

Health access and utilization survey among Syrian refugees in Lebanon

UNHCR, December 2018



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 10 PHC facilities where a basic package of health care services¹ is provided for free or at subsidized prices for refugees. In addition, UNHCR supports two centers specialized in mental health. In total, there are 137 primary health care facilities² countrywide supported by partners in which subsidized care is available for refugees. Referral 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 referral care support, UNHCR contracts a Third Party Administrator (TPA) and since January 2017 this is NEXtCARE. In July 2018, in order to control utilization and high costs of the UNHCR referral care programme, a new cost-sharing scheme was introduced which meant that beneficiaries need to pay a higher proportion of low-cost admissions than before. At the same time beneficiary contribution to high cost admissions was reduced. This change is expected to increase beneficiaries' expenditure on low cost admissions such as deliveries and might influence health seeking behavior for certain pathologies (common infectious diseases) towards primary health care rather than hospital emergency rooms (ER).

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 telephone HAUS surveys 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 refugees' 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 2017.

Methods

- The survey was conducted through telephone interviews from the 8th to 15th of November 2018.

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.

- The survey was conducted by operators in a call-center who got 1 day of training.
- Surveyed households were selected using random sampling, from a master list provided by UNHCR registration unit containing all registered refugees in Lebanon (as of October 2018), with a valid telephone number in the database.
- The WHO STEP sample size calculator was used to obtain a representative sample³.
- 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 respondents were informed that information provided would be confidential and participation 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**
 - In case of absence, adult 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 2011.

Key findings

A. Baseline characteristics of population

- At the time of the survey, the population of registered Syrian refugees in Lebanon numbered 951,629 individuals, living in 217,034 households (4.4 individuals per household).
- 48% of the refugees were male and 52% female.
- 16% of the refugee population was less than 5 years old.

B. Baseline characteristics of sample

- A total of 1351 households were selected to participate in the survey (originally 1051 but 300 added due to low response rate).
- 479 (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. Only two households actively declined to take part in the study.

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

- The main reason for the lower than expected response rate is believed to be that refugees are familiar with the call-center number and choose not to respond to calls.
- Participating households had a total of 2214 members, and surveyed households had an average number of 4.6 individuals.
- 51% of surveyed household members were female and 19% were less than 5 years old.

C. Knowledge about available services and health care expenditure

- 457 households answered on questions about knowledge on available assistance
- 60% 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 2017 was 55%.
- 80% of households knew that UNHCR supported life-saving hospital care and care for deliveries. Corresponding figure from 2017 was 74%.
- 62% knew that vaccination for children <12 years is free at primary health care facilities. Figure in 2017 was 59%.
- 22% of respondents were aware of how to obtain services for survivors of domestic abuse or sexual violence. Figure in 2017 was 31%.
- 34% of respondents knew that drugs for acute conditions could be obtained for free at primary health care facilities. Figure in 2017 was 42%.
- 73% of households reported spending money on health care the previous calendar month. This is a significant increase from corresponding figure from 2017 which was 53%. However, corresponding figure in 2016 was 65%. The increase seen for 2018 is also reflected in the number of persons reporting having an acute condition during the previous month (see below).
- Refugees who needed care spent an average of USD 157 (median: USD 87) in the month preceding the survey. Corresponding figures from 2017, 2016 and 2015 were USD 154, USD 148 and USD 136 respectively. Median expenditure increased from 75 USD in 2017.

D. Sexual and reproductive health

(i) Antenatal care services

- 219 women reported having been pregnant during the 2 years preceding the survey. 78% (171) delivered during this period.
- 72% (123) of the women who had delivered had received antenatal care (ANC) services. Corresponding figure from 2017 was 74%.
- Out of the 123 women attending ANC, 72% went for 4 visits or more.
- Of all women that delivered, 51% went for 4 or more ANC visits which is an increase compared with 2017 during which the corresponding figure was 41%.
- Most common reasons for not accessing ANC services were clinic fees (38%), and thinking that ANC was not necessary (26%). 19% reported to not know where to go for ANC.
- 156 women answered the question about where they had received ANC care. 88 (56%) had gone to a primary health care facility and 67 (43%) had gone to a private clinic.
- 30% of women had received ANC at more than one facility.

- 81% (127) reported having paid for ANC visits while 17% (27) reported they got ANC for free. Median cost for an ANC visit at a primary health care facility (for those who paid and could recall an amount) was USD 9. Corresponding cost at a private clinic was USD 27 USD.

(ii) Delivery services

- 162 out of the 171 women who delivered answered the question about where they had delivered. 88% (143) had delivered in a hospital and 5% (8) had delivered at home. 6% (10) had delivered in facilities that were not hospitals. 4 of the 10 women who had delivered at home were assisted by a trained birth attendant (TBA), 2 by family members and 1 delivered alone.
- Reasons for delivering at home include worrying about hospital costs (50%), and the fact that a midwife was available to assist the delivery at home (50%).
- The proportion of women who reported delivering via caesarean section was 31%.
- 163 of the women who had delivered answered on questions about financial assistance. 75% (122) reported having received financial assistance from UNHCR for their delivery. 13% (22) did not pay anything for their delivery.
- 66 respondents had a UNHCR-supported normal vaginal delivery (NVD) and could estimate what they had paid. The median cost reported was USD 80. The corresponding figure from 2017 was USD 75.
- 11 respondents had vaginal deliveries without UNHCR financial support and could recall the cost. The median cost was USD 200.
- 38 respondents had a UNHCR supported C-section and could estimate what they had paid. The median cost was USD 237.
- 9 respondents that underwent C-section without financial support had a median cost of USD 500.
- Median cost for home-delivery was USD 100.

(iii) Post-natal care services

- Only 26% (42) of the 163 women who had delivered and answered the question, had sought post-natal care (PNC) services. The corresponding figure in 2017 was 28%.
- Reasons for not seeking PNC were thinking that the services were not necessary (56%), and inability to afford the clinic fees (35%).

(iv) Family planning

- 347 households were willing to answer questions about family planning.
- Of these, 57% (197) reported using some method of family planning which is an increase from 48% reported in 2017.
- 38% of respondents used contraceptive pills, 31% used intrauterine devices (IUDs), 13% used condoms, and 25% only used traditional methods (withdrawal, calendar etc.).
- Reasons for not using family planning include, planning for pregnancy (35%), not affording the cost (10%), worries about side-effects (7%), that one (or both) of the spouses was too old for sex or for becoming pregnant (6%) and that contraceptives are culturally unacceptable (5%).
- 29% gave “other” as a reason for not using contraceptive methods. The respondents had been given the option of specifying “other” and closer analysis of these responses revealed reasons such as spouse being away, being ill or dead.

E. Childhood vaccinations

- 430 children < 5 years old were part of the survey and questions were asked about their vaccinations. 88% (379) had received a vaccination booklet.
- 83% of children had received oral polio vaccination, and 88% had received injectable vaccines.
- 10% (38) of 377 children that had received injectable vaccines were vaccinated before arriving in Lebanon.
- The respondents were asked where in Lebanon the children had been vaccinated with injectable vaccines. 80% of the children had been vaccinated at least once in a primary health care facility, 16% in a UNHCR reception center and 10% in a mobile clinic. 10% indicated UNHCR reception center as the only place where they had been vaccinated with injectable vaccines.
- 39% (128) of refugees that had received injectable vaccines in Lebanon had to pay for the vaccination.
- Refugees paid a median cost of USD 7 for vaccination services (for those who reported paying).
- Reasons given by the 27 respondents who did not take children for vaccination included, clinic fees being too high (26%) and didn't know where to go (19%). 48% reported "other" reasons and closer analysis revealed that most commonly it was because the child had been sick at the time for vaccination.

F. Chronic conditions

- 36% (173) of 479 households responding to the question reported at least one member with a chronic medical condition.
- 11% (245) of the 2,210 household members answering, reported to have a chronic medical condition. (16% in 2017).
- Conditions include: (29%) hypertension, (26%) asthma/pulmonary disease, (14%) heart disease, (13%) diabetes and (5%) mental disease.
- 19% reported to have more than one chronic disorder.
- A large proportion (26%) of respondents reported "other" as one of the chronic disorders that they suffered from. Closer analysis showed that the most common other disorders were: Congenital conditions in children, rheumatism, thyroid disorders and embolism/thrombosis.
- 66% of the 238 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 (65% in 2017).
- Of the 165 individuals who could recall the facilities where they had sought care, 45% (69) had gone to a primary health care facility, 14% (22) to a private clinic and 35% (53) to a pharmacy.
- 22% of those who sought care did not have to pay for the services. 43% of those who went to PHCCs received services for free.
- Of those who did have to pay in a primary health care facility median cost was USD 33. Of those who went to a private clinic the median cost was USD 37. Of those who went to a pharmacy the median cost was USD 19.
- The main barrier to accessing care for those with chronic conditions was the inability to pay clinic fees (66%) or cost of drugs (34%).

G. Acute conditions

- 30% (664) of the 2,202 household members who responded to the question reported to have an acute medical condition during the month preceding the survey. This constitute a significant increase from 2017 that had the corresponding figure of 8%. Possible explanation for the big difference is that there were more seasonal infections (i.e. respiratory) during the investigated period in 2018 than 2017. It needs to be considered that the period investigated in 2018 was later in the year than in the 2017 HAUS.
- Among them, 36% (237) did not seek health care for their acute medical condition (23% in 2017). The majority (66%) could not afford clinic fees and 27% did not think it was necessary to seek care.
- Out of the 418 who sought health care and answered the question, 32% (133) went to a primary health care facility, 13% (53) to a private clinic and 7% (28) to a hospital. 47% (196) went to a pharmacy for care.
- 86% (351) of 410 who sought care and responded to the question got health care at the first facility they went to. The corresponding figure from 2017 was 87%.
- 12 of the ones who didn't get care at the first facility sought health care at a second facility and 75% (9) got the needed care. Proportion of all individuals that sought care and eventually got it was 88%.
- 94% (324) of the refugees that received care for acute medical conditions had to pay for the services: 12% got assistance from UNHCR in paying for the services.
- Respondents who could recall the amount they had paid for care reported the following median costs: Overall USD 15 USD, primary health care facilities clinics USD 13, Private clinics USD 44, pharmacies USD 13, and hospitals USD 100.
- Reasons for not receiving services despite seeking them include the facility could not offer the needed services (31%), couldn't afford the fees (26%) and the facility refused to provide the service (4%).

Limitations

- Survey was limited to refugee households registered with UNHCR with a telephone number which means that households without a phone could not be included.
- Despite attempts to account for non-response during sampling and verify telephone numbers prior to the survey, some households declined to participate in the survey and others could not be reached, either because no-one answered or because the phone-number no longer was active. When calling from a call-center with a known number it seems like the likelihood of not answering the phone increased significantly.
- 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 clinics and hospitals might not be clearly understood by the respondents which in turn will affect their answers.

Conclusions

- Awareness of available support remains at same level as in 2017. Areas for which knowledge remains low are: where to obtain free medication and where to obtain support for SGBV.
- Significant increase in proportion of households reporting spending money on health during month preceding survey compared to 2017. On the other hand this year's figure is close to figure of 2016 which suggests that need to spend on health is a dynamic parameter. This year's survey was conducted later in the year than during 2017 which means that incidence of seasonal infections might have been higher among this year's respondents. Average amount spent per household is similar to last year even if trend over several years is increasing.
- No change in number of pregnant women accessing ANC – the figure remains low at 72%. However, the proportion of women who do access ANC seems to go for more visits than previously. A surprisingly high proportion of women prefers private clinics over primary health care facilities despite a clear difference in reported median cost between the two (USD 27 vs 9). The majority of respondents not going for ANC report cost as the major factor influencing the decision but more than a quarter also believe that ANC is not necessary.
- No significant difference in proportion of home deliveries compared to 2017. Median cost for a normal vaginal delivery (NVD) did not increase significantly from 2017.
- Uptake of post-natal care services continue to be low, although no significant change since 2017. As before, the most reported reason for not going for PNC is that it is believed not to be necessary.
- As in previous years, less than half of surveyed households report using a family planning method. As before the most reported reason for not using contraceptives is “planning for pregnancy”.
- There is a decrease compared to 2017 in proportion of respondents reporting having a chronic medical condition. In 2017 however, the proportion was unexpectedly high. A factor that might cause this figure to fluctuate is the difficulty to explain to the respondents the definition of “chronic medical condition”. Minimal changes were seen regarding prevalence of the most common chronic disorders within the sample such as Hypertension, Diabetes and Asthma/Pulmonary disease. Access to services for chronic disorders remains unchanged at around two-thirds of respondents and most commonly reported reason is inability to afford clinic fees. There is little difference in costs between private clinics and primary health care facilities but those seeking care directly at pharmacies pay significantly less.

- There was a remarkable increase of proportion of respondents reporting to have had an acute medical condition during the month preceding the survey. Possible explanations include increase of seasonal infections (since survey was conducted at a later point in the year in 2018 than in 2017) and difficulty for respondents to define “acute”. A significantly smaller proportion sought health care for acute conditions compared to 2017, but out of the ones who did, the proportion who got care was the same as last year. Regarding facilities in which respondents sought care for acute conditions, a higher proportion turned to pharmacies compared to 2017 while a lower proportion went to primary health care clinics or hospitals. As in 2017 the most reported reasons for not seeking health care for an acute condition were not being able to afford clinic fees followed by not thinking it was necessary. It should be noted that since the type of conditions for which respondents sought care might differ between 2017 and 2018 it is difficult to compare the two years in terms of health seeking behavior. Median cost going to a private clinic was significantly higher than going to a primary health care facility, but there was no difference in cost between primary health care facility and pharmacies.

Recommendations

Similarly to previous years, cost is the major barrier for seeking health care among Syrian refugees, but at the same time a surprisingly large proportion of refugees choose private alternatives which often are more costly than primary health care facilities. This is specifically true for antenatal care. For acute and chronic disorders it seems like seeking care at pharmacies makes financial sense to refugees as they are paying less or as much as when they seek care at primary health care facilities. This despite the fact that medication for minimal fees should be available at primary health care level. To overcome the barrier that cost constitutes it is therefore recommended to

1. Maintain and possibly expand number of services available to refugees at reduced costs and number of facilities where they are offered;
2. Improve information sharing to refugees about available services at reduced costs and where they are offered. Awareness raising through existing communication channels with refugees as well as expanding use of outreach networks and social media is recommended.
3. Enhance monitoring and oversight of clinics and hospitals to ensure adherence to agreed upon fees, tackling hidden costs, rational prescribing of essential medicines and rational use of laboratory investigations. Furthermore to ensure, through supporting the national supply system and capacity of primary health care pharmacists that supported facilities have uninterrupted supplies of vaccines and essential medications to avoid unnecessary out of pocket expenditure at private pharmacies.

Regarding ANC and PNC there are still a large proportion of refugees who do not consider these services necessary which highlights a need to

4. Increase awareness among refugees about the importance of ANC and PNC for safe pregnancy, delivery and neonatal care. The same also applies for family planning services which remains underutilized.

1) Baseline Characteristics of Population and Sample

1.1 Survey response

1351

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

479

Number of households reached and agreed to participate in the study

2,214

Number of household members in surveyed households

4.6

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

52%

Proportion of household members who are female (n=2,214)

16%

Proportion of household members who are <5 years old (n=2,214)

Figure 1: Distribution of households by governorate (n=479)

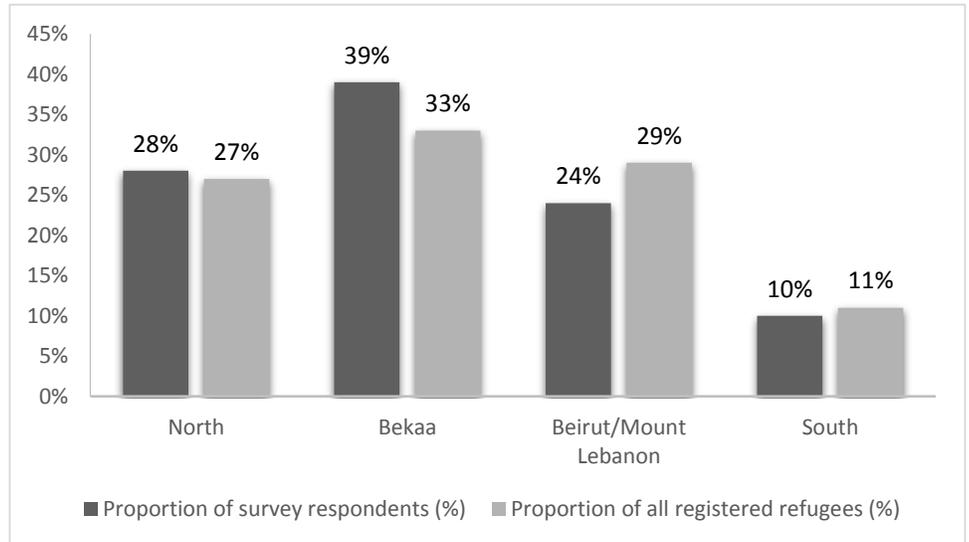
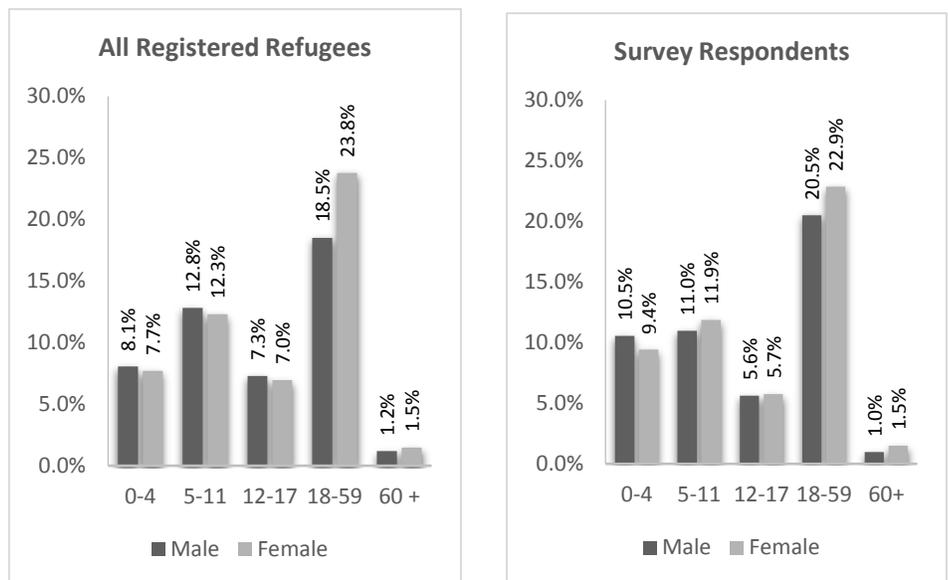


Figure 2: Age and sex distribution of household members (n=2,214)



2) Knowledge about available services and health care expenditure

2.1 Knowledge

60%

Proportion of households knowing that consultations in governmental PHCCs for between 3000 and 5000 LBP (n=456)

80%

Proportion of households knowing that UNHCR supports hospitalization for life threatening conditions and deliveries (n=457)

62%

Proportion of households knowing that vaccinations are free for children <12 years in government facilities (n=452)

34%

Proportion of households knowing that drugs for acute conditions can be obtained for free in governmental PHCCs (n=451)

2.2 Health care expenditure

73%

Proportion of households spending money on health care the month preceding the survey (n=461)

87USD

Median amount spent by the households spending on health care the month preceding the survey (n=327)

Figure 3. Proportion of respondents answering yes n=457

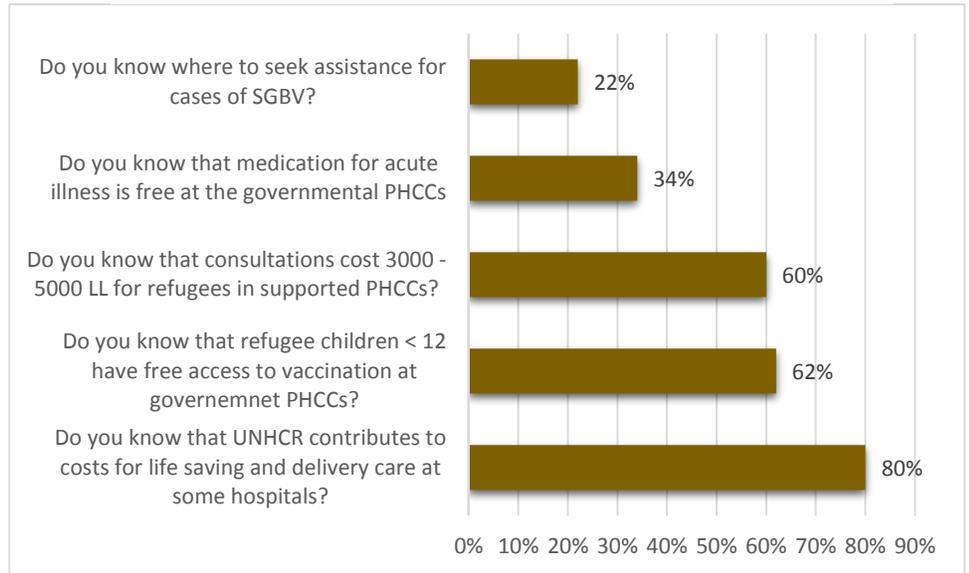
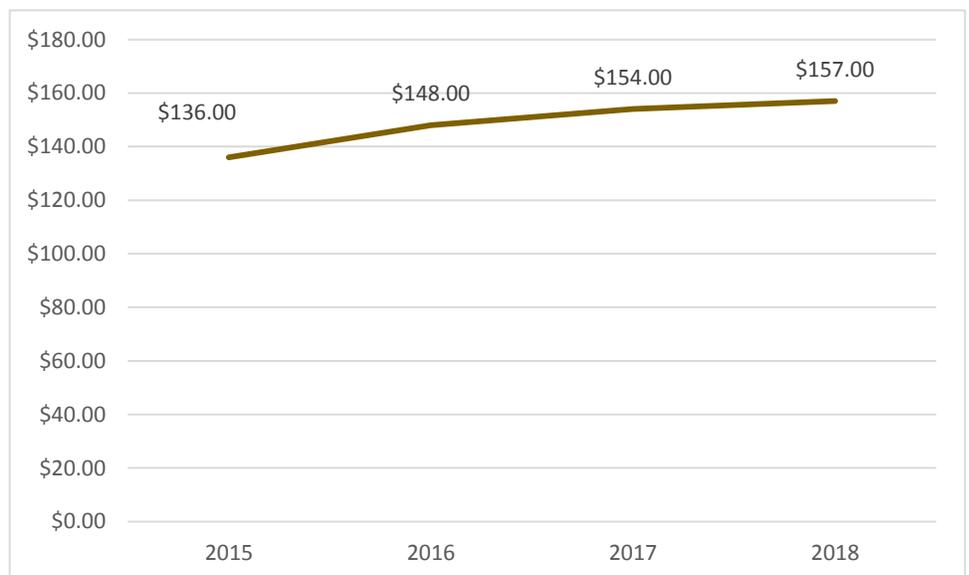


Figure 4. Average amount spent by the household during month preceding the survey (of household that reported spending money on health) between 2015 and 2018 (n=327)



3) Antenatal Care and Deliveries

2.1 Antenatal care (ANC)

72%

Proportion of women who delivered who accessed ANC (n=171)

51%

Proportion of women who delivered who went for at least 4 ANC visits (n=171)

30%

Proportion of women who received ANC at more than one facility (n=158)

2.2 Deliveries

5%

Proportion of deliveries at home (n=162)

75%

Proportion of deliveries supported financially by UNHCR (n=163)

31%

Proportion of deliveries by C-section (n=164)

80 USD

Median cost of vaginal delivery supported by UNHCR (n=66)

237 USD

Median cost of C-section supported by UNHCR (n=38)

Figure 3: Number of ANC visits among women who delivered during past 2 years (n=171)

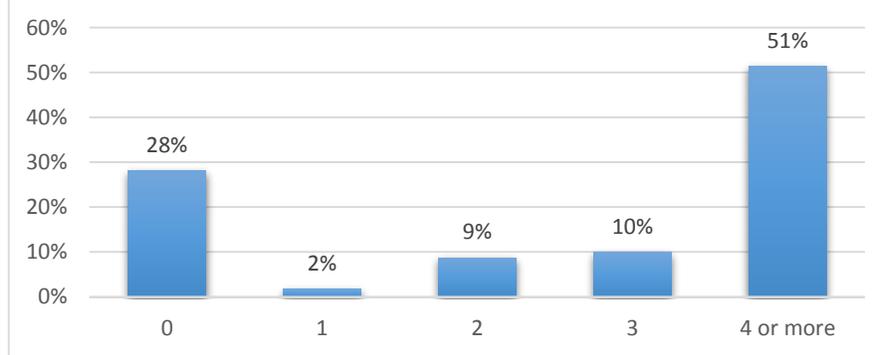


Figure 4: Reasons for not accessing ANC (n=46)

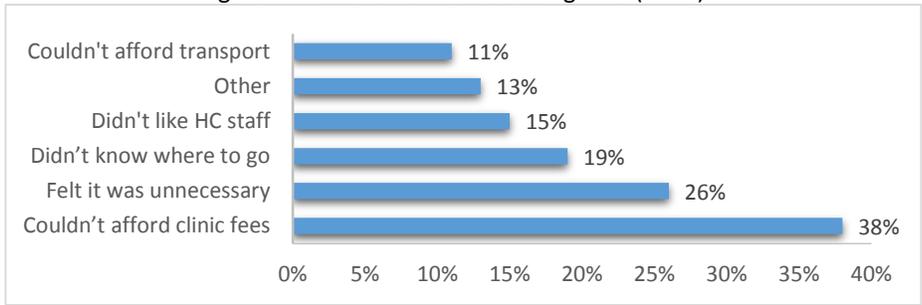


Figure 5: Place for last ANC visit (n=156)

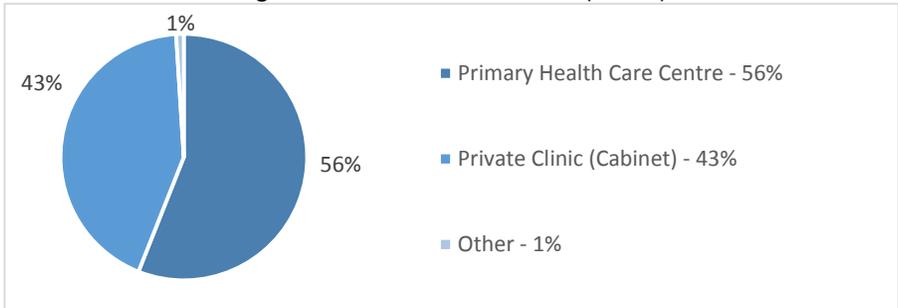
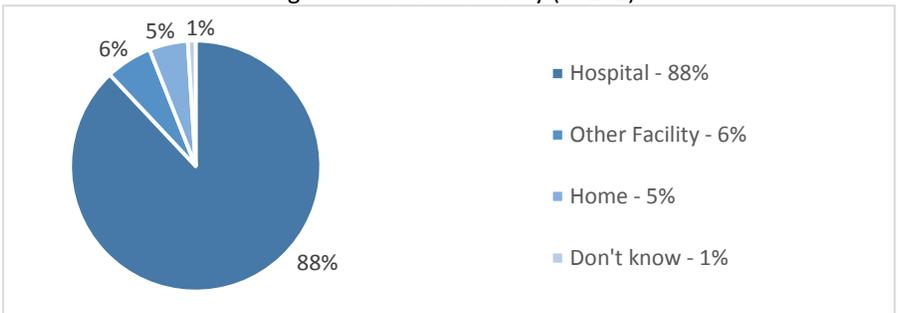


Figure 6: Place of delivery (n=162)



4) Postnatal Care, Family Planning and Child Care

3.1 Postnatal Care (PNC)

26%

Of women who delivered went for a postnatal care visit (n=163)

3.2 Family Planning

41%

Of households reporting using some kind of contraceptive method (n=479)

3.3 Child Care

88%

Proportion of children <5 that had received injectable vaccines at any point (n=428)

78%

Proportion of children that got vaccinated in Lebanon (n=428)

61%

Proportion of children vaccinated in Lebanon that was vaccinated for free (n=329)

80%

Proportion of children vaccinated in a PHCC (n=329)

10%

Proportion of children vaccinated in a Mobile Unit (n=329)

10%

Proportion of children that only had received vaccination in a UNHCR reception center (n=329)

Figure 7: Reasons for not going for PNC (n=111)

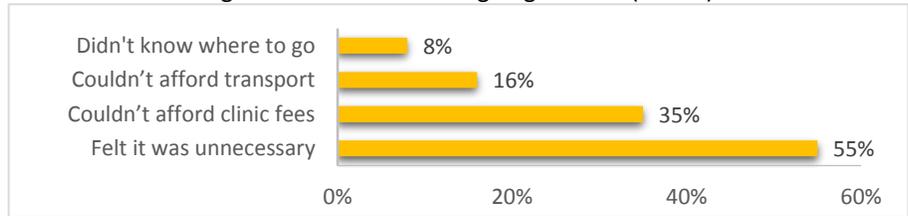


Figure 8: Reasons for not using family planning (n=136)

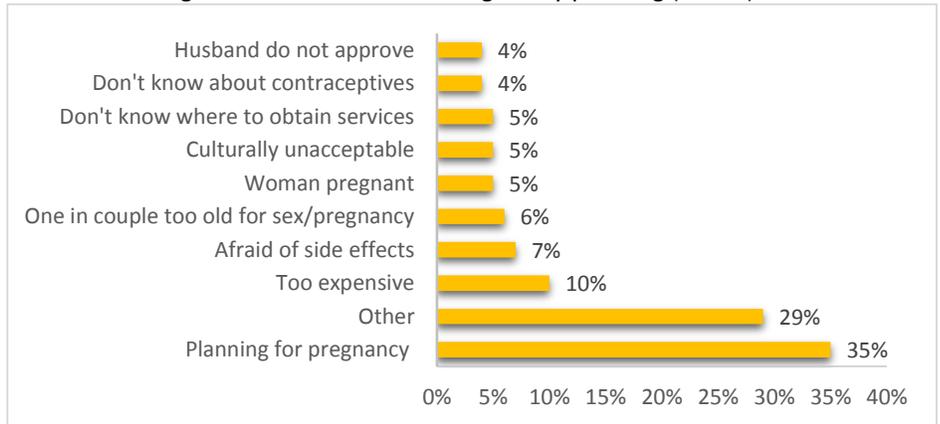


Figure 9: Choice of family planning methods (n=194)

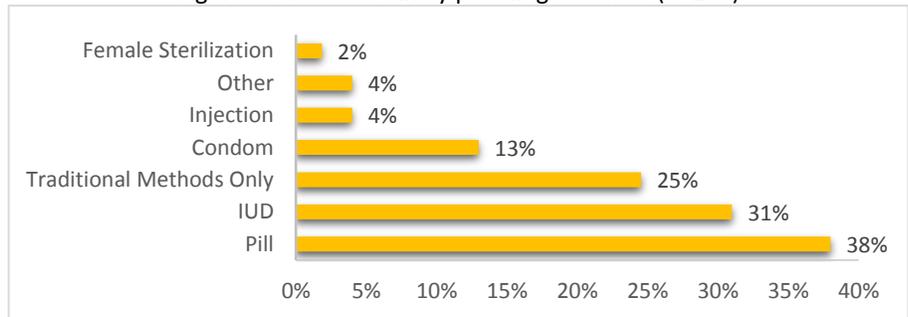
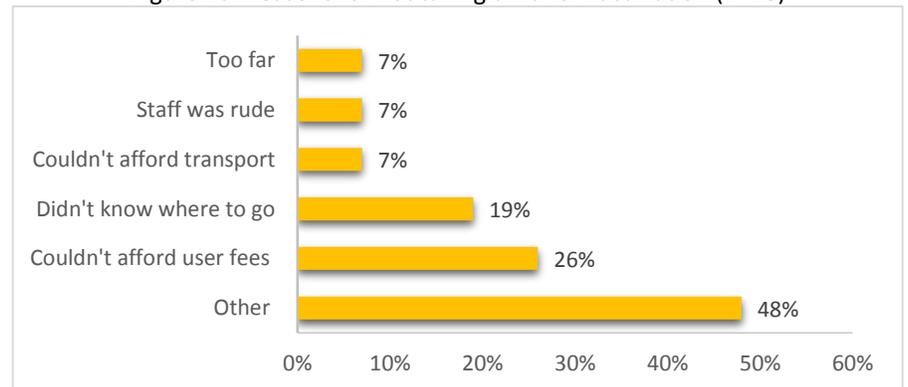


Figure 10: Reasons for not taking child for vaccination (n=28)



5)Chronic Conditions

4.1 Prevalence

11%

Proportion of respondents who reported having a chronic condition (n=2210)

36%

Proportion of respondents 40 years or above who reported having a chronic condition (n=284)

37%

Proportion of households with at least one member having a chronic disorder (n=471)

19%

Proportion of individuals that reported having more than one chronic condition (n=384)

4.2 Access

66%

Proportion of respondents who have accessed care/medication for their chronic condition during the last 3 months (n=238)

59%

Proportion of individuals that had sought care in a PHCC or private clinic (n=153)

33 USD

Median cost of care/medication for chronic disorders during the last 3 months (n=119)

Figure 11:Proportion of different chronic conditions reported (n=384)

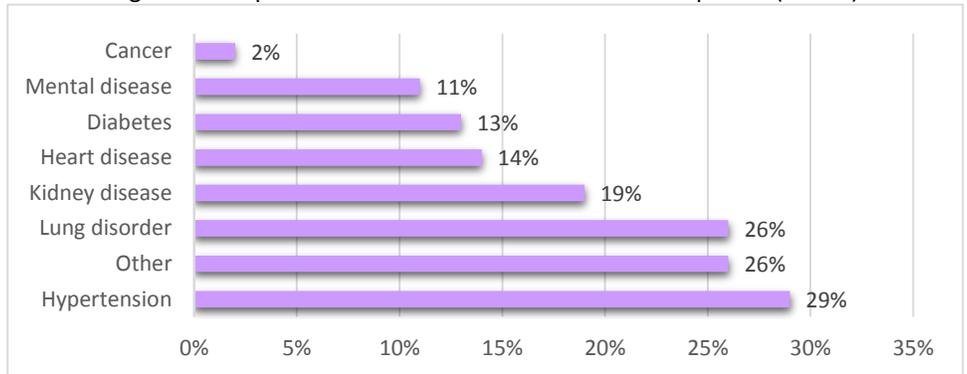


Figure 12: Reasons for not accessing chronic care (n=130)

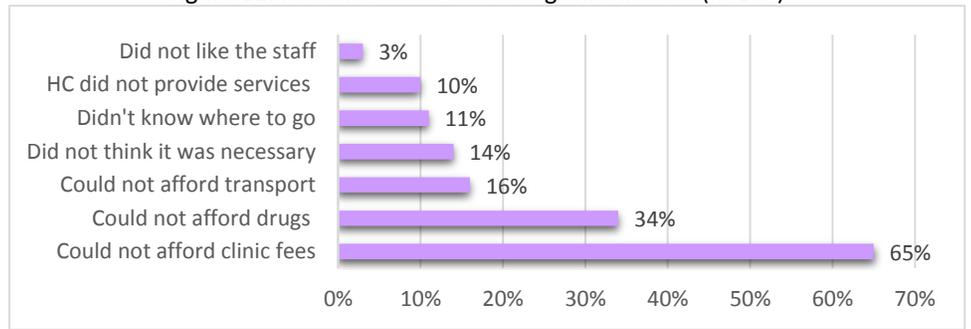
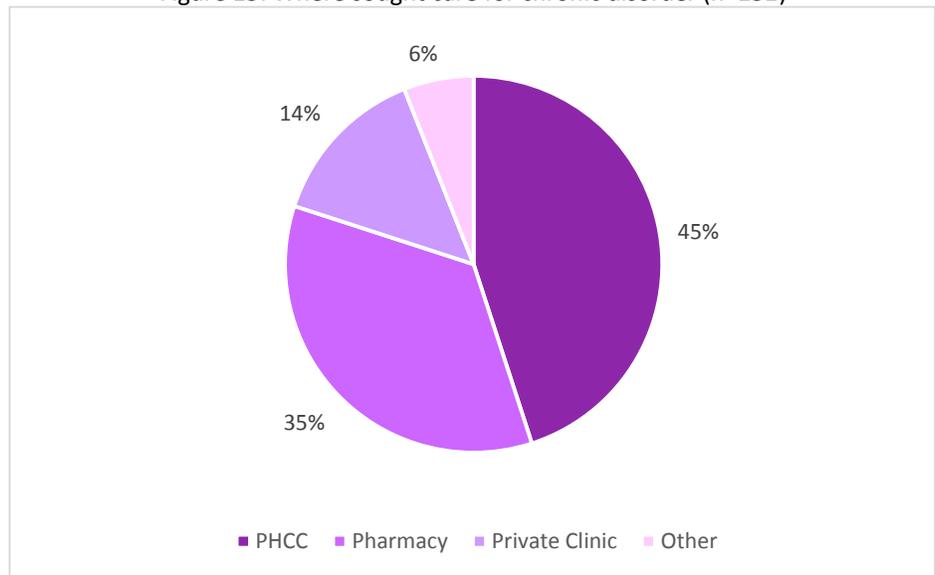


Figure 13: Where sought care for chronic disorder (n=252)



6) Acute Conditions and knowledge about UNHCR support

5.1 Incidence

30%

Proportion of respondents who reported having an episode of acute illness during the last month (n=2202)

5.2 Access

64%

Proportion of respondents who sought health care for the episode of acute illness (n=662)

86%

Proportion of individuals that sought health care that got it at first point of care (n=410)

88%

Proportion of individuals that sought health care that got it at either first or second point of care (n=410)

15 USD

Median cost of care for episode of acute illness during the last month (n=321)

Figure 14: Reasons for not seeking care for acute illness (n=130)

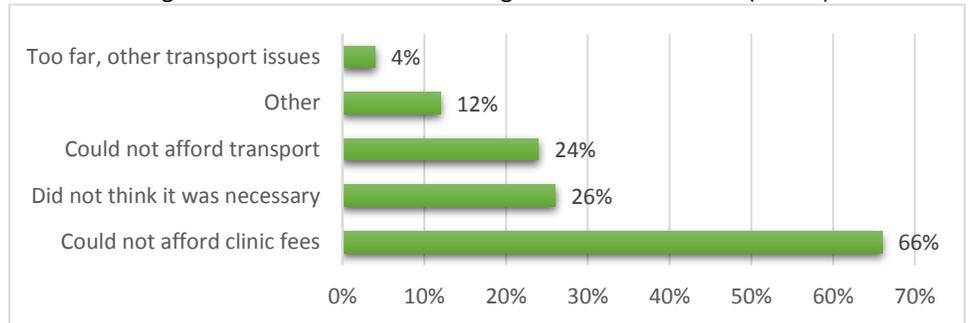


Figure 15: Reasons for not getting care when sought (n=18)

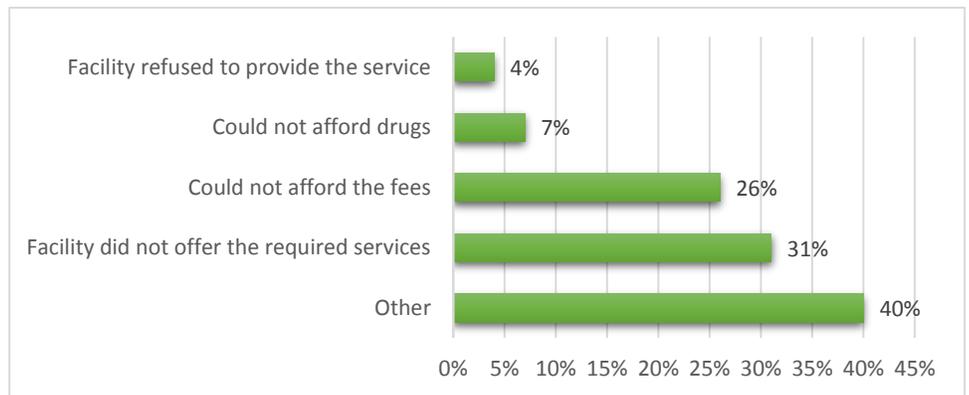


Figure 16: where sought care for acute illness (n=138)

