BAU Journal - Health and Wellbeing

Volume 1 Issue 3 *Urban Health & Wellbeing Building Collaborative Intelligence for Better Lives in Cities*
ISSN: 2617-1635

Article 32

October 2018

BARRIERS FACED BY SYRIAN REFUGEES IN ACCESSINGHEALTHCARE IN URBAN AREAS IN LEBANON

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Abstract

The crisis in Syria continues to take a devastating toll on the country's civilian population. Lebanon now has 1.2 million Syrian refugees registered with the United Nations High Commission for Refugees, where over 1 million of them live outside of camps in urban settings and informal settlement. The high prevalence of communicable and noncommunicable diseases among Syrian refugees in Lebanon is being faced with a variety of multifaceted barriers leading to limited access to and use of healthcare services in terms of provision of appropriate secondary and tertiary services, continuity of care, access to medications, and costs. Aim: This study aims at exploring barriers faced by Syrian refugees in accessing health care in urban settings in Lebanon. Methodology: This qualitative study will be conducted on 40 Syrian refugees living in urban settings across Lebanon. Data will be collected through interviews to explore the context, reasoning and perception of the participants of existing barriers, and then will be phenomenologically analyzed. Results: The results of this study showed that the Syrian refugees who participated recognized financial, structural and cognitive barriers to accessing health care services.

Keywords

Barriers, Refugees, Syrian, Urban

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ABSTRACT: *The crisis in Syria continues to take a devastating toll on the country's civilian population. Lebanon now has 1.2 million Syrian refugees registered with the United Nations High Commission for Refugees, where over 1 million of them live outside of camps in urban settings and informal settlement. The high prevalence of communicable and non-communicable diseases among Syrian refugees in Lebanon is being faced with a variety of multifaceted barriers leading to limited access to and use of healthcare services in terms of provision of appropriate secondary and tertiary services, continuity of care, access to medications, and costs. Aim: This study aims at exploring barriers faced by Syrian refugees in accessing health care in urban settings in Lebanon. Methodology: This qualitative study will be conducted on 40 Syrian refugees living in urban settings across Lebanon. Data will be collected through interviews to explore the context, reasoning and perception of the participants of existing barriers, and then will be phenomenologically analyzed. Results: The results of this study showed that the Syrian refugees who participated recognized financial, structural and cognitive barriers to accessing health care services.*

KEYWORDS: *Barriers, Refugees, Syrian, Urban.*

1. INTRODUCTION

The conflict in Syria, which has concluded its seventh year in March 2018, remains a catastrophic threat to country's civilian population. An approximated sum of 7.5 million civilians were obliged to relocate within Syria, and more than 4 million have sought refuge in neighboring countries where, 1.2 million Syrians refugees in Lebanon registered with the United Nations High Commission for Refugees (UNHCR, 2015). Consequently, the number of people living in Lebanon has augmented suddenly by approximately 30 % since March 2011 in a country of just 4 million Lebanese (UNHCR, 2015). Health care, water and sanitation amenities, accommodation, and other assets that were already exhausted in Lebanon have been placed under further stress due to the sharp and abrupt influx of Syrian refugees.

Lebanon presently provides for over 1 million Syrian listed refugees who reside outside of camps in urban settings and irregular settlements. United Nations High Commission for Refugees (UNHCR) is offering help and support to the refugees through various plans covering basic assistance, security, accommodation, Water, Sanitation and Hygiene (WASH), education and health (Inter-agency Coordination Lebanon, 2015). UNHCR serves an overall management role for multiple actors engaged in offering healthcare support to Syrian refugees in Lebanon. These healthcare plans point at enhancing refugee usage of the ample of health services within Lebanon. Primary health care (PHC) is the center of all health care involvements and in collaboration with native and international associates; UNHCR is providing for 30 PHC institutions where a basic plan of health care services is offered at studied prices. In sum, there are roughly 100 PHCs over the country backed by collaborators where sponsored care is accessible for refugees. Healthcare amenities involve medical consultations, diagnostic tests, pharmacy prescriptions and free vaccinations. Referral services are a crucial element of access to holistic health care amenities for refugees. UNHCR sponsors deliveries and life-saving emergency care by covering 75–90% of hospital expenses taking into consideration the socio- economic status of the refugees and the fees of the admission (UNHCR, 2017).

Utilization of health care includes a complementary relationship between the patient and health care system where the patient recognizes health care necessities, seeks health care facilities, reaches out, obtains, and fulfills the requirements for these services (Amnesty International, 2014; Cammett, 2011). Health care services should usually be accessible, satisfactory, obtainable, accommodative, inexpensive, and suitable (Cammett, 2011). Even though refugees may approach with augmented health care necessities, they are confronted by substantial

obstacles to accessing health care services in Lebanon (Pierre Louis, Ayodeji Akala, Karam, 2014; Rainey, 2015).

Other than access to elementary facilities including, primary health care and pedagogy for school-aged children, many refugees fleeing from Syria have stern health care necessities due to precedent chronic conditions and impairments inflicted during the Syrian crisis (Coutts,2015; Taleb, 2014). Yet, upon arrival to Lebanon, they are encountered with overstrained health care structures in which the facilities accessible to refugees are scarce and challenging to use. The underprivileged communities in northern Lebanon, which were already striving to access elementary amenities, have now hosted the most susceptible Syrian refugees (Inter-agency coordination Lebanon, 2015). The dispersed and unstructured settlements of refugee population across the country have impactful repercussions on present health services.

The indistinct governmental policy and scheme for health care and the overpowering mass of an uncontrolled private sector in sponsoring and provision of health care sum up the major barriers in the current health system (Ammar, 2009). The immense expenses that are drained by the system which predispose families to financial jeopardies from ill health and the negligible public spending on primary health care paralleled with secondary and tertiary care bring more afflictions on the Lebanese and the susceptible population in specific (Salti, Chaaban, Raad, 2010).Various structural and social barriers restrict access to care amid refugees. The most referenced barriers in the literature include cost, lack of insurance, transportation, working hours of facilities, and time consumption (Morris, 2009; Mirza, 2014).

Issues that also may impede access to care involve child care, appointment convenience, dialect, acculturation, prospects of health facilities, stigma, mistrust, fear of deportation, perceived discrimination, adaptation to a new health system, low prioritization of health care (Asgary, Segar, 2011; Riggs et al, 2012), lack of quality, lack of adequate health personnel and medication, lack of health awareness in the population, cost of medication and specialized services, and refugee status (Wahoush, 2009). Identification mental illness (De Antiss and Ziaian, 2009) and somatization (Jensen, et al, 2013) were recognized as barriers to accessing mental health care. Reproductive health care was impeded due to cost, lack of knowledge, inaccessibility, and discomfiture (Masterson et al, 2014).

Barriers, which are hypothetically quantifiable and modifiable, are identified as financial, structural, or cognitive barriers in this study. The classified barriers, independently or conjointly, may cause reduced screening, late access to care, and lack of management, which act as intermediate factors leading to poor health outcomes and health inequalities.

The government facilities were the most preferable when participants were questioned about where they go when they are sick and require health care attention. The majority of the refugees reported the use of Public Health Care Centers (PHCs), next came the use of government facilities, fewer refugees recorded accessing private clinics as their health providers, and the very few accessed other facilities, including community-based institutions, private clinics, and PHCs. Community-based organizations, NGO clinics, and other clinics were noted to be used of much lesser extent. Most refugees recorded using health services for free. However, notable sums of the refugees have been spending money for health care (Ay, González, Delgado, 2016).

2. METHODS

Max A qualitative research study design was employed to investigate the Syrian Refugee's perceptions regarding the process of accessing health care services in Lebanon. This method- enabled refugee to describe their perception based on the reality there are experiencing.

2.1 Participants and data collection

40 Syrian Refugees residing the area of Beirut, have participated in this study. Data was collected from the participants at locations that they have identified as convenient and comfortable for them to sit for an interview (e.g. Home). Beirut Syrian Refugees were recruited through purposive sampling. Each interview took between 30 and 60 min to complete. Field notes were recorded after each interview to describe the interview context.

In the interviews, we asked questions like:

-Please describe how it is like to reach out to health care facilities in Beirut.

-Please describe any financial problems that you have faced in accessing health care services.

-Please describe any problems that you have faced to access health care services.

-Please describe your experience with the health care system and providers that you have dealt with.

-Please describe any barriers or problems that have hindered your access to health care services in Beirut.

2.2 Data analysis

Qualitative data analysis is a continuous process starting from the time of data collection and continuing after the recorded interviews have been transcribed. Content analysis approach was used to analyze transcripts of in-depth interviews in the study. The interview tapes were transcribed verbatim and checked for errors. During the process of transcription and listening, investigator was immersed in the data, which served the aim of the research, and allowed the generation of an initial chain of meaningful codes and labels. Transcripts were coded into broad categories based on the research objectives and interview questions. Each broad category was subjected to more manual detail analysis by the researcher, which led to the formation of more specific categories within each theme. As categories become more firmly defined, text is stored in groups and sub-groups forming a tree. Each group or sub-group structure represented one theme or sub-theme. This method of analysis is useful because it allows the researcher to split up the broad categories by identifying the interlinking facets, which serve as sub-themes under the broad category, or theme.

Demographic data was analyzed using SPSS (Statistical Package for the Social Sciences) version 22.0 (IBM SPSS Statistics for Windows). Reflexivity was maintained through on-going documentation in an audit trail and comparing this reflection against the data in the analysis process (Van Manen, 1990).

2.3 Ethical considerations

This research was carried out while abiding by the ethical considerations at each step of the study process.

3. RESULTS

Our results are delineated in the following section by summarizing the socio-demographic characteristics of the participants and then thoroughly describing the experiences and challenges that they have faced during their quest in accessing health care services.

3.1 Participant characteristics

40 Syrian refugees residing in the area of Beirut have participated in this study; there were 21 (52.5%) females and 19 (47.5%) males between the ages 15 and 50 years, 40% of participants were younger than 35 years of age. In addition, the multitude of the refugees who participated in the study reached only middle school in their education (60%), while only 17.5% reached high school and none went into college.

3.2 Financial barriers

The results of this study have shown that the expensive transportation to be a major challenge for Syrian Refugees to reach out and access healthcare services. The cost of commuting from and to health care facilities has been also recognized as an obstacle among urban Syrian refugees. It is also a frequent barrier identified in previous studies, with disregard to the host country (Morris, et al., 2009; Riggs, et al., 2012).

> *In order to get to the hospital where I can access health care, I need to take 2 taxis which cost a lot of money. We use this money to pay rent and feed our children. This is mostly why I skip my appointments most of the time.*

Most of the refugees residing in Beirut have been found to have very low income or are unemployed; they live in very poor and unhealthy environments, which in turn affect their health status. My son started developing breathing problems and illnesses as soon as we moved into this place. It is not very clean and healthy to live in.

Moreover, the refugees have describe that the cost of accessing health care services is very high, which renders them unable to make use of it and attend to their health needs. This is regarded as a remarkable finding as the multitude of refugees have described using available health care services for free especially those provided by the UNCHR and Médecins Sans Frontières (MSF). The primary health care services are also provided in governmental health care facilities free of charge for registered refugees. The refugees

may have impractical perceptions regarding the amount of money to be spent on health care, yet the expense of buying medication can pose a serious obstacle as there is a notable deficit on the amount of declared-free medications which obliges refugees to buy their medicines from pharmacies which commonly sell these commodities for highly set prices. Therefore, the protests raised by the refugees maybe due to anticipation in receiving financial aid or due to anxiety regarding cessation of services upon complaint.

> *Most of the medication that we need to maintain our illnesses are not covered by the government or by NGOs, and they are very costly at the local pharmacies. We sometimes rely on home remedies to avoid buying the medications needed.*

The results have also shown that the participants found the expense of medications and non-essential care (e.g. dental care) to be very high. Dealing with these expenses was notably challenging, especially for refugees who do not have a good steady income rendering them unable to even pay their monthly bills. It was also noteworthy that families particularly those who have children, were distraught as the expenses of health care services were too high for them to even think about accessing services and meeting their health requirements.

> *My children have a lot of tooth problems like carries and abscesses, but dental care is very expensive especially for families who do not have a job to cover these expenses, so it is very difficult for me and, my family to take care of our teeth or go to the dentist. Also it is very expensive to go to a specialist like an eye doctor, they charge a lot for just a checkup.*

3.3 Structural barriers

The results of this study revealed that the refugees find that the very long distances from their residence to health care facilities an important barrier to access. Refugees described obstacles such as transportation, long waiting times in facilities, and late appointment dates for consultations or tests as structural barriers that they have to deal with in order to obtain the medical attention they need. With regard to obstacles of transportation, the participants were not able to seek health care as they were still getting used to a new environment in a new city and they depended on public transport system that had fixed schedules. In that regards, the refugees required different means of transportation, which was not accessible.

> *"Most of the time it is very hard to attend my appointments due to long distances thatI would have to cross and keeping in mind that I do not have a car".*

The refugees who participated in this study also described their disappointment with the health care system, as they at least expect the available services to be affordable and acceptable. Refugees were distraught by the length of waiting time that they have to suffer every time they want to go for an appointment or even seek emergent medical attention.

"We had to go to the emergency room to seek medical attention for our son, however we had to wait for more than 4 hours to talk to a doctor, and yet nothing happened, we just kept waiting. Eventually we gave up and went home".

Even though they were disappointed by the amount of time they had to wait in order to be treated, some of the refugees explained it as relating to the deficit of health care professionals practicing in the system.

In addition, the participating refugees also recalled certain practices of care, which they recognized as unacceptable, and rendered them mistrusting the health care system and the practicing providers. The refugees found the quality of care that was offered and made available to them to be shockingly low.

Recently I was very ill and went to see a doctor and I was told that I had an infection, yet the doctor didn't carry out an assessment, or didn't bother to look for the cause, he just wrote me a prescription and discharged me.

The complicated referral system was also described by the participating refugees as a challenge to easy access to care. The requirement to be referred by a primary health care center and sign multiple forms in order to be able to access the hospital was very confusing for many refugees.

Back home we used to directly receive our treatment. Here you have to go to the clinical and be examined by the doctor then sign referral forms. Then you'll have to go to the hospital and be examined by another physician and check your papers and then be referred to a specialist which is not easy to find available. So you will have to wait.

3.4 Cognitive barriers

Furthermore, the results of this study showed that the cognitive barriers were the least to be described or highlighted upon by the participating Syrian refugees. The multitude of refugees who were interviewed reported a lack of information regarding the available facilities, structures and process of the system, how to use the system, and procedures of care, which was recognized as challenges to access and usage of available health care services. Various refugees found it to be very challenging to comprehend some procedures of care, and found that the practicing personnel did not care about clarifying certain concepts. A female refugee reported that the nurse at one of the hospital in Beirut did not even educate her about the tests and procedures she was running which caused hear fear and anxiety about her hospitalization.

> *One time I was pregnant and I went to my checkup appointment, the nurse was running a fetus monitoring to check the baby's heart. Yet, she did not even talk to me she did not even say hi all she did was strap me to the machine and write on the paper. I asked about an explanation but she did not respond.*

The results has also shown that the variations in culture between Syria and Lebanon has created confusion and frustration in delivering and receiving and most importantly accessing health care services and medical attention, where the refugees recognized certain health care practices as being culturally and morally inappropriate for them to go through.

> *When I go to an appointment for checkup or treatment, I get very uncomfortable to undress in front of a male doctor. My culture prohibits me from undressing in front of a male so I make sure to have a female doctor and if I could not access I wait until I can.*

Finally, the results showed that the participating refugees had a sense of perceived discrimination as with regards to their status of being refugees, and it was the highest reported cognitive barrier. The high rate may be due to real discrimination or merely a misconception. Many refugees reported that they were treated unequally or were insulted verbally while they were being hospitalized or cared for.

> *I avoid going to the local clinic or hospital, as I would have to hear insulting words and be treated in a very bad way*

4. INTRODUCTION

Other studies also have supported our results, where a qualitative study highlighted the health care personnel's point of view regarding access to care showed that refugees had displayed barriers in language and interpretation, differences in culture, health care coverage, and availability of services, isolation, poverty, and poor transport (McKeary , Newbold, 2010). Another qualitative study has shown that refugees and specifically Syrian mothers have faced a lot of challenges to access health care, and this study identified mainly income level, lack of knowledge about services, and feelings of being judged as a refugee as barriers to care (Wahoush, 2009). In line with our results, this study showed that one third of Syrian mothers witnessed or were the object of discrimination in the health-care system ((Wahoush, 2009). Moreover, in an analysis report, refugees were found to face discrimination and stigmatization, and logistical concerns were additional barriers to refugees' access to health care services (Szajna, 2015), which is consistent with the results of our study. The augmenting load of work due to the peaking influx of refugees put the practicing workforce under pressure and might lead to discrimination, especially in the case of prioritizing Syrian refugees over vulnerable Lebanese, which makes the health care work force susceptible to hostility towards refugees due to the negative impact of the heavy influx on the Lebanese economy. Various other publications report that the public health care sector in Lebanon to be overburdened and with the stress of Syrian refugees using the system, it is being even more excessively overstretched. Evaluations of the past years have proven that the governmental health care facilities to lack the proper equipment, machinery and human resources to satisfy the demand on the system, which might cause structural barriers that, have been identified by the refugee such as long waiting time and late appointment dates (UNHCR, 2016). Yet, this was in contrary to reports by our respondents, the majority of who did not see any

lack of equipment or specialist physicians as barriers. Therefore, this discrepancy needs more evaluation in order to identify the actual gap and reach the root cause of these barriers.

5. CONCLUSION AND RECOMMANDATIONS

The purpose of this research paper was to recognize the challenges and barriers that Syrian refugees residing in Beirut, Lebanon are facing in their endeavors to access adequate health care services. This study has shown that these refugees have high needs for health care services and mainly for control of chronic conditions. However, there were negligible requests for mental health services which can be explained by the lack of knowledge regarding mental illness and stigmatization of accessing mental health facilities. In addition, the study showed that the refugees found that secondary and tertiary care even more inaccessible in comparison with primary health care, and have highlighted the complexity of the system processes which they had to suffer, from complex referral procedures to long waiting times in order to gain access to the care they need. Most importantly, Syrian refugees recognized three types of barriers, which are summarized as financial, structural, and cognitive. The participants in this study found that accessing health care is very costly, especially services that are not covered by the government or third party payers such as dental care and medications. They also reported structural difficulties, which hindered them from obtaining the needed medical attention such as long distances and difficulty of transportation, long waits at the facilities as well as a very complicated referral system, which made it almost impossible for them to acquire services of good quality, as the overburden health care system in Lebanon could not satisfy the growing need for services, supplies and facilities. As for cognitive barriers, the Syrian refugees reported perceived discrimination, which made them uncomfortable and unwilling to seek medical help when needed in order not to be put in position of humiliation.

This study recommends more research to be conducted with larger representative samples in order to recognize the gaps in the health care system and work on overcoming the barriers to access thus contributing in improving the quality of life of refugees in Lebanon. The research should also aim at studying the poor living conditions that these Syrian refugees are living in, and target these populations with relevant preventative interventions in order to help reduce their illness rates and thus reduce the strain on the already overstretched health care system.

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