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Lebanon's unprecedented political and economic crisis, exacerbated by the COVID-19 pandemic and last August's port explosion, has had a devastating effect on the country's health situation, which was described as "very dire" by the World Health Organization in September 2021. Electricity outages and fuel shortages have left hospitals functioning at 50% capacity, and shortages of basic and essential medicines have become increasingly severe throughout 2021.<sup>1</sup> Just a few years ago, Lebanon was a leader in medical care in the region, but, in the first half of 2021 alone, an estimated 2,500 doctors and nurses have left the country.<sup>2</sup> This, as another surge in COVID-19 cases is once again threatening to overwhelm the health care system.

Health services are available to refugees through primary health care (PHC) facilities<sup>3</sup> and hospitals. The VASyR examined the ability of households to access the required care, as well as the barriers to health care access. The VASyR did not reflect on the quality of the received care. Reported access included all types of care accessed by refugees. In addition to access to services, some further factors related to refugee health and health seeking behavior were examined: incidence of childhood diseases, incidence of home deliveries, need for and access to medication, and knowledge about COVID-19 related services.

## Key findings

- The demand for PHC (60%) and hospital care (17%) was similar to 2020.
- Access to PHC remained stable at 91%, while access to hospital care decreased slightly to 81% from 87% in 2020.
- 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 costs, such as treatment or doctor's fees, and indirect costs, such as transportation.
- The share of refugee children under the age of 2 who suffered from at least one disease in the 2 weeks prior to the survey was 24%, which was similar to 2020 and half the 48% recorded in 2019.

<sup>1</sup> <https://news.un.org/en/story/2021/09/1100172>

<sup>2</sup> <https://apnews.com/article/middle-east-business-health-lebanon-coronavirus-pandemic-4efbac49a458d76cc2b13879c91d3511>

<sup>3</sup> Primary health care facilities include centers within the Ministry of Public Health network and dispensaries outside of the network.

## Primary health care

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

It is worth noting that the need for care is often dependent on seasonal fluctuations, and data collection for the 2020 and 2021 VASyRs took place at different times in the year (fall of 2020 and summer of 2021).

### Demand for and access to primary health care

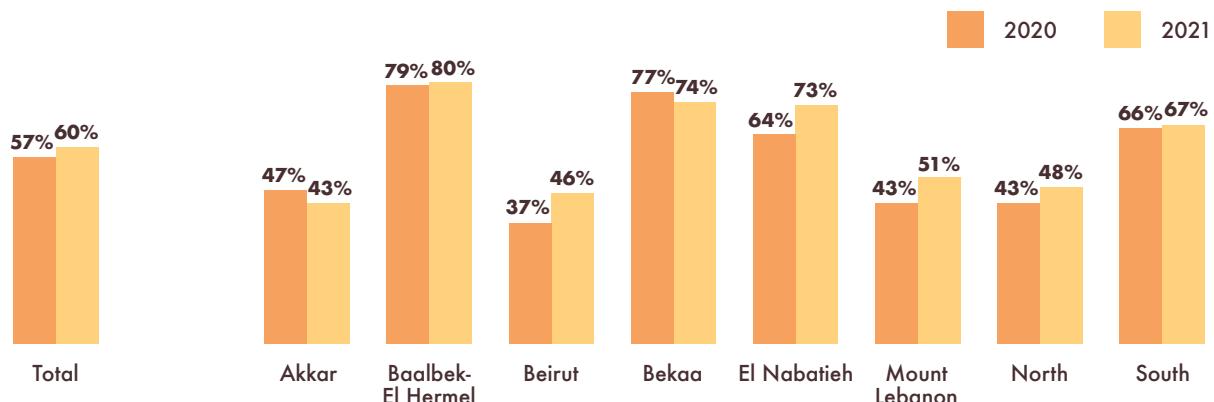
Demand for PHC services increased slightly since 2020, with 60% of households reporting that at least one member required PHC in the past 6 months, compared to 57% in 2020, 63% in 2019, 54% in 2018, and 46% in 2017. The increased demand could be explained by seasonal variations of incidence of certain diseases and the fact that

the 2021 VASyR was conducted during a different time-period compared to 2020. The COVID-19 situation and restrictive preventive measures implemented at various levels might also have impacted health seeking behavior and the perceived need for health care. Beirut, Mount Lebanon, and El Nabatieh showed increases in demand for PHC since 2020 of 9, 8, and 9 percentage points respectively. While the ability to access PHC at the national level remained high, with only 9% of households reporting that they were unable to access the needed PHC, geographical differences were noted. In the South, the share of households without access to needed care decreased significantly from 26% in 2020 to 10% in 2021. In Beirut, this trend was inverted with 27% of households reporting that they were unable to access the needed PHC, compared to 16% in 2021. The percentage of households not able to access the required PHC was highest in households in the bottom expenditure quintile, with a value of 20% compared to 8% or less in the other expenditure quintiles.

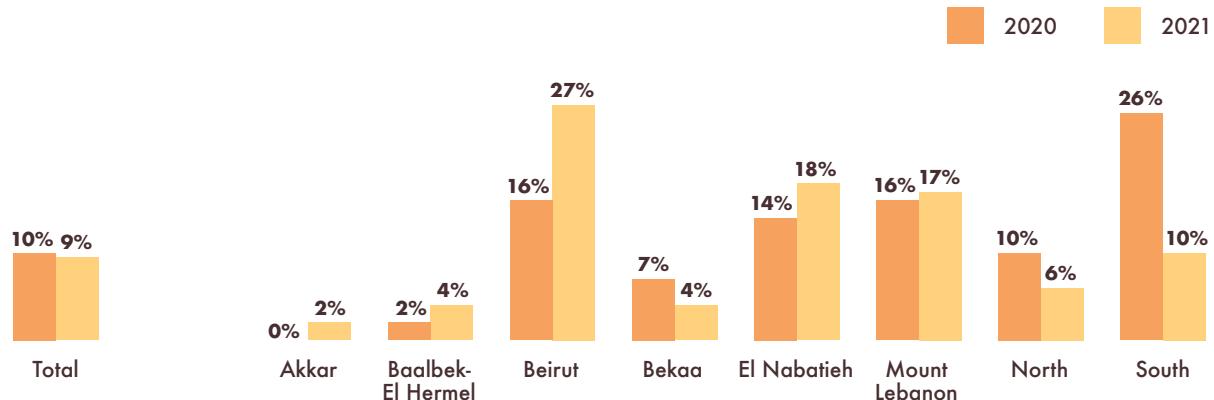
Similar to trends noted in previous years, a larger proportion of households in non-permanent shelters reported requiring PHC (69%) compared to those in residential (59%) or non-residential (53%) shelters.

About 67% of the households with at least one member with a disability reported to require PHC assistance. Around 15% of these households did not receive the required services.

**Figure 1: Share of households requiring primary health care services in the past 6 months, by governorate**



**Figure 2: Share of households that required primary health care in the past 6 months but did not receive it, by governorate**



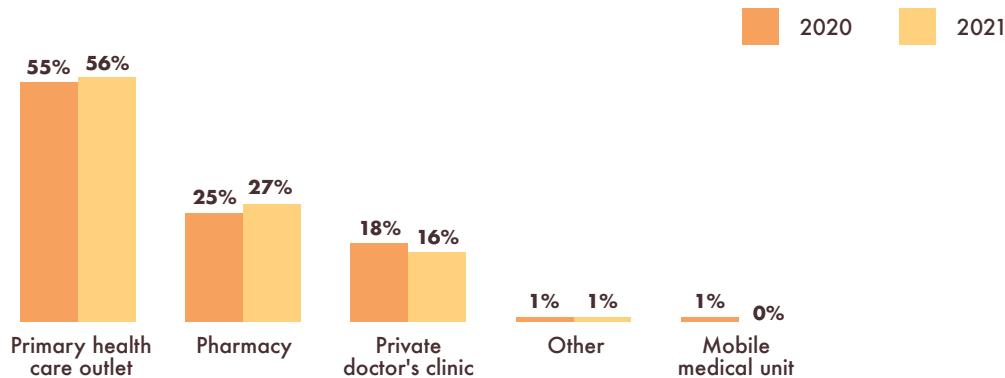
## Type of primary health care provider

Almost all households reported accessing PHC in Lebanon, with only 1% reporting to have received PHC in Syria. Most households received services through a PHC outlet (56%). The share of households that reported receiving PHC at a pharmacy reached 27% compared to 25% in 2020 and 12% in 2019, while those who accessed services through private doctor's clinics decreased slightly to 16% from 18% in 2020. For those who accessed services at a private doctor's clinic, the majority (69%) cited trust in the physician as the main

reason compared to 51% in 2020 and 60% in 2019. In 2021, proximity to the doctor's clinic was cited by 30% of families as the reason for using this service compared to 45% in 2020 and 22% in 2019.

The majority of households reported paying for the PHC services in full (58%) while 37% reported paying a discounted price. Only 5% received the service for free.

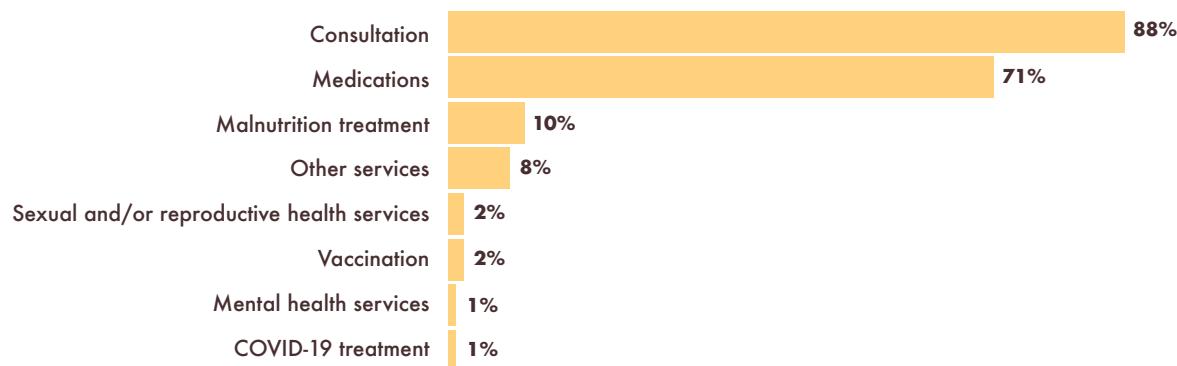
**Figure 3: Places where primary health care services were accessed in Lebanon**



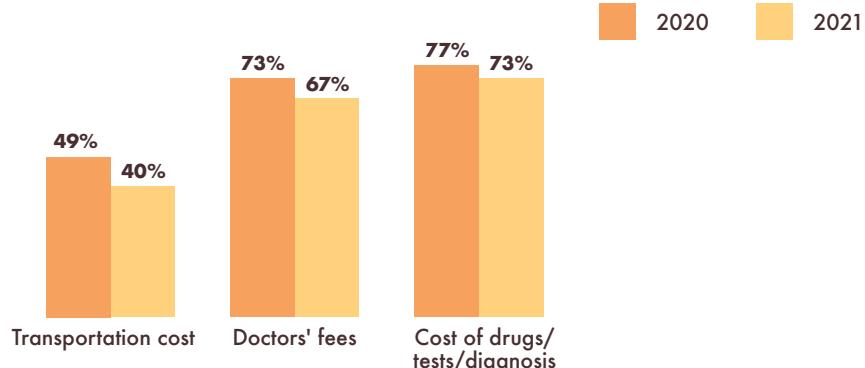
## Health care services not accessed

The most commonly PHC service cited as not accessed was consultations (88%), followed by medications (71%). For 2021, the largest barrier to receiving the needed PHC was the cost of drugs, diagnostics, and tests (73%), followed by doctor's fees (67%) and transportation costs (40%).

**Figure 4: Primary health care services that were not accessed**



**Figure 5: Barriers to accessing primary health care services**



## Hospital care

Similar to PHC, 17% of households reported to have needed hospital care in the past 6 months compared to 16% in 2020 and 22% in 2019. A significant decrease in demand was noted in the South with 17% of households indicating to require hospital care compared to 28% in 2020, while an increase in demand was noticed in Beirut and Mount Lebanon to 18% from 12% in 2020.

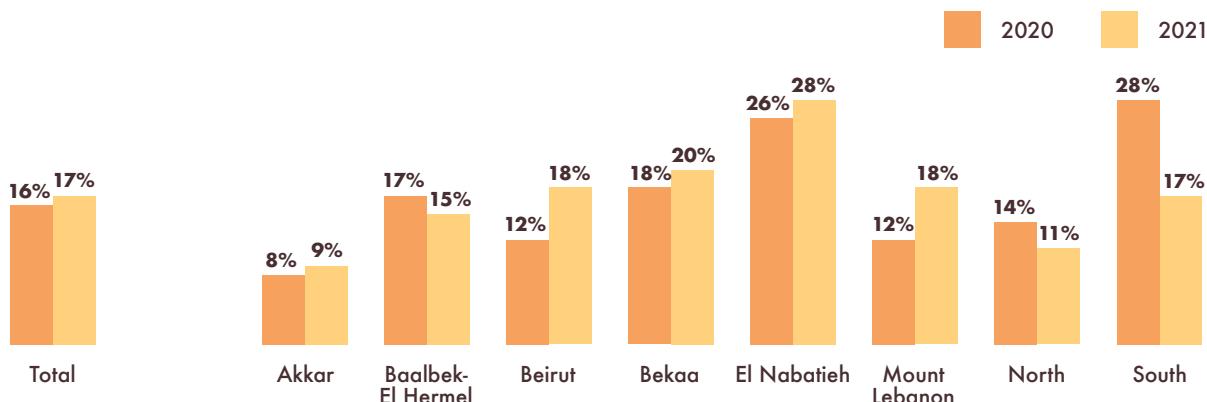
At the governorate level, the percentage of households requiring hospital care and not accessing it doubled in Beirut, Mount Lebanon, and El Nabatieh since 2020. However, access to hospital care improved in the North and the South where the percentage of households requiring health care and not accessing it decreased by half since

2020. The percentage of households not able to access the required hospital care was by far the highest among those in the bottom expenditure quintile with a value of 53% compared to 17% or less in the other expenditure quintiles.

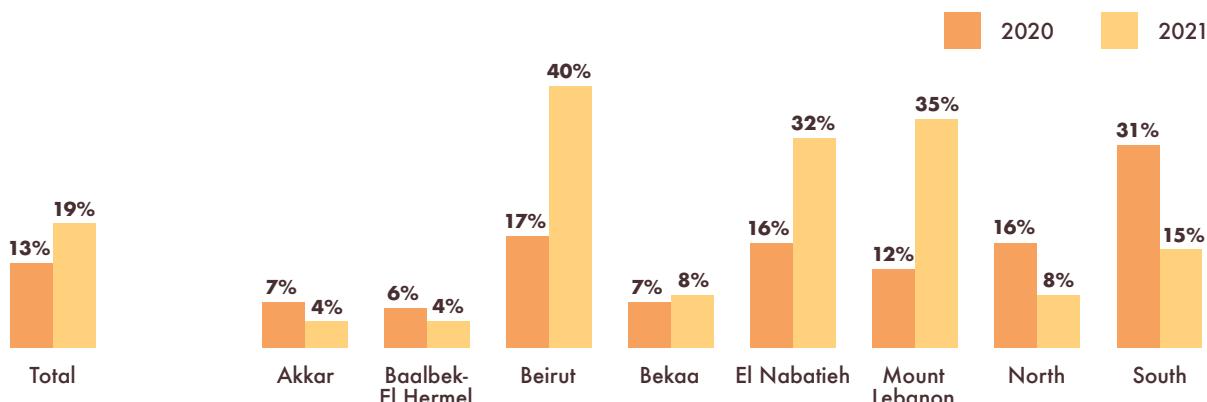
About 20% of the households with at least one member with a disability reported to require hospital care. Seventeen percent did not receive the required hospital care.

The majority of the interviewed households reported that they accessed the hospital care in Lebanon. For those who had accessed hospital care, 51% reported paying for the service in full while 41% paid a discounted price and 8% received free care.

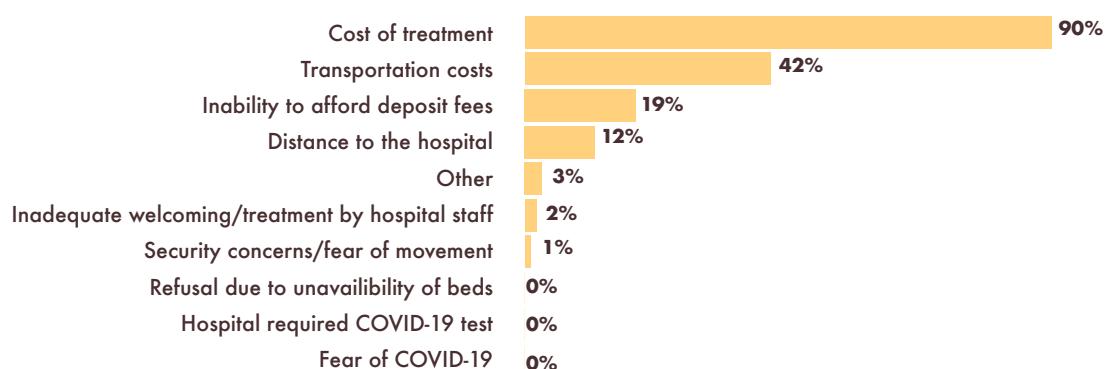
**Figure 6: Share of households requiring hospital care in the previous 6 months, by governorate**



**Figure 7: Share of households that required hospital care in the past 6 months but did not receive it, by governorate**



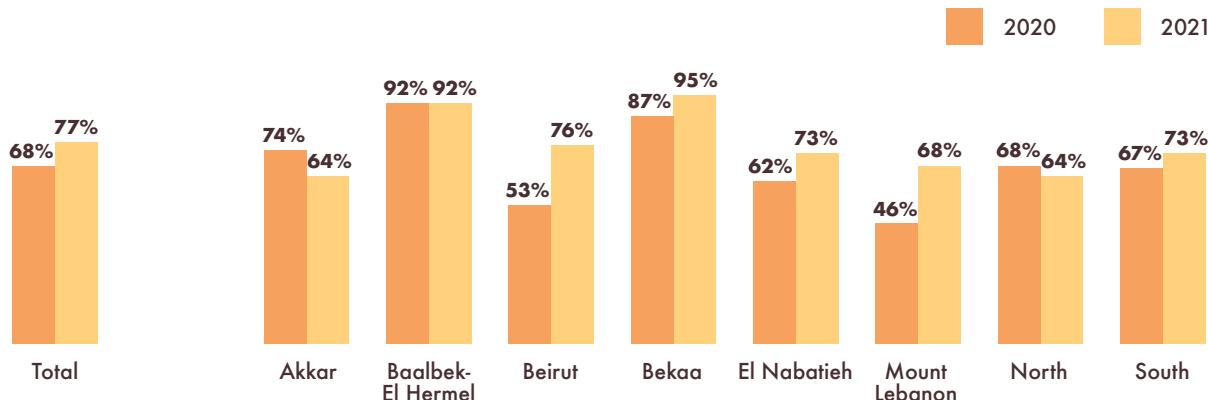
**Figure 8: Barriers to accessing hospital care**



As with PHC, costs came up as the main barriers to accessing hospital care, much more so than physical barriers related to distance or accessibility to centers. The main cost barrier was cost of treatment followed by transportation costs. Nineteen percent of households who did not receive the required hospital care cited that they were refused services due to their inability to secure a deposit compared to 8% in 2020.

The share of households that reported knowing where to access emergency medical care or services increased to 77% from 68% in 2020 and 76% in 2019. The lowest rates were in Akkar and the North (64%).

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



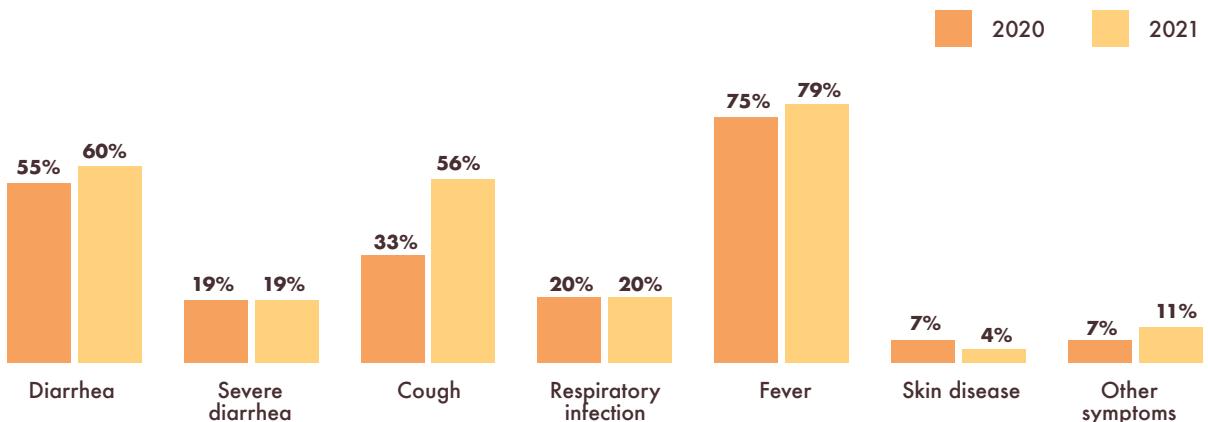
## Childbirths

The vast majority of newborns (93%) were delivered in a hospital. Four percent of families reported having newborns delivered in health care facilities (not hospitals). About 2.5% of families reported home deliveries, whereas deliveries in other places was less than 0.5%. The percentage of births in hospital was the lowest in Baalbek-El Hermel (79%) and Akkar (86%).

## Child health

The share of refugee children under the age of 2 who suffered from at least one disease in the 2 weeks prior to the survey (24%) was almost the same as in 2020 (23%), but half that of 2019 (48%). Of those who were sick, 60% suffered from diarrhea and 19% from severe diarrhea. The proportion of children who suffered from respiratory infection remained the same at 20%.<sup>4</sup>

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

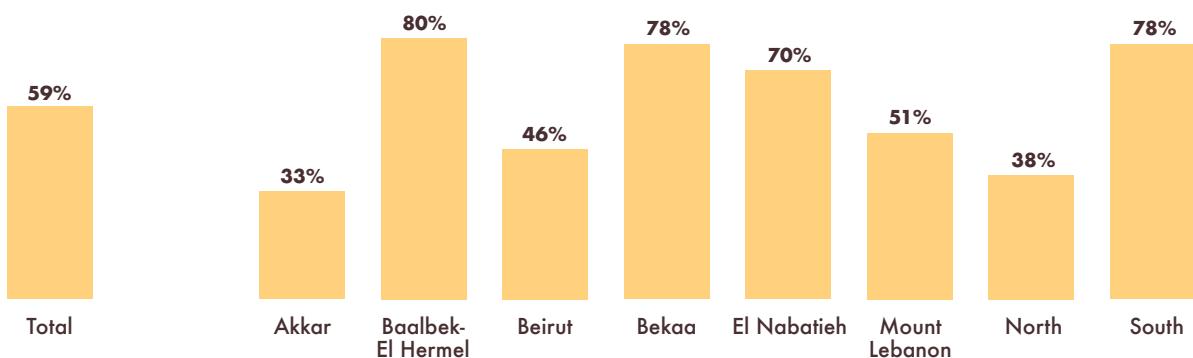


<sup>4</sup> Results on illness may be affected by COVID-19 related precautions taken during data collection where enumerators were instructed not to conduct interviews with households if any family member was exhibiting COVID-19 related symptoms. It might also be affected by the fact that the survey was done during a different time of the year in 2021 compared to 2020.

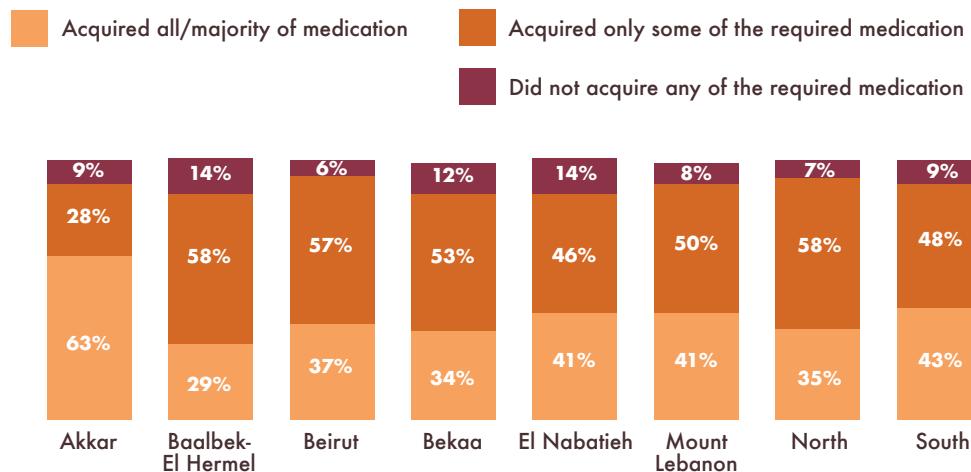
## Knowledge and access to COVID-19 related services

The majority of households (73%) reported knowing how to access medical assistance if a family member was suspected to have contracted COVID-19, up significantly from 51% in 2020. The percentage was the highest in Beirut (79%) and the lowest in the North (63%), and was higher among male-headed households (74%) than female-headed ones (69%) and among households residing in residential shelters (75%) versus non-residential shelters (69%). The percentage of households not knowing how to access the required health assistance in case of COVID-19 infection was highest among those in the bottom expenditure quintile with a value of 35% compared to 28% or less in the other expenditure quintiles.

**Figure 11: Households that required medications in the last 3 months**



**Figure 12: Households receiving the required drugs**



## Access to medications

The percentage of households requiring medicines in the last 3 months was the highest in Baalbek-El Hermel (80%) and the lowest in Akkar (33%), and 59% at national level. The percentage of households not accessing any of their required medications was 9% at the national level, with the highest share in Beirut and Mount Lebanon (14%) and the lowest in Akkar (3%). The percentage of households not able to access the required medication was highest among those in the bottom expenditure quintile with a value of 21% compared to 8% or less in the other expenditure quintiles. Overall, the percentage of households acquiring only some of their required medication was 48%, while 40% of households were able to require all/majority of their medications.

# CHILD NUTRITION



# Infant and Young Child Feeding practices

Optimal Infant and Young Child Feeding (IYCF) practices is pivotal to reducing malnutrition, morbidity, and mortality. According to UNICEF and WHO, infants should be put to breast within 1 hr of birth, exclusively breastfed the first 6 months of life and up to 2 years of age and beyond. When the infant is above 6 months, solid, semi-solid, and soft foods are introduced along with breastmilk. This transition is known as complementary feeding that is crucial for

the child's development. With the current situation in Lebanon, infants' and young children's survival, growth, and development is at high risk.

*This assessment examined IYCF practices in Syrian refugee households. The information was collected on 373 infants under 6 months old and 1,309 children aged 6-23 months.*

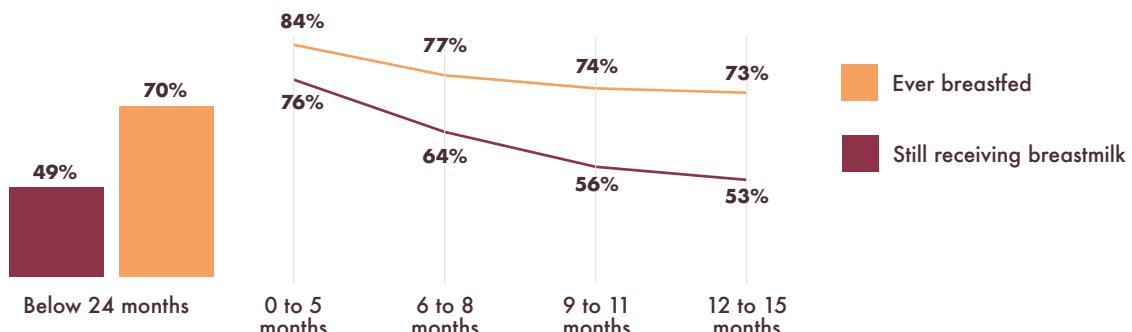
## Key findings

- There was a slight decrease of 4 percentage points in children between 12 and 15 months of age who were fed breastmilk the day prior to the survey, from 57% in 2020 to 53% in 2021.
- Complementary feeding for children between 6 and 8 months increased notably in comparison to last year's rate, from 35% to 49%.
- The percentage of children between 6 and 23 months who met the minimum diet diversity in 2021 was 19%, a 7 percentage points increase from last year's 12%.
- The minimum acceptable meal frequency for children between 6 and 23 months of age continued to decrease drastically this year from 80% in 2019 to 51% in 2020 to 36% in 2021.

## Breastfeeding practices<sup>5</sup>

Out of all infants below 24 months, 70% were ever breastfed and almost half of them were still being breastfed. Being ever breastfed and still receiving breastmilk were both found to be decreasing with age. Among children below 6 months, 8 out 10 were ever breastfed. This decreased to 73% among the 12 to 15 months old and saw a drop to 56% among those between 16 and 23 months.

**Figure 13: Breastfeeding practices**

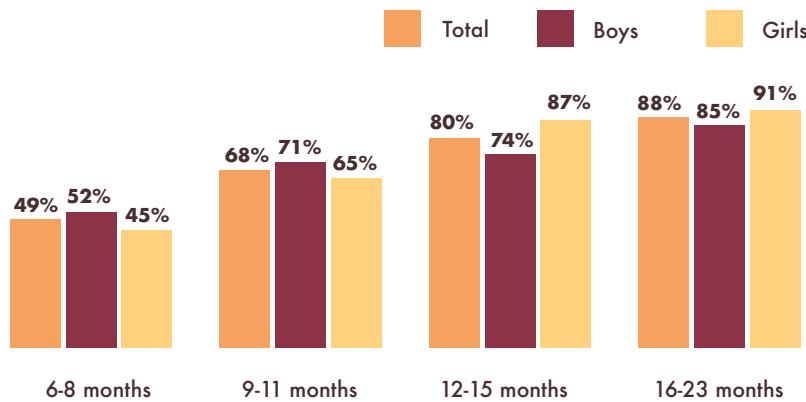


## Complementary feeding

Complementary feeding is a critical period in growth where the child transitions from exclusive breastfeeding to family food that includes solid, semi-solid, soft foods, or other liquids. The percentage of children between 6 and 8 months of age who received complementary feeding the previous day increased this year to 49% in comparison to 2020 (35%).

Additionally, the rates of complementary feeding increased with age, reaching 88% for children between 16-23 months of age. There was a notable difference between boys and girls according to age. The ratio for boys between 6 and 11 months was higher than that of girls. Inversely, the rate was higher among girls aged between 12 and 23 months.

<sup>5</sup> Exclusive breastfeeding for infants under 6 months was not generated due to the solid, semi-solids, and fluids questions being asked for infants between 6 and 23 months.

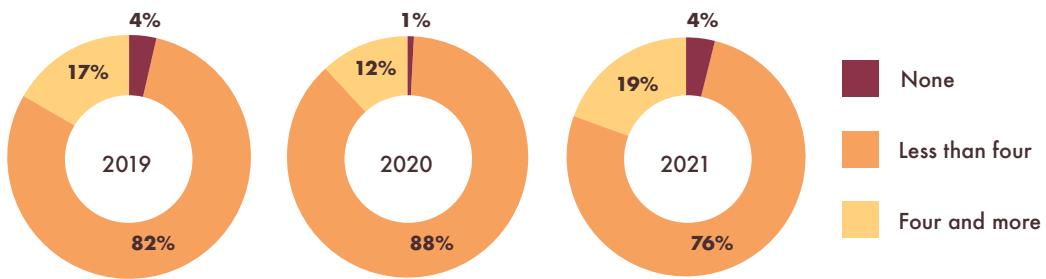
**Figure 14: Percentage of infants who received solid, semi-solid or soft foods during the previous day**

## Minimum dietary diversity

According to the WHO guidelines (2008)<sup>6</sup> for assessing IYCF 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:

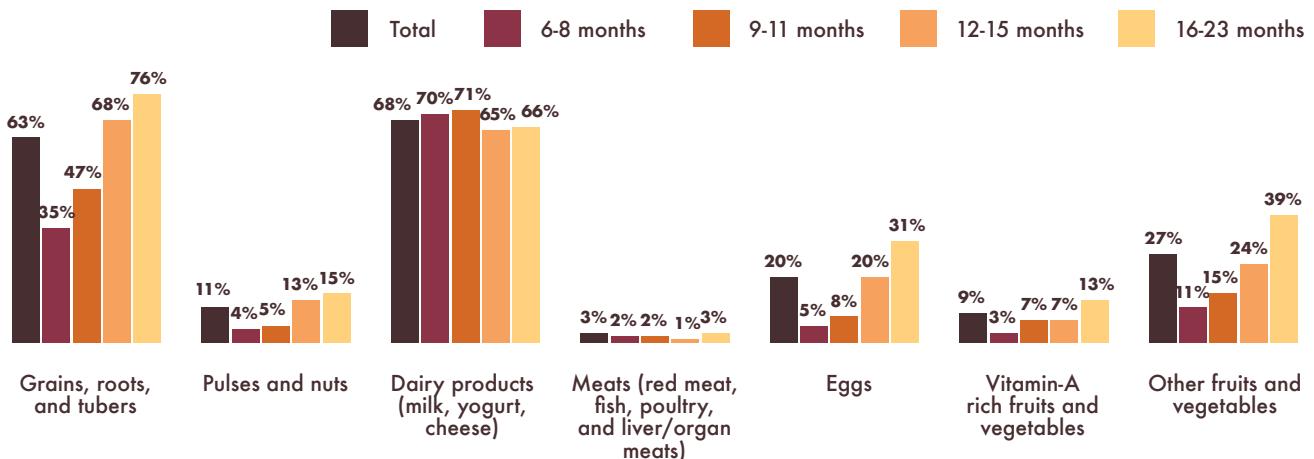
- 1- Grains, roots, and tubers
- 2- Pulses and nuts
- 3- Dairy products (milk, yogurt, cheese)
- 4- Meats (red meat, fish, poultry, and liver/organ meats)
- 5- Eggs
- 6- Vitamin A rich fruits and vegetables
- 7- Other fruits and vegetables

In 2019, only 17% of children between the ages of 6 and 23 months were fed a diverse diet on the previous day, consisting of four or more food groups. In 2020 that figure dropped to 12% and increased by 7 percentage points in 2021 to 19%.

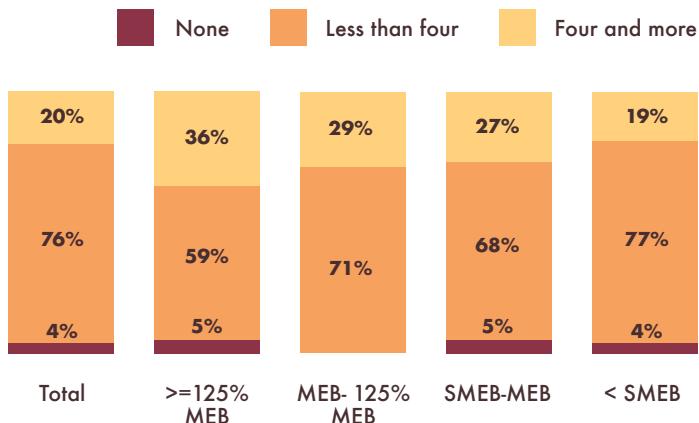
**Figure 15: Proportion of children 6-23 months old who receive foods from four or more food groups/categories**

Taking a closer look at each food group/category, notably there was a very low proportion of children aged 6 – 23 months who were eating pulses and nuts, meats, and Vitamin A rich fruits and vegetables. The highest consumption was for grains, roots, and tubers (63%), as well as dairy products (68%).

<sup>6</sup> <https://www.who.int/publications/i/item/9789240018389>

**Figure 16: Proportion of children 6-23 months old who receive foods from each food groups/categories**

For children aged 6-23 months, the share that received food from four or more food groups was lower among those living below the Survival Minimum Expenditure Basket (SMEB) (490,000 LBP) compared to those with expenditures above 125% of the SMEB (19% versus 36%).

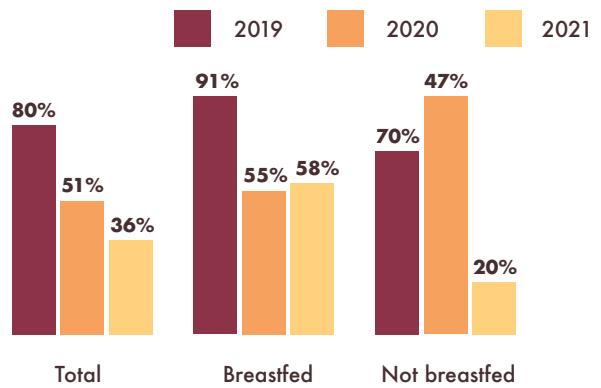
**Figure 17: Children 6-23 month old who received foods from four or more food groups by SMEB category**

## 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)

There was a notable decrease from 51% to 36% in children between 6-23 months who received the minimum acceptable number of meals every day. Among children who were breastfed, the minimum acceptable meal frequency was at 58%. For those who were not breastfed the figure decreased to 20%, compared to 55% and 47% respectively in 2020.

**Figure 18: Minimum meal frequency for children 6-23 months**

**Annex 9: Households access to primary and secondary health care**

	Primary Health Care (PHC)			Hospital Care			Medication		
	Share of families that needed PHC	Share of families that received the needed PHC	Share of families that needed hospital care	Share of families that received the needed hospital care	Households with members requiring drugs in the last 3 months	Households which accessed all or most of the required drugs	Households that know were to access services if someone is suspected to have COVID 19	Share of households that know were to access emergency care	
Total	43%	91%	17%	81%	59%	43%	73%	77%	
<b>Governorate</b>									
Akkar	43%	98%	9%	96%	33%	56%	70%	64%	
Baalbek-El Hermel	80%	96%	15%	96%	80%	63%	77%	92%	
Beirut	46%	73%	18%	60%	46%	29%	78%	76%	
Bekaa	74%	96%	20%	92%	78%	37%	77%	95%	
El Nabatiéh	73%	82%	28%	68%	70%	34%	73%	73%	
Mount Lebanon	51%	83%	18%	65%	51%	41%	75%	68%	
North	48%	94%	11%	92%	38%	41%	63%	64%	
South	67%	90%	17%	85%	78%	35%	73%	73%	
<b>Gender of the head of household</b>									
Women	66%	92%	12%	75%	62%	44%	69%	78%	
Men	59%	91%	18%	82%	58%	43%	74%	76%	
<b>Shelter type</b>									
Residential	59%	90%	16%	79%	56%	42%	75%	74%	
Non-residential	53%	89%	16%	73%	55%	43%	69%	75%	
Non-permanent	69%	94%	17%	90%	68%	45%	71%	84%	