

Syrian Refugee Health Problems caused by Host Country Policies

Kelsey Richard, Hanna LeBuhn, Madeline Dee, Rachel Neff and Michaela Sargent

More than 5 million people have escaped Syria in recent years; The ongoing conflict has created a complex environment for its members who have chosen to take refuge in other countries. The number of migrants seeking refuge elsewhere is far beyond what was anticipated. The conditions that Syrian refugees are exposed to while in camps have multifaceted effects on their health. According to Yamin, “we can easily overlook the social, political, economic, and cultural factors that shape the resources and barriers- the opportunity structures- that people have to take account of with respect to their health.” (Yamin, 2016, 73). These barriers, which are extremely prevalent in the lives of these refugees deny their access to basic health needs. Even with these barriers, all people have an equal right to access the highest attainable standard of physical and mental health, according to International Human Rights Standards. The lack of adequate resources available in these camps furthers the health issues that refugees experience from both a mental and physical point of view. The prolonged crisis is only furthering the demand for adequate services. The policies of differing host countries, such as Turkey and Jordan, determine many of the conditions of life for these marginalized people. Not only is mental illness extremely prevalent, but the factors that stem from such issues transcend into many quality issues of life.

Policies

Some countries, such as Turkey and Jordan, have historically been open and accepting of refugees, and the policies they create majorly determine the outcome of these groups of people. Although refugees may be considered a short-term consequence of war, they have become the norm in many countries. The overarching constitutional provisions, domestic legislation, and

general policies towards these refugees determines their ability to access certain resources and overall quality, or lack thereof, of life. Delving deeper into the layers of these policies allows one to examine the consequences created in the handling of these migrant people.

The flow of Syrian refugees into Turkey can be seen as early as 2011. According to United Nations estimates, Turkey's Syrian refugee population was more than 1.7 million as of March 2015 (Syria Regional Refugee Response). The initial inflow of people was met with an "open-door" policy and Turkish authorities set up tents in the provinces of Hatay, Kilis, Gaziantep, and Şanlıurfa. Although Syrian refugees were granted no legal rights, they were considered guests in the eyes of the Turkish officials. As the violence persisted, more than 20,000 Syrian refugees were beginning to arrive in Turkey monthly, with no sign of ceasing. By 2014, the number had increased to 40,000. Turkey did not anticipate such numbers entering the country or the prolonged state of conflict within Syria and consequently did not have the framework in place in order to handle the large influx of people. The violence that continued in Syria fueled the increasing amount of people fleeing and seeking refuge amongst thousands of others. The large influx of people led to the Foreigners and Internal Protection Act in 2014, as more than 500,000 refugees arrived in the following year. This act further outlined the policies regarding people who are forced to flee and in need of temporary protection.

The EU and Turkey began to construct ways in which to control and reduce the flow of refugees. They came to the Action Plan on November 29th, 2015 in which the EU committed to "re-energise Turkey's accession process by establishing structured and more frequent high level dialogue with Turkey and opening new negotiation chapters; b) accelerate the lifting of visa requirements for Turkish citizens in the Schengen zone by October 2016; and c) provide an initial three billion euros to improve the situation of Syrians in Turkey" (Ahmet, Evin, 2016).

The Turkish government began to grant work permits for refugees that had been in Turkey for more than six years. This work permit states that employers must apply on behalf of employees when residency, registration, and health requirements are met. The permit also states that Syrians, “cannot exceed 10 percent of the employed Turkish citizens in the same workplace” (Zanolli, 2016). As of 2016, only 0.2 percent of the Syrian refugee population has been granted work permits. In regard to health care, the Temporary Protection Regulation grants Syrians temporary protection in which they have the right to benefit from health services. These services are provided under the control of the Ministry of Health in partnership with the Disaster and Emergency Management Presidency. Refugees must be registered with Directorate General of Migration Management in order to receive these health services (Mehmet, 2016). Bodies such as the WHO are working to train refugee nurses and doctors and have set up six centers in the largely dense areas. While these services might be available to those who qualify, a large number of refugees are living outside of these largely dense areas and outside of the camps. With a majority living outside of the cities, they are unable to obtain the same services as those living in the center cities.

According to the Library of Congress, Jordan’s current refugee population is estimated to be 1.1 million. Despite the large number of refugees, Jordan has not signed the 1951 Refugee Convention and its 1967 Protocol which establishes refugees as “autonomous persons who are entitled to dignity and rights in exile” (Saliba, 2016). Those seeking refuge in Jordan are subject to Law No. 24 of 1973 concerning Residency and Foreigners’ Affairs, although Jordan does not recognize these refugees legally and refers to them as visitors. Jordan and the United Nations High Commissioner for Refugees (UNHCR) signed a memorandum of understanding (MOU) in which calls Jordan to respect the term refugee and the principle of non refoulement. This MOU

serves as the basis for legal framework in regard to refugees and although the legal framework is unclear; the UNHCR has granted Syrian refugees access to health, education, and other services.

Living Conditions

The aforementioned policies suggest that both Turkey and Jordan are making sincere efforts to accommodate the vast amounts of refugees that are entering their countries. Nonetheless, the conditions of living that they face are very poor. According to the WHO Commission's proposal, "National and local governments, in collaboration with civil society, ensure greater availability of quality housing and the provision of water, sanitation, electricity, and paved streets for all households regardless of ability to pay" (Chapman, 2011, 136). However, what happens when the people who need the services no longer have a government to call their own? Because Turkey and Jordan must care for their citizens and do not have the time or money to provide solely for refugees, these displaced peoples are left in the worst living conditions available as they cannot be prioritized by their host nations.

Refugees subsequently do not have access to resources that most people do because of their current situation and how the governments of their respective countries are handling their placement and care. Originally, conditions of life in Turkey were comfortable as Turkish policies were generous towards those they hosted and camp conditions were considered "more comfortable, standardized, and controlled than those in neighboring countries hosting Syrian refugees" (Indygo, 2015, 7). However, as refugees flooded Turkey and less state money proportionally was able to be spent on these visitors, conditions of camps became atrocious. Additionally, according to a recent Human Rights Watch report, over 400,000 Syrian refugee children in Turkey are not attending school ((McEwen, 2017, 15). Reports show that Turkish refugee camps fail to provide "basic human services such as clean water, emergency

medical services, and protection from dangers such as kidnappings” (McEwen, 2017, 23). The refugees housed in these camps not only have been run out of their own country, but cannot even feel safe in the place that they are temporarily living.

Additionally, in Turkey, many refugees are not able to fit into the camps and while they are accepted into the country, they are not housed in a camp. It is estimated that about 3 million people seeking asylum and refugees are left to find shelter on their own (McEwen, 2017, 23). This has led to many refugees living in Turkish cities. Multiple families are living in small apartments with almost no money, jobs, or opportunities. A report by the *Transatlantic Council on Migration* noted that “[m]any urban refugees struggle to access adequate housing and services; their lack of work authorization forces them to find employment in the informal economy, often in unacceptable conditions and for extremely low wages” (Indygo, 2015, 1). These people are unable to access services or jobs as they are not registered refugees as they would be if they lived in the initial camps set up in the early days. They cannot receive treatment for health issues and cannot afford to pay for treatment out of pocket. “By law, all registered refugees qualify for Turkish health care, education and, with a permit, the right to work. But these benefits and jobs are hard to find outside the major cities, where most Syrian refugees can’t afford to live, or in the smaller border towns, which have fewer social services.” (Inside, 2016) Therefore, these people are left to menial labor or under the table jobs off of which they are unable to support their families. While conditions of living for Syrian refugees in Turkey originally were welcoming, the more stringent policies recently have led to less registered refugees, less camps, and harsher conditions.

Jordanian government policies have also led to poor conditions for refugees. Jordan has only allotted a certain amount of money towards the health and lives of these displaced peoples

and they therefore have been left in poverty. According to a study done by the UN Refugee Agency, nine out of every ten registered refugees are defined as poor. One single mother who got to Amman, Jordan one year prior stated that “[m]e and my two sons are still wearing the same clothes we came to Jordan in’... She and her eldest son regularly skip meals to ensure her 10-year-old daughter and other son, who has a mental disability, have enough to eat” (Dunmore, 2015). This situation is not uncommon as increasing numbers of refugees are impoverished in large Jordanian cities. 71.9% of refugees in one study in Amman reported not having adequate funds to treat their chronic diseases (Gammoth, 2015, 8). Many refugees in Jordan are also in tents on their own rather than camps as a result of the lack of funds put towards housing refugees. For instance, one article reports “[d]wellings are makeshift and unable to withstand the increasingly harsh, cold weather conditions” (Rainey, 2014). There are no physicians in these “tent cities” besides the ones who come irregularly to do medical service trips. Diseases subsequently go untreated and basic primary care is virtually nonexistent, adding to the stress and danger of living in these communities.

One of these tent city refugee camps, Za’atari, houses over 150,000 refugees in tents that have now become near permanent homes for refugees. These people lack adequate food and shelter and CNN describes the camp as “a loud and dirty place. The sewers smell and the dust settles into people’s wrinkles. Crime remains a problem. Too many kids aren’t in school. There’s been an uptick in early marriages” (Dokupil, 2016). People of Syria went from living quiet, normal lives to being restricted to makeshift homes as they watch bombs drop in their home country. The stress of living in such a temporary and unpleasant environment is unbearable. One father states, “How can we have a normal life here? You can only leave the camp if you have permission... And if anyone gets sick we have to go and stand in a clinic for

hours” (Amar, 2015). Not only are they unable to escape this unsafe place, but they are also lacking in the critical medical attention that they need. Zaatari is just one example of a tent city in Jordan. These unsanitary and dangerous tent cities have become a necessary solution when the Jordanian government is unable and unwilling to allocate more funds to help these refugees.

The harsh living conditions endured by the displaced people of Syria in Turkey and Jordan are severe. They are unable to find adequate shelter, work, or food in the countries that they now live because of the policies towards them and lack of funds allocated to their care. The poverty, lack of access to healthcare, and lack of stable jobs are all social determinants of health. These determinants, according to the World Health Organization, “have a determining impact on whether a child can grow and develop to its full potential and live a flourishing life, or whether it's life will be blighted” (WHO, 3). These conditions, therefore, place added stress on the people and the lack of resources available to them negatively affects their lives.

Health Issues

Turkey:

There are a slew of illnesses and diseases, physical and mental, that stem from the poor living conditions Syrian refugees are forced into. The overcrowded camps and lack of sanitation provide a breeding ground for a host of communicable diseases. For example, cases of cutaneous leishmaniasis, a parasitic infection have been reported in Turkey. In general, however, the physical treatment has proved to be successful despite such poor conditions. An article in the *Avicenna Journal of Medicine* reports that “the health care services provided by the local Turkish authorities are in general adequate and appropriate, the available data and the direct observation generally indicate a satisfactory health condition in all the refugee camps over the period. There were no reported cases of measles, severe respiratory infections, severe diarrhea, malaria, or

tuberculosis at the visited sites” (Sahloul, Zaher, et al., 2012). While this is crucial in keeping large populations of people in good physical standing, there has not been sufficient care administered to those suffering from mental health issues, a prominent issue in this vulnerable population.

One study in a Turkish refugee camp found alarming statistics about Syrian children. “These children had experienced very high levels of trauma: 79 percent had experienced a death in the family; 60 percent had seen someone get kicked, shot at, or physically hurt; and 30 percent had themselves been kicked, shot at, or physically hurt.” These displaced children are exposed to extreme violence and turmoil at such a young age. Even though 45% of Syrian children displayed symptoms of PTSD (post traumatic stress disorder) there is a complete lack of mental health care in these camps (Sirin, S.R. and L. Rogers-Sirin, 2015).

Health issues faced by Syrians fleeing the conflict are exacerbated by the conditions in the refugee camps in Turkey. One report lists concerns: the “number of cases seen by a clinician on a single day may exceed the recommended number by the NHCR at <50 visits/day/clinician especially in pediatrics”(Sahloul, Zaher, et al., 2012). There are a lack of resources at these camps within Turkey. The lack of trained clinicians in these areas reduces the quality of healthcare. It is reported that there is a “deficiency in child psychology” in Turkey (Sahloul, Zaher, et al., 2012). This is unacceptable as symptoms of PTSD are seen in almost half of the Syrian children in Turkey, “ten times the prevalence among children around the world” (Sirin, S.R. and L. Rogers-Sirin, 2015).

Many also are concerned about the cultural sensitivity of the health care providers in the camps.” One major observation found is the lack of adequate awareness of refugees to the psychological implications of this type of trauma. The language barrier and cultural differences

are great obstacles in addressing this crucial health issue that may lead to significant consequences such as somatization, escalation of violence and/or suicide” (Sahloul, Zaher, et al., 2012). Adopting a culturally sensitive framework in the discourse is not only imperative for diagnosing the patient, but also for providing the best treatment. The partnership between a healthcare professional and a patient is of the utmost importance. There must exist a level of trust and comfort for a full and stable recovery. In order to achieve this relationship, one’s culture and all that comes with it, must be taken into consideration. The Center for Disease Control’s (CDC) 2016 report of Syrian Refugee Health includes a section titled “tips for clinicians”. It explains that Syrian people may have “certain care preferences, attitudes, and expectations driven by cultural norms, particularly religious beliefs, and expectations.” (CDC, 2016, 4). It goes on to list some examples of things that Syrian patients may be more likely to do than a patient in the United States, which these specific health care professionals are accustomed to. The advice listed can be used to make patients feel more comfortable. For example, when a nurse reads in the report that Syrian patients are likely to “request long hospital gowns for modesty (especially female patients)”, he can come prepared with a long hospital gown. The patient will not feel distressed asking for one, and feel as though this doctor understands his or her specific needs. This adds a layer of trust in the relationship, and can lead to better treatment. This is especially important in cases of mental illness because they are highly stigmatized and need sensitive treatment.

Cultural knowledge can also give the healthcare professional an insight on how to treat the patient. For example, it is listed in the report that Syrians are likely to “fast or refuse certain medical practices (e.g., to take oral medication) during certain periods of religious observance such as the month of Ramadan” (CDC, 2016, 4). A doctor will know not prescribe oral

medication during Ramadan because the patient will not take it. She instead will find a better way of treating this patient: prescribing a patient to take the medication between sunset and sunrise, or prescribing a long-lasting medication that will last the day perhaps. (National Institute of Health, 2017). Without the knowledge of this cultural practice, the doctor would not be aware of the health implications, and would not be able to adapt her treatment plan to avoid causing further harm to the patient. Even though the CDC provides these tips for cultural sensitivity, there is still a lack of resources to be able to fully implement these concepts into the healthcare delivery system of Turkish refugee camps. This weakens the quality of care provided to the refugees located in these camps.

The case in Turkey, however, is unlike the typical environment for a doctor-patient relationship in that patients are not the only ones struggling. Many doctors still struggle with the same psychological trauma as their patients. Physicians for Human Rights (PHR), and organization who draws attention to human rights violations and comes to the aid of those in dire need, came out with a report “Doctors in the crosshairs: Four Years of Attacks on Health Care in Syria” discussing the effects that the conflict and conditions have on the health care professionals themselves. They report, “over the past four years, they have not only provided medical care in desperate conditions, but have also witnessed colleagues, friends, family members, and thousands of civilians die from unlawful attacks and lack of care due to the country’s decimated health care system” (PHR, 2015, 3). It is easy to overlook the doctors’ experiences when the focus is constantly on the direct victims of such a crisis. The main issue that accompanies this is that a doctor cannot properly administer the best care when they, themselves are struggling.

The conditions of the refugee sites in Turkey have an extreme effect on health outcomes within the Syrian refugee population, especially concerning mental illness. Lack of resources and

health care professionals, the environment that the conflict and the conditions create, and even the clinician's mental health all play a role in reducing the quality of care in Turkey and therefore degrading the overall health of Syrian refugees.

Jordan:

As of May 15th 2017, 736,393 people of concern were registered with UNHCR in refugee camps in Jordan. One of Jordan's refugee camps, Za'atari, is among the top 5 largest refugee camps existing (Refugee Council USA, 2016). One may assume that one of the largest camps would be progressing towards a viable lifestyle for its refugees, but this holds untrue. Of the roughly 80,000 refugees in this camp, about 44,000 of them are children under the age of 18. Children's brains are extremely plastic, meaning that neural pathways are constantly being modified, due to physical changes or changes in one's environment (Bryan Kolb, 2012). Because of this, a child who endures a single traumatic event with extensive therapy and care immediately after has hope for living a normal life. For the children in Jordan coming from war zones in Syria, brain plasticity is not a reliable way to protect their mental health.

Za'atari is located 13 kilometres from the Syrian border, where some Syrian families left their homes and walked for up to 15 hours to the refugee camp. Their new homes in the Za'atari composed of a sole tent - a huge adjustment to the lives they left behind. Many Syrian families are relatively large. The reported average family size for Syrian refugees coming to Nova Scotia was 7 members (Mills, 2016), and this number is similar across all refugee camps. Living spaces are cramped, and with no electricity, the winter nights are brutal. A father of a family of ten, which nine of them under the age of sixteen, reported, "when we arrived at the Za'atari Camp in February 2013 it was very cold. We were all living in a tent that used to leak every time it rained.

But there was no option. We either stayed in that tent or took our children to their death.” The refugees coming to Syria have little to no freedom about their life choices.

It is impossible to discuss mental health without having a conversation about physical health as well. Multiple studies on Syrian refugees in Jordan as well as the knowledge we have about mental illness demonstrate that mental and physical health are comorbidities of each other. According to the Yale Global Health review in context of Syrians in Jordan:

“It is estimated that people with schizophrenia die, on average, 25 years earlier than people with similar backgrounds who do not have the disorder. Premature death in these individuals occur due to high rates of suicide, acute and chronic lower respiratory tract illnesses, chronic cardiovascular disease, and diabetes.”

A large discrepancy in physical health that is the consequence of many mental illnesses is a weakening of the immune system. In addition, multiple sclerosis is a rising issue in both adults and children in the camps. Some of the effects that multiple sclerosis can have a person’s life are extreme fatigue, chronic pain, tremors and trouble walking, cognitive and emotional problems, and depression. This can be extremely life threatening, especially when there are only two hospitals for thousands of people.

It is easy to assume that the more pressing mental illnesses present in refugee camps would be depression or PTSD, but UNHCR reported that schizophrenia is among the highest prevalence. Surprisingly, schizophrenia yields many physical impairments, including epilepsy, a high stroke risk factor, multiple sclerosis, etc., and this disease can even cause violence in an individual as well. Author Sally Hayden spent time conducting research in the Za’atari camp and met a couple who experienced this mental disorder. They discussed that it hindered their relationship and took a toll on their happiness and well being in the camp. The wife in the relationship stated, “First he was for the revolution, then he was against it. He started beating me but when he started beating the children I couldn’t take it anymore” (Hayden, 2017). Stress can

play a large role in triggering these episodes for people with the disorder. Studies on immigrants have shown higher rates of schizophrenia and more severe symptoms than in individuals who have been in the culture longer and are already adapted to the culture in said country. (Cantor-Graae & Selten, 2005; Coid et al., 2008; Kirkbride et al., 2006.) Refugees in the Za'atari camp leaving their homes and being in the midst of a warzone is a likely explanation of the high rates of schizophrenia.

Mental illnesses, like schizophrenia, cannot be cured in the sense that one can take a medication for a duration of time and all symptoms will be relieved. However, there are many drugs such as typical and atypical antipsychotics, ie. clozapine and chlorpromazine, that can relieve some of the positive symptoms, categorized as delusions and hallucinations, and negative symptoms such as avolition, mood changes, and a withdrawal from society (Nolen Hoeksema, 2016). The suppression of these symptoms would aid the paralleled physical illness immensely, but mental disorders are often overlooked in Jordan refugee camps. There are only two small hospitals in Za'atari mainly occupied by those coming from Syria with serious traumatic brain injury, open wounds, and other physical injuries. With such serious physical injuries flooding the few hospitals in Za'atari, mental health of the refugees is put on the back burner, as it does not appear as a life or death situation.

The loss of loved ones, leaving a place many families called home, and seeing multiple deaths via bombing and gunshots can also cause depression in many of these individuals in refugee camps. PTSD and major depression are large comorbidities (Pfefferbaum, 1997; AACAP, 1998), which is why it is important that PTSD is addressed immediately in order to prevent depression from developing. Following the two disorders in refugees, researchers found that depression was caused by the current living conditions that refugees were in, while PTSD

was caused by the war and having no way of coping with the many traumatic events the Syrian natives were exposed to (Sack, Clarke, & Seeley, 1996), such as seeing people killed and seeing limbs blown off of strangers or even loved ones in some cases.

The lack of adequate care and extreme stress that Syrian refugees in Jordan are experiencing not only affects individual refugees, but others around them. There are multiple accounts of family and sexual violence, which is causing many refugees to live in fear. Having no mental outlets, especially due to the negative stigma of mental illness in the camp, leads to violence from family members being one of the more prevalent issues, and for those who have PTSD, the best way to ease symptoms of depression are to talk to someone and have emotional support from those around you, specifically family and loved ones (Kareem Shaheen, 2016; Suzan Song, 2013; Bustillo et al., 2001; Pitschel-Walz et al., 2001). But, with such limited resources available, a lack of education about resources, and no social support, children are bound to have their symptoms worsen (Bustillo et al., 2001). A lack of coping methods can also cause children to engage in risky behavior, which is another large prevalence in the camp. Conduct Disorder, a mental disorder that is commonly linked to juvenile delinquency, has a 6% prevalence in refugee camps. While this number seems low, it is important to note that this is higher than the current world prevalence, standing at 5%.

Current Strategies

Every year the UNHCR releases a sector report covering certain goals and objectives that they hope to achieve for each host country. A few of the regional sector strategies that the UNHCR hopes to improve upon the lives of these refugees are conditions such as their basic needs, education, employment, security and protection, health and nutrition, food security, and shelter (UNHCR, 2017). The UNHCR sets a budget that they hope to obtain within these

services and in addition to these budgets; they set objectives that target a certain amount of the refugee population to be successfully accounted for (UNHCR, 2017).

One of the main initiatives that the UNHCR has been working towards is the No Lost Generation (NLG). This initiative was originally launched in 2013, and its concern surrounds the possible “loss” of the entire generation of the children and youth that were affected by the crisis in Syria (UNHCR, 2017). The NLG is focused on prioritizing education and children protection amongst this generation and focuses their success on the five main host countries, which are Turkey, Lebanon, Jordan, Iraq, and Egypt (UNHCR, 2017). The NLG centers itself around three core pillars, which are education, protection, and adolescents & youth (UNHCR, 2017). These three core pillars are guided by four interdependent strategies: “increasing the supply of and access to services, improving the quality of these services, increasing the demand and addressing the barriers to access, and advocating for the legal and policy reforms to strengthen national education and child protection services” (UNHCR, 2017).

The goal of the education pillar focuses on improvement in the quality of learning and education for children residing in refugee host countries. The four objectives that are geared to achieve this goal are: increasing fair access to education in formal/non-formal settings, increasing the demand for learning through community and family engagement in the education of their children, overall improvement in the quality and relevance of education, and through building up national and sub-national education systems (UNHCR, 2017). This initiative hopes to better the lives and futures of children that are suffering the repercussions of the crisis in Syria. This allows many children the opportunity to continue their childhood and have the chance to have a bright future in a time of darkness.

The goal of the second pillar surrounds child protection. Children are the most susceptible to a variety of protection issues such as sexual and physical violence, child labor, and child marriages (UNHCR, 2017). These protection issues can be seen as a direct result of the limited access to basic needs as well as a lack of legal documentation of many refugee children (UNHCR, 2017). The NLG hopes to improve child protection by increasing access to quality community-based child protection (including but not limited to psychosocial support), improving the national formal child protection services through legal and policy reform, and providing specialized child protection services that are linked to livelihood support to families and children (UNHCR, 2017).

The goal of the third pillar surrounds the adolescent and youth population. It was found that the boys and girls of the adolescent population have experienced persisting levels of isolation, depression, and hopelessness within their communities (UNHCR, 2017). The NLG strives towards breaking this habit amongst the youth and focuses on empowering and encouraging the youth to live to their fullest potential (UNHCR, 2017). They intend to do this through “increasing the access of meaningful civic engagement opportunities, improving network and mentorship opportunities, amplifying the voices of adolescents and youth at local and national levels, and ensuring that both males and females within this population having expanded livelihood opportunities in line with national legislation framework” (UNHCR, 2017).

According to data taken by the UNHCR, the total population of refugees has risen to 654,877 as of November 5, 2017 (UNHCR, 2017). Funding continues to be the primary issue as well, with only 42% of the required funding that they needed for the year (UNHCR, 2017). Looking deeper into the financial situation, it was found that during the time span from January 2017-September 2017, about 77% of the funds that the agency requested for the basic needs of

the refugees was received, and even further, the amount of money that the UNHCR had requested towards shelter was roughly a bit over \$1.5 million (UNHCR, 2017). Of this \$1.5 million, zero dollars were granted to the agency (UNHCR, 2017). As of November 2, 2017, the UNHCR reports that Turkey has over 3 million Syrian refugees in their country (UNHCR, 2017). The UNHCR has also only received 37% of the funding required for the year, leaving around 225.5 million refugees unaccounted for (UNHCR, 2017).

Without proper funding, many refugees face the possibility of being without homes, food, protection, and health care. This prevents any possible opportunities for the UNHCR to improve conditions that might be harmful to an individual's health due to this lack of funding. Syrian refugees can be classified as "forced migrants" who are often times represented as "unfortunate, faultless victims of circumstance who deserve society's attention and material support. This logic is often invoked to mobilize humanitarian and human rights commitments at the national and international levels" (Willen & Cook, p. 103). With the increasing number of refugees and the lack of adequate funding, the discussion of health-related deservingness arises. Seeing that the idea of health-related deservingness clashes with the theory of human rights, it forces the decision of "who deserves what" based off of "social, historical, and ideological contexts" (Willen & Cook, p. 97). Although there are many initiatives being put into place, with the number of refugees inevitably increasing, it is likely that host countries will not be able to sustain an adequate quality of these given services.

Conclusion

When people are forced out of their own countries and placed in host countries, their futures are subject to the whims of these hosts. In the case of Syrian refugees, the major hosts include Turkey and Jordan, who are receiving such large influxes of refugees that they must

implement stringent policies to keep the population under control. The policies of these countries lead to conditions of life for these refugees that are not conducive to healthy and happy futures: lack of adequate housing, poverty, lack of food, inconsistent medical care, lack of running water, unemployment, and lack of education. In conditions like these, it is no surprise that refugees face high rates of depression, PTSD, chronic stress, Schizophrenia, and chronic diseases. Not only are they coming from a country fraught with conflict and trauma, but they are thrust into a situation where they must fight to survive and cannot receive adequate healthcare or live normal lives.

This is a fundamental violation of human rights as, according to the Universal Declaration of Human Rights, “Everyone has the right to a standard of living adequate for the health and wellbeing of himself and of his family, including food, clothing, housing, and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age, or other lack of livelihood in circumstances beyond his control” (Beracochea, 2011, 7). Although actions are being taken by international health organizations to improve the lives and health of Syrian refugees, more must be done. However, without a country to call home, will these refugees ever be able to have this human right to health that they deserve?

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