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# Gender identity as a barrier to accessing adequate and inclusive healthcare for Syrian refugees in Lebanon's Northern regions

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The structure and modes of operation of Lebanon's healthcare system cast a blind eye upon refugees' specific challenges and needs. It not only remains highly privatized, but additionally involves a number of exclusionary practices across both private and public sectors. This reality, coupled with political agendas, partisan politics, clientelism, and an overall lack of transparency at the level of public administration, gives private health providers substantial amounts of subjective influence – and more importantly, the authority to be exclusionary. This article explores how gender identity has impacted access to healthcare services for the Syrian refugee community since 2019 – with a specific focus on women and members of the LGBTIQ+ community. The study focuses on the regions of Tripoli and Akkar – regions found to be tainted by socio-cultural sensitivities hindering women and LGBTIQ+ individuals from being honest and expressive about the gender-specific care they need, and thus, hindering adequate service provision. Specifically, the research aims to implore an intersectional lens to exploring health, gender and displacement in application. It aims to respond to the following questions: (1) To what extent have gender identity, gender expression and gender norms impacted Syrian refugees' ability to access gender-sensitive health services in Tripoli and Akkar?; (2) To what extent have the aforementioned gender considerations, when intersecting with refugee status, served as an added layer/barrier to accessing health services in Tripoli and Akkar?; (3) To what extent do socio-cultural norms in Tripoli and Akkar impact Syrian refugee women and LGBTIQ+ refugees' ability to be honest and transparent about their specific health needs? (4) To what extent does the nature of the Lebanese health system, coupled with the limited knowledge among healthcare providers around gender-sensitive care, serve as a catalyst toward exclusionary health access for refugees first, and for sexual and gender minorities (SGM) second?

KEYWORDS

**refugees, health, gender, identity, Lebanon**

## 1 Introduction

Across the last decade, upward of 1.5 million Syrian refugees have fled to Lebanon seeking refuge and protection from Syria's ongoing conflict (Karasapan and Shah, 2021). With a total population of close to six million people (including the refugee community), Lebanon presently hosts the highest number of refugees per capita in the world (UNHCR, 2023). Lebanon's population has grown substantially since this mass influx, a drastic

increase that has placed significant pressure on the country's institutions and health facilities (International Crisis Group, 2020). The said facilities are already compromised due to the prolonged intersectional national crises exacerbated by the ongoing economic and financial crisis, the aftermath of COVID-19 (Fouad et al., 2022), and the ongoing socio-political implications of the Beirut Port explosion (MSF, 2021). As Lebanon maintains its status as a "country of transit" as opposed to a country of asylum for refugees, the dispossessed remain in legal limbo (United Nations, 2016). The Lebanese government's response to the influx continues to be a series of patchwork legislation and ad hoc policies – even more so recently, amid conversations on Syrian refugees' repatriation (Diab, 2023). In this climate, refugeehood, gender, and health remain at a sensitive and overlooked intersection within larger migration narratives and discourse – particularly within larger debates on refugee rights and their access to health services. Among marginalized refugee communities, this intersection poses particularly dire consequences on the physical, mental, and psychological health of sexual and gender minorities (SGM), and women within the refugee community.

The structure and modes of operation of Lebanon's healthcare system cast a blind eye upon refugees' specific challenges and needs. It not only remains highly privatized, but additionally involves a number of exclusionary practices across both private and public sectors (Diab, 2023). This reality, coupled with political agendas, partisan politics, clientelism, and an overall lack of transparency at the level of public administration, gives private health providers substantial amounts of subjective influence – and more importantly, the authority to be exclusionary (Diab, 2023). In light of the aforementioned, private healthcare facilities, UN agencies, international humanitarian organizations, and local NGOs continue to shape refugees' access to healthcare and health-related services along with (tele)mental health support (United Nations Lebanon, 2023). While becoming increasingly difficult amid limited access to resources, efforts to enhance the provision of healthcare services to Syrian refugees in Lebanon have mainly been a collaboration between the Lebanese Ministry of Public Health (MoPH), the UN Refugee Agency (UNHCR) and local and international humanitarian organizations (United Nations Lebanon, 2023). Despite the fact that there are more than two hundred primary healthcare facilities in Lebanon where refugees are able to receive subsidized treatment, medication and vaccinations (AOAV, 2020), access to these facilities remains challenging for refugees amid fears over crossing checkpoints, issues with residency paperwork, and concerns over deportation or detention (Fouad et al., 2021).

The research aims to explore how gender identity has impacted access to healthcare services for the Syrian refugee community since 2019 – with a specific focus on women and members of the LGBTIQ+ community. The research also explores how the country's ongoing economic and financial crisis has impacted the health sector, as well as the provision of health services to the refugee community in general, particularly in increasingly vulnerable regions in North Lebanon. The study focuses on the regions of Tripoli and Akkar – a selection rooted in the demographic compositions of these regions as two of the most refugee-dense in Lebanon, as well as their social and political significance. Since the Lebanese Civil War, Tripoli and Akkar have become massively de-industrialized, and most investments are directed toward Beirut (Bakhache et al., 2023). This has significantly impacted the provision of services and access, particularly in the areas of access to healthcare for the region's host community and its incoming refugee population (Bakhache et al., 2023). The war in Syria (2011 to present) has caused the mass displacement of Syrians to Tripoli and Akkar, mainly from nearby Syrian cities such Homs, Al Qousayer, and Hama (Bakhache et al., 2023). According to multiple reports, Tripoli and Akkar witnessed a 17% increase in population since the beginning of the Syrian conflict, with its population exceeding 440,000 as of 2021 (between host and refugee community) (Bakhache et al., 2023).

Alongside being marred by decades of armed conflict and instability, resulting in a fragile economy that is struggling to support the local population, the regions of Tripoli and Akkar host 226,508 registered Syrian refugees according to UNHCR (UNHCR, 2022), with estimates placing unregistered Syrian refugees anywhere between 150,000 and 200,000 individuals. The "true" number of Syrian refugees is undoubtedly larger and difficult to pin down according to key informants, as there are many more Syrians in the city who have not registered with UNHCR, following a request from the Lebanese Government to halt registration as of 2015 (Gallart, 2015). As a Municipal Staff Member from Tripoli interviewed for the purpose of this study insists, "[...] there is no real way of knowing the numbers. UNHCR has official estimates only of those registered; however, between Tripoli and Akkar how can you count those unregistered? Some INGOs and other humanitarian organizations have rough estimates, and at the municipality level we have estimates as well, but as you know there is an overall lack of accuracy in numbers even on a national scale. I would argue that there are close to as many unregistered Syrian refugees in our areas as there are registered refugees. We observe this because we live it. We see the pressure on our regions on all levels, and particularly in the areas of access to healthcare facilities and support."[1]

Amid this strain on services and access for refugees, gender minorities within the refugee community continue to endure exacerbated vulnerabilities when it comes to receiving the specific forms of health support they need. As one Gender and Displacement Expert from MOSAIC MENA[2] and ILGA Asia[3] explains: "[...] refugees in Tripoli and Akkar are already marginalized. This is undeniable. The issue is that whilst discussing refugees in this region, and in Lebanon in general, we make the error in assuming that they are a homogeneous group with the same vulnerabilities and needs. For refugee women, as well as refugees from the LGBTIQ+ community, the challenges they endure in accessing healthcare and services are specific to them; often charged by social, cultural and gender-related stigma. Imagine being a trans refugee woman in Akkar. There is no way that this person faces the same types of vulnerabilities as a cis gender man from the refugee

1 Key Informant Interview, Tripoli, March 2023.

2 The MENA Organization for Services, Advocacy, Integration and Capacity-building.

3 The Asian Region of the International Lesbian, Gay, Bisexual, Trans and Intersex Association.

community. Through our work, and the individuals we speak to, we recognize this reality each and every day."[4]

Historically, refugees have encountered significant barriers to accessing adequate health services, as have women and members of the LGBTIQ+ community. When these components of one's identity overlap, particularly in a context similar to Lebanon's, and in remote regions, these barriers become layered, intersectional, and exacerbated. This paper aims to unpack this – specifically, it aims to give an unprecedented look into this understudied reality from within the refugee community itself.

## 2 Methodology

This research applied a qualitative approach that is participatory, inclusive and target group sensitive. This method ensured that the study findings were derived from a collective contribution from a wide range of target groups, triangulated and validated, and that gender considerations were integrated into the data collection and analysis methods where relevant. Purposeful sampling, also known as judgmental, selective, or subjective sampling, was adopted for the identification and selection of informants and participants with the aim of ensuring that they could contribute to the phenomenon of interest.

The data collection phase began with two inception focus-group discussions (FGDs) with a total of 25 experts from humanitarian and aid organizations operating at the intersection of displacement, gender and health spaces in Tripoli, Akkar and the national level. These inception FGDs contributed to tailoring research tools, sharpening the study focus, and highlighting emerging intersections prior to moving on to key informant interviews (KIIs) with experts and in-depth interviews with Syrian refugees in North Lebanon. Following these initial FGDs, 15 KIIs with UN Agencies, international humanitarian organizations, health facilities and local municipal staff were carried out in both areas of focus. Alongside KIIs, in-depth interviews (IDIs) were carried out with 50 Syrian refugees from Tripoli and Akkar who identify as women and/or part of the LGBTIQ+ community. In Tripoli, a total of 32 interviews were carried out with Syrian refugees who self-identified as follows: 10 cisgender straight women, 8 lesbian women, 3 trans women, 2 trans men, and 9 gay men. Conversely, a total of 18 interviews were conducted in Akkar with Syrian refugees who self-identified as follows: 3 gay men, 3 lesbian women, and 2 cisgender straight women.

All interviews, FGDs and other discussions were conducted in accordance with best ethical practice in research, particularly with respect to ensuring participants' safety, anonymity, the protection of data, and risk mitigation. A Do No Harm approach was strictly followed, with relevant considerations for the safety of interviewees upheld throughout this research.

Informed verbal consent was obtained ahead of all KIIs, IDIs and FGDs. The research team explained that participation was voluntary and that participants could withdraw from the interviews at any point, as well as refrain from responding to any questions deemed too sensitive in nature. The purpose of the research was explained ahead of all interviews and FGDs. All participants in the study were anonymized, and transcripts were coded and stored on a secure device only accessible to the research team. All participants in both interviews and in FGDs were between 23 and 45 years of age. The research team accessed the community and recruited participants through a partnership with the MENA Organization for Services, Advocacy, Integration and Capacity Development (MOSAIC MENA), a local organization operating in Lebanon whose aim is to "[…] provide services to all marginalized groups and for LGBTIQ+ communities," and work to "[…] bridge service gaps for survivors of sexual violence, and trans* persons (Mosaic Mena, 2023)". Interviews were carried out by Advisory Board Members and staff of MOSAIC MENA to ensure participants (Syrian refugees) felt safe sharing their experience, were speaking to trusted and familiar actors, as well as to ensure that power dynamics were eliminated and controlled. Participants were interviewed individually, and were given the liberty of selecting the male or female interviewer at their own discretion.

Qualitative data collected was thematically analyzed and engaged with based on the following research questions: (1) To what extent have gender identity, gender expression and gender norms impacted Syrian refugees' ability to access gender-sensitive health services in Tripoli and Akkar?; (2) To what extent have the aforementioned gender considerations, when intersecting with refugee status, served as an added layer/barrier to accessing health services in Tripoli and Akkar?; (3) To what extent do socio-cultural norms in Tripoli and Akkar impact Syrian refugee women and LGBTIQ+ refugees' ability to be honest and transparent about their specific health needs? (4) To what extent does the nature of the Lebanese health system serve as a catalyst toward exclusionary health access for refugees first, and for gender minorities second?

## 3 Gender as a barrier to health access in displacement settings

### 3.1 Gaps in public policy, the humanitarian landscape and the literature

Gender dynamics, norms, identity and expression have long formed part of intersectional concerns around access to healthcare in conflict and displacement settings (Namer and Razum, 2018). Independent of whether or not gender-related persecution constituted a motivation behind their refugee or asylum-seeking status, non-heteronormative identity in displacement settings is known to complicate experiences, access and protection in host countries due to precarious policy frameworks (or lack thereof), discriminatory practices and hostile societal attitudes (UNHCR, 2013).

When refugees do receive forms of "gender-sensitive" care, health services aimed at LGBTIQ + individuals within this community have conventionally over-focused on HIV and other STIs (Keygnaert et al., 2014), and overlooked other more specific health concerns such as hormone treatment for trans* refugees for instance who had already begun this type of treatment in their home countries (Keygnaert et al., 2014). For women within the refugee community, "gender-sensitive" health services are routinely reduced to perinatal care as well as gender-based violence (GBV) support, often overlooking more comprehensive sexual,

4 Key Informant Interview, Beirut, March 2023.

reproductive and health (SRH) needs (Keygnaert et al., 2014). Importantly, gender-sensitive health services have fallen short in comprehending the inherent heterogeneity of both women and LGBTIQ+ individuals within the refugee community, at times, failing to make important distinctions between the specific healthcare concerns of non-heterosexual and non-cisgender refugees who are confronted with policies, norms and systems in the host community and who interact with them very differently.

National legal and policy frameworks within the host country have long-determined the accessibility of services for refugees, particularly the gender-sensitive ones. Importantly, the criminalization of migration, as well as the precarious legal standing host countries impose on refugees within their borders, impacts their realization of their right to access adequate health care (Martinez et al., 2015). Moreover, this has conventionally circumscribed refugees' access to emergency and immediate care solely (Martinez et al., 2015), and further rendered access to care in emergency situations dependent on regional and sub-national differences, as well as on host-refugee dynamics (Martinez et al., 2015).

Both gray literature and reporting on refugees' access to healthcare through a "gendered" lens have been predominantly produced by a range of humanitarian actors, who adopt more of an umbrella approach to discussions on gender, health and displacement – often, reducing this intersection to the need for more SRH services, maternal health services and psychosocial support (PSS).[5] At the intersection of gender, health and displacement, relevant academic literature additionally falls short in unpacking refugee women in all their diversity (WiTD), as well as zero in on the diversity within the LGBTIQ+ refugee community itself. Studies on refugee health have especially described the need for more mental health support, and research addressing refugees' SRH needs have rarely moved past conversations on maternal health and GBV support for refugee women, and HIV/AIDS for refugees who identify as part of the LGBTIQ + community.

Despite recommendations and an overall sense of acknowledgment of the necessity to undertake a more multi-dimensional approach to refugees' and gender minorities' health needs (particularly when these two components of one's identity intersect), very few studies have effectively combined the sociocultural, normative, political, economic and administrative complexities attached to this knowledge gap at the global level. In the Middle East, these efforts are almost entirely absent. Despite a growing need identified from within the humanitarian space, as well as an interest in expanding conversations on gender-sensitive healthcare access for diverse groups of refugees, this has yet to play out in application based on the testimonies of key informants.

## 3.2 The de-prioritization and fragility of gender-sensitive health responses

As a consequence of this narrow approach, pivotal aspects of gender-sensitive health care topics and responses for refugees remain out of focus and de-prioritized. These topics include sexual education, family planning, choice of sexual/intimate partner, sexual agency, awareness and autonomy. In the areas of responses and services, these include hormone support, contraception, and private checkups between refugees and their physicians – especially whilst discussing SRH and gender-specific/sensitive treatment. Despite the fact that evidence shows that access to the aforementioned topics and support improves general health outcomes overall, efforts to integrate them in the healthcare response in rural areas remain restricted by a multitude of social, economic and health-related factors. In many cases, these restrictions, coupled with what key informants describe as the "shaky nature" of the gender-sensitive health response for refugees, has made it increasingly difficult for the humanitarian landscape to overcome even the most periodic "external shocks (see text footnote 1)." Importantly, key informants attest to the fact that gender-sensitive programming is sometimes "the first to go, or take a major hit" when budget cuts are imposed, or when prioritization to serve the "refugee community as a whole" comes into play throughout specific challenging periods or developments in a given context (see text footnote 1).

A 2023 study published in *BMC Women's Health* that explored the impact of Lebanon's compounding crises on the provision and use of family planning services including modern contraception methods for Syrian refugee women in the Beqaa found these types of gender-focused services were largely impacted by the local and national contexts (Mourtada and Melnikas, 2023). The study found that since 2019, disruption of reproductive health services that provide family planning and modern contraception, as well as the reduced supply of modern contraception methods were major outcomes of Lebanon's economic demise and its COVID-19 restrictions (Mourtada and Melnikas, 2023). According to the same study, women also reported "financial limitations in accessing and paying for services," and "concerns about insecurity" as major contributors to the decrease in their access to quality gender-sensitive care (Mourtada and Melnikas, 2023).

Along similar lines, a 2021 narrative report published in *Reproductive Health* that aimed to explore the SRH response for Syrian refugee women and girls in Lebanon, with a focus on the Minimum Initial Service (MISP) implementation,[6] found that women and girls were not only disproportionately affected in times of forced displacement, but that disturbance in access to healthcare services leading to poor sexual and reproductive health outcomes was inevitable as a result (Nabulsi et al., 2021). While this narrative review found a wide range of SRH services being delivered in Lebanon to Syrian refugee women, "access to and quality of these services remain a challenge," with multiple sources listing

5 https://www.unhcr.org/what-we-do/protect-human-rights/public-health/sexual-and-reproductive-health; and https://www.emro.who.int/fr/lbn/programmes/maternal-and-child-health.html

6 In order to address the disruption in access to basic SRH services, the Inter-Agency Working Group on Reproductive Health in Crisis Settings (IAWG) developed the Minimum Initial Service Package for Reproductive Health in Crisis (MISP). The MISP objectives in emergency settings are: (1) identifying an agency to lead its implementation, (2) preventing and managing the consequences of sexual violence, (3) reducing Human Immunodeficiency Virus (HIV) transmission, (4) preventing excess maternal and neonatal morbidity and mortality, (5) preventing unintended pregnancies, and (6) planning for comprehensive services and their integration into existing services.

the lack of coordination as a leading cause of both fragmented service provision and duplication services provided (Nabulsi et al., 2021). Multiple barriers to healthcare access were also identified as part of this narrative report, including system-level, financial, informational and sociocultural factors, as well as the lack of overall knowledge and training of healthcare workers on specific sexual health- and gender-related issues (Nabulsi et al., 2021). It concluded that despite the "multitude of services provided," that the humanitarian response in Lebanon not only remains decentralized with limited coordination, but that intersectional and layered barriers continue to hinder the utilization of and access to such gender-sensitive services (Nabulsi et al., 2021).

Alongside gender-sensitive health programming being de-prioritized in conflict and displacement settings, as well as being the most susceptible to being impacted or "cut," there remains a very binary approach to gender in much of the health response in displacement settings – often resulting in a gap in defining target groups and catering to their gender-specific needs. These groups include LGBTIQ+ refugees certainly, but also adolescents, women without children, men, the elderly, and persons who are differently-abled (Nabulsi et al., 2021).

A 2020 study published in the *International Journal of Environmental Research and Public Health*, that explored health and healthcare utilization among asylum-seekers from Berlin's LGBTIQ+ shelter found that residents of the LGBTIQ+ shelter exhibited elevated rates of chronic and mental illness – often resorting to the use of mental health services more frequently than asylum-seekers from other non-LGBTIQ+ shelters (Gottlieb et al., 2020). The same study found that emergency room utilization was also more frequent in the LGBTIQ+ group (Gottlieb et al., 2020). It concluded that asylum-seekers from the LGBTIQ+ community required tailored services that help them obtain the adequate gender-sensitive healthcare they need, and that even in some of the most "developed" countries in the world, that amid an overall absence of an intersectional approach to refugee health management and responses, unmet needs "remain and warrant further research (Gottlieb et al., 2020)."

The truth of the matter is that refugee healthcare access, particularly in developing countries, casts parallels all over the world – with access to intersectional health approaches and responses not only being extremely limited and binary, but in many cases, also entirely unattainable. A 2019 report published by the Istanbul Policy Center at Sabanci University that adopted a gender-sensitive perspective to Syrian refugees' healthcare access in Istanbul, outlined healthcare as "a key issue as Syrian refugees are exposed to intersectional factors that influence their health and their ability to use the healthcare system (Cloeters and Osseiran, 2019)." In addition to challenges pertaining to refugees' registration, the overall slow approach places refugees at the center of a precarious health predicament – ultimately, making their demands in the areas of more gender-focused care very limited, binary and in many cases for LGBTIQ+, entirely unavailable (Cloeters and Osseiran, 2019). Other important barriers outlined in this report include an overall lack of health literacy among refugees, a lack of knowledge of the healthcare system, as well as the limited "gender knowledge" of healthcare practitioners refugees have access to Cloeters and Osseiran (2019). Intersectional discrimination toward refugees was additionally cited as a major hindrance to their access – particularly for refugee women. The report outlines "[…] structural barriers that refugees face when accessing healthcare services as intersectional patterns of discrimination against them [refugees]," as well as the fact that "bureaucratic obstacles in reaching healthcare services can intersect with racism toward refugees and/or specifically gender-based discrimination toward refugee women" in particular (Cloeters and Osseiran, 2019).

When it comes to the LGBTIQ+ refugee community more specifically, a 2022 qualitative systematic review published in *Sexuality Research and Social Policy* highlighted that the ill-effects of sociocultural stigma, systemic violence, and forced migration due to sexual orientation, gender identity or expressions, and sex characteristics (SOGIESC) are not the only challenge this group of refugees faces (Nematy et al., 2022). It described the "[…] cumbersome asylum process in host countries" as negatively affecting their mental health and wellbeing (Nematy et al., 2022). Important emerging themes from the study included reports of violence and discrimination in accessing health services, mental healthcare access barriers, asylum system challenges, as well as unaddressed mental health difficulties (Nematy et al., 2022). A 2017 study published in *The American Journal of Psychiatry* that explored the mental health of LGBTIQ+ refugee populations in the United States, found that a rise in the proportion of refugees that identify as LGBTIQ+ who suffer from a range of mental health conditions from posttraumatic stress disorder (PTSD), to depression, anxiety and substance abuse – going further in insisting that these mental health conditions vary and are in many cases exacerbated at various "phases of exile (Messih, 2017)." The same study also attributed "the loss of familiar social structures, values, and even language," to refugees' poor mental and physical health in the long-term (Messih, 2017).

## 3.3 Health implications doctor-patient dynamics and practices

Alongside sociocultural and structural barriers to refugees' attainment of gender-sensitive healthcare, refugee women and LGBTIQ+ refugees remain hesitant to not only request gender-sensitive health services, but also to disclose gender-specific information from fear of discrimination and due to the stigma attached to asking for these services – especially SRH for single refugee women, birth control, sexually transmitted infection (STI) testing, and GBV/sexual assault health support. This is particularly true for LGBTIQ+ refugees. A 2019 study published in the *British Journal of General Practice* found that SGM individuals were "[…] unwilling to disclose their SGM identity to their general practitioners due to fear of discrimination or receiving poorer quality care," – a factor largely impacting the community's mental health and physical wellbeing (White et al., 2019).

Importantly the study found that only six researches were published on mental illness among SGM in refugee and asylum settings, with all studies being based in North America, and none focusing on SGM in refugee camps or detention centers (White et al., 2019). Where research was completed, it only focused on cisgender male and female sexual minorities, with close to "no focus on transgender women, and none on transgender men,

other gender minorities or intersex people (White et al., 2019)." This lack of research in the areas of health responses targeting the community, whether this be in the areas of physical or mental health, has impacted gender minorities within the refugee community drastically. Not only has it made information on SGM refugee and asylum seekers who live outside the West (or even North America) scarce, it has also meant that general practitioners and physicians remain less informed about the community, and in turn, less able to adequate cater to their health needs overall.

Even in some of the most "inclusive" societies, studies found that general practitioners encountered "difficulties" or were even "embarrassed" when discussing sexual health issues with lesbian and gay patients in primary care consultations in their day to day work (Hinchliff et al., 2005) – let alone in contexts where these practitioners are not trained, are operating in conflict settings, are not gender-sensitized, are discriminatory amid sociocultural norms, or are not open to having these discussions in the first place with refugee and host communities. In conflict and displacement settings more specifically, this intersects with a multitude of challenges associated on just with the hesitancy of general practitioners and their overall lack of training, but also, their inability to make SGM from within the refugee community feel safe whilst seeking out health support – eventually leading to hesitancy from within the SGM refugee community to seek out healthcare to begin with.

Multiple studies attribute the lack of gender-sensitive health responses to an overall lack of training of medical personnel around gender-specific health needs. A 2020 qualitative study published in *BMC International Health and Human Rights* that aimed to understand access to professional healthcare among asylum seekers who were survivors of GBV in Switzerland from a stakeholder perspective, found that there were several reasons why the care needs of these women remained either unnoticed or unaddressed (Sapia et al., 2020). The study found that alongside an overall lack of knowledge among GBV survivors from the refugee community about the availability of these services, that health professionals, for their part, did not always possess "the competencies to recognize the specific needs," and that they additionally "lack training and knowledge to identify vulnerable individuals or groups (Sapia et al., 2020)."

An overall lack of knowledge and understanding among practitioners on gender-sensitive care extends far beyond displacement contexts, and is not limited to refugees' experiences solely. Members of the LGBTIQ+ community have long-endured discrimination whilst receiving healthcare. A study published in the *Journal of General Internal Medicine* that compared the health and healthcare experiences of sexual minorities with heterosexual individuals of the same gender, adjusting for age, race/ethnicity, and socioeconomic status in the UK, found that sexual minorities were about one and one-half times more likely than heterosexual individuals to report "unfavorable experiences" when seeking care (Elliott et al., 2015). The same study found that discrimination affected both the quality of care that sexual minorities receive, as well as how comfortable they feel when accessing care (Elliott et al., 2015). It additionally found that healthcare workers may be "uncomfortable communicating with sexual minority patients and insensitive to their needs," leading to a reluctance among sexual minorities to disclose their orientation to medical practitioners who they find to be unsympathetic and disrespectful (Elliott et al., 2015).

## 3.4 Filling the gender gap in existing work on refugee access to healthcare

While research has been undertaken in the areas of migrant and refugee health access across multiple contexts, an explicit focus on the gendered impacts of access remain limited in the discourse – particularly in developing contexts. More specifically, when gender does form part of the conversation, the gendered lens is limited to quantitative results and is predominantly binary in its approach. A 2022 study published in the *Journal of Immigrant and Minority Health* that explored differences in barriers and discrimination in healthcare for young undocumented migrants in the United States found that respondents experienced discrimination, as well as financial, language, and cultural barriers, when seeking healthcare or by a health provider rooted in their documentation status (Woofter and Sudhinaraset, 2022). In this study specifically, gender is unpacked across the number of men and women who took part in the study, ultimately failing to unpack these two gender categories across all their diversity. On the point of gender specifically, and without delving into gender dimensions further, the study only states that "in addition to race and documentation status, gender may further impact patient-provider interactions (Woofter and Sudhinaraset, 2022)."

A 2022 scoping review published in the *International Journal of Environmental Research and Public Health* that explores healthcare for refugees in Europe found that barriers in access to health care are highly prevalent among refugee populations, and can lead to under usage, misuse and higher costs of health care (Nowak et al., 2022). It additionally found that little to no attention is paid to the living situations of refugees, particularly when it came to conversations on access, and doctor-patient interaction (Nowak et al., 2022). Albeit relying on multiple socio-economic variables in their approach, this study once again falls short in attributing a gender dimension to the barriers in accessing health care. In fact, in the concluding section of this paper, the authors assert that "[…] the impact of gender or socioeconomic background on health care needs and associated use and access to health care services was not considered (Nowak et al., 2022)." The only mention of "gender" in the scoping review was in a statement where authors admit that "[…] a lack of culturally and gender-sensitive systems inhibits access to health care (Nowak et al., 2022)." This statement is not unpacked further.

A 2022 study published in *Social Science & Medicine – Mental Health* that delves into structural barriers to refugee, asylum seeker and undocumented migrant healthcare access through the perceptions of Doctors of the World case workers in the United Kingdom found various complexities faced by these communities when trying to access vital health care, including charging regulations, the refusal to register patients at without proof of identification, language barriers and complications navigating the healthcare system (Asif and Kienzler, 2022). Such deterrents were found to lead to risky help and health seeking behaviors as well worse health outcomes among these populations

(Asif and Kienzler, 2022). Importantly, gender dimenstions in this study were also lacking and binary; often, reduced to the needs of pregnant women throughout their pregnancy and childbirth (Asif and Kienzler, 2022).

The trend of disregarding an in-depth look into gender considerations as they intersect with displacement and refuge is an observed trend across health research in other contexts as well. A 2022 study published in *Healthcare* that unpacks the experiences and perceived barriers of asylum seekers and refugees in accessing healthcare services in Romania found that accessing the healthcare system remains a challenge for these groups – namely, due to cultural, linguistic, structural, and financial barriers (Dumitrache et al., 2022). While the study did interview women who were asylum seekers and refugees themselves, findings are not unpacked across gender lines, nor is an intersectional lens to interpreting what the paper refers to as "cultural barriers" implored. The word "gender" is in fact not mentioned once in the study (Dumitrache et al., 2022). A 2015 literature review published in *Risk Management and Healthcare Policy* that undertook a review of published articles from the last ten years in PubMed using three main concepts: immigrants, undocumented, and access to health care cites 6 out of 75 studies with a focus on immigrant and refugee women, and a single study where a gender lens is implored – once again in a very binary fashion (Hacker et al., 2015).

As outlined, filling the gaps in refugee health research is an urgent imperative, and one that demands the application of a more gendered lens. The challenges and vulnerabilities faced by refugees, often stemming from conflict, persecution, and displacement, are not uniform across genders. Women, men, and gender-diverse individuals experience distinct health risks and needs, which have long been overlooked in the broader discourse on refugee health and barriers to access. A gender-sensitive approach to research is essential in order to comprehensively understand and address the unique physical and mental health concerns, as well as the socio-cultural dynamics that impact refugees differently based on their gender. By adopting a more nuanced perspective, this study hopes to outline the need for more effective and intersectional healthcare interventions, as well as the need for advancing the cause of global health equity for displaced groups. By adopting Lebanon as a case study, the study further aims at shifting the focus from other geographies that dominate the research at these intersections – ultimately, moving the conversation to the Middle East, and some of its most understudied and neglected regions.

## 4 Complexity, discrepancy and discrimination in refugee healthcare in Lebanon

While there is progress in improving refugee healthcare in Lebanon, largely through the support of international humanitarian actors and the efforts of national health authorities, the healthcare system as it currently stands is increasingly discriminatory and complex. Lebanon's highly privatized healthcare system is expensive, inaccessible, and unattainable for the country's most vulnerable – particularly migrant and refugee groups (Kreichati, 2020). Despite the Ministry of Public Health's ongoing efforts to support and increase availability of primary and secondary healthcare for refugees, the cost of consultations, testing, and medication remains a major barrier for the 90% of refugees who continue to live below the poverty line (European Commission, 2023). Other significant costs for refugees include those of antenatal and maternal care, childcare, and baby milk (Karas, 2017). While the UNHCR health budget in Lebanon is the largest in its history, it only covers life-saving services, leaving few options for those with serious or chronic health conditions such as cancer and kidney disease, or those with mental health needs (Karas, 2017).

Beyond the economic and financial challenges, geographic disparity poses a major obstacle for the refugee community in Lebanon. It is particularly noteworthy that while healthcare may be "available," barriers to access because of geographical location remain unaddressed (El Arnaout et al., 2019). As one health expert from Akkar insists, "[...] Lebanon has its challenges, and then Akkar has its challenges. Along with us having social, cultural and demographic challenges, we also have major barriers to access, and are seen as a very neglected region. This has left both the refugee and host communities to essentially fend for themselves. Moving to your question on gender and health, of course there are challenges specific to our area. You know, our area is conservative, Syrian women cannot leave their homes without their husbands' permission, and then in many cases when they attempt to access services without a male guardian, they are refused the help from the health practitioners themselves who do not want to cause any unnecessary trouble for themselves."[7]

Furthermore, due to the country's overall uncoordinated refugee response, coupled with the fact that Lebanon has halted establishment of formal refugee camps for various groups, refugee communities are spread among remote villages and cities across the country (Rainey, 2015). Moreover, the heavy presence of refugee communities in low-resource areas such as Tripoli and Akkar, and among vulnerable host communities renders it increasingly difficult to access healthcare due to distance and isolation (Rainey, 2015). For prolonged periods of time, particularly between 2021 and 2022, the country's fuel crisis exacerbated this reality (T. R. T., World, 2021). As a Syrian refugee woman from Akkar insists, "[...] as you know, we are still grappling with the long-term effects of the fuel crisis, the COVID-19 pandemic and other layered and overlapping challenges that our region endured. We were cut off from fuel in a much more severe way than people around Beirut were. We were cut off from everything. Alongside also not having internet or power, many people with health concerns were unable to seek out treatment, and many of the men in our community, fathers, husbands, were not keen on letting women carpool to see a medical professional, or even travel by foot alone if she needed to. While there are structural issues related to access to healthcare, when you discuss a refugee woman, many of the challenges are predominantly cultural and societal first, and then structural second. You can only imagine how much being cut off from transportation made things worse for many of us women. I know that women in Beirut, who are not so cut off, have more options than we do."[8]

7 Key Informant Interview, Akkar, March 2023.

8 In-depth Interview, Akkar, March 2023.

Women and LGBTIQ+ refugees in Lebanon continue to endure extreme forms of violence, discrimination, stigmatization, and isolation in the "safe" places they seek (HRW, 2019; Diab, 2021a). The physical and mental violence they report is severe, and continues to be perpetrated by both refugees from within their communities and by members of host communities (Saltmarsh, 2016). Despite the fact that sexual and gender minority refugees are assisted by a range of actors across the country, it is widely understood that refugees from gender minorities are at significant risk, largely because of sexism/homophobia and their lack of access to justice and health services (Women's Refugee Commission Mosaic, 2017). LGBTIQ+ refugees face exceptional challenges in finding shelter and employment (Human Rights Watch, 2019). Their specific needs are often discounted from mainstream refugee services, and very little humanitarian programming is tailored specifically for them – a matter that translates into a dire need for health services and mental health support (Human Rights Watch, 2019).

As a staff member from MOSAIC states, SGM refugees, as well as women, often flee to cities rather than remaining in informal tented settlements in areas such as Tripoli and Akkar because these areas offer the possibility for anonymity and safety. He explains: "[...] Beirut, and areas close to Beirut offer greater opportunities to access health services, human rights networks, and even other members from their communities. For refugee women and refugees who identify as members of the LGBTIQ+ community, social and cultural barriers restrict them from accessing the healthcare and services they need. Testimonies from people we have spoken to, particularly those from the LGBTIQ+ community, insist that they have been turned down at healthcare centers, treated with discrimination, or dismissed and not helped at all because of what they describe as homophobia, sexism and a fear of the other." He further elaborates: "[...] Tripoli and Akkar as you know as well, have additional challenges attached to the overwhelming poverty in the area, as well as the social and cultural constraints associated with seeking out medical attention, especially for sexual and reproductive health, sexually transmitted diseases, birth control, etc. (see text footnote 4)."

# 5 Findings

According to key informants, the profound lack of transparency from the Lebanese government, coupled with donor fatigue on refugee issues, has made it increasingly difficult for organizations to demonstrate impact and secure funding, particularly for vulnerable groups within the refugee community. These realities have pushed women and LGBTIQ+ refugees further down the list of communities who receive targeted healthcare and tailored support – as well as further down the donor priority list in many cases where umbrella approaches need to be adopted toward the refugee community. Emerging themes from data collection highlight a number of experiences from within the refugee community itself that echo these realities.

## 5.1 The role of partnerships in ensuring an intersectional approach

For UN agencies and other international humanitarian organizations whose mandates include the provision of protection for *all* refugees, including those with diverse gender identities and expressions, working outside the limitations of camps and informal tented settlements provides the opportunity to partner with local actors who are specialized and experienced in helping these segments of the community. These local groups serve as entry points into particularly hard-to-reach populations; they also contribute significantly to improving humanitarian health responses and preventing gender-based violence. This is pivotal for high-risk marginalized groups, including women and LGBTIQ+ refugees, especially when beneficiaries and participants in these types of health programming are involved in the discussions and humanitarian efforts at an early stage. Indeed, SGM refugees have reported that the support and protection of humanitarian actors has proven to be instrumental to their immediate safety, health and wellbeing.

Moreover, partnerships and the targeted health responses they develop, assist in sharing information about mitigating risks, the availability of specialized services, and referrals – a matter the country's Ministry of Health and central government fails to adequately and comprehensively provide. As one Syrian refugee respondent community explains: "[...] in many cases for us as women, and more specifically as women from the LGBTIQ+ community, smaller organizations on the ground are our key to accessing services. For instance, when a larger UN agency partners with an NGO we are comfortable with, and one who is familiar with the needs of our community, this is where the gaps are filled in access – and this is particularly true for health care and mental health support. We can speak to them directly and have clearer lines of communication with them. They have been able to push for priorities that are important to us. I can tell you, I have benefited from mental health support in many cases, especially when I was rejected by my family."[9]

## 5.2 Prioritization amid limited capacities to respond in the regions in question

With the influx of Syrian refugees, the ongoing economic crisis and the COVID-19 pandemic, Tripoli and Akkar's capacities to meet host community and refugee health needs are severely strained according to multiple key informants. Although localized conflicts in Tripoli and Akkar ended in 2015, security concerns continue to exacerbate the city's chronic poverty (Human Rights Watch, 2019). As of 2021, the poverty rate in Tripoli alone exceeds 70%, and the unemployment rate exceeds 60% (Geldi, 2021). As a municipal staff member from Tripoli informs the study, "[...] the influx of Syrians is the second wave of forced migration to hit Tripoli, with the influx of Palestinians being the first. Many Syrian households have relocated to the Palestinian 'gatherings', areas not formally recognized as refugee camps, to take advantage of the low

9 In-depth Interview, Tripoli, March 2023.

rents, the prospect of aid/health services from Islamic charities, and the diminished Lebanese military presence that exist in these gatherings. This mostly due to the fact that in North Lebanon, our resources are limited, and most recently, refugees and the host community have both been fending for themselves – especially when it comes to health support (see text footnote 1)."

As one Syrian refugee woman from Akkar puts it: "[...] the implications of COVID-19 and the economic crisis are still felt to this day (see text footnote 8)." Some of the ways in which the economic crisis has impacted the lives of refugees include: supply shortages, political gridlock, high costs for services and transportation, and barriers to high-quality healthcare for people at the intersection of refugee status and gender minorities – this is particularly true where refugees who identify as members of the LGBTIQ+ community are bribed and "tormented" to receive care. As the Director and Founder of MOSAIC MENA explains: "[...] refugees in North Lebanon are in a dire situation of course – as is the host community. However, for refugees who are LGBTIQ+, access to services is a challenge for many reasons, one of the most important being that they are bribed, tormented, and required to go to extreme lengths to receive support in cases where healthcare providers, particularly at SDCs[10], perceive them as part of the community. For trans refugees, we have heard horror stories about what is asked of them even if they want to request a short checkup (see text footnote 4)."

The ongoing economic crisis has additionally meant that Syrian refugees cannot find affordable services in their areas. As another Syrian refugee woman from the Akkar region shares: "[...] when it comes to health services, we cannot afford any of the medications or operations' costs, so even though the UN covers 75% for those of us who are registered refugees, we still need to cover the remaining 25%. Amid the current crisis, this now equates to more than 100% of what it used to be. The Lebanese Pound loses its value daily. Nowadays we get 5 million Lebanese pounds per family per month from UNHCR – we are a family of five. This today equates to around 50 USD and my rent is 30 USD now and therefore I barely have enough left for electricity, food – let alone our medical costs (see text footnote 8)." For many households, particularly women-led households, this has also meant needing to prioritize other expenses at the expense of their health. As one Syrian refugee woman from Tripoli informs the study: "[…] I definitely have my own need, as a woman, in the areas of my sexual and reproductive health; however, we live in such a poor area. Our priorities are different amid all other expenses we have. Sometimes, you compromise your specific needs for the rest of your family (see text footnote 8)."

## 5.3 Brain drain and a loss of medical experts and specialists

The economic crisis in Lebanon has additionally served as a major contributor to the country's brain drain – particularly, to the migration of specialized medical and health professionals (Ramadan, 2022). The World Health Organization estimated in September 2021 that close to 40% of Lebanon's doctors and almost 30% of its nurses had migrated outside the country since October 2019 (Ramadan, 2022). This has not only left the country at a national shortage, but has also impacted different regions of the country disproportionately. In Tripoli and Akkar, respondents share that the shortage in medical and health experts is visible, and that this shortage presents itself in the form of irregular appointments, prolonged waiting periods to access services, as well as the inability of the health system to respond to emergencies such as labor, pregnancy, GBV, STIs as well as SRH concerns. As one Syrian refugee woman from Tripoli's Bab al-Tabbaneh region shares: "[...] at the primary healthcare center where we typically go, the availability of doctors decreases to the point where there was only one. Now, if we're lucky, the doctor comes once a week, and you need an appointment at least a week in advance to secure a checkup. For urgent matters, we cannot do anything. One lady at the settlement was losing blood. She was pregnant. She had to wait two entire days for help, and the doctor saw her when it was too late. Healthcare is generally not accessible. The economic crisis continues to make it worse. All the doctors have left the country, and many of them women's doctors. We also cannot afford to leave our areas amid increased transportation costs to get this support from Beirut or larger cities (see text footnote 9)."

For Syrian refugee women, as well as refugees from the LGBTIQ+ community, the economic crisis has placed them at increased vulnerability, exploitation and bribery when they seek out a health service. One Syrian trans* woman shares her experience attempting to get an urgent medication to treat what she described as wounds from a sexual assault at the hands of her landlord when she could not pay her rent. She shares: "[...] I did not have any money left at all to pay my rent. My landlord bribed me and sexually assaulted me as a result. I was severely injured. Bleeding. I managed to make it to a small primary healthcare center in our area of Akkar, where a female nurse was on shift. She was so incredibly hostile toward me. Refused to even give me medication for the pain – as I left the center, she yelled out homophobic and transphobic slurs at me until I left. She would not even give me a band aid. I am also not a registered refugee. This poses an entirely new layer of vulnerability since UNHCR does not help me much either. I could not even check if I contracted an STI – the nurse was extremely homophobic and also very anti-refugee. It was obvious (see text footnote 8)."

## 5.4 Humanitarian actors, bridging gaps and access to the community

Humanitarian organizations continue to develop innovative strategies to increase the availability and affordability of services for the refugee community – especially for gender minorities and women. These include the creation of "safe" spaces, outreach volunteers, integration of LGBTIQ+ and GBV services with mainstream primary health care, and partnerships with municipalities and authorities. Humanitarian organizations have additionally reportedly been partnering with local grassroots organizations to increase tailoring services, as well as ensuring that an intersectional lens is upheld. As one staff member from a leading feminist organization operating between Tripoli and Akkar insists: "[...] larger humanitarian organizations have the resources to give

10 Social Development Centers.

people what they need. They have the money for the vaccines, the birth control, the contraception, the medication – they also have the resources and expertise to lead on awareness sessions about physical and mental health. However, what they often don't have, is direct access to the community of refugees, especially women, as well as an overall awareness about their specific and contextual needs. We are a smaller group of volunteers operating in the feminist space in our region, and what we do is offer this access, as well as most importantly, the insights into the complexities of the region (see text footnote 7)."

Accessing the community does pose an important barrier for multiple international humanitarian organizations – particularly those aiming to give targeted health support to women and SGM within the refugee community. One important reasoning is the fact that women and LGBTIQ+ refugees remain socially marginalized, isolated within their homes, as well as disconnected from means of communication in many cases. These groups are also known to face barriers to their own agency and control over their bodies, physical and mental health. As one staff member from Medicine without Borders informs the study: "[...] in many cases, partnerships are a point of entry for us. Members of the LGBTIQ+ community are not exactly visible among refugees in these regions. Similarly, women are seen to have more of a larger role in their households – often, limited from using phones, the internet, or even leaving their places of residence. This prevents us from knowing what they need. We need to speak to them. This is where speaking to local actors, grassroots movements and community leaders comes in. Not only are they trusted by women and the LGBTIQ+ community, but they are also the ones guiding us to people, communities and vice versa. These are the groups most hesitant to look for health services as well (see text footnote 1)."

## 5.5 Hierarchies of access and vulnerability from within the refugee community itself

Registration and legal status offers a fuller range of protection and services that are inaccessible to unregistered refugees or those with a precarious legal standing. Following Lebanon's decision to suspend UNHCR's registration of refugees in 2015 (UNHR Lebanon, 2023), gaps in service provision, support as well as protection have widened between the two groups of refugees at the national level: those registered with UNHCR (estimated to be 820,000 individuals), and those unregistered (estimated to be over 600,000 individuals) (UNHCR Global Focus, 2023). Alongside gaps in the areas of essential services such as food and cash, health support differs largely between both groups. As a former member of the Municipal Council in Tripoli explains: "[...] it is important not to assume that all refugees are the 'same' in our areas. In Tripoli and Akkar, there are refugees that have a UNHCR card, and others that are not registered or came recently who do not. This impacts what type of support and services they receive in general, and this extends into health provision. If you are a registered refugee, you simply have more access, you are part of cash schemes, etc. This allows you to also seek out medical attention, support, or even visit a pharmacy on your own expense for example. For refugees that exist outside the UNHCR system to a certain extent, things are more difficult. There are some women and children in informal tented settlements that are on no one's radar for instance. I am not sure how they receive support – some of them do not even leave their homes. Some of them don't even have identification, let alone a UNHCR registration number (see text footnote 1)."

While UNHCR does insist that registration "[...] ensures that they [refugees] will face fewer challenges when accessing their rights, especially children who are more at risk (Sheikhsaraf, 2022)," the Agency has been unable to register Syrian refugees for close to eight years now (Sheikhsaraf, 2022). It continues to advocate for the resumption of registration activities so as to "better manage needs and responses in Lebanon (Sheikhsaraf, 2022)." For refugee women, and refugees from the LGBTIQ+ community, this is yet another added layer of vulnerability in the case of a lack of registration. As one Syrian refugee woman from Akkar who identified as a member of the LGBTIQ+ community shares: "[...] we already face discrimination and homophobia from our families and community. We already face stigma and a lack of conversation around our mental health. Women in general are also not granted access to health services for everything from their periods, all the way to GBV and domestic violence in many cases. Imagine all this, and then not even being registered – perceivably 'illegal' in the country and not welcome. Many health providers I managed to get to, ask me for my UNHCR registration card. Much of the support registered refugees receive is out of our reach. They are in many cases, even questioned less than us and harassed less than us."[11]

According to a former UNHCR staff member stationed in North Lebanon, unregistered refugees from the LGBTIQ+ community are some of the "most isolated and cut off refugees in Lebanon." He explains: "[...] at least that layer of UNHCR protection affords you some sort of access to health support, to cash, to services. If you are an LGBTIQ+ refugee, then you can utilize this as a key into services that are otherwise not afforded to you if you are not registered. At least this is something. UNHCR knows of you. You have a registration number, a UNHCR card. For so many refugees, LGBTIQ+ and women especially, they are tucked away in an informal tented settlement – likely victims of a patriarchal and violent surrounding – and no one knows they're there. This is extremely dangerous when you think of hate crimes, acts of violence and physical and mental health implications that are not only unreported, but also that there are no repercussions for (see text footnote 1)."

Syrian refugee women, and members of the LGBTIQ+ community highlighted the importance of registration with UNHCR on multiple accounts. As a refugee woman from Akkar shares: "[...] registering with the UNHCR generally helps. For example, if we go to a hospital, they help us with the payment. They also sometimes send us SMS notifications about different health services, recently, for example, when there was the Cholera outbreak, and before that during COVID-19. Many were able to get the vaccine because of that (see text footnote 8)." Registration has particularly assisted some of the most vulnerable members of the LGBTIQ+ refugee community – particularly in cases of sexual assault and violence through referrals. As one trans* refugee woman from Tripoli shares: "[...] I was once physically and sexually

11 In-depth Interview, March, 2023.

assaulted, and I informed UNHCR about the incident. I am a registered refugee with the agency. Two weeks after the incident, they referred me to the Norwegian Refugee Council that was able to provide me with a free medical examination and needed medication. Unregistered trans* men and women are not as lucky, and the support they receive is much less structured and processes tend to be more sporadic or less clear. This makes them even more vulnerable to sexual assault and abuse, as well as long-term health complications following such incidents." The same woman further elaborates on the importance of registration in receiving support from other humanitarian organizations and service providers who receive funding from UNHCR, and are thus more compelled to assist the community – especially women, and members of the LGBTIQ+ community. According to her testimony, this is particularly true for feminist organizations, shelters, safe spaces as well as SHR service providers.

This study additionally found that refugee women in general, are not only less likely to be registered, but are additionally less likely to have their documentation and legal paperwork in order. According to UN Women, Syrian women are 9% less likely to have a legal residency in Lebanon than their male counterparts and Lebanese sponsorship is very rarely granted to refugee women (U. N. Women Arab States, 2019). As a former member of Tripoli's Municipal Council adds: "[...] while we are well aware that most refugees are not registered and that their paperwork is expired, at least the men, because they move around, work, have odd jobs, leave their homes, we can spot. The issue is with their families and wives. At times, a Syrian refugee man has multiple wives in Lebanon, none of which are registered nor have their paperwork in order. And it is easy for women to get away with this, because they are largely restricted to their informal tented settlements or their homes. They do not leave, or even cross a checkpoint. They hardly ever even seek services, report GBV, or attempt to have a role outside the household. This is culturally acceptable to them, and for us, this makes our jobs much more difficult (see text footnote 1)." As depicted, social and cultural barriers, coupled with familial relationships and partnerships that grant refugee women little to no agency or role outside the household, has not only isolated refugee women from obtaining legal documentation, but has additionally further isolated them from accessing the services and support they need for their physical and mental health needs due to fear of being reported, detained, deported or located by local authorities (Diab, 2021a).

## 5.6 Hesitancy around disclosing gender identity and gender-sensitive health needs

Social and cultural stigma surrounding gender roles, identities and expressions continue to serve as leading causes for hesitancy to access services or report on health concerns in Tripoli and Akkar. Findings from data collection across both regions confirm this – with LGBTIQ+ and women refugees insisting that reporting on their SRH, their mental health, implications of sexual assault and GBV all pose a threat to them across multiple intersections. For women specifically, discussions on their menstrual health, sexual health as well as their GBV survival is often met with stigma from health professionals as well as society at large. One refugee woman from Akkar explains: "[...] it is not like I can go to a healthcare provider in our region, or a clinic or even a pharmacy and discuss my period with them, my sexual and reproductive health, as well as sexual assault and abuse in general. Health practitioners in our region are very much part of the close-minded community we live in, and also very inexperienced. While NGOs and UN Agencies might have some exceptions, as a refugee who is not registered, and who needs to resort to public facilities in many cases, my concerns are not treated as health concerns, but are rather treated as a social and cultural issue – an issue used to shame me. In many clinics, I even require my husband's approval to go. Some women even require their fathers' approvals and presence. Imagine this. This has made me, and so many other women from the community hesitant to seek out services. Let's also not forget, that word and gossip travels through the community here (see text footnote 8)."

Refugees from the LGBTIQ+ community in both Tripoli and Akkar support this view, insisting that their hesitancy to report physical and mental health challenges, as well as their health needs, is deeply rooted in an overall fear of retaliation from the local community, as well as a fear of being outed, in many cases by the health practitioners themselves. As one Gender Expert from ILGA Asia informs the study: "[...] there remains an overall lack of awareness in Lebanon's Northern regions. This is not exclusive to Lebanon of course; this is an issue at the MENA level. Conservative communities such as the ones in Tripoli and Akkar add social stigma to non-heteronormative individuals – basically to health complications, gender roles and intersectional needs that they do not understand. And this is not just a societal issue. This social stigma exists in the health facilities themselves. Refugees are already marginalized from the health and service provision spaces. Now, add a layer of gender discrimination into the mix. The result is a community that is afraid to come forward, and a community that self-medicated, self-soothes, and inherits health concerns (see text footnote 4)." This view is reiterated by participants in the study from the LGBTIQ+ community. They insist that their gender identity "affects them personally" and "directly impacts their access to health support." On the issue of gender identity and access, a trans* refugee woman from Tripoli explains: "[...] I rarely find any organizations that support me specifically when it comes to my own needs as a trans* woman. It is hard to talk about our specific needs with anyone, and I don't feel that people around where I live are understanding or accepting. As a refugee, I am discriminated against, and as a trans* woman, I am discriminated against. This has not only isolated me from access to physical and mental health services, but has also isolated me from the narrative and the conversation around refugee health (see text footnote 8)."

Alongside societal and cultural stigmas the LGBTIQ+ refugee community endures, this community in particular describes a constant and ongoing fear of being outed. This has directly impacted the extent to which they feel comfortable requesting the health services they need even when they are made available. As a refugee man from Akkar shares: "[...] I have many [LGBTIQ+] friends in the North that are scared to request any services from organizations because they are afraid that people will find out about them. So they remain without the services that they need. They are afraid of society because they know it will reject them in case they

know about their gender identity and orientation. They believe that they could hurt them in different ways, and some have been hurt (see text footnote 8)." Another participant who is a trans* woman from Akkar shares: "[...] I cannot talk to the medical staff about anything that can reveal my sexual orientation or gender identity because they might refuse to assist me. This has happened. I don't know what they can or would do, but I'm just too scared in general if they find out what might happen (see text footnote 8)."

## 6 Discussion

LGBTIQ+ and women refugees in Lebanon continue to be at risk of being subjected to violence, abuse, and marginalization – sometimes at the hands of people from within their own communities (Diab, 2021b). For those at a particularly vulnerable intersection (trans* women refugees for instance), the perils are often magnified (Diab, 2021b). The multiple, ongoing crises have dramatically impacted local humanitarian programming as well as the ability to expand outreach to meet these intersectional needs. This is a matter that key informants have insisted has impacted access to health services (including mental health support) for this very vulnerable group within the refugee community. As an informant from the Lebanese American University's Title IX Office explains: "[...] when an ongoing crisis such as the one in Lebanon is this deep and this complex, this carries ramifications for humanitarian programming, which then carries implications for the most vulnerable of the vulnerable – in this case, women and LGBTIQ+ refugees. This not only makes it harder to cater to their specific needs in the areas of sexual and reproductive health, but additionally makes it increasingly difficult for the humanitarian space to focus on health-related issues that are specific to the community such as GBV, SRH services, as well as mental health support. Many of these refugees are either isolated from their community for identifying as part of the LGBTIQ+ community, or marginalized as women due to the patriarchal nature of the society they live in."[12]

Our aim was to analyze the extent to which gender identity, gender expression and gender norms impacted Syrian refugees' ability to access gender-sensitive health services in Tripoli and Akkar. Through aiming to answer this question, we explored how refugee status and gender identity co-exist to create very specific forms of intersectional and layered discrimination, and in turn, discriminatory practices in the health care space. Our study found a number of important barriers to healthcare access for SGM and women refugees in the areas of focus, all of which were related to their refugee status, their gender identity/expression or the interplay of both. We further found that Lebanon's national healthcare system as well as its ongoing socio-economic crisis have contributed to the perpetuation of discriminatory practices in the health space – for refugees, most specifically. To the best of our knowledge, this is the first study focusing exclusively on the impact of gender identity on access to healthcare services for the Syrian refugee community in Tripoli and Akkar. In doing so we wished to highlight the ongoing plight of diverse refugee groups, and in turn unpack, de-homogenize and humanize the intersectional and layered refugee experience.

## 7 Concluding remarks and recommendations

In Lebanon there is no refugee policy, and thus there is an inadequate refugee health policy. There is also no gender policy; and thus, there are no gender-sensitive health policies. In both cases, the lack of policy has acted as an enabler of fragmented and *ad hoc* directives, laws and socio-cultural health practices that have served as an ongoing barrier to access for sub-groups under the refugee umbrella. Breaking the cycles of discrimination against women and LGBTIQ+ refugees, especially at the level of healthcare providers in Lebanon's Northern region will only be ensured through the provision of awareness and training on how to provide culturally/gender-sensitive care to refugees, particularly sub-groups within the refugee community. The stigma associated with these populations is rooted in an overall lack of awareness, as well as an overall lack of understanding around the layered vulnerabilities and challenges these groups of refugees endure. Healthcare providers must be trained to create a welcoming and inclusive environment for all patients. Alongside the creation of a safe space for women and LGBTIQ+ refugees, organizations in the humanitarian space operating in the North (that are already working closely with primary healthcare centers) must develop a form of monitoring that assesses the safety and risks associated with certain regions, certain groups, as well as certain forms of vulnerability. At the intersection of gender, health and refugeehood, conversations on safety, protection and access remain complex – and in many cases, unattainable. It is only when refugees are de-homogenized as a group that policy makers and health practitioners can address the intersectional and specific needs of women and SGM within the refugee community.

The overall lack of access to adequate information at this intersection poses an important challenge to research on these migrant groups, as well as to migration and health experts' abilities to ensure that tailored responses, programming and support is made available to the community accordingly. In light of the aforementioned, healthcare organizations must continue to prioritize the formation of partnerships with community-based organizations that work with refugees, particularly those that focus on the needs of women and LGBTIQ+ individuals. These partnerships can help to bridge the gap between healthcare providers and refugees, increase awareness about available healthcare services, and provide tailored services for the targeted communities in addition to safe referrals to healthcare providers. Alongside conversations on physical health, mental health services must also constitute a priority for humanitarian agencies and healthcare providers, and should be made more accessible to refugee groups – particularly women and members of the LGBTIQ+ community. The traumatic experiences that refugees have undergone can have severe long-term effects on their mental health, and access to mental health services can be a key factor in their overall health and wellbeing. Similarly, tailored programs should be developed in partnership with local organizations that work with LGBTIQ+ and women refugees more specifically –

12 Inception FGD, Online, June 2022.

importantly, programs that address their intersectional needs as a result of heightened GBV, intimate partner violence as well as sexual assault toward these groups.

The question of women and LGBTIQ+ refugees' access to adequate, gender-sensitive and tailored health services is key to understanding the complexities and hierarchies within healthcare access. Lebanon's positionality as either strategically indifferent to refugee and gender issues, or hostile toward communities in either of or both of these categories continues to push their health and wellbeing down the priority list. The absence of clear legal and policy frameworks, coupled with discriminatory practices continue to breach to the realization of a rights-based approach to health at the national level, and in North Lebanon more specifically. Overall, our findings support the need for the development of health responses that not only cater to the needs of women and LGBTIQ+ refugees, but also that ensure that medical practitioners are as educated and informed around gender-sensitive practices. Additional recommendations include: (1) Improving communication about SRH with women and SGM refugee patients. This includes gender-sensitization and rights-based training for medical professionals in order to ensure that non-discriminatory practices toward refugees, women and SGM are upheld. (2) Fostering a safe environment for SGM and women from the refugee community to disclose their sexual orientation and/or gender identity, as well as their gender-specific needs. In practice, this would mean reassuring patients that they will be treated with respect regardless their gender identity and legal status, as well as ensure the use of non-heteronormative language in consultations. (3) Referring women and LGBTIQ+ refugees to specialized support services – as many refugees in Akkar and Tripoli may not feel safe in refugee-specific or public health provision spaces.

## Data availability statement

The raw data supporting the conclusions of this article will be made available by the authors, without undue reservation.

## Ethics statement

The studies involving humans were approved by the Institutional Review Board at the Lebanese American University. The studies were conducted in accordance with the local legislation and institutional requirements. Written informed consent for participation in the study was provided by all participants.

## Author contributions

JD led on the conceptualization, project administration, supervision, analysis, and writing the original draft. BS and DM contributed to data collection, transcription, translation and thematic analysis. KC contributed to supervision, analysis, editing, and led on submission.

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## Conflict of interest

The authors declare that the research was conducted in the absence of any commercial or financial relationships that could be construed as a potential conflict of interest.

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