HEALTH

Health services are available to refugees through primary health care fixed and mobile outlets and hospitals. Through the VASyR, ability of households to access needed care has been examined as well as the barriers to healthcare access. VASyR did not reflect on the quality of the received care. Reported access included all types of care accessed by refugees. Moreover, knowledge and access to COVID-19 related services were examined, in addition to child birth details (where deliveries took place). The assessment has also examined the proportion of children under 2 years of age who were suffering from at least one disease and needed hospitalization or doctor's consultation.

KEY FINDINGS

- There has been a decrease in both demand for primary health care and hospital care since 2019.
- Access to primary health care remained stable at 90%, while access to hospital care increased slightly to 87% from 81% in 2019.
- For both primary and hospital care, cost was, by far, the main barrier to accessing the needed care, rather than physical limitations. This included direct and indirect costs. Direct such as treatment fees or doctor's fees and indirect such as transportation costs with the share of households citing transportation costs as a barrier to primary health care having increased.
- The share of refugee children under the age of two who suffered at least from one disease in the two weeks prior to the survey decreased by more than half to 23% in 2020, compared to 48% in 2019.

PRIMARY HEALTH CARE

Primary health care (PHC) refers to health care that does not require hospital admission. This includes services such as: vaccination, medication for acute and chronic conditions, non-communicable diseases care, sexual and reproductive healthcare, malnutrition screening and management, mental healthcare, dental care, basic laboratory and diagnostics as well as health promotion. Primary healthcare fixed outlets are either primary health care centers (PHCCs) that are part of the Ministry of Public Health's (MoPH) network or dispensaries outside the MoPH's network; other types of primary health care fixed outlets include private clinics and pharmacies. Primary health care mobile outlets are referred to as mobile medical units.

It is worth noting that need for care is often dependent on seasonal fluctuations of incidence of certain diseases and data collection for the 2019 and 2020 VASyR took place at different times in the year (spring of 2019 and fall of 2020). Demand for PHC services decreased since 2019, with 57% of families reporting that at least one household member required PHC in the past six months, compared to 63% in 2019, 54% in 2018 and 46% in 2017. The decreased demand can be explained by seasonal variations of incidence of certain diseases and the fact that 2020 VASyR was conducted during a different time-period compared to 2019. Other possible reasons might be related to a change in health seeking behaviors due to the ongoing crises and financial hardship where households are not prioritizing health needs and are not considering preventive or primary health care as a necessity. COVID-19 situation and restrictive preventive measures implemented at different levels might also have impacted health seeking behaviors and therefore the perceived need for healthcare. Baalbek-El Hermel was the only governorate where demand for PHC increased since 2019 (79% compared to 64%). While at the national level, ability to access PHC remained high with only 10% of households reporting that they were unable to access the needed PHC, geographical differences were noted. In the South and El Nabatieh, share of households that did not have access to needed care increased drastically from 8% and 3% in 2019 to 26% and 14% in 2020, respectively. In Mount Lebanon, the trend was inversed with 16% of families reporting that they were unable to access the needed PHC, compared to 26% in 2019.

Similar to trends noted in previous years, a larger proportion of families residing in non-permanent shelters reported requiring PHC (75%), compared to those in residential (47%) or non-residential (51%) shelters.

Figure 1: Share of households that reported requiring PHC services in the past six months, by governorate

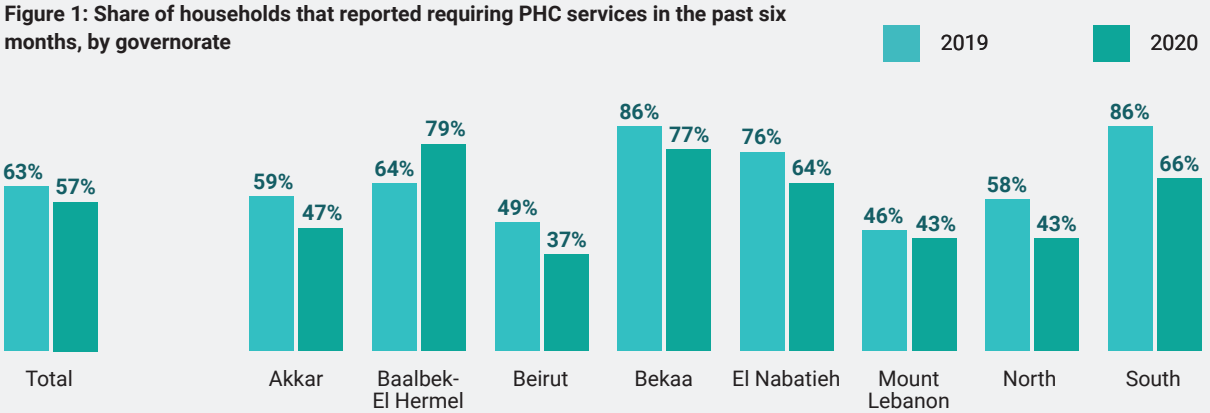
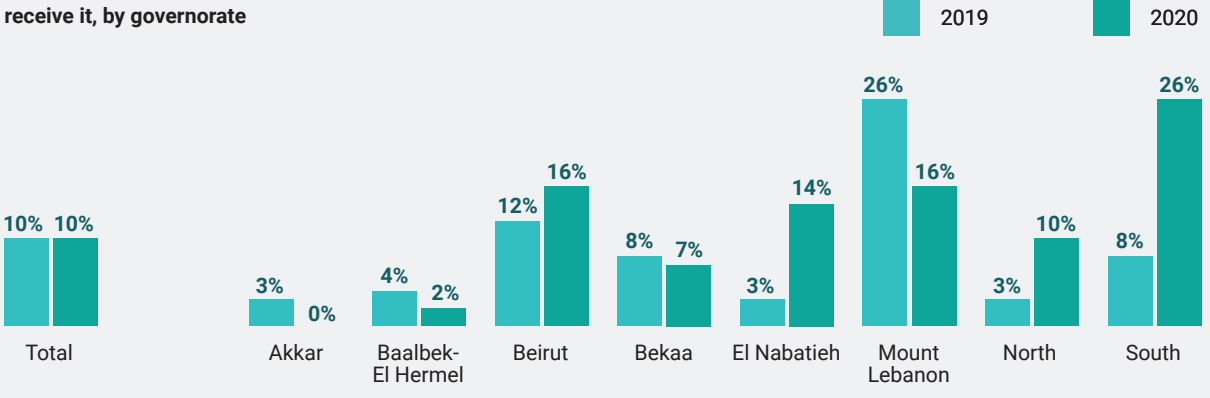


Figure 2: Share of households that required PHC in the past six months but did not receive it, by governorate



Almost all the households reported accessing PHC in Lebanon, with only 1% reported having received PHC in Syria. Most households received primary health care through a primary health care outlet (55%). share of households that reported receiving PHC at a pharmacy increased reaching 25% in 2020, compared to 12% in 2019, while those who accessed services through a private doctor remained stable (18% in 2020). For those who accessed services at a private doctor's clinic, the majority (51%) cited trust in the physician as the main reason, compared to 60% in 2019. In 2020, proximity to the doctor's clinic was cited by 45% of families as the reason for using this service (compared to 22% in 2019).

The majority of families reported paying for the PHC received in full (54%) while 40% reported paying a discounted price. Five per cent reported receiving the service for free.

Figure 3: Places where Primay Health Care Services were accessed in Lebanon

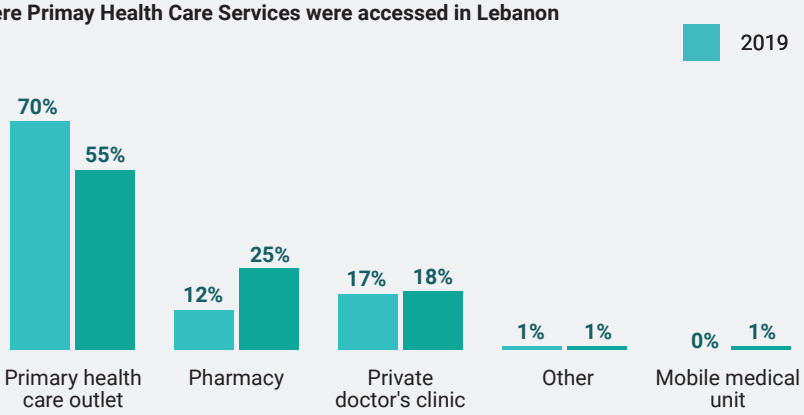
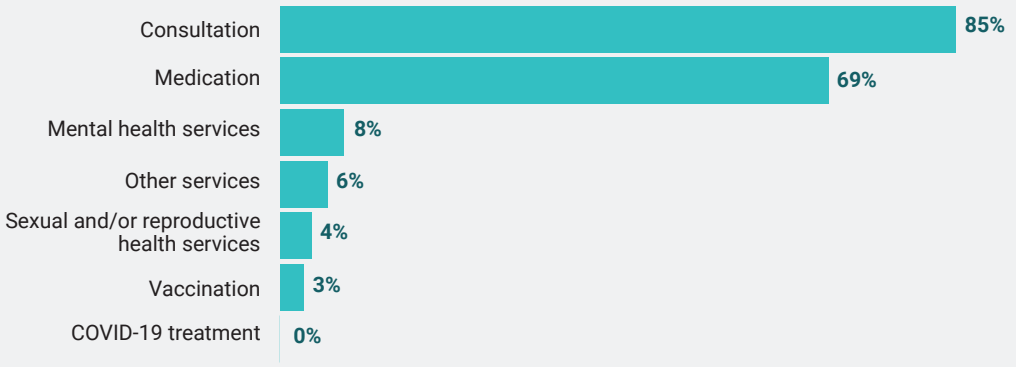
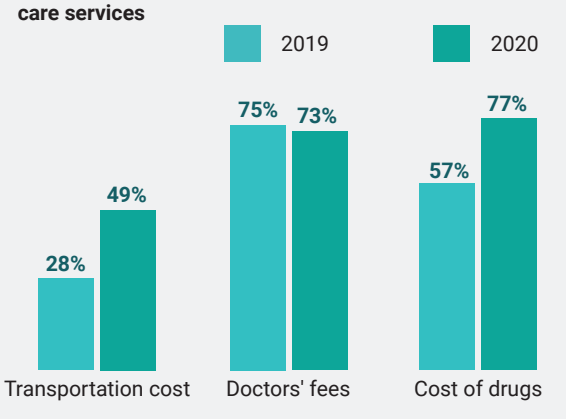


Figure 4: Primary health care services that were not accessed



The most commonly cited PHC service that was not accessed was consultations (85%), followed by medications (60%). For 2020, despite of the COVID-19 outbreak which was a great barrier to accessing health care, cost remained the overwhelmingly largest barrier to receiving the needed primary health care, including the costs of drugs (77%), doctors' fees (73%) and transportation costs (49%). This further highlights the increasing financial hardship that is resulting from the multi-faceted economic, financial, socio-political and medical crisis. Compared to 2019, the share of households citing transportation costs and costs of drugs increased substantially. Other, much less commonly cited reasons (3% or less) included being rejected by the facility, inadequate treatment, distance, fear of COVID-19, restricted movement, or not knowing where to go.

Figure 5: Barriers to accessing primary health care services



HOSPITAL CARE

Similar to PHC, the reported need for hospital care decreased with 16% of households reporting to have needed hospital care in the past six months, compared to 22% in 2019. While this decrease was noted across all the governorates, South and El Nabatieh recorded the highest rates of demand for hospital care. Access to the care, however, increased slightly with 87% reporting being able to receive it (81% in 2019). Baalbek- El Hermel and Mount Lebanon saw the most substantial improvements in access to hospital care, while rates deteriorated in the South. Unlike PHC, trends across the shelter types did not significantly differ.

As with PHC, few (2%) of the interviewed households reported that they accessed the hospital care in Syria. For those who have accessed it in Lebanon, 46% reported paying for the service in full while 42% reported having received a partial contribution from UNHCR. Six per cent reported having receive hospital care for free.

Figure 6: Share of households that reported requiring hospital care in the previous six months, by governorate

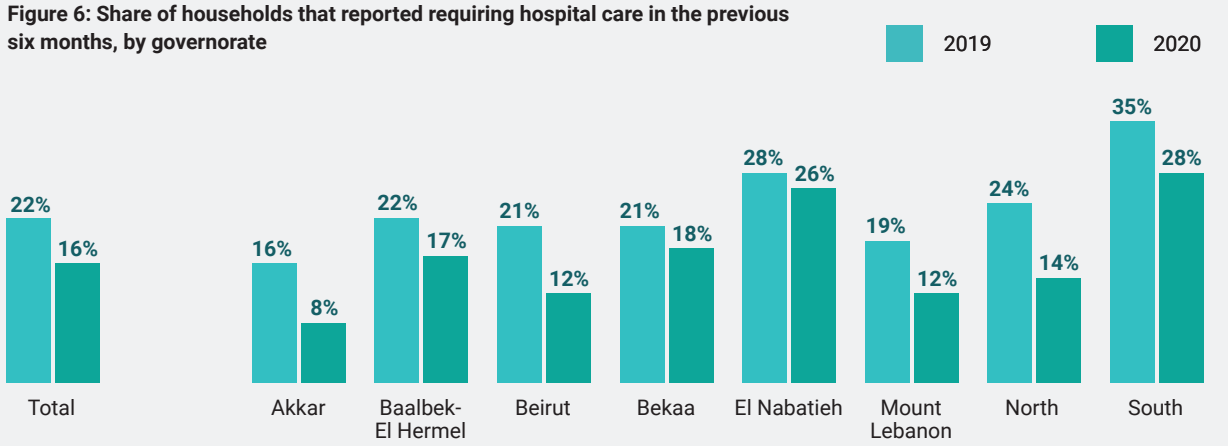
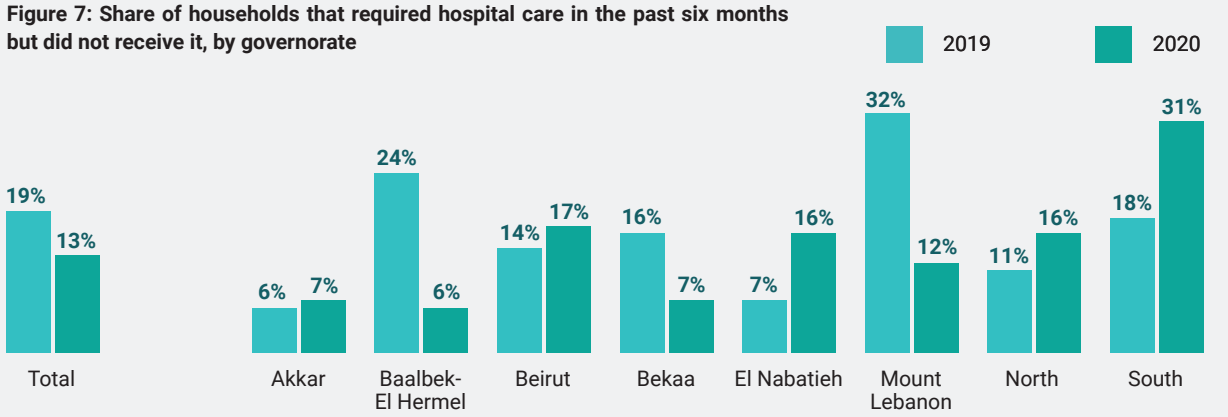
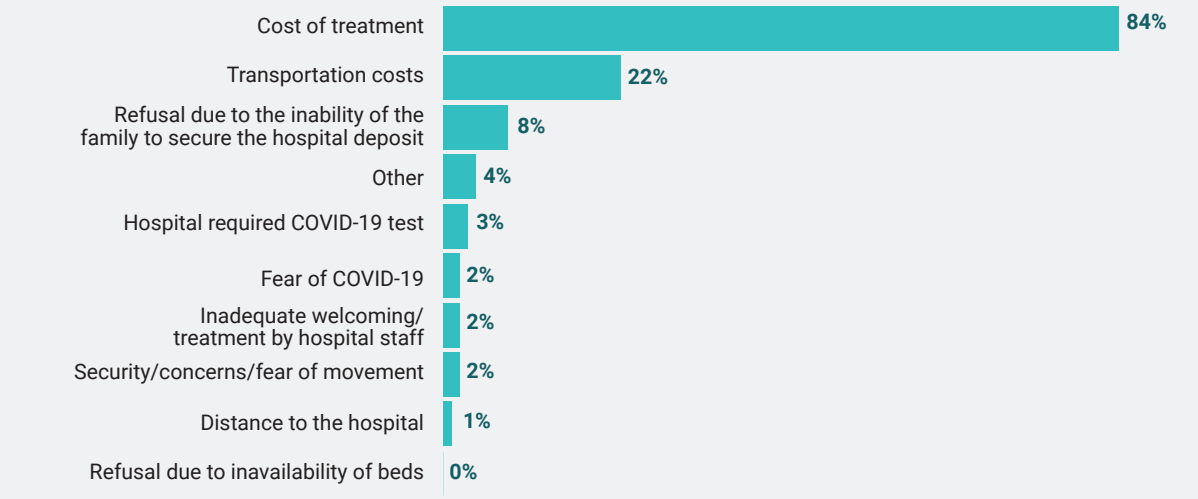


Figure 7: Share of households that required hospital care in the past six months but did not receive it, by governorate



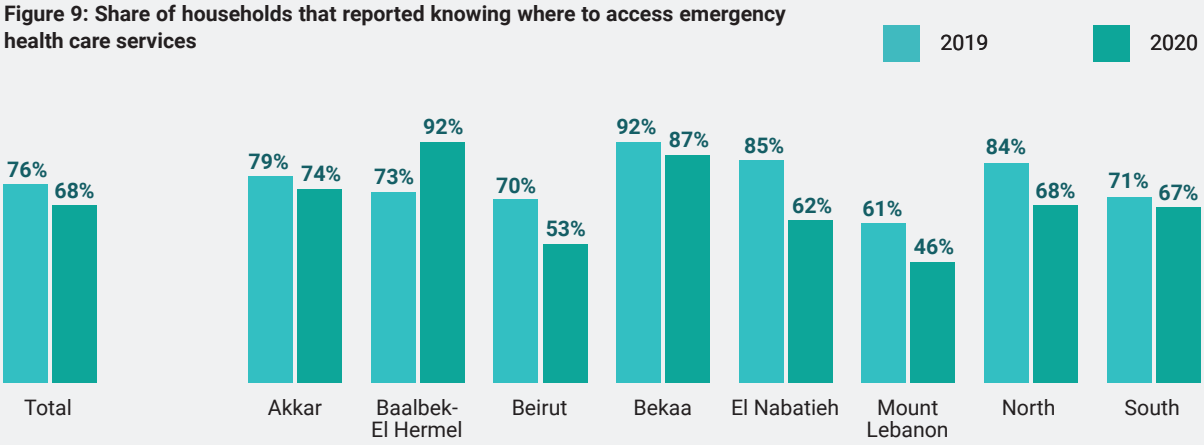
Again, cost came up as the main barrier to accessing hospital care, much more so than physical barriers related to distance or accessibility to centers. The main cost barrier was the cost of treatment, followed by transportation costs. Eight percent of household cited that they were refused services due to their inability to secure a deposit.

Figure 8: Barriers to accessing hospital care



The share of households that reported knowing where to access emergency medical care or services declined slightly to 68% from 76% in 2019. The lowest rates remained to be in Beirut and Mount Lebanon.

Figure 9: Share of households that reported knowing where to access emergency health care services



CHILD BIRTH DETAILS

Of the children in the sample born after 2011, 64% were born in Lebanon. Almost all births (95%) were delivered in a hospital, with a small percentage reporting home delivery (5%) and less in other healthcare facilities (1%). Examined over time, no significant difference was noted in terms of increases or changes in the proportion of children who were being delivered at home.

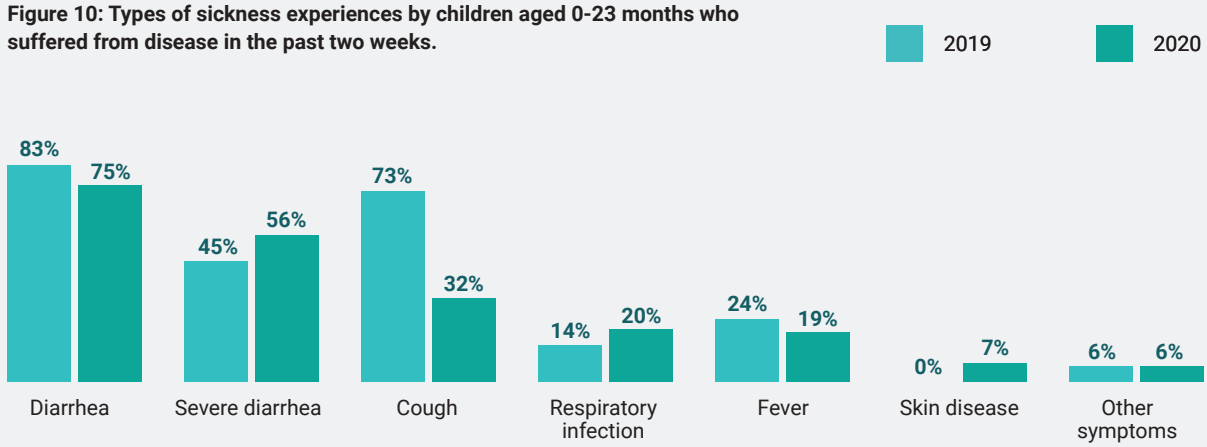
KNOWLEDGE AND ACCESS TO COVID-19 RELATED SERVICES

The majority of households (68%) reported that they had received information related to COVID-19. The main type of information received was related to prevention and symptoms of COVID-19 (97%) followed by where to access services (69%) and information on treatment (58%). However, only around half (51%) reported that they knew where to access services in the event that a household member was suspected to have contracted the virus.

CHILD HEALTH

The share of refugee children under the age of two who suffered at least from one disease in the two weeks prior to the survey decreased by more than half to 21% in 2020, compared to 48% in 2019. The most prominent disease was reported to be fever (75%) followed by diarrhea (55%). The remaining diseases were reported at much lower rate with cough at 33%, respiratory infection at 20%, severe diarrhea at 19%, and skin diseases and other symptoms at 7%, each[1].

Figure 10: Types of sickness experiences by children aged 0-23 months who suffered from disease in the past two weeks.



The rate of children under 2 years of age who suffered from severe diarrhea which required hospitalization or a doctor's consultation was reported to be 32%, an increase of 8 percentage point from 2019. In contrary, children who suffered from respiratory infection and required hospitalization or a doctor's consultation decreased from 28% in 2019 to 23% in 2020.

[1] *Results on illness may be affected by COVID-19 related precautions taken during data collection where enumerators were instructed not to conduct interviews with families if any family member was exhibiting COVID-19 related symptoms.*

CHILD NUTRITION

INFANT AND YOUNG CHILD FEEDING PRACTICES

The assessment examined infant and young child feeding (IYCF) practices in Syrian refugee households. Information was collected on 877 children aged 6-23 months and 493 infants under six months old.

KEY FINDINGS

- There was an increase of 13 percentage points in children under 6 months of age who received only breast milk the day prior to the survey, from 42% in 2018 to 56% in 2019. As for children between 12 and 15 months, there was a slight increase of 4%, from 50% to 54% .
- The Minimum Diet Diversity for children between 6 and 23 months of age remained the same as last year, at 17%.
- The Minimum Acceptable Frequency for children between 6 and 23 months of age increased from 64% in 2018 to 80% in 2019.

BREASTFEEDING

The share of infants under 6 months of age who were exclusively breastfed decreased by 12 percentage points from 2019, reaching 44% in 2020.

COMPLEMENTARY FEEDING

Complementary feeding included solid, semi-solid, soft foods or other liquids received during the previous day. The percentage of children between 6 and 8 months of age who received complementary feeding was at 35%, close to the 31% of the previous year.

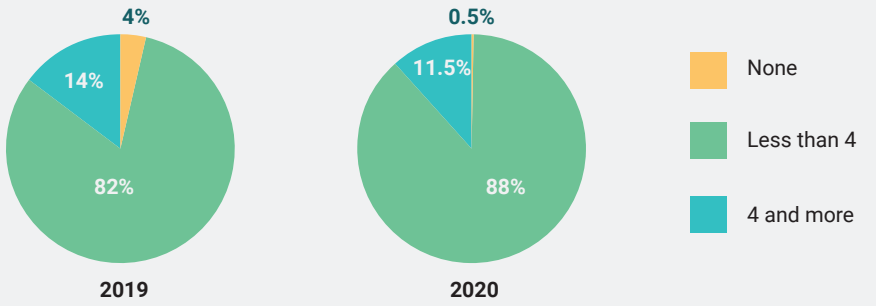
MINIMUM DIET DIVERSITY

According to the WHO guidelines (2008) for assessing infant and young child feeding practices, children 6-23 months old should consume a minimum of four food groups out of seven to meet the minimum diet diversity target, independent of age and breastfeeding status. The food groups are:

1- Grains, roots, and tubers;
2- Pulses and nuts;
3- Dairy products (milk, yogurt, cheese);
4- Meats (red meat, fish, poultry, and liver/organ meats);
5- Eggs;
6- Vitamin-A rich fruits and vegetables;
7-Other fruits and vegetables.

In 2018 and 2019, the share of children between the ages of 6 to 23 months who were fed a diverse diet, which consisted of four or more food groups, on the previous day was at 17%. In 2020, the share dropped to 12%.
Eleven percent of children aged 6 to 23 months living in households with a per capita expenditure below the Survival Minimum Expenditure Basket (SMEB US$87) received foods from four or more food groups. The share among households living with a per capita expenditure between $114 – and $142 recorded the highest share at 36%, when households living above the MEB (higher than or equal to $143) were found to be at 13%.

Figure 7: Minimum dietary diversity for children between 6 and 23 months old

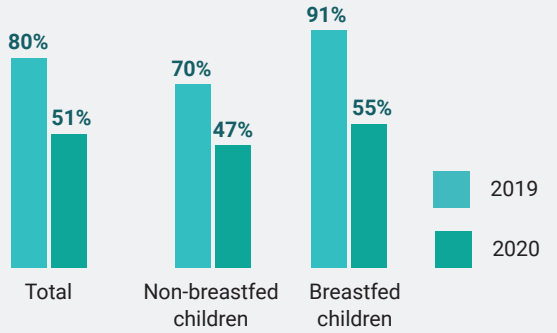


MINIMUM ACCEPTABLE MEAL FREQUENCY

WHO defines the minimum acceptable meal frequency for young children as follows:
- 2 meals/day for breastfed infants (6 - 8 months old)
- 3 meals/day for breastfed children (9 - 23 months old)
- 4 meals/day for non-breastfed children (6 - 23 months old)

From 2018 to 2019, the share of children between 6 -23 months who have received the minimum acceptable number of meals every day witnessed an increase of 16 percentage points reaching 80%. The same rate dropped by 29 percentage points, 51% in 2020. Among children who were breastfed, the minimum acceptable meal frequency was at 55%, as for those who were not breastfed the figure was 48%.

Figure 7: Minimum Acceptable Meal Frequency among children between 6 and 23 months



Annex 5: Household access to primary and secondary health care

	Primary Health Care (PHC)		Hospital Care				
	Share of families that needed PHC	Share of families that received PHC (of those that needed)	Share of families that needed Hospital Care	Share of families that received Hospital Care (of those that needed)	Share of households that know where to access services in someone is suspected to have COVID19	Share of households that know where to access emergency care	Place of birth (births that occurred in Lebanon)
Total	57.0%	89.9%	15.5%	87.0%	50.8%	67.9%	93.7%
Governorate							
Akkar	47.2%	99.6%	8.2%	92.5%	56.9%	73.7%	88.7%
Baalbek-El Hermel	79.3%	98.4%	17.3%	94.4%	56.9%	91.6%	89.0%
Beirut	36.7%	84.3%	12.4%	82.9%	55.5%	52.7%	90.7%
Bekaa	77.4%	92.7%	17.6%	92.9%	55.5%	87.0%	95.3%
El Nabatieh	64.1%	86.1%	25.6%	84.5%	63.2%	62.2%	98.6%
Mount Lebanon	42.9%	84.1%	12.3%	88.2%	49.0%	46.3%	94.6%
North	43.0%	90.4%	14.5%	84.2%	36.2%	67.5%	92.6%
South	66.1%	74.0%	27.6%	69.3%	47.4%	67.0%	99.2%
Gender of the head of household							
Female	60.5%	90.8%	13.3%	89.0%	49.8%	67.6%	94.1%
Male	55.5%	89.6%	16.4%	86.4%	51.1%	68.0%	89.6%
Shelter type							
Residential	52.6%	89.2%	15.0%	87.2%	50.4%	63.4%	95.0%
Non-residential	48.8%	85.6%	16.7%	82.2%	37.5%	59.3%	93.1%
Non-permanent	75.4%	93.3%	16.6%	89.2%	60.0%	86.8%	90.8%