THEMATIC FACTSHEET: MATERNAL HEALTH

AKKAR GOVERNORATE, LEBANON

ASSESSMENT PERIOD: 21 AUGUST – 2 SEPTEMBER 2014

CONTEXT AND BACKGROUND

The 2014 Regional Response Plan (RRP6) estimated that nearly 25% of Syrian refugee women of child-bearing age were likely to be pregnant.[1] Named as a priority target group in the health response, pregnant and lactating women are still considered to face numerous challenges in accessing care and services.[2] **An RRP6 regional update published in July highlighted on-going challenges related to maternal health, namely, low use of antenatal services, high rates of caesarean sections, and inadequate access to normal delivery services**.[3]

There are strong reasons to believe that these challenges are more acute in informal settlements (IS). Isolated from services and oftentimes with severe shelter and water, sanitation and hygiene (WASH) needs, **refugees living in IS form the most vulnerable substrata of the refugee population in Lebanon**. Generally located on the outskirts of host communities, **IS lack utilities, have low access to services and protection, and are substandard in terms of site planning, shelter, and WASH.** Problems with accessing services may be exacerbated by a lack of protection, making support for IS a priority for the humanitarian community.[4]

This assessment sought to provide information about access to healthcare among pregnant women and recent mothers living in IS in Akkar. It builds off of two previous assessments conducted by REACH in informal settlements in Akkar. The first is REACH's on-going work to identify and map informal settlements in Akkar as an Interagency Mapping Platform (IAMP) partner. The second is an in-depth assessment of informal settlements. Since February 2014, REACH field teams have been collecting data on demographics, registration status, settlement leadership, landlords, dates of establishment, rental costs, and place of origin in each IS through geographic sweeps of the Governorate.

While providing a baseline of data about settlements, these geographic sweeps do not provide extensive details about the vulnerabilities and needs of IS. To acquire more information about the populations living in IS as well as their living conditions and needs, REACH, with the support of The Office of the United Nations High Commissioner for Refugees (UNHCR), conducted a multi-sector, community-level assessment of informal settlements based on key informant interviews with the settlements' *shawish* (community leader), site observations, and focus group discussions. Taking place in June and August 2014, and sampling from IS identified during REACH's second sweep, this assessment examined needs and vulnerabilities in WASH, shelter, livelihoods, protection, education and health with the aim of providing information that could be used in planning interventions.

The multi-sector assessment counted 26,641 refugees living in the 289 IS assessed throughout Akkar. Altogether, key informants reported the presence of 917 pregnant women and girls living in IS, 10% of whom were under 18 years of age. **Based on key informant interviews, approximately one third of pregnant women and girls did not access health services in Lebanon.**

---

[1] Regional Response Plan 6 (2013), p. 23
[2] Regional Response Plan 6 (2013), p. 46-48
[3] RRP6 Monthly Update
[4] REACH (Geneva, Forthcoming) Multi Sector Community Level Assessment of Informal Settlements

METHODOLOGY

REACH developed an assessment tool which was crosschecked with existing health data collection tools for mainstreaming and compatibility. After being presented to, and validated by, the Health Working Group in Akkar, the tool was translated into Arabic and a team of Lebanese information officers were trained in administering the questions. Due to the topic of the assessment and the nature of the questions, only female information officers conducted interviews.

For purposes of this assessment, women were divided into two groups: those that were currently in their second or third trimester of pregnancy and those that had given birth in the past six months – "recent mothers." **Together, the two population groups provide a snapshot access to health for pregnant and lactating women living in IS over the past year in Akkar.**

REACH conducted interviews in 139 IS, nearly half of the total it assessed in its multi-sector community-level assessment. Initially, information officers sought to conduct interviews using a random cluster sampling approach in which the IS where interviews were to be conducted were selected randomly. Once the IS were identified, a target number of interviews were assigned to each IS in proportion to their population and information provided by the *shawish* (community leader) about the number of pregnant women living in them from data REACH collected previously. Information officers visited IS with the goal of completing interviews with a predetermined sample of women who were also randomly selected for interviews from among the population of residents. In some cases, however, IS had relocated or population figures fell below or surpassed ones provided during the community-level IS assessment.

Data collection was conducted with a version of the tool built on the Open Data Kit (ODK) platform and deployed on Android smartphones. Data collected in the field was validated by the team leader before being uploaded to the centralised database, after which a final data quality check was conducted by a REACH database specialist. In addition to this factsheet, the collected data during key informant interviews was used to develop maps and individual IS profiles to inform the targeting of specific interventions.

Information officers sought to conduct interviews with approximately the same number of women who are currently pregnant and who recently gave birth. **In total, 326 women were interviewed** at a 95% confidence interval and 5% margin of error:

- Pregnant women: n = 163
- "Recent mothers:" n = 168

Five women were both recent mothers and currently pregnant. These women answered questions related to health access during their current pregnancy as well as their experiences as recent mothers. For these women, answers to core questions about demographics, registration, women's health and access to health services were only counted once.

Upon completion of the interviews, information officers handed out informational materials to the women interviewed on health resources available in Akkar and Lebanon that could be shared with others.

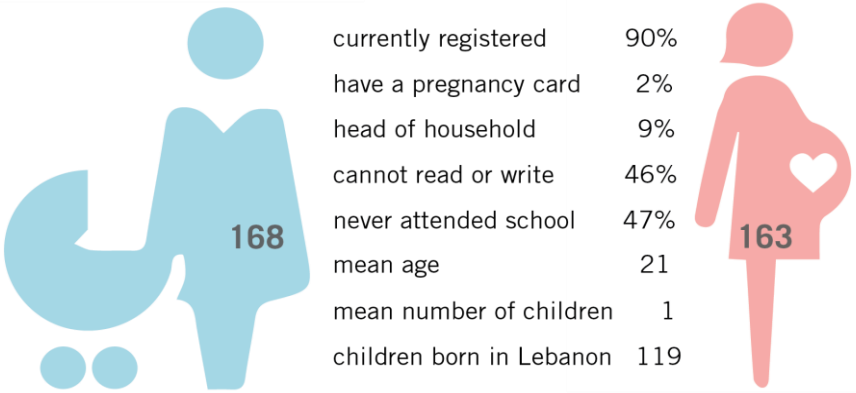
While efforts were made to ensure that information was collected in environments that were conducive to privacy, many IS, particularly in sites that were crowded, complete privacy was not always possible. A desire to provide socially acceptable answers or reluctance to answer questions about personal matters may have also caused some respondents to provide incomplete or less than accurate answers. While the women interviewed were instructed that their answers would not be tied to the provision of aid, some may have felt compelled to provide motivated answers.

Clashes between the Lebanese Armed Forces and militant groups in Arsal were taking place at the same time as this assessment. This limited access to some border regions in Akkar, particularly Wadi Khaled. The impact of limited access on the overall results is likely to be minimal as IS in these areas host approximately 1% of the population relying on this shelter solution in Akkar.

KEY FINDINGS

DEMOGRAPHICS

In addition to information about health access, REACH collected basic demographic information from the women it interviewed during the course of the assessment. Of the 326 women interviewed, 31% reported having given birth to other children in Lebanon since the start of the crisis and 6% of the total population interviewed had given birth twice. **Subjects reported that birth registration was common; 116 of the 119 children born in Lebanon reportedly had their births registered.**



The average education levels of women interviewed was low, with 46% reporting not being able to read or write. Approximately the same percentage also reported having never attended school and another 38% reported having only attended primary school. Women who completed secondary school or higher were uncommon and made up only 3% of the population interviewed.

Knowledge about health care opportunities was mixed; **61% of respondents reportedly knew that UNHCR-registered refugees have subsidized access to services at selected primary health care centres and hospitals,** and 59% said that they knew the name or location of a UNHCR-subsidized facility. Asked to name the facility or the village where it was located, 89% of those who said they knew were able to provide the name or location of a UNHCR facility.

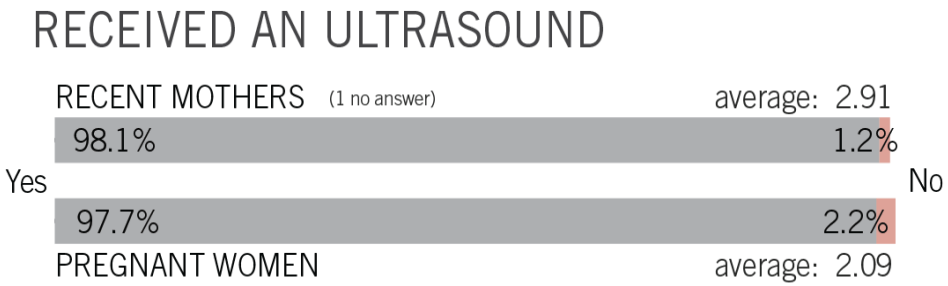
ACCESS TO ANTENATAL HEALTH CARE

This assessment found that a large majority of women were seeking and obtaining some form of antenatal care. **Among women that were currently pregnant, 81% had already sought and obtained antenatal care;** of the 19% that had not sought care, most (74%) felt it was necessary to do so. **Among recent mothers, 93% report having sought antenatal care before giving birth.** Of the 7% of recent mothers who did not obtain antenatal care (14), only two sought care but were not able to obtain it and in both cases, women cited transportation and distance as barriers.

The 12 recent mothers who did not seek antenatal care during their last pregnancy cited tradition, a lack of necessity, and expense as factors, although seven felt it was necessary to obtain antenatal care. Similarly, only one of expectant mothers who had not yet obtained antenatal care had sought it but was not able to obtain it, with the reason provided being inadequate welcoming and the behaviour of the staff at the facility she visited.

Friends and family members were by far the most common source of information for learning about health facilities, with 85% of pregnant women and recent mothers naming them as their source of information. Approximately one eighth of interviewees (11% for pregnant women and 13% of recent mothers) named UNHCR informational materials as their means of identifying antenatal care facilities. In very few cases, interviewees listed community leaders, UNHCR outreach workers, and doctor referrals as how they learned about where to go.

All women, both pregnant and recent mothers, preferred private clinics to ones subsidized by UNHCR when seeking antenatal care. Among recent mothers, 48% reported having visited private clinics for antenatal care, while 38% visited ones subsidized by UNHCR. Pregnant women also reported seeking antenatal care in private clinics rather than in UNHCR-subsidized ones, but by a slightly narrower margin. Many pregnant women also reported utilizing other clinics, including clinics run by other humanitarian partners. Midwives, hospitals, and mobile clinics were also cited as less commonly used sources of antenatal care. Reasons why women prefer (or are advised to go) to some settings for medical care but not others may be a subject that requires additional analysis.



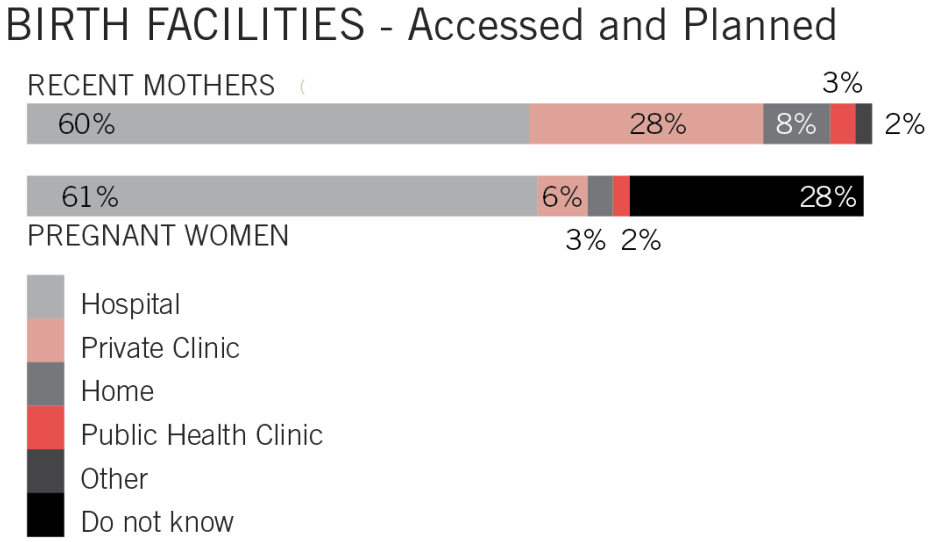
Ultrasound coverage was widespread amongst all women, with 98% of recent mothers who sought antenatal care reporting that they received an ultrasound during their last pregnancy. The same proportion of pregnant women indicated having received an ultrasound (98%). On average, recent mothers reported receiving nearly three ultrasounds during their last pregnancy and pregnant women reported having received two to date on average.

In spite of the fact that women in IS report receiving basic antenatal care, REACH found that **many women were hesitant to go to a doctor if they faced complications during their pregnancy**.

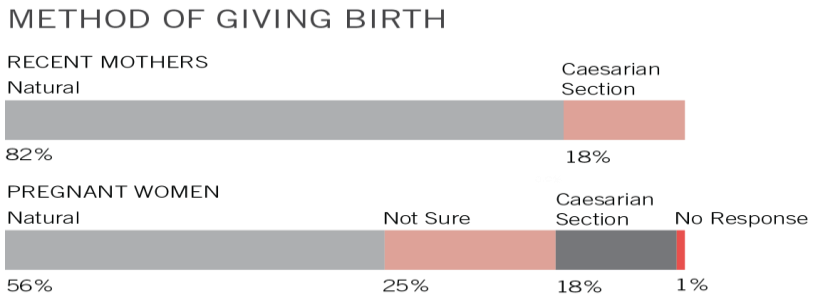
Asked what they would do if they faced complications, women often provided multiple responses, but **a significant portion gave responses that did not entail seeking medical attention.** Approximately 61% of pregnant women said they would visit a clinic or hospital, and nearly half said it was the only action they would take. Consulting other mothers or community members was another common course of action and was cited by 21% and 11%, each, respectively. Approximately 16% said they would take natural remedies if they faced complications, with 10% of respondents naming it as their sole course of action.

Access to Birth Facilities

While 28% of recent mothers gave birth in private clinics, only 6% of pregnant women said that they planned to give birth in one. **With 28% of pregnant women unsure about where they would give birth, private clinics likely absorb a significant proportion of pregnant women who are not sure about where to deliver.**



While hospitals and private clinics accounted for nearly 88% of births, it is worth highlighting several other trends, particularly among women giving birth at home. **While only 3% of women who were currently pregnant expected to give birth at home, 8% of recent mothers reported doing so**.



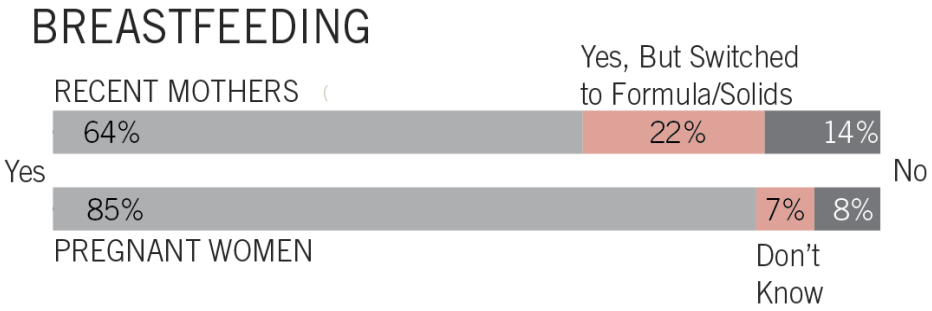
Previous assessments have found rates of Syrian refugee women undergoing caesarean sections to be disproportionately high, but this assessment found rates that were much lower (18%). Country-level data collected by UNHCR, for example, indicated that 30% of Syrian refugee women who had given birth in Lebanon had undergone caesarean sections. While still above the 15% threshold recommended by the World Health Organisation, [5] the lower rates found by REACH suggest that what has been identified as a problem nationally may be less acute in Akkar.[6] Reproductive health indicators from Syria compiled by the World Health Organization (WHO) in 2008 (figures cited were from 2001) showed that the rate of caesarean sections to be 15% of all deliveries.[7]

Breastfeeding

Marked by concentrated poverty and poor access to markets and food supplies, feeding practices among recent mothers living in IS are an area of particular concern. Data collection on recent feeding indicators shows poor infant feeding practices across the Syrian refugee population.[8]

[5] Multi Sector Needs Assessment Health Chapter (Beirut, 2014), p.30
[6] Ibid.
[7] Syrian Arab Republic: Reproductive Health Profile, 2008
[8] RRP6, Monthly Update, June 2014.

This assessment found that a majority of women reported breastfeeding or expressed plans to do so; however, a significant proportion of recent mothers also reported relying on other feeding practices. Among pregnant women, 85% reported that they planned to breastfeed; only 8% reported planning not to and 7% were uncertain about their plans.



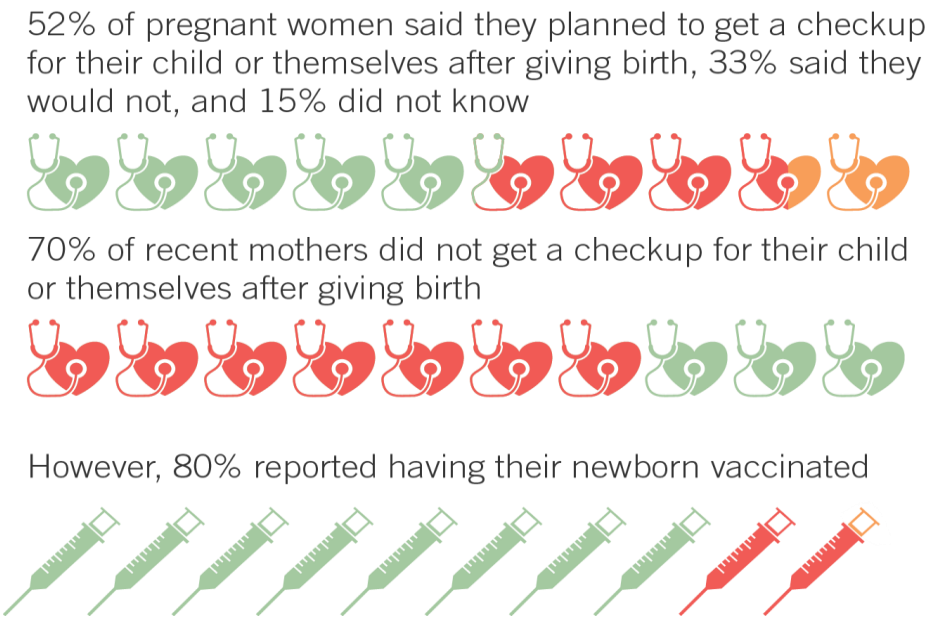
Among recent mothers, 64% reported breastfeeding *only* and 22% of recent mothers reported breastfeeding but also relying on formula or solid foods. Approximately 14% of recent mothers reported that they did not breastfeed and 2% said that they had breastfed but stopped. Women who did not breastfeed or stopped breastfeeding cited a lack of breast milk, and in several cases, inconvenience or medical conditions as barriers.

Difficulties sustaining breastfeeding may be linked to poor nutrition. In the 30 days before the interview, **61% of women reported that they experienced a lack of food or money to buy enough food to meet the needs of house hold members; 37% reported having to rely on the use of coping strategies**, including borrowing food, relying on less preferred food, and restricting adult consumption.

Postnatal Care

While women living in IS indicate a number of positive practices with regard to seeking antenatal care, attitudes towards seeking postnatal care are less encouraging. **Only 30% of recent mothers reported having gone to a doctor for a check-up since giving birth.** Approximately 23% of women reported getting a check-up for their new-

born, 6% reported going for them and the new-born, and 1% reported seeking care for them only. About 20% of women who went for a check-up sought care for both the new-born and themselves, and only 4% for a check-up for themselves.

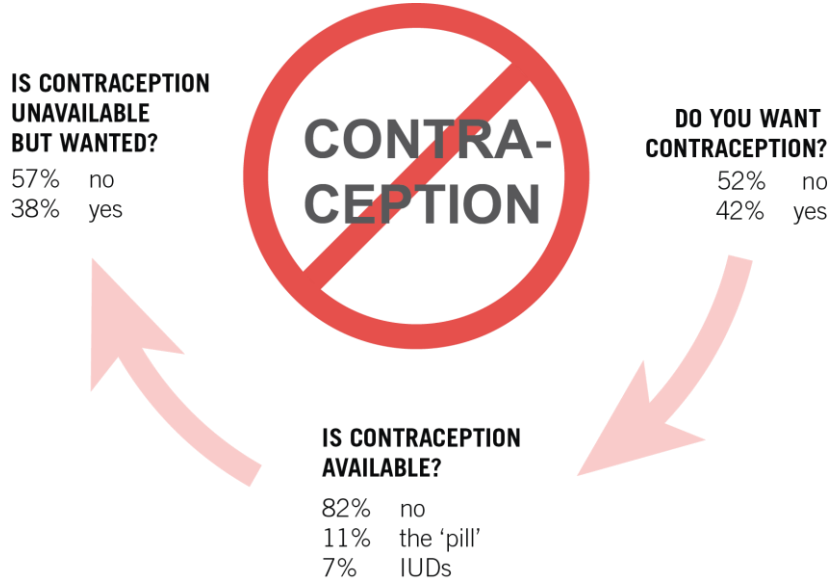


There was a difference of 23 percentage points between pregnant women who planned to get a postnatal check-up and recent mothers who actually did, indicating that low levels of postnatal care may be due in part to attitudes (women may feel it is not necessary) as well as other factors related to access.

Among pregnant women, only 53% said that they planned to have a check-up after they gave birth, 15% were not sure, and 33% said that they would not. In instances where women said that they would get a check-up, 70% said that they would for both themselves and their new-born, while 10% would go only for themselves and 20% reported that they would only go for their new-born.

Despite low levels of postnatal care, a majority of recent mothers report having gotten their new-borns vaccinated – 80% overall. This assessment did not collect data on which types of vaccines new-borns have received, however.

Access to Reproductive Health Services



REACH found that women living in IS generally lack access to contraception. **In this assessment, only 18% of women interviewed indicated that they *had access* to contraception, with "the pill" (11%) and intrauterine devices (7%) being the most common.** 42% of women overall indicated that they wanted contraception or forms other than the ones they currently have. Notably, 38% of women expressed interest in contraception if they did not have it already. Attitudes towards contraception differed widely by age. Interest was highest among women over 30 (57% wanted contraction) and lowest among women 18-29 (35%).

CONCLUSION

With large majorities of women reporting that they receive some form of antenatal care, efforts to improve women's and children's health may be directed towards ensuring that a similar proportion of women receive check-ups after giving birth. Improving postnatal care, including supporting breastfeeding, vaccinations, and proper nutrition, may also be an important component of this effort.

Improving access to contraception should be made in tandem with efforts to improve attitudes towards using it as well as a greater awareness of family planning. However, the fact that nearly half of women living in IS cannot read or write and receive information via friends and family members may pose additional challenges and opportunities for public health and outreach workers.

Additional research may be needed to understand preferences among women for some healthcare settings over others. Understanding why some refugees may prefer private facilities, which may charge higher fees, over subsidized ones, may help humanitarian actors improve their coverage and enhance their ability to monitor public health issues.

As part of a follow up to this thematic fact sheet, REACH will conduct focus group discussions aimed at contextualizing data collected during key informant interviews. Focus group discussions will provide additional information regarding factors informing refugees' choices of health care facilities, barriers to accessing care and proper nutrition, and attitudes towards post natal care and contraception.