

# When Refugees Care for Refugees in Lebanon

Providing Contextually Appropriate Care from the Ground Up

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## Abstract

Despite a surge in initiatives to integrate foreign-trained physicians into local health systems and a drive to learn from localised humanitarian initiatives under the COVID-19 pandemic, we still know little about the on-the-ground strategies developed by refugee doctors to meet the needs of refugee patients. In Lebanon, displaced Syrian health professionals have mounted informal, local responses to care for displaced Syrian patients. Drawing on ethnographic work shadowing these healthcare providers across their medical and non-medical activities, we explore how clinical encounters characterised by shared histories of displacement can inform humanitarian medicine. Our findings shed light on the creation of breathing spaces in crises. In particular, our study reveals how displaced healthcare workers cope with uncertainty, documents how displaced healthcare workers expand the category of ‘appropriate care’ to take into account the economic and safety challenges faced by patients, and locates the category of ‘informality’ within a complex landscape of myriad actors in Lebanon. This research article shows that refugee-to-refugee healthcare is not restricted to improvised clinical encounters between ‘frontliners’ and ‘victims of war’. Rather, it is proactively enacted from the ground up to foster appropriate care relationships in the midst of violent, repeated, and protracted disruptions to systems of care.

## Keywords

Culturally-appropriate care, Refugees, Syria, Lebanon, Ethnography.

## Introduction

In a non-governmental organisation (NGO) office in the south of Beirut, a Syrian doctor reflects on some of the clinical decisions he and his colleagues routinely make when caring for Syrian refugees in Lebanon:

Syrian doctors try to prescribe limited numbers of X-rays and laboratory tests, because they know about refugees' problems. They know that most refugees don't have the money to pay for these tests. Lebanese doctors want to go through the guidelines, but sometimes we need to accept that these guidelines are made for people with [health] insurance or money, but not for vulnerable people (Informant interview, Lebanon, May 2018).

By laying bare the political and economic constraints shaping decisions on refugee-to-refugee care, this account touches on the complexity involved in providing appropriate health services to Syrian patients in Lebanon. The perspective offered by this clinician also speaks to the challenges faced by patients in the host community—financial barriers to medical tests are also a concern for growing numbers of poor Lebanese patients, some of whom used to seek more affordable tests across the border in Syria before the war. More generally, this account raises the question of what can be learnt from the relationship displaced Syrian healthcare workers build with displaced patients, to inform how to provide culturally appropriate care for refugees more widely.

For decades, the provision of health services for refugees in the Middle East has been negotiated at the intersection of national guidelines, international and humanitarian programmes, and the lived realities of forced displacement. Protracted conflicts and successive migration waves across the region have transformed how providers and patients experience healthcare services and clinical encounters (Dewachi, Rizk, and Singh 2018). Through our own fieldwork in Lebanon, a country in which refugees are estimated to represent 25% of the total population, we saw an illustration of these transformations through the response mounted by displaced trained health professionals to care for displaced patients.

How does sharing a history of forced displacement and common standards of healthcare translate into clinical encounters between Syrian doctors and patients? What lessons can be learnt from the refugee-to-refugee practices of care in humanitarian medicine? In this study, we draw on existing literature and our own ethnographic data on the experiences of displaced Syrian doctors caring for displaced Syrian patients in Lebanon. We argue that the creative solutions developed by Syrian care providers can help us to consider the importance of building relationships of empathy between carers and patients in humanitarian

settings. In particular, our findings highlight the following: (1) how displaced healthcare workers and patients share experiences of navigating uncertainty; (2) how displaced providers expand the category of 'appropriate care' to account for economic and legal challenges faced by patients; and, (3) how the category of 'informality' is located within a pluralistic landscape of myriad actors in Lebanon. In a context of chronic crisis, exploring relationships between displaced health providers and carers reveals the emergence of 'breathing spaces'. In these spaces, specific medical, economic, and political challenges attached to an imposed condition of 'refugeeness' are simultaneously recognised and transcended to foster mutual understanding between patients and providers.

### **Migration, health, and the localisation of aid**

Migrant healthcare professionals (including refugees) have been shaping health systems across borders for a long time (Monnais and Wright 2016). Particular focus has been directed at the barriers faced by refugee doctors trying to find formal employment in their host country (Piętka-Nykaza 2015), and on training opportunities to enhance refugee doctors' integration into health systems (Özdemir, Kickbusch, and Coşkun 2017). Accreditation processes and pathways to gaining licences to practise medicine for refugee doctors are among the many elements considered by health systems and medical boards in host countries (Wenzel 1999; Abbara et al. 2019). More recently, the COVID-19 pandemic has cast into the spotlight the presence of unlicensed, foreign-trained health workers in countries throughout the world, triggering debate on how to fast-track accreditation processes to support those countries' emergency responses (Taylor 2020; UNRIC 2020). There is undoubtedly growing consensus on the opportunities that come from integrating refugee healthcare workers into national health systems. Nevertheless, the discursive view of the refugee medical workforce as an 'untapped pool of resources' or a means to fill structural gaps is problematic and dismissive of the specific skill sets these providers can bring, particularly to the care of forcibly displaced patients (Batalova, Fix, and Fernandez-Peña 2021).

Interest in culturally appropriate care for refugees and asylum-seekers in high-income countries has also been rising (Knipper, Seeleman, and Essink 2010), recognising that immigrants are especially vulnerable to inequalities in access to healthcare. Special emphasis has been put on training healthcare workers in transcultural skills in these settings (Ekblad 2004; Coker 2004; Napier et al. 2017; Knipper, Akinci, and Soydan 2010). Much less consideration has been given to this kind of approach for refugee populations in spaces geographically and culturally closer to their home country. Moreover, little thought has been given to how to provide culturally appropriate care to people seeking refuge in regions where resources for systems of care are scarce and where services are provided by a diverse range of actors, networks, and institutions.

Both renewed impetus to make humanitarian aid ‘as local as possible and as international as necessary’<sup>1</sup> and the COVID-19 pandemic have revealed the leading role of local actors in driving responses on the ground—especially at a time when the direct involvement of international humanitarian actors has been constrained by pandemic lockdown measures. These convergent dynamics have sparked debate on the limits of a vertically coordinated humanitarian system overwhelmingly governed by Western actors, and on the opportunities presented by putting power into the hands of local actors—or more accurately, on valuing the power of local actors (Barbelet, Bryant, and Willitts-King 2020). Nevertheless, the role played by ‘local actors’ in humanitarian responses has sometimes been framed as a way to ‘gain access’ to populations when international responders are unable to reach them. This, too, is to overlook their specific sets of skills and expertise as well as the many risks they take to assist populations of concern in humanitarian crises (Duclos et al. 2019).

Telling the stories of refugee-to-refugee healthcare in Lebanon helps to shift the humanitarian approach from one driven by United Nations (UN) agencies, NGOs, and implementing partners that is ‘premised upon a provider–beneficiary relationship’ (Pincock, Betts, and Easton-Calabria 2020), to one driven by refugee-led networks (Duclos and Palmer 2020). That said, it is important to recognise that refugee-to-refugee responses are not situated outside the global humanitarian landscape and power dynamics shaping humanitarian partnerships (Barbelet 2018). In a recent contribution documenting or archiving the role played by Beddawi camp residents in Lebanon in locally and promptly responding to the public health and socio-economic threats of COVID-19, Elena Fiddian-Qasmiyeh (2020) sheds light on ‘refugee–refugee’ modes of solidarity. She argues that ‘In essence, we cannot understand either the vulnerabilities that people face in displacement or the responses they are developing without considering the ways that local experiences and responses are framed by national and international systems, including long-standing structural inequalities and processes of marginalization and exclusion’ (Fiddian-Qasmiyeh 2020, 33). A humanitarian frame inclusive of clinical encounters between refugee patients and physicians can provide a space to explore the role of social history, understood as a way to ‘deterritorialize the narrowed social body and situate biological suffering in the realm of economic, political, historical, and gendered injustice’ (Premkumar, Raad, and Haidar 2016). Intertwined conceptions of social justice and health provide lenses through which to link ‘the matter of the living (biological, whether as an irradiated or infected body) and the meaning of politics (citizenship, in terms of

1 Multiple humanitarian organisations committed to the recommendations made during the World Humanitarian Summit that took place in Istanbul in 2016 to enable local and national actors to play a more prominent role in humanitarian responses. See <https://charter4change.org/2016/12/16/as-local-as-possible-as-international-as-necessary-humanitarian-aid-internationals-position-on-localisation/>.

social as well as civil rights, since the migrants not only get access to medical protection but also obtain the freedom of movement, for instance)' (Fassin 2009). Accounting for clinical encounters between refugee patients and physicians can therefore expand our understanding of culturally appropriate care beyond a competence-based approach, to imagine one rooted in history, politics, health systems, and identities.

### **Locating refugee healthcare in histories of mobility, health systems, and protection**

Refugee movements from Syria to Lebanon are embedded in longer-term, cross-border migration processes taking place from the 1950s onwards. Consequently, Syrian migrants, working mainly in agriculture, construction, manufacture, and services, have contributed significantly to the Lebanese workforce for decades (Chalcraft 2009; Dorai 2018). The latest available figures indicate that 879,598 Syrian refugees are registered in the country (UNHCR 2020). How many unregistered Syrian refugees there are is not known.

Lebanon did not sign the 1951 Refugee Convention outlining the status of refugees nor the related 1967 Refugee Protocol;<sup>2</sup> and since 2014, national policy has been to restrict access to Lebanese territory and renewals of residency. Moreover, following its experience of hosting Palestinian refugee camps—considered as 'extraterritorial spaces' by the country's national authorities (Ramadan and Fregonese 2017)—the government decided not to set up any formal refugee camps for Syrians fleeing the war since 2011 (Sanyal 2017). The non-encampment policy was initially praised by some in the international community (Turner 2015). However, it is also viewed as increasing the vulnerability of Syrian refugees by 'producing spaces that are transient, flexible, and marginal', in the form of informal settlements (Sanyal 2017, 118). This vulnerability was exacerbated following Lebanon's introduction of visa-entry requirements (Janmyr and Mourad 2018), and the decision of the United Nations High Commissioner for Refugees (UNHCR) to suspend the registration of new arrivals since 2015 (Janmyr 2018).

Refugees seeking healthcare in Lebanon must navigate privatised social and health services: 'The welfare regime is highly fragmented and relatively unregulated, providing ample opportunities for sectarian organisations to supply social service and to take credit for the public benefits' (Cammett 2011). Accessing healthcare services requires either the user to pay fees or insurance cover. The UNHCR subsidises Syrian patients' access to a network of primary healthcare centres run by the Lebanese Ministry of Public Health or by partner organisations, and partially funds access to secondary care mainly provided by private hospitals.

2 See the 1951 Convention and 1967 Protocol here: <https://www.unhcr.org/uk/about-us/background/4ec262df9/1951-convention-relating-status-refugees-its-1967-protocol.html>.

Nevertheless, for all refugees, high out-of-pocket payments required for transportation fees, drugs, and health services constitute a significant barrier to healthcare. Moreover, those with no registration and no residency status are more likely to limit their movements—including visits to hospital and health centres—to avoid controls at checkpoints (Nabulsi et al. 2020).

In an in-depth ethnographic study documenting how Syrian and Palestinian patients from Syria negotiate access to health in Lebanon, Parkinson and Behrouzan (2015) revealed the complexity of therapeutic itineraries in the context of a privatised health system, and pre-existing migration flows. Importantly, their findings illustrate the agency of refugees (registered or otherwise) in negotiating healthcare and making decisions under a complex humanitarian arrangement, using social networks and information as social capital and safety nets to cope with their displacement (Parkinson and Behrouzan 2015). Even so, the agency of refugees remains highly 'bounded' (Mendelsohn et al. 2014). For Syrian refugees, this typically means that they face many social, environmental, and structural barriers to healthcare. It is within this context, and within a health system fragmented by an extra layer created by the humanitarian system (Blanchet, Fouad, and Pherali 2016), that displaced, Syrian-trained health professionals have mounted their own local response to care for displaced Syrian patients.

Syrian doctors primarily work informally, from the perspective of Lebanese authorities. Here, 'informality' usually refers to medical professionals who obtained their degree in Syria and are not legally registered to practise in Lebanon—because of their refugee status and their non-right to work—or to health workers whose education in Syria has been interrupted by the conflict (Ismail et al. 2018). If the emigration of qualified Syrian health workers seeking opportunities abroad had already started before the war, the systematic targeting of the health workforce in non-government-controlled areas in Syria has dramatically intensified their migration and emptied the Syrian health system of its own qualified health personnel (Ismail et al. 2018). Nevertheless, healthcare workers trained abroad face administrative and legal barriers that can prevent them from entering the formal Lebanese health system. Here, foreign-trained doctors require both their original diploma to be formally recognised and accreditation, the latter coming at a high cost (around US\$50,000) (Ismail et al. 2018). Accreditation also depends on how willing the countries involved are to grant it: the willingness of the original academic institution to recognise its validity, and therefore on the relationship between the countries of origin and of refuge; or the willingness of the host countries to acknowledge the original qualifications through their own accreditation programme (Handlos 2017). In Turkey, for instance, alternative accreditation mechanisms have been created. There, the Ministry of Public Health has introduced short courses and a mentoring system that gives Syrian health workers

accreditation to work in the Turkish healthcare system, providing health services to Syrian refugees in migrant health centres (Yıldırım, Komsuoğlu, and Özekmekçi 2019).

In Lebanon, in addition to accreditation barriers Syrian healthcare workers are further impeded by the country's labour laws which, since 2015, have become more and more restrictive. In spite of all this, Syrian professionals operate along a 'formal–informal' continuum rather than in a strictly informal space (Ismail et al. 2018). This is because most of them have formal medical degrees and practise in formal clinical settings (Honein-AbouHaidar et al. 2019), albeit under the name of Lebanese doctors, for example. They also mainly treat Syrian patients. At the time of our study, it was sometimes understood that the Lebanese authorities would tolerate unregistered Syrian health professionals working, as long as they dealt with Syrian patients only. Thus, the existence of these informal health networks, supported to some extent by certain Lebanese doctors, can be seen as a pragmatic way for the Lebanese government to bridge immediate gaps in Syrian refugees' geographical and financial access to health services without compromising its national health system in the longer term. However, growing numbers of deportations to Syria and added pressure to voluntarily return to their home country (especially since 2019) (Fakhoury and Ozkul 2019), have further exposed Syrian healthcare workers' fragile living and working conditions in Lebanon. Such actions have exacerbated their fear of being arrested or deported, or of the medical practice in which they work being shut down by the authorities.

## **Researching refugee-to-refugee healthcare in Lebanon**

### **Methodological approach and ethical considerations**

Our fieldwork essentially consisted of ethnographic work shadowing Lebanon-based Syrian health providers across their clinical and non-clinical activities. The first author of this article (DD) shadowed Syrian physicians practising in their clinics over several periods of fieldwork in 2017 and 2018. This entailed spending time in the health facilities and talking to the practitioners between consultations and in the break rooms, as well as conducting in-depth follow-up interviews with some of them.

Access to each of the study sites was negotiated with the individual healthcare providers, building initially on the second author's (FMF) personal and professional network and subsequently on new connections cultivated over the course of the study. In addition, Syrian healthcare workers facilitated our access to the coordination meetings of responders from various organisations involved in providing health services in Lebanon. Finally, we conducted interviews with

international and local workers whom we met during our field visits and who formed part of the humanitarian response to Syrian refugees in Lebanon.

By adopting this approach, the research team was able to iteratively investigate practices labelled as 'informal' by the national authorities in a way that was contextually appropriate and safe for the study participants. Focusing on the perspectives of the displaced healthcare providers themselves was key to unveiling the breadth of work Syrian clinicians perform, from medical encounters to advocacy. However, our limited interaction with patients is a shortcoming in the account of socially and culturally appropriate care constructed through this study. Given the scope of this research, we decided not to conduct interviews with Lebanese local and national authorities. Although this constitutes a further limitation of the study, we were conscious of the fact that in the sensitive political context at the time—which involved a national electoral campaign focusing largely on the presence of Syrian refugees in the country and, for some political parties, on the need for refugees to return to Syria—this study could have been exploited for electoral purposes. How we would disseminate our findings was also carefully considered in order to protect participants. The kind of information that could put them at risk was discussed during introductory conversations and as part of our consent-seeking processes prior to interviews. Finally, ethics approval for this study was granted by the LSHTM ethics committee in the UK and by the American University of Beirut institutional review board in Lebanon.

### **Study sites**

Ethnographic data for this study was generated across five clinical sites that we visited between 2017 and 2018. The first study site is a medical centre situated inside a refugee settlement in the Beqaa Valley and run by a Lebanese NGO. The clinic is served by both Syrian and Lebanese doctors who provide a wide range of services, for residents from the settlement in which the clinic is based and for patients coming from other refugee settlements and rented accommodation in the Central and the Western Beqaa. These services include general public health, paediatrics, dentistry, gynaecology, cardiovascular diseases, and gastrointestinal diseases, as well as orthopaedic surgery, physiotherapy, and a rehabilitation centre.

The second site is located in an urban setting in the north of Lebanon. In this clinic, which is supported by a global relief diaspora organisation, a Lebanese doctor 'hosts' Syrian doctors and nurses providing general surgical care to patients. The third study site is located in a southern city of Lebanon and is adjacent to a large public hospital. To reach the consultation room used by one of our study participants, one must enter the building through a private family clinic. Spread over two floors, this facility conveys the impression of a wealthy clinic offering a



wide range of services including plastic surgery, radiology and imaging. Higher up in the building, the floor where the informant we visited works is more modest. The waiting room and consultation room are shared by providers who take it in turns to see patients. At the time of our visits, patients were waiting for orthopaedic consultations.

Our fourth site is only a five-minute walk from the family clinic. In contrast, the entrance here is very discreet, almost difficult to find for someone visiting for the first time. This medical centre is run by a Lebanese NGO and hosts Syrian and Lebanese doctors offering health services predominantly to Syrians and Palestinians from Syria. These services include paediatrics, dentistry, orthopaedics, gynaecology, and fertility services. There is also a pharmacy on site. The Non-Communicable Diseases (NCD) clinic hosted in this facility was not operating when we visited because medicines, including commodities for kidney dialysis patients, were out of stock.

Finally, our fifth site is a primary healthcare centre in the east of the country, close to the Syrian border. This polyclinic is run by a Lebanese NGO in partnership with a Syrian diaspora medical organisation. Services available to refugees here include internal medicine, paediatrics, gynaecology, dentistry, echocardiography, mammography, orthopaedics, ophthalmology, and dermatology.

## **Assembling breathing spaces through the care of refugees**

‘When I entered the door and saw the Syrian doctors, I could breathe ...’

This comment, made by a Syrian patient we encountered in a waiting room in one of the clinics visited early in our fieldwork, resonated throughout the study. As our research proceeded, we were able to discern how certain clinical practices were associated with a sense of safety in the context of forced displacement, a sense of ‘feeling at ease’ in a foreign and sometimes hostile environment.

This article focuses on three particular thematic streams that emerged as essential when creating breathing spaces across refugee-to-refugee care relationships: the first concerns the strategies developed by healthcare providers and patients to cope with uncertainty; the second explores the notion of culturally appropriate healthcare in contexts of forced migration, looking at how providers adjust their medical practice to the day-to-day economic and legal challenges faced by patients; and the third highlights the connectiveness of ‘refugee-to-refugee’ models of care by exploring how Syrian doctor-led healthcare intersects with other health networks in Lebanon. Key elements to consider across these three themes are the multiple and complex experiences that refugees draw on to make decisions about

their health. These include refugees' previous encounters with health services as well as the personal histories of both refugee health personnel and refugee patients, histories that may enable empathy and mutual understanding.

### **Coping with uncertainty to seek and provide health services**

The clinic is bright and comfortable. I am greeted by a Lebanese provider, referred to as the 'host doctor' by the Syrian doctors and nurses to whom I am introduced. They all work informally under the name of the Lebanese doctor (...) Later, a Syrian family composed of two grandparents, their daughter, and granddaughter arrive at the clinic. They had been given the contact details of a Syrian orthopaedic doctor working here and have travelled 150 km seeking treatment for the little girl who has been diagnosed with a dislocated hip. The doctor they have come to see is not here, and they are asked to come back the following day. They do not know where to spend the night. Syrian doctors advise them on where to get help to find a place to stay (...). When I leave the clinic that day, a [Syrian] anaesthetist doctor leaves the building with me. He needs to visit the local authorities to renew the residencies of the Syrian clinical staff. On their cards, their occupation is given as 'driver', 'carpenter', etc. ... Writing 'doctor' would put them at risk of being checked by local authorities, and subsequently arrested as they are not allowed to practise medicine in Lebanon (Excerpt from DD's fieldnotes, 2017).

Examining the clinical encounter recounted in the ethnographic vignette above, we see patients being talked to, advised, and cared for by doctors working informally in Lebanon who are themselves in an extremely precarious situation. Most of them would not be able to gain or renew their residency if they were discovered practising as unregistered clinicians. Syrian healthcare providers are thus also stuck in uncertain ways of relating to the world, dependent as they are on negotiations with authorities and agreements with Lebanese doctors to provide for themselves and their relatives. Going through the experience of displacement, navigating bureaucratic obstacles to secure a fragile livelihood, and facing uncertainties in plans for their future all profoundly shape how displaced healthcare workers relate to patients in similar situations. This sense of common history between patients and providers does not erase the heterogeneity of backgrounds, journeys, and everyday reality in Lebanon. However, for a moment in this clinic, the 'otherness' characterising humanitarian spaces and medical encounters is dissolved.

Thinking through such interactions can teach us how 'to let go' of the power relationships defining humanitarian spaces that have been imagined, experienced, and contested over time (Bennett, Foley, and Pantuliano 2016), and to look instead at 'the everyday politics of aid' as dynamic processes (Hilhorst and Jansen 2010).

Such clinical encounters also encapsulate the importance of engaging with displaced patients in the context of their social lives: sending a patient ‘home’, 150 km away from the clinic, without having been examined by a doctor could be risky in the absence of any social support—in this case, in the form of advice on where to spend the night. Furthermore, this account of clinical care, poised on the border between formal and informal provision, demonstrates how international aid and national health systems create marginalisation, where both patients and providers bear risks when seeking and providing health services.

Previous studies have shown that seeking access to health services under protracted forced displacement is often repeatedly reconfigured over space and time according to personal and external circumstances. Usually they entail strenuous efforts to overcome bureaucracy and recurring encounters with systems that may be perceived as hostile (Parkinson and Behrouzan 2015). Here, the idea of uncertainty not only pertains to the impossibility of predicting one’s future; it also translates into everyday experiences of violence and the need to make decisions and take risks to cope with arising challenges. In other words, these uncertainties can be considered ‘as part of life rather than external to it’ (Horst and Grabska 2015; Bjertrup et al. 2018).

The instability surrounding their work was repeatedly raised in our discussions and interviews with unlicensed doctors. Such uncertainty was sometimes described as manageable, in the sense that the risk of being arrested was counter-balanced for some by the unlikeliness of it actually happening. In line with the findings of Honein-AbouHaidar and colleagues (2019), however, other Syrian providers did fear the consequences of being reported to the Lebanese authorities and mentioned stories of Syrian health workers having been arrested. In this vein, some participants saw failing to adopt a ‘low profile’ approach to providing healthcare, for example by putting ‘big signs’ outside one’s practice, as increasing the risk of being arrested. Uncertainty and insecurity also shaped how these providers talked about their future—including, for example, the need to advocate for temporary registration in order to practise in Lebanon or aspirations to return to Syria. This situation also affected their ability to build professional futures in Lebanon in the longer-term. One participant, who had not yet graduated, was planning to continue on to Germany where some close relatives had relocated and where she was hoping to finish her medical studies.

Finally, uncertainty and fear in Lebanon was also embedded in broader personal and collective narratives that included physical violence, threats, and insecurity experienced in war-torn Syria, as well as accounts of violence experienced by friends and colleagues in the health sector.

### **Adjusting care to meet the day-to-day challenges faced by refugee patients**

In the clinics in which Syrian physicians provide health services to Syrian refugees, certain knowledge and practices are shaped by their shared experiences of displacement. This deeply affects the relationship between carers and patients.

On one of our visits to a clinic in a refugee settlement in the Beqaa valley, a Syrian dentist and her assistant, a Syrian gynaecologist, a Syrian paediatrician, a Syrian orthopaedist, a Lebanese cardiologist, and two Syrian nurses were receiving Syrian patients from neighbouring settlements. Upon our arrival on the morning of what was our first visit to this clinic, the waiting room was full. While we waited for one informant in the waiting room, patients and their families struck up conversations and talked about their medical journeys in Lebanon. One patient admitted that it was easier for her to see a Syrian doctor because of the language: 'Doctors in Lebanon switch to French or English when it comes to medical terms,' she explained. Some Lebanese doctors are indeed medically trained in French and English, while Syrian doctors are trained exclusively in Arabic in their country.

The standard rate for a consultation at the time of the study was 5,000 LL (Lebanese pounds, about US\$3). Following their consultations, the doctors would sometimes write prescriptions for patients who could then buy the medicines in the pharmacy situated in the settlement; on other occasions, they orally referred patients to a Lebanese or Palestinian hospital, or to NGOs. In all cases, the Syrian health providers we spoke to recognised the need to adjust their vision of refugee health to suit the realities of their patients while still being able to generate an income for themselves. In Lebanon, this means deviating from national guidelines, negotiating special rates for medicines with local pharmacies on behalf of their patients, providing information on relevant health networks, and sometimes personally contacting colleagues on behalf of patients to enquire about treatment options and prices. For instance, if a doctor prescribes extensive lists of tests, including scans and laboratory tests, that turn out to be too expensive, patients are unlikely to take any of them. What is considered more appropriate in this situation is to prioritise the prescribed tests, negotiate more affordable prices for them, and then follow up with the patients. Despite this pragmatic approach, Syrian doctors do not accept that refugees should receive lower standards of care. On the contrary, Syrian healthcare workers across the range of health and humanitarian systems would at times advocate for better treatment for Syrian patients, for example by raising awareness of gaps in services for certain health conditions.

### **Relocating Syrian doctor-led healthcare within entangled health networks**

The first time I approached Dr A.—a Lebanon-based clinician, to arrange a meeting, he invited me to the Lebanese NGO where he was working (although not as a physician there). One day, Dr A. invited me to an emergency meeting

on dialysis treatment for Syrian refugees. It had emerged that some refugee patients were not receiving their treatment. At the start of the meeting, a UN staff member tried to assess the number of patients in need by drawing on NGO data. However, not all the NGOs at this coordination meeting had submitted data. Dr A.'s organisation had phoned round all hospitals in Lebanon and estimated that about 100 patients were not getting their treatment. Dialysis treatment costs the equivalent of more than US\$1,000 per month per patient (Karah et al. 2018), meaning that international funders are often reluctant to commit to supporting patients with chronic renal failure. For example, only a small number of patients have seen their treatment fully covered by the UNHCR; some international NGOs deal with dialysis patients on a case-by-case basis; Palestinians from Syria go to other organisations, through the United Nations Relief and Works Agency for Palestine Refugees (UNRWA); and other patients return to Syria for treatment. ... During a subsequent interview, one UN staff member reflected on the interactions during the meeting and concluded that, overall, Syrian doctors were 'more committed to the cause' (Excerpt from DD's fieldnotes, 2018).

The account above suggests that Syrian health workers, despite being labelled as working informally, are not totally excluded from the formal humanitarian response in Lebanon (sometimes working in non-clinical roles in local NGOs) or from the national health system (mainly through personal connections with Lebanese doctors). Additionally, it shows that not all Syrian health workers necessarily operate exclusively in a 'low-profile' mode: some actively participate in humanitarian health responses across a wide range of networks, advocating for resources and offering up their on-the-ground expertise. Their circumstances may not allow these physicians to 'put big signs' outside their practice or to frame and hang their medical diplomas in an office or consultation room. Nevertheless, reports containing their clinical expertise and knowledge of what is happening on the ground are channelled across the country's health networks. In addition, the case of patients returning to Syria to receive dialysis treatment urges us to consider the role played by the health systems in countries of origin when thinking about geographies of care in displacement; and to think about the implications of these cross-border strategies for the safety of patients, given that returning to Syria can be a reason for the UNHCR to de-register refugees and given that greater restriction on movement increasingly hinders such cross-border strategies (Janmyr 2018).

'Breathing spaces' created across and beyond refugee-to-refugee healthcare are an agile way of enabling patients' and healthcare workers' circumstances to be mutually understood and transcended—allowing the practice of care and humanitarianism to be adapted to their constrained and changing realities; and

allowing their stories of access to and gaps in medical treatment across health networks in Lebanon to be shared.

## **Social distance and the shared experiences of providers and patients in refugee healthcare**

The findings of this study confirm the role that ‘culture’—understood ‘as not only habits and beliefs about perceived wellbeing, but also political, economic, legal, ethical, and moral practices and values’ (Napier et al. 2014)—plays in shaping how people experience health across places and societies. Such experiences are not fixed; rather, they are dynamic processes influenced by a wide range of factors, including clinical encounters with health providers who are themselves inclined, through complex values systems, to specific practices.

In forced migration contexts, clinical encounters can be highly disruptive experiences for patients and providers. Refugees travelling from Syria carry familiar and intimate pictures of clinical care there that will be different from their experience of clinical care in Lebanon. How these differ and how refugees seek appropriate services away from home can inform the broader humanitarian sector. So too can providers’ experiences of navigating refugee governance regimes and how those experiences in turn influence how they treat patients. As argued by Premkumar and colleagues, ‘The medical response to humanitarian reason should begin at the level of a social history (...) expanded social history, combined with knowledge derived from the social sciences, can have significant clinical implications’ (Premkumar, Raad, and Haidar 2016). Examining such encounters can therefore teach us how to care for refugees in the context of their social histories (Malkki 1995). However, that shared experiences and assumed shared social norms necessarily enable clinicians to provide culturally appropriate forms of care should not be taken for granted. Nor is it necessarily the case that their experiences and assumed social norms are shared only by those with similar social histories. We also met Lebanese health providers at the clinical sites we visited: some of them reported that they were ‘hosting’ Syrian doctors in their practice, while others regularly visited some of the sites mentioned in this article to offer refugees specialised care such as cardiology or gynaecology. It is also common for Lebanese physicians treating refugee patients to help the latter navigate the Lebanese national healthcare system. This might entail, for example, personally facilitating referrals to other services or liaising with the UNHCR or with relevant NGOs. Interestingly, in all these scenarios these Lebanese doctors justified their involvement in terms of a sense of mutual solidarity, emphasising shared and cross-border experiences of war and displacement.

Encounters between displaced Syrian patients and healthcare providers arise through more or less institutionalised systems of care. In this sense, establishing connections between people in places in motion through clinical practice supports the idea of looking at migration beyond a narrow 'crisis' frame of reference. Healthcare is just one example of broader mechanisms and processes that may be developed on the move, to cope with displacement from home and to craft ways of belonging to collective values and practices. The communities of practice emerging from these processes transcend the sense of belonging to a lost public health system. Dewachi and colleagues have recently pointed to the need to go beyond technocratic frameworks of conflict and health to reclaim a political and historical analysis of conflict (Dewachi et al. 2018). Our study does not focus on how different actors might build political legitimacies by providing or destroying healthcare in conflict. It does, however, contribute to the (re)politicisation of these debates, by showing that clinical encounters in displacement shape the political demands of displaced doctors to give refugees appropriate care, including by negotiating their professional identities from the margins and by offering alternative spaces in which to provide that care.

Our findings also challenge how we define or value local health workers in crises settings. On the one hand, our study shows the agency of individuals and communities who creatively cope with displacement in order to either seek or provide care in a way that is acceptable and meaningful to them. This also reflects a certain humanitarian pragmatism in terms of using, or at least tolerating, whatever human resources are available in an overstretched public health system. On the other hand, such circumstances suggest that patients attending these clinics risk not receiving the highest standards of care, for example where referral systems rely on doctors' personal networks.

The role played by Syrian providers caring for Syrian patients in Lebanon, in many ways resonate with the position of Syrian health professionals in Syria. Syrian health professionals are highly involved in responding to the needs of Syrians affected by the violence of the conflict inside Syria and in neighbouring countries. Syrian clinicians practicing medicine in Lebanon risk being arrested and deported. Nevertheless, those same clinicians spoke of colleagues and friends who had died in Syria while caring for patients as well as instances of disappearances and imprisonment. The experiences of displaced Syrian healthcare workers in Lebanon cannot be separated from the deaths and imprisonment of their fellow workers in Syria. As anthropologist Clara Han states: 'Learning to listen to grief attunes us to the echoes of a death' (Han 2015, 507).

Informal cross-border health services both within and outside Syria have brought to light the 'humanitarian system' challenges of accessing humanitarian spaces,

while the need to rely on 'local actors' to save lives has risen to the top of the agenda (Duclos et al. 2019). In his work on humanitarianism as the politics of life, Didier Fassin shows how the hierarchies of lives—from the person who rescues to the person who is helped, or from international to national staff in organisations—are exposed in the unravelling of humanitarian interventions (Fassin 2010). Moving beyond the depiction of the 'local aid worker' as either subaltern or hero, we need to think about how humanitarian responses can simultaneously empower and protect displaced clinicians so that the humanitarian agenda of localisation does not institutionalise the structural inequality of lives but rather enhances the appropriate care available to patients.

Echoing the comment from the Syrian patient who declared that once she had entered the clinic 'she could breathe', our study suggests that contextually grounded and locally valued systems of care create 'breathing spaces' in which the constraints faced by refugees and their expectations are understood and integrated into healthcare. In a context of protracted displacement, where crises may become 'endemic' rather than 'episodic' (Vigh 2008), these alternative spaces of care are key to renegotiating one's identity across and beyond ascribed labels of being 'a refugee' or being 'unregistered'. Refugee-to-refugee healthcare captures a certain quest for connectedness, underscoring the idea that providing contextually appropriate care is not only technical competence but also, importantly, an emotionally charged social encounter. Interestingly, the presence of Lebanese doctors in the clinical sites we visited reveals both that these breathing spaces are not exclusively restricted to refugee-to-refugee clinical encounters, and that beyond their obvious divides host and displaced providers collaborate on the ground. Closer examination of the relationship between patients and providers in these spaces can provide a much-needed, on-the-ground perspective to inform longer-term strategies for improving the care of patients living in protracted displacement.

## **Conclusion**

Our article presents a particular 'ethnography of practice' that reflects the diversity of medical humanitarianism (Abramowitz and Panter-Brick 2015). We have shown how displaced Syrian health providers creatively cope with their professional situation by drawing on their skills, knowledge, experience, and relations to improve their livelihood in Lebanon. We have further described how they establish dynamic, informal networks of care that are responsive to the everyday constraints on and expectations of displaced Syrian patients. In particular, we suggest that taking into account the economic, safety, and political dimensions of health-seeking in situations of forced displacement can enrich the concept of culturally appropriate care by expanding the scope of 'cultural competence'—often



understood as cross-cultural communication skills—in providing health services for refugees in high-income countries. However, these clinical activities, while intersecting informally with other health networks, often unravel at the margins, increasing the vulnerability of both providers and patients. We have argued that a better understanding of such practices of care could be key to reframing discussions on the multiple roles that displaced healthcare workers play in crises, drawing on their unique skills and positionality as opposed to overwhelmingly valuing them as resources to ‘tap into’ when a crisis arises. Refugee-to-refugee healthcare is not restricted to improvised clinical encounters between ‘frontliners’ and ‘victims of war’; rather, it is proactively enacted from the ground up to foster appropriate care relationships in the midst of violent, repeated, and protracted disruptions of systems of care.

The ‘vernacular’ enactment of refugee care we have presented is a less visible form of humanitarianism than are, for instance, the larger-scale humanitarian medical interventions carried out by international organisations and widely publicised in the media (Brković 2017). Our accounts of care contribute to more critical examinations of ‘the local’ and/or the ‘localised’ that form part of current efforts to localise humanitarian action. The social embeddedness of the responses mounted by displaced Syrian doctors highlights the relevance of taking account of the contextual elements in clinical care. The lessons learnt from their experiences should not, however, be confined to their local context. Anthropology can play a critical role in documenting clinical encounters that take place in these liminal spaces of care. By exploring categories such as ‘the localised’, knowledge generated through refugee-to-refugee accounts of care can be de-provincialised, in turn informing more culturally appropriate, wider humanitarian programmes and refugee health services and policies.

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