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Negotiating health and life: Syrian refugees and the politics of access in Lebanon

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ABSTRACT

In the context of ongoing armed conflicts in Libya, Syria, Yemen, and Iraq, it is vital to foster nuanced understandings of the relationship between health, violence, and everyday life in the Middle East and North Africa. In this article, we explore how healthcare access interacts with humanitarian bureaucracy and refugees' daily experiences of exile. What are the stakes involved with accessing clinical services in humanitarian situations? How do local conditions structure access to healthcare?

Building on the concept of "therapeutic geographies," we argue for the integration of local socio-political context and situated knowledge into understandings of humanitarian healthcare systems. Using evidence gathered from participant observation among Syrian and Palestinian refugees in Lebanon, we demonstrate how procedures developed to facilitate care—such as refugee registration and insurance contracting—can interact with other factors to simultaneously prevent and/or disincentivize refugees' accessing healthcare services and expose them to structural violence. Drawing on two interconnected ethnographic encounters in a Palestinian refugee camp and in a Lebanese public hospital, we demonstrate how interactions surrounding the clinical encounter reveal the social, political, and logistical complexities of healthcare access. Moreover, rather than hospital visits representing discrete encounters with the Lebanese state, we contend that they reveal important moments in an ongoing process of negotiation and navigation within and through the constraints and uncertainties that shape refugee life. As a result, we advocate for the incorporation of situated forms of knowledge into humanitarian healthcare practices and the development of an understanding of healthcare access as nested in the larger experience of everyday refugee life.

1. Introduction

In the context of ongoing armed conflicts in Libya, Syria, Yemen, and Iraq, it is vital to foster nuanced understandings of the relationship between health, violence, and everyday life in the Middle East and North Africa. Recent scholarship on the region has productively examined the relationship between governance and healthcare (Batniji et al., 2014) and the nexus of armed conflict and public health (Dewachi et al., 2014). Building on these foundations, we explore relatively understudied connections between healthcare access, violence, and quotidian refugee experiences in humanitarian contexts (Ager, 2014). As such, we ask: How do everyday political and social interactions in receiving countries structure refugees' access to healthcare? What are the stakes involved with accessing clinical services in humanitarian situations?

Drawing on Dewachi et al.'s (2014) concept of "therapeutic geographies," we argue for the integration of local socio-political context and situated knowledge into understandings of humanitarian healthcare. Using evidence gathered from participant observation among Syrian and Palestinian refugees in Lebanon, we first contend that the very humanitarian and bureaucratic procedures that have been put in place to facilitate care—such as refugee registration and insurance contracting—may at once hinder and/or discourage refugees' accessing healthcare services and expose them to more violence. Second, beyond a straightforward issue of service or treatment availability, we argue that the process

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of negotiating access should be situated within the broader experiences and practices of everyday refugee life (Watters 2001). For example, while one might receive a specific treatment, one might simultaneously be subject to various degrees of humiliation or invalidation in the broader socio-political and economic context, thus diminishing one's sense of wellbeing.

This article proceeds in five parts. First, we present our case and methodological approach. Second, we argue for the explicit incorporation of micro-level socio-political context and practice into the concept of therapeutic geographies. Third, we present a two-part ethnographic vignette in order to evoke some of the core issues with treatment access for refugees from Syria in Lebanon. Fourth, we link these interludes back to the concept of therapeutic geographies and explore how they operate on different scales. We conclude in the hope of problematizing current practices, making new conceptual frameworks available to researchers, and facilitating new therapeutic possibilities for humanitarians, clinicians, and policymakers.

1.1. Refugees from Syria and access to health services in Lebanon

Syrian refugees currently constitute the second largest refugee population in the world (3.88 million registered refugees) after Palestinians (5.09 million) (UNHCR, 2015b, p. 3; UNRWA, 2015, p. 1). Though approximately 23.5% of the world's refugees now live in Lebanon, Jordan, and Turkey (UNHCR, 2015b, p. 3), little research addresses their lived experience of healthcare in these evolving contexts. While scholarship on refugee and migrant healthcare access often centers on encounters in the Global North (Gottlieb et al., 2012; Koehn, 2005; McKeary and Newbold, 2010; Okie, 2007), a growing number of studies conducted in the Global South (Arnold et al., 2014; Posner et al., 2002; Rowley et al., 2006) and specifically in the Middle East and North Africa (Briant and Kennedy, 2004; Gottlieb et al., 2012) provide a useful foundation from which to build grounded insights into contemporary refugee crises. This scholarship should also be integrated with previous research that focuses on the politics of state and non-state provider organizations in the Middle East (Batniji et al., 2014; M. C. Cammett, 2011; M. Cammett and Issar, 2010; M. Cammett, 2014; Challand, 2008; Chen and Cammett, 2012; Onyedum, 2012).

Research on these issues is acutely needed in host countries such as Lebanon. Beginning largely in the spring and summer of 2012 and directly preceding the siege of the northern Syrian city of Aleppo, thousands of refugees from Syria (both Syrian nationals and Palestinian refugees from Syria, or "PRS") flooded into Lebanon (Abu Sa'Da and Serafini, 2013; Dahi, 2013). While the United Nations High Commissioner for Refugees (UNHCR) reported 126,800 registered Syrian refugees in 2012, that number rose to 851,300 in 2013 and over one million in 2014 ("UNHCR Syria Regional Refugee Response," n.d.; UNHCR, 2013a, p. 2, 2014a, p. 2; the United Nations Relief and Works Agency for Palestine Refugees in the Near East, or UNRWA, overseas care for PRS). Officials believe that several hundred thousand refugees have remained unregistered; for example, Médicins Sans Frontières surveys conducted in January 2012 and June 2013 indicated that approximately 41% of Syrian refugees were unregistered (Abu Sa'Da and Serafini, 2013, p. 72). By 2014, Lebanon "hosted the largest number of refugees in relation to its national population" in the world at 232 refugees for every 1000 people (UNHCR, 2015b, p. 3).

While many remained in areas close to the border in northern Lebanon and in the eastern Biqa' Valley, thousands of refugees also relocated to the coastal cities of Tripoli, Beirut, Sidon, and Tyre. They found housing in rurally located "informal tented settlements," slept in common shelters such as mosques, leased urban apartments, and rented rooms in Palestinian refugee camps. For instance, in August 2013, the South Beirut districts of Chiyah and Burj al-Barajna, which house the Mar Elias, Shatila, and Burj al-Barajna Palestinian refugee camps (as well as the heavily Palestinian neighborhoods of Tariq al-Jadida, al-Da'uq, and Sabra) hosted the two largest populations of Syrian refugees in the Beirut region, at 18,143 and 10,312 people respectively (UNHCR, 2013c). By April 2014, there were 40,538 registered Syrian refugees in Chiyah and 20,658 living in Burj al-Barajna (UNHCR, 2014b).

UNRWA officials estimate that tens of thousands of Syrians have moved into the Shatila and Burj al-Barajna camps, prompting public health and socio-economic concerns (the camps' 2011 registered Palestinian populations were 9154 and 16,888, respectively) (Author conversations with Chief Area Officers and Camp Services Officers, January 2014, May 2014, June 2014; UNRWA Public Information Office, 2011). Rampant new, unregulated construction and visible overcrowding support the conclusion that many refugees from Syria are living in the Palestinian camps (Field notes, January 2014, May 2014, June 2014). Besides offering cheap housing and proximity to work opportunities, the Palestinian camps also offer a specific form of security; many Syrian refugees and PRS who have not acquired or cannot maintain legal status choose to live in these communities because Lebanese security forces do not patrol them (On Palestinian refugee camps in Lebanon see: Allan, 2013; Peteet, 1987, 2005; Sayigh, 1995; Suleiman, 1999).

The strain on the Lebanese health system has been immense (Dahi, 2013; Dewachi et al., 2014; Lebanese Center for Studies and Research, Beirut Research and Innovation Center and Oxfam, 2013; Parkinson, 2014a). For example, an April 2013 UNHCR report emphasizes that the Syrian refugee influx strained Lebanese capacities and that the Lebanese cost-sharing model consequently stretched UNHCR's own financial resources in comparison to state-paid healthcare systems in Iraq and Jordan (UNHCR, 2013b). The Lebanese Ministry of Health declared in a June 2013 press release that the hospital systems were being overwhelmed by the influx of Syrian patients and that this development posed a risk to Lebanese public health (Minister's Office, 2013). Likewise, Dahi reported in September 2013 that Lebanese hospitals in the Biqa' Valley were out of beds and that non-governmental aid organizations were running out of resources for health programs (Dahi, 2013).

The heavily privatized nature of the Lebanese healthcare system has profoundly influenced this situation. Exemplary care is available at private facilities such as the American University Hospital, but is accessible only to those with good insurance or extensive financial means. As Batniji et al. (2014, p. 350) note: "In Lebanon, the state has played a minimal part in providing and regulating health care, opening up the field to a diverse array of providers," many of them linked to political parties. Political parties frequently favor supporters and allies in their allocation of health and social services (Batniji et al., 2014; Cammett and Issar, 2010; Cammett, 2011; Cammett, 2014). One study found that joining or volunteering for a political party made a person twice as likely to receive financial aid for healthcare; the authors noted that poor Lebanese were systematically excluded from these systems (Chen and Cammett, 2012).

The system is thus informally biased against non-citizens—who do not join Lebanese political parties—as well as many Lebanese citizens with limited financial means. Perhaps unsurprisingly, a Norwegian Refugee Council (NRC) report published in March 2014 relayed that 74% of Syrian refugees living in the North, the Biqa', and the South reported difficulty accessing healthcare (Norweigan Refugee Council, 2014, p. 15). A joint study published in June 2015 by the International Rescue Committee (IRC) and the NRC noted that 55% of Syrian refugees in Mount Lebanon and Beirut experienced difficulty accessing healthcare and that the lack of specialized services was particularly acute in the