Health access and utilization survey among Syrian refugees in Lebanon

UNHCR, November 2019

Background

Lebanon currently hosts just under 1 million registered refugees who live both in urban centers and informal settlements. UNHCR is providing assistance and support to refugees through a variety of programs covering basic assistance, protection, shelter, WASH, education and health. The public health unit of UNHCR plays a role both in provision of health care services and institutional support through implementing partners and in coordination of the response together with the Lebanese Ministry of Public Health (MOPH) and the World Health Organization (WHO). The UNHCR public health programme aims to enhance refugee access to comprehensive health services within Lebanon. Primary health care (PHC) is the core of all health interventions and in partnership with local and international implementing partners UNHCR is supporting 11 PHC facilities where a basic package of health care services[1] is provided for free or at subsidized prices for refugees. In addition, UNHCR supports two centers specialized in mental health. In total, there are 183 primary health care facilities[2] countrywide supported by partners in which subsidized care is available for refugees. Hospital care is an essential component of access to comprehensive health services for refugees. UNHCR supports deliveries and life-saving emergency care by paying a part of hospital fees depending on the cost of the admission. To facilitate the administration of hospital care support, UNHCR contracts a Third Party Administrator (TPA) and since January 2017 this is NEXtCARE. The programme is based on cost-sharing in which the patient share on average constitutes one third of the total cost of the admission. The scheme is designed so that beneficiaries pay a higher proportion of low cost admissions and a lower proportion of high cost admissions (around 5%).

It is challenging to collect reliable routine data on the health service needs of urban/non-camp refugees when compared to those residing in traditional camps. For this reason, Household Access and Utilization Surveys (HAUS) allow UNHCR to monitor trends in how refugees access and utilize health services over time. The proportion of registered Syrian refugee households with telephone numbers in Lebanon is 98%. Since 2014, UNHCR Lebanon has conducted annual HAUS per telephone which have provided important information on the challenges faced by refugees in accessing health care services. The survey results guide program delivery by providing timely and regular information in a cost-efficient manner on key variables relating to access and utilization.

Objective

To monitor refugee access to and utilization of available health care services. The survey will aim to assess significant changes, if any, occurred since the last survey which was conducted in 2018.

Methods

- The survey was conducted through telephone interviews from the 28th of August to 5th of September 2019.
- The survey was conducted by operators in a call-center who received 1 day of training.

[1] Including: vaccination, malnutrition screening and management, medication for acute and chronic conditions, laboratory tests and consultations for acute as well as non-communicable diseases, sexual and reproductive health and mental health.

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

- Survey households were selected using random sampling, from a master list provided by UNHCR registration unit containing all registered refugees in Lebanon (as of August 2019), with a valid telephone number in the database.
- The WHO STEP sample size calculator was used to obtain a representative sample[3].
- Sample size was determined based on a desired confidence level of 5% 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)
- Selected HHs were contacted and interviewed over the phone by the interviewers.
- Participation was fully voluntary and everyone was informed that participating or not would not have any consequences in regards to UNHCR support and assistance to the household.
- The head of household, or an adult (aged ≥18) who could respond on his/her behalf, was interviewed.
- The specific inclusion and exclusion criteria for individuals within a selected household are as follows:

  Inclusion
  - Head of household
  - Person ≥ 18 years of age who can provide response on behalf of the household

  Exclusion
  - Not providing informed consent
  - Under 18 years of age
  - Not registered in the database
- Costs were asked for in Lebanese Pounds and converted to USD (1 USD=1500 LBP).
- Data was entered in real time on call-center desktops using the software Project X developed by UNHCR Lebanon. Data was analyzed using Microsoft Excel 2013.

Key findings

A. Baseline characteristics of population

- At the time of the survey, the population of registered refugees in Lebanon numbered 942,565 individuals, living in 217,751 households (4.3 individuals per household).
- 48% of the refugees were male and 52% female.

B. Baseline characteristics of sample

- A total of 2,682 households were selected to be called by the enumerator. The needed sample size was 958 households. The much larger number of households to be called was based on last year's low response/participation rate.
- 950 (35%) households were interviewed. The most common reason for non-response was either that no-one responded to the call or that the number was not functioning.
- Participating households had a total of 4,707 members, which means that surveyed households had an average number of 5.0 individuals.

[3]WHO | STEPS Sample Size Calculator and Sampling Spreadsheet; http://www.who.int/chp/steps/resources/sampling/en/

- 51% of surveyed household members were female and 18% were less than 5 years old.

C. Knowledge about available services and health care expenditure

- 947 households answered on questions about knowledge on available assistance
- 59% of interviewed households knew that refugees have access to subsidized services at primary health care facilities for between 3,000 and 5,000 LL. Corresponding figure from 2018 was 60%.
- 84% of households knew that UNHCR supported life-saving hospital care and care for deliveries. Corresponding figure from 2018 was 80%.
- 65% knew that vaccination for children <12 years is free at primary health care facilities. Figure in 2018 was 62%.
- 23% of respondents were aware of services for survivors of domestic abuse or sexual violence. Figure in 2018 was 22%.
- 39% of respondents knew that drugs for acute conditions could be obtained for free at primary health care facilities. Figure in 2018 was 34%.
- 69% (657) of households reported spending money on health care the previous calendar month. The figure from 2018 which was 73%.
- The households who had spent money on health care the previous month spent on average USD 131 (median: USD 87). The averages from 2018, 2017, 2016 and 2015 were USD 157, USD 154, USD 148 and USD 136 respectively. This year's figure constitutes a dramatic decrease compared to previous years. However, since the median expenditure remained the same as in 2018 (87 USD) the decrease in average cost would not have affected the great majority of households.

D. Sexual and reproductive health

(i) Antenatal care services

- 394 women reported having been pregnant during the 2 years preceding the survey. 82% (325) delivered during this period.
- 88% (286) of the women who had delivered had received antenatal care (ANC) services. Corresponding figure from 2018 was 72%.
- Out of the 286 women attending ANC 69% went for 4 visits or more (72% in 2018).
- Of all women that delivered, 61% went for 4 or more ANC visits which is an increase compared with 2018 during which the corresponding figure was 51%.
- Most common reasons for not accessing ANC services were thinking that ANC was not necessary (44%) and not being able to pay clinic fees (38%). 6% reported to not know where to go for ANC which is a considerable decrease from last year when the corresponding figure was 19%.
- 338 women answered the question about where they had received ANC care. 207 (61%) had gone to a primary health care facility and 123 (36%) had gone to a private clinic.
- 25% of women had received ANC at more than one facility.
- 77% (262) reported having paid for ANC visits while 22% (74) 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 USD 7 (USD 9 in 2018). Corresponding cost at a private clinic was USD 23 (USD 27 in 2018).

(ii) Delivery services

- 318 out of the 325 women who delivered answered the question about where they had delivered. 83% (265) had delivered in a hospital and 3% (10) had delivered at home. 11% (35) had delivered in medical facilities other than hospitals. 4 women who had delivered at home were assisted by a trained birth attendant (TBA), 3 by family members and 2 delivered alone.
- Reasons for delivering at home included worrying about hospital costs (40%), and difficulties finding transportation (30%). 30% claimed that the fact that a midwife was available to assist the delivery influenced their decision.
- The proportion of women who reported delivering via caesarean section was 33%.
- 316 of the women who had delivered answered on questions about financial assistance. 73% (231) reported having received financial assistance from UNHCR for their delivery. 12% (38) did not pay anything for their delivery.
- 128 respondents reported to have had a UNHCR-supported normal vaginal delivery (NVD) and could estimate what they had paid. The median cost reported was USD 163. The corresponding figure from 2018 was USD 80. This increase corresponds to the changed cost-sharing scheme introduced second half of 2018.
- 38 respondents reported to have had a UNHCR supported C-section and could estimate what they had paid. The median cost was USD 250 (USD 237 in 2018).
- Average cost for assisted home-delivery was USD 92.

(iii) Post-natal care services

- Only 27% (85) of the 316 women who had delivered and answered the question had sought post-natal care (PNC) services. The corresponding figure in 2018 was 26%.
- Reasons for not seeking PNC were thinking that the services were not necessary (72%), and inability to afford the clinic fees (18%).

(iv) Family planning

- 850 households were willing to answer questions about family planning. (This constitutes 89% of all households. Corresponding figure from 2018 was 72%)
- Of these, 57% (488) reported using some method of family planning (57% in 2018).
- Since more households chose to respond to the question the proportion of total households reporting using some sort of contraceptive method increased from 41% to 51% compared with 2018.
- 34% of respondents used traditional methods only (withdrawal, calendar etc.), 26% used contraceptive pills, 22% used IUDs and 13% used condoms. This is a shift from 2018 when 25% reported using traditional methods only and 38% reported using contraceptive pills. Possibly a reflection of more households responding to the question.
- Most common reasons for not using family planning include planning for pregnancy (35%), spouse being away/divorced or dead (26%), one of the spouses incapable of childbearing due to age (12%) and one of spouses incapable of childbearing due to health reasons/sterility (12%)

E. Childhood vaccinations

- Questions about vaccinations were asked about 841 children < 5 years old. 90% (760) had received a vaccination booklet.
- 81% of children had received oral polio vaccination, and 84% had received injectable vaccines. This is a decrease compared with 2018 when 88% had received injectable vaccines.
- 11% (75) of 704 children that had received injectable vaccines were vaccinated before arriving in Lebanon (10% in 2018).
- 89% of the children who had received injectable vaccines in Lebanon got at least one of their vaccinations in a primary health care facility, 10% in a UNHCR reception center and 4% in a mobile clinic. 5% indicated UNHCR reception center as the only place where they had been vaccinated with injectable vaccines.
- 32% (177) of refugees that had received injectable vaccines in Lebanon had to pay for the vaccination (39% in 2018).
- Refugees paid a median cost of USD 5 for vaccination services (for those who reported paying). Corresponding figure 2018 was USD 7.
- Reasons given by the 27 respondents whose children had not been vaccinated included, clinic fees too high (21%), did not think it was necessary (20%), didn't know where to go (17%) and child was ill at the time of vaccination (16%).

F. Chronic conditions

- 35% (329) of 950 households responding to the question reported at least one member with a chronic condition.
- 10% (456) of the 4,706 household members answering, reported to have a chronic medical condition. (11% in 2018)
- Most common conditions were: hypertension (23%), asthma/pulmonary disease (19%), diabetes (16%), heart disease (14%), physical disability – such as cerebral palsy or paralysis after stroke (7%), thyroid disorders (5%) and rheumatic conditions (6%).
- 27% reported to have more than one chronic disorder.
- 71% (322) of the 455 household members with a chronic condition that responded to the question had accessed medical care and/or medicines for their condition during the last 3 months. (66% in 2018)
- Of the 318 individuals who could recall the facilities where they had sought care, 46% (145) had gone to a primary health care facility, 31% (99) to a pharmacy and 16% (51) to a private clinic.
- 77% of those who sought care had to pay for the services. 35% of those who went to primary health care facilities received services for free.
- Of those who did have to pay, the median cost, not considering health care outlet, was USD 20. In a primary health care facility the median cost was USD 7. This is a considerable decrease compared to 2018 when the corresponding number was USD 33. For those who went to a private clinic, the median cost was USD 43 (USD 37 in 2018), while for those who went to a pharmacy, the median cost was USD 23 (USD 19 in 2018).

- The main barrier to accessing care for chronic conditions was the inability to pay clinic fees (65%) or drugs (24%).

G. Acute conditions

- 12% (574) of the 4,689 household members who responded to the question reported to have had an acute condition during the month preceding the survey. This is a return to previous figures (8% in 2017) compared to 30% in 2018. Fluctuations probably reflect seasonal change in incidence of certain infections.
- The most common symptoms reported were: upper respiratory tract symptoms (runny nose, sore throat) (25%), cough (17%), fever (17%) and diarrhea/vomiting (15%)
- Among the ones reporting being acutely ill, 21% (118) did not seek health care (36% in 2018). The reasons reported were: could not afford clinic fees (75%) and thinking it was not necessary (15%).
- Out of the 452 that sought health care and answered the question, 34% (152) went to a primary health care facility, 33% (151) to a pharmacy, 22% (100) to a private clinic and 10% (44) to a hospital.
- 90% (409) of the 454 who sought care and responded to the question got health care at the first facility they went to. The corresponding figure from 2018 was 86%.
- 27% (11) of the ones who didn't get care at the first facility sought health care at a second facility and 45% (5) got care. Proportion of all individuals that sought care who eventually got it was 91%.
- 94% (409) of the refugees that received care for acute conditions had to pay for the services.
- Respondents who could recall the amount they had paid for care reported the following median costs: Overall USD 20, primary health care facilities USD 7, Private clinics USD 33, pharmacies USD 17, and hospitals USD 92.
- Reasons for not receiving services despite seeking them include: couldn't afford the fees (48%) the facility could not offer the needed services (26%) and could not afford drugs (17%).

Limitations

- Survey was limited to refugee households registered with UNHCR with a telephone number. This together with high proportion of non-respondents may contribute to making the sample not representative for the refugee population as a whole.
- 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 available to the household respondent might have affected the quality of response and led to bias.
- Despite training of surveyors and phrasing questions in an explanatory way, concepts such as chronic and acute illness, primary health care centers, private cabinets and hospitals might not be clearly understood by the respondents which in turn will affect their answers.

Conclusions

- There was a significant Increase of women that delivered who reported having gone for ANC. The reasons are probably a combination of an increase in number of supported primary health care facilities, decrease in cost for services and increased knowledge about where to get them.

- There was an increase in median cost for deliveries which reflects the changes made to the cost sharing scheme for UNHCR hospital care programme.

- The proportion of women accessing PNC after delivery remains low and the reason continues to be that the majority consider the service unnecessary.

- Continued low proportion of deliveries reported to take place at home.

- There was an increase of households reporting that they used some sort of contraceptive, but a simultaneous increase was also seen in proportion of respondents that used "traditional methods" only.

- Knowledge about available services remained roughly the same with low proportion of respondents knowing about services related to SGBV and that primary health care facilities should provide essential drugs for minimal fees.

- The proportion of respondents reporting having spent money on health care the preceding month remained stable as did median expenditure even though average amount spent had reduced. The latter signifies a reduced in variability of health care costs.

- There was a slight decrease in respondents reporting that their children had received injectable vaccination. This is worrying considering the measles outbreaks of 2018 and 2019.

- There was a decrease in respondents who reported household members having been acutely ill during previous months. Possible reason are seasonal variations in incidence of infections.

- There was an increase in proportion of respondents reporting acute illness who sought health care and a slight increase in proportion of respondents seeking care that got care.

- The proportion of respondents with chronic illnesses who had accessed care/medication had increased slightly.

- There was an overall decrease in the amount that respondents reported having paid for care in primary health care facilities. For chronic conditions this decrease was considerable. Compared to 2018 it has become cheaper to seek care in primary health care facilities compared to pharmacies and private clinics. Possibly these changes result from increased support from the international community and the increased number of facilities using a single fee model – thereby decreasing hidden costs.

Recommendations

Some of the results of the 2019 HAUS are encouraging, especially the rising proportion of women accessing ANC and the overall reduction of refugee expenditure per consultation in primary health care

facilities. However, in the group that is not accessing health care for acute and chronic illnesses, cost is increasingly referred to as the main barrier.

Recommendations based on the 2019 HAUS findings are:

1. Design targeted interventions to support the group that is still not accessing health care;
2. Renew efforts to increase vaccination coverage;
3. Maintain current low cost services offered in primary health care facilities and disseminate information about their availability;
4. There seems to be an increasing interest for family planning within the population, but too much reliance is put on traditional methods. Renewed efforts are needed in promoting and making available safe contraceptive methods such as the pill and IUDs.

1)Baseline Characteristics of Population and Sample

1.1 Survey response

2,682
Number of households selected to participate in the study

65%
Households called but not responding (i.e. could not be interviewed due to invalid number, not answering the phone or declining to participate)

1.2 Sample population

950
Number of households reached and agreed to participate in the study

4,707
Number of household members in surveyed households

5.0
Average number of household members in surveyed households, including the head of household

52%
Proportion of household members who are female (n=4,707)

18%
Proportion of household members who are <5 years old (n=4,707)

Figure 1: Distribution of households by governorate (n=950)

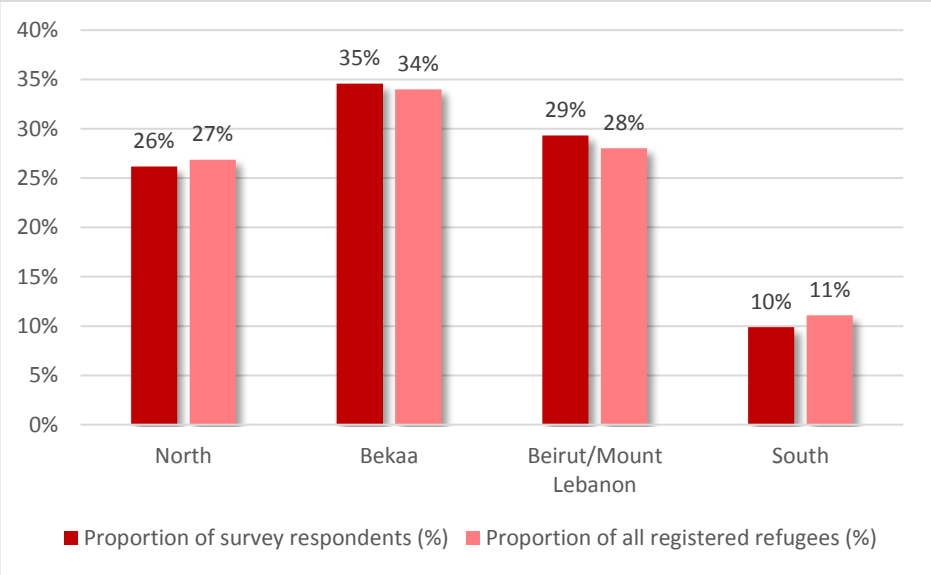
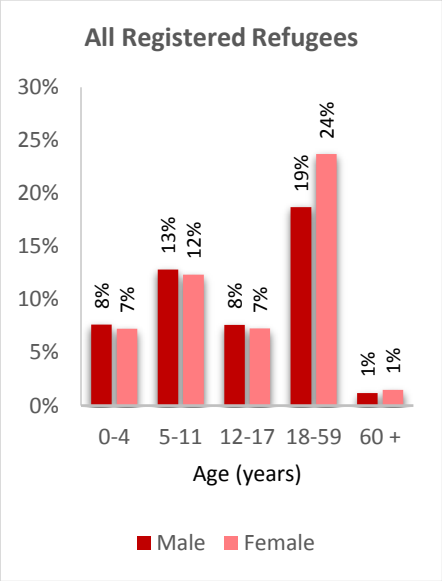
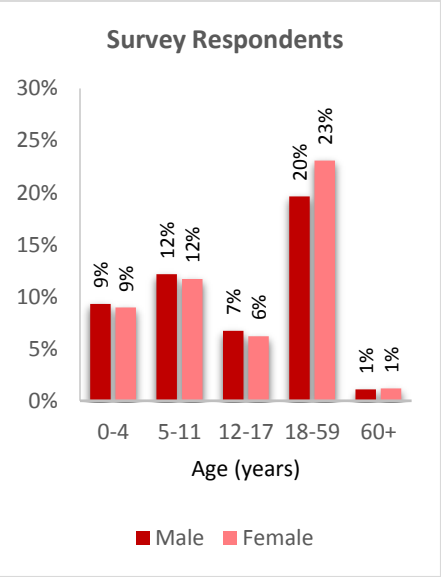


Figure 2: Age and sex distribution of household members (n=4,707)





2) Knowledge about available services and health care expenditure

2.1 Knowledge

59%

Proportion of households knowing that consultations in governmental PHCCs for between 3000 and 5000 LBP (n=947)

84%

Proportion of households knowing that UNHCR supports hospitalization for life threatening conditions and deliveries (n=947)

62%

Proportion of households knowing that vaccinations are free for children <12 years in government facilities (n=947)

34%

Proportion of households knowing that drags for acute conditions can be obtained for free in governmental PHCCs (n=947)

2.2 Health care expenditure

73%

Proportion of households spending money on health care the month preceding the survey (n=947)

87USD

Median amount spent by the households spending on health care the month preceding the survey (n=657)

Figure 3. Proportion of respondents answering yes (n=947)

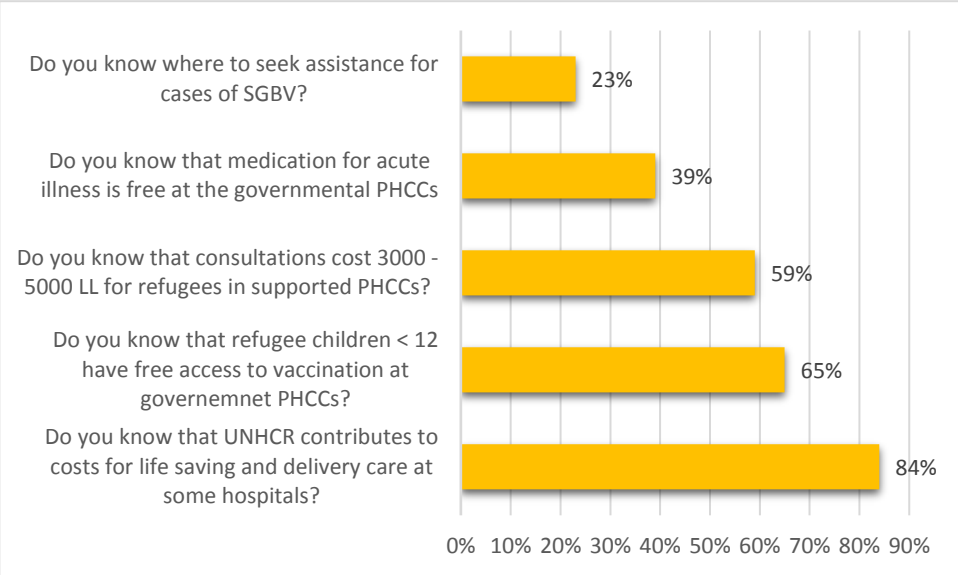
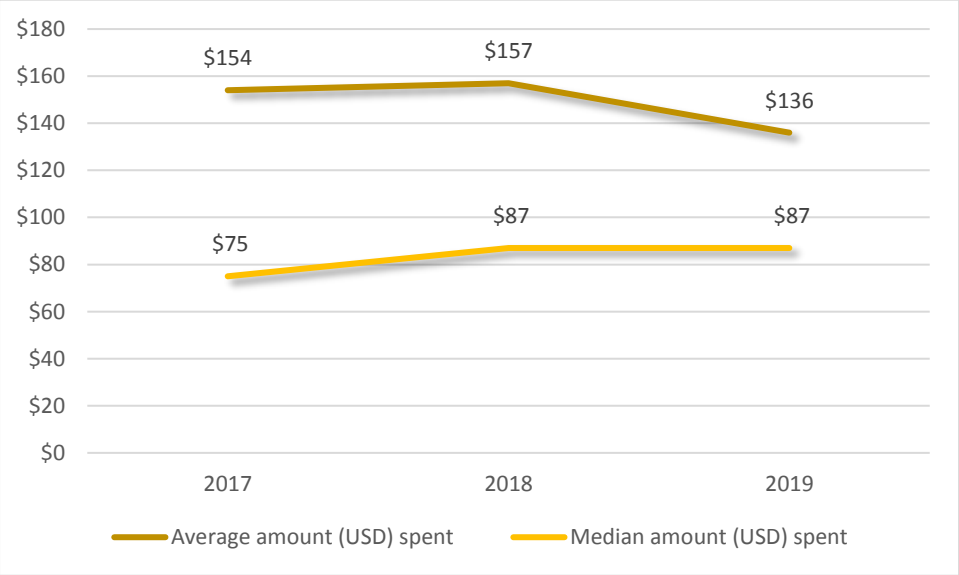


Figure 4. Average and median amounts spent by the household during month preceding the survey (of household that reported spending money on health) between 2017 and 2019



3)Antenatal Care and Deliveries

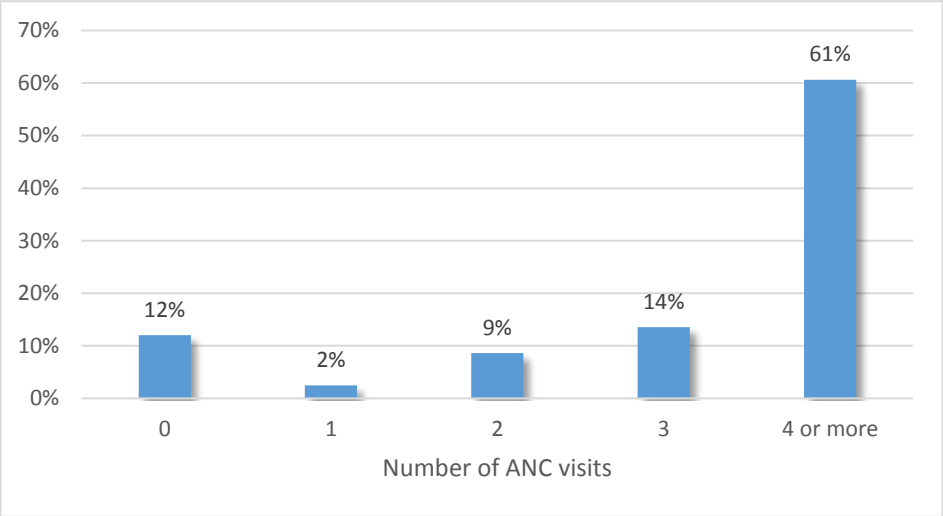
2.1 Antenatal care (ANC)

88%
Proportion of women who delivered who accessed ANC (n=325)

61%
Proportion of women who delivered who went for at least 4 ANC visits (n=325)

25%
Proportion of women who received ANC at more than one facility (n=286)

Figure 3: Number of ANC visits among women who delivered during past 2 years (n=325)



2.2 Deliveries

3%
Proportion of deliveries at home (n=318)

73%
Proportion of deliveries supported financially by UNHCR (n=316)

33%
Proportion of deliveries by C-section (n=325)

163 USD
Median cost of vaginal delivery supported by UNHCR (n=128)

250 USD
Median cost of C-section supported by UNHCR (n=69)

Figure 5: Place for last ANC visit (n=338)

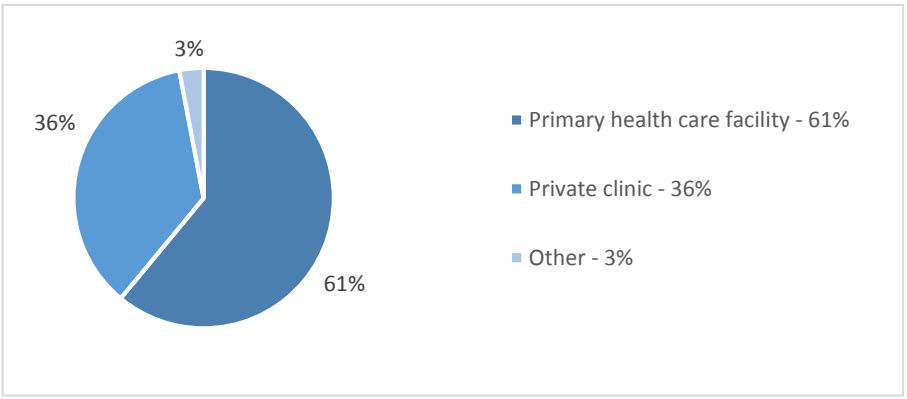
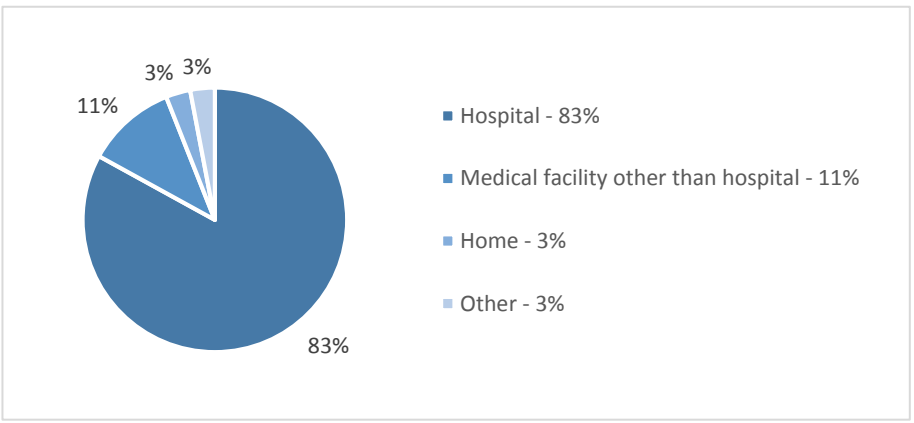


Figure 6: Place of delivery (n=318)



4)Postnatal Care, Family Planning and Child Care

3.1 Postnatal Care (PNC)

27%

Proportion of women who delivered who went for a postnatal care visit (n=316)

3.2 Family Planning

51%

Proportion of total households reporting using some kind of contraceptive method (n=950)

3.3 Child Care

84%

Proportion of children <5 that had received injectable vaccines at any point (n=841)

89%

Proportion of children received injectable vaccine that got vaccinated in Lebanon (n=704)

68%

Proportion of children vaccinated in Lebanon that was vaccinated for free (n=557)

89%

Proportion of children vaccinated in a PHCC (n=557)

5%

Proportion of children that only had received vaccination in a UNHCR reception center (n=557)

Figure 7: Reasons for not going for PNC (n=218)

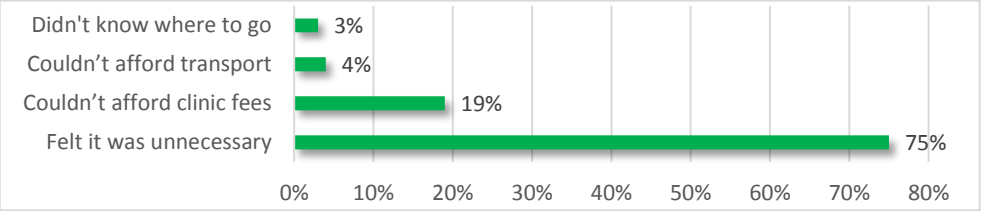


Figure 8: Reasons for not using family planning (n=354)

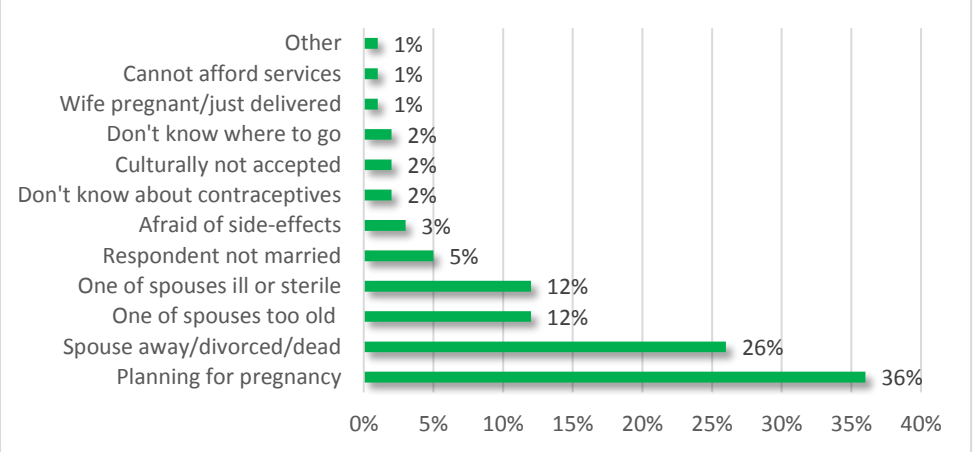


Figure 9: Choice of family planning methods (n=487)

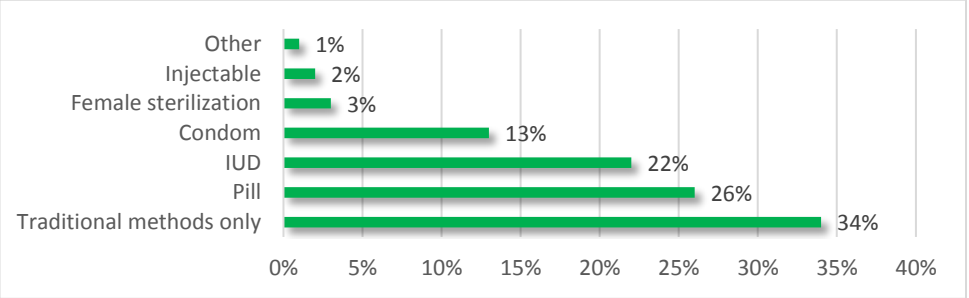
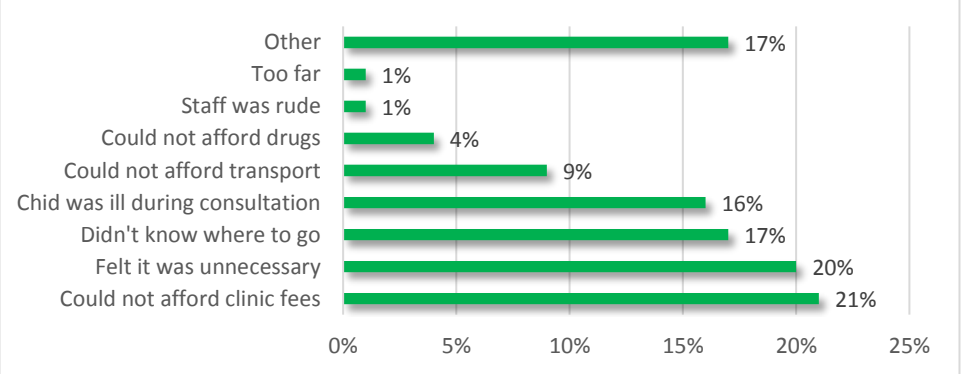


Figure 10: Reasons for not taking child for vaccination (n=75)



5)Chronic Conditions

4.1 Prevalence

11%

Proportion of respondents who reported having a chronic condition (n=4706)

31%

Proportion of respondents 40 years or above who reported having a chronic condition (n=600)

35%

Proportion of households with at least one member having a chronic disorder (n=950)

27%

Proportion of individuals that reported having more than one chronic condition (n=447)

4.2 Access

71%

Proportion of respondents who have accessed care/medication for their chronic condition during the last 3 months (n=455)

62%

Proportion of individuals that had sought care in a PHCC or private clinic (n=318)

20 USD

Median cost of care/medication for chronic disorders during the last 3 months (n=242)

Figure 11:Proportion of different chronic conditions reported (n=447)

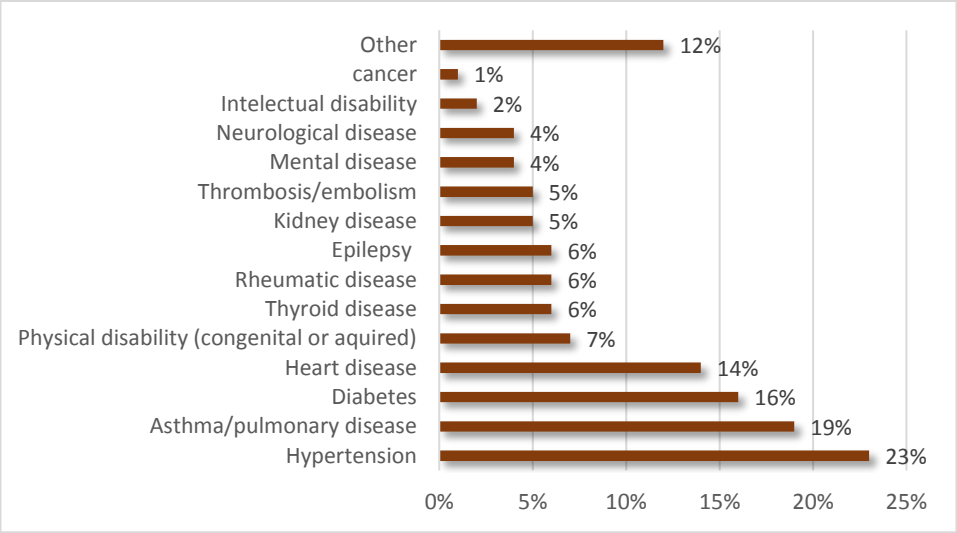


Figure 12: Reasons for not accessing chronic care (n=131)

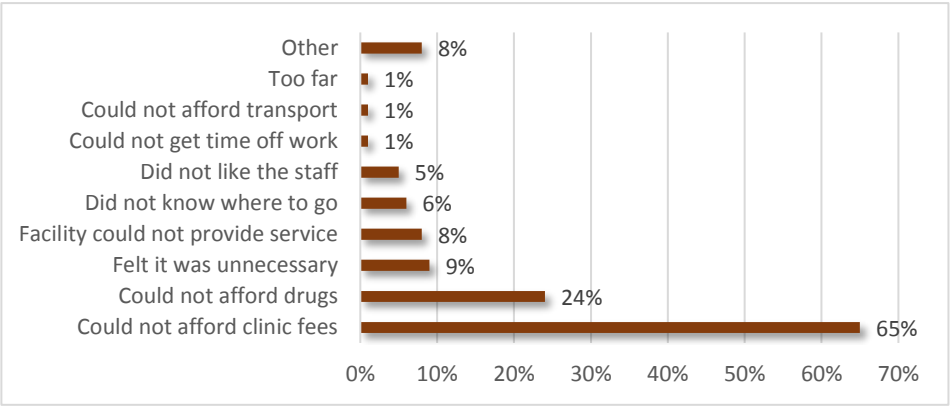
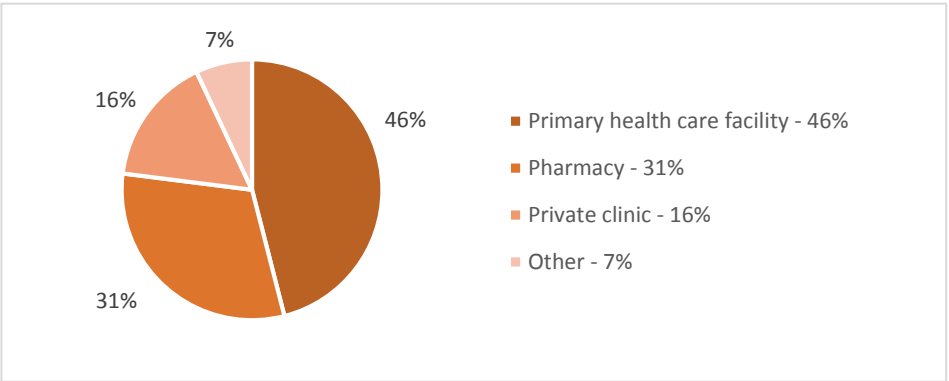


Figure 13: Where sought care for chronic disorder (n=318)



6) Acute Conditions

5.1 Incidence

12%

Proportion of respondents who reported having an episode of acute illness during the last month (n=4689)

5.2 Access

79%

Proportion of respondents who sought health care for the episode of acute illness (n=574)

90%

Proportion of individuals that sought health care for an acute illness that got it at first point of care (n=454)

91%

Proportion of individuals that sought health care that got it (n=454)

20 USD

Median cost of care for episode of acute illness during the last month (n=374)

Figure 14: Symptoms of reported acute illness during last month (n=557)

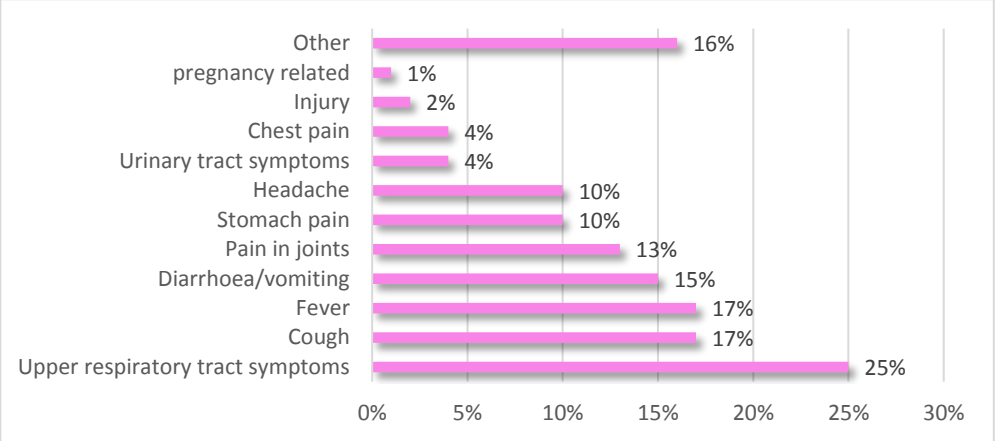


Figure 15: Reasons for not seeking care for acute illness (n=118)

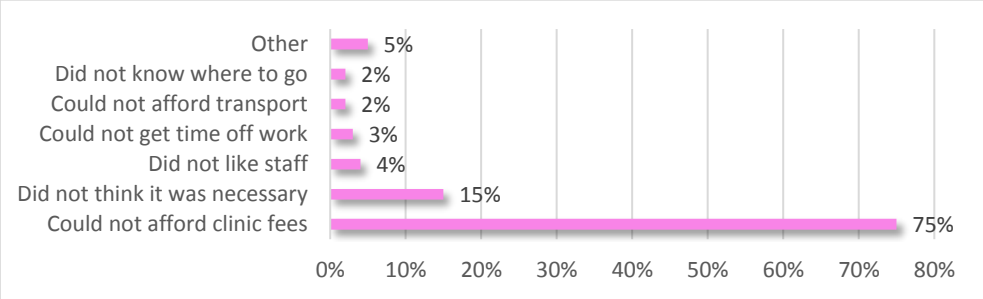


Figure 16: Reasons for not getting care when sought (n=42)

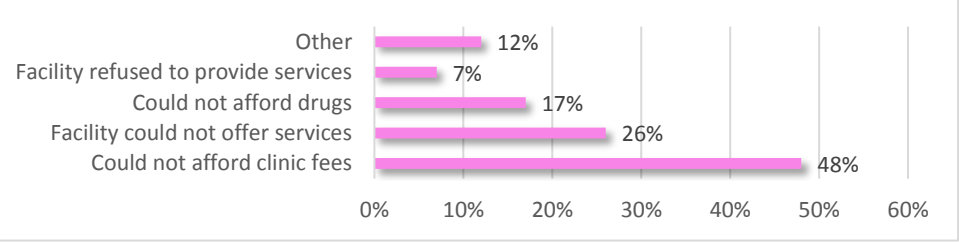


Figure 17: where sought care for acute illness (n=452)