The Syrian Refugee Crisis and the Lebanese Response

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Roughly 865,531 (194,331 households) Syrian refugees registered by the UN High Commissioner for Refugees (UNHCR) reside in Lebanon (UNHCR 2021). However, the Lebanese Government states that the country has the largest per capita population of Syrian refugees in the world estimating the number to be 1.5 million Syrian refugees. They are located in the north, center, and south regions of the country (UNHCR 2021). The refugees live in informal tent settlements or camps, deserted buildings, or cramped spaces either in community housing or the country's decades-old Palestinian camps (American Near East Refugee Aid 2021). This situation with the addition of the COVID-19 pandemic has put more burden on the country's already struggling economy, infrastructure and social systems (Abdallah 2020; American Near East Refugee Aid 2021).

According to the latest statistics Lebanon hosts 15.5 per cent of the total registered Syrian refugees in the MENA region (UNCHR 2021). This situation has created a need for Lebanon in all its components, 'governmental and non-governmental entities', to address and respond to the large influx of people and safety seekers. The official governmental response during the early stages of influx could be described as a response of no response. On the opposite side, several nongovernmental Organizations (NGOs) and international institutions took the lead in helping the Syrian refugees to fulfill their basic needs. As the situation developed and the conflict continued, forcing more people to flee, the responses of the Lebanese government and NGOs also changed. This chapter discusses the Lebanese response to the Syrian refugees' crisis from both governmental and non-governmental perspectives.

Lebanese Government Response

Lebanon has not signed the 1951Geneva convention and also does not have precise asylum laws (Lenner and Susanne 2016). Collaboration with the UNHCR has been based on a memorandum of understanding (MOU) (Lenner and Susanne 2016). There is a lack of an updated MOU regarding Syrian refugees in Lebanon, which means that the Lebanese government does not recognize UNHCR registration as a type of legal status (Janmyr 2016). Consequently, most Syrian refugees are unprotected legally and vulnerable to arrest as unauthorized immigrants (Janmyr 2016). In 2015, the Lebanese government directed UNHCR to temporarily suspend registration for both new guests and those already inside the country (Frangieh 2015). This led refugees to leave Lebanon (Lenner and Susanne 2016).

The Lebanese government was non-functional with weak state establishments; therefore, UNHCR has led the crisis response (Janmyr 2016). In 2014 the Lebanese administration issued new visa and residence regulations to replace its open-door policy and reassert itself (Frangieh 2015). The new laws made entry into Lebanon and the renewal of residence permissions extremely difficult (Frangieh 2015). Consequently, about half or more of the displaced Syrians in Lebanon are now considered to be without valid status documents (Frangieh 2015). This precarity greatly raises the vulnerability of refugees in Lebanon and blocks access to healthcare, education, and other services and limits mobility inside the country (Lenner and Susanne 2016).

Lebanon does not have official camps for Syrian refugees; nonetheless, new laws have strongly curtailed mobility in the country over the years (Lenner and Susanne 2016). The Lebanese government mostly gave the humanitarian response to various local and international organizations (Janmyr 2016). Due to security concerns, the government maintained a firm stance against building formal refugee camps for Syrians (Atallah and Mahdi 2017). The non-camp policy is also connected to demands for a readily available Syrian workforce (Lenner and Susanne 2016).

This disorganized management has led Syrians to mobilize their long- standing social relationships and work connections inside Lebanon (Lenner and Susanne 2016). Syrians live across the nation, mainly in the Bekaa Valley, the west/central region, and north Lebanon (Reliefweb 2017). Living conditions vary broadly, while some refugees live in informal tented settlements, others live in ruins, building shells and garages, and more than half rent an apartment or house. This flexibility of settlement and movement has become more limited. In 2014, a few cities imposed curfews, and during 2015–2016, numerous individuals lost their legal status documents and mobility (Frangieh 2015; Lenner and Susanne 2016); As a result, many now stay inside their living area, fearing being stopped at a checkpoint (Lenner and Susanne 2016).

The Lebanese healthcare system is largely private, and that fact has had a great impact on the Syrian refugee crisis (Parkinson and Behrouzan 2015). Private facilities as the American University Hospital provide excellent care; nevertheless, those facilities are accessible only with good insurance or extensive financial means (Parkinson and Behrouzan 2015). The Lebanese government has played a minimal role in building and managing healthcare (Batniji et al. 2014). Diverse providers control the health system, most of them connected to political parties who usually favor their supporters in health and social assistance (Batniji et al. 2014; Parkinson and Behrouzan 2015).

The Ministry of Public Health (MoPH), with the support of the World Health Organization (WHO) and the UNHCR, made a partnership with international and national NGOs to increase the accessibility of basic primary health care services (Blanchet, Fouad, and Pherali 2016; Truppa et al. 2019). Syrians registered with the UNHCR are given healthcare insurance; insurance covers

75 per cent of costs, and Syrians pay 25 per cent. Payment for the unsubsidized portion of care has imposed an additional burden on Syrians. While some poor refugees received financial aid from Islamic associations, others have gone into debt (Atallah and Mahdi 2013). Those who cannot pay have had their legal papers confiscated by hospitals, exposing them to detainment and deportation by Lebanese authorities (Parkinson & Behrouzan, 2015; Truppa et al. 2019). Syrian refugees have entered a fragmented, complex, and uncoordinated healthcare system that was already strained in Lebanon and has been put under additional pressure because of the abrupt influx of Syrian refugees (Blanchet et al. 2016). The system is informally discriminatory against non-citizens and many Lebanese citizens with limited financial resources (Blanchet et al. 2016; Parkinson & Behrouzan 2015). Therefore, Syrian refugees living in the North, the Bekaa Valley, Mount Lebanon, Beirut, and the South reportedly had trouble accessing healthcare (International Rescue Committee and Norwegian Refugee Council 2015).

In Lebanon, Syrian refugees encounter obstacles in accessing formal work opportunities and education (Lenner and Susanne 2016). The pledge for UNHCR-registered refugees work prohibition has led to full reliance on aid assistance. Limited access to formal work opportunities puts refugees at risk of being blocked from obtaining jobs or pushed towards informal and exploitative labor (Janmyr 2016). The Norwegian Refugee Council (NRC) field assessment (2014) proved that restricted legal status for Syrian refugees doubles the risk of abuse and exploitation, also diminishes their ability to seek redress and access justice (NRC 2014). Syrian nationals are exposed to the same risks in the sponsorship system, which builds upon Lebanon's sponsorship system for other migrants (Janmyr 2016). Under sponsorship, Syrian refugees can be subjected to state-sanctioned exploitation (Janmyr 2016). The sponsorship system was created to provide a legal relationship between employer and employee; however, this system has not improved legal or social security for Syrian employees (Lenner and Susanne 2016; Janmyr 2016). The sponsorship system has increased reliance on the employer, creating harsh work conditions due to fear of expulsion and deportation (Janmyr 2016; Lenner and Susanne 2016).

The Lebanese Ministry of Education and Higher Education (MEHE) is the only entity in charge of managing education in Lebanon and prohibits any handling or opening of schools by other entities, even NGOs. The MEHE

facilitated the access of Syrian refugees into the schools by mandating Syrian students to be enrolled irrespective of their legal status. Moreover, it mandated the waiving of school fees (Reliefweb 2013). The Ministry also introduced second shift classes to public schools for refugee students (Charles and Denman 2013). However, access to formal education came with many challenges for these refugees, including transport costs, bullying, verbal and physical abuse, and adapting to the language of instruction (Charles and Denman 2013; Mahfouz et al. 2020). These challenges, caused many of the Syrian refugees' students to drop out of school (El-Ghali, Ghalayini, and Ismail 2016; Mahfouz et al. 2020). With all its efforts the MEHE schools and the education system was not able to accommodate the large numbers of refugees due to cost burden and lack of capacity (Reliefweb 2013; Mahfouz et al. 2020).

Nongovernmental Organizations' Response

As the Syrian refugee crisis gained momentum in Lebanon over the years, several NGOs and international institutions took the lead in helping Syrian refugees to address their basic needs. This section presents how NGOs and international entities responded to this crisis. The complexity of the donors and sources of funding makes it hard to get a clear picture of the actual number of donors and total donations that has come to Lebanon related to the Syrian refugees' crisis. In the early phases of the Syrian refugee crisis, the Lebanese government authorized the UNHCR to take charge of the response (Anholt 2020).

One of the areas that donors worked on is to reduce the tension between the Syrian refugees and the host communities in Lebanon and assist local communities. For example, the UN-Development Program (UNDP) implemented a project called 'Support to Integrated Service Provision at the Local Level' (known as 4M) with the help of the European Decentralized Cooperation, to address issues in the health, social, and educational sectors. The project also supported the development of regional health services and plans with the aim of improving vulnerable local communities' access to excellent primary health care (Ministry of Public Health 2015). O'Driscoll (2018) reported on donors' response to the refugee crisis. According to that report the UNHCR has introduced a variety of community support initiatives in regions with high poverty and refugee populations, including new wells, community centers with water, sewage, and waste management systems, and enhanced medical facilities. Another form of the response funded by the EU is supporting a number of initiatives, attempting to enhance waste collection, water distribution, public health delivery, and community services, which have helped to reduce tensions between host and refugee populations to some extent. In addition, the Department for International Development funds were used by humanitarian organizations to support both refugees and Lebanese by implementing initiatives that include vaccination and food for livestock, work schemes for Lebanese and refugees, water and sewage infrastructure, repair, and school upgrades (O'Driscoll 2018).

The NGO response covered multiple areas including health care, education, food security, housing, and employment. The response for health care took many shapes and activities. The majority were to sport local communities and addition to the refugees. HelpAge International (HAI); AMEL Association International, Medical Teams International, and the Center for Public Health Practice at the American University of Beirut (AUB) implemented a program to improve primary healthcare services that are introduced for both Syrian refugees and Lebanese local host communities. This program targeted patients with Diabetes Miletus (DM) and Hypertension (HTN) for individuals older than 40 years. The interventions were carried out at six of AMEL's healthcare facilities: three Primary Health Centers and three Mobile Medical Units – situated in deprived areas in Lebanon: North Bekaa, West Bekaa, and Beirut suburbs. The interventions were divided into three components: 1) logistics and technical support Centers, which included supplying the facilities with essential technologies and tools such as blood pressure devices, glucometers, stethoscopes, weight/height scales, blood glucose test strips for managing and screening HTN and DM; 2) human resource development and the promotion of good practice through training the medical and pharmaceutical staff on HTN and DM management; and 3) improving patient knowledge by on-site patient educational and awareness-raising events.

In 2013, a Médecins Sans Frontières clinic was established as a nongovernmental primary healthcare center at *Shatila* Refugee Camp, south of the capital Beirut. It provided care for refugee patients and vulnerable host communities who suffer from non-communicable diseases such as DM, HTN and other cardiovascular diseases. Although this center allowed both host community and refugee patients to benefit from its program, this descriptive

cohort study showed that from 3,500 patients who visited the center at the end of 2017, 76 per cent of them were Syrian refugees and they were not only from the catchment area of Shatila, but they came also from other different areas (Kayali et al. 2019). The other major organization contributing to the health care response was the UNHCR. The agency primarily covered the costs of entering primary health care centers in Lebanon for registered Syrian refugees. However, the UNHCR has criteria of eligibility for health care coverage with a payment scale of $1,500 (Akik et al. 2019).

The NGOs response to other areas was provided in the form of cash assistance which covered education, food security, housing, and employment. The cash assistance program consisted of providing Syrian refugees with financial aid in the form of monthly multi-purpose cash assistance with unconditional cash transfers. This package provided each refugee with $27 per person to cover food needs and $173.50 per household to meet other basic needs, for an average of $332 per household per month (Bastagli et al. 2021).

The NGO sector considered a main source of support for the Lebanese government and public to handle the Syrian refugee crisis impact on the Lebanese Education System. The involvement of the NGOs in education assistance included offering alternative classes to school aged students within the public schools, fast-tracked learning curricula to facilitate refugee students' integration in the Lebanese system, and basic literacy and proficiency for children who have never been to school (El-Ghali, Ghalayini, and Ismail 2016). Another method NGOs followed to aid is opening schools for the Syrian refugees, but those often had to risk operating without accreditation and certification by the Ministry of Education and Higher Education which prohibited such activities as it is the only authority in charge of managing education in Lebanon (El-Ghali, Ghalayini, and Ismail 2016). Moreover, help to cover their fees and transportation costs was provided by the UNHCR and other NGOs (UNHCR 2013).

Food security is another sector in which NGOs have aided and responded to refugees' needs. This aid and response came in the shape of providing a monthly food card or multipurpose cash card by the World Food Bank and other international agencies (Medina 2020; Bastagli et al. 2021), food items and care-packages by individuals and private donors (Medina 2020). Over the years of the refugee crisis and the COVID-19 pandemic burden hit them hard and high percentage of them survive on less than $2.90 per day (Medina 2020). According to the Country Director of the UN World Food Program (WFP) the hardship of the pandemic that was added to the collapsed Lebanese economy has pushed many refugees to adopt coping strategies like reducing health expenses, borrowing money from acquaintances and relatives living abroad, or withdrawing children from school. In the words of the WFT Director, 'If they had been eating meat twice per month, now they would not eat meat even once and they skip meals'. The WFP also reported plans to deliver in-kind food parcels to the families of school students who were included in the WFP school snack program (Medina 2020).

In terms of the NGOs' response to the refugee employment, at the early stages of Syrians residing in Lebanon they were allowed to work until early 2015 based on the 1993 Lebanese-Syrian bilateral agreement for Economic and Social Cooperation (Errighi and Griesse 2016). Starting in 2015, the Lebanese authorities suspended all Syrians' work rights under mounting social unrest and problems with public services provision. Since these changes Syrians who were displaced to Lebanon were required to sign a pledge not to work in the country (UNHCR 2015). This resulted in them only sustaining their livelihoods through humanitarian assistance provided by the Lebanese government and NGOs (UNHCR 2015). However, in some cases Syrian refugees were able to obtain sponsorship and a work permit, but their legal status was changed to 'migrant workers'. Nevertheless, they were employed without permit with less pay, facing harmful working conditions, and exploitation (Rescue 2016). Also, it was reported that they were able to work in three restricted sectors, construction, agriculture, and cleaning services, because of Lebanese nationals' labor shortage in these sectors as these occupations do not match the income expectations and skills of the Lebanese labor force (Rescue 2016). In a report by the International Labor Organization (ILO) (ILO 2020), the COVID-19 crisis has resulted in a high number of permanent and temporary job lay-offs in Lebanon, particularly among informal workers, which Syrian refugees made the majority. Additionally, 60 per cent of the Syrian refugees were permanently laid-off and 31 per cent were temporarily laid-off (ILO 2020).

In conclusion, the Lebanese response can be described as complex, strategic at times, unresponsive at other times, with total reliance on international agencies and donors. The response covered multiple sectors including health care,

education, food security, housing, and employment. The economy and health care system were hard hit by the crisis. Moreover, the response appeared not to be strategically planned. It was also evident that the response appears to have been based on perceived short-term political imperatives, and the availability of donor funds.

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