

Intersecting Vulnerabilities among Syrian refugees

Vulnerability is a word that is common in our humanitarian lexicon. The IFRC defines vulnerability as the “diminished capacity of an individual or group to anticipate, cope with, resist and recover from the impact of a natural or man-made hazard” (1).

The impact of the ongoing crisis in Syria is overwhelming: Currently 12.2 million people are in need of humanitarian assistance and protection (2). 3,980,623 Syrians have sought refuge in neighboring countries (3). Approximately 1 million individuals have been injured in this conflict (4), and after four years, there is still no end to the conflict in sight. Intersecting factors such as sex, age, disability, social and economic status contribute to and compound the effects of violence and discrimination (5).

In May, the UNHCR suspended new registration in Lebanon due to government request (3). There is no clarity as to when registration will be re-instated. Barriers to service-access are greater than ever among Syrians refugees in Lebanon as eligibility for services-such as health care services for acute and chronic conditions-is usually dependent on valid UNHCR registration.

This issue of the Equal Access Monitor seeks to highlight how certain vulnerabilities intersect with the existing challenges of injury, disability, old age and chronic disease. These factors create acute needs amongst Syrian refugees due to multiple vulnerabilities.



For further information please contact

Myroslava Tataryn
Handicap International
Regional Inclusion Adviser

+ 962 (0) 7 80555723 / + 961 76 40 89 72

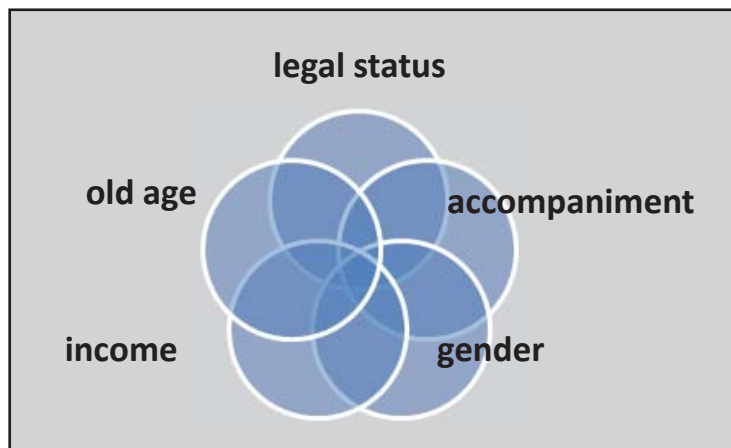
ta.region.inclusion@hi-emergency.org

Becky Achan
HelpAge International
Regional Age Technical Adviser

+962 (0) 7 86146990

becky.achan@helpage.org

The complexity of vulnerability factors that intersect with disability, injury & chronic disease



Legal status and access to healthcare:

Access to basic services for refugees in their country of asylum is tied to their registration status. Irregularity in legal status compounds the challenges of people with injuries and serious medical conditions. These people may be at risk of deportation instead of receiving the longer-term medical assistance necessary to fully stabilize their conditions.

Being an unaccompanied patient increases the vulnerability of those who are not registered. They have no caregiver that can assist them to sort out their legal status, or to care for them within their host country should a care facility not be available. Unaccompanied minors and other injured persons without proper identification documents are vulnerable to being returned to Syria (*refoulement*), with consequent interruption of necessary post-operative care and risk of further injury or death. Human Rights Watch reports that in mid-2014, Jordan began enforcing a requirement that every wounded person have a valid ID card. This has caused particular problems for children under 12 who do not carry individual ID cards, or Syrians whose documents had been destroyed as a result of the violence” (7).

In addition, unregistered refugees with chronic diseases do not have access to UNHCR-funded services or to public services in government facilities. This has created significant problems for older refugees (who make up 45.9% of registered Syrian refugees in the region (3)) as they experience a high incidence of chronic disease. For example, 81% of refugees surveyed in Jordan reported being diagnosed with hypertension (6).

Accompaniment of injured persons: Ostensibly the governments of Lebanon and Jordan allow injured persons to cross the border with a caregiver or, in the case of Lebanon, if family are identified in-country. However, our discussions with physiotherapists working in Jordan and Lebanon suggest this is not always the case. One particularly striking case we encountered was in a hospital on the outskirts of Zarqa, Jordan’s second largest city:

We interviewed Rama, a 32 year old woman, in the hospital where she was admitted 16 days ago and had been discharged 2 days before our interview. We met her in the hospital two days after her discharge as she had nowhere else to go. In December 2014, Rama’s house in Syria was hit by a rocket. The resulting explosion left her with shrapnel in her cervical spine causing paralysis.*

Immediately after her injury, Rama was sent to Jordan for treatment. She arrived at the border with her son and husband but she told us that neither one was allowed to cross with her. Over the past 6 months she has been in and out of residential care, first due to surgery, later due to inadequate follow-up care and pressure sores. Rama remains unable to move independently or transfer in and out of bed.

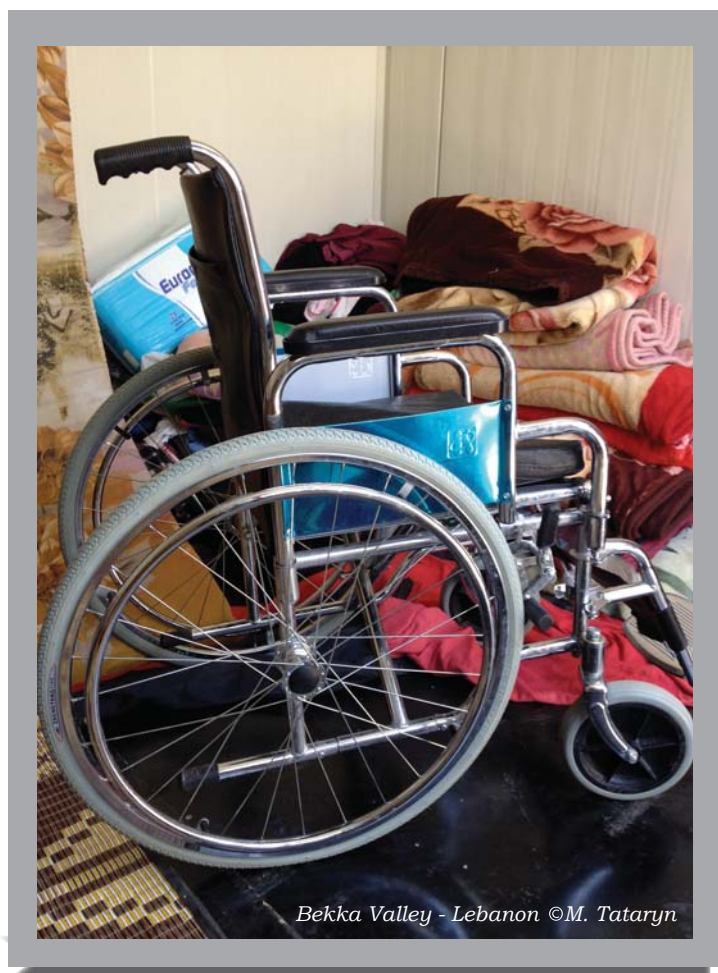
Rama says that since her arrival in Jordan her husband and children (4 daughters and 2 sons) have each tried to cross the border in order to join and support her, but not one of them has succeeded in entering Jordan.

In this case, thanks to multiple phone calls and advocacy Rama was accepted into one of the only longer-term care facility open to Syrian women in Jordan. Nevertheless, this acute situation highlights the lack of options for longer-term care for the unaccompanied injured and the importance of injured people crossing borders to be accompanied by a caregiver. An interview with a Syrian physiotherapist alleged that in 2014, after the closure of a Syrian-run care home in Amman by Jordanian authorities, 4 men with spinal cord injuries were required to return to Syria. There were no facilities able to care for them without a caregiver, and their family members were not able to cross the border.

Gender: In Jordan, where we have greater access to information about informal residential care facilities run by Syrians also known as “Syrian house care,” there are less long-term care-spaces available to injured women than there are for injured men. There are more injured men exiting Syria than injured women. Yet the needs of those injured women remain acute and need to be addressed in a culturally-sensitive manner which ensures their safety, privacy and dignity.

Being the head of a household as well as coping with injury, disability or other chronic health condition is a significant challenge in its own right. However, being a single woman heading a household as a refugee in a patriarchal cultural context exacerbates the challenge. 16% of the Syrian refugee households in Lebanon are led by women (8). During the course of our investigations we met several women heading up a household which included many other single women (widowed, divorced, unmarried, or with husbands remaining in Syria).

(Photo below) Some basic needs of an injured refugee requiring long-term care: diapers, bedding, a wheelchair with an appropriate cushion.



Bekka Valley - Lebanon ©M. Tataryn

In addition to physical health concerns, most of these women were also coping with mental health issues that arose due to the trauma induced by being separated from their husbands, witnessing the death of close family members, and struggling to survive and ensure the wellbeing of their children (and often an elderly mother, daughters-in-law and grandchildren as well).

(Photo right) This woman and her grandson are cared for by her daughter. She needs to consistently ask favours of her neighbours in order to meet basic subsistence needs; she shared with us her anxiety about her own vulnerability to sexual assault.



Income: Recent UNHCR statistics show that “almost half of the refugee population lives below the Lebanese poverty line of US \$ 4 per day, with a third at or under US \$ 2 – 3 per day and unable to meet basic needs. In Jordan...two-thirds of the refugees are now living below the poverty line and one in six are below the line of extreme poverty” (8). The average household size of Syrian refugees in Lebanon is 6.6 members with an older person in every fourth household. 7% of these households are headed by older people while 31% of Syrian refugee households have 5 or more dependents per single working individual (9).

Given that most refugees in Jordan and Lebanon do not have a right to work in their country of asylum, they have no means of responding to stressors or emergency costs themselves, apart from seeking humanitarian assistance, personal donations or loans. When informal work is available, whether legally or not, it is usually manual work for which older people and those with physical impairments cannot compete for.

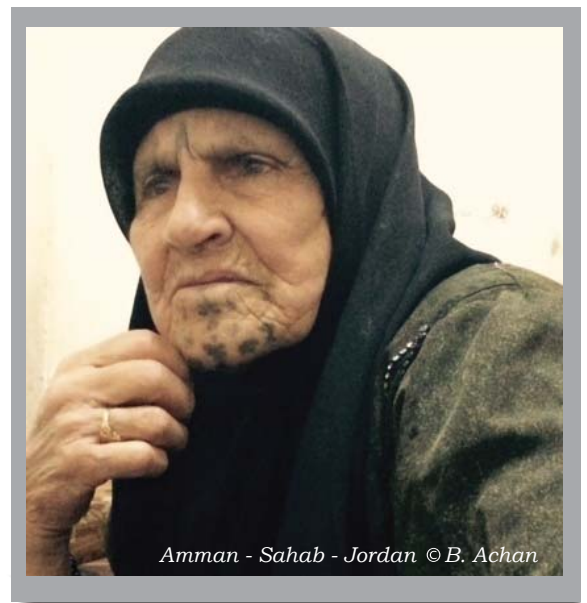
Another illustration of these multi-layered challenges is the story shared by a Palestinian refugee who came from Syria to Lebanon and recently lost her husband to heart disease when the treatment became too expensive:

Last year the UNHCR sponsored Sabah’s husband’s hospital admission to treat his cardiac condition. They covered 75% from the hospital fees the remaining 25% fell to the family and it amounted to \$500 which they covered through a combination of savings, gifts, and loans from family and friends. Each additional night in the hospital would cost them another \$250; therefore the family was obliged to discharge him. They were able to buy medication twice thanks to society donations and cash assistance from HI, although the third time they*

went into debt with the pharmacy. Three and half months ago his condition worsened and he needed to be re-admitted to hospital; but because they were not able to cover the costs, he was not admitted and died at home. He is survived by Sabah, her 73 year-old mother, and 5 children (4 of which are under the age of 17). The death has also contributed to a worsening of the mental health problems Sabah's children live with since witnessed the death of their aunt and uncle during a rocket attack in Syria.

Old age: Personal factors relating to aging such as reduced mobility and muscle strength, and impaired sight and hearing make it more difficult for older people to access services: such as health care, registration and distributions. The lack of sex, age and disability-disaggregated data contributes to persistent invisibility in humanitarian responses and leads to a lack of consultation and involvement of older persons in interventions (10). Vulnerability is often even further compounded when the single woman heading the household is elderly and living with chronic diseases and disability. For example:

Mouna is 80 years old and lives in Sahab, a rural area on the outskirts of Amman. She fled Syria in 2011 with her adult son and daughter. Mouna's son lost his wife due to the conflict in addition to sustaining an injury that resulted in the amputation of both his legs. He is now the single parent of his four teenage daughters. Mouna's second child, her 35 years old daughter, also lives in the same house. She is asthmatic but is nevertheless the sole provider of the household. She occasionally works as a cleaner earning 5 to 6JD in a day.*



Amman - Sahab - Jordan © B. Achan

The family lives in a one-bedroom rented house (75JD per month) which is dilapidated with no windows. They are also at risk of eviction due to rent arrears. The family has no assets other than an old television. Apart from 10JD per person per month from the WFP, Mouna's household is not receiving any other humanitarian assistance. Mouna's biggest challenge is covering food and medical costs. She was diagnosed with hypertension and reports needing to spend 11JD per month on medication.

Mouna's case demonstrates the multifaceted challenges older refugees face. In addition to their own struggles with ill-health and physical impairments, older persons also often become the primary caregivers of their children or grandchildren with injuries, disabilities or other serious medical conditions. These personal factors are compounded by barriers to access health, employment, education and other public services which are also tied to registration status.

Examples of mechanisms to address vulnerability

The Vulnerability Assessment Framework (VAF) in Jordan is one example of a mechanism established jointly by UN agencies, INGOs and donors to ensure that assistance is efficient and effective, targeting the most vulnerable areas and households (11). The VAF assesses and profiles different vulnerabilities within a refugee household, as well as its susceptibility to risk that could make the household extremely vulnerable in the near future. Launched in May 2015, organizations including the WFP, UNICEF and ACTED are currently using the VAF to target assistance provided to the Syrian refugees.

Referral mechanisms exist between humanitarian agencies to address the intersecting vulnerabilities among refugees. Case management forums have been established to manage individual cases. Different organizations take the lead for case management. For example, in Jordan's Zaatari camp, the lead case management agency is IRD. IRD manages referrals to different service providers within the camp based on needs assessed by its social workers; while the Age and Disability Taskforce in Zaatari camp is co-chaired by HI and UNHCR. In Lebanon's Bekaa valley, InterSOS play the primary referral role in protection cases, and refer cases to different agencies for psychosocial support, physiotherapy, and a variety of other support services available for identified vulnerable people. Yet, very acute cases of vulnerability are still falling through the cracks.

Remaining gaps

Protection: the acute socio-economic shortfalls of refugees—particularly those experiencing multiple vulnerabilities—place them at higher risk of entering situations of dependency and possible exploitation. In Lebanon where there are no official, government-sanctioned camps, there are countless examples of landlords, informal camp owners, and others in positions of relative power requesting sexual favors in lieu of rent. In return, food, protection, or other basic needs are granted that otherwise would be inaccessible for female refugees. Where the needs are greater—such as a single mother providing for a child with multiple disabilities needing 24 hour care, medical attention, diapers, special food—there may be particular pressure and threats from persons, such as landlords, who have control over her precarious situation. Our HI field staff has witnessed men with disabilities being targeted

for theft, and their wives being targeted with sexual abuse, specifically because they have disabilities. These men are being taunted as not being “real men.” There are currently no mechanisms for reporting or guarding against disability-specific or disability-motivated violence.

Legal status: Legal status is linked with protection. There is a need for formal and effective protection measures and resettlement policies so that highly vulnerable individuals are not sent back to an active war zone (principle of *non-refoulement*) but rather are given the protection and assistance they are entitled to (12). It is also crucial to work towards ensuring that injured persons and others with ongoing care-needs have access to asylum along with a caregiver and that they are protected from deportation. Resettlement criteria should take into account intersecting vulnerabilities and prioritize persons whose

basic health and protection needs cannot be met in the current country of asylum.

Free and accessible maternal and child health services: Jordan's public health care system is more accessible than Lebanon's system, which is privatized and based on user-fees (12). Nevertheless, in November 2014, Syrian refugees in Jordan were required to start paying user fees in public facilities at the same rate as un-insured Jordanians. Since then, a 40 JD fee is charged for an uncomplicated delivery (13). The fee for a caesarean section in a public hospital in Jordan is cited at 140 JD (13). Additionally, beneficiaries report that subsidized medication is often out of stock and must be purchased privately, at full cost. Vulnerable refugees who are in receipt of financial assistance are eligible for 100% coverage of hospital fees, however the UNHCR must be asked in advance for this coverage (14). The most vulnerable families we encountered are not even able to pay the cost of transportation to their nearest UNHCR office.

How many women are now delivering without skilled attendants and risking death due to possible complications in a country that has the infrastructure to provide safe childbirth with skilled attendants?

Acute as well as long-term care and rehabilitation: For people with neurologic conditions such as spinal cord injuries. The number of hospital beds open to Syrians with spinal cord and brain injuries are decreasing, in spite of these injuries continuing to be sustained as a result of the conflict. Moreover, many of these cases do manage to cross the border. Some care options exist in Jordan that are run by and for Syrians but the vast majority

have been deemed illegal under Jordanian law and thus have closed. The Jordanian government understandably must monitor and regulate health care facilities. However, these closures have left little care options for people who with spinal cord or brain injuries. The few hospitals with treatment capacity discharge quickly due to the shortage of beds and high demand, while these injuries require long term care. In Lebanon options are even more limited. Humanitarian organizations and their donors are hesitant to commit to long-term care, opting for the treatment of cases that report noticeable improvement. This calls into question the commitment of the humanitarian community to support those most seriously and permanently affected by the ongoing war in Syria.

Our teams further report declining care options for people with chronic diseases in Lebanon. Earlier this year, our teams were able to recommend people with chronic diseases for "fast-tracking" for international resettlement requests. However criteria have since changed. Chronic disease is no longer considered priority criteria for resettlement. Yet the availability of care in Lebanon for people with chronic diseases has not improved.

Livelihood / income: The restriction of refugees' access to livelihood and employment in both Lebanon and Jordan drastically reduce their ability to cope in protracted refugee situations. These restrictions furthermore negatively influence their resilience and ability to cope with unforeseen stresses such as illness, or other causes of medical expenditures such as pregnancy.

Conclusion

Given the decrease in bi-lateral and multi-lateral commitments to support responses to the ongoing crisis in Syria, it was expected that 2015 would be difficult for the humanitarian response in the countries surrounding Syria. Governments of hosting countries are reaching capacity and are tiring in their responses. This means that the refugees themselves, still unable to return to their home country due to ongoing (and even increasing) threat of violence, injury, and death, are exhausting their savings and their resilience. We can expect to see an increase of preventable deaths due to the most basic causes, such as complications encountered during childbirth unattended by a skilled attendant, untreated cardiovascular disease, and untold suffering of patients and families dying from terminal conditions – such as cancers – but with only intermittent access to basic palliative care.

Additional costs and restrictions to registration, normalization of legal status, and access to primary and maternal health services is another aspect of a worsening situation that is alarming for security, public health and protection reasons. Syrian refugees have become the “undesirables” of neighboring countries as well as of G8 countries. Host countries, donors and the recipient humanitarian agencies are about to become complicit in a worsening humanitarian disaster.



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** All names used are pseudonyms to protect the confidentiality of the people interviewed**

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