal care and family planning. CHVs and CMWs carry out household visits, community outreach in informal settlements within SDC catchment areas and meet refugees and vulnerable host communities in community shared places.

The survey

Medair conducted its first KPC survey of the Syrian refugee and vulnerable Lebanese population residing in Lebanon in November 2015. Medair has repeated the survey each year since, with the purpose of providing *"robust data that will inform Medair, Ministry of Public Health (MoPH), Ministry of Social Affairs (MoSA) and other NGO programming and provide a strong evidence base to current and potential donors."*

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 behaviour
- Diarrhoea 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

A two-stage cluster survey was conducted among 751 vulnerable Lebanese women and 1482 Syrian refugee women. The target respondents were women of child bearing age with children under the age of five. The data was collected by approximately 70 enumerators, trained and supervised by Medair staff.

Results

Demographics

100% of respondents were married at the time of the survey. 18.2% of vulnerable Lebanese women and 45.7% of Syrian refugee women were married before turning 18 years old. Among vulnerable Lebanese women, the reported rate of illiteracy is 8.4% and among Syrian refugee women, illiteracy is 41.0%. All vulnerable Lebanese women reported that they live in a solid house (100%). Two out of five houses rated as overcrowded. Among Syrian refugee women, all reported living in a tent (100%). The homes of nine out of ten Syrian respondents rated as overcrowded

Health seeking behaviour

Almost nine in ten respondents reported that they or their child needed medical assistance: 85.2% for vulnerable Lebanese and 86.7% for Syrian refugees. More than nine out of ten Lebanese women and Syrian refugee women actually visited a qualified health service. For vulnerable Lebanese women, the most commonly accessed health service is a private clinic (by 50.8% of care seekers). For Syrian refugee women, the most commonly accessed health service was a dispensary (by 81.5% of care seekers).

Among those who needed medical care in the previous year, but could not access it, the main reason among vulnerable Lebanese was a result of affordability. This may also be the case for Syrians, as around half of the 'other' category related to money constraints as well, such as reference to their own income as opposed to the cost of the service. The second biggest issue for Syrian refugees is access to transport to a health facility.

Non-Communicable Diseases (NCDs)

Hypertension and diabetes are major causes of morbidity and mortality in Lebanon. Nationally, diabetes prevalence is at 14.6% (International Diabetes Foundation), and hypertension at 29.3% (Mouhatadi BB, et al., 2018). Knowledge about how to mitigate risks of NCDs was low. Lebanese women were twice as knowledgeable as Syrian women. Among Lebanese women, 57.7% could correctly cite two or more behaviours that reduce risks. Whereas only 26.7% of Syrian women cited two or more correct behaviours. A quarter of Syrian and half of Lebanese mothers in the entire sample knew the importance of reducing sugary foods and reducing smoking. Around a fifth of Syrians and a third of Lebanese cited reducing stress of anger. No other risk reduction behaviour was cited by more than 8% of Syrian mothers.

Diarrhoea and respiratory tract infection management for children

In the previous two weeks 48.9% of vulnerable Lebanese households, and 55.6% of Syrian refugee households contained one or more child experiencing an **acute respiratory infection (ARI)**. The higher rate among Syrian refugees is very statistically significant ($p=0.003$).

Encouragingly, the majority of children with ARI were taken for treatment to a qualified health provider. Of those who had ARI, 74.6% of Lebanese children and 62.6% of Syrian refugee children were taken to a private clinic, dispensary or hospital for treatment. In the two weeks prior to the survey, 16.9% of vulnerable Lebanese and 25.1% of Syrian refugee mothers reported having one or more children under 5 sick with **diarrhoea** in their household. The prevalence was 14.0% of vulnerable Lebanese children and 18.9% of Syrian refugee children experienced diarrhoea. The proportion of mothers who sought treatment for their child with diarrhoea was very high: 89.9% of vulnerable Lebanese, and 83.2% of Syrian refugees. The differences are not quite statistically significant ($p=0.068$). However, for these high levels of care-seeking, optimal treatment of diarrhoea was surprisingly lacking, with less than half of either nationality receiving ORS.

Vaccinations

Age appropriate vaccination coverage is extremely low in both populations. On the face of it, Syrian refugees have a slightly poorer coverage than vulnerable Lebanese for the sentinel shots of measles, polio and diphtheria-pertussis-tetanus (DPT). However, as we look at the coverage for all age-appropriate vaccinations¹, we see that a large gap between coverage of Syrian and Lebanese children exists for older children (aged 24 to 59 months). The youngest category of Syrian children (12 to 17 months) has twice the immunisation coverage as older Syrian children (18 to 59 months): over 10% vs. 5%.

Reproductive health

Awareness about antenatal care (ANC) is quite high at over 75% for both populations, though all other services are less well known: postnatal care (PNC), family planning/contraception advice (FP), and care for sexually transmitted infections (STIs). Over 80% of Lebanese and Syrian mothers reported that they would be able and comfortable in accessing such services. 8.1% of Lebanese and 8.5% of Syrian women expressed they would not be comfortable accessing the services, and **14.4% of Lebanese and 19.5% of Syrian women expressed that they would not be able to access the services**. Among Syrian refugee women, the most common reasons were due to financial constraints (reported by 21%); poor service or overcrowding (reported by 13%), lack of transportation (10%). Among Lebanese, 43% said their constraint was financial reasons, and 28% said it was due to poor service or overcrowding.

Antenatal Counselling (ANC): Among both Lebanese and Syrian refugee mothers of children under two years old, every mother (100%) reported having received an ANC session within the first three months of pregnancy. For those who participated in an ANC session, almost all were facilitated by a doctor (99.9%) for vulnerable Lebanese women; and 95.7% for Syrian refugee mothers.

Delivery: While vulnerable Lebanese and especially Syrian refugee women rarely consult a hospital, we see that the majority of both choose to give birth in a hospital (87% of vulnerable Lebanese women and 80% of Syrian refugees). Most births were attended by a doctor, though results for Syrian refugees are inferior to vulnerable Lebanese women (98% vs. 84%). When we look at the durations that women remain in hospital after giving birth, we see that twice the proportion of Lebanese women are able to remain in hospital longer than 24 hours compared to Syrian refugees. The difference in hospital duration is likely to be related to expense. Longer stays cost more, and we see that for Lebanese mothers, the modal expense for their hospital stay was 200,000 to 400,000 Lebanese pounds (USD 130-260). For Syrian refugee women, the modal expense was less than 100,000 (USD65).

92.3% of Syrian women also said that they received a birth certificate for their youngest child. The majority reported that they obtained their birth certificate from a hospital. However, only 22.2% of Syrian refugee parents reported that their youngest child was registered at the Syrian embassy.

Postnatal Care (PNC): WHO recommends that each mother and newborn remain in hospital for at least 24 hours after delivery, receives the first postnatal contact within 24 hours of birth (preferably in the first hour), and receives at least four PNC contacts in the first six weeks/40 days. Only 10.5% of vulnerable Lebanese women and 2.7% of Syrian refugee women received at least three PNC contacts in the first forty days. The PNC check was conducted by a doctor in 99.2% of cases for Lebanese mothers, and 93.9% of cases for Syrian refugee mothers. Syrian refugee mothers are most inclined to visit a dispensary and vulnerable Lebanese mothers prefer a private clinic.

¹ According to the Lebanese ministry of public health vaccination calendar, children of each age group should have received the following vaccinations:

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

Chn 18-23 months: Above + Polio Booster 2 + Penta Booster 1 + MMR 2.

Chn 24-59 months: same as 18-23 months. (NB: DPT 1 shot is DUE between 48 and 60 months, so is not OVERDUE until month 60, so not counted in these figures)

Family Planning: A third of pregnancies to vulnerable Lebanese women and half of pregnancies to Syrian refugee women were not planned. Few women in either sample has discussed family planning/contraception options with a trained provider in the last 12 months, and a little more than a quarter of Lebanese mothers and a sixth of Syrian refugee mothers of a child under two are using any form of modern contraception. Reasons given for not using any form of pregnancy delaying technique, around half of the respondents cited a current pregnancy, or currently breastfeeding. **Knowledge about pregnancy spacing is quite poor** among Syrian refugees, and modest among vulnerable Lebanese. Sixty-nine percent of vulnerable Lebanese mothers² could cite at least one risk associated with getting pregnant less than two years after the previous birth. Fewer than half of their Syrian peers could cite just one risk.

Breastfeeding practices

The majority of children of the mothers surveyed are breastfed while infants. Among the two samples, the results were: 85% of Lebanese infants and 91% of Syrian refugee infants were breastfed for some time as newborns. However, a third of Syrian infants and more than half of Lebanese infants were breastfed for less than six months. **Only a quarter of infants under six months born to vulnerable Lebanese mothers a third of infants born to Syrian refugee mothers were exclusively breastfed** at the time of the survey. Of further concern is that between a third and a fifth of newborns were not given breastmilk in their first hour of life.

Psychosocial support (PSS) services

The survey found that 71% of vulnerable Lebanese mothers and 75% of Syrian refugee mothers felt sad, stressed or under pressure, or know someone who was at some point in the six months prior to the survey. Of those who felt stressed or knew someone stressed, only 6% of vulnerable Lebanese mothers and 2.5% of Syrian refugee mothers consulted a trained service provider. Three quarters chose to just deal with it on their own, and between a third and a half also consulted family or friends. Awareness is low about services to assist people to deal with such mental health challenges, with only around a fifth of respondents correctly citing at least one psychosocial support service (PSS) by a trained service provider in their community, and little more than a tenth of all people knowing where to access such a service.

Conclusion

The findings point to the reality that the health risks and the societal constraints for which the Medair projects were designed still exist and continue to require ongoing programmes to reduce those vulnerabilities across the Bekaa Valley. Large gaps still exist in access to general health care, and reproductive health care. Non-communicable diseases are still a major source of adult morbidity, and most likely mortality. High-risk preventable illnesses like respiratory infections and diarrhoeal diseases are being under-reported to health care providers and they often provide inappropriate treatment. Children's health is at risk due to low coverage of vaccination, low rates of exclusive breastfeeding and early weaning off breast milk.

The findings in relation to household demographics and psychosocial/mental health also justify the original design of the Medair projects which focus on health care at primary health care level (dispensaries), and outreach to women's homes and wider community outreach events.

Recommendations

(See [Section 9](#) for Details on each of the following recommendations)

1. **Ensure any health advice materials rely heavily on pictorial and verbal media**, and any accompanying written information is basic and brief.

² Mothers of a child under two

2. **Prioritise house-to-house outreach and very local social gatherings that require no transportation to access.**
3. For NCDs, to optimise survival rates in the short-term, **focus the project priorities on facilitating access to medication to manage hypertension and diabetes**, and secondly on behaviour change.
4. **Review and revise dispensary staff training to emphasise correct medication for sick children**
Reduce the over-prescription of antibiotics for ARI and diarrhoeal diseases and under-prescription of zinc with ORS for diarrhoeal diseases.
5. **Provide vouchers for pregnant Syrian refugee women to cover hospital fees to stay in hospital for more than 24 hours after delivery.**
6. If it is possible for SDCs to have notification of births from hospitals, **SDC/dispensaries should lead the provision of the first home-based PNC visits** in the first and third days out of hospital.
7. In coordination with recommendation #2, **reorient CHVs' mobilisation of women around organising mothers of newborns into small groups in each neighbourhood.** i.e. each month, bring together mothers in each settlement who have given birth within the same month, as small solidarity clubs. These can become the central mobilisation conduit for all health promotion to women.
8. **Extend the psychosocial resilience strategy to include vulnerable youth.** This may be commenced by mapping what social and skills development opportunities already exist for Syrian and Lebanese youth and determine whether the health project can support such providers to build health awareness and especially psychological resilience competencies for such youth.
9. **Investigate barriers to women's ability to exclusively breastfeed their child and continue breastfeeding for at least 12 months.**

Core impact indicators

Theme	Indicator	Vulnerable Lebanese	Syrian refugees
Health seeking behaviours	% of mothers of children aged under 5 years of age in project area who went to qualified health services when they needed medical services	95.3%	91.8%
NCDs	% of mothers of children under 5 years who reported having at least one HH member with NCD	19.6%	17.8%
	% of women who know 2 or more ways to reduce the risk of NCDs	57.7%	26.7%
Diarrhoea and respiratory tract infection management for children	% of children under 5 years with fast or difficult breathing for whom advice or treatment was sought from an appropriate health facility or provider	74.6%	62.6%
	Prevalence of diarrhoea: % of children under 5 years that experienced diarrhoea in the last 2 weeks	14.0%	18.9%
	% of children under 5 years with diarrhoea receiving ORS or zinc supplementation	39.4%	30.6%
Vaccinations	% of children aged 12 months - 5 years who are vaccinated for measles in clinics' coverage area	32.0%	23.2%
	% of children aged 12 months - 5 years who are vaccinated for polio in clinics' coverage area	39.2%	31.5%
	% of children aged 12 months - 5 years who are vaccinated for Diphtheria and Pertussis and Tetanus (DPT) in clinics coverage area	37.1%	28.9%
	% of children age 12-23 months who received age appropriate vaccination at time of survey	7.8%	7.7%
Reproductive Health	% Women in the targeted communities who correctly identify available RH services	90.0%	76.6%
	% women in the targeted communities who correctly report where to access RH services	72.0%	24.4%

	<i>% women in the targeted communities who report that they would be comfortable and able to access these (RH) services as needed</i>	85.6%	80.5%
Antenatal Counselling	<i>% of mothers of children under two years of age who had 4 comprehensive antenatal visits when they were pregnant with their youngest child</i>	76.5%	55.8%
Delivery	<i>% of mothers of children under 5 years who delivered at hospital</i>	87.0%	79.6%
	<i>% of mothers of children under 5 years who delivered by caesarean section.</i>	53.7%	28.1%
Mortality in Pregnancy	<i>% of women who had a sister, whose sister died due to problems related to pregnancy</i>	8.1%	7.8%
Child Registration	<i>% of children under 5 years officially registered in their country (for Syrians)</i>	na	22.3%
Postnatal Care	<i>% 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</i>	57.6%	41.3%
	<i>% of children under two years of age who were examined by an appropriately trained health worker 3 days after delivery</i>	47.6%	30.4%
Family Planning and Child Spacing	<i>% of mothers of children under 5 years who report discussing FP with a trained service provider in the 12 months preceding the survey</i>	10.8%	6.8%
	<i>% of mothers of children 0-23 months who are using a modern contraceptive method</i>	27.3%	15.8%
Breastfeeding practices	<i>% of infants 0-5 months (At time of study) who are exclusively breastfed</i>	25.4%	32.9%
Psycho Social Support (PSS) services	<i>% WGMB in the targeted communities who correctly identify available PSS services</i>	23.6%	18.4%
	<i>% WGMB in the targeted communities who correctly report where to access PSS services</i>	10.1%	11.9%
	<i>% of mothers of children under 5 years who report discussing PSS with a trained service provider in the 12 months preceding the survey</i>	24.5%	17.6%
	<i>% women in the targeted communities who report that they would be comfortable and able to access these (PSS) services as needed</i>	40.7%	33.1%
	<i>% of mothers of children under 5 years who report accessing PSS support services in the 6 months prior to the survey</i>	4.1%	1.6%
	<i>% of mothers of children under 5 years receiving PSS services who report satisfaction with support provided</i>	97.6%	95.5%

End of Executive Summary.

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Report Approval

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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. Data collectors were also trained to ensure privacy and protection of confidentiality by staying aware of uninvited observers or eavesdroppers.

The data analysis lead, Peter Weston is a member of the Australian Evaluation Society (AES) and abides by the AES ethical standards.

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 care
ARI	Acute Respiratory Infection
CBO	Community Based Organisation
CHVs	Community Health Volunteers
CMW	Community Midwife
DPT	Diphtheria and Pertussis and Tetanus
EBF	Exclusive Breastfeeding
EU-MADAD	European Union -
FANTA III	Food and Nutrition Technical Assistance – Guidelines for Nutrition Measurements
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	Medicins Sans Frontiers/Doctors without borders
NCD	Non-Communicable Diseases
NGO	Non-Governmental Organization
ODK	Open Data Kit
ORS	Oral Rehydration Solution
PHC	Primary Health Care
PNC	Postnatal care
PSS	Psycho Social Support
PTSD	Post-traumatic stress disorder
RH	Reproductive Health
SDC	Social Development Centre
SGBV	Sexual or gender-based violence
SPHERE	The Humanitarian charter and minimum standards in humanitarian response
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 Organisation
WRC	World Relief Canada

2. Project Background and Context³

The Context

In 2018 the Syria crisis entered its seventh year with almost 1 million registered, and many more unregistered Syrian refugees continuing to reside in Lebanon, a third of whom reside in the Bekaa Valley (UNHCR Data Portal, November 2018). 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 the Ministry of Social Affairs (MoSA) Social Development Centres (SDC) by implementing a project to improve refugees' and affected host communities' access to primary health care (PHC) services. In collaboration with MoSA, in 2018, Medair supported seven clinics in Central, West and North Bekaa with **a focus on mother and child health** in addition to mental health and psychosocial support. Medair provides these SDCs with human resources, medicines, equipment, capacity building and supportive supervision to each of the clinics.

At the community level, Medair's Community health volunteers (CHVs) have been trained on relevant health topics and referral systems. These CHVs in the SDC catchment area deliver the developed HFPH (healthy family peaceful house) package (that includes a set of key linked interventions and messages mainly related to reproductive health, newborn and child health, mental health and well-being and gender) to households. These messages address the specific barriers Syrian refugees and vulnerable Lebanese face and reinforce the benefits to of adopting healthy norms. 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 meet refugees and vulnerable host communities in community shared places.

3. Purpose and Scope of the Consultancy

Medair conducted its first KPC survey of the Syrian refugee and vulnerable Lebanese population residing in Lebanon in November 2015. Medair 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 overall purpose of this Part One report is: "to analyse 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, Ministry of Social Affairs (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 behaviour
-

³ Extracted verbatim from consultancy Terms of Reference

- Diarrhoea 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

4. Objective of the Report⁴

“Using appropriate data analysis software, conduct in-depth data analysis based on, but not restricted to, the required indicators, and provide a draft report (including project background, methodology, results, discussion, conclusions and recommendations and annexes)”

5. Methodology

5.1 Document Review

Desktop review was performed on

- Medair’s project design documents
- previous survey reports
- external reports and surveys related to Lebanon’s health care system and the Syrian refugee response
- the questionnaire used by Medair to collect the data under review in this report

5.2 Household Survey

The survey was conducted using a two-stage 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)	46 x 32	1472	1482
Vulnerable Lebanese	30 x 24	720	751
	TOTAL	2192	2233

The sampling populations are **Syrian refugees** (made up of those living in informal settlements only) and **vulnerable Lebanese** in the catchment areas of the (as of December 2018) seven Medair-supported SDCs (Talia, Rafid, Brital, Kfarzabad, Marj, Kabelias, Jib Janine). For further details on the clusters selected, see the Annex below. The target respondents were women of child bearing age with children under the age of five. 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 2192 questionnaires were planned to be completed. Data collection achieved 2233 valid responses, exceeding the minimum required.

⁴ Extracted from consultancy ToR, pp.5-6

Sampling approach

General cluster selection procedure:

1. Syrian refugees:

- a. Using IAMP (Inter-Agency Mapping Project) 56, the number of Syrian refugee households living in Informal Tented Settlement (ITS) within the coverage area of the 7 Medair supported SDCs was broken down by Cadaster and ITS, and a cumulative population list was made.
- b. Based on the total household population, an interval was calculated for 46 clusters, the starting points for which were selected from the cumulative population list using systematic random sampling.
- c. Again using the household data from IAMP 56, the ITSs closest to the 'starting point' ITS (where the 'starting point' ITS was too small for the cluster size) were pre-selected so that 32 households with mothers (or care givers) with children under 5 could be identified.

2. Vulnerable Lebanese:

- a. In the same way that IAMP 56 was used for Syrian refugees in ITS, a cumulative population list of Lebanese was made by household per Cadaster. The general population data (previously made available by Municipalities for the 2017 survey) was used to create the list, with some adjustments made based on local knowledge.
- b. Again based on the total household population, an interval was calculated for 30 clusters, the starting point Cadasters for which were selected from the cumulative population list using systematic random sampling.
- c. Then, to identify the starting points within the Cadasters, the enumerator teams were directed by the Municipality to a starting point in the Cadaster that contained high known numbers of vulnerable Lebanese. After the first household was identified, snowball sampling was used to reach the 24 required households per cluster.

Using EPI info® sample sizes were decided on taking into consideration the respective denominators per required indicator⁵, to ensure that 95% confidence levels with 5% margins of error could be calculated. A design effect of 2 was used to take into account the two-stage cluster sampling frame, and assumed an infinite population (Chochrane, 1977).

The consultant applied the following formula to manually verify the sample size produced by EpiInfo for each population:

$$n = \left[\frac{Z^2 (p)(q)}{d^2} \right] deff$$

Where:

n = sample size

⁵ For example, the denominators of some of the required indicators were mothers with children under 2, rather than under 5.

- Z = statistical certainty, related to the error risk, equals 1.96 for an error risk of 5% (for a 95% Confidence interval)
- p = estimated prevalence of indicator in the population, expressed as a fraction of 1 (where prevalence is unknown 50% is used to give the largest sample size). For this exercise, we assume that approximately 80% of participant HHs gained some benefit from the project.
- q = (1-p), proportion of sample not presenting with that indicator, expressed as a fraction of 1
- d = desired precision or margin of error (% sampling error), expressed as a fraction of 1 (6% sampling error is acceptable).
- deff= expected design effect (for cluster sampling), usually 2

$$\begin{aligned}
 \text{Thus } n &= \left[\frac{1.96 \times 1.96 \times (0.5) \times (0.5)}{0.05 \times 0.05} \right] \times 2 \\
 &= \left[\frac{3.8416 \times 0.25}{0.0025} \right] \times 2 \\
 &= 768
 \end{aligned}$$

As the sample is disaggregated during analysis, such as by mothers with different aged children, the precision reduces. In such instances, p values may be calculated using a two-tailed chi-square test. P values are interpreted via the following conventions:

p value	Interpretation of statistical significance
< 0.001	Extremely significant
0.001 to 0.01	Very significant
0.01 to 0.05	Significant
0.05-0.09	No quite significant
≥ 0.09	Not significant

5.3 Data analysis

Data cleaning

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.

The consultant analysts also removed 12 entries from respondents who were not the child's mother – either a grandparent or other caregiver.

Any errors in recording nationality, zone or cluster number were identified and corrected.

All free text responses in Arabic were translated into English.

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 chi-square was used to determine statistical difference between the two groups: vulnerable Lebanese and Syrian refugees.

Frequency calculations included: percentage, unweighted count, and 95% confidence intervals. Some additional cross tabulations were used to confirm statistically significant differences with the chi-square in most cases, p-values and odds ratio. All the working files have been supplied to Medair: datasets, analysis scripts, analysis plans and outputs.

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

5.4 Limitations of the survey

Measuring beyond the boundary of Medair's SDC catchments areas. The survey covered a catchment with a 5km radius around each Cadaster where a Medair-supported facility is located. While community outreach among Syrian refugees is carried out, full coverage is not achieved among this target population, nor do all vulnerable Lebanese access the SDCs. Consequently, findings of the survey can only be used to partially assess coverage and impact of Medair's work. Secondly, the survey covered health practices in vulnerable Lebanese communities. The Medair health project has previously focussed on outreach to Syrian refugees, and only commenced active outreach to Lebanese communities in 2019, after the survey was carried out. In addition, the vulnerable Lebanese accessing the Medair supported clinics constituted only 35% of the total beneficiaries accessing them. Therefore, while the surveying of Lebanese households is useful for comparison with Syrian refugees and as a baseline as of December 2018, such data do not represent the results of Medair activities.

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. To overcome this, the analysts had regular meetings with Medair staff to align expectations.

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. The most salient example is in relation to exclusive breastfeeding (EBF) practices. This year employed a definition of EBF based on recall of the first 6 months of each child's life. Whereas the 2017 survey employed the WHO/FANTA III protocols that only rely on recall of feeding in the previous 24 hours in an infant's life. Secondly, in the past, surveillance of vaccination utilised information on vaccination cards plus maternal recall for those without a vaccination card. This year, the survey used only information on vaccination cards.

Some responses had incomplete data. Data/responses were missing for some questions. Where detected, these respondents were excluded from the analysis, to avoid blank cells being misinterpreted as responses representing 'zero'.

6. Results

6.1 Sampled Demographics

The following tables and pie chart outline the demographic characteristics of the survey sample and their households.

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)
Number of valid survey respondents	751 mothers of a child under 5	1482 mothers of a child under 5
Number of household members in respondents' households	3865	10073
Number of children under 5 in respondents' households	1024	2267
Mean HH size:	5.15	6.80
100% of respondents were female.		
100% of respondents lived in a household containing a child under 5 years old.		
Average age of respondents:	30	29
Median Age:	28	28
Minimum age:	16	14
Maximum age:	50	50

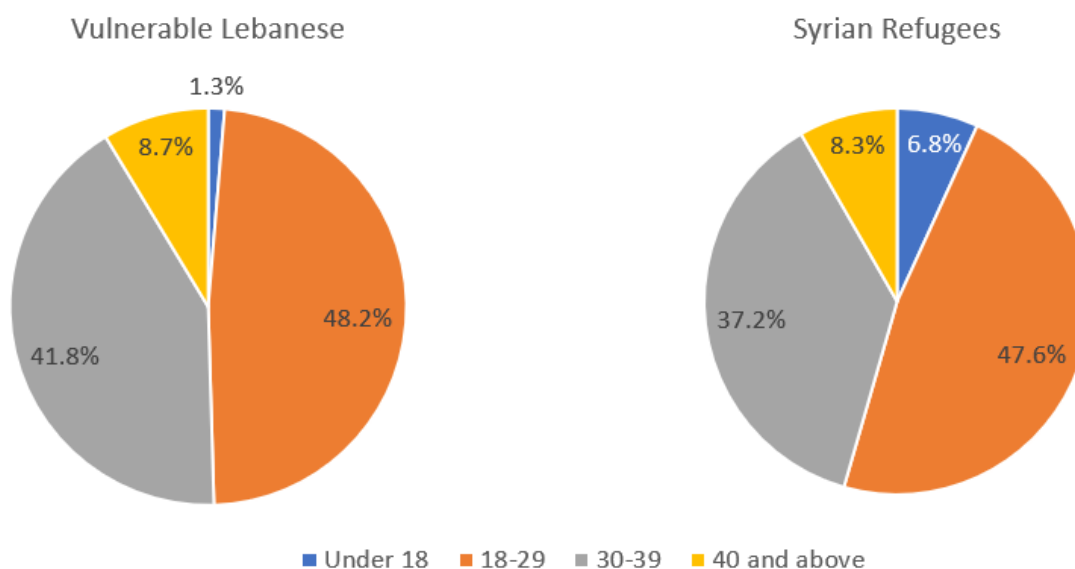


Figure 1- Age distribution of samples' households

Marital status of respondents

100% of respondents were married at the time of the survey.

18.2% of vulnerable Lebanese women and 45.7% of Syrian refugee women were married before turning 18 years old.

Thus, we see that female Syrian refugees are more than twice as likely to be married before they reach adulthood.

Literacy rates

The survey found that illiteracy (cannot read or write) rates were quite high among both samples, though more than four times higher among Syrian refugees. This is perhaps partially a reflection of the propensity for early marriage among Syrian refugee women.

Among vulnerable Lebanese women, the reported rate of illiteracy is 8.4% (freq = 63/751, CI: 5.4% - 12.7%), and among Syrian refugee women, illiteracy is 41.0% (freq = 607/1482. CI: 37.4% - 44.6%)

Habitation

Though an imperfect proxy, to interpret the level of poverty, the survey made note of the house construction of each respondent. The results highlighted the transience and the crowdedness of accommodation for Syrian refugees in Lebanon (noting that the sample was for those living in informal settlements only).

All vulnerable Lebanese women reported that they live in a solid house (100%. N=751). Two out of five houses rated as overcrowded: that is a house with more than 1.5 inhabitants for each room of the house (Gray A, 2001) (40.6%. freq = 307/751. CI: 33.6% - 48%). The mean household size among Lebanese respondents was 5.15 residents.

Among Syrian refugee women, all reported living in a tent (100%. N=1482). The homes of nine out of ten Syrian respondents rated as overcrowded (93.1%. Freq = 1387/1482. CI: 91.3% - 94.6%). Syrian household contained more people with the mean household size being 6.81 residents per household.

The survey trialled a measure of 'overcrowdedness' that differs from the ITS standard (less than 4.5sqm per occupant, which equates to the Sphere standard). However, the trialled measure is easier and more accurate to measure in the context of a long household survey. Using the 4.5sqm per occupant standard, based on Medair's unified shelter assessment in ITS in 2018, 26.9% of Syrian refugee dwellings in the Bekaa Valley are overcrowded.

6.2 Health seeking behaviour

Measuring health-seeking behaviour generally focusses on ascertaining what proportion of the target population know what qualified health services are available to them, know where to access them, and do access them. In this instance, we will consider this. However, the KPC study has also considered behaviours affecting longer term health outcomes, in the form of behaviours for managing non-communicable diseases, and also registering newborn children to ensure they can access health services and other life services as they grow.

Health care access general

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

2018 result:

n =

Vulnerable Lebanese

Syrian Refugees

640

1284

Estimate:

95.3%

91.8%

95% CI Lower:

93.7%

90.3%

95% CI Upper:

97.0%

93.3%

Almost nine in ten respondents reported that they or their child needed medical assistance: 85.2% for vulnerable Lebanese (freq=644/756) and 86.7% for Syrian refugees (freq=1291/1489). Of these, over nine out of ten Lebanese and Syrian refugee women actually visited a qualified health service.

The survey found that the network of dispensaries is crucial for minimising barriers to health care access for Syrian refugees. While, for vulnerable Lebanese women, the most commonly accessed health service is a private clinic (by 50.8% of care seekers). For Syrian refugee women, the most commonly accessed health service was a dispensary (by 81.5% of care seekers).

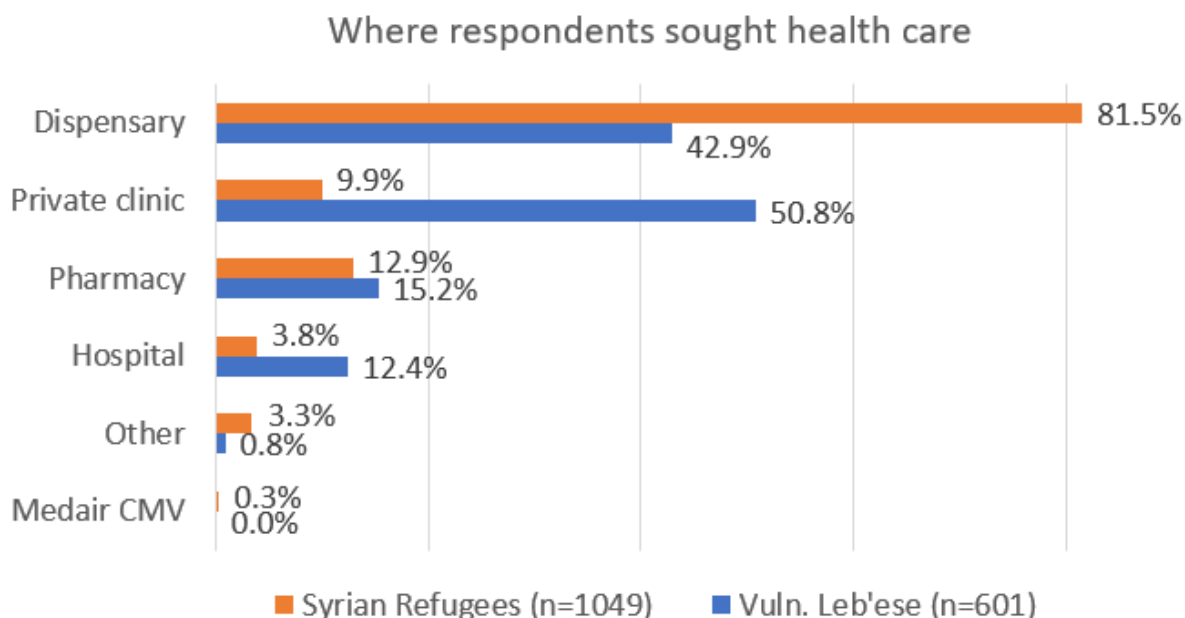


Figure 2

The Medair supported dispensaries (SDCs) formed a crucial access point for both populations, as we see from the following table:

Table 2 - % of mothers of children aged under 5 years of age in project who visited any Medair supported dispensary during the 12 months prior to the survey

		Nationality		
		Lebanese	Syrian	Total
<i>Sample size =</i>		751	1482	2233
Estimate		34.2%	42.2%	39.5%
95% Confidence Interval	Lower	26.2%	34.7%	33.9%
	Upper	43.2%	50.0%	45.4%
Frequency		257	625	882

For those that have not used a Medair-supported SDC, the main reason cited by both Lebanese (65.2%) and Syrian (66.1%) respondents was that they had not heard about it. The next most common reason was that they did not know where to find it (cited by 17.9% of Lebanese and 12.3% of Syrians).

Barriers to access:

Among those who needed medical care in the previous year, it could not be accessed by 4.3% of Lebanese (freq=28/644) nor by 8.0% of Syrians (freq=103/1291) who reported that they were not able to access the medical support they needed in the past 12 months. The main reason among vulnerable Lebanese was a result of affordability. This may also be the case for Syrians, as around half of the 'other' category related to money constraints as well, such as reference to their own income as opposed to the cost of the service. The second biggest issue for Syrian refugees is access to transport to a health facility.

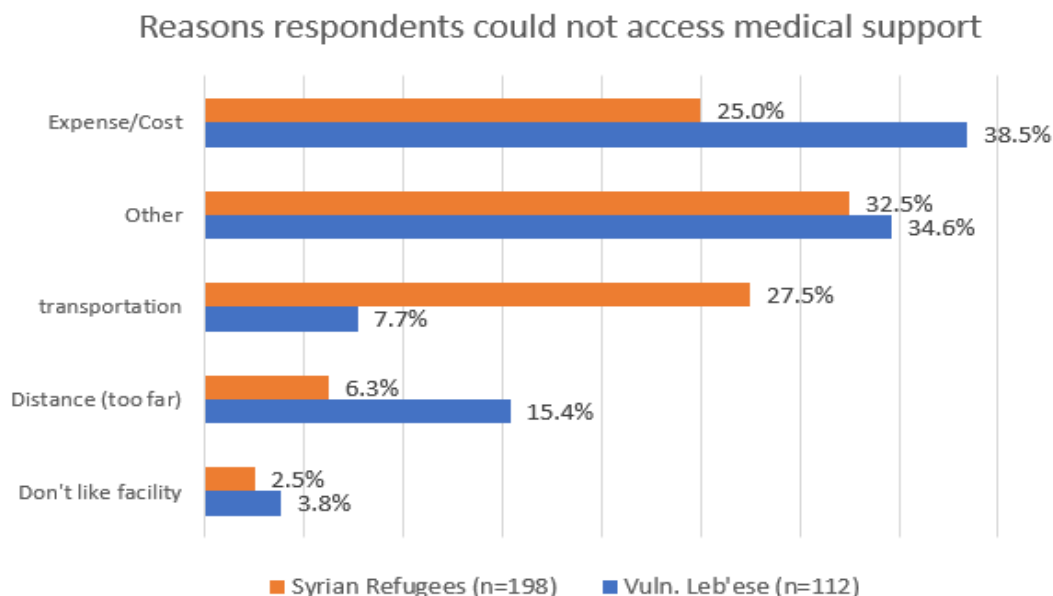


Figure 3

Non-Communicable Diseases (NCD)

Summary of core indicator targets: NCDs
% of mothers of children under 5 years who reported having at least one HH member with NCD

2018 result:	Vulnerable Lebanese	Syrian Refugees
n =	751	1482
Estimate:	19.6%	17.8%
95% CI Lower:	16.3%	15.1%
95% CI Upper:	23.4%	20.9%

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

2018 result:	Vulnerable Lebanese	Syrian Refugees
n =	735	1288
Estimate:	57.7%	26.7%
95% CI Lower:	52.4%	23.3%
95% CI Upper:	62.8%	30.4%

Hypertension and diabetes are major causes of morbidity and mortality in Lebanon. Nationally, diabetes prevalence is at 14.6% (International Diabetes Foundation) and hypertension at 29.3% (Mouhatadi BB, et al., 2018). Therefore, 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.

As we can see from the following graph, both populations reported similar prevalence of hypertension. However, vulnerable Lebanese communities reported statistically a higher burden of diabetes (p=0.001). Overall, the difference between the two sample groups in the presence of any NCD is not statistically significant (p=0.3).

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

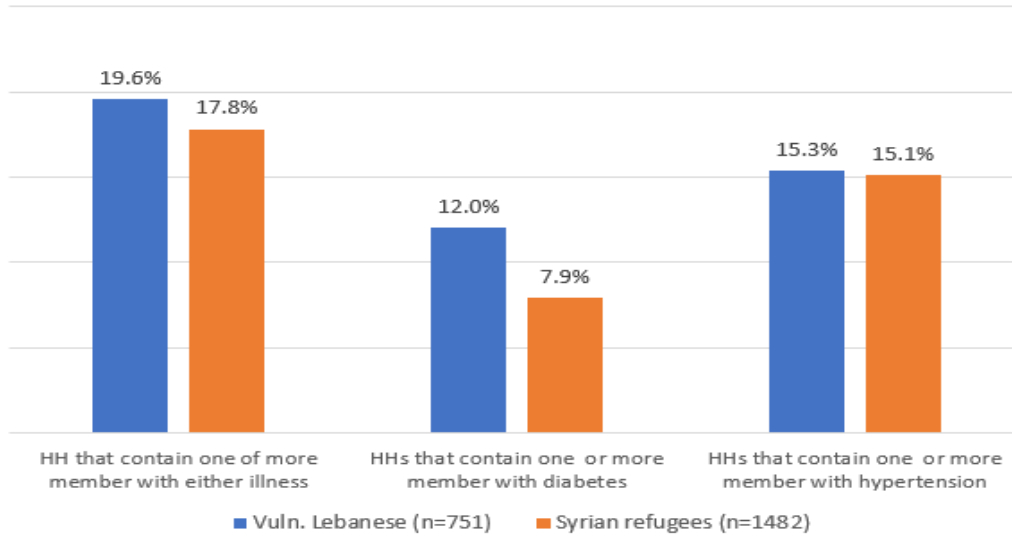


Figure 4

Knowledge of prevention and management of NCDs

Women were asked if they could cite any ways of reducing one's risk of getting diabetes or hypertension. Lebanese women were twice as knowledgeable as Syrian women. **Among Lebanese women, 57.7% (freq=424/735) could correctly cite two or more behaviours that reduce risks. Whereas only 26.7% (freq=344/1288) of Syrian women cited two or more correct behaviours.** As we see from the following table, there was little consistency in knowledge. For both samples, a quarter of Syrian and half of Lebanese mothers in the entire sample knew the importance of reducing sugary foods, and reducing smoking. Around a fifth of Syrians and a third of Lebanese cited reducing stress or anger. No other risk reduction behaviour was cited by more than 8% of Syrian mothers.

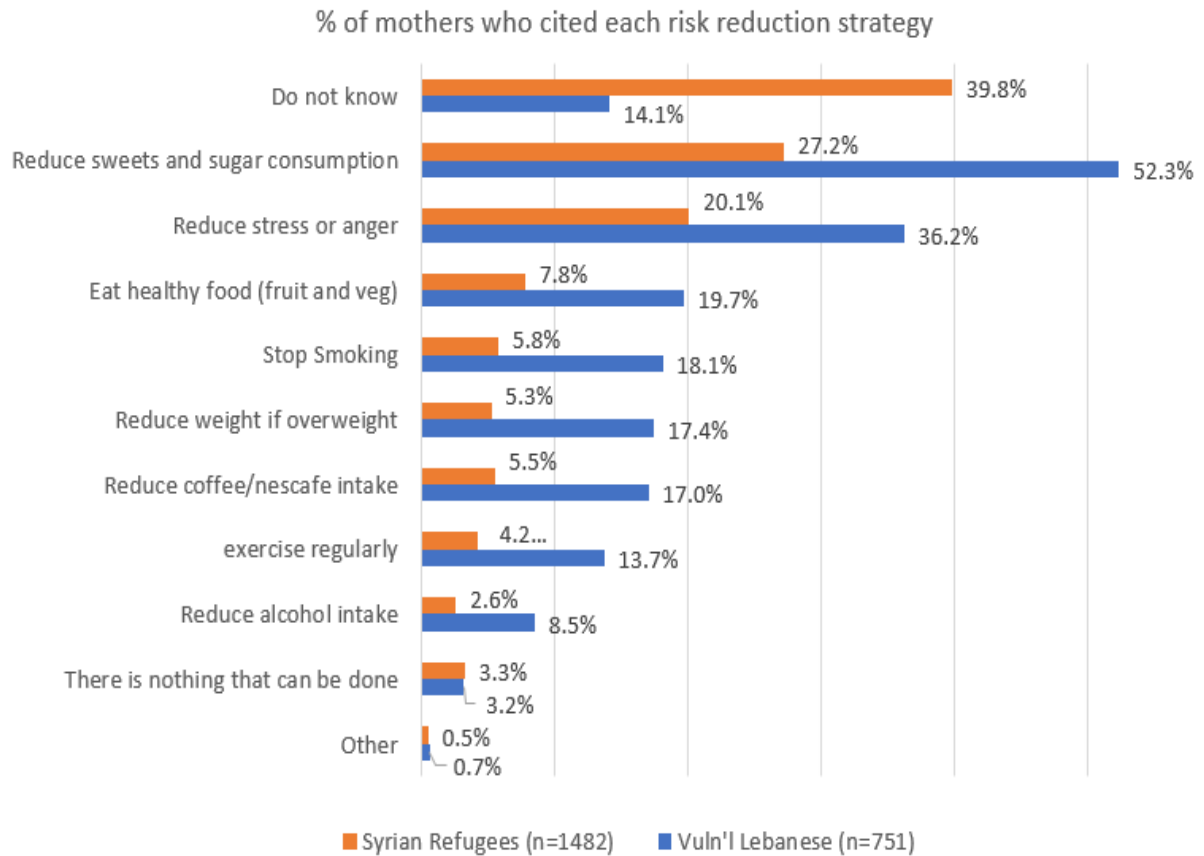


Figure 5

Medair project has not had a focus on prevention and management of non-communicable diseases (NCDs), other than a small number of awareness sessions in addition to a pilot project of NCD treatment in one of Medair supported clinics which is the only one out of the 7 Medair supported MoSA SDCs that has a wide range of NCD medications and laboratory tests

6.3 Diarrhoea and respiratory tract infection management for

Summary of core indicator targets: Diarrhoea and respiratory tract infections

% of children under 5 years with fast or difficult breathing for whom advice or treatment was sought from an appropriate health facility or provider

2018 result:	<i>n</i> =	Vulnerable Lebanese	Syrian Refugees
Estimate:		74.6%	62.6%
95% CI Lower:		68.6%	57.7%
95% CI Upper:		79.8%	67.2%

Prevalence of diarrhoea: % of children under 5 years that experienced diarrhoea in the last 2 weeks

2018 result:	<i>n</i> =	Vulnerable Lebanese	Syrian Refugees
Estimate:		14.0%	18.9%
95% CI Lower:		11.0%	16.6%
95% CI Upper:		17.0%	21.1%

% of children under 5 years with diarrhoea receiving ORS or zinc supplementation

2018 result:	<i>n</i> =	Vulnerable Lebanese	Syrian Refugees
Estimate:		39.4%	30.6%
95% CI Lower:		30.9%	25.1%
95% CI Upper:		48.5%	36.8%

children

To understand the risks and management of high-risk childhood illnesses among the two populations, the survey explored the prevalence and treatment responses for acute respiratory infections (ARI) and diarrhoea. Globally, after perinatal complications, ARI and diarrhoeal diseases are the top causes of child mortality (WHO, 2017).

Treatment of children with Acute Respiratory Infection (ARI)

Each year, October to April is a peak time for respiratory infections in Lebanon (Kesteman T, et al. 2018). The survey took place during this period in December and we observe that around half of all households containing a child who had severe coughing or breathing difficulties in the preceding two weeks. In the previous two weeks **48.9% of vulnerable Lebanese households, and 55.6% of Syrian refugee households contained one or more child experiencing an ARI**. The higher rate among Syrian refugees is very statistically significant ($p=0.003$).

Encouragingly, the majority of children with ARI were taken for treatment to a qualified health provider. Of those who had ARI, 74.6% of Lebanese children (freq=276/370) and 62.6% of Syrian refugee children (freq=518/828) were taken to a private clinic, dispensary or hospital for treatment.

We can see from the following table that vulnerable Lebanese will go to a private clinic or dispensary, whereas Syrian refugees are heavily dependent on dispensaries for treatment.

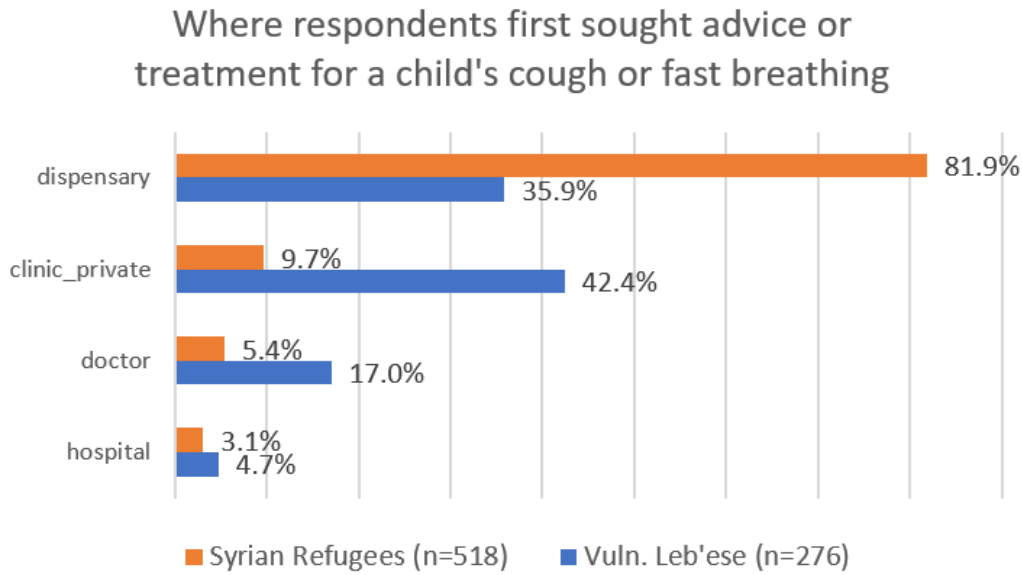


Figure 6

As we consider the types of treatment that children receive, we can assess whether children are receiving appropriate care. Most treatments are provided to reduce the symptoms, rather than treat the illness.

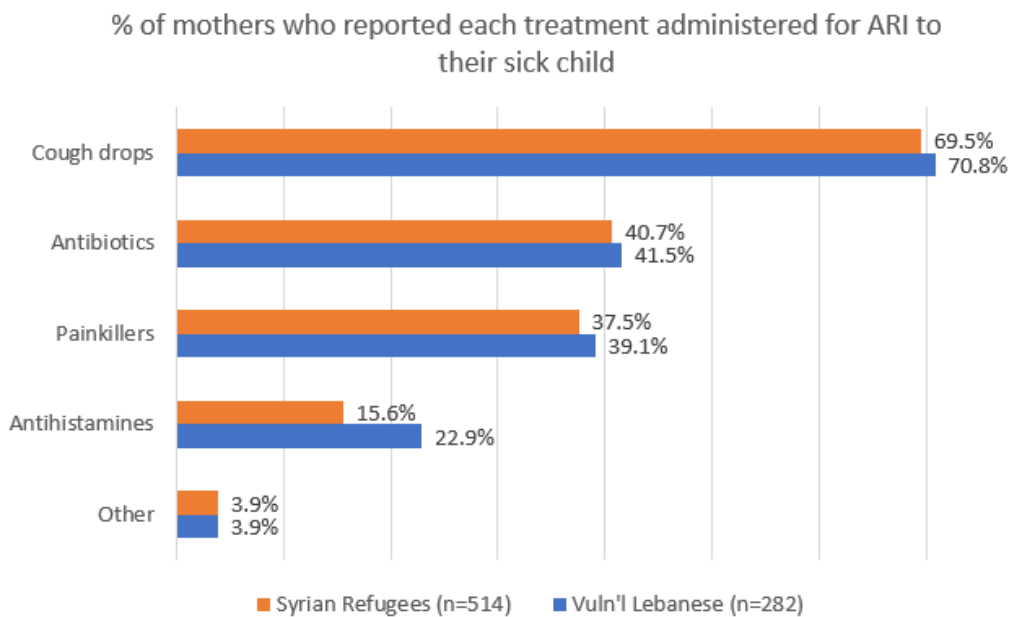


Figure 7

Treatment of children with diarrhoea

In the two weeks prior to the survey, 16.9% of vulnerable Lebanese (freq=127/751) and 25.1% of Syrian refugee mothers (freq=372/1482) reported having one or more children under 5 sick with diarrhoea in their household.

The prevalence was 14.0% of vulnerable Lebanese children and 18.9% of Syrian refugee children experienced diarrhoea. The additional burden for Syrian children is very statistically significant ($p=0.001$). It must be remembered that the Syrian children sampled are those living in the informal settlements rather than buildings.

The proportion of mothers who sought treatment for their child with diarrhoea was very high: 89.9% of vulnerable Lebanese, and 83.2% of Syrian refugees. The differences are not quite statistically significant ($p=0.068$).

However, for these high levels of care-seeking, optimal treatment of diarrhoea was surprisingly lacking, with less than half of either nationality receiving ORS. **Only 7% of vulnerable Lebanese children and 2.7% of Syrian refugee children received both oral rehydration solution (ORS) and zinc supplementation.** The inferiority of treatment for Syrian children is statistically significant ($p=0.026$). In the following graph, we can see the most popular treatments administered for diarrhoea:

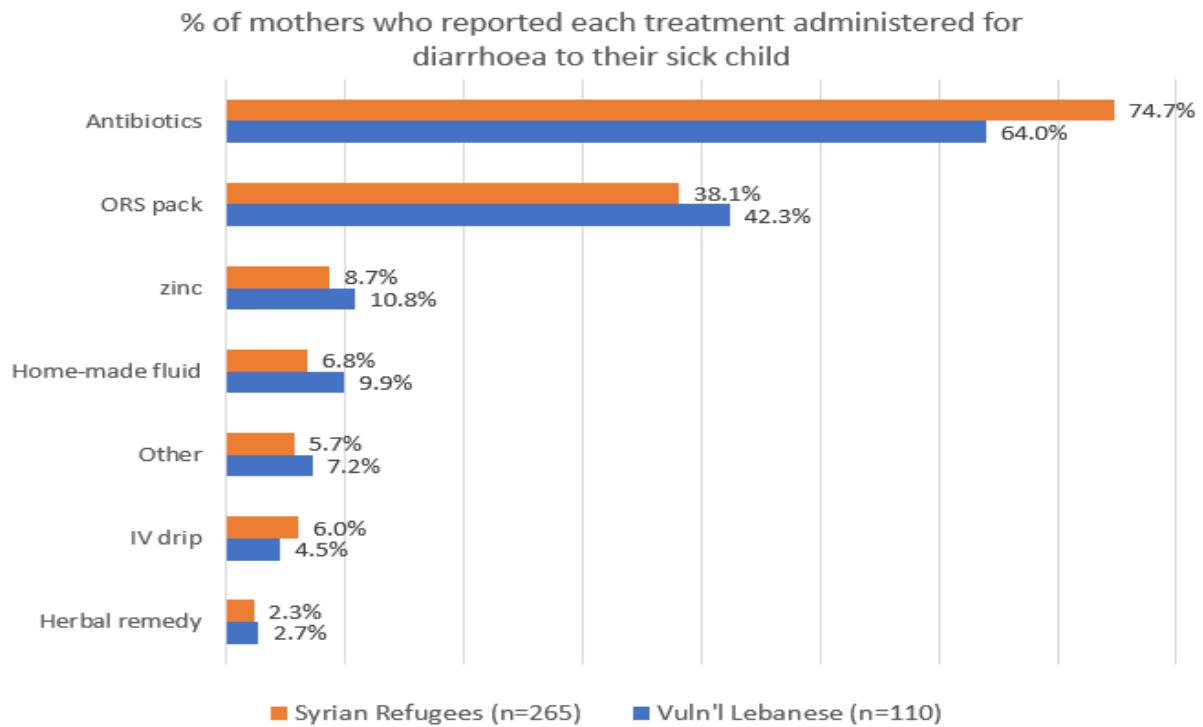


Figure 8

The most common treatment, antibiotics, is not appropriate for treating diarrhoeal infections.

Summary of core indicator targets: Vaccinations

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

2018 result:	Vulnerable Lebanese	Syrian Refugees
n =	551	963
Estimate:	32.0%	23.2%
95% CI Lower:	27.5%	19.5%
95% CI Upper:	36.7%	27.4%

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

2018 result:	Vulnerable Lebanese	Syrian Refugees
n =	551	963
Estimate:	39.2%	31.5%
95% CI Lower:	34.7%	27.0%
95% CI Upper:	44.0%	36.5%

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

2018 result:	Vulnerable Lebanese	Syrian Refugees
n =	551	963
Estimate:	37.1%	28.9%
95% CI Lower:	32.6%	24.5%
95% CI Upper:	41.7%	33.8%

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

2018 result:	Vulnerable Lebanese	Syrian Refugees
n =	168	442
Estimate:	7.8%	7.7%
95% CI Lower:	4.9%	5.2%
95% CI Upper:	12.0%	11.2%

6.4 Vaccinations

The survey only collected vaccination data from mothers who presented a vaccination card for inspection. This reduced the coverage compared to past years which also relied on recall for those without a card. However, by eliminating recall responses, the accuracy of this year's data is much greater. In total, 82.9% of vulnerable Lebanese and 68.4% of Syrian refugees were able to produce a valid vaccination card for their youngest child.

As we look at the findings above for vaccination coverage for children aged 12 to 59 months of age (i.e. under 5), on the face of it, Syrian refugees have a slightly poorer coverage than vulnerable Lebanese for the sentinel shots of measles, polio and diphtheria-pertussis-tetanus (DPT). The inferiority in coverage for Syrian refugee children is very statistically significant for measles ($p=0.001$); polio ($p=0.008$) and DPT ($p=0.003$).

However, as we look at the coverage for all age-appropriate vaccinations⁶, we see that a large gap between coverage of Syrian and Lebanese children exists for older children (aged 24 to 59 months). But that gap closes

⁶ According to the Lebanese ministry of public health vaccination calendar, children of each age group should have received the following vaccinations:

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

Chn 18-23 months: Above + Polio Booster 2 + Penta Booster 1 + MMR 2.

Chn 24-59 months: same as 18-23 months. (NB: DPT 1 shot is DUE between 48 and 60 months, so is not OVERDUE until month 60, so not counted in these figures)

and disappears the younger the child. This may signal that recent campaigns among the Syrian refugee population are succeeding in recruiting mothers of newborns for vaccination. This contention is reinforced by the observation that the youngest category of Syrian children (12 to 17 months) has twice the immunisation coverage as older Syrian children (18 to 59 months): over 10% vs. 5%. **Nevertheless, age appropriate vaccination coverage is extremely low in both populations.**

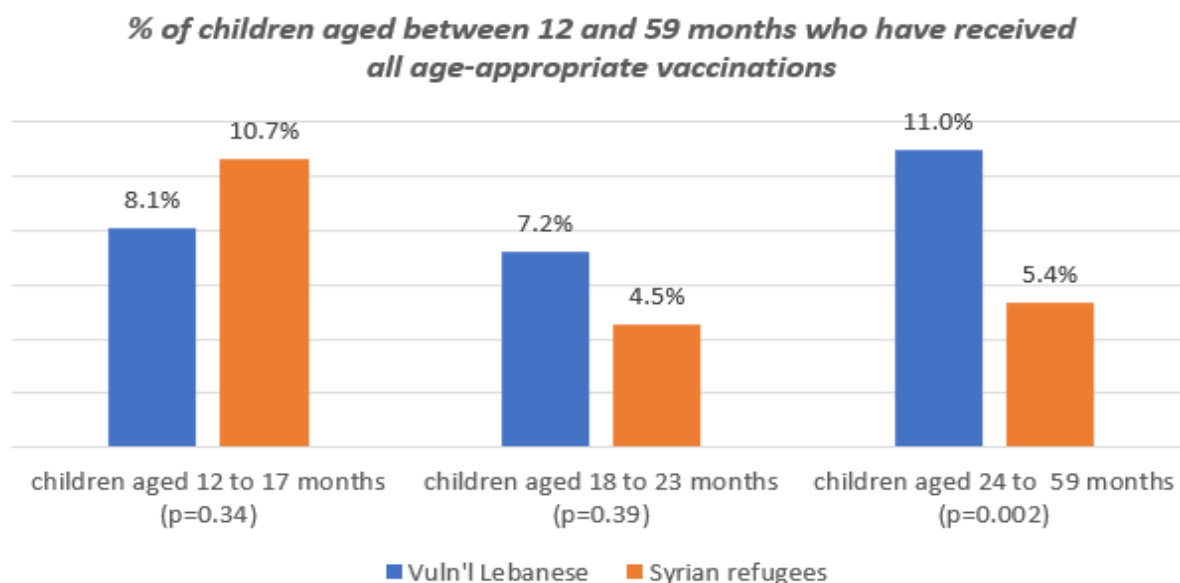


Figure 9

In the following graphs, we see that coverage rates vary between project areas⁷. For all vaccinations, coverage is statistically lower in North Bekaa than either West Bekaa or Central Bekaa. Initially, to observe rates of coverage across all children under five (12 to 59 months), we see that rates are consistently lower for Syrian children. However, when we compare vaccination rates of younger children (12 to 23 months) to older children (aged 24 to 59 months), we see that the difference disappears for the younger children. Therefore, we can safely conclude that, while overall rates identified via vaccination cards remain too low, campaigns to increase immunisations among infants of Syrian refugees have caught up to rates of immunisation of Lebanese children in West Bekaa and Central Bekaa (a gap persists in North Bekaa, though not statistically significant: p=0.5).

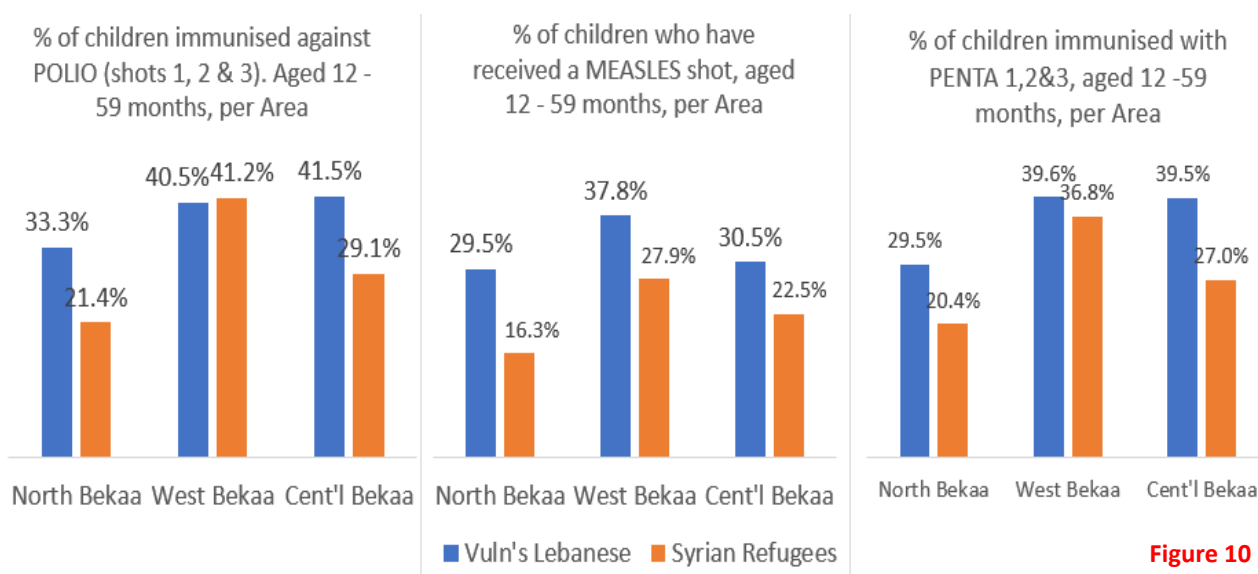


Figure 10

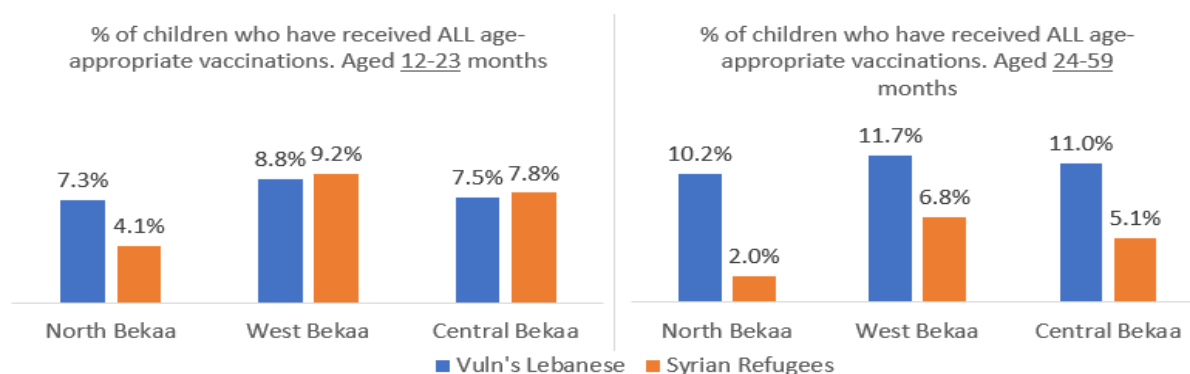


Figure 11

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

The following section investigates access and behaviours in relation to the continuum of reproductive health: pregnancy, antenatal care (ANC), delivery (including perinatal deaths and child registration) and postnatal care (PNC). Access to Reproductive Health (RH) Services.

Summary of core indicator targets: Reproductive health

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

2018 result:	Vulnerable Lebanese	Syrian Refugees
<i>n</i> =	751	1482
Estimate:	90.0%	76.6%
95% CI Lower:	85.3%	68.3%
95% CI Upper:	93.3%	83.2%

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

2018 result:	Vulnerable Lebanese	Syrian Refugees
<i>n</i> =	541	362
Estimate:	72.0%	24.4%
95% CI Lower:	66.2%	20.8%
95% CI Upper:	77.2%	28.5%

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

2018 result:	Vulnerable Lebanese	Syrian Refugees
<i>n</i> =	751	1482
Estimate:	85.6%	80.5%
95% CI Lower:	82.9%	77.8%
95% CI Upper:	88.0%	83.0%

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

2018 result:	Vulnerable Lebanese	Syrian Refugees
<i>n</i> =	751	1482
Estimate:	51.4%	43.6%
95% CI Lower:	47.0%	38.6%
95% CI Upper:	55.7%	48.7%

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

2018 result:	Vulnerable Lebanese	Syrian Refugees
<i>n</i> =	391	739
Estimate:	98.2%	97.3%

With regard to awareness about what RH services are available to them, awareness about antenatal care (ANC) is quite high at over 75% for both populations. Though all other services are less well known: postnatal care (PNC), family planning/contraception advice (FP), and care for sexually transmitted infections (STIs).

The proportion of mothers not aware of any RH services was at 10% for Lebanese women, and 23.4% for Syrian refugee women.

% of mothers who are aware of each type of reproductive health service available in their community

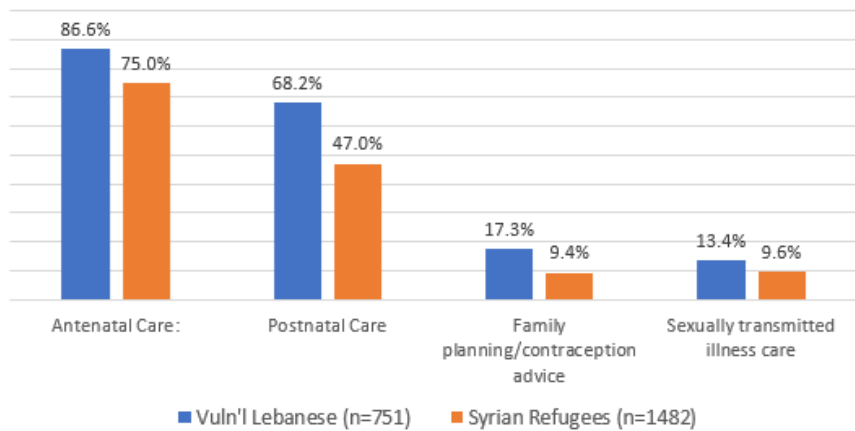
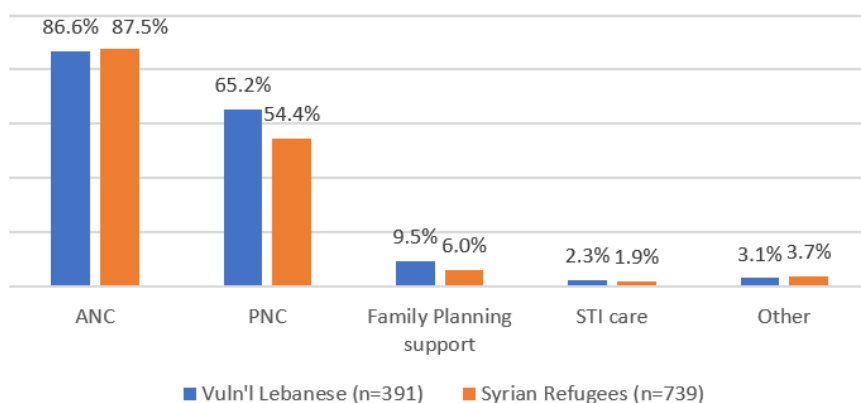


Figure 12

The results of the second core indicator above appears to be misleading, as fewer mothers claimed to know where RH services are located as actually accessed the services. The fourth core indicator creates more clarity. Again, **over 80% of Lebanese and Syrian mothers reported that they would be able and comfortable in accessing such services.** While the results are similar, the inferiority of the Syrian mothers' responses is statistically significant ($p=0.003$). 8.1% of Lebanese and 8.5% of Syrian women expressed they would not be comfortable accessing the services, and **14.4% of Lebanese and 19.5% of Syrian women expressed that they would not be able to access the services.** Reasons were diverse. Among Syrian refugee women, the most common reasons were due to financial constraints (reported by 21% of those could not access services. Freq=52); poor service or overcrowding (reported by 13%. Freq=32), lack of transportation (10% of those who could not access service. Freq.=25) and six stated the services did not exist in their community (2%). Among Lebanese, 43% (freq=38) said their constraint was financial reasons, and 28% (freq=25) said it was due to poor service or overcrowding.

Around half of all mothers in both samples sought some form of RH service in the past year. However, while almost all Lebanese women succeeded in accessing the service they sought, **12.6% of Syrian refugees seeking RH services did not succeed in accessing them.** The difference between access for Lebanese and Syrian women is extremely statistically significant ($p<0.0001$). No difference is present between access to ANC. However, Syrian women have inferior utilisation to all other services, as we see in the following graph (statistically significant inferiority for PNC and FP service utilisation).

Among women who accessed a service, what specific services they accessed



'Other' services reported consisted of mammography, ovarian cyst, menstrual difficulties and pregnancy termination.

While gaps may exist in service coverage, service quality is clearly very high with over 97% of Lebanese or Syrian women reporting satisfaction with the PH service they received. Among the very few who expressed dissatisfaction, the main reason was for bad or disrespectful service.

As we consider **where women have accessed RH services**, we see, as with general health care, Syrian refugee women are heavily dependent on the dispensaries. Whereas vulnerable Lebanese women are most likely to access services at a private medical clinic. Those seeking services at a hospital are still very low for both populations.

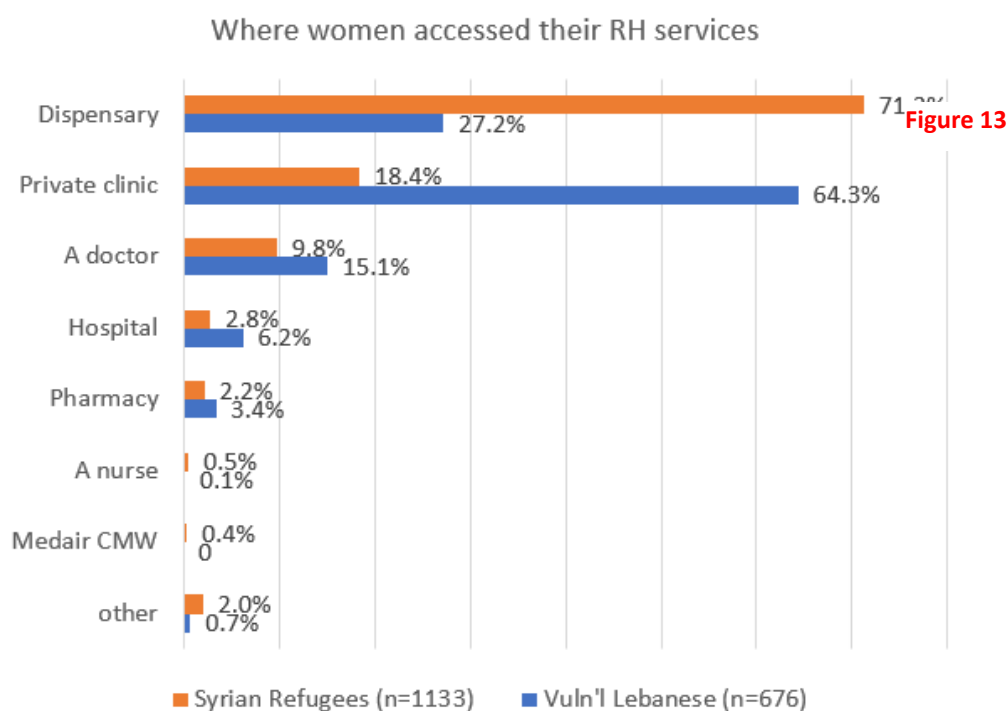


Figure 14

ANC visits

Summary of core indicator targets: ANC visits

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

2018 result:

	Vulnerable Lebanese	Syrian Refugees
<i>n =</i>	370	965
Estimate:	76.5%	55.8%
95% CI Lower:	70.7%	51.1%
95% CI Upper:	81.4%	60.3%

We observe some positive results in relation to pregnant women accessing ANC. Among both Lebanese and Syrian refugee mothers of children under two years old, every mother (**100%**) **reported having received an ANC session within the first three months of pregnancy**: 332 vulnerable Lebanese women and 712 Syrian refugee women.

Around eight out of ten mothers of a child under two attended an ANC session in the month prior to giving birth:

- 82.5% of vulnerable Lebanese mothers (freq=274/332)
- 78.8% of Syrian refugee mothers (freq=561/712) (the difference is not statistically significant)

However, the gap in access to service opens in relation to how many ANC visits were attended. Traditionally, WHO has recommended a minimum of four ANC contacts during pregnancy (WHO, 2017). This has occurred for 76.5% of sampled Lebanese mothers of a child under two years old (freq=238/370). However, only 55.8% of Syrian refugee mothers accessed at least four (freq=538/965). The inferiority of the result for Syrian mothers is extremely statistically significant ($p < 0.0001$).

For those who participated in an ANC session, almost **all were facilitated by a doctor** (99.9% for vulnerable Lebanese women (freq=686/687); and 95.7% for Syrian refugee mothers (freq=1082/1131).

The remainder were almost all sessions with a midwife. In terms of where ANC contact took place, we see the trend repeated of the reliance on dispensaries for pregnant Syrian refugee women, and a strong preference for private clinics by vulnerable Lebanese women, and little engagement with hospitals.

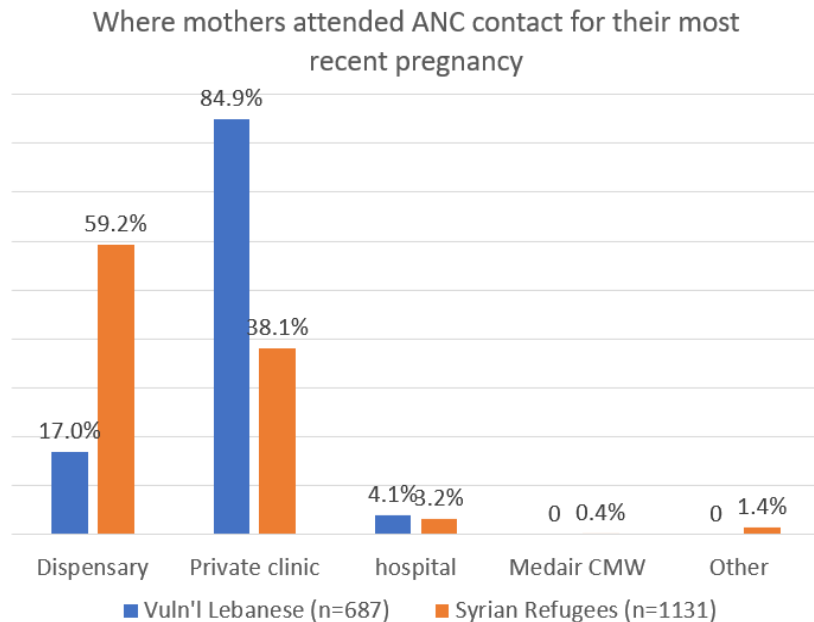


Figure 15

Among Syrian women 16.3% said that they received ANC in Syria (freq=242/1481), and 15.1% said they gave birth to their baby in Syria also (freq=223/1481). Reasons for delivering in Syria were:

- They were living in Syria at the time (68.6%)
- To be registered in Syria (15.4%);
- They have family in Syria (11.7%),
- They were stuck at the border (2.7%)

Delivery

Summary of core indicator targets: Delivery

% of mothers of children under 5 years who delivered at hospital

2018 result:

n =

Vulnerable Lebanese

751

Syrian Refugees

1482

Estimate:

87.0%

79.6%

95% CI Lower:

83.3%

76.1%

95% CI Upper:

89.9%

82.8%

% of mothers of children under 5 years who delivered by caesarean section.

2018 result:

n =

Vulnerable Lebanese

751

Syrian Refugees

1482

Estimate:

53.7%

28.1%

95% CI Lower:

48.2%

25.2%

95% CI Upper:

59.1%

31.2%

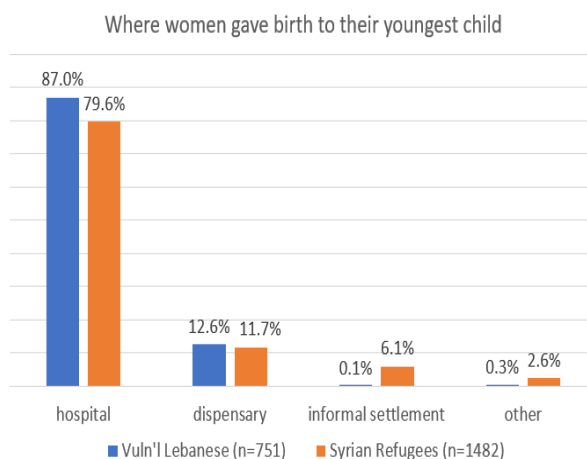


Figure 17

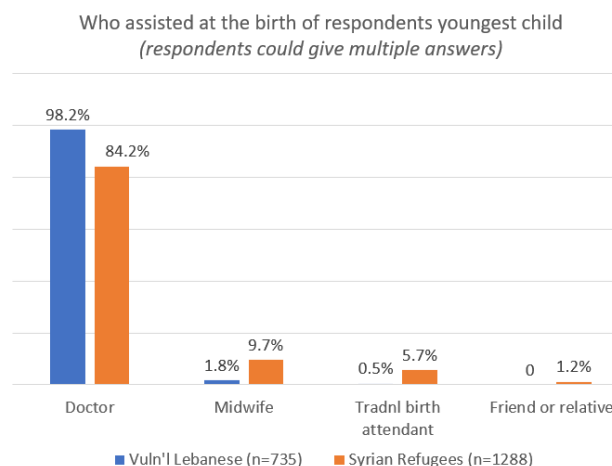


Figure 16

While vulnerable Lebanese and especially Syrian refugee women rarely consult a hospital, we see that the majority of both choose to give birth in a hospital. Nevertheless, yet again, though hospital deliveries are close between the two samples, the inferiority of access for Syrian women is statistically significant ($p < 0.0001$).

A statistically similar proportion of Lebanese and Syrian women gave birth in a dispensary, and a small but significant number of Syrian women gave birth within an informal settlement. Among the few that reported delivering at a 'other', 21% of those delivered at a midwife's facility, and 63% delivered at an MSF health facility. Medair SDCs/dispensaries do not facilitate deliveries. Therefore, it is likely the MSF dispensaries account for all births at a dispensary.

Among those who did not deliver at a hospital, the top reasons given were:

- It is too expensive
- Labour came on too fast
- No transportation

Consistent with the proportion of births at hospitals and dispensaries, most births were attended by a doctor, though results for Syrian refugees are inferior to vulnerable Lebanese women.

When we look at the durations that women remain in hospital after giving birth, we see that Syrian women are dispatched from hospitals much quicker than Lebanese women. Around a fifth of Lebanese women leave hospital within 12 hours of giving birth. Whereas almost half of the Syrian refugee women leave within 12 hours. Likewise, twice the proportion of Lebanese are able to remain in hospital longer than 24 hours compared to Syrian refugees.

The difference in hospital duration is likely to be related to expense, as 87.2%

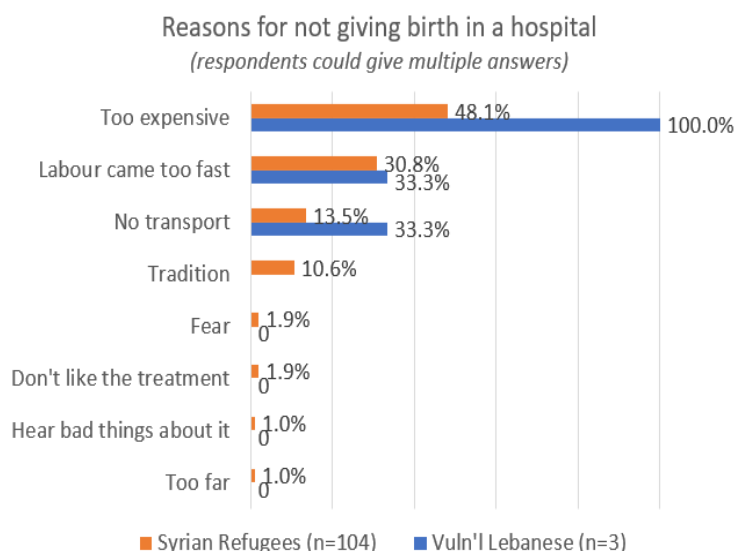


Figure 18

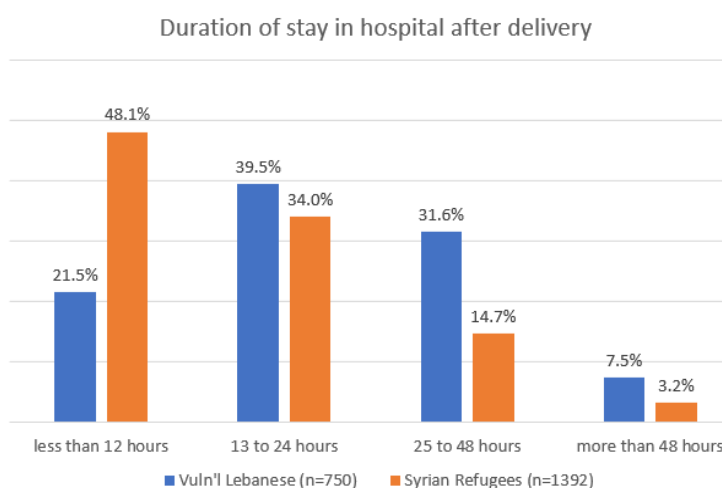


Figure 19

of Lebanese women and 91.1% of Syrian refugee women who gave birth in a hospital reported that they had to pay to stay in hospital. For Lebanese mothers, the modal expense for their hospital stay was 200,000 to 400,000 Lebanese pounds (USD 130-260). For Syrian refugee women, the modal expense was less than 100,000 (USD65).

In reference to those who received a health booklet while in hospital, the proportion of the sample who answered this question was extremely low (n=334). Among the few asked, 30% of Lebanese (freq=9/30) and 17.8% of Syrian mothers (freq=54/304) stated they were given documentation with their child's health status details.

Summary of indicator targets: Mortality in Pregnancy

% of women who had a sister, whose sister died due to problems related to pregnancy

2018 result: **Vulnerable Lebanese** **Syrian Refugees**

n =	652	1320
Estimate:	8.1%	7.8%
95% CI Lower:	5.7%	6.2%
95% CI Upper:	11.4%	9.7%

Mortality in Pregnancy

We see in the above table, that, despite the inferior rates of health coverage for Syrian refugee women, the rates of reported maternal mortality are not statistically different to that of vulnerable Lebanese women⁸.

Summary of core indicator targets: Child registration

% of children under 5 years officially registered in their country (for Syrians)

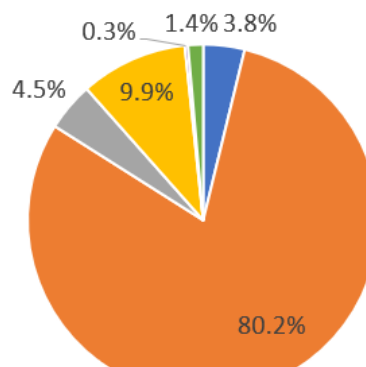
2018 result: **Vulnerable Lebanese** **Syrian Refugees**

n =	-	1488
Estimate:	na	22.3%
95% CI Lower:	-	19.5%
95% CI Upper:	-	25.4%

Child registration

92.3% of Syrian women also said that they received a birth certificate for their youngest child (freq=1367/1481). The majority reported that they obtained their birth certificate from a hospital. However, only 22.2% of Syrian refugee parents reported that their youngest child was registered at the Syrian embassy (freq=329/1481) and a further 5.1% said they have started the process. Those who had not registered their child were asked how they intended to register. Ninety-one percent responded that they did not know how. The remaining 9% gave

Where Syrian mothers obtained a birth certificate (n=1367)



⁸ This indicator was requested for inclusion in the KPC survey by the Lebanese MoPH. The results are surprisingly high. The report analysts have checked the data and calculations, which contain no errors. The wording of the question was checked in English and Arabic, and we are confident its wording could not easily be misunderstood.

■ doctor ■ hospital ■ midwife
■ moktar ■ no_answer ■ other

various explanations of the cost, not being able to return to Syria, the newborn being too young, waiting for other legal documents, or they have contacted a lawyer about it.

Figure 20

Postnatal Care (PNC)

Summary of core indicator targets: Postnatal Care (PNC)		
<i>% 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</i>		
2018 result:	Vulnerable Lebanese	Syrian Refugees
<i>n =</i>	370	965
Estimate:	57.6%	41.3%
95% CI Lower:	52.6%	38.1%
95% CI Upper:	62.4%	44.7%
<i>% of children under two years of age who were examined by an appropriately trained health worker 3 days after delivery</i>		
2018 result:	Vulnerable Lebanese	Syrian Refugees
<i>n =</i>	370	965
Estimate:	47.6%	30.4%
95% CI Lower:	40.7%	26.0%
95% CI Upper:	54.5%	35.1%

“Most maternal and infant deaths occur in the first month after birth: almost half of postnatal maternal deaths occur within the first 24 hours and 66% occur during the first week.”(WHO, 2015). WHO recommends that each mother and newborn:

- ✓ remain in hospital for at least 24 hours after delivery,
- ✓ receives the first postnatal contact within 24 hours of birth (preferably in the first hour), and
- ✓ receives at least four PNC contacts in the first six weeks: on day 1; day 3 (48-72 hours); at the 7 – 14 day period, and 6 weeks after birth.

We have seen, in the preceding section, ‘Delivery’, that the majority of Lebanese and Syrian women are discharged too soon, in under 24 hours from birth: especially for Syrian refugee women.

The study set a benchmark lower than the WHO by testing how many mothers of children under two years old received three PNC contact within 40 days of giving birth. The results are very low, with **only 10.5% of vulnerable Lebanese women (freq=39/370) and 2.7% of Syrian refugee women (freq=26/965) receiving at least three PNC contacts in the first forty days.**

In terms of first PNC visit, 47.6% of vulnerable Lebanese (freq=176/370) mothers and 30.4% of Syrian refugee mothers of a child under two had their first visit within 3 days of giving birth. By two weeks after delivery, still only 57.6% of vulnerable Lebanese (freq=213/370) and 41.3% of Syrian refugee mothers (freq=399/965) had received a PNC contact.

The PNC check was conducted by a doctor in 99.2% of cases for Lebanese mothers, and 93.9% of cases for Syrian refugee mothers.

In terms of where women are accessing PNC, we see the general trend repeated where Syrian refugee mothers are most inclined to visit a dispensary and vulnerable Lebanese mothers prefer a private clinic. The proportion of mothers who attended PNC at a hospital is higher than for other health care purposes.

Among Syrian women, 12.2% reported that they received PNC in Syria.

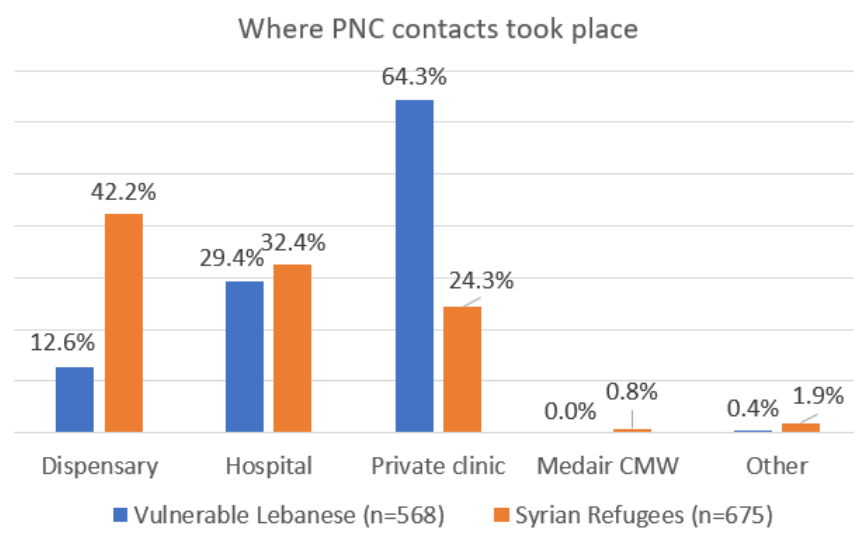


Figure 21

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

2018 result:

	Vulnerable Lebanese n = 751	Syrian Refugees n = 1482
Estimate:	10.8%	6.8%
95% CI Lower:	8.3%	5.4%
95% CI Upper:	13.8%	8.6%

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

2018 result:

	Vulnerable Lebanese n = 370	Syrian Refugees n = 965
Estimate:	27.3%	15.8%
95% CI Lower:	21.4%	12.8%
95% CI Upper:	34.1%	19.3%

Family Planning (FP) and child spacing

Women in the study were asked whether their most recent pregnancy was planned or not. A third of pregnancies to vulnerable Lebanese women and half of pregnancies to Syrian refugee women were not planned.

- 36.4% of pregnancies to vulnerable Lebanese women were unplanned (freq=273/751)
- 50.9% of pregnancies to Syrian refugee women were unplanned (freq=754/1482)

This result highlights the high unmet need for family planning among both populations, but especially among Syrian refugee women.

As we see in the indicators above, few women in either sample has discussed family planning/contraception options with a trained provider in the last 12 months, and a little more than a quarter of Lebanese mothers and a sixth of Syrian refugee mothers of a child under two are using any form of modern contraception.

Reasons given for not using any form of pregnancy delaying technique, around half of the respondents cited a current pregnancy, or currently breastfeeding.

In relation to those who cited an 'other' response, most referred to the husband being away, deceased or incapacitated in some way; or due to a health problem for the woman; or wanting to become pregnant. It is, perhaps, surprising that fewer than 10% cited their reason for not wanting to delay as due to their husband's wishes for more children.

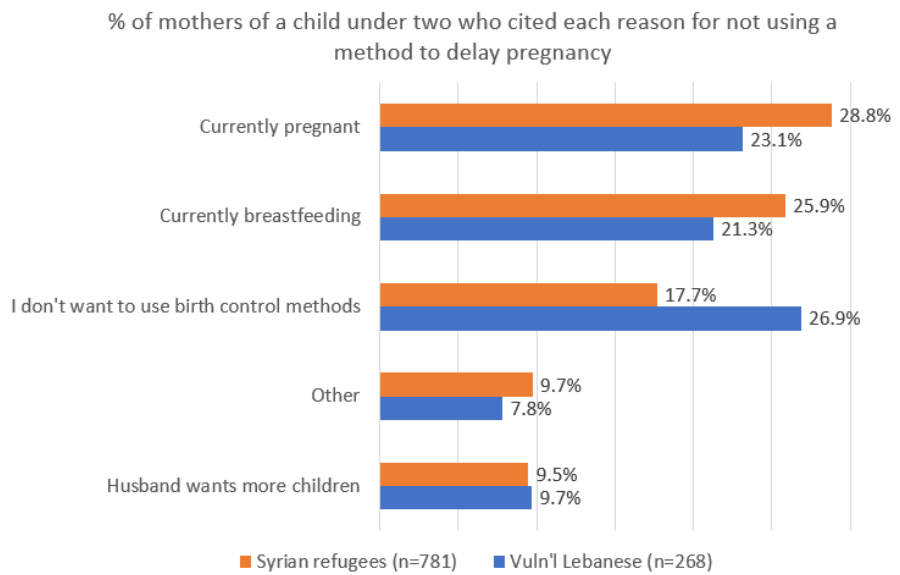


Figure 22

Among those using any form of contraception, the most popular method was using oral pills, followed by inter-uterine devices (IUD).

Knowledge about pregnancy spacing is quite poor among Syrian refugees, and modest among vulnerable Lebanese. While 68.9% of vulnerable Lebanese mothers of a child under two could cite at least one risk associated with getting pregnant within less than two years of the previous birth (freq=255/370), fewer than half of their Syrian peers could cite just one risk (47.0%. Freq=454/965). No risks were cited by a majority of respondents. The most commonly cited risk was fatigue.

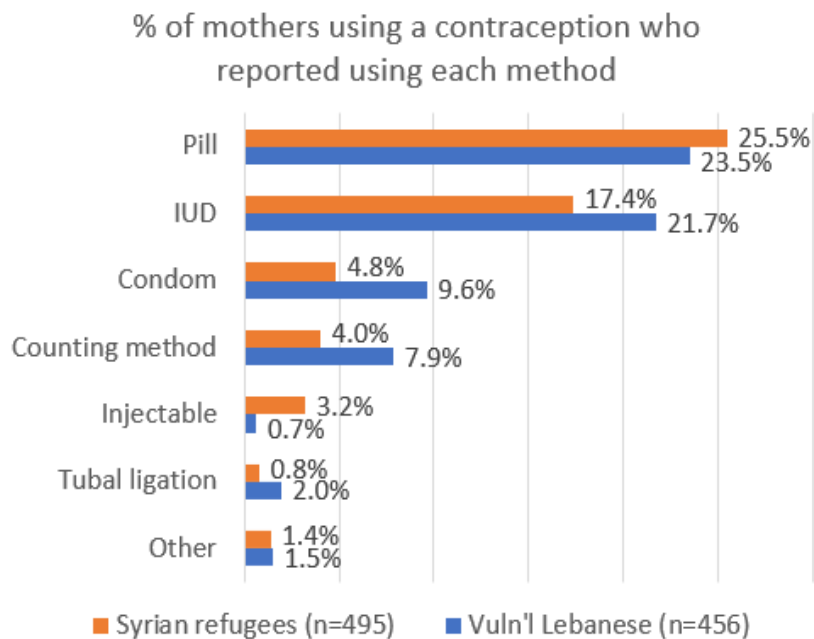


Figure 23

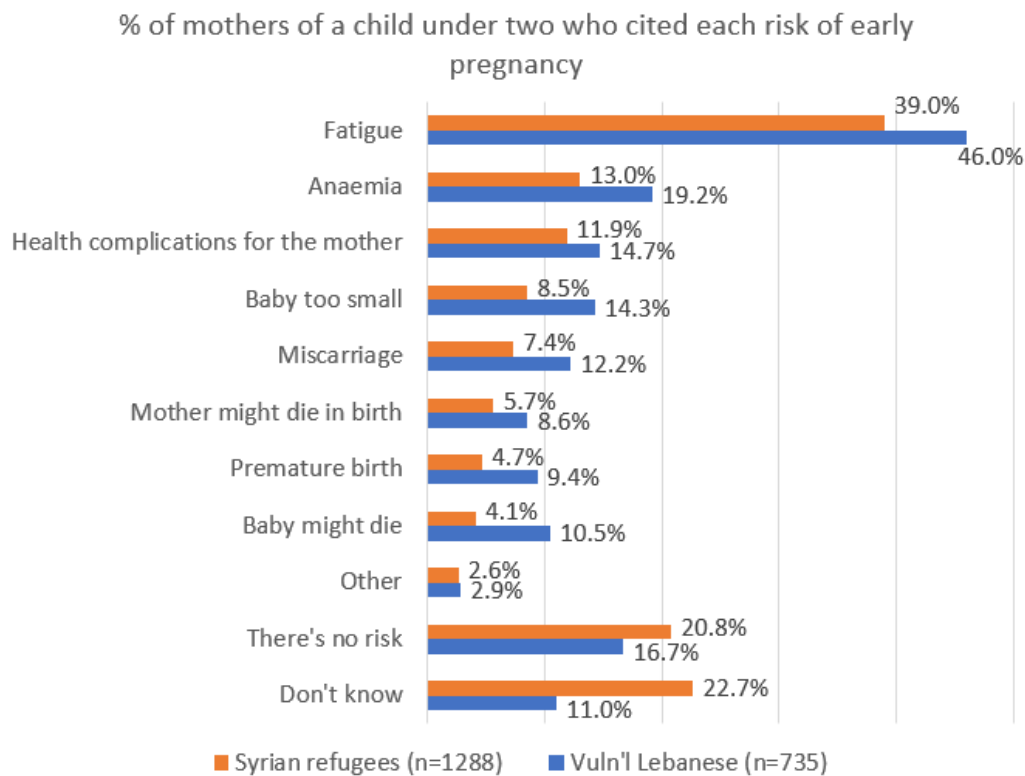


Figure 24

There was no dominant pattern in responses recorded under 'other'.

When asked what the ideal minimum birth spacing period would be, less than half of vulnerable Lebanese mothers of a child under two, and just a third of Syrian refugee mothers cited two years or longer:

- 48.6% of vulnerable Lebanese mothers of a child under two (freq=180/370),
- 33.0% of Syrian refugee mothers of a child under two (freq=318/965)

Summary of core indicator targets: Breastfeeding practices

% of infants 0-5 months (At time of study) who are exclusively breastfed

2018 result:

	Vulnerable Lebanese	Syrian Refugees
<i>n =</i>	114	255
Estimate:	25.4%	32.9%
95% CI Lower:	17.3%	27.8%
95% CI Upper:	35.7%	38.5%

6.6 Breastfeeding practices

The vast majority of children of the mothers surveyed are breastfed while infants. Among the two samples, the results were:

- 85.1% of Lebanese infants were breastfed in their first six months of life (freq=639/751).
- 91.3% of Syrian refugee infants were breastfed in their first six months of life (freq=1353/1482)

Inversely, 14.9% of Lebanese infants and 8.7% of Syrian infants were not breastfed.

However, a third of Syrian infants and more than half of Lebanese infants were **breastfed for less than six months**. The main reason given for halting breastfeeding was that the mother had no more breastmilk (cited by 69.6% of Lebanese and 85.3% of Syrian women). No other reason was cited by more than 10% of women.

Among Lebanese mothers, a surprising proportion described being directed to stop breastfeeding by a doctor or hospital procedure such as the child having to be incubated, or the mother having x rays.

For what proportion of infants were exclusively breastfed for their first six months of life, the result is extremely low. **Only a quarter of infants born to vulnerable Lebanese mothers and a third of those born to Syrian refugee mothers were exclusively breastfed** at the time of the survey. This result is consistent with 2016 findings.

Concerning also, is that between a third and a fifth of newborns were not given breastmilk in their first hour of life.

- 68.7% of Vulnerable Lebanese infants were breastfed in their first hour of life (freq=171/373)
- 78.2% of Syrian refugee infants were breastfed in their first hour of life (freq=527/968)

For breastfed infants, for how many months were they breastfed?

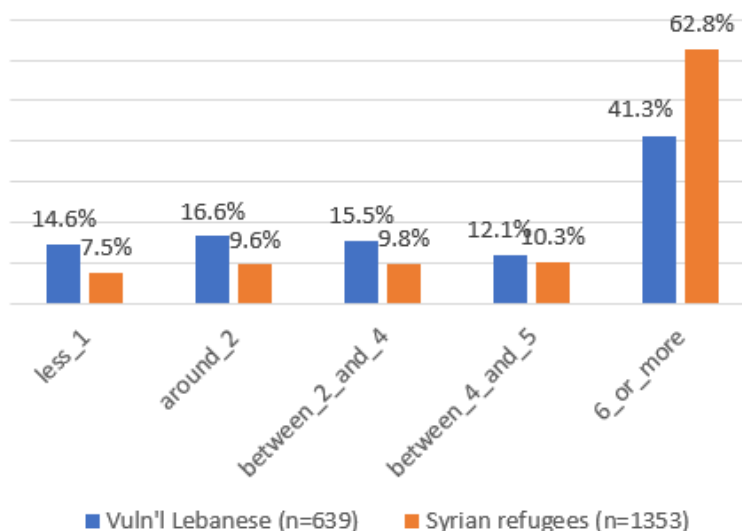


Figure 25

Reasons given for ceasing breastfeeding

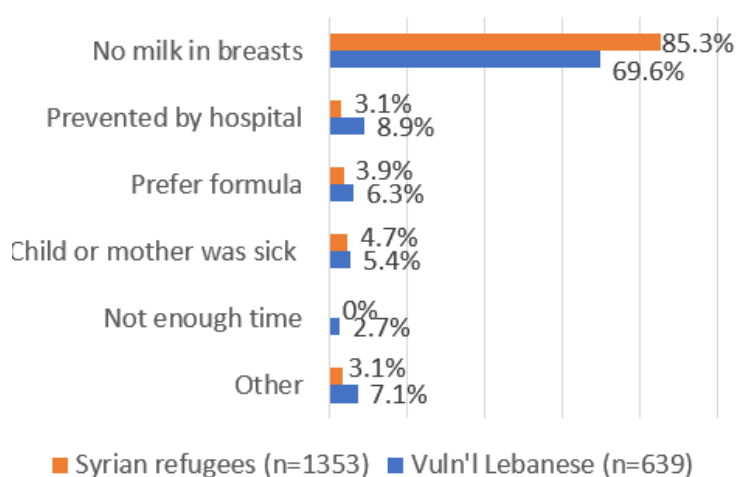


Figure 26

6.7 Access to Psychosocial Services

Psycho Social Support (PSS) services

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

Note: The indicators presented here include reference to women, girls, men and boys (WGMB) as they are standard donor indicators. This study only interviewed women with children under 5.

% WGMB in the targeted communities who correctly identify available PSS services

2018 result:	Vulnerable Lebanese	Syrian Refugees
n =	751	1482
Estimate:	23.6%	18.4%
95% CI Lower:	17.9%	14.8%
95% CI Upper:	30.4%	22.5%

% WGMB in the targeted communities who correctly report where to access PSS services

2018 result:	Vulnerable Lebanese	Syrian Refugees
n =	751	1482
Estimate:	10.1%	11.9%
95% CI Lower:	7.6%	9.4%
95% CI Upper:	13.4%	14.8%

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

2018 result:	Vulnerable Lebanese	Syrian Refugees
n =	751	1482
Estimate:	24.5%	17.6%
95% CI Lower:	18.4%	13.7%
95% CI Upper:	31.8%	22.3%

% WGMB in the targeted communities who report that they would be comfortable and able to access these (PSS) services as needed (To be presented disaggregated by sex)

2018 result:	Vulnerable Lebanese	Syrian Refugees
n =	751	1482
Estimate:	40.7%	33.1%
95% CI Lower:	36.1%	28.8%
95% CI Upper:	45.6%	37.8%

% of mothers of children under 5 years who report accessing PSS support services in the 6 months prior to the survey

2018 result:	Vulnerable Lebanese	Syrian Refugees
n =	751	1482
Estimate:	4.1%	1.6%
95% CI Lower:	2.6%	1.0%
95% CI Upper:	6.5%	2.5%

% of mothers of children under 5 years receiving PSS services who report satisfaction with support provided

2018 result:	Vulnerable Lebanese	Syrian Refugees
n =	42	44
Estimate:	97.6%	95.5%

Mental health pressures are high in the surveyed areas. The survey found that **70.7% of vulnerable Lebanese mothers (freq=531/751) and 75.1% of Syrian refugee mothers (freq=1113/1482) felt sad, stressed or under pressure**, or know someone who was at some point in the six months prior to the survey. Of those who felt stressed or knew someone stressed, only 6.0% of vulnerable Lebanese mothers (freq=31/521) and 2.5% of Syrian refugee mothers (freq=24/973) consulted a trained service provider.

In terms of how they dealt with sadness, stress or pressure, three quarters chose to just deal with it on their own, and between a third and a half also consulted family or friends. Almost 4% of vulnerable Lebanese mothers

attended a private clinic. But all other forms of support were cited as being used by less than 1% each, as the following table reveals:

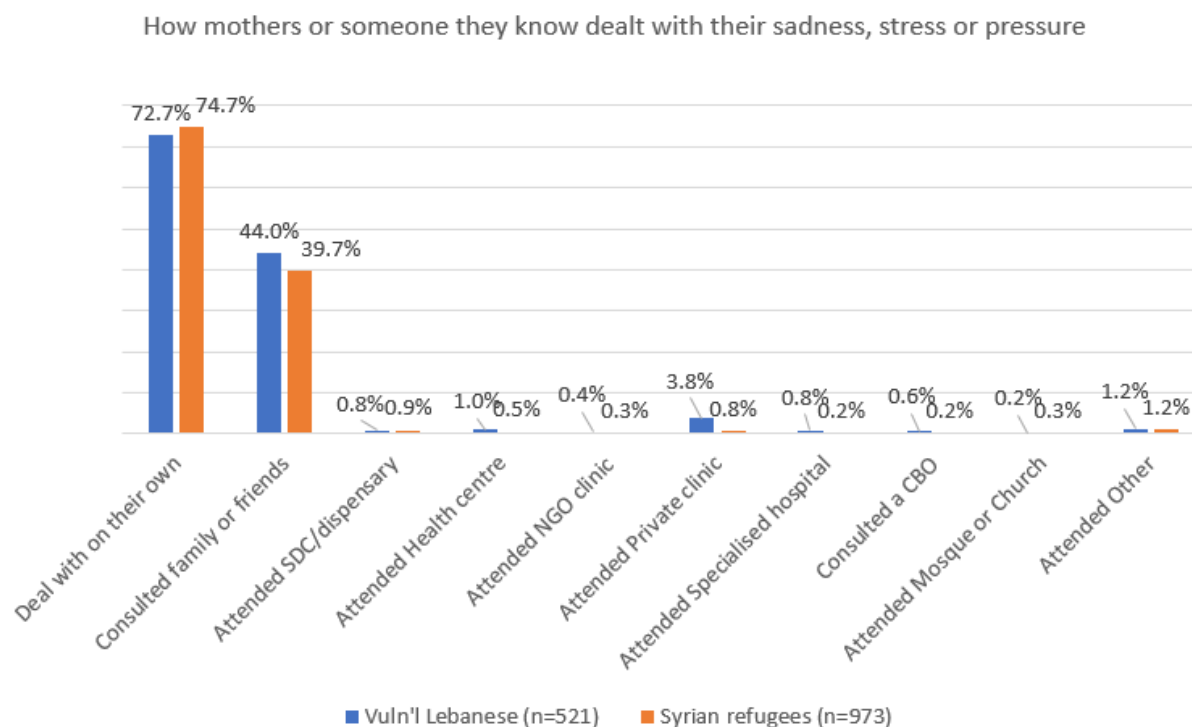


Figure 27

Clearly, **awareness is low about services** to assist people to deal with such mental health challenges, with only around a fifth of respondents correctly citing at least one psychosocial support service (PSS) *by a trained service provider* in their community, and little more than a tenth of all people knowing where to access such a service.

- 23.6% of vulnerable Lebanese mothers correctly named at least one available PSS service (freq=177/751)
- 18.4% of Syrian refugee mothers correctly named at least one available PSS service (freq=272/1482)
- 10.1% of vulnerable Lebanese mothers stated they knew where to access such PSS services (freq=76/751)
- 11.9% of Syrian refugee mothers stated they knew where to access such PSS services (freq=176/1482)

'Trained service provider' covered health centres, NGO clinics, private clinics, SDCs/dispensaries, a specialised hospital, or a CBO.

Asked whether they would be able, and comfortable to access such PSS services if they needed to, only around a third of women said they would be:

- 40.7% of vulnerable Lebanese mothers (freq=306/751)
- 33.1% of Syrian refugee mothers (freq=491/1482)

The top reasons given for not being willing to access them were:

1. They would not want to disclose their condition (cited by 47.5% of vulnerable Lebanese and 39.7% of Syrian refugees).
2. That the service would be too expensive (cited by 41.4% of vulnerable Lebanese and 45.7% of Syrian refugees).

Other reasons cited by 6% or fewer included: not knowing where to go; not needing the service; being uncomfortable with such a service; or being afraid of social stigmatism or gossip; and not being able to leave the house due to family obligations or a husband's will.

7. Discussion

7.1 Population/Demographic Interpretation

Indicator	Medair KPC: Vulnerable Lebanese. Bekaa	Medair KPC: Syrian Refugees. Bekaa	VaSyR 2018: Syrian refugees nationally
Size of household:	5.1	6.8	4.9
Married before 18	18.2% of mothers	45.7% of mothers	29% of girls currently between 15 and 19 y.o.
Households living in overcrowded shelters	40.6% (<i>more than 1.5 inhabitants per room</i>)	93.1% (<i>more than 1.5 inhabitants per room</i>)	34% of refugee HHS (<i>calculated as <4.5m2/person</i>) (p.47) ITS data: 26.9% of refugee HHS
% of households that are female-headed			Total: 18% Baalbek/North Bekaa: 27% Bekaa: 24% (p.147)

We see that the prevalence of early marriage is very high among Syrian refugee women with almost half having married before the age of 18 (compared to just less than one in five among vulnerable Syrians). Early marriage of girls is associated with the loss of personal freedoms, lower psychosocial and emotional development and wellbeing, poorer reproductive health outcomes, higher fertility rates, and loss of educational opportunity. It is also associated with social isolation, further compounding psychosocial hardships (UNCEF, 2001). The VaSyR survey also found that early marriage practices are continuing into the next generation such that “... 20% of girls aged 15 to 17 ... were not enrolled in school [and] reported marriage being the reason for it.” (VASyR 2018, p.149)

We also see that the Syrian households have more members compared to vulnerable Lebanese households (6.8 vs. 5.15) and that literacy rates for Syrian women are much lower: 41% of Syrian refugee women in the sample are illiterate compared to just 8% among vulnerable Lebanese women.

All Syrian respondents reported they live in tent accommodation. The temporary nature of habitation combined with overcrowding that is borne by Syrian refugee households is likely to result in higher rates of stress and higher rates of transmission of communicable diseases among residents. We saw from the data on child illnesses and psychosocial difficulties that both are elevated among Syrian refugees in the sample compared to vulnerable Lebanese.

The implications for health programming may be that:

1. Health outreach must access Syrian women in their homes, instead of relying on them having social and transportation mobility.
2. Health promotion must rely on verbal and visual communication and minimise written materials.
3. Creating social and acceptable safe spaces for women to meet, learn and create friendship networks will improve peer learning and improve mental health. This point must work within the constraint of women’s reduced mobility due to family obligations and social norms).

The VaSyR survey (cited above) found a high proportion of Syrian refugee households are female-headed in the Bekaa and Baalbek/North Bekaa areas: around one in every four households. The report highlighted that “...female-headed households remained more vulnerable than male-headed households... A partial explanation for the greater vulnerability of female-headed households could lie in the fact that 55% of female-headed

households did not have any member working, while only 27% of households headed by males had no working members.” (VaSyR 2018, p.146).

7.2 Health seeking behaviour

Health care access general

Indicator	Medair KPC: Vulnerable Lebanese. Bekaa	Medair KPC: Syrian Refugees. Bekaa	VaSyR 2018: Syrian refugees nationally
% visits by health facility type (HC, private clinic, hospital) in past 6 months	Dispensary: 42.4% Private clinic: 43.1%	81.4% 7.7%	PHC/Dispensary: 86% Private clinic: 28%
% reasons of not going to health facilities	Cost: 38.5% Distance: 15.4%	Transportation: 27.5% Cost: 25% Distance: 6.3%	Distance: 6% Don't know where to go: 9% Transport cost: 28% Doctors' fees: 53% Cost of drugs and treatments: 54%

Since 2014 Medair has been improving PHC access and quality by directly supporting seven SDC dispensaries in North, Central and West Bekaa Districts under the Tearfund/Canadian government-funded project. The project's approach has been to provide up-skilling training to the doctors and health staff, fund additional staff positions in the dispensaries, and provide resources for essential medicines, immunisations, health screening, and record-keeping support. The project also intended to subsidise treatment costs and provide transport vouchers to reduce the financial burden of seeking health care.

To date, the project has focussed almost entirely on health access outreach to the Syrian refugee population, and not vulnerable Lebanese households. According to Medair staff, around 65% of patients at SDC dispensaries supported by Medair are Syrian.

In the data analysis, we see that access to health care for Syrian refugees is catching up to that of vulnerable Lebanese mothers, with more than nine out of ten Syrian mothers who required health support accessing it. Given that eight out of ten Syrian refugees who obtained health support did so at a dispensary, we see that the project's focus is bearing fruit. However, it should be noted that, in addition to the 7 SDCs (also known as dispensaries) supported by Medair, there exist at least 16 other dispensaries in the same Cadasters. Some, though not all, of these are supported by NGOs. A third of all vulnerable Lebanese and not quite half of all Syrian refugee mothers visited a Medair-supported SDC dispensary in the previous 12 months.

The survey covered a radius of 5km from each supported dispensary. Thus, it is not surprising that the lack of transportation combined with distance to health care is the most significantly cited barrier to accessing health care for Syrians. Whereas, for vulnerable Lebanese, who, throughout the survey questions, showed a higher preference for seeking health care at private clinics, cost barriers are more significant than distance.

Non-Communicable Diseases (NCD)

Project Target: 15% increase in % of women who know 2 or more ways to reduce the risk of NCDs (WRC)

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 <i>UNHCR's survey covered all chronic illnesses. Medair's covered only hypertension and diabetes. This contributes to the difference in results.</i>	19.6%	17.8%	36% of HHs

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 dispensaries to track each individual patient efficiently, and support the establishment of a pilot NCD clinic.

Though, Medair staff note that, to date, the project has not had a strong NCD focus beyond a small number of community awareness events. Overall, levels of knowledge about how to minimise risk of hypertension and diabetes was extraordinarily poor in both sampled groups. Still, vulnerable Lebanese mothers were two to three times more likely to know of the risks than Syrian refugee mothers.

Paradoxically, the survey found that knowledge of how to reduce NCD risks was far superior among vulnerable Lebanese mothers, yet there was no difference in rates of hypertension between the two populations (Around 15%), and Syrian households had a lower prevalence of diabetes (7.9% vs. 12%). This suggests that, in the Lebanese context, messages is not sufficient to reduce risky behaviours. A wider analysis and strategy around social norms and 'environmental' factors is required if the health care community hope to reduce the prevalence of hypertension and diabetes. To mitigate loss of life, in the short to medium term, a focus on efficient and affordable provision of appropriate medicine is the most appropriate course of action.

7.3 Diarrhoea and respiratory tract infection management for children

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)

Indicator	Medair KPC: Vulnerable Lebanese. Bekaa	Medair KPC: Syrian Refugees. Bekaa	VaSyR 2018: Syrian refugees nationally
Types of sickness reported among refugee children under the age of two	% of HHs containing a child with: Cough: 48.9% Diarrhoea: 16.9%	Cough: 55.6% Diarrhoea: 25.1%	% of HHs containing a child with: Cough: 38% Diarrhoea: 28%.

To combat preventable childhood illnesses, Medair's Tearfund/Canadian government-funded project is providing additional training to doctors and nurses on WHO guidelines for diagnosis and treatment of common illnesses, surveillance and reporting, and provide a buffer stock of essential medicines to treat them.

We see from the data, that in the Bekaa Valley the presence of ARI in particular was high in households at the time of survey data collection. Each survey was conducted in December. The winter months from November to April are the peak period for respiratory infection in Lebanon and account for 80% of all clinical consultations for children during these months (Kesterman et al, 2018).

While the majority of children with ARI were taken for health care treatment, the proportion of Syrian children who were taken for treatment was much lower among Syrian households (63% vs. 75% in Lebanese households).

This is concerning, given that respiratory infections “are among the leading causes of morbidity and mortality in children and adults affected by the current humanitarian crisis in Lebanon.” (Kesterman et al, 2018, p.3).

By contrast, both Lebanese and Syrian families are much more vigilant for children experiencing diarrhoea, with over 80% of sick children taken for health care.

Treatment is still poorly administered. Mothers report that antibiotics are being over-prescribed for diarrhoea cases (received by 64% of Lebanese children and 75% of Syrian children with diarrhoea), though antibiotics is not advocated for treatment of diarrhoea (WHO and UNICEF, 2013). While antibiotics are over-prescribed, the recommended treatment for diarrhoea: oral rehydration and zinc supplementation, is under-prescribed. Less than half of children who were treated for diarrhoea received ORS, and only around 10% of children in either sample received zinc. Thus, less than half of children with diarrhoea are receiving ORS and only 7% of Lebanese and 3% of Syrian children presenting for diarrhoea received both ORS and zinc.

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
% vaccination card or booklet	82.8%	68.4%	88%
Had received polio vaccination	39.4%	32.6%	83%
<i>NB: the Medair KPC counted only if each child had received all three polio doses. UNHCR may have only tested for at least one polio dose (the UNHCR report is not explicit)</i>			

The survey only recorded vaccination coverage for children whose mother produced a vaccination card. Therefore, no recall was relied upon. Only two-thirds of mothers could produce a vaccination card, whereas over 80% of vulnerable Lebanese mothers did.

Through its Tearfund/Canadian government-funded project, Medair is providing immunisations through the SDC dispensaries it supports in collaboration with MoSA and MoPH. CHVs are also trained and supervised to include promotion of vaccination in their community contacts.

Coverage is still very low as recorded in the vaccination cards. Only a third of Lebanese and a quarter of Syrian children under 5 had received a measles vaccination, and just over a third of each sample had received the full three doses of polio vaccine. For children under two years old, less than 8% of either sample in the Bekaa Valley had received the full complement of age-appropriate vaccinations promoted by the Ministry of Public Health vaccination calendar. West Bekaa performed best with just over 40% of Lebanese and Syrian children under 5 being fully immunised for polio, and Baallbek/North Bekaa performed worst with 33% of Lebanese and 21% of Syrian children being fully immunised for polio.

Generally, Lebanese children are more likely to be vaccinated in all locations and age ranges except in relation to the youngest. In the 12 to 17-month age bracket, more Syrian children had received all age-appropriate vaccinations (10.7%) than Lebanese children (8.1%). The difference is not statistically significant (p=0.3), however, the absence of a gap between Lebanese and Syrian very young children suggests that recent vaccination promotions among new mothers is having a positive impact.

With no more than 10% of either sample’s children fully immunised, 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” (Immunisation Coalition). Given that, Zahle in Central Bekaa: one of Medair’s project locations, was cited as the centre of a measles outbreak early in 2018 (MoPH, 2018), the call to intensify existing immunisation campaigns cannot be over-emphasised.

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

Reproductive health services are vital for the Lebanese and Syrian refugee communities in Bekaa valley, as the data shows that around half of all mothers accessed some form of RH service just in the previous six months. Coverage for antenatal care counselling is quite high, yet a quarter of pregnant Syrian refugee women are not aware that ANC is available. All other forms of RH (PNC, family planning and STI care) lag considerably, both in awareness and access.

Through Medair's Tearfund/Canadian Government-funded project and its EU-MADAD-funded project, Medair is providing family-planning, ANC and PNC and referral of emergency obstetric cases through the SDC dispensaries they support, via material support and training for doctors and nurses. The project also trains and supports Medair midwives to conduct ANC and PNC visits, and refer emergency obstetric cases, based on WHO guidelines.

Medair's EU-MADAD-funded project is also training 27 CHVs in Lebanon to conduct household visits to provide reproductive health counselling to women who are pregnant, recently delivered or breastfeeding. It also seeks to mobilise women's and men's support groups.

Again, for targeting the most vulnerable, we see Medair's focus on the SDC dispensaries justified with 71% of Syrian refugees who accessed RH services, gaining them from a dispensary, compared to just 18.4% of Lebanese women, among whom 64% favoured attending a private clinic. For RH services, hospitals are almost irrelevant to either population, except in relation to giving birth.

ANC visits

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 (WRC)

Indicator	Medair KPC: Vulnerable Lebanese. Bekaa	Medair KPC: Syrian Refugees. Bekaa	UNHCR 2018: Syrian refugees nationally
% received ANC services during last pregnancy			72% of the women who had delivered had received antenatal care (ANC) services.
Received 4 ANC contacts	76.5% of all women who delivered.	55.8% of all women who delivered.	72% (of those who had ANC) went for 4 visits or more Of all women that delivered, 51% went for 4 or more ANC visits
Where ANC was received:	Dispensary: 16.7% Private clinic: 75.7%	58.5% 31.6%	Dispensary/PHC: 56% Private clinic: 43%

In the data, we see that little over half of all pregnant Syrian refugee women accessed the minimum four ANC contacts, and vulnerable Lebanese women fared somewhat better with 76% receiving at least four contacts.

Encouragingly, all expectant mothers had an ANC contact in their first three months of pregnancy, and eight out of ten had one in the month prior to delivery.

Delivery

Indicator	Medair KPC: Vulnerable Lebanese. Bekaa	Medair KPC: Syrian Refugees. Bekaa	UNHCR 2018: Syrian refugees nationally
Where delivered:	Hospital: 86.5% Dispensary: 12.6% Informal/other: 0.4%	79.6% 11.7% 8.7%	Hospital: 88% (143) Home: 5% Other: 6%
Why not in a hospital:	Cost: 100% (n=3) Labour too fast: 33.3% No transport: 33.3% Tradition:	Cost: 48.1% Labour too fast: 30.8% No transport: 13.5% Tradition: 10.6% Bad impression: 2.9%	Cost: 50% Convenience (of a local midwife): 50%
% c-sections out of deliveries in health facilities	53.7%	28.1%	31%

With around eight out of ten deliveries being performed in a hospital, this result is positive, but with room for improvement. We see that dispensaries (most likely assisted by MSF and other NGOs) are picking up the majority of births outside a hospital. Births in informal locations are almost non-existent among vulnerable Lebanese women, but still account for 9% of births for Syrian refugee mothers.

Two stand-out reasons were put forward by those mothers who gave birth in an informal location (such as at home or a midwife's place). Cost was a major factor cited by half of the Syrian women and all (n=3) of the Lebanese women who did not give birth in a health facility. After this, the related reasons of the speed of labour and the lack of transport were the other main reasons.

To further reinforce the impact of cost upon Syrian women in particular, we see that 82% of Syrian women who gave birth in hospital left hospital on the same day. WHO recommends that to reduce maternal and infant mortality, all mothers should remain in hospital for at least 24 hours for uncomplicated deliveries (WHO, 2014). Therefore, increasing the ability of women to remain in hospital without fearing financial penalty is imperative.

Child registration

Indicator	Medair KPC: Vulnerable Lebanese. Bekaa	Medair KPC: Syrian Refugees. Bekaa	VaSyR 2018: Syrian refugees nationally
Level of birth documentation of Syrian refugee children born in Lebanon	-	92.3%	Received birth certificate: 97%
Share of children with birth registered at the Foreigners' Registry, by governorate	-	22.2% (registered at the Syrian embassy)	17% had their birth registered with the Syrian embassy

We find, in the survey coverage area, the proportion of parents who register their child with the Syrian embassy is approximately equal to the wider Syrian population in Lebanon at around 20%. However, over 90% receive a birth certificate from the hospital or muktar.

Postnatal Care (PNC)

Indicator	Medair KPC: Vulnerable	Medair KPC: Syrian	VaSyR 2018: Syrian
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	Lebanese. Bekaa	Refugees. Bekaa	refugees nationally
% received PNC services	57.6%	41.3%	26%

PNC is a critical intervention for mothers and their newborns in the critical days and weeks after delivery. WHO estimates that 30-60% of maternal and newborn mortality could be prevented by effective home-based PNC (WHO-SEA). Yet, in relation to maternal services, this has proven to be the weakest link for Syrian refugees and vulnerable Lebanese families compared to ANC and delivery. WHO recommends at least four PNC contacts in the first 6 weeks (WHO 2014). Yet, only one in ten vulnerable Lebanese mothers of a child under two and less than 3% of Syrian mothers of a child under two achieved even three PNC contacts.

While it is laudable that almost all PNC checks were conducted by a doctor, almost all PNC contacts occurred at a health facility: a dispensary, hospital or private clinic. We have seen in earlier themes, that consultation cost and transport are major barriers especially for Syrian women. PNC coverage will improve substantially if PNC contact occurs at home by midwives.

Family Planning (FP) and child spacing

Project target: 20% increase in % of mothers of children ages 0-23 months who are using a modern contraceptive method (measured by survey) (WRC)

Indicator	Medair KPC: Vulnerable Lebanese. Bekaa	Medair KPC: Syrian Refugees. Bekaa	UNHCR 2018: Syrian refugees nationally
% reported use of family planning method	27.3%	15.8%	57%
<i>NB: The Medair KPC excluded 'counting days as a modern contraceptive. This contributes to the lower result than UNHCR</i>			
Breakdown of FP method used	Pill: 23.5% IUD: 21.7% Condom: 9.6% Counting: 7.9% Injectable: 0.7%	25.5% 17.4% 4.8% 4.0% 3.2%	Pill: 38% IUD: 31% Condoms: 13% Counting: 25%
Reasons for not using FP methods.	Currently pregnant: 23.1% Breastfeeding: 21.3% Don't like to use: 26.7% Husband wants more children: 9.7%	28.8% 25.9% 17.7% 9.5%	Planning pregnancy: 35% Cost: 10% Worry about side-effects: 7% Too old: 6% Culture: 5% Other: 25% (esp. spouse away, ill or dead)

The study found that 51% of most recent pregnancies to Syrian respondents, and 36% to vulnerable Lebanese respondents were unplanned. Awareness that family planning/contraception support is available was very low with 9% of Syrian respondents and 17% of vulnerable Lebanese respondents aware of such services. Utilisation is also low at 27% among Lebanese and 15% among Syrian refugee mothers. The most cited reasons for not using contraception were related to reproduction: currently pregnant or breastfeeding.

Only 10% of Syrian and Lebanese mothers not using contraception cited that it is because of their husband's wish to have more children. This may imply that women have a reasonable amount of agency in determining their use of contraception. However, motivation may be low for extending the spacing between births, especially for Syrian mothers. Fewer than half of the Syrian women surveyed could cite even one risk of having pregnancies close together, and only a third of them thought that two or more years apart was an appropriate spacing. Knowledge among Lebanese respondents was around 50% higher.

Thus, continued attention on mainstreaming knowledge among women and about birth-spacing, risks of close pregnancies, and options and availability to delay pregnancies should be continued.

7.6 Breastfeeding practices

Project target: 20% increase in % of infants 0 to < 6 months who are exclusively breastfed. (WRC)

Indicator	Medair KPC: Vulnerable Lebanese. Bekaa	Medair KPC: Syrian Refugees. Bekaa	VaSyR 2018: Syrian refugees nationally
% of children breastfed	41.3% (breastfed more than 6 months)	62.8% (breastfed more than 6 months)	50% (of children 12-15 months breastfed)
% of children under 6 months exclusively breastfed.	25.4%	32.9%	42%

The lower result in the Medair KPC around exclusive breastfeeding may be due to the survey using a different and more strict set of questions. VaSyR asked mothers to cite what had been given to an infant in the previous 24 hours. This year's Medair KPC asked the mother about whether anything other than breastmilk was ever given during the entire first five months of life.

Receiving breastmilk during their first year of life provides infants with decreased risk of diarrhoea and respiratory, ear, and urinary tract infections and long-term benefits of decreased incidence of obesity and chronic illnesses such as diabetes (Gatti, 2008). Consequently, to make these benefits available to all children, the UN agencies recommend newborns are breastfed within the first hour of life, exclusive breastfeeding for the first 6 months of life and receive continued breastfeeding until at least 1 year (UNICEF 2010).

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 dispensaries 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 Medair midwives to conduct ANC and PNC visits, and refer emergency obstetric cases, based on WHO guidelines.

Breastfeeding practices among Lebanese and Syrian samples is suboptimal still. Fifteen percent of Lebanese infants and 8.7% of Syrian infants were not breastfed at all, and among those who were breastfed, a third of Syrian infants and more than half of Lebanese infants were breastfed for less than six months.

Furthermore, we see from the indicator above, that very few children are exclusively breastfed.

While the survey did not test why supplementary fluids were given to infants under 6 months, the main reason cited for giving up breastfeeding completely was because women said their breasts were not producing enough milk: cited by 70% of Lebanese and 85% of Syrian mothers. The most common cause of a reduction in supply is as a result of supplementary feeding which causes the child to suckle less, so less breastmilk is produced (UNICEF, 2000; Gatti, 2008). Other common causes are psychological factors for the mother such as a lack of confidence in one's breastfeeding adequacy, stress, or depression (Gatti, 2008, GP Notes). In rare instances, it is a result of illness, premature birth or congenital abnormality of the infant; medications or obesity (GP Notes).

Apart from insufficient breastmilk, no other reason for ceasing breastfeeding was cited by more than 6% of Lebanese or Syrian mothers.

Thus, to increase the exclusivity to six months and persistence of breastfeeding past 12 months, the project will need to understand the psychological and environmental causes of mothers resorting to supplementary feeding, in order to break the downward cycle of more supplementary feeding leading to less breastmilk production.

7.7 Access to psychosocial services

Levels of stress and trauma are high in the study's Lebanese and Syrian refugee samples, with 70% of Lebanese and 75% of Syrian refugee women feeling stressed, sad or pressured, or knowing someone who is.

High levels of trauma are common among people fleeing a war zone. Studies of war-affected communities in Iraq has shown that post-traumatic stress disorder (PTSD) can be as high as 60% among parents, and 87% for children (Al-Ghzawi et al, 2014). A very recent study of Syrian refugee children and adolescents found that 45.6% had developed PTSD with excessive risk of contributing to other illness and with emotional/behavioural dysfunction, especially among older refugee children/adolescents. It also found that rates of PTSD were higher in Syrian refugee children and adolescents in Lebanon than in Jordan (Khamis, 2019).

Medair's EU-MADAD-funded project seeks to mobilise 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 behaviours and psychological resilience through social relationships and fitness groups. The project is also mobilising small counselling groups for survivors of trauma related to sexual or gender-based violence (SGBV) or conflict. It will also sensitise and train faith leaders to better understand and counsel men and women about social norms that promote or reduce SGBV. Training on all such programmes will also be conducted for four CBOs in Lebanon to adopt the methods used by Medair, to extend the support through their own programmes.

Much stands in the way of Lebanese and Syrian residents of the Bekaa Valley accessing trained service providers for mental health support. Around eight in ten Lebanese and Syrian women were not aware of any psycho-social services in their community. Sixty percent of Lebanese and 67% of Syrian women suggested they would either not be able or not be comfortable to access such services, mainly due to not wanting to discuss their problems, and secondly due to a perceived prohibitive cost for such services. Only 4% of Lebanese and 1.6% of Syrian women surveyed actually accessed any psychosocial support from a trained service provider. The majority (over 70%) chose to deal with it on their own, and around one out of four also consulted a friend or relative.

Clinical services are, thus, perceived as either not safe, or not affordable avenues for dealing with psychosocial difficulties. It may be necessary to look to community-based or informal approaches for creating perceived safe spaces for women and children to process their psychosocial difficulties.

A high prevalence of trauma exists among Syrian refugee children. Given the potential for lifelong negative impacts on the individuals and society (Misiak, 2019) Medair and other health actors working with Syrian refugees should consider an explicit focus on helping children and adolescents process trauma and build personal and collective resilience.

While not discounting that vulnerable Lebanese people experience psychosocial pressures, the experience of war and displacement from home and country means that mental health vulnerabilities are higher for Syrian refugees, and therefore, should remain the focus for any future PSS activities.

8. Conclusion

The findings point to the reality that the health risks and the societal constraints for which the Medair projects were designed still exist and continue to require ongoing programmes to reduce those vulnerabilities. Large gaps still exist in access to general health care, and reproductive health care. Non-communicable diseases are still a major source of adult morbidity, and most likely mortality. High-risk preventable illnesses like respiratory infections and diarrhoeal diseases are being under-reported to health care providers and they often provide inappropriate treatment. Children's health is at risk due to low coverage of vaccination, low rates of exclusive breastfeeding and early weaning off breast milk.

The findings in relation to household demographics and psychosocial/mental health also justify the original design of the Medair projects which focus on health care at primary health care level (dispensaries), and outreach to women's homes and wider community outreach events.

The findings provide a robust snapshot of health factors in communities of vulnerable Lebanese and Syrian refugee families across the Bekaa Valley.

9. Recommendations

1. **Ensure any health advice materials rely heavily on pictorial and verbal media**, and any accompanying written information is basic and brief. This will help ensure non-literate women benefit. Some research into mobile phone access by Syrian and Lebanese women may assist to consider multimedia advice that may be shared phone to phone.
2. **Prioritise house-to-house outreach and very local social gatherings that require no transportation to access.** Such learning events provide women and men the means for learning while building relationship networks for psychological resilience. Building in facilitated discussion plus unstructured time will help conversations to deepen intimacy between attendees. The consultant has found, in other contexts, that learning events motivate higher attendance when the activities are highly interactive (rather than didactic) and involve food.
3. For NCDs, to optimise survival rates in the short-term, **focus the project priorities on facilitating access to medication to manage hypertension and diabetes**, and secondly on behaviour change. Effective behaviour change should focus on intensively focussing on a small number of priority changes, rather than trying to educate people on all risk factors. Behaviour change should also seek to influence people by understanding the societal environmental factors that perpetuate negative behaviours, and how to convert those to new environmental enablers (Svanemyr et al, 2015, Parker W, 2007). This also requires designing multiple forms of frequent contacts with the message from diverse sources, and not just one or two communication approaches at infrequent intervals.
4. **Review and revise dispensary staff training to emphasise correct medication for sick children.** Reduce the under-prescription of antibiotics for ARI, and over-prescription of antibiotics and under-prescription of zinc with ORS for diarrhoeal diseases.
5. **Provide vouchers for pregnant Syrian refugee women to cover hospital fees to stay in hospital for more than 24 hours after delivery.** This is to reduce the rate of 82% of Syrian new mothers leaving hospital on the same day as delivery.
6. If it is possible for SDCs to have notification of births from hospitals, **SDC/dispensaries should lead the provision of the first home-based PNC visits** in the first and third days out of hospital.
7. In coordination with recommendation #2, **reorient CHVs' mobilisation of women around organising mothers of newborns into small groups in each neighbourhood.** i.e. each month, bring together mothers in each settlement who have given birth within the same month, as small solidarity clubs. These can become the central mobilisation conduit for all health promotion to women. However, a key emphasis for SDC-based facilitators will be to enable the women to learn about the challenges of breastfeeding and encourage one another to persevere instead of giving in to supplementary feeding in the first months.
8. **Extend the psychosocial resilience strategy to include vulnerable youth.** This may be commenced by mapping what social and skills development opportunities already exist for Syrian and Lebanese youth and determine whether the health project can support such providers to build health awareness and especially psychological resilience competencies for such youth. Collaborate with MOSA and the wider Syria response agencies to identify the sufficiency of diversionary activities currently in place to engage at-risk youth. Establish whether the health project can support such providers to build health awareness and especially psychological resilience competencies for such youth.
9. **Investigate causal barriers to women's ability to exclusively breastfeed their child and continue breastfeeding for at least 12 months.**

10. Appendices

Appendix A: KPC Report Terms of Reference



KPC 2018
consultancy ToR.pdf

Appendix B: Survey Tool

KPC survey questions:

Question: English	Question: Arabic
Today'd date	اليوم
Deviceid	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. Their 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 Medair) بشتغل مع مدير (X)مرحبا أنا) إنسانية. 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 بالمرأة الحامل. بتستغرق المشاركة بالدراسة لإستبيان حوالي ال40 دقيقة، ورح نحافظ على سرية المعلومات اللي بتقدميها ورح نحللها من دون ربطها باسمك. المشاركة بالدراسة لإستبيان اختياري وبتقدري تختاري تشاركي أو ما تشاركي. وإذا فررت تشاركي، بتقدري تختاري عدم الإجابة عن أي من الأسئلة. ما رح يكون في أي نتائج إيجابية أو سلبية من المشاركة أو عدم المشاركة بالدراسة لإستبيان، وما رح يكون في أي افادة مباشرة من المشاركة. رح نستعمل الأجوبة بهدف تحسين الخدمات الصحية اللي بتقدمها مدير (Medair). بتحي تسألني أي سؤال لتستوضحي عن (Medair) الدراسة لإستبيان؟ إذا ما كان عندك أي سؤال، هل بتحي تشاركي بالدراسة لإستبيان؟
KPC Survey Form	أسئلة تحضيرية للإستبيان

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 عمره تحت الخمس سنين عايش معك؟
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
How many individuals are living with you in the household?	كم شخص يعيش معك بالبيت بما فيهم انت؟
How many rooms does your house have, including a kitchen?	من كم غرفة مؤلف البيت بما فيهم المطبخ؟
Health-Seeking Behavior	استخدام الخدمات الصحية
In the last year, have you or your child/children needed medical services?	خلال آخر سنة، احتجت شي أنت أو طفلك/ أطفالك إلى خدمات صحية؟
Did you get the medical services when you needed them?	تلقيت الخدمات الصحية لما كنت بحاجة الي ؟
Why didn't you get when you needed the medical services?(except the birthing)	ليش ما قدرتي تاخدي الخدمات الصحية لما احتجتني الي (باستثناء الولادة)؟
What was the expensive service you needed?	شو كانت الخدمة الصحية المكلفة؟
How much expensive was the survices(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 سمعتني
Which health facility did you go to?	وين رحتي لتاخدي الخدمات الصحية؟
Which dipensary did u visit?	أي مستوصف زرتي؟
Where did you visit the doctor?	وين زرتي الدكتور؟
Which dipensary did u 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 مبيدبر السنة الماضية؟ (المرج، جب جنين، قب الياس، طاليا، بيريتيل، رفيد، كفر زيد)

why didn't you visit one of these SDC?	لماذا لم تزوري أحد هذه المستوصفات المدعومة من ميدير 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	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 الإصابة 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 التنفس 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 اللي بتتعلق بالمرأة الحامل خلال الحمل أو من بعد ما تولد وكمان بتتعلق بمعالجة الالتهابات النسائية... شو هي أنواع الخدمات للصحة الإنجابية الموجودة في مجتمعك؟
Where can you access reproductive health services in your community?	وين فيكي تحصلي على خدمات الصحة الإنجابية بمجتمعك؟
For any type of reproductive healthcare needs, would you feel comfortable accessing one of these services?	إذا احتجتني 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	إذا كنت بحاجة لخدمات الصحة الإنجابية لأي سبب من الأسباب، بتحسي أنك بتقدرني تحصلي على واحدة من هيدي

services?	الخدمات؟
Why would you not feel comfortable or be able to accessing one of these services?	لي ما بتحسي بالراحة أو مش قادرة انك تحصلي 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 لتحصلي على أيّ من الخدمات المتعلقة بالصحة الإنجابية؟
Which services did you access?	شو هي الخدمات لحصلي عليها؟
Where did you access those services?	وين حصلي 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 حصلي 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 حصلي 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 حصلي على شهادة الولادة؟
did you registered your child in the syrian or lebanese embassy ?	هل سجلت طفلي بالسفارة السورية او بسوريا
how will you register your child ?	كيف رح تقومي بتسجيل الطفل؟
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 شفني 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 dispensary did u 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	خلال حملك بطفلك الأصغر في أي شهر من الحمل كنت عندما

received antenatal care?	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 ولدت 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 او 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 تلقيت 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 تلقيتني 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 u visit?	أي مستوصف زرتني؟
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	متي 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 الاصغر من صدرك؟
For how many months, did you breastfeed your child?	كم شهر ارضعتي طفلكي الاصغر؟
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 use to give him bottle at night or during the day?لما كان طفلك كان لما؟	لما كان طفلك بعمر 0 إلى 6 أشهر عطيتي قنينة ليلاً أم نهاراً؟
when your baby was 0 to 6 months did you use to give him 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 use to give him 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؟
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؟
Vaccinations¹	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 اولى (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 اولى (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)	صغيرة (ب) جرعة 0 عند الولادة
PCV13 first dose 4 months	الاولى الجرعة الرئوية المكورات لقاح (اشهر 4 ال عمر)
PCV 13 2 nd dose 6 months	الثانية الجرعة الرئوية المكورات لقاح (اشهر 6 ال عمر)
PCV13 3 rd 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 nd 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	
Family Planning/Child Spacing	تنظيم الاسرة والمباعدة بين الولادات
For you what is the best convenient time to get pregnant again after delivery?	بالنسبة لك، بعد ادي 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 شى 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 dipensary did u 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?	بأخر 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?	بأخر 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 diabetes including yourself?	كم شخص ببيتك عندو سكري بما فيهن انت ؟
How many members in your household have high blood pressure, hypertension, including yourself?	كم شخص ببيتك عندو ارتفاع بضغط الدم بما فيهن 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 duabetes or hypertension?	في شي شخص ببيتك بياخد أي دواء لمرض السكري أو ارتفاع ضغط الدم؟
How are they/you able to procure the medicine?	كيف عم بتجيبيوا 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 أو الضغط النفسي؟
in the past year did you seek advices from anyone concerning psychosocial support ?	بالسنة الماضية هل استشرتي او اخذتي معلومات من حدا عن خدمات بتخص الدعم النفسي الإجتماعي
from where did you get these information ?	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 تحصلي 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 تحصلي 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 تحصلي 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 تحصلي 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 died 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 ?

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

Appendix C: Data Sources

Criteria for vulnerable Lebanese (Ministry of Social Affairs criteria for provision of free medical care)

- Caregiver or parent with no regular income (to be evaluated case by case)
- Elderly persons (Person of 60 years old or above, with specific needs)
- Women headed households, women at risk, women victim or survivor of SGBV
- Children at Risk (child engaged in child labor, child at risk of not attending school, child parent, unaccompanied child, (teenage pregnancy – if unmarried with minimal support)
- Single parent or caregiver
- Persons with disabilities – care related to this disabled person only
- Serious medical conditions (Mental illness, malnutrition, difficult pregnancy, chronic illness, critical medical condition) where this creates a significant financial burden with which the family is unable to cope (NOTE: any compensation is related to this condition only)
- Large family – breadwinner with no regular income (family with minimum 7 members or more and children still under parents' responsibility)

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