



Worsening access to healthcare in crisis-hit Lebanon - May 2020

This paper focuses on exacerbated barriers in accessing healthcare for displacement-affected populations and vulnerable Lebanese households during COVID-19. The analysis is based on a survey conducted by NRC's Information, Counselling and Legal Assistance (ICLA) team with households with persons with disabilities¹, IRC's protection monitoring² and HI's impact survey with refugee (Syrian and Palestinian) and Lebanese users of specialised services³.

Background

In Lebanon the outbreak of **COVID-19 needs to be considered against the backdrop of unprecedented economic and political instability**. As part of their ongoing activities, the DFID consortium agencies monitor and aim to address the impact of these compounding crises on refugee communities in Lebanon. This paper specifically focuses on access to healthcare in light of the converging crises and exacerbated vulnerabilities. Through nationwide protection monitoring, access to healthcare for medical needs not necessarily linked to COVID-19 has consistently emerged as a key humanitarian concern. When refugees were asked their main problems in relation to the COVID-19 crisis, the third most common response was 'shortage of medicine' (41% of respondents).⁴ The **deterioration in the economic context, compounded by the disruption to livelihoods, has left the cost of healthcare beyond the reach of many**.

Moreover, field experience indicates that persons with disabilities face disproportionate vulnerability as they are not systematically included in contingency planning, assessments, design and delivery of humanitarian relief.⁴ Multiple layers of crisis in Lebanon have **compounded existing inequalities and heightened the vulnerability of persons with disabilities and older persons**.

¹ NRC ICLA teams rolled out a phone survey between 21 and 23 April 2020 with 130 households with persons with disabilities (60 in North Lebanon and 70 in the Bekaa valley). These families were identified pre-COVID through the use of the Washington Group Questions during ICLA counselling sessions. While this report was developed under the DFID-funded consortium between IRC, NRC and HI, NRC's broader ICLA programme is also funded by ECHO, SEM, KfW, OCHA and the Norwegian MFA.

² IRC commenced remote protection monitoring using the COVID-19 Refugee Household Monitoring tool on March 27. To date, protection monitoring data from 886 assessments has been analysed.

³ HI conducted an assessment with 197 users of specialised services on the impact of the financial crisis and COVID19 on households with at least one person with disabilities. The assessment included Syrian, Lebanese, and Palestinian Refugees from Lebanon from across all governorates of Lebanon.

⁴ 'Disability in Humanitarian Contexts: views from affected people and field organizations.', Handicap International, 2015.

This paper draws together analytical findings of the three agencies using distinct assessment tools. While this approach reduces the direct comparability of results, it provides a broader overview of the protection context through a multi-sectoral lens and enables the triangulation of data. The assessments primarily targeted Syrian refugees, however the needs of vulnerable Lebanese and PRL were reflected to an extent in HI's impact assessment.

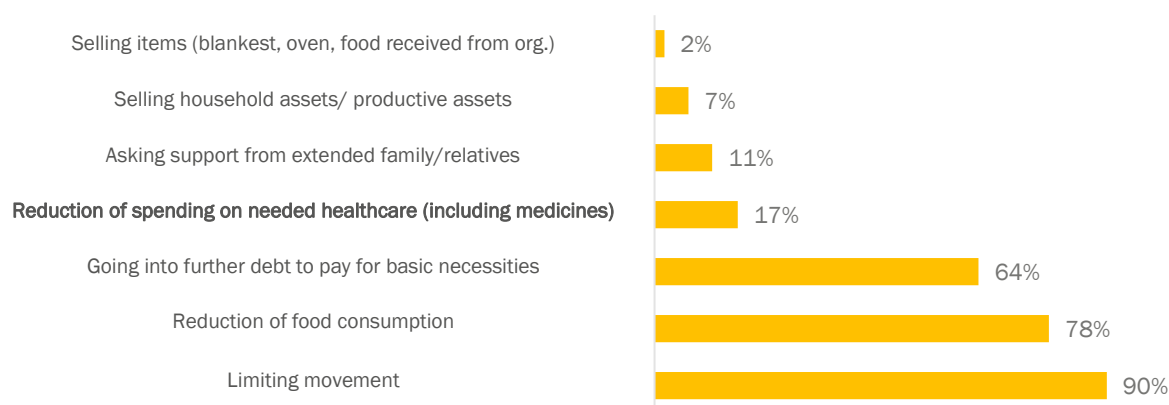
The analysis of the three DFID consortium agencies clearly shows the exacerbation of pre-existing barriers to healthcare faced by vulnerable households. While there are **isolated incidents of discrimination and excessive documentary requirements at health care facilities** and **area-specific restrictions which further challenge the access for refugees to healthcare**, these are **not wide-spread practices at the time of writing**.

Exacerbated pre-existing barriers to healthcare

In the context of COVID-19 various NGO surveys have looked at the ability of refugees to access health facilities. Protection monitoring data indicates that movement restrictions at the municipal level are not the primary barrier to accessing health care. Refugees interviewed in late April stated that, despite movement restrictions, they would still be able to access medical care in emergencies or at restricted times of the day.⁵ This aligns with a recent NRC shelter survey conducted in (peri)urban areas⁶, in which the vast majority (85%) of respondents reported having access to Primary Health Care (PHC). However, the **main reported barriers to accessing PHC were financial (40%) or linked to transportation (23.5%)**. These two barriers were also the most cited ones in another NRC survey conducted in Informal Tented Settlements in March 2020⁷. While these barriers pre-dated COVID-19⁸, they are **further exacerbated due to the ongoing economic crisis and reduction in public transportation**.

An analysis of longer-term protection monitoring trends shows a recent deterioration in access to health services. Prior to the nationwide lockdown, 15% of households reached through IRC's systematic protection monitoring reported facing barriers to access healthcare.⁹ However, in protection monitoring conducted since March 27 2020, 41% of households reported that the 'main problem' they faced was shortage of medication and **17% reported reducing spending on needed healthcare as a result of the crisis** (see graph).

How has your household responded to the corona situation?



⁵ In locations such as Deir al-Ahmar (Baalbek), respondents reported that they were required to seek permission from the municipality prior to movement, and required to wear masks/gloves. In a number of other municipalities, additional daytime curfews are imposed; refugees can only access pharmacies before 1pm.

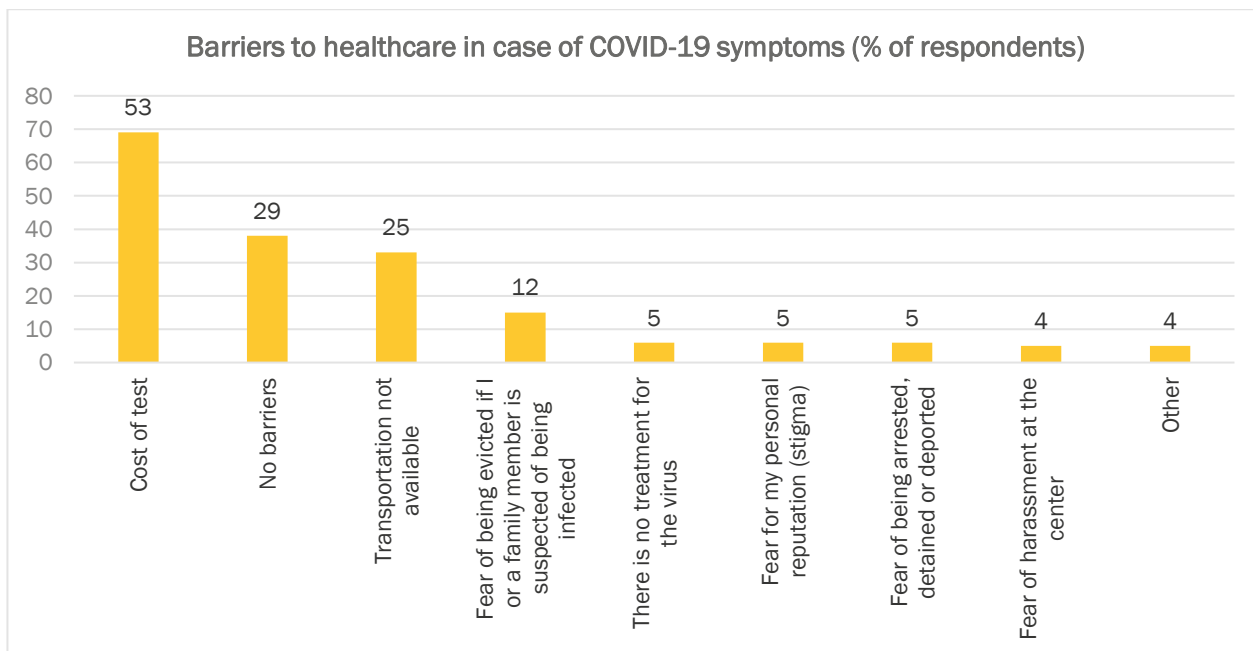
⁶ Between March 18 and April 1st NRC shelter teams conducted 285 phone surveys with beneficiaries from its Occupancy Free of Charge (OFC) programme in Bekaa (119), South (67), North (37), Baalback El Hermel (42), El Nabatieh (12) and Akkar (8). Details can be provided upon request.

⁷ "Knowledge and Protection Concerns around COVID-19 in Informal Tented Settlements in the Bekaa, Lebanon" (NRC WaSH survey findings - March 2020): https://www.nrc.no/globalassets/pdf/reports/knowledge-and-protection-concerns-around-covid-19-in-informal-tented-settlements-in-the-bekaa-lebanon/nrc-wash-survey-findings_covid-19_march-2020.pdf

⁸ Data collected for the VASyR in early 2019 (prior to the sharp economic decline) already found that "for both primary and hospital care, cost of treatment was, by far, the main barrier to accessing the needed care." Financial barriers to accessing healthcare has seen a steady increase over the years; in 2018 69% of respondents reported that the cost of treatment was the primary reason for not accessing needed hospital care; in 2019 this jumped to 80%.

⁹ IRC analyzed protection monitoring data on access to healthcare from August 2019 to March 2020. Of the 3467 households monitored, 534 (15% of respondents) reported facing barriers to accessing healthcare.

In the ICLA survey with households with persons with disabilities, **71% of respondents reported they might face barriers** in accessing healthcare if they would develop COVID-19 symptoms. These include test costs (53%), lack of transportation (25%) and fear of eviction (12%) as a result of being a suspected COVID-19 case (see graph below¹⁰). The fact that COVID-19 testing costs and transportation is indicated as a potential barrier, indicates that at least in those areas surveyed, **refugees are not sufficiently informed about the Lebanese Red Cross' support role in transporting people with severe symptoms and the coverage of testing costs by UNHCR and UNRWA for Syrian and Palestinian refugees respectively.**



In an impact assessment conducted by HI between March 24 and April 1 with users of specialized services, including Syrian, Lebanese, and Palestinian Refugees in Lebanon (PRL), 74% of respondents reported difficulties accessing health services in the current situation; the figure was 24% prior to October 2019. However, **Syrian households appear to face greater difficulties in accessing healthcare compared to their Lebanese and PRL counterparts, both prior to October 2019 (39%) and currently (93%).** Of the surveyed households, 68% cited a lack of financial means as the main barrier to accessing healthcare; 32% reported financial means as the main barrier to healthcare prior to October 2019.¹¹

In order to facilitate refugees' access to healthcare in Lebanon, UNHCR has contracted primary health centres to provide services either free or at a subsidized cost. Admission to hospital is supported through a Third Party Administrator (TPA), 'NEXtCARE', which enables access to hospitals based on a cost-sharing model.¹² At minimum, a refugee is required to pay a 100 USD 'patient-share'. However for bills of over 2,900 USD the patient-share is up to 800 USD.¹³ HI, IRC and NRC have all confirmed that the **patient-share is prohibitively expensive for the most socio-economically vulnerable. The inability for refugees to cover this cost leads to exacerbated protection risks.**

Despite being unlawful, the **confiscation of identity documents by hospitals due to refugees' inability to afford medical fees** is a relatively common practice which pre-dates the current COVID-19 crisis. During the period January to April 2020, NRC ICLA teams identified and followed up on **36 cases of confiscation of identity documents** carried out by hospitals, affecting refugees across Lebanon.

Given the current economic strain experienced by refugees **it is anticipated that there may be an increase in such incidents.** Collaborative dispute resolution services are provided by NRC ICLA teams in order to negotiate the payment of the arrears with the hospitals, reduce fees, set repayment schedules and return confiscated identity documents to the refugees.

Along with food and inability to pay rent, which have been consistently highlighted by humanitarian actors, a **shortage of medicine** was also cited by Lebanese (62%), Syrian (70%) and PRL (79%) households as a top unmet

¹⁰ Multiple selection option, does not add up to 100%.

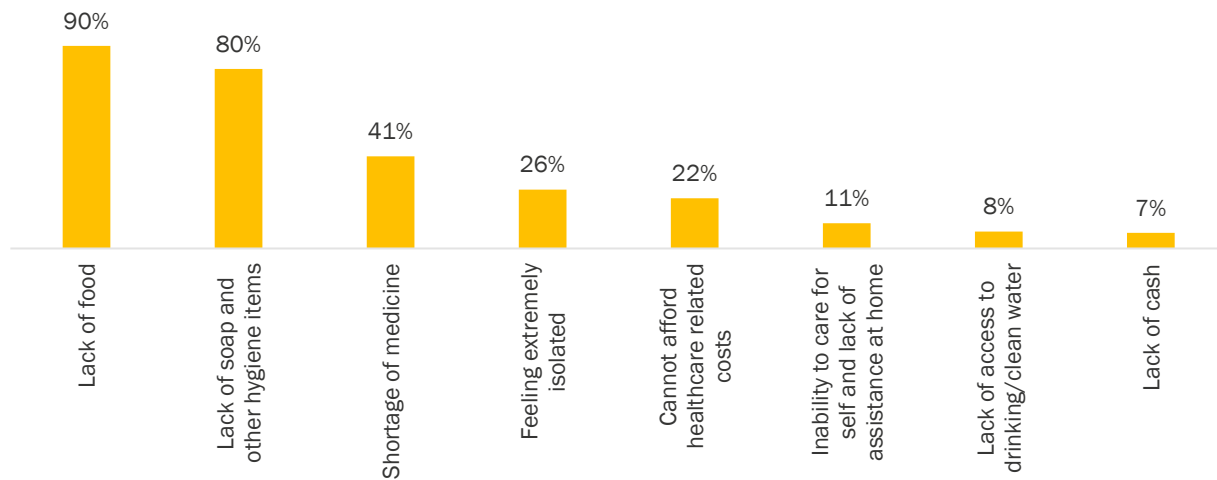
¹¹ See 'Latest Q&A (01/07/2018)': <https://www.refugees-lebanon.org/en/section/4/health>

¹² Health Access and Utilization Survey Among Syrian Refugees (OCHA, 27 November 2019): <https://m.reliefweb.int/report/3414033?lang=ru>

¹³ See UNHCR's 'Latest Q&A (01/07/2018)': <https://www.refugees-lebanon.org/en/section/4/health>

need in HI's impact assessment. This finding is triangulated with IRC's protection monitoring (see graph below. data April 21-30).

What are the main problems that you are facing in relation to COVID-19?



Reduced ability to access healthcare reflects a 'convergence of crises' in Lebanon. In late March, Human Rights Watch reported that the shortage of USD in Lebanon has critically reduced the import of medical supplies.¹⁴ As cited in the recent COVID-19 Emergency Appeal, 'access to basic services has been increasingly challenging with a **quarter of acute medications out of stock in December**'.¹⁵ Across the board, dramatic price hikes have been observed on all imported goods (including medicines) while job losses persist. In HI's impact assessment, **lack of financial means** was cited by respondents **as the main barrier to access healthcare**. Most households (89%) participating in HI's impact assessment reported a **significant loss in income as compared to six months earlier**, with a lack of work opportunities being the main reason; other reasons included roadblocks following wide-spread protests in late 2019, and government-imposed movement restrictions in response to COVID-19.

The current nationwide lockdown has further compounded socio-economic hardship. In HI's impact assessment, 74% of respondents reported purchasing food on credit, 53% reduced spending on non-food items including hygiene items (potentially perpetuating risk of poor health outcomes given the threat of Covid 19), 28% spent savings on food, 23% sold household assets (furniture, phone, jewellery) to buy food, 22% asked other households for food in the last 30 days.¹⁶ Half of the respondents reported they would have to rely on charity in the coming 30 days, 49% would seek assistance from other households in order to meet their food needs. **Lack of income combined with inflation puts healthcare and medication out of reach for vulnerable households.**

The **cycle of poverty and disability is perpetuated by barriers to access**: a poor household is at a higher risk of acquiring a disability due to inadequate nutrition, dangerous employment, and limited access to healthcare. Once a disability is acquired, a person faces increased barriers in accessing healthcare, among other services. Households with a person with disabilities already face greater financial strain, due to extra costs associated with nutritional requirements, medication needs, hygiene needs, transportation, and care, leaving fewer resources available for other household members.

Prohibitive cost of healthcare

Assessments conducted by the three DFID consortium agencies all highlight the prohibitive cost of health-care. For example, in the most recent protection monitoring data 25% of respondents reported that a key impact of COVID-19 on their household is **the inability to procure essential medicine** (see graph below). Of those who mentioned inability to procure essential medicine, 72% also reported loss of livelihood. In comparison to their male

¹⁴ 'Lebanon: COVID-19 Worsens Medical Supply Crisis' (Human Rights Watch, 24 March 2020): <https://www.hrw.org/news/2020/03/24/lebanon-covid-19-worsens-medical-supply-crisis>

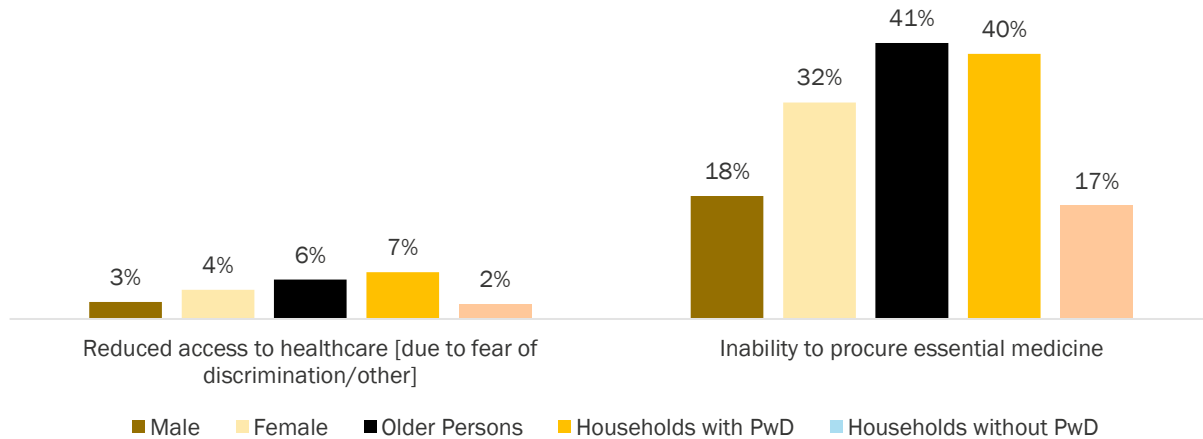
¹⁵ 'COVID-19 Emergency Appeal - Lebanon' (OCHA, 7 May 2020), p6 < <https://reliefweb.int/report/lebanon/lebanon-covid-19-emergency-appeal-07-may-2020> >

¹⁶ Multiple selection option, does not add up to 100%.

counterparts, women were also more likely to raise concerns regarding the inability to procure essential medicines; this is most likely linked to reproductive and maternal health needs.

Older persons and households with persons with disabilities are also much more likely to report an inability to procure essential medicine, highlighting the link between poverty and disability. HI's previous assessments have illustrated that persons with disabilities face additional barriers to accessing healthcare primarily due to services being too expensive and inaccessible.¹⁷

Covid-19 Impacts on Access to Health



Stigma and discrimination at healthcare facilities

In IRC's recent protection monitoring, a limited number of households (3% of respondents) reported reduced access to healthcare due to fear of discrimination. This was reported by refugees both in informal settlements and those living in informal housing. Reports of inadequate care and discriminatory treatment at hospitals is not uncommon. VASyR (2019) found that 17% of Syrian refugees visit private doctors over primary health centres primarily due to 'trust in the physician'.¹⁸ The following examples of ill-treatment at hospitals were reported by refugees who received one-off Emergency Cash Assistance under IRC's protection programming.

Examples from the field:

-Ten days after delivering her baby, the woman suffered from a respiratory problem and was transported to [name removed] hospital. The hospital refused to admit her and made her wait outside for several hours (10 pm till 3 am) in a terrible state. The hospital requested 23,000,000 LBP, and only agreed to admit her after her family paid a deposit of 550,000 LBP. Her husband borrowed 1,250 000 LBP. The wife went into a coma and is still at the hospital. The husband's ID was confiscated after he could not pay the remaining patient share. IRC provided Emergency Cash Assistance (ECA) to the husband to cover the cost of his transportation back-and-forth to the hospital and to cover basic needs for the new born child. The case was referred to UNHCR's Protection Cash Assistance Program (PCAP) for longer term financial assistance and legal assistance.

-Client reported suffering from cancer and need of urgent hospitalization. He attended to the [name removed] hospital who refused to admit him before paying a deposit. Furthermore, hospital staff were condescending with the patient. As he was in a terrible shape, he was not able to reach another hospital because of the long distance, his family had to borrow the amount needed to get the treatment.

While the above incidents pre-date the current COVID-19 crisis, they highlight broader concerns as to whether services goods and facilities are available, accessible, acceptable and of good quality.¹⁹ In the context of COVID-19, it is critical that all persons feel comfortable to access testing and treatment through designated health providers. Fear of stigmatization at hospitals may negatively impact on the willingness of individuals to seek care through the Ministry of Public Health (MoPH) referral partners.

¹⁷ 'Removing Barriers; The Path Towards Inclusive Access' (Lebanon Report, July 2018), p42.

¹⁸ Vulnerability Assessment of Syrian Refugees in Lebanon (VASyR) 2019, p75

¹⁹ Standards set out in: The Right to Health (Office of the United Nations High Commissioner for Human Rights and World Health Organization), Fact Sheet No. 31, p4

Documentary requirements to access healthcare

In order to assess the documentary requirements required to access healthcare, NRC's Information, Counselling and Legal Assistance (ICLA) team contacted a total of 81 primary healthcare centres and 26 hospitals in South Lebanon, Beirut-Mount Lebanon, Bekaa and North Lebanon.²⁰

The majority of health facilities contacted are requesting Syrian and Palestinian refugees to present identification documents to access health, mainly UNHCR certificate, UNRWA card and identification documents (identity card, passport, individual extract or family booklet) for adults and birth notification or birth certificate for children.

In the **survey** conducted by NRC ICLA teams with the households with people with disabilities in the Bekaa and North Lebanon, **84% of the respondents confirmed that health centres require identity documents to proceed with the provision of the health service.** The **UNHCR certificate** was mentioned by 92% of the respondents as the main document requested by the centres, followed by the identification card. The **birth notification** (39%) and the **birth certificate** (48%) were reported to be required for children in need of health assistance.

According to the World Health Organization²¹, **healthcare providers have the responsibility to check and verify a patient's identity** upon admission and prior to the administration of health-care. However, in this context, the documents required for identification and access to healthcare, should **take into consideration the limitations that refugees might face in providing specific documentation**, especially regarding documents that cannot be issued by Lebanese authorities. Also, the legal status should not limit healthcare access.

In addition to documentary requirements to access medical facilities, the **presence of checkpoints continues to challenge access to services, including healthcare, for the majority of refugees who lack legal residency.** At the time of writing a limited number of municipalities established additional checkpoints to monitor movements during the national lockdown specifically.²² In HI's impact assessment, **13% of Syrian refugees who reported a significant loss of income over the past six months also indicated that they were afraid to leave home to look for work due to the increased number of checkpoints and their current legal status.**



An NRC ICLA staff member delivers a birth certificate to a Syrian refugee for her daughter in south Lebanon. Photo: NRC Lebanon

Accessing healthcare for non-COVID related issues

The **vast majority of refugees report that they are willing to access public health centers for non-COVID-19 related medical needs.**²³ However, a **small percentage reported fear of infection at health facilities.** They also mentioned the fear of sitting in often-crowded waiting rooms. Similar concerns were shared with ICLA Information Focal Points in phone conversation with residents from other communities across governorates.

Mental Health and psychosocial support (MHPSS) needs have steadily increased since the beginning of March 2020. In IRC's most recent protection monitoring April 21-30, 25% of respondents, with and without disabilities (90 households) reported facing psychological distress/anxiety. This is in contrast data to collected during 30 March – 3 April where only 16% of respondents reported experiencing psychological distress and anxiety. **When specifically looking at households with a person with disabilities, this figure was even higher;** 47% of households with a person with disabilities reported facing psychological distress/anxiety. **Female respondents were also more likely to report distress and anxiety.** This may relate to increased financial pressures and changes in roles/responsibilities. Agencies providing case management, including IRC, have continued to support refugees with remote case

²⁰ The paper outlining the findings of this mapping exercise can be provided upon request.

²¹ <https://www.who.int/patientsafety/solutions/patientsafety/PS-Solution2.pdf>

²² Please refer to the Situation Report developed by the DFID-funded consortium in April 2020 "Protection Space for Refugees in Lebanon during COVID-19."

²³ IRC's protection monitoring (6 April – 16 April) found that of 404 respondents, 95% of respondents reported that in a health emergency not related to COVID-19 they would still feel comfortable to access healthcare. Of the 5% who said they would not be comfortable to access healthcare for non-COVID related emergencies the primary reason was due to fear of infection while at health facilities.

management and in-person case management for high-risk cases. Further access to Emergency Cash Assistance (ECA) and tailored in-kind assistance is required to provide timely interventions in critical instances.

Communication with Communities

In addition to inquiring about documentation requirements at healthcare facilities and challenges for people underlying medical conditions, the phone survey NRC conducted with 130 refugee households with persons with disabilities also aimed to assess remaining information gaps on COVID-19 and the impact of containment measures. The survey used the same questionnaire²⁴ as the one used for surveys conducted by NRC's WASH²⁵, Shelter²⁶ and Emergency Response Unit²⁷ and also overlaps with some of the standard questions in IRC's protection monitoring.

Findings from the ICLA survey are comparable²⁸ with the abovementioned earlier surveys although **fear of the virus spreading inside people's communities was less prominent** and **respondents were better informed on COVID-19 precautionary measures**. The main concerns of respondents revolved around children getting infected, financial concerns, and shortage of food and basic needs.

Respondents from all three surveys reported that their **main sources of information are Media (TV, Radio), Ministry of Health SMS and UNHCR SMS** ranked in this order of importance.

Key Recommendations

- Donors and health actors should **seek to minimize financial barriers to healthcare for the most vulnerable**, including older persons and persons with disabilities. In light of the current crises, the **patient-share should be revised** to ensure that health-care is within the reach of all.
- The broader donor community is urged to **maintain a focus on non-COVID-19 related illnesses**, which are likely to be exacerbated by the current economic decline.
- The Government of Lebanon must **guarantee equitable and non-discriminatory access to information, prevention and medical care** for all persons irrespective of their citizenship, nationality or migratory status. Access to healthcare should not be dependent on the ability to present identification documents or residency permits, particularly for individuals in need of urgent care.
- **Continued support for case management and Psychosocial support (PSS)** is vital to mitigate negative outcomes linked to mental health and reduce the risk of violence in the home.
- Emergency Cash Assistance and other forms of tailored in-kind support are critical to **ensure a flexible and timely response for high-risk cases**.
- UNHCR and NGOs should proactively reach out to refugee communities with **information about coverage of COVID-19 test costs**.



²⁴ The questionnaire can be provided upon request.

²⁵ Ibid., p 2.

²⁶ Ibid., p 2.

²⁷ "Covid-19: Concerns and Needs of Syrian Refugees in Informal Tented Settlements in Lebanon"; survey conducted under the ECHO-funded Lebanon Protection Consortium, April 2020): <https://www.nrc.no/resources/reports/covid-19-concerns-and-needs-of-syrian-refugees-in-informal-tented-settlements-in-lebanon/>

²⁸ Any differences in results between the ICLA survey and other surveys conducted by NRC, could potentially but not necessarily be linked to the fact that the ICLA sample *only* included households with Persons with Disabilities while the other surveys may have included some households with Persons with Disabilities. However, the sample size would have been too different to compare.