Health Access and Utilization Survey (HAUS) among refugees in Lebanon - 2024

HAUS 2024

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Table of Contents

Introduction

Lebanon remains the country hosting the largest number of refugees per capita, with the Government's estimation of 1.5 million Syrian refugees and 12,184 refugees of other nationalities.[1] These populations live across all governorates in Lebanon in urban locations, collective shelters, and informal tented settlements. UNHCR is aiding refugees through a variety of programs covering basic assistance, protection, shelter, WASH, education and health. As the crisis prolonged, UNHCR expanded its efforts to include more sustainable support to help refugees become more self-reliant. Over the years, UNHCR has also increased its emphasis on protection services, including legal assistance and protection from gender-based violence, recognizing the heightened vulnerabilities of refugees living in protracted displacement. UNHCR has also strengthened its coordination with local authorities and other humanitarian organizations to maximize the impact of its interventions and address the complex and evolving needs of the refugees in Lebanon.

Over the years, since the influx of displaced populations from Syria to Lebanon, and under the Lebanese Response Plan, UNHCR played a crucial role in ensuring the effective provision of both primary and secondary health care services, especially in resource-limited or underserved regions. In primary health care, UNHCR enhances access of refugees, asylum seekers, and vulnerable host communities to essential services such as immunization, reproductive health, specialized mental health, and care for acute and chronic diseases, which are critical to improving overall health outcomes and preventing widespread illness. With operational partners, a total of 157 primary health care facilities[2] provide subsidized health care services.

In secondary health care, as the primary agency covering hospital care for refugees, UNHCR ensures its commitment to facilitating their access to hospitalization for life and limb saving conditions including deliveries in UNHCR contracted hospitals through a cost sharing scheme. UNHCR secondary health care standard operational procedures witnessed several amendments in the recent years adjusting UNHCR coverage and conditions supported to the funding cuts. UNHCR hospitalization support is executed through a Third-Party Administrator (TPA) that verifies eligibility of cases, audits bills and effectuates the transfer of money to the health care providers.

[1] https://reporting.unhcr.org/operational/operations/lebanon

[2] In this report primary health care facilities refers to MOPH Primary Health Care Centers (PHCCs), dispensaries, Social Development Centers (SDCs) and UNRWA clinics.

For a more comprehensive community-based approach, UNHCR continuously works on enhancing community capacity through promoting health education, disease prevention, and knowledge about available services with the aim to reduce barriers and enhance access to health services.

With the multifaceted and continuous crises in Lebanon, UNHCR plays a pivotal role in supporting the health care system and the people it serves through emergency preparedness and response. This includes responding to public health emergencies like disease outbreaks (COVID-19 and cholera) and enhancing the capacity of health system during many emergencies including Beirut Port explosion (2020), Lebanon-Israel armed conflict (2023-2024), ensuring that affected populations receive timely medical care and resources, and health care systems have adequate capacity to respond to the health needs of vulnerable populations. Starting end of 2023, the armed conflict which has escalated in September 2024, majorly impacted access to health care services due to moving restrictions for patients and staff, partial or complete damage of health facilities (both primary health care facilities and hospitals), and displacement of people in high-risk areas among others. UNHCR as part of its commitment to enhance access to care, expanded its hospital network in hard-to-reach and high-risk areas from 33 to 44 hospitals to provide critical care to war-injured refugees, covering 100 % of war injured patient bill. UNHCR also increased the capacity of partners working on primary health care (PHC) and mental health projects to meet the urgent needs of internally displaced populations and returnees, including deploying primary satellite units to shelters. Additionally, UNHCR donated 60 trauma kits for effective treatment and initiated procurement of 10 medical ambulances to support the health system in patient transportation to the hospitals particularly to those with specialized trauma care services.

UNHCR Lebanon has conducted annual Health Access and Utilization Survey (HAUS) since 2014 in order to collect reliable routine data on health service needs and access of refugees residing in both urban and non-urban settings. Similar to previous years, HAUS is held through telephone interviews; results are utilized to guide the health response for refugees in PHCs and also hospitalization services based on the refugees' needs and available access to the various health services in country.

Objective

- To monitor refugee access to and utilization of available health care services and provide an analysis in trends over the years.

Methods

- The survey population was households that are registered with UNHCR and where the head of the household has a valid contactable telephone number.

- The sample size was calculated by the 'HAUS sample size calculator' which follows the principles of the 'WHO STEPS' sample size calculator to obtain a representative sample for the indicators of interest[3].

- The survey was conducted through telephone interviews during the period 02nd to 20th September 2024 by the trained interviewers from the national call center operators' team under the supervision of UNHCR staff.

- Comprehensive training was provided to all callers engaged in the current survey to ensure similar level of skills across the data collectors. On-the-job coaching was also held by the technical focal point to ensure that operators were well acquainted and capacitated to conduct the survey. The focal person was always available to receive any queries from the operators.

- Survey households were selected using random sampling from the UNHCR database in Lebanon as of July 2024, with a valid telephone number in the database.

- Sample was determined based on a desired confidence level of 95% for key indicators, design effect of 1, and accounted for a non-response rate of 50% (i.e. number of responders double as many as non-respondents)

- Participation was fully voluntary, and everyone was assured confidentiality. Everyone was informed that their decision to participate in the survey would not have any consequences regarding UNHCR support and assistance to the respective household.

- The head of household, or an adult (aged ≥18) who could respond on behalf of the household, was interviewed.

[3] WHO |STEPS Sample Size Calculator and Sampling Spreadsheet; https://www.google.com/url?sa=t&rct=j&q=&esrc=s&source=web&cd=&cad=rja&uact=8&ved=2ahUKEwi86ei5z-j_AhVVYKQEHbz_BF0QFnoECA4QAQ&url=https%3A%2F%2Fcdn.who.int%2Fmedia%2Fdocs%2Fdefault-source%2Fncds%2Fncd-surveillance%2Fsteps%2Fsample-size-calculator.xls%3Fsfvrsn%3Dee1f4ae8_2&usg=AOvVaw0FXBROD6VkM8r0dbV0WFdW&opi=89978449

- The specific inclusion and exclusion criteria for individuals within a selected household was as follows:

Inclusion Criteria

- Head of household
- Known to UNHCR
- Person ≥ 18 years of age who can provide response on behalf of the household.

Exclusion Criteria

- Not providing informed consent
- Under 18 years of age
- Not known to UNHCR as per the database

Data management and analysis

- Data was entered in real time on call-center desktops using the software Project X developed by UNHCR Lebanon. The software has standard data protection measures in place and the desktops are password protected and can be logged in by the respective enumerators only.
- Data was analyzed using Microsoft Excel for Microsoft 365 MSO (Version 2402 Build 16.0.17328.20346).
- Data was collected from September 2nd to 20th 2024 and analyzed in November 2024.

Key findings

Baseline characteristics of the sample

- A total of 4,171 households, of which 3,979 were Syrians and 192 non-Syrians, were imported to project X to be called by the enumerators. Out of these 2,336 households were called by the enumerators. The minimum statistically significant sample size required for the survey was 1,376 households.
- 1,448 (62%) households were interviewed, among them 1,373 HH were Syrians and 75 HH were non-Syrians. The non-response rate was 38% with the most common reason being either that no-one responded to the call when called up to three times or that the number was not functioning.

- Participating households had a total of 6,910 members, which means that surveyed households had an average number of family member is 4.7
- 50.1% of surveyed household members were female and 14.3% were less than 5 years old.
- The distribution of the respondents per region was: 23% in the North, 31.5% in the Bekaa, 32.9% in the Beirut and Mount Lebanon region and 12.6% in the South. The corresponding figures in the year 2023 were 23.2% in the North, 36.8 % in the Bekaa, 27.9% in the Beirut and Mount Lebanon region and 12.1% in the South.

Knowledge about available services and health care expenditure

- 1,418 households answered questions about knowledge on available assistance.
- 69.9% of interviewed households knew that refugees should pay contributions in Lebanese Pounds at primary health care facilities. The knowledge about this was 72.1% in 2023 and 67% 2022.
- 87.3% of households knew that UNHCR supported life-saving hospital care and care for deliveries. The corresponding figure from 2023 was 89.4% and 82% in 2022.
- 70.3% knew that vaccination for children <12 years is free at primary health care facilities. Corresponding figure in 2023 was 77.6% and 71% for 2022.
- 32.8% of respondents were aware of services for survivors of domestic abuse or sexual violence. This figure in 2023 was 29% and 27% in 2022.
- 40.6% of respondents knew that medicines for acute conditions could be obtained for free at primary health care facilities. This figure in 2023 was 40.1% and 37% in 2022.
- 69.6% of households reported spending money on health care the previous calendar month. The figure from 2023 was 63% and 73 in 2022%.
- The households who had spent money on health care the previous month spent on average LBP 4,070,236 (Median: 1,500,000 Interval: 90 – 360,000,000) The averages from 2023, 2022, 2021, 2020 and 2019 were LBP 14,400,000, LBP 3,261,741, LBP 1,119,800, LBP 269,103, and LBP 196,500 respectively.

Sexual and reproductive health

Antenatal care services

- 422 women reported having been pregnant during the 2 years preceding the survey. 73.9% (312) delivered during the same period.
- 81.3% (343) of the women having been pregnant during the 2 years had received antenatal care (ANC) services. .
- Out of the 343 women who had delivered and attended ANC, 69.1% went for 4 visits or more a similar figure in 2023.
- In 2024, the most common reasons for not accessing ANC services were inability to afford clinic fees (52.2%) and not thinking it was necessary (31.9%). By comparison, in 2023 and 2022, the primary reason was not thinking it was necessary (59.4% in 2023; 29.3% in 2022), followed by inability to pay clinic fees (18.8% in 2023; 27.6% in 2022). Other reasons varied slightly across the years, including affordability of transport, service availability, and staff preferences, but these were less significant overall.
- 343 women answered the question about where they had received ANC care. 197 (57.7%) had gone to primary health care facility and 126 (36.7%) had gone to a private clinic. This is a slight change from 2023 in which 58.1% went to a primary health care facility and 39.0% went to a private clinic.
- 33.8% of women had received ANC at more than one facility. The corresponding figure from 2023 was 26.7% and 23% from 2022.
- 78.6% (268) reported having paid for ANC visit and 17.9% (61) got ANC for free. In 2023, 73.7% reported having paid for ANC visits while 24% got ANC for free.
- Median cost for an ANC-visit at a primary health care facility for those who paid and could recall the amount was LBP 200,000 corresponding figure in 2023 was LBP 250,000.

Delivery services

- 310 out of 312 women who delivered answered the question about where they had delivered. 90% (279) had delivered in a hospital (90.7% in 2023 & 88% in 2022), 7.7% (24) had delivered in a medical facility other than hospitals (8.2% in 2023 and 8% in 2022), 0.6% (2) had delivered from home (0.74% in 2023 and 3% in 2022). For the two women who delivered at home, difficulties with transportation and labor starting at night were cited reasons.

- 73.4% (229) of the women who had delivered reported having received financial assistance from UNHCR for their delivery (78.7% in 2023 and 76% in 2022). 11.5% (36) did not pay anything for their delivery (21.6% in 2023 and 15% in 2022), it could be due to the support of other actors covering deliveries during the period.

  The proportion of women who reported delivering via caesarean section was 35.6%. It was 31.5% in 2023 and 37% in 2022.
- 199 (64.4%) respondents reported to have had a normal vaginal delivery (NVD). The median cost reported was LBP 1,800,000. The corresponding figure from the year 2023 was LBP 2,789,795, year 2022 was LBP 400,000, year 2021 was LBP 260,000, and the year 2020 was LBP 300,000.
- Of the 101 respondents reported to have had a C-section and recalled the cost in LBP, the median cost was LBP 2,450,000. (LBP 5,251,250 in 2023). The corresponding figure from 2022 was LBP 1,000,000, 2021 was LBP 400,000, 2020 was LBP 425,000 and the year 2019 was LBP 375,000.

Post-natal care services

- 36.1% (112) of the of the 310 women who had delivered and answered the question had sought post-natal care (PNC) services. The corresponding figure in 2023 was 38.4% and in 2022 was 32%.
- Of the ones not seeking PNC, 67% thought that the services were not necessary (69.8% in 2023 and 75% in 2022), and 23.7% could not afford the clinic fees (17.4% in 2013 and 12% in 2022).

Family planning

- 1,169 (84.5%) households were willing to answer questions about family planning. It was 89.6% of all households in 2023 and 76.5% in 2022.
- Of these, 56.7% (668) reported using some method of family planning (61.9% in 2023 and 53% in 2022).
- 38.3% of respondents used traditional methods (withdrawal, calendar, etc.) 26.1% used contraceptive pills, 23.3% used IUDs and 10.5% used condoms. In 2023, 32.6% of respondents used traditional methods (41.8% in 2022), 26.1% used contraceptive pills (20.6% in 2022), 25.7% used IUDs (25.9% in 2022) and 10.8% used condoms (5.9% in 2022).

- The most common reasons for not using family planning included planning for pregnancy (34.6%), spouse being away/divorced or dead (21.5%), one of the spouses being incapable of childbearing due to age (9%) and one of the spouses being incapable of childbearing due to health reasons/sterility (21.7%). The same top four reasons were reported in 2023.

Childhood vaccinations

- Questions about vaccinations were asked to households for 941 children < 5 years old. 84.8% (798) had received a vaccination booklet. Corresponding figures were 88.4% 2023 and 89% in 2022.
- 77.2% of children had received oral polio vaccination, and 79.8% had received injectable vaccines. The corresponding figures from the year 2023 were 78.9% and 81.8%, year 2022 were 76% and 89%, year 2021 were 72% and 86% and for the year 2020 were 83% and 87%. The corresponding figures from the year 2019 were 81% and 84% respectively.
- 84% of the children who had received injectable vaccines in Lebanon got at least one of their vaccinations in a primary health care facility, 7.1% in a UNHCR reception center and 2.7% in a mobile clinic. Corresponding figures from 2023 were 91.4% (PHC), 4.8% UNHCR reception center and 3.6% in a mobile clinic.
- 24.5% (182) of refugees that had received injectable vaccines in Lebanon had to pay for the vaccination (23.2% in 2023).
- Refugees paid a median cost of LBP 200,000 for vaccination services (for those who reported paying). The Corresponding figure in 2023 was LBP 50,000 and in 2022 was LBP 82,500. This fluctuation is due to the changes in the exchange rate[4].
- Reasons given by the 111 respondents whose children had not been vaccinated were 25.2% did not think it was necessary (20.0% in 2023 and 14% in 2022), 16.2% couldn't afford transportation (6.7% in 2023 and 7% in 2022), 14.4% child ill at time of vaccination (24.4% in 2023 and 17% in 2022), 15.3% could not afford clinic fees (17.8% in 2023 and 15% in 2022) and 4.5% didn't know where to go (6.7% in 2023 and 2% in 2022).

Chronic conditions

- 40.3% (582) of 1,446 households responding to the question reported at least one member with a chronic condition (42.3% in 2023 and 49.8% in 2022).

[4] https://treasury.un.org/operationalrates/OperationalRates.php

- 12% (827 of the 6,907) household members reported to have a chronic medical condition (12.8% in 2023 and 21% in 2022). This constitutes a slight decreased trend in 2024 but may be an effect of how respondents define a chronic condition. Despite using the same phrasing in the questionnaire this figure has fluctuated significantly over the years in a way that cannot be a result of changing prevalence of chronic disorders. Looking at prevalence of the most common disorders (hypertension, asthma, and diabetes), the prevalence remains quite stable. What fluctuates is the size of the large group of "other" disorders (see below).
- Most common conditions among those reporting one or more chronic conditions were: 16.7% asthma/pulmonary disease (15.6% in 2023 and 16% in 2022), 11.8% hypertension (21.5% in 2023 and 17% in 2022), 14.3% diabetes (13.6% in 2023 and 12% in 2022), 6% heart disease (10.1% in 2023 and 11% in 2022), 4.1% physical disability – such as cerebral palsy or paralysis after stroke (5.3% in 2023 and 4% in 2022), 3.6% thyroid disorders (6.0% in 2023 and 5% in 2022) and 3.2% kidney disease (4.3% in 2023 and 3% in 2022).
- 54.77% (453) of the 827 individuals that had reported having a chronic condition and had responded to the question had accessed medical care and/or medicines for their condition(s) during the last 3 months. Corresponding figures for the previous years are 59.5% in 2023, 61% in 2022, 46% in 2021.
- 452 individuals amongst the 453 individuals who had accessed medical care and/or medicine for their condition during the last 3 months could recall the facilities where they sought care. Of these 452individuals, 43.4% (196) went to a pharmacy, 40.9% (185) had gone to a primary health care facility, and 9.7% (44) to a private clinic. In 2023, 50% (200) had gone to a pharmacy, 36.8% (147) had gone to a primary health care facility and 9% (36) to a private clinic.
- 80.3% of those who sought care had to pay for the services (78.1% in 2023 and 72% in 2022). 27.3% of those who went to primary health care facilities received services for free (42.1% in 2023 and 25% in 2022).
- Of those who did have to pay, the median cost, not considering health care outlet, was LBP 500,000 while it was LBP 1,075,000 in 2023, LBP 360,000 in 2022 and LBP 122,500 in 2021[5].

[5] https://treasury.un.org/operationalrates/OperationalRates.php

- The main barrier to accessing care for chronic conditions was the inability to pay clinic fees at 61.1% (46.9% in 2023, 39% in 2022, 50% in 2021 and 50% in 2020) or medicines at 10.6% (20.1% in 2023, 24% in 2022, 33% in 2021 and 28% in 2020). Another important observation was that 11.7% (8.4% in 2023 and 10% in 2022) could not access the services as they were not provided by the health center. Furthermore, 5.7% (7.9% in 2023 and 5.3% in 2022) felt it was unnecessary.

Acute conditions

- 12% (826) of the 6,876 household members amongst the households who responded to the question reported to have had an acute condition during the month preceding the survey (14.5% in 2023, 37.6% in 2022; 13% in 2021). The most common symptoms reported were diarrhea/vomiting at 28.3% (13.1% in 2023; 6% in 2022; 11% in 2021), upper respiratory tract symptoms runny nose, sore throat at 26.9% (23.5% in 2023; 32% in 2022; 28% in 2021), cough/asthma at 9.2% (15.9% in 2023; 11% in 2022; 21% in 2021), joint and back-pain 8.9% (13.2% in 2023; 8% in 2022; 11% in 2021), fever 6.7% (12.1% in 2023; 13% in 2022; 15% in 2021), stomach pain 4.2% (7.4% in 2023; 4% in 2022; 12% in 2021), headache 1.3% (7.1% in 2023; 4% in 2022; 14% in 2021), and chest pain which was reported at 3.3%.
- Among the ones reporting being acutely ill, 21.8% (174) did not seek health care (24.3% in 2023; 24% in 2022; 33% in 2021). The reasons reported were could not afford clinic fees 78.8% (56.7% in 2023, 56% in 2022 and 68% in 2021), thinking it was not necessary 15.9% (14.4% in 2023, 2% in 2022 and 16% in 2021) and not affording transport 1.2% (18.2% in 2023; 13% in 2022; 13% in 2021).
- Out of the 621 that sought health care and answered the question, 45.7% (284) went to a pharmacy (42% in 2023, 39% in 2022), 28% (174) to a primary health care facility (36% in 2023, 39% in 2022), 17.1% (106) to a private clinic (13% in 2023 and 2022) and 7.4% (46) 8% (65) to a hospital (8% in 2023 and 6% in 2022).
- 95.2% (592) of the 621who sought care and responded to the question got health care at the first facility they went to. The corresponding figures in previous years were 89.3%in 2023, 91% in 2022 and 89% in 2021.
- Respondents who could recall the amount they had paid for care reported an overall median cost of LBP 600,000 (LBP 500,000 in 2023, LBP 900,000 in 2022; LBP 150,000 in 2021[6]

[6] https://treasury.un.org/operationalrates/OperationalRates.php

Reasons for not receiving services despite seeking them includes couldn't 42.3% afford the fees (56.7% in 2023, 56% in 2022 and 43% in 2021), 38.5% reported the center could not offer services, and 7.7% could not afford the cost of drugs.

Infant and young child feeding (IYCF) and Nutrition

These set of questions were posed to all households that had a child less than 23 months of age.

- 73.6% (184) (79.6% in 2023 and 76% in 2022) of respondents whose household had a child less than 23 months old, reported that the infant in the household has been breastfed. 40.2% (99) (41.1% in 2023 and 50% in 2022) of respondents reported that the infant in the household has been breastfed one day before the interview. 69.2% (171) (57.6% in 2023 and 70% in 2022) of respondents reported that the infant in the household ate solid/semi-solid food one day before the interview.
- Regarding initiation of breastfeeding, 26.1% (36.9% in 2023 and 23% in 2022) were initiated for breastfeeding within the first 1 hour, and 44.1% (32.0% in 2023 and 55% in 2022) after one hour. Meanwhile, 30% of the respondents don't know when breastfeeding was initiated.
- 17.7% (34) of respondents who noticed growth and feeding difficulties for their child sought care (18.8% in 2023 and 20% in 2022). However, amongst these 32.4% (n/N=11/34) were not enrolled into any nutrition programme (56.3% in 2023 and 46% in 2022), 50% were enrolled as outpatients (31.3% in 2023 and 37% in 2022) while 17.6% were enrolled as inpatients (25% in 2023 and 15% in 2022).

Third-party administrator (TPA) for UNHCR referral health care services

- 23.1% (319) of the respondents were aware of the third-party administrator that UNHCR has contracted to support in provisioning referral health care services to the refugees. (The corresponding figure was 20.9% in 2023 and 18% in 2022).
- 26% (82) of survey respondents who knew about the UNHCR TPA for referral health care program but did not know how to reach them (37.7% in 2023 and 32% in 2022).
- The methods cited by the refugees for reaching out to TPA includes, 'by telephone' 45.7% (42.2% in 2023 and 54% in 2022), 'going to TPA office in the hospital' 27.3% (18.7% in 2023 and 11% in 2022), 'going to the emergency room and the hospital will refer them to the TPA office in the hospital' 1% (1.4% in 2023 and 2% in 2022).

Health communication

- 90.6% (n=1,313); (64.0% in 2023 and 93% in 2022) of respondents preferred some form of phone communication (Phone call, Text message or WhatsApp message regarding communication relating to health.
- The most preferred mode for receiving health care is text messages / SMS at 37.9% (29.7% in 2023 and 58.6% in 2022) followed by WhatsApp communications 34.9% (15.7% in 2023 and 16% in 2022), phone call 22.5% (18.6% in 2023 and 18% in 2022), and community health volunteers 2.3% (9.4% in 2023 and 2.8% in 2022).

Limitations[7]

- Survey was limited to refugees in Lebanon known to UNHCR with a telephone number. To ensure the representative nature of the survey, the sample size has been calculated considering the non-response rate and other statistical parameters for adequate representation.
- Interviews were held with only one key informant from each household and answers are self-reported. Lack of information by the informant or poor recall of the household respondent might have affected the quality of response and led to bias.
- HAUS is conducted using phone calls and due to the nature of this modality, visual verification is not possible, if required.
- Despite training of enumerators and phrasing questions in an explanatory way, concepts such as chronic and acute illness, primary health care centers, private clinics and hospitals might not be clearly understood by the respondents which in turn will affect their answers.
- Fluctuation of the national currency, the Lebanese Pound (LBP) has posed challenges during interview as well as during analysis and interpretation. To maintain uniformity, questions about costs were asked for both in Lebanese Pounds and USD and presented accordingly.
- The HAUS was conducted between 02nd to 20th of September 2024; this coincided with the start of war escalation between Lebanon and Israel on the 17th of September 2024. This might have had an impact on the accessibility of operators to the respondents and access of operators themselves to the call center.

[7] Survey was held between 02 and 20 September 2024 which coincided with the escalation of armed conflict in Lebanon (17 September 2024)

Conclusions

These findings highlight both progress and persistent challenges in healthcare access and utilization among refugee households in Lebanon.

- The proportion of households aware of key health services has slightly declined compared to previous years. For example, 69.9% of households knew that contributions in primary health care facilities should be paid in Lebanese Pounds, compared to 72.1% in 2023. Awareness about free vaccination for children under 12 years has also decreased from 77.6% in 2023 to 70.3% in 2024.
- There has been a gradual increase in awareness of services for survivors of domestic abuse or sexual violence, rising from 27% in 2022 to 32.8% in 2024.
- The percentage of households spending on healthcare rose to 69.6%, with a significant variation in median expenditure compared to previous years. Average expenditures have fluctuated, showing the impact of inflation and economic challenges. Previous figures were 71% in 2022 and 68% in 2021.
- Access to antenatal care has a potential for enhancement. However, cost remains the most common barrier, with 52.2% mentioning it as a reason for not accessing ANC services.
- Most women (90%) delivered in hospitals, consistent with previous years. However, fewer women received financial assistance from UNHCR for delivery in 2024 (73.4%) compared to 78.7% in 2023.
- Utilization of postnatal care services remains low at 36.1%, with the primary barrier being the perception that such care is unnecessary.
- There has been a decrease in the use of family planning methods, with 56.7% of households reporting usage in 2024 compared to 61.9% in 2023. The use of traditional methods remains high at 38.3%.
- Coverage for childhood vaccinations has declined slightly, with 84.8% having vaccination booklets in 2024, down from 88.4% in 2023. From 2019 to 2024, trends in oral polio vaccination (OPV) and injectable vaccine coverage show fluctuations. OPV coverage peaked in 2020 at 83% but declined to 77.2% in 2024, with the lowest rate observed in 2021 at 72%. Injectable vaccine coverage was highest in 2022 at 89% but dropped

steadily to 79.8% in 2024, though it was consistently higher than OPV across all years. While both indicators showed improvement from the low levels in 2021, there has been a notable decline in 2024, indicating potential challenges in vaccine delivery or access. Vaccination costs have also increased, with the median cost rising from LBP 50,000 in 2023 to LBP 200,000 in 2024; this might be related to transportation costs since the cost of consultation for vaccination remained the same as defined by MoPH circular.

- The reported prevalence of chronic conditions has slightly decreased, with only 12% of household members reporting a chronic condition, down from 12.8% in 2023. However, access to care for these conditions has slightly improved, with 54.8% seeking care. Financial constraints remain the primary barrier to accessing care, with 61.1% citing the inability to pay clinic fees as a major issue, up from 46.9% in 2023.
- The prevalence of reported acute conditions has decreased to 12%, down from 14.5% in 2023. Among those with acute conditions, a significant proportion (21.8%) did not seek care due to affordability issues.
- Pharmacies remain the most visited health facilities for acute conditions (45.7%), followed by primary health care facilities (28%). However, the median cost of seeking care for acute conditions has increased from 400,000 LBP in 2023 to 500,000 LBP in 2024.
- While a majority (73.6%) of infants under 23 months were breastfed, the rate of breastfeeding on the day prior to the interview has steadily decreased over the years (50% in 2022 to 40.2% in 2024). This decline suggests challenges in sustaining breastfeeding practices, potentially due to changing socioeconomic factors or reduced awareness/support.
- Only 26.1% of infants were breastfed within the first hour of birth, marking a decline from previous years. This highlights a persistent gap in early breastfeeding practices, which is crucial for infant health, indicating the need for improved maternal education and IYCF counselling during ANC visit and hospital-based support for new mothers.
- Despite some increase in awareness of UNHCR's TPA services (23.1% in 2024, up from 18% in 2022), a significant proportion (26%) of those aware still did not know how to access these services. This underscores the need for a more robust and accessible communication strategy. UNHCR should implement targeted health awareness campaigns, enhance the clarity and visibility of information regarding access to TPA

services, and ensure that this information is disseminated through various channels to reach a wider audience.

- A vast majority (95.2%) of respondents prefer receiving health-related information through phone-based communication (calls, SMS, or WhatsApp), with text messaging being the most favored. This preference indicates a strong opportunity to enhance health communication and outreach through digital platforms tailored to refugee communities' health needs.

Discussion

- The survey findings reveal some shifts in awareness and utilization of healthcare services among refugee households. Awareness of key health services, such as payment at primary health care facilities and free vaccinations for children, has slightly declined compared to previous years. This could reflect a need for more consistent health messaging, particularly considering ongoing economic and conflict challenges that have led to displacement. It is important to note that during the year, MoPH amended the patient contribution to the health services at PHCCs through a circular shared with all PHCCs and to all partners. Some PHCCs implemented this directly however, some had delays in implementation which might have led to confusion among refugees. Conversely, there has been a gradual improvement in awareness of services for survivors of domestic abuse or sexual violence, indicating that targeted outreach efforts in this area may be yielding positive results. However, overall gaps in knowledge about health services highlight the necessity for enhanced community engagement and information dissemination and health awareness messaging from the health facilities (PHCCs) and MoPH.

- Healthcare expenditure remains a significant burden, with nearly 70% of households reporting out-of-pocket spending, and the median costs for services such as childhood vaccinations and care for acute conditions rising sharply. It is evident to flag that UNHCR coverage to Secondary Health Care Admissions was reduced from 70% to 60% in June 2024 which might have exerted financial burden on refugees to cover remaining 40%. Relatedly from the 2024 Q2 protection monitoring report, 32% of respondents reported inability to purchase essential medicine due to lack of money; those medication might be not available in the PHCCs due to the recurrent medication shortages.

- While access to antenatal care has improved significantly, cost barriers persist, affecting both antenatal and postnatal care. This disparity underscores the need for expanded financial assistance programs and targeted subsidies to ensure equitable access to maternal and child health services. Despite high rates of hospital deliveries, fewer women received financial support from UNHCR for delivery costs in 2024. This may be related to the potential preference of women not to deliver under UNHCR support given the reduced coverage %, the fact that some hospitals offer discounted delivery rates to the mothers.
- Challenges in preventive health behaviors are also evident, with declines in breastfeeding practices, family planning utilization, and vaccination coverage. The reduction in breastfeeding initiation within the first hour of birth underscores the need for stronger advocacy and support for early breastfeeding. This might be linked to the individual behavior and perception or the organization (hospital) practices in relation to breast milk substitutes (formula milk). Additionally, the decline in the use of family planning methods, coupled with the persistent reliance on traditional methods, suggests potential barriers in accessing modern contraceptive options. These findings highlight the importance of reinforcing health education and providing accessible, cost-effective interventions to promote preventive health practices across the refugee community with the involvement of both men and women in addressing barriers to family planning and birth spacing.

Recommendations

Based on the findings from the 2024 Health Access and Utilization Survey (HAUS), several areas for improvement have been identified in the accessibility, affordability, and awareness of healthcare services for refugees. The following recommendations aim to address these gaps, ensuring that refugees receive the necessary healthcare while minimizing financial and other access barriers.

- **Enhance Awareness Among Refugees:** Enhance awareness of refugees about the available health services through targeted education campaigns, enhanced community engagement, use of digital platforms including social media and SMSs to inform about the available services, costs, and how to access. Awareness will focus on gaps in knowledge regarding child vaccinations, reproductive health services including ANC and PNC, family planning, chronic disease care, IYCF, etc.

- **Strengthen Financial Support Mechanisms:** Expand advocacy for financial support programs to reduce out-of-pocket expenses, especially for antenatal care, chronic and acute condition management. Where possible, review cost-sharing mechanisms to align with refugees' financial capacities that has been over stretched from the ongoing conflict. This also includes facilitating access of patients to services through avoiding transportation cost barriers especially in remote areas or the use of telemedicine services in some conditions that do not require clinical examination and deploying PHC Satellite Units (PSU) to ensure availability of health services in rural areas.
- **Enhance Access to Antenatal (ANC) and Postnatal Care (PNC):** Address barriers to antenatal and postnatal care and promote awareness to increase uptake and early detection of potential complications. This can include targeted campaign about importance of ANC, PNC, and RH in general. Involving community leaders in promoting awareness is key in avoiding the barrier related to the importance perception. Incentivizing access to care can be also explored to encourage pregnant women to seek services in PHCCs.
- **Improve Accessibility of Chronic Disease Management:** Jointly with the MoPH, national health sector, WHO, and relevant partners develop strategies to improve access to medications for chronic disorders, including ensuring availability of essential medications at PHC facilities and addressing financial barriers to medication access. Advocate and support the availability of essential medications for chronic disorders at PHC facilities with MoPH and WHO, ensuring uninterrupted access for patients with potential contextualization of model of care for stable patients.

- **Facilitate Access to Family Planning Services:** Strengthen community-based awareness about importance of family planning and birth spacing along with the different family planning modalities emphasizing importance for maternal and child health. Education can be expanded to sessions related to misconceptions related to family planning. Finally, expand availability of modern family planning methods at primary health care centers and ensure cost-free access. Conduct education campaigns to address misconceptions and increase the uptake of modern contraceptives.
- **Target Barriers to Childhood Vaccinations:** Enhance awareness about the importance of immunization through community-based interventions and use of social media campaigns. Ensure availability of vaccines at primary health care facilities and through mobile clinics to some specific areas with low vaccination rate based on the PHENICS

data, school vaccination records, etc Expand vaccination outreach programs through schools, rural PHCCs, and mobile units.

- **Strengthen Support for Survivors of Gender Based Violence:** Increase the visibility and accessibility of services for survivors of Gender Based Violence (GBV). Information about GBV, including where to get treatment, should be regularly disseminated to the community through existing channels. Another activity is training and sensitizing a broad spectrum of the health personnel in health facilities including PHCCs and hospitals on GBV and Clinical Management of Rape to avoid challenges resulting from turnover of staff.
- **Strengthen IYCF counseling and support for early breastfeeding initiation:** Enhance counseling on Infant and Young Child Feeding (IYCF) practices during antenatal care (ANC) and postnatal care (PNC) visits. Utilize and enhance the culturally sensitive educational materials to emphasize the importance of early breastfeeding on infant health. Hospital staff should be trained to provide immediate breastfeeding support to mothers post-delivery. It is critical for MoPH and UNICEF to monitor the IYCF activities implemented by PHCCs and hospitals to ensure that the women are properly supported and that all the baby friendly hospital initiative pillars are implemented.
- **Monitor and Evaluate Health Service Utilization:** Regularly review the effectiveness of health programs through continuous data collection and analysis mechanisms like HAUS. Utilize findings to adapt public health programs and address emerging challenges, ensuring services remain relevant and accessible.

Implementing these recommendations would help improve healthcare access and reduce health-related financial hardships for refugees, fostering better health outcomes and well-being.

Summary charts

Baseline Characteristics of Population and Sample

1.1 Survey response

4,171
Number of households selected to participate in the study

38%
Proportion of households called but not responding (i.e., could not be interviewed due to invalid number, not answering the phone, or declining to participate) (n=888/2,336)

1.2 Sample population

1,448
Number of households reached and agreed to participate in the study

6,910
Number of household members in surveyed households

4.7
Average number of household members in surveyed households, including the head of household

49.5%
Proportion of household members who are female (n=3420/6,910)

14.3%
Proportion of household members who are <5 years old (n=988/6,910)

Figure 1: Distribution of households by governorate (n=1,448)

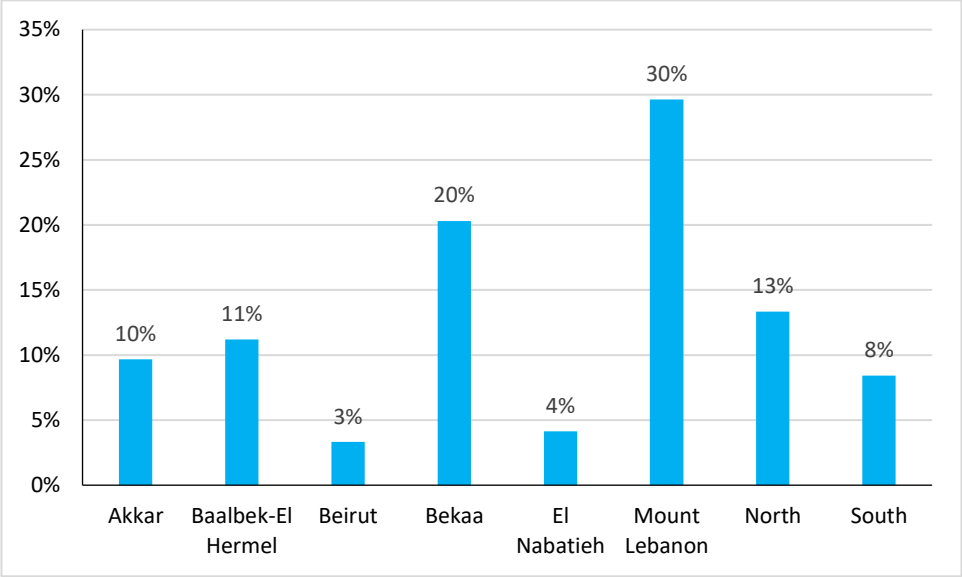
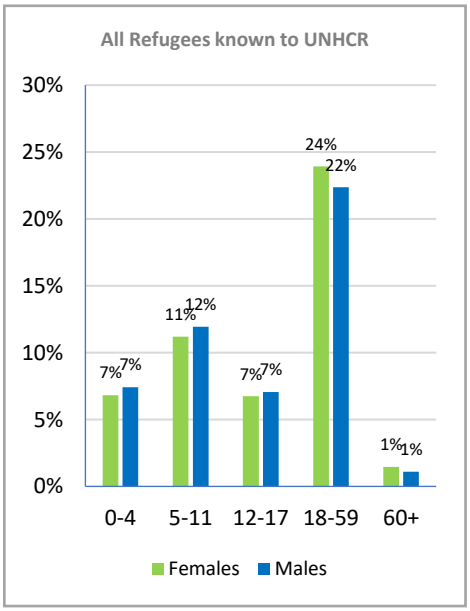
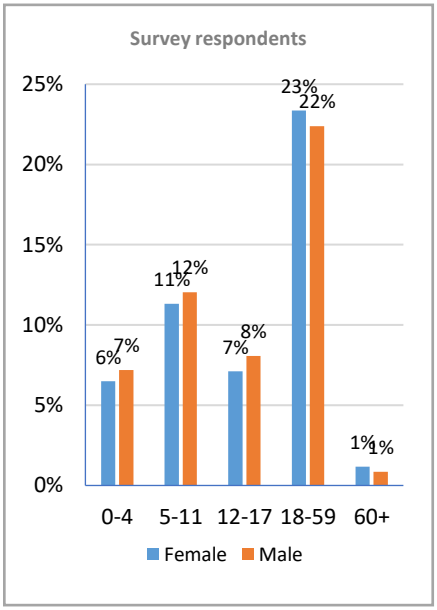


Figure 2: Age and sex distribution of household members (n=6,910)





Knowledge about available services and health care expenditure

2.1 Knowledge

69.9%

Proportion of households knowing that refugees should pay contributions in Lebanese pounds at the PHCCs (n=964/1379)

87.3%

Proportion of households knowing that UNHCR supports hospitalization for life threatening conditions and deliveries (n=1201/1376)

70.3%

Proportion of households knowing that vaccinations are free for children <12 years in government facilities (n=963/1370)

40.6%

Proportion of households knowing that medicines for acute conditions can be obtained for free in governmental PHCCs (n=559/1376)

2.2 Health care expenditure

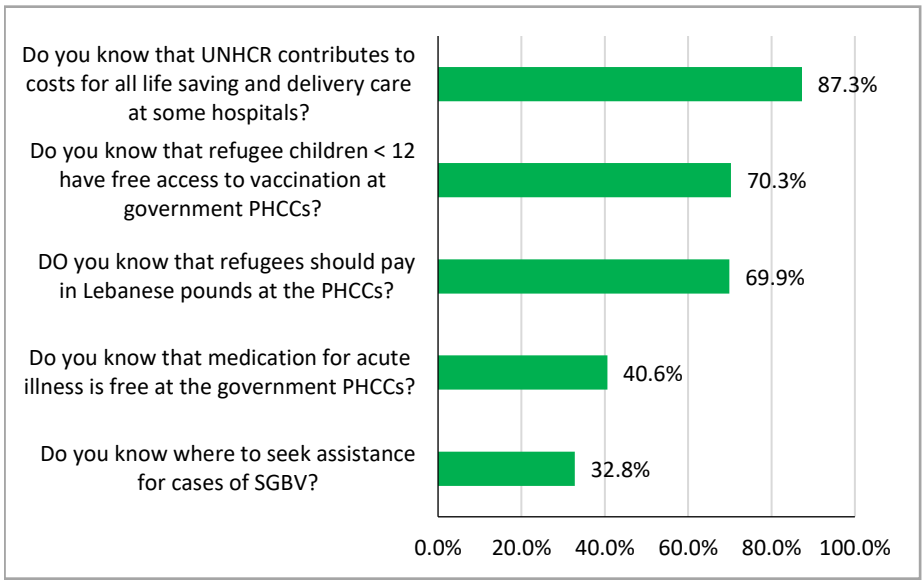
69.6%

Proportion of households spending money on health care the month preceding the survey (n=965/1386)

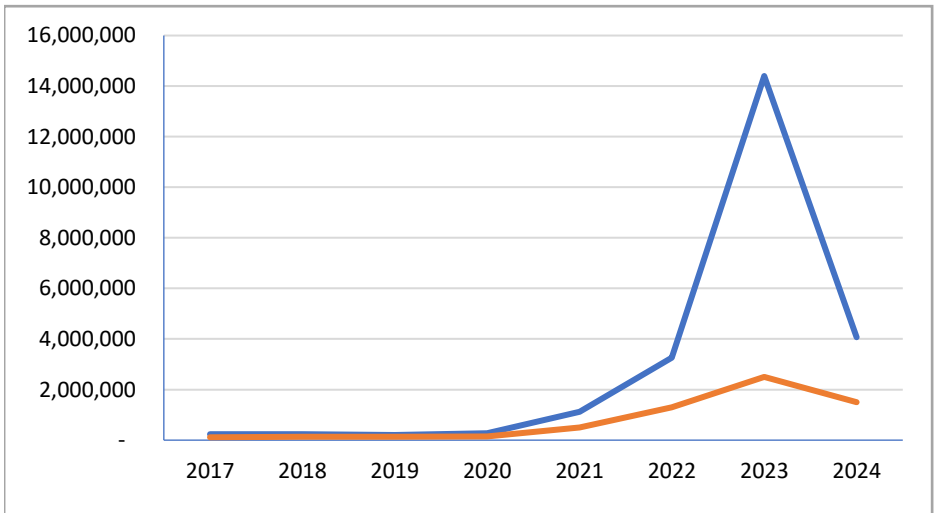
1,500,000 LBP

Median amount spent by the households spending on health care the month preceding the survey (n=224)

Figure 3 Proportion of respondents answering yes.



preceding the survey (of household that reported spending money on health) between 2017 and 2024.



Antenatal Care and Deliveries

3.1 Antenatal care (ANC)

81.27%
Proportion of women who were pregnant in the past 2 years who accessed ANC (n=

69.1%
Proportion of women who delivered who went for at least 4 ANC visits (n=237/343)

33.8%
Proportion of women who received ANC at more than one facility (n=115/340)

3.2 Deliveries

0.6%
Proportion of deliveries at home (n=2/310)

73.4%
Proportion of deliveries supported financially by UNHCR (n=229/312)

35.6%
Proportion of deliveries by C-section (n=110/309)

1,800,000 LBP
Median cost of vaginal delivery supported by UNHCR (n=29)

2,450,000 LBP
Median cost of C-section supported by UNHCR (n=10)

Figure 5: Number of ANC visits among women who delivered during past 2 years (n=343)

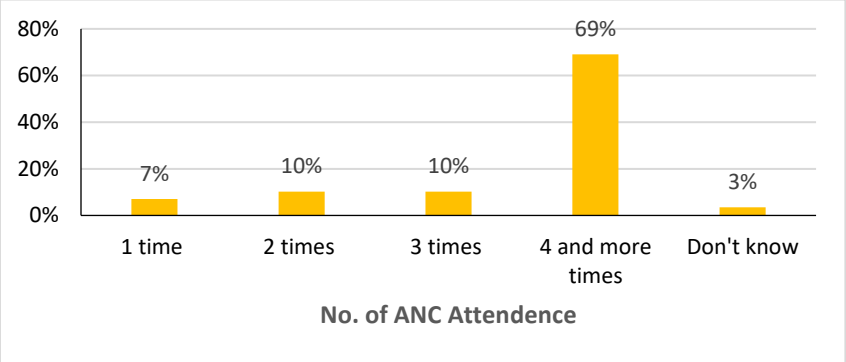


Figure 6: Place for last ANC visit (n=343)

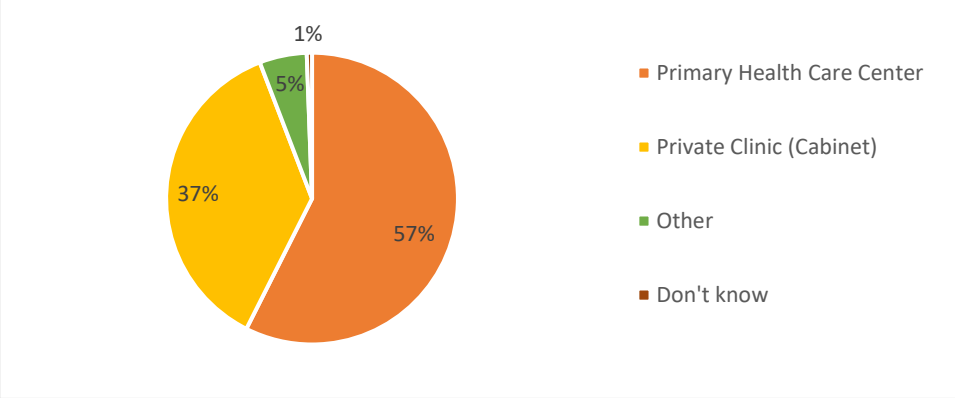
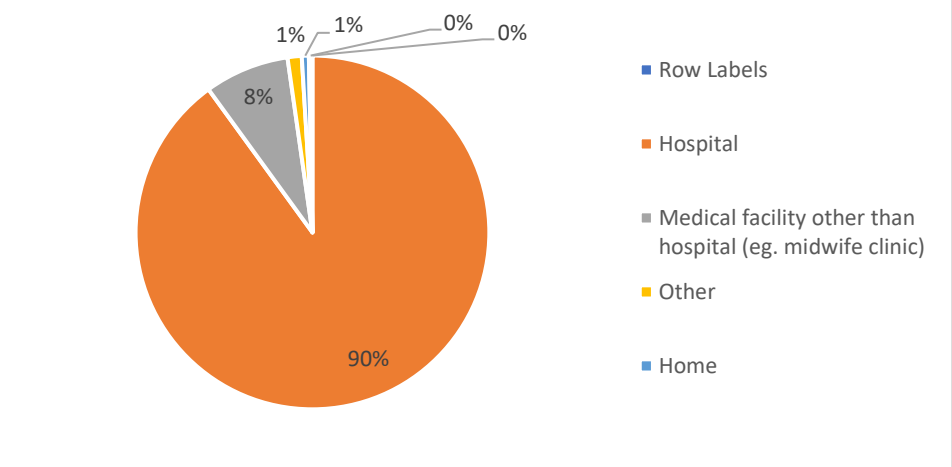


Figure 7: Place of delivery (n=310)



Postnatal Care, Family Planning and Childcare

4.1 Postnatal Care (PNC)

35.89%

Proportion of women who delivered who went for a postnatal care visit (n=1

4.2 Family Planning

56.7%%

Proportion of total households reporting using some kind of contraceptive method (n=668/1179)

4.3 Child Care

79.8%

Proportion of children <5 that had received injectable vaccines at any point (n=750/940)

84%

Proportion of children received injectable vaccine that got vaccinated in Lebanon (n=630/750)

73.1%

Proportion of children vaccinated in Lebanon that was vaccinated for free (n=543/743)

84%

Proportion of children vaccinated in a PHCC (n=627/746)

7.1%

Proportion of children that only had received vaccination in a UNHCR reception center (n=53/746)

Figure 8: Reasons for not going for PNC (n=194)

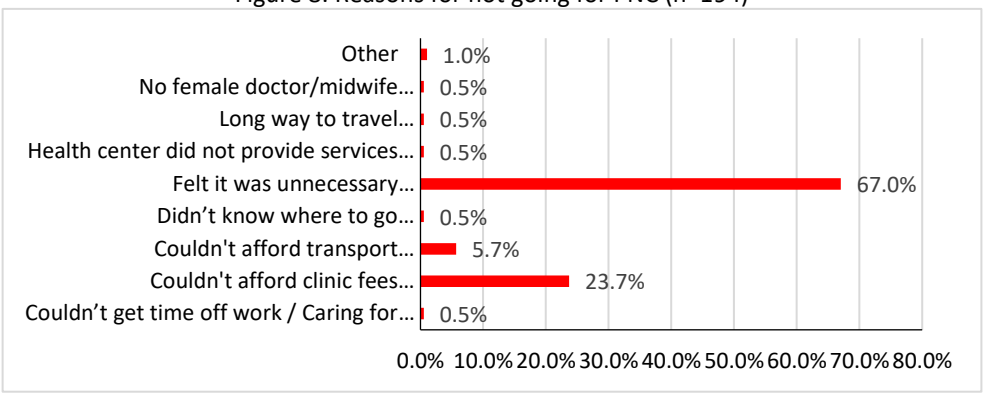


Figure 9: Choice of family planning methods (n=668)

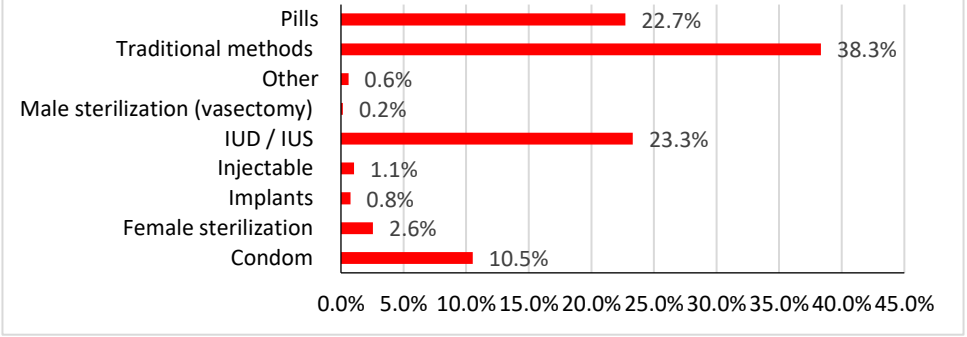


Figure 10: Reasons for not using family planning (n=489)

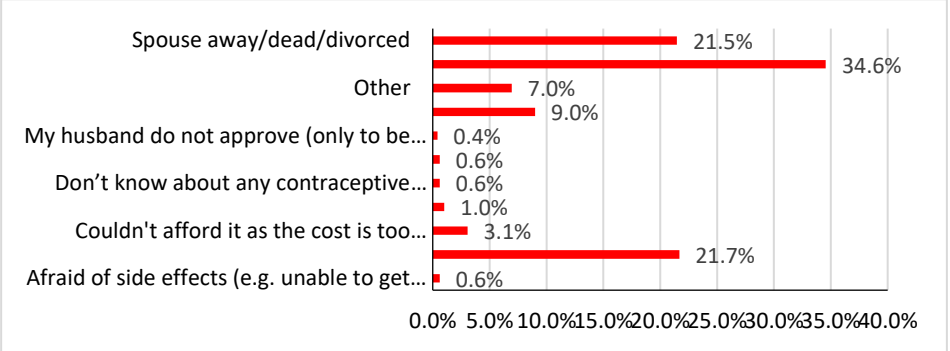
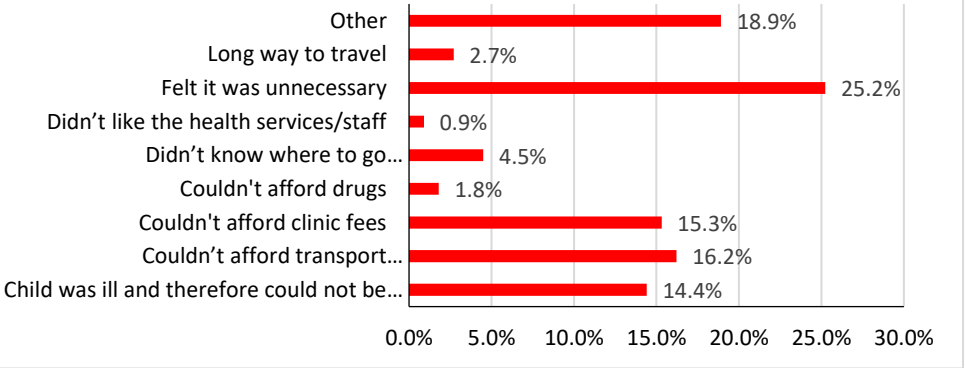


Figure 11: Reasons for child not being vaccinated (n=111)



Chronic Conditions (n=6,936)

5.1 Prevalence

12.8%
Proportion of respondents who reported having a chronic condition (n=827/6907)

28.7%
Proportion of respondents 40 years or above who reported having a chronic condition (n=236/827)

41.1%
Proportion of households with at least one member having a chronic disorder (n=582/1,416)

20.4%
Proportion of individuals that reported having more than one chronic condition (n=166/812)

5.2 Access

54.8%
Proportion of respondents who have accessed care/medication for their chronic condition during the last 3 months (n=453/826)

43.3%
Proportion of individuals that primarily sought care in pharmacies (n=196/452)

500,000 LBP
Median cost of care/medication for chronic disorders during the last 3 months (n=198)

Figure 12: Proportion of different chronic conditions reported (n=812)

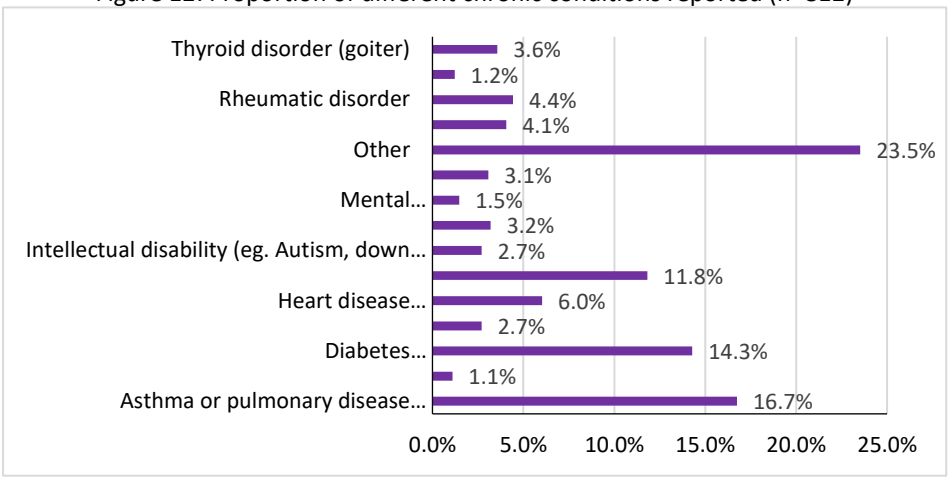


Figure 13: Reasons for not accessing chronic care (n=368)

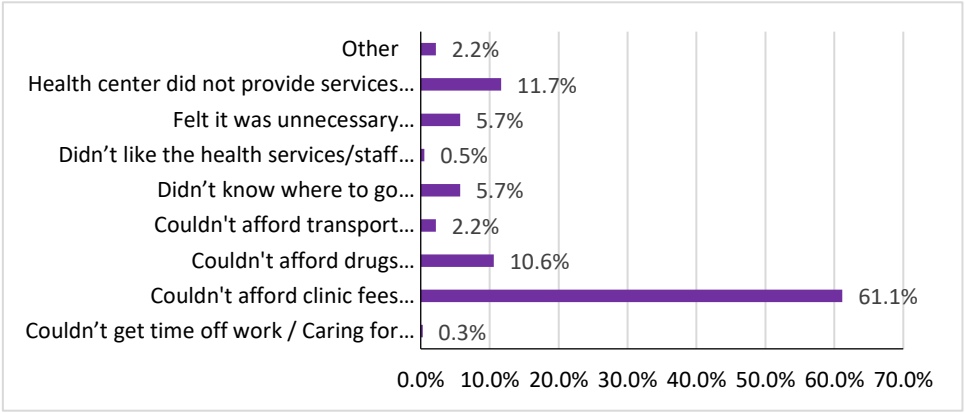
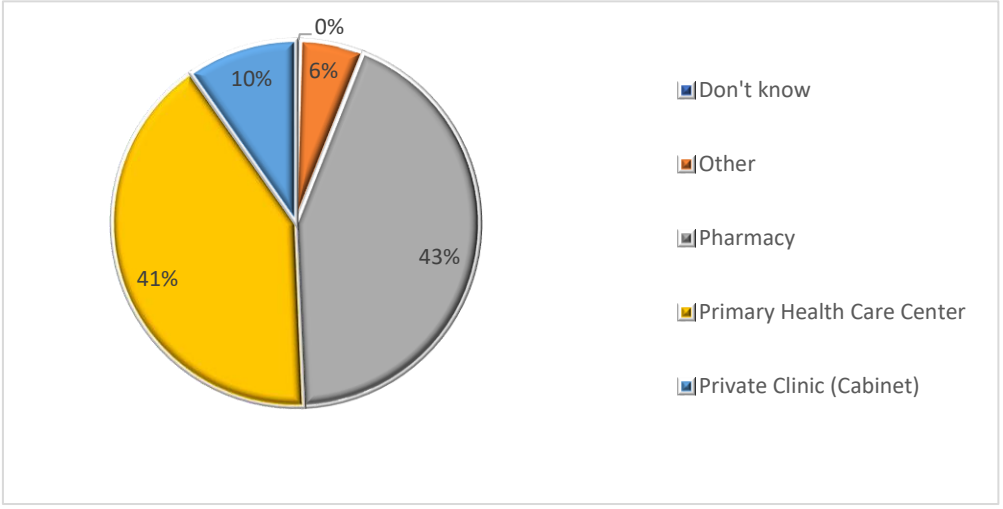


Figure 14: Where sought care for chronic disorder (n=452)



Acute Conditions (N=6,876)

6.1 Incidence

12%

Proportion of respondents who reported having an episode of acute illness during the last month (n=826/6,876)

6.2 Access

75.7%

Proportion of respondents who sought health care for the episode of acute illness (n=801/1058)

78%

Proportion of individuals that sought health care for an acute illness that got it at first point of care (n=623/799)

45.7%

Proportion of individuals that sought health care primarily in pharmacies (n=284/621)

600,000 LBP

Median cost of care for episode of acute illness during the last month (n=9)

Figure 15: Symptoms of reported acute illness during last month (n=819)

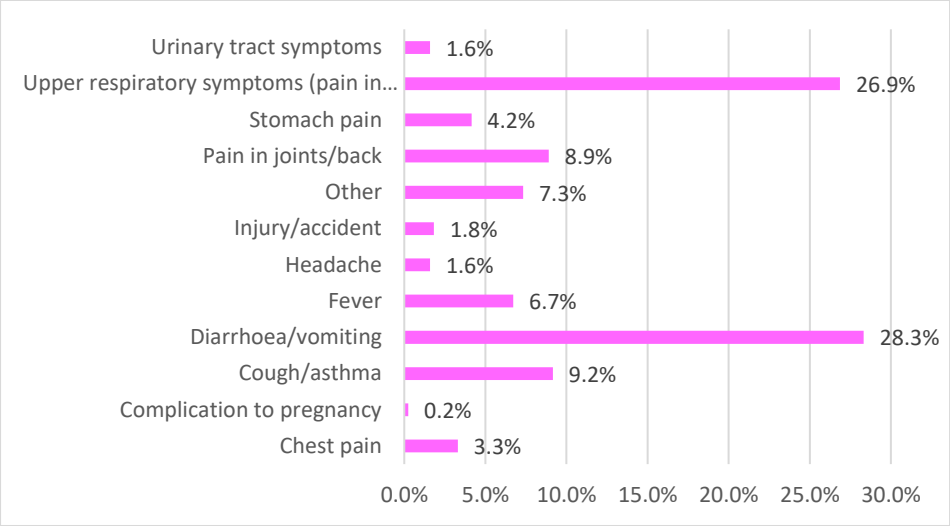
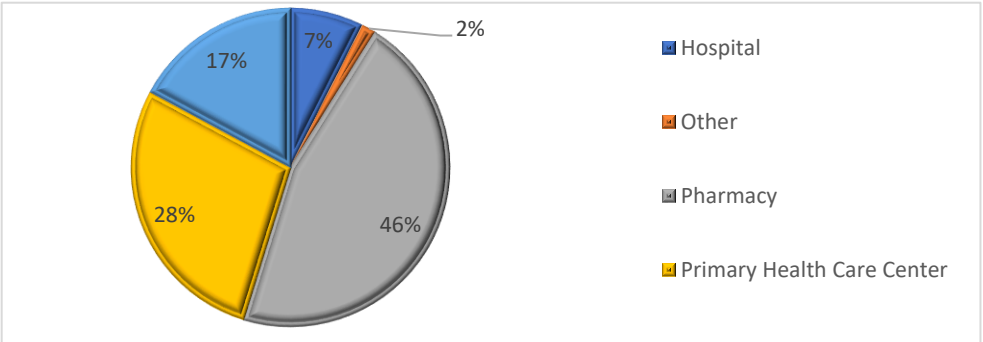


Figure 16: Reasons for not seeking care for acute illness (n=170)

Figure 17: where sought care for acute illness (n=621)



Infant and young child feeding (IYCF)& Nutrition

8.1 IYCF

73.6%

Proportion of respondents reported that the infant in the household has been breastfed (n=184/250)

40.2%

Proportion of respondents reported that the infant in the household has been breastfed one day before the interview (n=99/240)

69.2%

Proportion of respondents reported that the infant in the household ate solid/semi-solid food one day before the interview (n=171/240)

8.2 Nutrition

17.7%

Proportion of respondents that noticed growth and feeding difficulties for their child and did seek care (n=34/192)

Figure 18: Time when the initiation of breastfeeding took for the infant in the household (n=245)

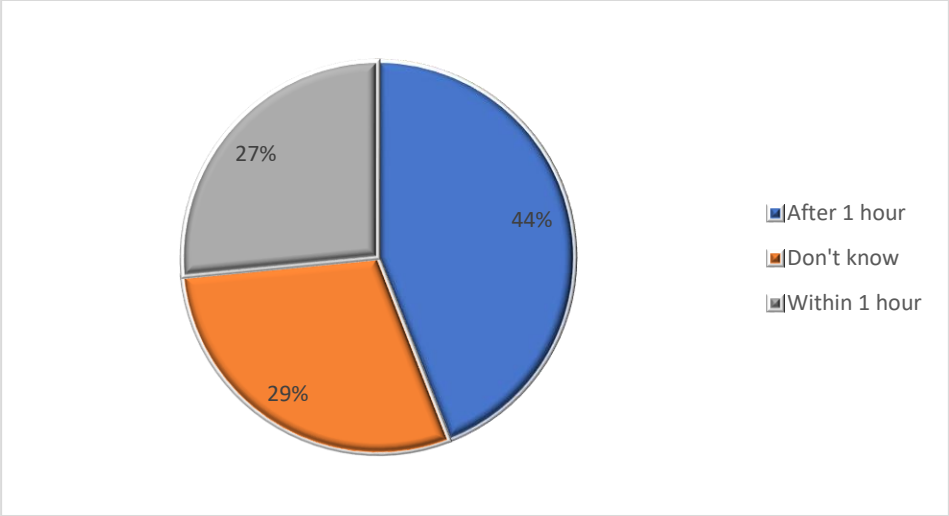


Figure 19: Respondents noticed any growth and feeding difficulties over the last months (n=900)

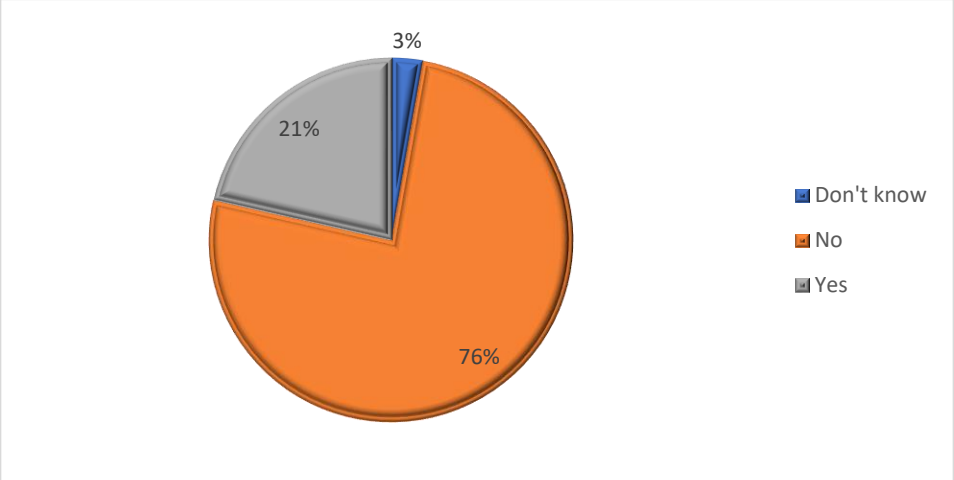
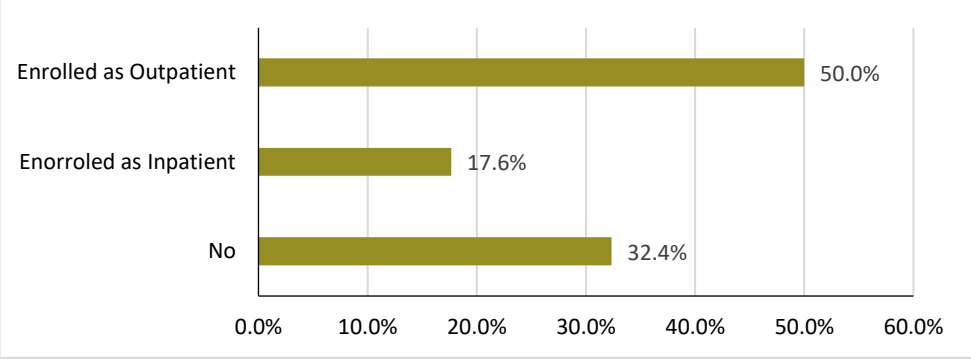


Figure 20: Is the child enrolled in any nutrition program (n=34)



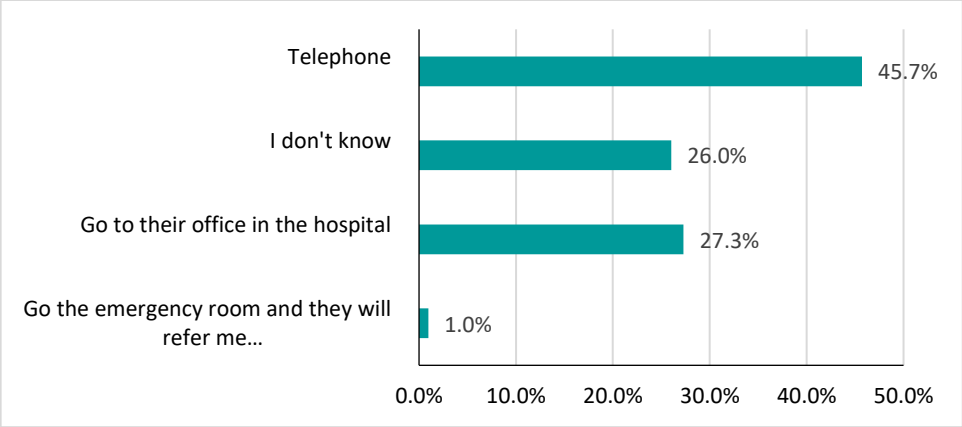
Third-party administrator – TPA (N= 289)

9.1 Knowledge

26%

Proportion of survey respondents who knew about the UNHCR TPA for referral health care programme, but did not know how to reach them (n=82/315)

Figure 21: Methods for reaching TPA (289)



Health communication (N= 1379)

10.1 Health communication

95%

Proportion of respondents who preferred some form of phone communication (Phone call, Text message or WhatsApp message (n=1,313/1379)

Figure 22: Preferred mode for receiving health information reported by the respondents (n=1379)