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An Integrated Approach to Syrian Refugees' Health Care in Lebanon

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Abstract: The purpose of this paper is to learn from the integrated health care approach for the Syrian Armenian refugees by the HKCC (Howard Karagheusian Commemorative Corporation) in Burj Hammoud in Lebanon from the perspective of the beneficiaries themselves, i.e. the Syrian Armenian refugees. One hundred families who had been residing in Burj Hammoud and who had been regularly benefiting from the health services of the HKCC for at least one year were interviewed. The interviewees used a semi-structured questionnaire. Data were analyzed and emerging themes were mapped. The Syrian Armenian refugees who participated in this study generally expressed their satisfaction with the equitable access afforded by the HKCC's integrated health care approach. There were several reasons why the HKCC's integrated approach to serve refugees and the local population on equal footing was given positive reviews by the sampled refugees. Based on the responses of the refugees, these reasons are mainly (a) the convenient location of the center, which is walking distance for most refugees; (b) the ability of the treating doctors to communicate with the refugees in Armenian, which facilitates diagnosis and understanding of the health problems; (c) suitable opening hours; (d) friendly staff; and (e) thorough doctors. The results do not statistically represent the overall refugee population that is served by the HKCC; due to the study's limited demographic scope, the results cannot be generalized. This limitation was due to lack of funding to cover the whole beneficiary Syrian Armenian refugee population. The HKCC's approach has helped in providing access to treatment and preventive measures to a refugee population that was in need of it; as a consequence, it may have improved the health outcomes of this refugee population, especially in regard to the immunization of children. An integrated approach to healthcare which provides "equal ability by refugees and host nationals to access the same healthcare resources from the same providers" seemed to have been successful in the case of the HKCC. This paper provided first exploration of an integrated health approach for refugee healthcare provision in Lebanon.

Key words: Syrian refugees, Armenian, integrated health services, Burj Hammoud, Lebanon.

1. Introduction

The Syrian crisis, which began in March 2011, has brought about the displacement and forced migration of around eight million Syrians. Half of the affected population (4,052,011) has crossed the borders to neighboring countries where they were registered as refugees with the UNHCR. According to the latter, "this figure includes 2.1 million Syrians registered by UNHCR in Egypt, Iraq, Jordan and Lebanon, 1.9 million Syrians registered by the Government of Turkey, as well as more than 26,700 Syrian refugees registered in North Africa." [1]

According to a UNHCR-released map dated September 30, 2015, the number of Syrian refugees who have registered with it in Lebanon is 1,113,941. A similar UNHCR map released on May 31, 2015 indicates that the total number of Syrian refugees in Lebanon stood at 1,192,342; this means that 78,401 refugees were in Lebanon awaiting registration. The Lebanese government has asked the UNHCR to suspend registration of Syrian refugees as of May 6, 2015 [2], following government estimates that the total number of refugees would approach 1.6 million [3]. It was only in early 2015 that Lebanon placed restrictions on the entry of Syrian refugees, after four years of maintaining open-border and "non

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refoulement" policies. On October 21, 2014, Lebanese Minister for Social Affairs Rashid Derbas "announced that Lebanon would not accept any more refugees from Syria. [...] the border would remain open to 'emergency cases' and Syrian nationals travelling for purposes other than seeking refuge" [3]. The reason behind the decision is that Lebanon had reached its capacity for hosting refugees [3].

Syrian refugees can be found in every city, town, and village in Lebanon, living with family or friends or in rented residences, rooms, and ITSs (informal tented settlements).

Lebanon's open-border and "non-refoulement" policies resulted in its receiving an overwhelming number of the displaced Syrian population, which adversely impacted the country in every aspect. U.N. Secretary-General Ban Ki-moon stated in September 2014 that "Lebanon hosts the highest ratio per capita of refugees in the world," and that Lebanon has received "far less assistance than it needs" [4] to cope with this heavy burden.

The U.N. Secretary-General added that, "As long as the region is aflame and the war in Syria continues, the rights and safety of refugees in Lebanon must be respected in accordance with international humanitarian norms. But the strains on Lebanon will remain immense and the burden it is bearing must be shared." [4]. Even if a negotiated peace is achieved in Syria in the near future, many refugees may choose not to return out of fear for their personal safety or because they have lost their homes.

The Syrian crisis and the refugee influxes have placed political, security, economic, demographic, and social constraints on Lebanon. One of the most costly and important constraints is the health bill that Lebanon is paying to care for the Syrian refugees. According to the 2014 Syria Regional Response Plan (RRP6) Annual Report, "health services in Lebanon [are] characterized by a dominant private sector and high costs for patients," and "RRP6 partners supported health care for Syrian refugees by subsidizing primary health care and hospital admissions during 2014" [5]. The limited capacity and financial resources of the public sector have led the Lebanese to use private sources and out-of-pocket payments to care for their health. According to a Johns Hopkins/MDM/ IMC/AUB report published in July 2015, "The high out-of-pocket expenditures for households, in particular large and unanticipated payments for secondary care and hospitalizations, can be catastrophic for vulnerable refugee and Lebanese households that have limited incomes and savings and struggle to meet basic needs" [6].

Although Syrian refugees have access to basic health care services through the public sector institutions, these institutions are already strained to meet the needs of the Lebanese population, let alone to accommodate the needs of the mounting number of Syrian refugees. The demand by the Syrian refugees for care, particularly in surgery, maternal health, chronic diseases, trauma care, and the like, has exhausted the health care system in Lebanon, leading to an increase in the vulnerability of both the disadvantaged Lebanese and the Syrian refugees.

The UNHCR has been coordinating secondary health care services through its local partners (e.g., Caritas, Makhzoumi Foundation, Howard Karagheusian Commemorative Corporation) and international partners (e.g., International Medical Corps, Red Cross, International Rescue Committee, and Save the Children).

The HKCC[1] which is working with the UNHCR to provide health care to Syrian refugees in Burj Hammoud, was already serving the local community of the borough prior to the Syrian refugee influx. What the HKCC did was somewhat innovative, in the sense that they integrated the health care services needed by the Syrian refugees with their services to the local community.

[1] For further information about HKCC, please see http://www.hkcc.org.lb/.

This innovative approach is the topic of this report. The importance of our research project which yielded this report is that it presents a model for integrated health care and will allow specific and more general lessons to be learned, and conclusions to be drawn about the integrated health care approach for refugees and host populations.

Among the Syrian refugees who fled the fighting in Syria were the Armenian Syrians from Aleppo, who settled mainly in Burj Hammoud, an area mainly populated with Armenian-speaking Lebanese and characterized by a moderately poor population. By settling in Burj Hammoud, the Armenian Syrian refugees relied on the support of their co-ethnic host community and on the local NGOs (non-governmental organizations) for social and medical care.

According to Anais Tuepker and Chunhuei Chi, "A defining element of an integrated approach is an equal ability by refugee and host nationals to access the same healthcare resources from the same providers." [7]

In conducting our study, we evaluated the integrated health care of the HKCC by using one of the criteria provided by Tuepker and Chi,[2] namely increased equitable use of health care resources.

One of the main care givers is the Howard Karagheusian Commemorative Corporation, which devised an integrative approach to medical care for refugees. In 2012, the HKCC established the Emergency Relief Aid for Syrian Armenian Displaced Families to further assist this co-ethnic population.

2. Methods

The survey was carried out from April 27 to May 27, 2015. One hundred Syrian Armenian families (437 members), who had been residing in Burj Hammoud and who had been regularly benefiting from the health services of the HKCC for at least one year, were interviewed.

To identify the suitable size for the survey, we randomly selected the 100 families from a pool of 2,100 families that fit the criteria set above and who were eligible to take the questionnaire. The randomly selected families' home addresses were given to the surveyors, who were familiar with Burj Hammoud's layout, fluent in both Arabic and Armenian, and were acquainted with this population through their work as social assistants in the district.

Families were first contacted over the telephone and sometimes in person to arrange for a convenient day and time when the head of the family would be present to answer the questions of the survey. Families that were not available for the interview were replaced from the pool of families who were originally eligible to take part in this survey.

The questionnaire was designed with the purpose of collecting information addressing the equal ability by refugees to access the same health care resources as host nationals, and from the same provider, in this case the HKCC. The questionnaire encompassed basic demographic characteristics including age, gender, education, some details concerning their shelter and housing, and date of arrival in Lebanon, as well as questions related to their own health, including types of chronic diseases, children's immunization, medicine needed, frequency of visits to medical doctors at the HKCC, type of doctors sought, and fees paid. There were also questions related to employment, income, and expenditures related to health care. Other questions included registration with UNHCR, source of knowledge about HKCC, registration with HKCC, assessment of the HKCC health services received, difficulties faced in getting health care at HKCC, quality of services of the HKCC, satisfaction score, and suggestions to improve care by HKCC.

At the onset of the interview, each head of family was informed of the purpose of the survey as well as of the intention to use the information provided for

[2] The authors put forward a general model for evaluation of integrated health care with four criteria: (1) improved health outcomes for hosts and refugees, (2) increased social integration, (3) increased equitable use of health care resources, and (4) no undermining of protection. *Tuepker and Chi*, p. 1.

academic research. He/she was also notified that the survey was anonymous and that in order to continue with the interview his/her verbal consent was needed. Participants were notified that responding to the questionnaire would not affect their relationship with the center. Only those who agreed and gave their consent were interviewed; non-consenting family heads were not interviewed, and were replaced from the pool of families that was formed during the preparation phase of the research project.

Responses were tabulated on a Microsoft Excel spreadsheet and updated as new responses were received. The data were double-checked for accuracy.

3. Limitations

A design limitation lies in that we did not interview the host population to determine whether the HKCC's integrated health care approach has in any way affected the host population's access to services. Rather, we studied Syrian Armenian refugees who had registered with HKCC and who had benefited from its services for at least one year. The report generated from the answers provided by the interviewees makes available an analysis of perceptions of the themes covered in this study by the targeted refugees and in the location in which it was conducted.

The results do not statistically represent the overall refugee population that is served by the HKCC; due to the study's limited demographic scope, the results cannot be generalized. However, they may prove useful to institutions and organizations working in the field of refugees and health.

Some of the limitations of the study include:

- Despite randomization, Armenian Syrian refugee families who did not take part in this study may have different opinions about the integrated health care services of the HKCC from those who were interviewed; consequently the findings may not be generalizable to all the Armenian Syrian population served by HKCC.
- Though the purpose of the study was to gather hard facts about Armenian Syrian refugees' experiences with the HKCC, all the responses were of course based on the subjective perceptions of the refugees themselves.
- The reliance on household surveys as opposed to individual refugee interviews means that information is generally based on the opinions of heads of households, possibly to the detrimental representation of differing opinions from other family members.
- Some of the interviewees may have given answers perceived as "right" and "accepted" (both by themselves and by the interviewers) rather than saying what they really thought and felt.

4. Findings

4.1 Demographic Characteristics

A total of 100 households within the region of Burj Hammoud in Lebanon were interviewed. The dates of arrival in Lebanon varied from 2011 to 2015 with the majority or 54% arriving in 2012, 19% arriving in 2014, 18% in 2013, 5% in 2011, and 4% in 2015.

Sixty-three percent (63%) of the families had been residing in Burj Hammoud for more than two years, 15% for two years, 20% for one year, and 2% preferred not to answer this question.

Fifteen percent (15%) of the interviewed heads of households were female while an overwhelming 85% was male. These heads of households were of different age groups: 6% were 20-29 years old, 17% were above the age of 60, 30% were between 46 and 59, and 47% (the majority of the sample) were between 30 and 45 years old.

The marital status of the heads of households in question was divided into three main categories. The overwhelming majority of the respondents (87%) were married, while only 6% were unmarried and 7% were widows/widowers.

The total number of the persons residing in those 100 studied households was 437, of whom 28.2% were under the age of 14, 15.5% were between the ages of 15 and 29, 28.6% were between 30 and 45,

14.9% were between 45 and 59 and 12.8% were older than 60. Forty-nine percent (49%) of the household members were female and 51% male.

Average reported size of household was 4.37. Twenty-three percent (23%) of the households had six persons in residence, 17% had five persons, 33% had four persons, 23% had three persons, and 4% had two persons.

The heads of the households surveyed had different educational backgrounds but all were literate: 1% had a professional degree; another 1% had received a university education; 2% were uneducated/had not received any form of education; 5% had completed secondary education; 26% had received some primary education; 30% had completed primary education; 35% had partially completed their secondary education.

Across the sample, 100% of the heads of households spoke Armenian; 97% also spoke Arabic; 60% spoke Turkish, and 36% spoke English.

4.2 Shelter, Water, and Sanitation

Among households interviewed, 63% lived in apartments, 36% lived in houses, and a small percentage (1%) lived in rented rooms.

All the households had regular access to water. The main source of drinking water was the municipal water network (65%), bottled water (29%), water from protected wells (5%), and filtered water (1%).

All the households had regular access to a toilet or latrine.

5. Employment and Income

Employment is vital for the livelihood of refugees. Refugees need to supplement the aid they receive in order to sustain themselves. Despite the unfavorable economy in Lebanon, some refugees have managed to find alternative sources of income through employment.

Among households interviewed, 56% had one member who worked for pay, 34% had 2 members working for pay, 7% had 3 members, and 2% had 4 members. Only one household only did not have any members working for pay.

Minimum wage in Lebanon is set at $450 US Dollars per month. The survey found that the average monthly income per interviewed household ranged between $300 USD and $1,000 USD. Seven percent (7%) made $301-400 per month, 24% or the majority of the households earned $401-$500, 23% earned between $501 and $600, 8% netted $601-$700, 12% made between $701-$800, 12% grossed between $801-$1000, 7% earned more than $1000, and 7% did not know due to fluctuating earnings.

6. Registration with the UNHCR

Registering with the UNHCR as a refugee is vital if one is to receive protection, services, and settlement options. The UNHCR is the designated agency that protects, assists, and facilitates solutions for refugees and other people of concern by working together with the host government, the judiciary, other international agencies, NGOs, and the refugees themselves.

Furthermore, the UNHCR is mandated to register the Syrian refugees; to ensure a favorable, protected environment; to collect funds from international donors; to support the government in improving its ability to provide refugees with basic services; to provide for the shelter, health, and education of the refugees; and above all to find settlement outside the host country for the most vulnerable refugees [8].

Eighty-seven percent (87%) of the households interviewed were currently registered with the UNHCR, while 13% were not.

7. Knowledge about HKCC Health Services

The majority of families had heard of the HKCC through family members (89%), the rest heard about HKCC through multiple sources such as the UNHCR, the Church, other NGOs, the local municipality, and the schools.

The discovery of the HKCC by the refugee community does not date back beyond four years. Of

the households interviewed, the majority (31%) first heard of the HKCC two years ago; 29% heard of the center three years ago; 18% heard about HKCC one year ago; 21% of the sample heard about the center less than a year ago; and a mild 1% heard about the center four years ago.

8. Health Issues

Several different health conditions persuade the households in question to resort to the services of the HKCC. The predominant condition is heart disease, for the treatment of which 32% of the households currently rely on the center. The second-highest percentage among health conditions is hypertension at 18%, followed by diabetes at 15%. Other conditions for which the interviewed refugees sought treatment are COPD (chronic obstructive pulmonary disease), 10%; pediatric issues, 6%; physical injuries, 4%; and asthma, spinal disk, bronchitis, cancer, and ophthalmological issues at 3% each.

The type of doctor most families reported to have visited was the pediatrics (49% of families); general practitioner (42% of families); an obstetrician/gynecologist (28%); a cardiologist (24%); an endocrinologist (17%), the dentist, and the optometrist (16%) and (9%) respectively.

With regards to their health care primacies, medication ranked first among families' priorities (43% of families), dental care and health education ranked second (35% of families), immunizations ranked fourth (22% of families), followed by diagnostics (12% of families).

HKCC is sought after for children's immunization by members of the interviewed households, primarily vaccinations against polio (46%) and measles (24%). Vaccinations for "whatever needed" constituted 12% of questionnaire replies and administrations of Havrix constituted 9% and Varilix 9%.

Of the reason for seeking care in the previous month, the majority of the households (29%) stated that they sought medical assistance for chronic diseases. This was followed by 13% for pediatrics and checkups; 10% for reproductive health; 9% each for dental care; 9% for immunization; 7% for cardiovascular diseases, 4% for acute respiratory illness, and 3% each for urinary infections and ophthalmology.

9. Health Expenses

The majority of the households in question do not receive medicine from the HKCC. Those who receive medicine from the HKCC constitute 34% of the sample, while 35% said they do not, 26% said they receive medicine from the center "sometimes," and 5% did not respond.

Sixty-nine percent (69%) of the households within the sample ranked medication as the first expense, 46% ranked diagnostics/labs as the second expense, 10% put facility fees in the third place, 7% ranked equipment/supplies in the fourth place, and 6% ranked vaccinations as the fifth expense.

Moreover, in the area of paying nominal fees for medicine at the HKCC, 40% of the sample said they do; 29% of the sample said they do not and the remaining 26% of respondents said they do "sometimes." Five percent (5%) did not answer this question.

10. Rating Access to and Quality of HKCC Services

When asked to rate the access to medical doctors at the HKCC, the majority of the households were "mostly satisfied" (48%); 36% were "completely satisfied," while 8% and 6% responded that they were "somewhat satisfied" and "dissatisfied," respectively; 2% did not answer.

In assessing the quality of service of the center, the majority of the sample (82%) stated that the staff's positive attitude was a determining factor in the formation of their opinion. Moreover, 80% also cited "quality of care" as a contributing factor. This was followed by 79% who referred to the "non-discrimination" within the center and the 48%

who cited the ability of doctors to speak the Armenian language.

The majority of the sample (74%) also "strongly agreed" that they received equal access to medical services as Lebanese, while 21% stated that they "agreed" with this statement, 3% responded with "undecided," and 2% with "disagree".

Of the sample, 69% stated that they had access to the medical specialists they needed, while 67% stated that they were able to get medical care from the center when they needed it. Furthermore, 59% of the households within the sample agreed that they received enough information from the center in order to stay healthy.

In the areas of overall satisfaction, the majority of the households within the sample (88%) stated that they felt the doctor spent enough time with them. Also, 84% stated that the doctor treated them in a friendly and courteous manner, and 83% stated that the doctor was thorough in treating and examining them. Furthermore, 77% of the sample stated that the reason for medical tests or treatment was explained, and 74% of the households within the sample added that the hours that the clinic is open throughout the week are convenient.

11. Conclusions

Although this study has its limitations, it provides some evidence of positive outcomes of an integrated health care approach for the refugee population.

HKCC has initiated an integrated health care system to respond to the growing Syrian Armenian refugee population that has settled in Burj Hammoud—the center's own area of operation.

There are several reasons why the HKCC's integrated approach to serve refugees and the local population on equal footing was given positive reviews by the sampled refugees. Based on the responses of the refugees, these reasons are, among others:

- The convenient location of the center, which is walking distance for most refugees;
- The ability of the treating doctors to communicate with the refugees in Armenian who facilitates diagnosis and understanding of the health problems;
- Suitable opening hours;
- Friendly staff;
- Thorough doctors.

Kinship may have also played a role in the success of this approach. Although HKCC serves patients without any type of discrimination, whether by race, religion, nationality, sex, or the like; being an Armenian institution in the Armenian district of Burj Hammoud might have encouraged the Armenian Syrian refugees to frequent it, feeling more at ease among their kith and kin, their own co-ethnic group who speak their own language and have similar customs.

The fact that the host community and the refugee community were both Armenian facilitated easy incorporation of the HKCC's integrated health care approach from the perspective of social integration.

The HKCC's approach has helped in providing access to treatment and preventive measures to a refugee population that was in need of it; as a consequence, it may have improved the health outcomes of this refugee population, especially in regard to the immunization of children.

HKCC's approach uses health care resources and facilities in a more efficient and beneficial way.

More research is needed on integrated approaches to health care for host and refugees that go beyond the emergency phase to fill a gap in this neglected area in refugee literature, as Tuepker and Chi have articulated [7].

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