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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.

Keywords

Syria, Lebanon, refugees; violence; healthcare; humanitarianism; therapeutic geographies; ethnography

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 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.

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, Filc, & Davidovitch, 2012; Koehn, 2005; McKeary & Newbold, 2010; Okie, 2007), a growing number of studies conducted in the Global South (Arnold, Theede, & Gagnon, 2014; Posner et al., 2002; Rowley, Burnham, & Drabe, 2006)

and specifically in the Middle East and North Africa (Briant & 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 & Issar, 2010; M. Cammett, 2014; Challand, 2008; Chen & 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 & 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 & 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 Beqa'a 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-Jdeede 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 9,154 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, & 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 Beqa'a 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; M. Cammett and Issar 2010; M. C. Cammett 2011; M. 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 & 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 Beqa'a, 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 Palestinian refugee camps (International Rescue Committee & Norwegian Refugee Council, 2015, pp. 24, 26). These arrangements stand in stark contrast to the pre-war Syrian system, where both Syrians and Palestinians had access to cheap, centralized, state-run services.

Refugees from Syria have thus entered a complex healthcare environment characterized by weak state regulation and private, politicized provider organizations where partisan activism accessible only to citizens partially determines financial access to services. Syrians who are registered with the UNHCR are entitled to subsidized healthcare through a private insurance provider that contracts with the Lebanese public system; insurance covers 75% of costs and Syrians 25%. Payment for the unsubsidized portion of care has proved a point of contention. While Islamic associations have provided some needy refugees relief from the financial burden, others have gone into debt (Lebanese Center for Studies and Research et al., 2013) or have had their identification papers confiscated by hospitals when they cannot pay (rendering them vulnerable to detainment and deportation by Lebanese authorities).

Towards a Micro Dimension of Therapeutic Geographies

The concept of "therapeutic geographies—the geographic reorganisation of health care within and across borders under conditions of war" (Dewachi et al., 2014, p. 449) provides powerful insight into shifting patterns of healthcare provision and access by building on scholarship on conflict and forced migration (p. 454). The authors' empirical focus on transnational movement, militarisation, and regionalisation (p. 450-454) and their presentation of therapeutic geographies indicate the need to evaluate expressly multi-level (e.g. regional-city) and multi-sited (e.g. community-hospital) interactions in refugees' health outcomes and

experiences. Dewachi et. al. compellingly present this perspective as a counterpoint to the more state-centric health systems framework (p. 454). Yet to take their approach a step further, "mapping" evolving therapeutic geographies should capture both broad transformations such as regionalisation *and* bottom-up feedback based on the situated practices and knowledge of refugees themselves (Haraway, 1988). This extension underscores the inherently variable microdynamics of healthcare access, including factors such as the local security environment and the field of (non)state providers. Yet it also, and perhaps most importantly, affords space for refugees' own agency and resourcefulness, which are undertheorized in current conceptualizations of therapeutic geographies.

On this note, global public policy approaches emphasize the importance of understanding complexity and scaling; situations such as refugee crises must be understood as involving multiple policy and political domains, state and non state actors, and local, regional, and national contexts (Miller, 2014, p. 503). Much scholarship on medical humanitarianism and refugee health supports a similar perspective (see, e.g. Gottlieb et al., 2012). Scholars have emphasized how factors such as multilevel funding structures and privatized systems (McKeary & Newbold, 2010; Posner et al., 2002), separate health and registration bureaucracies (McKeary & Newbold, 2010), changing visa requirements (Briant & Kennedy, 2004), and fragmented personal support networks (Briant & Kennedy, 2004, p. 440) all change the calculus of healthcare access. Using an ethnographic approach and building on studies of comparative environments of access (e.g. Garcia-Subirats et al., 2014), we thus develop the concept of therapeutic geographies in a way that allows micro level experiences to inform macro understandings of the complex and discursive relationship between refugee life, humanitarian bureaucracy, political context, and healthcare access.

Methodology

Studying how Syrian refugees approach healthcare in Lebanon allows scholars to observe a case where the *politics of access* (M. C. Cammett & MacLean, 2011; Matthew, Burns, Mair, & O'Donnell, 2014) rather than the *presence or perception of services* (Pavlish, Noor, & Brandt, 2010; Singer & Adams, 2011) is a core factor in refugees' healthcare experiences. This perspective allows researchers to build upon and further specify previous critiques of humanitarian practices conceptualized and developed in the Global North (de Waal, 2009; Kennedy, 2005; Terry, 2002) and to refine understandings of healthcare access by way of local immersion rather than a bird's eye view. It also provides an important, humanizing complement to the population-level statistics that often drive policymaking.

As part of two broader projects focused on the evolution of Palestinian political organizations in Lebanon (Parkinson, 2013) and on Palestinian refugees' development of aid programs for refugees from Syria, Parkinson conducted participant observation with Palestinian humanitarian providers working with refugees from Syria (both Syrian and PRS) in January and May-June of 2014. Building on nearly two years of interview-based, archival, and ethnographic research conducted between 2007 and 2014, including during May-June 2012 at the beginning of the current crisis, Parkinson spent this time living with a Palestinian family in a Beirut refugee camp. Having previously stayed in the camp and its environs, she interacted around-the-clock with old and new interlocutors, including her long-term Palestinian contacts, Syrian refugees and PRS who visited them, members of five Syrian families who lived in the same building, community members, and local volunteers.

This research approach allowed Parkinson to explore new categories and spaces of inquiry via the perspective of lifelong refugees (Palestinian refugees in Lebanon) as they

interacted with refugee populations new to Lebanon (Syrians and PRS). Specifically, she witnessed informal interactions where Syrian refugees sought out their Palestinian neighbors' help in answering questions (e.g. where the cheapest local pharmacy was), sharing advice (e.g. how to occupy young children in the absence of outdoor play spaces in the camp), or providing material and logistical help (e.g. accompanying them to renew paperwork with Lebanese General Security)(Parkinson, 2014a). Parkinson also interviewed Palestinian humanitarian workers and observed their interactions with refugees from Syria at a local non-governmental organization that hosted events such as community workshops and English language classes. These interactions gave Parkinson a grounded perspective on the challenges refugees from Syria confronted and the type of situated knowledge necessary to navigating quotidian life as refugee in Lebanon (Fiddian-Qasmiyeh, Loescher, Long, & Sigona, 2014).

Research was conducted under IRB Protocol 1312S46161 at the University of Minnesota, which details consent and confidentiality procedures. Research was conducted in the Levantine colloquial dialect without a translator. All interlocutors' names are pseudonyms. The camp and hospital where Parkinson conducted participant observation are left unidentified to protect the people involved.

This approach achieves two specific goals. First, it explicitly highlights the fragmentary effect of aid regimes conceptualized in the Global North from the perspective of refugees themselves, emphasizing the way that Palestinian refugees act as sources of knowledge and social protection for Syrian refugees. Second, it sheds light on some of the multi-level challenges and paradoxes of healthcare access in the wake of violence while identifying important sources of resilience. More, it illustrates how humanitarian interventions in violent situations can

simultaneously spotlight and unintentionally perpetuate inequality and injustice (de Waal, 2009; Kennedy, 2005; Terry, 2002).

The Politics of Access: Negotiating Health and Life in Lebanon

"I found him in the road," Um 'Umar tells Mo and I (Parkinson) when we meet in front of the Palestinian Red Crescent Society (PRCS) hospital. Ahmad, a Syrian refugee, is standing with the middle-aged grandmother and her adult daughter, looking deeply troubled. We already know part of the story from earlier WhatsApp messages. Ahmad's wife, Muntaha, is in labor; they are both Syrian refugees from Aleppo.

Um 'Umar and Mo, both Palestinian refugees born in Lebanon and active in social associations, immediately assess Ahmad's situation in terms of legal and financial ramifications. Asking about the couple's registration status allows them to quickly evaluate potential pros and cons of different access strategies. They ascertain that Muntaha is registered with the UNHCR while Ahmad is not. Mo, an employee of a major international aid organization in his mid-twenties, consequently relays that it would be cheaper for her to give birth in the Lebanese government hospital. Mo elaborates: if they go to a public Lebanese hospital, the couple will have to pay 25% of the bill, likely between LL199,000 and LL250,000 (US$131 and US$165); UNHCR will cover the rest. To give birth at the PRCS, by contrast, the couple would pay about LL500,000 (around US$332); 50% of the cost would be covered by the hospital and the Palestine Liberation Organization (Parkinson, 2014a). These financial differences are significant; academic and aid organizations' studies have repeatedly shown that cost is a dominating factor in Syrian refugees' access to healthcare (Dewachi et al., 2014; Gulland, 2013).

Palestinian refugees in Lebanon are accustomed to weighing healthcare options in terms of necessity, quality, and price. Receiving subsidized care through a constellation of organizations including UNRWA (if they are registered), the PRCS, aid organizations, and Lebanese public hospitals makes them skilled at navigating segmented healthcare systems. Because these systems still often leave patients and their families with substantial bills, Um 'Umar and Mo are also sensitive to cost considerations. In the road outside the PRCS hospital, these experiences become an important resource for Ahmad. The two Palestinians' approach—carefully presenting multiple options—and combined knowledge—e.g. of costs and facilities—shape how Ahmad decides what he and his wife will do.

During their careful, sensitive questioning, two other factors emerge: Ahmad's legal status and the network of security checkpoints on the way to the hospital. The government hospital is across the city whereas the PRCS hospital is walking distance to their rented room and within the comparatively safe confines of a camp. As Mo carefully outlines these options, Ahmad shares that he was recently detained by Lebanese General Security for working without a proper visa. They told him to obtain a labor visa for LL500,000; if he is caught outside of the Palestinian camp without it, he may face extortion, detainment, or deportation.

Evoking a common theme in the literature of healthcare access for refugees and migrants (Sargent & Larchanché, 2011, p. 348), the risk of encountering security forces proves a pressing concern for Ahmad, who expresses fear that the government hospital might check his identification. Mo tries calling the UNHCR information hotline for Syrian refugees to confirm the intake process and costs at the Lebanese hospital. He is greeted with a recording: "For English, press 1. For French, press 2. For Arabic, press 3." He bitterly notes that for a refugee from Syria, this process would waste precious credit from their limited account; he has already

spent more than US$1 before pressing his selection. He hangs up. Ahmad decides that borrowing US$200 for the government hospital fees is much easier than borrowing more than US$300 for the PRCS. He also decides to remain in the camp rather than accompanying Muntaha.

Ahmad's experiences, uncertainties, and anxieties resonate with that of other refugees from Syria. Studies conducted by humanitarian organizations' have found that refugees with limited legal status consistently report fear of crossing checkpoints as an impediment to healthcare access (Aranki & Kalis, 2014; Norweigan Refugee Council, 2014, pp. 15–19). Indeed, during Parkinson's field research in South Beirut, conversations about rules governing refugees' legal status, particularly with concern to the shifting rules governing entry and permit extension, surfaced nearly every day (Field notes, January 2014, May 2014, June 2014). For example, in a different camp, Ashraf, a PRS, explained that while he was supposed to go renew his *iqama* (residence card) he was afraid to get sent back to Syria; known as an activist, he was convinced that he would die if he returned even for a day. Ashraf then shared that he simply planned to stay in the Palestinian camp because he cannot risk getting sent back (Field notes, May 27, 2014).

Ahmad brings Muntaha from their room and we help her into Um 'Umar's daughter's car for the drive. At the camp exit, Ahmad bids his wife goodbye and helps her sister, who will join us in Ahmad's place, into the car. As he closes the car door, Ahmad tells Mo that he will begin visiting his family and friends to gather donations for the hospital bills.

Exclusion through Inclusion: Lived Experience as a Frame for Healthcare Encounters

Mo and I take a separate cab to the hospital. When we arrive, a family from rural Syria--identifiable to Mo by their clothing and accents--is finishing a heated and visibly emotional

conversation with a hospital employee. The prospective patient is a middle-aged woman; she is swaying and pale. Her eyes are unfocused. The conversation ends with the hospital employee shrugging and walking away. With concern, Mo postulates that they probably didn't have the money for a deposit and notes that the hospital staff is not supposed to be expelling refugees over their inability to pay.

Healthcare refusal was a headline-grabbing issue in Lebanon in late 2013 and early 2014. Within the same timeframe, many poor Lebanese were also being denied access to health services at public hospitals due to political disputes in the Ministry of Health (as-Safir, 2014; Lebanon Files, 2014). Scholars such as Sibai and Sen (2006, p. 848) have also long argued that Lebanon's healthcare system has "little interest in the poor" and is focused on (profitable) curative rather than primary care. However, the complexities of Syrian refugee life—registration, work permits, geographically fragmented families—interact in unique ways with this context and point to a specific politics operating within humanitarian structures.

The way that refugees' broader lived experiences feed into this politics of access is evident as Muntaha navigates the hospital system. When the car with Muntaha arrives, we walk through the deserted hospital lobby and through heavy doors marked "Emergency." We reach a counter; five doctors and nurses are casually arranged on chairs and desks, gossiping behind the partition. Mo takes the lead, explaining that we have a woman in labor with us. Disinterestedly, they wordlessly point us to an elevator bank. No one asks if Muntaha is able to walk or offers her a wheelchair.

Our party reaches the 2nd floor and weaves into the obstetrics waiting room. There is one row of unmovable, black, molded plastic bus station chairs and a vending machine; several women who are visibly in labor occupy the rigid chairs. Husbands stand, often holding bags of

spare clothing or clutching passports and family books (a form of formal Syrian documentation). The room is visibly unclean; there are cigarette butts, dirt, and trash on the ground.

We go looking for a nurse. Passing through a metal door, we face another counter. Mo greets the nurses behind it and explains that we have a woman in labor with us; the nurses look Muntaha up and down, registering her clothing, physical state, and facial features. Is there a room where we can bring her? Can she be examined? They're not sure if there's a room. They don't know where the doctor is. They'll check. Without looking at patient registers, computers, or into doorways, they then declare that nothing's open. They offer us no more information. We return to the waiting room.

Syrians and PRS often understood negative encounters such as these as part of a larger array of bureaucratic strategies being used to disincentivize their staying in Lebanon; no one in our party is surprised by these interactions. True or apocryphal, rumors in the camps often emphasized the harshness of the Lebanese healthcare apparatus and worked to construct Lebanese healthcare providers as actively working against refugees' interests, thus providing a common frame through which refugees understood their own subsequent experiences. For example, one particularly distressing rumor centered on a hospital in Sidon refusing to give the parents of a deceased Syrian infant his corpse for burial until they paid his hospital bill (Field notes, January 2014). Others emphasized that hospital billing offices would confiscate Syrians' papers if they could not pay; one version featured hospital employees in South Lebanon physically ripping up three refugees' papers (thus rendering them vulnerable to detainment and deportation)(Field notes, January 2014).

The theme of financial uncertainties also reemerges as Mo continues to worry about the billing procedure. Unsurprisingly, given the rumors circulating, he and I had spent our cab ride

worrying that Muntaha's papers might be confiscated by the hospital if she couldn't pay up front; I tell him that I'll accompany him to deal with the billing department. We don't want to bring Muntaha or her sister for fear of exposing them or having someone demand their papers. As a nurse directs us downstairs to billing, we watch others escort a Lebanese woman into an examination room. When we arrive at the elevator bank, a UNHCR poster elaborating the refugee insurance program hangs next to the elevators. Downstairs, the cashier tells us that "births start at LL250,000" and that our friend will have to pay a deposit ahead of time.

Um 'Umar's interim attention to the other families in the waiting room reveals one way that social interaction fundamentally interacts with therapeutic geographies. When we return, the waiting room is busy. Um 'Umar has been chatting with people and tells us that another family has just paid a LL550,000 deposit because they are not registered with UNHCR. Mo asks her to identify the couple, introduces himself, and asks them gently about their situation as I look over the bill to ascertain the nature and legitimacy of the charges. Mo gives them his mobile number and carefully outlines how the problem of being unregistered can compound itself; even if they are not registered with the Lebanese authorities, they must register the child. He walks them through this process: they must go to a local *mukhtar* with the family book (a form of legal identification) and the proof of birth from the hospital, pay a small fee and then go to the Lebanese government's civil affairs office to register the child in Lebanon. Their uncertainty shows how, for refugees from Syria in Lebanon, the simple matter of registering a child under these circumstances becomes a fraught bureaucratic endeavor involving multiple Lebanese government officials. The results, according to UNHCR, are worrisome: "A 2014 survey of 5,779 newborns found that 72 percent do not possess an official birth certificate, raising concerns over the recognition of their nationality by the Syrian authorities" (UNHCR, 2015a).

A nurse tells Muntaha to go home and come back in the morning; she argues that because Muntaha "is not bleeding," the hospital cannot admit her. She ignores Muntaha's appeals that she did not bleed with any of her other four children. Driving into the camp, the soldier at the checkpoint demands all of our passports and IDs.

The Mirage of Care

These ethnographic vignettes shed light on the intersecting socioeconomic, political, and bureaucratic dynamics that shape healthcare access for refugees from Syria in Lebanon. They also reveal how knowledge of these types of dynamics ought to be incorporated into the concept of therapeutic geographies. For example, Muntaha's and Ahmad's initial predicament illustrates that the very procedures that have been put in place to facilitate care--in this case refugee registration and insurance contracting--may at once interact with other factors to hinder and/or discourage refugees' accessing healthcare services and expose them to more violence. Yet their ongoing negotiation of the situation also demonstrates how contingent local circumstances—such as the presence of an already established refugee community—shape the more recent arrivals' experiences as well as the situated knowledge they develop (Haraway, 1988).

In this case, Palestinian refugees' knowledge of available healthcare options, pricing, and security risks serve to inform what Ahmad and Muntaha decide. Their actions thus serve as a particularly important window onto the complex informal interactions that structure healthcare access—and provide sources of resilience—to vulnerable populations. As situated actors, and as refugees themselves, Um 'Umar's and Mo's evaluation of the situation is not simply about Muntaha's health, but about the potential for legal, social, financial, and emotional consequences

of her decision to: 1.) Choose a Lebanese or Palestinian hospital for her delivery and; 2.) Leave the camp as a result. Mo, in particular, is aware of the fact that Ahmad runs an immense risk in order to accompany his wife; protecting Ahmad and his family is less of a question of healthcare availability (or quality) and more about weighing the risks that each option entails. Due to their role in accessing healthcare, these relationships thus constitute an important component of "therapeutic geographies."

Similar to Okie's (2007, p. 525) observations in the case of recent immigrants to the United States, "seeking health care often involves daunting encounters with a fragmented, bewildering, and hostile system." Crucially, though Muntaha's UNHCR registration entitles her to subsidized care, and though her visa status is current, the risk her *husband* and caretaker would shoulder in order to accompany her to the hospital changes their calculus. Though not directly health-related, these factors are central aspects of Syrian refugees' experience of healthcare (Gulland, 2013; International Rescue Committee & Norwegian Refugee Council, 2015; Norweigan Refugee Council, 2014).

To refugees from Syria, the hospital is far from a neutral care provider. Nor is a hospital visit an isolated occurrence. It is an ongoing process of negotiation and navigation within and through the constraints and uncertainties that shape their daily lives. Even the 25% financial obligation that accompanies any medical visit requires refugees to maintain financial reserves (difficult in harsh economic circumstances), borrow from friends and relatives, or to work (often illicitly or under discriminatory conditions). The interaction between health, financial instability, and visa requirements creates a complicated and potentially threatening environment. In this case, the hospital is a space where, due to the interaction of refugee status, hospital

administration practices, and national politics, Ahmad and Muntaha are rendered vulnerable and exposed.

Yet the hospital is also an institution operating in the broader context of Lebanese politics, where members of the cabinet and party leaders have publicly emphasized their desire to deport refugees from Syria and/or disincentivize further refugee flight to Lebanon (Hodeib, 2014; NOW Lebanon, 2013; The Daily Star, 2013). Foreign Minister Gebran Bassil, for example, has stated: "All this aid – be it food, shelter or health care – encourages Syrian refugees to stay in Lebanon, while what we want is to encourage their speedy exit" (Hodeib 2014). Ministry of Education policies announced for the 2012-2013 and 2013-2014 school years convinced thousands of Syrian students who lacked "full" educational records (including three years of records stamped by the Syrian Ministry of Education and certified by the Syrian Ministry of Foreign Affairs in Damascus) that they were barred from taking advancement exams. Though exceptions were made, these policies were effectively a means of dissuading Syrian student enrollment (Parkinson, 2014b). In this socio-political context, the expulsion of visibly ill patients who cannot pay, the staff's ambivalence in the emergency room, the obstetrics nurses' dismissiveness, and the final, seemingly patronizing claim that a patient cannot be admitted because she "is not bleeding" all play into a broader narrative that Syrians are unwelcome and that they should "go home."

Refusing or delaying care, along with care provision that is inseparable from humiliation and threat, emerges from larger political structures as a weapon of party and national politics (Abdelaaty, 2014). They are means of control, exclusion, and intimidation. Social, political, and economic instabilities such as unclear birth documentation requirements and churning rumor mills constantly shift the grounds of negotiation, forcing individuals to constantly re-evaluate

and re-calculate their choices with regards to their health. Muntaha and Ahmad's experience thus reveals how *therapeutic geographies* operate both within and *across* multiple social and policy domains and can be used as vehicles for political strategy and performance. It warns about probable implications of interactions between factors such as vulnerable visa statuses and poor health and social outcomes (Steel et al., 2011). Withholding care in these situations is not as a weapon of war in the same way that refusing treatment to a wounded protester is (Dewachi et al. 2014). Rather, violence operates as a series of diffused moment fragments located in what anthropologists have called lived life (Behrouzan & Fischer, Michael M.J., 2014; Behrouzan, 2015; Das & Cavell, 2006; Das, 2000; Kleinman, Das, & Lock, 1997) In a longer timeframe and across many refugee lives, the bureaucratic processes of registration and residency permission, combined with the subjective experience of daily life, disincentivizes seeking sanctuary in Lebanon.

Conclusion

Public health scholarship on humanitarian interventions frequently separates health from the intricacies of everyday refugee life by locating it solely in the structured/restricted space of the clinical encounter. Yet isolating these moments and assessing them in a vacuum fails to recognize health as integrated and experiential. In other words, access to health care needs to be situated in larger socio-political and economic structures that can exclude, divide, stigmatize, and privilege. The experiences and processes that characterize the politics of access create hierarchies of eligibility and deservingness (Gottlieb et al., 2012; Marrow, 2012; Sargent, 2012; Soss, 2002; Willen, 2012a, 2012b)--Lebanese versus Syrian, registered versus unregistered--and regimes of care that are contingent on shifting political realities.

Incorporating factors such as the bureaucratic uncertainties, social resources, and situated knowledge of refugee life into the concept of therapeutic geographies is an important step in recognizing how therapeutic geographies operate on both transnational *and* micro-level scales. "Health-related" or not, these ostensibly mundane experiences are the building blocks of the very socio-political and medical conditions that humanitarian interventions and policy aim to address. To trivialize them would be to fail to address the problem at its core. Moreover, refusing to recognize the local socio-legal aspects of refugee life, may, in fact, expose refugees to more health risk. As Okie (2007, p. 526) argues, "laws and bureaucratic barriers that reduce…use of key preventive health services, such as immunizations and screenings for infectious disease, make for bad public health policy."

Developing the concept of therapeutic geographies across policy domains and investigating micro level dynamics helps scholars and practitioners to better understand the intersection of humanitarian service provision, national politics, and everyday refugee life (Dillon 2011; Kennedy 2005; Terry 2002; de Waal 2009; Miller 2014). Public health, development, and medical approaches to health have often focused on specific types of standardized outcomes (e.g. mortality and morbidity) thereby eclipsing situated forms of knowledge as well as unquantifiable implications of therapeutic interventions. Focusing solely on access, without addressing the social experience of healthcare, misses the point of humanitarianism altogether.

Future research should focus on the lived experience of both therapeutic and socio-political structures that shape access to health services (Sargent & Larchanché, 2011). More immediately, researchers can also evaluate how humanitarian initiatives such as cash aid programs, midwife trainings, and mobile clinic visits can be designed to simultaneously aid and

protect populations such as Syrian refugees in Lebanon (Holmes, 2012). There are related lessons in the Ebola crisis in West Africa, where anthropologists have argued that the epidemic occurred despite and at times because of large scale investments in pandemic preparedness that privileged medical understandings over social interactions (Moran & Hoffman, 2014). In this light, Nguyen has proposed efforts that "stress community mobilization and care" in light of the important role that Ebola survivors play in caring for patients (Nguyen, 2014). These suggestions necessitate both inter-disciplinary as well as North-South dialogue that does not privilege certain know-how and knowledge practices over others; that is socio-politically situated; and that unpacks disciplinary and cultural assumptions to make concepts broadly accessible.

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Negotiating Health and Life: Syrian Refugees and The Politics of Access in Lebanon

Highlights

- Ethnographic evidence from Syrian refugees' pursuit of healthcare in Lebanon
- Complexities of everyday refugee life shape strategies of access
- Humanitarian bureaucracy interacts with local factors to disincentivize access
- Palestinian refugees' situated knowledge provides social support
- Argument specifies and extends concept of therapeutic geographies