Health Access and Utilization Survey among refugees in Lebanon - 2023

HAUS 2023

UNHCR, January 2024

Contents

Background

Lebanon remains the country hosting the largest number of refugees per capita, with the Government's estimation of 1.5 million Syrian refugees and 11,645 refugees of other nationalities.[1] These populations live across all governorates in Lebanon 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. UNHCR plays a role both in provision of health care services and institutional support through implementing partners, third party administrator (TPA) and in coordination of the response together with the Lebanese Ministry of Public Health (MOPH), the World Health Organization (WHO), and other UN agencies under the Lebanese Response Plan (LRP). The UNHCR public health programme aims to ensure equitable refugee access to comprehensive health services within Lebanon including primary health- and hospital care. Primary health care (PHC) is the core of all health interventions and in total, there are 158 primary health care facilities[2] countrywide in which subsidized care is available for refugees. UNHCR subsidizes consultation costs through international and national partners some of these facilities that either are situated in areas which have sizeable refugee populations in rural areas with limited services or providing services that are generally not widely available in the Lebanese system (e.g., Mental Health care services). Hospital care is an essential component of access to comprehensive health services for refugees. UNHCR supports deliveries and life/ limb -saving emergency care by paying a part of hospital fees depending on the cost of the admission. In this process, UNHCR works with a Third-Party Administrator (TPA) that verifies eligibility of cases, audits bills and effectuates the transfer of money to the health care providers. The programme is based on cost-sharing mechanism where a patient shares a certain proportion of the total cost of the admission.

It is challenging to collect reliable routine data on the health service needs of urban/non-camp refugees and refugees residing in informal tented settlements (ITSs) when compared to those residing in formal camps. For this reason, Health Access and Utilization Survey (HAUS) was conducted to allow UNHCR to monitor trends in how refugees access and utilize health services over time. Since 2014, UNHCR Lebanon has conducted annual HAUS by telephone (the proportion of Syrian refugee households known to UNHCR with telephone numbers in Lebanon is 98%) which has provided information on the challenges faced by refugees in accessing health care services. The survey results guide program delivery by providing 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 and provide an analysis in trends over the years.

[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.

Methods

- The survey was conducted through telephone interviews during the period: 07 September to 16 October 2023.
- The survey was conducted by operators in a call-center who have conducted similar surveys for UNHCR in the previous months. A comprehensive training was provided to all callers engaged in the current survey to ensure similar level of skills for all callers engaged in the survey.
- Survey households were selected using random sampling from the UNHCR database in Lebanon as of September 2023, with a valid telephone number in the database.
- 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].
- Sample size 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)
- Selected HHs were contacted and interviewed over the phone by the trained interviewers.
- 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.
- The specific inclusion and exclusion criteria for individuals within a selected household were as follows:

  Inclusion
  - Head of household
  - Person $\geq$ 18 years of age who can provide response on behalf of the household.

  Exclusion
  - Not providing informed consent
  - Under 18 years of age
  - Not known to UNHCR as per the database
- Data was entered in real time on call-center desktops using the software which was developed by UNHCR Lebanon. The software has standard data protection measures in place and the desktops were password protected and could be logged-in by the respective enumerators only. Data was analyzed using STATA 2021 (StataCorp. 2021. *Stata Statistical Software: Release 17*. College Station, TX: StataCorp LLC)[4].

[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

[4] https://www.stata.com

Key findings

A. Baseline characteristics of the sample

- A total of 4,039 households were called by the enumerators. The minimum statistically significant sample size required was 1,374 households.
- 1,579 (39%) households were interviewed. Non-response rate was 60.9% with the most common reason being either that no-one responded to the call or that the number was not functioning.
- Participating households had a total of 7,576 members, which means that surveyed households had an average number of 4.79 individuals (Range: 1 - 12).
- 50.1% of surveyed household members were female and 11.3% were less than 5 years old.
- The distribution of the respondents per region was: 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. The corresponding figures for the year 2022 were 24% in the North, 37% in the Bekaa, 26% in the Beirut and Mount Lebanon region and 12% in the South.

B. Knowledge about available services and health care expenditure

- 1,392 households answered on questions about knowledge on available assistance.
- 72.1% of interviewed households knew that refugees should pay contributions in Lebanese Pounds at primary health care facilities. This question was adjusted in 2023 due to change in patient share at PHC as per inflation rate. The knowledge about this was limited to 67% in the year 2022.
- 89.4% of households knew that UNHCR supported life-saving hospital care and care for deliveries. Corresponding figure from 2022 was 82%.
- 77.6% knew that vaccination for children <12 years is free at primary health care facilities. Corresponding figure in 2022 was 71%.
- 29% of respondents were aware of services for survivors of domestic abuse or sexual violence. This figure in 2022 was 27%.
- 40.1% of respondents knew that medicines for acute conditions could be obtained for free at primary health care facilities. This figure in 2022 was 37%.
- 63% of households reported spending money on health care the previous calendar month. The figure from 2022 was 73%.
- The households who had spent money on health care the previous month spent on average LBP 14,400,000 (Median: LBP 2,500,000; Range: 100,000 – 6,000,000,000). The averages from 2022, 2021, 2020 and 2019 were LBP 3,261,741, LBP 1,119,800, LBP 269,103, and LBP 196,500 respectively. This constitutes a dramatic increase that mirrors the devaluation of the LBP and the increasing cost of services due to removal of subsidizes.

C. Sexual and reproductive health

(i) Antenatal care services

- 354 women reported having been pregnant during the 2 years preceding the survey. 99.2% (351) delivered during the same period.
- 67.2% (236) of the women who had delivered had received antenatal care (ANC) services. Corresponding figure from 2022 was 88%.

- Out of the 236 women who had delivered and attended ANC, 69.1% went for 4 visits or more (61% in 2022).
- Most common reasons for not accessing ANC services were, not thinking it was necessary (59.4%); 2022: 29.3%) followed by not being able to pay for clinic fees (18.8%); 2022: 27.6%). Other reasons cited were inability to afford transport (4.0%;), long travel time (3.0%;), didn't knew where to go (2.0%;), didn't like the staff (2.0%;), no female doctors (1%;) and others (10%;). This is similar to the year 2022 where 'not thinking it was necessary' was also the most common reason.
- 236 women answered the question about where they had received ANC care. 137 (58.1%) had gone to a primary health care facility and 92 (39.0%) had gone to a private clinic. This constitutes a slight change from 2022 during which 62% went to a primary health care facility and 34% went to a private clinic.
- 26.7% of women had received ANC at more than one facility. The corresponding figure from 2022 was 23%
- 73.7% (174) reported having paid for ANC visits while 24% (120) 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 250,000 (LBP 400,000 in 2022; 72%). The fluctuation from last year could be related to the small sample for the mothers who remembered having paid the amount for ANC visits.

(ii) Delivery services

- 269 out of the 351 women who delivered answered the question about where they had delivered. 90.7% (244) had delivered in a hospital (88% in 2022) and 0.74% (2) had delivered at home (3% in 2022). 8.2% (22) had delivered in medical facilities other than hospitals (8% in 2022). For both the women who delivered at home, difficulties with transportation were cited as the reason for the same.
- The proportion of women who reported delivering via caesarean section was 31.5% (37% in 2022).
- 78.7% (210) of the women who had delivered reported having received financial assistance from UNHCR for their delivery (76% in 2022). 21.6% (58) did not pay anything for their delivery (15% in 2022).
- 183 (68.5%) respondents reported to have had a normal vaginal delivery (NVD). The median cost reported was LBP 2,789,795. The corresponding figure from the year 2022 was LBP 400,000, year 2021 was LBP 260,000, year 2020 was LBP 300,000 and the year 2019 was LBP 244,500. The increased cost in 2023 may relate to patient share increase to 50% and in Sayrafa rate applied from March 2023.
- 84 respondents reported to have had a C-section. The median cost was LBP 5,251,250 (LBP 1,000,000 in 2022). The corresponding figure from 2021 was LBP 400,000, 2020 was LBP 425,000 and the year 2019 was LBP 375,000.
- Median cost for assisted home-delivery was not recalled by both the respondents who mentioned to have had a home delivery (LBP 400,000 IN 2022; LBP 362,500 in 2021 and LBP 340,000 in 2020).

(iii) Post-natal care services

- Only 38.4% (103) of the 268 women who had delivered and answered the question had sought post-natal care (PNC) services. The corresponding figure in 2022 was 32%.

- Of the ones not seeking PNC, 69.8% thought that the services were not necessary (75% in 2022), and 17.4% could not afford the clinic fees (12% in 2022).

(iv) Family planning

- 1,415 households were willing to answer questions about family planning. (This constitutes 89.6% of all households which is higher than that in 2022 (76.5%).
- Of these, 61.9% (670) reported using some method of family planning (53% in 2022).
- 32.6% of respondents used traditional methods (withdrawal, calendar, etc.) 26.1% used contraceptive pills, 25.7% used IUDs and 10.8% used condoms. This is an improvement from the year 2022 where 41.8% of respondents used traditional methods only (withdrawal, calendar etc.) 20.6% used contraceptive pills, 25.9% used IUDs and 5.9% used condoms.
- Most common reasons for not using family planning included planning for pregnancy (27.8%), spouse being away/divorced or dead (14.4%), one of the spouses being incapable of childbearing due to age (21.0%) and one of the spouses being incapable of childbearing due to health reasons/sterility (12.7%). The same top four reasons were reported in 2022.

D. Childhood vaccinations

- Questions about vaccinations were asked to households for 895 children < 5 years old. 88.4% (791) had received a vaccination booklet. Corresponding figures in 2022 were 89%.
- 78.9% of children had received oral polio vaccination, and 81.8% had received injectable vaccines. The corresponding figures from the 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.
- 91.4% of the children who had received injectable vaccines in Lebanon got at least one of their vaccinations in a primary health care facility, 4.8% in a UNHCR reception center and 3.6% in a mobile clinic. Corresponding figures from 2022 were 87% (PHC), 3.7% UNHCR reception center and 3.7% in a mobile clinic.
- 23.2% (169) of refugees that had received injectable vaccines in Lebanon had to pay for the vaccination (25% in 2022).
- Refugees paid a median cost of LBP 50,000 for vaccination services (for those who reported paying). Corresponding figure 2022 was LBP 82,500.
- Reasons given by the 84 respondents whose children had not been vaccinated included child ill at time of vaccination (24.4%; 2022: 17%), did not think it was necessary (20.0%; 2022: 14%), fees too high (17.8%; 2022: 15%), couldn't afford transportation (6.7%; 2022: 7%) and didn't know where to go (6.7%; 2022: 2%).

E. Chronic conditions

- 42.3% (668) of 1579 households responding to the question reported at least one member with a chronic condition (49.8% in 2022).
- 12.8% (949 of the 7,412 household members, reported to have a chronic medical condition (21% in 2022). This constitutes a decrease 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: asthma/pulmonary disease (15.6%; 16% in 2022), hypertension (21.5%; 17% in 2022), diabetes (13.6%; 12% in 2022), heart disease (10.1%; 11% in 2022), physical disability – such as cerebral palsy or paralysis after stroke 5.3%; (4% in 2022), thyroid disorders 6.0%; (5% in 2022) and kidney disease 4.3%; (3% in 2022).
- 59.5% (560) of the 941 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 61% in 2022, 46% in 2021 but closer to the 2020 values of 68%.
- 400 individuals amongst the 560 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 400 individuals 50% (200) to a pharmacy, 36.8% (147) had gone to a primary health care facility and 9% (36) to a private clinic. This shifted in the direction of more people accessing medicines from the private pharmacies as compared from the previous year where the corresponding figures were 44% (426) had gone to a primary health care facility, 34% (326) to a pharmacy, and 15% (144) to a private clinic.
- 78.1% of those who sought care had to pay for the services (72% in 2022). 42.1% of those who went to primary health care facilities received services for free (25% in 2022).
- Of those who did have to pay, the median cost, not considering health care outlet, was LBP 1,075,000 while it was LBP 360,000 in 2022 and LBP 122,500 in 2021.
- The main barrier to accessing care for chronic conditions was the inability to pay clinic fees (46.9%; 39% in 2022, 50% in 2021 and 50% in 2020) or medicines (20.1%; 24% in 2022, 33% in 2021 and 28% in 2020). Another important observation was that 8.4% (2022: 10%) could not access the services as they were not provided by the health center. Furthermore, 7.9% (2022: 5.3%) felt it was unnecessary.

F. Acute conditions

- 14.5% (1074) of the 7,338 household members amongst the households who responded to the question reported to have had an acute condition during the month preceding the survey (37.6% in 2022; 13% in 2021). The most common symptoms reported were upper respiratory tract symptoms runny nose, sore throat - (23.5%; 32% in 2022; 28% in 2021), cough/asthma (15.9%; 11% in 2022; 21% in 2021), fever (12.1%; 13% in 2022; 15% in 2021), headache (7.1%; 4% in 2022; 14% in 2021), joint and back-pain (13.2%; 8% in 2022; 11% in 2021), diarrhoea/vomiting (13.1%; 6% in 2022; 11% in 2021) and stomach pain (7.4%; 4% in 2022; 12% in 2021).
- Among the ones reporting being acutely ill, 24.3% (257) did not seek health care (24% in 2022; 33% in 2021). The reasons reported were could not afford clinic fees (56.7%; 56% in 2022 and 68% in 2021) and thinking it was not necessary (14.4%; 2% in 2022 and 16% in 2021) and not affording transport (18.2%; 13% in 2022; 13% in 2021).

- Out of the 801 that sought health care and answered the question, 42% (333) went to a pharmacy, 36% (284) to a primary health care facility, 13% (102) to a private clinic and 8% (65) to a hospital. In the year 2022, 39% (819) went to a pharmacy, 39% (825) to a primary health care facility, 13% (283) to a private clinic and 6% (126) to a hospital.
- 89.3% (698) of the 782 who sought care and responded to the question got health care at the first facility they went to. The corresponding figure from 2022 was 91% and 2021 was 89%.
- Respondents who could recall the amount they had paid for care reported the following median costs: Overall LBP 500,000 (LBP 900,000 in 2022; LBP 150,000 in 2021), primary health care facilities LBP 250,000 (LBP 200,000 in 2022; LBP 30,000 in 2021), pharmacies LBP 500,000 (LBP 120,000 in 2022; LBP 150,000 in 2021), and hospitals 2,500,000 (LBP 1,217,500 in 2022; LBP 500,000 LBP in 2021). The reduction in the overall median cost could be attributed to an increase in the number of individuals who sought health care at the pharmacy.
- Reasons for not receiving services despite seeking them includes: couldn't afford the fees (56.7%; 56% in 2022 and 43% in 2021), could not afford transport (18.2%; 13% in 2022 and 13% in 2021) and felt it was unnecessary (14.4%; 2% in 2022 and 16% in 2021).

G. COVID-19: Knowledge and vaccination

- This section was newly introduced in the HAUS 2022 and continued in HAUS 2023.
- Regarding methods for protecting households against COVID-19, most respondents reported methods such as wearing mask in public places (20.9%; 2022: 28%), using hand sanitizer (20.3%; 2022: 19%), physical distancing (13.9%; 2022: 17%), washing hands with soap and water (18.4%; 2022: 16%), staying at home (18.5%; 2022: 11%) and not touching face (7.6%; 2022: 4%).
- 88.9% (n=1224) of the respondents reported that they would seek care if anyone in their household had COVID-19 disease. The corresponding figure from 2022 was 81%.
- Regarding places that respondents would seek care for COVID-19, most mentioned were NGO facility (49.2%; 2022: 38%), UNHCR contracted hospitals (28.5%; 2022: 30%), pharmacy (7.9%; 2022: 10%), private clinic or hospitals (7.1%; 2022: 7%). However, 7.3% (2022: 6%) of the respondents did not know where to seek care.
- 65.9% (n=904) of the respondents knew that UNHCR subsidizes the cost for care COVID-19 disease. Corresponding figures from 2022 was 63%.
- All population residing in Lebanon aged 12 years and above were eligible to receive COVID-19 vaccination. Amongst the eligible participants 45.2% (2022: 41%) were reported to have received any vaccination against COVID-19. 34.4% of the eligible participants (2022: 25%) were reported to have received at least two doses of the vaccine.
- 73.4% (n=1200) (2022: 75%) of the respondents who received the COVID-19 vaccine had received it at the National Vaccination Centre (MOPH). 19.9% (n=326) (2022: 18%) of the respondents that received COVID-19 vaccine, reported to have received it at the UNHCR mobile vaccination unit.
- The main reason for vaccination hesitancy was limited trust in the vaccine (54.4%; 2022: 46%), family member or a friend advised against it (11.0%; 2022: 8%), no information about immunization (2.4%; 2022: 1.0%), limited knowledge about where to get it (1.2%; 2022: 1.6%), transportation challenge to the vaccination center (0.6%; 2022: 1.4%).

H. Infant and young child feeding (IYCF) and Nutrition:

- This section was newly introduced in the HAUS 2022 and continued in HAUS 2023. These set of questions were posed to all households that had a child less than 23 months of age.
- 79.6% (n=179) (2022: 76%) of respondents whose household had a child less than 23 months old, reported that the infant in the household has ever been breastfed. 41.1% (n=92) (2022: 50%) of respondents reported that the infant in the household has been breastfed one day before the interview. 57.6% (n=129) (2022: 70%) of respondents reported that the infant in the household ate solid/semi-solid food one day before the interview.
- Regarding initiation of breastfeeding, only 36.9% (2022: 23%) were initiated for breastfeeding within the first 1 hour, and 32.0% (2022: 55%) after one hour.
- 18.8% (n=32) (2022: 20%) of respondents that noticed growth and feeding difficulties for their child sought care. However, amongst these 56.3% (n/N=18/32) (2022: 46%) were not enrolled into any nutrition programme. Amongst the one which were enrolled in any nutrition programme, 31.3% (2022: 37%) were enrolled as outpatients while 25% (2022: 15%) were enrolled as inpatients.

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

- This section was newly introduced in the HAUS 2022 and continued in HAUS 2023.
- 20.9% (290) (2022: 18%) 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 methods cited by the refugees for reaching out to TPA includes, 'by telephone' (42.2%; 2022: 54%), 'going to TPA office in the hospital' (18.7%; 2022: 11%), 'going to the emergency room and the hospital will refer them to the TPA office in the hospital (1.4%; 2022: 2%).'
- 37.7% (109) (2022: 32%) of survey respondents who knew about the UNHCR TPA for referral health care programme but did not know how to reach them.

J. Health communication:

- This section was newly introduced in the HAUS 2022 and continued in HAUS 2023.
- 64.0% (n=882) (2022: 93%) 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 (29.7%; 2022: 58.6%, followed by internet (23.9%; 2022: 1.7%), phone call (18.6%; 2022: 18%), WhatsApp communications (15.7%; 2022: 16%) and community health volunteers (9.4%; 2022: 2.8%).

Limitations

- 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 recollection available to 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 surveyors 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.
- Due to the COVID-19 related public health restrictions some of the statistics from the year 2023 and 2022 are not directly comparable with the year 2021 and 2020. Therefore, wherever required, the findings from 2021 and 2020 are also shared in the report.
- Fluctuation of the national currency, the Lebanese Pound 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 an USD and presented accordingly.

Conclusions

The access-to and utilization of health care showed mixed findings in comparison to findings from previous years:

- There was a decrease in the access to ANC (67% in 2023 vs 88 %, 70% and 86% in 2022, 2021 and 2020) but the ones who had delivered went for 4 ANC visits showed an increase (69% in 2023 vs 61%, 49% and 61% in 2022, 2021 and 2020);
- Of pregnant women going for ANC, 58% went to public PHC facilities compared to 62%, 68% and 59% in 2022, 2021 and 2020.
- The usage of family planning measures has improved as compared to the year 2022 (62% in 2023 versus 53%, 63% and 61% in 2022, 2021 and 2020). However, of these, 1/3rd of the households were only using traditional methods for family planning.
- The percentage of children below 23 months of age who had ever been breastfed was 79.6%. This is slight improvement from last year when 76% of the children less than 23 months of age were breastfed. Amongst those who were breastfed, 37% were initiated breastfeeding within an hour which is an improvement from last year when less than a quarter (23%) were initiated breastfeeding within the first 1 hour.
- Access to medications for chronic disorders stayed low and decreased as compared to the previous year (60% in 2023 versus 61%, 46% and 68% in 2022, 2021 and 2020).
- There was a decrease in the number of chronically ill persons who accessed care in PHCs (37% in 2023 versus 44%, 44% and 39% in 2022, 2021 and 2020).
- The number of persons with acute disorders who decided to seek health care stayed the same as compared to the previous year (76% in 2023 compared to 76%, 67% and 77% in 2022, 2021 and 2020).
- Like the previous year, 39% of the acutely ill persons sought care in public PHC facilities compared to 39%, 40% and 31% in 2022, 2021 and 2020.

- There has been a slight improvement in number of children who have received the oral polio vaccine and a slight decline in the percentage who received injectable vaccine in the year 2023 as compared to the previous years. The low values in the year 2021 could be attributed to the COVID-19 related public health restrictions whereby vaccination coverage was declining (79% of children had received oral polio vaccination and 82% had received injectable vaccines in 2023; 76% of children had received oral polio vaccination and 89% had received injectable vaccines in 2022; Corresponding figures for the year 2021 were 72% and 86% respectively and for the year 2020, the figures are 83% and 87% respectively).
- 72% of households knew that that refugees have to pay in Lebanese Pounds for accessing subsidized services at primary health care facilities. This question was adapted from last year where 67% of the households knew that refugees have access to subsidized services. There was a significant improvement in the number of households who knew that UNHCR supported life-saving hospital care and care for deliveries (89% in 2023 versus 82% in 2022).
- Albeit with a slight decline, preferred mode of communication for health and health services remained through some form of phone communication (Phone call, Text message or WhatsApp message) (64% in 2023 versus 93% in 2022). However, there was an increase in the number of respondents who preferred communication by internet (24% in 2023 versus 2% in 2022).
- There is an increase in the household expenditure on health services and reflects the devaluation of the Lebanese pound and the removal of subsidies on medicines. Albeit, the quantification of this increase is limited by the fluctuation of the currency over the year.

Discussion:

The Health Access and Utilization Survey (HAUS) for 2023 highlights both improvements and challenges in healthcare access among refugees in Lebanon. According to the 2023 vulnerability assessment for Syrian refugees (VASyR), 20% had to borrow money in 2023 to pay for healthcare. Albeit there is slight improvement as compared to 24% and 22% in 2022 and 2021 respectively. Notable findings include a decrease in overall access to antenatal care (ANC) compared to the previous three years. However, among those who delivered, the proportion who attended four ANC visits increased showing improvement over previous years which suggests that while fewer individuals accessed ANC services, those who received care were more likely to adhere to the recommended four-visit schedule showing a need to address barriers to accessing ANC. Family planning usage showed improvement, though traditional methods remain prevalent. Access to medications for chronic disorders and healthcare utilization in primary health care (PHC) centers decreased slightly, reflecting ongoing challenges. Low vaccination coverage was observed with 79% receiving oral and 82% injectable polio vaccine. Vaccination is provided free-of-charge at the PHCs, all LRC mobile medical units and the UNHCR reception centers. Therefore, cost should not be the major factor contributing to decline. Further, exploration into the causes mentioned for failure to vaccinate is needed. Despite increased awareness among refugees that healthcare services should be paid for in Lebanese Pounds, their understanding of UNHCR-supported life-saving hospital care and delivery services has not significantly improved compared to previous years highlighting need for additional measures to improve awareness of these healthcare services. The survey findings, though affected by the

COVID-19 pandemic, currency fluctuations, and potential response biases, provide critical insights for addressing healthcare gaps and planning interventions.

Recommendations

Recommendations based on the results of the 2023 HAUS findings are:

1. Enhance Access to Antenatal Care (ANC): Implement targeted interventions to improve access to ANC services, especially among pregnant women. This could include community outreach programs, mobile clinics, and awareness campaigns highlighting the importance of ANC visits. Focus on increasing the number of ANC visits per pregnancy to ensure comprehensive prenatal care and early detection of potential complications.

2. Strengthen Utilization of Public Primary Health Care (PHC) Facilities: Address barriers to accessing PHC facilities by pregnant women, including geographical barriers, financial constraints, and through culture-sensitive communication.

3. Promote Modern Family Planning Methods: Expand access to a variety of modern contraceptive methods, including long-acting reversible contraceptives (LARCs), through subsidized family planning services at PHC facilities.

4. Support Early Initiation of Breastfeeding: Integrate breastfeeding education and support programs (e.g., baby friendly hospital initiatives, etc.) into routine ANC visits to ensure that pregnant women receive information and counseling on the importance of early initiation of breastfeeding.

5. Enhance Awareness Raising on Services for Survivors of Domestic Abuse or Sexual Violence. Conduct awareness activities jointly with other sectors through outreach volunteers and in visited facilities on Domestic Abuse and Sexual Violence with focus on where to access relevant services.

5. Improve Access to Medications for Chronic Disorders: 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. This includes but is not limited to establishing medication supply chains and procurement systems that prioritize the availability of essential medications for chronic disorders at PHC facilities, ensuring uninterrupted access for patients.

6. Increased Awareness and Utilization of Vaccination Services: Conduct targeted community outreach campaigns to raise awareness about the importance of vaccination and address misconceptions, particularly among caregivers of young children. Address misinformation and vaccine hesitancy through targeted communication campaigns and community engagement efforts highlighting the important of childhood vaccination amidst multiple constraints.

7. Enhance Health Communication Strategies: Adapt health communication strategies to meet the evolving preferences of the population, including increased use of internet-based communication platforms alongside traditional methods. Furthermore, develop culturally sensitive and interactive health education materials for internet-based platforms, leveraging social media influencers and online communities to disseminate accurate health information effectively.

8. Mitigate Financial Barriers to Healthcare: Explore options to mitigate the financial burden of healthcare expenses on households, particularly considering the devaluation of the Lebanese pound, removal of subsidies on medicines, increased patient share for hospitalization. Consider exploring innovative schemes which support risk-pooling and sharing responsibilities with refugees to enhance protection for the most vulnerable populations.

9. Monitor and Evaluate Interventions: Continue monitoring and evaluation mechanisms such as HAUS, to assess the impact of implemented interventions on healthcare access and utilization indicators. These data-driven insights should be used to refine and adapt public health programs to address emerging needs and challenges effectively considering the resource limitations.

Summary Charts

Baseline Characteristics of Population and Sample

1.1 Survey response

4,039
Number of households selected to participate in the study

60.9%
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=2460/4039)

1.2 Sample population

1,579
Number of households reached and agreed to participate in the study

7,576
Number of household members in surveyed households

4.8
Average number of household members in surveyed households, including the head of household

50.1%
Proportion of household members who are female (n=3761/7502)

11.3%
Proportion of household members who are <5 years old (n=847/7502)

Figure 1: Distribution of households by governorate (n=1576)

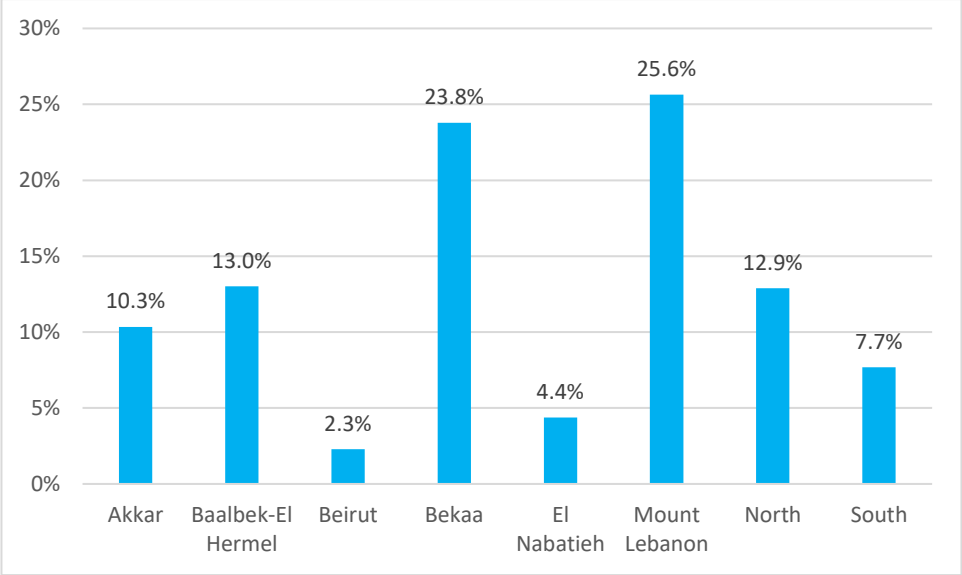
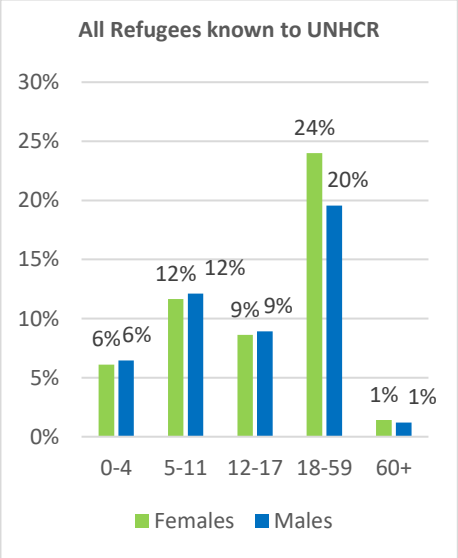
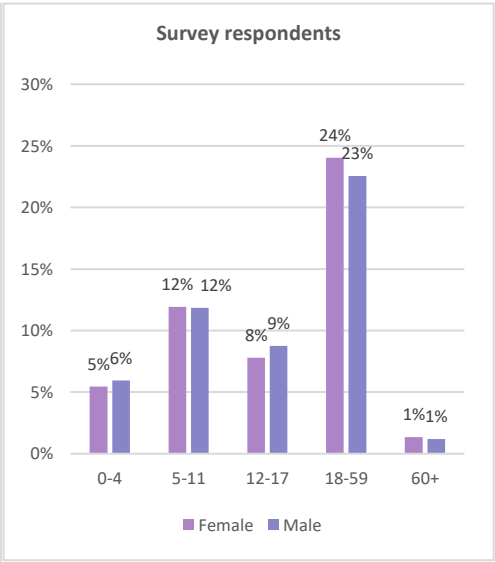


Figure 2: Age and sex distribution of household members (n=7,502)





Knowledge about available services and health care expenditure

2.1 Knowledge

72.1%

Proportion of households knowing that refugees should pay contributions in Lebanese pounds at the PHCCs (n=1003/1392)

89.4%

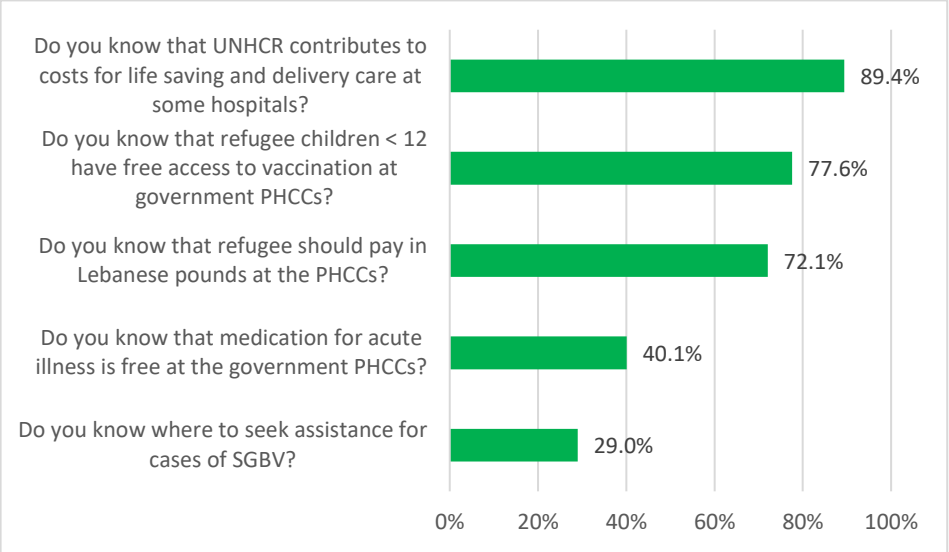
Proportion of households knowing that UNHCR supports hospitalization for life threatening conditions and deliveries (n=1239/1386)

77.6%

Proportion of households knowing that vaccinations are free for children <12 years in government facilities (n=1070/1379)

40.1%

Proportion of households knowing that medicines for acute conditions can be obtained for free in governmental PHCCs (n=553/1380)



2.2 Health care expenditure

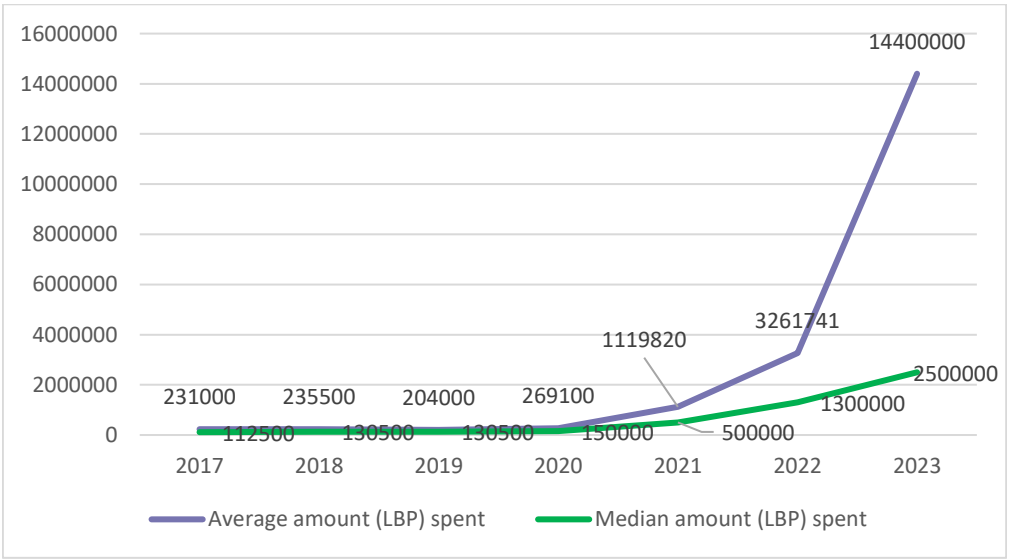
63.0%

Proportion of households spending money on health care the month preceding the survey (n=879/1395)

2,500,000 LBP

Median amount spent by the households spending on health care the month preceding the survey (n=564)

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 2023



Antenatal Care and Deliveries

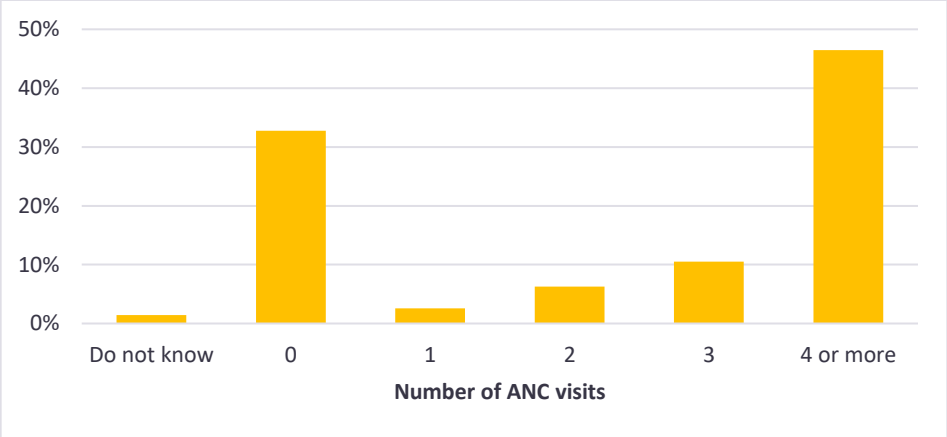
3.1 Antenatal care (ANC)

67.2%
Proportion of women who delivered who accessed ANC (n=236/351)

69.1%
Proportion of women who delivered who went for at least 4 ANC visits (n=163/236)

26.7%
Proportion of women who received ANC at more than one facility (n=63/236)

Figure 3: Number of ANC visits among women who delivered during past 2 years (n=351)



3.2 Deliveries

0.7%
Proportion of deliveries at home (n=2/269)

78.7%
Proportion of deliveries supported financially by UNHCR (n=210/267)

31.5%
Proportion of deliveries by C-section (n=84/267)

2,789,795 LBP
Median cost of vaginal delivery supported by UNHCR (n=183)

5,251,250 LBP
Median cost of C-section supported by UNHCR (n=84)

Figure 4: Place for last ANC visit (n=236)

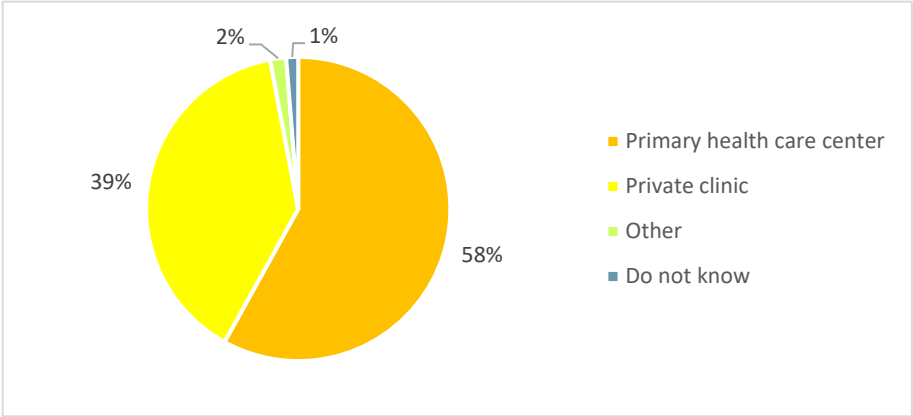
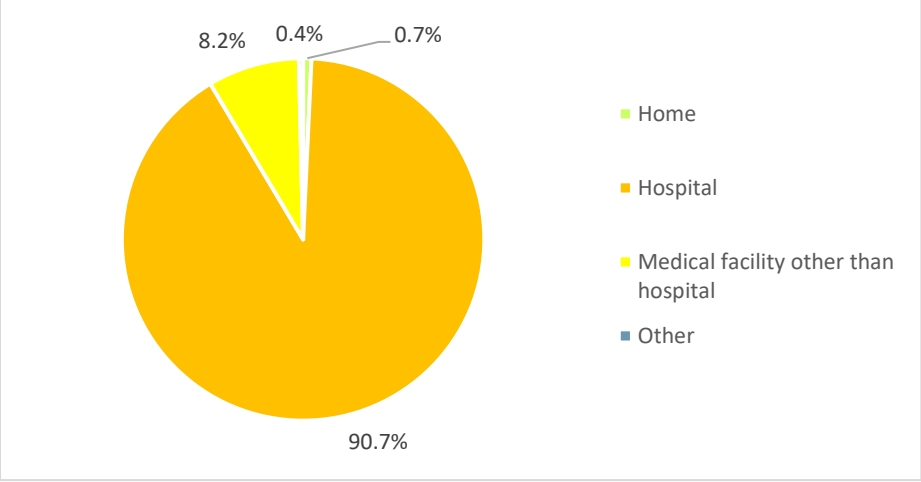


Figure 5: Place of delivery (n=269)



Postnatal Care, Family Planning and Child Care

4.1 Postnatal Care (PNC)

38.4%

Proportion of women who delivered who went for a postnatal care visit (n=103/268)

4.2 Family Planning

61.9%

Proportion of total households reporting using some kind of contraceptive method (n=670/1082)

4.3 Child Care

82%

Proportion of children <5 that had received injectable vaccines at any point (n=732/895)

96%

Proportion of children received injectable vaccine that got vaccinated in Lebanon (n=698/726)

75%

Proportion of children vaccinated in Lebanon that was vaccinated for free (n=549/729)

91.4%

Proportion of children vaccinated in a PHCC (n=668/731)

3.6%

Proportion of children that only had received vaccination in a UNHCR reception center (n=26/731)

Figure 6: Reasons for not going for PNC (n=149)

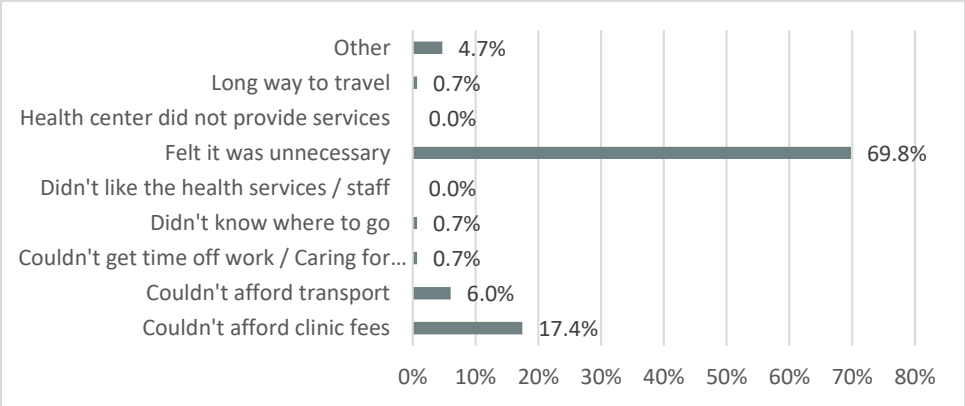


Figure 7: Choice of family planning methods (n=410)

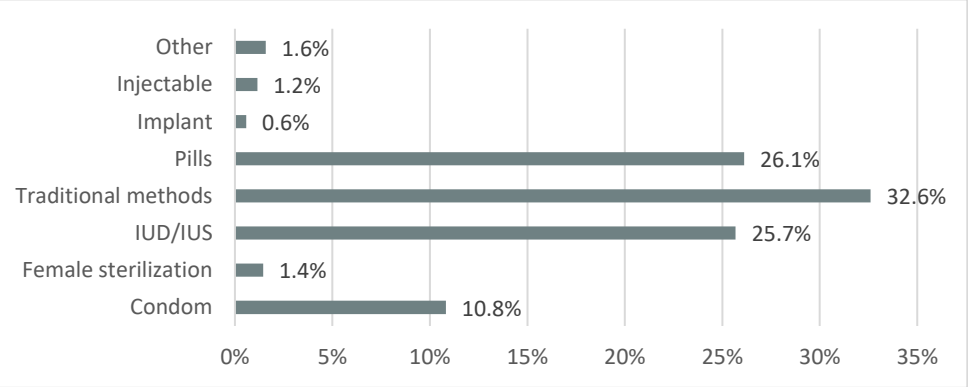


Figure 8: Reasons for not using family planning (n=693)

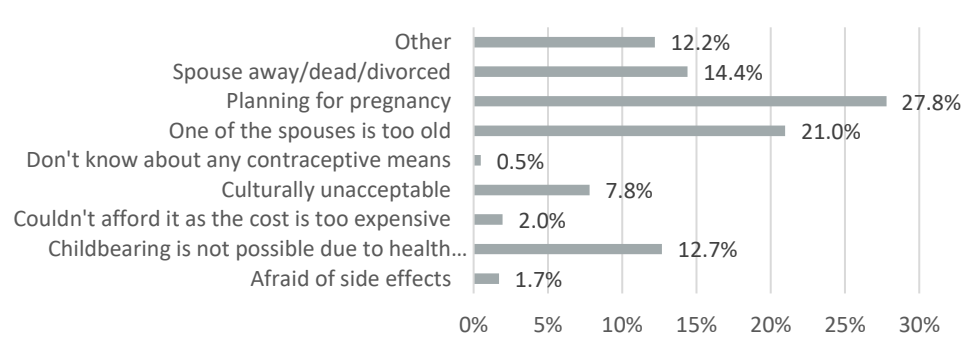
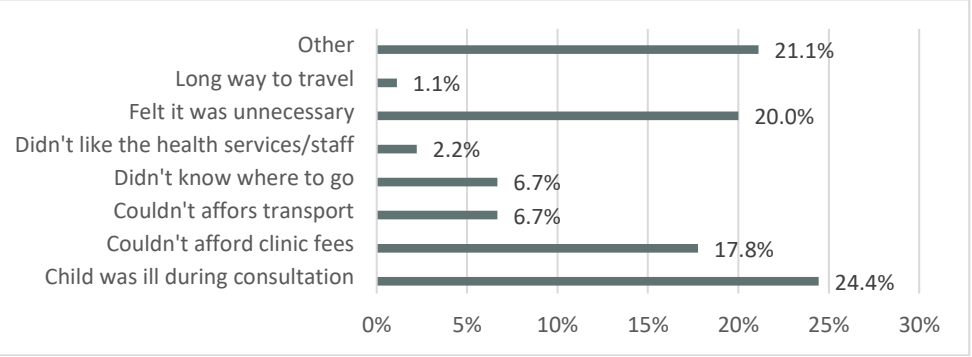


Figure 9: Reasons for child not being vaccinated (n=90)



Chronic Conditions (N=7439)

5.1 Prevalence

12.8%
Proportion of respondents who reported having a chronic condition (n=949/7412)

37.3%
Proportion of respondents 40 years or above who reported having a chronic condition (n=424/1137)

42.3%
Proportion of households with at least one member having a chronic disorder (n=668/1579)

38.2%
Proportion of individuals that reported having more than one chronic condition (n=360/943)

5.2 Access

59.5%
Proportion of respondents who have accessed care/medication for their chronic condition during the last 3 months (n=560/941)

48.3%
Proportion of individuals that primarily sought care in pharmacies (n=270/559)

1,075,000 LBP
Median cost of care/medication for chronic disorders during the last 3 months (n=420)

Figure 10: Proportion of different chronic conditions reported (n=1258)

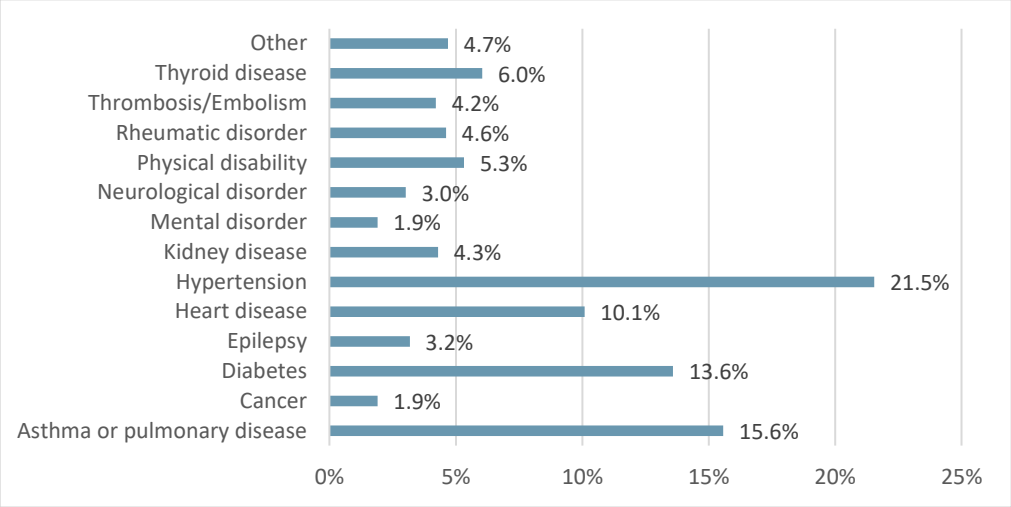


Figure 11: Reasons for not accessing chronic care (n=478)

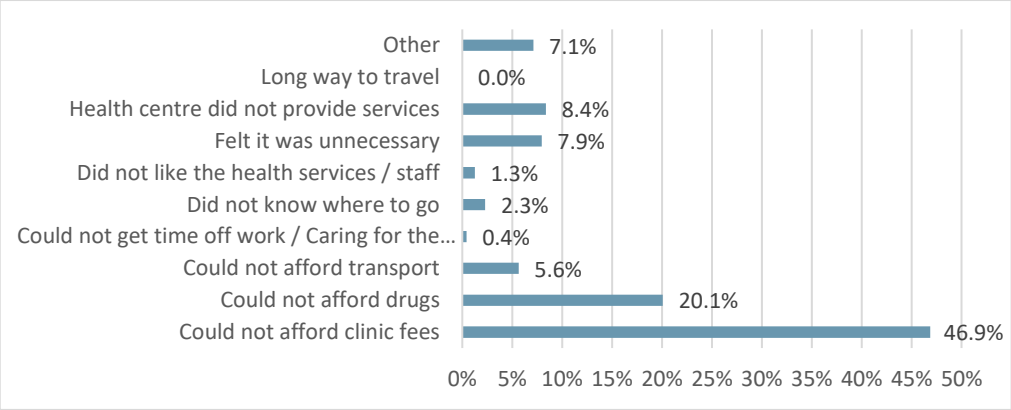
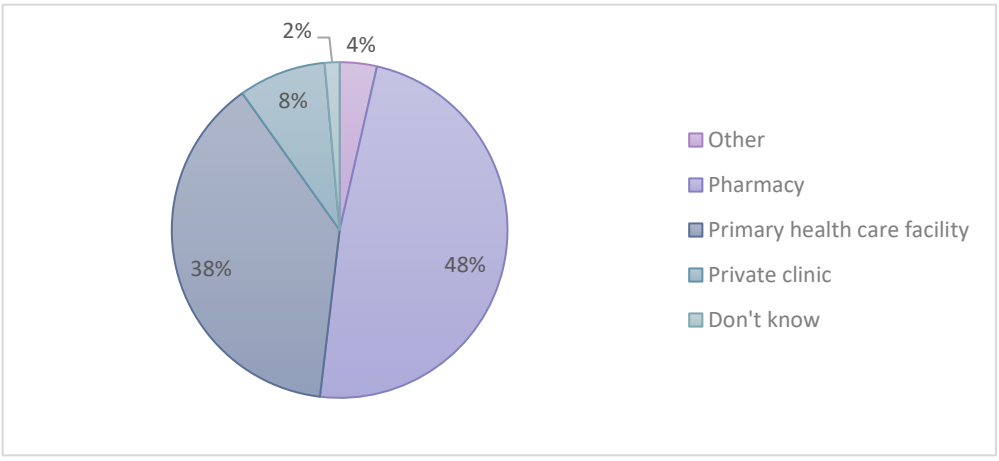


Figure 12: Where sought care for chronic disorder (n=559)



Acute Conditions (N=7,388)

6.1 Incidence

14.5%

Proportion of respondents who reported having an episode of acute illness during the last month (n=1074/7388)

6.2 Access

75.7%

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

89.3%

Proportion of individuals that sought health care for an acute illness that got it at first point of care (n=698/782)

41.7%

Proportion of individuals that sought health care primarily in pharmacies (n=333/798)

500,000 LBP

Median cost of care for episode of acute illness during the last month (n=43)

Figure 13: Symptoms of reported acute illness during last month (n=1518)

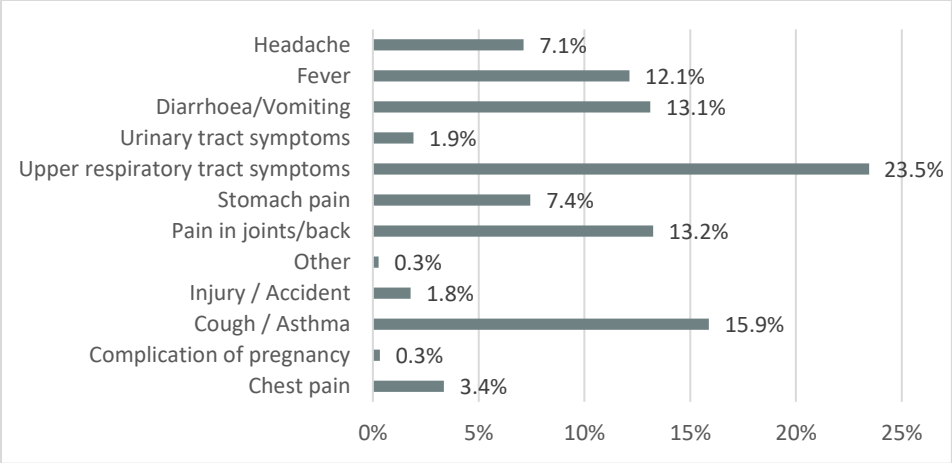


Figure 14: Reasons for not seeking care for acute illness (n=291)

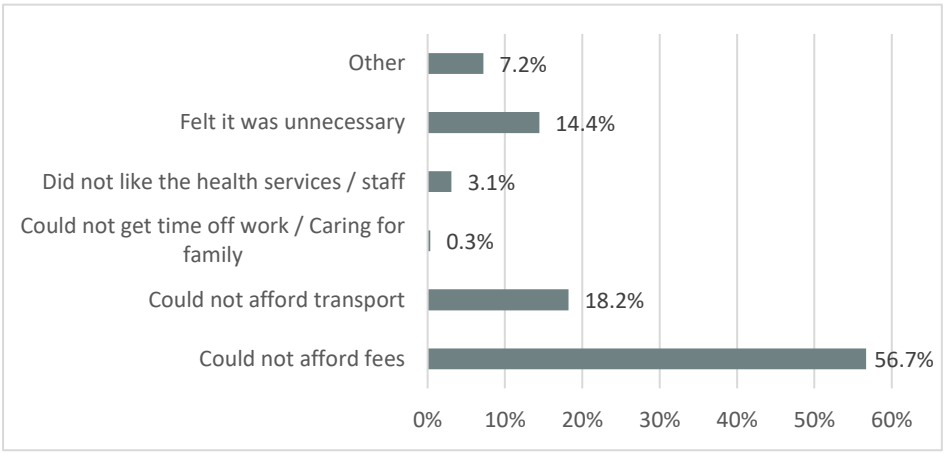
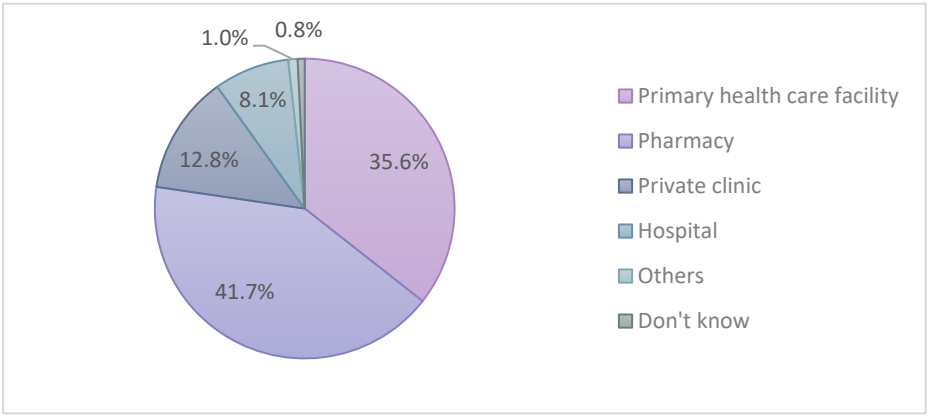


Figure 16: where sought care for acute illness (n=798)



COVID-19

7.1 Knowledge

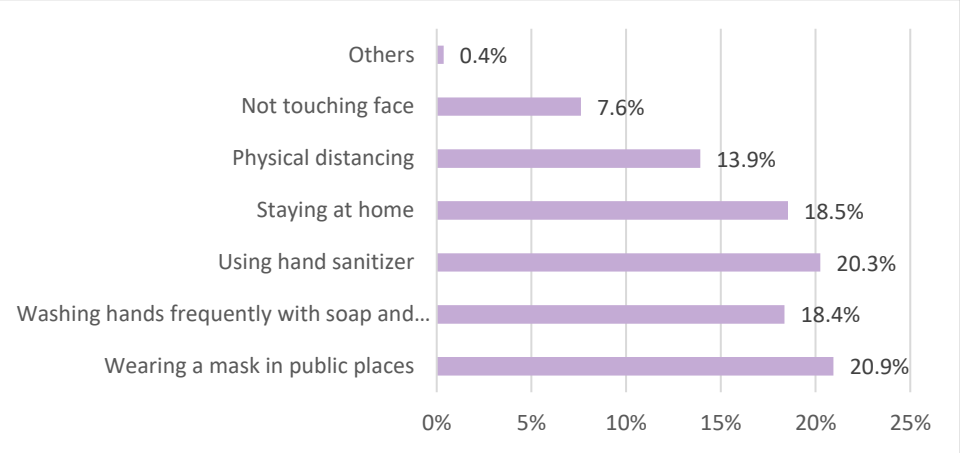
88.9%

Proportion of respondents reported that they would seek care if anyone in their household had COVID-19 (n=1224/1377)

65.9%

Proportion of respondents that knew that UNHCR subsidizes the cost for COVID-19 care (n=904/1372)

Figure 17: Methods for protecting households by COVID-19 reported (n=4335)



7.2 Vaccine

45.2%

Proportion of household members that reported having received any vaccination against COVID-19 (n=1638/3622)

34.4%

Proportion of respondents that reported to have received two doses of COVID-19 vaccine (n=1246/3622)

73.4%

Proportion of respondents that received COVID-19 vaccine, reported to have received it at the National Vaccination Centre (MOPH) (n=1200/1635)

19.9%

Proportion of respondents that received COVID-19 vaccine, reported to have received it at the UNHCR mobile vaccination unit (n=326/1635)

Figure 18: Places that respondent would seek care for COVID-19 (n=1720)

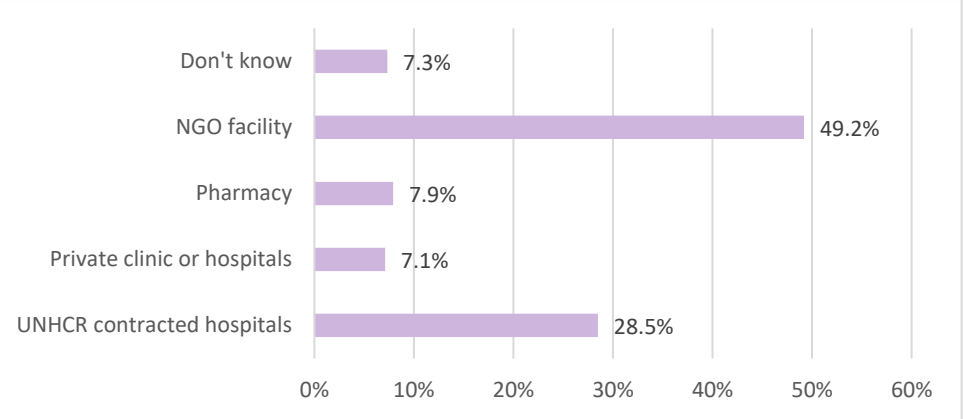
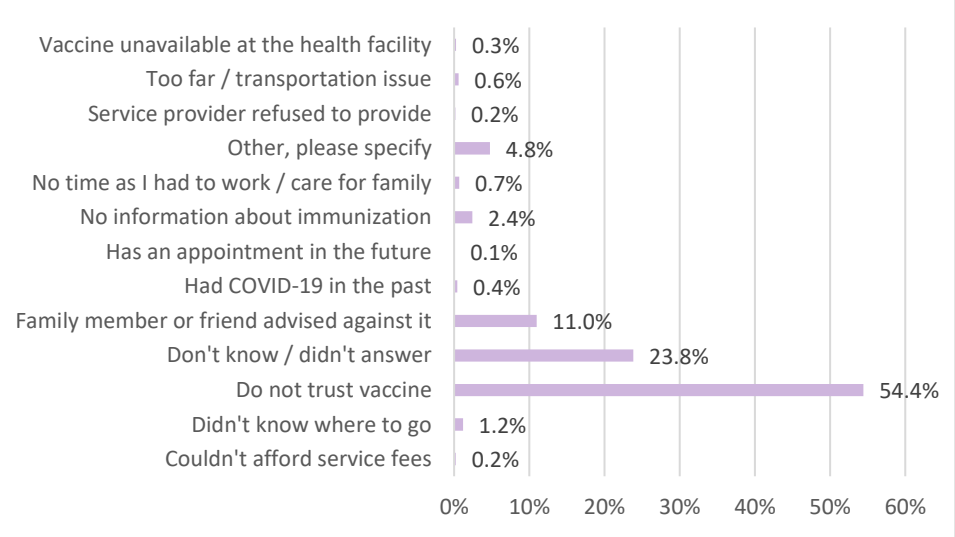


Figure 19: Reasons for not taking the COVID-19 vaccine (n=1868)



Infant and young child feeding (IYCF)& Nutrition (N= 225)

8.1 IYCF

79.6%

Proportion of respondents reported that the infant in the household has ever been breastfed (n=179/225)

41.1%

Proportion of respondents reported that the infant in the household has been breastfed one day before the interview (n=92/224)

57.6%

Proportion of respondents reported that the infant in the household ate solid/semi-solid food one day before the interview (n=129/224)

8.2 Nutrition

18.8%

Proportion of respondents that noticed growth and feeding difficulties for their child and did seek care (n=32/170)

Figure 20: Time when the initiation of breastfeeding took for the infant in the household (n=222)

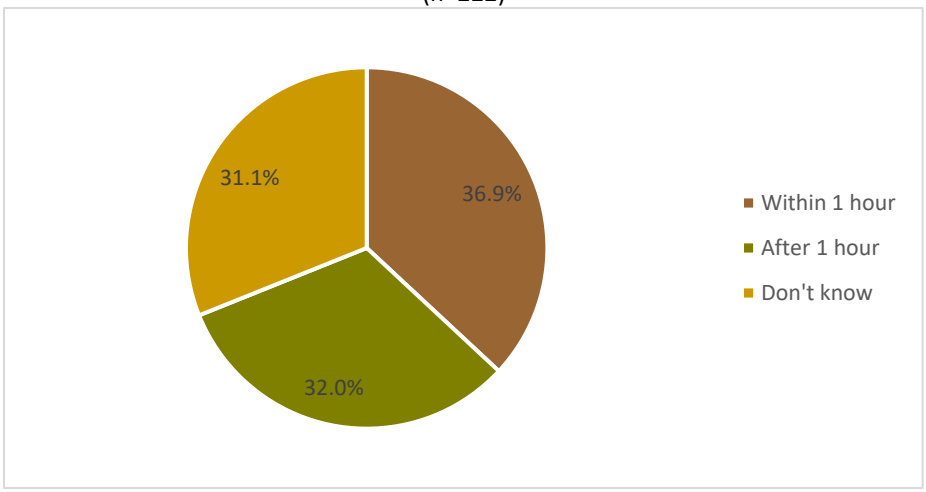


Figure 21: Respondents noticed any growth and feeding difficulties over the last months (n=889)

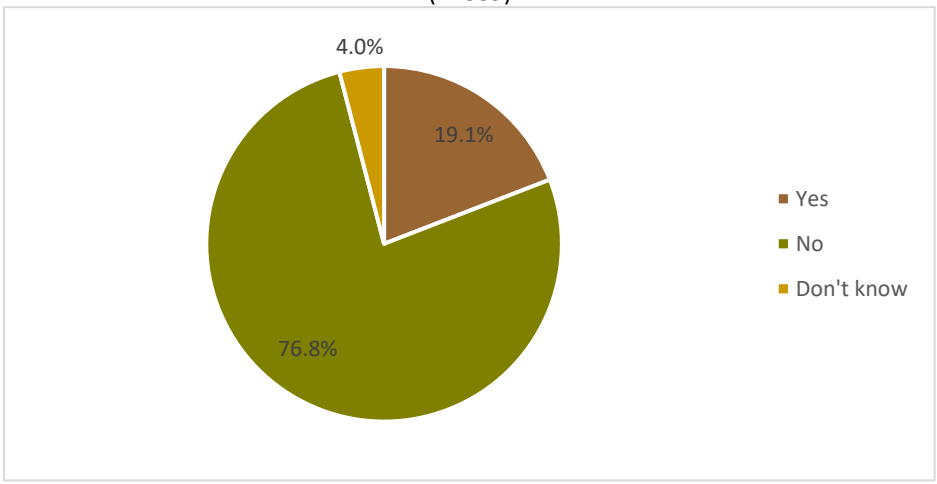
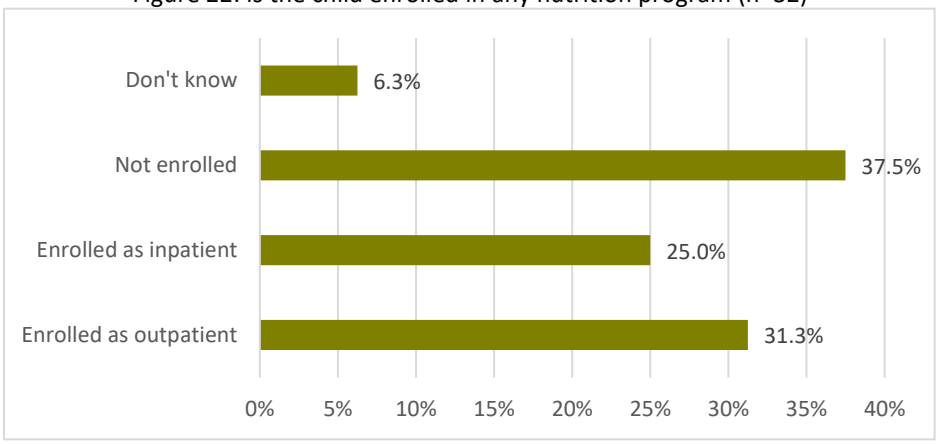


Figure 22: Is the child enrolled in any nutrition program (n=32)



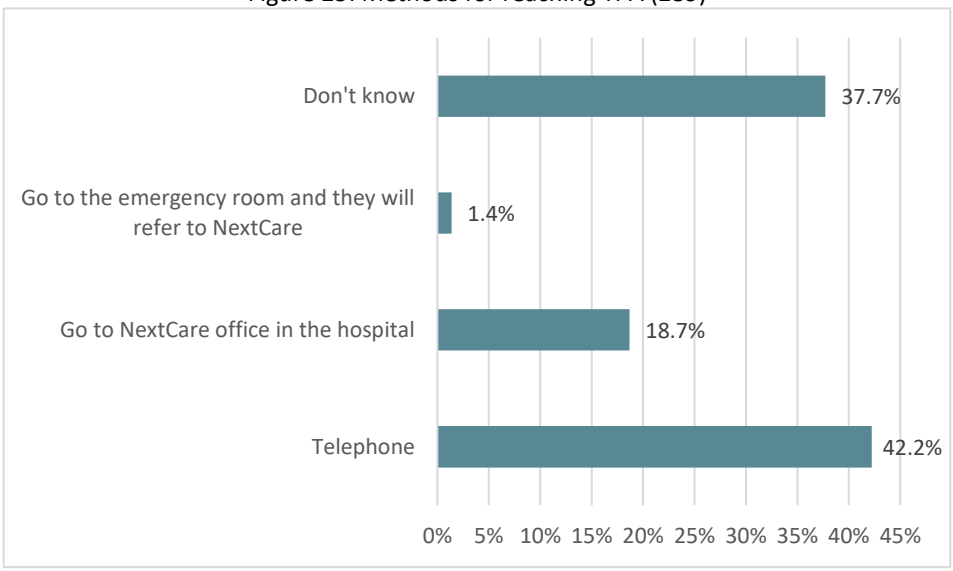
Third-party administrator – TPA (N= 289)

9.1 Knowledge

37.7%

Proportion of survey respondents who knew about the UNHCR TPA for referral health care programme, but did not know how to reach them (n=109/289)

Figure 23: Methods for reaching TPA (289)



Health communication (N= 1379)

10.1 Health communication

64.0%

Proportion of respondents who preferred some form of phone communication (Phone call, Text message or WhatsApp message (n=882/1379)

Figure 24: Preferred mode for receiving health information reported by the respondents (n=1379)