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Exploring the impact of multidimensional refugee vulnerability on distancing as a protective measure against COVID-19: The case of Syrian refugees in Lebanon and Turkey

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ABSTRACT

Background: The unequal physiological and socioeconomic consequences of the COVID-19 pandemic across the world are revealing the multidimensional components of health and vulnerability. As governments have pushed physical and social distancing as protective strategies, this study explores the extent to which this approach is relevant for Syrian refugees living in Lebanon and Turkey.

Methods: This qualitative study draws on 11 interviews with refugee experts and development practitioners (3) and Syrian refugee families (4 from Turkey, 4 from Lebanon) during the COVID-19 pandemic, as well as a review of recent literature. In addition, it draws on 71 semi-structured interviews with staff at NGOs supporting refugees (48 from Turkey, 23 from Lebanon) collected in 2018. Qualitative data analysis software ATLAS.ti 8 was used to perform content-based thematic analysis using both deductive and inductive coding.

Findings: The study finds that distancing—physically and socially—can be ineffective as a disease protection strategy in Syrian refugee communities. This is influenced by six major interconnected dimensions of refugee vulnerability—political, material, spatial, physiological, psychological and sociocultural—which collectively form an interdisciplinary framework to guide more relevant COVID-19 interventions in refugee communities. The inability to distance is not necessarily rooted in lack of knowledge. Rather, when the inside conditions of living are crowded and unhygienic, but also include cultural expectations of familial care, and the outside conditions of survival-necessitated work are perpetuated through precarious political protections, distancing becomes impractical in application, despite the sense of internalized responsibility to keep one another safe.

Conclusions: The findings suggest that more relevant COVID-19 interventions and protection measures must consider the non-physiological manifestations of disease across multiple dimensions of vulnerability to mitigate decreased distancing abilities in settings of refugee life.

1. Introduction

As of early 7 December 2020, over 67 million cases of COVID-19 have been reported internationally (John Hopkins University 2020). Health organizations and governments continue to advocate physical and interpersonal distancing measures as the most effective means of protection (WHO 2020). Unfortunately, certain populations may be at higher risk of infection, given multiple dimensions of vulnerability that create difficulties in practicing recommended distancing guidelines (Patel et al., 2020; Vonen et al., 2020). Falling into this risk category (Vonen et al., 2020; Alawa et al., 2020; Khor and Heymann, 2020; SEED 2020) are 3.6 million Syrian refugees in Turkey and 1.5 million in Lebanon (UNHCR 2020), displaced as the world's singularly largest group by the ongoing Syrian Civil War. Without more appropriate interventions, disproportionately serious health and socioeconomic outcomes could result in these large refugee populations.

Given these challenges, this study contributes to the current literature on COVID-19 and recommended protective strategies, focusing on the applicability of distancing in refugee communities. Based on recent qualitative interview data and literature on refugee life in Turkey and Lebanon collected during the pandemic, as well as earlier interview data collected in 2018, it questions the extent to which distancing as a protective approach is relevant or even feasible. It identifies six dimensions of vulnerability—political, material, spatial, physiological, psychological and sociocultural—that together hinder refugees' ability to practice distancing measures in both camp and urban settings. Taken collectively

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as a framework, the identified dimensions of refugee vulnerability can be used as an analytical tool to better inform COVID-19 interventions in refugee communities and address major obstacles against effective protection, as well as demonstrate the need for interdisciplinary approaches combating pandemics within vulnerable communities more generally.

1.1. Threats of COVID-19 in Syrian refugee communities

COVID-19, caused by the novel pathogen SARS-CoV-2, is a disease that primarily affects the respiratory system (Harvard Health Publishing 2020). Although many cases incur few—if any—mild flu-like symptoms (e.g., fever, cough, body aches), others result in severe respiratory distress, blood clots, seizures or serious strokes (Harvard Health Publishing 2020). Various comorbidities and conditions of reduced health (e.g., diabetes, obesity, cardiovascular disease) can worsen susceptibility to COVID-19 and the severity of outcomes (Yang et al., 2020). Additionally, access to relevant, timely treatments—often influenced by socioeconomic factors—plays a role in the apparent demographic variability of COVID-19′s outcomes (Patel et al., 2020).

COVID-19 has affected the general populations of Turkey and Lebanon to middling degrees. Turkey is among the top-20 countries worldwide with the highest number of cases; over 828,000 have been confirmed as of early December, 2020 (John Hopkins University 2020). Lebanon has had over 137,000 cases (John Hopkins University 2020). Case-fatality rations in both countries have been on the lower end (Turkey = 1.8%; Lebanon = 0.8%) (John Hopkins University 2020). Both Turkey and Lebanon have implemented internationally common distancing measures to reduce COVID-19′s spread and promote individual protection, to include: curfews; mandated personal protective equipment in public spaces; isolation if ill and separation in public spaces; closures or remote delivery of business, government and education services; and restrictions on travel and transit.

Although underreporting of infections in refugee communities is likely (Mhaissen, 2020; Balcioglu and Erdogan, 2020; Üstübici and Karadağ, 2020) and has made the disease burden in these populations difficult to assess, this does not indicate decreased risk to refugees in these countries overall (Alawa et al., 2020). For Syrian refugees, living conditions have been consistently poor, even following migration. The majority of refugees in Lebanon and Turkey live in poverty; food insecurity and nutritional deficiencies remain problematic (Cuevas et al., 2019; Syrian Center for Policy Research (SCPR) 2019; Yassin, 2019; Syrian Center for Policy Research (SCPR) 2020). The number of Syrians with chronic, non-communicable diseases (e.g., diabetes, heart disease, cancer, depression) has also been steadily growing (Silbermann et al., 2016; Abbara et al., 2020). Higher rates of unvaccinated individuals, communicable disease (e.g., measles), multidrug-resistant infections, malaria and hepatitis have also been increasingly documented in refugee communities in Turkey and Lebanon (Doganay and Demiraslan, 2016; Tayfur et al., 2019; Ozaras et al., 2016). These conditions are similar to those affecting other international refugee populations during the COVID-19 pandemic; poor political protections, reduced access to healthcare, low-quality accommodations and compromised water, sanitation and hygiene (WASH) conditions are showing that capacity to distance is limited (Alawa et al., 2020). Modeling has predicted that these conditions have the potential to exacerbate COVID-19 spread quickly in refugee communities (Truelove et al., 2020). Such threat is unsurprising, given that communicable diseases have been historically problematic in refugee populations (Khor and Heymann, 2020), and respiratory viral infections specifically have been associated with high rates of illness in refugee camps (Ahmed et al., 2012).

1.2. Applying an interdisciplinary refugee vulnerability framework in a setting of pandemic intervention

As situational inequalities enhance the primary and secondary effects of COVID-19 in certain communities, we employ an interdisciplinary perspective relying on concepts of asset vulnerability, institutional exclusion and the biosociality of disease to provide a more relevant refugee vulnerability framework for the assessment of distancing as a protective strategy in refugee communities.

Fundamentally, vulnerability is the “insecurity and sensitivity in the well-being of individuals” [(Moser, 1998), p.3] to withstand stresses and shocks in the cadence of daily living (Chambers and Conway, 1992). Although stresses are continuous or regular events, and shocks are sudden and unpredictable (Chambers and Conway, 1992), both are especially acute in the refugee context due to the institutionally complex and constraining dimensions of refugee living, which make them difficult to withstand and recover from. Across the world—whether living in camp, informal or urban settings—refugees suffer from poorer conditions of health (Giuntella et al., 2018), employment integration (Brell et al., 2020), rights (Betts and Collier, 2017) and socioeconomic opportunities (Jacobsen, 2002), compared to both citizens of the countries they live in, as well as other types of migrants. These conditions are largely driven by exclusionary governance frameworks that pertain specifically to refugees (Betts et al., 2016): they constrain multiple life determinants such as freedom of movement, family unification and integration capacity, but also access to the labor market, humanitarian aid, education, healthcare and physical protection. Collectively, these conditions generally limit refugees’ access to the material and immaterial assets needed to enhance their holistic capability to enjoy a decent standard of living and avoid perpetual conditions of multidimensional vulnerability (Betts and Collier, 2017; Jacobsen, 2002).

As an unexpected natural event with unexpected legal and economic responses, the current COVID-19 pandemic is a shock to which Syrian refugees are more vulnerable. A syndemic, biosocial approach to disease may more accurately consider this positioning by examining not just the biological pathogen itself, but also “the ways in which social environments, especially conditions of social inequality and injustice” contribute to the presentation of disease and further deepen vulnerability [(Singer et al., 2017), p.941]. The COVID-19 pandemic, although originating from a novel biological pathogen, is inherently positioned for analysis with this perspective; its cross-species transmittance occurred via economic processes of animal trade and urbanization and spread via international, national and local interpersonal processes of everyday interactions (Hartigan, 2020). At community and individual levels, the comorbidities worsening COVID-19′s outcomes are not merely biological factors like age or sex, but rather, the ways in which these factors have been subject to a variety of social, political, economic and cultural forces shaping their manifested individual experiences over lifetimes (Gibbon et al., 2020; Willen et al., 2017). COVID-19 cannot be reduced only to its biology because both its perpetrators and effects go beyond biology.

Based on these perspectives, and supplemented by emerging categories from our data, we suggest an analytical framework (Fig. 1) identifying six interrelated dimensions of refugee living—political, material, spatial, physiological, psychological and sociocultural dimensions—that not only increase refugees’ susceptibility to COVID-19 more generally, but their inabilities to distance as a relevant protection strategy.

In the refugee context, political vulnerability is a unique dimension relating to the precarity of legal protections of residency, rights and service access. It underlies and drives the other dimensions, as these are the aforementioned governance structures that make the bounds and possibilities of refugee living distinct from other types of migrants or host-country residents. Material, physiological, psychological, sociocultural and even spatial dimensions of vulnerability can be conceptualized similarly as in other vulnerability frameworks describing the urban and rural poor (Moser, 1998; Chambers and Conway, 1992), but with elements of application more specific to refugee living. Refugees are particularly susceptible to material vulnerability, in that monetary and physical resources are frequently lost in war or flight, hard to re-establish through sustainable livelihood activities and thus difficult to draw on during adverse events (Jacobsen, 2002). As material inadequacies lead

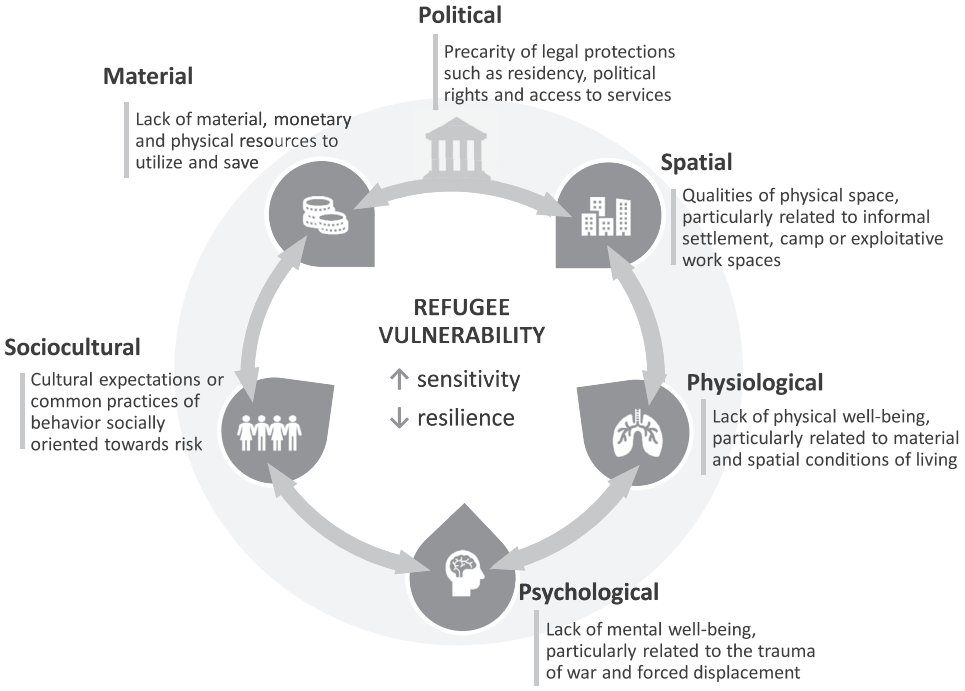

Fig. 1. Dimensions of refugee vulnerability impacting distancing ability in the COVID-19 pandemic context.

to poor-quality living and working spaces, the related spatial dimension refers to the effects of these qualities (Agier et al., 2002; Cutter et al., 2003), which may expose refugees to greater environmental hazards, corporal risks and mental difficulties in coping with them. As such, the physiological and psychological dimensions of vulnerability refer to the ways in which refugees are unable to take care of their overall physical and mental well-being, also threatened by the experiences of enduring war and trauma (Willen et al., 2017). Finally, the sociocultural dimension of vulnerability refers to social practices of behavior that may be socially positioned towards risk. In the refugee context, at the community level, this includes conflict-related social network dissolution, as well as disruptions in local provisioning networks driven by community-based organizations (CBOs), international NGOs (INGOs) and local government intervention programs (Moser, 1998; Cutter et al., 2003). At the household level, social expectations, gender roles and cultural practices may predispose certain people towards engaging in higher-risk activities (Cutter et al., 2003).

Ultimately, the framework serves to capture the layered interplays and feedback mechanisms of these vulnerability dimensions, especially to better understand the complex effects of COVID-19 across various strata of living.

2. Methods

2.1. Key definitions

2.1.1. Syrian refugee

We consider Syrian refugees to be any Syrian national forcibly displaced to neighboring Turkey and Lebanon due to the Syrian Civil War and related fear of persecution. This includes Syrians with a formal refugee protection status, but also those with residency visas without specific refugee protections and those without legal documentation. We include this variety of statuses to account for the reality of refugee migration conditions in both countries

2.1.2. Distancing

Drawing from the World Health Organization (WHO 2020) and Johns Hopkins University (Maragakis, 2020), we consider distancing to be spatial separation (e.g., remaining 2m apart, staying isolated preventatively or when ill), as well as the minimization of interpersonal interactions (e.g., closing services/institutions, restricting travel, reducing gatherings, obtaining essential provisions, using adequate personal protective equipment when interactions are necessary).

2.2. Study design and data

This qualitative study was exploratory with the purpose to describe the specific vulnerability-related challenges faced by Syrian refugees living in Turkey and Lebanon when attempting to practice distancing as a protection measure in response to COVID-19.

A review of literature, focusing on reports and empirical studies written after 2018, was used to assess the general vulnerability context within different dimensions of contemporary refugee living. 11 semi-structured interviews with refugee experts and development practitioners (3) and Syrian refugee families (4 from Turkey, 4 from Lebanon) were conducted via online communication channels in June—September 2020. Additionally, we drew on interviews from dissertation fieldwork conducted between October—December 2018 in Istanbul, Izmit and Ankara in Turkey and Beirut and the Akkar area in Lebanon, areas with high concentrations of Syrian refugees and support NGOs. During this period, semi-structured interviews were gathered with 71 staff working in these NGOs and key experts (48 from Turkey, 23 from Lebanon).

Participants were selected using a combination of purposeful and snowball sampling, given the need to diversify the sample across demographic characteristics and reach specific experts (Patton, 2000). Interviews were conducted in either English or Arabic, until responses were repetitive and saturated (Fusch and Ness, 2015). Interviews were translated from audio recordings and transcribed to English by the study's first author, a bilingual native speaker of Arabic and English.

Ethics approval was obtained through the director of the Department of Political and Cultural Change and the fieldwork ethics committee of the Center for Development Research, University of Bonn. We obtained written or verbal consent from all participants. We prioritized confidentiality through the anonymization of all data.

2.3. Data analysis

Interview data was analyzed through the interpretive process of thematic content analysis (Swain, 2018), using both deductive (from concepts in literature) and inductive (from meaning in data) coding. Immersive familiarization with the data was the first step of the coding process (Braun and Clarke, 2006). Next, using ATLAS.ti 8 qualitative data analysis software, we constructed an initial hierarchical code template, based on our familiarizations and reviewed literature (Swain, 2018). Each interview was coded in the software line by line by applying descriptive, in-vivo and process codes to relevant words and phrases (Saldaña, 2009). As the analysis progressed, we modified and derived more precise codes and organizational hierarchies to be grounded within the data, continuing until we could identify no new patterns or code manifestations (Swain, 2018; Braun and Clarke, 2006). Finally, we explored the relationships between the codes, grouping basic units into broader concepts in order to identify the most salient themes and meanings (Saldaña, 2009). We validated the coding and themes through collaborative dialog and review.

3. Results

The results reveal that six dimensions of vulnerability—political; material and spatial; physiological and psychological; and sociocultural—limit distancing abilities of Syrian refugees in Lebanon and Turkey during the COVID-19 pandemic. The findings are organized by the primary dimension of vulnerability, discussing their influences from two perspectives: first, how these conditions have been forming in Syrian refugee communities before the COVID-19 pandemic, and second, how their persistence affects distancing abilities during the pandemic.

3.1. Political dimension

To date, both Turkey and Lebanon have approached refugee governance with degrees of exclusion and temporality. Turkey, despite being a signatory to the 1951 Refugee Convention, grants full refugee-status rights exclusively to refugees coming from Europe (Chatty, 2016). Other Syrian refugees receive temporary forms of asylum or pursue alternate student, retirement or investor visas, which confer varying levels of service access and generally prevent the most robust legal forms of protection (Cantekin, 2018; Ineli-Ciger, 2017). Although the Government of Turkey (GoT) has avoided protracted camp living with just under 3% of Syrian refugees residing in them (Chatty, 2016; World Bank 2015; Erdoğan and Çorabatır, 2019), urban refugees do not receive the same material benefits from state support (Woods, 2016), instead relying on CBOs as a primary source of assistance (Mackreath and Sağnıç, 2017). Lebanon has avoided supporting Syrian refugees as a long-term political endeavor (Jagarnathsingh, 2016). Refusing to sign the 1951 convention, the Government of Lebanon (GoL) has instead referred to refugees merely as “displaced persons” [(Janmyr 2016), p. 61]. These exclusionary structures—along with large numbers of undocumented refugees and the 2015=suspension of UNHCR registration—have largely transferred health, education and livelihood provisioning responsibility to CBOs and INGOs (Janmyr, 2016; Shamieh, 2015; Kabbanji and Kabbanji, 2018). Although locality-based responses can offer more flexibility in program design, they can also create perceptions that support is conditional, inconsistent or discriminatory (Mhaissen, 2020; Janmyr, 2016).

These precarious political conditions have created inequality in legal residency protections, service access and welfare provisioning, forming the base conditions from which other vulnerability dimensions stem:

> This [access problem] exists before Corona, and during Corona and after Corona, and it won’t change, because there are no rights in Lebanon. (Syrian male, Beirut, Lebanon. 09.06.20)

In the context of COVID-10, better access to these support mechanisms might encourage or even incentivize distancing if they could be applied more equitably:

> [Vulnerability] is related with how inclusive the hosting country’s policy is or not. In Lebanon, they are highly exclusive, … the lack of documentation makes accessing hospitals etc difficult, so this adds great responsibility to NGOs. Exclusive policies make refugees more vulnerable…. The government gives 1200 TL monthly for Turkish citizens that were negatively impacted by COVID-19, but not Syrians. (Refugee migration expert, Ankara, Turkey. 08.18.2020)

Similarly, this precarity in legal status and service access can discourage the practice of distancing measures related to maintaining residency paperwork, and more critically, obtaining testing and health information to isolate when ill, for fear of deportation or other political reprisal:

> I think there is no fear for the people that are regular (with the correct paperwork), but if I’m from [registered in] another city or especially for refugees that have the refugee papers or *Kimlik*, things are very difficult because they don’t know what happens next [after treatment], so some of them I feel risk it [by avoiding testing or treatment]. (Syrian female, Istanbul, Turkey. 09.11.2020)

3.2. Material and spatial dimensions

Poverty has been and continues to be a dominant material condition of living in Syrian refugee communities in both Turkey and Lebanon. In Lebanon, 91% of refugees are food insecure, 76% live in poverty and 58% live in extreme poverty (SCPR 2020). In Turkey, around 25% of refugees may have inadequate food consumption (Cuevas et al., 2019), around 64% live in poverty and 18.4% live in extreme poverty (Utas et al., 2019). Worsening macroeconomic conditions, inflation and unchanging wages in both Lebanon and Turkey have contributed to these conditions (FAO 2019).

Limited labor-market access and informal employment exacerbate these conditions. Although in 2016, the GoT legalized the right of Syrian refugees to formal employment, a mere 3% of the working-age population possesses work permits (FAO 2019). In Lebanon, refugees are legally permitted to work only in a limited number of low-skilled occupations, such as construction and agricultural labor (Janmyr, 2016; Kabbanji and Kabbanji, 2018; Yahya et al., 2018). Recent estimates suggest that 95% of employed Syrian refugees in Lebanon are working informally due to legal status issues, with only 2% eligible for security benefits (Kattaa et al., 2020). The effects of these working conditions include wages far below legal minimums, a lack of welfare eligibility, an inability to purchase necessary materials for living and exposure to physically unsafe working environments (Ineli-Ciger, 2017; Shamieh, 2015; Knappert et al., 2018; Médecins du Monde Turkey 2019). As such, Syrians in both countries face the ongoing survival necessity of working in whatever conditions are necessary.

Material vulnerability has also included a lack of high-quality shelter. Whether inside or outside camps, large numbers of Syrian refugee households in Turkey and Lebanon live in substandard accommodations. In 2018, a third of Syrian refugees in Lebanon were living in overcrowded (<4.5m^2/person) and substandard shelters with conditions such as leaking walls and roofs, lack of weathering, rot or other hazards (Yassin, 2019). In densely populated urban areas where COVID-19 infection rates are high and the majority of refugees live (Kirisci and Yavcan, 2020), housing conditions vary, but overcrowding, poor ventilation, mold and lack of heating are common problems (Balcioglu and Erdogan, 2020; Médecins du Monde Turkey 2019). Across Turkey, 20% of Syrian households lack access to clean drinking water, and 32%, adequate WASH conditions (Médecins du Monde Turkey 2019).

These rote material difficulties of living make distancing measures difficult to face practically. With scarce financial resources at their dis-

posal becoming even scarcer during the pandemic, Syrian refugees find themselves having to choose between food, rent payments or supplies related to distancing measures—such as masks, cleaning products and gloves. The additional expenses are too much to absorb:

> People who have no capacity to isolate because they have to work, those are at main risk. We need to identify how we can make people less dependent on daily wages. Syrian refugees in Lebanon live on hourly or daily wages. (Refugee public health expert, UK university. 08.26.2020)

> When I instruct them that they have to wash their hands, buy disinfectants, or say, you need to buy gloves, mask, they are not able to afford buying these things. Some families tell you that we are not able to buy a bottle of disinfectant that costs this much, I need to buy a bottle of milk instead with this amount, I need to buy bread, I need to buy something for my children especially for families with 5 or more children. It is very difficult for them, and they can't afford it, and this is the main obstacle. (Syrian female, Ouzai slum, Beirut, Lebanon, 09.12.20)

The compromised material conditions of living intersect with the spatial during COVID-19. Given the spatial conditions of work and domestic life, there is no practical way to physically remove oneself from those around, in crowded homes, slums, workplaces or transportation:

> Nine people on average living together in the camps, they use whatever utilities are available to them. Also, in slums outside the camps in the middle of Beirut, sometimes up to 3 families live in one apartment. … Already a lot … are saying living conditions in [camps] are so bad and they fear infection. … you are more exposed, and you expose others. (Refugee public health researcher, UK university. 08.26.2020)

> There were also huge violations of the imposed curfew among informal Syrian workers, like those working in the textile industry. … If your boss says you must come … and you need to take public transportation to get there, you just do it. Therefore, they are at a higher risk than formal workers who have aid to cover their expenses. If they refuse to go [work], it means no money to buy food or *colonia* [high-alcohol perfume used as disinfectant] and no masks. (Refugee migration expert, Ankara, Turkey. 09.10.20)

3.3. Physiological and psychological dimensions

Access to healthcare has not been straightforward in either country, even before COVID-19. Registered Syrian refugees in Turkey have access to free public healthcare like Turkish citizens, while the undocumented are granted access to emergency services (Batalla and Tolay, 2018). However, access has historically been limited by the number of refugees overcrowding health care facilities (FAO 2019; Diker, 2018), as well as poor information availability, language barriers, legal status issues, fear of deportation, cost and lack of facilities in some areas (Balcioglu and Erdogan, 2020; Médecins du Monde Turkey 2019; Kirişci and Erdoğan, 2020; Relief International 2020). Prior to COVID-19, an estimated 1 in 3 Syrians in Turkey did not have access to reliable healthcare (Médecins du Monde Turkey 2019).

Lebanon relies primarily on a highly privatized and expensive health care system (World Food Programme 2020; Political Economy of Health in Conflict, 2020). Syrian refugees have access to public healthcare institutions, which focus on primary care and provide limited service (Lyles and Doocy, 2015). Given these structures, Syrians face serious challenges accessing healthcare due to affordability. As late as 2018, 70% of Syrian households needed, but could not access hospitalization with costs cited as the main barrier (Yassin, 2019). Upwards of 70% of Syrians have reported inability to afford medicine (World Food Programme 2020). Refugees' healthcare costs are covered partly by the Ministry of Public Health, INGOs, and UNHCR, but these sources of help do not provide full or consistent coverage (Political Economy of Health in Conflict, 2020).

Health and care access during COVID-19 has been mixed in both countries. In April 2020, the GoT announced that all migrants—irrespective of their status—would have access to public health care (Balcioglu and Erdogan, 2020; Kirişci and Erdoğan, 2020). However, 61% of Syrian households in Turkey surveyed in the aftermath of COVID-19 stated that their healthcare access was negatively affected by the virus (Relief International 2020; Médecins du Monde Turkey 2020). In Lebanon, COVID-19-related losses in income influencing the abilities to pay food and rent have discouraged refugees from pursuing treatment related to COVID-19 symptoms, although theoretically UNHCR will cover testing and treatment costs (Mhaissen, 2020).

Even so, due to accurate government and NGO information campaigns, health-related knowledge about the virus, its symptoms and the theoretical importance of distancing measures is generally high among refugees, even given potential language issues:

> At the moment, the Minister of Health [in Turkey] makes a press conference every week and explains. Mosques, and all the shops, also write the rules, and that wearing a mask is obligatory in private and government bodies, and about distance, and disinfection and these things…they [Syrians] have many pages [i.e., social media sites in Arabic], the most trustworthy is by a Syrian man that is very well known. He … translates trusted news and publishes them. (Syrian female, Ankara, Turkey, 08.13.2020)

> The Minister of Health [in Lebanon] was one of the most active persons during the Corona crisis … sending instructions and information, as well as the Lebanese TV channels. I think regarding the Corona disease, everyone has a very clear idea about it. (Syrian male, Beirut, Lebanon, 08.30.20)

In this way, it is not necessarily a lack of health knowledge that discourages distancing from physiological or psychological perspectives. Many refugees already suffer physical and functional disabilities due to the war, or have existing chronic diseases that worsened because of it; psychologically the experience of conflict, poverty and displacement leave many with regular feelings of distress, anger and fear (World Food Programme 2020). Compromised both physically and psychologically, refugees question the relevancy of practicing distancing measures. They may feel overwhelmed with how to logistically cope with the threat of the virus, given the interactions of various vulnerability dimensions of living:

> Worries about how they will pay the rent… fear and worry and burden. The media talk and its hype, that alone is psychologically difficult… For those who go to work and might mix with other people, for those, yes there exists some worry. So, it is normal, there is fear and psychological stress, and may God protect everyone. (Syrian female, Ankara, Istanbul. 08.13.2020)

A sense of psychological hopelessness can follow in the most extreme instances. The purpose of distancing is called into question, when death might come from already depressed immunity, the lack of ability to treat other illness or starvation related to not being able to work:

> They [refugees] often say their choices are 'we either die [from COVID-19] or starve. I don't want to starve, it's a more painful death.' ... This comes as a response when you have no other options. (Refugee public health researcher, UK university. 08.26.2020)

> Lebanese people themselves were not going out, they were afraid for themselves more than us. But us, honestly, we say we are dead and dead anyway. We want to go out, let what happens happen. What's going to happen worse than this? (Syrian husband and wife, Tripoli, Lebanon. 08.27.20)

3.4. Sociocultural dimension

3.4.1. Household level

Familial domestic care structures are culturally of high significance (Al Munajed, 2020). Families are multigenerational and feel socially obligated to prioritize the care of one another. In the context of COVID-19, these expectations of familial obligations impact distancing ability in the clearest way. On the one hand, women are often at home, expected to care for those who are ill (Evans, 2020), increasing their own risk if they were to be caring for those infected (Evans, 2020). Men, on the other hand, are expected to work, with little realistic ability to stay home (Médecins du Monde Turkey 2020). Individuals feel compelled to act within their structured roles, even if distancing ability is impaired for different, gendered reasons:

> My parents are always social distancing. … My mother only leaves the house when she needs to for paperwork. … I don't practice social distancing as much as my parents though, because I usually run their errands and buy the groceries. (Syrian female, Kocaeili, Turkey. 08.15.2020)

3.4.2. Community level

Prior to COVID-19, familial and social networks, as well as levels of trust in others, have been threatened due to displacement, reducing an important form of material and mental support (SCPR 2020; Uzelac et al., 2018; SCPR 2017). As a result, Syrian refugees in Turkey and Lebanon rely heavily on material aid and support from networks of CBOs in particular (Mhaissen, 2020; Médecins du Monde Turkey 2019). The COVID-19 outbreak has caused serious disruptions in this support, as the movement of humanitarian workers has become restricted, and NGOs suspend assistance to adapt to home-based working (SEED 2020; Mhaissen, 2020; Balcioglu and Erdogan, 2020). Provisioning is not being provided adequately such that it might better encourage distancing measures:

> Without financial and moral support for these poor, weak families by organizations, … give them a bit of aid, maybe they can reduce the burden on the father, to be able to at least get protection for himself, to buy the mask and gloves, and small disinfectant so he won't enter his house carrying this virus. But unfortunately, this support doesn't exist at all. (Syrian female, Ouzai slum, Beirut, Lebanon, 09.12.20)

> COVID-19 is exposing the cracks, the biggest crack is that everything that was done since 2016 to today … under humanitarian and emergency response was not enough if you still have 1 in 3 Syrian refugee households without access to clean water. This is a huge problem, what NGOs are doing, their errors. (Refugee migration, Ankara, Turkey. 08.18.2020)

The distribution of social welfare aid in both Turkey and Lebanon has historically shown a degree of ethnic bias in that prioritizes host populations over Syrian refugees, often to meet political ends, non-local funding requirements or even organizational self-interest (Mhaissen, 2020; FAO 2019; Médecins du Monde Turkey 2019). This persists during COVID-19, making some aid conditional on certain sociodemographic characteristics, cutting off support from those who need it most, or even increasing threat of exposure to COVID-19 in how the aid must be retrieved:

> There are also some religions giving people aid, but they take advantage of them in a certain way, and people seeking aid have to sit with them, so they can get this carton [aid], they [religious NGOs] try to pull people in need to them, and if you don't go, they don't give you. (Syrian refugee husband and wife, Tripoli, Lebanon. 08.27.20)

Despite the strain on social resources over time, a feeling of obligation to help other refugees in the community persists:

> '*Al Ghirbeh*'. [Arabic term meaning *living in estrangement* or *abroad*] We went from being a 'people' to a 'community.' We feel a sense of duty to the community that is here, it is also a form of psychological support for us. (Syrian female NGO volunteer, Istanbul, Ankara. 10.27.2018)

This attitude continues during the COVID-19 pandemic, as refugees acknowledge the roles they themselves play in keeping other members of their community safe, distancing to the best of their abilities:

> You feel a very big sense of responsibility that you can infect others … If I did [have Corona], I could have infected others, others with a weaker immunity, and they could get Corona faster than me. That's why I felt very responsible and uncomfortable. (Syrian female student, Istanbul, Turkey, 09.11.20)

> Its nothing, it's our duty to help each other, … to help ourselves and others around us as much as we can, … raising our own awareness and the awareness of those around us, and as much as possible to protect ourselves from Corona. (Syrian female, Ouzai slum, Beirut, Lebanon, 09.12.20)

4. Discussion

Like several studies conducted to date (Alawa et al., 2020; SEED 2020; Mhaissen, 2020; Balcioglu and Erdogan, 2020; Médecins du Monde Turkey 2020), our study findings suggest that Syrian refugees living in Lebanon and Turkey display increased susceptibility to the primary and secondary effects of COVID-19. As a group, they are positioned to be more sensitive to contracting the disease and less resilient in recovering from its physical and socioeconomic effects, due to the identified vulnerability dimensions of refugee living complied in this study's suggested framework.

These dimensions lead to inability to distance as a relevant protection strategy. A lack of information or perceived ignorance of protection measures does not seem to be a primary contributing factor. Rather, given the nature of the considered shock, a pandemic with a spatial factor in the disease's spread, being forced to live, work and commune in crowded, compromised-quality areas with few physical and legal means of protection confers difficulties simply existing within the physical spaces of living. Other studies similarly find that the impacts of high rates of job loss, declines in household income and lack of legal support for job security, liveable wages and work-related protective equipment are more important factors (SEED 2020; Mhaissen, 2020; Kattaa et al., 2020; Relief International 2020; World Food Programme 2020; Médecins du Monde Turkey 2020; Akyıldız, 2020). These conditions have resulted in depressed material resources to pay for essential items such as food and rent, much less distancing-related health necessities such as protective equipment. Additional sociocultural factors, such as gender roles (Médecins du Monde Turkey 2020; Al Munajed, 2020) and inadequacies in community-based provisioning (Médecins du Monde Turkey 2019), also influence exposure risks and distancing abilities, as in other studies. Female caretakers at home or male heads-of-household working to provide for their families are vulnerable for different gendered reasons.

Consequently, the irreleavance or inapplicability of mainstream distancing measures is a recurrent theme in this study's collected data. In the context of being compelled or told to distance by authorities, refugees are left with feelings of confusion and frustration, as well as hopelessness in extreme cases. Similar to other studies finding that refugees report high levels of stress, anxiety and hopelessness directly related to quarantine measures (SEED 2020; Médecins du Monde Turkey 2020), our findings show they worry not only about how they might be forced to face the effects of COVID-19 as a disease, like poor health or even death, but also its secondary socioeconomic effects, like the inability to earn a living or get treatment for other health conditions. At the same time, social expectations and a sense of responsibility towards an-

other to work together to protect each other from harm prevail as they attempt to do what they can, even while access to aid and other forms of support are threatened.

Despite the congruence of findings with other literature, the primary limitation of the study is the lack of generalizability to all Syrian refugees living in Lebanon or Turkey. Expanding the sample size of interviews completed in 2020 was severely limited by travel restrictions, communication difficulties and general situational instabilities in both countries. Further studies would use the suggested framework to expand similar research inquiries to larger communities. Additionally, surveys operationalizing the framework concepts quantitatively would also offer greater insight into the specific causality mechanisms driving the components, an element lacking in this study. An additional limitation is the singular focus on distancing as a protective measure. These limitations are mitigated, however, by the fact that the study positions itself as an exploratory, theoretical and empirical base for other empirical work relating to COVID-19 and refugees.

5. Recommendations

Based on our interdisciplinary approach and findings, we propose recommendations for practitioners for more relevant COVID-19 protection efforts in Syrian refugee communities.

5.1. Acknowledge co-occurring vulnerabilities in intervention design

Primarily stakeholders must acknowledge the specific, co-occurring vulnerabilities of refugee living and consider them simultaneously in designing effective COVID-19 interventions. For example, free COVID-19 clinics in refugee camps may facilitate access to health care and reduce physiological vulnerabilities, but may not work effectively if politically-related fears are ignored. In addition, as psychological vulnerability is tied to worsening conditions in other dimensions, effective interventions that reduce feelings of helplessness or futility are an essential component to encourage distancing or program adoption. Such interventions may include offering acute material assistance to reduce feelings of desperation, protective equipment to promote feelings of safety and support to local community-based efforts to enhance fragile social networks and capitalize on empowering feelings of the shared responsibility to help one another.

5.2. Build more inclusive COVID-19 governance policies

Governments play a critical role reducing refugee vulnerabilities, especially political ones resulting from exclusionary policies. For example, formalizing access to more affordable healthcare as a fundamental right and eliminating actual or perceived political consequences of individual action may improve disease protocol adoption and treatment within refugee communities. Distributing government aid among host and refugee communities equally, and adopting policies to encourage refugees' formal employment and eligibility for work environment protections and social welfare programs, are further examples of government-specific measures to improve the material and spatial vulnerability of refugees. Government protections in these areas are especially important to address, given ongoing material impacts from generally worsening macroeconomic conditions.

5.3. Enhance collaboration between governmental and non-governmental stakeholders

Governments, INGOs and CBOs have complementary and collaborative roles in supporting refugees during the COVID-19 pandemic. In the upcoming months, working together to address acute, survival-related material vulnerabilities through direct financial aid should be a major priority. In the longer term, with the presumed emergence of a COVID-19 vaccine, both can ensure that various refugee vulnerabilities will not act as a barrier to access, for example, in terms of formalizing the eligibility to receive it, subsidizing its cost, offering information about its risks and benefits and distributing it through appropriate channels. To improve support efforts during the COVID-19 pandemic, historical sociopolitical challenges in the operating conditions of INGOs and CBOs—such as non-transparent, bureaucratic funding conditions or politicized aid distribution—must be minimized to increase program effectiveness and encourage the increased participation of Syrian refugees in their design and execution.

6. Conclusion

Supported by an interdisciplinary conceptual framework, the study findings demonstrate how key stakeholders involved in COVID-19 responses might form a more comprehensive understanding of refugees' unique living conditions and the related obstacles they face in practicing standard protection measures. While our findings concentrate on aspects related to the refugee vulnerability experience as described in Lebanon and Turkey, they can be broadly applied to other vulnerable communities, in that they encourage practitioners to account for various dimensions of vulnerability that can have a practical influence on program applications. Ultimately, without specific measures geared towards addressing these specific dimensions of living, host governments, aid agencies and international organizations risk perpetuating not only pandemic disease, but endemic vulnerability in refugee communities in particular.

Declaration of Competing Interest

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

Credit authorship contribution statement

Dima Al Munajed: Conceptualization, interviewing, transcribing, writing

Elizabeth Ekren: Data organization, coding, writing, editing, formatting

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