Healthcare Accessibility for Syrian Refugees: Understanding Trends, Host Countries’ Responses and Impacts on Refugees’ Health

An honors thesis presented to the Department of Public Policy and Administration, University at Albany, State University Of New York in partial fulfillment of the requirements for graduation with Honors in Public Policy and graduation from The Honors College.

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Abstract
The Syrian civil war, now in its 6th year is the biggest refugee and humanitarian crisis in present times. Since March 2011, over 11 million Syrians have fled out of their country to neighboring countries, Europe and other parts of the world. Associated with refugee movement is the movement and spread of communicable and non-communicable diseases among Syrian refugees and beyond. The war also continues to affect the psychosocial and emotional states of Syrian refugees, especially young people and children. This paper seeks to identify trends in health conditions among Syrian refugees and those who are internally displaced within the country. It focuses on Syrian refugee mothers and children (0-5 years old), who are most vulnerable to the Syrian crisis.

This research paper is divided into 4 parts. The first part explores population trends, health conditions and diseases among globally displaced persons, including refugees. The second part of the paper dives into the health status and conditions of internally displaced Syrians. The third part explores the prevalence of certain health conditions among Syrian refugees and responses of host countries—Turkey, Lebanon and Jordan— to refugees and their healthcare. The last section discusses main findings and attempts to outline some recommendations to mitigate the challenges of healthcare access to Syrians, both internally displaced and refugees.

*Displaced persons:* refers to refugees, asylum seekers and internally displaced persons.
Acknowledgements

I would first like to thank my thesis advisor Dr. Kamiar Alaei, Director of the Global Institute of Health and Human Rights (GIHHR) at the University at Albany. Dr. Alaei consistently steered me towards the right direction and motivated me to present a well-written thesis. The door to Dr. Alaei’s office was always open and he introduced me to a new level of research and the possibility of owning my work.

I would also like to thank my mentors, Dr. Chris Fernando and Ms. Sheri Stevens, who always reminded me that the sky is the limit. I am also grateful to Ms. Sheryl DeCrosta, whose encouragement and moral support sustained me during difficult transitions. I would also like to acknowledge everyone in the Project Excel office, especially Ms. Makisha Brown for the sense of community they provided me, as I wrote my thesis.

Finally, I would like to thank the Honors College for giving me the opportunity to go beyond my academic horizon and challenging me to become a well-rounded student.
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Population and Health Trends among Globally Displaced Persons

The highest number of displaced people since the end of World War II was recorded in 2015. “Displaced populations” refer to refugees who flee to escape crisis by crossing recognized international borders; and internally displaced persons (IDPs), who flee but remain within the borders of their own country.¹ The United Nations High Commissioner for Refugees (UNHCR) reports that about 65.3 million people, including 21.3 million refugees were forcibly displaced mainly because of wars, conflicts and persecution.² The 2015 population of displaced persons would constitute the 21st largest country in the world, i.e. larger than the population of United Kingdom, or the combined population of Canada, Australia and New Zealand.³ Every day, 42,500 people—an average four times more than that in 2005—become refugees, asylum seekers, or internally displaced from their homes⁴, and one of three displaced people is below 18 years old.⁵ Startlingly, half of all the world’s refugees are children.⁶ Displacement population is highest in the Middle East (one of 20) and Africa (one of 60) people are displaced.⁷ Notably, the

³ UNHCR, Global Trends.
⁶ UNHCR, Worldwide Displacement.
ongoing Syrian conflict has contributed significantly to the increase in globally displaced people since 2011.

Health Risks for IDPs, Migrants and Refugees

Refugees, migrants and IDPs face health risks as they move from one place to another, thereby increasing cases of fatal communicable and non-communicable diseases. Displaced persons may experience severe health complications from injuries, hypothermia (low body temperature), burns, and other migration-related conditions. Family loss, relocation and difficult cultural adjustments, as well as traumatic experiences from conflict can cause psychological trauma for displaced persons. Refugees and migrants fleeing from conflicts and persecution may experience depression, post-traumatic stress disorders (PTSD) or attempt suicide (especially torture victims). Unfortunately, more resources are often devoted towards the physical needs of displaced persons than their psychological needs.

Displaced persons can be exposed to serious communicable diseases like tuberculosis, sexually transmitted diseases (STDs) including HIV/AIDS and viral hepatitis, vector-borne diseases like malaria and leishmaniasis, cholera, influenza and other common respiratory infections. Some displaced persons may suffer from non-communicable diseases (NCDs) including cardiovascular diseases, diabetes, cancer and chronic lung diseases. Female displaced persons particularly face pregnancy and delivery-related complications, and are also

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10 WHO, Migration and Health.
12 WHO, Migration and Health.
prone to domestic violence. Displaced women and adolescents may also lack sexual and reproductive health services. Children are vulnerable to malnutrition, diarrhea and vaccine-preventable diseases like measles and polio; and affecting specific regions, meningococcal meningitis, yellow fever and hepatitis A.

Many communicable and non-communicable diseases among displaced persons are preventable and containable. Majority of preventable diseases among refugees arise from exposure to bad migratory and living conditions—contaminated food and unclean water, improper hygiene, poorly-ventilated and overcrowded settlements, and other unsanitary conditions. Lack of access to basic public services like electricity and transportation in settlements can also alter healthy lifestyle for displaced persons, especially IDPs. Thus, lack of access to basic necessities of life can increase health risks among displaced persons. The political, social and economic state of a displaced person’s country of origin or destination can contribute to the prevalence of a health condition. Hence, some health issues may be more severe among displaced persons from one region than from another.

**Population and Health Trends among Syrians**

The Syrian Republic currently produces the highest number of both internally displaced people and refugees. The war, which is now in its sixth year has led to over 250,000 deaths and the displacement of more than half of the population. One of every 5 Syrians is either wounded

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13 Ibid.
14 UNHCR, *Refugee Health*.
15 Ibid.
16 Lam, McCarthy, and Brennan, *Vaccine-preventable Diseases*.
17 WHO, *Migration and Health*.
18 Ibid
or dead. By 2015, more than 12 million Syrians: about 4.9 million refugees, between 6.6 to 7.6 million IDPs and almost 250,000 asylum-seekers were displaced. More than 13 million Syrians, half of which are children need humanitarian assistance. Most alarmingly, 50 percent of internally displaced Syrians are in hard-to-reach areas, including areas besieged by rebel forces and other non-state actors (areas include Damascus, Zabadani, Madaya and Douma).

Children make up a sizeable percentage of the Syrian refugee population. About 34 percent of all Syrian refugees are below 11 years old, and every two of five Syrian refugees are 17 years old or younger.

Table 1. Displaced Women (2015) and Children (2016) in Syria, Turkey, Lebanon and Jordan

<table>
<thead>
<tr>
<th></th>
<th>TURKEY</th>
<th>LEBANON</th>
<th>JORDAN</th>
<th>SYRIA</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Women</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Reproductive Age</td>
<td>500,000</td>
<td>296,360</td>
<td>152,711</td>
<td>3,000,000</td>
</tr>
<tr>
<td>Pregnant</td>
<td>30,000</td>
<td>20,597</td>
<td>12,000</td>
<td>500,000</td>
</tr>
<tr>
<td>% of Pregnant Women</td>
<td>6.0</td>
<td>6.9</td>
<td>7.9</td>
<td>16.7</td>
</tr>
<tr>
<td><strong>Children</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Under 5 years old</td>
<td>374,511</td>
<td>173,630</td>
<td>105,680</td>
<td>2,900,000*</td>
</tr>
<tr>
<td>Under 18 years old</td>
<td>1,221,944</td>
<td>552,929</td>
<td>338,046</td>
<td>6,000,000</td>
</tr>
<tr>
<td>% of children under 5 years</td>
<td>30.6</td>
<td>31.4</td>
<td>31.2</td>
<td>48.3</td>
</tr>
</tbody>
</table>

Health Risks for Syrian IDPs

The health of many people living in Syria has been adversely affected by the civil war. Before the war began, the health of Syrians was improving. Life expectancy was growing, and

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20 Ibid.
21 UNHCR, *Worldwide Displacement*.
22 UNHCR, *Global Trends*.
24 Ibid.
26 Ibid.
health patterns were changing. Now, many Syrians have limited healthcare access due to the destruction of healthcare infrastructures, fewer health care staff and lack of secure transportation means. Over 40 percent of the Syrian population cannot access basic health services in the country because more than half of Syria’s medical facilities are not in service or are partially functioning. The lack of health infrastructure has also impacted immunization programs for the people living in the country. Vaccination coverage among Syrians is estimated to have dropped by half from in besieged areas between 2010 and 2013. Limited accessibility to healthcare is exacerbated among Syrians living in host countries as well. A majority of the Syrian population lack access to quality health services, especially those who live in war-torn communities. As a result, many Syrians face severe health risks due to massive displacement.

**Communicable and non-communicable diseases:** Similar to other displaced populations, Syrian refugees and IDPs may suffer from physical injuries, cardiovascular diseases and skin infections, malnutrition, food and water-borne diseases and other communicable diseases. Recent studies have revealed that displaced Syrians are prone to getting infectious diseases like leishmaniasis, malaria, measles and polio, Middle East respiratory syndrome (MERS), and other gastrointestinal, skin and respiratory infections. Cases of cutanea leishmaniasis—the insectborne, skin-ulcer causing disease—has increased among IDPs and Syrian refugees since the war began.

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30 Eskild Petersen, Susan Baekeland, Ziad A. Memish, and Hakan Leblebicioglu, “Infectious Disease Risk from the Syrian Conflict”, *International Journal of Infectious Diseases* 17, no. 9 (2013). http://dx.doi.org/10.1016/j.ijid.2013.06.001

**Maternal and child health:** About 11.5 million Syrians—half of which are children—are currently in need of healthcare.32 The population of pregnant women in Syria was three more times in 2015 (16.7%) than the population of pregnant Syrian women in host countries. By 2016, 5 of 10 children in Syria was under 5 years old, as compared with 3 of 10 Syrian children in Turkey, Lebanon or Jordan (see Table 1). These statistics highlight the vulnerability of these two populations. That is, the higher proportions in Syria may be due to migration difficulties pregnant women and young children face.

IDP Syrian women face difficult conditions in their pregnancies. About 200,000 women in Syria, and another 70,000 Syrian refugee women were pregnant in 2015, with almost 1,500 women giving birth a day.33 Within 4 years, maternal mortality among pregnant Syrian women had increased by 31 percent, from 52 deaths in 2011 to 68 deaths in 2015.34 The increase in mortality rates is explained by the “psychological difficulties, gynecological problems, nutritional shortages and complications from early pregnancies” pregnant mothers in Syria face.35 Unsafe and unsanitary delivery conditions are also associated with the high morbidity.

Birth through Caesarian section has also increased among Syrian mothers. By 2013, 46 percent of all deliveries in Syria, especially in affected war areas was performed through Caesarean section as compared to 19 percent in 2011.36 This is a staggering difference, especially since global guidelines allow up to 15 percent of all deliveries to be performed through this

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32 OCHA, About the Crisis.
35 UNPF, Pregnant Women in Syria, n.d.
36 Ibid.
delivery method. Unborn babies may also be affected by intergenerational adverse effects, thus leading to increased infant mortality, impaired immunity and other health complications. These effects include maternal trauma resulting from domestic violence or rape, inadequate nutrition for both mother and child, and lack of medication.

**Children:** Children are among the groups most affected by the war. Half of the six million internally displaced Syrians are children and as of 2015, about one million children were living in besieged or hard-to-reach areas. By August 2013, almost 11,500 children had died from the war, with majority of death caused by explosive weapons. Syrian children suffer gravely from death and displacement, food insecurity and communicable diseases. Exposure to violence also makes them vulnerable to mental health risks like post-traumatic stress disorder (PTSD). There have been increased cases of polio, measles and cutaneous leishmaniasis and documented increase in malnutrition among Syrian children since the war.

**Mental health:** Displaced Syrians may also suffer poor mental health due to traumatic experiences from war. A 2014 mental health assessment of 8,000 displaced Syrians showed that many of them suffered from depression, anxiety and anger. The poor mental state of adults is more likely to contribute to violence, neglect and bad parenting. Syrian children and

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37 Ibid.
38 Devakumar et al, *Child Health in Syria*.
39 Ibid.
40 Ibid.
41 Ibid.
42 Ibid.
44 Sharara and Kanji, *War and Infectious Diseases*.
45 Devakumar et al, *Child Health in Syria*.
47 Ibid.
adolescents also suffer from psychological trauma caused by the war. Because of the current internal health risks, accessibility to healthcare is crucial to internally displaced Syrians, especially children and pregnant mothers who need natal care.

Figure 1. Syrian Refugee Population in Turkey, Jordan and Lebanon

<table>
<thead>
<tr>
<th>Year</th>
<th>Turkey</th>
<th>Jordan</th>
<th>Lebanon</th>
</tr>
</thead>
<tbody>
<tr>
<td>2012</td>
<td>1.71</td>
<td>1.17</td>
<td>1.29</td>
</tr>
<tr>
<td>2013</td>
<td>5.60</td>
<td>5.76</td>
<td>11.18</td>
</tr>
<tr>
<td>2014</td>
<td>16.23</td>
<td>6.23</td>
<td>14.18</td>
</tr>
<tr>
<td>2015</td>
<td>25.04</td>
<td>6.33</td>
<td>10.69</td>
</tr>
<tr>
<td>2016</td>
<td>28.15</td>
<td>6.49</td>
<td>10.11</td>
</tr>
</tbody>
</table>

Source: UNHCR

Major Host Countries’ Response to Syrian Refugee Crisis

Turkey, Jordan, and Lebanon host majority of Syrian refugees. As of 2016, Turkey hosts more than half of the Syrian refugee population, about 2.8 million (see Figure 1). Lebanon and Jordan host over 1 million and about 650,000 Syrian refugees respectively. Following Syria,

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48 Devakumar et. al, Child Health in Syria.
Lebanon had the highest proportion of Syrian children under five years old in 2016 (see Figure 2). Each host country has responded to the Syrian refugee crisis differently: This can be explained by differing political, social and economic environments present in each country, with each country’s commitment to refugees through international and domestic legislation (discussed later). Nonetheless, refugee health conditions and restraints appear to be similar in all three major host countries (see summary in Tables 2 and 3). Little data and assessment exist about the welfare and healthcare of Syrian refugees in Turkey.

**Turkey’s Response to The Syrian Refugee Crisis**

Turkey has ratified several treaties to ensure right to health, including the International Covenant on Economic, Social and Cultural Rights (ICESCR), the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW), and the Convention on the Rights of the Child (CRC), as well as the Convention on the Rights of Persons with Disabilities (CRPD).\(^{52}\) It is also a state party of the 1951 Refugee Convention and its additional protocol.\(^{53}\) Turkey now hosts the largest number of refugees in the world, of which about half are children.\(^{54}\) Despite presence of refugee camps and settlements near the Syrian border, many refugees have moved to larger Turkish cities; namely Ankara, the capital city, Istanbul and Izmir.\(^{55}\)


Turkey’s Healthcare System. In Turkey, primary healthcare services are free and accessible to Syrians registered with the government under the Temporary Protection Regulation, a legislation that outlines protection proceedings for foreigners.\textsuperscript{56} Health care provided to refugees in Turkey is either covered by the government or by the hospitals themselves (which discharge refugee patients without receiving payment).\textsuperscript{57} Emergency health care is provided to both registered and unregistered Syrians, who would have to register to receive advanced care.\textsuperscript{58} Mental health provision is also a major concern due to language barrier and inadequate provision of mental and psychosocial services.\textsuperscript{59} The World Health Organization and the University of Gaziantep have developed a curriculum that trains Syrian doctors and nurses and allows them to provide health services to Syrian refugees within the Turkish health system.\textsuperscript{60} This project aims to address the language barrier for Syrian patients and decongest Turkish health facilities.\textsuperscript{61}

Syrian Mothers and Children’s Healthcare Access in Turkey

Syrian refugees in Turkey are increasingly exposed to vaccine-preventable diseases like measles and pertussis. As of 2016, reports documenting mental health and psychological problems have increased among Syrian refugees in Turkey. There is also risk of child malnutrition due to difficulty in meeting basic nutritional needs.\textsuperscript{62} A 2013 report indicated that

\textsuperscript{56} 3RP, Turkey’s Regional Refugee and Resilience Plan 2016-2017.
\textsuperscript{57} Büyüktiryaki et. al, Neonatal Outcomes.
\textsuperscript{59} Ibid.
\textsuperscript{61} 3RP, Turkey’s Regional Refugee and Resilience Plan 2016-2017.
\textsuperscript{62} Ibid.
some Syrian refugees in camps had requested for ingredients to cook themselves, but they were refused by authorities: Camp residents are supplied with food three times daily but they report that food is inedible as well as cases of food poisoning.63

![Figure 2: Under 5-year-old population of Syrians in Syria, Turkey, Lebanon and Jordan](image)

<table>
<thead>
<tr>
<th>COUNTRY</th>
<th>2013</th>
<th>2014</th>
<th>2015</th>
<th>2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>Syria*</td>
<td>12.1</td>
<td>23.8</td>
<td>20.7</td>
<td>17.8</td>
</tr>
<tr>
<td>Turkey</td>
<td>0</td>
<td>13.4</td>
<td>20.0</td>
<td>13.7</td>
</tr>
<tr>
<td>Lebanon</td>
<td>19.7</td>
<td>19.4</td>
<td>18.8</td>
<td>16.8</td>
</tr>
<tr>
<td>Jordan</td>
<td>18.8</td>
<td>17.3</td>
<td>17.2</td>
<td>16.1</td>
</tr>
</tbody>
</table>

Source: UNICEF

*based on estimated children internally displaced

Syrian refugees are unable to access healthcare mainly due to language barrier, lack of registration and the lack of information regarding availability and accessibility.64

There is very limited data to assess health outcomes of Syrian women and children in Turkey. In 2016, about 4 percent of Syrian women in Turkey was pregnant.65

living in Turkish camps may have concerns about unfavorable living conditions including lack of access to potable drinking water, feminine hygiene products and basic hygiene products. A 2015 study of pregnant Syrian refugees in Turkey showed that one of four children are born preterm, and neonatal mortality was 1.8 percent, four times the rate in Turkey.

**Lebanon’s Response to The Syrian Refugee Crisis**

Lebanon has also ratified the ICESCR, CEDAW, and the CRC. The country has however not ratified the 1951 Convention Relating to the Status of Refugees (the Refugee Convention) or its 1967 additional protocol. The Lebanese government emphasizes that the country is not an ultimate destination for refugees or asylum seekers. Lebanon was fully opened to Syrian refugees until 2014, when it adopted a policy to limit Syrian refugee flow. Currently about 1 in 4 people in Lebanon is Syrian.

There are no refugee camps in Lebanon: many Syrian refugees live in host communities within over 1,600 localities in the country. More than a third of Syrian refugees live in some of the poorest communities in Bekaa (Arsal) and North (Akkar). A 2016 CDC report shows that displaced Syrian households spend an average of 18 percent of financial resources on health. This is alarming especially since 1 of 4 Syrian households count at least one member with a

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67 Büyüktiryaki et. al, Neonatal Outcomes.


69 UNHCR, States Parties to the 1951 Convention.


72 Blanchet, Fouad, and Pherali, Syrian refugees in Lebanon.
specific health need.\textsuperscript{73} Many Syrian refugees in Lebanon live in bad conditions, including lack of access to drinkable water or sanitation facilities.\textsuperscript{74}

Decline in food security also increases risk in malnutrition among the population.\textsuperscript{75} They also suffer from various diseases including leishmaniasis, measles, polio and scabies.\textsuperscript{76} High incidences of tuberculosis and hepatitis A have also been reported among the population.\textsuperscript{77} Syrian refugees also report emotional, physical, psychological and sexual violence and physical assaults.\textsuperscript{78}

\begin{table}[h]
\centering
\begin{tabular}{|l|l|l|}
\hline
\textbf{HEALTH CONDITIONS} & \textbf{DISPLACED SYRIAN WOMEN} & \textbf{DISPLACED SYRIAN CHILDREN} \\
\hline
\textbf{Gynecological, Pregnancy and Birth Conditions} & Reproductive health issues including: & \textbf{Childbirth complications including:} \\
& \begin{itemize}
\item Reproductive tract infections
\item Menstrual irregularity
\item Severe pelvic pains
\end{itemize} & \begin{itemize}
\item Low birthweight
\item Preterm delivery
\item Miscarriage
\end{itemize} \\
& Delivery/abortion complications including: & \textbf{Infant-related complications including:} \\
& \begin{itemize}
\item Anemia
\item Bleeding
\item Abdominal pains
\end{itemize} & \begin{itemize}
\item Birth asphyxia
\item Infections (mainly pneumonia, sepsis and meningitis)
\end{itemize} \\
\hline
\textbf{Prominent Health Conditions} & \begin{itemize}
\item Hypertension
\item Diabetes
\item Cancer
\item Asthma
\item Anemia
\item Cardiovascular diseases
\item Renal failure
\item Increased mental and psychosocial problems including post-traumatic stress disorder (PTSD), depression and distress.
\end{itemize} & \begin{itemize}
\item Measles
\item Hepatitis A
\item Anemia
\item Diarrhea
\item Leishmaniasis
\item Fever
\item Pertussis (Whooping cough)
\item Cholera
\item Polio
\end{itemize} \\
\hline
\end{tabular}
\caption{Health Characteristics of Displaced Syrians, Women and Children\textsuperscript{iii}}
\end{table}

\begin{footnotesize}
\textsuperscript{73} 3RP, \textit{Lebanon Crisis Response Plan 2015-16}.
\textsuperscript{74} Cherri, González, and Delgado, \textit{The Lebanese-Syrian Crisis}.
\textsuperscript{76} Ibid.
\textsuperscript{77} Ibid.
\textsuperscript{78} Blanchet, Fouad, and Pherali, \textit{Syrian refugees in Lebanon}.
\end{footnotesize}
**Prominent Social Conditions**

- Overcrowded settlements
- Poor sanitation
- Lack of proper food and nutrition
- Risk of malnutrition
- Inadequate access to clean water
- Lack of privacy
- Gender-based violence
- Early marriage and early pregnancy

<table>
<thead>
<tr>
<th>Prominent Social Conditions</th>
<th>Acute malnutrition, vitamin and mineral deficiencies</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overcrowded settlements</td>
<td>Inadequate access to clean water</td>
</tr>
<tr>
<td>Poor sanitation</td>
<td>Infant mortality risk</td>
</tr>
<tr>
<td>Lack of proper food and nutrition</td>
<td>Intergenerational effects on mental and physical health from war and trauma</td>
</tr>
</tbody>
</table>

**Lebanese Healthcare System.** The current refugee crisis has worsened fragmentation of Lebanon’s healthcare system. Lebanese hospitals and health centers are overwhelmed by the overall population increase caused by the influx of displaced Syrians. As a result, Lebanon’s healthcare system is uncoordinated, very fragmented and highly privatized.79 Public hospitals suffer the most from underfunding because many Syrians are unable to afford healthcare even after substantial subsidization (up to 75 percent) from healthcare partners.80 Those who can afford also report being turned away from hospitals and health centers, or charged very high rates.81

Access to primary health care (PHC) services is through the Ministry of Public Health (MoPH) PHC network, some centers of the Ministry of Social Affairs (MoSA), NGO clinics and others, and mobile medical units (MMUs).82 Syrian refugees receive subsidized PHC services in about 100 MoPH PHC centers. However, healthcare access in about 60 hospitals for displaced Syrians is coordinated primarily through UNHCR contract with third-party administrators: Registered refugees are expected to cover 25 percent of hospitalization fee under this UNCHR scheme. 83 UNHCR covers 85 percent of diagnostic costs for pregnant and nursing mothers, and

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79 Ibid.
80 3RP, Lebanon Crisis Response Plan 2015-16.
81 Ibid.
82 Ibid.
83 Ibid.
children. All medicinal (drug) costs for this population are covered by a program under a Lebanese charitable organization.\textsuperscript{84}

**Syrian Mothers and Children’s Healthcare Access in Lebanon**

Mother and children services carry the highest burden in Lebanese health sector.\textsuperscript{85} 1 of 5 women in a Syrian household in Lebanon is either pregnant or a breastfeeding mother.\textsuperscript{86} Studies also report increasing deliveries via Caesarian sections and declining use of contraceptive methods to prevent pregnancy among Syrian women.\textsuperscript{87} Women also reported having gynecological problems including menstrual irregularity, reproductive tract infections and pelvic pains.\textsuperscript{88} Assessment of reproductive-health services showed that 1 of 3 Syrian women did not seek antenatal care mainly because it was too expensive. Those who sought antenatal care during pregnancy also reported high healthcare costs and transport difficulties.\textsuperscript{89} Barriers to contraceptive use reported by Syrian women included cost, distance or transportation difficulty, unavailability, fear, and personal procrastination.\textsuperscript{90}

In a 2014 assessment, Syrian mothers reported adverse birth outcomes like low birthweight, preterm delivery and infant mortality.\textsuperscript{91} Child vaccination efforts among Syrian refugees have increased in Lebanon: The proportion of refugees reporting difficulties in obtaining vaccination for their children declined from 31 percent in 2013 to 7 percent in 2014.\textsuperscript{92}

\begin{flushright}
\textsuperscript{84} Blanchet, Fouad, and Pherali, *Syrian refugees in Lebanon.*
\textsuperscript{86} 3RP, *Lebanon Crisis Response Plan 2015-16.*
\textsuperscript{87} Ibid.
\textsuperscript{88} Masterson et. al, *Assessment of Reproductive Health.*
\textsuperscript{90} Masterson et. al, *Assessment of Reproductive Health.*
\textsuperscript{91} Ibid.
\textsuperscript{92} UNHCR, *Health Access and Utilization Survey.*
\end{flushright}
There are still barriers to vaccination services including long waits, transport difficulties and vaccination costs (for persons 12 years and older).  

**Jordan’s Response to The Syrian Refugee Crisis**

Jordan is also not a signatory of the 1951 Refugee Convention but has ratified the ICECSR, CEDAW and CRPD treaties. About 80 percent of Syrian refugees live among host Jordanian communities, and the rest reside in camps, predominantly in Zaatari camp. Lack of opportunities and difficult living conditions have increased stress levels and psychosocial issues among Syrians living in Jordan. 86 per cent of refugees were living below the Jordanian poverty line of 68 Jordanian Dinar (95 dollars) per capita per month.  

**Jordanian Healthcare System.** Jordan’s health sector is currently burdened and under-resourced. In November 2014, the Jordanian cabinet announced that registered Syrian refugees were no longer entitled to access free services at Jordanian Ministry of Health (MOH) facilities. UNHCR and other partners, with the support of the Jordanian MoH provide health and humanitarian support in the camps. Refugees residing in Jordanian camps have access to free health care services. Outside camps, Syrian refugees pay the non-insured Jordanian rate for all MOH services. Immunization, ante-natal/post-natal care and family planning are offered free

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93 Ibid.
94 “UNHCR, States Parties to the 1951 Convention.”
100 Murshidiemail et. al, *Syrian Refugees and Jordan’s Health Sector*.

of charge. However, health facilities within refugee-populated areas are overburdened, and there is shortage of medicine, health resources and [overworked] staff.

Syrian Mothers and Children’s Healthcare Access in Jordan

There is great concern for sexually transmitted infections (STIs), teenage pregnancy and pregnancy-related complications among Syrian refugee women. Deliveries for girls under 18 years old was 8.5 percent in 2014, a 3.5 percent jump from the previous year. Anemia is also prevalent among Syrian women of reproductive age. Antenatal care is limited for about half of Syrian pregnant women mainly due to health, transportation and delivery costs. About 58 percent of breastfeeding women also report having no access post-natal health services.

Table 3. Healthcare Accessibility Status (Perceived Barriers to Access) Affecting Syrian Refugee Women and Children

<table>
<thead>
<tr>
<th>HEALTHCARE LIMITATIONS</th>
<th>OUTREACH LIMITATIONS</th>
<th>STAFF AND POLITICAL LIMITATIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Shortage of medicines and equipment</td>
<td>Difficulty in reaching “sparse” refugee population * ~</td>
<td>Limited and overworked number of specialized staff</td>
</tr>
<tr>
<td>Inadequate access to ante-natal and post-natal health services</td>
<td>Overwhelming patient caseloads</td>
<td>Limited staff movement due to political environment and security concerns *</td>
</tr>
<tr>
<td>Inadequate mental health services</td>
<td>Difficulty in transportation</td>
<td>Bureaucratic obstacles</td>
</tr>
<tr>
<td>Limited healthcare services and inadequate health infrastructure</td>
<td>Language barrier ~~</td>
<td>Limited number of health-related NGOs</td>
</tr>
<tr>
<td>Lack of quality healthcare services</td>
<td>Weak research and inadequate evidence-based information on refugee situation ~~</td>
<td>Changing national policies ~</td>
</tr>
<tr>
<td>Inadequate vaccination services</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

102 3RP, Regional Strategic Overview.
103 UNHCR, Health Sector Humanitarian Response.
104 UNHCR, Health Sector Humanitarian Response.
105 JRP, Jordan Response Plan.
107 JRP, Jordan Response Plan.
Many Syrian children in Jordan suffer from respiratory problems, fevers, skin infections and diarrhea. In Zaatari camp, about 48.7 percent of children under five years old were suffering from anemia and high mortality (47 percent in 2014). Cost was cited as the main barrier to seeking healthcare for children in need. Many households can seek healthcare services for children and receive medication for children. However, many care seekers who received medication for their children had to make an average payment of 8.8 Jordanian dollars (12.40 US Dollars) out of pocket.

**Analysis of Host Countries’ Response to Refugee Crisis**

Commitment to international and domestic legislation can encourage proper and effective response to the Syrian refugee crisis. The extent to which Turkey, Lebanon and Jordan have ratified relevant legislation has an effect on how each country has responded to the influx of Syrian refugees. All host countries are signatories to important Human Rights conventions and protocols like ICESCR, CRD and CRC: Only Turkey however, has signed the 1951 Refugee Convention (see Table 4a). Aside specified domestic legislations (in Constitution and passed by

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108 UNHCR, Syrian Refugee Health Access.
109 UNHCR, Health Sector Humanitarian Response.
110 Ibid.
111 UNHCR, Syrian Refugee Health Access.
112 UNHCR, Health Sector Humanitarian Response.
Congress) on foreigners in each country, the amendment and adoption of other domestic and joint legislation following the Syrian civil war seem to be an important step for refugee response. For instance, Jordan (1998) and Lebanon (2003) signed a memorandum of understanding (MOU) to increase joint UN cooperation during the influx of Iraqi and Palestinian refugees respectively. Turkey has ratified more domestic laws to assist Syrian refugees, as compared to Lebanon and Jordan. It is not surprising that there was an astronomical increase of Syrian refugees (see Figure 1) following the adoption of the Temporary Protection Regulation (TPR) enacted in 2014 (see Table 4b). The TPR set an objective to “determine the procedures and principles pertaining to temporary protection proceedings that may be provided to foreigners… [including] proceedings to be carried out related to their reception… their rights and obligations and their exits from Turkey”. The TPR supplemented the Law on Foreigners and International Protection (LFIP), a law adopted by Turkey’s Ministry of Interior in 2013 as a direct legal response to the influx of Syrian refugees. The latest legislation in response to the refugee crisis by the Turkish government is the 2015 EU-Turkey joint action plan (JAP), which reflects an understanding between the two parties to “step up their cooperation on support of Syrians under temporary protection and migration management in a coordinated effort.” Hence, Turkey’s commitment to the Refugee Convention and several domestic legislation distinguish the country’s response and reception to Syrian refugees, as compared to Lebanon and Jordan. These law amendments may have contributed significantly to the shift of Syrian refugee population from Lebanon to Turkey, now making it the biggest refugee host country in the world.

Secondly, support and capacity, with limited constraints are important for adopting policies that improve refugee status. Turkey has adopted relatively more policies that can improve health status of Syrian refugees (see Table 4c). Following the adoption of new legislation in 2013, Turkey began to adopt “refugee-friendly policies”. The state also revised policies in certain areas, including the establishment of a new institution, the General Directorate of Migration Management as means to maintain technical and financial capacity. This new creation shifted responsibilities from emergency response organizations like the Turkish Red Crescent and the Disaster and Emergency Management division under the Prime Ministry (AFAD). As compared to Lebanon and Jordan, Turkey has developed more comprehensive and inclusive policies in education, health and work to increase Syrian refugee status.

It is however important to note that social, political and economic constraints present obstacles to effectively responding to Syrian refugees. This is especially true for Lebanon. Lebanon adopted restrictive policies as response to the spillover effects the country has experienced following as the Syrian civil war continues. As noted early on, a significant proportion of the Lebanese population today—about 25 percent—is Syrian. Also, about 1 of 10 people in Lebanon is a Palestinian refugee. The flow of Syrian refugees has plunged Lebanon’s economy: As of 2016, it is estimated that about 200,000 Lebanese are in poverty. In 2015, Lebanon’s public debt rose to 158.7 percent of its GDP, reflecting the country’s humanitarian costs. Lebanon has also suffered casualties from the Syrian civil war due to

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118 Ibid.
counterattacks from ISIS against Hezbollah, the Lebanese-based Shi’a political part and military group.\textsuperscript{119} The political, social and economic status in Lebanon makes it difficult for the state to respond effectively to Syrian refugees’ need.

Jordan also faces some economic, legal and political constraints in attending to refugees’ needs. Jordan is also a major host of Palestinian refugees: About 3 of 10 Jordanians are Palestinian.\textsuperscript{120} Over 10,000 Palestinian refugees formerly residing in Syria have relocated to Jordan, with the current Syrian population in the country.\textsuperscript{121} Hence, Jordan’s capacity to receive refugees is limited. Also, Jordanian law and policies restrict refugees’ social status in the country. The country’s Constitution limits the right to work for only Jordanian citizens. Like Lebanon, they refer to refugees in their country as “guests” since they are not obligated under the Refugee Convention to recognize refugees. (Turkey previously referred to Syrian refugees as “guests” in official reports too until the TPR amendment. This terminology suggests that the Turkish state may not have felt obligated to provide protection as required by the Refugee Convention to Syrian refugees.) There are also discrepancies between official Jordanian reports and UNHCR reports in Jordan. According to UNHCR, Syrian refugees in Jordan are considered residents, whereas official Jordanian reports insist that residency is not automatically granted.\textsuperscript{122} Like Lebanon, Jordan is constrained in its capacity to respond effectively to Syrian refugees.


\textsuperscript{121} Ibid.

Laws (International and Domestic) and Policies for Turkey, Lebanon and Jordan Affecting Syrian Refugees

Table 4a. *International Legislation Affecting Turkey, Lebanon and Jordan’s Response to Refugee Crisis*

<table>
<thead>
<tr>
<th>INTERNATIONAL LEGISLATION</th>
<th>TURKEY</th>
<th>LEBANON</th>
<th>JORDAN</th>
</tr>
</thead>
<tbody>
<tr>
<td>Refugee Convention</td>
<td>✓</td>
<td>×</td>
<td>×</td>
</tr>
<tr>
<td>1951 Convention Relating to the Status of Refugees</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ICESCR</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>International Covenant on Economic, Social and Cultural Rights</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CEDAW</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Convention on the Elimination of All Forms of Discrimination against Women</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CRPD</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Convention on the Rights of Persons with Disabilities</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CRC</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Convention on the Rights of Children</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Table 4b. *National Legislation Affecting Turkey, Lebanon and Jordan’s Response to Refugee Crisis*

<table>
<thead>
<tr>
<th>DOMESTIC LEGISLATION</th>
<th>TURKEY</th>
<th>LEBANON</th>
<th>JORDAN</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Temporary Protection Regulation (2014)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Table 4c. Domestic Policies Affecting Turkey, Lebanon and Jordan's Response to Refugee Crisis

<table>
<thead>
<tr>
<th>POLICIES</th>
<th>TURKEY</th>
<th>LEBANON</th>
<th>JORDAN</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Overview</strong></td>
<td>Following the 2015 EU/Turkey JAP, Turkey has developed several comprehensive policies aimed at increasing access to health, education and social services. Some of the policies also ensure inclusion and acceptance of diversity.</td>
<td>The Lebanese government introduced some restrictive policies to control refugee flow. This is attributed to spillover effects Lebanon has experienced due to the influx of refugees.</td>
<td>Jordanian policies towards refugees are unclear. There are discrepancies in UNHCR reports on Jordan. According to UNHCR, Jordan has granted Syrian refugees in host communities' access to health, education, and other services.</td>
</tr>
<tr>
<td><strong>Health</strong></td>
<td>-Free primary healthcare services to Syrians under the Temporary Protection Regulation</td>
<td>-Primary healthcare access after registering with the UNHCR via state’s ministries, primary healthcare networks, NGOs and mobile medical units (MMUs)</td>
<td>-Free health care services for refugees living in camps</td>
</tr>
<tr>
<td></td>
<td>-Emergency healthcare provision to both registered and unregistered Syrians</td>
<td>-Subsidized primary healthcare services for refugees, including pregnant mothers and children</td>
<td>-Non-insured Jordanian rates for Syrians living outside camp who used the state’s health services</td>
</tr>
<tr>
<td><strong>Education</strong></td>
<td>-Access to primary and secondary education</td>
<td>-Provision of primary education with support of humanitarian community (although limited due to strained educational system)</td>
<td>-Free access to public schools for Syrian children, regardless of their status</td>
</tr>
<tr>
<td></td>
<td>-Adoption of a revised Syrian curriculum in some schools</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Work</strong></td>
<td>-Registration and proof of identity provided to refugees</td>
<td>-Application for work permits without paying a deposit. However, residency regulations in 2015 required some refugees to sign a pledge not to work.</td>
<td>-Right to work is for only Jordanian citizens, per country’s 1954 constitution</td>
</tr>
<tr>
<td></td>
<td>-Work permits granted</td>
<td></td>
<td>-Work opportunities limited. Certain professions are closed to non-Jordanians.</td>
</tr>
<tr>
<td>Other Accommodative And Inclusive Policies</td>
<td></td>
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<td></td>
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<tr>
<td>-------------------------------------------</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Adjustment of state ministry to attend to refugee issues</td>
<td></td>
<td></td>
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<tr>
<td>- Travel permits granted</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Law on Foreigners and International Protection adopted in 2013: Syrian refugees are not considered “guests” following implementation in 2014</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Presence of social assistance services in camps to provide basic needs</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>- Strategic inclusion of Syrian refugees into workforce</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>- Translation services in public settings</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Path to naturalization</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Residency regulations allowing Syrian refugees to obtain residency permit ($200 fee per person)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- New border regulations ratified in 2014 to limit refugee admission</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Avoids recognizing Syrians as refugees in official reports: prefers to refer to Syrian refugees as ‘visitors’, ‘irregular guests’, ‘Arab brothers’ or simply ‘guests’</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Residency not automatically granted to Syrian refugees according to official Jordanian reports</td>
<td></td>
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</tr>
</tbody>
</table>
Discussion and Recommendations

Commonality of diseases among refugees. The prevalence of certain communicable diseases among Syrian refugees, including Syrian mothers and children is unsurprising, as fleeing and settlement conditions contribute to refugee illnesses in general. Hence, many health conditions reported among Syrian refugees are reflective of the global refugee population. What is startling about the Syrian refugee crisis is the spillover effect it has on host, neighboring and far countries. Internally displaced persons, especially those living within besieged areas with health complications pose great health risk to the remaining Syrian population. Fleeing Syrians may carry diseases along as they flee into host countries: The movement of Syrian refugees into big cities and being part of a sparse population pose severe health risks to the greater population.

A human rights-based response to refugee healthcare. Syrian refugees in all three countries face similar challenges in their access to healthcare: limitation of medical services, outreach and political limitations. Most notable challenges are affordability of health services, inadequate medical resources and overworked staff. These challenges highlight the need for a human rights-based approach for designing health policies that improve refugees’ right to health. In response to these direct challenges, health policies should be aimed at improving (i) availability, where health and healthcare facilities, products and programs are sufficient, (ii) accessibility, where refugees can physically and economically access healthcare without facing discrimination and lack of information: (iii) acceptability, where healthcare personnel respond appropriately to refugees’ health needs while considering culture, ethics and other sensitive factors, (iv) quality of
health facilities, goods and services and (v) accountability, where entities are transparent about healthcare strategies set in place.\textsuperscript{123} 

*Improvement in natal services.* Assessment of Syrian women's access to proper healthcare also suggest the particular need for improvement in natal services. Syrian refugee women in all three host countries report pregnancy-related complications and reproductive health issues and difficulty in getting access to antenatal and reproductive services. Increased cases of domestic violence are also crucial to the health of this population. As the UNHCR and WHO continue to provide specific assistance and resources to Syrian women of reproductive, host countries should be encouraged to increase healthcare access for Syrian women of reproductive age without the burden of cost and transportation. The horrific impact of war on children, as seen through reports of infant morbidity and risen mortality rates is expected to be the case for Syrian children.

*Increased routine vaccinations for children.* An assessment of the health conditions of Syrian refugee children show that apart from childbirth deaths, a significant amount of such neonatal outcomes is caused by vaccine-preventable diseases like measles. This calls for increased access to routine vaccinations for Syrian refugee children. The psychosocial state of many Syrians is also an issue of concern. Both young and old Syrians report suffering from a spectrum of psychological difficulties, including emotional and mental distress, depression and anxiety. Child victims of war may be prone to severe psychological trauma that can affect how they see the world. Hard living conditions among Syrians may also exacerbate mental instability among some Syrians. Hence, host countries should seek to explore policies that address psychological needs

of Syrian refugees, especially children. Community building projects may be an effective way to promote social cohesion within the Syrian community and integration in host country.

*Effective response to refugee crisis from countries.* Given differences in resources, political environment and other socioeconomic factors, each host country responds to the refugee crisis differently despite the similar challenges refugees face. Host countries should seek individualized approaches to improve healthcare access for Syrian refugees. Firstly, countries should pursue stable *internal* legal and policy reforms to address the refugee crisis. Internal reforms are some changes host governments can implement directly using legislation. Efforts to provide urgent and proper healthcare for Syria’s vulnerable population—elderly, women and children—should continue especially as the war lingers. Individual countries should attempt to modify domestic policies that encourage diversity and inclusion, as the influx of refugees is changing national demographics. Policies that encourage Syrian participation in the workforce, education and society can increase socioeconomic status, thereby mitigating concerns on healthcare costs among refugees. Secondly, host countries should seek stable *external* legal and policy reforms to improve refugee status. External reforms can be put into action through cooperation among government, sponsors and local communities. This includes efforts to 1) mitigate language and other social barriers by implementing “migrant-friendly” policies in major social settings like hospitals and schools; 2) transparency and proper assessment of refugee status; 3) poverty alleviation policies in affected communities and 4) proper implementation of protocols signed by host countries. Currently, Jordan seems to provide the most thorough reports on Syrian refugee status. Thirdly, Turkey, Lebanon and Jordan should foster community building between refugee and host communities through emphasis on shared societal and cultural norms: Many refugees and members of the host community share common religion (Islam and
Christianity), language (Arabic) and food (Levantine cuisine). Community building based on similarities can increase cooperation and integration, thereby aiding the spread of healthcare information and improved response. This can also alleviate the sense of otherness some refugees may feel in their host communities. Finally, the international community should increase humanitarian aid and sponsorship to Syrian refugees through 1) increased funding for healthcare, 2) increased provision of medical resources to host countries and 3) “refugee-friendly” policies, including open borders and proper process to welcome Syrian refugees.

Table 4. Human Rights-Based Recommendations to Improve Syrian Refugees’ Healthcare

<table>
<thead>
<tr>
<th>INTERNAL LEGAL AND POLICY REFORMS</th>
<th>EXTERNAL LEGAL AND POLICY REFORMS</th>
</tr>
</thead>
<tbody>
<tr>
<td>-Direct healthcare reforms addressing most vulnerable population</td>
<td>-Migrant-friendly policies to mitigate language and social barriers</td>
</tr>
<tr>
<td>-Syrian participation in host country’s workforce</td>
<td>-Proper and transparent assessments of refugees’ health status</td>
</tr>
<tr>
<td>-Diversity and inclusion policies in public areas like hospitals and schools</td>
<td>-Poverty alleviation</td>
</tr>
<tr>
<td></td>
<td>-Proper implementation of human rights and refugee protocols</td>
</tr>
<tr>
<td></td>
<td>-Community building between locals and Syrian community</td>
</tr>
</tbody>
</table>

These recommendations come with several challenges, with implementation cost being the major challenge. These host countries continue to suffer damaged economies, with security threats and political instability since the refugee crisis began. Social perception and lack of social acceptance can also exacerbate tensions between refugee and host communities. Also, absence of will and motivation can deter the refugee population from pursuing opportunities and resources available to them.
Conclusion

The Syrian civil war has led to thousands of deaths, injuries and major displacement of Syrians. Accompanied by the war is the emergence of a health crisis. Many Syrians continue to suffer from several communicable and non-communicable diseases. Syrian women have seen a rise in reproductive and pregnancy-related complications, and children suffer from vaccine preventable diseases like measles. Mental health is an area of rising concern among Syrians. The war in Syria is also a war on health, especially for Syrian mothers and children. Hence, improving healthcare for Syrians, internally displaced and refugees depends significantly on government response and cooperation, community acceptance and individual efforts.

There is currently inadequate information to fully understand the outcomes of these policies. This is probably due to ineffective or biased reporting of refugee status in host countries. However, further research is needed to analyze implementation of the refugee policies each country has adopted: This will provide better assessments of Turkey, Lebanon and Jordan’s response to the Syrian refugee crisis.

NOTES

i Table 1 Sources:

ii Ref. to Table 1: Based on UNICEF’s polio vaccination target for children below 5-years old in Syria

ii Table 2 Sources:


Masterson et. al, Assessment of Reproductive Health.


Table 3 Sources:


Table 4 Sources:


