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Health care access for Syrian refugees in Lebanon

“Most importantly, I hope God keeps illness away from us”: The context and challenges surrounding access to health care for Syrian refugees in Lebanon

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Abstract

The influx of 1.5 million Syrians into Lebanon has created an increased demand for health services, which is largely unmet, due to cost, a highly fragmented and privatized system, and crises around legal documentation and refugee status. The aim of this study was to use a constant comparison analysis of qualitative data to explore how Syrian refugees living in Lebanon describe their experiences accessing healthcare (N=351 individuals within 46 families). Pervasive fear, lack of confidence in the medical system, and high costs all hinder access to healthcare for Syrians in Lebanon. Findings demonstrate the need for attention to the costs and accessibility of care, and for stronger coordination of care within a centrally led comprehensive emergency plan. While we attend to understanding and alleviating the barriers surrounding refugee healthcare, we must also address the underlying cause of health crisis: the brutal realities caused by armed conflict.

Keywords: refugees; health; healthcare systems; Syria; Lebanon; war or political violence or armed conflict

Introduction

Syria is the site of one of the largest humanitarian crises of our time, marked by profound violation of international law and a failure of the international community, particularly the medical community, to adequately respond (Akbarzada & Mackey, 2018; Lancet, 2017). The United Nations estimates that there are over 13 million people in need of assistance in Syria, 6.6 million internally displaced, and over 5.6 million people who have fled across Syria's borders, mostly to neighboring countries (UNHCR, 2018b).

As of February 2018, 1.5 million Syrians have been displaced to Lebanon (Inter-Agency Coordination Lebanon, 2018). Poverty, food insecurity, unsafe and crowded living conditions, lack of access to clean drinking water, and interruptions with access to healthcare all pose serious problems for health and safety among Syrian refugees in Lebanon (see Table 1).

Un(der)employment, lack of legal documents, trauma, and tensions within the host community within Lebanon compound these problems (Hassan, 2015). Taken together, the challenges faced by refugees increase the risk of communicable diseases within refugee communities and jeopardize the effective management of non-communicable diseases (Blanchet, 2016; Cousins, 2015; Langlois, Haines, Tomson, & Ghaffar, 2016; Sethi, Jonsson, Skaff, & Tyler, 2017).

The rapid influx of such a vulnerable population poses a major health and humanitarian crisis within Lebanon – a country that was already characterized as a vulnerable state due to its overwhelmed systems, particularly related to healthcare (Cherri, 2016; Refaat, 2013). The World Health Organization (WHO) estimates a 50% increased demand for health services in Lebanon due to the growing population of Syrian refugees with urgent health needs (World Health Organization [WHO], 2015). In many ways the Lebanese system has responded well, ramping up services despite continued crises in funding and management of the crisis (Ammar, 2016).

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Nonetheless, healthcare access remains challenging for Syrians who have fled to Lebanon, and some evidence suggests that Syrian refugees in Lebanon access care at considerably lower rates than do Lebanese citizens (Doocy, 2016). A 2017 assessment of almost 5,000 randomly selected Syrian refugee households in Lebanon (N=24,415) found that one in ten Syrian refugees in Lebanon had no access to primary healthcare in the prior six months, and one in four had no access to necessary secondary healthcare (United Nations High Commissioner for Refugees (UNHCR), United Nations Children's Fund (UNICEF), & World Food Programme (WFP), 2018).

Scholars and leaders charge that we, as a public health community, have failed the people of Syria through our lack of knowledge and, relatedly, systems that we set up that have trouble effectively mitigating the health impacts of the crisis (Blanchet, 2016; Cousins, 2015; Horton, 2016). At the same time, there is a growing body of research about the factors that might underlie resilient health systems (Alameddine et al., 2019); much of this literature is specific to the crisis we describe here. Building knowledge about effective responses to this crisis requires examining the lived realities of experiences with healthcare via narratives elicited from those most affected. Thus, responding to the call to action around understanding and supporting the healthcare needs of Syrian refugees, this study examines qualitative data collected among Syrian refugees to explore the health and healthcare experiences of Syrian refugees living in Lebanon (N=351 individuals within 46 families).

Background

Healthcare for Syrians is managed by UNHCR through a private insurance company - a third-party administrator (TPA), which was Medivisa until 2016, when the contract was moved to NEXtCARE (Marsi, 2017; Singh et al., 2020). Generally, care is delivered within supported

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Primary Health Care Centres (PHCc), which are the first access point for medical attention (UNHCR, 2019). Here, patients can access doctors for consultations and care and, if necessary, be referred to other services (UNHCR, 2019). In case of medical emergency, people are required to contact the TPA when they get to the hospital to ensure that their services will be covered (UNHCR, 2019). Most of the PHCCs that provide care through these arrangements are in the private sector – 68% of PHCCs are owned by NGOs and 80% of the associated hospitals are private (Government of Lebanon & United Nations, 2019).

When accessing a PHCc, Syrians pay a fee of 3,000-5,000 LBP, with the UNHCR covering the remainder of the cost for a doctor consultation (UNHCR, 2019). Out of pocket payments for refugees increased in 2013 (Blanchet, 2016), and also in 2019 (UNHCR, 2019). Fees for laboratory and diagnostic tests are paid by the individual except in cases where they belong to a special subgroup of the population (UNHCR, 2019). For hospital care, refugees are covered at 75%, if they qualify and have an appropriate referral (UNHCR, 2019). Pamphlets for refugees and asylum seekers instruct that “the health system in Lebanon is privatized and you may have to contribute to your healthcare.” Materials specify that patients must pay 25% towards their care, with UNHCR covering the other 75%, though, as detailed in these instructions, patients may be asked to pay a deposit exceeding their 25% contribution – in this case, the pamphlet instructs, the patient must obtain the necessary receipts and apply for reimbursement (UNHCR, 2017a).

To qualify for this subsidized care from a PHCc, Syrians are required to be registered as refugees with UNHCR or be recognized as a Person of Concern (PoC) (UNHCR, 2018a). Persons of concern include a variety of marginalized groups including Palestinian and Lebanese citizens as well as children born in Lebanon to fathers with PoC status (UNHCR, 2018a). The

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UNHCR policy states that care is provided to individuals while determination of their PoC status is expeditiously reviewed (UNHCR, 2018a). This allowance of care pending determination exists within a backdrop of decades of tension around the official policies of Lebanon towards refugees. Despite housing the highest number of refugees in the world (relative to its size and population), Lebanon has never ratified the 1951 Convention Relating to the Status of Refugees or the 1967 Protocol, and the UNHCR registration process in Lebanon has been under scrutiny due to problems such as the government of Lebanon promoting a liberal practice of the UNHCR un-classifying Persons of Concern and those previously been registered as refugees (Janmyr, 2018).

Legal residency permits are only held by one out of five Syrians in Lebanon (Inter-Agency Coordination Lebanon, 2018). Crises around legal documentation, residency permits, and sometimes, UNHCR registration, restricts the mobility of Syrian refugees who fear capture and repatriation at the frequent checkpoints in Lebanon (Akesson & Coupland, 2018; Medecins Sans Frontieres (MSF), 2013). Refugees are instructed to go to a PHCc aligned with the network of care, or else they will be charged more. Yet, the availability of subsidized care differs across regions, with some areas experiencing lower access to care than others (UNHCR, 2019). Uneven availability of services thus especially problematic due to problems of mobility and associated safety of Syrians in Lebanon.

The complexities we described above illustrate multiple reasons why – despite its many achievements and bold attempts to adjust to the dramatic influx of displaced persons - the Lebanese system has been characterized by health scholars as highly privatized, fragmented, and uneven with regards to access to care, not only for Syrian refugees, but also for other vulnerable groups (Chatty, Mansour, & Yassin, 2013; Khalife, 2017; Parkinson & Behrouzan, 2015; Sen &

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Mehio-Sibai, 2004). Above, we have provided a broad picture of healthcare access for Syrian refugees in Lebanon. To understand better the perceptions about the realities of accessing healthcare, we now turn to the results of our analysis of narratives from Syrian families living in Lebanon.

Methods

The research received human subjects' approval through Wilfrid Laurier University's Research Ethics Board (REB #4661) and followed all REB guidelines. Data were gathered using collaborative family interviews with 351 individuals within 46 families who had fled Syria in the previous five years and had 'temporarily' resettled in three regions of Lebanon: northern Lebanon, Beirut, and Bekaa Valley. Community and international organizations aided in the recruitment of participants, who were also recruited through word of mouth and via *shawesh* (community leaders). All recruited families agreed to participate.

Data collection was done in 2016 and 2017 via collaborative family interviews, with both immediate family members (e.g., mother, father, and children) as well as extended family members (e.g., aunts and uncles, grandparents, etc.) in the homes of families. Families were consented into the study with a script that detailed the purpose of the study, the risks, and their rights to refuse to participate in the study with no influence on the services they receive from agencies that might have referred them to us. Table 2 shows the demographics of the research participants. Workers affiliated with community-based organizations, non-governmental organizations, and the United Nations were also interviewed in English for the research. Collaborative family interviews were conducted in Arabic by a Lebanese research team member who all first took part in a three day training led by the study PI. The training consisted of content on sensitivity and ethics, as well as the technical aspects of the research methods.

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Collaborative family interviews lasted between one and two hours (see interview guide – Appendix 1). The procedure included brief follow up interviews one week later, where families were invited to share their thoughts about the initial interview, along with any additional thoughts or questions. All interviews were audio-recorded, translated into English, and transcribed.

Data was uploaded to Dedoose, an online qualitative analysis software package. In this platform, we coded and organized data. Codes were created collaboratively, with both the original research team (via regular conference calls for the duration of building the initial codebook) and with additional research assistants, who came in to help refine and further organize the coding scheme. Throughout the ongoing process of establishing and refining of our coding scheme, we used the constant comparison method (Glaser & Strauss, 1967) to move continuously between data and theory. In so doing, we compared across cases and used this information to then build themes which integrated disparate stories into carefully constructed and verified descriptions of the experiences faced by Syrian families in Lebanon. The findings presented in this paper specifically relate to health and healthcare. For this paper, we performed further analysis only on the data contained within the themes related to health and healthcare. To maintain confidentiality, in presenting the results we chose pseudonyms for family members, using the title of *abu-* and *umm-* to signify father and mother (respectively), joined by the name of their first-born son.

Results

Cost

Our findings indicate that cost was a major barrier to families seeking medical care. Expenses in accessing care in Lebanon was typically described in contrast to their experiences

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obtaining medical care in Syria before the war. Umm-Amir explained that in Syria, ‘...there are clinics, [and] they don’t take money. They’re public clinics. Here [in Lebanon] they take money. For a normal visit they take LBP13,000 [US\$8], LBP3,000 [US\$2] if you have the UN papers. Now recently, they started saying that they are taking LBP13,000 even for the vaccines.’ The cost is prohibitive for mothers like Umm-Amir: ‘If for the vaccine, they are charging LBP13,000, and you have days where you don’t have LBP3,000, [let alone] LBP13,000. How will you take her to have her vaccinated?’

Families described the high cost of healthcare in Lebanon as being further exacerbated by the amounts of debt Syrians have accumulated due to displacement and resettlement. One family paid over SYP5,000,000 [US\$22,500] in bribes to secure their safe arrival in Lebanon. The average Syrian family in Lebanon has an estimated debt of almost US\$800 per household (UNHCR, 2017b). Growing debt (much of it resulting from health care costs) combines with pervasive poverty in a vicious cycle, as explained by our participants, who described that with very little money to survive, they rely on NGOs for food support and medicine from NGOs. Facing such dire economic circumstances, interviewees described that injury or illness threatens the economic well-being of the family. For example, many women shared how difficult it was when their husbands cannot work due to illness. Umm-Imad explained how she typically relies on her husband’s income to take care of the household. But recently, Abu-Imad had surgery on his eye, which cost them a large amount of money. Umm-Imad said, ‘We ran from charity to charity, [and] not one helped us, not even the United Nations! We had to borrow money from his siblings. So these two months were very stressful. Life is hard here.’

Like Umm-Imad, others talked about their income not covering the medicine. 39-year-old father of four, Abu-Rafik explained, ‘Back in Syria, education was free and so was the

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medication. But now everything is expensive. You work all day, and you barely make enough money to buy food. The medication and medical services are very expensive.’ Abu-Rafik’s wife, Umm-Rafik has diabetes and needs medication to control her blood sugar. But securing the medication poses a hardship for them because of the cost. Abu-Rayyan, father of nine, put it simply:

Our life in Syria was much cheaper. But here if I take my child to the doctor, it won’t be any less than 50,000LL. Healthcare in Lebanon is not healthcare, it’s a business. In Syria when we used to enter a hospital we didn’t pay. They simply treated you. Here it’s the other way around. You can be standing at the door dying and they ask you to pay in order to enter. They tell you: pay 2000\$ or 3000\$ or we can’t accept you here.

Sama, a Lebanese UNHCR worker, noted the limitations of the UNHCR mandate as ‘...only covers the life-saving, and pregnancy is covered.’ Sama described how UNHCR sometimes covers 75% of medical costs, as does UNICEF, but oftentimes Syrian families cannot cover the other 25% (UNHCR, 2014). Sama agreed with reports that have found that that secondary healthcare is particularly expensive for Syrian refugees (UNHCR, 2014). 37-year-old father of seven, Abu-Farid shared that his daughter, two-year-old Aziza, was born with two small holes in her heart. Because of what Abu-Farid identified as ‘the economic situation’, they are unable to get Aziza medical treatment. Abu-Farid took Aziza to two separate doctors, including one through the UN, who both wanted US\$200 for medical imaging, a cost well beyond the family’s current financial capacity. For now, the family monitors Aziza’s health and hope that their economic situation will improve.

Arrangements for care

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Problems of the highly privatized system related to the issues of costs. One mother, for example, when asked what life was like back in Syria said, “We used to be happy. We had no expenses whatsoever. The child’s education was insured from the beginning until the end. The government paid everything. Same for health services. Now there’s a big difference. A huge difference.” Parents also discussed the unevenness of the system in Lebanon, as one father, who said: “Before the war, there were no problems and Syria was pretty much safe. Educational and health care facilities were not a problem for anyone of different socioeconomic classes. They all could manage.” Speaking of inequities due to a tiered system, Nasa, a Lebanese NGO worker, noted, ‘The Lebanese have certain advantages that the Syrians do not have that are not covered by the [refugee health] system.’ Nasa explained that even the public hospitals will not treat Syrian refugees unless, ‘...you have proper identification and [even] then it is not necessarily the same wait for the different populations.’.

Geographic unevenness was another problem mentioned by participants. Even if the UN or Ministry of Health (MOH) covers some of Syrian’s medical costs, the need to travel to obtain care was detailed as an impediment for Syrians. There are regions with no clinics, even mobile clinics. While the distances to obtain care may not be long, families explained they rarely travelled at all (previously reported in second author, 2018), and related to this study, they described how their lack of registration incited fear of being arrested in their quest to access health care, as we describe below.

Effects of precarious status and documentation on healthcare

One element of our research explored people’s experiences of flight from Syria to Lebanon. Here, families discussed escaping with nothing except the clothes on their backs. For the Abu-Haytham family, their city in Syria became ‘a battlefield,’ with their own street being

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bombed and ‘scattered by body pieces’ as they were fleeing. They decided to leave Syria after they saw ‘kids slaughtered in front of our eyes.’ Twenty-nine-year-old mother of three, Umm-Imad explained:

We ran away because there were bombings. Everybody in the village ran away with any vehicle they can find. The airplane was above us. We would run, God protected us, and our child was in the street begging for the car as well. We do not forget [how] he started crying...’ Umm-Amir, a thirty-three-year-old mother of five, explained: ‘We were the last, what can I tell you? We left barefoot, we didn’t take anything with us.

In panicked rushes to escape, families often left important documents behind, which creates hardship. When they lack identification documents, families severely restrict their mobility to avoid authorities and checkpoints. One 28 year old mother in Bekaa said they ‘never leave camp.’ When asked why not, she replied, ‘mainly, it’s because I don’t have my legal cards; meaning I’m a trespasser.’ Umm-Mahdi, a 44 year old mother of six, for example, shared that when her son travels to visit her from Beirut, she demands he calls after crossing each checkpoint. She described,

The Syrian who doesn’t have a guarantee or his documents are expired, goes to jail. We used to go to renew the documents. My son would pay \$200 to renew his entry to Lebanon. But now it is not the same. We need a guarantee and no one is willing to sponsor us. This is a very hard thing in my life. Every time he comes I’m extremely scared. If they catch him they imprison him and then he will have to pay a fine.

Proper identification is so important that it becomes a type of currency in situations where power is being abused. For example, the Abu-Amir family shared a story about how their identification papers were confiscated when their five-month-old son died, because they could

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not pay for the hospital fees. Umm-Amir stated that this never would have happened in Syria, specifying that the hospitals there are public, not private, and do not charge for services. Umm-Amir shared, 'After he passed away, they didn't give him to us as they wanted a big amount of money.' According to Abu-Amir, the hospital wanted LBP1,250,000 [approximately US\$825] more than the fees covered by the UN. Since they 'didn't have a pound to give them,' the hospital agreed to release the body in exchange for their identification documents, with the idea that once the family could pay the fees, the family could return to the hospital to retrieve their documents. Abu-Amir and his family trying desperately to save money to pay to get their identity documents back. However, at the time of the interview, they were still unable to collect the money and so the hospital still retained their identification documents.

Problems around precarious documentation has direct implications for accessing healthcare. For example, the father above, Abu-Amir, described how, now lacking documents stated, he does not go more than 100 metres away from his home due to fear of being apprehended. Likewise, this experience made Umm-Amir more afraid of reaching out for help when medical situations arose.

Consequences of problems accessing care

In discussing the consequences of difficulties accessing or paying for healthcare, people talked about simply giving up on obtaining medical care. For example, in discussing the consequences of her experiences trying to access healthcare, Umm-Amir continued, '[In Lebanon], if one of my children gets sick, I don't take him to treat him. I have a fear now from this experience [when my son died].' Umm-Amir's children face several health challenges. Six-year-old Abdul has asthma, and has an asthma inhaler, but no medicine to put into the device. Umm-Amir does not take him for medical care even though 'every week now, he collapses in

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my hands'. Their one-and-a-half-year-old daughter, Qamar, has not received her childhood vaccinations and has faced a range of medical issues including influenza and a broken wrist. But Umm-Amir hesitates to take her daughter to receive medical care due to a combination of her previous negative experience with her son's death and her daughter not being registered. Since she was born in Lebanon, Qamar can be registered with UNHCR. But Umm-Amir explained that every time she goes to register Qamar, 'They put us off.' When Umm-Amir takes Qamar to the hospital, 'They don't take her in. They want to take money from us like other people.' One result of the problems in accessing care indicated by our findings is that families tend to turn to informal mechanisms of medical care. In the case of Qamar's broken wrist, Umm-Amir found a local woman: 'She fixed it. She put eggs and soap on it.'

People shared getting treatment for people with disabilities is particularly difficult; these long-term medical conditions require full engagement with a medical system. For example, Umm-Eyad, a 33 year old mother of four, shared that her daughter needs physiotherapy to help her speak and medications, and she cannot provide either because of financial constraints. Abu-Farid's 16-year-old son, Farid, had a major physical disability that required his use of a wheelchair. Abu-Farid passionately expressed his frustration at not being able to access services for his son: 'My son has been sitting in a chair for two years. My son doesn't need a chair to sit on. He needs a treatment. In Syria [he was] treated...and he got better. After the crisis, I couldn't [get him] treat[ed]. If he was treated in these two years, I won't tell you that he would get 100% better, but he would get 95% better. He would at least lift himself up and walk.' This father connected their crisis in accessing care to a larger crisis of human rights; he shared that he wants his children to travel and be educated in a different context, one that 'respects human rights.'

Discussion

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Fear and discouragement, lack of confidence in the medical system, and costs all combine to make access to healthcare difficult for Syrian families in Lebanon. The accumulation of these challenges are what led one family, for instance, to simply conclude their narrative by sharing, ‘Most importantly, I hope God keeps illness away from us’.

As our findings demonstrate, covering out-of-pocket or uncovered expenses in a context of the escalating poverty and debt Syrians endure is difficult. Data for our study were collected in 2016 and 2017; a 2017 assessment of almost 5,000 Syrian refugee households from across Lebanon found that cost (including fees for consultations and medications) was the primary barrier to accessing healthcare (United Nations High Commissioner for Refugees (UNHCR) et al., 2018). The problems of medical expenses was also highlighted in a more recent needs assessment of 24,415 Syrian refugees in Lebanon, with two thirds of respondents citing cost of drugs and consultation fees as the main reason they were unable to access medical care (United Nations High Commissioner for Refugees (UNHCR) et al., 2018).

In January 2017, when UNHCR in Lebanon began contracting with the private insurance company, NEXtCARE, to negotiate healthcare claims from Syrian refugees, there was a shift in co-payment arrangements, with a new \$800 USD cap on contributions expected from refugees (UNHCR, 2019). This change, along with the steady rise in the number of PHCs (Government of Lebanon & United Nations, 2019), provide some encouragement that refugees may begin to fare better – though this remains to be seen, as there are new requirements at the lower end of costs for refugees, and much control still rests in the hands of a private company whose motivations for, as they put it in their materials, “maximum cost optimization (NEXtCARE, n.d.)”

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The results of our analysis point to how challenges around finances collide with geographic unevenness, confusion, and a lack of trust encountered by newcomers who must adjust to highly privatized and fragmented systems for the first time. These findings align with studies of refugees from other countries, such as Iraq, in finding that refugees find it particularly challenging to move from nationalized healthcare systems to privatized and fragmented systems that require complex negotiations with various configurations of health insurance and providers (Salman & Resick, 2015). The highly privatized nature of care and the reliance on a third party administrator for approval of care stands in stark contrast to the system Syrians knew, as prior to the conflict, Syrians benefited from a centrally controlled, predominately public, universal health care system that prioritized primary care and integrated networks of care across levels (Sen, Al-Faisal, & AlSaleh, 2012).

In line with other analyses of healthcare for Syrian refugees and Lebanon's Crisis Response Plan, our results highlight the need for comprehensive emergency plans to pay close attention to the costs and quality of care; to providing clear reception and information to incoming families within tightly coordinated care systems; and to ensuring human rights, safety, and dignity (Aburas, 2018; Government of Lebanon & United Nations, 2019; Refaat, 2013). As health scholars from within Lebanon argue, partnership and collaboration are critical to the efforts to make the health system in Lebanon more responsive to Syrian refugees (Ammar, 2016). The Ministry of Health is key to leading these efforts and avoiding problems with parallel systems (Ammar, 2016; Khalife, 2017), in line with evidence that support the critical role of the public sector in providing healthcare, particularly in times of great economic or humanitarian crises (Pfeiffer et al., 2008).

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Here, we have explored the crisis in healthcare provision caused by political conflict. Our findings make clear that the health effects of political violence are felt not only during the violence itself, as others have documented (Alwan, 2015; Sidel & Levy, 2008), but also in the challenges posed for countries receiving people who must flee political violence. While we attend to the urgent tasks of understanding and alleviating the barriers that refugees face within regards to healthcare systems, we must also address the underlying cause of the crisis: the brutal realities caused by armed conflict. On a broader scale then, one that is more upstream, our study further highlights how understanding war, and promoting the prevention of it, are essential functions of public health professionals (Hagopian, 2017; Wiist, 2014).

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Health care access for Syrian refugees in Lebanon

Table 1

Overview of indicators of well-being among Syrian refugees in Lebanon

# of Syrian refugees in Lebanon...	
Living below the poverty line	75% ¹
Living on less than \$87/person/mo.	58% ¹
Experiencing food insecurity	91% ¹
Moderate to severe food insecurity	38% ¹
Dependent on food aid	40% ¹
Living in inadequate shelter	41% ²
Living in dangerous dwellings	10% ²
Living in overcrowding	34% ³

¹ (Inter-Agency Coordination Lebanon, 2018)

² (Government of Lebanon & United Nations, 2017)

³ United Nations High Commissioner for Refugees (UNHCR), 2018

Table 2

Family Demographics (Age & Gender)

	Index Family		Other Extended Family		Total
Adults (18+)	Male (father)	36	Male	7	43
	Female (mother)	44	Female	13	57
	80		20		100
Children (<18)	Male	117	Male	9	126
	Female	115	Female	10	125
	232		19		251

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Without access to clean drinking water	22% ¹
Living in debt	91% ²

Appendix 1: Family interview guide

Consent Form

Family Demographics

Names?

Ages?

Levels of education completed?

Marital status?

Profession and current means of livelihoods?

Total number of children?

Pre-Flight

Total	312	39	351
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Health care access for Syrian refugees in Lebanon

Tell about your life back home in Syria.

Where were you born?

When did you get married?

What was your living situation like prior to the war?

Please draw me a map of your home (where you were living prior to migrating here).

What made you decide to leave Syria?

Explain how your children were a factor in whether you would leave Syria or not.

Flight and Displacement

Please draw me a map of your journey from your home to where we are today.

Tell me the story of how you got from your home in Syria to here.

Present

Please draw me a map of where you are living today.

Describe what your typical day is like here.

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What are your dreams for the future?

What are your personal dreams?

What are your dreams for your children?

What are your dreams for your family?

What are your plans for the future (e.g., migrating elsewhere, staying here permanently, etc.)?

Ending Questions

Is there anything that you might not have thought about before that occurred to you during this interview?

Is there anything else you think I should know to understand your situation here?

Is there anything you would like to ask me?